MUNICIPAL YEAR 2014/15

MEETING TITLE AND DATE Health and Wellbeing Board 16th October 2014	**Agenda - Part: 1**	**Item: 4**
	Subject: Better Care Fund Plan Submission Update and Governance Arrangements **Wards:** all	
Chief Officer, Enfield CCG and Director of Health, Housing and Adult Social Care Contact officer and telephone number: Bindi Nagra E mail: bindi.nagra@enfield.gov.uk	**Consulted:** Cllr Don McGowan	

1. EXECUTIVE SUMMARY

The Better Care Fund (BCF) 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 April 15/16. Councils and their CCG partners are asked to develop a joint plan that explains how each area will enhance the integration of Health and Social Care locally in order to access the fund. It also stipulates 'payment by performance' metrics in the reduction of emergency care episodes by 3.5% annually.

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. A new submission was submitted on September 19th 2014 with the agreement of the Chair of the Health and Wellbeing Board, the Chair of the Clinical Commissioning Group (CCG) and the Leader of the Council.

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 submission of the Joint Better Care Fund plan. The Health and Wellbeing Board now need to consider the governance structure going forward for the performance management and implementation of the joint BCF 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 two options for new governance arrangements and it is recommended that the Health & Wellbeing Board consider the options below and agree the governance structure for the Better Care fund set out in this paper.

OPTION 1- a new **Integration Board** is established as a Sub Board of the Health and Wellbeing Board to take forward the BCF plan and design a blueprint 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 Clinical Lead and Long Term Conditions Programme 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

The Chosen Option will be supplemented and aided in decision making by the implementation of a **Professional Reference Group.**

2. RECOMMENDATIONS

The Health and Wellbeing Board are asked:

i. To note that the Joint Better Care Fund Plan was submitted by the 19 September 2014 as detailed in Annex 1, having been approved on behalf of the Board by the Chair under delegated authority." The contents of the plan are included in Annex 1; and
ii. Consider and approve a Preferred Option for the governance structures put forward in this report
iii. Agree the membership and Terms of Reference for the Options (Annexes 2 3 and 4); and
iv. Agree to the deletion of the appropriate groups upon selection of the preferred Governance option
v. To continue to receive regular progress updates

3. BACKGROUND

3.1 This report sets out proposed options for a 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. The new governance is also designed to reinforce the renewed emphasis on partnership working with local providers, that was expanded with the most recent BCF submission.

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 (3.5% reduction in emergency care within the September 19th submission although ambition for the medium to longer term is much greater than this) and long term care, to a focus on promotion of living healthy lives and well-being, and the extension of universal services away from high cost specialist services. This approach promotes quality of life and seeks peoples' and providers' 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 realise the full potential of integration locally. Our Better Care Fund Plan was submitted on 19th September, 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 ANNEX 1 – THE FINAL JOINT BETTER CARE FUND PLAN FOR ENFIELD submitted on 19th September 2014.

3.4 Informal feedback has now been received and the current submission has been classified as 'Approved with Support'. The plans and review process are currently being reviewed under NCAR with feedback on our local plan received officially by the end of October 2014.

4. BETTER CARE FUND GOVERNANCE

4.1 THE OPTIONS

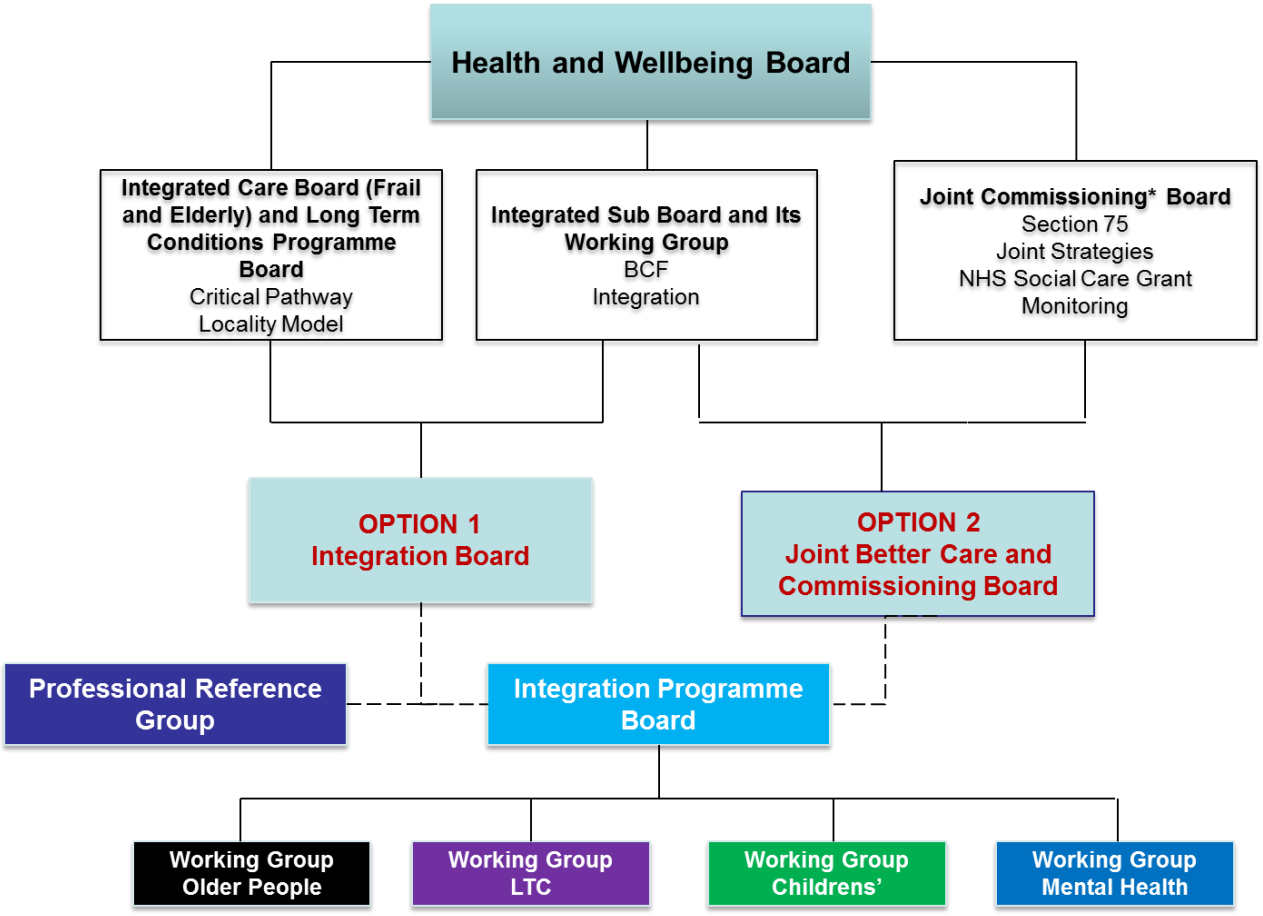
This section sets out the options for the new governance structures. Two Options are proposed for consideration by the HWBB:

OPTION 1- a new **Integration Board** is established as a Sub Board of the Health and Wellbeing Board to take forward the BCF plan and design a blueprint 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 Clinical Lead and Long Term Conditions Programme Board. Refer to Annex 2 for Terms of Reference and Membership of this Board Option.

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. Refer to Annex 3 for Terms of Reference and Membership of this Board Option.

The Chosen Option will be supplemented and aided in decision making by the implementation of a **Professional Reference Group.** Refer to Annex 4 for Terms of Reference and Membership of the Group.

The Options are illustrated below:



4.2 OPTIONS APPRAISAL

Both Options to be considered by the HWBB have pros and cons in their selection. These are highlighted in the table below for consideration and to aid decision making by the HWBB.

Option (s)	Description	Pros	Cons
Option 1	Establish an **Integration Board**	• Commissioning is bigger and broader than integration and should remain separate • Brings together key decision makers around Integration as well as BCF • Embeds the BCF in the whole system approach • Provides visibility across partner organisations • Powerful decision makers • Provides a clearer remit for JCB decisions • Resources can be jointly managed	• Leaves JCB as stand alone • Will need to manage potential conflict of interests with providers
Option 2	Establish a new **Joint Better Care and Commissioning Board**	• Clearer remit than current JCB • Some potential synergies with joint commissioning function of BC	• Too big to be effective • Membership does have not enough vision for change • Conflict of interest with providers • Confusing commissioning with programme delivery aspirations

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 Care Fund Plan. To ensure that the delivery of integration is happening at the pace and scale required, an Integration Programme Board will be established. 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 Reference Group, which will be the subject of a further report. 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 continue 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. 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 with governance arrangements that encourage and bolster our plans, then we are unable to deliver the efficiencies identified in our plan and maybe at risk of removal of the payment by performance element of the funding.

6 REASONS FOR RECOMMENDATIONS

We are recommending that the Joint Better Care Fund Plan sits under the new governance Board selected by the HWBB. The selected new Board will be part of the Health & Wellbeing Governance Structure.

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

7.1 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 are being developed jointly by NHS Enfield CCG and the local authority and will be approved and signed off by each of these parties and Enfield's Health and Wellbeing Board. In addition new guidance recommends that acute sector providers also have an input to and agree these plans. 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.

8 LEGAL IMPLICATIONS

8.1 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.'

Section 102 (3) Local Government Act 1972 permits the appointment of persons who are not members of the appointing authority to be members of a committee or sub-committee.

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

9.1 Please refer to ANNEX 1 – Question 5 of the BCF local plan for details of the major risks associated with the BCF plan.

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 and our partners holistically across the economy of Enfield. It calls for clear leadership, accountability and assurance so that the partnership works for the benefit of all adults. We are being 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.

11. PERFORMANCE MANAGEMENT IMPLICATIONS

11.1 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 – NEW Submission JOINT STRATEGIC BETTER CARE FUND PLAN

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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	
Date agreed at Health and Well-Being Board:	**09/09/2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£20.586**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£20.586**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Please see attached PDF for signature
By	Mo Abedi
Position	Chair Enfield CCG

Date	

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Please see attached PDF for signature
By	Councillor Doug Taylor
Position	Leader of London Borough of Enfield
Date	

<Insert extra rows for additional Councils as required>

Signed on Behalf of the Health and Wellbeing Board	Please see attached PDF for signature
By	Councillor Don McGowan
Position	Chair of Health and Wellbeing Board McGowan
Date	

c) 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_st

	roke_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 FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision locally for integration of health and social care is:

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

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

Our Health and Wellbeing Strategy that is based upon our JSNA, sets out the following priorities:

- Ensuring the best start in life
- Enabling people to be safe, independent, and well, and delivering high-quality health and care services
- Creating stronger, healthier communities
- Narrowing the gap in healthy life expectancy
- Promoting healthy lifestyles and healthy communities

We are committed to ensuring that the Better Care Fund is a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities and deliver our vision. Accordingly, our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these is a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make.

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 re-ablement and self-management is a key part of our objective of maximising the independence of all people, including carers, within Enfield who have received health and social care interventions. In common with other areas, we are increasingly focussing on enabling people – especially people with long term health conditions – to manage their conditions. Our work on integrated care has been developing and being implemented over the past 18 months. Initially focussed on older people, this work has been extending to other populations including adults with long term condition, people with mental health issues, and children with health needs.

Our Integrated Care Programme Board has agreed the widening of integrated care to other populations. Enfield CCG and the London Borough of Enfield have been working together with our patients, and public, and with our providers, to develop a model of health and social care that is fit for purpose for the future. Fit in terms of how we respond to our patients, fit in terms of how we manage a growing demand, particularly unplanned emergency demand, fit for purpose in how our providers work together to organise their care around our patients, fit for purpose in terms of how the commissioner and provider workforce develops.

We believe our model of care needs to be focused on the following principles:

1. Focused on the patient, and those important to the patient
2. Focused on the outcomes that are important to our patients
3. Continually builds resilience within our patients, those important to our patients and the communities in which they live
4. Care delivery is based on the populations residing within our 4 localities, with care delivery matching needs and outcomes for those different locality populations
5. Providers across health and social care, across primary, community and secondary care, work together to organise their care around the needs and outcomes of our patients in those localities
6. Providers work within locality integrated teams (multi-disciplinary, multi-provider teams) to deliver the outcomes for our patients, calling on specialism as required to deliver the outcomes those locality populations
7. Locality populations are stratified to ensure the appropriate level of planned assessment, intervention and stabilisation focussing on the achievement of patients goals in returning to their agreed normal
8. Providers are commissioned to ensure collective responsibility for locality populations and their outcomes.

We have been working with our health and social care providers to begin to organise their services into multidisciplinary teams.

We have worked with our providers to develop multi-disciplinary teams delivering care and case management to patients within care homes. We have our providers working together in our Older People's Assessment Unit (OPAU) which enables patients to access same day consultant led MDT assessment and diagnostics with a management plan back to community teams. Since April 2014 some 640 patients used the services of the OPAU with high levels of patient satisfaction and GP satisfaction. We have established core assessment and case management teams for older people within each of our localities, working closely with primary care to enable assessment and case management of patients identified through risk stratification. These teams are currently being expanded to include care delivery; community nursing, enablement, intermediate care, over the next several months including expanding our provision for dementia services.

We are therefore using the above model and guiding principles to underpin our development of locality based teams to the other populations affected by both CCG and LBE work streams, but also directly as a result of the better Care Fund: adults with long term conditions, adults with mental health issues and children with health needs.

b) What difference will this make to patient and service user outcomes?

For each of our populations outlined above we have been working with our patients and providers to develop an agreed set out of outcomes. This has initially focused on older people and people with diabetes and is part of our approach to outcomes based commissioning. Enfield CCG has been working with the other CCGs of North central London to develop Value Based Commissioning and as part of that we have been developing outcomes. These include a series of patient ''I' statements'' which will be translated into a set of measurable key performance indicators for the future.

