**MUNICIPAL YEAR 2013/2014**

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| **MEETING TITLE AND DATE**<br>**Health and Wellbeing Board**<br>**19 September 2013** | **Part 1** \| **Item: 6**<br>**Subject:** Integrated Transformation Fund and plan<br><br>**Wards:** All |
| **Report of:** Ray James (Director of Health, Housing and Adult Social Care)<br>**Contact officer** Kate Charles<br>020 8379 2433<br>E mail: **kate.charles@enfield.gov.uk** | **Cabinet Member consulted:**<br>Councillor Donald McGowan |

## 1. EXECUTIVE SUMMARY

NHS Enfield Clinical Commissioning Group (CCG) and the Council are seeking to further develop joint integrated working arrangements. This paper summarises existing integration arrangements, describes the conditions of the Integration Transformation Fund (ITF) and provides an overview of opportunities for integration in the future.

The £3.8bn Integration Transformation Fund (ITF) will be a pooled fund, held by local authorities. It is estimated that the ITF will locally be £20.317m, which is drawn from existing local authority and CCG budgets. Conditions of the funding will be that it is pooled into a budget which will formally sit with local authorities but will be subject to plans being agreed by local Health and Wellbeing Boards (H&WBs) and signed off by CCGs and Council Leaders. Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

Health and social care integration and local accountability are not new concepts. They have been considered as options for improving local service delivery, improved patient / user satisfaction and produce better value for money . Today, rising demand for health and social care, combined with increasing scarcity of resources, is leading to renewed interest in 'integrated care' as a potential solution to a challenging economic climate and growing demographic pressures.

This paper focuses on partnership working and establishing a framework for a unified vision and plan for the future to ensure that integration is fully embedded in everything we do.

## 2. RECOMMENDATIONS

The Health & Wellbeing Board are requested to take note of the context of this report and particularly, the conditions of the ITF and requirements for a jointly agreed integration plan and agree the following actions:-

2.1. To set up an Integration Sub-group reporting directly to the HWBB (See attached draft Terms of Reference as Appendix 1).

2.2. To task the sub group with developing a jointly agreed ITF plan that is compliant with the conditions of the fund and seeks to deliver the integration agenda in the true spirit of partnership with a view to improving the customer experience, delivering better services and good value.

2.3 To provide local leadership of and positively market the integration agenda to ensure that the partnership workforce have information, guidance and support to feel empowered to deliver this ambitious agenda locally.

## 3. BACKGROUND

NHS Enfield Clinical Commissioning Group (CCG) and the Council are seeking to further develop joint integrated working arrangements. This paper summarises existing integration arrangements, describes the conditions of the Integration Transformation Fund (ITF) and provides an overview of opportunities for integration in the future.

*Integrated care is not about structures, organisations or pathways, nor about the way services are commissioned or funded. It is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes.*

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

A sound incremental approach needs to be taken to further develop integration between the Council and NHS Enfield, based on local circumstances, to developing and agreeing opportunities for integrated working and use of joint financial arrangements. Current governance structures, services and projects being delivered through integrated working initiatives are:-

- The Joint Commissioning Board (membership includes Adults and Childrens services) – *this Board essentially monitors progress of strategy implementation and projects but does not have decision making power in terms of agreeing new projects.*
- Joint Commissioning Team (Adults)

- Joint Mental Capacity Act and Deprivation of Liberty Safeguard Resource (Adults)
- Joint Safeguarding Nursing Assessor
- Independent Mental Capacity Advocacy Service (Adults)
- Integrated Community Equipment Service (ICES) (Adults)
- Drug and Alcohol Action Team (DAAT) (Adults)
- Joint Stroke Prevention and End of Life Pathway (Adults).
- Winter capacity planning
- Integrated Learning Disabilities Service (Adults)
- Mental Health Services (Adults)
- Joint Commissioning Strategies and implementation plans (Stroke, Dementia, End of Life Care, Intermediate Care/ Enablement and Autism (Adults)
- Single Point of Entry (SPOE) (Childrens)
- MASH (Multi Agency Safeguarding Hub) (Childrens)
- Change and Challenge (the local Troubled Families initiative)
- Behaviour Support Service(Childrens)
- Children's Centres provide services, over a minimum of 5 days a week, to meet the needs of families with pre school children (Childrens)
- SAFE (Service for Adolescents and Families in Enfield) (Childrens)
- Joint Service for Children with Disabilities (Childrens)
- Enfield Community Services is the 'health' part of the Joint Service and includes Carers, Nursery Nurses, Physiotherapists and Paediatric Occupational Therapists. (Childrens)

