Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 13 February 2014 at 6.30 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

Contact: Penelope Williams
Board Secretary
Direct : 020-8379- 4098
Tel: 020-8379-1000
Ext: 4098
Fax: 020-8379-3177 (DST)
Textphone: 020 8379 4419
E-mail: penelope.williams@enfield.gov.uk
Council website: www.enfield.gov.uk

Dear All

To Follow Papers

Please find attached the “to follow” Papers mentioned on the agenda for the next meeting of the Health and Wellbeing Board.

Item 5 Better Care Fund

Please bring these papers with you to the meeting.

Please note that a part 2 report will be circulated next week in relation to this matter.

If you have any queries about the meeting please contact me, details above.

Yours faithfully

Penelope Williams

Penelope Williams
Board Secretary

This page is intentionally left blank

Agenda Item 5

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **13 February 2013**	**Agenda - Part: 1** | **Item: 5** **Subject: Development of the local Better Care Fund Plan** **Wards:** all
Director of Health, Housing and Adult Social Care Contact officer and telephone number: Peppa Aubyn E mail: peppa.aubyn@enfield.gov.uk	**Cabinet Member consulted:** Cllr Don McGowan

1. EXECUTIVE SUMMARY

The Better Care Fund is the creation of a pooled budget made up of existing resources, for the integration of local health and care from 15/16. There is a requirement for the Council and CCG to develop a joint plan to further enhance the integration of Health and Social Care locally. Health and Wellbeing Boards have been asked to agree plans, monitor progress and implementation. 25% of the fund will be performance related and linked to outcomes achieved.

The local allocation for the Better Care Fund is **£20.585m** which includes £18.518 m revenue and £2.068 m capital committed expenditure, which is drawn from existing local authority and CCG budgets. Please note; that the majority of the fund is top sliced from CCG core funding, which is currently committed to the delivery of acute services. *Key Note: £5.146 m (25%) of the funding will be linked to outcomes achieved.*

The Better Care Fund (BCF) is a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities and deliver our vision. Accordingly, our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make.

The conditions associated with the Better Care Fund and its performance framework, have been set down as: -

- Plans to be agreed jointly
- Protecting social care services
- 7 day services to support discharge
- Data sharing
- Joint assessment and accountable lead professional
- Agreement on the consequential impact of changes in the acute sector

Other key themes associated with the conditions are; to Set out arrangements for redeployment of funding held back in event of outcomes not being delivered.

The performance framework for the fund and measures for the 'Payment for Performance' element of the BCF, are based upon the following outcomes:-

- admissions to residential and care homes;
- effectiveness of reablement;

- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

Much of the emphasis of the Better Care Fund conditions is focussed on developing integration models that are specifically aimed at hospital avoidance and reducing admissions to residential care for frail older people and those with dementia. These two groups are predominantly the largest consumers of health and social care services, and would therefore benefit more in terms of further integration between health and care. The Integration Working Group has considered the information in the JSNA and has recommended that a large proportion of the BCF is invested in targeted interventions that seek to reduce hospital admissions for older people and populations that are at greater risk of hospitals admission.

The vision, aims and objectives for the local joint BCF plan are aligned with the draft Health & Wellbeing Strategy, the CCG's 5-year plan and the Council's vision. Part 1 of the local draft BCF plan can be found at **ANNEX 1.**

The details of the BCF plan, that is due to be submitted in draft on the 14th of February 2014, are still being developed. The BCF is made up of existing funding that is already committed to the delivery of front line services. Considering this, there is a need to finely balance our ambition between; how investment is re-distributed in a way that does not destabilise the existing system but seeks to strive to deliver more innovative services at the right point to promote prevention, reablement and recovery – a population that is more confident to self-manage with minimal intervention.

Our vision locally for integration of health and social care is: *"The system responding as a whole with the right intervention at the right time"* and the means for delivering this vision is for our integrated health and care system will deliver flexible, multi-agency, and multi-disciplinary working, always led by the needs of local people and founded on a firm evidence base of what works and what does not. Our determination to be person-centred in everything we do means that services will be tailored to respond to individuals, providing the care people need and where and when they need it.

The Integration Working Group who are leading on development of the local BCF plan have recommended that we take a life course approach to implementing the integration agenda locally. By targeting key areas and stages of the life course pathway (i.e. childhood, adults of working age, promotion of health and wellbeing and older age) and by providing the "right intervention at the right time" in a personalised and proactive way, we will enable the population of Enfield to lead healthy lives that they are more in control of. The Integration working group have developed the following innovative programmes of transformational change that are focussed on prevention, early identification, community intervention, hospital avoidance, reablement/ recovery and independence; throughout the life course(Childhood to End of Life Care) :-

- **Older people** – focussed on those experiencing frailty and/or disability
- **Working age adults** – focussed on those with long term conditions
- **Health and wellbeing –** focussed on those experiencing mental health issues
- **Children –** focussed on those with health needs

This paper focuses on what the local allocation is and provides an update in terms of development of the local plan and timeline.

2. RECOMMENDATIONS

The Health and Wellbeing Board are asked:

i. Note the work of the Sub-Group and Steering Group and the 4 priority populations; and
ii. Endorse the draft Better Care Fund submission [attached at annex 1] to NHS England;
iii. Note the contents of the part 2 report; and
iv. to receive a further report on the final submission at your March meeting prior to submission.

3. BACKGROUND

3.1 This paper sets out to provide an overview of what is meant by integration when we are referring to health and care. It describes the conditions of the Better Care Fund and outlines the process for delivery of the local BCF plan within timelines set nationally. In terms of scene setting, this paper also highlights the challenges of the BCF and on balance, the opportunities that it creates.

3.2 The ambition of much Health and Social Care integrated working and commissioning is to shift the balance of resources from high cost secondary treatment and long term care to a focus on promotion of living healthy lives and well-being, and the extension of universal services away from high cost specialist services. This approach promotes quality of life and seeks people's engagement in their own community. To achieve these shifts we need to change the way services are commissioned, managed and delivered. It also requires redesigning roles, changing the workforce and shifting investment to deliver agreed outcomes for people that are focussed on preventative action. This builds on existing arrangements between health & care.

3.3 Our approach to securing value for money and achieving efficiencies while putting the needs of our population first has been challenging in the current economic climate and it will remain so. Enfield council despite having already saved £60 m over the last 3 years will need to save a further £60 m over the next 3 years. The CCG has indicated a projected £12 m savings each year which means that the CCG will need to save in the region of £36 m over the next 3 years. The further integration of Health and Care is viewed by many as the means to ensure the future viability of the health and care system. The system will need to respond as a whole to meet individual's needs 'at the right time with the right intervention'. This will secure better outcomes for our population; while delivering services in the most streamlined and efficient way possible. To facilitate this transformation, we will need to challenge the way we do things now, understand and acknowledge what we are doing well together and where we can improve, and seek to invest in our joint infrastructure to support the process of greater integration between health and care.

3.4 *Integrated care is not about structures, organisations or pathways, nor about the way services are commissioned or funded. It is about individuals and*

communities having a better experience of care and support, experiencing less inequality and achieving better outcomes.

3.5 Our vision locally for integration of health and social care is:

"The system responding as a whole with the right intervention at the right time"

Enfield has already embarked upon its journey towards the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to **'live longer, healthier, happier lives in Enfield'**.

Our Health and Wellbeing Strategy, sets out the following priorities.:

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

We welcome the Better Care Fund as a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities and deliver our vision. Accordingly our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make.

Our agreed delivery model across all areas is:

To invest in targeted community interventions and integrated 'first contacts' that offer preventative, personalised approaches to individuals that are at risk of crisis and / or hospitalisation. The 'first contact' will seek to offer holistic (health, care and support) assessments with the distinct purpose of working with the individual to understand individual life history, triggers and underlying issues that maybe contributing to the accumulation of difficulties managing daily living and increasing risk of vulnerabilities that lead to hospitalisation. The first contact will then work with the individual to apply the principles of recovery and re-ablement models to promote self-management, health and wellbeing. The groups we will be targeting experience "negative" symptoms that impair their motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking, etc) and place them at risk of serious self-neglect and if left unaddressed can led to hospitalisation or extended periods of treatment in costly specialist placements i.e. residential admissions.

Please refer to ANNEX 1 for further information on the local performance framework.

4. ABOUT THE BETTER CARE FUND (FORMERLY THE INTEGRATION TRANSFORMATION FUND):

4.1 The June 2013 Spending Round was challenging for health authorities and local government, handing reduced budgets at a time of significant demand pressures on services. The announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was viewed by many as a real positive. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". This funding is called the health and social care Better Care Fund (BCF). In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The message was clear that integration was viewed by many as a means to ensure the future viability of adult social care services and ensure that health services are more community focussed. The BCF does not come without its challenges. The BCF is made up of existing funding spread across health and care and is committed to the delivery of frontline services. Local Authorities and Clinical Commissioning Groups nationally are concerned that this is not new money so therefore presents a challenge to further enhancing the integration agenda locally. However, the Better Care Fund provides an opportunity to review the current health and care system and improve the lives of some of the most vulnerable people in our society, giving them control and placing them at the centre of their own care and support. In doing so we can provide them with better services and better quality of life. The fund will support the aim of providing people with the right care, in the right place at the right time, including through a significant expansion of care in community settings. This will build upon the work the CCG and local authority are already doing through jointly agreed priorities through the section 75 agreement, joint commissioning strategies and through the delivery of agreed objectives utilising the NHS Social Care Grant.

4.2 The local allocation for the BCF is **£20.585m** which includes £18.518 m revenue and £2.068 m capital committed expenditure. Costs and benefits modelling for expenditure of the BCF are currently being developed by the integration Working Group and finance teams from across the CCG and local authority. When this exercise is complete, it will produce an options appraisal that details how investment in integration in specific areas of the health and care system i.e. community intervention, prevention, reablement and recovery initiatives, will produce benefits in the medium and longer term that will benefit the whole health and care system by reducing acute and residential admissions and enabling vulnerable people to lead more healthy and independent lives in their own home and in the community.

4.3 The local allocation is made up of the following existing funding:

Total BCF			**£20.586m**
Total Capital			**£2.068m**
	Disabled Facilities Grant - programme commitments	£1.345m	
	Social Care Grant - Mental Health: Health & Wellbeing Centre	£0.723m	
Total Revenue			**£18.518m**
	Assumed Commitments: Care Purchasing already in Council MTFP (formerly NHS Social Care Fund), £4.5m in 2014/15 plus demand growth for 2015/16	£5.952m	
	Potential for consideration: LBE Enfield CCG	£12.566m	

Key Note: £5.146 m (25%) of the funding will be linked to outcomes achieved.

4.4. As the BCF includes NHS funding for carers' breaks and reablement, local plans will therefore need to demonstrate a continued focus on both these areas.

4.5 The Better Care funding will be pooled into a budget as from April 2015. The Better Care Fund guidance requires the Local Authority to manage the pooled fund. The BCF is subject to plans being agreed by local Health and Wellbeing Boards and signed off by CCGs and Council Leaders, and the Chair of the HWBB.

4.6 Draft Better Care Fund plans will need to be submitted to the NHS England by 14th of February 2014. The final plan that sets out Enfield's vision, objectives and planned changes for the next 3-5 years will need to be submitted on the 2nd of April 2014. In terms of conditions and expectations attached to the Better Care Fund, plans will need as a minimum to:

NATIONAL CONDITION	DEFINITION
Plans to be agreed jointly	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups.
Protecting social care services	Local areas must include an

	explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Dept. of Health guidance.
7 day services to support discharge	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement.
Data sharing	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information.
Joint assessment and accountable lead professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. in line with the Mandate requirements on achieving parity of esteem for mental health, plans should not have a negative impact on the level and quality of mental health services.

And consider the following:-

- Set out arrangements for redeployment of funding held back in event of outcomes not being delivered.

