Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 20 March 2014 at 8.00 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Cabinet Member for Adult Services and Care – Councillor Donald McGowan (Chairman)
Cabinet Member for Community Wellbeing and Public Health – Councillor Christine Hamilton
Cabinet Member for Children and Young People – Councillor Ayfer Orhan
Cabinet Member for Environment – Councillor Bond
Chair of the Local Clinical Commissioning Group – Dr Alpesh Patel
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer - Liz Wise
NHS England Representative – Dr Henrietta Hughes
Joint Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Director of Schools and Children's Services – Andrew Fraser
Director of Environment – Ian Davis
Voluntary Sector Representatives: Vivien Giladi, Litsa Worrall (Deputy)

AGENDA – PART 1

1. WELCOME AND APOLOGIES

2. DECLARATION OF INTERESTS

Members are asked to declare any disclosable pecuniary, other pecuniary or non pecuniary interests relating to items on the agenda.

3. JOINT HEALTH AND WELLBEING STRATEGY (8:05-8:15PM) (Pages 1 - 66)

To receive an update on the development of the Joint Health and Wellbeing Strategy from Dr Shahed Ahmad.

4. BETTER CARE FUND (8:15-8:25PM) (Pages 67 - 120)

To receive a report on the submission of the Better Care Fund from Bindi Nagra (Assistant Director Strategy and Resources Health, Housing and Adult Social Care) and Graham MacDougall (Director of Strategy and Performance Enfield CCG).

To agree to the final submission of the Better Care Fund.

5. ENFIELD CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN (8:25-8:35PM) (To Follow)

To receive a report on the Enfield Clinical Commissioning Group (CCG) Operating Plan from Liz Wise (Chief Officer Enfield CCG).

6. MINUTES OF THE MEETING HELD ON 13 FEBRUARY 2014 (8:35-8:40PM) (Pages 121 - 132)

To receive and agree the minutes of the meeting held on 13 February 2014.

7. DATES OF FUTURE MEETINGS

To note that the dates of future meetings will be agreed by the Council on 11 June 2014.

8. EXCLUSION OF PRESS AND PUBLIC

If necessary, to consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for any items of business moved to part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

(There is no part 2 agenda)

Agenda Item 3

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE:
Health and Wellbeing Board

20 March 2014

REPORT OF: Shahed Ahmad, Director of Public Health.

Contact officer and telephone number:
Keezia Obi, Head of Public Health Strategy
Keezia.Obi@enfield.gov.uk
Telephone: 020 8379 5010

Agenda - Part: 1	**Item:** 3
Subject: The Joint Health and Wellbeing Strategy 2014 -19 **Wards:** All **Key Decision No:** N/A	
Cabinet Member consulted: Cllr Don McGowan, Cabinet Member for Adult Services, Care and Health	

1. EXECUTIVE SUMMARY

Attached to this report is Enfield's new Joint Health and Wellbeing Strategy (JHWS) and Executive Summary covering the period 2014-19. The JHWS was approved at the 13th of February meeting of the Health and Wellbeing Board, subject to final amendments which have been made.

A strategy implementation plan which will include detailed action plans is currently being developed. This will enable the Health and Wellbeing Board to review the progress of the actions and measures of success on a regular basis, updating as required in response to changes in the evidence base (JSNA) and to reflect progress.

A communications plan for the JHWS is being produced.

A detailed report about the JHWS consultation process has been produced and will be available and distributed to the Board by the end of March.

The full Joint Health and Wellbeing Strategy will be reviewed in 2018/19.

2. RECOMMENDATIONS – the Health and Wellbeing Board is asked to:

a) Receive the Joint Health and Wellbeing Strategy 2014 – 19.

3. BACKGROUND

3.1 The Health and Wellbeing Board is responsible for developing and then publishing a Joint Health and Wellbeing Strategy (JHWS). The JHWS is the document that describes the key health and wellbeing priorities for the borough and central to this, is addressing the inequalities that exist in the borough and making a difference where it is needed most. As set out in statutory guidance, the JSNA has been used as the evidence base upon which the strategy has been developed.

3.2 The strategy sets out how the Enfield Health and Wellbeing Board (HWB) will work with partners and the population of Enfield to improve health and wellbeing across the borough over the next five years. The strategy was produced by a working group representing the partners on the HWB.

3.3 The HWB has already engaged the local community through the consultation on the priorities in this strategy. However, this is just the start of an on-going process. The HWB will continue to engage people through a mixture of formal consultations and activities, including with community and voluntary groups, faith groups, schools and children's groups and patient/service user groups throughout the implementation of this strategy.

3.4 This strategy will ensure greater integration between health and social care. The HWB are committed to the aim of supporting individuals to plan and control their care and bring together services to achieve the outcomes important to them. The Board will develop integration plans, which will involve the HWB in dialogue with both the population of Enfield and with local stakeholders.

3.5 The priorities and actions adopted in this strategy draw on the strengths of the HWB, and are designed to provide additional impetus for improving health and wellbeing in Enfield into the future.

4.0 Vision, principles and priorities

4.1 The HWB vision is:

"Working together to enable you to live longer, healthier, happier lives in Enfield"

4.2 The vision is underpinned by five supporting principles:

- ✓ **Prevention and early intervention**
- ✓ **Integration**
- ✓ **Equality and Diversity**
- ✓ **Addressing health inequalities**
- ✓ **Ensuring good quality services**

4.3 The vision will be delivered through five key 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**
- ✓ **Reducing health inequalities - Narrowing the gap in life expectancy**
- ✓ **Promoting healthy lifestyles and making healthy choices**

5. ALTERNATIVE OPTIONS CONSIDERED

None - it is a statutory requirement to produce a Joint Health and Wellbeing Strategy.

6. REASONS FOR RECOMMENDATIONS

It is a statutory duty on local authorities to produce a Joint Health and Wellbeing Strategy. Health and Wellbeing Boards are required to involve the local community in the preparation of this document.

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

7.1 **Financial Implications –** As detailed in other parts of the report, the purpose of the 5 year joint Health and Wellbeing Strategy is to improve the health and wellbeing of local people. The Health and Wellbeing Board (HWB) is a partnership of the Council, Enfield Clinical Commissioning Group (CCG), Healthwatch and the Voluntary and Community sector and they will oversee the implementation of the strategy.

The delivery of the strategy will be funded from existing Council and CCG resources and pooled funds. This includes the Better Care Fund (BCF) which is a pooled budget between the Enfield CCG and the Council.

7.2 **Legal Implications -**Section 116A of the Local Government and Public involvement in Health Act 2007 (the 2007 Act) (as amended by the Health and Social Care Act 2012) has been in force since 1 April 2012.

Where a Joint Strategic Needs Assessment (JSNA) is prepared by a responsible local authority, Section 116A(2) of the 2007 Act requires the responsible local authority and each of its partner clinical commissioning groups to prepare a joint health and wellbeing strategy (JHWS) for meeting the needs identified in the JSNA by the exercise of the functions of the authority, the NHS Commissioning Board or the clinical commissioning groups.

Section 116A(3) requires the local authority and its partner clinical commissioning groups to consider, in preparing the JHWS, the extent to

which the needs identified in the JSNA could be met by making arrangements under section 75 of the National Health Service Act 2006.

Section 116A(5)(b) requires people who live or work in the area to be consulted as part of the preparation of the JHWS.

Section 116A(6) requires the responsible local authority to publish each JHWS prepared by it.

Section 196(1) Health and Social Care Act 2012, which has been in force since 1 April 2013, states that the functions of a local authority and its partner clinical commissioning groups under section 116A of the Local Government and Public Involvement in Health Act 2007 are to be exercised by the Health and Wellbeing Board established by the local authority.

There is therefore a statutory duty on local authorities including London boroughs to prepare and publish Joint Health and Wellbeing Strategies. Local Authorities should follow the statutory guidance in preparing these documents unless there is a well-documented good reason not to do so.

The proposals set out in this report comply with the above requirements.

8. KEY RISKS

8.1 The JHWS supports the on-going need for partnership and integration between local authority, health and voluntary and independent sector to find better ways of preventing ill health and meeting the health and wellbeing needs of local people. The JHWS will help to manage and mitigate the risks associated with this. Specific risks are noted as follows:

8.2 Partnership – key to the effective delivery of this strategy is collaborative working among the key partners represented on the Health and Wellbeing Board (HWB), particularly given the current financial climate and budgetary constraints. This will be mitigated by the delivery of the strategy by all partners, in particular the Council and Clinical Commissioning Group, and crucially the actions and measures of success contained within.

8.3 The delivery of the actions and measures of success – the risks associated with this are being mitigated by the production of a more detailed action plan (performance management framework) which the HWB will monitor at regular intervals and allows for corrective action to be taken as necessary.

8.4 Engaging local people – also refer to point 3.3. Central to the success of the JHWS is the involvement of local people in implementing this strategy. This risk will be mitigated through a range of activities including the use of social marketing techniques, existing mechanisms available to partners on the HWB, alongside their commitment to build on the success of the consultation of the HWB as outlined in the strategy.

9. IMPACT ON COUNCIL PRIORITIES

9.1 **Fairness for All**
Central to the delivery of the JHWS is addressing the inequalities that exist in the borough and making a difference where it is needed most.

9.2 **Growth and Sustainability**
Central to the delivery of the JHWS is addressing the wider determinants of health such as the environment in which we live, education and employment.

9.3 **Strong Communities**
One of the priorities of the JHWS is “creating stronger, healthier, communities”.

10. EQUALITIES IMPACT IMPLICATIONS

An Equalities Impact Assessment (EQIA) has been undertaken and summarised in the strategy document. EQIA’s will also need to be undertaken as services change as a result of commissioning arrangements.

11. PERFORMANCE MANAGEMENT IMPLICATIONS

The delivery of the JHWS will contribute to the achievements of the council and CCG’s priorities and key targets.

12. HEALTH AND SAFETY IMPLICATIONS N/A

13. HR IMPLICATIONS N/A

14. PUBLIC HEALTH IMPLICATIONS – this is a Public Health report.

Background Papers

None.

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Enfield Joint Health and Wellbeing Strategy 2014-2019

Your Health and Wellbeing

FINAL – April 2014

www.enfield.gov.uk/jhws

In partnership with local people and

NHS Enfield Clinical Commissioning Group

healthwatch Enfield

ENFIELD Council

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Appendices

1. Foreword from the Chair

The vision of Enfield's Health and Wellbeing Board is that the people of the borough live longer, healthier, happier lives. From the results of the consultation, in which over two thousand of you took time out to respond, we were not only heartened by the numbers, but also that the vast majority of you agreed with the vision and the aims of the Health and Wellbeing Board.

In many ways, it is difficult to disagree with this vision. Good health and wellbeing begins with the mother and the unborn child and continues to develop through childhood to influence everything we do. Our mental health, emotional wellbeing, social interaction and physical health all have a significant impact on our educational attainments, employment opportunities, ambitions and achievements. Not to mention how we interact with others, our personal development, family and wider relationships. And it goes without saying, how long we live.

Many of us are now living longer lives. Unfortunately in many cases it is not healthier lives as we may have to contend with one or more life threatening or long term conditions. The pressures on the NHS are increasing and the resources to deal effectively with these challenges are diminishing. To enable people to live longer, healthier, happier lives in this constraining environment can only be achieved through partnerships. A partnership of, on the one hand the Health and Wellbeing Board, and the other the residents of Enfield, and for this strategy to succeed prevention must be at its core.

The Board will undertake to increase positive outcomes in health and social care. For prevention, we will provide opportunities to increase individual and group exercise and encourage changes in those behaviours that we know have negative consequences for our health. The people of Enfield for their part must take advantage of opportunities to engage in activities and adopt behaviours that will encourage healthier lives.

The Board intends to make a real difference by investing in how its members work together and in partnership with local residents, and as we do now, ensure we make fundamental changes and improvements to the lives of local people. The organisations and individuals represented on the Board are committed to making sure there is far more integration between health and social care services, and that the wider determinants to good health and wellbeing continue to be addressed, such as the impact of housing, employment and the environment. Our priorities are supported by a set of actions and measures of success which will enable us to do this.

It will be challenging. Like many other areas of the country, Enfield faces a range of health inequalities and concerns such as growing numbers of children and adults living with obesity, and the increasing prevalence of long term conditions like diabetes, heart disease and dementia. All of which results in many of us dying earlier than we should. This is no more apparent than the stark difference between the east and west of Enfield where those in the east are expected to live significantly shorter lives than those in the west. Enfield also has a very diverse population and the need to respond

to the changes in the demographics such as the ageing population and the boroughs ethnic makeup is essential. We also need to provide better solutions for people who require support with their mental health needs and in general take an approach that is preventative and which supports positive health and wellbeing for all.

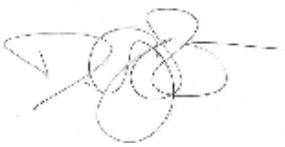
We cannot underestimate the impact of the considerable change the public sector is undergoing, not least the significant financial pressures. We know we'll need to implement this strategy with fewer resources, so we will be prudent and focus our efforts where we know we can make a real difference and pool resources where we can and it is right to do so.

We will do this by creating a robust partnership which has the people of Enfield right at its heart. We will respond to the changing expectations and needs of local residents, ensuring greater access to GP's and community based services and supporting residents to manage their own care, thereby avoiding unnecessary use of services and hospital admissions. Where support and services are required, we will make them more accessible and develop them in a coordinated way that avoids unnecessary and repetitive appointments and treatment; whether this is for our mental health and wellbeing, or for physical conditions.

As noted a key part of the development of this strategy was listening to the views of local residents. The responses to the formal consultation and the variety of comments received from the questionnaires and events that took place, made it clear residents want to live healthier lives and take a more active role in their own and others health. Many people said they want to be involved in strengthening local networks and communities, whether this is with neighbours, local community and voluntary groups, led by faith and community leaders, or the private sector. The success of this strategy is largely dependent on how residents and organisations promote and encourage changes in behaviours. Therefore, the strategy includes a number of actions to enable us to build on the success of the consultation and continue the discussions about how we can improve health and wellbeing in the borough.

I would like to thank everybody that has been involved in developing this strategy, in particular local residents for their views and support, the Health and Wellbeing Board, elected Members and individuals who demonstrated their commitment to this important agenda.

Finally, the success of any strategy is in its execution and our first step is to widely communicate what we intend to do. Then we begin the challenging and exciting journey of implementing a strategy which will deliver the best outcome for local residents – to live longer, healthier, happier lives.



Cllr. Don McGowan
Cabinet Member Adult Services, Care and Health
Chair Enfield Health & Wellbeing Board
Turkey Street Ward

Our 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

Reducing health inequalities – narrowing the gap in life expectancy

Promoting healthy lifestyles and making healthy choices

2. Introduction

2.1 Purpose of the strategy

Many factors affect health and wellbeing; issues such as unemployment, poor housing and feeling unsafe can all impact upon mental and physical health. The Health and Wellbeing Board (HWB) will work to mitigate such factors, as well as encouraging people to take a more active role in their own and others health, by promoting healthy weight management through diet and physical activity, controlling excess alcohol intake and supporting people to stop smoking.

This strategy is as much about wellbeing as it is about health. The HWB is committed to promoting and supporting wellbeing in our local community, enabling local people to live happy and fulfilling lives. The HWB wants to foster wellbeing throughout the life course; supporting parents to raise confident, happy children, improving opportunities for employment, training and education for young people, and enabling people to be independent and to benefit from meaningful social interaction. We want to build flourishing communities, in which everyone has someone to talk to, neighbours look out for each other, people have pride and satisfaction with where they live and feel able to influence decisions about their area.

Good mental health is as important to wellbeing as good physical health. Enfield supports the concept of “parity of esteem” between services for mental and physical illnesses, and this strategy incorporates actions which will impact directly or indirectly on residents’ mental health. This Joint Health and Wellbeing Strategy (JHWS) recognises that good mental health should be supported throughout people’s whole lives, from birth onwards.

The purpose of this strategy is to set out how the HWB will work with the population of Enfield to improve health and wellbeing across the borough over the next five years. The JHWS describes the key health and wellbeing priorities for Enfield. Central to this is addressing the challenges that exist in the borough and making a difference where it is needed most.

The HWB is a partnership which brings together the Council, Enfield Clinical Commissioning Group (CCG), Healthwatch and the voluntary and community sector. Its roles include producing needs information in a Joint Strategic Needs Assessment (JSNA), and responding to that information through the production of a JHWS.

The priorities and actions adopted in this strategy draw on the strengths of the HWB, and are designed to provide additional impetus for improving health and wellbeing in Enfield into the future.

The HWB sees its strategy as transformative, seeking to achieve a structural generational change in the health and wellbeing of the population of Enfield.

This JHWS document focuses on outcomes and high-level actions, and is supported by a range of working documents including a detailed action plan and a performance framework. The action plan is a living document, and will be developed and updated throughout the lifetime of the strategy to ensure that actions and

measure of success continue to reflect local needs and challenge partners to deliver improved outcomes for local people.

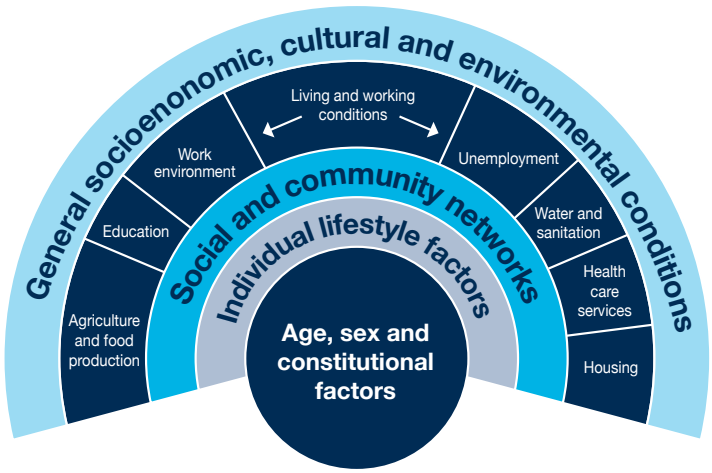
2.2 What is health and wellbeing?

The World Health Organisation defined health in 1946 as:

> "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1]

The model shown in the figure below summarises the many influences on health and wellbeing.

Figure 1: The wider determinants of health[2] (1992) Dahlgren and Whitehead



As this diagram shows, social and community networks can have a significant influence upon an individual's health and wellbeing, as well as that of families and the wider community. Feelings of loneliness can have significant detrimental effects on peoples' mental and physical health and wellbeing. The HWB is committed to working with local people to strengthen communities and social networks to minimise the impact of loneliness and social isolation.

