MUNICIPAL YEAR 2013/2014

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

1. EXECUTIVE SUMMARY

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

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

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

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

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

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

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

2. RECOMMENDATIONS

The Health and Wellbeing Board are asked:

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

3. BACKGROUND

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

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

for people that are focussed on preventative action. This builds on existing arrangements between health & care.

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

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

4. GOVERNANCE AND PERFOMANCE MANAGEMENT GOING FORWARD:

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

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

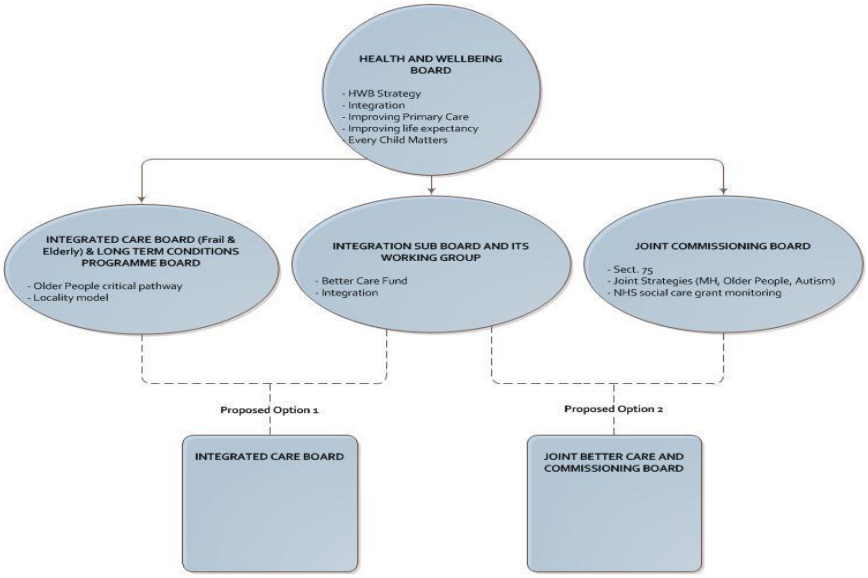
Option 1: a new Integrated Care Board is established as a Sub Board of the Health and Wellbeing Board to take forward the BCF plan and design a blue print of what fully Integrated Services will be like across health and social care in Enfield. The new Board will replace the Integration Sub Board and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

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

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

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

Option 1 and Option 2 – illustration of consolidation



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

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

5. OUTLINE PROGRAMME APPROACH

Our BCF plan takes a life course approach to implementing the integration agenda locally. By targeting key areas and stages of the life course pathway (i.e. childhood, adults of working age, promotion of health and wellbeing and older age) and by providing the "right intervention at the right time" in a personalised and proactive way, we will enable the population of Enfield to lead healthy lives that they are more in control of. Our BCF plan has been separated into 4 innovative programmes of transformational change that are focussed on prevention, early identification, community intervention, hospital avoidance, reablement/ recovery and independence; throughout the life course(Childhood to End of Life Care). These are :-

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

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

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

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

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

6. ALTERNATIVE OPTIONS CONSIDERED

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

7. REASONS FOR RECOMMENDATIONS

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

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

8.1 Financial Implications

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

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

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

It should also be noted that the fund consists of both existing resources being reallocated to the pool and additional NHS Social care grant funds.

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

9.2 Legal Implications

9.2.1 Under section 195(1) of the Health and Social Care Act 2012, there is a duty on a Health and Wellbeing Board to 'encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner', for the purpose of 'advancing the health and wellbeing of the people in its area'.

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

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

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

9. KEY RISKS

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

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

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

10. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

10.1 Healthy Start – Improving Child Health

The main thrust of the BCF is to integrate health and care further which will have a positive impact on the whole health and care economy in Enfield.

10.2 Narrowing the Gap – reducing health inequalities

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

10.3 Healthy Lifestyles/healthy choices

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

10.4 Healthy Places

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

10.5 Strengthening partnerships and capacity

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

11. EQUALITIES IMPACT IMPLICATIONS

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

12. PERFORMANCE MANAGEMENT IMPLICATIONS

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

ANNEX 1 – OUR JOINT STRATEGIC BETTER CARE FUND PLAN

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

Our approach to Better Care Planning

The London Borough of Enfield and Enfield CCG's Better Care Plan (BCP) is based on accelerating our progress to deliver the priorities and outcomes agreed by our Health and Wellbeing Board. This document has been prepared in partnership by NHS Enfield Clinical Commissioning Group and Enfield Council, which includes Public Health.

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

The population groups are:

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

We have agreed a common pathway approach across all of our population groups – which spans the full range of our ambition from prevention and early intervention right through to integrated pathways and support for people at home. Our pathway is backed up by the locality structure we have already developed with our Health and Wellbeing

Board, providers and partners in response to the priorities they have helped us to shape. In doing so, we will address multiple issues, including accelerating our existing programme for integrating care for older people, investing in safeguarding and quality, supporting carers, maximising the contribution of the third sector and building our infrastructure to support more integrated ways of working.