We have included the substantial work undertaken by ''National Voices'' and have underpinned our vison for planned care delivery with the following:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

We therefore expect the difference to our patients and service users outcomes to include:

1. Patients are as resilient as they can be for as long as they can be but will know when to seek help quickly and from where
2. Patients will tell their narrative once and multidisciplinary teams will use that narrative to plan care around the needs of the patient and the goals that are important to them
3. Patients will fully understand their care plan and will achieve their goals in the least amount of time possible
4. Patient experience of care delivery will be consistently high
5. A range of clinical outcomes will be improved and variation reduced: e.g. HbA1c, BP Cholesterol, COPD exacerbations, Depression and Anxiety, actual disease prevalence
6. Planned care, both urgent and routine, will become optimal with minimal emergency care required

The areas of improvement in performance for our people, through the Better Care Fund are summarised below:

1. A 3.5% reduction in emergency admissions to hospital (equal to just over 1,000 fewer admissions in 2015/16) across children, adults and older people.
2. An 18% reduction in the number of days people spend in hospital when they are medically fit for discharge (just over 1,000 bed days less)
3. A low level of admissions to residential care for older people maintained
4. More people enabled to live independently within their own homes after a hospital stay
5. More people diagnosed earlier with dementia receiving the support they need to be safe and independent in the community(a 12% increase in diagnosis)
6. High levels of satisfaction with people getting access to the services they need to help them stay safe, well, out of hospital and living independently within their own homes (national indicator definition still to be agreed).

The table below summarises the differences that people will see, how they will be achieved and the impact and outcome.

Differences People will See…	They Will Be Achieved By…	Impact/Outcome
Better and more pro-active identification, tracking and reviewing of, and engagement with, patients across the whole-system	Taking an intelligence-based view of patients' evolving needs within primary care (enabled through technology & local knowledge) and stratifying needs and the response to this need	Early identification or self/management of needs avoiding unplanned hospital admission & a better joined-up response leading to increased satisfaction levels with services; reduction in the number of people considered to be at very high/high risk of hospitalisation

Improvements in people's ability to make lifestyle choices that improve health & well-being and improvements in their capacity to self-manage care, conditions & lifestyles thus reducing future care needs	Access to good information, advice & help will enable people to better prevent or manage their conditions, functional abilities or situations as effectively and independently as possible, including about issues like healthy living & social inclusion, with voluntary sector playing a vital role, e.g. help to nudge people's behaviour or improve their situation. Doing so will also help children & adults build resilience	Short to medium term impact will be improved diagnosis rates of high impact conditions like hypertension & diabetes, improved access to services through self-management, fewer emergency admissions to hospital or residential care. Longer term improvement in healthy years across the population.
Better coordinated & joined-up assessment, care planning, case management, treatment and care delivery, appropriately tailored to needs & preferences	Patients (and their carers) at heart of planning and delivery and engaged in decisions about them & their care, including self-management. People will have realistic choice & control over assessment, goal-setting, planning & delivery of current & future care needs (including Advanced Care Planning), including their own & carers' desired outcomes & responsibilities – so people don't feel "dependent on a system" with as much autonomy as possible.	more streamlined services across the health and social care economy; professionals gain a more holistic view of a person's life; treating the person not the symptom; people more in control and enabled to make good, informed choices; independence rather than dependency encouraged and supported
Ensure all elements of care system act as single system to provide care to individuals (avoiding duplication and fragmentation), with a range of public-, private- and voluntary-sector providers involved in delivery.	People will know their named Lead Accountable Professional and care manager, if appropriate to their needs. Delivery of planned care will be under-pinned through effective communication between professionals and between professionals & patient and carer. Professionals in all local agencies will have appropriate shared access to individuals' care plans, including to help respond in a crisis	Shared care record/patient held records will improve access to more joined up information for professionals and patients/service users who are better informed
	Care is assessed, planned and delivered in appropriate setting (with an emphasis on delivery closer to home) and in extended hours (including 7-day working), with effective coordination, appropriate access to specialists and seamless interfaces with disease-specific pathways;	care and support interventions are better planned with service users/patients more in control; improved access to the right services at the right time with fewer hand-offs and better continuity of care and support

Reduced crisis-driven episodes of care & support, including reduced hospitalisation and less intensive care solutions, and ensuring nobody stays in hospital or care home longer than they need to	Care planning will be facilitated via rapid access to diagnostics & treatment in a multi-disciplinary environment. Where crises arise due to an acute episode or significant change in circumstances, individuals are well-supported to avoid or mitigate these crises via a Rapid Response element of care planning, underpinned by effective hospital discharge and intermediate care & enablement.	reductions in unplanned, crisis interventions through hospital or residential services; better community services support people to remain independent and in control; service users/patients benefit from a joined up approach to their situations
Delivery of care will be planned and delivered in such a way that it always respects individuals' dignity. Staff and organisations treat service users/patients with empathy and respect.	Care throughout the pathway will be delivered to a high-quality standard across all agencies. This will be underpinned by effective workforce development and quality assurance to ensure individuals' are safeguarded across the pathway.	Staff feel supported & equipped to deliver high quality care and support; Staff & service users/patients are clear about the standards of care and support they should expect; increased satisfaction levels with services;

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The Better Care Fund allows us the opportunity to accelerate the reshaping and re-organising of care around the population of Enfield. We have been working with our health and social providers to enable them to work together to reshape care systems that are able to deliver what patients need. There are a number of ways we have been doing this:

1. Reconfiguring community services away from individual services lines towards MDTs around locality based populations: older people, adults with LTC, adults requiring episodic care, children with universal needs, children with additional needs, looked after children
2. MDT teleconferences to enable discussions of complex or challenging patients and agree MDT care plan
3. Developing our integrated care for older people as outlined above and detailed within Annex 1, in particular the development of locality integrated teams and the Older People's Assessment Unit
4. Expansion of enablement and intermediate care and greater integration between those two services
5. Development of our integrated care model for the other populations based on multidisciplinary teams, early diagnosis and intervention, case management, building resilience
6. Integrating across the CCG and LBE where this makes sense: personal health budgets with direct payments, community based wheelchair services into the Integrated Equipment Store, jointly commissioning risk stratification
7. The development of Value Based Commissioning for older people and people with diabetes as part of our overall approach to outcomes based commissioning. Outcomes

based commissioning will be developed for all out populations as part of the better care fund but also forms part of the CCGs Transformation programme work

8. Working with Voluntary and Community Services to develop their role in the provision of care and case management to our locality populations and their role in building and maintaining resilience in our patients.

What is presented below is our overarching model of care which focuses on locality based teams delivering care and case management to locality populations of patients supported by wider specialisms and which forms the basis of our planning over the next 5 years to 2020.

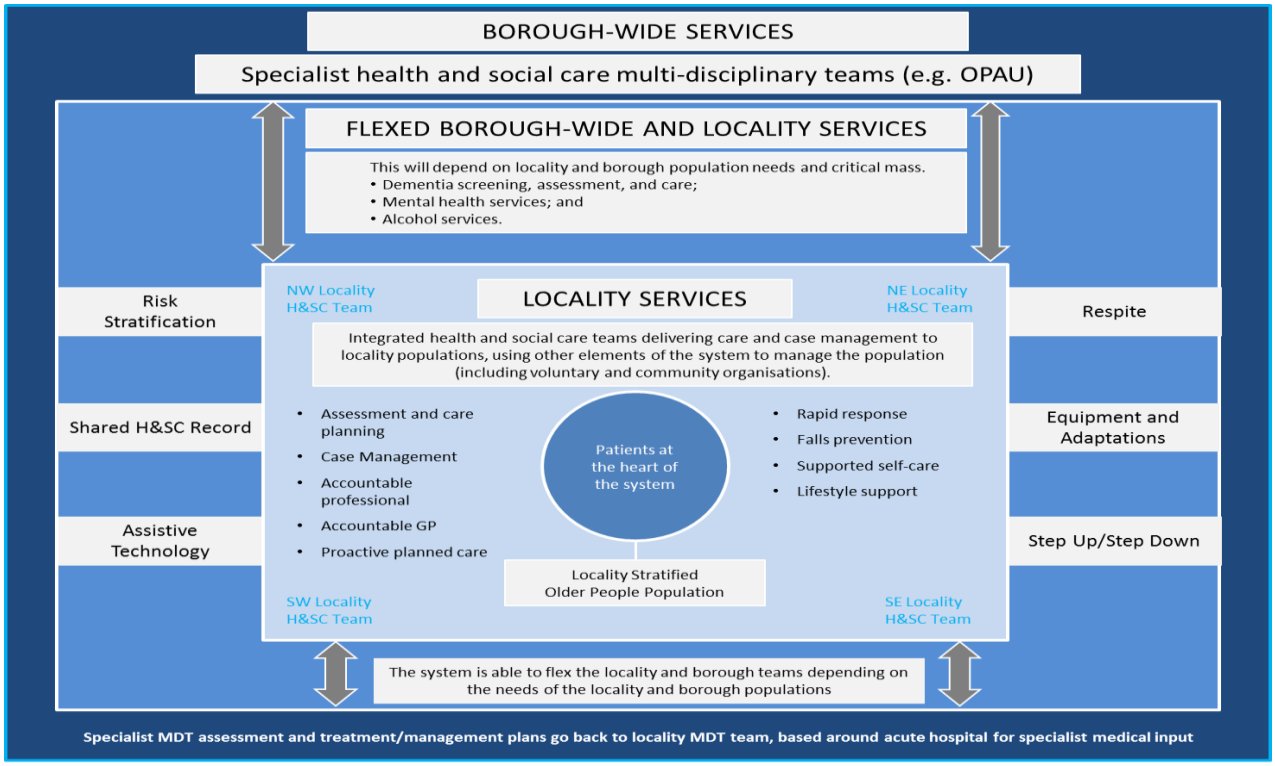


Figure 2 – Our Integrated Care Operating Model

The most significant transformative changes in services over the next 5 years will be:

1. Individuals will benefit from joined-up & well-planned high-quality care pathways across primary, community & secondary health & social care tailored to their current or changing needs, abilities and preferences delivered in appropriate settings. This is a significant change from the patchwork of service responses some residents told us they experience currently;
2. Care in the pathway will be commissioned through a cross-organisational value-based approach focussing on rewarding multi-agency **delivery of outcomes** for cohorts (e.g. older people with frailty) rather than single agency activity-based commissioning;
3. Delivery of a range of enabling solutions to deliver the above aspirations, including:

   - Effective workforce and organisational strategies to ensure the principles and practises of integrated care are well-understood and practised by all relevant care professionals;
   - Services being available in extended hours to respond rapidly (e.g. to prevent hospital admission or facilitate discharge) and as part of planned delivery of care for individuals;
   - Secure and shared record systems and IT system infrastructure across all relevant agencies to enable joint working, with patient consent driving this sharing of data.

Operating Model to Support Individuals (see also Annex 1)

The multi-disciplinary model and approach has been developed with the following features:

- An accessible Community Health/Council single point of entry (SPOE) to take enquiries and

referrals from the public etc. augmented through practice-based risk stratification to pro-actively identify patients at risk of adverse health outcomes;
- Delivery of primary care management in each of the 4 CCG localities with:
  - The GP at the heart of the process as Lead Accountable Professional;
  - Multi-disciplinary locality-based care professionals working together and with GPs to identify, assess, care plan and deliver care to patients, with a named manager for case;
  - Interfaces with other relevant specialists as part of this care planning & delivery process;
  - Voluntary sector solutions focussing on prevention and improving quality of life.
- Same day access to specialist diagnostic and treatment functions where needed;
- Access to rapid response functions to manage crises delivered as far as possible as part of primary care management, but which includes hospital discharge and bed-based solutions;
- Where needed, extended (7-day) working, e.g. as part of a rapid response function.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

This section builds the business case for the development of our transformative model, assessing the current and future needs of our population groups (including stratification), how the current system manages these needs and the areas for improvement. The table below summarises the case for change across our populations.