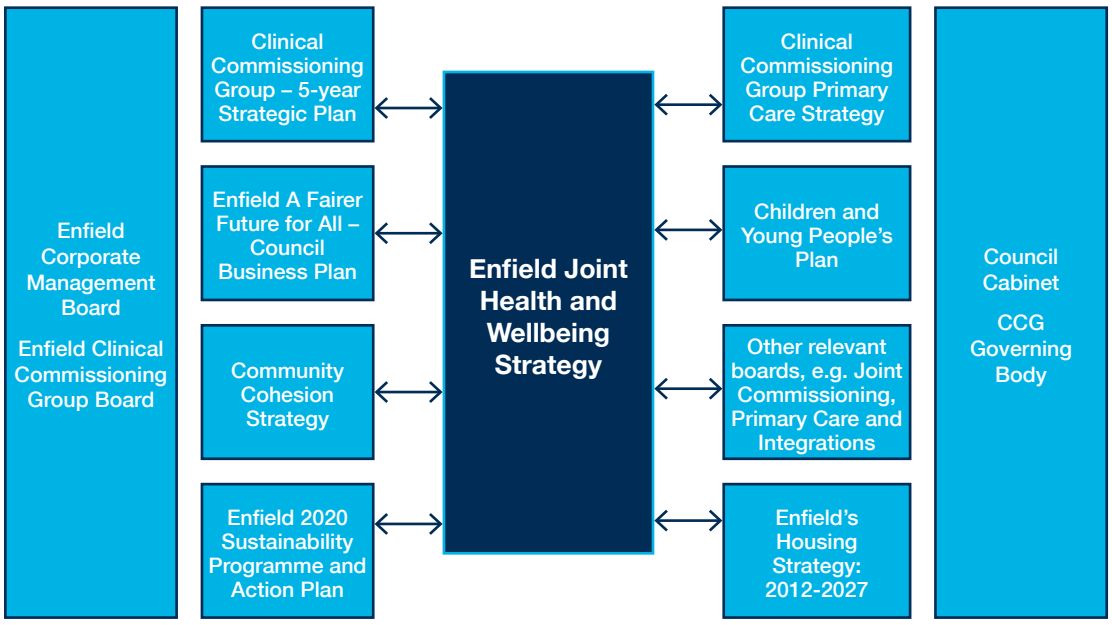
The HWB also needs to consider the very long term of 20 to 30 years, as changes to the wider determinants of health can take a generation to show their improvement in the population. This strategy provides the foundation on which the HWB can take positive steps towards making long term improvements in health and wellbeing.

This JHWS touches on many aspects of life in Enfield, and will require the cooperation of a wide range of stakeholders to ensure that it is effectively implemented. It also considers the inequalities which exist in the borough, and aims to make a difference where it is needed most.

2.3 How this strategy relates to other local strategic documents

A key role of JHWS is to provide a strategic steer to encourage integrated working between health and social care commissioners, as well as between other health-related services such as housing, transport, the economy and environment. As such, the JHWS must influence, and be complemented by other local strategic commissioning documents. The diagram below highlights some of the key strategic documents and partnerships that the JHWS relates to:

Figure 2: Relationship of the JHWS with other strategies and work programmes



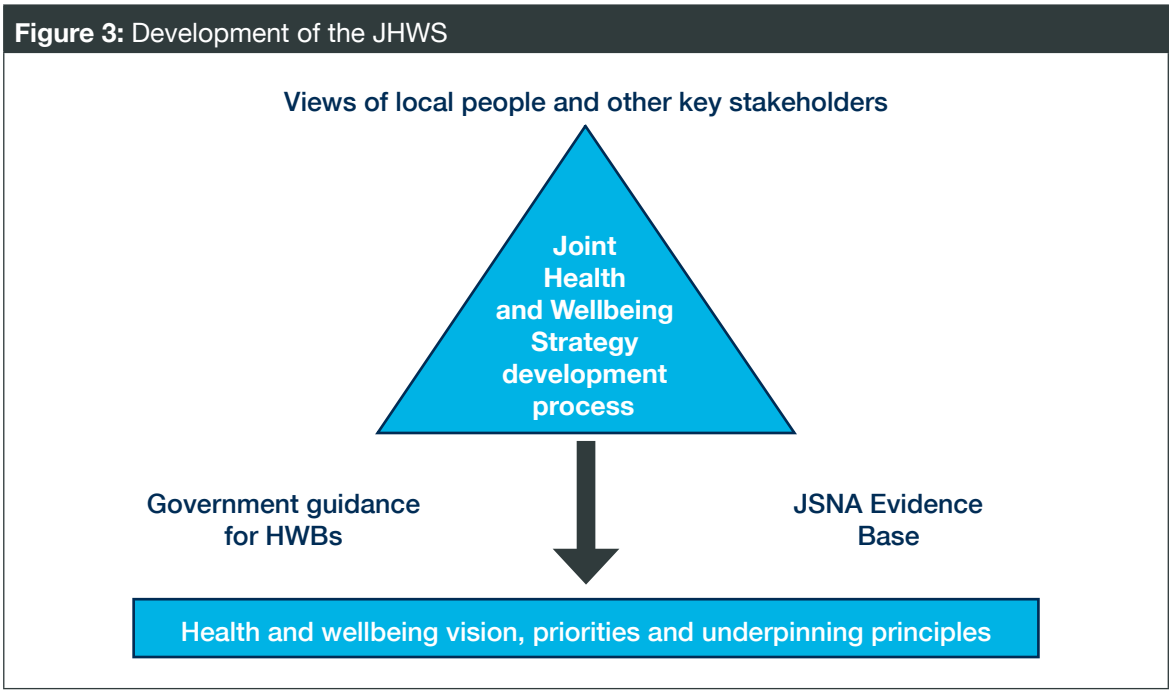
Enfield CCG is required to respond to the JHWS when developing its commissioning plans.

It should be noted that the strategies and work programmes shown in the figure are not exhaustive. A number of other relevant strategies are included in Appendix 4, and many others are available on the Council and CCG websites.

2.4 How this strategy was developed

This strategy has been developed through a rigorous process based on evidence, the views of the HWB partners, and the views of the local population, as shown in the figure below.

Figure 3: Development of the JHWS



The process has involved:

- The development of an evidence base through the updating of the JSNA
- The creation of a long-list of options for priorities at a workshop of the HWB
- An assessment of that long-list against a set of prioritisation criteria
- The development of draft priorities
- Consultation on the draft priorities
- Finalisation of the priorities in this document

2.4.1 The Joint Strategic Needs Assessment (JSNA)

The JSNA is a key resource of health and wellbeing information, which was produced as an online resource in 2013. The information within the JSNA forms the evidence base relating to the health and wellbeing needs of local communities, that underpins the JHWS. The JSNA is also a key resource of health and wellbeing information for commissioners, local people and organisations.

As at April 2014, the JSNA is set out as follows:

- Introduction
- Enfield People
- Enfield Place
- Enfield Resources
- Health and Wellbeing of Children, Young People and their Families
- Health and Wellbeing of Adults
- Health and Wellbeing of Older People
- Related Strategies and other information
- Projections and Locality Profiles
- Glossary

The JSNA can be accessed at www.enfield.gov.uk/jsna

Links to relevant sections of the JSNA have been included in this strategy to give easy access to up to date information on key topics. These can be found primarily in the 'Context and Case for Change' section.

2.4.2 *Prioritisation of options*

When considering options for priorities to include in this strategy, the HWB considered the following questions:

- What is the scale of the problem?
- Will addressing the issue result in a reduction in health inequalities?
- Is there a financially sustainable solution available?
- Does resolving this issue contribute to the prevention and self-help agenda?
- What does the evidence-base tell us about the likelihood of success?
- What are the long-term implications of addressing this issue?
- Will it lead to a positive change in lives?
- What is the importance and quality of the service at the moment?

2.4.3 *The draft priorities*

The process described in this section produced a list of five draft key priorities, which 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 making healthy choices

These are described in more detail in Section 4.

2.4.4 *Consultation process*

The HWB has a duty to involve the local community in the preparation of the JHWS, for example Healthwatch, the voluntary and community sector, Youth Parliament and other user groups.

Consultation on the draft priorities ran for twelve weeks, between the beginning of October to the end of December 2013. This consultation utilised a range of techniques in order to obtain views from the public, staff, carers and other key stakeholders. Further details of the consultation methods are available in Appendix 2.

By the end of the consultation, a total of 2,003 responses had been received; 562 questionnaire responses and 1,441 token votes. Comments were also gathered through consultation events, which included views of the community and local organisations.

Questionnaire responses indicated that 99% of respondents supported a few, some, or all of the draft priorities, with 77% supporting all five draft priorities.

When asked to select which priority or priorities respondents thought were the most important, respondents most frequently chose 'Enabling people to be safe, independent and well and delivering high quality care health and care services'

(selected by 71% of respondents), and 'Ensuring the best start in life' (selected by 61% of respondents)

210 respondents chose to provide a comment. These comments were grouped by theme, the outcome of which is summarised in the word cloud below:

The size of the font in the word cloud indicates the relative frequency with which a topic was mentioned by respondents – as such, we can see that the most commonly raised themes were Healthy Places, Primary Care, Access to Services, Health Promotion and Mental Health.

The token box votes identified that the most commonly voted for priority was 'Creating stronger, healthier communities', with 39% of token votes, followed by 'Enabling people to be safe, independent and well and delivering high quality health and care services' with 21%.

A range of comments were also received from public events. Frequently commented themes included Primary care, Healthy activities and exercise, Community involvement, Health promotion and Access to services.

During the consultation process, a number of comments were received regarding the meaning of the priority – 'Narrowing the gap in healthy life expectancy'. This was discussed by the HWB, and the decision was made to rename the priority 'Reducing health inequalities – narrowing the gap in life expectancy', to reflect comments from local people and organisations.

All comments received were reviewed and considered in the preparation of this strategy. The majority of comments from both the questionnaires and public events have influenced the body of the report or the actions and measures of success.

The HWB is committed to continuing the dialogue that has begun with local people and organisations regarding health and wellbeing. As such. consultation on the JHWS will be an on-going process throughout the life of the strategy.

2.5 Vision, principles and priorities

The Health and Wellbeing Board vision is:

Working together to enable you to live longer, healthier, happier lives in Enfield

The vision is underpinned by five supporting principles:

- **Prevention and early intervention** – The lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

  The HWB recognise that in many cases poor health can be avoided through better life choices and recognising risks to health. Early diagnosis, positive interventions and good quality service delivery will lead to the people of Enfield enjoying better health and wellbeing into the future.

  Good health and wellbeing starts before birth. The HWB recognises the importance of ensuring that women, parents and families are able to give children the best start in life by encouraging and enabling early access to antenatal care and promoting healthy lifestyle choices before, during and after pregnancy.

- **Integration** – Service users should receive a seamless service, regardless of the source of the support. The HWB will encourage integration across all relevant health and social services, schools' and children's services, and the voluntary and community sector where appropriate. Service integration will require the use of single points of contact, to simplify interactions between local people and services, and improve coordination across health, social care and other departments or organisations. The HWB recognise that as the main consumers of health and social care, integration of services is a key issue for older people.

  The introduction of the Better Care Fund will ensure greater integration between health and social care. A pooled budget, which is subject to plans agreed by the Health and Wellbeing Board, will support individuals to plan and control their care and bring together services to achieve the outcomes important to them.

  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 wellbeing, and the extension of universal services away from high cost specialist services. This approach promotes quality of life and seeks peoples' engagement in their own community. To achieve these shifts we need to change the way services are commissioned, managed and delivered. It also requires the redesign of roles, changing the workforce and shifting investment to deliver agreed outcomes for people that are focused on preventative action.

- **Equality and diversity** – Enfield HWB initiatives will address equality and diversity, by ensuring services are accessible, high quality and tailored appropriately to the different groups in Enfield, particularly in the light of the east-west divide across the borough in health and wellbeing outcomes.

- **Addressing health inequalities** – Making a difference where it is needed most. The HWB will ensure that its initiatives will target health inequalities in Enfield, with the aim of minimising variation in health and life expectancy between east and the west of the borough, while also improving the health and wellbeing of all Enfield residents.

- **Ensuring good quality services** – All services will be designed around the patient or user, will be safe, and will be caring and compassionate. The HWB are developing a response to the Winterbourne View review which will focus on this supporting principle.

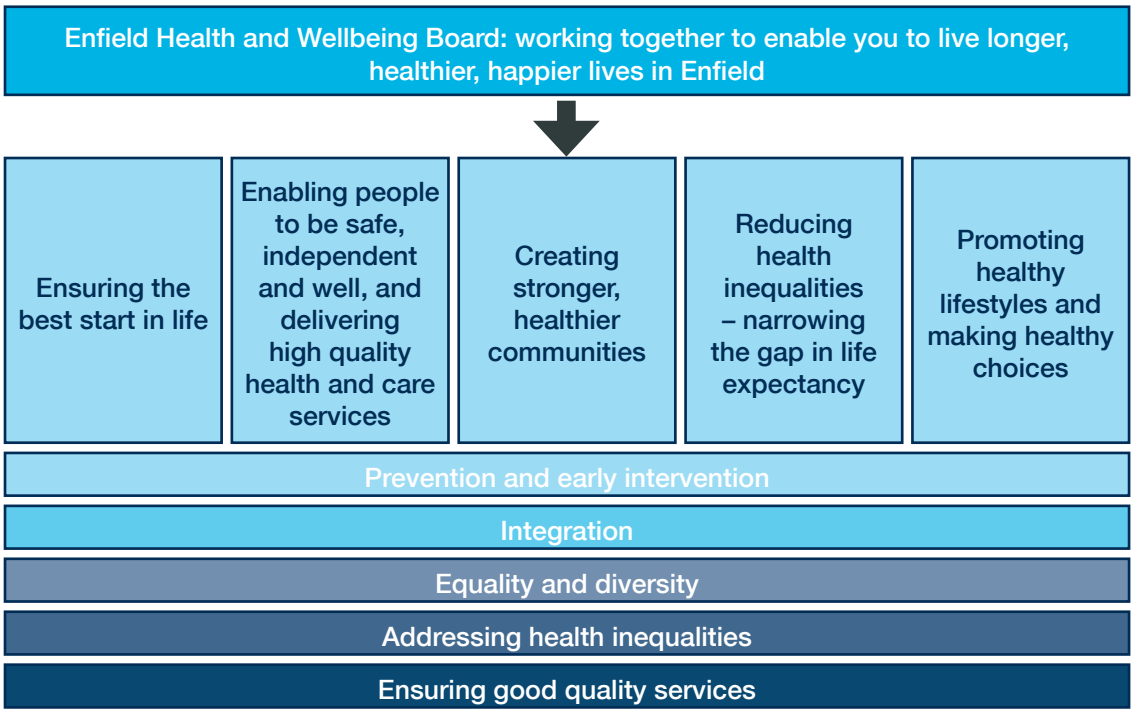
The HWB vision will be delivered through five key priorities:

- 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
- Reducing health inequalities – narrowing the gap in life expectancy
- Promoting healthy lifestyles and making healthy choices

The implementation of the strategy priorities aims to deliver a long-term generational change in health and wellbeing in Enfield.

The figure below gives a summary of the vision, priorities and supporting principles of this strategy.

Figure 4: Enfield Joint Health and Wellbeing Strategy



The HWB's vision will be delivered in line with Enfield Council's three strategic aims, which underpin all of the Council's work and the decisions it makes, in support of the Council's vision of making Enfield a better place to live and work. These strategic aims and underlying priorities are:

- Fairness for all
  - Serve the whole borough fairly and tackle inequality
  - Provide high quality, affordable and accessible services for all
  - Enable young people to achieve their potential

- Growth and sustainability
  - A clean, green and sustainable environment
  - Bring growth, jobs and opportunity to the borough

- Strong communities
  - Encourage active citizenship
  - Listen to the needs of local people and be open and accountable
  - Provide strong leadership to champion the needs of Enfield
  - Working partnership with others to ensure Enfield is a safe and healthy place to live

3. Context and Case for Change

3.1 The national context

The Government has introduced new policy and legislation that will have a fundamental impact on the way in which public health, health services and social care are to be delivered. This change included giving local authorities, through Health and Wellbeing Boards (HWBs), a new role in encouraging joined-up commissioning across the NHS, social care, education, public health and other local partners.

Nationally the NHS is developing new models of primary care that; provide more proactive, holistic and responsive services for local communities, particularly for frail older people and those with complex health needs; play a stronger role in preventing ill-health; involve patients and carers more fully in managing their health; and ensure consistently high quality of care.

The Marmot Review in 2010, 'Fair Society, Healthy Lives'[3] proposed evidence-based strategies for reducing health inequalities, including addressing the social determinants of health in England from 2010. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are the fundamentals for improving quality of life and reducing health inequalities. We understand that to address health inequalities we need to improve opportunities for all our residents, with a focus on those who are experiencing poverty and deprivation.

Therefore this strategy also responds to the Marmot Review, the recommendations of which were:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

3.2 The local context

Service delivery in Enfield has undergone major changes, including a revision in the role of Chase Farm Hospital. This has seen the closure of emergency services and maternity and the expansion of elective care, including the development of an urgent care centre, an older people's assessment unit and a paediatric assessment unit on the site. Patient flows will change, with a larger role for North Middlesex Hospital. The CCG is working to ensure primary and community care provision can prevent unnecessary emergency admissions. These changes are occurring within the context of significant financial pressures on health and social care, which will continue into the foreseeable future.

The Better Care Fund, which comes into operation in 2015/16, will see resources across England redirected with the aim of supporting the integration of health and social care. The HWB will be developing its vision and joint plan for how health and social care will work together in the borough to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospitals or care homes. This will require health and social care in Enfield to develop stronger partnerships and encourage people to take responsibility for their own health.

Throughout the consultation, local people have made it clear that they are willing and keen to work in partnership with the HWB by taking a lead role in improving their own health and wellbeing.

3.3 About Enfield

A detailed description of Enfield and the health and wellbeing of its people can be found on the Enfield JSNA website[4]. The JSNA is continually updated and maintained as a live online resource.

This section identifies some of the key facts about the health and wellbeing of the population of Enfield.

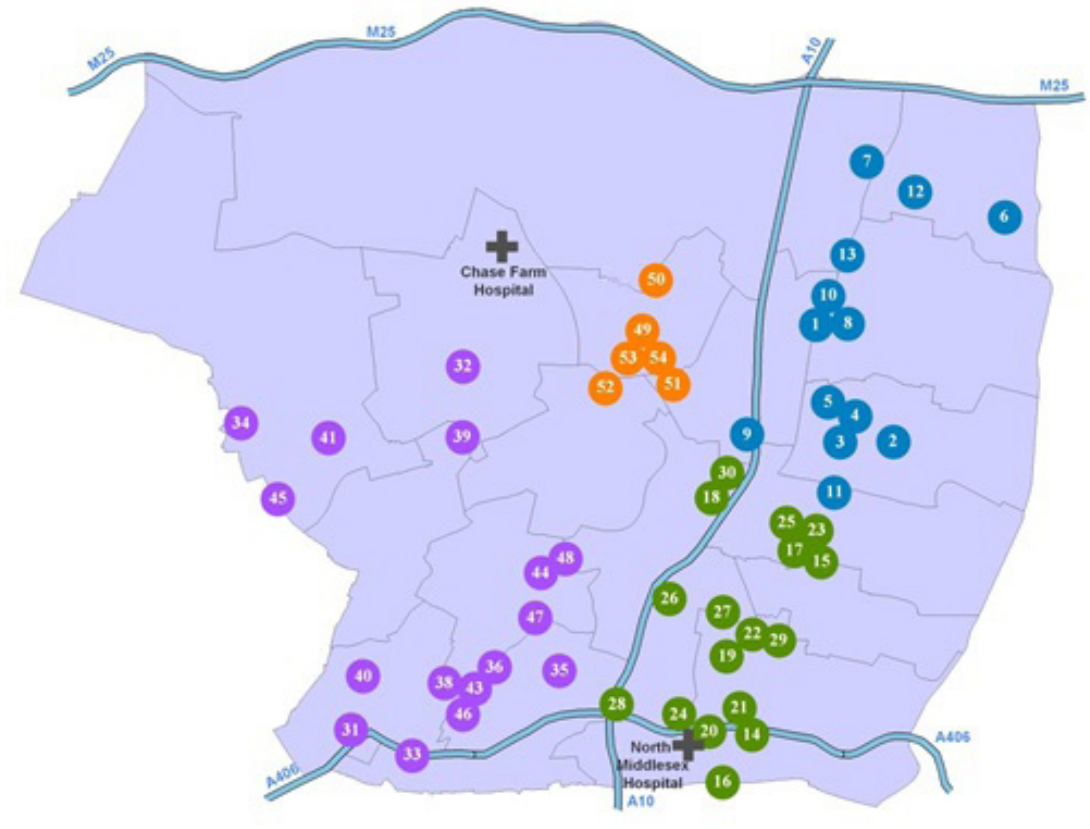
Population estimates for mid-2012 suggest that there were **a total of 317,287 individuals living in the borough**[5]. Over the next decade, this figure is expected to steadily increase, reaching around 330,000 people by 2022, and **340,000 by 2032**[6].