Children and Young People

The Council and NHS Enfield CCG, and now Enfield CCG, have a history of effective partnership working for children and young people. Joint priorities are set out in the third Enfield Children and Young People's Plan (2011 -2015). We aim to sharpen the focus on effective strategies to tackle child poverty, improve outcomes for vulnerable groups and ensure that all children and young people are safe, have a healthy start to life and achieve their full potential.

This approach has enabled the Council and NHS Enfield to make sound progress on developing joint arrangements in a challenging environment. Despite the achievements of the above mentioned functions and services, more could be done to ensure that Health & Social Care work together to better identify, assess, treat and support people earlier in the patient / customer pathway. With the introduction of the Integration Transformation Fund there is now an incentive to analyse existing structures, services and pathways to develop an agreed formalised plan at executive level with clear timescales on how to move forward the Integration Agenda in Enfield.

The Statutory Framework

The Section 75 partnership arrangements in the National Health Service Act 2006 (formerly Section 31 of the Health Act 1999 – Health Act Flexibilities) have been developed to give local authorities and NHS bodies the ability to respond effectively to improve services, either by joining up existing services or

developing new, coordinated services. Section 75 agreements can be agreed for one or more of the following:

**Pooled funds** - the ability for partners each to contribute agreed funds to a single pot, to be spent on agreed projects for designated services

**Lead commissioning** - the partners can agree to delegate commissioning of a service to one lead organisation

**Integrated provision** - the partners can join together their staff, resources, and management structures to integrate the provision of a service from managerial level to the front line.

**Children and Young People**

A Section 75 Partnership Agreement people was agreed in November 2012to enable the Council to take on lead responsibility for the joint commissioning of services for children and young. It enables the partnership to:

- achieve a better balance between prevention and early identification and intervention, and more specialist services;
- commission innovative and effective services; and
- develop the social infrastructure and market for integrated children's services.

Ultimately the anticipated benefits of the Agreement will include the ability to make better use of resources and deliver improved services for the local community. The Agreement is in line with national guidance which supports the further development of joint working and the integration of children's services.

- The Children's Act (2004) requires Local Authorities to take the lead in making arrangements to promote co-operation between agencies to improve the well-being of children in the authority's area, and establishes that relevant partners, including Primary Care Trusts, have a duty to co-operate with these arrangements.
- The Health White Paper "Equality and Excellence: Liberating the NHS" outlines the changes to be made to the NHS over the coming years, which include a new role for Local Authorities with regard to Public Health, and the abolition of Primary Care Trusts and the creation of Clinical Commissioning Groups and Health and Wellbeing Boards. The changes in responsibility for different elements children's health services make collaboration through Health and Wellbeing structures particularly important.

It is anticipated that the Section 75 Partnership Agreement for commissioned children's services offers the following opportunities:

- Improved commissioning that can consider the whole needs of children, young people and families
- Development of shared local priorities for service provision and the alignment of funding to deliver these
- An evidence based approach to commissioning which incorporates joint assessment of needs
- Development of a shared vision for services to deliver more cohesive and comprehensive outcomes for children young people and families
- Development of joint performance indicators, monitoring processes and key strategic information such as baselines and tracking systems
- Easier identification of gaps in provision
- Reduced bureaucracy
- Better use of resources to deliver improved value for money
- Production of joined up strategies, service specifications and care pathways for all children, young people and families service areas.
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## 4. ABOUT THE INTEGRATION TRANSFORMATION FUND:

The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". This funding is called the health and social care Integration Transformation Fund (ITF). In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