CASE FOR CHANGE ISSUE SUMMARY	Population Groups			
	Integrated Care for Older People	Mental Health	Working Age Adults & LTC	Children with Health Needs
	All above have cross-cutting theme: Supporting Carers			
Population Needs: The health of population continues to improve, but there remain many issues to address				
Larger than London average population sizes	✓	☐	✓	☐
Evidence high number of complex cases in general population	✓	✓	✓	☐
Known health inequalities & differences (including those linked to deprivation) across localities	✓	✓	✓	✓
Adverse outcomes affected by holistic issues, e.g. social isolation, nutrition, access to work etc.	✓	✓	✓	✓
Prevalence in population on upward trajectory over next 5 years	✓	✓	✓	✓
Evidence impact on longer-term life chances	✓	✓	✓	✓
Quality & Outcomes: Care services have strengths, but can be better integrated & people's cases better managed				

Evidence too many people are hospitalised as part of unscheduled care compared to England	✓	☐	✓	✓
Evidence planned primary care management of population could improve, including diagnosis	✓	✓	✓	✓
Evidence care service response fragmented with inconsistencies in response	✓	✓	✓	✓
Evidence outcomes important to individuals are not always realised in the current system	✓	✓	✓	✓
Evidence quality of care & safeguarding could improve & made more consistent for individuals	✓	✓	✓	✓
Evidence people's choice and resilience could improve, including in self-management	✓	✓	✓	✓
Evidence better rapid response could be planned to support individuals	✓	✓	✓	✓
Evidence people's carers could be better supported	✓	✓	✓	✓
Finance & Sustainability: 'No Change' scenario is unsustainable over next five years given financial pressures				
Population need changes likely to mean significant financial pressures on care system	✓	☐	✓	☐
Opportunities to identify significant cashable and non-cashable efficiencies from transformation	✓	✓	✓	☐
Opportunities to commission and incentivise outcomes as part of medium-term development	✓	☐	✓	☐
Opportunities to commission and incentivise outcomes in the longer-term	✓	✓	✓	✓
Consequences of transformation has potential to provide significant challenges to acute providers	✓	☐	✓	☐
Opportunities to build health and social care partnerships to deliver collective efficiencies and manage more sustainably	✓	✓	✓	✓
Opportunities to develop infrastructure to support and sustain transformation	✓	✓	✓	✓

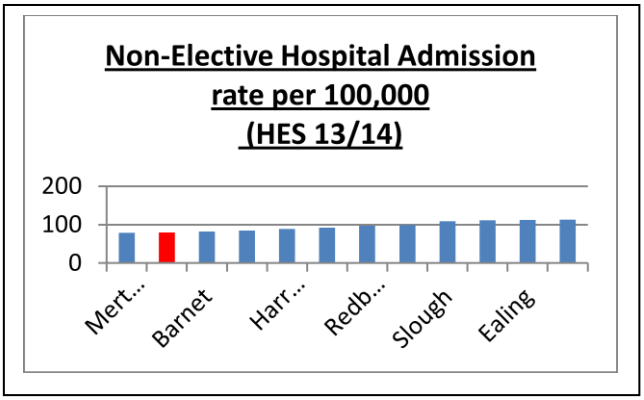
Enfield has increasing numbers of people living with long term conditions or disabilities and a challenging financial context which means that the case for change has never been stronger. Feedback from the people who work within our services and from those people with whom we work is equally clear. Joined up services which are efficient, easily accessible and which provide care and support closer to home are what everyone wants. The integration of health and social

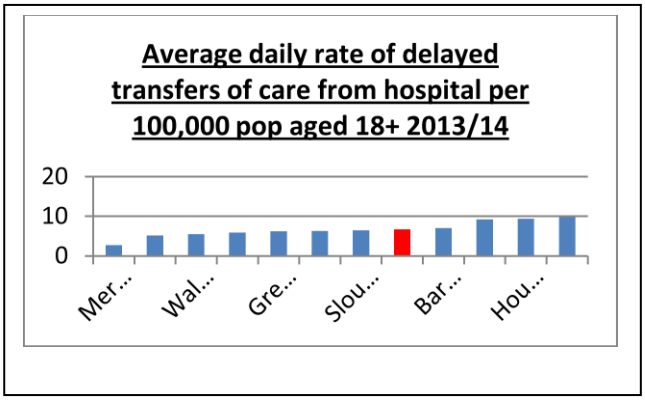
care economies is happening but needs to progress more quickly if we are to meet the challenges facing us. The purpose of the better care fund plan is to accelerate progress towards our key goals:

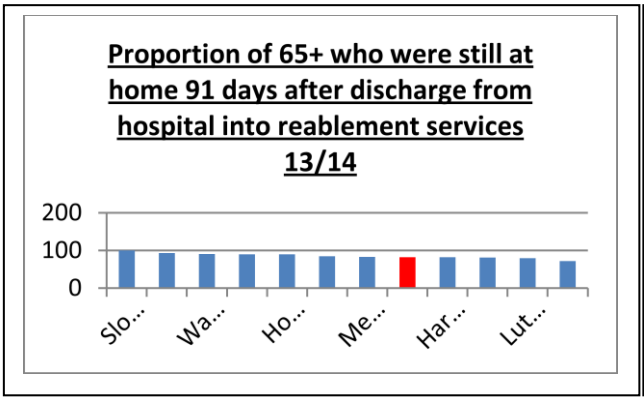
- Effective case finding which enables professionals and patients/service users to work together at an earlier stage to prevent deterioration and crisis
- Integrated health and social care locality teams providing access to good community services 7 days a week
- Reducing A&E attendances by providing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

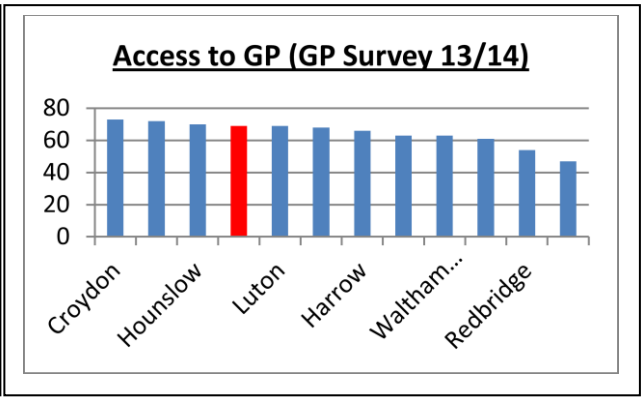
Our Challenges

When compared to other London Boroughs and nationally, Enfield performance across key areas appears to be good.









However, good average performance masks significant inequalities across the borough, which contribute to:

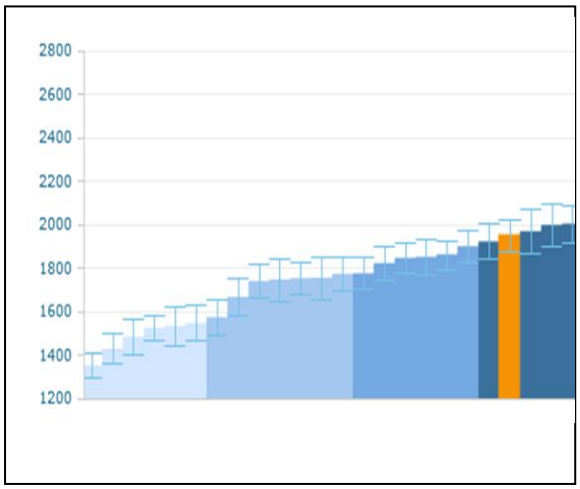
Enfield's Health Headlines:

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

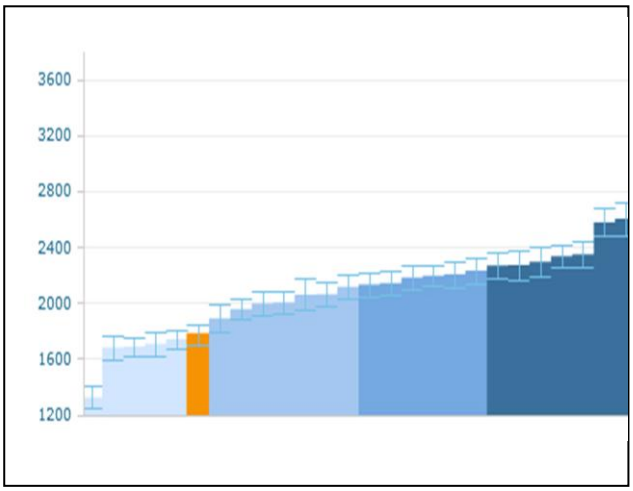
The charts and heat map below demonstrate the difference in PYLL where healthcare could have made a difference:

PYLL for all ages amenable to healthcare

PYLL for Women



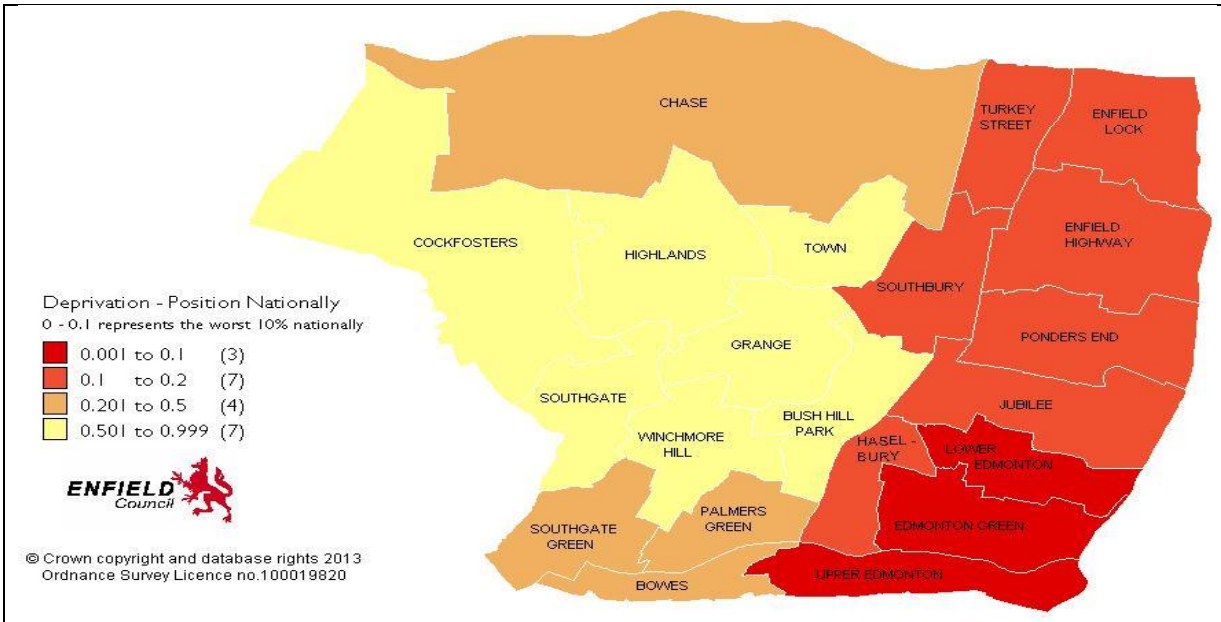
PYLL for Men



Deprivation

Deprivation is a key determinant of health and Enfield is one of the most highly deprived Outer London boroughs. In Greater London, Enfield is ranked as the 14th most deprived London Borough, out of 32. Nationally, Enfield is ranked 64th most deprived out of the 326 local authority areas in England.

However, within Enfield itself, the most deprived wards, in rank order, are Edmonton Green, Upper Edmonton, Lower Edmonton, Ponders End and Turkey Street. Such are the levels of deprivation in the top three (Edmonton Green, Upper Edmonton, Lower Edmonton) that they fall within the most deprived 10% of wards in England. Twelve of Enfield's twenty-one wards are in the most deprived 25% of wards in England. The heatmap below demonstrates the polarity around deprivation which exists in Enfield.



Heat Map – Deprivation in Enfield

Variation across the Borough

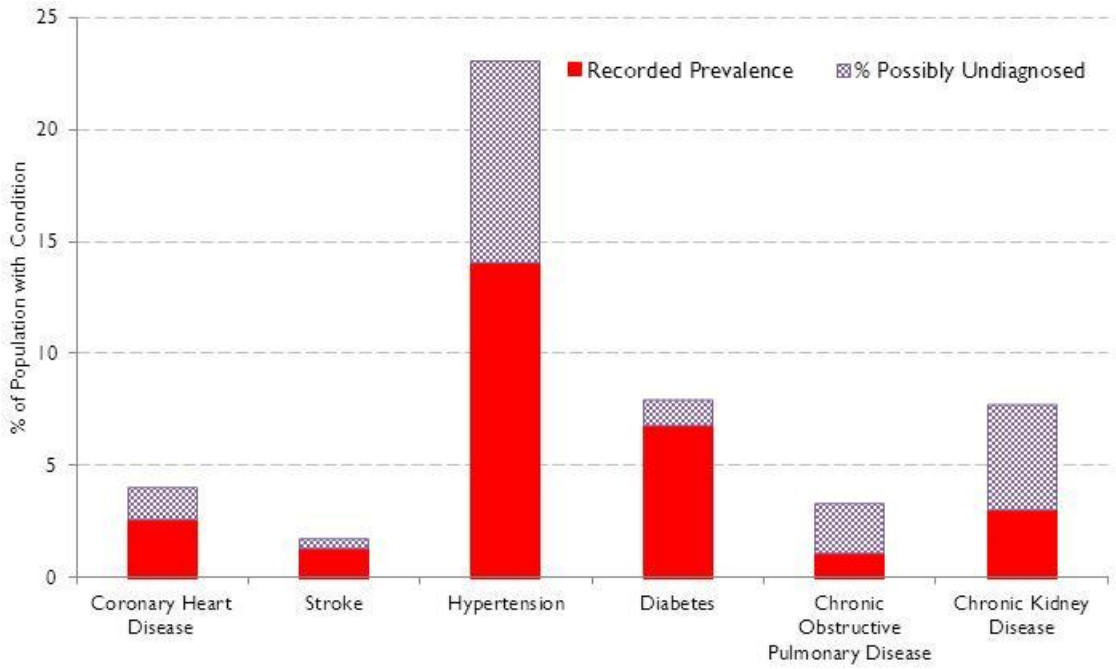
Deprivation is associated with, amongst other things, Cardiovascular Disease (CVD) mortality. The all age mortality rate from CVD in 2009-11 for persons who live in the most deprived areas of Enfield was 199.2 per 100,000. This is 1.3 times greater than the overall mortality rate for Enfield and 1.7 times greater than the mortality rate for persons who live in the least deprived areas of Enfield. This further demonstrates the point that while Enfield may perform on a par or better than average in terms of deprivation, health and outcomes for people accessing health and social care services, the polarity which exists between the different parts of the borough leads to marked geographical and socio economic differences in:

- Levels of obesity
- Levels of physical activity
- Levels of undiagnosed long term conditions
- Levels of A&E attendance
- Reliance on intensive social care support
- Ease of access to health and social care services within the community
- Reliance on in-patient Mental Health services

Enfield's Population

The population in Enfield, currently estimated at just over 323,000 is growing at about 3,500 people per year, making it the fourth largest and one of the most ethnically diverse in London. It has a large population of people aged 65 and over at just over 40,000. The proportion of the population living with long term conditions, mental ill health, dementia and learning disabilities is increasing. The charts below show for the most prevalent long term conditions the levels of undiagnosed cases in the borough.

