HEALTH AND WELLBEING BOARD

Thursday, 21 April 2016 at 6.15 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Leader of the Council – Councillor Doug Taylor (Chair)
Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu
Cabinet Member for Public Health and Sport – Councillor Nneka Keazor
Cabinet Member for Education, Children's Services and Protection – Councillor Ayfer Orhan
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi (Vice Chair)
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer – Paul Jenkins
NHS England Representative – Dr Henrietta Hughes
Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Interim Director of Children's Services – Tony Theodoulou
Director of Environment – Ian Davis
Voluntary Sector Representatives: Vivien Giladi, Litsa Worrall (Deputy)

Non-Voting Members

Royal Free London NHS Foundation Trust – Kim Fleming
North Middlesex University Hospital NHS Trust – Julie Lowe
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright

AGENDA – PART 1

1. WELCOME AND APOLOGIES (6:15-6:20PM)

2. DECLARATION OF INTERESTS

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

3. CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN 2016/17 (6:20-6:35PM) (Pages 1 - 6)

To receive a report on the Clinical Commissioning Group Operating Plan 2016/17.

4. NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST UPDATE (6:35-6:50PM) (Pages 7 - 14)

To receive a presentation on the North Middlesex University NHS Hospital Trust, from Julie Lowe, Chief Executive.

5. BETTER CARE FUND REVIEW 2015-16 AND BETTER CARE FUND PLAN FOR 2016-17 (6:50-7:05PM) (Pages 15 - 60)

To receive a report for information reviewing the 2015-16 Better Care Fund.

To consider a report on the Better Care Fund Plan for 2016-17.

6. LONDON ASSEMBLY: LONDON ASSEMBLY HEALTH COMMITTEE - END OF LIFE CARE INVESTIGATION (7:05-7:15PM) (Pages 61 - 68)

To receive for information a report from the London Assembly Health Committee on an investigation into End of Life Care.

7. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE (7:15-7:30PM) (Pages 69 - 86)

To receive a report reviewing the Health and Wellbeing Board Terms of Reference.

The Board is asked to agree the proposed changes to the terms of reference and to recommend their approval to Council.

8. NORTH CENTRAL LONDON SUSTAINABILITY AND TRANSFORMATION PLAN (7:30-7:40PM) (Pages 87 - 98)

To receive a progress update on the North Central London Sustainability and Transformation Plan.

9. ST MUNGO'S HOMELESS HEALTH CHARTER (7:40-7:50PM) (Pages 99 - 106)

To receive for discussion a report on St Mungo's Homeless Health Charter and to consider agreeing to sign up to the charter, indicating the board's support of the commitment towards tackling health inequality among people who are homeless.

10. SUB BOARD UPDATES (7:50-8:10PM) (Pages 107 - 110)

To receive updates from the following sub boards:

- Health Improvement Partnership Board (To Follow)
- Joint Commissioning Board (To Follow)
- Primary Care

11. MINUTES OF THE LAST MEETING (8:10-8:15PM) (Pages 111 - 118)

To receive and agree the minutes of the meeting held on 11 February 2016.

12. DATE OF NEXT MEETING

Dates of future meetings are due to be agreed at full Council on 11 May 2016.

13. 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 2016/2017	

MEETING TITLE AND DATE Health and Wellbeing Board 21 April 2016	Agenda - Part: 1	Item: 3
	Subject: Delivering the Forward View – NHS Planning Guidance 2016/17 to 2020/21	
	Wards: All	
Report of: Graham MacDougall, Director Strategy & Partnerships	Cabinet Member consulted: N/A	
Contact officer - Claire Wright Email: claire.wright@enfieldccg.nhs.uk		

SUMMARY:

The paper provides a progress report to the Enfield Health and Wellbeing Board on the CCG's development and implementation of the NHS Operating Plan 2016/17. This is the annual planning cycle for the NHS and its focus is on finance, acute activity, constitutional performance targets, any new national targets and the Quality Premium.

The NHS published its planning guidance *Delivering the Forward View*: *NHS planning guidance 2016/17-2020/21*, on 22 December 2015, to inform the development of the:

1. One-year ***Operational Plan 2016/17***, organisation based but consistent with the emerging Sustainability & Transformation Plan,,
2. Five year ***Sustainability and Transformation Plan*** (STP), through a place-based planning approach (NCL Strategic Planning Group) and driving the Five Year Forward View,

The guidance also sets out a requirement for local systems that in order to achieve future sustainability they must accelerate their work on ***prevention*** and *care redesign* and expect ***acceleration in transformation*** in a few priority areas, in order to build momentum.

The CCG's Operational Plan 2016/17 will set a clear plan and priorities for 2016/17 that reflects the Mandate to the NHS and next steps on Forward View implementation. The important changes for 2016/17 involve partial roll-out rather than national coverage. NHS ambition by March 2017:

- 25% of population will have access to acute services that comply with four priority clinical standards on every day of the week
- 20% of the population will have enhanced access to primary care

2015/16 saw a year in which nationally more Trusts faced financial challenges and deficits and there were worsening issues with performance particularly A&E, referral-to-treatment, access to diagnostics, and cancer 62 days treatment. Through both changes to national tariff and the Sustainability Transformation Fund, the NHSE expect to see an improved financial position for Trusts, particularly acute Trusts, and an improved performance in the areas highlighted above for 2016/17. The NHS expects A&E performance to be at 95% during Q4 of 2016/17 and maintained going forward.

The CCG's first draft operational plan for 2016/17 was submitted to NHS England on 8th February 2016, and the second draft on 2nd March 16 following its associated assurance meeting with NHS England on 25th February 2016. The CCG had a further assurance and alignment meeting with NHSE on 5 April 2016 prior to its now final submission which is due on 18 April 2016. Acute activity

plans were submitted to NHSE on 7 April 2016 to allow NHSE to view an aggregated position for the regions and nationally prior to final submission by CCGs on 18 April 2016. NHSE have indicated to the CCG that their planned control total of a deficit of £14.9m for 2016/17 will not be acceptable.

SUPPORTING PAPERS:

RECOMMENDED ACTION:

Health and Wellbeing Board is asked to NOTE the contents of this report

1. Overview

Following publication of the NHS Planning Guidance 2016/17 by NHS England, in December 2015, the CCG has continued to develop the two separate but interconnected plans required for 2016/17, including the

- Operational Plan 2016/17, an organisation plan to deliver the NHS Constitution standards and associated targets consistent with the direction of the 5-year Sustainability & Transformation Plan (STP),
- North Central London Strategic Planning Group's Sustainability & Transformation Plan in response to the triple aim set out in Delivering the Five Year Forward View 2016/17-2020/21, NHS England Planning Guidance.

NHS England published the Better Care Fund technical guidance at the end of February 2016.

2. Operational Plan 2016/17 - Background

In accordance with the NHS England Planning guidance 2016/17-2020/21, the operational plan 2016/17 must demonstrate delivery of the NHS Constitution standards and ensure there is a robust grip on demand and activity supported by reasonable planning assumptions and capacity plans. Commissioners are required to demonstrate an understanding of demand pressures and underlying growth in order to translate these into an agreed contractual position with providers for elective and non-elective activity.

The guidance also sets out a requirement for local systems in order to achieve future sustainability they must accelerate their work on ***prevention*** and *care redesign* and expect ***acceleration in transformation*** in a few priority areas, in order to build momentum.

The CCG's Operational Plan 2016/17 will set a clear plan and priorities for 2016/17 that reflects the Mandate to the NHS and next steps on Forward View implementation. The important changes for 2016/17 involve partial roll-out rather than national coverage. NHS ambition by March 2017:

- 25% of population will have access to acute services that comply with four priority clinical standards on every day of the week. The four priority clinical standards relate to: time to consultant review; access to diagnostics; access to consultant-directed Interventions; and ongoing review.
- 20% of the population will have enhanced access to primary care

CCG's are also required to deliver the national "Nine Must Do's, as described below:

1. Develop the 5-year Strategic Planning Group Sustainability & Transformation Plan, in support of the triple aim in the Five Year Forward View,
2. Return the system to aggregate financial balance – including engaging with Lord Carter's productivity programme, addressing agency spend on staff, and implementing Right Care to tackle variation,
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues,
4. Meet access standards for A&E and ambulance waits: four hour maximum A&E waits and ambulance responses to Category A calls within eight minutes,
5. Meet 18 week referral to treatment target, as per NHS Constitution,
6. Meet cancer standards on waits and improve one year survival rates,
7. Meet two new mental health access standards: more than 50% of people experiencing a first episode of psychosis to commence treatment with a NICE approved care package within two weeks of referral; 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme to be treated within six weeks of referral, with 95% treated within 18 weeks. Continue to meet dementia diagnosis target,
8. Deliver local plans for better care for people with learning disabilities,
9. Develop and implement affordable plans to improve quality. Providers must participate in the annual publication of mortality rates,

In addition, the CCG's Financial Plan 2016/17 must also account for the NHS England financial requirements:

- Deliver a cumulative surplus of 1% - or at the very least an in-year break-even position. Plan to drawdown all cumulative surpluses in excess of 1% over the next three years;
- Plan to spend 1% of allocations non-recurrently. This 1% should be uncommitted at the start of the year, and released in agreement with NHS England and NHS Improvement as evidence emerges of risks to the health economy not arising or being effectively mitigated through other means. CCGs required to hold an additional contingency of 0.5%;
- Continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase;

Overall, the CCG's Operational Plan 2016/17 will need to reconcile activity and financial assumptions along with the planned contribution to efficiency savings (from QIPP) as well as maintaining and improving quality and safety. NHSE have indicated to the CCG that their planned control total of a deficit of £14.9m for 2016/17 will not be acceptable.

The CCGs across North Central London are working in collaboration in order to ensure that there is future alignment to the emerging NCL Sustainability & Transformation Plan to inform the aggregation of operational plan assumptions for 2016/17, in order to inform key deliverables of the first year of the STP.

3. The Operation Plan 2016/17 – progress towards submission

3.1 2015/16 saw a year in which nationally more Trusts faced financial challenges and deficits and there were worsening issues with performance particularly A&E, referral-to-treatment, access to diagnostics, and cancer 62 days treatment. Through both changes to national tariff and the Sustainability Transformation Fund the NHSE expect to see an improved financial position for Trusts, particularly acute Trusts, and an improved performance in the areas highlighted above for 2016/17. The NHS expects A&E performance to be at 95% during Q4 of 2016/17 and maintained going forward.

3.2 As required by the national planning timetable, the CCG submitted the 1st draft operational plan 2016/17 to NHS England on 8th February 2016, and the 2nd draft of plan on the 2nd March 2016.

The submission of both drafts was followed by assurance stocktake meetings with NHS England who were seeking assurance of

- Activity and finance forecast outturn,
- Reflection of the national growth assumptions (informed by the indicative hospital activity model) against local assumptions for elective and non-elective changes,
- Delivery of NHS constitutional standards,
- Alignment with the financial plan and its associated affordability,

The CCG had a further assurance and alignment meeting with NHSE on 5 April 2016 prior to its now final submission which is due on 18 April 2016. Acute activity plans were submitted to NHSE on 7 April 2016 to allow NHSE to view an aggregated position for the regions and nationally prior to final submission by CCGs on 18 April 2016. NHSE have indicated to the CCG that their planned control total of a deficit of £14.9m for 2016/17 will not be acceptable

3.3 NHS England published guidance on the Quality Premium (QP) 2016/17 on 9th March 16 to CCGs as an incentive to improve the quality of the services they commission, for associated improvements in health outcomes and reductions in health inequalities. The 2016/17 scheme has been designed to support the delivery of the major priorities for the NHS, as set out in the Five Year Forward View and in the NHS Mandate.

CCGs earn Quality Premium payments by achieving improvements in outcomes measures related to quality of services, which are as follows:

- **Cancers diagnosed at an early stage.** This measure has a value of 20 percent of the total Quality Premium. To earn this, CCGs will need to:
    - demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year; or
    - achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year.

- **Increase in the proportion of GP referrals made by e-referrals**. This measure has a value of 20 percent of the total Quality Premium. To earn this, CCGs will need to:
    - meet a level of 80% (of new first outpatient appointments referrals booked through the e-referrals system as a proportion of total GP referrals) in March 2017 **and** demonstrate an increase in the percentage of referrals made by e-referrals from 2015/16 to 2016/17 (or achieve 100% e-referrals); or
    - the March 2017 performance is to exceed March 2016 performance by 20 percentage points.

- **Overall experience of making a GP appointment.** This measure has a value of 20 percent of the total Quality Premium. To earn this, CCGs will need to, from the July 2017 publication of the GP Patient Survey results:
    - achieve a level of 85% of respondents who said they had a good experience of making an appointment; or
    - a 3 percentage point increase from July 2016 publication on the percentage of respondents who said they had a good experience of making an appointment

- **Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary and secondary care.** This measure has a value of 10 percent of the total Quality Premium, with that award being split equally for achievement of each of the two following parts:
    - Reduction in the number of antibiotics prescribed in primary care. The required performance in 2016/17 must either be:
        - a 4% (or greater) reduction on 2013/14 performance; or

- equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU
- Reduction in the number of broad spectrum antibiotics (co-amoxiclav, cephalosporins and quinolones) prescribed in primary care. The required achievement in 2016/17 must either be:
- the proportion to be equal to (or lower than) 10%; or
- to reduce (the proportion) by 20% from the CCG's 2014/15 value,

- **Three locally determined measures, to be identified from the Right Care Commissioning for Value packs.** These measures will have a combined value of 30 percent of the total Quality Premium (10 percent each). CCGs will need to work with NHS England regional teams to agree the local proposal, and the levels of improvement needed to trigger the reward. NHS Enfield CCG is proposing to include local measures for cancer, IAPT and dementia:
-

1. Cancer - 85% of Enfield patients will receive first definitive treatment within two months of urgent GP referral from Q2
2. Mental Health - Reported numbers of dementia on GP registers as a % of estimated prevalence. Target 66.7%.
3. Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression. Target 15% at year end.

4. North Central London Strategic Planning Group's Sustainability & Transformation Plan

The NCL Strategic Planning Group (SPG) must produce a sustainability and transformation plan (STP) to close the gaps identified in three key areas: health and wellbeing, care and quality, and finance and efficiency. The STP covers the Five Year Forward View ambitions to 2020/21. On 15 April 2016, NHS England have requested an initial submission of the STP that includes five deliverables:

1. A clinical case for change – to identify the key messages emerging on the health
2. and wellbeing, and care and quality gaps
3. A finance base case – the "do nothing" scenario to identify the finance and
4. efficiency gap
5. Governance arrangements – to provide appropriate leadership and control to the STP development
6. Resource agreements – to support to the development of the STP provided by
7. the SPG, including performing a gap analysis of existing resources and scoping
8. the programme budget
9. Programme plan – to close the identified gaps and achieve sustainability via
10. defined workstreams and milestones

5. Better Care Fund Plan 2016/17

NHS England published the Better Care Fund (BCF) planning guidance at the end February16 and the CCG is required to develop a joint plan with local partners and formally agree with the local Health and Wellbeing Board. The BCF plan must meet national conditions including:

1. maintain provision of social care services,
2. agreement for the delivery of 7-day services across health and social care in order to prevent unnecessary non-elective admissions to acute settings,
3. improve data sharing between health and social care,
4. ensure a joint approach to assessments and care planning,

and two new national conditions, reflecting on progress made in 2015/16:

1. agreement that a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services or retained as part of a local risk sharing agreement,
2. agreement on a local action plan to reduce delayed transfers of care.

The CCG is working with the London Borough of Enfield to develop the BCF Plan 20161/7 in accordance with the NHS England planning timetable, with a draft submission of the BCF Plan 2016/17 submitted on 23 March 16 and a final plan submitted now due on 3rd May 2016 (deadline extended from 25th April 2016). The CCG and LBE have received assurance feedback on the first submission. However the CCG and LBE have yet to agree an investment plan for 2016/17.

Enfield Health and Well Being Board
21 April 2016
Emergency Department

The ED issue

2

- Long term issues recruiting senior doctors
- Critical inspection of junior doctors training in July 2015
- Need to provide more training and supervision and reduce reliance on juniors for training
- Longer waiting times in ED and failure to achieve 4 hour ‘target’
- At times very long waits and very busy department leading to patient safety concerns

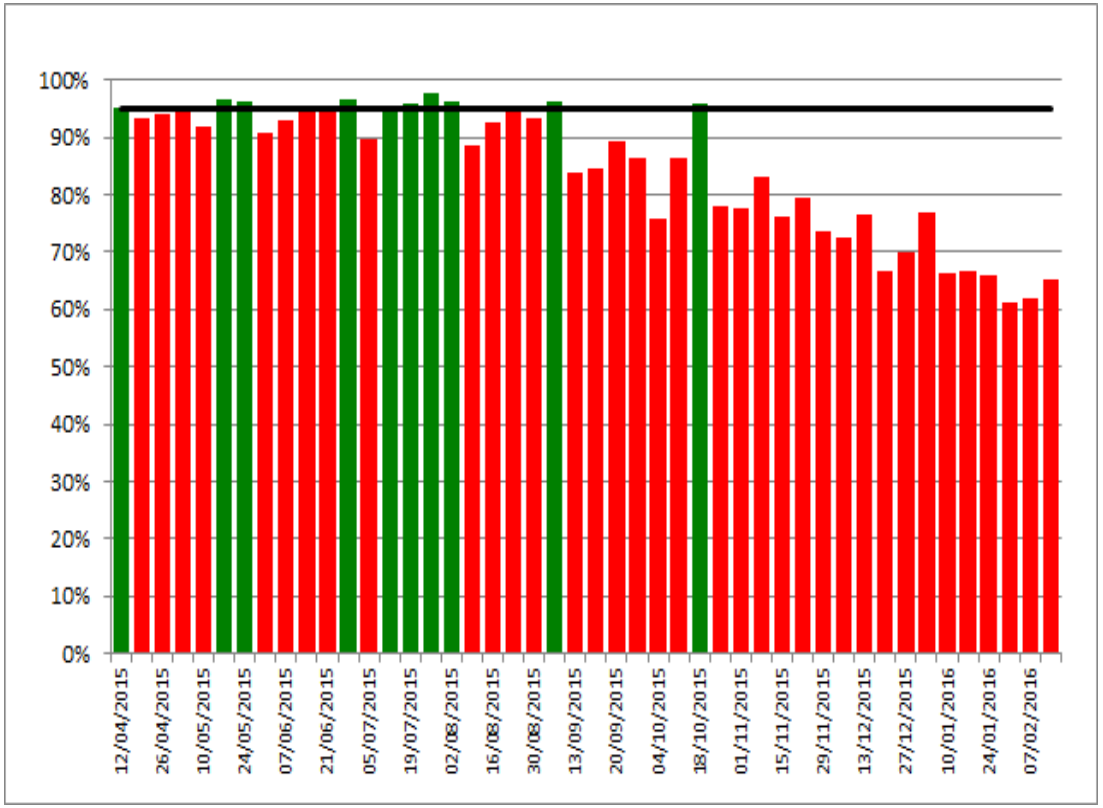
ED
performance against 95% standard

3

Summary Monthly Performance

Month	14/15	15/16
Apr	95.9%	94.2%
May	95.2%	94.2%
Jun	94.1%	94.8%
Jul	91.7%	95.0%
Aug	97.7%	92.4%
Sep	97.2%	86.7%
Oct	93.4%	84.3%
Nov	93.9%	77.3%
Dec	87.8%	71.9%
Jan	94.3%	66.4%
Feb	90.5%	63.5%
Mar	91.3%	
YTD	**94.1%**	**84.7%**

Weekly 4hr Target Performance



External reviews key findings- solving the problem long term

4

- Poor Performance driven by supply side factors (rather than demand)
- Whole system problem played out in ED
- Reduced attendances – but reduction achieved across 9-5, volume of out of hours complex and elderly attendances has increased
- Significant deterioration in A&E process times
- Disproportionate impact upon elderly patients (over 85s), but small numbers
- Admission rate from ED has increased but remains below national average
- Zero LoS admissions have increased year on year
- Required focus on reducing Length of Stay rather than admissions
- Volume of social care delays has increased significantly over last 12 months
- Need to expand GP redirection and GP direct referrals to national levels
- Weekend discharges are below significantly below national average and have deteriorated
- Weekday discharge remains heavily weighted to late afternoon profile that impacts significantly upon flow management

Risk Summit Actions- Keeping it safe short term

5

- **ED Workforce**
- Appointed substantive Clinical Director- starting June 2016
- Expand medical workforce (4 WTE consultants and 5WTE middle grades)
- Improve pastoral and educational support for ED workforce (GMC, HENCEL, RCN, Tavistock consulting)

- **Patient Flow**
- GP See & Redirect pilot launched 17/02
- Mutual aid with local providers (including LAS)
- Increased triage capacity
- Senior care of the elderly doctor based in ED 4hours/day

- **Governance and risk**
- Specific mitigating actions underway in ED including very close monitoring
- Weekly dashboard in place

Immediate actions to ensure patient safety

6

- Increased number of nurses on shift
- Long wait patients nursed on beds rather than trollies
- Hourly rounding (comfort and safety)
- Treatment plans initiated and followed while in ED
- Daily assessment of patient experience
- Regular open meetings with staff
- Daily Director of Nursing and Medical Director presence
- Daily incident reviews
- Daily silver control meetings to manage patient flow

Improving discharge

7

- Daily meeting including all key stakeholders incl. LBE
- Assistant Director chair of daily meeting
- Morning ‘Board round’ review of actions for each patient
- Escalation of actions in the afternoon if not complete
- Weekly review of themes and trends including bed days lost to system

Programme management

8

- Dedicated Safer, Faster, Better programme director based at Trust but working with CCGs too
- Trajectory to achieve 95% by end of 2016/17
- Junior doctors re-inspection March 2016- further actions to support training and supervision
- Clinical Director starts June 2016

Agenda Item 5

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **21st April 2016**	**Agenda – Part: 1**	**Item: 5**
	Subject: Better Care Fund: **a) Update and review of the 2015-16 Better Care Fund plan** **b) The 2016 -17 Better Care Fund plan**	
	Wards: All	
REPORT OF: Bindi Nagra, Asst. Director, Health, Housing and Adult Social Care, LB Enfield, and Graham MacDougall, Director of Strategy and Partnerships Enfield CCG	**Cabinet Member consulted:** Cllr. Doug Taylor, Leader of the Council	
Contact officer: Keezia Obi **Email:** Keezia.Obi@enfield.gov.uk **Tel:** 020 8379 5010		

1. EXECUTIVE SUMMARY

This report provides an update on the 2015-16 Better Care Fund (BCF) plan including the performance and financial position and in year achievements. It also sets out the activity taking place to produce the 2016-17 BCF plan in preparation for Health and Wellbeing Board approval by 2nd May 2016, following the publication of local allocations and guidance issued by NHS England.

2015-16 BCF plan

Performance and achievements - the report is attached as Appendix 1. The performance dashboard covers the period up to January 2016 and was presented to the March Integration Board. We can report achievements in a number of areas including admissions to residential and nursing care, integrated locality team working, community based rapid response services. Activity continues in order to improve performance across the key metrics and this is outlined in the report.

Finance - As reported to the Health and Wellbeing Board (HWB) in February, the Quarter 3 financial report was presented to the BCF Management group in February. This followed a review of the financial position of all projects and programmes and as anticipated the year-end position is within budget.

The governance and management of the BCF – previous reports to the HWB reported that we had participated in an NHS England support scheme and engaged in a number of audits. This process had identified areas where we could strengthen local management and this report highlights some key areas of improvement.

Development sessions – it has been agreed that external facilitators are engaged to assist the HWB in shaping the future of integration in Enfield. As part of a series of events, a second development session took place on 17th February. This session was with the Integration Board and focused on integrating health and social care in Enfield in order to reveal a common purpose and shared ambitions.

2016-17 BCF plan

Since reporting to the HWB in February NHS England released the policy framework and guidance for the 2016-17 BCF plans. In summary, the process has involved an initial template submission, a second submission and a final submission due to be submitted on Tuesday 3rd May 2016, having been formally signed off by local HWB's. The timetable is included in the body of the report (see page 11).

Whilst the majority of conditions remain the same as 2015-16, a simplified planning and assurance process has been put in place, including removal of the £1 billion payment for performance framework. This has been replaced by 2 new national conditions:

- Agreement to invest in NHS commissioned out-of-hospital services (which may include a wide range of services including social care services), or retained pending release as part of a local risk sharing agreement.
- Agreement on clear and focused, local action plans and agreed targets to reduce delayed transfers of care (DTOCs)

Narrative plan – there is a requirement that the BCF plan includes a narrative which supports the national conditions, together with the local vision for health and social care, the case for change and expected activity during the year ahead. The plan which formed part of submission 2 is attached as Appendix 2.

Scheme plan – a further requirement is a scheme plan setting out details of what types of services and activity will be delivered. This plan including the related expenditure is currently subject to discussion between the Council and CCG and as such is not yet available.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note** the update on the 2015-16 BCF plan, including the current performance metrics and achievements.
- **Note** the activity taking place in response to participation in the NHS England support scheme and audits, in particular improvements being made.
- **Note** the publication of the 2016-17 planning guidance and timetable, and key changes to last year's guidance.
- **Receive** the attached BCF 2016-17 narrative plan (submission 2 as noted above), noting that this may be subject to change as a result of the final agreement to the investment plan.
- **Agree** delegated authority is given to the Chair and Vice-Chair of the HWB to approve that the final 2016-17 BCF submission. This is in view of the very tight timescale and that the Council and CCG have not yet reached agreement on the investment plan.
- **Note** at the time of writing that on April 11th we received verbal feedback from NHS England on the 2nd BCF submission, but are awaiting the formal feedback. The summary feedback is a rating of 'approved with support' and further details have been included in the report, but it is noted that it may be subject to change.
- **Note** that since the last report to the HWB in February, a further development session has been held with the Integration Board.