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

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

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

Our plan is being underpinned by a shared action plan for delivering on the programmes of work we have identified and our benefit modelling so that we can ensure that the schemes of work deliver what is required. Our benefit modelling is based on a combination of managing increasing demographic demand, meeting productivity and efficiency savings, managing the number of people requiring services through early intervention and prevention, improving the impact of services by redesigning and respecifying them and driving through process savings in our current services and contracts.

It will also be clear about the governance and plans we are putting into place to ensure that as we disinvest from secondary care provision into more preventative primary care and community provision, we are clear about the impact and potential for destabilising secondary health care provision.

Our strong governance and accountability arrangements and the performance framework we have agreed will guide our appreciation of the progress we are making across the programmes and allow us to make adjustments as these are required.

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Enfield**
Clinical Commissioning Groups	**Enfield Clinical Commissioning Group**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**20 March 2014**
Date submitted:	**04 April 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£20.586m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£20.586m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Enfield Clinical Commissioning Group
By	Alpesh Patel
Position	Chair
Date	03 April 2014

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

Signed on behalf of the Health and Wellbeing Board	Enfield Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Donald McGowan
Date	02 April 2014

c) Service provider engagement

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

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

As part of our development of integrated care over the past two years, we have held regular provider forums across commissions and client groups. Open days, including the CCG's Provider Day, bring together providers to discuss emerging trends in our population, as well as strategic and financial issues and commissioning intentions. In addition, regular operational meetings are held with all providers to ensure that all providers are inputting into the development of the integrated care model within Enfield. Providers, together with commissioners, have developed and implemented the MDT model of Older People's Assessment Unit and are currently working together to develop a locality based integrated health and social care teams. Enfield CCG and London Borough of Enfield are jointly re-commissioning community services along adult and children populations which include older people with complex needs and working age adults with Long Term Conditions. The same is true in adult social care, where large events bring together providers from across the borough, alongside more specific client

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

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

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

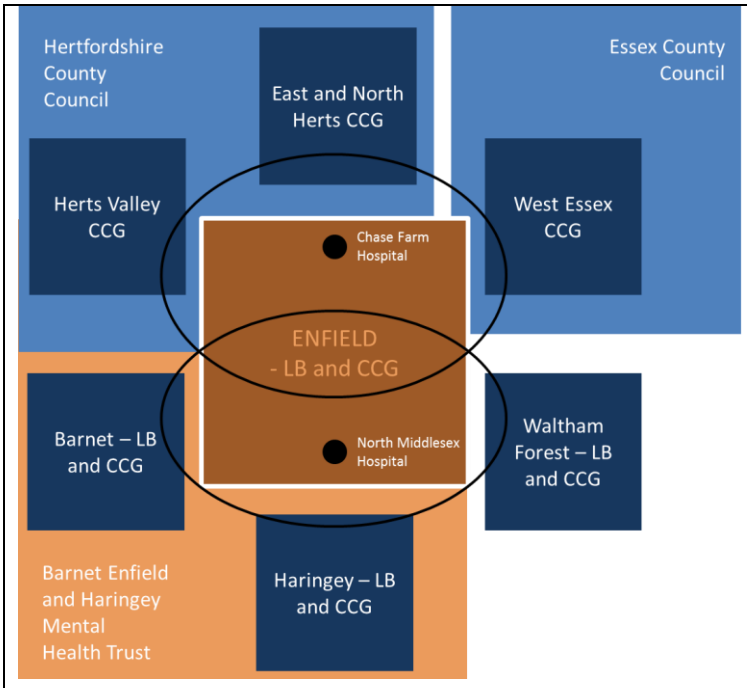
In addition to this provider engagement, because of the cross-CCG implications arising from the BCF we are working actively with our neighbouring CCGs, specifically those CCGs acting as lead commissioners for our two main acute providers.

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

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

The geography of service provision around Enfield

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



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

d) Patient, service user and public engagement

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

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

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

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

This long-standing public engagement means that our plan to integrate health and social

care in Enfield is based on what we know about local needs, what local people have already told us is important to them, and what they think about our refreshed priorities in the JHWS.