Enfield has a **large population of residents aged under 15**, representing just over one fifth (21.23%) of the population, while **12.6% of residents are aged 65 or over**[7]. The proportion of residents aged 65 and over is expected to rise to 16.6% by 2032.

Enfield is a home to a hugely diverse population, with just under **two fifths of the population identifying themselves as belonging to a Black and Minority Ethnic (BME) group**[8]. This strategy has been designed to respond to the many different groups that live and work in Enfield.

As of April 2014, there were **52 GP practices in the borough**, and two main hospitals; North Middlesex University Hospital NHS Trust and Chase Farm Hospital (Barnet and Chase Farm Hospital NHS Trust).

Figure 5: Distribution of GP practices and Hospitals in Enfield

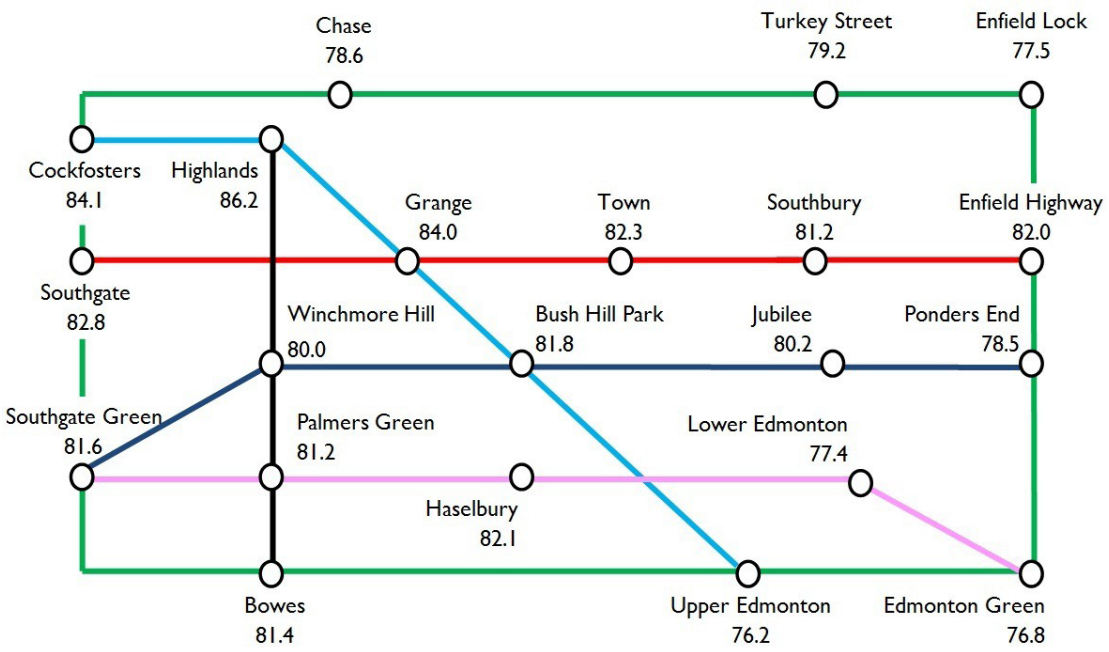


3.4 Case for change

Based on the evidence contained in Enfield's JSNA, and changes in funding for health and social care across England, Enfield must change to ensure improvements to health and wellbeing over the long term. This section highlights key issues in Enfield.

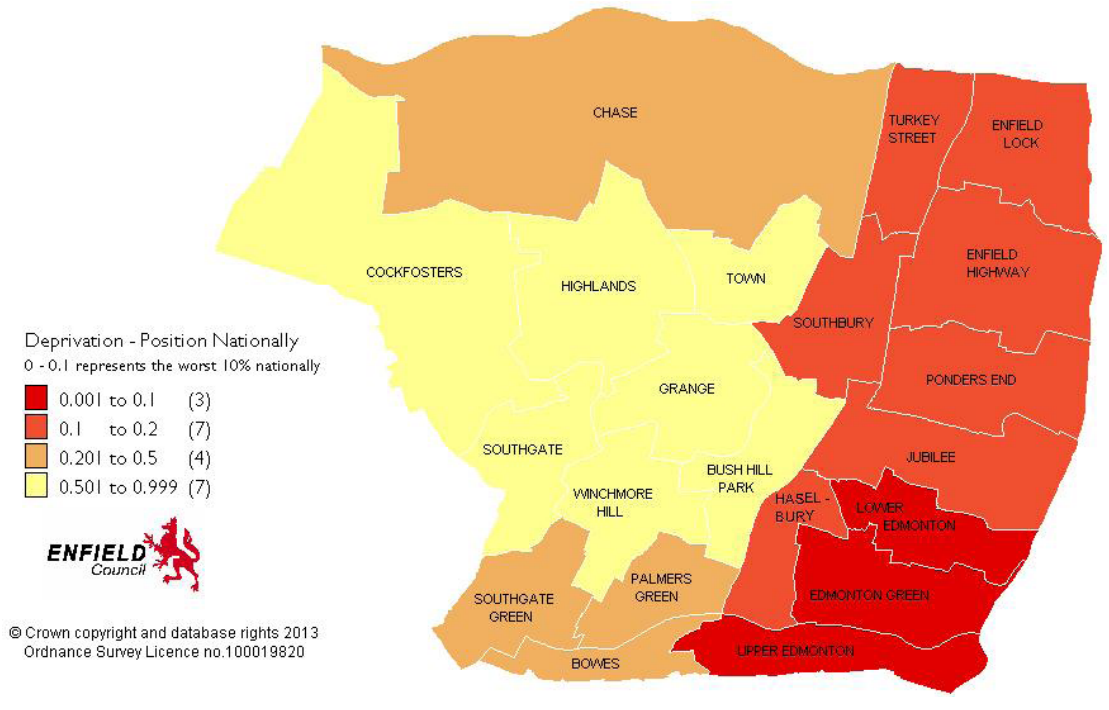
There is a stark discrepancy between the life expectancy of the residents of the east and the west of Enfield. **Those in the east are expected to live significantly shorter lives than those in the west**. For example, a man born in Edmonton Green is currently expected to have a lifespan nearly eight years shorter than a man born in Grange ward[9]. Even starker is the difference in female life expectancy, with a woman born in Upper Edmonton expected to have a lifespan over 13 years shorter than a woman born in Highlands ward[10].

Figure 6: Enfield combined life expectancy, 2006-2010, by ward[11]



Enfield is ranked as the 64th most deprived out of 326 local authorities in England[12]. Deprivation is correlated with worse health, high morbidity and high mortality.

Figure 7: Deprivation by ward[13]



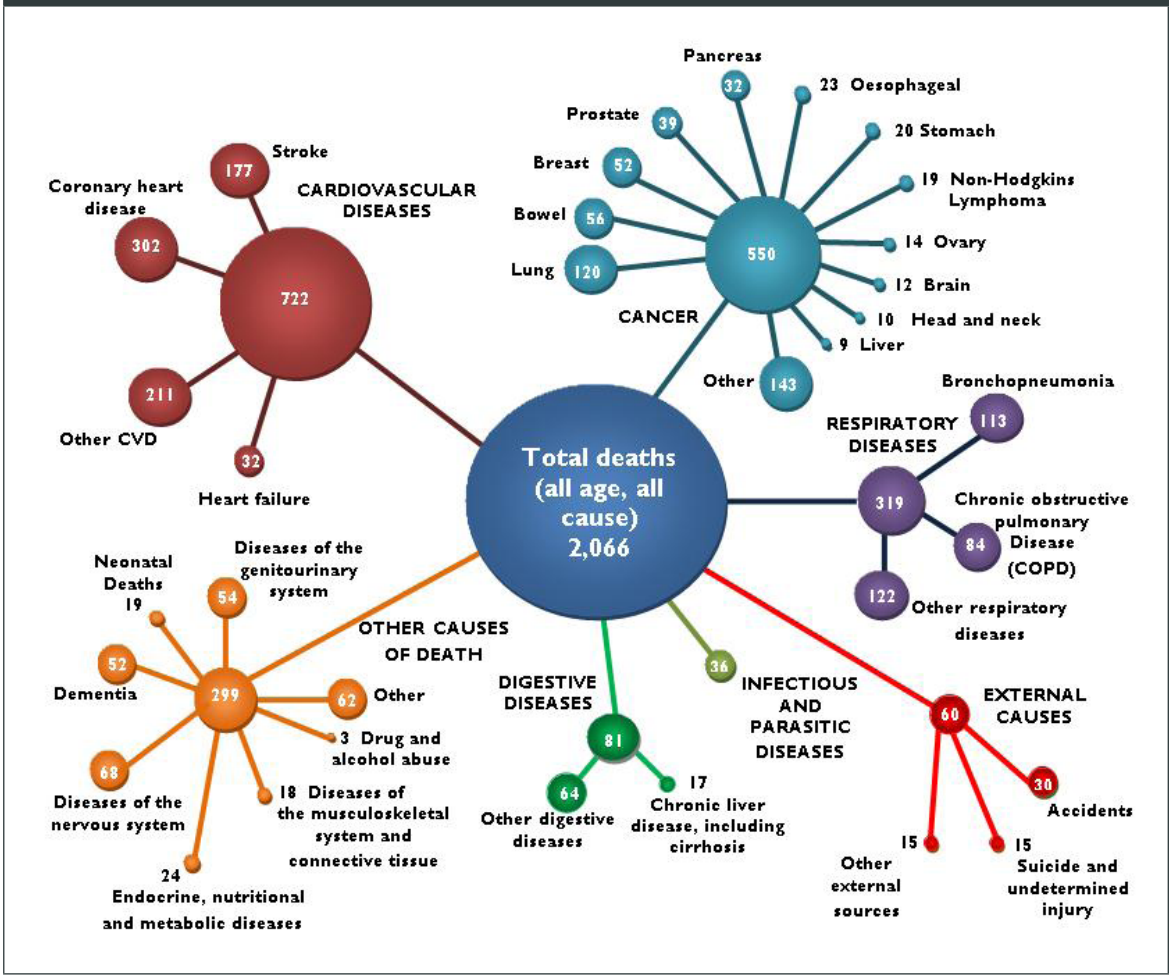
Working age benefit data and the estimated under-18 population size can be used to produce a proxy indicator for the proportion of children in poverty.

Table 1: Childhood poverty rates[14]

Area	Childhood poverty rate (2010)
Enfield	33%
London	28%
England	21%

The largest cause of death in Enfield is Cardiovascular Disease (CVD) followed by cancer[15].

Figure 8: Causes of death in Enfield, 2007-2009[16]



Much of the burden of early mortality and its associated morbidity could be avoided by changes in lifestyle. For example:

- Meeting the Chief Medical Officer's guidelines on physical activity reduces the risk of heart disease, stroke and cancer by 30%
- Not smoking reduces the risk of respiratory disease by up to 95% and eating the recommended levels of fruit and vegetables may reduce the risk of cancer
- Alcohol is associated with 7 cancers including breast and bowel

Further strengthening clinical management of existing disease also plays a key role in reducing associated morbidity and mortality.

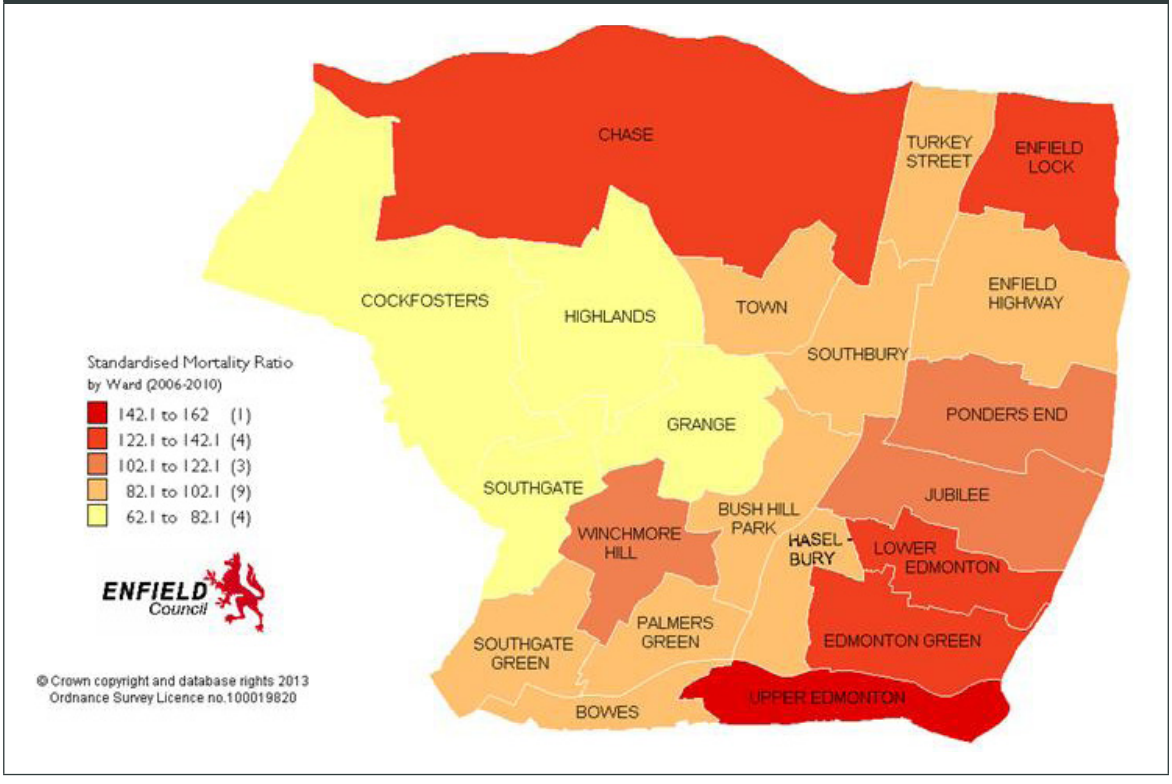
In Enfield:

- **18.5% of adults smoke**[17]; it is estimated that 4% of 11-15 year olds smoke more than 1 cigarette a week[18]
- **95% of the population is not physically active enough** to maximise benefits to their health[19]
- **64.2% of the adult population is overweight or obese**[20], and **24.2% of pupils in Year 6 are obese**[21]

Long term conditions represent a significant cause of morbidity across the borough, and can be greatly influenced by a range of lifestyle factors. In 2012, **18,769 people aged 16 and over were thought to be living with diabetes**[22], around 18% of which were thought to be undiagnosed[23]. Projections suggest that diabetes prevalence could rise from around 8.3% in 2012 to 9.5% by 2020 – an increase of approximately 3,500 cases[24]. Similar projections for a range of other long term conditions, such as stroke and chronic obstructive pulmonary disease suggest that the prevalence of such conditions will be likely rise in future years.

Figure 9 gives an indication of where people experience the best and worst health in the borough, based on rates of all-cause mortality.

Figure 9: All Age, All Cause Mortality in Enfield – Standardised Mortality Ratio by Ward: 2006-2010[25]



The darker the colour on the map, the higher the relative rates of all-cause mortality. In Enfield the contrast is stark; those in Upper Edmonton have a mortality rate over 1.5 times that of the national average.

Immunisation coverage in Enfield is below the level required to achieve 'herd immunity'[i], which is 95% in the UK. In 2012, **76.8% of children had received two doses of MMR before their 5th birthday**[26]. This is lower than both the London and England rates.

In 2011, **HIV prevalence in Enfield was 4.0 per 1,000 population** aged 15-59 compared to 2.0 in England and 5.4 in London. **58% of people with HIV were diagnosed late in Enfield** in 2010 compared to 44% overall in London[27] and 52% in England[28]. 38% of men who have sex with men were diagnosed late (compared to 31% in London) and 65% of heterosexuals were diagnosed late (compared to 61% in London)[29].

Mental health needs vary according to gender, ethnicity and age, and are influenced by family, social and environmental determinants. People with long term mental health problems are at increased risk of long term social exclusion, including worklessness and insecure housing.

Mental ill health is associated with an increased risk of premature death, with people suffering from severe mental illnesses dying on average 20 years earlier than the general population[30]. **Enfield had the third highest excess mortality rate in London amongst people with severe mental illness** compared to the general population in Enfield in 2010/11[31].

In 2011/12 Enfield's **inpatient admission rate for mental health disorders amongst children and young people aged 0-17 years was the highest in London**, with 135 admissions being recorded[32].

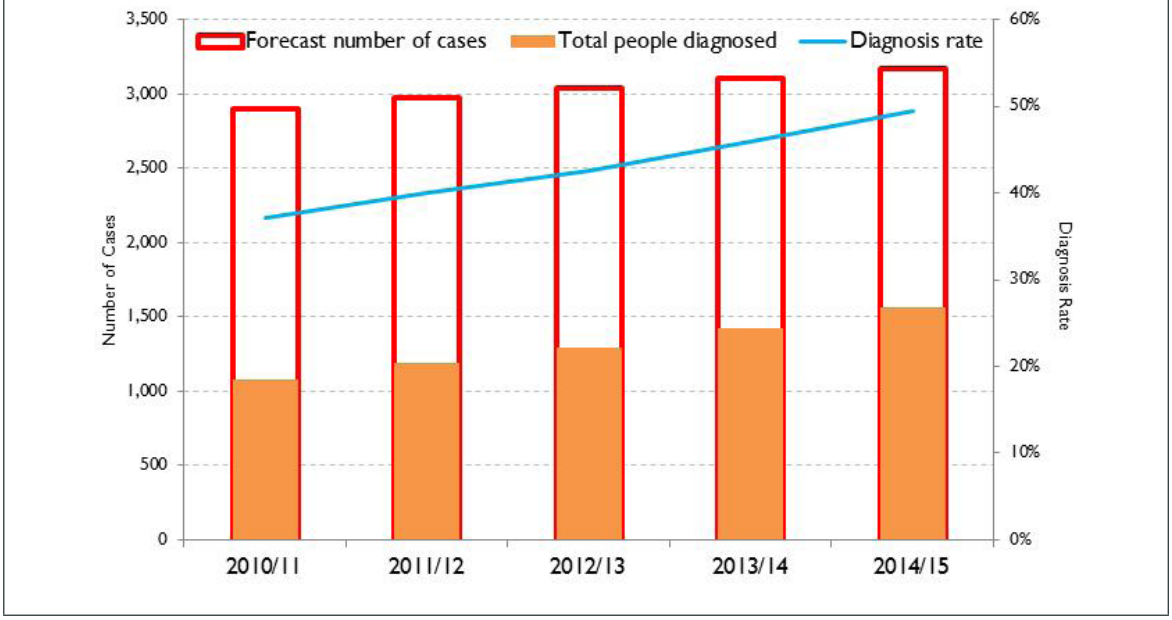
Table 2: Inpatient admission rate for mental health disorders 0-17 years[33]

Area	Inpatient admission rate for mental health disorders, 0-17 years (rate per 100,000)
Enfield	171.90
London	87.8
England	91.3

The **estimated number of people living with dementia in Enfield is 2,828**[34], which is approximately 7% of Enfield's older persons population. The number of people with dementia is expected to increase by approximately 20% over the next 8 years to 3,500 people[35]. This represents an increase of approximately 75 people per year. However, there is an issue with undiagnosed dementia, as illustrated by the figure below.

i Herd immunity (or community immunity) describes a form of immunity that occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. 95% is standardly used as the threshold for the proportion of the population that need to be vaccinated to achieve herd immunity.

