Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 17 July 2014 at 6.30 pm
Room 2, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Leader of the Council – Councillor Doug Taylor
Cabinet Member for Health and Adult Social Care – Councillor Donald McGowan (Chair)
Cabinet Member for Culture, Sport Youth and Localism – Councillor Rohini Simbodyal
Cabinet Member for Education, Children's Services and Protection – Councillor Ayfer Orhan
Chair of the Local Clinical Commissioning Group – Dr Alpesh Patel
Enfield 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 in the items on the agenda.

3. BETTER CARE FUND PROGRAMME AND GOVERNANCE (Pages 1 - 56)

To receive a joint report on the Better Care Fund programme and governance arrangements from Liz Wise, Chief Officer Enfield Clinical Commissioning Group (CCG) and Ray James, Director of Health, Housing and Adult Social Care.

4. CARE ACT 2014 (Pages 57 - 66)

To receive a report from Ray James, Director of Health, Housing and Adult Social Care on the general duties and implications of the Care Act 2014.

5. CLINICAL COMMISSIONING GROUP OPERATING AND STRATEGIC PLANS (Pages 67 - 76)

To receive a report from Liz Wise, Chief Officer of the Enfield Clinical Commissioning Group (CCG), on the Clinical Commissioning Group Operating and Strategic plans.

6. SEND (SPECIAL EDUCATIONAL NEEDS AND DISABILITIES) REFORMS (Pages 77 - 86)

To receive a report from Andrew Fraser, Director of Schools and Children's Services on the SEND (Special Educational Needs and Disabilities) reforms.

7. SUB BOARD UPDATES (Pages 87 - 136)

To receive the following updates from the Board's Sub Boards:

a. Health Improvement Partnership Board
b. Joint Commissioning Board
c. Improving Primary Care Board

8. WORK PROGRAMME 2014/15

To note that the Board work programme for 2014/15 will be discussed at the development session to be held on 9 September 2014.

9. MINUTES OF MEETING HELD ON 20 MARCH 2014 (Pages 137 - 140)

To receive and agree the minutes of the meeting held on 20 March 2014.

10. DATES OF FUTURE MEETINGS

To agree the dates set aside for future meetings of the Board:

- Thursday 16 October 2014
- Thursday 11 December 2014
- Thursday 12 February 2015
- Tuesday 14 April 2015

To agree the dates for informal development sessions:

- Tuesday 9 September 2014
- Thursday 13 November 2014
- Thursday 22 January 2015
- Thursday 12 March 2015

Please note that the dates for future meetings and development sessions

have been reversed and differ from those previously sent out to board members.

11. 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)

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Agenda Item 3

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE Health and Wellbeing Board 17 July 2014	**Agenda - Part: 1** **Item: 3** **Subject: Better Care Fund Governance** **Wards:** all
Chief Officer, Enfield CCG and Director of Health, Housing and Adult Social Care Contact officer and telephone number: Peppa Aubyn E mail: peppa.aubyn@enfield.gov.uk	**Consulted:** Cllr Don McGowan

1. EXECUTIVE SUMMARY

The Better Care Fund is a national programme that will see the creation of a pooled budget made up of existing resources, to drive forward the further integration of health and care from 15/16. Part of the conditions to access the fund is that; Councils and their CCG partners are to develop a joint plan that explains how each area will enhance integration of Health and Social Care locally. The Health and Wellbeing Board at its meeting on 22nd of March 2014 approved the Enfield Joint BCF plan and the plan was submitted by the 4th of April deadline.

The Integration Sub-Board and its Working Group were established by the Health and Wellbeing Board to develop an integrated system in Enfield and deliver the Joint Better Care plan by 4th of April 2014. The Integration Sub-board and its Working Group were established under a fixed term arrangement which expired on the 4th of April 2014 with submission of the joint Strategic Better Care Fund Plan. Therefore, consideration will need to be given to the governance structure going forward for the performance management and implementation of the joint plan. This will need to be under the auspices of the Health and Wellbeing Board governance structure in line with national guidance.

This report proposes that the Health and Wellbeing Board review the on-going governance arrangements for the Better Care fund which will ensure delivery of the integration agenda and implementation of the local BCF plan is consistent with National guidance. It is recommended that the Health & Wellbeing Board consider options for the governance structure for the Better Care fund and 2 viable options are set out in this paper with a brief overview outlined as follows:-

Option 1: a new Integrated Care Board is established as a Sub Board of the Health and Wellbeing Board to take forward the BCF plan and design a blue print of what fully Integrated Services will be like across health and social care in Enfield. The new Board will replace the Integration Sub Board and its Working Group, and consolidate the Frail and Elderly Integration Board Chaired by the CCG Chief Officer and Long Term Condition's Programme Board. PLEASE REFER TO APPENDIX 1 – DRAFT TERMS OF REFERENCE FOR THE INTEGRATED CARE BOARD

Option 2: a new Joint Better Care and Commissioning Board be established as a Sub Board of the Health and Wellbeing Board to take forward the implementation of the BCF plan and design a blue print of what fully Integrated Services will look like across health and social care in Enfield. The new Board will replace the Integration Sub-Board and its

Working Group and the current Joint Commissioning Board. PLEASE REFER TO APPENDIX 2 – DRAFT TERMS OF REFERENCE FOR THE JOINT BETTER CARE AND COMMISSIONING BOARD.

It is proposed that the CCG's Chief Officer is the Chair of any new Sub Board (either Option 1 and 2) and that in addition to the new Sub Board; Executive Management from the CCG, Adult and Children's Social care will need to meet on an ad-hoc basis, yet with some frequency to design the blue print for Integration and set out what a fully immersed Health and Care system may look like for the Enfield Community. Nationally it is recognised that many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around the needs of patients and individuals. For them, co-ordinated care is essential to help them live healthy, fulfilling and independent lives. This means providing integrated care, with health and social care professionals working together to ensure care is co-ordinated around the Individual and their carer. Considering this, it is essential to set out to create a governance structure that is flexible to facilitate creativity yet is rigid in its determination to move forward the Integration Agenda at a pace so that we can improve the system for the benefit of the Enfield community.

2. RECOMMENDATIONS

The Health and Wellbeing Board are asked:

i. Note that the Joint Better Care Fund Plan was submitted by the 4th of April 2014 deadline and the content of the plan in Annexe 1; and
ii. Consider the 2 governance structures put forward in this report and approve one of the options; and
iii. Agree the membership and Terms of Reference (Appendix 1 or 2 dependent on option chosen); and
iv. Agree to the deletion of the Integration Sub Group and Working Group ; and
v. Continue to receive regular progress updates

3. BACKGROUND

3.1 This report sets out a proposed programme and new governance structure for the Joint Better Care Fund plan. The new arrangements are intended to ensure strategic and operational oversight of the Better Care Fund locally, ensuring that programmes are delivered to time, within resources and meet the conditions as set out in national guidance.

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 Better Care Fund Plan explains our approach to the further integration of health and Care and planned changes that will bring about a shift in focus and resources to realize the full potential of integration locally. Our Better Care Fund Plan was submitted on 4th of April 2014, which was the national deadline. Our Better Care Fund Plan meets all the national conditions stipulated to access the fund and explains our approach to achieving the performance outcomes attached. PLEASE REFER TO ANNEXE 1 – THE FINAL JOINT BETTER CARE FUND PLAN FOR ENFIELD.

3.4 Feedback was received from the national Better Care Fund assurance team. The plans were reviewed and assured by NHS England (London Region) with local authority input provided by the London Social Care Partnership and London Councils. The assurance process set out to ensure that plans indicated a shared vision for transformational improvement; delivering sustainable services, driving closer integration and improving outcomes for patients and service users. Feedback on our local plan was received on the 6th of May 2014. Enfield met all the criteria apart from one area of the performance metric where there were perceived gaps in information. We resubmitted the plan with further information on the 12th of May 2014.

4. GOVERNANCE AND PERFOMANCE MANAGEMENT GOING FORWARD:

It is proposed that a new Sub Board of the Health and Wellbeing Board is created to take forward and implement the Joint Better Care Fund plan and take the lead in developing thinking around the integration agenda and what a fully immersed health and care system in Enfield would look like. Many users of health and social care services experience care that is fragmented, with services reflecting professional and institutional boundaries when it should be co-ordinated around the needs of patients and individuals. For them, co-ordinated care is essential to help them live healthy, fulfilling and independent lives. This means providing integrated care, with health and social care professionals working together to ensure care is co-ordinated around the Individual and their carer. Considering this, it is essential to set out to create a governance structure that is flexible to facilitate creativity yet is rigid in its determination to move forward the Integration Agenda at a pace so that we can improve the system for the benefit of the Enfield community. As a community, we have a vested interest in getting Integrated Care right. It will enable us to provide health and care services that are seamless, joined up and place the patient / service user at the centre of what we do. Patients / service users will be empowered by an integrated health and care system that places their views, aspirations and choices above situational and institutional boundaries.

This paper sets out 2 options for the new governance structure and these are:

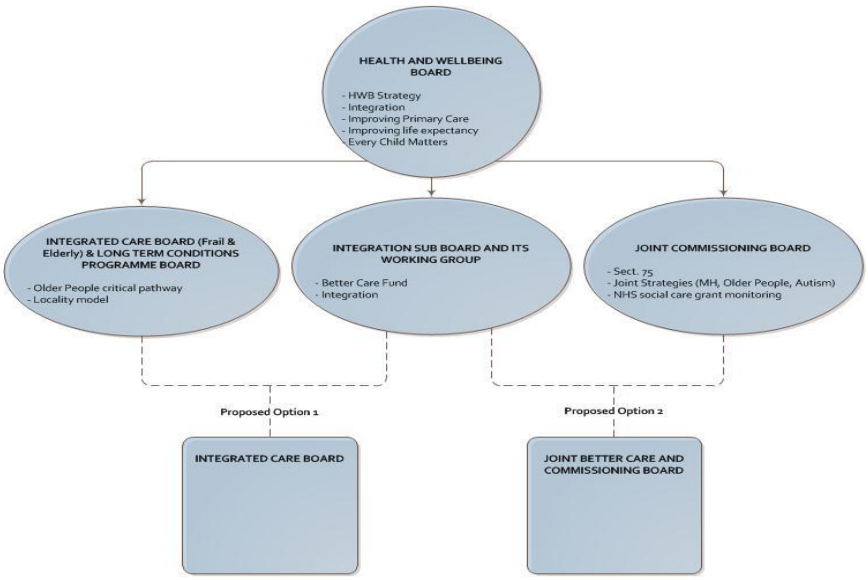
Option 1: a new Integrated Care Board is established as a Sub Board of the Health and Wellbeing Board to take forward the BCF plan and design a blue print of what fully Integrated Services will be like across health and social care in Enfield. The new Board will replace the Integration Sub Board and its Working Group, and consolidate the Frail and Elderly Integrated Care Programme Board Chaired by the CCG Chief Officer and Long Term Condition's Programme Board. PLEASE REFER TO APPENDIX 1 FOR THE DRAFT TERMS OF REFERENCE FOR THIS BOARD.

The focus of the current Integrated Care Programme Board for Frail and Elderly People and the Long Term Conditions Board is to redesign the critical pathway for Older People and those with Long Term Conditions and both these Boards are attended by clinicians, community groups, Healthwatch Representatives, operational staff, programme managers and commissioners.

Option 2: to create a new Joint Better Care and Commissioning Board be established as a Sub Board of the Health and Wellbeing Board. This will replace The Integration Sub Board and it's Working Group and the Joint Commissioning Board. PLEASE REFER TO APPENDIX 2 FOR THE DRAFT TERMS OF REFERENCE FOR THIS BOARD.

The focus of the current Joint Commissioning Board is to oversee joint commissioning activity such as the Sect.75 agreement and joint strategy development and implementation. This Board is also used to agree potential areas for further integrated services and working. This group is mainly attended by CCG's and Local Executive Management and Commissioners

Option 1 and Option 2 – illustration of consolidation



The chosen new Sub-Board will meet monthly to provide appropriate levels of leadership with a view to shaping the integration agenda and overseeing implementation and delivery of the Joint Better Fund Plan. The Chair of the new Board will be the CCG's Chief Officer.

It is important to note that; although Enfield's health and care system has already identified and implemented opportunities for integration locally, we still need to take time to develop a definitive vision and blue print for the integration of the health and care system in its entirety. In view of this, it is important that the Executive Management Team from the CCG and the council, under the auspices of the Health and Wellbeing Board, continue to meet on an ad-hoc basis to discuss the subject of Integration in order to develop thinking, build partnerships and take time out to start the process of understanding what a fully immersed and integrated system would look like, the benefits for the Enfield community and what the steps are to realise the vision.

5. OUTLINE PROGRAMME APPROACH

Our BCF plan takes 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. Our BCF plan has been separated into 4 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). These are :-

- **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

Additionally, we have added another programme that underpins and is considered as an interdependency to the other programmes yet requires is own focus, this is Infrastructure. We will map out opportunities for co-location, joint and integrated resources, automated self-service and systems with a view developing a business case. Each programme has been allocated a Programme Sponsor or SRO and Programme lead / deputy SRO, Clinical and Finance lead. The different programmes will be project managed in the same way with only one set of key milestones that will be monitored through monthly meetings of the Joint Better Care and Commissioning Board.

The projects that sit under each programme already have well thought out and considered business cases. However, it has been identified that each programme will require its own overarching business case that maps out all interdependencies (e.g. projects) and includes overarching benefits modelling with likely issues and risks. It is expected that these will be contingent with the issues and risks already highlighted as part of our Joint Strategic Better Care Fund Plan. We will of course continue to develop these business cases and ideas through regular engagement with providers, especially of acute services, patients and service users and parent / carers as well as the community of Enfield. With regards to financial monitoring and performance outcomes data collection, we are currently jointly developing our approach to these areas to ensure that we have a robust and fully encompassing monitoring framework and system. We already have a baseline for performance and finance monitoring activity as this was derived as part of the development of the plan. The Integration Working Group at its meeting on the 8th of April agreed that a Programme Manager was needed to drive forward the Integration agenda and better co-ordinate delivery of the Better Care Fund plan. We have appointed an interim programme manager and are currently going through the recruitment process to appoint on a permanent basis.

The CCG and Local Authority are working together to develop a phasing plan that looks at the activity under the different programmes and prioritises programme activity on the basis of which projects will make the most impact and produce the best outcomes for patients and service users in terms of benefit realisation. The Better Care Fund Working Group is overseeing the development of the business cases for each programme to test the viability of system redesign being proposed. The BCF plan and funding allocations may change dependent

upon recommendations in the phasing plan. There is a need to push forward with the delivery of the joint better care fund plan while being mindful about maintaining the fine balance between our level of ambition for implementing integration and destabilising the current health system.

6. ALTERNATIVE OPTIONS CONSIDERED

Do nothing – this is not a viable option and should not be considered. If we do not move forward with the integration agenda locally and implement our joint strategic plan as a partnership then we are unable to deliver the efficiencies identified in our plan and maybe at risk of removal of the performance related element of the funding.

7. REASONS FOR RECOMMENDATIONS

We are recommending that the Joint Better Care Fund Plan sits under the proposed Joint Better Care and Commissioning Board. This new Board will replace the Integration Sub Board and its Integration Working Group, as well as the Joint Commissioning Board. The new Joint Better Care and Commissioning Board will be part of the Health & Wellbeing Governance Structure. The Integration Working Group will continue in its current function until such time as new governance arrangements are agreed.

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 nationally £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 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 the fund consists of both existing resources being reallocated to the pool and additional NHS Social care grant funds.

The actual allocation of the BCF for Enfield from 2015/16 will be £20.586m. The pooled budget will included plans to protect local social care services (£5.6m) and support unavoidable demographic/demand in growth for 2015/16.

9.2 Legal Implications

9.2.1 Under section 195(1) of the Health and Social Care Act 2012, there is 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'.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 govern the functioning of the Health and Wellbeing Board. Regulation 3 (2) amends Section 101(2) of the Local Government Act 1970 to read: **'**Where any functions may be discharged by a Health and Wellbeing Board by virtue of any enactment, other than section 196(2) of the 2012 Act (other functions of health and wellbeing boards) then, unless the local authority which established the Board otherwise directs, the Board may arrange for the discharge of any of those functions by a sub-committee of the Board.'

The proposals set out in this report would appear to fall within the above provisions.

The Better Care Fund (BCF) Frequently Asked Questions guidance notes that have been issued by NHS England states that 'the accountable body will be the organisation from where the money originated, but the existing statutory section 75 arrangements will still apply for the delivery of services.'

9. KEY RISKS

10.1 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.

10.2 £1bn of the funding will be linked to outcomes achieved. This represents a significant proportion of the BCF. It is unclear at present what the impact could be if localities under perform.

10.3 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

Equalities Impact Assessments will need to be undertaken as necessary at the point of any service reconfigurations or planned changes.

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, recovery, self-resilience and independence.

ANNEX 1 – OUR JOINT STRATEGIC BETTER CARE FUND PLAN

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 in partnership by NHS Enfield Clinical Commissioning Group and Enfield Council, which includes Public Health.

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 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 and community 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:	**20 March 2014**
Date submitted:	**04 April 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	03 April 2014

Signed on behalf of the Council	London Borough of Enfield
By	Councillor Doug Taylor
Position	Leader of the Council
Date	02 April 2014

Signed on behalf of the Health and Wellbeing Board	Enfield Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Donald McGowan
Date	02 April 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. In addition, regular operational meetings are held with all providers to ensure that all providers are inputting into the development of the integrated care model within Enfield. Providers, together with commissioners, have developed and implemented the MDT model of Older People's Assessment Unit and are currently working together to develop a locality based integrated health and social care teams. Enfield CCG and London Borough of Enfield are jointly re-commissioning community services along adult and children populations which include older people with complex needs and working age adults with Long Term Conditions. The same is true in adult social care, where large events bring together providers from across the borough, alongside more specific client

group activity. This is followed up with regular communication, including newsletters. Both the CCG and the Council have established a culture of open communication with our providers, including through one-to-one leadership sessions and our ongoing contract management and commissioner-provider relationships.