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

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

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

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

e) Related documentation

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

Document or information title	Synopsis and links
Enfield JSNA	Setting out our changing demographic pressures and arranged according to a series of themes, in order to make it accessible. www.enfield.gov.uk/healthandwellbeing/info/3/joint_strategic_needs_assessment_jsna
Enfield JHWS (for link to consultation survey)	Setting out our agreed priorities for the area. www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy
Enfield CCG – Plan on a Page	Providing the basis for our strategic planning and work with neighbouring CCGs. www.enfieldccg.nhs.uk/Downloads/Policies/ECCG%20Plan%20FINAL%204%20280313.pdf

North Central London Primary Care Strategy	Setting out the acute commissioning landscape and changes agreed across Boroughs. www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf
Enfield's Joint Commissioning Strategy for End of Life Care 2012-16	Our priorities and plans for this important group. www.enfield.gov.uk/downloads/file/8457/enfields_joint_commissioning_strategy_for_end_of_life_care_2012-16
Enfield's Joint Stroke Strategy, 2011-2016	Explaining our priorities in this condition-specific area. www.enfield.gov.uk/downloads/download/2627/enfield_joint_stroke_strategy_2011-16
Enfield's Joint Dementia Strategy, 2011-2016	Setting out our initial plans for dementia sufferers in the Borough. http://www.enfield.gov.uk/downloads/download/1317/joint_dementia_strategy_2011__2016
Enfield's Joint Carers Strategy, 2013-2016	Explaining our joint plans for carers, working across health and social care. www.enfield.gov.uk/downloads/download/2429/enfield_joint_carers_strategy_2013-2016
Enfield's Joint Intermediate Care and Reablement Strategy, 2011-2014	This important strategy sets out our approach to increasing the numbers of people supported through our intermediate care work as well as continually improving outcomes as a result of our interventions. www.enfield.gov.uk/downloads/download/1319/joint_intermediate_care_and_re-ablement_strategy_2011-2014
Adult Social Care - Voluntary and Community Sector Strategic Commissioning Framework 2013-2016	This document has been shaped by our partners in the voluntary and community sector and explains our plans for supporting them to meet need in the community. www.enfield.gov.uk/downloads/file/8459/voluntary_and_community_sector_strategic_commissioning_framework_2013-2016

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

OUR VISION FOR HEALTH AND CARE IN ENFIELD

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

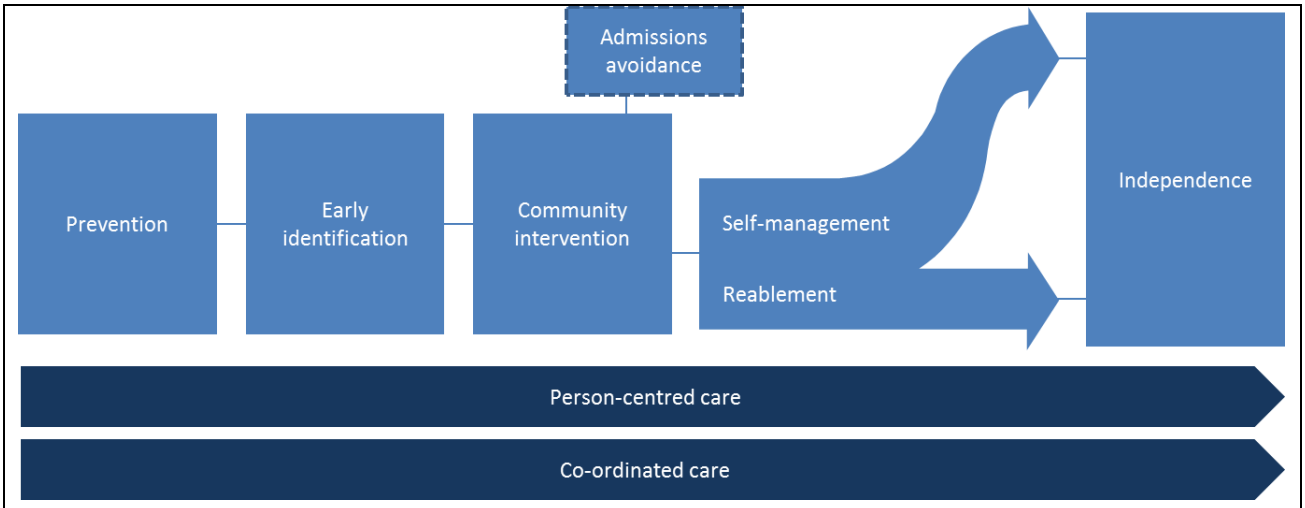
Our Health and Wellbeing Strategy, which has been refreshed alongside the development of this plan, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

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

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

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

Our agreed model is shown in the following diagram:



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

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

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

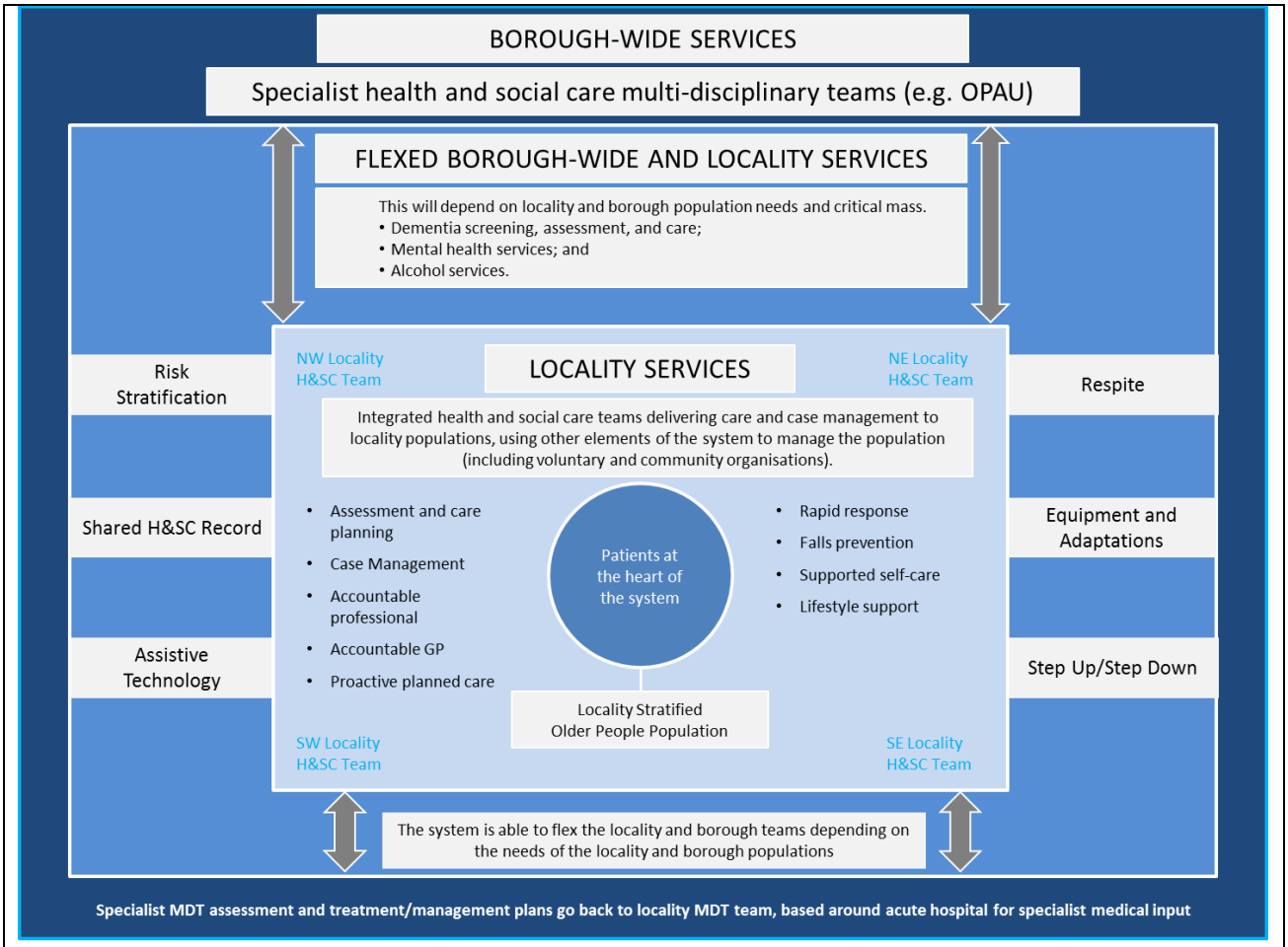
The four population groups are:

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

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

Our agreed locality model across our population groups

The locality model is depicted in the following diagram:



Enfield CCG and LBE have been working with all our providers over the past year to develop our model of integrated care for older/ people.

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

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

- A known, accessible single access point
- The GP at the heart of the process as Lead Accountable Professional
- MDT professionals to jointly identify, triage, assess, care plan & case manage patients through a case coordinator;
- Interface with other relevant professionals as part of the specialist functions;
- Interface with a locality based voluntary sector hub with a focus on prevention, reablement and improved quality of life;
- Interface and connectedness with the wider integrated care model and solutions;
- Where needed, extended (7-day) working in the wider context of such working in integrated care.