3. The BCF 2015-16 performance and achievements

3.1 The performance report is attached as Appendix 1.

Non-Elective Admissions (NEA's) - General and Acute

3.2 The current increase in NEA activity represents a 6% increase in admissions from April to December 2015 compared to the same period in 2014, with increases across all age groups.

3.3 The increases of activity are mainly being attributed to paediatrics but also cover orthopaedic and immunology specialties. A&E conversion rates have significantly increased since 2014/15. Non-elective admission audits have been undertaken at both North Middlesex University Hospital Trust and Royal Free Hospital to better understand patient flow to inform how best to reduce emergency admission across different age groups

3.4 NEA admissions for 65+ have increased by 3%, against a background of the 6% increase for all age groups. Since December 2015 there has been an increase in activity in the Older People's Assessment Unit, whilst the Integration Board agreed to fund a GP Local Incentive Service to encourage practices to work with the integrated care network in the multi-agency management of complex cases of (predominantly older) patients most at risk of hospitalisation. This has been rolled out from January 2015 with over half of Enfield practices signing up already. It is expected that both these solutions will help avert avoidable hospital admission in the remainder of 2015/16.

3.5 We are clear that the work we have done in 2015/16 to reduce emergency admissions for older people (65+) needs to be extended into paediatrics and our 50+ population as these have shown themselves to be areas of increased pressure this year.
The increase in the number of people whose discharge from hospital was delayed in 2015/16 has been identified as a priority with particular issues around:

- non acute mental health discharge and support arrangements
- shortage of residential/nursing stepdown provision
- patient choice (for residential/nursing care)
- completion of assessment

An action plan is in place and has been implemented with a 45% reduction in delays achieved in January 16 compared to September 15. This remains an area of priority for 2016/17. This is supported by the System Resilience Groups focussed around our two main acute providers.

Residential Admissions

3.6 Residential admissions within Enfield for people aged 65 and over have decreased over the last two years to a level which is below both London and national averages as more people are supported (either with or without ongoing social care support) to continue living independently within their own homes. There has been an increase in the number of people entering residential or nursing care for dementia related care and support.

3.7 The majority of residential and nursing placements also continue to be made from hospital (60% of whom were not previously known to social care). Work is underway to

better understand how earlier intervention across the health, social care and voluntary sector partnership can provide appropriate access to the kind of support which will reduce the impact of declining health, prevent falls, support carers to continue caring and provide earlier diagnosis of dementia and support services which prevent or postpone hospitalisation and the need for residential/nursing care support.

Reablement

3.8 This national indicator (NI 125) looks at the proportion of people who have entered the service from hospital and whether or not they are living independently within 3 months of receiving the service. Independent means continuing to live in the community (with our without support). It excludes people who have moved into a residential/nursing placement or people who have died.

3.9 The Council continues to work in partnership with colleagues in health to develop its enablement service. Over the last three years capacity within the service has been doubled from just over 800 people seen per year to over 1600. The review and move on process has been improved to ensure that service users gain maximum benefit from the service.

3.10 The target of 88% was always very ambitious, particularly with significantly increased numbers of people passing through the service. Performance is currently at 82%. However, if people who have subsequently passed away within the three months are taken into account, performance stands at around 87%. The service also monitors the number of people who receive the service (both to prevent hospital admission and ensure appropriate and timely discharge) where no further input is required (people are living independently) and performance here has continued to improve year on year. Currently at over 72% this compares very favourably with London and national averages around the low 60%.

Delayed Transfers of Care

3.11 Delays April - December 2015:

- There were 4528 days delayed between April and December which is above the cumulative target of 3425
- There were 16 patient delays during December, of which 9 were Health delays, 5 were attributable to Social Care and 2 were joint delays.

3.12 Acute delays **-** Assessment delays are the main cause of acute adult social care delays to date. Within health, the main reasons have been the need to await further non acute NHS care, awaiting a continuing healthcare nursing home placement, community equipment delays and patient choice for residential/nursing care.

3.13 Non-acute delays - The main reasons for a delay within adult social care were assessment completion, funding and residential/nursing placements. Within health the main reasons for a delay were assessment completion, continuing healthcare nursing placements and family choice.

3.14 Partners continue to look to ways of improve their discharge processes to avoid delays in the system. In response, an action plan has been developed to reduce functional mental health delays, to include analysis of the reasons and analysis of the mental health enablement service capacity/accommodation options for people with mental health struggling to maintain tenancy arrangements.

3.15 Actions are also being explored to address delays in the completion of assessments and the provision of value for money placements for continuing healthcare patients. Similarly, a more rigorous monitoring and discharge

process for older people with organic mental health issues was agreed and implemented between Barnet, Enfield & Haringey Mental Health Trust, Enfield CCG and LBE to better identify earlier and manage the discharge of people from non-acute beds.

3.16 **Dementia Diagnosis**

Enfield CCG continues to make good progress on dementia diagnosis. The latest data published by Health and Social Care Information Centre (HSCIC) is for January 2016, and shows a diagnosis rate of 68% (figures for 7 GP practices are estimated, based on their last available data). The Direct Enhanced Services (DES) scheme for GP practices and Commissioning for Quality and Innovation (CQUIN) scheme for community services, introduced in 2015/16 for the first time to encourage screening of patients known to community services, are expected to boost diagnosis rates. Recent increases in memory clinic waiting times are being addressed to further improve patient experience and diagnosis rates.

3.17 **NHS England reporting**

The NHS England quarter 3 data report (for the period October to December 2015) was submitted on February 26th and the report for quarter 4 (January to March 2016) will be due late May / early June.

3.18 **Achievements**

Despite significant challenges across our health and social care services in Enfield the implementation of our Better Care Fund programme of work has seen some success in 2015/16:

- Admissions to residential and nursing care continue to reduce and our target, already very ambitious, will be met this year.
- Our enablement service continues deliver excellent outcomes with over 71% discharged with no further need for support;
- On track to achieve 88% of people living independently after receiving the service upon discharge from hospital;
- Our satisfaction measure shows good performance against continuity of care co-ordination (continuity of support and telling your story once);
- Seven day working is in place across health and social care and our integrated locality teams are working well to bring a multi-disciplinary approach to supporting people who need our help.

3.19 There is a shared ambition and acknowledgement of the challenges which we are facing as a partnership and this is reflected in our 2016-17 BCF narrative plan submission. We are already expanding the work we do across integrated pathways to improve our response for children and for adults to ensure we have the right services in the right place at the right time.

- An action plan is in place to reduce our delayed discharges with a reduction of 45% already achieved in January 16 compared to September 15. This plan has been reviewed and strengthened to respond to our local challenges
- We are jointly recommissioning our voluntary sector activity with a focus on integrated hub based approaches which will see VCS organisations both working together and with statutory services to deliver early intervention support which is

evidence based. This will see an increased focus on enabling support, self-management of long term conditions, increased support for carers and ensuring that our most vulnerable people continue to have a voice both through service development and advocacy support.

3.20 The community-based rapid response services work together to ensure people avoid hospitalisation where this is unnecessary at weekends and out-of-hours:

- GP Urgent Access Hub - established in 2015/16 to enable professionals to schedule GP appointments for patients with clinical needs who need to be seen quickly in the evening or at the weekend at a local practice. This was commissioned to support winter system resilience.
- Community Nursing & Rehabilitation Out-of-Hours services - include 7-day working, with the latest addition being the nurse-led Community Crisis Response Team to support people in the community and in care homes to avoid hospitalisation, a service linked to the Council's 24/7 Safe & Connected Service which ensures a rapid response is mobilised should a user's alarm be triggered;
- Other Out-of-Hours services - The integrated care model includes access to out-of-hours and weekend social care duty and community mental health services as appropriate.

These activities will continue to be monitored and adapted in our 2016/17 plan.

3.21 The Integrated Locality Teams and the Care Homes Assessment Team support assessment and care planning for people with dementia and have access to Community Mental Health Teams for specialist support in individual cases. Due to this improved care management and increased resources and training in primary care and the Memory Service, the proportion of Enfield residents living with dementia who had formal diagnoses increased from 45% to 67% over the last 18 months. We established a voluntary sector role of dementia navigator to support people post-diagnosis in 2015/16, a role linked to joint planning in our integrated care network, in particular, the Memory Service and Integrated Locality Teams.

4.0 Finance

4.1 As reported to the Health and Wellbeing Board (HWB) in February, the Quarter 3 financial report was presented to the BCF Management group later that month. This followed a review of the financial position of all projects and programmes and as anticipated, the year-end position is within budget.

5.0 The governance and management of the BCF

5.1 Previous reports to the HWB reported that we had participated in an NHS England support scheme and engaged in a number of audits. This process had identified areas where we could strengthen local management and some key areas of improvement have been:

- The Finance and Activity sub group has been re-focused and has resolved the historic commissioning and invoicing issues and the end of year position
- Agreement to review the Terms of Reference and membership of the Board and sub groups for 2016/17
- Agreement to update business cases for existing schemes that are continuing during 2016/2017

- Producing quarterly updates to outline progress, performance, funding spend and forecast spend by year end. This will be subject to challenge by the Finance and Activity Sub group.

5.2 **Leadership development sessions**

A second session took place at the meeting of the 17th of February Integration Board. The focus of the session was to consider a range of options for integrating health and social care in Enfield in order to reveal common purpose and shared ambitions. The desired outcomes were:

- Agreement about the parameters for a shared vision for change
- Increased understanding between partners, leading to clarity about areas of consensus and areas of difference
- An agreed set of next steps to which partners can commit sufficient leadership resources to in order to make progress

5.3 During the session three key areas were identified and will be taken forward to the next session and the invite extended accordingly.

- Strategic financial discussion across health and social care commissioning and provision affecting Enfield
- Local examples of integration working in practice
- Agreeing Enfield's models of integration going forward

6.0 Better Care Fund 2016/17

6.1 Better Care Fund planning guidance 2016/17

NHS England has published the BCF detailed planning guidance, including the approach to regional assurance of the plans and the minimum and further key lines of enquiry (KLOE). These are being used as part of the compliance checks and provide the framework for the assurance review of plans at a regional level. The guidance can be accessed using the following link: http://www.local.gov.uk/documents/10180/5572443/BCF+planning+2016-17+Approach+to+regional+assurance+of+Better+Care+Fund+plans/33067cda-d4e0-41b2-8bff-b004efecc29c

A key requirement is for Better Care Fund plans to demonstrate how the following national conditions will be met:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care
- Agreement on local action plan to reduce delayed transfers of care.

6.2 Better Care Fund policy framework 2016/17

The Department of Health has also published a policy framework which includes:

- The Statutory and Financial Basis of the Better Care Fund
- Conditions of Access to the Better Care Fund
- The Assurance and Approval of the Local Better Care Fund Plans
- National Performance Metrics
- Implementation 2016-17

The framework can be accessed using the following link:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf

The following conditions have been set out that local areas will need to meet to access the funding:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

6.3 What has changed in 2016-17?

- A simplified planning and assurance process, including removal of the £1 billion payment for performance framework
- Payment for Performance has been replaced by 2 new national conditions:
- Agreement to invest in NHS commissioned out-of-hospital services (which may include a wide range of services including social care services) or retained pending release as part of a local risk sharing agreement.
- Agreement on clear and focused, local action plans and agreed targets to reduce delayed transfers of care (DTOCs)
- Updates to the national condition regarding agreement for delivery of 7 day services across health and social care to prevent unnecessary non-elective admissions to acute services.

6.4 Better Care fund allocations 2016/17

The allocations for Enfield are as follows:

- Revenue funding from CCG - £19,185,445
- Local Authority contribution (Disabled Facilities Grant) - £2,540,000
- Total - £21,725,445

And the allocation includes the following:

- Protection of Adult Social Care Services - £6,055,000
- Care Act monies (priorities are for advocacy and carers) - £734,000
- Funding held as a contingency as part of a local risk sharing agreement - £1,500,000

6.5 Agreement of the 2016-17 BCF (narrative plan and investment).

As noted in the Executive Summary, we have submitted the necessary documentation to NHS England. The next step is to submit the plan having been formally agreed by the Health and Wellbeing Board.

The majority of the BCF schemes build on the 2015-16 activity e.g. the Integrated Care programme, protection of social care monies, Care Act funding (in particular for Advocacy and Carers services), wheelchair services. However there is ongoing discussion regarding the risk share agreement and the investment plan. Therefore, at this stage the HWB is being asked to review the attached narrative plan produced in line with the policy guidance and delegate authority to the Chair and Vice-Chair to approve the final 2015-16 BCF plan for submission to NHS England on 3rd of May 2016.

6.6 Verbal feedback from NHS England to our March 21st submission (2nd submission)

The deadline for a response to the March 21st submissions from NHS England to local areas to confirm draft assurance status and actions required was April 11th. However to date we have only received summary verbal feedback. This feedback is outlined below but may be subject to change following receipt of the formal feedback:

6.7 Assurance Rating

The assurance rating is 'Approved with support' (medium level). It was noted that there were no fundamental areas of concern and that we had a strong plan that was viewed as being under development

For information the levels are:

- High –answers all the minimum requirement KLOEs (Key Lines of Enquiry) comprehensively and addresses the further requirement KLOEs;
- Medium quality –answers the minimum requirement KLOEs for all plan elements, but with further work required to strengthen these and/or meet further KLOEs;
- Low –fails to answer some or all the minimum requirement KLOEs for one or more of the plan elements.

6.8 Assurance against KLOEs and gaps highlighted:

Narrative plan – the key gap is related to risk sharing and the local arrangements that are in place. For information the minimum requirements for our local risk sharing plan are:

- Quantification of what proportion of the pooled funding is 'at risk', if any, and how this has been calculated?
- An agreed approach to sharing risk on Non-elective admissions (NEA's) and delayed transfers of Care (DTOCs) in line with national conditions 7 and 8
- Articulation of any other risks associated with not meeting BCF targets in 2016-17

- Articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting

National conditions:

- Agreement for the delivery of 7-day services across health & social care to prevent unnecessary non-elective admissions (physical and mental health) to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

  Gap – this needs to be underpinned by a delivery plan for the move to seven-day services which includes key milestones and priority actions for 2016-17
  So we will need to expand on the narrative and send our plan as a separate attachment for the final submission

- Ensure a joint approach to assessment and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

  Gap – identification of which proportion of the local population will be receiving case management and named care co-ordinator

- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care

  Gap – not enough detail to support the KLOEs for this condition, so this section in the narrative will need to be reviewed and expanded.

National metrics:

Gap - More detail required for how the targets will be met and the analysis used to set the targets. This comment relates to all four targets – NEAs, DTOC, Re-ablement and admissions to residential and care homes. So again the narrative will need to be expanded and we will also include our latest performance dashboard as an attachment.

6.9 2016/17 planning and narrative submissions to NHS England

For 2016/17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational plan planning and assurance process. The assurance process for the BCF is based on meeting the national conditions and KLOEs, as detailed in 6.1 above.

The submission timetable is as follows:

Planning guidance and planning template issued	22 February
Submission 1 BCF Planning Return submitted by HWB areas to DCO teams, copied to the national team. This will detail the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.	**2nd March**
National team provide analysis of BCF planning returns in a single spreadsheet and send to DCOs and BCMs, highlighting any potential issues in the information provided	7th March
Feedback from regions, DCOs and BCMs to the national team on any outstanding issues or support needs arising from the first submission. To be coordinated regionally.	16 March
Submission 2 Full BCF plan submitted by HWBs to DCO teams, including BCF Planning Return version 2, which is to be copied to the national team for analysis	**21st March**
National team provide analysis of BCF planning returns in a single spreadsheet and send to DCOs and BCMs, highlighting any potential issues in the information provided	24th March
Deadline for regional confirmation of draft assurance ratings for all BCF plans to the **national team**	6th April
National calibration exercise carried out across regions to ensure consistency	7th – 8th April
Deadlines for feedback from DCO teams and BCMs **to local area**s to confirm draft assurance status and actions required	11th April

Submission 3 Final plans submitted, having been formally signed off by HWBs	**3rd May**
Deadline for regional confirmation of final assurance rating to BCST and local area	13th May
Deadline for signed Section 75 agreements to be in place in every area	30th June

End of Report.

Better Care: Current Period Data

Report Author: Sam Buckley

Generated on: 09 March 2016

1. Non-Elective admissions (general and acute)

Indicator		Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Latest Note
Number of Admissions	ACTUAL	2,355	2,453	2,515	2,546	2,356	2,499	2,656	2,477	2,758	2,681			
	TARGET	2,291	2,291	2,292	2,378	2,377	2,378	2,499	2,499	2,500				
Cost of Admissions														

2. Residential Admissions

Indicator		Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Latest Note
New Admissions to Residential and Nursing Care (65+) per 100,000 pop 65+	ACTUAL	47.4	74.8	104.7	159.5	187.0	214.4	226.9	261.8	304.1	331.6			**ANNUAL TARGET 2015/16 = 486 (199 admissions).** There have been 133 admissions this FY; to fall in line with SALT this now includes full cost and 12 week disregard clients.
	TARGET	40.6	81.1	121.8	162.4	202.8	243.0	283.9	324.5	365.0	405.5	446.1	486.6	
Number of admissions to supported permanent Residential and Nursing Care (65+)	ACTUAL	19	30	42	64	75	86	91	105	122	133			
Enfield Population 65+	ACTUAL	40,113	40,113	40,113	40,113	40,113	40,113	40,113	40,113	40,113	40,113	40,113	40,113	

3. Reablement

Indicator		Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Latest Note
(BC) - Achieving independence for older people through rehabilitation/ intermediate care	ACTUAL	83.95%	80.25%	81.61%	83.00%	82.69%	82.71%	82.74%	81.42%	81.49%	80.21%			Target for 15/16 is 88%. Current performance is under target at 80.21%. 539 of the 672 clients who were discharged from hospital and received Enablement were independent. Of the remaining 133 - 46 are Deceased and 89 are in Residential/Hospital (14 of which have been privately arranged).
	TARGET	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	
Number of clients living independently 3 months after ICT service	ACTUAL	68	130	182	249	301	373	417	460	493	539			
Number of clients discharged from hospital with ICT	ACTUAL	81	162	223	300	364	451	504	565	605	672			

4. Delayed Transfers of Care

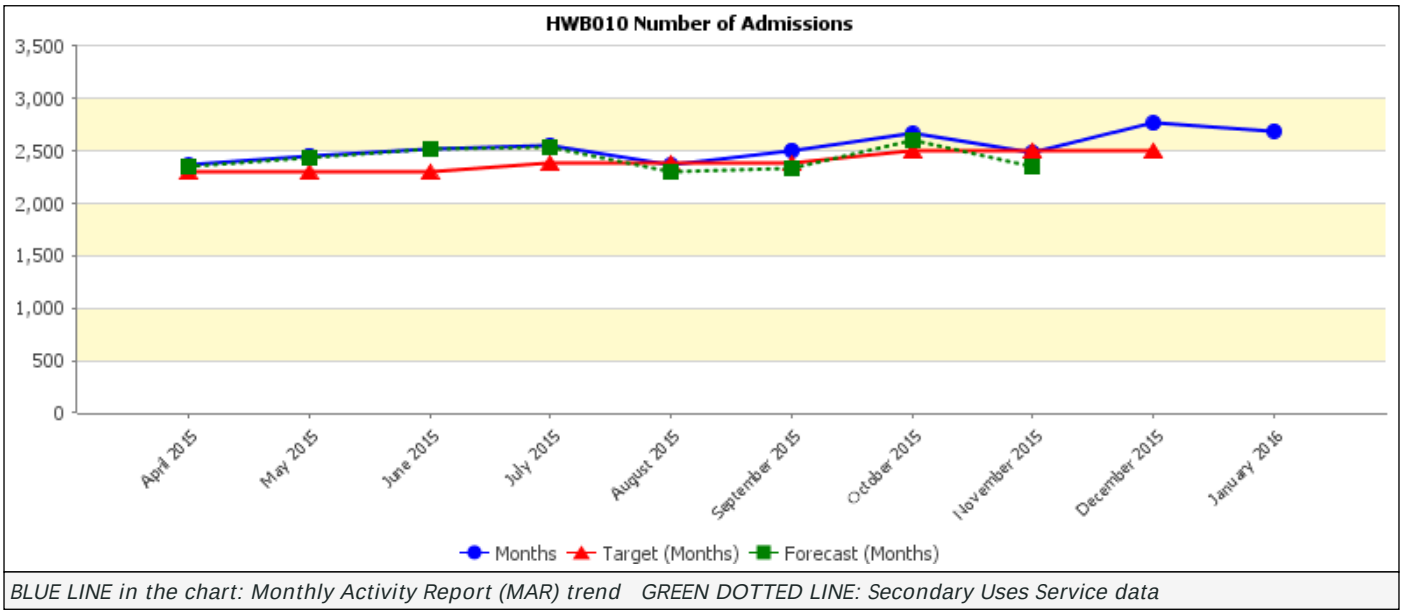
Indicator		Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Latest Note
Delayed transfers of care (patients) per 100,000 pop	ACTUAL	5.01	6.89	8.47	8.77	8.68	8.85	9.18	9.1	8.81				There were 16 patient delays during December, of which 9 were Health Delays and 5 were attributable to Social Care, and 2 were joint delays. **PLEASE NOTE:** There is always a one month delay in the availability of data for this indicator and so November is the latest information. Please see the report for further information. Action Plans are in place to address performance thorough the Joint Commissioning and integration Board.
	TARGET	5	5	5	5	5	5	5	5	5	5	5	5	
Delayed transfers of care (days)	ACTUAL	351	758	1270	1780	2403	2918	3592	4136	4528				There were 4528 days delayed between April and November which is above the cumulative target of 3425 day
	TARGET	381	761	1142	1522	1903	2283	2664	3044	3425	3805	4186	4566	
Population 18+	ACTUAL	239,600	239,600	239,600	239,600	239,600	239,600	239,600	239,600					

5. Dementia Diagnosis

Indicator		Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Latest Note
Dementia Diagnosis Rate	ACTUAL	68.10%	65.40%	68.60%	68.60%	67.30%	67.80%	67.60%	68.00%	67.60%	67.90%			
	TARGET	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	

Better Care: Number of Admissions

Generated on: 09 March 2016



BLUE LINE in the chart: Monthly Activity Report (MAR) trend GREEN DOTTED LINE: Secondary Uses Service data

Monthly Activity Report

	Value
April 2014	2,346
May 2014	2,321
June 2014	2,254
July 2014	2,370
August 2014	2,318
September 2014	2,378
October 2014	2,401
November 2014	2,455
December 2014	2,528
January 2015	2,296
February 2015	2,119
March 2015	2,336
April 2015	2,355
May 2015	2,453
June 2015	2,515
July 2015	2,546
August 2015	2,356
September 2015	2,499
October 2015	2,656
November 2015	2,477
December 2015	2,758
January 2016	2,681

Target

	2,374
	2,374
	2,374
	2,459
	2,459
	2,459
	2,583
	2,584
	2,585
	2,323
	2,323
	2,324
	2,291
	2,291
	2,292
	2,378
	2,377
	2,378
	2,499
	2,499
	2,500

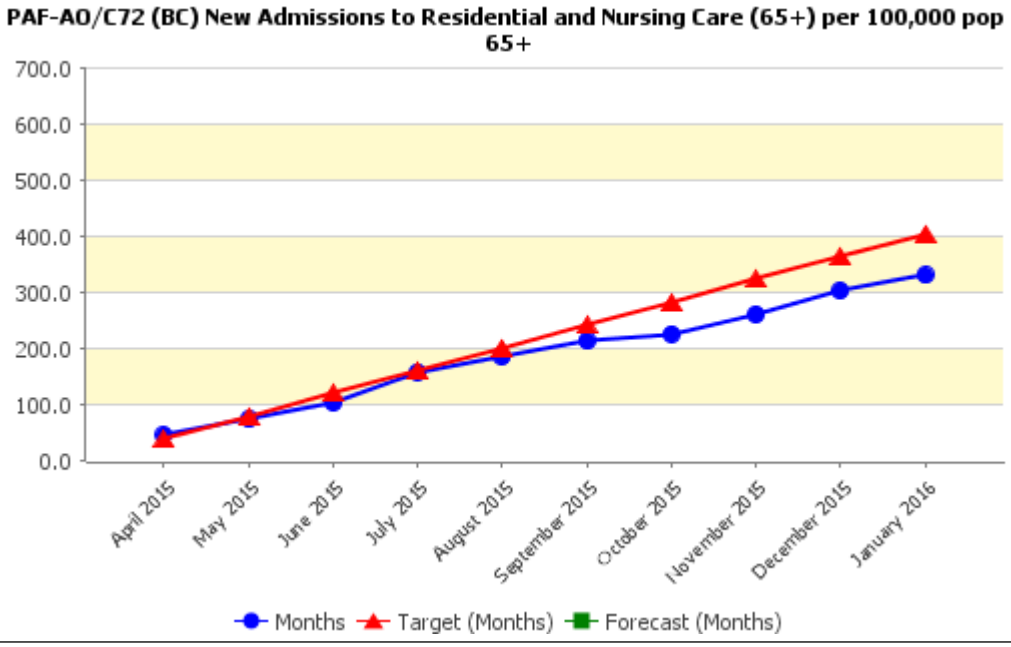
Secondary Uses Service

	2,196
	2,152
	2,088
	2,161
	2,015
	2,100
	2,132
	2,114
	2,253
	2,081
	1,861
	2,083
	2,338
	2,420
	2,507
	2,527
	2,287
	2,336
	2,596
	2,339