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

The 5 CCGs of North central London held a strategic planning event with all its providers on 21 March 2014 where we discussed key strategic drivers including Value Based Commissioning and the Better Care Fund and discussion as to how as a Unit of Planning we continue to work strategically together as well as in individual CCGs.

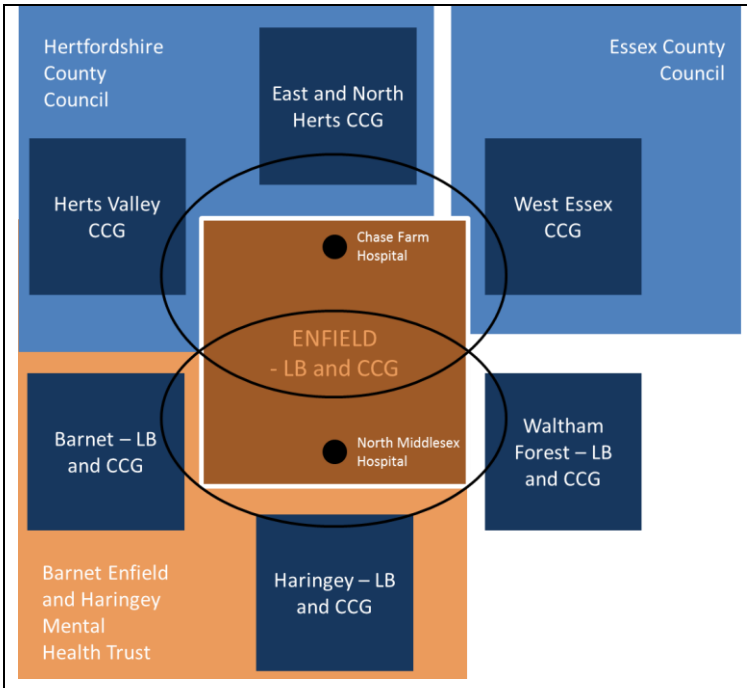
In addition to this provider engagement, because of the cross-CCG implications arising from the BCF we are working actively with our neighbouring CCGs, specifically those CCGs acting as lead commissioners for our two main acute providers.

The work with our providers builds on the substantial work we have undertaken with all our main health and social care providers in developing and implementing our integrated care programme for older people. This has enabled us to operationalise key elements of that programme – risk stratification, Older People's Assessment Unit (multi-provider MDT based at Chase Farm Hospital and North Middlesex Hospital) as well as the integrated health and social care teams at a locality level.

Activity reductions have been a part of the contract negotiations with our providers for both 2013/14 and 2014/15 contracts as part of implementing our integrated care programme for older people.

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 engaged 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, carers 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 Sector Strategic Commissioning Framework 2013-2016	This document has been shaped by our partners in the voluntary and community sector and explains our plans 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'.

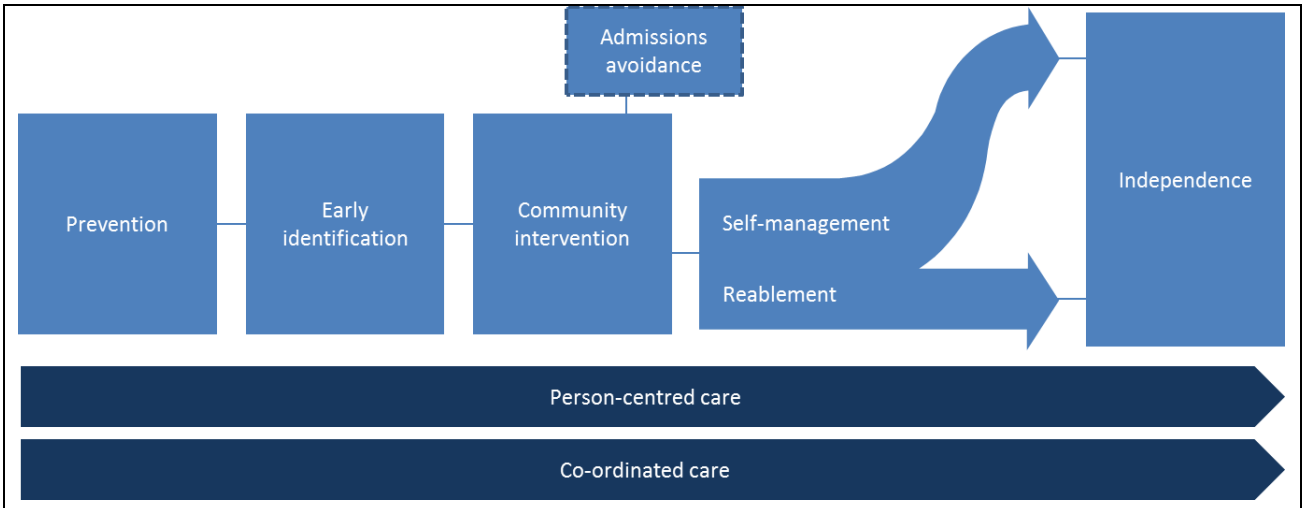
Our Health and Wellbeing Strategy, which has been refreshed alongside the development of this plan, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

- 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.

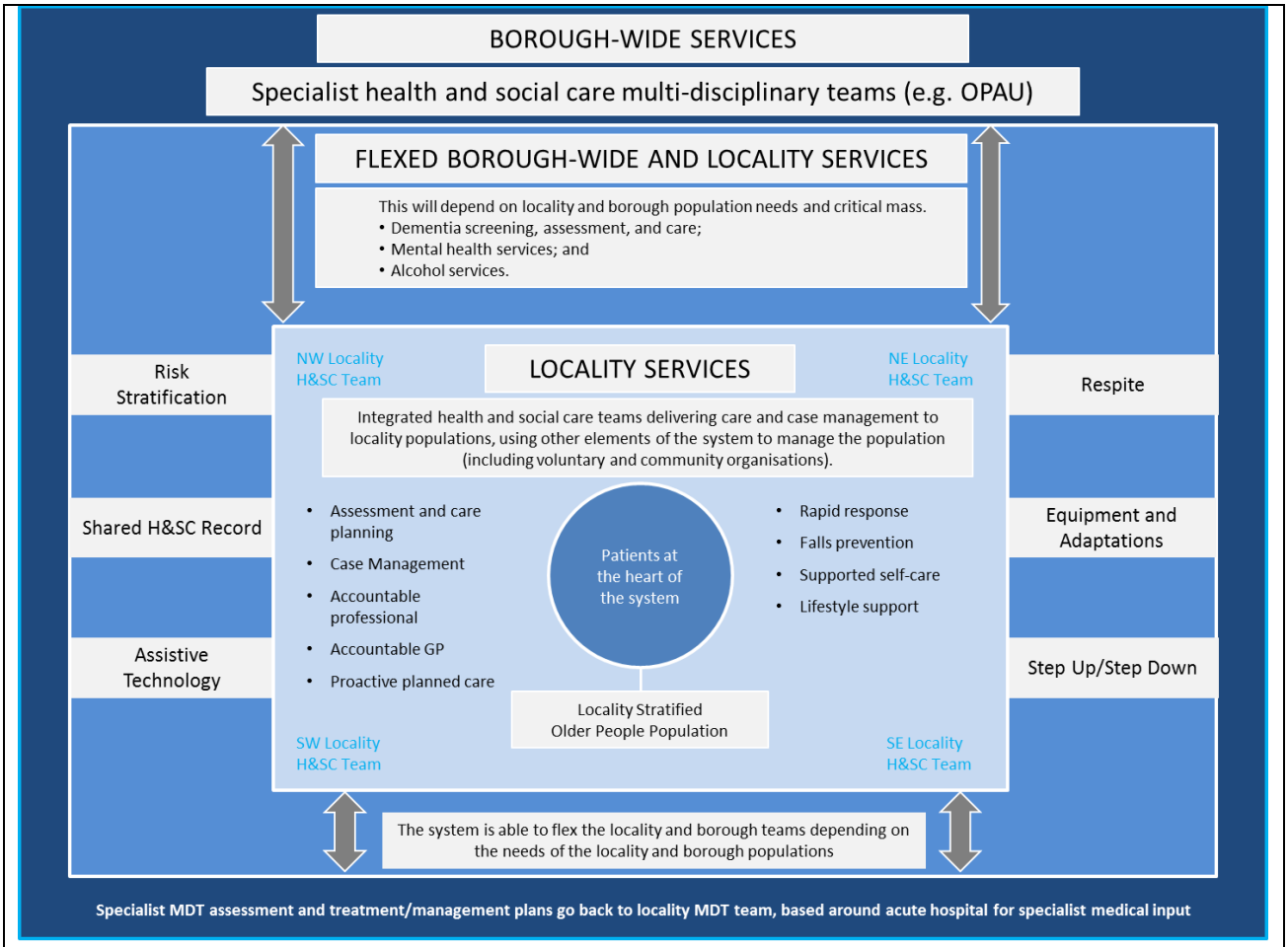
The four population groups are:

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 which 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 with a focus on prevention, reablement and improved quality of life;
- 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 aims to 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.

Phasing in of the programme has already started with an initial 3-month pilot in the North West Locality hub.

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 on those experiencing frailty and/or 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 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
	Older people – focussed on those experiencing frailty and/or disability (continued)	

	Older people – focussed on those experiencing frailty and/or disability (continued)	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**	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	

	Children with health needs – continued	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

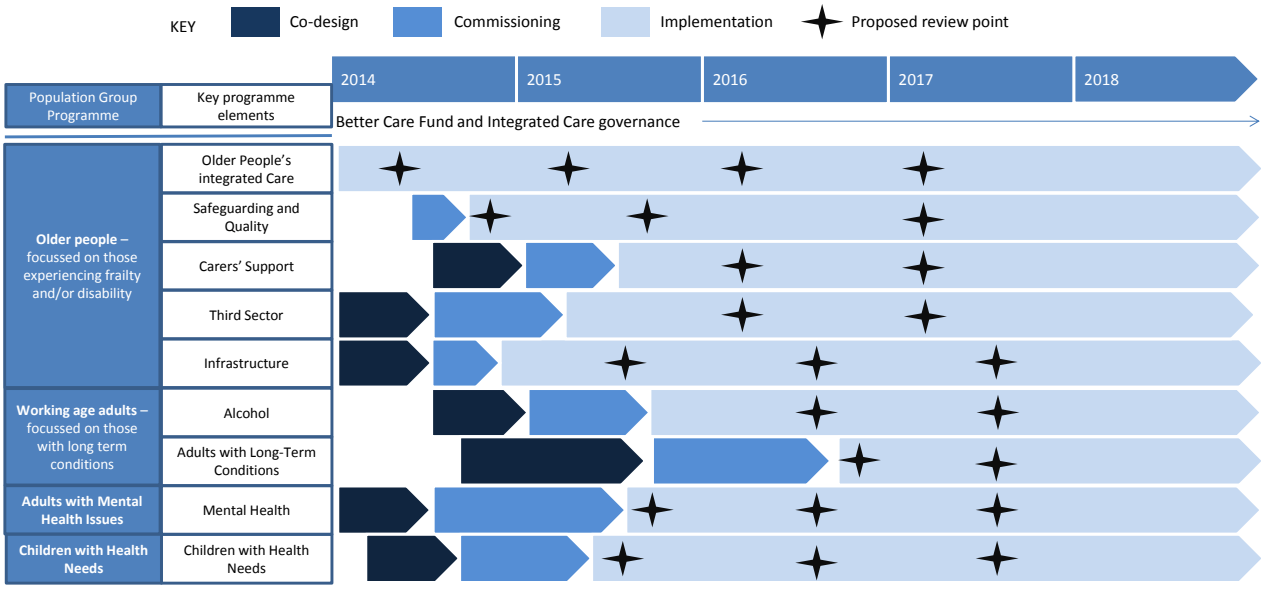
We will deploy our established partnership governance structures and processes, which cover all aspects of the commissioning cycle from the JSNA to individual commissioning plans and delivery networks, to ensure delivery of our integrated care programme in accordance with the key success factors set 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 being further advanced than others with implementation proceeding at a rapid pace.



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. The development of this plan has enabled us to be quite clear about what we expect to see in each of the four areas we have highlighted.

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

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

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

	Older people – focussed on those experiencing frailty and/or disability – continued	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 with dignity 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 and looking after their own health and wellbeing. • 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 recognition for the vital role the voluntary sector will play in realising the locality-based working model 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 and remain committed to working through the implications for our acute sector partners and plan to continue 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 for 2014/15, and post BEH Clinical Strategy, is currently c£91m and c£54m-56m respectively (contracts are still being negotiated and finals investments will be agreed shortly). 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 both those contracts. Both NMUH and BCF will be affected by other borough's 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. The intention is for the CCG and LBE to jointly develop a risk share with our providers which mitigates the risk of not realising the full shift in activity and therefore, the full saving.

We have had discussion with all our main health and social providers over the past year as part of jointly developing and implementing our integrated care for older people programme. As part of this development we have worked together to agree a set of outcome measures and metrics and have used the 2013/14 and 2014/15 contracting round to bed down the activity reductions through system changes. This has focused on reductions of emergency admission for those aged 65 years and above with a length of stay of 0-5 days. We are currently in discussion with both Barnet and Chase Farm Hospital (via Royal Free Hospital contracting team)and North Middlesex Hospital to aim to achieve the following reductions though the system changes resulting from locality MDTs and the more specialist MDT of the Older People Assessment Unit:

Trust	Activity Reduction (Admissions reduced for 2014/15))	Activity Reduction (% reduction for 2014/15))	Financial Impact (financial impact of activity reductions for 2014/15))	Investment to Acute Provider (via OPAU) 2014/15
North Middlesex Hospital	622	12.5	£2m	£408K
Barnet & Chase Farm Hospital	364	12.5	£1.3m	£343K

Initial work has been undertaken to map this activity against specific HRGs and Diagnostic Codes, including those relating to ambulatory care sensitive condition. Further work will be completed over the next few months to finalise the key HRGs where our integrated care programme expects to make impact.

d) Governance

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

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

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

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

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

NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

- Funding for personal budgets/care packages, recognising unavoidable demand and demographic growth;
- Funding increased capacity to meet growing demand for reablement, telecare, and associated interventions to reduce ongoing demand and cost; and
- Funding increases in capacity/infrastructure to ensure more integrated case management and, crucially, to protect the supply of locally available services.

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

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

Care Group	Projected annual increases over three years	Spend in 2015/16 at 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 working in all services, with the aim to coordinate seven-day working for all relevant agencies across the pathway where it makes sense to do so, in particular to avoid hospitalisation and facilitate hospital discharge. In fact, extended working arrangements were put in place as part of winter planning across the health economy in 2013/14. Such schemes were designed to be integrated care pilots in Enfield as it was important to test the use, effectiveness and impact of extended working in this environment including:

- Developing extended working within community health and social care services and at the hospital interface to ensure a timely and appropriate response to assessing patients and putting in place care and support tailored to their needs 7 days per week, including through a RAID model to support older people, including those with dementia, within hospital;

- Develop 7 day working for primary care, at network level, linked to accountable GP role

- These solutions included provision of extended working within the enablement and intermediate care teams to respond to the needs to support patients in the community quickly to avoid admissions or to facilitate hospital discharge.

These pilots provided the opportunity to understand how care and support could best be deployed at the weekend, as well as assessing the benefits and risks to such arrangements. For example, outcomes of putting such solutions in place were sustained reductions in both the number of people admitted to Council-funded residential/nursing care and in delayed transfers of care during the winter, despite a heightened level of hospital admissions. Informed by this ongoing evaluation, partners plan to invest in developing extended working in the following areas:

- Increasing the level of 7-day working in hospital-based community services (e.g. additional capacity for hospital social work and RAID teams to support joint assessments and to facilitate hospital discharge, including from A&E);

- Increased availability of locality-based multi-disciplinary workers – nursing, therapy and social care staff – including within 7 days working model of primary care and in

care homes to provide direct input into assessment, care planning & case management. This will be supported through 7-day access to community equipment and assistive technology and its response, notably Tele-Health;

- Increased availability of brokerage, intermediate care and reablement services to ensure patients, including those with dementia, are well-supported to recover and recuperate through extended working. This includes support at home as well as additional capacity and coordination of intermediate care beds;

- Extended hours and 7-day working in the Borough's Older People's Assessment Unit to facilitate assessment, diagnosis, treatment and support. A pilot to extend the hours the Unit's opening hours from 8am in response to the need to prevent older people being admitted to hospital in the morning has shown promising results.

All of these solutions will be carefully planned and evaluated to ensure there is a focussed approach to respond to the need for 7-day working across partners to ensure they represent good value for money (assuring productivity levels in extended working) for all agencies. Furthermore, extended working will only be fully effective if it is coordinated across all parts of the integrated care system, e.g. in terms of Locality Working and GP access etc.

Enfield has established both a specialist Multi-Disciplinary Team (MDT), through the Older Peoples Assessment Unit (OPAU),and a locality focussed integrated health and social care MDT in NW Locality as a pilot in collaboration with practices. We want to understand the particular areas that would benefit most from 7 day working resource coverage so we will be testing this out via both NW Locality team and the OPAU at Chase Farm hospital site. We will develop a 7 day networked model of primary care to deliver planned care as part of our integrated health and social care teams within our integrated care programme. Local practices have submitted an application to the Prime Minister's Challenge Fund to develop the infrastructure delivery for 7 day working for primary care in 2014/15. It is the intention to develop a 7 day model with or without this funding. We will run this new 7 day health and social care system for a minimum of 3 months to understand its impact on the system and to inform our formalised approach to taking forward 7 day working across the whole of Enfield.