Deliverables:

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

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

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

The programme has 3 phases:

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

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

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

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

The locality model diagram on page 26 aims to show the model of care for older people but can be applied across populations. The model shows that patients and service users are placed at the heart of the integrated health and social care system. They will interact with this system on three levels, working outwards from the middle of the diagram:

- Through services provided only through the localities, such as assessment and care planning, case management and working with their accountable professional.
- Through services provided either through the localities or borough-wide – the system will be able to flex its locality and borough teams depending on the needs of the locality and the borough population.
- With services provided borough-wide, such as the Older Person's Assessment Units and

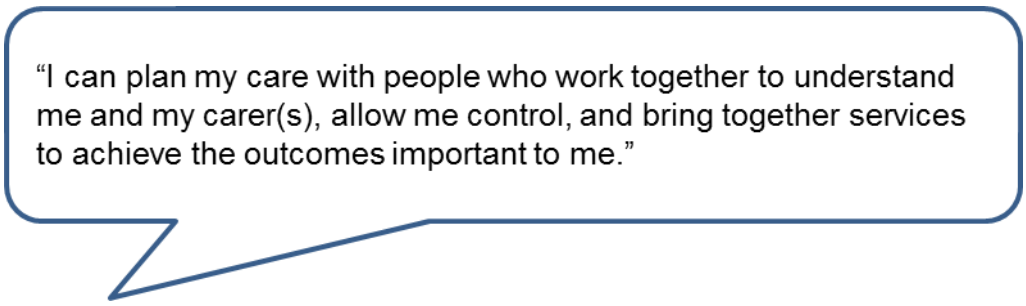
specialist MDTs, recognising the interventions that specialists may need to make.

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

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

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

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



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

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

Together, the CCG and Council have identified four programmes based on our population groups that, with funding from our BCF, will drive forward our integration agenda through our locality model. These are listed below. They have been discussed and agreed at the Health and Wellbeing Board and reflect discussions we have had with our providers: both will continue to be involved in ongoing discussions about prioritisation and timeframes as we work up our final submission. This will take place in addition to the governance arrangements detailed below. The tables in the following two sections detail the aims and objectives of each programme and describe our planned changes in each area.

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

No.	Our population based programme in..	Enabling us to..
1.	**Older people – focussed on those experiencing frailty and/or disability**	Accelerate the work of our established Integrated Care for Older People programme, with rapid assessment through our Older People's Assessment Units (OPAUs), and more integrated support at every stage of the care pathway
2.	**Working age adults – focussed on those with long term conditions**	Provide enhanced, integrated interventions in acute and primary care settings to avoid the need for work in outpatients
3.	**Adults experiencing mental health issues**	Expand our rapid intervention model for older people experiencing dementia and expanding our mental health care model
4.	**Children with health needs**	Enhance our health and wellbeing networks and provide better early intervention in psychosis and better post-transition support to vulnerable young adults.

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

Our implementation of this new system will also successfully manage demand for unscheduled care, which is a major expense within our local economy. It will do this as a result of the identification of need, with necessary interventions, before a person enters a crisis. This, in turn, provides a whole-system efficiency across health and social care and further assists both the CCG and the Council as we continue to shift the balance of resources from high-cost secondary treatment and long-term care to a focus on the promotion of living healthy lives and a picture of continually improving wellbeing.

b) Aims and objectives

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

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

A number of core aims and objectives underpin our vision for integrated care in Enfield and drive the

four programmes covered by our BCF plan. The aims and objectives underpinning our vision are:

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

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

We expect to see as a result:

- Increased volumes through MDTs and assessment units for older people, adults and children
- more self-management of long term conditions through increased use of telehealth/telecare
- reductions in unplanned admissions to hospital and fewer discharges delayed
- increased volumes through enablement/intermediate care services
- increased volumes dealt with in a planned way through what was traditionally considered to be out of hours services (so evenings and weekends)
- reductions in residential placements and increased use of step down provision
- improved management of long term conditions like hypertension and diabetes resulting in decreasing volumes of people categorised as high or very high risk of hospitalisation through our Risk Stratification tool.
- Improved diagnosis of dementia with more low level preventative provision versus high level support and improved quality of life
- Reduced length of hospital stay and readmission rates for people with mental ill health
- Increased numbers of people with mental ill health accessing community services, including IAPT
- Increased number of people receiving effective alcohol and drug treatment resulting in fewer alcohol and drug related hospital admissions and a reduction in drug related crime
- Longer term, increased levels of activity and reductions in obesity in children and adults

- Increasing numbers of carers supported through information, advice and services
- The creation of an integrated record across health and social care to better support assessment and case management within co-located or virtual MDTs