Long term conditions showing levels of diagnosed/undiagnosed cases



To convert the graph above into real numbers, the gap between the diagnosed and estimated levels of some long-term conditions suggests that the following number of people in Enfield could be living with a long–term condition that has yet to be diagnosed:

- 1,271 cases of stroke (25% of expected cases)
- 4,071 cases of coronary heart disease (35% of expected cases)
- 6,426 cases of chronic obstructive pulmonary disease (67% of expected cases)
- 25,971 cases of hypertension (39% of expected cases)
- 3,301 cases of diabetes (18% of expected cases)

Long term conditions not only significantly degrade people's quality of life but they are very costly in terms of treatment and social care support. For example, people with diabetes in Enfield were over 69% more likely to have a myocardial infarction, 43% more likely to have a stroke, 98% more likely to have a hospital admission related to heart failure and 21% more likely to die than the general population living in the same area. There has also been a significant increase in the number of adults receiving significant social care support due to diabetes related complications.

What our JSNA says and using that intelligence to focus on the key areas for change

Older People

An analysis of trends associated with emergency admissions for older people shows there will be significant long-term pressures if we continued with the current system, with a consistent increase in the number of such admissions between 2010/11 and 2012/13:

- An annual average growth of 2.8% in activity and 7.7% increase in cost for emergency admissions of people aged 65+ years between 2010/11 & 2012/13;
- 82% of this financial growth was attributable to people aged 75+, with 80% of the total increase in activity in HRG categories associated with many conditions (e.g. respiratory or cardiovascular) with the potential to be proactively managed in a more planned way;

- An audit found nearly half of older people admitted to care homes were not known to the Council 2 months prior to admission, with the majority of these individuals and their families reaching a crisis point, typically a hospital admission.

- A longer-term increase in the prevalence of musculoskeletal disorders (50% between 2010 & 2030), heart disease (50%), dementia (80%), and stroke (57%) in Enfield due to a welcome increase in the number of people living longer.

Our Response

- Strengthened integrated management of individual cases in a more planned way in the community and in primary care, learning from joint working already in place and national good practice to help avoid the need for people to attend A&E.

- Earlier identification of people at risk i.e. increasing diagnostic rates for conditions such as dementia, which averaged 43% of the population thought to have the condition (with this proportion varying between 8% & 100% across practices (End-to-End Dementia Pathway Review, 2014)).

- Patients' subsequent progress in their joint plans will need to be tracked and reviewed to step-up or step-down planned interventions in response; and to encourage people to make positive lifestyle choices to manage their care and conditions.

Mental Health Issues (Enfield JSNA & Enfield Joint Adult MH Strategy)

Enfield is estimated to have 37,300 adults aged 18-65 with a neurotic disorder or 19% of this population. Estimates of prevalence of serious mental illness vary but there may be up to 5,000 adults with these disorders – both figures are likely to rise by 3% by 2020. There is higher prevalence in eastern wards as deprivation is a risk factor for mental health problems.

However, there is:

- Under-diagnosis of serious mental illness (8% of people on GP register compared to 12% on the best performing London authorities

- Worse outcomes for these patients with Enfield having the third highest excess mortality rate for under 75s in London

- Excessive reliance on secondary care for help with mental health problems which could be better managed in primary care

- 92,543 patient days delivered by the Barnet, Enfield & Haringey MH trust for Enfield residents with common mh disorders

- A clear case for strengthening the diagnostics and support available in primary care for these people

- Enfield's Mental Health Strategy estimates 25% of people over 65 in the community have mental health symptoms,

- but only a third discuss this with their GPs, and only half of those get treatment

- An estimated 6,200 residents aged 65+ with depression

- Significant under-presentation of older people accessing Improving Access to Psychological Therapies (IAPT): 6% of this age group benefit from this service, well below the Department of Health's 12% target and despite its well-established benefits.

Our Response

Improving access to IAPT services for adults and older people linked to locality based primary care management within the integrated care model to reduce in-patient admissions

Strengthening our RAID model to facilitate timely discharge and joined up health and social care services which promote enablement, resilience and independence with appropriate support

Health Needs of People with Long-Term Conditions (Enfield JSNA)

- Nationally, people with LTC account for 50% of GP appointments, 64% of outpatient appointments and 70% of inpatient bed days (King's Fund, 2014).
- In Enfield, the number of people with LTCs will increase as the population ages and as detection improves. The conditions most related to our BCF proposals include: hypertension (estimated to affect 67,000 people in Enfield, of whom 39% were undiagnosed in 2012/13); CHD (11,600, 35%); COPD (9,600, 67%); stroke/TIA (5,084, 25%), dementia (3,000; 57%) and diabetes (discussed below). This under-diagnosis is one reason for our model's investment in rapid access to diagnostics and treatment.
- This under-diagnosis combined with the need for better management of such conditions in primary & community care is one reason for the high levels of A&E attendances amongst working age adults, with Enfield in the worst performing quartile for England for this metric.
- Diabetes is on the increase and is significantly under-diagnosed (as many as 3,300) and an increasing risk for older people leading to heart disease and COPD
- The number admitted as an emergency diabetes case was higher in Enfield (40/10,000 population) than England (29) (NHS Better Care Indicators, 2012/13).

Our Response

Enfield has already developed (e.g. stroke) or is developing (e.g. cardiology) disease-specific pathways to improve support. Such pathways have common features: a focus on prevention, early identification and/or recovery, self-management, ensuring care is delivered in the most appropriate setting and cross-agency planning and delivery of care. Our aim is to ensure such pathways are a seamless part of the model as they develop in 2015/16 and beyond so those with multi-morbidities benefit from a holistic *and* a specialist disease-specific approach.

We have a diagnostic rate that could be improved and a significantly high proportion of sub-optimally controlled diabetics, which leads to increased hospital admissions, particularly for older people. Our locality-based model therefore provides an opportunity to ensure patients are better managed in primary care through emerging GP networks.

Health Issues associated with Children & Young People (Enfield JSNA Children Section)

- High numbers of children attend A&E, with the number of attendances of those aged <16 in the worst performing quartile compared to England
- The subsequent rate of emergency admissions was much lower than average suggesting more children could have avoided visiting A&E immediately (e.g. routed through Urgent Care) or via longer-term prevention through primary care.
- 7% of children & young people have a physical and/or learning disability/difficulty, and there is evidence these numbers are increasing due to improved neo-natal care.
- Enfield Council and Enfield Health Services provided specialist services to 800 children & young people with disabilities, whilst the number of children aged 0-5 referred to our Early Support Resource Allocation Panel increased by 17% between 2010 & 2012.

Our Response

The planned development of locality-based GP Health & Well-Being Networks as part of our model is a direct response to latter need and this will be linked to improving support for disabled children and the mental health of young people.

The Children & Young Person's Plan identified improvements in support for those at transition into adulthood and in mental health services for young people, including for care leavers:

- Expansion of the Early Intervention in Psychosis Service for 16-25 year olds. It is estimated a quarter to half of adult cases could be prevented by effective treatment of youths with psychiatric disorders (Kim-Cohen J *et al*, 2003), suggesting effective EIP services improves long-term outcomes for those with psychosis and reduces the need for intensive support later in life, including hospitalisation. In Enfield, there is a gap in EIP for this age group.
- The lack of continuity of MH provision beyond transition was criticised in the 2012 Pilot LAC inspection report, and has been identified as a priority for development due to the vulnerability of care leavers - a 2012 survey of Enfield's care leavers found 56% had mental health issues. Looked after children are at five-fold increased risk of childhood mental disorders and suicide attempts as an adult (Meltzer *et al* (2003)). Despite this, a study showed only 4% of those aged 16-18 in London made the transition from CAMHS to adult services (Singh *et al*, 2010).

Infrastructure and Enabling Priorities

Shared Information

Making good decisions based on as much information as possible is key not only to patients and service users but also to professionals.

Working across 2013/14 and 2014/15 Enfield Council, CCG, GPs and the two hospital trusts, North Middlesex and Royal Free have collaborated to deliver a Risk Stratification tool using the NHS number as the primary identifier. Further work is being done with the Nuffield Trust to develop and refine the tool which is being used by Enfield GPs to casefind and work with those people at high or very high risk of hospitalisation. Looking forward, the partnership, through the better care fund, will develop risk stratification tools for social care and for carers. Using this information at an aggregated and disaggregated level we have been able link people on disease

registers to activity in primary, secondary and social care and to target health checks much more effectively.

Work is also underway to develop a shared care record which will combine data from GPs, acute services, community services and social care.

Support for Carers (Enfield Joint Carers' Strategy)

- 27,624 people providing unpaid care to an adult in Enfield (ONS Census, 2011), of whom 6,194 provided 50+ hours per week.
- The Strategy estimates 8% of all carers are parents of disabled children, which means 30,000 people are caring for an adult or disabled child in Enfield, 70% of whom are caring for someone aged 65+.
- Older carers often have their own needs – 80% report their responsibilities had an adverse effect on their health - and are at risk of social isolation, developing mental health problems or suffering financial hardship.
- It is vital support for carers is available so they can continue caring, helping to avoid those they care for being admitted to hospital or residential/nursing care due to the carer feeling they can no longer cope.
- Improving access to early assessment, preventative services and breaks will help more carers to continue caring
- Access to good information and advice to support self-management or supported self-management for carers.
- Increasing our capacity to assess and support plan with carers at an earlier stage will reduce crisis interventions, necessary when caring arrangements break down through ill health.
- Mental ill health, Dementia, Learning Disabilities are particular areas of focus with better primary care and preventative services in place to reduce the need for crisis management

Safeguarding, Quality Assurance & Infrastructure

We recognise changes to the whole-system at this pace and scale cannot be delivered without infrastructure investment, including cross-organisational investment in technology & systems (e.g. shared records), improved physical facilities and joint workforce development to support relationship building and the change agenda amongst professionals to support locality delivery.

Investment in quality assurance will assure our commissioned care solutions are consistently, safely and compassionately delivered to high-quality standards across the pathway. BCF investment will strengthen safeguarding arrangements across the care system and develop the Quality Checker role – those with experience of care themselves engaging with their peers about the care services they use to identify improvement areas, thus strengthening the customer voice.

What our Staff and the People we work with said:

Workshops were held with older people to elicit their views about how care is delivered and which outcomes they wanted to prioritise (Section 8). Their findings were in line with the "I Statements"

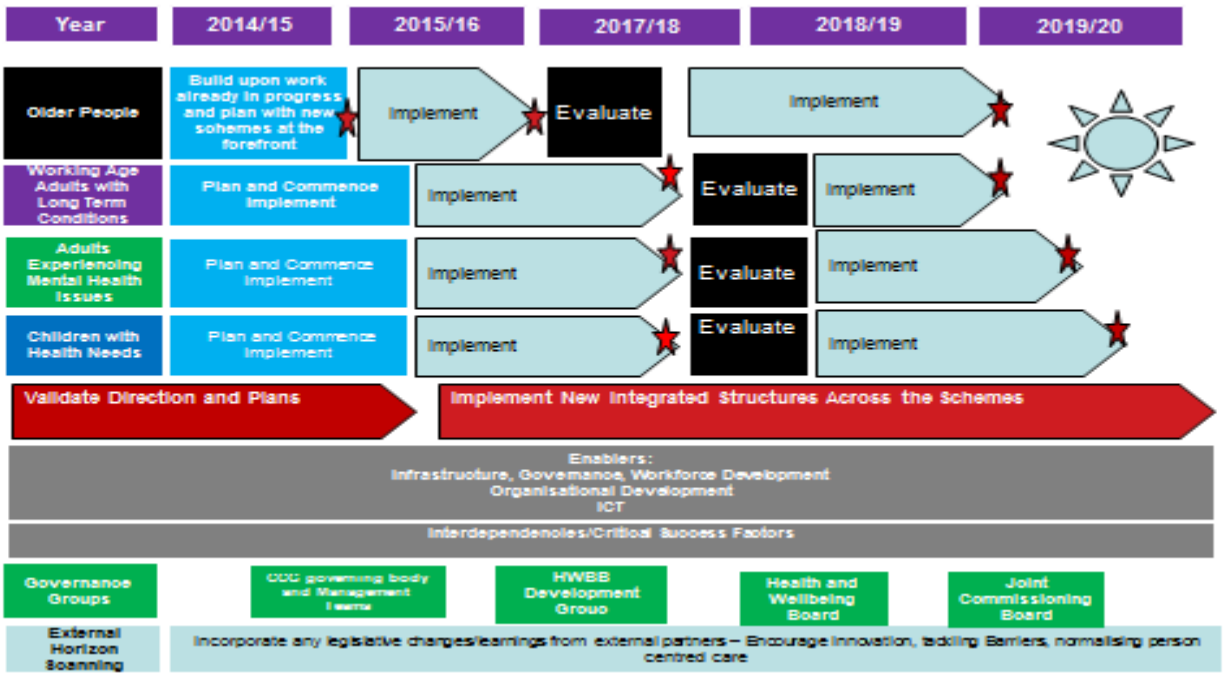
for coordinated care (National Voices, 2013), but also included some additional perspectives:

- *Goals/outcomes:* Being involved in and helping shape their assessment & planning, which patients felt did not always happen and wasn't shaped around their views or preferred goals;
- *Collaborative and Effective Care Planning:* Feeling able to contribute to and agree their care plan and knowing who coordinates and delivers it, but having control over how it's delivered and what to do in an emergency. Participants, however, felt this was less important than other issues;
- *Empowering Decision-Making:* Feeling they had choice and control over different aspects of their care, and the importance of respecting the role and involvement of carers. Many people reported they felt they had limited choice over their care;
- *Effective Information, Communication and a Joined-Up Approach:* The need to improve communication between professionals and patients and carers was a recurring theme, with individuals not always feeling they were listened to. There was a strong desire to ensure care was well-coordinated and communication between professionals was improved, so that patients told their story to as few people as possible. Many people felt could be improved in Enfield, including information-sharing across agencies.
- *Being treated with dignity, respect and empathy* in all aspects of their care and support which workshop participants felt did not always happen;
- *Not being seen as a burden to others*, an indication people feel they want to remain as independent as possible and do not want to be sucked into a system unnecessarily.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

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.