Notes

Better Care: New Admissions to Residential and Nursing Care (65+) per 100,000 population over 65

Generated on: 09 March 2016



Report Date Ranges

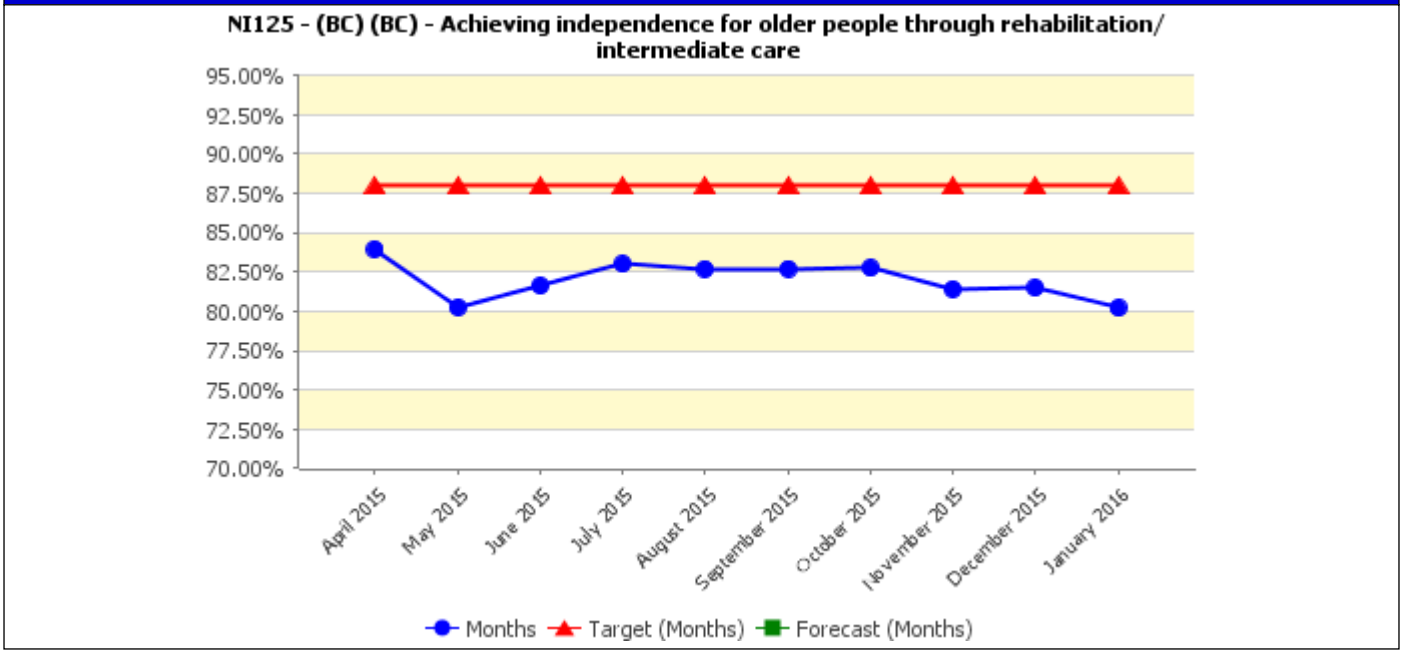
	2014-15	
	Value	Target
April 2014	22.4	36.0
May 2014	37.4	72.0
June 2014	57.3	108.1
July 2014	87.3	144.1
August 2014	112.2	180.1
September 2014	134.6	216.1
October 2014	162.0	252.1
November 2014	184.5	288.1
December 2014	201.9	324.2
January 2015	239.3	360.2
February 2015	271.7	396.2
March 2015	289.2	432.2
April 2015	47.4	40.6
May 2015	74.8	81.1
June 2015	104.7	121.8
July 2015	159.5	162.4
August 2015	187.0	202.8
September 2015	214.4	243.0
October 2015	226.9	283.9
November 2015	261.8	324.5
December 2015	304.1	365.0
January 2016	331.6	405.5

Notes

ANNUAL TARGET 2015/16 = 486 (199 admissions).
There have been 133 admissions this FY; to fall in line with SALT this now includes full cost and 12 week disregard clients.

Better Care: Achieving Independence for Older People through rehabilitation/ intermediate care

Generated on: 09 March 2016



Report Date Ranges

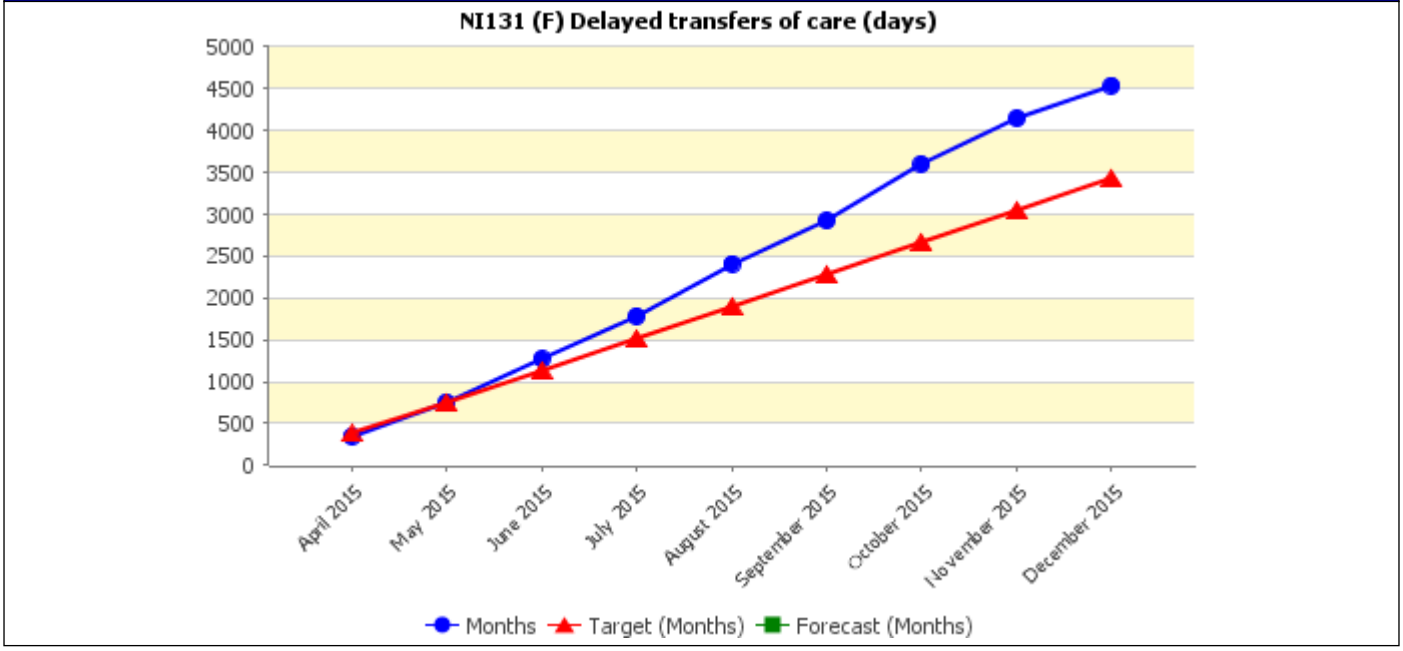
	2014-15	
	Value	Target
April 2014	83.87%	88.00%
May 2014	86.96%	88.00%
June 2014	84.29%	88.00%
July 2014	83.65%	88.00%
August 2014	83.14%	88.00%
September 2014	83.10%	88.00%
October 2014	83.05%	88.00%
November 2014	82.20%	88.00%
December 2014	82.61%	88.00%
January 2015	82.62%	88.00%
February 2015	82.79%	88.00%
March 2015	82.28%	88.00%
April 2015	83.95%	88.00%
May 2015	80.25%	88.00%
June 2015	81.61%	88.00%
July 2015	83.00%	88.00%
August 2015	82.69%	88.00%
September 2015	82.71%	88.00%
October 2015	82.74%	88.00%
November 2015	81.42%	88.00%
December 2015	81.49%	88.00%
January 2016	80.21%	88.00%

Notes

Target for 15/16 is 88%. Current performance is under target at 80.21%. 539 of the 672 clients who were discharged from hospital and received Enablement were independent. Of the remaining 133 - 46 are Deceased and 89 are in Residential/Hospital (14 of which have been privately arranged).

Better Care: Delayed Transfer of Care

Generated on: 09 March 2016



Report Date Ranges

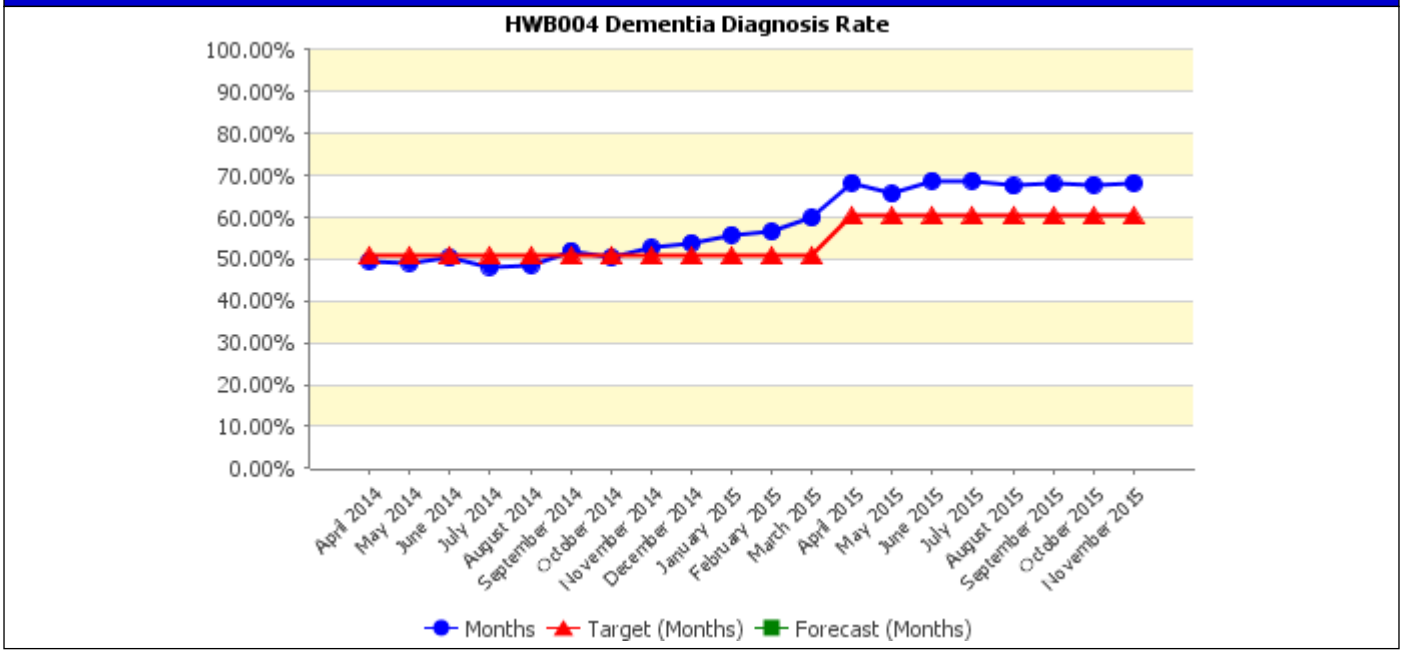
	2014-15	
	Value	Target
June 2014		
July 2014		
August 2014		
September 2014	2278	2432
October 2014	2859	2697
November 2014	3427	3082
December 2014	3875	3648
January 2015	4196	4055
February 2015	4486	4461
March 2015	4778	4866
April 2015	351	381
May 2015	758	761
June 2015	1270	1142
July 2015	1780	1522
August 2015	2403	1903
September 2015	2918	2283
October 2015	3592	2664
November 2015	4136	3044
December 2015	4528	3425
January 2016		3805
February 2016		4186
March 2016		4566

Notes

There were 4528 days delayed between April and November which is above the cumulative target of 3425 day

Better Care: Dementia Diagnoses

Generated on: 09 March 2016



Report Date Ranges

	2014-15	
	Value	Target
April 2014	49.49%	50.58%
May 2014	49.08%	50.58%
June 2014	50.10%	50.58%
July 2014	48.14%	50.58%
August 2014	48.53%	50.58%
September 2014	51.91%	50.58%
October 2014	50.26%	50.58%
November 2014	52.51%	50.58%
December 2014	53.78%	50.58%
January 2015	55.68%	50.58%
February 2015	56.44%	50.58%
March 2015	59.73%	50.58%
April 2015	68.10%	60.10%
May 2015	65.40%	60.10%
June 2015	68.60%	60.10%
July 2015	68.60%	60.10%
August 2015	67.30%	60.10%
September 2015	67.80%	60.10%
October 2015	67.60%	60.10%
November 2015	68.00%	60.10%
December 2015	67.60%	60.10%
January 2016	67.90%	60.10%

Notes

Better Care: Survey Data

Generated on: 09 March 2016

Short Name	Source	Frequency	Suggested target	13/14 Baseline	Latest ranking	Latest average	Latest top quartile	Current Value	Last Update
Proportion of carers who find it easy to find information about services	Carers survey	Biennial (completed April 2015)	65%	64.3%	17/33	65.6% (notional)	69.3%	61.7%	2014/15
Proportion of people who use services who find it easy to find information about services	ASC User Survey	Annual (May)	75%	74.30%	13/32	74.4% (notional)	77.9%	73.2%	2014/15
Last 6 months, enough support from local services/organisations to help manage long-term conditions	GP Patient Survey	bi-annual	60%	56%	15/32 (2nd survey 2015)	57.8%	60.6%	57.5%	H2 2015/16
OPAU – Did you not have to repeat your clinical history to different members of staff?	OPAU	annual	69%			67%		71.4%	2014/15
Composite Measure			67.3%	64.9%		67.0%			

Better Care Fund 2016/17

Enfield Narrative Plan – 21st March 2016

NHS
Enfield
Clinical Commissioning Group

1. Local Vision for health and social care services

In Enfield our vision for integration of health and social care continues to be:

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

Despite significant challenges across our health and social care services in Enfield the implementation of our Better Care Fund programme of work has seen some success in 2015/16:

- Admissions to residential and nursing care continue to reduce and our target, already very ambitious, will be met this year our enablement service continues deliver excellent outcomes with over 71% discharged with no further need for support;
- On track to achieve 88% of people living independently after receiving the service upon discharge from hospital;
- Our satisfaction measure shows good performance against continuity of care co-ordination (continuity of support and telling your story once);
- Seven day working is in place across health and social care and our integrated locality teams are working well to bring a multi-disciplinary approach to supporting people who need our help.

However, we are not complacent and know that the number of emergency admissions from our adult and child populations has increased this year, the number of days lost to delayed discharges has increased with more people in hospital due to mental ill health. We also know that we must improve access to good information which keeps people well informed and supports good, informed decision making.

The context in which we are working is equally important. Enfield is a borough which continues to experience significant population growth with many of its wards amongst the most deprived in the country. With annual population increases averaging around 3,500 people per year, growing numbers of children and adults under 65 and an increasingly older and frail older people population, there continues to be an upward movement in the numbers of people who access health and social care services. This is in addition to increased numbers of children and adults admitted as emergencies to hospital, greater demand upon all areas within social care, particularly within learning disabilities and older people with dementia. Our work to deliver more joined up and enabling services has contributed to our management of this demand, reducing the rate of increase most specifically across our older people population.

Nevertheless, there is a shared ambition and acknowledgement of the challenges which we are facing as a partnership. We are already expanding the work we do across integrated pathways to improve our response for children and for adults to ensure we have the right services in the right place at the right time.

- An action plan is in place to reduce our delayed discharges with a reduction of 45% already achieved in January 16 compared to September 15. This plan has been reviewed and strengthened to respond to our local challenges

- Our success at reducing emergency admissions for older people will be used to address increases in paediatrics and adults
- We are jointly recommissioning our voluntary sector activity with a focus on integrated hub based approaches which will see VCS organisations both working together and with statutory services to deliver early intervention support which is evidence based. This will see an increased focus on enabling support, self-management of long term conditions, increased support for carers and ensuring that our most vulnerable people continue to have a voice both through service development and advocacy support.

Our engagement activity with the community endorses our direction of travel. People do expect us to share information appropriately, provide good continuity of support and consider their situations holistically. We have also been clear about the challenges too. In order to deliver sustainable services and support to the people who need our help, we need to do much more with much less. This requires significant system and process change and a shared understanding of and participation in the design, development and delivery of the kinds of high quality support which people need and want and to ensure that our most vulnerable people continue to have a voice. We have also continued to develop and expand our quality checker service with an eye on maintaining good quality and delivering improvement where it is needed. Working with people who have experience of care (carers as well as service users) and service providers have welcomed this approach and the feedback which the quality checkers have provided to improve services.

There remains much still to do but we have made good progress this year on our journey towards fully integrated health and social care services. Our 2016/17 plan is more ambitious and will enable us to make further progress in integrating our plans and services.

2. An evidence base supporting the case for change

Enfield's population is increasing rapidly and the demographics and characteristics of the population is changing. Taken together, this is having a significant impact on the services that local people need and the way in which these services need to be delivered.

Between 2001 and 2014, Enfield's population has grown from 273,559 to 324,574 – an increase of over 50,000 people or 17.1% since 2001. This is well above the level of population growth in England of 9.8% and is also above the growth rate in London as a whole.

Projections from the Greater London Authority and Office for National Statistics all predict that Enfield's population will continue to rise significantly. According to the ONS, Enfield's population could reach 421,000 by 2037, which would represent an increase of over 100,000 people in a 25 year period.

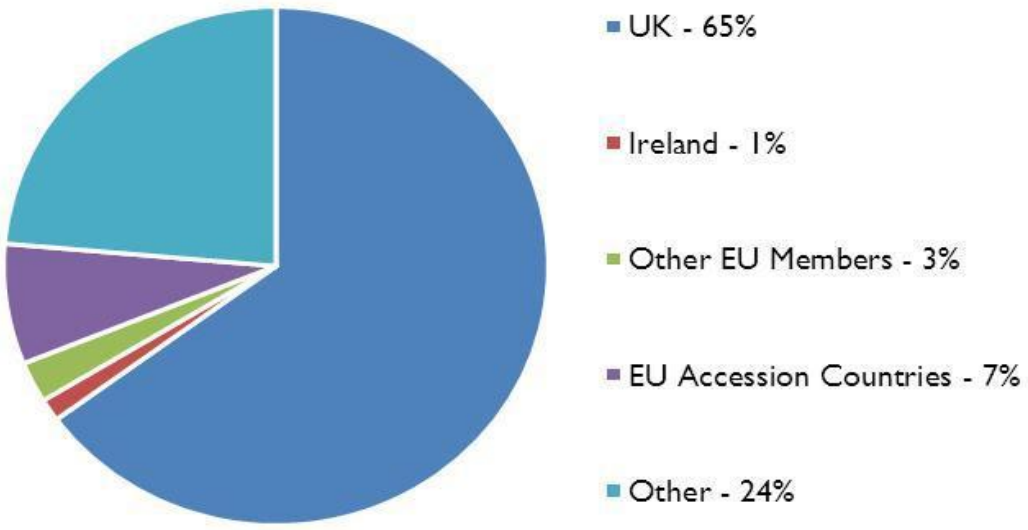
22.6% of Enfield's population are under 16. This is above the average for London (20.2%) and very nearly twice the proportion in the UK (11.5%). Children in Enfield live disproportionately in the less wealthy east of the borough, and this is reflected in

the fact that 29% of children are in poverty (compared with 23.5% in London and 18.7% across the UK.

12.8% of Enfield's population are over 65, which is a greater proportion than London as a whole (11.5%).

Enfield's population is increasingly diverse. Enfield Council estimates that around 35% of residents are white British (2015 local estimate). Some communities have grown substantially – the 'white other' group (including Greek, Turkish, Cypriot and Eastern Europeans) has grown from less than 13% in 2001 to over 23% by 2015. Altogether, the number of Greek, Greek Cypriot, Turkish, Turkish Cypriot and Kurdish residents numbered around 55,000 in 2015.

A large proportion of Enfield's population are born outside of the UK, and there are high levels of mobility and transience. At the 2011 census, 10.9% of Enfield residents had moved into the area in the previous year.
Country of Birth of Enfield Residents: 2011



Source: 2011 Census

This is reflected in the languages spoken within Enfield's communities. At the 2011 census, 14% of households did not have any occupants whose main language was English. A further 3.6% of households had no adults whose main language was English, but a child under 16 did have English as their main language.

Enfield has high levels of deprivation and poverty by both national and regional standards and significant economic challenges. Enfield is the 12th most deprived London Borough according to the 2015 Indices of Multiple Deprivation. It was the 14th most deprived in 2010 so has become more deprived relative to other parts of London.

In August 2015, 26,000 Enfield residents were claiming an out of work benefit - 12.6% of the working age population. This compares with 10.7% in London and 12.0% in Great Britain.

12,870 16-64 year olds were claiming either Employment Support Allowance or incapacity benefits, meaning that a large proportion of those claiming an out of work benefit had a disability, illness or limited mobility.

The above statistics are a clear demonstration supporting the case for change and resulting in the following health headlines:

- A life expectancy gap of almost 9 years between the most affluent and deprived wards
- A potential years of life lost (PYLL) score for women over 50 living in the south east of the borough significantly higher than the male population and for London as a whole.
- Deprivation scores which show Enfield wards in the east and south of the borough to be amongst the top 10% in England
- Significant levels of undiagnosed and debilitating long term conditions
- A reduction in healthy years lived as people live longer and marked differences between the potential years of life lost where good healthcare could have made a difference.

Enfield has increasing numbers of people living with long term conditions or disabilities and a challenging financial context which means that the case for change has never been stronger. Feedback from the people who work within our services and from those people with whom we work is equally clear. Joined up services which are efficient, easily accessible and which provide care and support closer to home are what everyone wants. The integration of health and social care economies is happening but needs to progress more quickly if we are to meet the challenges facing us. The purpose of the better care fund plan is to accelerate progress towards our key goals:

- Effective case finding which enables professionals and patients/service users to work together at an earlier stage to prevent deterioration and crisis
- Integrated health and social care locality teams providing access to good community services 7 days a week
- Reducing A&E attendances by providing good support in the community to prevent crisis
- Supporting more people to help themselves by giving them good information, advice, support and the tools to self-manage where they can appropriately do so
- Strong community enabling services which prevent hospital admission and facilitate speedy and safe discharge to the community

We are clear that the work we have done in 2015/16 to reduce emergency admissions for older people (65+) needs to be extended into paediatrics and our 50+ population as these have shown themselves to be areas of increased pressure this year.

The increase in the number of people whose discharge from hospital was delayed in 2015/16 has been identified as a priority with particular issues around:

- non acute mental health discharge and support arrangements
- shortage of residential/nursing stepdown provision
- patient choice (for residential/nursing care)
- completion of assessment

An action plan is in place and has been implemented with a 45% reduction in delays achieved in January 16 compared to September 15. This remains an area of priority for 2016/17. This is supported by the System Resilience Groups focussed around our two main acute providers.

Improving the availability of good accessible information which supports informed decision making and self-management of long term conditions is key to our vision of integrated care. Access to good quality information has been improved as a result of the Care Act implementation. Work has also started this year on recommissioning the VCS in partnership across the Council and the CCG with a view to commissioning evidence based support and services which will work jointly with statutory services. This will enable us to increase our focus on early intervention and preventative services which engage with people at an earlier stage increased resilience, self-care and to provide single points of access for information/advice/practical low level support as appropriate.

We are also increasing our nursing home capacity to support timely discharge from hospital (and to ease pressure on the rate of emergency admissions), in particular at North Middlesex Hospital. We are working within a very challenging care market and the 2016/17 BCF plan needs to demonstrate that we are putting in place new initiatives and services to improve the system as a whole.

The case of change was described in the Better Care Fund Plan 2015/16 and key issues to be addressed are taken forward in our joint Better Care Fund approach in 2016/17. The table below summarises the case for change across our populations.