The £3.8bn Integration Transformation Fund will be a pooled fund, held by local authorities and funded from the following existing / budgets:-

| **Grant / Budget** | **National allocation** | **Estimated local allocation** | **Sub totals** |
|---|---|---|---|
| NHS Social Care Grant *(existing)* | £0.9bn | £4.725m | £4.725m |
| Additional NHS Social Care Grant | £0.2bn | £1.050m | £1.050m |
| DH and other Government Dept. transfers (inc. DFG & capital grants) | £0.4bn | £2.100m | £2.100m |

| | | | |
|---|---|---|---|
| *(existing)* | | | |
| CCG pooled funding of:<br>- Reablement funding<br>- Carers' break funding<br>- Core CCG funding<br><br>*(existing)* | - £0.3bn<br>- £0.1bn<br>- £1.9bn | £1.575m<br>£0.525m<br>£9.975m | £12.075m |
| NHS contribution to Troubled Families Programme | £70m | £0.367m | £0.367m |
| | | | **TOTAL: £20.317m** |

*Key Note: £1bn of the funding will be linked to outcomes achieved. This means that the local 'Payment for Performance' amount is: £0.525m*

All of the above will be pooled into a budget which will formally sit with local authorities but will be subject to plans being agreed by local Health and Wellbeing Boards (H&WBs) and signed off by CCGs and Council Leaders.

Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

## 4.1 National Conditions for the joint plan

A paper produced for the "London Health Chief Officers Group dated 30th of July 2013" stated the following in terms of conditions and expectations attached to the ITF plans will need as a minimum to :

- Protect social care in terms of services;
- Support the concept of 'accountable clinicians' for out of hospital care for the most vulnerable;
- Enable 7 day working;
- Take a joint approach to assessment and care planning;
- Facilitate information sharing, including use of the NHS number across health & social care;
- Take account of the implications for the acute sector of service reconfiguration;

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

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

### 4.2 Impact on local CCG allocation

The average CCG contribution to the pooled ITF locally has been estimated at 3.00% or 10.0m. This is in addition to the money received through the Carers and Reablement funding.

It is likely that funding will not come directly to the Local Authority from NHS England through S256 requirements. More likely will be given directly to CCGs but this will require a change in legislation.

The executive decisions to be taken about the prioritisation, deployment of resources and the oversight of their effectiveness, set down in the joint plan will be with the executive functions of both the Council and NHS Enfield. However, the Health & Wellbeing Board will have a duty to monitor and ensure that the joint plan is delivered within timescale.

Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

The focus of this report is to make recommendations with regards to how we approach the development of the ITF plan and to outline the vision for integration going forward.

## 5. STRATEGIC DRIVERS FOR CHANGE – "A TIME FOR FAST PACED ACTION"

Health and social care integration and local accountability are not new concepts. They have been considered as options for improving local service delivery since as far back as 1974 when community health services and social care were split between the NHS and local government. Today, rising demand for health and social care, combined with increasing scarcity of resources, is leading to renewed interest in 'integrated care' as a potential solution.

The NHS Confederation and the Association of Directors of Adult Social Services (ADASS) have developed a joint programme of work looking at the issues around the commissioning and provision of integrated health and social care services. The shared vision is for integrated care to become the norm. One of the collaboration's first actions has been a call for 'health and social care integration pioneers' to demonstrate ambitious and innovative approaches – with the support of the 13 national partners – that will deliver integrated care efficiently, then to actively promote what they've learned for wider adoption across the country.

The collaboration recognises there is no ‘blueprint’ for how localities develop plans for integration. “While elements of different models will be transferable, every locality is unique and needs to develop its own model of integration to suit the needs of local people.”

Within five years, pioneers will be expected to have tackled local cultural and organisational barriers that prevent delivery of coordinated care and support and demonstrated a range of approaches and models involving whole system transformation across different settings.

*The time seems right for true transformation, including a shift in thinking so that care is not defined by who gives it. “People everywhere are realising that integration is not just desirable but a necessity. I’m not talking about a little bit of integration … but full integration of health and care.”*

One of the catalysts for this level of integration is a population that is living longer but with more complex needs, particularly the rising numbers of people with dementia, whose care needs to cross every sort of setting.

In recent months there have been some crucial developments that support major change. In March the King’s Fund, which has been instrumental in shaping national government policy on integration, published a paper *Making integrated care happen at scale and pace*, setting out steps to “convert policy intentions into meaningful and widespread change on the ground” based on lessons learned from experience.