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/com	Red	3	5	15	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions	• Development of the BCF plan across partnerships with shared priorities

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
munity services					• 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	
Need to deliver savings drives disinvestment & creates viability & sustainability issues for providers	High 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
Challenging financial climate and the level of CCG contribution, including the new Care Bill allocation, places additional risk on CCG funding of acute sector provision with risk of destabilisation increased	High Amber	3	4	12	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions that produce efficiencies and improve productivity in all parts of the system	• 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

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
Community/ primary service capacity and quality insufficient resulting in increased demand for crisis services (residential/hospital services)	High Amber	3	5	15	As above	As above
Change risks						
Transition hiatus between existing and new model of services leads to risks related to quality and safety	High amber	3	5	15	• The development of the BCF and strategic plan have been used as a key means to forward plan in detail • Accountability to H&WB board as well as internal governance boards	• A robust performance and quality outcomes framework needs to be developed to monitor outputs and quality of outcomes
Moving effectively from a focus on "services" to a focus on the "whole system"	High amber	3	5	15	• Work on jointly developed commissioning priorities and value based commissioning supports this • Accountability to H&WB board as well as internal governance boards	• A performance framework which captures a more holistic view of people's journey through the care and support systems • A programme of culture shift to support education and change in practice across all partners
The scale and pace of the change required with risk of increase in 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	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,

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
sufficient support to manage the change with resultant impact on morale and service delivery						practice and process change support for staff delivering the change • Service & team plans reflect high level priorities
London local elections in May 2014 - risk of programme delay in the event of political leadership changes	Amber	3	3	9	• Cross-party member briefings have taken place about this plan and the wider Health and Wellbeing Strategy	
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs	High amber	3	4	12	• Appropriate governance structures in place • Provision of regular, timely and accurate information to support monitoring of services	

APPENDIX 1 –TERMS OF REFERENCE AND MEMBERSHIP

Integrated Care Board

TERMS OF REFERENCE
(DRAFT)

Integrated Care Board

The Board will act as the key decision making body for the Programme by:

- Providing senior clinical & managerial leadership in the oversight & development of Integrated Care;
- Demonstrating through their actions commitment to integrated commissioning & provision supporting deployment of current resource to provide services to patients in an integrated manner;
- Owning the 'desired outcomes' (end states), benefits and value — the measures of success and overall value proposition and own the measurement of the outputs, outcomes, benefits and value against the plan and measurable expectations. This includes:
- Ensuring better outcomes for patients, service users and carers, value for money and joint working are delivered;
- The Government has established £3.8billion of funding called the Better Care Fund to explicitly enhance the further integration of health and care. To lead and performance manage the delivery local Better Care Fund 5 year strategic plan. The Integrated Care Programme Board , through the Joint Better Care Programme Manager, will provide regular reporting and monitoring information to the Health & Wellbeing Board particularly where there are perceived risks and issues to delivery.
- Ensuring clinical safety, access to care, quality of care and safeguarding adults are major considerations in all aspects of the development of integrated pathways and service redesign and that quality outcomes and patient experience are specified and monitored systematically;
- Monitoring the progress vs targets of the various work streams within the Integrated Care Programme during implementation, transition and 'business as usual'
- Leading the programme of work through facilitating and developing a positive culture across organisations for improved service integration;

- Individually and jointly take every opportunity to communicate the expected outcome to staff and patients/clients including supporting the communications campaign;
- In line with the existing and developing Joint Strategies across Enfield ensuring individual organisations are supported to implement any required changes and continue to develop robust working relationships across organisations;
- Identifying quick and sustainable opportunities for further integration of services across Enfield;
- Assisting in identifying and sharing of innovative and cost effective solutions and support unblocking of any actual or potential barriers to success;
- Having the authority to act given its senior decision maker membership and act to 'steer' the programme into the organisation, remove obstacles and manage the critical success factors;
- Jointly engaging with stakeholders (particularly staff and patients) in development and implementation of the Programme to ensure awareness and ownership;
- Ensuring that appropriate community engagement is taking place and feedback acted upon

Membership

First Name	**Surname**	**Title**
Andrew	Fraser	Director of Schools and Children's services
Barry	Chandler	AD Adults and Older People, Enfield Community Services
Bindi	Nagra	AD Adult Social Care, London Borough of Enfield
Christine	Whetstone	Over-50s Forum Representative
Dami	Akanbi	Interim Programme Administrator-Integrated Care, NHS Enfield CCG- **SCRIBE**
Deborah	Fowler	Chair Health Watch Enfield
Dr Marc	Lester	Interim Medical Director, BEH-MHT
Dr Maurice	Cohen	Physician for the Elderly and Clinical Director for Medicine, NMUH
Dr. Niel	Amin	GP Whitelodge Medical Practice & Primary Care Network Lead
Dr. Janet	High	Clinical Vice Chair, NHS Enfield CCG – **CHAIR**
Dr. Shahed	Ahmad	Director of Public Health, Enfield
Fiona	Jackson	Director of Partnerships, Royal Free Hospitals NHS Foundation Trust

First Name	Surname	Title
		(Royal Free NHS FT)
Eve	Stickler	Assistant Director of Children's Services, London Borough of Enfield
Graham	MacDougall	Director of Strategy and Partnerships, NHS Enfield CCG
Ian	Winning	Interim Chief Finance Officer, NHS Enfield CCG
Jennie	Bostock	Head of Commissioning, Community and Integrated Care, NHS Enfield CCG
Jill	Shattock	Director of Commissioning, Haringey CCG
Katie	Donlevy	Director of Integrated Care, Royal Free Hospitals NHS FT
Lee	Bojtor	Chief Operating Officer, BEH-MHT
Liz	Wise	Chief Officer, NHS Enfield CCG - **CHAIR**
Lorna	Reith	Chair Executive, Health Watch Enfield
Lorraine	Davies	AD Adult Social Care, London Borough of Enfield
Pat	McNulty	Head of Integrated Care, Royal Free Hospitals NHS FT
Paul	Allen	Programme Manager, Integrated Care, NHS Enfield CCG
Pauline	Kettless	Head of Commissioning, Procurement, Brokerage and Contracting, HASC London Borough of Enfield
TBC	TBC	Better Care Fund Programme Manager, Joint between CCG and London Borough of Enfield
Ray	James	Director of Health, Adult Social Care and Housing Services, London Borough of Enfield (LBE)
Tha	Han	Public Health Consultant, Enfield
Tim	Peachey	Chief Executive, Barnet and Chase Farm

Reporting

The Integrated Care Programme Board will receive updates from the Delivery Group chaired by the Integrated Care Programme Manager, and, in turn, provide updates to Enfield Health and Wellbeing Board. Individual members will be responsible for updating their own organisations on progress.

The Board will establish Working Groups to drive forward key programmes and engage providers and stakeholders where appropriate. Consideration is being given to establishing a Provider Reference Group and an Integration Working Group.

Chair and voting

The Chair is the Chief Officer from the CCG. The Chair will provide regular updates to the HWBB's Executive Board. Membership of the Executive Board includes the Director of Health, Housing and Adult Social Care, the Director of Children's and Schools, the CCG's Chief Officer and the Director of Public Health.

Executive members of the Board shall have one vote and decisions will be made by the majority.

Consideration will need to be given to how the Integrated Care Programme Board will share information with the Joint Commissioning Board, Value Based Commissioning and the Council's Transformation Board and Leaner 2017 programme.

APPENDIX 2 –Draft TERMS OF REFERENCE AND MEMBERSHIP

Joint Better Care and Commissioning Board

TERMS OF REFERENCE
(DRAFT)

Purpose

The purpose of the Joint Better Care and Commissioning Board is to provide a governance framework for health and social care commissioners to develop, agree, and govern the Better Care Fund, Integration of Health and Social Care and Joint Commissioning initiatives. The aim is to improve quality, safety and deliver efficiency savings through an integrated approach to the delivery of health and social care services for children and adults; and education services for children.

The Joint Better Care and Commissioning Board will report directly to the Health and Wellbeing Board and Clinical Commissioning Group Finance Recovery and QIPP Committee and the Council's Cabinet. Decision making will be through the Clinical Commissioning Group Governing Body and Council Cabinet. The Joint Better Care and Commissioning Board will be responsible for leading the implementation and performance management of the local Better Care Fund 5 year strategic plan. The Joint Better Care and Commissioning Board will report on activity to the Health and Wellbeing Board in line with key milestones of the local Better Care Fund plan.

The Joint Better Care and Commissioning Board will:

- Identify, develop and initiate service re-design and improvement projects that aim to integrate the delivery of health and social care services for children and adults with long term conditions and complex needs, and those populations identified through the joint better care fund plan.

- ensure a co-ordinated approach across health and social care commissioning (inc. Public Health) in partnership with the Clinical Commissioning Group.

  Examples might include:

  - multi-professional teams
  - link social care professionals in primary care
  - closer working with public health medicine and prevention

  - personalised care planning for high risk patients to reduce admissions to hospital
  - redesigning care pathways so they include social care as well as primary and hospital care
  - shared assessment and information sharing.
  - Co-location, shared resources, automated self-management and systems
  - 7-day working

- Lead on the development and implementation of integrated care pathways for agreed conditions in order to reduce bureaucracy and overlaps, ensure patients and their families get the care that will improve their health outcomes, and deliver efficiency savings.

- The Government has established £3.8billion of funding called the Better Care Fund to explicitly enhance the further integration of health and care. The Joint Better Care and Commissioning Board will lead and performance manage the delivery local Better Care Fund 5 year strategic plan. The Joint Better Care and Commissioning Board, through the Joint Better Care Programme Manager, will provide regular reporting and monitoring information to the Health & Wellbeing Board particularly where there are perceived risks and issues to delivery.
- Monitor implementation of joint commissioning strategies (Stroke, Dementia, Intermediate Care and Re-ablement, and End of Life Care) and receive reports on the development of new joint Strategies (for example, Autism, Mental Health, and Carers).

- Provide leadership and guidance on certain agreed commissioning intentions set out in Joint Commissioning Strategies, for example:

  - Joint Dementia Strategy: Reducing inappropriate prescribing of anti-psychotic drugs for people with dementia.
  - Joint Stroke Strategy: Introduction of ambulatory blood pressure monitors to reduce inappropriate prescribing of antihypertensive drugs.
  - Joint Mental Health Strategy (draft)

- Monitor performance of jointly commissioned services and highlight cost pressures or risks as they arise.
- Ensure that robust integrated performance management systems across health and social care are developed that enables us to monitor quality, outcomes and expenditure. The initial focus will be on ensuring integrated performance frameworks that measure the impact of joint commissioning strategy implementation are in place.
- Report through the Chair to the Health and Wellbeing Board and CCG on the performance of jointly commissioned services, the further development of integrated services and pathways, and the implementation and development of joint commissioning strategies.

Structure and Membership

The Joint Better Care and Commissioning Board will report to the Health and Wellbeing Board and Clinical Commissioning Group as per the attached governance chart. Decision making will be through the Clinical Commissioning Group Governing Body and Council Cabinet. Membership will be drawn from the Local Authority and CCG.

The Joint Better Care and Commissioning Board will establish Working Groups to drive forward key programmes and engage providers and stakeholders where appropriate. Consideration is being given to establishing a Provider Reference Group and an Integration Working Group.

Membership:

Liz Wise	Chief Officer	CCG (Chair)
Dr Alpesh Patel	CCG Clinical Lead	CCG
Bindi Nagra	Assistant Director of Strategy and Resources	LBE
Graham MacDougall	Director of Strategy and Partnerships	CCG
Eve Stickler	Assistant Director - Commissioning & Community Engagement, Schools and Children's Services	LBE
Ian Winning	Acting Director of Finance	CCG
Isabell Brittain	Assistant Director of Finance	LBE
Glenn Stewart	Assistant Director of Public Health	PH
Pauline Kettless	Head of Commissioning, Procurement, Contracting and Brokerage	LBE
Dr Anshumen Bhagat	CCG Board Member (Mental Health lead)	CCG
Dr Fahim Chowdhury	CCG Board Member (Children's lead)	CCG
Beverley James	Head of Mental Commissioning (interim)	CCG
Claire Wright	Head of Children's Commissioning	CCG
TB Recruited	Better Care Programme Manager	Joint CCG and LBE

Relevant members of the CCG and Enfield Council will be co-opted on to the Board as required.

Relevant CCG, Public Health and LBE Officers will be invited to join the Board as required.

Chair and voting

The Chair is the Chief Officer from the CCG. The Chair will provide regular updates to the HWBB's Executive Board. Membership of the Executive Board includes the Director of Health, Housing and Adult Social Care, the Director of Children's and Schools, the CCG's Chief Officer and the Director of Public Health.

Executive members of the Joint Better Care and Commissioning Board shall have one vote and decisions will be made by the majority.

Consideration will need to be given to how the Joint Better Care and Commissioning Board will share information with the CCG's Integrated Care Programme Board, Value Based Commissioning and the Council's Transformation Board and Leaner 2017 programme.

Clinical Governance

Clinical governance will be assured by the CCG Quality and Safety Committee and its Clinical Review Group.

Operation

1. Meetings will be held on a monthly basis, with working groups meeting more regularly as agreed by the Joint Better Care and Commissioning Board.

2. The Joint Better Care and Commissioning Board will be jointly chaired by CCG's Director of Strategy and Partnership and the Council's Assistant Director of Strategy and Resources from adult social.

3. Minutes will be taken and distributed no longer than 2 weeks after meetings.

4. The Chair will submit regular reports on the work of the Joint Better Care and Commissioning Board to the Health and Wellbeing Board and the Clinical Commissioning Group Finance and Recovery and QIPP Committee, through the Joint Commissioning Report.

5. Decision making will be through the Clinical Commissioning Group Governing Body, Health & Wellbeing Board and Council Cabinet.

6. The Terms of Reference, membership and meeting frequency will be reviewed after 6 months and thereafter on an annual basis.

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Agenda Item 4

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **17 July 2014**	**Agenda - Part: 1** | **Item: 4** **Subject:** The Care Act 2014 **Wards:** all
Report of: Ray James Director of Health, Housing and Adult Social Care	**Cabinet Member consulted:** Lead Cabinet Member, Health and Adult Social Care - Cllr Don McGowan
Contact officer and telephone number: Keezia Obi Email: Keezia.Obi@enfield.gov.uk Tel: 020 8379 5010	**Approved by:** Bindi Nagra, Assistant Director Strategy and Resources - Health, Housing and Adult Social Care

1. EXECUTIVE SUMMARY

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

1.2 **The Care Act (Part 1)** introduces a general duty on local authorities to promote individuals' wellbeing and rebalances adult social care towards prevention, wellbeing and independence. From 2015 council's will have a new legal framework for adult social care, putting the wellbeing of individuals at the heart of care and support. The Act will replace a number of separate pieces of legislation with a single modern law.

1.3 **Part 2 of the Care Act** gives effect to elements of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry that require primary legislation, **Part 3 – Health,** makes changes to the Trust Special Administration regime, and **Part 4 – Health and Social Care,** establishes a fund for the integration of care and support with health services, (the Better Care Fund) and makes provision for additional safeguards around the general dissemination of health and care information.

1.4 The Act is an historic piece of legislation and a significant programme of change. Draft Guidance and Regulations of Part 1 of the Act and the associated documentation alone is approximately 750 pages.

1.5 This report sets out the key requirements of Part 1 of the Care Act, the potential impact locally and progress made to implement it in Enfield.

2. RECOMMENDATIONS – this report is for information.

2.1 Note that the Care Bill received Royal Assent in May and is now an Act of Parliament.

2.2 Note that the consultation on the draft regulations and guidance for Part 1 of the Care Act has been published; and that Cabinet (at 23rd July meeting) are being asked to agree the delegation of the Council's response to Cllr Don McGowan; and

2.3 Note the implications of the Care Act on local authorities and progress made locally to prepare for implementation (see paragraph 6), including a full impact assessment and gap analysis on the basis of the key milestones set out in legislation for 2015 and 2016, and the funding allocations attached (see paragraph 7); and

2.4 Note the key risks associated with the implementation of the Care Act.

3.0 BACKGROUND

3.1 The Care Bill was introduced into the House of Lords in May 2013 and following agreement by both Houses on the text of the Bill it received Royal Assent on 14 May. It is the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support.

3.2 The current social care legislation has evolved over a number of decades and in a piecemeal manner. The Care Act sets out to consolidate several pieces of legislation with one Act and makes several new provisions. The new legislation is designed to be less complex and easier to apply for all concerned including local authorities and their practitioners and lawyers and, in the case of legal challenges, the Courts.

3.3 **The Act is in five parts. Part 1 – Care and Support,** is intended to give effect to the policies requiring primary legislation that were set out in the White Paper *Caring for our future: reforming care and support,* to implement the changes put forward by the Commission on the Funding of Care and Support, chaired by Andrew Dilnot, and to meet the recommendations of the Law Commission in its report on Adult Social Care to consolidate and modernise existing care and support law. This includes new rights for carers, a statutory framework for Safeguarding Adults and a cap on the costs of care.

3.4 **Part 2 – Care Standards**, gives effect to elements of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry that require primary legislation.

3.5 **Part 3 – Health,** makes changes to the Trust Special Administration regime. It also takes forward the necessary legislative measures for the proposals outlined in *Liberating the NHS: Developing the Healthcare workforce - From Design to Delivery*2, the establishment of Health Education England as a non-departmental public body; and those in relation to health research that were set out in the Government's *Plan for Growth3*, the establishment of the Health Research Authority as a non-departmental public body.

3.6 **Part 4 – Health and Social Care,** establishes a fund for the integration of care and support with health services, known as the Better Care Fund and makes provision for additional safeguards around the general dissemination of health and care information.

3.7 **Part 5 – General,** deals with various technical matters such as power to make consequential amendments, orders and regulations, commencement, extent and the short title of the Act.

4.0 THE CARE ACT IN PRACTICE AND UNDERLYING PRINCIPLES

4.1 The Care Act 2014 will make a difference to how people manage their own care and access care and support services. It places more emphasis than ever before on prevention and wellbeing – shifting from a system which manages crises, to one which focuses on people's strengths and capabilities and supports them to live independently for as long as possible.