Figure 10: People living with dementia[36]



Turning to some of the wider determinants of health and wellbeing, since 2004-05 there has been a **20% reduction in recorded crime in Enfield**, compared to a 23% reduction across the London region and a 29% reduction nationally. However, serious youth violence in Enfield escalated notably between 2007/08 and 2010/11, during which time **knife and gun injuries sustained by 10-19 year olds increased by 37%**[38].

Hotspots for gun and knife crime injuries sustained are largely concentrated in the south-eastern part of Enfield, with the three Edmonton wards combined accounting for 30% of gun and knife injuries in the Borough. Edmonton Green and Upper Edmonton both rank in the 30 highest London wards for gun, knife and weapons injuries in terms of London Ambulance Service Call-outs[39].

As well as crime, the population of Enfield is concerned about anti-social behaviour. There were **17,622 reports of anti-social behaviour to police in 2012** with a further 5,761 reports to the local authority regarding environmental anti-social behaviour (fly-tipping, abandoned vehicles, graffiti)[40]. However, in Enfield, **since 2008, there has been a 27% reduction in the volume of anti-social behaviour reports**[41].

In 2010, **12% of Enfield households were suffering from fuel poverty**[ii], giving Enfield the fifth highest rate of fuel poverty in London, and the 4th highest number of households (13,124) in fuel poverty[42]. The wards of Haselbury, Upper Edmonton and Ponders End had the highest levels of fuel poverty in Enfield.

National estimates suggest that about **30% of the population aged 65 and over feel mildly to intensely lonely**, with 12% of older people reporting feeling trapped in their own home[43]. Loneliness and social isolation have been shown to have significant negative impacts on people's mental and physical health and wellbeing, and can affect people of any age. Groups who are particularly vulnerable to the effects of social isolation include those with sensory impairments or limited mobility, people from ethnic minority groups and people who care for a friend or family member.

ii A household is defined as being in fuel poverty if it would need to spend more than 10% of its income to maintain an adequate heating regime

The recent **Welfare Reform Act** has introduced a wide range of changes to the provision of welfare in England. This will impact on Enfield in a number of ways:

- As one of the first councils to implement the Government's benefit cap, Enfield has seen the highest number of capped households in London. It predominately affects single parents households (77%) and larger family sizes and places their housing at risk if they cannot qualify for an exemption or find the money to pay their rent.

- From April 2013, local authorities were required to introduce their own local schemes to support families who need financial assistance with Council Tax payments. In Enfield, over 27,000 households are affected by these changes which have seen working age claimants receive reduced levels of support.

- Other changes include reductions in housing benefit for single people under 35, reductions for social housing tenants who are considered to have too many bedrooms (both of which can affect adults with disabilities), the introduction of personal independence payments, the abolition of aspects of the crisis loan scheme and phased roll-out of universal credit.

It is not yet possible to accurately identify what risks may be encountered but early indications show an increasingly unstable private rental market where families on low incomes are being excluded from housing choices resulting in higher levels of homelessness. Other risks include financial hardship (increasing numbers of food bank and emergency payment requests), increased mobility, increased over-crowding linking to family health and relationships, and increased mental health concerns.

Information for 2012/13 indicates that **63% of pupils in Enfield achieved 5 A*-C GCSEs including Maths and English**[44].

Figures for April 2012 to March 2013 show that the **rate of employment in Enfield is 67.0%**[45]. This is the eleventh lowest rate in London – well below the London average of 69.5% and the England average of 71.1%.

At the same time, the **economic activity[iii] rate in Enfield was 74.7%**[46]. This is the tenth lowest rate in London – just below the London average of 76.4% and the England average of 77.3%.

iii Economic activity describes all of those in work, or seeking work within the population. A person aged 16 to 74 is described as economically active if, they are:
- in employment, as an employee of self-employed
- not in employment, but were seeking work and ready to start work within two weeks, or
- not in employment, but waiting to start a job already obtained and available.

3.5 Key improvements

We are proud of improvements in health and wellbeing in Enfield in recent years. Some of our key improvements have been:

- Premature deaths in Enfield (that is, under the age of 75 years) are below the national average for cancers overall and for those cancers that are considered to be preventable[47].
- Under 75 mortality from CVD has declined in Enfield. In 2011, Enfield's rate of under 75 mortality from CVD was 49.3 per 100,000, well below the England rate of 58.8 per 100,000[48].
- Enfield was the first local authority area nationally where 100% of schools implemented the School Fruit and Vegetable Scheme as part of the '5 a day' programme. 96% of Enfield's primary and secondary schools meet the Healthy Schools scheme which includes a standard on Healthy Food[49].
- Child immunisation rates have been improving in recent years, reflecting on-going work to improve data management, public awareness and provision and access to immunisation.
- Enfield's rate of smoking amongst pregnant women at the time of delivery has fallen steadily over the course of the last five years.
- Since 2006 Enfield's under-18 conception rate has steadily declined, and is now lower than that of both the London and England averages. Enfield's teenage pregnancy rate in 2011 was 25.8 per 1,000 females aged 15-17 years. This was lower than the London rate of 28.7 and the England rate of 30.7, and represented a 24.3% reduction from the Enfield rate in 2010 of 34.1 and a 44.4% reduction from the baseline rate in 1998 of 46.4 per 1,000 females aged 15-17 years[50].

4. The Health and Wellbeing Board's Priorities and Action Plan

The sections below describe each priority in more detail and set out key actions for the short, medium and long term. Short term is defined as within 2014/15 and medium term is defined as within 2-3 years.

In order for the HWB to be able to provide the leadership needed, it will be putting a review of its structure in place. This action sits alongside the priority-related actions set out in this strategy.

The HWB will also be developing integration plans through implementation of the Better Care Fund.

Section 5 sets out the key outcomes and high-level actions. A range of working documents including a detailed action plan and a performance framework supports this. The action plan is a living document, and will be developed and updated throughout the lifetime of the strategy to ensure that actions and measure of success continue to reflect local needs and challenge partners to deliver improved outcomes for local people.

4.1 Ensuring the best start in life

We want all children to realise their full potential, helping them to prepare from an early age to be self-sufficient and have a network of support that will enable them to live independent and healthy lives.

We want targeted programmes of support to have lasting impact, especially towards the most vulnerable, in order to prepare for the responsibilities of adulthood and build up resilience for the future. We will support all stages of childhood, pre-birth, infancy, pre-school and through school, with the aim of realising the potential in all children. Educational attainment is recognised as being a key to achievement of long term health and wellbeing.

All Health and Wellbeing Boards have been asked to sign up to the **Disabled Children's Charter**[51], which has been developed to support HWBs to meet the needs of all children and young people with disabilities, special educational needs (SEN) or health conditions. The Enfield HWB committed to the Charter at its December 2013 meeting, and this will ensure that the Board:

- Publicly articulates a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Demonstrates an understanding of the true needs of disabled children, young people and their families in Enfield and how to meet them
- Gives greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Supports a local focus on cost-effective and child-centred interventions to deliver long term impacts

- Builds on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families
- Develops a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families

"Good health and wellbeing must start with messages we give our children. Educating them at an early age as well as their parents and families, is crucial to the long term prevention of ill health and long term conditions." *Comment from the consultation responses*

The table below sets out the short, medium and long term actions for this priority.

Table 3: Ensuring the best start in life	
Short term actions	• Understand and plan for the implications of the Children's and Families Bill on the changes for the Special Educational Needs (SEN) system up to age 25, including replacing Statements of Need with a local offer and Birth to 25 Education, Health and Care Plan. • Develop a multi-agency plan for reducing Infant Mortality, with the HWB having oversight of the plan and supporting its implementation. The plan will have a particular focus on child poverty, early access to antenatal services and integrating services. • Manage the transition of the responsibility for health visitors to public health, ensuring improved service delivery. • Enfield Council to host the local health protection forum, and in addition to co-operating with local health promotion campaigns, Enfield Public Health team will develop and implement local targeted health promotion campaigns to increase the uptake of MMR in the borough.
Medium term actions	• Develop a coherent overarching plan for transition to education for all children aged 2 and above which unifies the Healthy Child Programme and the Early Years Foundation Stage. • Redesign treatment pathways to ensure the delivery of high quality, integrated paediatric care, to provide more community-based care options and to improve the experience and outcomes of children who are ill. • Reduce paediatric admissions for asthma and other ambulatory care sensitive conditions by improving early identification and disease management in primary and community services. • Through more effective use of the School Nursing Service, and closer working with health colleagues, support schools in reducing pupil absence due to illness and medical appointments and thereby improve overall attendance rates.
Long term actions	• Improve educational attainment by ensuring all agencies involved with children in Enfield work together to provide the best educational experience possible for all children.

4.2 Enabling people to be safe, independent and well and delivering high quality health and care services

We want people of every age to live as full a life as possible, with good health and wellbeing being encouraged from the outset. This means that people are encouraged to have lifestyles which help to prevent the onset of some diseases. When they do occur, health issues both physical and mental, should be recognised as soon as possible, as early intervention is likely to lead to better long term outcomes. It also means that people who do live with long term conditions should be supported in a way that helps to minimise the impact on their daily lives.

People with any form of disability or impairment should be supported in a way that promotes inclusion, independence, choice and control.

Additionally, safeguarding children and adults from harm and abuse is fundamentally important for the health and wellbeing of individuals and the wider local community.

The greater people's independence, the less reliant they are on others. Independence, safety and wellbeing are interlinked: those who experience poorer health, or who feel less safe, are usually more dependent on others and less able to contribute to community life. Increasing levels of dependency create a demand for increasing intensity of service provision. We are working together to join up services to support children and young people, older people and people with long term conditions. We want to avoid duplication, improve people's experience of our services and ensure services are safe, effective and of high quality.

"Importance of Dementia Awareness and choices for older people."

Comment from the consultation responses

The table below sets out the short, medium and long term actions for this priority.

Table 4: Enabling people to be safe, independent and well and delivering high quality health and care services

Short term actions	• Develop a register of carers which is co-ordinated across primary care, social care, acute care and mental health. • Increase the early diagnosis of HIV infection.
Medium term actions	• Ensure that there is an increased focus on the early identification of long term conditions, in particular diabetes, chronic obstructive pulmonary disease (COPD), dementia, hypertension and CVD. • Develop a network model of primary care to ensure better access to consistent, good quality services with the potential to maintain continuity of care by: – Developing a stable system/model for a more integrated delivery of health care focused around networks and general practices, which in part will support early identification and good disease management. – Implementing a 7 day delivery model for integrated care for older people, which will support reductions in the rate of acute admissions. • Ensure that more people are able to access psychological therapies (Improving Access to Psychological Therapies – IAPT) locally by increasing uptake of the service through integrated approaches. • Co-ordinating services around the needs of the young person and family to ensure a positive experience of transition to adult services. • Establish an effective model of psychiatric liaison in North Middlesex University Hospital based on the RAID (Rapid Assessment Interface and Discharge) model. • Ensure co-ordinated care provision for people with co-occurring alcohol or substance misuse and mental health problems. • Increase the dementia diagnosis rate and improve dementia care.
Long term actions	• Develop a mental health and wellbeing service which focuses on recovery and independence for people with mental health concerns and aims to limit the number of people who require secondary mental health care. • Develop integrated models of care for older people. • Develop a whole-life mental health strategy.

4.3 Creating stronger, healthier communities

A large part of the lifetime health and wellbeing experience of people relates not to the health and social care that they receive, but the environment in which they live, and community that they are part of. People who are able to contribute to society through meaningful employment, live in warm, clean, safe accommodation, and are supported by strong social networks of family, friends and neighbours, are less likely to suffer from both mental and physical health issues.

We want to build strong communities that are integrated and cohesive, and provide residents with more resilience to cope with adverse life events.

We want to reduce loneliness and social isolation, and enable local people to take an active role in building and nurturing strong social networks and vibrant communities.

"It would be helpful to involve the local community through local community groups who should be enabled (say through funding and assisting to create local structures) to fully participate and mobilise their communities at grassroots level." *Comment from the consultation responses*

We want to encourage individuals, families and communities to make healthier choices and take a proactive role in improving their health and wellbeing.

We will utilise evidence-based health promotion and social marketing techniques to work collaboratively with our communities to improve their health.

The table below sets out the short, medium and long term actions for this priority.

Table 5: Creating stronger, healthier communities

Short term actions	• Develop understanding amongst local people of the role that community cohesion plays in improving health and wellbeing, including reducing loneliness. • Deliver an annual programme of community engagement with those who come from different backgrounds, and ensure that Enfield residents can continue to contribute to the development and implementation of the JHWS. • Support the outcome of the Home Office review regarding the links between ending gang and youth violence. In particular agree tasks to be overseen and delivered by the partnership represented on the HWB. • Following the publication of the JHWS, HWB to review its structures to ensure effective engagement of local people to improve their health and wellbeing.
Medium term actions	• To support and work in partnership with faith groups, the voluntary and community sector, schools and children's centres and other local organisations to deliver specific projects aimed at improving community wellbeing. • Partners on the HWB to show leadership by modelling healthy behaviours within their organisations (e.g. healthy eating choices, travel for work policies, work life balance). • Promote dementia friendly communities, which aim to improve awareness, inclusion and quality of life for people living with dementia and support for their carers.
Long term actions	• Strengthen community networks to enable individuals and families to take responsibility for their own health and wellbeing. • Improve the awareness of people of all ages and communities to make healthy lifestyle choices through positive communication and community interaction. • Building on the agreement with North Middlesex University Hospital, work in partnership with all large public sector providers and partners to promote and expand opportunities for employment, apprenticeships and volunteering for local residents, including children, young people and young parents in Enfield.

4.4 Reducing health inequalities – narrowing the gap in life expectancy

We want to reduce the gap in life expectancy that exists within the borough, of 8 years for men, and 13 years for women.

We will work with local people to prevent them becoming ill in the first place by addressing key lifestyle factors more common in the deprived areas of the borough; and addressing the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

We will encourage early diagnosis and management (including lifestyle change) of major killer diseases such as CVD and cancer; a focus on people over 50 will have the greatest impact on reducing the life expectancy gap. Initially we will work intensively with Upper Edmonton, as set out in the Central Leeside Area Action Plan[iv], and once models which work have been developed, these will be rolled out to other deprived areas.

"The difference in life expectancy across the Borough is shocking."

Comment from the consultation responses

The table below sets out the short, medium and long term actions for this priority.

Table 6: Reducing health inequalities – narrowing the gap in life expectancy	
Short term actions	• Support implementation of Integrated Care Pathways to improve efficiency and patient experience. • Work with partners and local people in Upper Edmonton to map existing community resources that support health and wellbeing, and identify where gaps exist when compared with evidence-based practice. • Encourage early diagnosis and management (including lifestyle change) of conditions such as CVD, diabetes, cancer and COPD, and work to reduce the risk of death amongst people living with long term conditions.
Medium term actions	• Work with the community to target and deliver specific interventions in Upper Edmonton, which address health inequalities, in line with the Upper Edmonton action plan. • Reduce smoking rates amongst groups known to be particularly affected by high smoking prevalence. • Further strengthen clinical management of CVD, diabetes and respiratory disease.
Long term actions	• Replicate the successful targeted interventions from the Upper Edmonton action plan to other deprived areas of the borough. • Work to address the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

iv For more information on Enfield Central Leeside Area Action Plan please visit: http://www.enfield.gov.uk/info/1000000456/local_plan_planning_policy/501/central_leeside__area_action_plan

4.5 Promoting healthy lifestyles and making healthy choices

The lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

We want to ensure that local people understand the impact of these choices, and are supported to choose healthier options throughout their lives, making use of the council's regulatory powers to influence local businesses and make local areas healthy places to live.

We want to ensure that people are encouraged and are able to access the borough's open spaces, leisure facilities, sports clubs and other opportunities for activity, including active transport such as cycling and walking.

"I think in Enfield we have many open spaces where people can walk, walking is an excellent exercise, no costs involved, it should be encouraged more." *Comment from the consultation responses*

The table below sets out the short, medium and long term actions for this priority.

Table 7: Promoting healthy lifestyles and making healthy choices	
Short term actions	• Produce a comprehensive obesity strategy, covering both children and adults. • Produce a comprehensive substance misuse strategy, covering both adults and young people. • Health and Education professionals to work jointly to support and promote the Healthy Schools London programme in the borough.
Medium term actions	• Agree an action plan with schools and young persons' organisations to prevent and reduce smoking uptake. • Identify and develop more opportunities to deliver Identification and Brief Advice (IBA) interventions for harmful drinking, particularly through digital customer pathways. • Reduce the rate of alcohol-related acute representations[v] to ensure that treatment is provided in appropriate and cost-effective settings. • Develop healthy workplaces throughout Enfield, for example, improving ease of access and visibility of stairs in office buildings, offering healthy choices in work place canteens. • Promote healthy eating throughout Enfield.
Long term actions	• Ensure that transport and building developments prioritise active transport (particularly walking and cycling).

v This refers to people who attend or are admitted to hospital on more than one occasion because of alcohol-related illness or injury.

5. Success Criteria – what does good look like?

5.1 Measures of success

The measures of success table below outline a number of key strategic outcomes the HWB wish to see realised through action in the short, medium and long term. This is not exhaustive, as further measures of success are included in the JHWS detailed action plan, to be monitored by the HWB.