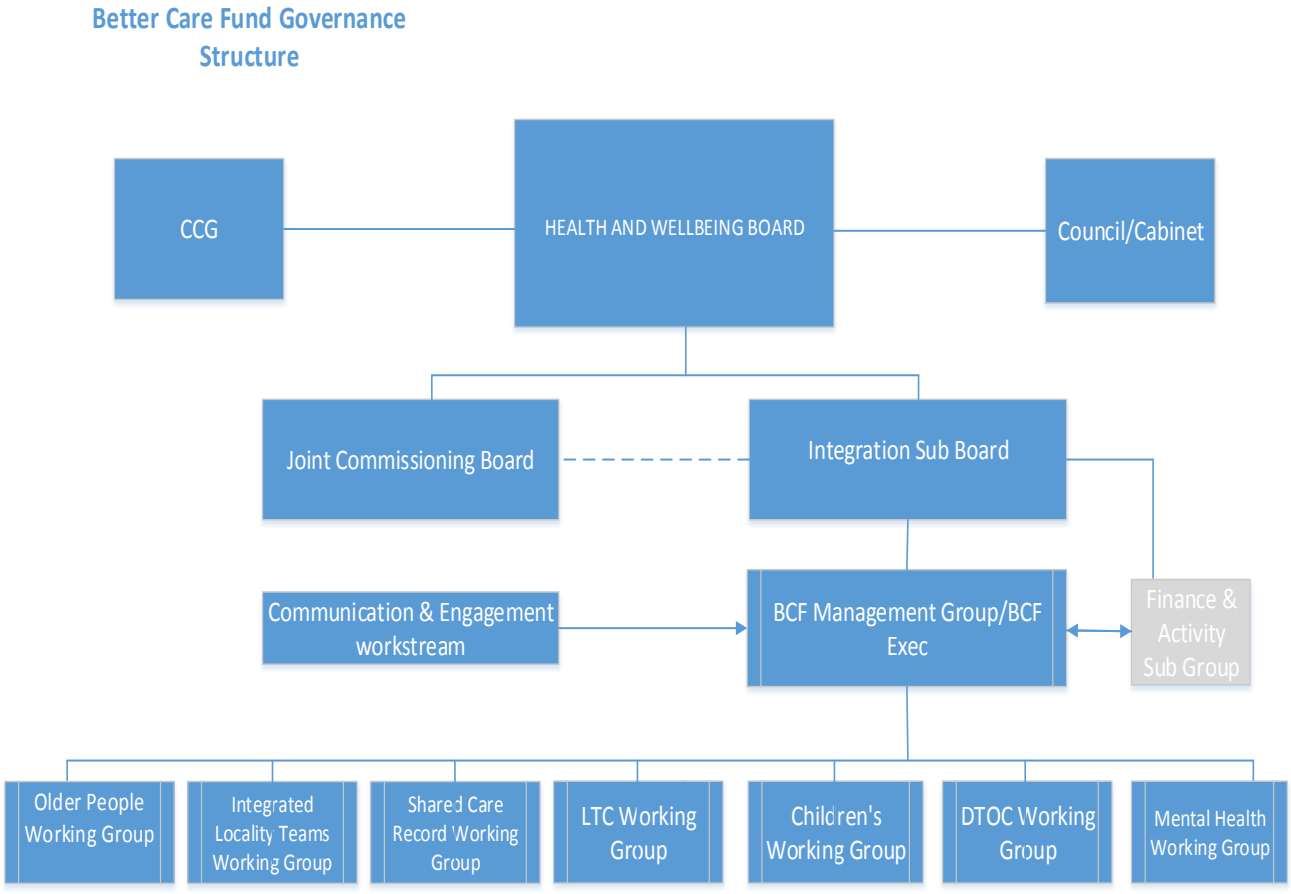
CASE FOR CHANGE ISSUE SUMMARY	**Population Groups**			
	Integrated Care for Older People	**Mental Health**	**Working Age Adults & LTC**	**Children with Health Needs**
	All above have cross-cutting theme: Supporting Carers			
Population Needs: The health of population continues to improve, but there remain many issues to address				
Larger than London average population sizes	✓	☐	✓	☐
Evidence high number of complex cases in general population	✓	✓	✓	☐
Known health inequalities & differences (including those linked to deprivation) across localities	✓	✓	✓	✓

Adverse outcomes affected by holistic issues, e.g. social isolation, nutrition, access to work etc.	✓	✓	✓	✓
Prevalence in population on upward trajectory over next 5 years	✓	✓	✓	✓
Evidence impact on longer-term life chances	✓	✓	✓	✓
Quality & Outcomes: Care services have strengths, but can be better integrated & people's cases better managed				
Evidence too many people are hospitalised as part of unscheduled care compared to England	✓	☐	✓	✓
Evidence planned primary care management of population could improve, including diagnosis	✓	✓	✓	✓
Evidence care service response fragmented with inconsistencies in response	✓	✓	✓	✓
Evidence outcomes important to individuals are not always realised in the current system	✓	✓	✓	✓
Evidence quality of care & safeguarding could improve & made more consistent for individuals	✓	✓	✓	✓
Evidence people's choice and resilience could improve, including in self-management	✓	✓	✓	✓
Evidence better rapid response could be planned to support individuals	✓	✓	✓	✓
Evidence people's carers could be better supported	✓	✓	✓	✓
Finance & Sustainability: 'No Change' scenario is unsustainable over next five years given financial pressures				
Population need changes likely to mean significant financial pressures on care system	✓	☐	✓	☐
Opportunities to identify significant cashable and non-cashable efficiencies from transformation	✓	✓	✓	☐
Opportunities to commission and incentivise outcomes as part of medium-term development	✓	☐	✓	☐
Opportunities to commission and incentivise outcomes in the longer-term	✓	✓	✓	✓
Consequences of transformation has potential to provide significant challenges to acute providers	✓	☐	✓	☐

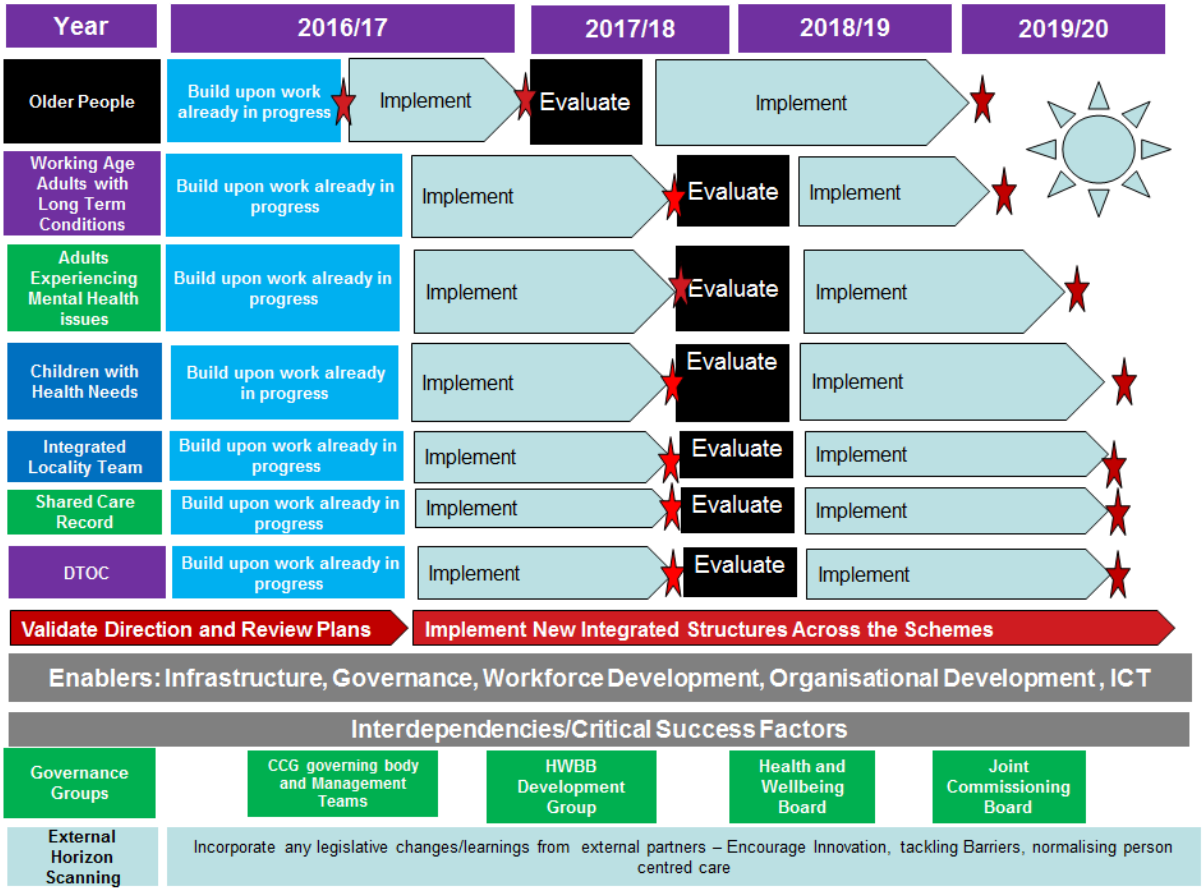
Opportunities to build health and social care partnerships to deliver collective efficiencies and manage more sustainably	✓	✓	✓	✓
Opportunities to develop infrastructure to support and sustain transformation	✓	✓	✓	✓

3. A coordinated and integrated plan of action for delivering that change

We recognise that in order for the implementation of the Better Care Fund to be successful and enable us to move towards 2020 health and social care integration, it needs to be recognised as a distinct programme of delivery, yet interwoven within our wider local commissioning arrangements. Furthermore, the governance arrangements must be such that it drives integration at both operational and strategic level. In response to the outcomes of NHS England support (PA Consulting) and our own audit activities, a review of our governance arrangements has taken place and the structure that has been operating in 2015/16 is currently under review, as is the terms of reference of our BCF Management Group and Integration Board. The following diagram illustrates our governance structure, although this is subject to further change to ensure it continues to be fit for purpose.



Included here is a summary of the BCF work plan with delivery of each part of the programme managed within separate working groups. The working groups report into the BCF Management Group/Executive, each with their own programme lead. The BCF programme of work itself is overseen by a Head of Service located within the Council's Transformation Office who then reports to the Assistant Director for Adult Social Care within the Council and the Director for Strategy and Engagement within the CCG.



Supporting the BCF Programme of work is a 'wrap-around' sub-group – Finance and Activity Group. Individual programme leads along with finance and performance representatives (Council and CCG) are the main officers of this group and attend regular meetings. The remit of this group is to monitor performance against individual programme targets, to assess the impact of schemes on the overarching performance measures and to monitor the pooled fund which, as agreed within the Section 75 agreement, is currently managed by the Council.

At strategic level, it has been established that partners would benefit from focused time and support to help shape the future of integration in Enfield. We have engaged independent external support to do this as we acknowledge that integration presents many challenges for individual organisations and as a whole. An approach which supports change across the system, whilst recognising the impact this will have on patients/service users, carers, organisations and providers is an approach that requires mature thinking, challenge and ultimately collaboration. We have identified a number of outcomes we wish to achieve as part of this external support, but

ultimately the key one is shaping what integration in Enfield looks like, how we are going to get there and what success looks like.

The Integrated Care Programme

The aim of our integrated care programme is to develop a person-centred response to planning and delivering care to individuals so local people will 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 outcomes important to me". Our principles are in line with the NHS Five Year Forward View:

- Patient & carers at the heart of care planning & delivery – services are integrated around them;
- Components of the model therefore need to act as a single system – a network of care;
- Enabled via joint assessment, care planning and interventions with patients and across the system;
- High-quality care delivered in the most appropriate settings including in out-of-hospital settings;
- All the above will mean unnecessary activity and costs incurred in the system will be avoided and this will help achieve long-term sustainability.

Priorities and Scope: Integrated Care Programme Aimed at 50+ Population

Our JSNA Factsheet[1] suggested older people with complex needs were most likely to benefit from an integrated approach to care planning and delivery. Last year's BCF Plan focussed on developing and implementing our integrated care network for people aged 65+ who were pre-frail or frail[2] including those with dementia. As a result of its success, we will extend our model to those with frailty 50+ using the same resources in 2016/17. The model's resources are tailored to need, with the greatest level of resources targeted on those identified as "high-risk pre-frail" or "frail" individuals.

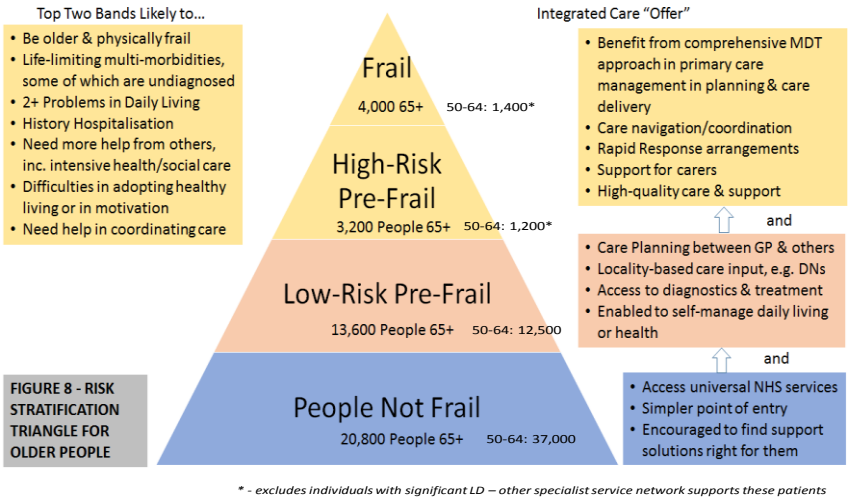


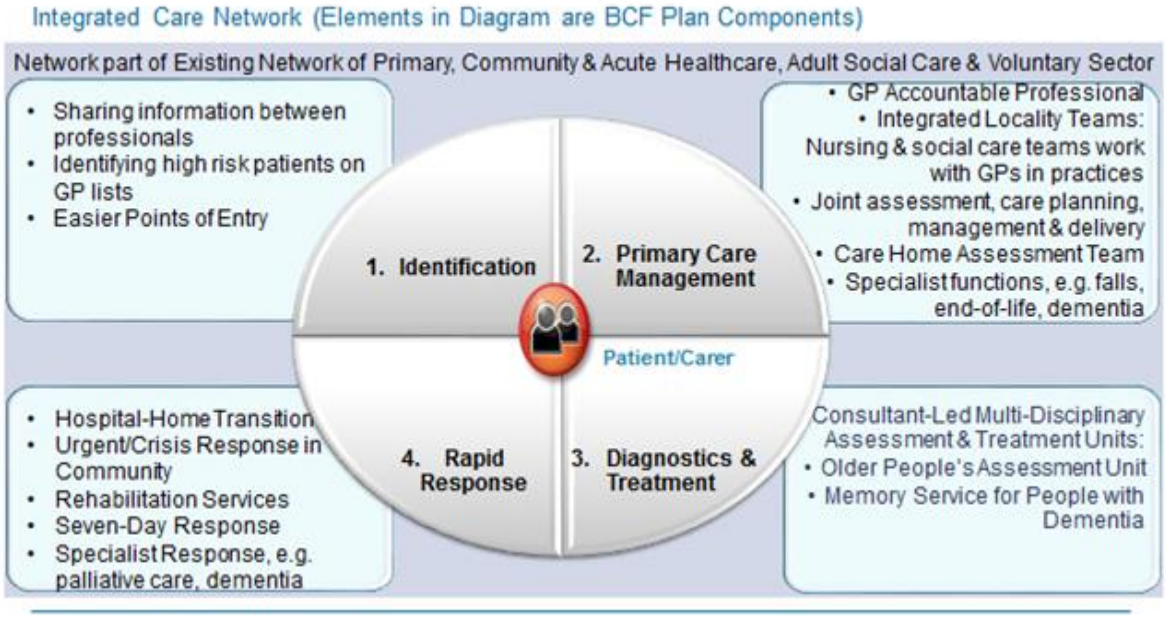
FIGURE 8 - RISK STRATIFICATION TRIANGLE FOR OLDER PEOPLE

** - excludes individuals with significant LD – other specialist service network supports these patients*

[1] http://www.enfield.gov.uk/healthandwellbeing/info/18/the_health_and_wellbeing_of_older_people/57/older_people_with_complex_needs

[2] Frailty" is "the impact of a combination of (often multiple) conditions including musculoskeletal, neurological, functional and organic mental health, respiratory and cardiovascular conditions & syndromes and their impact that collectively results in a person's vulnerability to sudden health changes triggered by minor stressor events." (Department of Health, 2013).

Integrated Care Network Model



The diagram shows how our community-based model delivers person-centred care to people with frailty to enable them to access the right solutions according to need. Our model operates in the wider context of the current health and social care system in Enfield and contains the following functions:

- *Identification and Filtering of Response Based on Patients' Needs:* We streamlined the number of access points for people with frailty in 2015/16. Individuals are now identified either via self/carer identification of a social need to LBE, the multi-agency hospital discharge process or care professionals working with GPs in their practices (including using risk stratification to identify high-risk patients). Our response is then matched to the patient's level of need;
- *Joint Assessment & Care Planning:* Some individuals will need a comprehensive assessment and the number of professionals involved is tailored to need – from 1 or 2 (e.g. a GP and/or social worker) through to a larger team of multi-sector professionals (including the voluntary sector) working together and with the individual to plan and coordinate care in the short- or longer-term;
- *Care Delivery* is based on individuals' needs and their plan but may include multi-disciplinary:
    - *Time-Limited Bed- or Community-Based Rehabilitation* to help people recover post-illness, maximise independence, avoid hospital or care home admission or facilitate hospital discharge;
    - *Arranging or Delivering Ongoing Social and Healthcare & Support* to help people who might need health and/or social care support following their rehabilitation;
    - *Specialist Diagnosis, Treatment and Intervention* for individuals whose conditions have changed and whose cases need to be managed pro-actively to help reduce risk of crisis in the near future;
    - *Rapid Response* for those who need an urgent or crisis response in the community to avoid unnecessary hospitalisation or need to be discharged from hospital safely in a timely way.

Our model is underpinned by an ethos of promoting individuals' autonomy, independence and self-care tailored to individual's needs. We are investing in training to ensure multi-agency staff (including in the voluntary sector) are able to successfully promote this ethos regardless of their role.

All of our model's components were implemented or commissioned in 2015/16, with further refinements in 2016/17, learning from the previous year and ensuring some of its enablers are implemented, e.g. Shared Care Record Solution and integrated workforce planning. We are evolving our network towards the new models outlined in the *Five Year Forward View*. Our co-location plans for the multi-sector, multi-disciplinary Integrated Locality Teams working at GP practice/locality level for people with frailty is a step towards a Multi-Speciality Community Provider model; whilst our Care Homes Assessment Team working with GPs delivers many functions of the Enhanced Support for Care Homes model.

Our model is designed to raise the quality of care and patient experience through its person-centred approach (which is what patients tell us they want) but also help reduce non-elective admissions. The table below describes the different components of our model, evidence of how they improve or are likely to improve the quality of care and their contribution to reducing to non-elective admissions.

Model Component		Funding Partially or Fully From BCF Plan	Model Functions Covered	Changes in 2016/17 from 2015/16	Conditions Supported							
					Reduce Pressures on Social Care	Known to Improve Quality of Care	Directly reduces emergency admissions	Joint Assessment & Care Planning	Supports People with Dementia	Includes 7 Day Working	Supports Hospital Discharge / Prevents Re-Hospitalisation	Benefit From Shared Record?
Risk Stratification Tool		Partially	Identification									
GP Local Incentive Scheme to Support Integrated Care		Fully	Identification; Assessment & Care Planning; Delivery	New scheme in 2016/17	✓	✓	✓	✓	✓			✓
4 x Integrated Locality Teams (ILTs), working GPs and others in their practices and in community	Co-located & jointly managed ILTs. Input from:	Partially	Identification; Assessment & Care Planning; Delivery	Will move from virtual to physical teams in Phase II							✓	
	- Social Care Professionals, including BCF funded hospital-to-home liaision	Partially									✓	
	- Community Matrons	Fully										
	- District Nurses	Partially			✓	✓	✓	✓	✓			✓
	- Intermediate Care at Home & LBE Enablement	Partially								✓	✓	
	- Falls Specialists/Fracture Liaison Nurse	Fully									✓	
	- Geriatricians input	Fully									✓	
	- Palliative Consultant	Fully		New - supports EOL care								
	- Joint ILT Manager of Service	Partially		New - will manage service	Infrastructure							
Assistive Technology (Tele-Health)		Fully	Assessment & Care Planning; Delivery	Expansion of service		✓	✓	✓			✓	
Bed-based Community Rehabilitation Investment		Partially	Delivery - Rapid Response		✓	✓	✓	✓		✓	✓	✓
Wheelchair Services		Fully	Delivery		✓	✓						
Voluntary/ Community Sector (VCS) Hub Phase I	Multi-agency VCS navigators working in integrated care network. Phase I focussed on 2 priorities:	-	Assessment & Care Planning; Delivery	Phase I development in late 2015/16 - full effect in 2016/17	✓	✓		✓	✓			
	- Post-Diagnostic Support for People with Dementia;	Fully			✓	✓		✓	✓			
	- Falls Prevention	Fully			✓	✓		✓				
Multi-disciplinary Care Homes Assessment Team (CHAT)		Fully	Assessment & Care Planning; Delivery	Expanded to cover all older people's care homes		✓	✓	✓	✓		✓	✓
Older People's Assessment Unit (OPAU)		Fully	Assessment & Care Planning; Delivery - Specialist Intervention	Expanded to cover 50-64 population.	✓	✓	✓	✓	✓			✓
Memory Service		Fully	Assessment & Care Planning; Delivery			✓		✓	✓			✓
Nurse-led 7-Day Out-of-Hours Community Crisis Response Team		Fully	Delivery - Rapid Response	Function implemented in Q4 2015/16 - full effect 2016/17		✓	✓		✓	✓	✓	✓
Out-of-Hours Enhanced Nursing Service		Partially	Delivery - Rapid Response			✓	✓		✓		✓	✓
Palliative Care Rapid Response		Partially	Delivery - Rapid Response			✓	✓		✓			✓
Additional Investment in Hospital-Based 7 Day Social Care		Partially	Assessment & Care Planning; Delivery - Rapid Response	Expanded service in 2016/17	✓	✓		✓	✓	✓	✓	✓
Consultant-led Psychiatric Hospital Liaison Service		Partially	Assessment & Care Planning Delivery - Rapid Response			✓		✓	✓		✓	✓

NHS England National Conditions

1. Plans to be jointly agreed

The Better Care Fund pooled fund amount for 2016/17 is £21,725,445 comprising £19,185,445 from the CCG and £2,540,000 from the Council. The financial allocations within this pool will be subject to sign off by the Health and Wellbeing Board once work to verify and validate has been completed by Council and CCG officers.

The Enfield Health and Wellbeing Board has an established group called the Integration Transformation Fund Sub Working Group ('BCF Management 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 Group 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.

The Health and Wellbeing Board has agreed that the Enfield Integration Board provides the overall Assurance to the Health & Wellbeing Board supported by the Joint Commissioning Board arrangements for managing commissioning arrangements across health & social care in Enfield.

Discussion and agreement of the plans is taking place at the Integration Sub Board which includes representation from the CCG, Council, acute trusts, community and mental health trust and the VCS. Subject to agreement of performance targets for 2016/17 and the associated impact on all partners, discussion regarding the impact on providers will take place at the integration board. This will include reaching agreement on what the impact on providers will be and how this will be managed. Specifically within the context of our two hospital trusts in Enfield, this will be related to a reduction in emergency admissions of 736 next year and a reduction in delayed discharge days lost of 300.

All our NHS providers have been signalled CCG commissioning intentions and have been involved in the development and delivery of new services during 2015/16 as part of our integrated care programme. Furthermore, there have bene embryonic discussion with our main NHS providers about developing new model of care to support integrated delivery. This will need to be substantially developed during 2016/17 as part of delivering the 5 Year Forward View. As part of this we are seeking greater system, ownership of both reductions of emergency admissions and reductions of delayed transfers of care to support system resilience.

The Council and CCG are also working jointly on a workforce development plan with key points to include:

- Moving towards enabling and self-care

- Recruitment and retention of qualified practitioners (nurses, social workers, occupational therapists) to address local shortages
- Working in integrated care settings to support new ways of integrated working

The Council is also in discussion with colleagues within housing to agree the spending plan and business case for the disabled facilities grant for 2016/17 with a view to maximising independent living options for people living with disabilities and illness. Included within the DFG allocation for 16/17 is the DOH capital grant and discussions are underway currently between the council, CCG and voluntary sector with a view to commissioning a mental health and wellbeing hub. This hub will be developed on the basis that it will be fully integrated with an agreed shared ambition.

2. Maintain provision of social care services

Within the Better Care Fund £6,055m has been allocated to maintain the provision of social care services in 2016/17 compared to £5,952 for 2015/16. 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 enablement, 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 high quality services.

With a focus on improved access to better care and support services in the community the schemes within Enfield's Better Care Fund will provide the necessary capacity to:

- Work proactively to prevent crisis
- Reduce the number of people admitted to hospital as emergencies
- Maintain the low number of people admitted to residential care from hospital (the bulk of placements are made from hospitals with 80% of those people not previously known to social services).
- Reduce the number of people admitted to hospital from residential/nursing care
- Promote self-management for people with long term conditions with improved access to support when needed at any time reducing dependency on long term support
- Integrate and improve access to community equipment and assistive technology solutions to promote independent living for carers, patients and service users
- Further increase capacity within the enablement service in order to provide more rehabilitative options for people both in the community and from hospital.

Now London's fourth largest borough by population, Enfield has experienced significant population growth. With a population figure of 312,466 at the 2011 census, this has now increased to an estimated 327,000 in 2015, an increase of 4.6% or more than 3,500 people per year.

Within this population, the number of people living with long term illness or disability is also increasing. Between 2011/12 and 2014/15 the number of people receiving Adult Social Care services in Enfield has increased by 6.3% (over 8% when the increased number of people accessing enablement services is included) (local service intelligence) with the most significant % increase in the Integrated Learning Disability service at over 15%. Between 2014/ and 2016 the proportion of people with a long term illness or disability is projected to increase by a between 2.7% and 3.6%. Within this increase the most significant increases are likely to be within learning disability and dementia.