4.2 In many respects is an extension of the principles of Personalisation such as information for all, access to universal services, the focus on early intervention and prevention and maximising individual choice and control, whilst maintaining a responsibility to care and protect where required. At the heart of the Act is the intention to ensure that people can remain at home as long as possible, using their own resources and continuing to play a part in the community.

4.3 The Act sets out duties for local authorities to ensure that people will have access to clearer information and advice to help them navigate the system, and a more diverse, high quality range of support to choose from to meet their needs. It will make the care and support system clearer and fairer for those who need it.

4.4 The Act sets out a new national minimum eligibility threshold to help people better understand whether they are eligible for local authority support, and it will enable older people and those with disabilities to move from one area to another with less fear of having their care and support interrupted.

4.5 The Act brings in new duties to respond to the needs of carers as they will be put on the same legal footing as the people they care for, with extended rights to assessment, and new entitlements to support to meet their eligible needs.

4.6 Of significance is a reform in the way that care and support is paid for. This includes how people pay for care and what financial support they can expect from the state, and making an existing scheme called 'Deferred Payment Agreements' more widely available. The Government has committed to making the changes recommended by an independent commission led by the economist Andrew Dilnot in 2011, which includes a cap on the amount people have to spend on the care they need at £72,000. Additionally, the means testing level has been increased so that state support is available to help to people with modest wealth. These changes will mean that people with around £118,000 worth of assets (savings or property), or less, will start to receive financial support if they need to go to a care home. The intention of the Act is that people are protected from catastrophic care costs and that the people with the least money get the most support.

5.0 KEY REQUIREMENTS AND IMPLEMENTATION TASKS

5.1 The key tasks and dates are as follows:

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

5.2 Details about the principles of the Care Act and the required changes have been set out by the Local Government Association as follows:

5.3 **FUNDING REFORM (CAP ON COSTS): IMPLEMENTATION APRIL 2016**

Key principles:

- Financial protection: everyone will know what they have to pay towards the cost of meeting their eligible needs for care and support.
- People will be protected from having to sell their home in their lifetime to pay for any care home costs.
- People will be helped to take responsibility for planning and preparing for their care needs in later life.

Important changes

- Introduction of a cap on costs of meeting eligible needs for care and support (to be set at £72,000 for those of state pension age and above when it is introduced) including independent personal budgets and care accounts. The cap will be adjusted annually, as will the amount people have accrued towards the cap.
- No contribution expected for young people entering adulthood with an eligible care need.
- Lower cap for adults of working age (level to be determined).
- Increase in capital thresholds / extension to the means test providing more support to people with modest wealth.
- New legal basis for charging covering both residential and non-residential care.
- Consistent approach towards calculating a contribution towards living costs for people in residential care.
- New framework for eligibility with threshold to be set nationally (to be implemented in April 2015).

What will need to be in place to support implementation of the Act?

- Financial and IT systems to establish and monitor care accounts.
- Arrangements for assessments for all self-funders who ask for a care account.

Suggested key tasks

- Identify local self-funders.
- Estimate time needed to assess self-funders ahead of go live date.
- Estimate cost of meeting care costs for self-funders locally.
- Identify potential impact on current workforce (new skills, capacity and configuration).
- Consider ways of conducting proportionate assessments (including for the significant volume of self-funders who will want to set their care account running) including via third sector or self-assessment.
- Calculate costs of implementation
- Review financial processes, information and advice systems and IT.
- Start a conversation with local providers about the potential impact of the reforms.

Having a good understanding of the volume of self-funders will underpin the planning and preparation for large parts of the Act, as well as inform an understanding of the overall costs of implementation locally.

5.4 DEFERRED PAYMENTS: IMPLEMENTATION APRIL 2015

Key principle:

People who face the risk of having to sell their home in their lifetime to pay for care home fees will have the option of a deferred payment.

Important changes

- Everyone in a care home who meets the eligibility criteria will be able to ask for a deferred payment regardless of whether or not the local authority pays for their care.
- Councils will be able to charge interest on loans to ensure they run on a cost neutral basis.

What will need to be in place to support implementation by April 2015?

- Sound financial processes to support increased number of Deferred Payment Agreements (DPAs).
- Sufficient staff / IT capacity.
- Robust financial processes.

Key tasks for councils

- Estimate likely increase in requests for a deferred payment locally.
- Review existing arrangements for DPA – workforce capacity, IT, finance.
- Estimate implementation costs (average length of stay in residential placements, average client contribution).
- Estimate related costs (properties subject to a DPA may be exempt from council tax).

5.5 ADDITIONAL ASSESSMENTS AND CHANGES TO ELIGIBILITY: IMPLEMENTATION APRIL 2015

Key principles:

- Early intervention and prevention: supporting people as early as possible to help maintain their wellbeing and independence.
- Eligibility to be set nationally based on risk to the individual's wellbeing (as opposed to the risk to the individual's independence).
- Focus on outcomes and wellbeing.
- Assessment to take into account the needs of the whole family as well as of any carers.
- New arrangements for transition to adult care and support.

Important changes

- Councils will have a new duty to carry out a needs assessment for all carers (no longer dependent on the cared-for person meeting the FACS eligibility criteria).
- New duty to provide advice and information to service users and carers who do not meet the eligibility threshold.
- Duty to assess young people, and carers of children, who are likely to have needs as an adult where it will be of significant benefit, to help them plan for the adult care and support they may need, before they (or the child they care for) reach 18 years.
- Legal responsibility for local authorities to cooperate to ensure a smooth transition for people with care needs to adulthood.
- New national eligibility threshold.

What will need to be in place to support implementation by April 2015?

- Expanded assessment capability to cope with increased demand.
- Assessment process that is focused on outcomes and wellbeing.
- Strong and effective partnership working across adults' and children's services during transition.

Key tasks for councils:

- Estimate the volume of additional assessments locally and the cost.
- Review assessment process to ensure it focuses on prevention and wellbeing.
- Review support and arrangements for young people and their families during transition – update procedures and training.
- Ensure workforce skills, configuration and capacity are sufficient to meet new demand and legal duties.
- Consider how assessments will be carried out for local self-funders.

5.6 ADVICE AND INFORMATION: APRIL 2015

Key principles:

- Information should be available to all, regardless of how their care is paid for.
- Good quality, comprehensive and easily accessible information will help people to make good decisions about the care and support they need.
- Councils have a key role in ensuring good quality advice is available locally and for sign posting people to independent financial advice.

Important changes:

- Councils will be required to provide comprehensive information and advice about care and support services in their area and what process people need to use to get the care and support that is available.
- They will also need to tell people where they can get independent financial advice about how to fund their care and support.
- Councils will be required to provide independent advocates to support people to be involved in key processes such as assessment and care planning, where the person would be unable to be involved otherwise.

Key tasks for councils

- Review existing advice and information services: ensure adequate funding and capacity.
- Review advice, advocacy and brokerage services locally.
- Ensure good quality financial information and advice independent of the local authority is available and people know how to access it.

5.7 COMMISSIONING: IMPLEMENTATION APRIL 2015

Key principles:

- A wide range of good quality care and support services will give people more control and choice and ensure better outcomes.
- Councils have an important role in developing the quality and range of services that local people want and need.

- Integrated commissioning with key partners, including health and housing, is essential to ensure quality as well as value for money and improve user satisfaction.

Important changes

- Duty on councils to join up care and support with health and housing where this delivers better care and promotes wellbeing.
- Duty on councils to ensure there is a wide range of care and support services available that enable local people to choose the care and support services they want (market shaping).
- New right to a personal budget and direct payment.

Key tasks for councils

- Review commissioning arrangements including capacity, skills and leadership.
- Develop market position statement(s) which clearly identify strengths / weaknesses in local provision.
- Review engagement / dialogue with local providers and service users.
- Use Better Care Fund (formerly Integration Transformation Fund) to promote coordinated health and social care which focuses on early intervention and prevention, and avoids duplication of process.

6.0 CURRENT PROGRESS TOWARDS IMPLEMENTATION OF THE CARE ACT

6.1 A Programme Board with accompanying work streams has been established in order to oversee the changes required locally, with an appropriate programme management infrastructure to oversee the work. The Board is chaired by Bindi Nagra, Assistant Director Strategy and Resources in the Councils' Health, Housing and Adult Social Care Department. Mr Nagra is also the Council's named Senior Responsible Officer (SRO) for the purposes of implementing the Act. HealthWatch is represented on the Programme Board and representation from the Clinical Commissioning Board (CCG) is being sought.

6.2 As noted the first key task is to fully understand the impact of the Act locally and an impact analysis is being undertaken. Other priority tasks underway are:

- Identifying the risk associated with the implementation of the Act including a full risk assessment
- Understanding the opportunities presented by the implementation of the Act including a benefits map
- Raising awareness of the Act including briefings for all stakeholders starting with staff and providers (further information will be made available as they are developed)
- A review of the Guidance and Regulations of Part 1 of the Act with an initial focus on the most contentious or high risk areas e.g. ordinary residence, eligibility, continuity of care, the cap and charging, transition.
- A local response to the Regulations and Guidance - the Government has opened a 10 week consultation period http://careandsupportregs.dh.gov.uk/
- Undertake research into the self-funders market

6.3 It should be noted that the Council has already established arrangements in a number of key areas of the Act so has strong foundations to build on. This is most evident in the Personalisation arrangements such as information and advice, early intervention and prevention and a scheme for Deferred Payment Agreements.

6.4 Furthermore, the Act sets out duties for local authorities regarding integration, cooperation and partnerships which includes strategic planning, integrating service provision and working with the NHS. Clearly, the planning and work already produced or being undertaken by the Health and Wellbeing Board, for example the utilisation of the Better Care Fund, the

production of Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, is further evidence of the arrangements already in place. Even so, the Act represents a significant programme of change.

7.0 THE FINANCIAL IMPACT OF IMPLEMENTING THE CARE ACT

7.1 The Government has made available an allocation to support local authorities in implementing the Care Act reforms, as follows:

Year:	2014/15			2015/16		
	Revenue	Capital	Total	Revenue	Capital	Total
Details/ Summary	£	£	£	£	£	£
Care Bill Implementation Grant 2014/15	125,000	0	**125,000**			**0**
Care Bill implementation funding in the Better Care Fund (£135m nationally)				725,000	271,000	**996,000**
Social Care New Burdens				1,542,000	270,000	**1,812,000**
	125,000	**0**	**125,000**	**2,267,000**	**541,000**	**2,808,000**

7.2 This above breaks down the allocations of Adult Social Care new burdens funding and the Better Care Fund element to cover implementation of the Care Act, which includes funding associated with the Dilnot reforms. It is important to note that the allocations may not reflect the full cost to the Council, so should be treated as indicative only.

7.3 The cap on costs the amount people will have to pay for their care is likely to be the most significant cost pressure resulting from the Act. It is expected that this will take effect in 2018/19, 3.5 years being the time expected for people to reach the cap. However, it is important to note that the wider reforms such as the increase in assessments, new rights for carers, developing the market, and the new business processes and costs relating to IT and finance systems e.g. for care accounts to calculate progression towards reaching the cap, will also have a financial impact.

7.4 Last July London Councils published their analysis of the potential financial impact of the reforms, and this indicated that the funding allocations to cover the cost of implementation will fall far short of the expected costs. It also identified that people living in London will reach the cap earlier than other parts of the country, adding to the financial burden. The report, Care and Support Reform: Cost implications for London[1], states:

"The government has announced that from April 2016 a cap will be introduced limiting the amount of money people will have to pay towards their care. This cap will be set at £72,000. The government will also raise the means testing threshold at which people are eligible for support from local authorities, from the current £23,250 to £118,000. London Councils has analysed the cost implications of these reforms, illustrating the additional cost pressures that can be expected by London boroughs.

[1] Care and Support Reform: Cost implications for London http://bit.ly/1a7ubwm

Cost pressures in London
London Councils' analysis has found that the potential total additional cost pressure that local authorities could be faced with by 2019/20 as a result of introducing the cap and raising the threshold AND the on-going social care cost pressures is approximately £1.3 billion. Approximately £877[2] million of this will be as a direct result of implementing the capped cost model for care and raising the eligibility threshold over the first four years.

National cost pressures
The government's estimates of providing £1 billion per year to fund the funding reforms nationally is inadequate. London Councils' analysis has found that the reforms nationally over four years will cost in the region of £6 billion – on average £1.5 billion per year (cost pressures will be heavily weighted in the first and fourth year of implementation)."

7.5 At local level we will develop a robust financial model to enable the Council to manage the impact of the reforms and the initial exercise of understanding the self –funders market is being undertaken as a priority.

8.0 ALTERNATIVE OPTIONS CONSIDERED

8.1 It is a statutory requirement to implement the Care Act, so no alternative options have been considered in the drafting of this report.

9.0 REASONS FOR RECOMMENDATIONS

9.1 It is a statutory duty to implement the Care Act. It is essential that the Health and Wellbeing Board is aware of the reforms and its implications.

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

10.1 Financial Implications

As stated above, the Care Act requirements are to be introduced by April 2015. The table under paragraph 7.1 above shows the grant allocations of £125k in 2014/15. Each Local authority has been awarded this allocation to "provide additional support to local Authorities for them to build change management capacity to implement the requirements of the Care Bill" (DoH circular ref: LASSL (DH)(2014)1)

A further £2.8m of grant funding has been allocated in 2015/16, of which revenue funding has been identified from the Better Care Fund (£725k), Social Care New Burdens (£1.54m) and capital funding of £541k.

As the report states the financial impact of the Care Act changes will be of a material nature. However these are unquantified at a local level, based on national estimation, once quantified this will add significant pressure to the council medium term financial plan for 2018/19, as the council will now need to provide care to self-funders once they reach the £72k cap and collect less income from clients that currently contribute towards their care costs.

When the government introduced the Care Bill it carried out an Impact assessment and advised that any new burdens on local government would be funded. However local government has been concerned for some time that there is potential for significantly greater costs than currently provided for by government.

[2] It is important to note that at the time of the financial modelling not all data was available regarding the working age thresholds of the cap.

This issue has been included in the Council's Risk Register; however it remains very difficult to accurately model the financial consequences of this significant change to legislation.

Recently the Local Government Association (LGA) has worked with London Councils, Chartered Institute of Public Finance and Accountancy (CIPFA) and the Association of Directors of Adults Social Care (ADASS) to distribute tools to help model the costs in a consistent way across the Country.

The full cost of implementation is unlikely to be felt until 2018/19 and we will continue to model and monitor the likely costs in intervening years.

10.2 Legal Implications

The Care Act 2014 received royal assent on 14 May 2014. Key implementation dates are April 2105 and April 2016. When it comes into force it will affect the law concerning the care of vulnerable adults.

The Care Act 2014 will impose a number of duties on local authorities and as yet the guidance is only in draft. It is therefore not possible at this stage to be definitive about the exact nature of the requirements which the Act will impose.

10.4 KEY RISKS - as noted, the Programme Board is currently in the process of analysing the impact of the Care Act reforms including a gap analysis. This will be followed by identification and assessment of the risk to enable us to fully understand the impact to the Council. It should be noted that until such tasks as the self-funders research is complete, some assumptions will need to be made. What is clear is that there is considerable financial risk to the Council, at a time when local authorities are required to make significant savings.

10.6 EQUALITIES IMPACT IMPLICATIONS (EIA) – a full impact assessment will be undertaken once the implications and risk business processes are completed.

10.7 IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY - the Care Act is about promoting independence and improving the health and wellbeing of local people. It will promote community networks and healthy lifestyles as people will be able to take more control of how they manage and access their own care and support.

Background Papers – None.

Agenda Item 5

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **17 July 2014**	**Agenda - Part: 1** | **Item: 5** **Subject:** NHS Enfield CCG Operating Plan and Strategic Plan **Wards:All**
Director of Strategy and Performance Contact officer - Graham MacDougall Telephone number: 0203 688 2823 Email: Graham.MacDougall@enfieldccg.nhs.uk	**Cabinet Member consulted: N/A**

1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on progress in relation to the final NHS Enfield CCG Operating Plan for 14/15 and 15/16 and the draft North Central London (NCL) Strategic Planning Group (SPG) Five Year Plan, which aligns the plans across all five NCL CCGs, Public Health, and NHS England (primary care and specialised services).

Changes to the Operating Plan are outlined, and following the discussion at the last Health and Wellbeing Board, progress on the reporting of medication errors trajectory, is explained.

Further work is still required on the NCL SPG Five Year Plan, but the latest draft was submitted to NHS England on 20 June 2014. Progress on the plan is summarised here, and the plan on a page is attached. The final version of the plan is to be submitted to NHS England in autumn 2014. It is intended that the plan will come to the Governing Body and Enfield Health and Wellbeing Board in September 2014 for approval prior to submission to NHS England.

The CCG is planning to develop a public facing Prospectus for Enfield that will draw on main themes form the NCL Five Year Plan with publication in the summer prior to the CCG's Annual General Meeting in September 2014.

The CCG's Strategic Plan (SP) and Operating Plan (OP) have previously been discussed at the Health and Wellbeing Board (HWB) on the 18th November 2013, 23rd January 2014, and 20th March 2014.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- Note revisions to the NHS Enfield CCG Operating plan
- Agree the proposed increase in reporting of medication-related safety incidents by 15%, based on NHS England guidance of a minimum expected 10% increase in reporting.
- Note progress to date on the development of the NCL SPG Five Year Plan

3. BACKGROUND

National Guidance to support the planning process, Everyone Counts, Planning for Patients 2014/15 to 2018/19, was published in December 2013. CCG's are expected to produce a two year Operating Plan and a five year Strategic Plan, for the NCL SPG. There is also a further requirement to submit a joint plan on a page.

NHS Enfield CCG is in the Strategic Planning Group, which includes the five NCL CCGs of Barnet, Camden, Enfield, Haringey, and Islington.

4. ALTERNATIVE OPTIONS CONSIDERED

No alternative options were considered.

5. REASONS FOR RECOMMENDATIONS

There is an expectation that CCG's will work with HWBB's, and specific agreement is required in relation to specific areas which were detailed in the paper that came to the Board meeting on the 20th March 2014. Agreement on the quality premium target for the reporting of medication errors is outstanding.