Table 8: Measures of success	
Ensuring the best start in life	
Child poverty to reduce to 25% by 2020, decreasing from the 2008 baseline of 36%	Percentage of children receiving the full course of MMR by their 5th birthday to increase from 76.8% to 95% by 2019
The gap between the most and least deprived wards measured in terms of child poverty to reduce from 42% (based on the 2009 baseline) to 30% by 2020	95% of pregnant women under the age of 18 who book for maternity care to receive a targeted antenatal intervention from Family Nurse Partnership/ Health Visitor Service
95% of new birth visits to be carried out between 10-14 days after birth	The percentage of absences from school due to illness to improve on the 2012/13 rate of 2.7%
Enabling people to be safe, independent and well and delivering high quality health and care services	
Late HIV diagnosis to reduce from the 2010 rate of 58% to 44% by 2019	A composite measure of avoidable emergency admissions to be included, as at publication, awaiting data to inform the following measure: Avoidable admissions to reduce from x per 100,000 population in 2012/13 to y per 100,000 population by 2014/15
Access to psychological therapies (IAPT) to improve locally by increasing uptake from the current rate of 5% to 15% by the end of 2014/15	A measure of bed days lost due to delayed transfers of care to be included, as at publication, awaiting data to inform the following measure: Delayed transfers of care to reduce from x per 100,000 population in 2012/13 to y per 100,000 population by 2014/15
Rate of admissions for people aged over 65 to residential and nursing care to reduce from 513.5 per 100,000 in 2012/13 to 476.12 per 100,000 by 2014/15	Health-related quality of life[vi] for people with long-term conditions to improve from 72.24 in 2012/13 to 75.10 by 2018/19
Creating stronger, healthier communities	
HWB structures to be reviewed by 2015 to ensure on-going engagement of local people in improving their health and wellbeing	Faith forums and community leaders to be enabled to take a lead role in improving local health and wellbeing
Communications and Engagement strategy to be developed and implemented to support the on-going implementation of the JHWS	The percentage of people who feel safe outside in their local area after dark to increase by 2019

vi Average health-related quality of life for people with long term conditions is derived from responses to the GP Patient Survey. Individuals who report having a long term conditions are asked to score their health status across five domains – mobility; self-care; usual activities; pain/discomfort; and anxiety/depression. These are used to produce an average score.

Reducing health inequalities – narrowing the gap in life expectancy	
75% of Enfield GP practices to achieve 90% in the percentage of patients with coronary heart disease whose blood pressure is controlled by 2019	The difference in female life expectancy between the best and worst wards to reduce from 13 years to 10 years by 2019
Promoting healthy lifestyles and making healthy choices	
The percentage of year 6 pupils classified as obese to reduce from 24% to 22% by 2019	Smoking prevalence to reduce from 18.5% in 2012 to 12% by 2030
The percentage of obese and overweight adults in Enfield to improve from the bottom 5 London boroughs to the top quartile by 2024	90% of all drug users in treatment to receive HIV and Hepatitis B interventions, and 90% of injecting drug users to receive Hepatitis C interventions
The proportion of drug users successfully completing treatment in 2014/15 to increase to 4% above the 2013/14 target rate	30% of local authority schools to achieve the Healthy Schools London Bronze Award, and 10% of local authority schools to achieve Silver Award by December 2014

5.2 Next steps

There are some clear health and wellbeing challenges in Enfield and this strategy demonstrates that the needs of local people vary across the Borough and the importance of working closely with communities and local organisations to meet those needs.

It also sets out the priorities that the HWB will focus on with the aim of making a real difference to the lives of Enfield people. There will be a more detailed action plan which will identify leads and outputs to deliver the programme of work as set out in the strategy. The HWB will review the progress of the action plan on a regular basis and will update the plan as required in response to changes in the evidence base (JSNA) and to reflect progress.

The HWB is committed to increasing community engagement in the delivery of the strategy. Successful implementation of the strategy relies on community and stakeholder organisations all of whom have an important part to play in this process.

The strategy will be implemented at a time when there are significant public sector financial cuts, so innovative use of existing resources will become even more important.

The full Health and Wellbeing Strategy will be reviewed in 2018/19.

6. Communications and Partnership

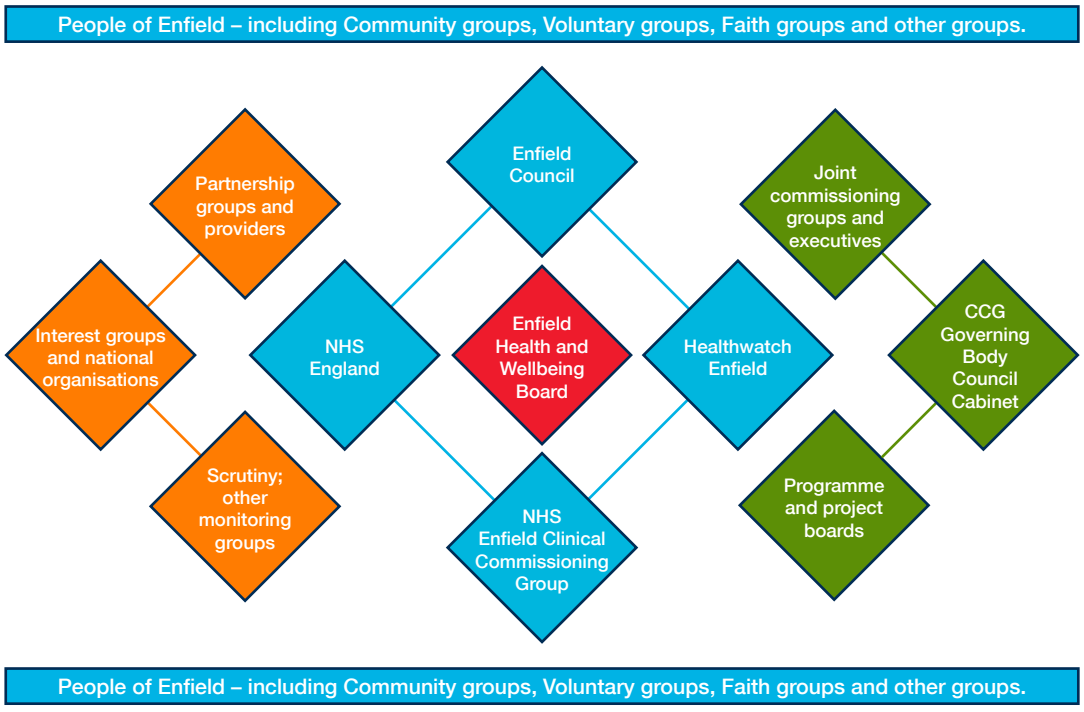
Our programme of change will require considerable partnership working between the HWB and other stakeholders within Enfield including the voluntary and community sector, private sector, police, local groups and Enfield residents. The HWB will develop a communications and engagement plan covering all stakeholders in this strategy. We will continue to provide evidence on the health and wellbeing needs of the local community and what we are doing to address these.

Partnership working will be crucial given the challenges brought about by the current economic climate and the fast changing environment in which the public sector is currently working.

In order to build on the success of the formal consultation that took place in the development of this strategy, we will review the HWB's current structures and ways of working. The aim of which is to develop mechanisms by which local people can take a lead role in the implementation of this strategy, thereby improving their own health and wellbeing. Additionally, our priority 'Creating stronger, healthier communities' sets out a number of actions to support this aim.

The figure below provides an overview of the HWB's approach to communications and partnership in delivering this strategy.

Figure 11: The HWB's communications and partnership approach



The HWB has already engaged the local community through the formal consultation on the priorities in this strategy. However, this is just the start of an on-going process. The HWB will engage with the community through formal consultations and other activities, including working with community and voluntary groups, faith groups, schools and children's groups and patient/service user groups, with the aims of:

- Working with community leaders to build strong relationships enabling all sectors of the local community to contribute to the implementation of the strategy
- Recognising the community as a valuable asset who can develop local solutions
- Understanding what is important to the people of Enfield when they think of their health and wellbeing
- Establishing what resources already exist in the community which could support the delivery of this strategy
- Exploring what works when encouraging people to make healthy choices
- Developing ideas for helping people take responsibility for their own health and wellbeing
- Shaping actions for delivering health and wellbeing, and developing future iterations of this strategy
- Holding the HWB accountable to the people of Enfield to deliver its key measures of success
- Creating and maintaining an open dialogue, to enable local people have their say on the on-going development of the strategy.
- Using the evidence base from the JSNA and social marketing techniques, we will work collaboratively with our communities to improve their health and wellbeing

At all times, the HWB will work in line with the government's ambition for shared decision-making – "nothing about me without me"[52].

Appendix 1
Glossary of terms

Better Care Fund	A fund which will pool existing budgets in 2015/16 to enable greater integrated working and transformation of local services to older and disabled people
BME	Black and minority ethnic groups within the population
CCG	Clinical Commissioning Group – groups of GPs responsible for designing the local healthcare system, through the commissioning (purchasing) of a range of health and care services; CCGs work with patients and healthcare professionals and in partnership with local communities and local authorities. CCGS replaced Primary Care Trusts (PCTs) in April 2013.
Child Poverty	Children living in families where the reported income is less than 60 per cent of the national median (mid-point) income
COPD	Chronic Obstructive Pulmonary Disease – the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease
CVD	Cardiovascular disease – a group of diseases of the heart and blood vessels
Health Inequality	Differences in health experiences and health outcomes between different population groups
Health Promotion	Health promotion is the process of enabling people to increase control over, and to improve, their health
Healthwatch	The consumer champion in health and care, ensuring the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services
HIV	Human immunodeficiency virus – the virus attacks the immune system, and weakens your ability to fight infections and disease; there is no cure for HIV, but there are treatments to enable most people with the virus to live a long and healthy life
HWB	Health and Wellbeing Board – a partnership board whose purpose is to improve the health and wellbeing of the residents of Enfield and reduce current health inequalities
IBA	Identification and brief advice – a brief alcohol intervention which usually consists of using a validated screening tool to identify people at risk of harmful drinking, and the delivery of short, structured 'brief advice' aimed at encouraging the drinker to reduce their consumption to lower risk levels. It should be initiated by front line health and care workers whenever they have a good opportunity

Immunisation	The process by which an individual's immune system is strengthened against a particular type of virus or bacteria through vaccination
Infant Mortality	Deaths occurring before the age of one year of babies who were born alive
JSNA	Joint Strategic Needs Assessment – the collection and collation of information and intelligence about the health and wellbeing needs of the local community
Life Expectancy	The theoretical age of death an average person born today could expect to live to if he/she had the same rate of death at each age as the current population
LTC	Long term condition – conditions or chronic diseases for which there is currently no cure, and which are managed with drugs and other treatment, e.g. diabetes
Marmot Review	An independent review by Professor Sir Michael Marmot which was commissioned by the Government to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010
MMR	The triple Measles, Mumps and Rubella vaccine, given as a single injection
Morbidity	A diseased state, disability, or poor health due to any cause. Also used to describe the rate of illness and ill health in a population
Mortality	Relating to death; a mortality rate indicates the number of deaths within a population over a given period of time (e.g. per year)
Obese	Describes an individual who is clinically overweight, with a body weight more than 20% greater than recommended for their height; individuals who are obese have a body mass index of over 30
SEN	Special Educational Needs – children have a statement of special educational needs if they have a learning difficulty which calls for special educational provision to be made for them
SMR	Standardised Mortality Ratio – a ratio of the number of actual deaths associated with a particular disease or condition in a local area, and the expected number of deaths from the same disease or incident, based on age and gender specific rates within a reference population
Social Marketing	Social marketing is an approach used to develop activities aimed at changing or maintaining people's behaviour for the benefit of individuals and society as a whole, utilising techniques developed in commercial advertising.
Ward	An electoral ward is a division of an administrative area used to elect councillors to serve on the councils of the administrative areas
Wider Determinants	Also known as the social determinants of health, they have been described as 'the causes of the causes' – the social, economic and environmental conditions that influence the health of individuals and populations

Appendix 2
Consultation about this strategy

A public consultation on the draft priorities ran for twelve weeks between October and December 2013.

The five draft priorities were consulted on using a questionnaire, available online and as paper copies. Printed copied were also available in an Easy Read format, and in five alternative languages (Bengali, Greek, Turkish, Polish and Somali).

People were also able to respond by voting at one of the token boxes provided for the consultation, whereby individuals were given a token to vote for which priority they thought was most important. A number of public events also took place during the consultation period, some catering to the general public, and others directed towards specific groups and organisations.

By the end of the consultation, a total of 2,003 responses had been received; 562 questionnaire responses and 1,441 token votes. A number of organisations also chose to provide questionnaire responses. Comments were also gathered through consultation events, which included views of the community and local organisations.

Questionnaires

Responses from questionnaires indicate that:

- Over three quarters of respondents, (77%) supported all five draft priorities.
- Over 99% were generally in favour of either a few, most or all of the draft priorities.
- Less than 1% of respondents supported none of the priorities.

When asked to select the priority or priorities that they felt were most important, respondents completing the questionnaire selected:

- 'Enabling people to be safe, independent and well and delivering high quality health and care services', with 71%
- 'Ensuring the best start in life' with 61%
- 'Promoting healthy lifestyles and making healthy choices' with 52%
- 'Creating stronger, healthier communities' was chosen by 44%
- 'Narrowing the gap in healthy life expectancy' with 33%

(It should be noted that as respondents were able to select more than one important priority, summed percentages equal more than 100%)

Respondents to the detailed questionnaire were also asked to add any comments about what they thought to be the key areas for the health and wellbeing of local people. 210 questionnaire respondents chose to provide a comment. Some of the longer or more detailed comments were broken down to accurately capture the range of topics covered. The resulting 267 comments were then grouped by theme, the outcome of which is summarised in the word cloud below:

The size of the font in the word cloud indicates the relative frequency with which a topic was mentioned by respondents – as such, we can see that the most commonly raised themes were Healthy Places, Primary Care, Access to Services, Health Promotion and Mental Health.

Token Boxes

People were invited to place a token in one of five boxes, each box being labelled with one of the JHWS draft priorities. By placing a token in a particular box, individuals indicated their preference in terms of which of the five draft priorities they felt was most important.

These token boxes were placed in three locations throughout the Borough; Enfield Civic Centre, Enfield Town Library and Edmonton Green Leisure Centre. Each location hosted the token box for one week, during which time anyone could take a token and vote for the draft priority that was most important to them.

Responses collected via the token boxes ranked priorities in a slightly different order to the questionnaire, though the popularity of priorities did vary depending on the location of the token box.

Overall, token box responses ranked the priorities in the following order:

- 'Creating stronger, healthier communities' – 39%
- 'Enabling people to be safe, independent and well and delivering high quality health and care services' – 21%
- 'Narrowing the gap in healthy life expectancy' – 17%
- 'Ensuring the best start in life' – 12%
- 'Promoting healthy lifestyles and making healthy choices' – 11%

Public Events

A number of public events took place during the consultation period, some catering to the general public, and others directed towards some specific groups and organisations – full details of these events are available in the JHWS consultation report.

Generally, those attending public events were in favour of the five priorities, with a number of people commenting on the interlinking or overlapping nature of the priorities. A wide range of comments were made at the public events, with key themes including Primary care, Healthy activities and exercise, Community involvement, Health promotion and Access to services.

Appendix 3
Equalities Impact Assessment (EQIA) summary

A key part of the Council's strategic aim of 'Fairness for All' is the principle of 'Serving the whole borough fairly and tackling inequality'. The Health and Wellbeing Board are committed to promoting equality and diversity, and working to reduce the disparities in health and wellbeing that exist across the borough. In some cases, positive action will be required to target improvements in health and wellbeing among particular groups in our community. This will require on-going, active engagement with local groups and communities to understand the diverse needs of the people of Enfield, and to put local people at the heart of shaping the way we deliver the Joint Health and Wellbeing Strategy (JHWS).

The impact of the implementation of the strategy on equalities in the borough will be monitored on an on-going basis, and further equalities impact assessments will be conducted as changes to local services are planned and implemented.

The full Equalities Impact Assessment report for the JHWS is available on the Council's webpage at www.enfield.gov.uk/jhws

Below is the EQIA action plan for the JHWS, which identifies the key steps for the implementation, monitoring and review of the strategy:

Issue	Action required	Lead officer	Timescale	Costs
Publication of full consultation report	Publish on the Council's website. Provide in accessible formats as required.	Public Health	Post final JHWS sign off	To be determined
Implement JHWS	Produce and agree a detailed action plan and performance framework. New EQIAs to be completed as advised and/or services are changed in response to commissioning decisions.	Health and Wellbeing Board	5 Year Strategy implementation/ Action plan	To be determined
Monitor JHWS action plan and risk register	Health and Wellbeing Board to have oversight of progress against JHWS detailed action plan and status of risk register.	Health and Wellbeing Board Public Health	On-going	No additional funding anticipated
Continue on-going consultation with community on Health and Wellbeing and impact of strategy	Develop communication and engagement strategy to lay out how the Health and Wellbeing Board will engage with local people.	Public Health	On-going	To be determined
Review of JHWS	Review strategy to assess outcomes and effectiveness.	Health and Wellbeing Board Public Health	Action plan to be reviewed as strategic needs change. Full strategy review due 2018/19.	No additional funding anticipated

Appendix 4
Other relevant strategies

- Barnet, Enfield and Haringey Clinical Strategy
  http://www.beh-mht.nhs.uk/Downloads/About%20Us/Publications/BEH-MHT%20Clinical%20Strategy%20-%20July%202013.pdf
- Enfield 2020 Sustainability Programme
  http://www.enfield.gov.uk/downloads/download/2227/enfield_2020_sustainability_programme
- Enfield A Fairer Future for All Council Business Plan 2012/2015
  http://www.enfield.gov.uk/download/downloads/id/851/enfield_business_plan-2012-2015
- Enfield CCG 5 year Strategic Plan – to be available at
  http://www.enfieldccg.nhs.uk/
- Enfield's Children and Young People's Plan 2011-2015
  http://www.enfield.gov.uk/ChildrensTrust/cypp
- Enfield Community Cohesion Strategy: 2010-2014
  http://www.enfield.gov.uk/esp/downloads/file/24/community_cohesion_strategy
- Enfield Core Strategy:
  http://www.enfield.gov.uk/info/200057/planning_policy/1047/core_strategy_2010
- Enfield Council Infrastructure Delivery Plan
  http://www.enfield.gov.uk/downloads/file/2075/infrastructure_delivery_plan
- Enfield Housing Strategy: 2012 – 2027
  http://www.enfield.gov.uk/downloads/file/6421/enfields_housing_strategy_2012-2027
- Improving Health and Wellbeing in Enfield, the Annual Report of the Director of Public Health 2012
  http://www.enfield.gov.uk/downloads/file/6581/public_health_report_2012
- Pharmaceutical Needs Assessment
  http://www.enfield.gov.uk/healthandwellbeing/downloads/download/1/pharmaceutical_needs_assessment
- Transforming the primary care landscape in North Central London – Primary Care Strategy
  http://www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf

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ENFIELD Council

Foreword and Executive Summary

Foreword from the Chair

The vision of Enfield's Health and Wellbeing Board is that the people of the borough live longer, healthier, happier lives. From the results of the consultation, in which over two thousand of you took time out to respond, we were not only heartened by the numbers, but also that the vast majority of you agreed with the vision and the aims of the Health and Wellbeing Board.

In many ways, it is difficult to disagree with this vision. Good health and wellbeing begins with the mother and the unborn child and continues to develop through childhood to influence everything we do. Our mental health, emotional wellbeing, social interaction and physical health all have a significant impact on our educational attainments, employment opportunities, ambitions and achievements. Not to mention how we interact with others, our personal development, family and wider relationships. And it goes without saying, how long we live.