April saw the new NHS structure become fully operational, offering opportunities for fresh thinking in response to local needs.

National commissioning body NHS England and foundation trust regulator Monitor have statutory duties to promote and enable integrated care. Health and wellbeing boards, comprising representatives from the local community, including the NHS, public health and local authorities including social care, housing, education and the police, have statutory duties to promote and encourage the delivery and advancement of integration within their local areas at scale and pace. Through joint strategic needs assessments and joint health and wellbeing strategies, these boards have the potential to facilitate initiatives on integrating care and support to suit local circumstances.

Integration is specifically covered in the 2013-14 assurance framework for clinical commissioning groups (CCGs), which states that they should recognise the importance of their relationships with other local commissioners, including local authorities.

The national collaboration (The NHS Confederation and ADASS) is working to clarify freedoms and flexibilities in the system, and some areas are already venturing into new approaches. In Solihull the plan is to create an integrated system with the acute hospital as the hub; having just one CCG and one local authority in the area should make this more achievable. The aim is to use the same housing and care provider that already offers rehabilitation to support

people into independent living on discharge to avoid hospital admissions in the first place, with complete care packages offering a realistic alternative to inpatient beds. Solihull is moving away from rigid payment systems and local commissioners have agreed a level of financial risk to enable more investment in care pre-admission and post-discharge.

This level of shared purpose is crucial to the success of transformation, and it is no surprise that 80% of 69 directors of adult social services and senior CCG leaders who took part in a recent ADASS and the NHS Confederation 'straw poll' saw strong leadership and commitment 'from the top' as the most important factors in taking forward integration locally.

The biggest obstacles to progress were considered to be data and IT systems, payment mechanisms and financial pressures. But to go from being a bit better at integrating what we have always done to undertake real transformation also requires personal resilience, energy and perseverance especially to continue relationships in the long term and take ownership of decisions and joint arrangements made by your predecessors. To truly achieve sustainable and realistic integration, that shared purpose must extend to not just everyone within an organisation but all those who use care services.

The NHS Confederation and ADASS, to support the pioneer sites and any providers and commissioners keen to learn from what others have done or share their own experiences, the national collaboration has established the Integrated Care and Support Exchange (ICASE), resource bringing together practical expertise from national partners. This will be an invaluable resource for developing an evidence base/ reference point for implementing the integration agenda.

The Health and Social Care information Centre already exists to manage data from across care, but now there is an impetus to break down silos to link data and make sense of it, not in relation to individual organisations but as a series of personal stories.

The report of the Children and Young People's Health Outcome Forum on **the Children and Young People's Health Outcomes Strategy** also highlights the importance of effective integration. Following on from Sir Ian Kennedy's 2010 report 2010 '***Getting it right for children and young people***' which concluded that "the health system has a poor track record in relation to children and has not seen it as a central concern" the report concludes that:

*"Too many health outcomes for children and young people are poor, and for many this is involved with failures in care. Despite important improvements – for example, reductions in the number of young people smoking and of teenage pregnancies – and in some areas of specialist healthcare, more children and young people under 14 years of age are dying in this country than in other countries in northern and western Europe. There is enormous and unexplained variation in many aspects of children's healthcare, and the UK is worse than other countries in Europe for many outcomes that could be improved through*

*better healthcare and preventative interventions. This alone makes a compelling case for change."*

The report welcomes the government's commitment to strengthening integration and goes on to conclude:

*"Integration of care around the needs of children, young people and their families is absolutely fundamental to improving their health outcomes. It also reduces duplication and waste and saves significant sums of public money that can be spent on service improvement. It is particularly important for children and young people with disabilities or at risk of developing disabilities, with long term conditions, with complex needs or with mental health disorders. For example, the most effective commissioning for disabled children integrates specialist healthcare, community services like NHS therapists and local authority educational support services, special schools and children's social care services."*

A significant development which will affect the delivery of integrated services for children and young people, and onwards into adulthood, will be the enactment of The Children and Families Bill 2013, which is expected to commence in 2014. This includes a requirement for local authorities and local clinical commissioning groups to '**work in partnership and make arrangements for commissioning special educational provision, healthcare provision and social care provision for children and young people with special educational needs for whom the local authority is responsible'**, and to 'consider and agree the special education, health, and social care provision required locally and to determine what provision is to be secured and by whom, in order to meet that need'.