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

Financial Implications – A five year financial plan for NHS Enfield CCG has been submitted with the Operating Plan

6.2 Legal Implications

7. KEY RISKS

The timescales for delivery present a significant challenge to ensure appropriate joint working with Health and Wellbeing Boards and other stakeholders.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

The proposals meet the Health and Wellbeing Strategy priorities – Refer to Appendix 2.

9. EQUALITIES IMPACT IMPLICATIONS

Equality Impact Assessments and Quality Impact Assessments are undertaken routinely as part of each project under the CCG Transformation Programme, and reported to the Transformation Programme Group as part of business as usual.

10. Background Papers

NCL SPG Five Year Plan on a Page

1. Introduction

This paper updates the Health and Wellbeing Board on progress in relation to the final NHS Enfield CCG Operating Plan for 14/15 and 15/16 and the draft North Central London (NCL) Strategic Planning Group (SPG) Five Year Plan, which aligns the plans across all five NCL CCGs, Public Health, and NHS England (primary care and specialised services).

Changes to the Operating Plan are outlined, and following the discussion at the last Health and Wellbeing Board, progress on the reporting of medication errors trajectory, is explained.

The Strategic Planning Group is the vehicle for strategic planning and includes CCGs, NHSE, and now providers. NHSE are keen to see SPGs drive forward strategic change at a SPG level rather than just at a CCG level. Therefore the Strategic Plan is very much based on change at the SPG level of commissioning.

CCGs also have a strong borough-facing relationship with planning and commissioning, particularly with the local authority and as part of the Health and Wellbeing Board. There is also a strong strategic planning relationship between the CCG and borough Public Health and they contribute to our strategic planning processes. However it is clear from NHSE that their focus is on strategic planning at the SPG level rather than at a borough level.

Further work is still required on the NCL SPG Five Year Plan, but the latest draft was submitted to NHS England on 20 June 2014. Progress on the plan is summarised here, and the plan on a page is attached. The final version of the plan is to be submitted to NHS England in autumn 2014. It is intended that the plan will come to the Governing Body and Enfield Health and Wellbeing Board in September 2014 for approval prior to submission to NHS England.

2. Background

National Guidance to support the planning process, Everyone Counts, Planning for Patients 2014/15 to 2018/19, was published in December 2013. CCG's are expected to produce a two year Operating Plan and collaborate with other CCG's at SPG level to produce a Five Year Strategic Plan and a Plan on a Page.

NHS Enfield CCG is in a Strategic Planning Group (SPG), which includes the five NCL CCGs of Barnet, Camden, Enfield, Haringey, and Islington.

According to the guidance, the SPG approach will enable wider and more strategic health economy planning across CCGs , NHS England Area Teams, Providers, and Local Authorities. The expectation is that SPG's will agree a set of outcome ambitions to deliver these national ambitions, which will be fundamental to the Operating Plan submissions.

There is a further expectation of alignment with plans produced by providers and other commissioning organisations and with Health and Wellbeing Board and Better Care Fund Plans.

Prior to the publication of the new Guidance, Enfield CCG had developed a 3 year Strategic plan for 2013/14 to 2016/17 and had been working on a five year plan. This work, and work on the six transformation programmes, has been used to

develop the Operating Plan, feed into the NCL SPG Five Year Plan. It was originally thought that CCG's would be expected to submit individual Strategic Plans, but this is no longer a requirement.

The CCG is planning to develop a public facing Prospectus for Enfield that will draw on main themes form the NCL Five Year Plan with publication in the summer prior to the CCG's Annual General Meeting in September 2014.

3. Changes to the Operating Plan submission

The CCG was given the opportunity to resubmit the operating plan on the 20th June 2014. This essentially consisted of a refresh of trajectories to reflect the fact that full year data for 2013/14 is now available. However at the request of NHS England were also asked to consider our previous submissions for IAPT Access and Dementia Diagnosis.

Improving access to psychological therapies is a quality premium with a target of 15%. The Governing Body of the CCG discussed the investment plan for mental health as part of 2014/15 contract negotiations. Three areas for investment were agreed: acute adult inpatients, RAID, and IAPT. The Governing Body discussed Mental Health investment for 2014/15 as part of the contract negotiation and made the decision that is had to invest in the care of severely ill adults as this group of patients was providing the biggest challenge to the provider in terms of increased activity in inpatients. This increase in adult inpatient activity is mirrored across London. In addition, the CCG agreed to continue for 2014/15 its £1.1m investment into psychiatric liaison and RAID and this is currently being evaluated to determine its effectiveness. This has meant that the CCG has only been able to continue to invest in IAPT services to meet the target of 10% rather than the expected 15%. A target of 10% has therefore been submitted by the CCG for 2014/15, rising to 15% in 2015/16 following additional investment in IAPT through the Better Care Fund.

The original submission for Dementia Diagnosis set a trajectory of 46.43% for 14/15 and 50.36% for 15/16. Following an audit of 250 patient records it was recognised that diagnosis is under-recorded on GP registers, which are used to measure performance. Our submission has therefore been revised so that the trajectory is now 58.09% in 14/15 and 67% in 15/16, which meets the national target.

In view of the CCG's position regarding IAPT access, we were asked to reaffirm our commitment to parity of esteem across physical and mental health services, and this was done. Enfield CCG's Mental Health Commissioning Strategy and the Barnet Enfield & Haringey Mental Health Commissioning Strategy both support a move toward greater physical and mental health integration, a significant focus on recovery and enablement and the development of primary care models for mental health. The CCGs across Barnet, Enfield and Haringey are working with BEHMHT to develop an recovery and enablement model of care.

4. Reporting of Medication errors

NHS England published Quality Premium guidance for Clinical Commissioning Groups which requires improved reporting of medication-related safety incidents. Guidance states a CCG will earn this portion of the quality premium if:

- It agrees a specified increased level of reporting of medication-related safety incidents from specified local providers for the period between Q4, 2013/14 and Q4, 2014/15;
- These providers achieve the increase.

It is also expected that increases in reporting are agreed with Health and Wellbeing Boards.

Enfield CCG's two main providers, specifically Barnet, Enfield and Haringey Mental health Trust and Barnet and Chase Farm Hospitals NHS Trust, are both currently reporting significantly below average for their trust size and type within their London wide peer group.

Calculations showed increases in reporting for both Trusts of at least 30% would be necessary to bring them up to current London averages within their peer groups. NHS England's Head of Patient Safety has since advised CCG's London wide that is reasonable to expect trusts with below average, around average or just above average levels to show an increase in the number of medication-related safety incidents reported by a minimum of 10% over the year.

CCG Directors have now agreed a reasonable stretch on the minimum to 15% during 2014/15. This will allow Trusts to work towards current London averages over a longer period, is more likely achievable, and less likely to lead to inappropriate reporting that may result to meet a higher target.

Every CCG has undertaken calculations using data from NHS England's National Reporting and Learning System (NRLS). Although this allows providers to be benchmarked against their peers, it provides only Trust wide data and does not provide borough level data as the HWBB had requested.

It is therefore anticipated that borough level data will be requested as part of reporting on numbers of medication-related safety incidents through Clinical Quality Review Groups held with provider trusts.

5. The North Central London Strategic Planning Group Five Year Plan

North Central London (NCL) health economy is a system comprised of partners from Barnet CCG, Camden CCG, Enfield CCG, Haringey CCG, and Islington CCG who have come together to agree refine and implement the following strategic intent:

"To drive improvement in the delivery of high quality, evidence–based and compassionate services, defined and measured by outcomes not process, to the population of north-central London".

Context

Across the five boroughs of North Central London (NCL), the Health Economy comprises five Clinical Commissioning Groups (CCGs) and their respective Local Authority partners, six acute and specialist trusts (of which three are Foundation Trusts), six community and/or mental health trusts and **over** 240 GP practices. NHS England is also one of the largest commissioners of services in North Central London.

The purpose of this North Central London Five Year Strategic Plan is to set out the collective plans and priorities of the five CCGs of NCL, who are working in partnership with NHS England (commissioners of primary care and specialist services), and Health Education North Central and East London.

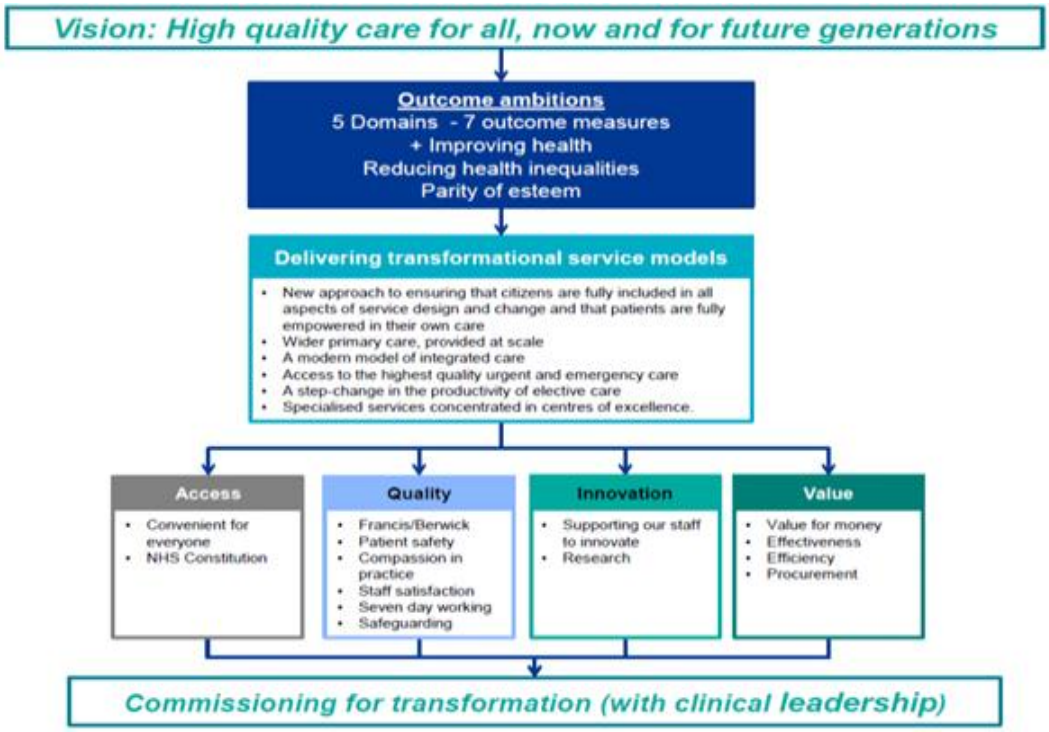
The SPG consults widely, and as part of the preparation of this strategy, has consulted particularly with Local Providers, Local Authorities and Health and Wellbeing Boards.

The NCL Five Year Plan sets out the vision and ambitions for patient care and service improvement. It summarises the full range of plans that have been developed across NCL, from how we will ensure patient safety in all settings of care, to how we will support research and innovation, through to how we will design and implement new models of joined up, person-centred care to address the fundamental challenges facing our health and care system.

The Plan also articulates how we will work more closely than ever with patients and the public, building on work to embed and sustain co-production as a first principle.

The Plan is also intended to demonstrate to NHS England that our plans are robust, comprehensive and fit-for-purpose. Therefore, the document reflects the latest planning guidance as published in *Everyone Counts: Planning for Patients 2014/15 to 2018/19*, including 21 fundamental national planning requirements.

The NCL Plan is consistent with NHS England's vision, outcome ambitions, service models and essentials, as is articulated throughout the document NHS England vision for the NHS, and is summarised in the diagram below:



Plan on a page

The plan on a page below summarises:

- The vision for the NCL Five Year Plan;
- The outcome measures to be achieved as a measure of delivering the vision; and
- The seven service interventions that will be used to support delivery.

The vision in the NCL Five Year Plan is to transform services through clinically-led, innovative service re-design so that in 5 years:

- The emphasis of the NHS will have shifted to:
  - Developing a systematic approach to preventing disease;
  - Diagnosing disease earlier to reduce complications;
  - Reducing inequalities in health outcomes by targeting vulnerable groups in new ways;
  - Encouraging individuals to take greater responsibility for their health; and
  - Supporting self-management of illness.

- Patients will experience the following:
  - Compassionate, high quality, safe, effective and efficient care pathways that they will have been involved in shaping and evaluating;
  - Care that is integrated within and between organisations and focussed around those outcomes defined and shaped by them; and
  - Easy access to services delivered in ways and settings most convenient to them.

- Integration of care will be driven and enabled by:
  - Development and deployment of shared digital records both for clinical record sharing, data sharing and systems measurement and evaluation; and
  - Services to be commissioned and contracted in ways that support partnership and integrated working.

- Long term financial sustainability across NCL will be achieved through
  - Clinically-driven focus on quality;
  - The delivery of effective (evidence-based) and efficient (right first time) care; and
  - Elimination of the 'cost of chaos' (duplication and fragmentation of care).

We will achieve the vision by working in closer partnership across the local health and social care systems to:

- Engage and involve the local population so they can work with commissioners to define outcomes that are important and meaningful to them;
- Engage with Public Health and the HWB Boards on innovative prevention and health promotion schemes in our schools, environment and work places;
- Empower CCGs member practices who now play a key role in defining local priorities and commissioning intentions, working to improve primary care quality and access and to monitor the quality and effectiveness of all our providers;
- Continue to collaborate with all providers and partners across Health, Local Authority, Social Care and Voluntary Sectors who have already demonstrated commitment to developing the integration of the system to work across organisational boundaries;
- Employ technological advances around sharing IT and information to improve communications across the whole system;
- Ensure commissioning is outcome-focussed rather than process driven with governance arrangements that see responsibility for delivering population outcomes across pathways of care not within individual organisations;
- Ensure the outcomes of providers are accessible to patients to enable and inform choice; and

- Extend existing links with local academic institutions, across CCGs and with NHS England with whom we will have a co-commissioning role across specialist commissioning and primary care and an assurance partnership to assist in delivering the CCGs' priorities.

6. Recommendations

The Health and Wellbeing Board is asked to:

- Note revisions to the NHS Enfield CCG Operating plan
- Agree the proposed increase in reporting of medication-related safety incidents by 15%, based on NHS England guidance of a minimum expected 10% increase in reporting.
- Note progress to date on the development of the NCL SPG Five Year Plan

Vision: An integrated care network between organisations focused on outcomes and shaped by patients

7 Outcome Measures to be delivered by March 2019

1. Reducing the number of years of life lost by 9.2%.
2. Improving the health related quality of life of those with 1+ long-term conditions by 4.3%.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital by 5.3%.
4. Increasing the proportion of older people living independently at home following discharge from hospital (to be agreed)
5. Reducing the proportion of people reporting a very poor experience of inpatient care by 8.5%.
6. Reducing the proportion of people reporting v. poor experience of primary care by 15.7%.
7. Making significant progress towards eliminating avoidable deaths in our Hospitals (to be agreed)

Integrated Care through Value Based Commissioning (VbC)
The NCL CCGs are working together on an innovative model to drive the future of healthcare commissioning whereby care will be delivered based on outcomes with providers encouraged to work together to provide integrated care across boundaries.

Mental Health strategy
Ensuring parity of esteem across the local health economy and
Delivery of consistent high quality care by CCGs with providers working together.

Urgent Care strategy
The CCGs are working collaboratively across NCL on commissioning a new NHS111/GP Out of Hours integrated service which improves access, patient experience and outcomes and deliver a consistent offering. Based on the principles of right care, right place first time.

Barnet, Enfield and Haringey Clinical Strategy
The BEH Clinical Strategy Programme delivered service changes across B&CF and NMUH

Primary Care strategy
This will be delivered through co-commissioning to ensure benefits for patient access and experience with development of a viable quality primary care service as the foundation for system wide improvement. This will be a federated model that is patient-centred, with networks as a central organising point of local care across NCL .

Barnet & Chase Farm acquisition
Improve the quality of care and bring financial stability to the NCL health economy through integration of the two organisations. The B&CF acquisition by RFH will allow for new models of care to deliver better patient experience and pathways across a number of CCG's.

QIPP
NCLQIPP schemes are being designed to achieve most efficient financial outcomes, and QIPP Schemes of £231m have been identified.
A overarching QIPP Programme Board is being established to allow the NCL CCGs to collaborate on QIPP Schemes to enhance deliver and allow greater efficiencies across NCL

ACCESS	QUALITY	INNOVATION	VALUE
Patients will be seen by the right person in the first contact, in the right place with access to more local services where possible to improve patient access, experience and outcomes. Improved GP access with availability of 8-8, 7 days a week	Quality reviews are undertaken in NCL through Clinical Quality Review Meetings. Quality is at the heart of NCL Commissioning. The CCGs and Providers are working together to ensure the recommendations of Francis, Winterbourne and Berwick are implemented	Across the five CCGs we share values in using clinical models to drive change and create supportive commissioning models that deliver the outcomes desired. We are also driving forwards the use of technology across providers to break down organisational barriers.	NCL is forecast to achieve an in year surplus from 16/17 onwards with a sound recurrent underlying financial position as a collective through the Transformation Fund. The QIPP efficiencies will support the delivery of a sound underlying financial position. VbC will also assist in delivering value for

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Agenda Item 6

MUNICIPAL YEAR 2014/2015.

MEETING TITLE AND DATE **Health and Wellbeing Board** **Thursday 17 July 2014**	**Agenda - Part: 1** **Item: 6** **Subject:** **The Children & Families Act 2014: The SEND Reforms** **Wards: All**
Report of: Andrew Fraser Director of Schools & Children's Services Contact officer: Sarah McLean SEND Project Manager 020 8379 5592 Sarah.mclean@enfield.gov.uk	**Cabinet Member consulted:** Cllr Ayfer Orhan
	Approved by: Andrew Fraser, Director of Schools and Children's Services

1. EXECUTIVE SUMMARY

This report provides:

- a summary of the Special Educational Needs & Disability (SEND) Reforms which form part of the Children & Families Act 2014, and;
- an update on implementation progress in Enfield.