Many of us are now living longer lives. Unfortunately in many cases it is not healthier lives as we may have to contend with one or more life threatening or long term conditions. The pressures on the NHS are increasing and the resources to deal effectively with these challenges are diminishing. To enable people to live longer, healthier, happier lives in this constraining environment can only be achieved through partnerships. A partnership of, on the one hand the Health and Wellbeing Board, and the other the residents of Enfield, and for this strategy to succeed prevention must be at its core.

The Board will undertake to increase positive outcomes in health and social care. For prevention, we will provide opportunities to increase individual and group exercise and encourage changes in those behaviours that we know have negative consequences for our health. The people of Enfield for their part must take advantage of opportunities to engage in activities and adopt behaviours that will encourage healthier lives.

The Board intends to make a real difference by investing in how its members work together and in partnership with local residents, and as we do now, ensure we make fundamental changes and improvements to the lives of local people. The organisations and individuals represented on the Board are committed to making sure there is far more integration between health and social care services, and that the wider determinants to good health and wellbeing continue to be addressed, such as the impact of housing, employment and the environment. Our priorities are supported by a set of actions and measures of success which will enable us to do this.

It will be challenging. Like many other areas of the country, Enfield faces a range of health inequalities and concerns such as growing numbers of children and adults living with obesity, and the increasing prevalence of long term conditions like diabetes, heart disease and dementia. All of which results in many of us dying earlier than we should. This is no more apparent than the stark difference between the east and west of Enfield where those in the east are expected to live significantly shorter lives than those in the west.

Enfield also has a very diverse population and the need to respond to the changes in the demographics such as the ageing population and the boroughs ethnic makeup is essential. We also need to provide better solutions for people who require support with their mental health needs and in general take an approach that is preventative and which supports positive health and wellbeing for all.

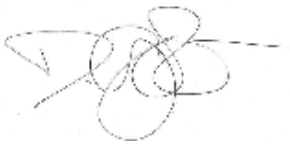
We cannot underestimate the impact of the considerable change the public sector is undergoing, not least the significant financial pressures. We know we'll need to implement this strategy with fewer resources, so we will be prudent and focus our efforts where we know we can make a real difference and pool resources where we can and it is right to do so.

We will do this by creating a robust partnership which has the people of Enfield right at its heart. We will respond to the changing expectations and needs of local residents, ensuring greater access to GP's and community based services and supporting residents to manage their own care, thereby avoiding unnecessary use of services and hospital admissions. Where support and services are required, we will make them more accessible and develop them in a coordinated way that avoids unnecessary and repetitive appointments and treatment; whether this is for our mental health and wellbeing, or for physical conditions.

As noted a key part of the development of this strategy was listening to the views of local residents. The responses to the formal consultation and the variety of comments received from the questionnaires and events that took place, made it clear residents want to live healthier lives and take a more active role in their own and others health. Many people said they want to be involved in strengthening local networks and communities, whether this is with neighbours, local community and voluntary groups, led by faith and community leaders, or the private sector. The success of this strategy is largely dependent on how residents and organisations promote and encourage changes in behaviours. Therefore, the strategy includes a number of actions to enable us to build on the success of the consultation and continue the discussions about how we can improve health and wellbeing in the borough.

I would like to thank everybody that has been involved in developing this strategy, in particular local residents for their views and support, the Health and Wellbeing Board, elected Members and individuals who demonstrated their commitment to this important agenda.

Finally, the success of any strategy is in its execution and our first step is to widely communicate what we intend to do. Then we begin the challenging and exciting journey of implementing a strategy which will deliver the best outcome for local residents – to live longer, healthier, happier lives.



Cllr. Don McGowan
Cabinet Member Adult Services, Care and Health
Chair Enfield Health & Wellbeing Board
Turkey Street Ward

Our 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

Reducing health inequalities – narrowing the gap in life expectancy

Promoting healthy lifestyles and making healthy choices

Executive Summary

Many factors affect health and wellbeing; issues such as unemployment, poor housing and feeling unsafe can all impact upon mental and physical health. The Enfield Health and Wellbeing Board (HWB) will work to mitigate such factors, as well as encouraging people to take a more active role in their own and others health, by promoting healthy weight management through diet and physical activity, controlling excess alcohol intake and supporting people to stop smoking.

This Joint Health and Wellbeing Strategy (JHWS) is as much about wellbeing as it is about health. The HWB is committed to promoting and supporting wellbeing in our local community, enabling local people to live happy, fulfilling lives.

The purpose of this strategy is to set out how the HWB will work with the population of Enfield to improve health and wellbeing across the borough over the next five years.

The HWB is a partnership which brings together the Council, Enfield Clinical Commissioning Group, Healthwatch and the voluntary and community sector. Its roles include producing a Joint Strategic Needs Assessment (JSNA), and responding to that information through the production of a JHWS.

The HWB has already engaged the local community through the consultation on the priorities in this strategy. However, this is just the start of an on-going process. The HWB will engage through a mixture of formal consultations and other activities, with various groups including community and voluntary groups, faith groups, schools and children's groups and patient/service user groups throughout the implementation of this strategy.

This strategy will ensure greater integration between health and social care. The HWB are committed to the aim of supporting individuals to plan and control their care and bring together services to achieve the outcomes important to them. The Board will develop integration plans, which will involve the HWB in dialogue with both the population of Enfield and with local stakeholders.

A detailed description of Enfield and the health and wellbeing of its people can be found within the Enfield JSNA, on the Enfield Health and Wellbeing website[1]. Links to relevant sections of the JSNA have been included in this strategy to give easy access to up to date information on key topics.

The largest cause of death in Enfield is Cardiovascular Disease (CVD) followed by cancer[2]. Much of the burden of early mortality, and its associated morbidity could be avoided by changes in lifestyle. For example:

- Meeting the Chief Medical Officer's guidelines on physical activity reduces the risk of heart disease, stroke and cancer by 30% – in Enfield, 95% of the population is not physically active enough to maximise benefits to their health[3]
- Not smoking reduces the risk of respiratory disease by up to 95% – in Enfield, 18.5% of adults smoke[4]; it is estimated that 4% of 11-15 year olds smoke more than 1 cigarette a week[5]
- In Enfield, 64.2% of the adult population is overweight or obese[6], and 24.2% of pupils in Year 6 are obese[7]

Further strengthening clinical management of existing disease also plays a key role in reducing associated morbidity and mortality.

There is a stark discrepancy between the life expectancy of the residents of the East and the West of Enfield. Those in the East are expected to live significantly shorter lives than those in the West[8].

The Health and Wellbeing Board vision is:

Working together to enable you to live longer, healthier, happier lives in Enfield

The vision is underpinned by five supporting principles:

- Prevention and early intervention
- Integration
- Equality and diversity
- Addressing health inequalities
- Ensuring good quality services.

The vision will be delivered through five key priorities, outlined below. For each of these, a number of key strategic actions have been identified, which have been selected as essential areas of work required under each of the health and wellbeing priorities.

The measures of success tables outline a number of key strategic outcomes the HWB wish to see realised through action in the short, medium and long term. This is not exhaustive, as further measures of success are included in the JHWS detailed action plan and performance framework, to be monitored by the HWB. The action plan is a living document, and will be developed and updated throughout the lifetime of the strategy to ensure that actions and measure of success continue to reflect local needs and challenge partners to deliver improved outcomes for local people.

Ensuring the best start in life: we want all children to realise their full potential, helping them to prepare from an early age to be self-sufficient and have a network of support that will enable them to live independent and healthy lives.	
Short term actions	• Understand and plan for the implications of the Children's and Families Bill on the changes for the Special Educational Needs (SEN) system up to age 25, including replacing Statements of Need with a local offer and Birth to 25 Education, Health and Care Plan. • Develop a multi-agency plan for reducing Infant Mortality, with the HWB having oversight of the plan and supporting its implementation. The plan will have a particular focus on child poverty, early access to antenatal services and integrating services. • Manage the transition of the responsibility for health visitors to public health, ensuring improved service delivery. • Enfield Council to host the local health protection forum, and in addition to co-operating with local health promotion campaigns, Enfield Public Health team will develop and implement local targeted health promotion campaigns to increase the uptake of MMR in the borough.
Medium term actions	• Develop a coherent overarching plan for transition to education for all children aged 2 and above which unifies the Healthy Child Programme and the Early Years Foundation Stage. • Redesign treatment pathways to ensure the delivery of high quality, integrated paediatric care, to provide more community-based care options and to improve the experience and outcomes of children who are ill. • Reduce paediatric admissions for asthma and other ambulatory care sensitive conditions by improving early identification and disease management in primary and community services. • Through more effective use of the School Nursing Service, and closer working with health colleagues, support schools in reducing pupil absence due to illness and medical appointments and thereby improve overall attendance rates.
Long term actions	• Improve educational attainment by ensuring all agencies involved with children in Enfield work together to provide the best educational experience possible for all children.

Ensuring the best start in life – Measures of success

- Child poverty to reduce to 25% by 2020, decreasing from the 2008 baseline of 36%
- Percentage of children receiving the full course of MMR by their 5th birthday to increase from 76.8% to 95% by 2019
- The gap between the most and least deprived wards measured in terms of child poverty to reduce from 42% (based on the 2009 baseline) to 30% by 2020
- 95% of new birth visits to be carried out between 10-14 days after birth
- 95% of pregnant women under the age of 18 who book for maternity care to receive a targeted antenatal intervention from Family Nurse Partnership/Health Visitor Service
- The percentage of absences from school due to illness to improve on the 2012/13 rate of 2.7%

Enabling people to be safe, independent and well and delivering high quality health and care services: we want people of every age to live as full a life as possible, with good health and wellbeing being encouraged from the outset. This means that people are encouraged to have lifestyles which help to prevent the onset of some diseases. When they do occur, health issues both physical and mental, should be recognised as soon as possible, as early intervention is likely to lead to better long term outcomes. It also means that where people do have to live with long term conditions, they should be supported in such a way that the condition has as small an impact on their daily life as is feasible. We want to ensure that people with any form of disability or impairment are supported in a way that promotes inclusion, independence, choice and control.	
Short term actions	• Develop a register of carers which is co-ordinated across primary care, social care, acute care and mental health. • Increase the early diagnosis of HIV infection.
Medium term actions	• Ensure that there is an increased focus on the early identification of long term conditions, in particular diabetes, chronic obstructive pulmonary disease (COPD), dementia, hypertension and CVD. • Develop a network model of primary care to ensure better access to consistent, good quality services with the potential to maintain continuity of care by: – Developing a stable system/model for a more integrated delivery of health care focused around networks and general practices, which in part will support early identification and good disease management. – Implementing a 7 day delivery model for integrated care for older people, which will support reductions in the rate of acute admissions. • Ensure that more people are able to access psychological therapies (Improving Access to Psychological Therapies – IAPT) locally by increasing uptake of the service through integrated approaches. • Co-ordinating services around the needs of the young person and family to ensure a positive experience of transition to adult services. • Establish an effective model of psychiatric liaison in North Middlesex University Hospital based on the RAID (Rapid Assessment Interface and Discharge) model. • Ensure co-ordinated care provision for people with co-occurring alcohol or substance misuse and mental health problems. • Increase the dementia diagnosis rate and improve dementia care.
Long term actions	• Develop a mental health and wellbeing service which focuses on recovery and independence for people with mental health concerns and aims to limit the number of people who require secondary mental health care. • Develop integrated models of care for older people. • Develop a whole-life mental health strategy.

Enabling people to be safe, independent and well and delivering high quality health and care services – Measures of success

- Late HIV diagnosis to reduce from the 2010 rate of 58% to 44% by 2019
- Access to psychological therapies (IAPT) to improve locally by increasing uptake from the current rate of 5% to 15% by the end of 2014/15
- Rate of admissions for people aged over 65 to residential and nursing care to reduce from 513.5 per 100,000 in 2012/13 to 476.12 per 100,000 in 2014/15
- A measure of bed days lost due to delayed transfers of care to be included, as at publication, awaiting data to inform the following measure: Delayed transfers of care to reduce from x per 100,000 population in 2012/13 to y per 100,000 population by 2014/15
- A composite measure of avoidable emergency admissions to be included, as at publication, awaiting data to inform the following measure: Avoidable admissions to reduce from x per 100,000 population in 2012/13 to y per 100,000 population by 2014/15
- Health-related quality of life for people with long-term conditions to improve from 72.24 in 2012/13 to 75.10 by 2018/19

Creating stronger, healthier communities: a large part of the lifetime health and wellbeing experience of people relates not to the health and social care that they receive, but the environment in which they live. People who are able to contribute to society through meaningful employment, live in warm, clean, safe accommodation, and live in a community with strong networks, are less likely to suffer from both mental and physical health issues.	
Short term actions	• Develop understanding amongst local people of the role that community cohesion plays in improving health and wellbeing, including reducing loneliness. • Deliver an annual programme of community engagement with those who come from different backgrounds, and ensuring that Enfield residents can continue to contribute to the development and implementation of the JHWS. • Support the outcome of the Home Office review regarding the links between ending gang and youth violence. In particular agree tasks to be overseen and delivered by the partnership represented on the HWB. • Following the publication of the JHWS, HWB to review its structures to ensure effective engagement of local people to improve their health and wellbeing.
Medium term actions	• To support and work in partnership with faith groups, the voluntary and community sector, schools and children's centres and other local organisations to deliver specific projects aimed at improving community wellbeing. • Partners on the HWB to show leadership by modelling healthy behaviours within their organisations (e.g. healthy eating choices, travel for work policies, work life balance). • Promote dementia friendly communities, which aim to improve awareness, inclusion and quality of life for people living with dementia and support for their carers.
Long term actions	• Strengthen community networks to enable individuals and families to take responsibility for their own health and wellbeing. • Improve the awareness of people of all ages and communities to make healthy lifestyle choices through positive communication and community interaction. • Building on the agreement with North Middlesex University Hospital, work in partnership with all large public sector providers and partners to promote and expand opportunities for employment, apprenticeships and volunteering for local residents, including children, young people and young parents in Enfield.

Creating stronger, healthier communities – Measures of success
• HWB structures to be reviewed by 2015 to ensure on-going engagement of local people in improving their health and wellbeing • Faith forums and community leaders to be enabled to take a lead role in improving local health and wellbeing • Communications and Engagement strategy to be developed and implemented to support the on-going implementation of the JHWS • The percentage of people who feel safe outside in their local area after dark to increase by 2019

Reducing health inequalities – narrowing the gap in life expectancy: we want to reduce the gap in life expectancy that exists within the borough, of 8 years for men, and 13 years for women.	
Short term actions	• Support implementation of Integrated Care Pathways to improve efficiency and patient experience. • Work with partners and local people in Upper Edmonton to map existing community resources that support health and wellbeing, and identify where gaps exist when compared with evidence-based practice. • Encourage early diagnosis and management (including lifestyle change) of conditions such as CVD, diabetes, cancer and COPD, and work to reduce the risk of death amongst people living with long term conditions.
Medium term actions	• Work with the community to target and deliver specific interventions in Upper Edmonton which address health inequalities in line with the Upper Edmonton action plan. • Reduce smoking rates amongst groups known to be particularly affected by high smoking prevalence. • Further strengthen clinical management of CVD, diabetes and respiratory disease.
Long term actions	• Replicate the successful targeted interventions from the Upper Edmonton action plan to other deprived areas of the borough. • Work to address the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

Reducing health inequalities – narrowing the gap in life expectancy – Measures of success
• 75% of Enfield GP practices to achieve 90% in the percentage of patients with coronary heart disease whose blood pressure is controlled by 2019 • The difference in female life expectancy between the best and worst wards to be reduced from 13 years to 10 years by 2019

Promoting healthy lifestyles and making healthy choices: the lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

We want to ensure that local people understand the impact of these choices, and are supported to choose healthier options throughout their lives, making use of the council's regulatory powers to influence local businesses and make local areas healthy places to live.

Short term actions	• Produce a comprehensive obesity strategy, covering both children and adults. • Produce a comprehensive substance misuse strategy, covering both adults and young people. • Health and Education professionals to work jointly to support and promote the Healthy Schools London programme in the borough.
Medium term actions	• Agree an action plan with schools and young persons' organisations to prevent and reduce smoking uptake. • Identify and develop more opportunities to deliver Identification and Brief Advice (IBA) interventions for harmful drinking, particularly through digital customer pathways. • Reduce the rate of alcohol-related acute representations[i] to ensure that treatment is provided in appropriate and cost-effective settings. • Develop healthy workplaces throughout Enfield, for example, improving ease of access and visibility of stairs in office buildings, offering healthy choices in work place canteens. • Promote healthy eating throughout Enfield.
Long term actions	• Ensure that transport and building developments prioritise active transport (particularly walking and cycling).

Promoting healthy lifestyles and making healthy choices – Measures of success

- The percentage of year 6 pupils classified as obese to reduce from 24% to 22% by 2019
- The percentage of obese and overweight adults in Enfield to improve from the bottom 5 London boroughs to the top quartile by 2024
- Smoking prevalence to reduce from 18.5% in 2012 to 12% by 2030
- 90% of all drug users in treatment to receive HIV and Hepatitis B interventions, and 90% of injecting drug users to receive Hepatitis C interventions
- The proportion of drug users successfully completing treatment in 2014/15 to increase to 4% above the 2013/14 target rate
- 30% of local authority schools to achieve the Healthy Schools London Bronze Award, and 10% of local authority schools to achieve Silver Award by December 2014

i This refers to people who attend or are admitted to hospital on more than one occasion because of alcohol-related illness or injury.

Next steps

There are some clear health and wellbeing challenges in Enfield and this strategy demonstrates that the needs of local people vary across the Borough and the importance of working closely with communities and local organisations to meet those needs.

It also sets out the priorities the HWB will focus on with the aim of making a real difference to the lives of Enfield people. There will be a more detailed action plan which will identify leads and outputs to deliver the programme of work as set out in the strategy. The HWB will review the progress of the action plan on a regular basis and will update the plan as required in response to changes in the evidence base (JSNA) and to reflect progress.

The HWB is committed to increasing community engagement in the delivery of the strategy. Successful implementation of the strategy relies on community and stakeholder organisations all of whom have an important part to play in this process.

The strategy will be implemented at a time when there are significant public sector financial cuts, so innovative use of existing resources will become even more important.

The full Health and Wellbeing Strategy will be reviewed in 2018/19.

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6. 2.12 – Excess weight in Adults 2012. Public Health Outcomes Framework, Public Health England. http://www.phoutcomes.info/
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In partnership with local people and

NHS Enfield Clinical Commissioning Group

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ENFIELD Council

Agenda Item 4

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **20 March 2014**	**Agenda - Part: 1** | **Item: 4** **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.

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:** Previously £5.146 m (25%) of the funding was to be linked to outcomes achieved. This condition has now been removed.

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 are based upon the following outcomes:-

- Supported admissions to residential and nursing 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 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.

It was also announced as part of the spending round in 2013 that the Better Care Fund would include funding for costs to Councils resulting from care and support reform. Plans

should show how the new duties will be met. National allocations are:

- £50m of the capital funding earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.
- £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

This £185m will equate to £1m in Enfield and is contained within the £20.586m BCF allocation.