Enfield's Plan on a Page

The Programmes are made up of the schemes identified in Section d) below. These are highlighted, with their programme links in the table below.

Programme	Scheme	Scheme Details
1	01	Locality-based MDT teams for case management and delivery with GPs at heart of delivery
1	02	Support from specialist roles involved in case management or planned care delivery
1	03	Rapid primary care access to diagnostic & treatment, e.g. Older People's Assessment Unit
1	04	Short-term rapid response interventions, such as intermediate care or enablement.
1	05	Older People with Dementia
2	06	LTC - Diabetes
3	07	Mental Health RAID
3	08	Mental Health - IAPT
4	09	Childrens' Health and Wellbeing Network
4	10	Childrens' early Intervention
4	11	Childrens' Post Transition

Each programme is managed by a programme manager, who reports to the BCF Programme Portfolio office and on to the Working Group. It is envisaged that BCF leads from the CCG, LBE, acute providers and area partners will present on the Programme Board/Steering Group which will:

- Ensure the vision and outcomes are embedded in delivery
- Manage the delivery of all workstreams/schemes and programmes

- Communicate and engage with senior stakeholders
- Monitor delivery performance through a portfolio management process of benefits management, and highlight reporting
- Report to the Sub Group and Health and Wellbeing Board

Interdependencies will be managed via a detailed governance and Programme Portfolio Management Process implemented across the health and social care economy outlined in c) below.

Interdependencies include:

- Strategic national initiatives
- Local Health and Wellbeing Strategic Plans
- Strategic and Operational Plans for acute sector partners
- Strategic Plans for the CCG
- Efficiency Plans for the CCG and London Borough of Enfield
- Primary care and locality based planning

We have also included in our planning a series of cross cutting, enabling workstreams to ensure the success of the BCF Programme.

- Workforce Development
- Governance
- Infrastructure
- ICT
- Organisational development
- Carers Support
- Safeguarding

- 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 integration, quality and budgets most quickly. Our work on the older people's integrated care programme is already in train and beginning to deliver results. 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 Plan on a Page above 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 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.

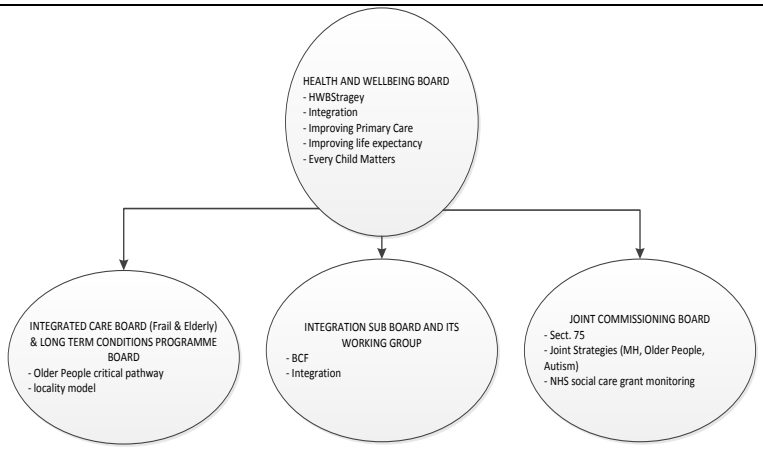
- We are conscious of the timescales for the delivery of this work and the performance improvements we need to see in 2015/16 in particular, but we are also mindful that some of this work – particularly changing our whole approach to elderly care – is going to take us the full 5 years specified by this 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 and managed basis.
- Workforce development and changes are a major challenge to the successful delivery of this BCF plan. The integrated care Locality Model requires multi skilled, new integrated teams and multi-agency working (primary, community, and mental health teams). Along with this there are challenges in moving to a culture of choice, self - care, and re-ablement. The managed worksteams will mitigate this challenge.

Our portfolio management approach ensures 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.

b) Please articulate the overarching governance arrangements for integrated care locally

The Enfield Health and Wellbeing Board has an established 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.



The Health and Wellbeing Board has agreed that this sub-group will exist on a temporary basis, to be considered when the terms of reference for the Health and Wellbeing Board are reviewed prior to April 2015. 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.

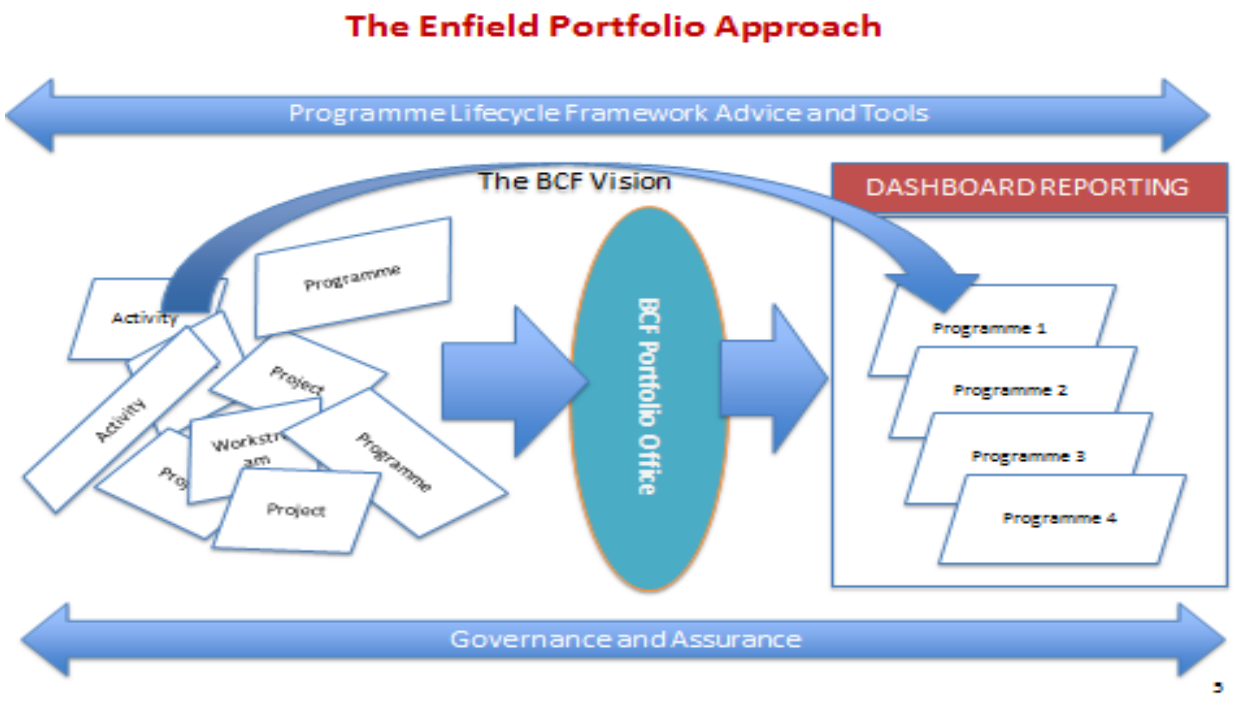
Currently we anticipate that the sub-group will continue and assume responsibility for performance managing the implementation of the plan. Our emphasis in devising these arrangements will be to mainstream BCF governance to the greatest extent possible, in order to achieve the maximum alignment of the programmes involved into existing change programmes.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Enfield Better care Fund programme will be run under a managed portfolio approach. The approach sets in place the overarching governance (see b) above), but also the programme framework for reporting across the partners within the BCF programme. Decisions are made in a culture of visibility and oversight, enabling swift remedial action to be taken across partner organisations. Tools will include:

- Highlight Reports
- Dashboard Reporting

Individual leads across the partnership will have the tools to take responsibility for ensuring that their relevant governing bodies are informed and consulted where appropriate on all work of the working group and can act quickly on their behalf.



The approach to the management and oversight of the delivery of the BCF plan is outlined below.

- **Be Consistent** - Establish consistent, repeatable practices that are in use across the Portfolio partners. All programmes and are held to the same standards (though not necessarily documentation) and requirements for success. Eliminate redundant, bureaucratic project management practices that bog down programmes and projects and report upon outcomes.
- **Be Transparent** - Have visibility into the progress and cost of all programmes and projects across the Enfield portfolio. Understand and know exactly how resources are being used across the portfolio and how these relate to outcomes for our population. Distribute this cost, scheduling and resource information to the appropriate stakeholders throughout the enterprise (for example, cost information to the SRO/DoF/Partner SRO).
- **Be Flexible** - Adapt to the Enfield portfolio's specific project and programme management needs as well as to the corporate structure and culture(s).
- **Be Agile** - Use accelerated and 'Agile' portfolio and project management practices most suitable to Enfield.
- **Educate** - Sponsor training and skills transfer. Facilitate communities of practice (and champions groups) to promote best practices across the transformation portfolio.
- **Focus on the metrics that matter** - In addition to metrics associated with cost and schedule, track criteria that are important to the business of Enfield, such as risk appetite.

Focus on the stakeholders and metrics that are meaningful.

This is underpinned by a detailed set of criteria, which all partners across the BCF programme will sign up to.

- **Co - produced** – by all appropriate involved partners/stakeholder in Enfield
- **Adaptable** - tailored to the size and risk of the programmes and outcomes they deliver
- **Fit for purpose** - includes all factors relevant to a fit for purpose solution in terms of outcomes for Enfield citizens
- **Understandable** - clearly relevant, logical and, although perhaps demanding - simple to complete and evaluate across the entire Enfield economy
- **Measurable** - all key aspects can be quantified so their achievement can be tracked and measured
- **Transparent** - key elements can be justified directly from the high level benefits work, with a direct link to outcomes
- **Accountable** - accountabilities and commitments for the delivery from all partner organisations, sanctioned by the Enfield HWBB

A detailed portfolio programme plan will be produced for the better care Fund programme.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Locality-based MDT teams for case management and delivery with GPs at heart of delivery
2	Support from specialist roles involved in case management or planned care delivery
3	Rapid primary care access to diagnostic & treatment, e.g. Older People's Assessment Unit
4	Short-term rapid response interventions, such as intermediate care or enablement.
5	Older People with Dementia
6	LTC - Diabetes
7	Mental Health RAID
8	Mental Health - IAPT
9	Childrens' Health and Wellbeing Network
10	Childrens' early Intervention
11	Childrens' Post Transition

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

Risk	Current Risk rating (Red, Amber, Green)	Likelihood 1-unlikely 5-highly likely	Impact 1-no impact 5 - catastrophic	Risk rating	Mitigating Actions	Revised Risk Score following mitigating actions
Failure to manage increasing demand for services through prevention/community services	Red	3	5	15	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions • OPAUs & MDTs established to do preventative work • Locality Teams in development • Business plans & Strategies across joint areas agreed and aligned with BCF plan • Contingency fund of £1m in place for emergency admissions	3 x 4 - amber
Staff across the partnership organisations do not receive sufficient support to manage the change with resultant impact on morale, service delivery and benefits realisation	amber	3	5	15	• Workforce strategies across partners developed to take into account change requirements • High level strategic intentions need to translate into practical system, practice and process change support for staff delivering the change • Service & team plans reflect high level priorities • Joint approach to the development of the workforce across the partnership	3 x 4 amber
Need to deliver savings drives disinvestment & creates viability & sustainability issues for providers	Amber	3	4	12	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of Savings Plans on providers • Phasing of savings & reinvestment from 15/16 to 16/17 & 17/18 provides scope to assess impact and plan • Impact of plans on quality of service delivery monitored	*3 x 3 amber*
Challenging financial climate and the level of CCG contribution, including the new Care Act allocation, places additional risk on CCG funding of acute sector provision with risk of destabilisation increased	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	3 x 3 amber

Risk	Current Risk rating (Red, Amber, Green)	Likelihood 1-unlikely 5-highly likely	Impact 1-no impact 5 - catastrophic	Risk rating	Mitigating Actions	Revised Risk Score following mitigating actions
					• Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered • Focus in Care Act of high quality, safe services and early intervention with service users and carers contributes towards within the BCF plan of helping more people to help themselves and receiving care closer to home	
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	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 aligned to Council, CCG & acute provider plans • Further development of integrated service delivery projects with robust evidence base to measure success	3 x 3 amber
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs	amber	3	4	12	• Appropriate governance structures in place • Provision of regular, timely and accurate information to support monitoring of services, quality and SUIs/Safeguarding alerts • Contingency plans and fund in place to ensure partners continue to meet their statutory duty	3 x 3 amber
The scale and pace of the change required with risk of increase in number of SUIs and safeguarding referrals across the partnership	amber	3	4	12	• 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	3 x 3 amber

Risk	Current Risk rating (Red, Amber, Green)	Likelihood 1-unlikely 5-highly likely	Impact 1-no impact 5 - catastrophic	Risk rating	Mitigating Actions	Revised Risk Score following mitigating actions
					(MASH) to deliver a more joined up approach to safeguarding and SUIs across the partnerships	
Information sharing arrangements to provide accurate/timely information is not robust resulting in low referral rates to MDTs and OPAUs	amber	3	4	12	• Information Sharing protocols in place • NHS No used as common identifier across all parties • Risk Stratification using shared data and NHS no in place • Access to Case finding tool to be provided to OPAUs • Performance Framework to be agreed and implemented to monitor outcomes • Project currently underway to develop shared care record across all stakeholders	2 x 3 green

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Enfield CCG is a financially challenged under capitated organisation with a substantial transformation programme already in place. Its provider landscape is changing following the acquisition of BCF by RFL, which has brought some stability but this will be maintained only through a significant transformation programme across the RFL and its commissioners. The NMH is significantly dependent on emergency flows for its sustainability and currently developed its strategic and financial plan in preparation for an FT application.