- In line with the Health and Social Care Act, that local plans have regard for the JSNA for their local population, and existing commissioning plans for both health and care, in how the funding is being used.

4.6 DCLG are currently identifying how the Disabled Facilities Grant element of the capital funding will be handled, taking account of local statutory duties.

4.7 The national performance metric (measures) for the fund are as follows:

• admissions to residential and care homes;

• effectiveness of reablement;

• delayed transfers of care;

• avoidable emergency admissions; and

• patient / service user experience.

4.8 The Better Care Fund Performance Framework has been developed as part of the national BCF requirement, following national guidance. Baseline and trajectories have been produced for the following recommended outcomes:

1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
3. Delayed transfers of care from hospital per 100,000 population
4. Avoidable emergency admissions (composite of four indicators) - historic data is not yet available at local authority level, and so CCG based data have been used as a proxy measure. NHS England will provide this data in January 2014.
5. Patient/service user experience (to be assigned locally)

Baseline level of performance is based on 2012-13 data. Trajectories have been calculated for 2014-15 and 2015-16 which reflect the growth in population, given current levels of intervention. For comparison, trajectories have also been presented to reflect the level of performance over time if current levels of intervention were not in place.

4.9 Enfield experienced an increase in population in excess of both London and national averages between 2001 and 2011 (census figures) with numbers increasing by 36, 300 over the 10 years. It is now the fourth largest London borough by population with the latest GLA estimates adding 10,500 additional people to the population between 2011 and 2014 (population now estimated at over 323,000). Within this population figure it is clear that there are more people with disabilities or long term conditions and they are living longer. The increase in longevity has not been accompanied by an increase in the number of healthy

years lived, however. This population growth together with an increase in the prevalence of ill health and disability will result in more people requiring access to health and social care services. Target trajectories were developed based on what we know about our capacity to provide services (based on historical finance/activity trend data and future trend information), the move towards a more preventative model of care and support and the increasing number of people who will need those services. There are two trajectories with the first looking at how we would perform with the current level of resource and model of care. The second trajectory line takes into account a funded increase in capacity and full roll out of new preventative models of service as defined by the priorities within the Better Care Fund Action Plan in order to manage the demographic pressures.

4.10 Further technical guidance will be released on the national metrics including the detailed definition, the source data underpinning the metric, the reporting schedule and the advice on the significance of ambition for improvement. It is vital that Enfield make early progress against the National conditions and the performance measures set out in the local plan. This is important, since some of the 'Payment by Performance' is linked to performance in 2014/15.

4.11 In addition to the five national metrics, Enfield will need to select one additional indicator that will contribute to the 'Payment by Performance' element of the BCF.

The Integration Working Group is recommending that the local performance outcome is "Estimated diagnosis rate for people with dementia". The Integration working group have selected this indicator as this is a condition that will affect a large proportion of the Enfield population and requires targeted interventions to enable people to lead independent and fulfilling lives in the community.

Please refer to ANNEX 2 for further information on the draft performance framework which continues to be subject to validation and conformation.

5. DEVELOPMENT AND DELIVERY OF THE LOCAL PLAN

5.1 NHS Enfield Clinical Commissioning Group (CCG) and Enfield Council has put in place processes and structures to develop the BCF plan under the auspices of the Health & Wellbeing Board (HWBB) governance structures with additional powers to allow internal reporting. Executive management from the CCG and Enfield Council have been working together to develop a shared vision, aims and objectives for further integration of health and care that will benefit the local community. The proposed vision is based on and aligned to the priorities set in the draft health and wellbeing strategy.

5.2. The Sub-Group and Working Group of the BCF are working to develop the BCF Plan for the approval of the Health and Wellbeing Board.

- The groups have been established by the Health and Wellbeing Board through the approval of their Terms of Reference at its meeting on the 12th December.
- The purpose and regularity of the BCF Sub-Group is to meet monthly to formally make recommendations to the Health and Wellbeing Board
- The BCF Working Group are to meet on a weekly basis to overview all of the development to the BCF.
- Additional meetings are currently being co-ordinated for the co-chairs of the BCF Sub and Working Group to meet with the main providers affected by the BCF

- The Co-Chair of both groups are CCG Chief officer, Liz Wise and LBE Director of HHASC Ray James

5.3 The BCF is viewed by the CCG and Enfield Council as a means to drive forward fast paced change to deliver the integration agenda and facilitate closer working between health and care. It is not without its challenges. The Partnership have openly acknowledged - in recent workshops - that the budgets that contribute towards the BCF pooled fund are already committed which means that there is a natural inclination to protect existing services and limits the ability to commit to new initiatives or 'doing things' radically differently. However, the Integration Working Group has been working together in partnership to challenge the way the current health and care system works locally and create a vision for integration for the future; that is balanced and takes into consideration existing arrangements but strives to implement integration that will benefit some of the most vulnerable people in the Enfield Community.

5.4 Commissoners from across the partnership (CCG and Enfield Council) agreed the following points to take the BCF Project forward locally:-

- Develop a shared understanding of the requirements and limitations of the BCF
- Be clear across organisations about the process required to access it
- Develop a shared vision and strategy for integrated care, which the BCF would support
- Engage the full range of stakeholders involved early on – including providers, members, clinicians, users and others
- Align and marry up change programmes and initiatives across the CCG and local authority (as well as with providers) so that resources could be deployed efficiently
- Recognition that the money for the BCF has already been allocated to existing services
- The role of the commissioners is to jointly define the problem / issue to be resolved
- In terms of a solution form should follow function, the focus is about outcomes in an organisationally agnostic way
- Providers need to be in the room as we define the use of the BCF
- The sustainability of providers needs to be considered and this includes looking at the impact of plans made by other commissioners on each provider
- Representatives from the local population (that reflects the different populations) must be a voice in the room
- Think of the BCF as a milestone for the medium term programme for integration

5.5 Enfield has already embarked upon its journey towards the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to **'live longer, healthier, happier lives in Enfield'**.

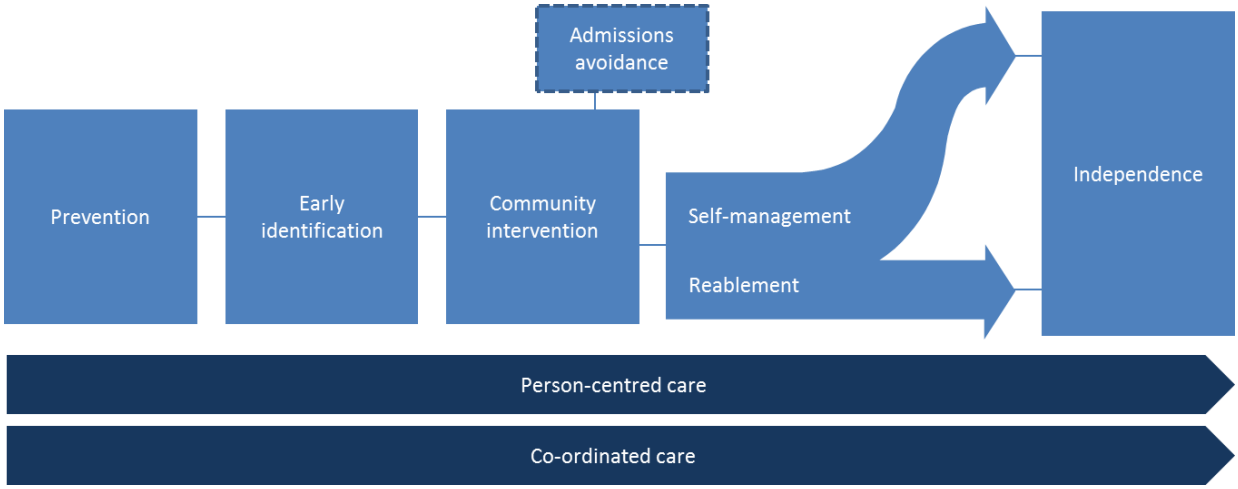
Our Health and Wellbeing Strategy, which is currently out for consultation, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

- Ensuring the best start in life
- Enabling people to be safe, independent, and well, and delivering high-quality health and care services

- Creating stronger, healthier communities
- Narrowing the gap in healthy life expectancy
- Promoting healthy lifestyles and healthy communities

5.6 We welcome the Better Care Fund as a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities. Accordingly our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make through reabling people after a health episode.

5,7 Our agreed delivery model across all areas is shown in the following diagram:



Co-ordinated and person-centred care underpins interventions at every stage.

Our integrated health and care system will deliver flexible, multi-agency, and multi-disciplinary working, always led by the needs of local people and founded on a firm evidence base of what works and what does not. Our determination to be person-centred in everything we do means that services will be tailored to respond to individuals, providing the care people need and where and when they need it. In Enfield's integrated system, people come before historic boundaries between organisations and their budgets.

5.8 Much of the plan is focussed on developing integration models that are specifically aimed at hospital avoidance for frail older people and those with dementia. These two groups are predominantly the largest consumers of health and social care services, and would therefore benefit more in terms of further integration between health and care. The Integration Working Group who are leading on development of the local BCF plan have recommended the following client groups and models of service are targeted with a view to developing innovative programmes of transformational change to the way health and care community services are delivered:-

Enfield BCF proposed population groups, initiatives and total resource

1. Proposed population group/ new programme heading	**5. Example initiatives being considered for BCF support –**	**6. Planned BCF investment in £m**
Older people – focussed on those experiencing frailty and/or disability	• Older People Assessment Unit [N.Mid/BCF] • Falls programme • End of life care • Tissue viability • Assistive technologies/Tele Health • Nursing beds capacity/Step down beds • Intermediate care/reablement support • Dementia support/memory clinic • Seven day working • Locality model support • Safeguarding and Quality – Nursing/SW/Quality checker volunteering • Carers support • Preventative services • Warm homes programme • Primary care implementation • Data sharing • Support to providers	**9.146**
Working age adults – focussed on those with long term conditions	• Outpatient avoidance • Wheelchair service • Personal health budgets • Alcohol interventions	**1.615**

Mental health	• IAPT extension • MH primary care model • RAID	**1.136**
Children with health needs	• Health and wellbeing networks • Early intervention in mental health support services • Post-transition/vulnerable young adult service	**0.525**

Detailed schemes and benefits proposed under each programme are provided in the part two report.

5.9 Interventions specifically targeted to support carers to continue in their caring role will be a key theme for the plan. Consideration is being given to carers breaks and enhanced services.

5.10 This report has set out the direction of travel in terms of how the local BCF plan is being developed. The final version of the recommended draft plan will be presented to the HWBB Board on the 13th of February 2014 for approval. This will then be submitted to the NHS England by 14th of February 2014. The BCF plan will continue to be developed by the Integration Working Group with a view to submitting the final plan on the 4th of April 2014.

5.11 As part of our development of integrated care over the past two years, we have held regular provider forums across commissions and client groups. Open days, including the CCG's Provider Day, bring together providers to discuss emerging trends in our population, as well as strategic and financial issues and commissioning intentions. The same is true in adult social care, where large events bring together providers from across the borough, alongside more specific client group activity. This is followed up with regular communication, including newsletters. Both the CCG and the Council have established a culture of open communication with our providers, including through one-to-one leadership sessions and our ongoing contract management and commissioner-provider relationships. For further detail on provider engagement please refer to the plan in ANNEX 1

6. ALTERNATIVE OPTIONS CONSIDERED

Do nothing – this is not a viable option and should not be considered. If we do not move forward and develop a plan with our health partners then we are unable to access the BCF.

7. REASONS FOR RECOMMENDATIONS

The development of the plan is a mechanism to access the Better Care Fund in order to develop closer integrated working between Health and Care. The HWBB is requested to note the activity reported in this paper and endorse the direction of travel in terms of developing the local BCF plan. The final version of the recommended draft plan will be presented to the HWBB Board on the 13th of February 2014 for approval. This will then be submitted to the Department of Health by 14th of February 2014. The BCF plan will continue to be developed by the Integration Working Group with a view to submitting the final plan on the 4th of April 2014.