The Children & Families Act introduces the biggest changes to the SEND system for 30 years for children/young people and their families, Local Authorities, Health and Schools. The new system will be implemented from September 2014 when the reforms will be statutory. The Local Authority and its partners are not expected to take a "big bang" approach with everything changing on 1st September. There are 3 years to fully implement and embed the changes.

The main aim of the new reforms is to put children, young people and their families at the heart of the system giving them greater choice and control. The paradigm shift required is the biggest challenge of all. We must move away from a system that tells families what they need, to a system that works with them, listening to, and respecting their views and opinions. Professionals, parents/carers and children and young people must work together to agree and reach consensus about what services and support are required to enable the child/young person to achieve their outcomes.

There is a greater emphasis on integrated working, particularly around the joint commissioning of services and how this must change over time, where appropriate, to reflect the introduction of personal budgets.

Enfield has been selected by the DfE as a Champion, working in partnership with Bexley and Bromley Local Authorities. As a Champion Enfield will be expected to provide support to other London Boroughs.

2. RECOMMENDATIONS

The Health & Wellbeing Board are asked to:

- Note the content of the Children & Families Act in relation to SEND;
- Note the progress to-date in Enfield towards implementation of these reforms;
- Note the requirements around joint commissioning and personal budgets and support the implementation in Enfield;
- Consider how parents/carers can contribute to the work of the Health & Wellbeing Board.

3. BACKGROUND

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

The main aim of the new reforms is to put children, young people and their families at the heart of the system giving them greater choice and control. The main changes to affect families are:

- **Replacing Statements of Special Educational Need with the new statutory Education, Health & Care Plans (EHCP) from September 2014**

  An EHCP is written in partnership with parents and children and describes the additional specialist support a child requires to do well at school, to stay healthy and safe, to enjoy themselves with friends and to develop independent skills leading to longer term opportunities including higher education and employment. The child's EHCP will be reviewed at least annually. The new reforms mean that support can continue up until the age of 25 for those who go on to Further Education or Sixth Form Colleges, including preparation for employment and independent living.

  All children who currently have a Statement of SEN will continue to have their needs met through their Statement. This remains a statutory document. Arrangements will be made with families to transfer their Statement to a Plan, where appropriate, over the next 2 – 3 years.

- **A new SEN Code of Practice**

  The Code provides practical advice on how to carry out statutory duties to identify, assess and make provision for children and young people with special educational needs and disability (SEND). The Code was laid before Parliament on 11 June 2014, and once approved will come into

force. The Code can be viewed at https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

- **Personal Budgets**

  For families whose child has an EHCP, they will have the right to ask for a personal budget. This option will be discussed with the family as part of the EHCP planning process. There is no automatic right to "be given" a personal budget.

- **The Local Offer**

  Local Authorities have a duty to publish a "Local Offer". The Local Offer brings together in one place all the support available to disabled/SEN children and young people and their families - not just those with an EHCP. It includes Education, Health, Social Care and Voluntary Sector services available to support families.

- **Mediation for Disputes**

  Mediation for disputes will be introduced. Since going to a Tribunal is very stressful & costly for all involved, prior to this, there will be an opportunity for families to meet and discuss concerns in order to try and resolve these more quickly and effectively.

- **Expressing a Preference**

  There will be a new legal right for children and young people with an EHCP to express a preference for state academies, free schools and further education (FE) colleges. This is currently limited to maintained mainstream and special schools.

Piloting the New Reforms

31 Local Authorities and over 2,000 families have been piloting the new reforms over the last 18 months, and it is reported that parents are happier than ever with the support available and have much more control over the services they are receiving. Findings from the pilots show that:

- parents feel more empowered and supported and are happier with the services they are receiving, with 88% saying their views had been taken into consideration.

- professionals are overwhelmingly supportive of the new approaches and feel they bring about a more family-centred way of working.

What's Happening in Enfield?

Governance

Key to implementation success is partnership working, and therefore this is reflected in our governance arrangements.

Janet Leach, Head of the Joint Service for Disabled Children is overall Project Lead. She is working closely with Claire Wright, Head of Children's Commissioning at Enfield CCG, Gillian Douglas, Manager of SEN Services and Judith Gordon, Primary SEN Consultant to deliver this agenda. Central to this reform agenda is "co-production" with parents and carers. Members of our local parent carer forum, Our Voice, are members of the Project Steering Group and are contributing to all the different work streams.

Sarah McLean has been appointed as the Project Manager to co-ordinate the changes in Enfield.

There is an overall Project Steering Group who is responsible for implementing the changes, whose membership includes parents, colleagues from Social Care, Education, Health, Schools, and the Voluntary Sector. The Project Steering Group report to the SCS DMT and the Clinical Commissioning Group.

Several Work Streams have been set up to look at how different aspects of the reforms will be implemented in Enfield.

Work Stream	**Progress**
Finance, Joint Commissioning and Personal Budgets	This Work Stream is chaired by Claire Wright from Enfield Clinical Commissioning Group. The Reforms introduce the option for parents of a child/young person with an EHCP to request a personal budget to support achievement of some or all of their outcomes in their Plan. Personal Budgets can be funded from education, health, social care or schools. The Work Stream is currently working on the proposals for what services can and can't be offered as part of a personal budget from September 2014. This information must be included in the Local Offer. The Code of Practice notes "Local authority commissioners and their partners should seek to align funding streams for inclusion in Personal Budgets and are encouraged to establish arrangements that will allow the development of a single integrated fund from which a single Personal Budget, covering all three areas of additional and individual support, can be made available". Joint commissioning of children's services already exists in Enfield, and commitment to this has been demonstrated through the establishment of a Section 75 Agreement. However, this needs to be developed further over the next 3 years. The SEN Code of Practice states that partners should: "identify how the new joint commissioning strategies will support greater choice and control year-on-year, as the market is developed and funding streams are freed from existing contractual arrangements" and, "as an integral part of this, partners should ensure children, young people and families are involved in the decision-making

Work Stream	Progress
	processes at both an individual and a strategic level".
The Local Offer	All partners have contributed to this piece of work, ensuring that accurate information is provided. Parents and professionals were consulted on Enfield's Consultation Draft Local Offer between 24 February 2014 and 7 April 2014. Over 150 parents engaged in various consultation events. Children and Young People are currently being asked their views on the draft Local Offer. The Local Offer will be revised as result of the feedback received during the consultation and published by 1st September 2014. Two feedback events have been held in order that parents can be advised about the outcome of the consultation and how the Local Offer will change as a result. A new SEND Website is being developed which will in effect be the Local Offer and this will be live by 1st September 2014. The Local Offer is expected to inform decisions about joint commissioning for children and young people with SEND.
The School's Local Offer and Individual Support Plan	Schools are required to publish, under the Special Educational Needs (Information) Regulations, more detailed information about their arrangements for identifying, assessing and making provision for pupils/students with SEN. Judith Gordon, Primary SEN Consultant has been working with schools through SENCo networks and conferences, to understand the impact of the new reforms. A template is being produced with a set of questions that schools should answer and this will be the starting point for the school's own Local Offer.
EHCP Pilot	Twelve schools have volunteered to participate in a short pilot project running from 22 April 2014 – 30 June 2014. The aim of the Pilot is to see how the EHCP will work in practice. The schools, families and professionals involved in the pilot will be asked to feedback their experience, and this will be used to inform the design of the process and documentation that will be implemented from 1st September 2014. Early feedback has indicated that parents feel positive about the experience, they feel listened to, and welcome the opportunity to participate in a multi-agency meeting to discuss their child/young person's outcomes and needs. A full evaluation report will be available following the evaluation and feedback day on 30 June 2014.
EHCP	The EHCP work stream is led by Gillian Douglas, SEN Manager, and has been working to design Enfield's EHCP, and it is being piloted as described above.

Work Stream	Progress
	An EHCP must be drawn up in partnership with the child/young people and their parents, taking into account their views and ideas. In particular, an EHCP must focus on the child/young person's aspirations and what outcomes they would like to achieve. There will be a much greater focus on preparing for adulthood. In addition, the LA will be investigating the possibility of having electronic EHCPs in the future.
The Co-ordinated Assessment Process	This work stream is led by Gillian Douglas, SEN Manager. Partners have contributed and helped to design a process that meets the needs of all concerned. The statutory requirement is for an EHCP to be produced within 20 weeks (currently 26 weeks), and this undoubtedly puts additional pressure on all professionals to meet this requirement. The new process must in place for 1st September 2014.
Partnership Development and Training	There is a specific work stream looking at this area, led by Judith Gordon, Primary SEN Consultant. The Reforms require a complete cultural change. Children/Young People, Parents and Professionals need to understand and embrace this change. This will involve new skills such as working in a person-centred way, structured conversations and understanding what is an outcome. The Partnership Development and Training work stream has undertaken an analysis of all the different groups that will require training across Education, Health, Social Care, Voluntary Sector and parents. They are now starting to look at specific training needs of the groups and will be developing and implementing a comprehensive training programme that will be rolled out across Enfield.
Transition of Statements to EHCP	Currently there are approximately 1400 Statements of SEN in Enfield. These will all need to be transferred to an EHCP if appropriate to do so. The LA has 3 years to move all children and young people with a Statement to an EHCP, and 2 years to move all young people post 16 with a Learning Difficulties Assessment to an EHCP. The DfE are currently consulting on the transitional arrangements and further guidance will be issue following the consultation. Gillian Douglas will work with the SEN Team to draw up a plan to ensure that the transition takes places as efficiently as possible and within the timescale. It is likely that children and young people who will be moving to secondary school or FE in the first instance will be prioritised.
Communication	The Communication & Engagement Work Stream led by Janet

Work Stream	Progress
& Engagement	Leach have a Strategy and Action Plan to ensure that information about the Reforms is communicated appropriately to all stakeholders. Communications so far have included: • Headteacher and SENCo Conference • SENCo Networks and Conferences • Two Parent Consultation Evenings • Local Offer Consultation • Briefings at School Coffee Mornings • Articles in “Our Voice” and “Parent Matters”. • Team Brief • Staff Matters • Governors Termly Pack • DMT • HWB Moving forward communications will include: • Members • GPs • Practice Managers • Heads of Service
Funding	LAs are being supported with additional funding to support implementation of the SEND reforms. This is being used to deal with the additional responsibilities and transition arrangements.
Independent Support	The Government is providing £30m for Independent Supporters. This is being led by the Council for Disabled Children (CDC). These will be individuals who will be recruited and managed by the private, voluntary and community sector to provide advice and support for parents of children with SEN, and young people with SEN, through the statutory assessment and EHCP processes. Independent Supporters will help to build resilience in families by offering a range of time-limited support such as liaison across different agencies and advice on personal budgets. CDC suggested it expects to see up to 1,800 Independent Supporters, which equates to around 12, on average, in each LA area.
Champion Status	Enfield, in partnership with Bexley and Bromley has been awarded Champion status. The role of Champions is to share and disseminate good practice. In addition to the prestige of being a Champion there is a small amount of additional funding.

4. ALTERNATIVE OPTIONS CONSIDERED

No alternative options have been considered given the imperative to be ready to deliver the new SEND reforms by September 2014

5. REASONS FOR RECOMMENDATIONS

To allow Children's Services, and others to fulfil their statutory duties imposed by the new legal and judicial framework.

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

6.1 Financial Implications

A one-off grant in the sum of £545k has been received in 2014/15 for the implementation of SEND reforms. The grant was not ring-fenced but approval has been given to allocate the grant to SCS and it has been earmarked for staffing, IT and training costs identified for the delivery of the project. Any on-going pressures that may arise in the SEN budget from the introduction of the EHCPs and personal budgets will be assessed and reported through the usual monitoring process and included in future budget setting decisions.

6.2 Legal Implications

The Children and Families Act 2014 received royal assent on 13 March 2014. It will have a major effect on the provision for children and young people with special educational needs.

Non-statutory advice, 'Implementing a new 0-25 special needs system: LAs and partners', has been issued by the Department for Education and the Department of Health which sets out the timescales for implementation of the changes. The timescales are as set out in the report above.

The proposals set out in this report prepare for the implementation of the Act when it comes into force.

7. KEY RISKS

Key risks have been identified as follows. A risk register is being drawn up and will be presented to the SEND Project Steering Group at its next meeting on 14 July.

- Co-ordinated assessment process and the new EHCP are not ready to be implemented from 1 September 2014;
- The Local Offer is not published by 1 September 2014;
- A transparent policy with criteria for accessing a personal budget is not ready by 1 September;
- A system for mediation is not in place for 1 September 2014;

- Inability of LA and Health to agree Joint Commissioning arrangements;
- Professionals do not understand the concept of working in a person-centred way and are not able to access training to support them deliver the reforms;
- Parent/carers and young people are not informed about the reforms.
- Schools are uninformed and not supported to implement the changes.
- Financial impact on costs arising from the new EHCPs and personal budgets.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

The SEND Reforms in their entirety will impact on the priorities of the Health and Well Being Board. They aim to ensure that children and young people are given the support they need to ensure they are able do well at school, to stay healthy and safe, to enjoy themselves with friends and to develop independent skills leading to longer term opportunities including higher education and employment.

8.1 **Ensuring the best start in life** – the services outlined in the Local Offer will make it easier for families to understand what services there are to support them and how to access them.

8.2 **Enabling people to be safe, independent and well and delivering high quality health and care services** – commissioning will focus on securing services and support for children and young people with SEND which promote safety, healthy lifestyles and opportunities which promote their independence.

8.3 **Creating stronger, healthier communities** –disabled children and young people, and their families will be encouraged to be aspirational and start thinking about preparing for adulthood early on.

8.4 **Reducing health inequalities – narrowing the gap in life expectancy** – the Education, Health & Care Plan will ensure that children and young people are given the support that they require to enable them to progress at school and take part in their local community activities.

8.5 **Promoting healthy lifestyles** - disabled children and young people will be given the same opportunity as their non-disabled peers to participate in sport and leisure.

9. EQUALITIES IMPACT IMPLICATIONS

The SEND reforms will give children, young people with SEND and their parents/carers greater choice and control about the things that affect their lives. It will improve the provision of information, advice and guidance to families so that they know what their options and choices are. An outcomes focussed system will allow professionals, schools and parents to look at children and young people with SEND in a more holistic way. Children and young people with SEND should be supported to have the same aspirations as any other children and young people.

Background Papers: None

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE
Health and Wellbeing Board
17 July 2014

Agenda – Part: 1	**Item: 7a**
Subject: Health Improvement Partnership Board Update **Wards: All**	
Cabinet Member consulted:	

REPORT OF:
Dr Shahed Ahmad, Director of Public Health

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1. EXECUTIVE SUMMARY

This report provides an update on the work of Public Health, including:

- Tobacco control / smoking cessation
- Obesity
- Improving Life Expectancy in Upper Edmonton
- Cycle Enfield
- Child Health
- Healthchecks

2. RECOMMENDATIONS

The Board is asked to note the contents of this report

3. Tobacco Control / Smoking Cessation

3.1 The smoking four-week quitters target for 2013-14 was achieved – 1708 quitters against a target of 1582.

3.2 The smoking contract with Haringey has been formally split so that Enfield has its own contract with the smoking cessation service provider; Innovision.

3.3 Following this the Enfield Tobacco Control Alliance is meeting on 27th July.

3.4 A steering group has been established to increase the number of smoking referrals from the North Middlesex following the implementation of an automatic referral system of all smokers to stop smoking services.

4. OBESITY

4.1 Active People Survey (7) included data questions on overweight / obese in those over 18. 26.4% of Enfield adults were obese and a further 37.8% overweight making Enfield the 5th most obese borough in London.

4.2 A workshop is being held on 26th June to look at the obesity care pathway in Enfield. This will be written up and form the basis of an obesity pathway.

4.3 The obesity strategy will be updated this summer.

4.4 Public Health is working with UCL to implement behaviour change models at a population level.

4.5 National Childhood Measurement Programme (NCMP) data is being collected throughout the summer and will be submitted in mid-August.

5. Cycle Enfield (formerly known as mini-Holland)

5.1 Following the successful tender to secure £27 million to improve cycling in the borough steering groups and governance structures have been established.

5.2 Consultation on projects will continue over the summer.

6. UPPER EDMONTON

6.1 A diabetes social marketing campaign was also implemented in the period Jan – Mar 2014. Upper Edmonton GPs made a significant contribution to the process. 4000 leaflets were printed and distributed in Somali, Turkish and English. In addition three community events were undertaken at Rumi Breakfast Club and Turkish and Cypriot Association Lunch Club. We have also supported the CCG's Medical Director to deliver diabetes pre-Ramadan sessions at 5 mosques.

6.2 An enhanced diabetes patient's pathway has been developed with the CCG. This will be implemented in September. We have defined an evidence-based validated risk assessment tool that will identify people

at risk of developing diabetes. In addition 'at risk' individuals will be directed to intervention in order to prevent the condition developing.

6.3 An Atrial Fibrillation, stroke prevention initiative and cardiovascular root cause analysis audit has also been commissioned in conjunction with the CCG.

6.4 Eighty people attended a further engagement event at Wilbury Primary School, Edmonton on 19th March 2014. And fifty people attended an evening stakeholder and engagement event at Snell's Park on the 10th April. 200 health questionnaires were completed and returned on a number of health issues.

6.5 The team has also been supporting the CCG to develop 6 care pathways, including those for diabetes, integrated care, and gastrointestinal, musculoskeletal, and mental health. To date the diabetes pathways, mental health and integrated care have reached advanced stages of development.

6.6 We have produced Locality specific profiles to assist the CCG in understanding their local needs and priority areas for commissioning. GP practice profiles are currently being developed for further insight and understanding of their local population needs.