The ITF plan will need careful planning and consideration as it will essentially form the cornerstone of how we build upon existing arrangements, embrace change and it will set out our commitment in terms of the vision for the future for Health and Social Care services in Enfield. Types of integration models can be seen in Fig. 1 (below)

## 6. AN OVERVIEW OF THE TYPICAL TYPES OF INTEGRATION MODELS

*"Integration is a process. It's something you do in order to achieve something, not an objective in itself."*

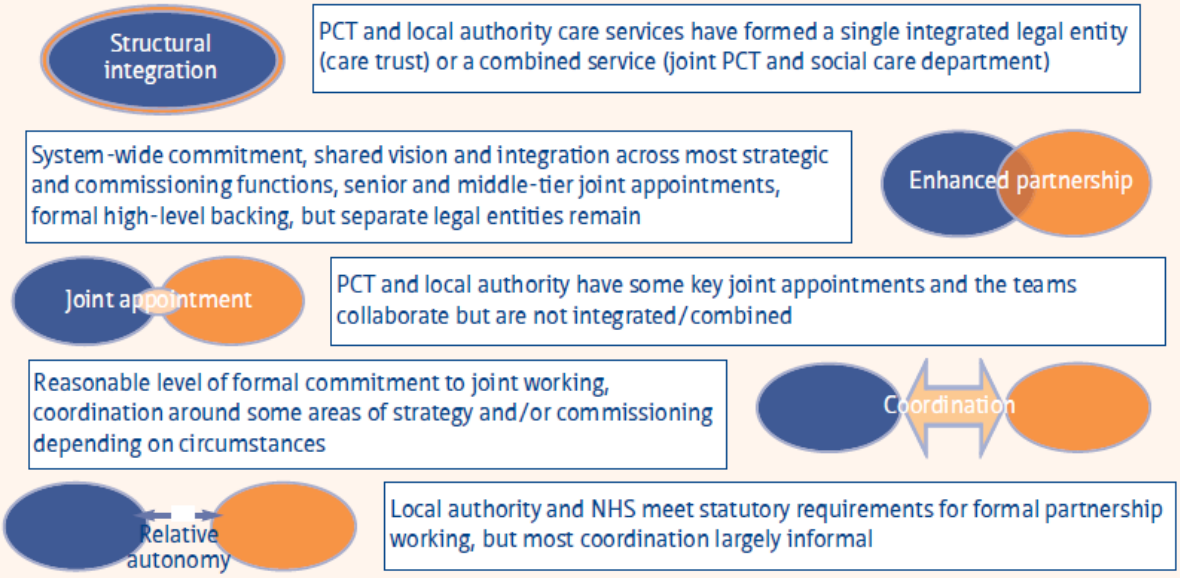
Health and social care integration covers a range of models, not a single solution. Local factors such as good relationships, commitment and joint strategy, and vision can enhance integration.

Below are a range of models being developed and applied nationally which are delivering locally integrated structural solutions. NB: this is only one part of the overall picture. Structural approaches when applied alone appear to detract from

or mean that less consideration is given to more practical based solutions such as pooled budgets, integrated teams and joint appointments.

Integration is a term open to wide variations in interpretation, from structural solutions to open book accounting across local public services. A working definition developed as part of the DH's recent survey may be useful in terms of establishing understanding of the range of models being considered (figure 1 below).

**Figure 1. Typology for degrees of health and social care integration[4]**




*Other models referred to nationally include Horizontal and Vertical integration*. A distinction can be made between horizontal and vertical integration. *Horizontal integration* occurs when two or more organisations or services delivering care at a similar level come together. Examples include mergers of acute hospitals as well as the formation of organisations such as care trusts that bring together health and social care. *Vertical integration* occurs when two or more organisations or services delivering care at different levels come together. Examples include mergers of acute hospitals and community health services, and tertiary care providers working with secondary care providers.