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

8.1 Financial Implications

As part of the 2013 spending round, it was announced that £3.8bn would be placed in a pooled budget to create an Integration Transformation Fund – the Better Care Fund(BCF).

The new fund will be a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the CCG and LBE. To access the BCF local plans will need to be developed by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and locally agreed targets attached to the performance-related element of the funding will be met.

Plans for the use of the pooled monies will need to be developed jointly by NHS Enfield CCG and the local authority and signed off by each of these parties and Enfield's Health and Wellbeing Board.

It should also be noted that as detailed in Table 4, the fund consists of both existing resources being reallocated and additional NHS Social care grant funds. The actual allocation of the BCF for Enfield will be subject to both jointly agreed local plans and in some cases locally set outcome measures, i.e. 'Payments for Performance'.

8.2 Legal Implications

8.2.1 Section 195(1) of the Health and Social Care Act 2012 imposes a duty on a Health and Wellbeing Board to 'encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner' for the purpose of 'advancing the health and wellbeing of the people in its area'. There is also a power under section 195(4) for a Health and Wellbeing Board to 'encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.' The proposals set out in this report would appear to be covered by these provisions.

8.2.2 The legal mechanisms (such as section 75 agreements, etc.) for achieving the service delivery within the plan will be considered and approved by Legal Services, and will be in accordance with the Councils

Constitution (including procurement of any external services in accordance with Contract Procedure Rules).

9. KEY RISKS

9.1 As indicated above this is not new money and any plans for integration / re-design needs to carefully consider the impact on local services, especially acute.

9.2 £1bn of the funding will be linked to outcomes achieved. This represents a significant proportion of the BCF. It is unclear at present what the impact could be if localities under perform..

9.3 Please refer to **ANNEX 1** – point 2 of the BCF local plan for details of the 12 risks associated with the BCF plan. Risks have been broken down into 3 categories; these are: Overall risks, Change risks and Organisational risks.

10. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

10.1 Healthy Start – Improving Child Health
The main thrust of the BCF is to integrate health and care further which will have a positive impact on the whole health and care economy in Enfield.

10.2 Narrowing the Gap – reducing health inequalities
The BCF is a means to ensure closer working between health and care so that adults living in the Enfield community are offered a range of services to keep them well and healthy in their own home or in a community setting, including those with long term conditions.

10.3 Healthy Lifestyles/healthy choices
Further integration of health and care services will produce better outcomes for people living in the Enfield community. It will ensure that people are at the heart of decision making with health and care outcomes that are focused on keeping people healthy and well in the community. In particular, it asks that health and care services are co-ordinated around the individual.

10.4 Healthy Places
By working in partnership, the BCF will ensure that we make Enfield a healthier place and address health inequalities faced by our adults living in the community.

10.5 Strengthening partnerships and capacity
Development of the BCF is an opportunity for closer working between health and care. It calls for clear leadership, accountability and assurance so that the partnership works for the benefit of all adults. We are asked to commission and work in an integrated way. This will of course strengthen partnerships and capacity to deliver services that meet the need of our adults living in the community.

11. EQUALITIES IMPACT IMPLICATIONS

An Equalities Impact Assessment will be undertaken at the same time that the Integration Transformation Fund (BCF) plan is being developed Background Papers

12. PERFORMANCE MANAGEMENT IMPLICATIONS

12.1 As defined by the conditions of the BCF, we are developing a performance framework that is focussed on understanding our baseline in terms of key activity and developing an outcomes framework to focus activity that promotes choice, control, empowerment, reablement and independence.

ANNEX 1 – the local joint BCF plan - *draft*

The London Borough of Enfield and Enfield Clinical Commissioning Group Better Care Plan

Our approach to Better Care Planning

The London Borough of Enfield and Enfield CCG's Better Care Plan (BCP) is based on accelerating our progress to deliver the priorities and outcomes agreed by our Health and Wellbeing Board. This document has been prepared by the Borough and CCG. It should be considered a work in progress and forms the basis of our first initial February submission. We will be continuing to work together including as part of the national NHS strategic planning process, in line with national timescales.

We know we have challenges in what is a large and mixed London borough feeding several acute and provider trusts spanning CCG and borough boundaries. We are the fourth largest London borough and as our Joint Strategic Needs Assessment (JSNA) makes clear the numbers of residents is set to increase to 340,000 by 2032. We are home to a larger than average population of young people, but our older population is also set to increase dramatically to over 16.6% of our population by 2032. For these reasons, and because of our particular demographic pressures, our plan is targeted at improving outcomes across four population groups. These are the population groups around which our NHS and local authority planning is based, and we have used these groups in order to provide clarity across our commissioning intentions.

The population groups are:

1. Older people – focussed on those experiencing frailty and/or disability
2. Working age adults – focussed on those with long term conditions
3. Adults experiencing mental health issues
4. Children with health needs

We have agreed a common pathway approach across all of our population groups – which spans the full range of our ambition from prevention and early intervention right through to integrated pathways and support for people at home. Our pathway is backed up by the locality structure we have already developed with our Health and Wellbeing Board, providers and partners in response to the priorities they have helped us to shape. In doing so, we will address multiple issues, including accelerating our existing programme for integrating care for older people, investing in safeguarding and quality, supporting carers,

maximising the contribution of the third sector and building our infrastructure to support more integrated ways of working.

In this plan, we set out the shared vision and strategic agreement we have in place, our overall agreed model for delivering integrated care, the four programmes we will deliver based on our population groups and and the impact and benefits we expect to see. We describe our agreed vision for health and social care in Enfield and the locality based delivery model we will use to make our vision a reality.

Underpinning all of this work is our shared evidence base in the Joint Strategic Needs Assessment (JSNA), Joint Health and Wellbeing Strategy (JHWS), our commissioning frameworks and corporate plans. We have already committed to integrate our commissioning and pathways based around shared resources and plans.

Our plan is being underpinned by a shared draft action plan for delivering on the programmes of work we have identified and our benefit modelling so that we can ensure that the schemes of work deliver what is required. Our benefit modelling is based on a combination of managing increasing demographic demand, meeting productivity and efficiency savings, managing the number of people requiring services through early intervention and prevention, improving the impact of services by redesigning and respecifying them and driving through process savings in our current services and contracts. Our strong governance and accountability arrangements and the performance framework we have agreed will guide our appreciation of the progress we are making across the programmes and allow us to make adjustments as these are required.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Enfield**
Clinical Commissioning Groups	**Enfield Clinical Commissioning Group**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**13 February 2014**
Date submitted:	**14 February 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£18.518m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£18.518m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Enfield Clinical Commissioning Group
By	Alpesh Patel
Position	Chair
Date	13 February 2014

Signed on behalf of the Council	London Borough of Enfield
By	Councillor Doug Taylor
Position	Leader of the Council
Date	13 February 2014

Signed on behalf of the Health and	Enfield Health and Wellbeing Board

Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Donald McGowan
Date	13 February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Engagement of our service providers is key to how the CCG and Council are driving and sustaining the integration of health and social care, based on our jointly-agreed JSNA and the priorities and plans agreed by the Health and Wellbeing Board. We have well-established mechanisms for doing this, which have been extended in response to the specific opportunities presented by the Better Care Fund.

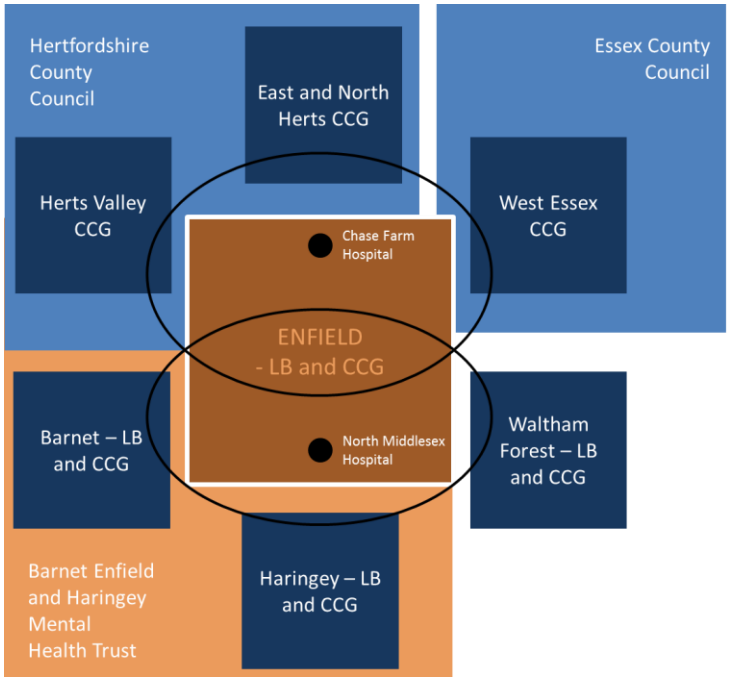
As part of our development of integrated care over the past two years, we have held regular provider forums across commissions and client groups. Open days, including the CCG's Provider Day, bring together providers to discuss emerging trends in our population, as well as strategic and financial issues and commissioning intentions. The same is true in adult social care, where large events bring together providers from across the borough, alongside more specific client group activity. This is followed up with regular communication, including newsletters. Both the CCG and the Council have established a culture of open communication with our providers, including through one-to-one leadership sessions and our ongoing contract management and commissioner-provider relationships.

We work hard to establish our engagement on the basis of partnership working and increasingly our engagement is joint enterprise between the CCG and Council. This has been true on our Better Care Fund plans in particular, about which we have held two group meetings with Enfield's acute, mental health, and community providers, including Barnet and Chase Farm Hospitals NHS Trust, North Middlesex University Hospital NHS Trust, Royal Free London NHS Foundation Trust, and Barnet Enfield and Haringey Mental Health NHS Trust. The first meeting, in November 2013, set out our strategic thinking in light of the BCF and the second meeting, in February 2014, described our emerging planning. We have made changes to our plan based on the providers' feedback and were pleased to note that our approach to engagement was highlighted by the King's Fund in a recent paper on this subject.

In addition to this provider engagement, because we understand that there will be cross-CCG implications arising from the BCF we are working actively with our neighbouring CCGs, including most specifically the CCGs that act as lead commissioners for our two main acute providers.

The geography of service provision around Enfield

The complex and interlocking geography of commissioners and providers is shown schematically in the diagram below.



In addition, to the network of commissioners and providers in health, we also have a diverse and rapidly changing market in adult social care. We have primary relationships with a small number of preferred domiciliary care providers and through our commissioning and brokerage relationships we also have preferred relationships and established quality standards with a number of residential care providers. Residential care provision in the Borough is not strong, but the commissioning mechanisms we have in place mean that we are able to communicate effectively and engage with our primary partners in the delivery of social care services.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The broader engagement that informs our Better Care Fund plan is grounded in the extensive work we conducted whilst developing our Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). This year's JSNA focussed on core themes relevant to this programme of work and the JHWS has been refreshed alongside the development of this plan.

The engagement on which the JSNA and JHWS are based includes:

- Partnership boards with service users and carer representatives from across all areas of our services;
- Ongoing activity through our customer network, which has a diverse community membership of over one hundred people actively influencing what we do;
- Specific and targeted consultation activities centred on the production of the JSNA and the JHWS, including questionnaires and public events; and
- Ongoing staff engagement events, which are key to developing the business plan priorities that emerge from our broader public engagement.

This long-standing public engagement means that our plan to integrate health and social care in Enfield is based on what we know about local needs, what local people have already told us is important to them, and what they think about our refreshed priorities in the JHWS.

In addition to this, through our work on Value Based Commissioning we have engaged with specific client groups to understand what is most important to them. This directly informs our commissioning planning and the dialogue we have with service users and patients, as well as providers. The client groups covered in this BCF plan have all been engage and include older people, adults with long-term conditions, adults with mental health issues, children with health needs, and carers.