In summary between 2015 and 2018 in Enfield there will be (Source POPPI/PANSI):

- 5.3% more people predicted to have two or more psychiatric disorders,
- 7.7% more older people with a limiting long term illness,
- 4.2% more adults with a moderate or severe learning disability and
- 8.4% increase in the number of people with a serious physical disability

There are over 29,000 carers living in Enfield, almost 7,000 of whom provide more than 50 hours of support a week. Adult Social Care works with around 10,000 service users a year providing support through Voluntary Sector Care services to a further 4,000 carers through the provision of information, advice, access to regular breaks, direct payments and therapeutic services which help people to continue in their caring role. Our new direct payments for carers, implemented in 2014, has had a positive impact on support and outcomes for carers with very positive outcomes reported. The direct payment scheme is administered on the Council's behalf by our VCS run Carer Centre and the Council has entered into agreement in 15/16 to delegate the assessment of carers to the Carer's Centre. This is also progressing well with over 180 carers accessing the direct payment with no further need for support (for their cared for person) from the Council.

Within the BCF allocation £747k has been allocated to Care Act responsibilities. We continue to assess the impact of the Care Act, including the increased demand for support from carers and for advocacy support services. The VCS will be key partners in the delivery of early intervention services which promote hospital avoidance, speedy and appropriate hospital discharge, self-management of long term conditions, advocacy support and our work with carers.

3. Agreement for the delivery of 7-day services across health & social care to prevent unnecessary non-elective admissions (physical and mental health) to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Our original business case estimated that delivering the entire integrated care network at a weekend would cost an additional 25% for all such services (£2m). We

decided to focus our 7-day BCF Plan investment on rapid response solutions that immediately prevent an individual's hospitalisation as the model's other components were pro-active, scheduled care that could be delivered Monday to Friday. These rapid response solutions therefore include measures that would support system resilience more generally. We have also funded from the Better Care Fund in 2015/16 a range of health and social care to support 7 days service and system resilience.

Our network's rapid response solutions support help people avoid unnecessary hospitalisation and facilitate safe and timely hospital discharge at the weekend. These services are funded partly via BCF (Section 2) with the remaining investment from mainstream commissioning budgets including System Resilience funding. We see the Shared Record Solution as a key enabler of weekend/OOH working.

In Hospital Settings
Our multi-disciplinary hospital-based community health and social care services facilitate discharge (including from A&E) at weekends. These professionals work with acute staff to assess and discharge suitable patients either home or to bed-based step-down facilities to start, or continue, patients' out-of-hospital rehabilitation over the weekend. Although this investment helps underpins many of the NHS 7-day service clinical standards, it particularly fulfils Standard 9.

In addition to this, System Resilience funding is also committed to increase 7-day working for specific hospital-based services specifically weekend working in paediatrics and A&E doctors and nurses, clinical support staff, pharmacy, therapies and discharge nurses. (In addition, System Resilience also funded the provision of a Mental Health Crisis lounge, a designated hospital place of safety, an area that provides privacy and dignity for someone in mental health crisis).

Out-of-Hospital Settings
Our community-based rapid response services work together to ensure people avoid hospitalisation where this is unnecessary at weekends and out-of-hours:

- *GP Urgent Access Hub* established in 2015/16 to enable professionals to schedule GP appointments for patients with clinical needs who need to be seen quickly in the evening or at the weekend at a local practice;
- *Re-commissioned 111 and GP Out-of-Hours Service* to be implemented Oct-16 which will strengthen our primary care out-of-hospital "offer" out-of-hours and at weekends;
- *Community Nursing & Rehabilitation Out-of-Hours services* (Section 2) include 7-day working, with the latest addition being the nurse-led Community Crisis Response Team to support people in the community and in care homes to avoid hospitalisation, a service linked to the Council's 24/7 Safe & Connected Service which ensures a rapid response is mobilised should a user's alarm be triggered;
- *Other Out-of-Hours services*: The integrated care model includes access to out-of-hours and weekend social care duty and community mental health services as appropriate.

These activities will continue to be monitored and adapted in our 2016/17 plan.

4. Better Data sharing between health & social care, based on the NHS Number

The NHS number is now being used across both health and social care as the primary identifier for individuals with whom we interact. We have implemented the Shared Care Record Summary and have been working across health and social care services and commissioners to implement a shared record solution across primary, secondary, community health and mental health care and adult social care sectors. The NHS number will be used as the primary identifier in this solution.

Implementing a Shared Record solution across North Central London is a key priority in the NCL Digital Footprint Roadmap. With a view to implement in Q3 2016/17, we are in the process of finalising the options for delivery. The decision about which solution we implement will be made in collaboration between NHS and Council operational and IT staff working in Enfield assessing each solution's fit against our system requirements (developed in collaboration between partners). These requirements will include the need for any solution to have open APIs.

Our project scope is to deliver a multi-agency professional and a patient-held record view to support adults with frailty/long-term conditions in the first instance. This will mean professionals and patients will be authorised and authenticated system users, the latter to their own records only. Explicit consent will be obtained from the patient to share information across agencies and to develop patient-held records; if no consent is given, the solution won't present that patient's records.

Our existing IG protocols to define patient-related information flows between partners are currently being updated to reflect the project's requirements, e.g. details of system user role-based access. With patient consent, the protocols will enable system users to view a (read-only) pre-defined dataset and documents bringing together information from multiple systems as far as possible in real-time to support high-quality care delivery (including unscheduled care) for individuals. The system will include a read-write Joint Care Plan Summary which multiple professionals will update to support integrated care.

Phased roll out beyond 2016/17 is still in development, but the expectation is the solution will cover our whole population in line with requirements in the NHS Personalised Health and Care Framework.

5. Ensure a joint approach to assessment and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Our joint assessment, care planning and allocation process will be the same as that in 2015/16 until implementation of the Shared Record Solution in Q3 2016/17. Our GPs are responsible as Lead Accountable Professionals for joint development of individuals' Care Plans on their Case Management Registers as part of NHSE Enhanced GP Service to support individuals at risk of unplanned hospital admission. GPs have implemented 5,000+ plans for people with frailty since Sep-14.

The degree of coordination across agencies depends on individuals' needs, with greater multi-disciplinary coordination of assessments and outcome-based planning for those with more complex needs. Our existing multi-disciplinary hospital discharge teams, Integrated Locality Teams (ILT) and Care Homes Assessment Teams (CHAT) all facilitate joint assessment and care planning process to support GPs fulfil their responsibilities and their support has proved popular with practices and patients (Section 2).

Phase II of the ILT development means community health & adult social care staff will be jointly managed and co-located from Oct-16 which our staff told us was an important enabler of joint working. We are re-designing ILT business processes to ensure each pre-frail or frail individual has a named community-based lead social care or health professional (if they need one) who they can contact and who will coordinate their care plan(s) and its delivery in the short- and/or longer-term. This is what our patients and service users told us they would prefer when we consulted with them in 2015.

ILTs and CHAT support assessment and care planning for people with dementia and have access to Community Mental Health Teams for specialist support in individual cases. Due to this improved care management and increased resources and training in primary care and the Memory Service, the proportion of Enfield residents living with dementia who had formal diagnoses increased from 45% to 67% over the last 18 months. We established a voluntary sector role of dementia navigator to support people post-diagnosis in 2015/16, a role linked to joint planning in our integrated care network, in particular, the Memory Service and ILTs (Section 2).

We plan to implement a Shared Record Solution to enable professionals to create and update an individual's Joint Care Plan Summary. This document will show who's involved in the case and their contact details (including the named lead professional) and will contain a high-level Plan summary to support professionals to jointly coordinate care, building on relationships established in the integrated care network. The solution will also support a Patient-Held Record in Q1 2017/18 to enable individuals to access their records and documents to support them to take control over their care.

Our approach prevents duplication in documenting assessment and care plans for professionals, as the Solution will enable them a single view of pre-defined data and documents from multiple host systems, whilst fulfilling individual agency's statutory responsibilities to have dedicated health or social care plans.

6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The Integration Board, which ultimately agrees the level of emergency admissions, includes membership of all our main acute, community and mental health providers. The agreements from the Integration Board are then discussed as part of the contract negotiations with our main providers. The impact of the better care fund on our providers is therefore clearly signalled during those contract negotiations. This

includes the impact on acute providers of reductions of emergency admissions and outlined both in the better care fund and the CCG operating plan.

The details of the initiatives within the 2015/16 better care fund are not substantially changing for 2016/17 but we expect the impact of those services to have great impact as they become joined up and offer integrated delivery. The Integration Board has bene fully sighted on all those initiatives throughout 2015/16 and on newly commissioned initiatives during 2015/16.

The CCG, Local authority and provider partners are already committed to developing integrated care for older people and for people with long term conditions which focuses on delivering a shift from crisis management and unscheduled care to an emphasis on prevention, early intervention and wellbeing and a more planned care approach to this client group.

We have taken an integrated approach to implementing personal health budgets for older people and people with physical and learning disabilities who are eligible for healthcare services. The Council's Personalisation journey started in 2006 and we now offer a range of support, information (including our e-market place), navigation, brokerage and management options for people with direct payments and their own budgets. Our infrastructure is already well established in this area. Through section 75 partnership arrangements, the Council on behalf of the CCG, have set up a pilot to introduce Personal Health Budgets for people who meet the Continuing Healthcare criteria and want to manage their own budget. This will be extended further through implementation of the Better Care Fund plan.

We view the Care Act as an extension of Personalisation wherein the principles of good information for all, access to universal services, the focus on early intervention and prevention and maximising individual choice and control whilst safeguarding individuals, are all promoted. Our integrated approach will provide personalised early interventions to this population whilst also fulfilling the requirements of the Care Act by developing joined up and holistic wellbeing plans that make best use of universal preventative services and focus on supporting people to remain independent for as long as possible.

7. Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care

Our integrated care programme and out of hours service are clear evidence of our investment in NHS commissioned out of hospital services. We already have community-based rapid response services which work together to ensure people avoid hospitalisation where this is unnecessary at weekends and out-of-hours:

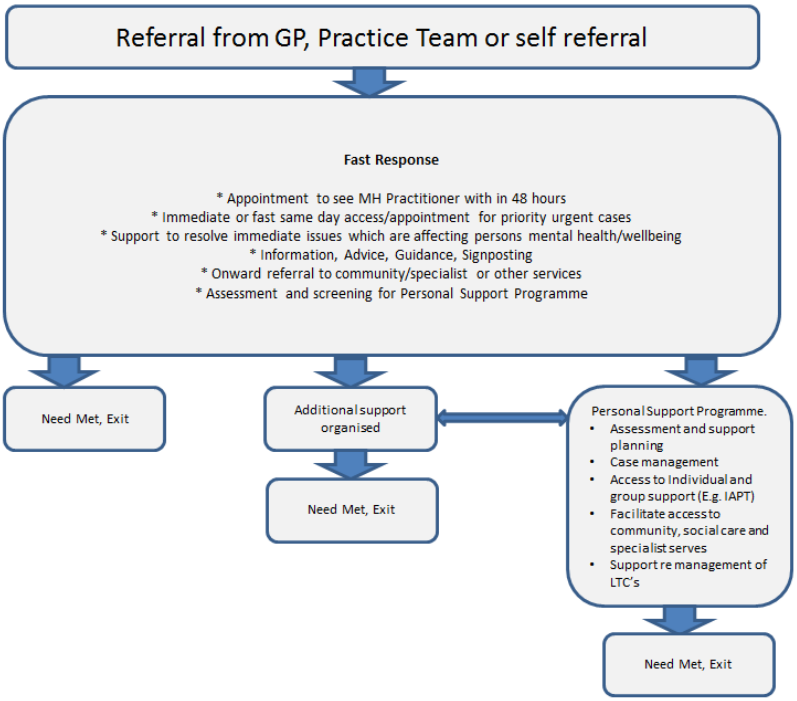
- *GP Urgent Access Hub* established in 2015/16 to enable professionals to schedule GP appointments for patients with clinical needs who need to be seen quickly in the evening or at the weekend at a local practice;
- *Re-commissioned 111 and GP Out-of-Hours Service* to be implemented Oct-16 which will strengthen our primary care out-of-hospital "offer" out-of-hours and at weekends;

- *Community Nursing & Rehabilitation Out-of-Hours services (Section 2)* include 7-day working, with the latest addition being the nurse-led Community Crisis Response Team to support people in the community and in care homes to avoid hospitalisation, a service linked to LBE's 24/7 Safe & Connected Service which ensures a rapid response is mobilised should a user's alarm be triggered;
- *Other Out-of-Hours services:* The integrated care model includes access to out-of-hours and weekend social care duty and community mental health services as appropriate.

Developing enhanced support for GP's managing patients with Mental Health issues

We are developing a proposal to support local GP's in managing patients presenting with mental health issues, which also include patients with physical conditions, as effectively as possible in primary care settings. We have identified funding from the BCF 2016/17 to develop a pilot by offering a trained mental health practitioner integrated into a general practice team, to enhance all the team's confidence and ability to manage mental health presentations, and 'spread the word' that mental health is mainstream health - breaking down barriers. We are proposing the pilot will encompass:

- Responsive and practical support in the GP surgery to the GP dealing with a mental health patient, including signposting to appropriate services and following up with the patient.
- Offer patients presenting in primary care a fast support service for those experiencing social/emotional crisis, anxiety and depression and where appropriate onward signposting and screening for appropriate service, e.g. IAPT.
- Fast signposting to a range of support opportunities (Statutory and voluntary) relevant for a patient at the time of presentation. E.g. Peer support, other community services and support forums, recovery focused programme (Recovery College concepts) and 'Do'.
- Support for patients heading for crisis, crisis support and assessment to signpost rapidly to CRHT.
- Support to practice staff as above and especially for more complex patients.
- Case management for patients who require support to access services related to Long Term Conditions.
- Effective communication 'bridge' between secondary care and the practice as appropriate to ensure as far as possible successful transition from secondary care to primary care.(Discharge from Inpatient services).



8. Agreement on local action plan to reduce delayed transfers of care

In Hospital Settings

Our multi-disciplinary hospital-based community health and social care services facilitate discharge (including from A&E) at weekends. These professionals work with acute staff to assess and discharge suitable patients either home or to bed-based step-down facilities to start, or continue, patients' out-of-hospital rehabilitation over the weekend. Although this investment helps underpins many of the NHS 7-day service clinical standards, it particularly fulfils Standard 9. We had had discussions through the System Resilience Groups about developing an Integrated Discharge Hub to better provide consistent system response to discharges.

NCL CCGs are developing a Single Health & Resilience Early Warning Database (SHREWD) for rollout view across the health economy using System Resilience funding. This is a real time information system to help health systems better manage winter pressures on an operational day-to-day basis through presenting more up-to-date information from each acute site at a glance to acute and community commissioners and operational staff.

Direct Access GP Pilot

We introduced a 7-day 10 to 10 "See & Direct" Service at North Middlesex University Hospital (NMUH) as 70% of our residents attending A&E do so at this hospital. Experienced GPs staff this service, with walk-in A&E patients screened and directed to the most appropriate settings outside A&E including to the integrated care network, e.g. the Older People's Assessment Unit.

Hospital Discharge

We have invested in managing timely and safe hospital discharge together, including weekend working (see 7 day working). Multi-agency services are funded partly via

BCF (Section 2) as part of wider investment from mainstream commissioning budgets including System Resilience funding, the latter with the agreement of partners at our 2 System Resilience Groups.

Acute
Multi-disciplinary hospital-based community health and social care professionals facilitate discharge supported by CCG Continuing Health Care commissioners who agree individual CHC placements, particularly in care homes. These professionals work with acute staff at North Middlesex and Barnet & Chase Farm hospitals (and liaise with out-of-hospital services such as care homes) 7 days per week to assess and manage suitable patients discharge either to return home or to step-down beds to start patients' out-of-hospital rehabilitation and/or order suitable equipment for individuals as part of transfer.

These professionals meet every day (included at ward rounds) to review more complex cases of patients approaching their expected discharge date and whose discharge may need multi-agency planning and agreement, including those who need to be assessed for CHC (including fast-track cases). In each case, actions with a named professional responsible and expected discharge dates are agreed to address any barriers to timely and safe discharge (e.g. family choice).

Individual cases are escalated to senior managers in each agency for resolution if there are any disputes about the way forward (this is rarely required). Where placement funding isn't clear at discharge, we will move the patient to the home and continue with the CHC assessment there (with a CHC Panel meeting later) to ensure the patient's case doesn't become DTOC.

Non-Acute
A similar multi-disciplinary discharge process is now in place for non-acute discharge, with community health and social care services meeting routinely with CCG CHC commissioners to discuss plans for individual patients in the same way as above.

Hospital Discharge Working Group (HDWG)
Our Hospital Discharge Working Group (HDWG) meets to address strategic and operational issues associated with acute and non-acute hospital discharge processes. The Group is chaired by LBE's Assistant Director of Adult Social Care and liaises with Barnet and Haringey System Resilience Groups, of which we are members. HDWG includes representatives from those involved in discharge from:

- CCG, including CHC, commissioners;
- LBE commissioners and operational functions;
- North Middlesex and Royal Free London acute Trusts;
- Barnet, Enfield & Haringey MH Trust (who provide both non-acute bed- and community-based Community Health and Mental Health Services;
- Care Homes who feedback from and to the wider care home community;
- Voluntary sector representatives running hospital-to-home services (see below);
- Enfield HealthWatch, to provide insight into the patient voice.

HDWG shares the same targets for DTOC as those published in the BCF Plan, and the current position on DTOCs against plan is shared with the Group.

9. An agreed approach to financial risk sharing and contingency

We have agreed a risk sharing approach to national condition 7. The proportion of the fund is £1.5m and this has been calculated per cost of non-elective admission at £2039 per admissions x 736 – see Submission 2 – Management Information document.

Reducing emergency admissions in Enfield must be seen within the in the context of a very significant growth in population. Our approach has been system change across health and social care to manage this increased demand for support. The agreed trajectory represents a reduction against this year's baseline but with the expectation that demand will continue to increase.

We are still working up the detail of our plans that we'll commission as a result of a release of funds. However, we expect that it will focus on the types of services set out in section 7 and shifting provision which will focus on people receiving support in the community delivered by the VCS working in partnership with acute providers, primary care and social care. In doing so, it will support people to remain at home and as a consequence, increasing the impact of reducing the non-elective admissions further.

The risk of not shifting services away from hospital is of a personal nature to individual wellbeing. People have told us that they want to remain at home, including at the end of their lives. It is a risk to the system as a whole as without more of a focus on this, we will continue to react, rather than intervene early in individual's health and social care journey and prevent and delay need in the first instance (as clearly set out in the Care Act). It is also likely that that our residential and admissions will increase as a result of continuing to provide a reactive service.

Discussions continue with our providers about the case for change. As noted in earlier sections of this narrative, the targets set out in the BCF plan support our approach with providers and for the VCS we are recommissioning in order to focus on early intervention and prevention.

We have a Health and Wellbeing Board on the 21st April. With a final submission due on the 25th April, the Integration Board is working together on the plan and it will recommend and obtain agreement of the final submission in order to meet the deadline.

10. Detailed Plans

As part of our annual review, we are revisiting the detail of our plans. We are happy to provide further information as part of our final submission.

Appendix

Better Care Fund Better Care Fund Related documentation
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
JSNA Older People with Complex Needs Factsheet	http://www.enfield.gov.uk/healthandwellbeing/info/18/the_health_and_wellbeing_of_older_people/57/older_people_with_complex_needs

Child & Adolescent Mental Health	http://www.enfieldccg.nhs.uk/about-us/child-and-adolescent-mental-health-services-camhs-strategy.htm
Hospital Discharge Action Plan	No link available, see document included in submission files

LONDONASSEMBLY

Health Committee

END OF LIFE CARE IN LONDON

The London Assembly Health Committee has been investigating the quality of care people receive at the end of their lives. This report summarises our key findings and suggests some areas for further investigation.

End of life care in London

Key findings from our investigation

There is huge variation in the quality of care people receive at the end of their life in London. Statistically, Londoners receive some of the very best and the very worst end of life care in the country. Overall, London performs poorly in end of life care compared with the national average.

Access to services is unequal. Some people are less likely to receive good quality specialist end of life care. Their diagnosis, whether they live alone, their cultural background and sexual orientation all affect the chances of a person receiving the care they need and want.

Older people struggle to access the care they need, particularly if they live alone. As the number of older people who live alone grows, this will place further strain on hospital services.

Fewer than half of London local authorities include end of life care as part of their Health and Wellbeing Strategies. Without this focus on end of life care provision, services struggle to meet local needs.

Many people, including medical professionals, find discussions of death and dying very difficult. But communication between individuals, families, and health and social care providers is an essential part of good end of life care.

What is end of life care?

A person approaching the end of their life will have a range of needs that can be met by family and friends, and health and social care providers.

The best care will be a package of care measures, tailored for the individual, that could include:

- Managing symptoms, including relief from pain
- Supporting with practical arrangements to reduce anxiety
- Helping to achieve a sense of resolution and peace
- Providing practical support with daily activities such as washing or dressing.

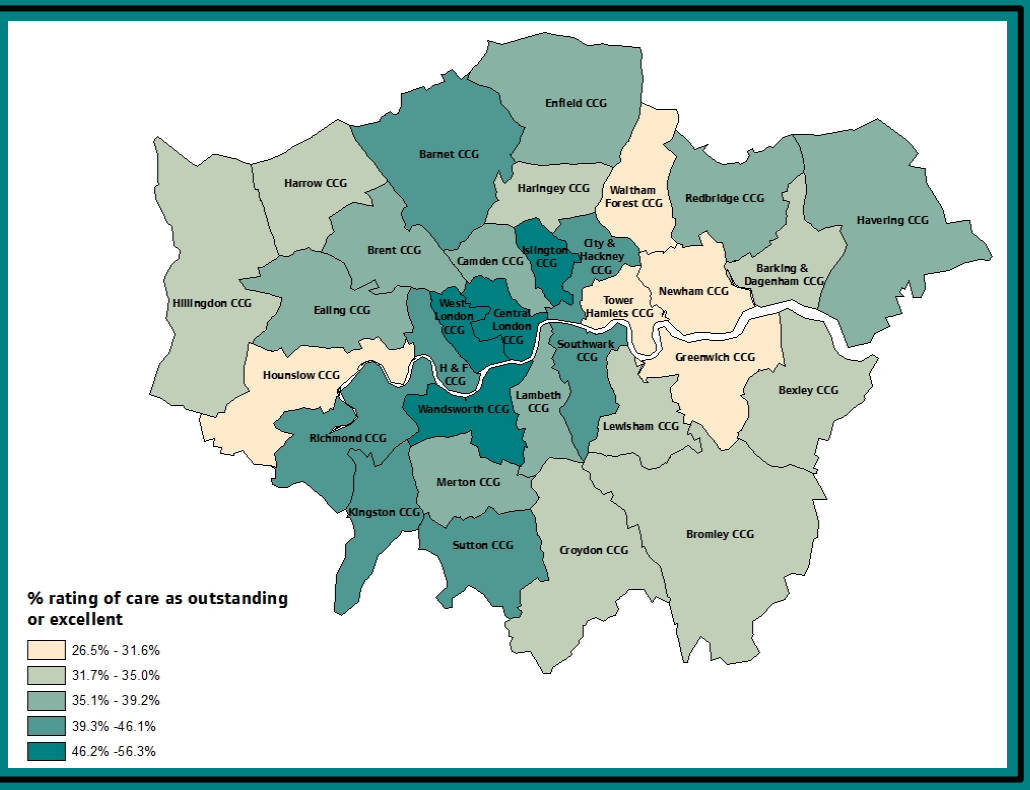
Expert guests at our meeting in October 2015 made a joint statement setting out their six ambitions for delivering better end of life care:

- Each person is seen as an individual.
- Each person gets fair access to care.
- Comfort and wellbeing are maximised.
- Care is coordinated.
- All staff are prepared to care.
- Each community is prepared to help.

LONDON ASSEMBLY

End of life care across London

There are significant variations in the provision of end of life care services across London. Even where services exist, these cannot be accessed at all times and by all who need them. In the absence of other options, many people will end up in hospital when they neither need or wish to be there.



Only 8 out of 33 London Clinical Commissioning Groups (CCGs) scored above the national average for end of life care quality indicators.

London CCG spend varies from £540 to £3,740 per death.

70% of London hospitals cannot provide specialist palliative care services seven days a week.

One in five community palliative care services is unable to provide out-of-hours services.

Figures from the Pan-London End of Life Alliance

"Each CCG has an end of life care lead; the challenge is to help them understand what a good death looks like, help them see where they stand on that benchmark, and encourage them to shift the funding."

Dr Caroline Stirling,
Clinical Director for End of Life Care, NHS England (London)

LONDON ASSEMBLY

Access to services

Evidence shows that certain groups of people are less likely to access specialist end of life care. Factors include:

Age: Older people are less likely to access specialist care. This may be in part because they are unaware of services that are available to them.

Diagnosis: The majority of palliative care services in London are geared towards cancer patients. People with other conditions, such as motor neurone disease and chronic obstructive pulmonary disease are less likely to receive specialist care.

Who you live with: If a person lives with family or a carer they are more likely to have an advocate for their care and wellbeing, as well as assistance with transport, treatment, organisation and personal care. They are also more likely to discuss their wishes for their end of life care.