By 2017/18 London Borough of Enfield's funding from central government will have been reduced by an additional 25%Like most local authorities, Enfield is facing its toughest financial challenge to date, due to grant damping which continues to have a negative impact on the value of our funding allocation. Despite having already made £75million of cuts over the last four years while still protecting services, continued funding cuts and increasing cost pressures mean that Enfield Council now needs to find a further £60million in savings over the next 3 years.

The approach to BCF planning and risk management has been pragmatic and open across the partnership. The CCG sought a BCF settlement that balanced funding for existing schemes against new investments to ensure that a manageable level of additional financial risk associated with the BCF. The planning assumptions associated with this have been clearly communicated

and shared with partners.

The plans align with and are part of the CCGs existing transformation programs but set more ambitious delivery expectations from the focus offered through the BCF.

Specific approach to risk sharing and risk management

i) Health and social care

The detailed governance arrangements for the pooled budget including management of financial risk are still to be developed. We will build on our experience of developing services jointly through the section 256 and s75 arrangements to do this. Within the proposed pooled fund we have set aside a contingency of £1m which is in addition to the CCGs planned contingency funds within its own budget for 2015-16. Current plans do not include the investment into the BCF pool of any additional local authority money. The risk to the local authority therefore relates only to the failure to earn the performance money, currently set aside as a contingency and not committed into any of the proposed schemes. The maximum financial risk to the BCF is therefore £1.5m, offset by the contingency from the CCG of £1.5m

i) Provider/commissioner

The CCG and LA have held several events with providers as the BCF proposals have been developed to ensure transparency around the BCF proposals and management of risk.

The CCG's contracts with both its main providers are currently on a payment by results basis and that is likely to be the dominant approach in 2015-16. This approach minimises the financial risk to the providers' income stream from non-delivery of admission prevention targets in 15-16.

However the CCGs in NCL intend to move in 16-17 to an outcome based approach to contracting wherein financial risk will be shared across providers and commissioners. We intend in 15-16 to apply a proportion of our contract funding against specific outcomes for frail and pre frail older people in 15-16 and are currently discussing this approach with a number of providers

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Our Better Care Fund Plan and our implementation of the Care Act will make a difference to how people manage their own care and how they access care and support services.

The CCG Local authority and provider partners are already committed to developing integrated care for older people and for people with long term conditions which focuses on delivering a shift from crisis management and unscheduled care to an emphasis on prevention, early intervention and wellbeing and a more planned care approach to this client group. Our work across NCL on integrated care and outcome based commissioning for the frail and pre frail groups will now form a key element of the BCF programme for older people.

We have taken an integrated approach to implementing Personal health budgets for older people and people with physical and learning disabilities who are eligible for healthcare services. The Council's Personalisation journey started in 2006 and we now offer a range of support, information (including our e-market place), navigation, brokerage and management options for people with direct payments and their own budgets. Our infrastructure is already well established in this area. Through section 75 partnership arrangements, the Council on behalf of the CCG, have set up a pilot to introduce Personal Health Budgets for people who meet the Continuing Healthcare criteria and want to manage their own budget. Although, this is limited to 28 people at present this will be extended further through implementation of the Better Care Fund plan.

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

Enfield has been on a journey of integrated care for the past 2 years and some of the areas that have been developed and commissioned are described elsewhere. Enfield therefore views the development of the Better Care Fund as a further extension, and acceleration, of that integration agenda. We have described our approach to delivering integrated services, focused around locality populations, delivering the outcomes that are important to our patients. Most progress has been made integrating services for our older patients for a variety of reasons: they represent a significant population for health and social care, variation in quality and outcomes and patient experience is too great, maintaining and improving on, our current good position in relation to emergency admissions requires a different approach to how services are organised around our patients, providers across the voluntary and statutory sector must work together to deliver earlier planned care while building ongoing resilience within our patients and their communities. We have begun to enable our patients to use personal health budgets and this will be expanded as part of our care planning processes within the integrated locality teams.

This approach to delivery will underpin our development for people with diabetes, people with mental health issues and a focus on enablement, children and young people with physical or mental health issues, all of which are part of our transformation programmes. Those programmes, within the CCG, are wider than what is described within the better Care Fund – e.g.

planned care and Long term Conditions includes integrated services delivery for both respiratory and cardiology but the better care fund will focus on people with diabetes, mental health will include investment into a substantial redesign adult mental health services to focus on early identification, early intervention and enablement and recovery but the better care fund will only focus on delivery of RAID and achieving the 15% access to IAPT.

Enfield has a well-established integrated learning disabilities team which continues to develop and be reshaped to ensure that it meets the needs of our patients, particularly at critical transition periods in their life. Building resilience, focusing on recovery and enablement and substantially supporting self-care and self-management will continue to underpin our commissioning processes. We have used CQUIN for all providers to begin to change the nature of clinical consultations to ensure that they are underpinned by shared decisions making and goal setting, two key features that improve outcomes.

We will continue to work with all our providers to enable them to operationalise the different ways of working within integrated teams, to enable them to share and develop their skill sets. We have developed a programme using the Health Education England funding to support the delivery of integrated locality teams focused around our key populations. This will form the beginnings of our workforce development plans with our providers.

In addition we will continue to develop our primary care providers to ensure that primary care is a fundamental part of locality integrated teams and we have begun a process for assuring our emerging primary care providers buy further work is required to enable then to manage locality populations rather than individual GP practice populations.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Alignment of the BCF schemes with the CCGs transformation programme is illustrated below:

BCF scheme	CCG transformation programmes						Comment
	Prevention and primary care	Integrated care for older people	Planned care and long term conditions	Urgent Care	Children and Maternity	Mental Health LD and Continuing healthcare	
Older People with Frailty:							
Locality Multi disciplinary teams	√	√					Key element of the older peoples integrated care programme and developing locality model of primary care and 8-8 working in primary care
Specialist Support		√					Key element of the older peoples integrated care programme
Rapid access to diagnostics and assessment		√					Key element of the older peoples integrated care programme
Rapid response service		√		√			Key element of the older peoples integrated care programme
Dementia		√					Key element of the older peoples integrated care programme
Long term conditions –	√		√				

diabetes							
Mental Health:							
RAID						√	
IAPT						√	
Primary Care	√					√	For implementation in 2016-17
Children:							
Health and Wellbeing networks					√		
Early Intervention					√		For implementation 2016-17
Post transition					√		For implementation 2016-17

In addition the BCF has identified the following interdependency areas which are common with the CCGs transformation programme cross cutting areas of :

- Workforce development for integrated working
- Shared record across acute and primary sectors
- Development of the third sector
- Funding for Carers
- Safeguarding

The BCF fits within the 5 year vision for Enfield CCG (Strategic Plan, 2014-19) whereby the CCG is 'committed to commissioning services that improve the health and wellbeing of the residents of Enfield by securing sustainable, high quality care'.

Specifically, this will be achieved by:

- Strengthening and extending partnership working across the whole Enfield community.
- Implementing a model which works for everyone including those who would prefer to self-care and/or want more independence and choice.
- Developing a joined up model which offers a range of prevention, early intervention and support (not just health) delivered by a variety of providers, including the community and voluntary sector working together in different ways to support people and families more effectively.
- Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing through enhancing existing strengths and resources.
- Developing the role of GP practices in prevention and community interventions e.g. delivery of prevention services and navigation to other Local Authority services.

Enfield CCG has undertaken extensive local consultation on our 5 year plan. The emphasis on working closely with a broad spectrum of local authority services, not only social care and public health, was acknowledged and welcomed by the local authority. Prevention is a strong theme in Enfield CCG's vision and plans delivered through closer integration of primary, community and mental health services. This approach will in time reduce the reliance of our local population on hospital based services and firmly aligns to the BCF.

Enfield's BCF plan is also strongly aligned with those of the 5 North Central London (NCL) CCGs of Barnet, Enfield, Haringey, Camden and Islington which make up the NCL Strategic Planning Group (SPG). The SPG is finalising the NCL SPG 5 year plan which is underpinned by the BCF plans.

Enfield CCG has been successful in securing over £200k HENCEL funding to support the delivery of better integrated patient care including a specific focus on the End of Life Care pathway and supported self-management. Working with: the HENCEL; Tavistock & Portman

Trust; Barnet Enfield and Haringey Mental Health Trust; Haringey CCG; and Barnet CCG, Enfield is leading work to improve integration in perinatal mental health services and outcomes.

The alignment with the BCF target has widened due to a change in criteria used for the BCF. The BCF target now includes reducing admissions by 3.5% across all non-elective general and acute admissions whereas the operating plan continues to include a reduction in avoidable admissions associated with ambulatory care sensitive conditions in adults and children. It is not yet known if the operating plan criteria will change in line with the BCF criteria.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The 5 CCGs of North Central London have submitted an expression of interest to co-commission primary care during 2014/15 with a view to taking on full delegated powers from April 2016. There is currently an NCL planning group with CCGs and NHS England to take forward this work. Some of the areas that are currently being reviewed as part of this work stream include:

1. London GP Development Standards
2. Information sharing about practices by exception
3. MPIG, PMS or other national policy decisions that have an impact on practices
4. Mergers, closures, acquisition, care home sudden removal of GP support
5. Sharing of good practice
6. Harmonising Locally Commissioned Service specifications and remuneration
7. Market development including federated working
8. Premises developments
9. NCL General Practice Balanced Score Card
10. Workforce, education and training
11. GP IT

There remains a substantial amount of work to be completed before the 5 NCL CCGs will take on full delegated commissioning of primary care, in terms of functions, budgets and governance. The 5 NCL CCGs currently remain com mitted to fully delegated commissioning powers from NHS England by 1st April 2016 and would further support the strategic primary care work that has been undertaken within each of the 5 CCGs over the past 3 years as part of implementing the NCL Primary Care Strategy.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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

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

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

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

Enfield experienced an increase in population in excess of both London and national averages between 2001 and 2011 (census figures) with numbers increasing by 36, 300 over the 10 years. It is now the fourth largest London borough by population with the latest GLA estimates adding 10,500 additional people to the population between 2011 and 2014 (population now estimated at over 323,000). Within this population figure it is clear that there are more people with disabilities or long term conditions and they are living longer. The increase in longevity has not been accompanied by an increase in the number of healthy years lived, however. This population growth together with an increase in the prevalence of ill health and disability will result in more people requiring access to health and social care services.

In summary between 2014 and 2018 in Enfield there will be (Source POPPI/PANSI):

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

The charts below demonstrate the demographic pressures facing Enfield across all care groups:

Chart 1 – Personal Care Disability

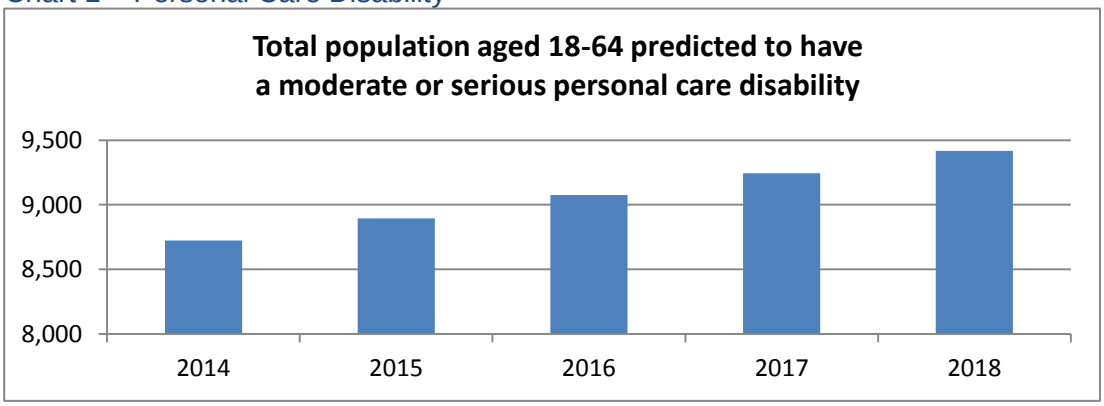


Chart 2 – Learning Disability

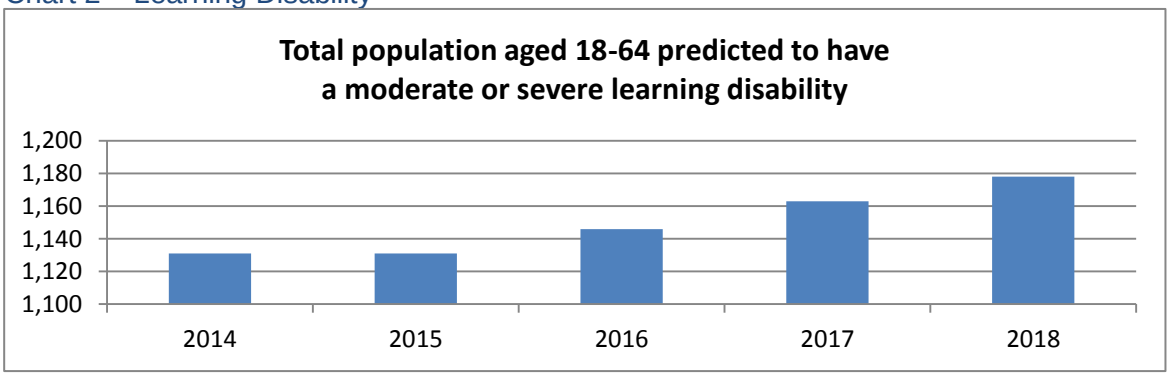


Chart 3 – Mental Health

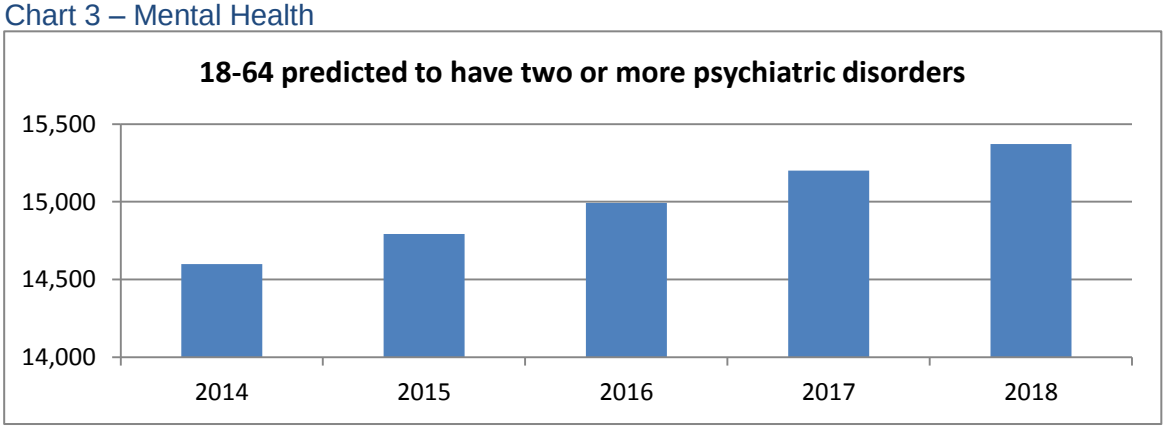
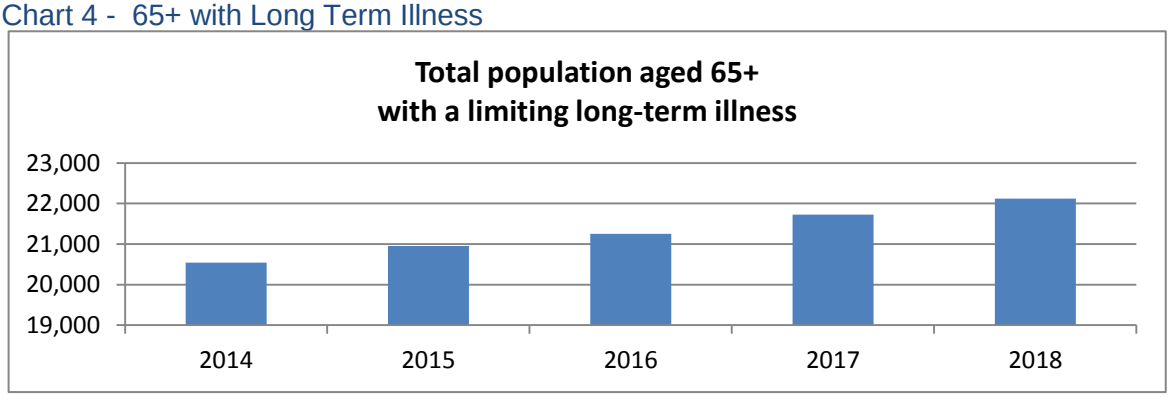


Chart 4 - 65+ with Long Term Illness



Funding to support the additional demand for services across all care groups (calculated at current prices) is:

- Older People - £900k
- Physical Disability & Sensory Impairment - £850k
- Learning Disability – £2,900k
- Mental Health - £950k

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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 current trend
Older People	5.7%	£900k
Physical Disability and Sensory Impairment	11.6%	£850k
Learning Disability	14.6%	£2,900k
Mental Health	23.0%	£950k

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

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

Enfield has CQC recognised leading practice in identifying and responding to concerns about the quality of care in local providers. We have seen a significant rise (38%) in safeguarding investigations during 2013/14, with a particular focus on nursing homes. This impacts system capacity both through the potential for increased hospital admissions and a reduction in nursing

home capacity to support discharges where restrictions on new care home admissions follow confirmation of safeguarding concerns.

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

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

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£734k specifically for the Care Act Duties (see also 7 a) iv)) from the Better Care Fund Allocation*

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Our Care Act Programme has identified a series of key tasks and duties in its implementation. We are supporting the plans set out in our Care Act Planning, which has been agreed by the Enfield health and Wellbeing Board. These are summarised in the table below by overarching duty and timescale.

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

v) Please specify the level of resource that will be dedicated to carer-specific support

Enfield's aim is to move towards a single funding approach for all carers across the health and

care economy. This will engender a consistency in approach and support offered to our carers across Enfield. One of Enfield's key Health and Wellbeing Board sponsored priorities is to develop a register of carers which is co-ordinated across primary care, social care, acute care and mental health.

BCF Carer Specific Support is set at £289k for 2015/16 for enhanced support and respite

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change in the original Forecast from April 2014 BCF Submission

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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 through rapid response to intermediate care, enablement and/or crisis management. Such schemes already exist and it is important to test the use, effectiveness and impact of extended working in this environment:

- Urgent Care Centres are open at Chase Farm and North Middlesex University Hospital;
- 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 and TREAT model to support older people in hospital;
- 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 as part of post-acute care enablement;
- Out-of-hours GP service and we are developing a 7 day working for primary care, at network level linked to an accountable GP role.

These solutions 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 management 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;
- 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 our intention to develop a 7-day model with or without this funding;
- 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 weekend working in the Older People's Assessment Unit to facilitate assessment, diagnosis, treatment and support.

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.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All clinical services commissioned by the CCG use the standard conditions in the NHS Standard Contract for 2013/14, 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 case find and refer into our MDTs and Older Peoples Assessment Units.

ii) Please explain your approach for 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 and will ensure that new IT systems will comply with this requirement.

The CCG and Council 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. A Shared Care Record Board has been established reporting to the Integrated Care Board. The agencies involved include Enfield's primary care community [GP IT], BEH MHT including Enfield Community Services, North Middlesex Hospital and Royal Free Hospital Foundation Trust incorporating Barnet and Chase Farm hospitals, London Borough of Enfield (LBE) and NHS Enfield CCG.

Multiple systems are used across providers. The Shared Care Record Programme is intended to ensure safe and efficient ways to access the patient record through the patient's journey of care, resulting in a reduction in:

- Reduction in unnecessary duplication of patient data,
- Reduce delays in patient care;
- Limit the need to ask patients for the same information on multiple occasions; and.
- Ensure links between providers which can reduce risks to patient safety.

It is recognised that developing an integrated shared record is not in itself an end solution but a key driver to enabling patients and clinical staff to have access to the right information at the right time.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The Council's ESP includes local NHS partners. 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 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 for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

We have implemented an IT-based risk stratification system based on the PARR-30 tool as part of our integrated care model. This allows GPs and primary care management MDTs to view all primary and secondary health and adult social care episodes about their patients. This tool identifies the risk of patients being re-admitted to hospital based on their previous history of hospitalisation from secondary health records, and, rather than assign a risk "low", "medium" or "high" as previously, ranks patients in order of likelihood of subsequent admission. This tool helped us to identify 4,600 Enfield residents of all ages in the top 2% of emergency hospital admissions (87% of whom are older people) - around 10% of the older population - as part of NHS England's Enhanced Services for Unplanned Admissions launched in 2014/15.

We are awaiting intelligence from NHSE to learn how many of these patients' care plans jointly developed with relevant professionals have been submitted from our GP practices, but our intelligence suggests a high level of compliance amongst GPs for completion of such plans by end Sep-14. GPs have triaged (and are continuing to do so) these cases to determine which patients are suitable for a comprehensive MDT approach (GPs can also refer patients to individual agencies, e.g. social care, as now as part of care planning). Those patients requiring a comprehensive MDT approach are the subject of tele-conferences and face-to-face meetings to

build care plans and delivery. Our experience suggests 25%-33% of the 4,600 patients require a comprehensive MDT, with the remainder a "lighter-touch" MDT care plan.

However, our current risk stratification identifies only those patients with a history of hospitalisation. Feedback from GPs suggest whilst this is valuable, the current tool has a bias towards identifying patients likely to be well-known to them. They have highlighted a need to risk stratify those patients likely to need intensive support, including those have no recent history of hospitalisation. In response, we are working with academic consultants to develop a frailty algorithm with our IT providers to identify older people with frailty as the basis for our stratification. Figure 8 describes our risk triangle and our model's proposed "offer". The figures were derived by applying studies on frailty prevalence to our 65+ population (Collard, 2012).

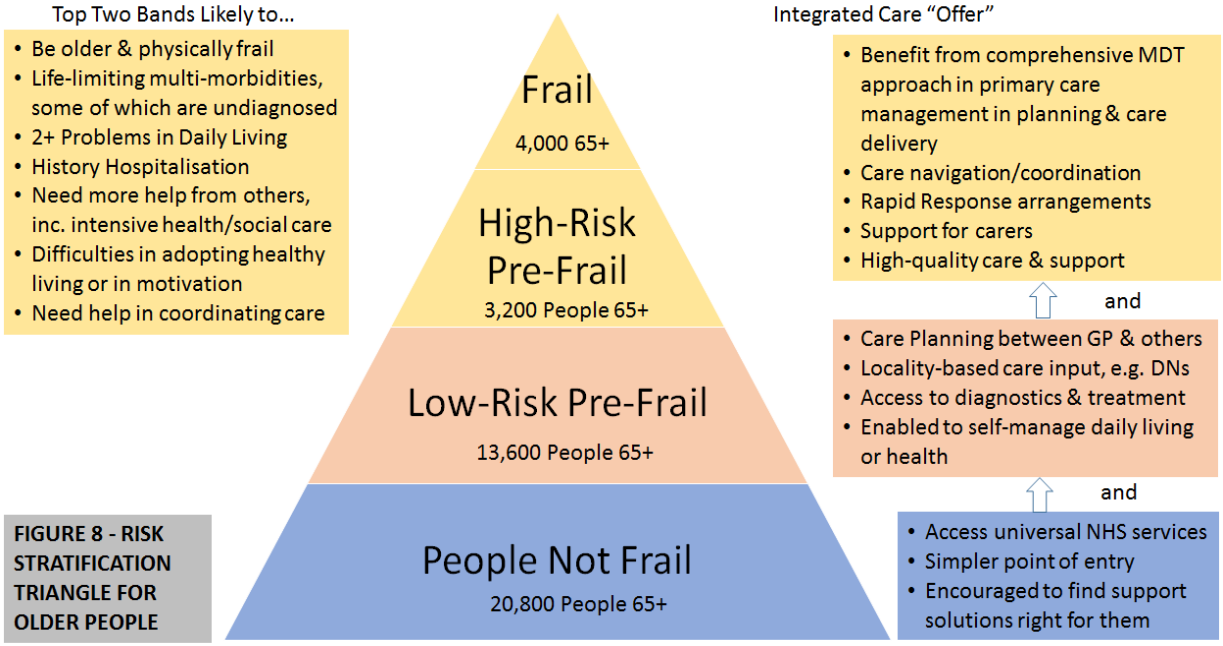


FIGURE 8 - RISK STRATIFICATION TRIANGLE FOR OLDER PEOPLE

Whilst primary care will reach out to the entire population as part of GPs' responsibilities to patients, our integrated care model will work with 20,800 older people (50% of the population aged 65+) and, in particular, the 7,200 people in the top bands in Figure 8, with 25%-33% of the 7,200 (including those in care homes) predicted to need intensive MDT case management.

Ultimately, we intend to screen all older people using an e-Frailty Tool (Clegg & Young, 2013) currently in development nationally as part of primary care monitoring. In the meantime, we will use existing primary & secondary healthcare and social care data, including diagnostic and case information data to flag individuals likely to be "frail", "pre-frail" and "not frail" to GPs; this categorisation will then be cross-referenced against likely hospitalisation risk.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The joint assessment, care planning and allocation process in 2015/16 will be the same as our current arrangements; what will change is the population cohort case-managed – those most at risk of hospitalisation (NHSE Enhanced Service in 2014/15), but the risk-stratified larger group of older people with frailty in 2015/16; and we will introduce similar arrangements to other population groups as part of our BCF Plan. Figure 9 summarises our joint process, making the best use of resources to provide a joined up person-centred response to stratified need.

The assessment, care planning and delivery function will have the following features:

- Risk stratification to pro-activity identify patients is enabled via e-solutions & joint working under-pinned by appropriately governed information-sharing with the GP having access to care records to help them filter which patients need which response;
- Joint assessment processes will incorporate, as far as possible, all individual assessment requirements within statutory frameworks, e.g. those associated with hospital discharge planning, Carers' Assessments, Continuing Health Care or social care assessments;
- Common care plans that sets out who is their Lead Accountable Professional and who their case manager, building on the new GP contract, which specifies arrangements for patients aged 75+ to have an accountable GP and the NHSE Enhanced Service;
- The case coordinator/manager will be appointed from the local health and social care system according to individuals' needs and circumstances, but with a view to match these needs to relevant staff functions, skills and qualification levels;
- Care planning incorporates a Rapid Response element setting out individuals' access to intermediate care, enablement and crisis management services, where relevant;
- Care planning will incorporate patient-determined outcomes, a development we are introducing through a Locally Commissioned Service this year, which will be used to provide an incentive to GPs to improve the management of older patients;
- A "core" MDT including the GP will work with patients (and carers) with more complex needs to jointly determine their care needs, plan, coordinate, deliver & review care, bringing in the necessary specialist input, resources and interventions flexed around individuals' needs.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

18% (as at August 2014)

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The CCG and its partners have engaged extensively with service users, carers and residents on the development of their plans. The views of service users and carers are critical particularly as we begin to develop an outcomes based approach to the commissioning of services for all the client groups impacted by the BCF and the CCG's own transformation programme.

In addition to engagement with specific service user groups the CCG has undertaken more general patient and public engagement on a number of areas, and was a pilot area for the NHS Call to Action in 2013-14. We have also continued to develop the practice based patient participation groups with the result that every GP practice has one. Our governing body includes representatives of PPGs and Health watch.