Engagement with patients and the public has been complemented by a variety of other forums, including:

- Patient Participation Group representation on the CCG's governing body;
- The CCG's Patient and Public Engagement Committee
- User and carer representation at provider management meetings in adult social care;
- Healthwatch Enfield, along with community and voluntary organisations;
- Our Health and Wellbeing Board (HWB), at which we have used innovative means of seeking out and understanding people's priorities for us as commissioners, including recently a voting approach to understand the public's most important priorities in the JHWS.

We will continue our engagement across patients, service users, and the public as we further develop our integrated care system, always ensuring that our work is informed by the views of our local population. Updates on progress will be provided at HWB meetings, through the Council's decision-making process (including the Overview and Scrutiny Committee structure), at the CCG's public

governing body meetings, and through information posted on our websites and through social media.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Enfield JSNA	Setting out our changing demographic pressures and arranged according to a series of themes, in order to make it accessible. www.enfield.gov.uk/healthandwellbeing/info/3/joint_strategic_needs_assessment_jsna
Enfield JHWS (for link to consultation survey)	Setting out our agreed priorities for the area. www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy
Enfield CCG – Plan on a Page	Providing the basis for our strategic planning and work with neighbouring CCGs. www.enfieldccg.nhs.uk/Downloads/Policies/ECCG%20Plan%20FINAL%204%20280313.pdf
North Central London Primary Care Strategy	Setting out the acute commissioning landscape and changes agreed across Boroughs. www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf
Enfield's Joint Commissioning Strategy for End of Life Care 2012-16	Our priorities and plans for this important group. www.enfield.gov.uk/downloads/file/8457/enfields_joint_commissioning_strategy_for_end_of_life_care_2012-16
Enfield's Joint Stroke Strategy, 2011-2016	Explaining our priorities in this condition-specific area. www.enfield.gov.uk/downloads/download/2627/enfield_joint_stroke_strategy_2011-16
Enfield's Joint Dementia Strategy, 2011-2016	Setting out our initial plans for dementia sufferers in the Borough. http://www.enfield.gov.uk/downloads/download/1317/joint_dementia_strategy_2011__2016
Enfield's Joint Carers Strategy, 2013-2016	Explaining our joint plans for carers, working across health and social care. www.enfield.gov.uk/downloads/download/2429/enfield_joint_carers_strategy_2013-2016
Enfield's Joint Intermediate Care and Reablement Strategy, 2011-2014	This important strategy sets out our approach to increasing the numbers of people supported through our intermediate care work as well as continually improving outcomes as a result of our interventions. www.enfield.gov.uk/downloads/download/1319/joint_intermediate_care_and_re-ablement_strategy_2011-2014
Adult Social Care - Voluntary and Community	This document has been shaped by our partners in the voluntary and community sector and explains our plans

Sector Strategic Commissioning Framework 2013-2016	for supporting them to meet need in the community. www.enfield.gov.uk/downloads/file/8459/voluntary_and_community_sector_strategic_commissioning_framework_2013-2016

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

OUR VISION FOR HEALTH AND CARE IN ENFIELD

Enfield has already embarked upon its journey towards the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to 'live longer, healthier, happier lives in Enfield'.

Our Health and Wellbeing Strategy, which has been refreshed alongside the development of this plan, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

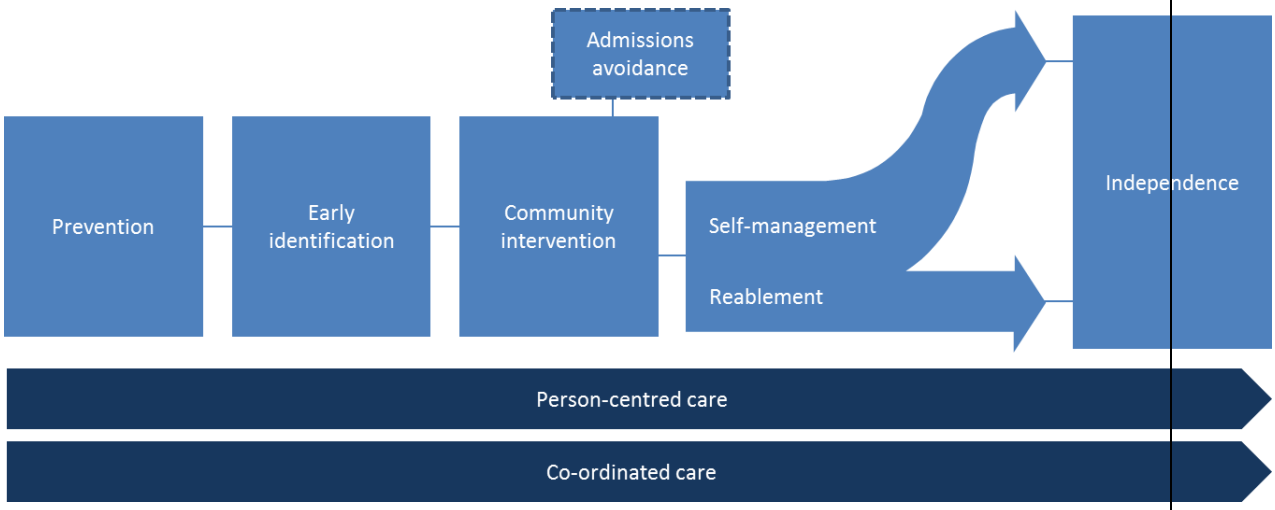
- Ensuring the best start in life – so that all children are able to realise their full potential, helped to be self-sufficient and part of a network of support that will enable them to live independent and healthy lives.
- Enabling people to be safe, independent, and well, and delivering high-quality health and care services – so that people of every age are able to live as full a life as possible, with health issues, both physical and mental, recognised as soon as possible.
- Creating stronger, healthier communities – with people living in stronger communities and able to contribute through meaningful employment, living in warm, clean, safe accommodation, supported by a strong network of family and friends and creating the resilience for residents to cope with adverse life events.
- Narrowing the gap in healthy life expectancy – by reducing the gap in life expectancy within the Borough by continuing to review and apply the evidence base on health inequalities, whilst working with communities to develop initiatives that will improve the health and wellbeing of local people through a series of short, medium, and long-term goals.
- Promoting healthy lifestyles and healthy communities – by helping residents to understand how their choices affect their health and wellbeing and supporting them to choose healthier options throughout their lives.

We welcome the Better Care Fund as a major opportunity to develop our work across the priorities contained within our Joint Health and Wellbeing Strategy. Accordingly, our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the

shift in resources we need to make through reabling people after a health episode.

Our agreed delivery model for integrated health and social care across all areas

Our agreed model is shown in the following diagram:



Co-ordinated and person-centred care underpins interventions at every point through the stages of care, starting with an emphasis on prevention and early identification. Providing both health and social care interventions in the community is a key part of our admissions avoidance strategy, which is designed to yield benefits related to both wellbeing and financial sustainability. Following up health and social care interventions with an emphasis on reablement and self-management is a key part of our objective of maximising the independence of all people within Enfield who have received health and social care interventions. In common with other areas, we are increasing focussing on enabling people – especially people with long term health conditions – to manage their conditions.

Our integrated health and care system will deliver flexible, multi-agency and multi-disciplinary working, always led by the needs of local people and founded on a firm evidence base of what works and what doesn't. Our determination to be person-centred in everything we do means that services will be tailored to respond to individuals, providing the care people need and where and when they need it. In Enfield's integrated system, people come before historic boundaries between organisations and their budgets.

In this plan, we set out how this overarching model will be increasingly applied to four specific population groups. These reflect the needs we have evidenced and discussed with our partners, as well as the significant opportunity the BCF provides to accelerate the delivery of our model.

The four population groups are:

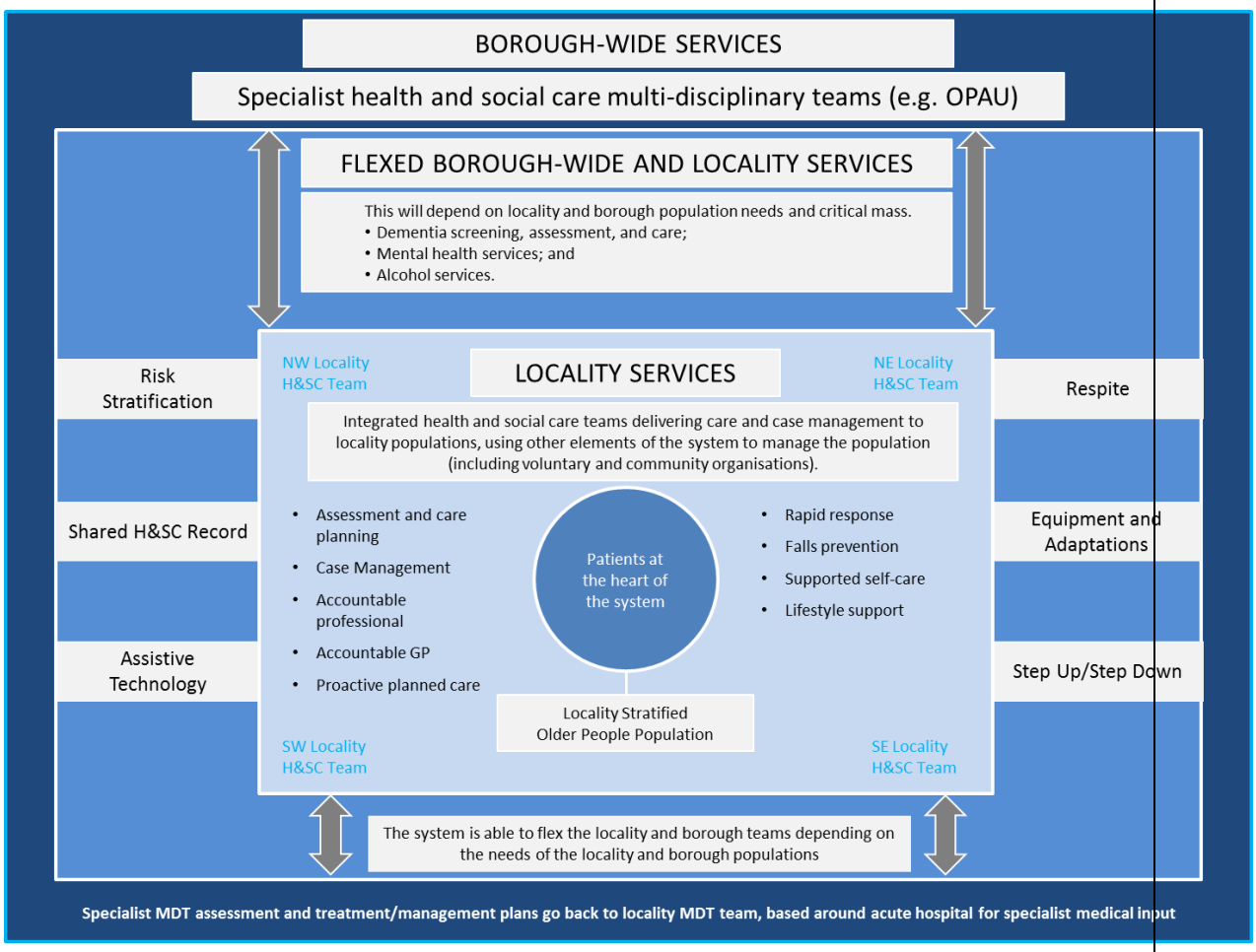
1. Older people – focussed on those experiencing frailty and/or disability
2. Working age adults – focussed on those with long term conditions

3. Adults experiencing mental health issues
4. Children with health needs

In all of these population groups and across our work, our services will be delivered through our locality based model.

Our agreed locality model across our population groups

The locality model is depicted in the following diagram:



Enfield CCG and LBE have been working with all our providers over the past year to develop our model of integrated care for older/ people. This model is currently being implemented but remains dynamic in terms of being able to adapt to necessary changes and pressures. All our models will be based on providers working together holistically and where relevant supporting MDT's either at a locality level or at a borough-wide level.