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

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

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

	Older people – focussed on those experiencing frailty and/or disability (continued)	planning and management of care, which will help them better self-manage their conditions and circumstances. For example, there is evidence nationally that assistive technology initiatives produce a health gain in terms of reduced health interventions, such as admissions to hospital. Four key parts of this approach – which span all of our population groups but are particularly important in this one – are: 1. **Our approach to safeguarding and quality in everything we and our providers do.** A core objective underpinning all of our health and social care services is that they deliver quality outcomes and safeguard the health, safety and wellbeing of the most vulnerable members of our community. We aim to deliver this by boosting various elements of our safeguarding capacity as well as through our Quality Checker Volunteering Programme, which provides key community intelligence and engagement. 2. **Improving our approach to the way we support carers.** Across all of our patient and service user groups, a major issue is the health and wellbeing of carers – the 30,000 carers who save our local economy the equivalent of £572.7m per annum by delivering unpaid care. There is a particular need for improved support for carers and, most importantly, respite breaks. By providing increased support to carers, we aim to see improved health and wellbeing outcomes for patients and recipients of care, improved health and wellbeing outcomes for carers (who suffer a disproportionally high level of ill health) and reductions in unwanted admissions, readmissions, delayed discharges in hospital settings, unwanted residential care admissions and lengthier periods of stay in settings. 3. **Working more closely with our Voluntary and Community sector partners.** Our Joint Strategic Framework, which was developed in collaboration with stakeholders from this sector, makes clear our aim to work in partnership with voluntary and community sector organisations. The objective of this is to complement statutory provision and enhance the range of quality services and supports that are available to meet community care needs. We see the BCF as an opportunity to accelerate our work in this area and, in particular, our aim to develop voluntary and community services that support existing work to delay and, where possible, to prevent hospital admissions and requirements for social care services. Incorporating these organisations more deeply into our ongoing work in this area will increase the capacity, capability and flexibility with which we can achieve this. 4. **Investing in our infrastructure to support integrated care.** We recognise that this is a key challenge and that changes will not be introduced without us doing more on the business	

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

3.	**Adults experiencing mental health issues** **Adults experiencing mental health issues – continued**	We are currently consulting our shared vision and joint commissioning strategy for adults requiring mental health treatment and support: in addition to the need we are experiencing in this area, the BCF provides another enabler for us to do this. Our shared vision is a focus on the quality of and access to integrated services, recovery and outcomes, delivered through effective partnerships. Through this programme we aim to: • Support patients and service users to find meaningful occupation or employment, maintain their income and develop meaningful relationships. • Increase the community presence of our services for adults with mental health problems. • Reduce the stigma and discrimination associated with mental health conditions, by, for example, increasingly working with our voluntary and community sector partners. • To tackle current challenges in local mental health services by putting patients and service users at the heart of the services they receive – this objective will be achieved by prioritising the outcomes that patients and service users have told us they value. • Support carers in providing effective care and maintaining their own health and wellbeing. Our work on value based commissioning with CCGs across North Central London has shown that the outcomes prioritised by patients and service users include: • Coping with adversity. • The ability to take care. • Psycho-education. • Timely and responsive services. • Continuity of care. • Autonomy. • Physical health. Our mental health programme will deliver these and relevant patient outcomes through effective incentivisation of our providers delivering services.	
4.	**Children with health needs**	The core objective of our broader programme of work for children with health needs is to deliver high-quality and integrated paediatric care with more community-based care options, designed to improve the experience and outcomes of children who are ill. Our aims cover five main headings: 1. **Heath improvement**: There are a number of multi-agency plans in place aimed at reducing infant mortality, obesity, and teenage pregnancy and increasing immunisation uptake and early	

	Children with health needs – continued	access to maternity services. These reflect our commissioning priorities for 2013/18. 2. **Early identification and intervention and building resilience**: Our aim is to ensure that services are better co-ordinated by using a 'team around the child' approach. Core services will be evidence-based and available to all. Through the Building Resilience strategy, priority is given to prevention and early intervention, with greater targeting and concentration of resources towards those children and families who are most vulnerable and most at risk. 3. **Primary Care:** We aim for an integrated provider or an integrated network of providers to support providing primary care practitioners with the opportunity to maintain the skills and competencies required in the assessment of acutely or critically ill children. 4. **Community-based specialist child health services**: We aim that specialist community health services provide as much care as possible in the child or young person's home, children's centres, schools and special schools, with specialist assessment and treatment centres available when required. 5. **Hospital provision**: We are reviewing the role of the district hospital on an ongoing basis with the objective that hospital-based services will increasingly be for specialist and tertiary services only. Another key objective for children and young people is that fewer people aged under 19 will be admitted to hospital for conditions such as asthma, diabetes, epilepsy and lower respiratory tract infections, as a result of better care in primary and community services.	