Both horizontal and vertical integration may be real or virtual: real integration entails mergers between organisations, whereas virtual integration takes the form of alliances, partnerships and networks created by a number of organisations. Virtual integration may occur along a continuum, ranging from formalised networks based on explicit governance arrangements at one extreme to loose alliances or federations at the other. Virtual integration is often underpinned by contracts or service agreements between organisations, as in the supply chains found in many manufacturing industries. It can therefore be seen as a form of contractual integration rather than organisational integration.

As part of the development of the ITF plan, close attention and monitoring of the ever-evolving national picture of applied and theoretical learning for integration will need to be undertaken to understand what is working well in terms of integration solutions. The ICASE system (referenced pg 6) will be invaluable resource in this context. Models will need to be evaluated and carefully considered to understand which ones may produce the best outcomes and results within our unique landscape.

The King's Fund suggests some key elements for integrated care to happen at scale and pace, include the following.

1. Find common cause with partners and be prepared to share sovereignty.
2. Develop a shared narrative to explain why integrated care matters.
3. Develop a persuasive vision to describe what integrated care will achieve.
4. Create time and space to develop understanding and new ways of working.
5. Identify services and user groups where the potential benefits from integrated care are greatest.
6. Build integrated care from the bottom up as well as the top down.
7. Pool resources to enable commissioners and integrated teams to use resources flexibly.
8. Use the workforce effectively and be open to innovations in skill mix and staff substitution.
9. Be realistic about the costs of integrated care.
10. Act on all these as part of a coherent strategy.

## 7. WHAT DO WE MEAN BY INTEGRATION – A PROPOSED SHARED DEFINITION

To enable a shared understanding of integrated care and support, nationally there is a drive to adopt a shared definition and narrative. The preferred and often referred to national definition is the one that *National Voices* have developed which places focus on the service user voice as the driving force and unifying factor behind integration. This definition is often aligned to 'Making it Real' from Think Local Act Personal (TLAP).

*The proposed shared narrative for the locality is therefore:* ***"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"***

NHS Enfield and the Council are often making reference to the above narrative in papers related to integrated working so therefore it would appear that it has already been informally adopted by staff on the ground who are delivering integration. It is therefore recommended that the localities definition / narrative is based upon the above-mentioned National Voices observation.

## 8. OPPORTUNITIES

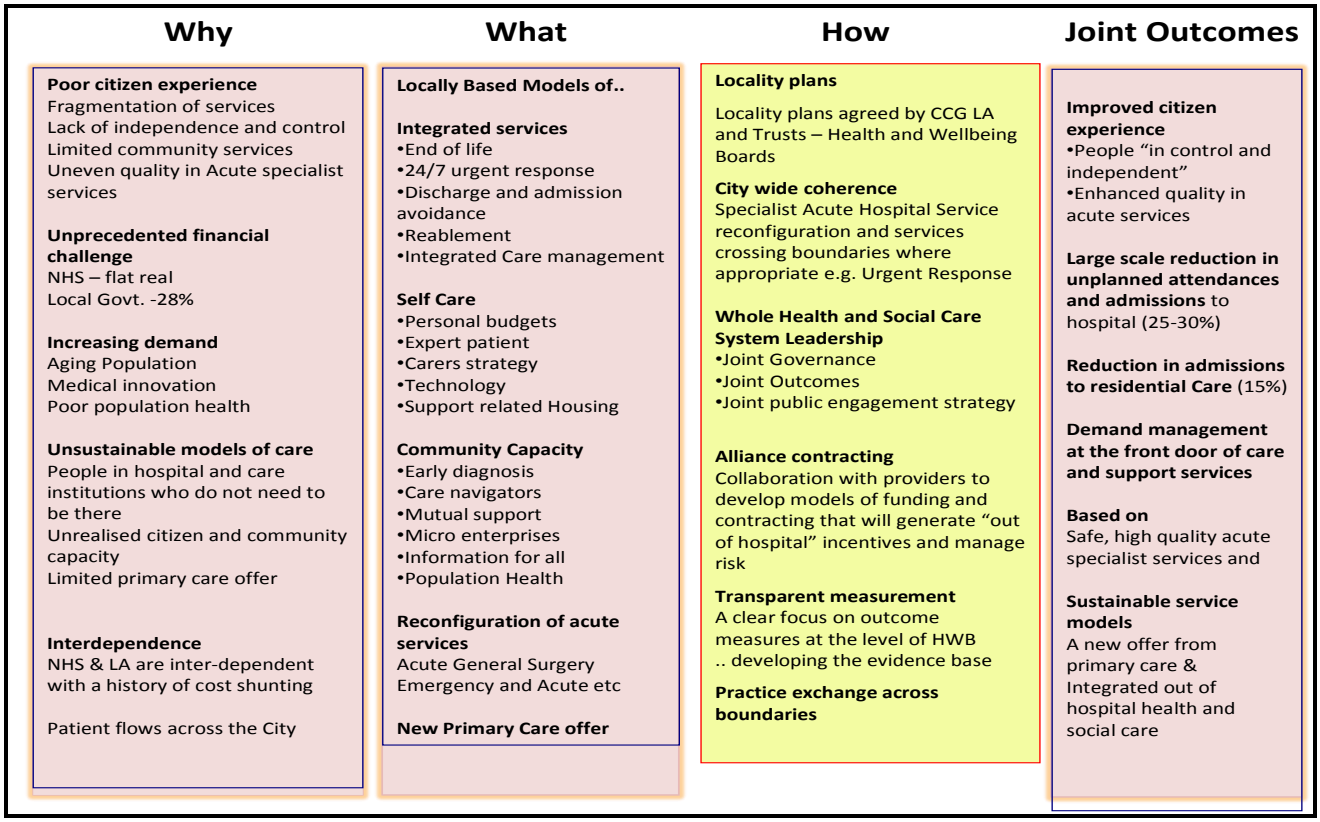
There is a clear and unifying emphasis on improving the quality of patient / customer experience as a core outcome of integration. This is underpinned by a presumption of service reconfiguration across acute, primary, secondary, tertiary and community services in terms of the customer pathway. There is a commitment to pursuing the evidence base for which models most benefit and produce results that are aligned to the preventative agenda.