The above diagram aims to show the model of care for older people but can be applied across populations. The model shows that patients and service users are placed at the heart of the integrated health and social care system. They will interact with this system on three levels, working outwards from the middle of the diagram:

- Through services provided only through the localities, such as assessment

and care planning, case management and working with their accountable professional.

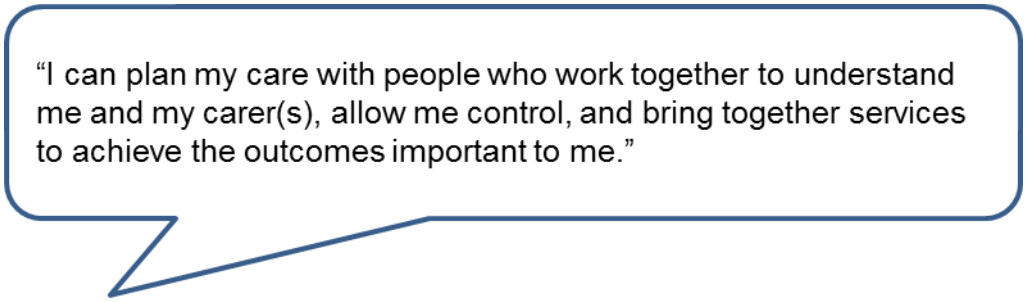
- Through services provided either through the localities or borough-wide – the system will be able to flex its locality and borough teams depending on the needs of the locality and the borough population.
- With services provided borough-wide, such as the Older Person's Assessment Units and specialist MDTs, recognising the interventions that specialists may need to make.

The system is support by our risk stratification model, assistive technology and a shared health and social care record.

Our ambition is that this model will be developed for all client groups, across both health and social care. This will drive the achievement of an integrated care system that is:

- person-centred, focussed on 'the outcomes I want to achieve'.
- more connected.
- more targeted.
- delivered through our localities.
- flexible and evidence-based.
- based on multi-disciplinary working.
- supportive to carers.
- promotes social inclusion and independence.
- focussed on prevention, early intervention, patient self-management and minimising unnecessary hospital admission.

Our focus on delivering person-centred services in particular means that every person in Enfield should be able to say,



As National Voices makes clear, this is founded on care planning, joint decision making, access to information, communication, the prioritisation of personal goals and outcomes, and effective transitions. These are all integral to our vision of integrated care and will enable us to provide care that is preventive, proactive, planned and personalised.

We will also encourage local people to take a more active role in their own and others' health, thereby extending the strengthened partnership between the CCG and Council to our local communities and involving local residents as active patients and service users. This is a core theme and priority in the way we deliver our model.

Together, the CCG and Council have identified four programmes based on our population groups that, with funding from our BCF, will drive forward our integration agenda through our locality model. These are listed below. They

have been discussed and agreed at the Health and Wellbeing Board and reflect discussions we have had with our providers: both will continue to be involved in ongoing discussions about prioritisation and timeframes as we work up our final submission. This will take place in addition to the governance arrangements detailed below. The tables in the following two sections detail the aims and objectives of each programme and describe our planned changes in each area.

A summary of our vision in the four population groups highlighted in our BCF plan

No.	Our population based programme in..	Enabling us to..
1.	**Older people – focussed on those experiencing frailty and/or disability**	Accelerate the work of our established Integrated Care for Older People program with rapid assessment through our Older People's Assessment Units (OPAUs), and more integrated support at every stage of care pathway
2.	**Working age adults – focussed on those with long term conditions**	Provide enhanced, integrated intervention acute and primary care settings to avoid t need for work in outpatients
3.	**Adults experiencing mental health issues**	Expand our rapid intervention model for o people experiencing dementia and expan our mental health care model
4.	**Children with health needs**	Enhance our health and wellbeing networ and provide better early intervention in psychosis and better post-transition supp vulnerable young adults.

The specific changes driven by these programmes will be achieved in part by working with our providers in a new way, facilitating and incentivising them to work collaboratively as a single system. We have already started this work, in part through the ongoing work within the programmes themselves and in part through the initiative of our providers for this better care fund. We will work together to incentivise them to deliver the outcomes desired by people in our Borough. This represents a major shift away from the historic focus on single-agency activity, input and process-led measures.

Our implementation of this new system will also successfully manage demand for unscheduled care, which is a major expense within our local economy. It will do this as a result of the identification of need, with necessary interventions, before a person enters a crisis. This, in turn, provides a whole-system efficiency across

health and social care and further assists both the CCG and the Council as we continue to shift the balance of resources from high-cost secondary treatment and long-term care to a focus on the promotion of living healthy lives and a picture of continually improving wellbeing.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

A number of core aims and objectives underpin our vision for integrated care in Enfield and drive the four programmes covered by our BCF plan. The aims and objectives underpinning our vision are:

- Eradicating fragmentation and silo working across health and social care.
- Ensuring that every part of the system is working effectively.
- Maximising health and wellbeing outcomes from the available resources.
- Minimising health and wellbeing inequalities across our borough.
- Improving the ability of the local population to make lifestyle choices that reduce future demand for health and social services.
- Improving the capacity of the local population to self-care, especially for minor ailments and long-term conditions.
- Avoiding unnecessary admissions to hospitals and care homes.
- Ensuring that nobody stays in a hospital or care home longer than they need to.
- Maximising the knowledge and skills of all staff, which underpins the achievement of all other objectives.

The aims and objectives of the four programmes covered by Enfield's BCF

This table sets out in more detail the aims and objectives of the four programmes that drive our integrated care programme.

Programme		Aims and Objectives
1.	**Older people –**	The aims of Enfield's integrated care system for older peop

	focussed on those experiencing frailty and/or disability	are to: 1. Assess, plan and provide appropriate, early prevention-focussed interventions to enable Enfield's older people to avoid a health and/or social care crisis, or to be quickly stabilised following a crisis. 2. Make the patient narrative on what's important to them a critical part of care planning and to actively engage patients (and their carers) in decisions about what care they may receive. 3. Ensure that all elements of the system act together to provide care delivered in the most appropriate setting for the patient and their needs and circumstances, and, where possible, closer to patients' homes and/or in a community setting. 4. Manage activity and cost across health and social care such that no unnecessary activity and costs are incurred within the system and thereby support its long-term sustainability.
	Older people – focussed on those experiencing frailty and/or disability (continued)	We anticipate that the key health gains for older people will be two-fold: 1. **A reduction in unnecessary admissions to hospital as a result of more preventative and planned care.** There was an 8% increase in acute sector costs in Enfield over the last three financial years, over 80% of which were attributable to those aged over 75. An audit of these additional admissions suggested that many could have been proactively managed in the community. A direct gain of the integrated care system is therefore associated with demand management in reducing unnecessary admission to hospital as a result of more preventative and planned care. Similarly, there should be a reduction in the number of people presenting to the Council at a crisis point and therefore needing intensive social care, including admission to care homes. Instead, cases will be identified at a more preventative stage and/or earlier – and be less expensive to treat. 2. **Improved self-management.** This is an indirect gain arising from patients and their families being equal partners in the planning and management of care, which will help them better self-manage their conditions and circumstances. For example, there is evidence nationally that assistive technology initiatives produce a health gain in terms of reduced health interventions, such as admissions to hospital. Four key parts of this approach – which span all of our population groups but are particularly important in this one – are: 1. **Our approach to safeguarding and quality in everything we and our providers do.** A core objective

	Older people – focussed on those experiencing frailty and/or disability (continued)	underpinning all of our health and social care services is that they deliver quality outcomes and safeguard the health, safety and wellbeing of the most vulnerable members of our community. We aim to deliver this by boosting various elements of our safeguarding capacity as well as through our Quality Checker Volunteering Programme, which provides key community intelligence and engagement. 2. **Improving our approach to the way we support carers.** Across all of our patient and service user groups, a major issue is the health and wellbeing of carers – the 30,000 carers who save our local economy the equivalent of £572.7m per annum by delivering unpaid care. There is a particular need for improved support for carers and, most importantly, respite breaks. By providing increased support to carers, we aim to see improved health and wellbeing outcomes for patients and recipients of care, improved health and wellbeing outcomes for carers (who suffer a disproportionally high level of ill health) and reductions in unwanted admissions, readmissions, delayed discharges in hospital settings, unwanted residential care admissions and lengthier periods of stay in settings. 3. **Working more closely with our Voluntary and Community sector partners.** Our Joint Strategic Framework, which was developed in collaboration with stakeholders from this sector, makes clear our aim to work in partnership with voluntary and community sector organisations. The objective of this is to complement statutory provision and enhance the range of quality services and supports that are available to meet community care needs. We see the BCF as an opportunity to accelerate our work in this area and, in particular, our aim to develop voluntary and community services that support existing work to delay and, where possible, to prevent hospital admissions and requirements for social care services. Incorporating these organisations more deeply into our ongoing work in this area will increase the capacity, capability and flexibility with which we can achieve this. 4. **Investing in our infrastructure to support integrated care.** We recognise that this is a key challenge and that changes will not be introduced without us doing more on the business systems and commissioning processes which are required to make this our new way of working. We aim to deliver effectively integrated services supported by infrastructure that is fit for purpose. We define this as meaning that the infrastructure supports our staff to deliver the outcomes our patients and service users desire. This means that our ability to deliver the patient outcomes that are at the heart of how we work with our population groups

		must not be compromised by systems and process issues. It is for this reason that we have made infrastructure a key element of our planning, with dedicated funding.
2.	**Working age adults – focussed on those with long term conditions** **Working age adults – focussed on those with long term conditions – continued**	The key objective of work with adults with long-term conditions is to enable them to develop their capacity to self-manage their conditions. Although this is our overriding aim across our population groups, this is especially important in this one. The aim of our programme here is both to normalise a greater semblance of wellbeing for patients and reduce the frequency with which they require outpatient and/or specialist interventions. This is in line with our broader objective to limit attendance in secondary care only to cases where this is clinically necessary. Where adults have multiple long-term conditions, our integrated care programme aims to provide them with flexible and multi-disciplinary teams that focus their care around the needs of the individual, co-ordinated through an active case management approach. There are two key targets for this approach through the BCF. They are: 1. **Our work with people experiencing issues with alcohol.** Our alcohol strategy aims to turnaround the health and wellbeing outcomes of the 3,648 people in our Borough who are dependent on alcohol through a range of brief interventions. Using the BCF as an enabler for this, we will target our work on high-risk individuals through brief interventions in primary and acute care. We will reduce the number of alcohol-related admissions to primary and secondary care, which currently has an associated cost of £6.57m in our local health and social care economy. 2. **The support we currently provide to adults through our s.75 agreement.** We fund a range of interventions for adults of working age through our agreement, and we plan to use the BCF to review and refine the support we provide through this fund. This will bring together the work we do as individual organisations as well as our commissioning work in condition specific groups including strokes, heart conditions and other public health related factors such as chronic pulmonary disorders (CPD). We recognise the significance getting this right will have on our residents' outcomes as well as the effectiveness and sustainability of the services we commission.
3.	**Adults experiencing mental health issues**	We are currently consulting our shared vision and joint commissioning strategy for adults requiring mental health treatment and support: in addition to the need we are experiencing in this area, the BCF provides another enabler for us to do this. Our shared vision is a focus on the quality of and access to integrated services, recovery and outcomes, delivered through effective partnerships. Through this programme we aim to:

	Adults experiencing mental health issues – continued	• Support patients and service users to find meaningful occupation or employment, maintain their income and develop meaningful relationships. • Increase the community presence of our services for adults with mental health problems. • Reduce the stigma and discrimination associated with mental health conditions, by, for example, increasingly working with our voluntary and community sector partners. • To tackle current challenges in local mental health services by putting patients and service users at the heart of the services they receive – this objective will be achieved by prioritising the outcomes that patients and service users have told us they value. • Support carers in providing effective care and maintaining their own health and wellbeing. Our work on value based commissioning with CCGs across North Central London has shown that the outcomes prioritised by patients and service users include: • Coping with adversity. • The ability to take care. • Psycho-education. • Timely and responsive services. • Continuity of care. • Autonomy. • Physical health. Our mental health programme will deliver these and relevant patient outcomes through effective incentivisation of our providers delivering services.
4.	**Children with health needs**	The core objective of our broader programme of work for children with health needs is to deliver high-quality and integrated paediatric care with more community-based care options, designed to improve the experience and outcomes of children who are ill. Our aims cover five main headings: 1. **Heath improvement**: There are a number of multi-agency plans in place aimed at reducing infant mortality, obesity, and teenage pregnancy and increasing immunisation uptake and early access to maternity services. These reflect our commissioning priorities for 2013/18. 2. **Early identification and intervention and building resilience**: Our aim is to ensure that services are better co-ordinated by using a 'team around the child' approach. Core services will be evidence-based and available to all. Through the Building Resilience strategy, priority is given to prevention and early intervention, with greater targeting and concentration of resources towards those children and

	Children with health needs – continued	families who are most vulnerable and most at risk. 3. **Primary Care:** We aim for an integrated provider or an integrated network of providers to support providing primary care practitioners with the opportunity to maintain the skills and competencies required in the assessment of acutely or critically ill children. 4. **Community-based specialist child health services**: We aim that specialist community health services provide as much care as possible in the child or young person's home, children's centres, schools and special schools, with specialist assessment and treatment centres available when required. 5. **Hospital provision**: We are reviewing the role of the district hospital on an ongoing basis with the objective that hospital-based services will increasingly be for specialist and tertiary services only. Another key objective for children and young people is that fewer people aged under 19 will be admitted to hospital for conditions such as asthma, diabetes, epilepsy and lower respiratory tract infections, as a result of better care in primary and community services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

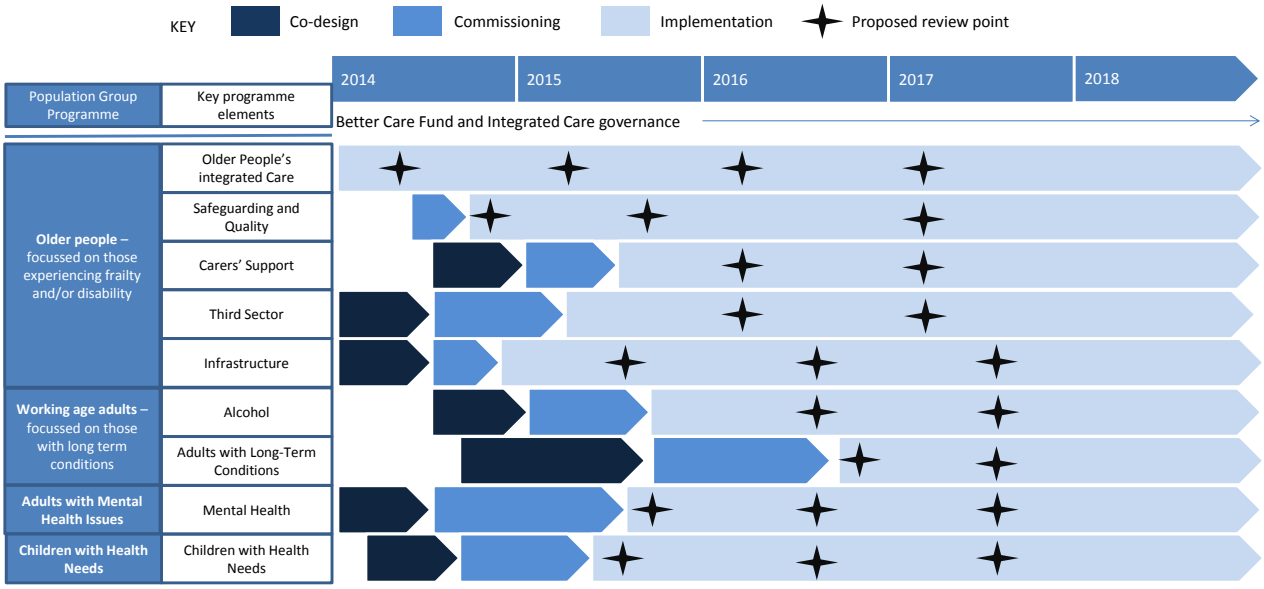
We will deploy our established partnership governance structures and processes, which cover all aspects of the commissioning cycle from the JSNA to individual commissioning plans and delivery networks, to ensure delivery of our integrated care programme in accordance with the key success factors set for each of our programmes. These in turn will form the key driving force for our wider commissioning activity, working as partners with our providers. Our performance management framework will allow us proactively to measure the impact of our programmes as well as the integrated care programme as a whole, supporting the achievement of both the outcomes desired by the people of Enfield and the financial benefits that we need to see and anticipate being realised.

By bringing together the CCG and Council, along with other partners and stakeholders where necessary, these structures will also be the means by which we ensure the alignment of all the activity covered by our Better Care Fund programmes. This includes ensuring that they remain rooted in our evolving JSNA and JHWS, the CCG's commissioning plans and the Council's plans corporately and for social care.

How we will deliver our BCF programmes

The diagram below shows at a high level how we will implement the four programmes we have identified in this BCF plan. We have not attempted to show the work we have undertaken so far in all of these areas but rather how we will phase our work and activity

following the completion of this BCF plan. It should be noted that the programmes are at different levels of development and implementation with the programme for older people by far the most developed with implementation proceeding.



Some of the important factors to note include the following:

- We have set deliberately ambitious timeframes for delivery but tried to focus our early work on where our benefits modelling and the available evidence and research tells us we should have most impact on quality and budgets most quickly. Our work on the older people's integrated care programme is already in train and beginning to deliver results. As the diagram below shows, following agreement to this plan we will instigate a review of this programme to identify what is working and what isn't, and where we can take action to accelerate improved outcomes more quickly.
- We have built in regular review points, and our reviews will be tied into our governance of the BCF. As the diagram shows, we have identified review points which allow us to take stock of progress so far, take place at the beginning of major commissioning activity and happen at least annually thereafter. We have also factored into our thinking national events, including the development of the CQC's inspection framework for adult social care and developments in their role which will come forward in the Health and Social Care Bill and associated regulations. We understand that this will have an impact on our work in safeguarding and quality, for example, as national and local responsibilities are defined in more detail in adult social care in particular.
- We are conscious of the timescales for the delivery of this work and the performance improvements we need to see in 2015/16 in particular, but we are also mindful that some of this work – particularly changing our whole approach to elderly care – is going to take us the full 5 years specified by this plan to fully embed. We see the delivery of our vision and aims as a continuous and iterative process, with adjustments being made on a regular basis. This means that the timeframes for delivery are ambitious and we have not specified end points for our work in the diagram below.
- We will ensure that other related activity aligns through our governance

arrangements, which are set out later in this plan, but we will also ensure alignment through regular and meaningful communication, especially with our providers, which has been assisted by the development of this Plan. We have been very fortunate to have had great support for our planning from our acute provider partners in particular and they have committed to working alongside us to implement our vision and to meet the challenges we all face as health and social care system leaders.

Description of planned changes

We believe that success will be more likely if we are clear up front about what we are looking to do and when. Although this is a draft plan and sets out our thinking at this stage (before more detailed discussions take place between now and April), this planning process has enabled us to be quite clear about what we expect to see in each of the four areas we have highlighted.

This table below outlines specific changes planned under each of the programme headings.

Programme		Description of Planned Changes
1.	**Older people – focussed on those experiencing frailty and/or disability**	The Better Care Fund will enable the integrated care model to become embedded in our health and care system. **The key changes will include:** • Overall we are trying to design a new care system for older people bringing together as much of the evidenced based initiatives as possible to create a system that works far better for older people and where providers accept collective responsibility for the outcomes for our older people. What is presented below are the elements of that new system which are in varying stages of implementation. • Access to well-trained and fully-informed GPs in primary care as the key gateway to early diagnosis and interventions, including in ensuring the cases of patients are managed, as far as possible, outside of an acute setting and delivering care closer to home. • Risk stratification supporting the identification of those people at particular risk of unnecessary hospitalisation and crisis. GPs and other lead professionals will be supported in assessing, planning and managing these cases through development of multi-agency and multi-disciplinary locality-based teams comprising of district and specialist community nursing, social care professionals, as well as input from clinical staff in secondary care, e.g. consultant geriatrician as part of planned or urgent care for individuals at risk. These are currently being developed • Access to specialist, consultant-led but multi-disciplinary and multi-agency Assessment Units, which provide planned assessment, diagnoses, treatment and health and social care interventions as part of a pathway available to the lead

	Older people – focussed on those experiencing frailty and/or disability – continued	professional in primary care to support those at risk. A similar "dementia hub" will be developed with the same function for this condition, and this relates directly to the priority we are setting on dementia support and the local measure we have identified for the BCF. Both Older People Assessment Units are now operational. • Improved access to intermediate care and reablement services and continuing health care to avoid hospital admission or to facilitate hospital discharge as part of these pathways, with an emphasis on developing increased capacity of different forms of intermediate care tailored to differing needs learning from best practice elsewhere, e.g. better support in hospitals for those with dementia to reduce lengths of stay, extended community-based "active convalescence beds" to support frail elderly people with a view to returning home, alongside shorter-stay "step-down"; models and turnaround services to prevent subsequent hospitalisation and admission to care homes. We have expanded enablement as part of the new system. • Re-design of hospital discharge planning to ensure it is better coordinated and supported across care professionals learning from best practice elsewhere and this planning, and the solutions to support it, consistently incorporate post-discharge planning, reducing the risk of hospital re-admission or admission to care homes so they can continue to live at home. • These solutions will be augmented through the deployment of assistive technology, including telecare and telehealth known to be under-utilised in Enfield, to ensure that people are as safe, healthy and live with the condition as independently and effectively as possible and an appropriate planned or urgent response is available to support people to live at home (avoiding inappropriate hospital admission). We are currently piloting this to inform the new system. • Building on progress in developing person-centred solutions across health and social care, e.g. personal budgets, solutions will be delivered and tailored to best support individuals and their families to live as well, healthily and independently as possible in the way they want. This will include, for example, further development of personal health budgets and a greater range of specialist personal assistant options so people can exercise as much choice and control as possible; as well as jointly delivered routine and urgent care support tailored to individuals, including to those with dementia, to support individuals at home for as long as possible. • Building on progress so far in the End of Life Strategy, the need to ensure older people with terminal conditions consistently have access to specialist and joint palliative

	Older people – focussed on those experiencing frailty and/or disability – continued	care solutions, which will lead to more people having advanced care planning and dying in a place of their choosing (often at home). • Building on plans in Enfield's Joint Carers' Strategy, the need to ensure carers and their needs are recognised and supported not just in continuing and managing their caring role (including managing their own health needs), but in having a life of their own. • The above solutions will be under-pinned through well-governed and appropriately accessible shared information about the patient through e-shared records which will track them through their access across the health and social care system as part of their pathway. • These solutions include a key role for the voluntary sector in providing information, advice and support alongside health and social care professionals to enable people and families to achieve the outcomes important to them. This includes in locality-based working within community and primary care settings (particularly preventative targeting of those most at risk during the winter months), facilitating hospital discharge ("hospital to home") and developing person-based solutions tailored to them to improve their health, mental or physical well-being and independence. Through the Better Care Fund we will work towards the delivery of these changes including in the following specific areas: • The continued operation of the Older People's Assessment Units at the North Middlesex and Barnet and Chase Farm. • The provision of additional step-down beds to reduce blockages in acute hospital beds and counter the recent increase in delayed discharges. • The provision of much-needed capacity in nursing beds for social care and continuing care, particularly around dementia care. • The further development of seven-day working practices to improve response to what would traditionally be considered out-of-hours cases, enabling a more timely and proactive interventions to reduce use of crisis situations and reduce unplanned hospital admissions. • A comprehensive falls programme. • An enhanced tissue viability service. • Dementia Friendly Communities and memory clinics, supporting people who suffer from dementia and their families to improve quality of life and inclusion in the community. • Specialist dementia nursing capacity.