Beliefs: Some religions and cultures do not believe in predicting death or planning for it. This can make it difficult or impossible to create effective care strategies.

Deprivation: The relationship between deprivation and access to health services is complex, but evidence suggests that people in poorer postcodes are less aware of end of life care options and how to access them.

Health inequalities persist across London. Commissioning the right services will depend on accurately assessing the needs and priorities of local communities, including the marginalised.

33% of people who die are over the age of 85, but this group makes up just 15% of hospice users.

Only 24% of London patients accessing palliative care have a non-cancer diagnosis.

70% of LGBT people surveyed felt isolated from end of life services by the language used.

"We know that hospices provide the gold standard for end of life care and deliver high quality care across London, yet…poorer people die in a hospice less frequently than their well-off peers."

Dr Jonathan Koffman, Kings College London

"BAME groups … face several challenges in relation to end-of-life care including language barriers, cultural differences around talking about the end of life and preparing for death and – for some – low trust in health services leads to them not accessing services and not planning ahead."

Compassion in Dying written response

End of life care for older people

Older people, and especially the very old, face additional challenges towards the end of life. Often they have multiple health conditions, and they are more likely to be socially isolated and lonely. This can lead to increasing practical challenges in looking after themselves and managing their conditions.

Older people are more likely to have multiple health issues. There are additional challenges to good end of life care when a person has multiple health conditions, such as cancer with dementia. These include predicting when death will occur and ensuring that wishes are established before capacity is lost.

Suitable housing allows older people to stay at home while they receive end of life care. But much of London's current housing stock is not fit for this purpose, and with a shortage of hospice and care home places, hospital can be the only remaining option.

Loneliness can make it harder for older people to get the care they need. Three in ten people over the age of 80 are lonely.[6] Without supportive networks and relationships, it can be difficult for them to navigate the health and care system or to make their wishes known. Loneliness also increases pressure on local authority services, and can be the tipping point for an individual being referred to adult social care. [7]

Currently there are around 124,000 people aged 85+ (the 'oldest old') living in London. By 2035 this figure is projected to have more than doubled to around 266,000.[2]

75% of people aged 75 or over who live alone are women.[3]

Around 10% of London households are occupied by a person aged over 65 who lives alone.[4]

1 in 3 people over 65 will die with dementia (but not necessarily *of* dementia).[5]

"Assumptions around older people and the frail elderly need to be challenged: typically, that they are more accepting of their fate and circumstances."

Dr Jonathan Koffman, King's College, London

"The [people] we have – the majority are over 75 – do not receive any visitors at all, have nobody to get their shopping, nobody to pop in and have a cup of tea with, to share concerns with or any happy memories."

Deborah Hayes, Age UK

Talking about end of life care

Involving people in decisions about their end of life care options is critical. But many people, including medical professionals, find discussions of death and dying very difficult. This needs to change if we are to support people to plan for the end of life.

Effective communication is an important component of good end of life care. Joined-up communication between service providers is vital. But conversations between individuals and their families, and more widely in society, are just as necessary. These conversations need to start early so that individual care plans can be developed, recorded and shared to ensure seamless care.

Health and care professionals: We need more skilled staff in all primary care settings (including nursing and care homes) who can initiate sensitive conversations about end of life and establish a trusting relationship to enable further discussion. They should aim to establish preferences and priorities for place and care of death, extent of treatment, and support for those important to the dying person. Ensuring that wishes are recorded and can be shared across care providers and services would greatly improve end of life care.

Communities: Increasing public discussions about death and dying, in culturally appropriate ways, can break down the barriers that prevent some people accessing the care that is right for them. Many people do not get the care they want because they do not know who to ask. Local strategies should identify ways to make sure that information reaches people who need it most.

Mandatory staff training in end of life care is only available in one in five hospital trusts.

24% of Londoners have asked a family member about their end of life wishes.

71% of Londoners agree that if people became more comfortable discussing dying it would be easier to have end of life wishes met.

"It takes communities working together to ensure that people who are dying receive the care and support that is right for them."

Claire Henry, Chief Executive, National Council for Palliative Care

"It requires an overt conversation with the patient and their loved ones, saying "We are having this conversation. We have made this decision".

Dr Caroline Stirling, Clinical Director for End of Life, NHS London

Next steps

We have written to the Mayor urging greater focus on end of life outcomes in developing mayoral policy. But much more can be done at a local level to improve end of life care across London. Local authorities are best placed to understand the needs of their local communities. By developing clear strategies and sharing good practice at a local level, more people will receive good end of life care in London.

Health and Wellbeing Boards can:

- **Ensure that end of life care is included in their Health and Wellbeing Strategy.**
- **Work with local partners to raise awareness of the services available in their areas, particularly for marginalised groups.**

Health Overview and Scrutiny Committees can:

- **Examine end of life care in their area or sub-region, to determine whether services are meeting local needs, and how effectively they are engaging with individuals and communities.**

The evidence base from our investigation is available to support future work at a local level. Please visit www.london.gov.uk/endoflifecare

How can end of life care in London be improved?

- Increase the focus on end of life care in Health and Wellbeing Boards and CCGs.
- Provide end of life care training to all social and healthcare staff.
- Ensure equitable access in boroughs to community nursing and specialist palliative care.
- Highlight the need to shift resources from acute and community providers to manage care out of hospital.
- Assess and respond to the need for housing and support for the increasing number of older people in London.
- Raise awareness of end of life care options locally.

"How we care for people at the end of life is a measure of the compassion of our society. It is vital that here in London we make quality of death, as well as quality of life, the best it can be."

Dr Onkar Sahota, Chair of the London Assembly Health Committee

About the investigation

The Health Committee issued a call for evidence and held a public meeting to discuss end of life care in London. At the meeting, the Committee was joined by a panel of experts:

- Dr Caroline Stirling, Consultant in Palliative Medicine and Interim Clinical Director, End of Life Care, NHS England (London region)
- Claire Henry, Chief Executive, National Council for Palliative Care
- Brian Andrews, Chair, Pan-London End of Life Alliance Lay Representatives Board
- Deborah Hayes, Director of Individual Services, Age UK East London
- Dr Jonathan Koffman, Senior Lecturer in Palliative Care, Kings College London
- Meeta Kathoria, Head of Programmes- Service Development, Marie Curie

The Committee is grateful to our guests and to all the organisations who submitted information to our review and also to John Powell, ADASS National Lead on End of Life Care, for his contributions.

End notes

1. Unless otherwise stated, figures and statistics in this document are taken from the Pan-London End of Life Alliance written submission to the Health Committee investigation November 2015
2. Office for National Statistics census data 2011
3. Age UK statistics 2015
4. Office for National Statistics census data 2011
5. The Alzheimer's Society 2015
6. Office for National Statistics "Nine things you might not know about older people in the UK" October 2015
7. The Campaign to End Loneliness 2015

About the Health Committee

The London Assembly Health Committee scrutinises the work of the Mayor and reviews health and wellbeing across London, with a particular focus on public health issues and reviewing progress of the Mayor's Health Inequalities Strategy.

Its members are:

- Dr Onkar Sahota AM (Chair)
- Andrew Boff AM (Deputy Chair)
- Kit Malthouse MP AM
- Murad Qureshi AM
- Valerie Shawcross CBE AM

You can find out more about the work of the committee at http://www.london.gov.uk/about-us/london-assembly/health-committee

Contact
Lucy Brant, Scrutiny Manager
lucy.brant@london.gov.uk

Media contact
Lisa Lam, Press Officer
lisa.lam@london.gov.uk

LONDONASSEMBLY

Agenda Item 7

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **21 April 2016**	**Agenda - Part: 1** | **Item: 7** **Subject: Enfield Health and Wellbeing Board (EH&WVB) Terms of Reference** **Wards: N/A** **Cabinet Member consulted: Cllr Taylor** **Approved by: Bindi Nagra**

Contact officer and telephone number:
Sam Morris **0208 3794245**
E mail: **sam.morris@enfield.gov.uk**

1. EXECUTIVE SUMMARY

1. Enfield's Health and Wellbeing Board (EH&WB) was set up in April 2013 as a committee of the Council under section 102 of the local Government Act 1972. This was consistent with the requirements of the Health and Social Care Act 2012.

2. As part of the ongoing review and development of the EH&WB, Board members agreed that a review of the terms of reference is undertaken. A revised Terms of Reference is being presented to the EH&WB which is clearer, legally compliant, and outlines the governance of the EH&WB.

3. The EH&WB Terms of Reference have now been reviewed by individual EH&WB members and Councils Corporate Management Board (CMB), and a number of changes to the original Terms of Reference have been set out. These are designed to clarify the Board's legal duties and position as a committee of the Council.

2. RECOMMENDATIONS

(a) Agree to recommend the revised Terms of Reference of the EH&WB are adopted by Full Council.

3. BACKGROUND

(a) EH&WB was set up in April 2013 as a committee of the Council under section 102 of the local Government Act 1972. This was consistent with the requirements of the Health and Social Care Act 2012.

(b) Since its establishment, the EH&WB has continued to meet at least five times a year on a formal basis, with informal development sessions also held throughout the year. However, to date there has been no formal reporting to the Council on the work of the Board.

4. ALTERNATIVE OPTIONS CONSIDERED

No alternatives considered.

5. REASONS FOR RECOMMENDATIONS

The EH&WB has not been reviewed since it was established in April 2013. A number of changes to the original Terms of Reference (ToR) are proposed in order to ensure that the ToR better reflects the legal role and powers of the Board.

Key amendments to the original ToR (outlined below)

(a) Job title- Director of Schools and Children's Services has now been changed to Director of Children's Services

(b) Director of Environment will not be a full member but will attend as necessary

(c) Responsibilities- The responsibilities section has been amended to reflect the legal responsibilities of the EH&WB and give members a clearer understanding of the Boards powers and mandate.

(d) Conduct- reference to the speaking Protocol has been removed from this section.

(e) Appendices- Appendix One has been changed to show an updated EH&WB Structure Chart as well as providing governance information on the EH&WB in the context of it being a Council committee. Other appendices including:

1. *Responsibilities of Members of the Enfield Health and Wellbeing Board (EH&WB)*

2. *Procedure for speaking at Health and Wellbeing Board Meetings*

3. *How to request a deputation to the Health and Wellbeing Board*

4. *How to find out the dates of the Health and Wellbeing Board meetings*

Have been removed as there is no longer the need for them now the EH&WB is a fully established forum.

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

6.1 Financial Implications

N/A

6.2 Legal Implications

Health and Wellbeing Boards (HWBs) were established under section 194(1) of the Health and Social Care Act 2012 and all local authorities have been under a statutory duty to establish an HWB since April 2013.

The statutory duties of an HWB include: to encourage integrated working in the provision of health and social care services; the preparation of a joint strategic needs assessment; the preparation of a joint health and wellbeing strategy; and the publication of a pharmaceutical needs assessment.

The duty to establish and delegate functions to an HWB is one for the local authority, in other words for full council.

The statutory membership of an HWB is set out at section 194(2) of the Health and Social Care Act 2012.

Section 194(8) of the Health and Social Care Act 2012 states that 'the Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.' Under subsection 9, once an HWB has been established, a local authority must consult the Board before appointing another person under (g) above.

The regulations governing HWBs are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ('the regulations'). These regulations state at Regulation 2 that Section 101of the Local Government Act 1972 ('the 1972 Act') applies to Health and Wellbeing Boards with some amendments, which means, for example, that the duty to have political balance on committees does not apply to HWBs.

In summary, the regulations give considerable flexibility to local authorities in making the arrangements for their HWBs. An HWB is a committee of the council not of the Cabinet, and it is for the council to determine its powers beyond its statutory duties. The membership of the HWB is to an extent determined by statute. However, once the HWB is established it can appoint further members that better allow it to deliver on its ToR. Although the Council can appoint further members as well, it must consult the HWB before making the appointment. While the legislation and guidance make no reference to reductions in membership it would be advisable to consult the HWB before reducing the membership of the Board.

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

7. KEY RISKS

Not relevant

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

A EH&WB with revised ToR will support the delivery of all the Health and Wellbeing Strategy Priorities (below).

8.1 Ensuring the best start in life
8.2 Enabling people to be safe, independent and well and delivering high quality health and care services
8.3 Creating stronger, healthier communities
8.4 Reducing health inequalities – narrowing the gap in life expectancy
8.5 Promoting healthy lifestyles

9. EQUALITIES IMPACT IMPLICATIONS

Not relevant

10. Background Papers

Appendix (a): Updated version of the EH&WB Terms of Reference
Appendix (b): Original version of the EH&WB Terms of Reference

Appendix (a): Updated version of the EH&WB Terms of Reference

Enfield Health and Wellbeing Board - Terms of Reference

1. Terms of Reference

2. Aims

The primary aims of the Board are to promote integration and partnership working between the local authority, Clinical Commissioning Group (CCG) and other local services and improve the local democratic accountability of health.

3. Name

The name of the Board will be 'Enfield Health and Wellbeing Board' (EH&WB)

4. Membership

- Leader of the Council
- Cabinet Member for Health and Adult Social Care
- Cabinet Member for Education, Children's Services and Protection
- Cabinet Member for Culture, Sport, Youth and Public Health
- Chair of the local Clinical Commissioning Group
- HealthWatch Representative
- NHS Commissioning Board Representative
- CCG Chief Officer
- Director of Public Health
- Director of Health, Housing & Adult Social Care
- Director of Children's Services
- Elected Representative of the Third Sector (Term of office 3 years – to expire April 2016)

Non-voting members

- Director of Planning from the Royal Free London NHS Foundation Trust
- Chief Executive from the North Middlesex University Hospital NHS Trust
- Director of Strategic Development from the Barnet, Enfield and Haringey Mental Health NHS Trust

Additional members may be appointed to the Board by the agreement of all current members and Council.

Membership of all non-statutory Board members will be reviewed annually in line with the Council representations.

The Board Manager or their representative will be in attendance at all Board and Executive Meetings.

5. Responsibilities

EH&WB will ensure:

- To develop a joint strategic needs assessment and joint health and wellbeing strategy which would be subject to final approval by the Council and the Clinical Commissioning Group (CCG)
- To encourage integrated working across the wider determinants of health including health and social care commissioners and other local services
- To encourage an integrated approach to commissioning
- To review the alignment of commissioning plans between the Joint Strategic Needs Assessment (JSNA), Pharmaceutical Needs Assessment (PNA) and the Joint Health and Wellbeing Strategy (JHWS) and the CCG commissioning plans including:
  - The duty to provide an opinion on whether the commissioning plan has taken proper account of the JHWS to the NHS Commissioning Body.
  - The power to provide the NHS Commissioning Board with opinion on whether a published commissioning plan has taken proper account of the JHWS (a copy must also be supplied to the Enfield CCG)
- To ensure that a Healthwatch service exists within Enfield and to consider its Annual Report
- To ensure that a Pharmaceutical Needs Assessment (PNA) is produced and published every 3 years
- To ensure that there is communication and consultation with the wider community on the work of the Health and Wellbeing Board and its priorities
- To ensure that a Health and Wellbeing work plan is implemented, reviewed and updated
- To ensure that a work programme for the sub committees is determined in line with the role of the Health and Wellbeing Board and is appropriately monitored
- To ensure that the Council, Cabinet , CCG Governing body and NHS Commissioning Board are kept informed of progress and work of the board by producing a Health and Wellbeing Board Annual Report)
- To receive the Annual Enfield Public Health Report
- Any other duties delegated by Council linked to the wider determinants of health.

6. Proposals for Sub-Boards and Work Programmes:

The EH&WB will be able to appoint sub committees to discharge their functions in accordance with section 102 of the 1972 Local Government Act.

All Sub-Boards will have their Terms of Reference and membership approved by the Health and Wellbeing Board and will need to operate in accordance with the requirements of the full board, and be focused on activity that is in line with the ToR and remit of the EH&WB.

The Board will have an executive group which will meet on a monthly basis to oversee on-going work in between board meetings. Its membership will consist of: the Director of Public Health, CCG Chief Officer, Director of

Children's Services and Director of Health, Housing and Adult Social Services.

7. Chairing

The Chair will be either the Leader of the Council or their appointed representative. The Vice Chair will be the Chair of the Enfield Clinical Commissioning Group.

8. Voting

Each full member of the Board shall have one vote and decisions will be made by a simple majority. The Chair will have the casting vote.

9. Quorum

The quorum for the Enfield Health and Wellbeing Board shall be at least four full members or one quarter of the full membership, to include a representative from the Clinical Commissioning Group, and a councillor.

10. Frequency of Meetings

Each year there will be at least five formal meetings of the EH&WB as well as any other additional extraordinary board meetings and/or development sessions as called by the board.

11. Conduct of Business of the Health and Wellbeing Board

(a) The meetings will generally be open to the public and other councillors except where they are discussing confidential and exempt information. This will need to be in accordance with the requirements of the Local Government Act 1972 as amended.

(b) Members of the EH&WB will be entitled to receive a minimum of five clear working days' notice of such meetings, unless the meeting is convened at shorter notice due to urgency.

(c) Any member of the Council may attend open meetings of the EH&WB and speak at the discretion of the Chair.

(c) **Agendas and notice of meetings:** There will be formal agendas and reports which will be circulated at least five working days in advance of meetings.

(d) **Exempt and confidential items:** There will be provision for exempt or confidential agenda items and reports where the principles of the relevant access to information provisions of the Local Government Act 1972 (as amended) apply.

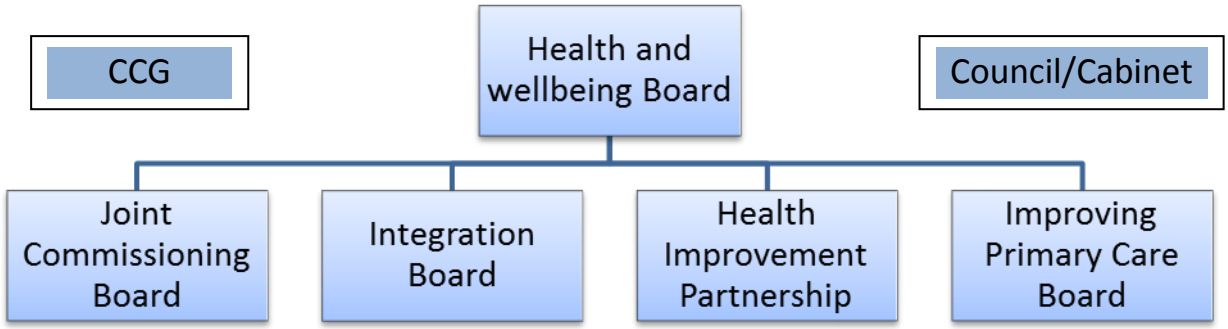
(e) **Reports:** Reports will usually be prepared by the relevant officer or EH&WB member.

(f) Reports will be presented by the appropriate Board member, and must include advice from relevant officers, including finance and legal implications and reasons for the recommendations.

(g) **Minutes of decisions made at EH&WB meetings:** Minutes will be made public within 10 working days of each meeting.

(i) **Officer advice:** Officer advice will be stated fully and clearly within reports to the EH&WB Board.

Appendix 1: Structure Chart (including sub boards)



Appendix 2: Governance Arrangements

1. **The Health and Wellbeing Board as a Council committee**
   EH&WB was set up in April 2013 as a committee of the Council under section 102 of the local Government Act 1972. This was consistent with the requirements of the Health and Social Care Act 2012.

   The regulations for HWBs do, however, modify and dis-apply certain provisions of the Local Government Act. The Board should be thought of as a section 102 committee, and it must follow the procedures and policies of its host organisation (the Council) rather than its constituent parts (such as the Clinical Commissioning Group [CCG]). However, there are some key differences between HWBs and other Council committees with regards to membership, decision-making arrangements and reporting structures.

2. **Decision-making arrangements**
   EH&WB is not a policy creating body, and cannot take decisions that are vested in either officers, Cabinet or Council. Neither is EH&WB a committee of the executive or cabinet. The Board cannot make executive decisions, only recommendations to the correct body to do so.

Regulation 6 modifies the Local Government and Housing Act 1989 (section13(1)) to enable all members of health and wellbeing boards or their sub-committees to vote unless the council decides otherwise. This means that the Council is free to decide, in consultation with the HWB which members of the HWB should be voting members.

The intention of the legislation is that all members of health and wellbeing boards should be seen as equals and as shared decision makers, acknowledging that health and wellbeing boards are about bringing political professional and clinical leaders and local communities together on an equal basis. It is hoped that this will be achieved by consensus, where possible. However there will be some occasions where votes will have to be taken.

3. Scrutiny

Overview and Scrutiny are able to scrutinise the work of the Health and Wellbeing Board in a similar way to the other work of the Council. However, although the discharge of functions by health and wellbeing boards falls within the remit of scrutiny, the core functions are not subject to being called in, as they are not executive functions.

4. Partnership Working

In order to fulfil its aims, EH&WB must do two things: empower the Council and CCG to deliver the objectives set out in the JHWS and strengthen its connections within the borough.

Firstly, in order for the Board to deliver its objectives, there must be a clear link between the Board's sub-committees and its priorities; for example, the Improving Primary Care Board will help fulfil the second aim by taking responsibility for the provision of quality primary care services. There must also be effective leadership for each aim, with individuals taking responsibility for the delivery of specific objectives against agreed targets. EH&WB must also ensure that those responsible have sufficient resources and capacity within their boards/teams to enable the objectives to be met.

Secondly, EH&WB must strengthen its connections across the borough in order to have the power to effect the changes it wants to make. Important partners include the Council's Schools and Children's Services; the Council's strategic transformation programme (Enfield 2017); the borough's Safer, Stronger Communities Board; local leisure services; partners involved in employment, training and volunteering; and NHS Acute and Primary Care providers.

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Appendix (b): Original version of the EH&WB Terms of Reference

Enfield Health and Wellbeing Board - Terms of Reference

[Updated: Council 19/11/14]

Purpose

The purpose of the Board is to improve the health and wellbeing of the residents of Enfield and reduce current health inequalities. The Board will work with partner agencies in delivering improvements to the provision of health, adult and children's social care and housing services.

Vision

Our vision is for a healthier Enfield, where everyone is able to benefit from improvements in health and wellbeing. We want to reduce health inequalities in Enfield and for its people to have a healthier, happier and longer life. We want Enfield to be a healthy and happy place to live, work, raise a family and retire in.

Terms of Reference

1. Aims

The primary aims of the Board are to promote integration and partnership working between the local authority, Clinical Commissioning Group (CCG) and other local services and improve the local democratic accountability of health.

2. Name

The name of the Board will be 'Enfield Health and Wellbeing Board' (EH&WB)

3. Membership

- Leader of the Council
- Cabinet Member for Health and Adult Social Care
- Cabinet Member for Education, Children's Services and Protection
- Cabinet Member for Culture, Sport, Youth and Public Health
- Chair of the local Clinical Commissioning Group
- HealthWatch Representative
- NHS Commissioning Board Representative
- CCG Chief Officer
- Director of Public Health
- Director of Health, Housing & Adult Social Care
- Director of Schools & Children's Service

- Director - Environment
- Elected Representative of the Third Sector (Term of office 3 years – to expire April 2016)

Non-Voting Members

- Director of Planning from the Royal Free London NHS Foundation Trust
- Chief Executive from the North Middlesex University Hospital NHS Trust
- Director of Strategic Development from the Barnet, Enfield and Haringey Mental Health NHS Trust

Additional members may be appointed to the Board by the agreement of all current members and Council.

Membership of all non-statutory Board members be reviewed annually in line with the Council representations.

NB the Board Manager or their representative will be in attendance at all Board and Executive Meetings.

4. Responsibilities

The Enfield Health and Wellbeing Board will ensure:

- London Borough of Enfield with its partners are equipped to meet its duties
- A Health and Wellbeing Board work plan is implemented, reviewed and updated
- An integrated approach to commissioning
- Alignment of commissioning plans between the Joint Strategic Needs Assessment (JSNA), Pharmaceutical Needs Assessment (PNA) and Joint Health and Wellbeing Strategy (JHWS) and the Clinical Commissioning Group (CCG) Commissioning Plans, including:
    1. Duty to provide opinion on whether the commissioning plan has taken proper account of the JHWS to the NHS Commissioning Board
    2. Power to provide NHS Commissioning Board with opinion on whether a published commissioning plan has taken proper account of the JHWS (a copy must also be supplied to the relevant CCG)
- The power to encourage integrated working across wider determinants of health:
    1. between itself and commissioners of health related services
    2. between commissioners of health and social care services and of health-related services

- The Council has an adequately resourced public health service
- HealthWatch service exists within Enfield and is represented at the Board
- The JSNA, PNA and Joint Health and Wellbeing Strategy are created
- Cabinet, CCG Governing Body and NHS Commissioning Board are kept informed of progress and work of the board

- A work programme for the sub committees is determined and this is kept on track
- To receive the annual public health report/public health issues
- Oversight over the Children's Trust Governance arrangements
- Oversight of the HealthWatch Plans / Annual Report
- The work of the EH&WB be communicated to all Enfield residents through its website and publications
- Equality and diversity issues are addressed
- Performance and quality management
- Promotion of integration and partnership across areas
- Determination of the allocation of any public health budgets
- Support for joined-up commissioning and pooled budget arrangements, where all parties agree this makes sense including Children and Adults Section 75 Arrangements

5. Proposals for Sub-Boards and Work Programmes:

The Enfield Health and Wellbeing Board will be able to appoint sub committees to discharge their functions in accordance with section 102 of the 1972 Local Government Act.