There is definite scope for creative thinking and innovation as neither the national models nor the community budget sites (set up by the ADASS and the NHS Confederation) are prescribing models yet. It is often described that local commissioners across the spectrum (Health and care) will lead the local development of preferred integration models.

The following services and user groups have been identified by Enfield NHS and the Council as potential areas that integrated care maybe described as of greatest benefit:-

- Development of joint working across Enfield council services; Childrens and education and Health and Adult Social Care.
- Reconfiguration of patient / customer pathways to reduce hospital re/ admission and keep people well in their own homes with support options that are individualised and responsive to their own needs.
- Integration of wheel chair services with integration community equipment services
- Consolidation of commissioning, procurement, contracting and performance management support
- Further enhancement and development of the Transition pathways across the client groups
- Development of Older People Assessment Units at Chase Farm and North Middlesex Hospital
- Development of Assistive Technology
- Development of an integrated Falls pathway
- Opportunities for co-location of staff, meeting areas and delivery resources
- The delivery of Choice and Control through health and care personal budgets which includes market stimulation and management (NHS operating framework requires the set up personal budgets for CHC use by November 2013)
- The further exploration of pooled budget arrangements for Continuing Health Care, Section 117 and ad-hoc secondary services (i.e. Occupational Therapy assessment)
- Exploration of risk share arrangements for assessment and treatment pathways (non client group specific)
- Exploration of shared resources in terms of back office functions (i.e. Human Resources, IT and Communications, Facilities Management, Legal advice etc)

All of the above mentioned areas can and will be considered when developing the ITF plan. The below figure indicates the process of implementation from identification of priority areas to the development of joint outcomes.




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

### 5.1 Financial Implications

As part of the 2013 spending round, it was announced that £3.8bn would be placed in a pooled budget to create an Integration Transformation Fund (ITF). The Table within Section 4 above provides an estimate of Enfield's allocation.