		Key system changes will include: 1. **Changes in our approach to safeguarding and quality –** including the supporting of quality assurance through the Enfield Quality Checker Volunteer Programme, which currently has over fifty members, an additional safeguarding nurse assessor, who will provide additional capacity and vital assurance on safeguarding issues, further support for the costs of adults safeguarding and additional safeguarding capacity through additional social workers. 2. **An increased number of carers supported by us** – reaching out to more carers by listing more on the carers' register and providing additional capacity for carers' respite breaks, in addition to the current base contract. 3. **More funding for voluntary and community sector services that prevent ill health and hospital admissions –** including working towards reducing winter deaths through the Enfield Warm Households Programme. 4. **A more robust infrastructure and better investment in integrated care** – including funding for programme management to implement the Primary Care Strategy (with a focus on changes to GP's premises), funding for data and analytics support and fund management and funding to prepare the acute sector for a shift in resources to community based services .
2.	**Working age adults – focussed on those with long term conditions**	The two key focusses of our activity in this area are on the prevention of escalating issues in alcohol misuse and support to help people manage their long term conditions. Key changes will include: 1. **In alcohol services** – a reduction in alcohol-related admissions to secondary care through brief interventions in both the primary and acute sectors, with an associated reduction in the financial cost of treatment. Programmes of interventions will be delivered by substance misuse liaison nurses – the nurses will also co-ordinate activity between primary and secondary care. 2. **In long term condition management** – we aim to develop a new system for people with long term conditions focused on MDts within localities which deliver as much a care and case management as possible without the requirement for hospital care. The system will work across prevention model through to end of life care and maximise self-management. This will build on the redesign already underway, more

		outpatient admissions will be avoided through the deployment of personal health and social care budgets, contributing towards better outcomes for people, such as living independently at home with maximum choice and control; and, more efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, and at the right time; and improved access to, and experience of, health and social care services. In addition to this, we will improve people's access to the vital aids, adaptations and equipment required to live independently and well. One specific change we will make is the movement of wheelchair services to ICES (Integrated Community Equipment Service). This move will also generate economies of scale across the health and social care economy.
3.	**Adults experiencing mental health issues**	The Better Care Fund will be used to support three specific elements of our new system approach to mental health: 1. **Supporting our RAID (Rapid Assessment Intervention Discharge) model**, the benefits of which include reduced admission rates to inpatient beds, lengths of hospital stay, and readmission rates to hospital for adults and older people; 2. **The continuation and extension of IAPT**, including targeting older people – this will provide more people with psychological therapies to support them in the community and thereby avoid hospital admissions. 3. **Developing our local primary care mental health model**, providing robust community support options for people with mental ill health and services that are more accessible, thereby reducing inpatient admissions. More broadly, our new system approach to mental health involves a number of elements: • More involvement of the service user and carer (where appropriate) in the delivery of care, including the development of personalised care plans for each service user and bringing relevant individuals agencies together to deliver an effective, seamless package of care. • Better integration of care and services within and across agencies through the development of integrated care pathways and integrated whole systems of care for adults of all ages, whether they have an organic or non-organic illness or a common mental health problem or serious mental illness. • The development of a community- and primary care-based mental health services model aimed at enabling individuals who do not need access to specialist mental health treatment to be supported effectively. This will

		build on the GP locality networking model, which aims to deliver a multi-agency approach to support in the community thorough an approach that brings voluntary and community sectors and specialist services into an effective network of treatment and support 24/7. • The establishment of an effective model of psychiatric liaison in the North Middlesex University Hospital, operating 24/7 and based on the RAID model. This will be linked to an integrated community-based system of care and ensure a timely and appropriate response to adults of all ages presenting with both an organic or non-organic illness, thereby avoiding preventable admissions and re-admissions. • Ensuring that the needs of adults with either and/or autism, drug and alcohol problems and forensic needs are met in a co-ordinated way. This will include ensuring that practitioners with the appropriate skills come together to work with the service user and his/her carer where appropriate, to understand and plan to meet those needs. • A cultural shift in the delivery of treatment and support that puts the service user, and carers where appropriate, in the driving seat when it comes to determining outcomes. This will be achieved through a focus on easily accessible, personalised and recovery-orientated care that is focussed on delivering positive experience and outcomes for individuals; and A number of tools, including multi-agency and stakeholder work to develop integrated care pathways, will be used to deliver better co-ordinated care that is more accessible and available earlier in the course of the illness.
4.	**Children with Health Needs**	The BCF will deliver the following changes in the way we work: • **Child Health and Wellbeing Networks** will deliver improved and more integrated paediatric care with more community-based care options, as well as improved early identification and disease management. A key benefit here is a reduction in paediatric admissions for asthma and other ambulatory care sensitive conditions. • **Enhanced early intervention in psychosis service**, which will improve the experience for children and young adults experiencing psychosis thanks to more community-based care options and fewer inpatient admissions. • A post-transition/vulnerable young adult service, which will ensure a smooth transition from children's to adults' services with better continuity of care and improved experience of support services.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

We are currently working through the implications for our acute sector partners and plan to do this with them as far as we can: we shared our initial understanding of the plans in early February as part of preparing this plan and have agreed to do more of this in future. The savings required to deliver the Better Care Fund will come significantly from our two acute main providers, which are North Middlesex Hospital and Barnet and Chase Farm Hospital. Enfield CCG's investment in the two organisations is £66.7m and £79.3m respectively. It is unlikely that any savings can be delivered via our community or mental health contracts, although we are looking at how we achieve greater productivity through those contracts. Both BCF and NMUH will be affected by other commissioners and we are currently working across the five CCGs of North Central London to understand the total impact on our acute providers.

Enfield CCG met with all its providers (BCF, NMUH and BEHMHT) to discuss the high-level impact of the Better Care Fund. A further meeting took place in February 2014 prior to submission of the plan. Further discussion will take place via CE-to-CE as well as through any acute-focused Transformation Boards and via the development of the North Central London Strategic Plan. Detailed activity and financial modelling will be undertaken to determine the impact for Trusts across NCL including specialty level impact. There will need to be a staged approach to the reduction of acute activity and funding with the acute providers in order to mitigate the risk of any potential destabilisation.

The realisation of savings will be delivered by the redesign of systems relating to the agreed transformation programmes and some of this activity reduction has already begun this year via the integrated care for older people programme and emergency admissions. Where savings are realised then service delivery and quality will be maintained or improved through those new systems being operational. Where savings are not realised then there will be high levels of unfunded activity at both our acute providers which may cause destabilisation to both providers and the CCG. In addition, this is likely to impact negatively on our key performance indicators including NHS Constitution, RTT, A&E Emergency Admissions and Ambulatory care.

d) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Enfield Health and Wellbeing Board has established a group called the Integration Transformation Fund Sub Working Group ('BCF Working Group'). This group is responsible for overseeing and governing the progress and outcomes associated with our Better Care Fund plan. It comprises senior offices from both Enfield CCG and the London Borough of Enfield; additional members may be appointed to the Board by the agreement of all current members prior to approval by the Health and Wellbeing Board.

Sign-off arrangements are in place with the Enfield Health and Wellbeing Board. The working group will make recommendations to the Health and Wellbeing Board and individual internal governing bodies.

Individual leads across the partnership have the responsibility to ensure that their relevant governing bodies are sighted on all work of the working group and are acting on their behalf.

The Health and Wellbeing Board has agreed that this sub-group will exist on a temporary basis until April 2014, when the terms of reference for the Health and Wellbeing Board as a whole will be reviewed. Decisions about the governance arrangements for the implementation and monitoring of the plan will be made as part of this review process. Currently we anticipate that the sub-group will continue and assume responsibility for performance managing the implementation of the plan. Our emphasis in devising these arrangements will be to mainstream BCF governance to the greatest extent possible, in order to achieve the maximum alignment of the programmes involved into existing change programmes.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Enfield will continue its current practice of providing social care support to adults and older people assessed as having either critical or substantial needs. This is considered to be broadly in line with the national eligibility criteria being proposed in the Care Bill. The preferred model for this is, and will continue to be, a personal budget.

In addition to the ongoing support described above, there is targeted provision of equipment, reablement, community alarms and other telecare, aimed to improve outcomes for local citizens and either reduce or avoid the need for ongoing care or complement ongoing support.

Please explain how local social care services will be protected within your plans.

Our plans protect local social care services in three main ways:

- Funding for personal budgets/care packages, recognising unavoidable demand and demographic growth;
- Funding increased capacity to meet growing demand for reablement,

telecare, and associated interventions to reduce ongoing demand and cost; and

- Funding increases in capacity/infrastructure to ensure more integrated case management and, crucially, to protect the supply of locally available services.

Given the reductions to local government funding, the Council's previously agreed Medium Term Financial Strategy (4-year budget plan) assumes that £4.5m of NHS to Social Care Grant is used to fund ongoing care packages/personal budgets in 2014/15. The Better Care fund will need to fund the 14/15 level, plus unavoidable demographic/ demand growth in 2015/16.

The table below sets out the level of demographic/demand growth in recent years by care group:

Care Group	Projected annual increases over three years	Spend in 2015/16 a current trend
Older People	5.7%	£900k
Physical Disability and Sensory Impairment	11.6%	£850k
Learning Disability	14.6%	£2,900k
Mental Health	23.0%	£950k

This data will be subject to ongoing review and continue to be openly shared to inform ongoing decisions about the use of the Better Care Fund.

In addition to the direct spend on care set out above, local infrastructure to deliver more integrated case management capacity and safeguarding oversight will also be required.

Enfield has CQC-recognised leading practice in identifying and responding to concerns about the quality of care in local providers. We have seen a significant rise (38%) in safeguarding investigations during 2013/14, with a particular focus on nursing homes. This impacts system capacity both through the potential for increased hospital admissions and a reduction in nursing home capacity to support discharges where restrictions on new care home admissions follow confirmation of safeguarding concerns.

It is therefore proposed that the BCF is used to supplement existing investment in this area to protect the locally available supply of safe and appropriate care in the independent sector and to respond in a timely way to emerging alerts of abuse and/or poor quality care.

Our current planning assumption, based on demand trends, is that reablement capacity will need to be increased 29% over the period during the period 2013-14/2015-16.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The development of the integrated care model includes a commitment to

extended hours in all services within the pathway, with the aim being to facilitate coordinated work through resourcing seven-day working provision for all relevant agencies within this model. It is planned to analyse and model the needs and resources for 7-day working jointly across agencies as part of on-going development of the integrated care, because of the need to ensure proposals represent good value for money through assuring productivity levels during extended working for all agencies.

The more preventative and pro-active approach should allow a more planned approach to assessing individuals and delivering their care across health and social care partners which will mitigate demand for short-term unplanned responses outside of weekdays, e.g. limiting the need for weekend A&E attendance. In turn, this will enable resources to support extended working to be invested in preventative, rather than reactive, solutions to support individuals in the community.