6.7 Latest life-expectancy data indicates that there has been an increase in life-expectancy of 1.3 and 1.1 years respectively for males and females. 2008-2012 data indicates that male life expectancy is significantly lower than the borough average in Upper Edmonton, Ponders End, Enfield Lock and Chase. Female life expectancy is significantly lower in Upper Edmonton, Chase and Enfield Lock. Accordingly our Life Expectancy activities will now be more distributed geographically across the Borough, but again will be emphasised in areas with poorer life expectancy data. These Wards will be Upper Edmonton, Chase, and Enfield Lock.

6.8 Our involvement in Mental Health has included supporting Jobcentre Plus, council departments, NHS, community organisations and employers in developing evidence-based support packages aimed at improving mental health and wellbeing, and employment opportunities, for residents in the local community. We have also facilitated Mental Health awareness training for Jobcentre Plus staff in Edmonton in addition to some of the Council's own staff from the Welfare Advice and Support Hub. We have also met with partners at the BEHMHT and the CCG and agreed that the Mental Health Directory being developed by BEHMHT can also be utilised or hosted by LBE.

6.9 Our activity in the area of Excess Winter Deaths. Includes a Rapid Needs Assessment, a Housing Risk Assessment and immunisation awareness campaigns

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6.10 Following from our previous activity in addressing life expectancy issues relating to Cardiovascular Disease [CVD] we are now localising this focus upon the burden of disease attributable to hypertension in Enfield. The full project plan is currently being worked up. There are a number of Hypertension initiatives intended for delivery in the period July-September 2014.

6.11 In May 2014 Stroke Action with the support of Public Health Enfield ran a stroke prevention campaign. Two major activities took place: a walk for prevention in Fore Street, Edmonton and a Stroke Prevention Conference 28th May 2014.

6.12 Community engagement is on-going and we have developed close links with a number of mosques in the Borough. Including Rumi and Palmers Green mosques and are continuing to work in partnership with them in delivering a number of health messages and also facilitating the healthchecks programme.

7. Child Health Update

7.1 The school nursing needs assessment has been completed in draft and informed the commissioning process/KPIs for 14/15 and longer term commissioning.

7.2 Work has commenced on a Female Genital Mutilation (FGM) needs assessment.

7.3 Child Death Overview Panel annual report has been written (draft).

7.4 Draft policy on working with the pharmaceutical industry has been written.

7.5 A draft report on smoking in young people in the Turkish community has been commissioned. Work will be developed from this including engagement with Turkish community leaders, local media, Turkish parents and young people.

7.6 As part of the implementation of the UNICEF breast feeding friendly initiative in the community, Public health has commissioned the National Childbirth Trust (NCT) to train a cohort of 12 breast feeding peer supporter, who will be given placements in the different children's centres to support mothers who need extra assistance to continue breastfeeding.

7.7 The Antenatal project is on-going. 12 Parent Engagement Champions will be trained to work within the community, supporting mothers with

good parenting and forming closer bonds with their babies. 5 of these will be part of the breast feeding training cohort and they will create the link between the community and the children's centres', supporting and encouraging mothers to use the centre facilities.

8. Heathchecks

8.1 The Healthchecks targets for 2013-14 have been exceeded; 6199 healthchecks were delivered against a target of 5500, 17,246 healthchecks were offered against a target of 12,500.

8.2 Public Health is working with Adult Social Services to implement electronic systems which will enable counting of the eligible population, remote recording of the number of healthchecks offered / delivered and an automatic call / recall system.

9. Supporting Pan London work

9.1 Health Education England has awarded £300,000 for public health workforce development. We have been part of the leadership team commissioning pan London Public Health Workforce Development.

10 Supporting National Work

10.1 We have been supporting the Public Health England Dementia Board.

10.2 We have been supporting the Public Health England Blood Pressure Systems Leadership Board.

10.3 The DPH has signed the Blackfriars Consensus Statement on dementia prevention.

11. Annual Public Health Report

11.1 The Annual Public Health Report is nearing completion. The topic is on narrowing the life expectancy gap. The Report will show that there have been promising improvements in the Edmonton area. This allows us to broaden our focus to other areas; in particular Enfield Lock and Chase. A short summary version will be produced which is accessible to a broad range of people.

12 Public Health Web Presence

12.1 Information has been uploaded to www.enfield.gov.uk/publichealth . Comments are welcome so we can improve the pages in the future.

13. Reasons for Recommendations.

The above recommendations reflect current work within the Directorate of Public Health

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

14.1 Financial Implications

No financial implications

14.2 Legal Implications

No legal implications

14.3 Property Implications

No property implications

15. KEY RISKS

None

16. IMPACT ON COUNCIL PRIORITIES

16.1 Fairness for All

16.2 Growth and Sustainability

16.3 Strong Communities

The work in this report is intended to reduce inequalities, increase growth and sustainability and stronger communities.

17 EQUALITIES IMPACT IMPLICATIONS

As above

Background Papers

None

MUNICIPAL YEAR 2014/15

Health and Wellbeing Board

17 July 2014

Agenda – Part: 1	**Item: 7b**
Subject: Joint Commissioning Board Report	
Date: Thursday 17th July 2014	

REPORT OF: Ray James,
Director of Health, Housing
and Adult Social Care

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1. EXECUTIVE SUMMARY

1.1 This report provides an update on the work of joint commissioning across health and social care in Enfield.

1.2 Updates for all key commissioning areas are included, as are relevant updates on commissioning activity from Partnership Boards.

1.3 This report includes note:

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

1. EXECUTIVE SUMMARY (CONTINUED)

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

2. RECOMMENDATIONS

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

3. THE CARE ACT 2014

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

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

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

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

3.5

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

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

4. BETTER CARE FUND

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

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 Primary Care Management & Risk Stratification

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

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

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

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

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

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

5.2 Older People's Assessment Unit (OPAU)

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

5.3 Falls

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

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

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

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

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

5.4 Care Homes Project

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

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

5.5 Assistive Technology

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

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

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

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

Tele-Health ("Remote Monitoring Pilot")

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

6. PUBLIC HEALTH

BARNET ENFIELD AND HARINGEY MENTAL HEALTH TRUST - Community Services Contract

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

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

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

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

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

7. CCG Commissioning Intentions

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

8. SERVICE AREA COMMISSIONING ACTIVITY

8.1 Older People

8.1.1 Additional Winter Pressures Funding

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

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

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

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

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

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

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

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

8.1.2 **Enfield Warm Households Programme**

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

8.1.3 **Delayed hospital discharges**

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

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

8.1.4 **Social Isolation Bid**

The Big Lottery Fund announced a new programme, Fulfilling Lives: Ageing Better, which aimed to reduce isolation, improve older people's ability to deal with change, and give them greater power to make choices. A multi-sector, multi-agency Enfield partnership led by Enfield Voluntary Action was one of 32 local partnerships to be shortlisted onto the next phase of bidding to become one of 15-20 areas to receive funding. Enfield's bid focussed on developing a responsive face-to-face and IT Voluntary Sector Hub staffed by Community Navigators (who would recruit volunteers) across the community, including within GP surgeries and as part of the emerging integrated care pathway. The purpose of the hub is to be a single point of contact for the voluntary sector to work with those who might be at risk of isolation and for volunteers to be

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

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

8.2 Mental Health

8.2.1 Joint Mental Health Strategy Consultation

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

8.2.2 Enfield Joint Autism Framework

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

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

8.3 Learning Disabilities

8.3.1 Learning Disabilities Self-Assessment Framework (SAF)

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

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

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

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

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

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

8.3.2 Winterbourne View Concordat

NHS Enfield Clinical Commissioning Group (CCG) and the council have developed a joint action plan in response to the Winterbourne View concordat. Key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism in low-high in-patient facilities to ensure that people are appropriately placed.
Where people are considered as inappropriately placed there is emphasis on considering community based services that are closer to home. Enfield completed reviews by the June 2013 deadline and are currently on track in terms of meeting the conditions of the concordat action plan. Patient choice and parent / carer involvement continues to be the focal point of implementation of the concordat action plan.

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

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

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

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

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

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

8.4 Carers

8.4.1 Enfield Carers Centre

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

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

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

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

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

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

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

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

8.4.2 **Carers Direct Payment Scheme**

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

8.4.3 Carers Week

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

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

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

8.4.4 **Primary Care Strategy**

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

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

8.4.5 **The Employee Carers' Support Scheme**

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

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

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

8.4.6 **Relatives Support Network**

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

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

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

8.4.7 **Carers Strategy Implementation**

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

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

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

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

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

8.5 **Children's Services**

8.5.1 Family Nurse Partnership (FNP)

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

8.5.2 School Nursing

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

8.5.3 Community Services Procurement

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

8.5.4 **Maternity**

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

8.5.5. SEND/Children and Families Act Implementation

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

The main changes to affect families are:

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

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

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

8.5.5 **Paediatric Integrated Care**

A paediatric integrated care work stream is supporting the implementation of the Barnet, Enfield and Haringey Clinical Strategy. The work programme has a number of elements:

- To support the development of the Urgent Care Centre and the Paediatric Assessment Unit on the Chase Farm Hospital Site;
- To improve collaboration across primary, community and secondary care;
- To increase the knowledge and confidence of GPs and other primary care professionals in working with children who are ill;
- To develop and implement protocols and/or care pathways for common childhood illnesses and long term conditions;
- To develop care closer to home, and reduce A&E and Outpatient attendances and unnecessary admissions to hospital.

A group meets monthly to progress this work.

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

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

8.6 Drug and Alcohol Action Team (DAAT)

8.6.1 Successful Completions (Drugs)

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

8.6.2 Numbers in Effective Treatment (Drugs)

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

8.6.3 Numbers in Treatment and Successful Completions (Alcohol)

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

8.6.4 Young People's Substance Misuse Performance

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

8.6.5 Performance Summary and Cost effectiveness

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

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

9. HEALTHWATCH ENFIELD

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

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

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

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

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

11. SAFEGUARDING

11.1 Safeguarding Adults Board (SAB)

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

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

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

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

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

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

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

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

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

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

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

11.2 Community Help Point Scheme on Tap-IT

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

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

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

11.3 Safeguarding Information Panel (SIP)

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

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

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

11.4 Quality Checker Programme

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

11.5 Quality Improvement Board (QIB)

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

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

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

11.5.2 Care Home Carers Network

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

11.5.3 Dignity in Care Panel

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

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

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

11.6 Multi-Agency Safeguarding Hub (MASH)

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

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

12. SECTION 75 AGREEMENT

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

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

This table below outlines the proposed changes:

MUNICIPAL YEAR 2014/15

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

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

13. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

13.1 Learning Difficulties Partnership Board (LDPB)

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

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

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

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

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

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

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

13.2 Carers Partnership Board

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

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

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

13.3 Mental Health Partnership Board
Update not available

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

13.4.1 Big Lottery Bid Submission

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

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

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

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

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

13.4.2 Integrated Care

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

13.4.3 Better Care Fund Update

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

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

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

13.4.4 Enfield Dementia Action Alliance Update

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

13.4.5 Terms of Reference and Membership Alliance Update

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

13.4.6 Commissioning Intentions Update

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

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

13.4.7 Next meeting items requested by Board

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

13.5 Physical Disabilities Partnership Board

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

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

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

13.6 Enfield Safeguarding Children Board (ESCB)

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

The priorities in the new Business Plan include:

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

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

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

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

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Appendix 1

DAAT ref 8.6.5

London Borough Drug & Alcohol Partnerships	Adult Treatment												Young People's Treatment				
	Partnership Funding		Numbers in Effective Treatment (Rolling 12 Months)						Successful Completions (Rolling 12 Months)				Numbers in Treatment (Rolling 12 Months)				
	Funding x £1,000	Funding Rank	Feb 13 Jan 14	Numeric Change	Current Rank	Rank Change	Unit Cost	Cost Rank	Apr 13 Mar 14	Numeric Change	Current Rank	Rank Change	Funding x £1,000	Funding Rank	Apr 13 Mar 14	Unit Cost	Cost Rank
Barking & Dagenham	2,652	26	804	+2	16	-	£3,298.51	1	283	+20	5	-1	146	17	302	£484.40	2
Barnet	2,991	23	759	-	22	-	£3,940.71	4	112	-5	27	+1	133	19	88	£1,513.16	17
Bexley	2,717	25	367	-3	31	-	£7,403.27	32	94	+8	29	+1	96	25	51	£1,888.59	22
Brent	5,700	10	1,144	-1	11	-	£4,982.52	14	323	-	2	-	192	7	114	£1,682.90	20
Bromley	2,289	29	475	+3	28	-	£4,818.95	12	107	-11	28	-1	106	22	133	£793.88	4
Camden	9,137	3	1,592	+26	1	-	£5,739.32	22	333	+2	1	-	160	14	59	£2,704.60	25
City of London	84	33	14	+2	33	-	£6,000.00	25	2	-1	33	-	2	33	0	*N/A	
Croydon	3,922	18	957	+10	14	-	£4,098.22	6	167	+13	17	+3	191	8	137	£1,392.72	14
Ealing	6,035	8	1,261	+2	8	-	£4,785.88	11	308	+16	3	-	187	9	69	£2,706.22	26
Enfield	**3,574**	**20**	**997**	**-38**	**13**	**-**	**£3,584.75**	**3**	**303**	**+40**	**4**	**-**	**165**	**13**	**167**	**£988.95**	**8**
Greenwich	3,285	22	769	-5	20	-	£4,271.78	8	183	-5	15	-1	168	12	153	£1,097.70	11
Hackney	6,453	7	1,436	+13	5	-	£4,493.73	10	231	+5	9	+1	218	4	20	£10,877.92	31
Hammersmith & Fulham	5,488	12	872	+4	15	-	£6,293.58	26	138	+4	23	+1	100	23	31	£3,210.20	29
Haringey	5,881	9	1,167	-15	10	-	£5,039.42	15	253	-7	7	-1	178	10	185	£963.42	7
Harrow	2,904	24	547	+9	25	-	£5,308.96	18	132	+2	24	+1	96	26	137	£702.79	3
Havering	2,394	28	671	+13	24	-	£3,567.81	2	246	+8	8	+1	95	27	63	£1,510.92	16
Hillingdon	5,320	13	798	+2	17	-	£6,666.67	28	143	+3	22	-	139	18	82	£1,699.43	21
Hounslow	5,098	14	703	+15	23	-	£7,251.78	31	77	-	31	-	126	20	44	£2,857.10	27
Islington	10,511	1	1,290	-11	7	-	£8,148.06	33	213	-4	13	-1	171	11	54	£3,173.56	28
Kensington & Chelsea	3,831	19	785	-7	18	-	£4,880.25	13	166	+7	18	-	68	30	50	£1,353.64	13
Kingston upon Thames	1,339	32	312	-4	32	-	£4,291.67	9	26	+2	32	-	47	31	21	£2,228.54	23
Lambeth	7,542	6	1,308	+2	6	-	£5,766.06	23	220	+1	11	-	197	5	8	£24,609.25	32
Lewisham	4,893	15	1,202	-14	9	-	£4,070.72	5	228	-22	10	-3	195	6	195	£1,001.65	9
Merton	2,086	31	375	-11	30	-1	£5,562.67	19	121	-16	26	-3	79	29	97	£811.94	6
Newham	5,599	11	1,089	+1	12	-	£5,141.41	17	157	-	20	-1	232	2	92	£2,524.95	24
Redbridge	3,498	21	541	+4	26	-	£6,465.80	27	126	+1	25	+1	115	21	142	£807.06	5
Richmond upon Thames	2,564	27	379	+2	29	+1	£6,765.17	30	93	-2	30	-1	34	32	34	£1,013.94	10
Southwark	8,212	5	1,443	-13	4	-	£5,690.92	21	216	-1	12	-	221	3	63	£3,513.88	30
Sutton	2,120	30	514	-4	27	-	£4,124.51	7	152	-11	21	-4	80	28	50	£1,607.74	19
Tower Hamlets	10,042	2	1,498	-14	3	-	£6,703.60	29	177	+12	16	-	241	1	178	£1,352.82	12
Waltham Forest	3,937	17	769	+3	20	+1	£5,119.64	16	184	-2	14	+1	159	15	103	£1,540.42	18
Wandsworth	4,346	16	776	-4	19	-	£5,600.52	20	160	+14	19	+2	99	24	216	£458.10	1
Westminster	8,930	4	1,530	-18	2	-	£5,836.60	24	259	+10	6	+2	151	16	101	£1,498.13	15
London DAT Average	**4,708**		**886**	**+4**			**£5,315.75**		**180**	**+81**			**139**		**98**	**£1,416.15**	

*City of London has been excluded from Young People's Treatment unit costs and cost rankings, as although they have a budget for treatment, there weren't any Young People in treatment.

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For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **17 July 2014**	**Agenda - Part: 1** **Item: 7c** **Subject: Primary Care Strategy for Enfield** **Wards: All** **Cabinet Member consulted: N/A** **Approved by:**

Dr Mo Abedi, Medical Director
NHS Enfield CCG
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1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on work to date to implement the Primary Care Strategy across the borough of Enfield.

The Primary Care Strategy project team reports jointly to the CCG Primary Care Strategy Implementation Board and the Health and Wellbeing Board.

2. RECOMMENDATIONS

The Enfield Health and Wellbeing Board are asked to note the contents of this report.

3. BACKGROUND

The Prevention and Primary Care Strategy (PCS) is one of six major programmes that support the transformation of healthcare in Enfield. Its aim has been to improve access to primary care services, improve patient experience and reduce variation in care for the population of Enfield.

2014/15 is the third and final year of the Strategy and as such will look to consolidate the successes of the first two years to ensure on-going sustainability. The main areas of focus will be:

- Integration
- Enhancing and improving health outcomes, access, patient experience and quality.

The Programme comprises seven key areas:

i. Integration
ii. Clinical services
iii. IT
iv. Premises
v. Productivity
vi. Workforce
vii. Communications

It is proposed that these key areas continue in 2014/15 with individual schemes grouped under each heading. Many of the proposed schemes are continuing investments from years one and/or two of the programme. There are also a small number of new schemes which have been added, such as cardiology, diabetes enhancing primary care urgent access. As anticipated, NHS England has assumed responsibility for the Minor Ailment Scheme this year.