c) Description of planned changes

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

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

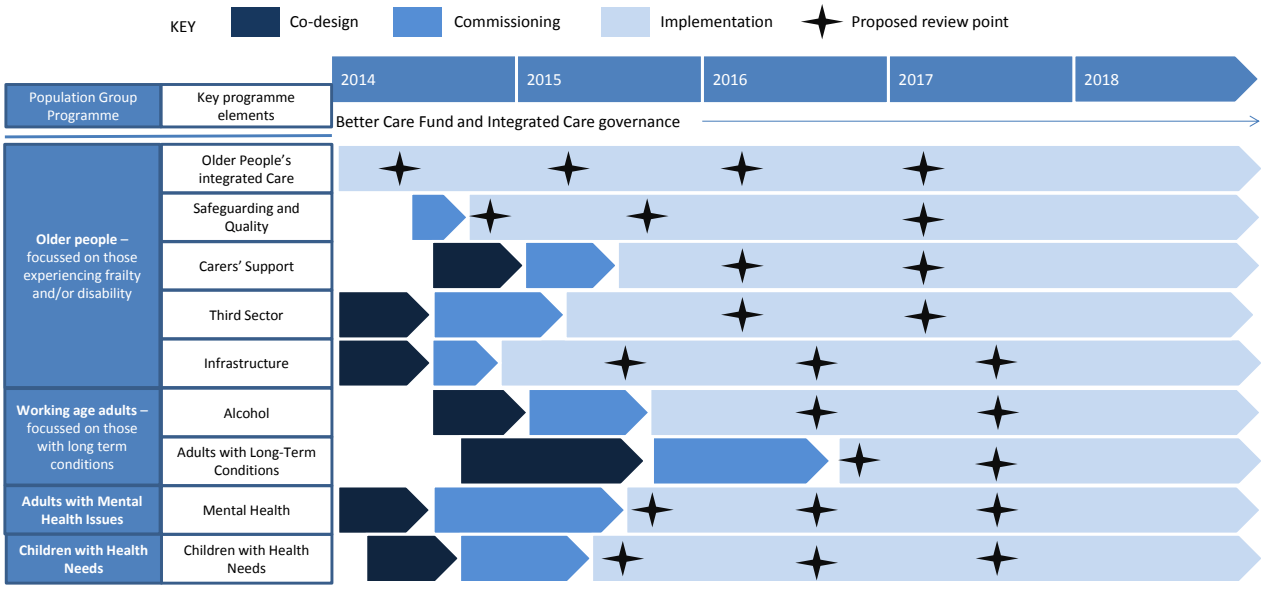
We will deploy our established partnership governance structures and processes, which cover all aspects of the commissioning cycle from the JSNA to individual commissioning plans and delivery networks, to ensure delivery of our integrated care programme in accordance with the key success factors set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

By bringing together the CCG and Council, along with other partners and stakeholders where

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

How we will deliver our BCF programmes

The diagram below shows at a high level how we will implement the four programmes we have identified in this BCF plan. We have not attempted to show the work we have undertaken so far in all of these areas but rather how we will phase our work and activity following the completion of this BCF plan. It should be noted that the programmes are at different levels of development and implementation with the programme for older people being further advanced than others with implementation proceeding at a rapid pace.



Some of the important factors to note include the following:

- We have set deliberately ambitious timeframes for delivery but tried to focus our early work on where our benefits modelling and the available evidence and research tell us we should have most impact on quality and budgets most quickly. Our work on the older people's integrated care programme is already in train and beginning to deliver results. As the diagram below shows, following agreement to this plan we will instigate a review of this programme to identify what is working and what isn't, and where we can take action to accelerate improved outcomes more quickly.
- We have built in regular review points, and our reviews will be tied into our governance of the BCF. As the diagram shows, we have identified review points which allow us to take stock of progress so far, take place at the beginning of major commissioning activity and happen at least annually thereafter. We have also factored into our thinking national events, including the development of the CQC's inspection framework for adult social care and developments in their role which will come forward in the Health and Social Care Bill and associated regulations. We understand that this will have an impact on our work in safeguarding and quality, for example, as national and local responsibilities are defined in more detail in adult social care in particular.
- We are conscious of the timescales for the delivery of this work and the performance

improvements we need to see in 2015/16 in particular, but we are also mindful that some of this work – particularly changing our whole approach to elderly care – is going to take us the full 5 years specified by this plan to fully embed. We see the delivery of our vision and aims as a continuous and iterative process, with adjustments being made on a regular basis. This means that the timeframes for delivery are ambitious and we have not specified end points for our work in the diagram below.

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

Description of planned changes

We believe that success will be more likely if we are clear up front about what we are looking to do and when. The development of this plan has enabled us to be quite clear about what we expect to see in each of the four areas we have highlighted.

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

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

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

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

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

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

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

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being

realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

We are and remain committed to working through the implications for our acute sector partners and plan to continue to do this with them as far as we can. We shared our initial understanding of the plans in early February as part of preparing this plan and have agreed to do more of this in future. The savings required to deliver the Better Care Fund will come significantly from our two acute main providers, which are North Middlesex Hospital and Barnet and Chase Farm Hospital. Enfield CCG's investment in the two organisations for 2014/15, and post BEH Clinical Strategy, is currently c£91m and c£54m-56m respectively (contracts are still being negotiated and finals investments will be agreed shortly). It is unlikely that any savings can be delivered via our community or mental health contracts, although we are looking at how we achieve greater productivity through both those contracts. Both NMUH and BCF will be affected by other borough's commissioners and we are currently working across the five CCGs of North Central London to understand the total impact on our acute providers.