However, the CCG, Council, hospital Trusts and their partners recognised the need for urgent action in Enfield in Winter 2013/14 as it is a Borough with two challenged health economies with high levels of A&E attendances at both Trusts. Partners locally therefore agreed to invest in solutions to support A&E and wider hospital performance that would also be critical elements of new or extended ways of working within the integrated care model with the aim of understanding how a longer-term approach could be embedded across agencies. For example, the social care hospital discharge and enablement teams implemented extended 7-day working to facilitate hospital discharge and help avoid hospital admission during the winter; whilst a RAID model was developed to support individuals with dementia across the hospital discharge process. The effectiveness and efficiency of these solutions will be evaluated post-winter to inform development of integrated care and its costed business case.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Enfield CCG as a commissioner of healthcare services has no legal right to use patient identifiable data, including the NHS number, without relying on a secure legal basis, i.e. patient consent or section 251 approval. However, all clinical services commissioned by the CCG use the standard NHS contract conditions in the NHS Standard Contract for 2013/14 at Section E paragraph 13.4, which requires providers to use the NHS number in accordance with the NPSA guidelines and for it to be part of the Health Record of the Service User and be shared in any medical correspondence in accordance with the law.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please see the previous box.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

In line with NHSE guidance, Enfield CCG is committed to migrating towards the use of open APIs and standards. The CCG and Council will work closely together to ensure that there is a joint approach towards achieving the effective and efficient use of data sharing across the two organisations.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The Council's Information Governance controls cover operational practice, including joint working with the NHS. Robust IG clauses are included in all contracts with third party providers of social care services and the Enfield Strategic Partnership (ESP) has agreed an Inter-Agency Information Sharing Protocol. The Council's ESP includes local NHS partners. The Council complies with all recommendations in the Caldicott 2 Review, has an N3 connection, and has approved status for v10 of the IG Toolkit for Social Care Delivery (including Public Health).

The contract documents used by Enfield CCG to commission clinical services conform to the NHS standard contract requirements for Information Governance and Information Governance Toolkit Requirement 132. Enfield CCG, as a commissioner and to the extent that it operates as a data controller, is committed to maintaining strict IG controls, including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies. Information Governance arrangements and the IG Framework conform to the IG Toolkit requirements in Version 11 of the IG Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of personal confidential data in accordance with Caldicott 2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

As part of the development of integrated care, the multi-disciplinary, multi-agency team approach within a primary care setting will jointly determine care needs and coordinate planned solutions with individuals and their carers, with the necessary professional support and resources flexed around personalised needs and preferences. This approach will be under-pinned by IT-enabled information-sharing about individuals to achieve the key principles about care planning identified by National Voices.

Where it makes sense, fully integrated assessment processes will continue as part of a wider approach to integrated care, including assessments associated with hospital discharge planning, Continuing Health Care/Personal Health Budgets or intermediate care/reablement pathway. Intelligence sharing within the MDT approach in integrated care will also enable health and social care to streamline and coordinate their own statutorily-required assessment, review, and care planning arrangements (e.g. social care assessment within the framework of the Community Care Act).

The CCG and Council are committed to the allocation of accountable lead professionals, who will be appointed from different parts of the local health and care system according to patients' and services users' specific circumstances. Allocation will be informed by our developing risk stratification process (see below) and the need for the accountable lead professional to provide the necessary service at the right time and in the right place. Establishing this will involve looking closely at staff skill and qualification levels, so that we can be sure can be sure that staff are allocated in the most efficient way possible, with nursing and other staff from primary care used where their skills are most well suited to need.

The CCG and its partners have implemented a risk stratification tool based on the Combined PARR+ model as part of the integrated care model. This tool allows GPs and the MDTs that support them to view all primary and secondary health and adult social care episodes about patients on their lists, with a focus on those at highest risk. This indicates there are around 7,900 Enfield residents of all ages at "high" or "very high" risk of admission to hospital. The full integrated care model, including risk stratification, has only recently been introduced, and the CCG and its partners are currently establishing a baseline for the number of people that would benefit from a joint approach to care planning, as well as who is the most suitable lead professional. The CCG and Council are currently working with their risk stratification tool supplier to develop another care data-driven algorithm. Its purpose is to better identify those patients with frailties who are at risk of needing repeat hospitalisation or intensive social care, but who may not yet have a "high-risk" combined PARR+ tool to improve the effectiveness of preventative intervention.

It is also estimated there are 2,750 older people with dementia, with 1,250 with advanced dementia, in Enfield. At 48%, diagnosis rates are in line with the national average, but clearly need to improve, and partners believe risk stratification tools can facilitate this.

As the government has determined, there will be a specific focus during 2014-15 on patients aged 75 and over and those with complex needs. The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and, for those who need it, a comprehensive and co-

ordinated package of care.

Our expectation is that similar arrangements will apply to increasing numbers of people with long-term conditions in future years. Enfield CCG will support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. The CCG will also provide additional funding to commission additional services that practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. In some instances, practices may propose that this new funding be used to commission new general practice services that go beyond what is required in the GP contract and the new enhanced service.

The CCG will also work with practices to make sure that their plans are complementary to other initiatives through the Better Care Fund, as described in this document.

2) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
Information sharing arrangements to provide accurate/timely information is not robust resulting in low referral rates to MDTs and OPAUs	High amber	3	4	12	• Information Sharing protocols in place • NHS No used as common identifier across all parties • Risk Stratification project in train	• Access to Case finding tool to be provided to OPAUs • Performance Framework to be agreed and implemented to monitor outcomes • Contract with existing provider of RS tool for 2/3 year period with ongoing development work of further case-finding tools
Failure to manage increasing demand for services through prevention/community services	Red	3	5	15	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions • OPAUs & MDTs established to do preventative work • Business plans & Strategies across joint areas agreed or in process with a greater focus on early intervention and support in the community	• Development of the BCF plan across partnerships with shared priorities
Need to deliver savings drives disinvestment &	Amber	3	4	12	• Early and broad engagement with providers and	• Alignment of savings and investment plans through agreement

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
creates viability & sustainability issues for providers					organisations engaged in health and social care • Monitor of impact of Savings Plans on providers • Impact of plans on quality of service delivery monitored	of BCF plan and priorities within the H&WB strategy to be delivered
Failure to agree strategic redirection of resources to meet the objectives within the BCF plan with resultant impact on commissioning decisions, investment decisions across health & social care	High Amber	3	5	15	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan	• Further development of integrated service delivery projects with robust evidence base to measure success
Community/ primary service capacity and quality insufficient resulting in increased demand for crisis services (residential/hospital services)	High Amber	3	5	15	As above	As above
Change risks						
Transition hiatus between existing and new model of services leads to risks related to quality and safety	High amber	3	5	15	• The development of the BCF and strategic plan have been used as a key means to forward plan in detail • Accountability to H&WB board as well as internal governance boards	• A robust performance and quality outcomes framework needs to be developed to monitor outputs and quality of outcomes
Moving effectively from a focus on "services" to a focus on the "whole system"	High amber	3	5	15	• Work on jointly developed commissioning priorities and value based commissioning supports this • Accountability to H&WB board as well as internal governance boards	• A performance framework which captures a more holistic view of people's journey through the care and support systems • A programme of culture shift to support education and change in practice across all partners
The scale and pace of the change required with risk of increase in	High amber	3	5	15	• Review of quality and Safeguarding arrangements in place to respond to and learn from any	• Development of a Multi Agency Safeguarding Hub (MASH) to deliver a more joined up

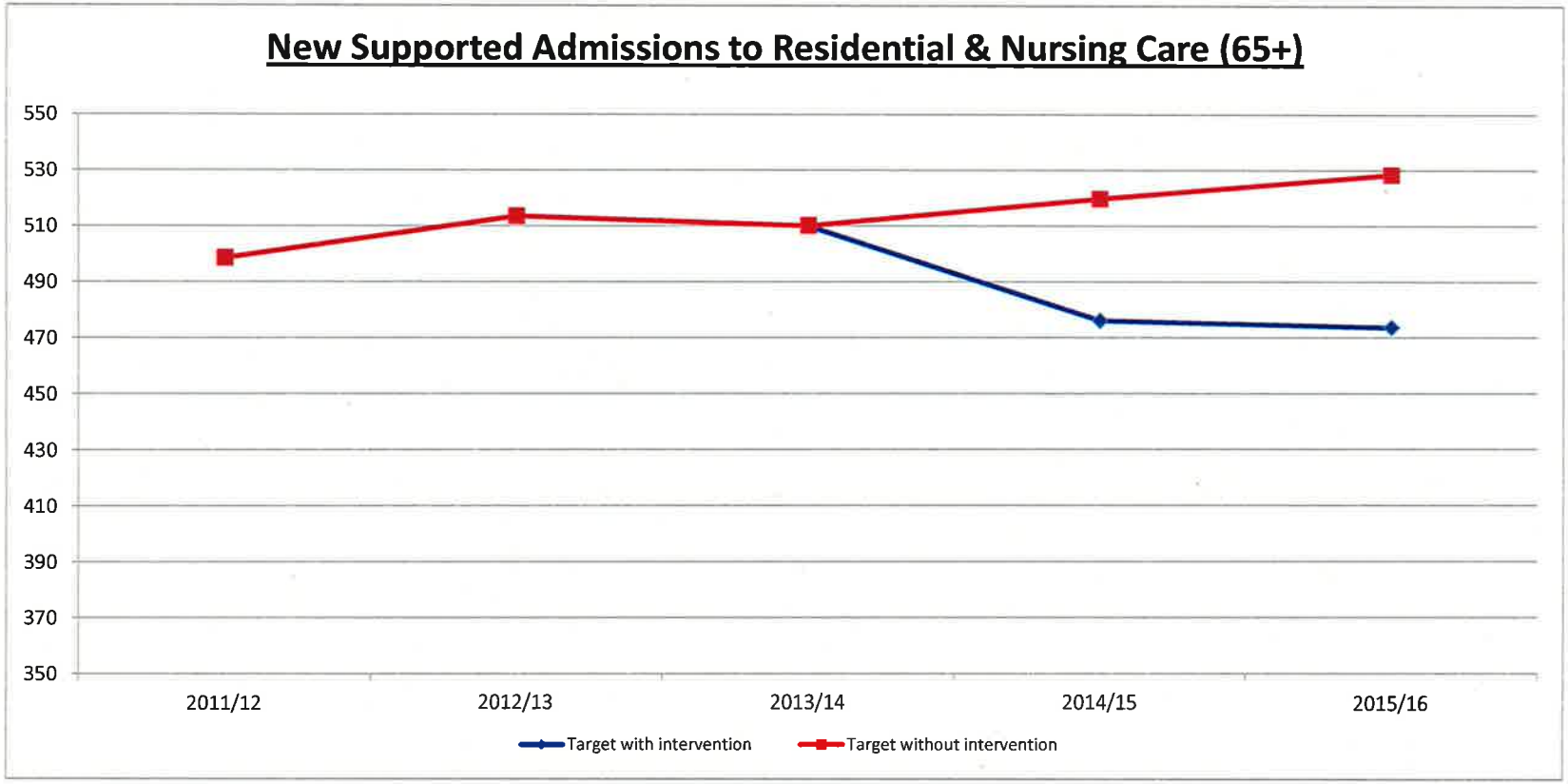
Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
number of SUIs and safeguarding referrals across the partnership					issues that arise • Accountability to H&WB board as well as internal governance boards • Review of existing resource capacity to deal with SUIs and Safeguarding referrals	approach to safeguarding and SUIs
Organisational risks						
Staff within partnership organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery	High amber	3	5	15	• Workforce strategies across partners need to take into account change requirements	• High level strategic intentions need to translate into practical system, practice and process change support for staff delivering the change • Service & team plans reflect high level priorities
London local elections in May 2014 - risk of programme delay in the event of political leadership changes	Amber	3	3	9	• Cross-party member briefings have taken place about this plan and the wider Health and Wellbeing Strategy	
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs	High amber	3	4	12	• Appropriate governance structures in place • Provision of regular, timely and accurate information to support monitoring of services	

This page is intentionally left blank

Current Performance & Targets

Indicator	2011/12	2012/13	London 2012/13	London Rank 2012/13	National 2012/13	Target 2013/14	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	Target 2014/15	Target 2015/16
Admissions to residential and nursing care (aged 65 years and over) per 100,000 population	498.5	513.5	493.6	19/32	676.8	512	124.3	261.8			476.12	473.63

	2011/12	2012/13	2013/14	2014/15	2015/16
Target with intervention	498.5	513.5	510	476.12	473.63
Target without intervention	498.5	513.5	510	520	528



This page is intentionally left blank