All Sub-Boards will have their Terms of Reference and membership approved by the Health and Wellbeing Board and will need to operate in accordance with the requirements of the full board.

The Board will have an executive group which will meet on a monthly basis to oversee on-going work in between board meetings. Its membership will consist of: the Director of Public Health, CCG Chief Officer, Director of Children's Services and Director of Health, Housing and Adult Social Services.

6. Chairing

The Chair will be either the Leader of the Council or their appointed representative. The Vice Chair will be the Chair of the Enfield Clinical Commissioning Group.

7. Voting

Each member of the Board shall have one vote and decisions will be made by a simple majority. The Chair will have the casting vote.

8. Quorum

The quorum for the Enfield Health and Wellbeing Board shall be at least four members or one quarter of the membership, to include a representative from the Clinical Commissioning Group, and a councillor.

9. Frequency of Meetings

Each year there will be at least five formal meetings of the EH&WB as well as any other additional extraordinary board meetings and/or development sessions as called by the board.

10. Conduct of Business of the Health and Wellbeing Board

(a) EH&WB meetings will generally be open to the public and other councillors except where they are discussing confidential and exempt information. This will need to be in accordance with the requirements of the Local Government Act 1972 as amended.

(b) Members of the EH&WB will be entitled to receive a minimum of five clear working days' notice of such meetings, unless the meeting is convened at shorter notice due to urgency.

(c) Any member of the Council may attend open meetings of the EH&WB and speak at the discretion of the Chair. A protocol for members of the public to speak at meetings has been drafted and is attached as Appendix 3 to the Terms of Reference.

(d) **Agendas and notice of meetings:** There will be formal agendas and reports which will be circulated at least five working days in advance of meetings.

(e) **Exempt and confidential items:** There will be provision for exempt or confidential agenda items and reports where the principles of the relevant access to information provisions of the Local Government Act 1972 (as amended) apply.

(f) **Reports:** Reports for the EH&WB will usually be prepared by the relevant officer or EH&WB member.

(g) Reports will be presented by the appropriate EH&WB Board member, and must include advice from relevant officers, including finance and legal implications and reasons for the recommendations.

(h) **Minutes of decisions made at EH&WB meetings:** Minutes will be made public within 10 working days of each meeting.

(i) **Officer advice:** Officer advice will be stated fully and clearly within reports to the EH&WB Board.

Appendix 1 to the Terms of Reference

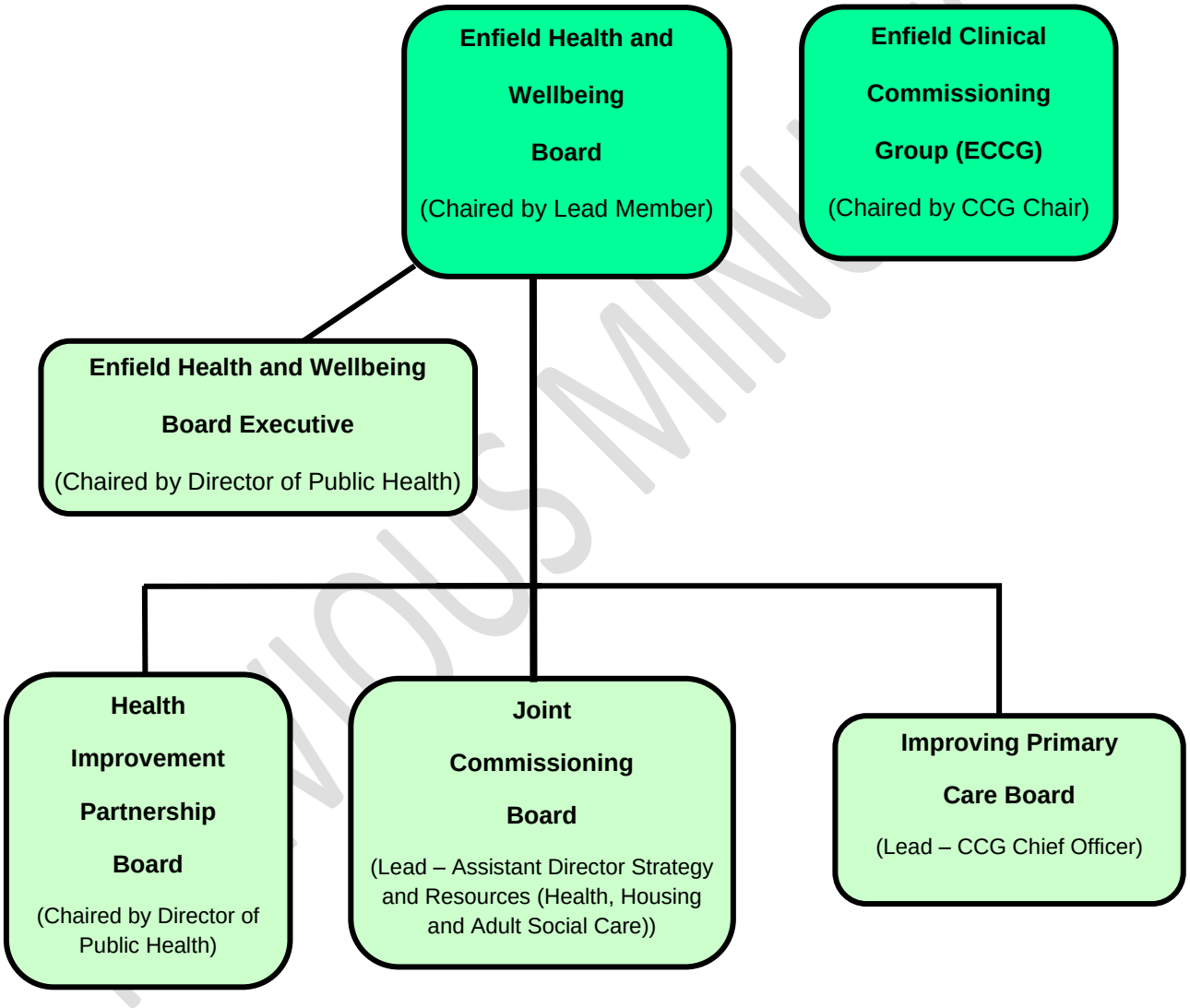
Protocol

Responsibilities of Members of the Enfield Health and Wellbeing Board (EH&WB)

- Represent and speak on behalf of their sector or organisation
- Power to appoint additional members to the board as deemed appropriate
- Be accountable to their organisation or sector for their participation in the EH&WB and ensure that they are kept informed of the EH&WB business and information from their organisation/sector is reported to the EH&WB
- Support the agreed majority view when speaking on behalf of the EH&WB to other parties
- Attend the EH&WB meetings
- Sign up to the Council's Code of Conduct and declare any disclosable pecuniary, other pecuniary and non pecuniary interests that arise
- Read agenda papers prior to meetings so that they are ready to contribute and discuss EH&WB business
- Uphold and support EH&WB decisions
- Work collectively with other board members in pursuit of EH&WB business
- Ensure that the EH&WB adheres to its agreed terms of reference and responsibilities
- Listen with respect to the views of fellow board members
- Will be willing to take on special tasks or attend additional meetings, functions or developed activities of the EH&WB

Appendix 2 to the Terms of Reference

Structure Chart
Enfield Health and Wellbeing Board
(including sub boards)



Appendix 3 to the Terms of Reference

Procedure for speaking at Health and Wellbeing Board Meetings

The Health and Wellbeing Board is a formal meeting. Members of the public cannot take part in the discussion unless they request permission in advance of the meeting, and then only with the agreement of the Chair.

The mechanism for raising an issue is through the deputation process.

If you want to speak at a meeting of the Health and Wellbeing Board you will need to request permission for a deputation.

A deputation must relate to an item on the agenda for the meeting. It can consist of no more than 5 people. Only one member of the deputation will be able to speak, for up to 5 minutes, to address the Board. Members of the Board will then be able to ask questions on the issues raised.

How to request a deputation to the Health and Wellbeing Board

All requests for a deputation to the Health and Wellbeing Board must be submitted in writing to:

The Health and Wellbeing Board Secretary
Governance Team
Finance, Resources and Customer Services Department
PO Box 50
1st floor, Civic Centre
Silver Street, Enfield
Middlesex EN1 3XA

Or by e mail to penelope.williams@enfield.gov.uk

We need to have your request by noon at least two working days before the Health and Wellbeing Board meeting that you wish to speak at.

You should include the following information:

- The purpose of the deputation – what is the matter to be discussed?
- The name, address and telephone number of the person leading the deputation.

How to find out the dates of the Health and Wellbeing Board meetings

The dates of all Health and Wellbeing Board meetings are available on the democracy pages of the Council's website www.enfield.gov.uk/democracy or by contacting the Governance Team on Tel: 020 8379 4098 or democracy@enfield.gov.uk.

Who decides whether the deputation will be allowed?

All requests for deputations to Health and Wellbeing Board meetings are considered by the Chair of the Board. The Chair will either:

- Agree the request;
- If the matter is not appropriate to the Health and Wellbeing Board the request may be referred onto the Chair of a more relevant body.
- Refuse the request.

The Board Secretary will advise you of the decision of the Chair regarding your request. If the request is refused you will be told why.

No more than two deputations will be allowed for any one agenda item at each Health and Wellbeing Board meeting.

A deputation should relate to the Health and Wellbeing Board's area of responsibility and relate to items on the agenda.

If you have any questions regarding the above please contact the Governance Team on 020 8379 4098.

Agenda Item 8

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **21 April 2016**	**Agenda - Part: 1** | **Item: 8** **Subject: Sustainability and Transformation Plans** **Wards: All**
Report of: Deborah McBeal (Deputy Chief Officer Enfield Clinical Commissioning Group (CCG)) Contact officer and telephone number: E mail:	**Cabinet Member consulted:** **Approved by:**

1. EXECUTIVE SUMMARY

Please see slide deck

Presented by:

Dr Mo Abedi, Chair – Enfield CCG
Deborah McBeal, Deputy Chief Officer – Enfield CCG

2. RECOMMENDATIONS

Members of the Health and Wellbeing Board are asked to note the report.

3. BACKGROUND

NHS Shared Planning Guidance 16/17-20/21 outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions.

As in previous years, NHS organisations are required to produce individual Operational Plans for 2016/17. In addition, every health and care system will work together to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision.

To do this, local health and care systems will come together into STP 'footprints'. The health and care systems within these geographic footprints will work together to narrow the gaps in the quality of care, their population's health and wellbeing, and in NHS finances.

Local health and care organisations have agreed to work across the North Central London (NCL) STP geographic footprint to develop an agreed STP.

The slides attached detail how this work is progressing.

4. ALTERNATIVE OPTIONS CONSIDERED

N/A

5. REASONS FOR RECOMMENDATIONS

N/A

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

6.1 Financial Implications

See slides.

6.2 Legal Implications

N/A.

7. KEY RISKS

See slides.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

See slides.

9. EQUALITIES IMPACT IMPLICATIONS

Will be undertaken at the appropriate time and where necessary.

Background Papers

None

North Central London
Sustainability and
Transformation Plan

North Central London Sustainability and Transformation plan Progress update

March 2016

There are a number of objectives for the NCL STP

Goals

The **goals** of our STP are:

- To improve the quality of care, wellbeing and outcomes for the NCL population
- To deliver a sustainable, transformed local health and care services
- To support a move towards place-based commissioning
- To gain access to a share of the national transformation funding which will ensure our hospitals get back to being viable, to support delivery of the Five Year Forward View, and to enable new investment in critical priorities such as primary care, mental health and cancer services

Outputs

The STP needs to deliver several **key outputs:**

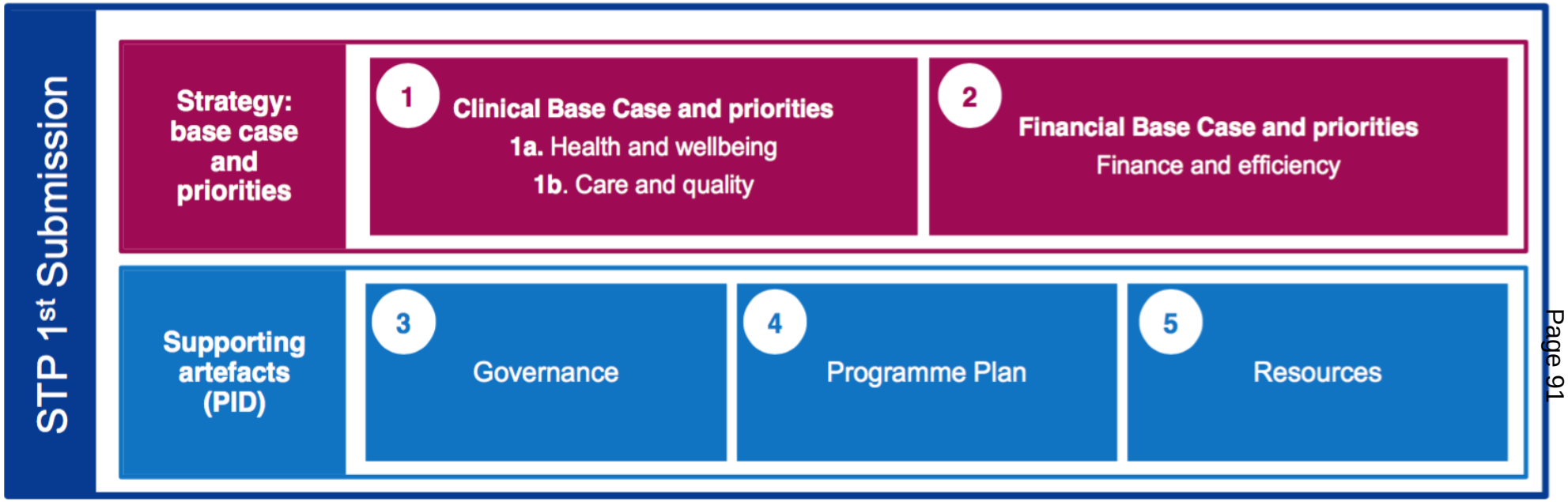
- A compelling clinical case for change that provides the foundation for the programme and is embedded across the work, and supports the identification of priorities to be addressed through the STP
- A single version of the truth financial 'do nothing' base case with quantified opportunity impacts based on the priorities identified
- A robust and credible plan for implementation and delivery over 5 years
- A governance framework that supports partnership working across the STP and collective decision making
- The resource in place to devliver transformation at scale and pace in the key areas identified

Process

The **process** to developing our STP needs to:

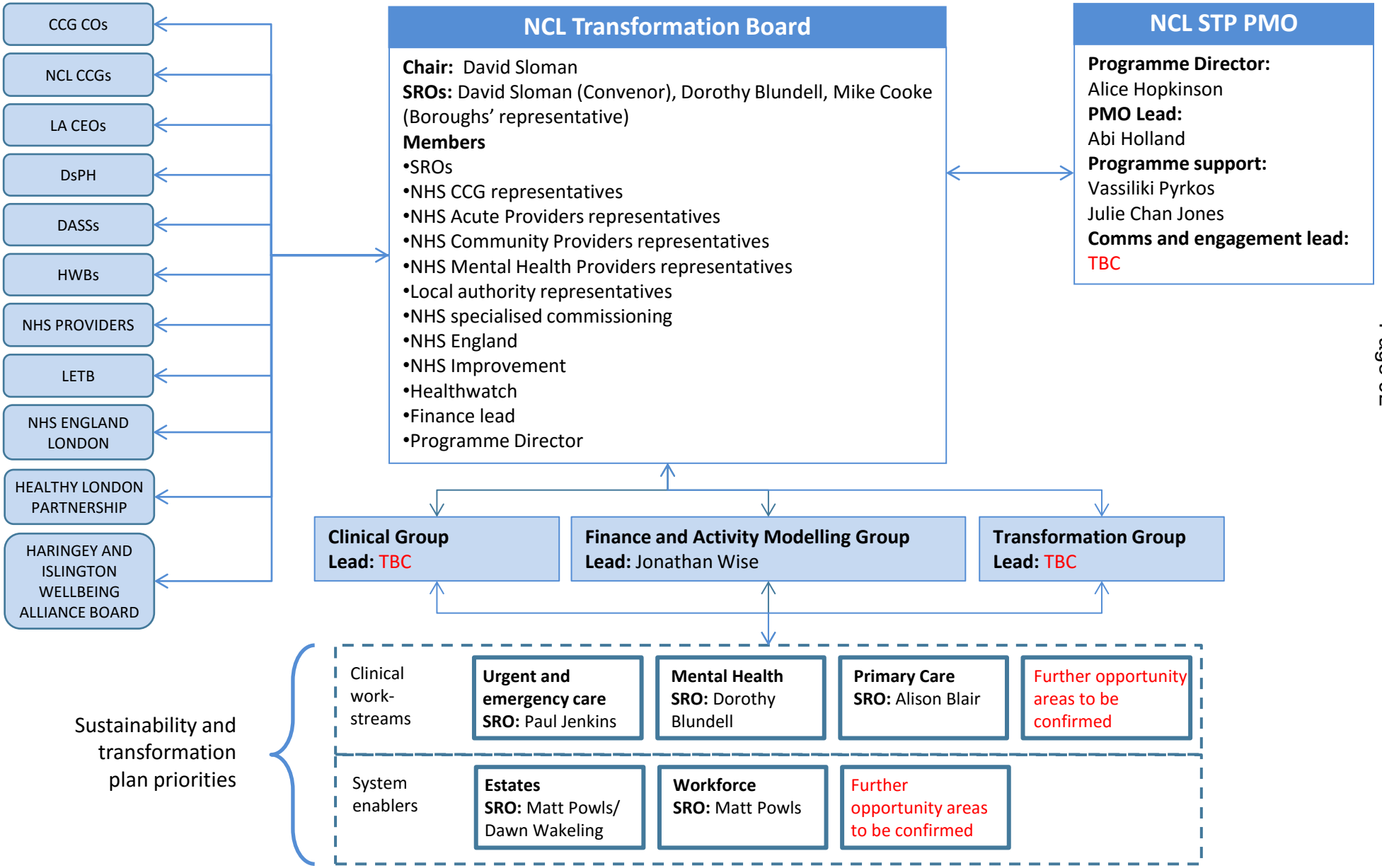
- Be collaborative, and owned by all programme partners in NCL
- Be structured and rigorous
- Move at pace, ensuring quick wins are implemented and transformation is prioritised
- Involve all areas of CCG, local authority and NHS England commissioned activity, including specialised services, primary care and reflecting local HWB strategies

The full STP needs to be submitted to NHS England on 30th June, but 5 key elements are required for the initial STP submission on 15th April

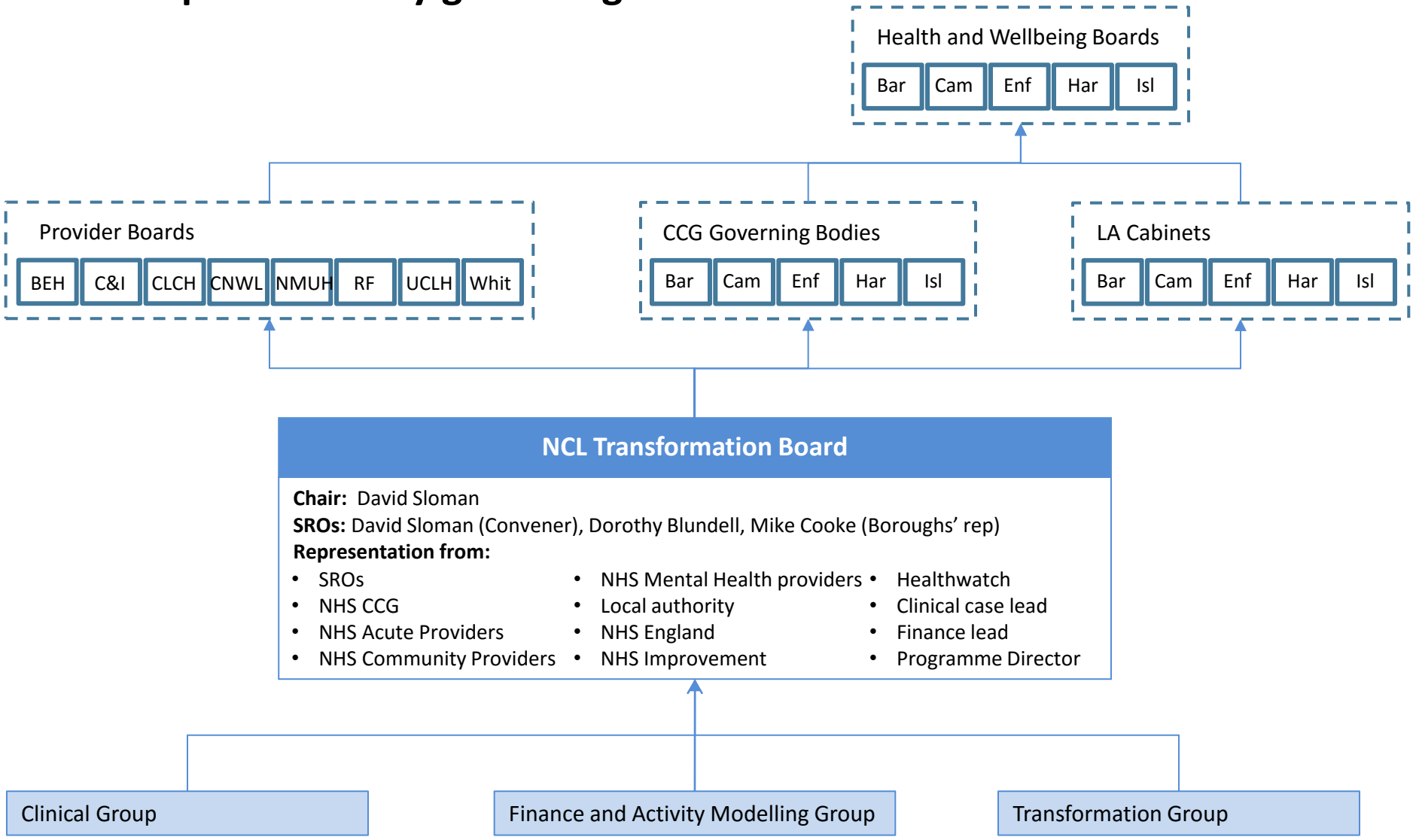


- A **base case**; both **financial** and **clinical** (i.e. the do nothing scenario)
- A number of supporting artefacts that enable development of the STP including:
  - A **programme plan** with clearly defined workstreams and milestones
  - **Governance arrangements** that provide appropriate leadership and control to STP development
  - **Resource agreements across the SPG** to support STP development
  - Interdependencies between both the financial and clinical base case have been considered and accounted for in designing and agreeing supporting artefacts

Current overarching governance framework for the STP



Relationship to statutory governing bodies



The Transformation Board has no formal decision making authority. The membership includes representatives from all statutory bodies (identified above) who will steer decision through their constituent boards for formal sign off.

Key messages emerging from the draft clinical case for change

Supporting fact base…

- People in NCL are living longer but are in poor health
- Widespread deprivation across NCL
- Differing levels of health and social care needs
- Challenges for primary care provision in some areas
- Lack of integrated care and support for those with LTCs
- Too many people in hospital beds who would be better treated at home or in the community
- Hospitals are finding it difficult to provide the most specialist care
- Challenges in mental health provision
- Workforce challenges
- Estates are not fit for purpose

…suggested priorities

- Mental illness
- Older people (particularly those with dementia)
- Long term conditions, including better integration of care and ensuring that suitable and sufficient social care is available
- Prevention
- Ensuring high quality services are available when required for the 78% of local people who are mostly healthy
- Primary care provision and reducing variation between practices, including a requirement for additional investment in primary care services
- Reducing the length of stay in acute hospitals, in partnership with social care
- Reducing delayed discharges in Haringey and Camden

NCL health economy status quo financial challenge at 2020/21

The total consolidated underlying (normalised) NCL health economy financial challenge at 20/21 (under the 'Status Quo' scenario*) is shown below:

Status Quo – NCL	Financial challenge, £m
NCL CCGs gap to 1% surplus at 20/21 (see **appendix 2**) – **note 1**	(169)
NCL Providers gaps to 1% surplus at 20/21 (see **appendix 3**) – **note 2**	(173)
NHSE Projected financial challenge (for NCL) at 20/21 – **note 3**	**TBC**
Triangulation variance at 20/21 – **note 4**	(40)
TOTAL NCL Financial Challenge at 20/21 under the 'Status Quo' – note 5	**(382)**

- **Note 1:** Under this scenario CCGs have assumed minimal QIPP, totalling £71m over 5 years (£54m in 16/17 and £17m in 17/18 to 20/21). Whilst £169m represents the normalised position, if RAB was taken into account the accumulated deficit would be c.£460m;
- **Note 2:** Trusts have assumed a reducing CIP % from 17/18 to 20/21. It should be also noted that the cost of implementing LQS across the providers is still being reviewed by a number of the providers which could add further cost pressures into the NCL position. Whilst £173m represents the normalised position, the accumulated cash requirement over the period would be £515m;
- **Note 3**: NHSE Spec Comm are currently producing a projected 'Status Quo' position for NCL which will be added into the overall NCL health economy challenge when available;
- **Note 4:** Based on CCGs projected expenditure (by trust) and Trusts projected income (by CCG) the preliminary estimate of the variance is £40m; and
- **Note 5**: This potentially includes some of the knock on impacts of social care pressures, but does not include an assessment on the pressure of overall social care budgets (previously assessed at £247m).