Feedback has been received from NHS England through their quality assurance process and a RAG rating applied to key areas of the plan. Overall, the feedback on Enfield's plan was positive. There were no areas flagged as Red:

"This was a strong and well- presented draft plan. There was a clear articulation of the system change required within the plan. There is a clear and comprehensive outline of schemes. The plan links to current projects, local population needs and the challenges faced by the acute providers within the local health economy."

"More detail is required in relation to implementation of the plan locally and in relation to LA, CCG and SPG plans. Further work is required on financial modelling."

Areas flagged as amber were:

- 7 day services – more clarity needed about what we consider this to be.
- Engagement with acute providers on the impact of the plan on their services.
- Overall confidence about affordability of the plan
- Data sharing

Areas flagged as amber mean that there is confidence that any issues will be addressed by the time the plan is submitted on 4th April 2014.

2. RECOMMENDATIONS

The Health and Wellbeing Board are asked to:

i. Note the feedback received from NHS England about Enfield's BCF plan.
ii. Delegate authority to the Chair and statutory chief officers responsible for the plan to sign off the final plan before 4th April 2014 having assured themselves that all feedback received from NHS England has been responded to appropriately.

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 which, if left unaddressed, can lead 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 social 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 Capital Grant - Mental Health: Health & Wellbeing Centre	**£0.561m**	
	Care Bill Capital Allocation	**£0.162m**	
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:	**£12.404m**	
	LBE		
	Enfield CCG		

Total BCF	**£20.586m**

Key Note: In previous guidance £5.146 m (25%) of the funding was to be linked to outcomes achieved. ***This condition has now been removed.***

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 have been submitted to the NHS England on 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 4th 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 in the 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. However, the statutory duty on local authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

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 (guidance stipulates that it is bed days that are counted rather than the snapshot count of people at each month end).
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.

4.11 In addition to the five national metrics, Enfield will need to select one additional indicator.

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 Health Housing and Adult Social Care, 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

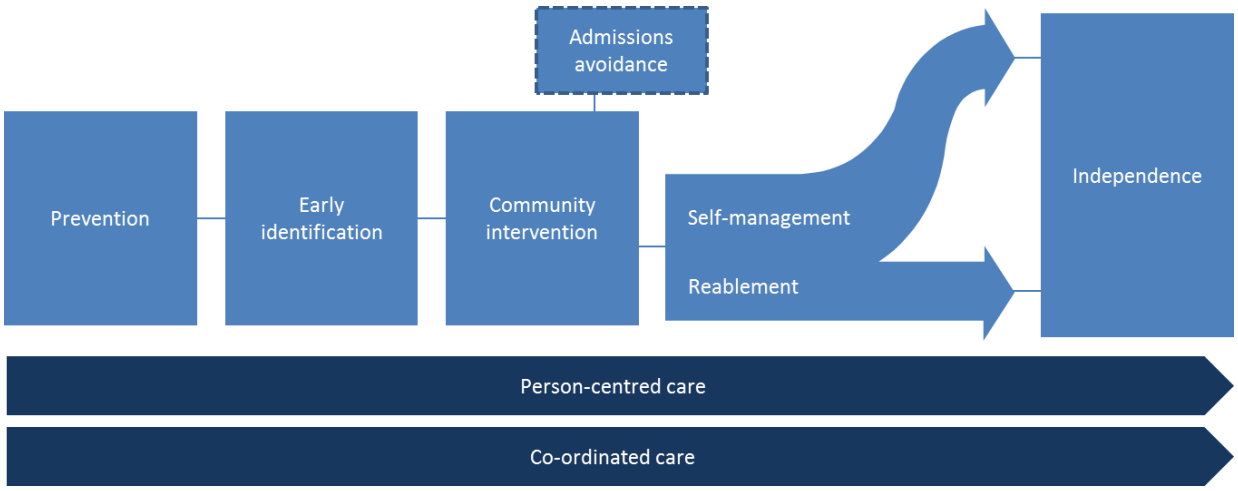
between health and care. It is not without its challenges. The Partnership have openly acknowledged - in recent workshops - that the budgets that contribute towards the BCF pooled fund are already committed which means that there is a natural inclination to protect existing services and limit the ability 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 The Better Care Fund is a major opportunity to develop our work across our 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 enabling people after a health episode.

5.6 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.

5.7 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 • Care Bill statutory framework for adults safeguarding • Carers support • Care bill statutory duty to undertake carer assessents • Preventative services • Care bill statutory duty around the provision of information and advocacy services • Warm homes programme • Primary care implementation • Data sharing • Support to providers • Care Bill national eligibility criteria	**9.340**
Working age adults – focussed on those with long term conditions	• Outpatient avoidance • Wheelchair service • Personal health budgets • Alcohol interventions	**1.565**

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.

5.8 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 as well as the new statutory requirements within the Care Bill.

5.9 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

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 was presented to the HWBB Board on the 13th of February 2014 for approval and submitted to NHS England on 14th of February 2014. The BCF plan will continue to be developed by the Integration Working Group with a view to submitting to the Health and Wellbeing Board on the 20th March with the final plan submitted on the 4th of April 2014.

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 20th March 2014 for approval. 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.

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.

9.3 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

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.

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.

It will also be clear about the requirements of the Care Bill for which funding allocations are contained within our Better Care Fund Allocation and the resource and plans to support them.

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 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.

It will also be clear about the governance and plans we are putting into place to ensure that as we disinvest from secondary care provision into more preventative

primary care provision, we are clear about the impact and potential for destabilising secondary health care provision.

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	**£20.586m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£20.586m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Enfield Clinical Commissioning Group
By	Alpesh Patel
Position	Chair
Date	20th March 2014

Signed on behalf of the Council	London Borough of Enfield
By	Councillor Doug Taylor
Position	Leader of the Council
Date	20th March 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	20th March 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.

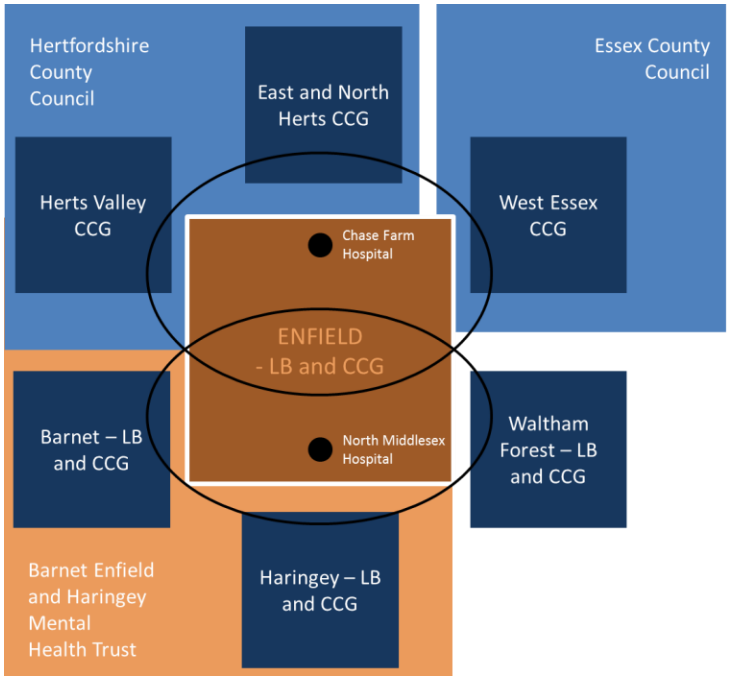
As part of our development of integrated care over the past two years, we have held regular provider forums across commissions and client groups. Open days, including the CCG's Provider Day, bring together providers to discuss emerging trends in our population, as well as strategic and financial issues 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 a 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'.

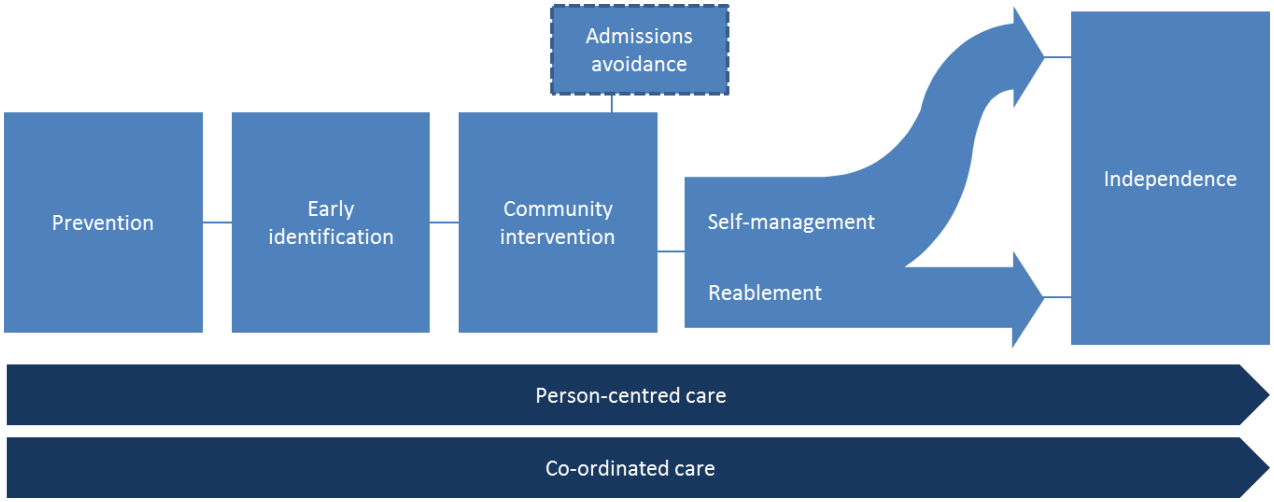
Our Health and Wellbeing Strategy, which has been refreshed alongside the development of this plan, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

- 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, CCG & provider operating plans. 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 both before and 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.

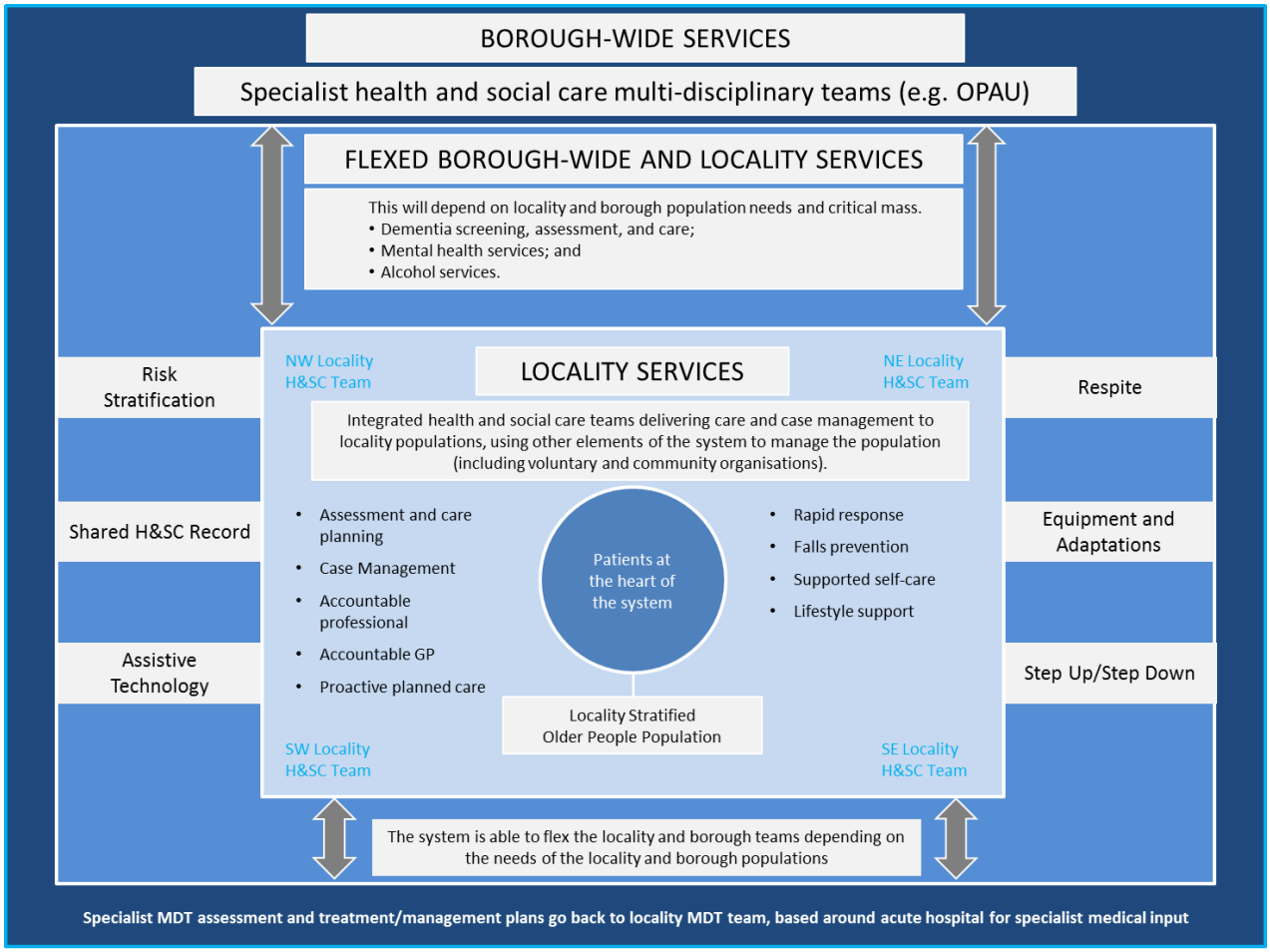
The four population groups are:

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.

The Business Case and Project plan have been developed and clearly specify expected volumes, costings and deliverables. The following comes from the business case:

A detailed multi-disciplinary model and approach has been developed and has the following features:

- A known, accessible single access point
- The GP at the heart of the process as Lead Accountable Professional
- MDT professionals to jointly identify, triage, assess, care plan & case manage patients through a case coordinator;
- Interface with other relevant professionals as part of the specialist functions;
- Interface with a locality based voluntary sector hub;
- Interface and connectedness with the wider integrated care model and solutions;

- Where needed, extended (7-day) working in the wider context of such working in integrated care.

Deliverables:

Working within the integrated care system and in line with the Better Care Fund's National Conditions, planning is underway to establish 4 multi-disciplinary Locality-Based Coordinated Community Care Teams in which the patient and GP, as the Lead Accountable Professional, are at the heart of decision-making. The delivery of this model, which will focus in this interim business case on older people with complex needs, will be developed in several phases over the next 2 years and deliver:

- Better and more pro-active identification of patients who could benefit from a community based approach to care and support across all relevant agencies;
- Better coordinated and more joined up assessment, care planning, treatment and case management of older people, appropriately tailored to their needs and preferences, in a more preventative, planned and enabling way;
- Improvements against a range of outcomes for older people and their carers including improved or maintained health, independence, quality of life and greater choice and control over their options;
- Reduced crisis-driven episodes of care and support, including reduced hospitalisation and less intensive social or health care solutions;

This will be under-pinned through an appropriate infrastructure of support, e.g. information-sharing, as part of the wider integrated care system, and the costs, resources, capacity and benefits will be fully developed in a way that represents good value for money and delivers on efficiency expectations across all commissioning agencies.

The programme has 3 phases:

Phase 1 – Rapid 3-month deployment of a locality based approach and model in 10 GP practices in the NW cluster.

Phase 2 – Moving from a locality based approach to full model implemented across Enfield by the end of March 2015.

Phase 3 – Fully embedded locality working as the norm in Enfield, expected to be in Apr-16.

The locality model diagram on page 26 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 supported 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,

> "I can 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."

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 programme, with rapid assessment through our Older People's Assessment Units (OPAUs), and more integrated support at every stage of the care pathway
2.	**Working age adults – focussed on those with long term conditions**	Provide enhanced, integrated interventions in acute and primary care settings to avoid the need for work in outpatients
3.	**Adults experiencing mental health issues**	Expand our rapid intervention model for older people experiencing dementia and expanding our mental health care model
4.	**Children with health needs**	Enhance our health and wellbeing networks and provide better early intervention in psychosis and better post-transition support to 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.

Supporting these aims we have a programme of work, some of which is already in train, some of which is being planned for implementation. Against each of these schemes is a clearly defined outcome or result. All schemes within the programme will be performance managed in order to evaluate volumes of activity, outcomes as a result of that activity, delivery of value for money and the quality of the activity. Appropriate governance structures are in place to ensure that delivery of what we are doing is evaluated against what we said we would do on a regular basis.

We expect to see as a result:

- Increased volumes through MDTs and assessment units for older people, adults and children
- more self-management of long term conditions through increased use of telehealth/telecare
- reductions in unplanned admissions to hospital and fewer discharges delayed
- increased volumes through enablement/intermediate care services
- increased volumes dealt with in a planned way through what was traditionally considered to be out of hours services (so evenings and weekends)
- reductions in residential placements and increased use of step down provision
- improved management of long term conditions like hypertension and diabetes resulting in decreasing volumes of people categorised as high or very high risk of hospitalisation through our Risk Stratification tool.
- Improved diagnosis of dementia with more low level preventative provision versus high

level support and improved quality of life

- Reduced length of hospital stay and readmission rates for people with mental ill health
- Increased numbers of people with mental ill health accessing community services, including IAPT
- Increased number of people receiving effective alcohol and drug treatment resulting in fewer alcohol and drug related hospital admissions and a reduction in drug related crime
- Longer term, increased levels of activity and reductions in obesity in children and adults
- Increasing numbers of carers supported through information, advice and services
- The creation of an integrated record across health and social care to better support assessment and case management within co-located or virtual MDTs

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 focussed o those experiencing frailty and/c disability**	The aims of Enfield's integrated care system for older people 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. 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
	Older people focussed o those experiencing frailty and/c disability (continued)	

	Older people focussed o those experiencing frailty and/c disability (continued)	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 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** **Adults experiencing mental health issues – continued**	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: • 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** **Children with health needs – continued**	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 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:

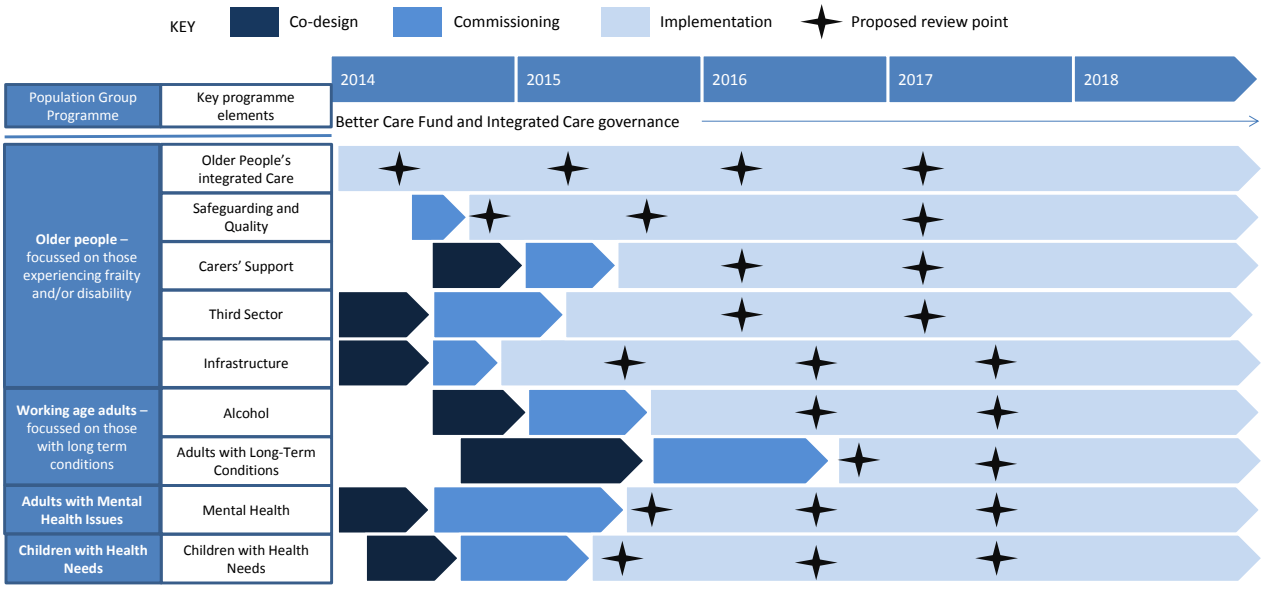
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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 tell 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, 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 o those experiencing**	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

	frailty and/c disability	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 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.
	Older people focussed o those experiencing frailty and/c disability continued	• 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

	Older people focussed o those experiencing frailty and/c disability continued	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 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 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.