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

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

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

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

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

d) Governance

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

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

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

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

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

NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

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

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

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

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

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

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

Enfield has CQC-recognised leading practice in identifying and responding to concerns about the quality of care in local providers. We have seen a significant rise (38%) in

safeguarding investigations during 2013/14, with a particular focus on nursing homes. This impacts system capacity both through the potential for increased hospital admissions and a reduction in nursing home capacity to support discharges where restrictions on new care home admissions follow confirmation of safeguarding concerns.

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

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

b) 7 day services to support discharge

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

The development of the integrated care model includes a commitment to extended working in all services, with the aim to coordinate seven-day working for all relevant agencies across the pathway where it makes sense to do so, in particular to avoid hospitalisation and facilitate hospital discharge. In fact, extended working arrangements were put in place as part of winter planning across the health economy in 2013/14. Such schemes were designed to be integrated care pilots in Enfield as it was important to test the use, effectiveness and impact of extended working in this environment including:

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

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

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

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

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

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

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

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

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

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

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

c) Data sharing

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

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

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

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

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

Please see the previous box.

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

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

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

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

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

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

d) Joint assessment and accountable lead professional

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

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

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

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

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

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

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

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

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

2) RISKS

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

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
Information sharing arrangements to provide accurate/timely information is not robust resulting in low referral rates to MDTs and OPAUs	High amber	3	4	12	• Information Sharing protocols in place • NHS No used as common identifier across all parties • Risk Stratification project in train	• Access to Case finding tool to be provided to OPAUs • Performance Framework to be agreed and implemented to monitor outcomes • Contract with existing provider of RS tool for 2/3 year period with ongoing development work of further case-finding tools
Failure to manage increasing demand for services through prevention/com	Red	3	5	15	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions	• Development of the BCF plan across partnerships with shared priorities

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
munity services					• OPAUs & MDTs established to do preventative work • Business plans & Strategies across joint areas agreed or in process with a greater focus on early intervention and support in the community	
Need to deliver savings drives disinvestment & creates viability & sustainability issues for providers	High Amber	3	4	12	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of Savings Plans on providers • Impact of plans on quality of service delivery monitored	• Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered
Challenging financial climate and the level of CCG contribution, including the new Care Bill allocation, places additional risk on CCG funding of acute sector provision with risk of destabilisation increased	High Amber	3	4	12	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions that produce efficiencies and improve productivity in all parts of the system	• Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered
Failure to agree strategic redirection of resources to meet the objectives within the BCF plan with resultant impact on commissioning decisions, investment decisions across health & social care	High Amber	3	5	15	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan	• Further development of integrated service delivery projects with robust evidence base to measure success

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
Community/ primary service capacity and quality insufficient resulting in increased demand for crisis services (residential/hospital services)	High Amber	3	5	15	As above	As above
Change risks						
Transition hiatus between existing and new model of services leads to risks related to quality and safety	High amber	3	5	15	• The development of the BCF and strategic plan have been used as a key means to forward plan in detail • Accountability to H&WB board as well as internal governance boards	• A robust performance and quality outcomes framework needs to be developed to monitor outputs and quality of outcomes
Moving effectively from a focus on "services" to a focus on the "whole system"	High amber	3	5	15	• Work on jointly developed commissioning priorities and value based commissioning supports this • Accountability to H&WB board as well as internal governance boards	• A performance framework which captures a more holistic view of people's journey through the care and support systems • A programme of culture shift to support education and change in practice across all partners
The scale and pace of the change required with risk of increase in number of SUIs and safeguarding referrals across the partnership	High amber	3	5	15	• Review of quality and Safeguarding arrangements in place to respond to and learn from any issues that arise • Accountability to H&WB board as well as internal governance boards • Review of existing resource capacity to deal with SUIs and Safeguarding referrals	• Development of a Multi Agency Safeguarding Hub (MASH) to deliver a more joined up approach to safeguarding and SUIs
Organisational risks						
Staff within partnership organisations do not receive	High amber	3	5	15	• Workforce strategies across partners need to take into account change requirements	• High level strategic intentions need to translate into practical system,

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

APPENDIX 1 –TERMS OF REFERENCE AND MEMBERSHIP

Integrated Care Board

TERMS OF REFERENCE
(DRAFT)

Integrated Care Board

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

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

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

Membership

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

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

Reporting

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

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

Chair and voting

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

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

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

APPENDIX 2 –Draft TERMS OF REFERENCE AND MEMBERSHIP

Joint Better Care and Commissioning Board

TERMS OF REFERENCE
(DRAFT)

Purpose

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

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

The Joint Better Care and Commissioning Board will:

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

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

  Examples might include:

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

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

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

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

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

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

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

Structure and Membership

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

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

Membership:

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

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

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

Chair and voting

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

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

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

Clinical Governance

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

Operation

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

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

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

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

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

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