*** Status quo definition**

- No service reconfiguration (i.e. that seek to change and transform, including those that reduce or discontinue services), other than those changes already in progress (i.e. maintaining the current service provision). It does assume implementation of London Quality Standards and 7 day services by 20/21
- No strategic capital available from the system (other than for essential high/significant backlog maintenance "BM") – BM should be loan funded
- No commissioner QIPP delivered (other than those schemes already in progress or where detailed plans (with timelines/PIDs exist) have been agreed by providers
- Limited (or nil) 'working together' between organisations

There is scope to consider further opportunity areas in addition to the four priorities, and these will need to be reflected in the initial STP submission

- The NCL Collaboration Board identified the following priorities:
  1. **Acute services redesign:** with an immediate focus on urgent and emergency care
  2. **Mental health:** with an immediate focus on transforming inpatient care
  3. **Pathways:** with an immediate focus on primary care, having common standards and reducing variation
  4. **System wide enablers:** with an immediate focus on estates

- The cumulative challenge for CCGs along in NCL in 2020/21 is £460m
- The impact of the four collaboration priorities could address £135m of the financial gap
- Further opportunities need to be identified and analysed to close the key gaps identified in the clinical case and the finance base case

- We have discussed a number of principles in our approach to selecting additional priorities as part of the STP:
  - We should be **radical in our approach** and **not constrict ourselves** to opportunities available within the constraints of the current system
  - We should be considering **more effective vehicles for taking change forwards** including taking advantage of opportunities to **share resources**
  - We should be able to **articulate the opportunities to all audiences**, including patients, health commissioners and providers, local authorities and NHS England
  - We should be looking to **reduce demand** through new opportunities
  - New opportunities should be focused around **eliminating variation** and **adding value**

Next steps: priority actions prior to STP submission in June

- ☐ Hold formal launch / kick off for the STP to gain buy-in from across the system
- ☐ Agree additional priorities, overarching structure of programme and develop detailed workstream implementation plans
- ☐ Map out existing local work and ensure alignment with STP plans
- ☐ Quantify potential impact of agreed priorities
- ☐ Hold interdependencies workshop to identify key dependencies across the programme
- ☐ Agree programme budget and funding
- ☐ Fill resourcing gaps through external and internal roles
- ☐ Mobilise sub groups: draft ToRs, agree membership and establish key meeting dates
- ☐ Develop comms and engagement strategy and roll out across NCL

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Agenda Item 9

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board – 21st April 2016.**	**Agenda - Part: 1** | **Item: 9** **Subject: St Mungo's Charter** **Wards: All**
	Cabinet Member consulted: Cllr Doug Taylor
Contact officer: Harriet Potemkin-Strategy and Policy Hub Manager T: 020 8379 8399 E: harriet.potemkin@enfield.gov.uk	**Approved by: Shahed Ahmed**

1. EXECUTIVE SUMMARY

St Mungo's has contacted all Health and Wellbeing Boards, encouraging them to sign their Homelessness Charter, to express commitment towards tackling health inequality among people who are homeless. The Charter seeks three commitments from the Health and Wellbeing Board:

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.
Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.
Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

To date over 38 Health and Wellbeing Boards around England have signed this Homeless Health Charter, including: Essex, Greenwich, Hammersmith and Fulham, Haringey, Islington, Lambeth, Lewisham and Waltham Forest.

2. RECOMMENDATIONS

The Board is asked to:

A. Note the content of the Charter for Homeless Health (**Appendix 1**)
B. Agree to the Chair signing the Charter on the behalf of the Board

3. BACKGROUND

St Mungo's Broadway is a national homelessness charity and housing association that provides nighty shelter and support to people who are homeless or at risk. St Mungo's have one hostel based in Enfield.

St Mungo's provides support to more than 2,500 people a night who are homeless or at risk. Among St Mungo's clients, 65% report a mental health problem and 70% report a physical health problem. Their evidence also suggests that the average age of death for men who die while they are homeless is 47, for women it's just 43.

A recent report from Homeless Link, 'The Unhealthy State of Homelessness", states that people who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental health and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need.

The Report also highlights that:

- 73% of homeless people in the UK reported physical health problems. 41% said this was a long term problem, compared with 28% of the general population.
- 80% of respondents reported some form of mental health issue, 45% had been diagnosed with a mental health issue, compared with 25% of the general population.
- 35% had been to A&E and 26% had been admitted to hospital over the past six months.

St Mungo's has contacted all Health and Wellbeing Boards, encouraging them to sign the Charter and express a commitment towards tackling health inequality among people who are homeless. To date over 38 Health and Wellbeing Boards around England have signed this Homeless Health Charter, including: Essex, Greenwich, Hammersmith and Fulham Haringey, Islington, Lambeth, Lewisham, and Waltham Forest.

A reduction in health inequalities is a key principle for the Board and is well promoted. Also the Board already acknowledge the effect of broader determinates on health and the particular health needs of vulnerable and excluded groups. The Board is committed to reducing inequalities in health where these exist. People who are homeless are a particularly high risk group who have very high health and social care needs.

Our existing strategies and services demonstrate our commitment to the charter, including via our Joint Strategic Needs Assessment; Health and Wellbeing Strategy and our commissioned services for homeless people. The table below sets this out in more detail.

The commitment	Current strategies and Intentions meeting the commitments	Future Considerations
Identify need: This should involve including the health needs of people who are homeless in our Joint Strategic Needs Assessment (JSNA). This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless working with homelessness services and homeless people to achieve this.	Our JSNA already states our responsibility to reduce health inequalities across the life course, including within hard to reach groups and to ensure the provision of population healthcare advice. It also highlights that high rates of Tuberculosis (TB) are seen in vulnerable groups including the homeless. Particular issues for young people who are homeless are cited within our Joint Commissioning Strategy for Emotional Well-being & Child and Adolescent Mental Health for 0-18 year olds, where it states that homeless young people had an 8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation.	When updating the JSNA, ensure homeless people's health needs are continued to be addressed appropriately and in line with the charter.
Provide leadership: This would require the Board to provide leadership on addressing homeless health. It proposes the Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.	We acknowledge the effect of the broader determinates of health and the particular health needs of vulnerable and excluded groups as part of our Health and Wellbeing strategy. Our strategy states that in some cases, positive action will be required to target improvements in health and wellbeing among particular groups in our community. This will require on-going, active engagement with local groups and communities to understand the diverse needs of the people of Enfield and to put local people at the heart of shaping the way we deliver the Joint Health and Wellbeing Strategy. 'Fairness for All' is one of the key messages in Enfield Council Business plan, with a strong focus on homelessness and health Inequities, stating: We are focused on improving the health and wellbeing of all residents, reducing health inequalities and empowering residents to choose to lead a healthier lifestyle.	All members of the Board should continue to consider the links between health and homelessness and identify ways to tackle inequalities.
Commission for inclusion: This proposes that we ensure that local health services meet the needs of people who are homeless and that they are welcoming and easily accessible.	NHS Enfield CCG Commissioning Intentions 2016-17 highlight programmes to be delivered city-wide, including the aim to 'transform the lives of the homeless and transform care for the mentally ill.' Enfield's Housing Strategy 2012-2027 stresses the need for improved integration of housing and health services, and the important role housing plays in reducing health inequalities. The Council funds early intervention and prevention homelessness projects within the VCS, including from St Mungo's. The Council also commissions accommodation based support for homeless and vulnerable groups, including hostel accommodation from St Mungo's.	The Board may want to consider a local awareness raising campaign around homeless health as part of a wider strategy of fairness for all. The Charter will need to be considered when making future commissioning decisions.

4. ALTERNATIVE OPTIONS CONSIDERED

The alternative option is to not sign up to the charter. Not signing the Charter would fail to demonstrate our commitment towards tackling health inequality among people who are homeless.

5. REASONS FOR RECOMMENDATIONS

On 4th November 2015, the Health and Wellbeing Board had a development session exploring the relationship between housing and health. Supporting this charter will contribute to meeting the priorities that the Council and our partners are already working toward. It is also an opportunity to publicly demonstrate our partnership commitment to improving the health and wellbeing of people who are homeless.

Although there is concern of future budget cuts and the impact this will have on services for homeless people, the Council's commitment to fairness for all and the Health and Wellbeing Board's commitment to reducing health inequalities demonstrates our intention to not lose sight of the needs of homeless people. Existing strategies and services demonstrate our commitment to the charter.

A key part of the Council's strategic aim of 'Fairness for All' is the principle of 'Serving the whole borough fairly and tackling inequality'. The Health and Wellbeing Board are committed to promoting equality and diversity, and working to reduce the disparities in health and wellbeing that exist across the borough. We currently meet the commitments set out in the Charter.

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

6.1 Financial Implications

There are no identified direct financial, staffing and resource implications to signing this Charter. Any work to fulfil the commitments in appendix 1 will be funded from existing budgets.

6.2 Legal Implications

Section 2B of the National Health Service Act 2006 requires each local authority in England to 'take such steps as it considers appropriate for improving the health of the people in its area.' These powers are very wide.

The Charter is not a binding legal document.

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

7. KEY RISKS

The commitments in the Charter go hand in hand with Enfield Council's Business Plan and Joint Partnership Strategies mentioned above, addressing health inequalities and homelessness, so there are no obvious risks.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life

8.2 Enabling people to be safe, independent and well and delivering high quality health and care services
8.3 Creating stronger, healthier communities
8.4 Reducing health inequalities – narrowing the gap in life expectancy
8.5 Promoting healthy lifestyles

Signing up to the Charter supports us in meeting the priorities in the Health and Wellbeing Strategy. In particular:

- Enabling people to be safe, independent and well and delivering high quality health and care services
- Reducing health inequalities – narrowing the gap in life expectancy
- Promoting healthy lifestyles

9. EQUALITIES IMPACT IMPLICATIONS

In making this decision Enfield Council must have regard to the public sector equality duty (PSED) of the Equalities Act 2010, i.e. have due regard to the need to:

A. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
B. Advance equality of opportunity between people who share a protected characteristic and those who do not.
C. Foster good relations between people who share a protected characteristic and those who do not include tackling prejudice and promoting understanding

Homeless people share a range of protected characteristics. Equalities implications of signing the Charter are positive as the Board recognise the needs of this hard to reach and vulnerable group and encourages services to be welcoming and accessible to all users.

Background Papers
Charter for Homeless Health (**Appendix 1)**

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A Future Now
Demanding action on homelessness

St Mungo's Broadway
Rebuilding lives, day by day

Charter for homeless health

People who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need.

The ..... **Health and Wellbeing Board** is committed to changing this. We therefore commit to:

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

Signed: .....

Chair: ..... **Health and Wellbeing Board**

Date: .....

St Mungo's Broadway, Griffin House, 161 Hammersmith Road, London W6 8BS
St Mungo Community Housing Association is a registered charity and a limited company registered in England and Wales
Registered Charity No. 1149085 Company No. 8225808 Housing Association No. LH0279

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Agenda Item 10

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE
Health and Wellbeing Board
21 April 2016

Agenda - Part: 1	**Item: 10**
Subject: Primary Care Update **Wards: All**	
Cabinet Member consulted: NA	
Approved by: NA	

Dr Mo Abedi, Chair
NHS Enfield CCG
Contact officer and telephone number:
E mail:
Jenny.Mazarelo@enfieldccg.nhs.uk
Tel: 020-3688-2156

1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on Primary Care matters across the borough of Enfield, in particular:

- The primary care element of the Sustainability and Transformation Plan
- Review of NCL Co-Commissioning arrangements
- NHS England (London Region) OD Review of the Primary Care Function

2. RECOMMENDATIONS

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

3.1 SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

It was a requirement of NHS England (London Region) that Strategic Planning Groups develop a primary care chapter for the plan prior to the first STP submission milestone of 15th April 2016. This was presented and discussed at the GP Transformation Sub-Group meeting on 22nd March and 6th April 2016 at which the Health and Wellbeing Board was represented by the Director of Public Health, Consultant in Public Health and Senior Public Health Strategist. The chapter sets out a shared North Central London vision for primary care which is to ensure the sustainability of the NCL health economy and reduce the variability of services through an increase in the quality of the offer to patients, enabling all patients to access a wide range of integrated services from premises that are fit for purpose and with the support to manage their own care. This also includes complete commitment to achieving the Strategic Commissioning Framework for Primary Care Transformation in London by 2018/19 in respect of accessible, co-ordinated and proactive care.

The NCL SPG has identified the following priority areas for delivering the vision:

1. We will ensure that we provide **high quality** care for all through a continued commitment to drive improvements in patient centred, clinically safe and effective care;
2. Through the way we deliver services, we will ensure care is **coordinated** around the needs of our patients;
3. We will ensure that care is delivered in a way that is **accessible** to our population, which will contribute to an improved patient experience for our patients;
4. Our practices will work in a **proactive** way to empower patients to take a greater role in their care, encouraging prevention and supporting people to receive the care they need in the community with which they live;
5. We will develop our workforce ensuring that NCL is a leader in primary care **workforce development**, ensuring we recruit the best staff and retain them securing the future of our workforce. Through commitment and investment in our staff we will develop the capacity and capability in primary care and make primary care in NCL a rewarding place to work;
6. We will work towards ensuring that our **premises** are of the highest possible quality within the resources we have, seeking out opportunities for improvement;
7. We will develop our **technology and information** systems ensuring that these are fit for purpose to support our primary care offer.

3.2 REVIEW OF NCL CO-COMMISSIONING ARRANGEMENTS

Following its establishment on 1st October 2015, the NCL Joint Committee held a workshop on 6th April 2016 in order:

- To take stock of the functioning of the NCL Primary Care Joint Committee.
- To enhance the Committee's understanding of the Strategic Primary Care work in North Central London.
- To assess whether NCL CCGs should engage on applying in October 2016 to move to Level 3 fully delegated authority for primary care commissioning and identify any additional information required to progress this.
- To review what needs to change now to improve the working of the Primary Care Joint Committee.
- To agree next steps for developing the Primary Care Joint Committee.

As a result, each CCG has agreed to explore whether it wishes to apply for fully delegated responsibility for co-commissioning of primary medical services by October 2016 to commence on 1st April 2017.

3.3 NHS ENGLAND (LONDON REGION) ORGANISATIONAL DEVELOPMENT AND DEVELOPMENT REVIEW OF THE PRIMARY CARE FUNCTION

Earlier this year, NHS England commissioned two linked pieces of work, looking at current primary care commissioning arrangements and identifying options for future arrangements. This work set out to:

- Understand the needs and expectations of key stakeholders
- Assess the strengths and challenges of the current co-commissioning operating model
- Identify and articulate the key challenges of delivering the Primary Care Commissioning function in the short and medium term in the light of the context set out above and the challenges of workforce and resource
- Provide options and make an assessment as to potential next steps both in the short- medium timescale - 2016/17 - and beyond

The NHSE Co-Commissioning Working Group will be overseeing this, although the governance is currently being worked through. Alison Blair is the SPG representative on this Working Group.

4. **CONCLUSION**

This report provides an update on Primary Care matters in Enfield.

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 11 FEBRUARY 2016

MEMBERSHIP

PRESENT Shahed Ahmad (Director of Public Health), Vivien Giladi (Voluntary Sector), Ayfer Orhan, Doug Taylor (Leader of the Council), Nneka Keazor, Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust) and Tony Theodoulou (Interim Director of Children's Services)

ABSENT Ian Davis (Director of Environment), Ray James (Director of Health, Housing and Adult Social Care), Deborah Fowler (Enfield HealthWatch), Dr Henrietta Hughes (NHS England), Alev Cazimoglu, Kim Fleming (Director of Planning, Royal Free London, NHS Foundation Trust), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust) and Paul Jenkins (Chief Officer - Enfield Clinical Commissioning Group)

OFFICERS: Jill Bayley (Principal Lawyer - Safeguarding), Sam Morris (Strategic Partnerships Officer), Christine Williams (Public Health) and Jess Khanom (Acting Head of Leisure, Facilities and Sport) Penelope Williams (Secretary)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting.

Apologies for absence were received from Councillor Cazimoglu, Paul Jenkins, Ray James, Dr Henrietta Hughes, Kim Fleming, Andrew Wright.

Apologies for lateness were received from Councillor Keazor.

Lorna Reith stood in for Deborah Fowler.

2
DECLARATION OF INTERESTS

There were no declaration of interests.

3
LEISURE AND CULTURE STRATEGY

The Board received a report from the Director of Finances, Resources and Customer Services on the Leisure and Culture Strategy.

Jess Khanom, Acting Head of Leisure, Facilities and Sport, presented the report to the Board highlighting the following:

- The Leisure and Culture Strategy, launched last July 2016, focusses on improving lives in the community though leisure and culture.

- Leisure and sport has a big impact on health and wellbeing, social development and the local economy. It can be fun and exciting and bring the community together. As well as helping to develop skills for life and work.

- The strategy is based on three key principles: engage, inspire and grow: engaging with alternative groups, making use of alternative technology methods and social media; inspire by helping to raise aspirations, challenging the community, encouraging step challenges and helping to promote community cohesion; grow by helping people to develop and build resource capacity.

- Some work is being focussed on the five priority wards by working with the community and through the training of local staff.

- Nationally the Government is due to launch Department for Culture Media and Sport strategy to encourage people to undertake more physical activity.

- The service would like to use the findings from the National Commissioning Project and the Leisure Officers Association and Sport England, exploring the strategic positioning of sport and physical activities for wider social and health outcomes, to develop a joint outcomes framework with the Health and Wellbeing Board.

- We need to find out how best to implement measures to achieve the desired health outcomes and how to work with our partners to add value to our work.

- This will also be discussed with the Health Improvement Partnership Board.

Questions/Comments on the Presentation

1. More work needed to be done when training new GPs, around the area of social prescribing, as well as encouraging exercise in the work place.

2. Primary Care would be the right place to start with these type of initiatives, but there were no resources for them or any formal referral mechanism.

3. Some funding had been made available to train up GPs in this area.

4. One challenge was finding ways to best engage with a diverse population and to reach out to the hard to reach groups.

5. A recent project had been undertaken visiting mosques during Ramadan to highlight the issue of diabetes. A similar initiative could be undertaken to promote the benefits of exercise.

6. The suggestion that consideration of where the greatest benefits would be, needs to take place in order to target limited resources effectively was made: segmenting different groups and developing targeted strategies to address specific needs.

7. Sport could be off putting for older people and younger people often give up after leaving school. Ways to encourage continued participation, needed to be developed. A health scare was often a wake-up call. School nurses had the opportunity to work with a whole family when they contacted parents about overweight children in Reception and Years 1 and 2.

8. The ambition must be that every resident will have opportunities for physical activity but resources must be provided for those with difficulties and those who are most vulnerable.

9. A universal programme should be put in place.

10. There was concern about the lack of baseline data and the inability of judging therefore, the success of any initiatives. However children were measured in reception classes and in Year 6.

11. A root cause analysis of the issues was required to find out the reasons for lack of participation in physical activity. The whole family's needs would have to be addressed. This was not easy to do and would be a long term programme, but work was progressing in the 5 target wards.

12. The Local Authority would be working with partners to stimulate demand. We needed to work out how to use local influence to encourage use of services and how to best use the resources available.

AGREED

1. To use the findings from the National Commissioning Project and work with the Chief Leisure Officers Association and Sport England to explore the strategic positioning of sport and physical activity for wider social and health outcomes.
2. To jointly develop and outcomes framework with the Health and Wellbeing Board and Health Improvement Partnership to enable a focus on key priorities.

4

FORWARD PLAN 2016/17

The Board received a report from Sam Morris, Strategic Partnership Officer, on a work programme for full board meetings and the development sessions.

He reported that:

- He had consulted all board members, writing to them and asking them to put forward items for a work programme and had received a good response.
- It was felt that the board should focus on strategic issues.
- The frequency and number of the development sessions had been considered.

NOTED the following comments from the board:

1. Some concern that too many medical and not enough prevention issues had been included.

2. The need for some prioritisation of items so that one major item and one lesser can be discussed at each session. Sam Morris agreed to look at the scheduling of items.

3. The view that a whole session on primary care would be beneficial.

4. How Enfield fits in to the North Central London and tri borough proposals is another issue for consideration.

5. It would be helpful if it could be clear on future agendas whether an item is for information or for decision.

6. Child and adult mental health should be added to the programme.

AGREED

1. To approve the forward plan for 2016/17 for formal board sessions with the amendments suggested above.

2. To approve the topics for discussion at the board development sessions in 2016.

5
SUB BOARD UPDATES

1. Health Improvement Partnership Update

The Board received an update report from Shahed Ahmad, Director of Public Health, on the Health Improvement Partnership.

NOTED

1.1 A public health sustainability fund was being considered.

1.2 The North Central London Strategic Planning Group was due to make an initial submission on its 5 year plan in March 2016 with a final application in June 2016. It was hoped that engagement would take place at an early stage and not just at the end of the process.

1.3 Public Health was collaborating with North Central London on the case for change. Gaps being addressed included health care and financial issues.

1.4 Enfield was co-leading on health care. There was a general feeling that talent was being fragmented and there was duplication in several areas.

1.5 Enfield's work on blood pressure was coming to prominence across London. Analysis shows that if London could do as well as Canada we could reduce stroke incidence by 5,000 which would save the NHS £80m over 5 years.

1.6 The problem of unregistered patients was highlighted. Shahed Ahmad would feed back to the Board on how GP registration was recorded and how this was being monitored.

1.7 A draft report on mental health had been produced and would be available shortly.

AGREED to note the contents of the report.

2. Joint Commissioning Board Update

The Board received a report from Bindi Nagra, Assistant Director Strategy and Resources, Health, Housing and Adult Social Care, updating them on the work of the Joint Commissioning Board. Christine Williams, Public Health Commissioning Manager introduced the report.

NOTED

2.1 Councillors Keazor and Brett have been working with officers to organise a conference for the Turkish community warning them on the dangers of smoking which is a particular problem for this community.

2.2 There has been a gradual long term improvement in the proportion of people with dementia with a formal diagnosis. This has improved from 45% to 68% between June 2014 and November 2015.

2.3 There is evidence that social isolation and loneliness are linked to a number of risk factors including risk to wellbeing, mental health and

vulnerability to abuse. A scheme was being piloted to address this issue.

2.4 The Quality Checkers Project were doing a piece to work to establish the quality of activities in care homes across the borough.

2.5 The increase in the proportion of people suffering from Hypertension, now estimated to be 3,000 is likely to be due to the improvement in collecting data. It is important that hypertension is recognised and assisted more than it had been in the past.

2.6 Concern was expressed about the lack of legislation surrounding the use of electric cigarettes. Current thinking indicated that most people using them were already cigarette smokers and that therefore they were less harmful that real cigarettes and helped people to give up smoking. Other people are concerned that the electronic cigarettes normalise smoking and are becoming fashionable, particularly among the young. If they were to encourage more young people to take up smoking, it would be dangerous. These concerns would be fed through to the Tobacco Control Alliance.

AGREED to note the content of the report.

Councillor Ayfer Orhan and Councillor Doug Taylor (Chair of the Board) left the meeting at this point. Mo Abedi (Vice Chair) took over the position of chair for the rest of the meeting.

3. Primary Care Update

Mo Abedi, Chair of the Enfield Clinical Commissioning Board) presented the report updating the Board on primary care matters across the borough focussing on the Enfield Patient Offer and the Quality and Outcomes Framework Achievement 2014/15.

NOTED

1. Four priority areas had been identified for implementation in respect of the patient offer: patients with atrial fibrillation, diabetes and cardio vascular disease, primary care estates, primary care work force development and optimisation and exploitation of clinical IT systems.

2. These areas had been discussed during a workshop involving 70% of GP practices.

3. Enfield scores in the Quality and Outcomes Framework had improved significantly to be listed 183 out of 206 CCGs. This was better than boroughs with similar demographics like Haringey and had been achieved with lower expenditure.

AGREED to note the report.

4. Better Care Fund Update

The Board received an update report from Bindi Nagra (Assistant Director Health, Housing and Adult Social Care and Graham MacDougal (Director of Strategy and Partnerships at the CCG).

Any questions would be forwarded to Bindi Nagra.

AGREED

1. To note the contents of the report, including the current performance metrics and activity taking place to improve performance in response to recent reviews.

2. To note that NHS England quarter three data submission was due in February 2016.

3. To note that the Better Care Fund 2016/17 policy framework has been published but the detail of the planning guidance was delayed.

4. To note that a further development session would be held on 17 February 2016 with the Integration Board. The session would inform strategic planning in relation to the Better Care Fund and the future of integration in Enfield.

5. To note that a London Better Care Fund network has been set up and led by ADASS (Association of Directors of Adult Social Services) and NHS London. The network would facilitate the sharing of good practice, address issues of concern and assist with embedding the principles of the Better Care Fund at the local level.

6
UPDATE FROM DEVELOPMENT SESSION

The Board received and noted the update from the Development Session held on 6 January 2016.

7
MINUTES OF MEETING HELD ON 10 DECEMBER 2015

The minutes of the meeting held on 10 December 2015 were received and agreed as a correct record.

It was noted that Julie Lowe had responded to the Board's letter regarding the ability for GPs to access blood pressure information from the North Middlesex University NHS Hospital Trust on line and this was now possible.

8
DATES OF FUTURE MEETINGS

NOTED the dates agreed for future board meetings as follows:

- Thursday 21 April 2016 at 6.30pm

NOTED the dates agreed for future board development sessions as follows:

- Wednesday 2 March 2016 at 2pm