Health and Adult Social Care services are currently sharing data using the NHS number as the primary identifier through the Risk Stratification project which brings together data from: GPs, Hospitals and Adult Social Care. 98% of Adult Social Care clients have an NHS number recorded. Plans are being implemented to provide NHS numbers in all correspondence with service users and professionals.

Data from the Risk Stratification tool is already being used by GPs as accountable lead professionals, to casefind and refer into our MDTs and Older Peoples Assessment Units.

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 Council has been successful in applying to become the first local authority Non-NHS Registration Authority in the country with full implementation due on 1st April 2014.

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 & creates viability & sustainability issues for providers	Amber	3	4	12	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of Savings Plans on providers • Impact of plans on quality of service delivery monitored	• Alignment of savings and investment plans through agreement 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	High Amber	3	5	15	As above	As above

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
insufficient resulting in increased demand for crisis services (residential/hospital services)						
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 number of SUIs and safeguarding referrals across the partnership	High amber	3	5	15	• Review of quality and Safeguarding arrangements in place to respond to and learn from any 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	• Development of a Multi Agency Safeguarding Hub (MASH) to deliver a more joined up 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	Amber	3	3	9	• Cross-party member briefings have taken place about this plan and the wider Health and Wellbeing	

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
event of political leadership changes					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	

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 13 FEBRUARY 2014

MEMBERSHIP

PRESENT Donald McGowan (Cabinet Member for Adult Services, Care and Health), Shahed Ahmad (Director of Public Health), Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Ayfer Orhan (Cabinet Member for Children & Young People), Dr Alpesh Patel (Chair of Local Clinical Commissioning Group) and Liz Wise (Clinical Commissioning Group (CCG) Chief Officer)

ABSENT Chris Bond (Cabinet Member for Environment), Ian Davis (Director of Environment), Christine Hamilton (Cabinet Member for Community Wellbeing and Public Health), Deborah Fowler (Enfield HealthWatch), Paul Bennett (NHS England), Litsa Worrall (Greek & Greek Cypriot Community of Enfield) and Vivien Giladi (Voluntary Sector)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Felicity Cox (Partnership Manager, Health and Well-being), Graham MacDougall (CCG - Director of Finance & Commissioning), Keezia Obi (Head of Public Health Strategy), Jill Bayley (Principal Lawyer - Safeguarding) and Eve Stickler (Assistant Director - Commissioning and Community Engagement) and Penelope Williams (Secretary)

Also Attending: Chris Neale (Price Waterhouse Coopers), Noelle Skivington (Enfield Healthwatch)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Councillors Bond and Hamilton, Vivien Giladi, Deborah Fowler, Paul Bennett, Litsa Worrall and Ian Davis.

2
DECLARATION OF INTERESTS

There were no declarations of interest.

3
JOINT HEALTH AND WELLBEING STRATEGY 2014-2019

The Board received a report from Keezia Obi, Head of Public Health Strategy, on the Joint Health and Wellbeing Strategy.

Keezia Obi presented the report to the Board:

NOTED

1. The strategy had been received by both the Council's Cabinet and Clinical Commissioning Group Board.
2. Some very minor amendments were still to be made and a foreword from the Chair included: this had been circulated separately at the meeting.
3. The final strategy document will be published and a printed version provided at March board meeting.
4. Keezia Obi thanked her team for their work on the strategy particularly for producing the document in such a short space of time.
5. The challenge would now be to implement the strategy.
6. A meeting of the working group, set up to oversee development of the strategy, will be arranged so that they can develop a performance framework and action plan. This will also be bought to the Board.
7. The chair was concerned to ensure that the targets were ambitious enough. (Post Meeting Note – the action plan and its implementation allows for change and further challenge if required).
8. The thanks of the Chair to all involved.
9. The consultation process had been recognised as excellent and was being put up as a model at a Public Health England Conference in September 2014.

AGREED

1. To note the success of the consultation process and that the majority of comments from both the questionnaires and public events have influenced the body of the report of the actions and measures of success.

2. To approve subject to minor amendments the Joint Health and Wellbeing Strategy 2014-19 as attached to the agenda report.

4
ENFIELD CLINICAL COMMISSIONING GROUP (CCG) BUDGET AND STRATEGIC PLAN 2015-20

The Board received a report from Graham MacDougal, Director of Strategy and Performance at Enfield Clinical Commissioning Group,

Graham MacDougal presented the report to the Board highlighting the following:

- The Clinical Commissioning Group is required to submit operating plans for 2014/15 and 2015/16 and a strategic plan for 2014/15 to 2018/19.

- The strategic plan is set out in the Plan on a Page Appendix to the report and covers 5 CCGs across North Central London. A draft has been submitted to NHS England, but there will be scope for revision.
- The operating plan follows the standard format laid down by Government and includes some self-assessment.
- The plan will be based on five domains and seven ambitions and a further three key measures set out on page 64 of the report. These will form the trajectory for the next five years.
- The domains and ambitions are in alignment with the aims of the Better Care Fund, the Health and Wellbeing Strategy as well as the CCG's own priorities.
- A £50m challenge fund has been set up by the Prime Minister to help GPs deliver core services.
- There will be a focus on health inequalities.
- The operating plan, together with a covering letter, was due to be submitted on the day following the meeting. Initial submission of the strategic plan is due in April with final submission in June 2014.
- The template has been provided by the Department for Health and follows a systematic process.

Questions/Comments

1. Bringing about parity of esteem and addressing inequalities was implied in the ambitions. In order to achieve the ambitions for all, certain groups would have to be targeted. Resources would be focussed on areas of greatest need and those facing greatest inequality. This will be set out more explicitly in the fuller document.

2. Parity of esteem will aim to ensure that those with mental ill health will not be disadvantaged.

3. Children, young people and maternity services will be a priority within Enfield's operating plans, even though this does not come through in the Government's template.

4. The CCG are already moving in the direction of the plans.

5. Only GP practices themselves can bid for the Prime Minister's Challenge Fund, but the CCG is working with them to help access the funds. The funds are specifically available to meet infrastructure costs and IT and to aid in transferring care from the acute sector to the primary care level. The Challenge Fund will provide one off funding, but will not help with maintaining services over the long term.

AGREED

1. To note the contents of the paper and the timetable for the submission of the Operating and Strategic Plans.

2. To recommend the Strategic and Operating Plans and to review the further budget and plans at the next Board Development Session and Board Meeting.

5
BETTER CARE FUND (FORMERLY INTEGRATED TRANSFORMATION FUND)

The Board received a report on the development of a local Better Care Fund Plan from Ray James, the Director of Health, Housing and Adult Social Care.

The report was introduced by Chris Neale from Price Waterhouse Coopers who has been working on putting together the fund submission.

NOTED

1. The Better Care Fund Plan was due to be submitted in draft on the day following the meeting.
2. Priorities for 2015/16 have been identified using the £20.5m drawn from existing local authority and CCG funding.
3. Additional information is set out in the Part 2 report.
4. The final version is almost ready, although there is more work to be done.
5. The priorities are consistent with the CCG Commissioning Plan and the Joint Health and Wellbeing Strategy.
6. The programme is capable of delivering significant benefits.
7. Much has been achieved within a very tight timescale.
8. There is still an opportunity to review proposals, and processes will be adapted as time passes.
9. The aim is to make the best use of resources based on the best available evidence.
10. Enfield will be focussing on children and young people.
11. Once submitted to NHS England, regional leads will be asked to consider and discuss the plans.
12. Ray James said that as a regional lead, Enfield's plan compared favourably with others that he had seen so far.
13. The work had been supported by the Council Management Board and the management teams at the CCG.
14. There will be challenges in implementing the proposals as the money allocated has to be taken from existing services.

AGREED

1. To note the work of the Sub Group and Steering Group and the four priority populations.
2. To endorse the draft Better Care Fund submission to NHS England, attached as Annex 1 to the report.
3. To note the contents of the part 2 report on the Fund.
4. To receive a further report on the final submission at the March Board meeting.

6
HOUSING AND HOMELESSNESS STRATEGY

The Board received a report from Sally McTernan, Assistant Director Community Housing Services on Enfield's Homelessness Strategy 2013-2018.

Ray James introduced the report to the Board.

NOTED

1. The strategy had been agreed by Cabinet in December 2013.
2. Enfield has adopted 5 key ambitions for homelessness as set out in paragraph 3.6 of the report.
3. The strategy has been bought to the Board for information, acknowledging the link between housing and health.
4. If they have been known to the authorities beforehand, homeless people are reconnected with support services.
5. There are low numbers of rough sleepers in Enfield, only 3-4 at any one time. North Middlesex Hospital runs an innovative project providing support as does UCH in Central London.

AGREED to note Enfield's 5 year Homelessness Strategy and Action Plan for 2013-2018.

7
CHILD AND FAMILY POVERTY STRATEGY UPDATE

The Board received an update report from Andrew Fraser, Director of Schools and Children's Services on the Drive towards Prosperity: Enfield's Child and Family Poverty Strategy.

Eve Stickler, Assistant Director Commissioning and Community Engagement, presented the report to the Board.

NOTED

1. The contents of the report had been discussed at a previous development meeting.
2. Eve Stickler welcomed the enthusiastic and constructive response from Board Members.
3. The report provided an update on recent activity against local pledges on reducing child poverty.
4. There is complexity around the range of measurements used for child poverty. The Government is currently consulting on this and no decision, on the key measure, has been made.
5. There has been progress in meeting the Child and Family Prosperity Strategy pledges made in 2102:

- For Pledge 1 “By 2020 we will reduce poverty to 25%”, the rate has improved from a baseline of 36% to 33%.
- For Pledge 2 “By 2020 we will narrow the gap between the most and least deprived wards, measured in terms of child poverty from 42% to 30%”, the rate has improved from the baseline of 42% to 35%.

6. Work is taking place to develop performance management, to complete an outcomes framework as part of a new measurement structure.
7. A large proportion of the work involved raising aspirations which was hard to measure.

AGREED to note the contents of the report, the recently revised action plan and progress updates.

8
PHARMACEUTICAL NEEDS ASSESSMENT 2014/15

The Board received a report on the Pharmaceutical Needs Assessment.

Allison Duggal, Consultant on Public Health, presented the report to the Board.

NOTED

1. Since 1 April 2013 the Health and Wellbeing Board has had responsibility for the Pharmaceutical Needs Assessment.
2. This had previously been produced by NHS England.
3. A steering group would be set up put together a new assessment by April 2015.

AGREED

1. To note that from 1 April 2013 the Board assumed responsibility for the Pharmaceutical Needs Assessment (PNA), published by NHS Enfield and that it has to publish its first PNA by April 2015.
2. To note that the inherited PNA was assessed externally as fit for purpose.
3. To adopt the inherited PNA for 2014/15
4. To set up a PNA Steering Group by April 2014 to produce a project plan for the HWB detailing timescales, governance structure and membership.
5. The responsibility for setting up the steering group was formally delegated to officers.

9
CHILDREN AND ADULT SAFEGUARDING ANNUAL REPORTS

1. Enfield Safeguarding Children Board Annual Report 2013-2014

The Board received the Enfield Safeguarding Children Board Annual Report 2012-2013.

Andrew Fraser, Director of Schools and Children's Services, presented the report to the Board.

NOTED

1. The apologies from Geraldine Gavin, Independent Chair of the Enfield Safeguarding Children Board, who had been unable to attend the meeting.
2. The report provided an overview of activity across all agencies. The Chair had visited a wide range of front line activities.
3. It was a good example of effective partnership working.
4. The Business Plan looks forward. A streamlined management is proposed.
5. The board has several sub committees including the Serious Case Review Panel, the Child Death Overview Panel, the Quality Assurance Panel and the Child Sexual Exploitation and Trafficking Group. The Board has been very active in working to prevent female genital mutilation and violence and sexual exploitation against women and girls.
6. OFSTED is expected to carryout and inspection of the service within the next few weeks.
7. Although they are concerned with all safeguarding activities much of the focus is on council services.
8. A good job is being carried out in very challenging circumstances.
9. The Children and Adult Boards work closely together. Many of the issues including domestic violence, drug and alcohol abuse affect both adults and children.
10. A transformation programme was being put in place.
11. Recent action against protecting children from second hand smoking was also welcomed.

2. Enfield Safeguarding Adult Board Annual Report 2012-2013

The Board received the Enfield Safeguarding Adults Board Annual Report 2012-2013.

Ray James, Director of Health, Housing and Adult Social Care, presented the report to the Board.

NOTED

1. Apologies from Marian Harrington, Independent Chair of the Enfield Safeguarding Adults Board who had been unable to attend the meeting.
2. The report sets out information on the multiagency activities taking place to safeguard adults from abuse.
3. The Board is not yet a statutory instrument, but was due to become so.

4. The report includes statements from partners setting out the progress being made in each of their areas.
5. The Board has received reasonable assurance about practice taking place. Quality Assurance is measured through independent sampling and feedback on processes.
6. There are shared processes between the Adults and Children safeguarding Boards.
7. Good work is being carried out by both the Council and the CCG.
8. There are increasing concerns about the quality of care in nursing homes, but partners are working together to improve this.
9. There is no room for complacency as there has been an increase in the number of alerts proceeding to investigation.
10. The efforts to raise awareness needed to be matched by the capacity to respond to increasing levels of referrals.

AGREED to note the progress being made in protecting vulnerable adults and children in the Borough as set out in the annual reports from the Safeguarding Children and Adults Boards.

10
SUB BOARD UPDATES

1. Health Improvement Partnership Sub Board Update

The Board received a report from Dr Shahed Ahmad, Director of Public Health updating the Board on the work of the Health Improvement Partnership Sub Board.

Allison Duggal, Public Health Consultant presented the report to the Board.

NOTED

1. The smoking quitters target has been achieved to date. Work continues in addressing the issue of smoking in cars following the national vote in favour of banning smoking in cars with children.
2. The health needs assessments are continuing and the majority should be completed by the end of the financial year. A work plan has been drawn up for next year which will include Female Genital Mutilation.
3. In terms of healthy lifestyles, many schools are receiving healthy schools awards.
4. Councillor Orhan was pleased with the decision to introduce legislation to ban smoking in cars and congratulated all involved.
5. In terms of the CCG authorisation process, the final conditions were lifted in September 2013.

6. Enfield was now top of their peer group in terms of premature mortality. Focus would now be directed on tackling inequalities such as the high rates of premature mortality among women in Upper Edmonton.

AGREED to note the contents of the report in particular:

- Enfield has the 16th highest smoking prevalence in London. The smoking quitters target has been achieved.
- The JSNA is nearing completion
- A review of maternity services is to take place in September 2014
- Public Health England has published data on premature mortality for all boroughs.

2. Joint Commissioning Sub Board Update

The Board received a report from Bindi Nagra, Assistant Director Health, Housing and Adult Social Care, Strategy and Resources, updating the Board on the work of the Joint Commissioning Sub Board.

Bindi Nagra presented the report to the Board:

NOTED

1. Before the winter period there had been concerns about the impact on the local hospitals accident and emergency services during the winter. Extra funding had been received from NHS England. As part of a range of measures to address this, 37 step down beds in care homes had been purchased – all but 4 of which were in the Borough.
2. The CCG had been asked to write up what had been done as an example of good practice.
3. There were still some issues around the transfer of care work and there had been a few issues at the Barnet and Chase Farm Hospital Trust in the past two weeks.
4. Alternatives were being sought to provide funding for the Enfield Dementia Friendly Communities, following the failure of the NESTA bid.
5. Enfield is one of 32 local areas which have been selected on to the second stage of the bidding process for the Fulfilling Lives Big Lottery Fund programme. Enfield Voluntary Action has been granted £18,000 to enable them to carry out the work required to progress the application.

AGREED to note the contents of the report.

3. Improving Primary Care Sub Group Update

The Board received a report updating them on the work to date to implement the Primary Care Strategy across Enfield.

Liz Wise, Enfield Clinical Commissioning Group Chief Officer, presented the report to the Board.

NOTED

1. We were now in the second year of a three year plan to improve services.
2. The report provided update information on key initiatives.
3. NHS England had been very complimentary about the HiLo initiative.

AGREED to note the report.

11
MINUTES OF THE MEETING HELD ON 12 DECEMBER 2013

The minutes of the meeting held on 12 December 2013 were agreed as a correct record.

12
WORK PROGRAMME 2013/14

The Board received a copy of the 2013/14 work programme.

NOTED

1. The main items to be discussed at the next informal and formal board sessions included the agreement on the Better Care Fund Submission and the CCG Commissioning Plan.

2. The Care Quality Commission were due to make a presentation to the next development session but this could be postponed to a future meeting if necessary.

AGREED that there would be no meeting on 24 April 2014 but that a short formal meeting of the Board would be held after the 20 March development session.

13
DATES OF FUTURE MEETINGS

The Board noted that the next meeting will take place on:

- Thursday 20 March 2013 at 8.00pm following the development session at 6.30pm.

The meeting which was to have taken place on 24 April 2014 has now been cancelled.

14
EXCLUSION OF PRESS AND PUBLIC

AGREED to pass a resolution under Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the items of business listed on part 2 of the agenda on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 1 (information relating to an individual) and Paragraph 2 (information likely to reveal the identity of an individual) of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

15
BETTER CARE FUND

The Board received the report containing exempt information on the Better Care Fund.

Bindi Nagra, Assistant Director Strategy and Resources, presented the report to the Board.

NOTED

1. The information contained in the report was defined as exempt under paragraph 3 (information relating to the financial or business affairs of any particular person) of schedule 12 A to the Local Government Act 1972 as amended.
2. The report contained a list of the proposed programmes, specific schemes and benefits.
3. Allowance had been made for the purchase of step down beds as there was no guarantee the money that had been made available this year would be available in future years.
4. It had been proposed that 25% of the money allocated to the fund will be performance related, subject to outcomes. This is to be clarified.
5. Workshops had been held with the acute hospital providers and they were aware of the implications.

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