This rough estimate is based on our current percentage allocation of the 2013/14 NHS social care grant. Information on Enfield's 2014/15 actual allocation has not been received yet

It should also be noted that as detailed in Table 4, the fund consists of both existing funds being reallocated and new funds

The actual allocation of the ITF locally will be subject to both jointly agreed local plans and in some cases locally set outcome measures, i.e. performance payments

### 6.2 Legal Implications

Section 195(1) of the Health and Social Care Act 2012 imposes a duty on Health and Wellbeing Boards *to encourage persons who arrange for the*

*provision of any health or social care services in that area to work in an integrated manner,* for the purpose of *advancing the health and wellbeing of the people in its area.*

Section 195(2) of the Health and Social Care Act 2012 states that *A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.*

Section 195 of the Health and Social Care Act 2012 has been in force since 1 April 2013.

Section 75 of the National Health Service Act 2006 has been in force since 1 March 2007.

Section 75(1) of the National Health Service Act 2006 enables the Secretary of State to make provision for enabling prescribed NHS bodies and prescribed local authorities to enter into prescribed arrangements in relation to prescribed functions of the NHS bodies and prescribed health-related functions of the local authorities, if the arrangements are likely to lead to an improvement of the way in which those functions are exercised.

Section 75(2) sets out the type of arrangements which may be prescribed.

The proposals set out in this report appear to meet the requirements of section 75 National Health Service Act 2006 and the duty to promote integrated working set out in section 195(1) of the Health and Social Care Act 2012.

**APPENDIX 1 –**

# Enfield Health and Wellbeing Board – Sub-Board: Integration Development Board

## Terms of Reference

### Purpose

- The Government have established at £3.8billion of funding to be distributed across all local authorities for social care funding, to explicitly develop an integrated care system.
- This fund is being called the Integrated Transformation Fund.
- This Sub-Board of the Health and Wellbeing Board is to meet to formulate the planning and preparation for allocating its share of the fund into developing an integrated system in Enfield until April 2014.
- Allocated funding is to come from joint NHS Funding for carer's breaks and reablement funding, with LBE funding for Disabled Facilities Grant, Adult Social Care Capital Grant and NHS Transfer due to the Health White Paper in addition to further allocation funding from the NHS
- Funding is to establish 7-day working arrangements, better data sharing joint approach to assessment and car planning, implications for the acute sector of service redesign and creating an accountable lead professionals for joint care packages

### 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 integrated health and social care system.

**2. Name**

The name of the Board will be Integration Development Sub-Board

**3. Membership**

- CCG Chief Officer
- Director of Health, Housing and Adult Social Care
- Director of Schools and Children's Services
- Enfield CCG Director of Finance
- LBE Assistant Director of Finance - Finance, Resource and Customer Service
- LBE Assistant Director of Strategy and Resources- HHASC
- CCG Head of Commissioning, Integrated and Acute Care

Additional members may be appointed to the Board by the agreement of all current members and approved by the Health and Wellbeing Board.

**NB** the support officer or their representative will be in attendance at all Sub-Board Meetings.

## 4. Responsibilities

The Integration Development Sub-Board will ensure:

Development of a time table for funding and work to be completed
Produce a plan by the end of 2013 for allocation of funding for 2014/15
Ensure the plan is formally agreed by April 2014 for financial years 2014/15 and 2015/16
Sign-off arrangements are in place with the Enfield Health and Wellbeing Board
Integration plans are to include a minimum of:

- Protect social care in terms of services
- Support the concept of an accountable clinician for out of hospital care for the most vulnerable
- Enable 7 days working
- Take a joint approach to assessment and care planning
- Facilitate information sharing, including the use of NHS number across health and social care
- Take account of the implication for the acute sector of service reconfiguration
- Set out arrangements for redeployment of funding held back in the event of outcomes not being delivered

## 5. Proposals for Sub-Boards and Work Programmes:

The Integration Sub-Board of the Health and Wellbeing 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 Sub-Board will develop its fixed term work plan and bring it to the Health and Wellbeing Board for formal approval

## 6. Chairing and Voting

The Chair will be a joint appointment between CCG Chief officer and LBE Director for Health, Housing and Adult Social Care

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

## 7. Frequency of Meetings

The Integration Sub-Board is a fixed term development board as to function on behalf of the Enfield Health and Wellbeing until the approval of an integration plan for 2014/16 is established by April 2014

**Appendix 1 to the Terms of Reference**

# Structure Chart 2013/14 Enfield Health and Wellbeing Board including proposed sub boards