The Primary Care Strategy Team now reports to the Assistant Director of Transformation and that post will be accountable at the CCG's Transformation Programme Group for delivery.

4. Integration – Network Development

Practices working together in Network(s) are fundamental to securing the future of general practice and achieving improvements in Enfield's primary care. They will provide strong, local clinical leadership for our Transformation Programme and local knowledge for a bottom-up approach to planning and delivery. Practices that join together in Networks will be able to offer a wider range of clinical services that would otherwise need to be delivered in a hospital setting.

In 2012/13, the CCG invested in seven Network Lead roles and management consultancy to progress the development of Networks in Enfield. Its thinking has developed over time to a position where there has been a need for the CCG to:

- define what it means by a Network,
- set out a process for assurance of Network Providers
- provide an indication of the timescale by which it expects Network Providers to be established;
- clarify the services it intends to commission from local Network Providers; and
- determine the level of support and funding, if any, the CCG will allocate to emerging Networks.

This workstream is now well developed and is being overseen by a Network Development Steering Group with any decision-making in respect

of support and funding proposed to be devolved to the CCG's Procurement Committee.

The CCG hopes to be in a position to have accredited one or more GP Provider Networks by September 2014.

4.0 Co-Commissioning of Primary Care Services

On 9th May, NHS England invited expressions of interest from CCGs to develop new arrangements for co-commissioning of primary care services. Proposals were invited from individual or by groups of CCGs to cover their combined localities. NHS England cannot delegate responsibility for commissioning of community pharmacy or primary care dental services, although it could in principle delegate responsibility for primary eye care services, with the exception of NHS sight tests.

Potential co-commissioning forms could be phased (introduced during 2014/15 and developed further during 2015/16) and include three potential levels:

- greater CCG involvement in influencing commissioning decisions made by NHS England's London Area Team;
- joint commissioning arrangements whereby CCGs and the London Area Team make decisions together, potentially supported by pooled funding arrangements; or
- delegated commissioning arrangements, whereby CCGs carry out defined functions on behalf of NHS England and the London Area Team holds CCGs to account for how effectively they carry out these functions.

Co-commissioning activity could include:

- continuing to work with the Health and Wellbeing Board and patients and the public to assess needs and decide strategic priorities;
- designing and negotiating local contracts, e.g. Personal Medical Services, Alternative Personal Medical Services or Enhanced Services commissioned by NHS England;
- approving discretionary payments, e.g. premises reimbursement;
- managing financial resources and ensuring expenditure does not exceed the resources available;
- monitoring contractual performance;
- applying contractual sanctions; and
- deciding in what circumstances to bring in new providers, manage associated procurements and make decisions on practice mergers.

It should be noted that while the CCG already has powers to commission services from general practice in their own right, in submitting an expression of interest for this arrangement, the CCG has a statutory duty

to manage conflicts of interest in which their members have a material interest.

Following lengthy discussion, the five north central London CCGs (Barnet, Camden, Enfield, Haringey and Islington) have submitted an at scale expression of interest in implementing joint commissioning arrangements from November 2014 and delegated commissioning arrangements from April 2016.

5. REASONS FOR RECOMMENDATIONS

To update the Health and Well Being Board of the proposed implementation plan for the current and final year of the Primary Care Strategy.

6. FINANCIAL IMPLICATIONS

Each year's Primary Care Strategy investment has to date come from an allocation from the NCL risk-share pool. It is anticipated that for the current year, the NCL risk-share allocation will be £2m and as such, a reduced programme of work has been developed to account for the level of funding set out in Appendix 1 of this report.

The CCG's Finance Resource and QIPP Committee is scheduled to approve the proposed plan on 2nd July 2014.

7. CONCLUSION

This report provides a summary of the on-going and new areas of focus for the Primary Care Strategy Programme in its final year, the delivery of which will be dependent upon the anticipated allocation of funding from the NCL risk-share.

Background Papers

Appendix 1 – Primary Care Strategy Programme Plan

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Appendix 1 - Primary Care Strategy Programme Plan (2014-15)

Key Area	Existing or New Scheme	Recommendation
1. Integration	New	**Network Development** Practices working together in Networks are fundamental to securing the future of general practice and achieving improvements in Enfield's primary care. They will provide strong, local clinical leadership for our transformation programme and local knowledge for a bottom-up approach to planning and delivery. Practices that join together in Networks will be able to offer services that would otherwise need to be delivered in a hospital setting. As constituent GP practices develop into provider Networks, the role of Network Lead for a commissioning organisation has become obsolete. This funding has been set aside to support the development of GP provider networks during 2014/15 starting with support from an external agency in developing accreditation criteria, a financial model and supporting an AQP process. A steering group has been set up to oversee the development of GP provider networks.
	Existing following review of networks leads role	**Clinical Improvement Leads** The CCG will continue to need a number of clinical lead roles to provide advice and guidance on the services it currently commissions and intends to commission in the future. A review of the existing leads and additional support plus a process for appointment of additional leads will be considered for the TPG meeting in May 2014.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Key Area	Existing or New Scheme	Recommendation
	New	**Locality Commissioning** NHS Enfield CCG's constitution states that there should be in place four locality groups across Enfield and that these locality groups should be accountable to the Governing Body (GB). Each locality group should be chaired by one of the GB GP board members. The Locality Groups are expected to: • meet as a minimum four (4) times per annum; • consider items requested by the Members and the Governing Body; • promote innovation in the Locality; • consider and agree locally the best way of utilising support offered by the CCG; • support each other in achieving the aims of the CCG by further risk sharing or sharing of CCG resources etc; • establish their local arrangements for peer reviews; • support each other in achieving improvements in quality and productivity; • agree locally areas of investment where funding is made available by the Governing Body; • put on the agenda for the Governing Body via their Locality Lead items for discussion; and • discuss other Locality specific issues. There is a need to re-establish this clear and regular communication between the CCG and its member practices regarding the challenge of the CCG's commissioning role, its QIPP target and the role of practices in helping overcome these challenges, as well as supporting them in improving their performance across the board.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Key Area	Existing or New Scheme	Recommendation
2. Clinical Services		
Anti-Coagulation	Existing	Two GP Practice providers have gone live in 2013/14 with further extension to provision to commence in 2014/15. Investment to date has supported the set up and governance of the new service. Funding of £3K for a Clinical Champion role was agreed at Primary Care Strategy Implementation Board on 21.01.14. The Clinical Champion was recruited and commenced in April 2014
Cancer Screening	Will not continue – the responsibility for Cancer Screening programmes is now with NHS England.	The intention for this year is to work with approximately ten practices whose patient population demonstrate poor uptake of existing national screening programme to focus on increasing the number of patients presenting for breast and bowel cancer screening. Patient sign-posting will continue to be delivered via LBE Health Trainers and a provider will work with the ten practices whose breast and bowel cancer screening are lowest to improve uptake by 5% in each area. This investment is an ongoing payment towards the health trainer support. A formal agreement and set of outcomes if being put in place for this project with LBE.
Cardiology Project	New Business case approved	The aim of this project is to enhance cardiology in primary care in Enfield for 2014/15 and onwards by: a) completing a retrospective audit in the South East locality of Enfield to ascertain causes at individual and population level for acute cardiovascular events in Enfield. b) piloting a primary care Atrial Fibrillation (AF) service in the South East locality of Enfield which will work across the health system to promote a systematic approach to reducing the incidence of stroke in Enfield.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Key Area	Existing or New Scheme	Recommendation
		This investment will be used alongside that from Public Health to invest in a Band 8A project manager to work for one year as part of the Long Terms Conditions Programme Team to deliver these two elements plus working as part of the wider redesign of cardiology in Enfield. Funding of this proposal was approved at PCSIB on 18/02/14
Carer's Health	Existing	The GP Liaison Manager at Enfield Carer's Centre will continue to work with all GP Practices collecting referral cards, updating notice boards, manning and updating surgery information stands and talking to practice staff to keep awareness raised and increase the number of carers receiving a carer's health check and on-going support. The Primary Care Strategy will not be in a position to fund Enfield Carer's Centre for a Carer's Nurse as originally planned and the direction of travel will need to be considered as part of LBE's overall Carers Strategy.
Childhood Obesity	Existing	Two elements of this project were completed in 2013/14. The third and final element of this initiative involves the review of current health and social care pathways, identifying the gaps and providing recommendations that are rooted in best practice, are evidence-based, and sustainable. A final evaluation report will be made available at the PCSIB meeting on 16th September 2014.
Diabetes Service (pilot)	New Business case approved	To pilot the delivery of systematic diabetes review in primary care, the development of a care planning training programme in primary care, additional diabetes specialist nursing resource to support practices, growth and increasing prevalence and reduction of hypo crisis in hospital. In addition to this investment, we are asking the consultants to support the MDT clinical meetings at network level and to support GPs and practice nurses in diabetes management in primary care at practice level. It was originally intended to pilot the initiative in the South East of the borough for

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Key Area	Existing or New Scheme	Recommendation
		2014/15 and the funding highlighted here is to support this. Funding approved at PCSIB meeting on 18/02/14 However, the intention now is to commission across a wider patient population than the South East locality.to implement this initiative on a pan-Enfield basis.
Domestic Violence	Existing	In the London Borough of Enfield, 80% of Metropolitan Police Service incident reports have a domestic violence and abuse element to them. Although this project got off to a slow start, twenty-seven GP practices in the east of the borough are now trained. It is proposed that the IRIS team and Solace Women's Aid be engaged to continue to provide advice, training and expert support for the IRIS delivery model.
Enhancing and Improving Access	New Existing	The focus of this scheme will be two-fold: **a)** To establish two locality urgent primary care hubs to provide GP practice appointments for patients who require same day appointments for low to medium urgent primary care and for patients who are redirected from the A&E Departments or Urgent Care Centres at Barnet and Chase Farm Hospital (BCF) and North Middlesex Hospital (NMUH). b) To continue the current Access Programme by working with two further waves of 8 GP practices per wave
Female Genital Mutilation	Will not continue – FGM is the joint responsibility of NHS England and LBE.	This project is proposed as a result of increasing incidence in the safeguarding referrals received by the CCG. A scoping paper will be provided at next month's TPG meeting in respect of this project.
Health Kiosks	Existing	This project has now been mainstreamed and will continue to be monitored on an on-going basis but requires no further funding.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Key Area	Existing or New Scheme	Recommendation
HiLo	Existing	Queen Mary and Westfield University of London will continue the work with two practices in July 2013 to improve the management of Coronary Heart Disease and Blood Pressure in general and in particular, for those patients traditionally referred to secondary care for management, following poor improvement outcomes when recommended primary care treatment guidelines are followed. The plan to extend this to incorporate more practices will not be implemented in 2014/15.
Minor Ailment Scheme	Existing	This scheme transferred to the responsibility of NHS England in 2014/15 and therefore has come to a close in terms of support from the CCG team. NHS England is currently conducting a review of all Minor Ailment Schemes commissioned across London with a view to standardising these and have indicated that they may devolve commissioning responsibility back to the CCG once the review is completed, along with the accompanying funding.
Patient Experience Tracker	Existing	This project has now been mainstreamed and will continue to be monitored on an on-going basis but there is no additional investment required.
Self-Care, including social marketing, assertive outreach, handbooks and online access to health information	New	This new scheme for 2014/15 will promote culturally-sensitive advice and support to adults and new births in Enfield regarding health issues and when/from whom to seek further support. Funding for a Children's handbook and on-line resource was approved by the Transformation Programme Group in March 2014..
Change and Challenge (Troubled Families) Initiative	This new scheme funded by LBE will continue, but without	This new scheme for 2014/15 will improve access to registration with and utilisation of primary care through a collaborative working arrangement with the LBE Change and Challenge team and upper Edmonton practices. This would include strengthening primary care input into multi -disciplinary teams for troubled families. It is proposed that the CCG will provide project management of the initiative, rather than funding. A scoping paper will be presented at a future TPG meeting for consideration.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Key Area	Existing or New Scheme	Recommendation
	project management support from the CCG	
3. IT	Existing	Enhanced funding provided directly by NHS England with additional bids for transitional (revenue) and capital funding currently being considered. Some additional funding for ad hoc requirements not funded by NHS England will be made available for services delivered by ICT Team at North and East London CSU and external suppliers.
4. Premises		Funded directly by NHS England
5. Productivity	Existing	This joint initiative with UCL for four Principal Clinical Teaching Fellows is scheduled to continue until 5th January 2016.
6. Workforce, Leadership and Team Development	Existing	1.0 WTE Programme Manager 1.0 WTE Estates, Planning and Implementation Manager 0.4 WTE Practice Nurse Network Lead 1.8 WTE Senior Project Managers 1.0 WTE Project Manager 1.0 WTE MDT Co-Ordinator to be funded from Integrated Care programme budget 0.6 WTE Network Co-Ordinator 1.0 WTE Administrator Protected Learning Time Out of Hours Cover Support of Practice Manager and Practice Nurse Forums, including staff training
7. Communications	Existing	An allocation to be used to purchase web-based newsletters (for staff, GPs and stakeholders), SurveyMonkey for gauging evaluation and feedback, adverts in Our Enfield, promotion of schemes via LifeChannel (waiting room audio-visual resource) leaflets and posters.

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 20 MARCH 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), Christine Hamilton (Cabinet Member for Community Wellbeing and Public Health), Deborah Fowler (Enfield HealthWatch), Dr Alpesh Patel (Chair of Local Clinical Commissioning Group), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Litsa Worrall (Voluntary Sector) and Dr Henrietta Hughes (NHS England)

ABSENT Chris Bond (Cabinet Member for Environment), Ian Davis (Director of Environment), Ray James (Director of Health, Housing and Adult Social Care), Ayfer Orhan (Cabinet Member for Children & Young People) and Vivien Giladi (Voluntary Sector)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Graham MacDougall (Director of Finance & Commissioning), Glenn Stewart (Assistant Director, Public Health), Keezia Obi (Head of Safeguarding Adults) and Doug Wilson (Interim Head of Strategy, Performance and Policy) Penelope Williams (Secretary)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Councillors Bond and Orhan, Ian Davis, Director of Environment, Ray James, Director of Health, Housing and Adult Social Care, and Vivien Giladi (Voluntary Sector Representative).

2
DECLARATION OF INTERESTS

There were no declaration of interests.

3
JOINT HEALTH AND WELLBEING STRATEGY

The Board received the report from Dr Shahed Ahmad, Director of Public Health, on the Joint Health and Wellbeing Strategy 2014-19 updating members of the Board on the development of the strategy.

Dr Shahed Ahmad presented the report to members highlighting the following:

- In response to the Board's request a more significant consultation process had taken place.

- The Strategy had now been finalised and prepared for publication; printed copies of the whole strategy,executive summary and an easy read version were circulated.

- Thanks were given to Keezia Obi and her team for their excellent work.

Keezia Obi, Head of Public Health Strategy, added:

- The next step was the implementation of the strategy.

- A meeting with the key partners would take place in the next few weeks where a more detailed action plan and performance framework with key targets would be developed. These would be bought back for consideration at a future meeting of the Board.

AGREED that the Joint Health and Wellbeing Strategy 2014-19 be formally received and this version approved.

4
BETTER CARE FUND

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

NOTED

1. That an informal meeting would be set up before 4 April 2014 to enable board members to discuss any concerns with the officers responsible for putting together the plan. Doug Wilson (Head of Strategy Policy and Performance for Public Health) would arrange the meeting.

Action: Doug Wilson

2. The feedback received on the draft plan, from NHS England, considered in the Development Session.

AGREED:

1. To note the feedback received from NHS England about Enfield's Better Care Fund Plan.

2. To delegate authority to the Chair of the Health and Wellbeing Board, the Chair of Enfield Clinical Commissioning Group, and the statutory chief officers responsible for the plan, to sign off the final plan before 4 April 2014 having assured themselves that all feedback received from

NHS England has been responded to appropriately and to include any issues raised by board members at the informal meeting to be arranged as described above.

5
ENFIELD CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN

The Board received the report from Liz Wise, Chief Officer Enfield Clinical Commissioning Group, on the Clinical Commissioning Group two year Operating Plan and five year Strategic Plan.

Liz Wise presented the report to the Board highlighting the following:

- She referred to the helpful presentations and discussion which had taken place in the Development Session held before this meeting.

- The CCG were required to submit the two year operating plan by 4 April 2014.

- A five year strategic plan, put together jointly by the five North Central London CCGs, also had to be submitted, by 20 June 2014.

- These were big challenges, but also opportunities.

- It was important to ensure and demonstrate that there was alignment between the intentions in all the strategic plans; the CCG Operating Plan, the Better Care Fund Plan and the Joint Health and Wellbeing Strategy.

- A draft Operating Plan had been submitted to NHS England in February 2014. Early comments received referred mainly to matters of detail, including the need for more detailed information on performance and activity trajectories.

- The final version was not ready for submission, as not all the contracts had been agreed and there was a need for further discussions on financial assumptions at both the Enfield CCG Governing Body and Quip Committee.

- Clarity on the contracts, risks and shared agreements with the other CCGs was also still required.

- Ray James, Director of Health, Housing and Adult Social Care, who sat on the CCG Governing Body, would be able to feed back to the Council on any outstanding issues.

- Concerns raised by Board members about medication safety incidence and the 30 day re-admission target would be discussed at the meeting

referred to above, which was due to be arranged to discuss the Better Care Fund Plan.

AGREED

1. To note the progress to date in putting together the Operating Plan (2014/15 - 2015/16) and the Strategic Plan (2014/15 – 2018/19).

2. To agree the sections of the Operating Plan set out in Section 3.3 of the Report subject to discussion at the informal meeting, involving Board Members, to be held before 4 April 2014.

6
MINUTES OF THE MEETING HELD ON 13 FEBRUARY 2014

The Board received and agreed the minutes of the meeting held on 13 February 2014 as a correct record.

7
DATES OF FUTURE MEETINGS

AGREED to note that the dates for future meetings of the Board will be agreed at full Council on Wednesday 11 June 2014.