Healthwatch are represented on the working group which has developed the BCF plans from its inception.

Engagement activities to date include the following:

- Work with user groups including older people, people with long term conditions and people with mental ill health to support the development of user outcomes measures to inform future commissioning of integrated care services,
- Work with user groups on the design of specific elements of the older peoples integrated care service including the Older Peoples Assessment Units ('OPAUs')
- Evaluation of patient feedback from their experience of our older peoples services including the OPAUs
- Involvement of users through voluntary sector, healthwatch and other expert patients in the partnership groups which drive these programmes
- Pan Enfield patient and public engagement events (3 a year) covering a range of topics including our strategic plans, overview and detail on our transformation programme and the development of patient quality outcome measures for example access, communications and person centred care
- Involvement of expert users in specific service transformation projects such as diabetes and mental health
- Proactive engagement with specific groups such as the Enfield Turkish Cypriot Association Luncheon Club and the over 50s forum including presenting at their AGM and at the Older People's International Day
- Running an Enfield CCG Stall at the two day July 2014 Edmonton Summer Festival (engaging with 100+ residents) and the September 2014 Enfield Town Show (meeting over 300+ residents over the 2 days)

- A public consultation exercise on the Enfield mental health strategy

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 and the previous 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;
- Patient Participation Group network meetings
- 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.

Some of the results of the engagement were:

- Stakeholders said that some residents were having difficulty getting to the Older People's Assessment Unit' so we commissioned a new transport service
- Stakeholders wanted more information about local health services, so we designed a Choose Well Campaign with Barnet and Haringey CCGs including an App – Choose well North London (available for apple and android devices)
- PPG members asked for support and help in working together, so we organised network meetings for Chairs and all PPG members as well as training through Enfield Voluntary Action, membership of the national Association of Patient Participation membership, a feedback form and an email address for all PPGs members to send feedback to the CCG

We will continue our engagement of the BCF 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, Patient and Public Engagement Events, Patient Participation Group Network meetings and through information posted on our websites and through social media.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

We remain committed to working through the implications for our acute sector partners of the Better Care Fund implementation.

We have engaged with our acute and mental health/community service providers both specifically on the development of our better Care Fund programme and have also included the BCF in our broader provider engagement. A summary of both areas follows.

3 Focused provider workshops on the BCF:

Given the financial and service challenges in the Enfield health economy the development of the BCF plan has been a matter of interest and scrutiny for our providers. While the schemes included within it fall with our existing transformation programmes there has nevertheless been concern at the additional potential risk to provider sustainability arising from the accelerated approach required from the BCF. We have therefore sought to ensure provider engagement in this work through both individual discussions with providers and through workshops for all our providers. We have carried out 3 provider workshops specifically on the BCF and have a programme of meetings and discussions with individual providers. Provides have been supportive of the direction of travel and the push to integrate services but concerned at the pace and risk associated with it.

Provider engagement in the development of the NCL strategic plan:

The NCL CCGs work together on the development of their 5 year strategic plan. Integration of services through an outcome approach to commissioning is one of the 6 NCL strategic interventions, of which locally with Haringey we are working on older people with frailty. Providers across NCL are part of the planning process and commissioners and providers across NCL meet every two weeks to take this work forward.

Provider engagement on steering and working groups for specific transformation programmes, including specific items on BCF:

Transformation boards are in place with the CCGs three main providers, meeting bi -monthly to drive the transformation agenda with specific focus on Better Care Fund programmes.

This approach will continue and is embedded in the organisations.

We plan to continue to do this with them in partnership. We have shared our plans with them 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 of those contracts. Both NMUH and Barnet Chase Farm 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 regularly meets with all its providers (BCF, NMUH and BEHMHT) to discuss the high-level impact of the Better Care Fund. Further meetings took place in September 2014 prior to submission of this plan. Further discussion will take place via CE-to-CE as well as through acute-focused Transformation Boards and via the development of the North Central London Strategic Plan. Our governance arrangements include plans to include acute providers in the decision making process of the Enfield health and care system. Financial modelling has and will be undertaken to determine the impact for Trusts across NCL including specialty level impact. There will 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 across the sector.

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 CCG and LBE are jointly developing a risk share with our providers which mitigates the risk of not realising the full shift in activity and therefore, the full saving.

We will ensure that other providers are engaged and all related activity aligned through our governance arrangements, which are set out 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.

ii) primary care providers

Enfield has been working with its general practices for 2 years now on developing integrated care. This has focused on the following areas:

1. Governing Body GP lead for Integrated Care established now for 18 months
2. Supporting activation of the risk stratification tool within each practice
3. Working with GP leads to develop the integrated care programme including the model of the Older People's Assessment Unit
4. Supporting participation in MDT teleconferences to provide opportunities to discuss complex or challenging patients
5. Supporting implementation of the Directed Enhanced Service for reductions of emergency admissions
6. Detailed work with individual practices as part of developing the locality integrated teams
7. Utilising the £5 per head to support the development of locality integrated teams, MDT

care plans and activity reductions.

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.

iii) social care and providers from the voluntary and community sector

The voluntary and community sector in Enfield is centrally placed and highly regarded in terms of how social care support has been developed to meet the needs of some of the most vulnerable people in the borough. Through innovative and collaborative working, and having the needs of customers at the heart of things, the voluntary and community sector has helped to make choice and independence for individuals a reality. The voluntary and community sector has also contributed in bringing new resources into the borough and in building greater resilience within communities.

The new Adult Social Care Strategic Commissioning Framework provides a clear statement of intent to provide a set of principles and long-term goals that form the basis of adult social care commissioning with the voluntary and community sector over the next three years. In deciding these objectives and outcomes to be commissioned, adult social care commissioners will maintain their commitment to engage with the voluntary and community sector, customers and other key stakeholders in order that they can contribute to the design of provision and to measures for performance monitoring.

The framework's principles and objectives were developed in partnership with a wide range of stakeholders including elected members, customers and residents, voluntary and community sector organisations, the Voluntary and Community Sector Strategic Group (co-chaired by the Cabinet Member for Community Wellbeing and Public Health and the Council's Chief Executive), health and social care professionals and the Council's Communities, Partnerships and External Relations team. The framework puts forward shared principles going forward to underpin commissioning from the sector which include:

- where appropriate, assessed needs of service users and carers met though personalisation and personal budgets
- views and voices of users and carers sought and included in commissioning and procurement activities
- proportionate market testing and engagement
- commissioning processes that seek to build social capital in collaboration

.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The Better Care Fund schemes are intended to transform the pattern of activity in Enfield

reducing non-elective admissions, delayed transfers of care and admissions into care placements.
The majority of Enfield's non-elective admissions (NELs) are shared amongst two acute providers: Royal Free London NHS Foundation Trust and North Middlesex University Hospital Trust. The table below shows the full-year activity for NELs across the acute trusts. Due to limitations in the data available 'well babies' admissions have not been excluded.

TRUSTS	NELS 13/14	%Share NELs
North Middlesex University Hospitals NHS Trust	11,170	44.9%
Royal Free London NHS Foundation Trust	694	2.8%
Barnet & Chase Farm Hospitals NHS Trust	10,541	42.3%
Other (A number of different trusts)	2,482	10.0%
	24,887	**100.0%**

The target reduction of non-elective admissions is 3.5% which translates to a reduction of 762 admissions and will generate savings of £1,722,882. Based on the percentage share of admissions amongst acute trusts, these savings break down as follows:

TRUSTS	Reduction Target	Savings (£)
North Middlesex University Hospitals NHS Trust	472	£1,067,192
Royal Free London NHS Foundation Trust	20	£45,220
Barnet & Chase Farm Hospitals NHS Trust	194	£438,634
Other (A number of different trusts)	76	£171,836
	762	**£1,722,882**

The Better Care Fund will be working alongside a broader range of Quality Innovation Productivity and Prevention (QIPP) Programmes to reduce non-elective admissions. These schemes will not duplicate BCF schemes.

The combination of activities in the Better Care Fund will result in the following impacts on acute activity:

1. Reductions in non-elective admissions will provide greater capacity within acute trusts to deliver quality improvements including performance on A&E 4-hour wait targets and Referral to Treatment time (RTT) targets.
2. Reductions in length of stay will enable acute trusts to repatriate patients to the most appropriate setting for their care and to manage peaks in demand.
3. Improved care planning and care co-ordination will give acute trusts greater access to patient information, support the most effective treatment responses and reduce duplication.
4. Self-management of Long Term Conditions will increase outpatient capacity for Long Term Conditions, where it is needed most.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 2 Terms of Reference and Membership – Integration Board

Terms of Reference

The Board will act as the key advisory body for the Integrated Care programme, with any formal decisions being subject to ratification by the Health and Wellbeing Board, by:

- Owning the Vison for Integrated Care
- Communicating the Vision for Integrated Care
- Defining and owning the blueprint for change
- Responsibility for defining and managing the overarching Risk Framework
- Managing by exception the identified Critical Success Factors, benefits and Milestones of the BCF Programmes
- Providing 'whole system' leadership in the oversight & development of integrated Care
- Providing Financial, Quality and Risk Management leadership (subject to delegated authority from the HWBB)
- Owning the 'desired outcomes' (end states), benefits and value for Enfield's people and monitoring them in light of safeguarding and quality of care considerations
- Providing regular reporting and monitoring information to the HWBB Board particularly where there are perceived high level risks and issues for delivery.
- Monitoring the benefits realisation and delivery milestones, via highlight reports, within the Better Care Fund programme and Integrated Care Programmes
- Leading the programme of work through facilitating and developing a positive culture across organisations for improved service integration for those populations identified through the joint Better Care Fund plan.
- Individually and jointly communicating key messages across staff partners/people - including supporting the communications campaign and strategy
- Identifying and ratifying quick and sustainable opportunities for further integration of services across Enfield
- Unblocking of any actual or potential barriers to success in partner organisations
- Jointly engaging with stakeholders (both internal and external) in development and implementation of the Programme to ensure awareness and ownership
- Ensuring that appropriate community engagement is taking place and feedback is captured and acted upon swiftly

Membership of Integration Board

Title	**Organisation**
Chief Officer/Chair	ECCG
Director HHASC	LBE
Director of Schools and Childrens' Services	LBE
Director of Strategy and Partnerships	ECCG
Chief Executive – Royal Free Hospital NHS FT	NHS
Chief Executive – North Middlesex NHS FT	NHS
Chief Executive - BEH-MHT	NHS

Chief Finance Officer	ECCG
Director of Finance	LBE
Better Care Fund Programme Manager	CCG/LBE

Reporting

The Integration Board will receive updates from the Integration Programme Board chaired by the Integration 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.

Chair and voting

The Chair is the Chief Officer from the CCG. The Chair will provide regular updates to the HWBB's Executive Board. 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 Integration Board will share information with the Joint Commissioning Board, Value Based Commissioning, the Council's Transformation Board and Leaner 2017 programmes of work. Consideration will need to be given to how the BCF and Integration Board will share information with the other governance arrangements already in place across both LBE and ECCG.

ANNEX 3 – Terms of Reference and Membership – Joint Better Care and Commissioning Board

Terms of Reference

The Board will act as the key advisory body for the Integrated Care programme, with any formal decisions being subject to ratification by the Health and Wellbeing Board, by:

- Leading and performance managing the delivery of the Better Care Fund 2 year strategic plan.
- Providing Financial, Quality and Risk Management leadership (subject to delegated authority from the HWBB)
- Owning the 'desired outcomes' (end states), benefits and value for Enfield's people and monitoring them in light of safeguarding and commissioning and quality of care considerations
- Ensuring a co-ordinated approach across health and social care commissioning (inc. Public Health) in partnership with the Clinical Commissioning Group and particular reference to BCF commissioned services.
- Leading on the development and implementation of integrated care pathways for agreed conditions in order to reduce bureaucracy and overlaps in integration
- Monitoring 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).
- Providing leadership and guidance on certain agreed commissioning intentions set out in Joint Commissioning Strategies and the BCF Programme
- Monitoring performance of jointly commissioned services and highlighting cost pressures or risks as they arise.
- Ensuring that robust integrated performance management systems across health and social care are developed that enable the programme 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.
- Reporting 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 under the BCF Programme.

Membership

Title	Organisation
CCG Chief Officer	CCG (Chair)
CCG Clinical Lead	CCG
Director HHASC	LBE
Assistant Director of Strategy and Resources	LBE
Director of Strategy and Partnerships	CCG
Assistant Director - Commissioning & Community Engagement, Schools and Children's Services	LBE
Chief Finance Officer	ECCG
Director of Finance	LBE
Assistant Director of Public Health	LBE

Head of Commissioning, Procurement, Contracting and Brokerage	LBE
CCG Board Member (Mental Health lead)	CCG
CCG Board Member (Children's lead)	CCG
Head of Mental Health Commissioning	CCG
Head of Children's Commissioning	CCG
Better Care Programme Manager	CCG/LBE

Reporting

The Joint Better Care and Commissioning Board will receive updates from the Integration Programme Board chaired by the Better Care Fund 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.

Chair and voting:

The Chair is the Chief Officer from the CCG. The Chair will provide regular updates to the HWBB's Executive Board. 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 Board will share information with the Joint Commissioning Board, Value Based Commissioning, the Council's Transformation Board and Leaner 2017 programmes of work.

Annex 4 – Draft Terms of Reference and Membership of Professional Reference Group

Terms of Reference

- To review, test and endorse the service models developed by the programmes
- To provide a source of professional expertise/assurance available across the programmes.
- Suggest, assure and endorse delivery models for approval in their Statutory Organisations
- Ensure active Professional Leadership supporting the agreed service model from all partner organisations
- Ensure that the workstreams and programmes provide appropriate designs and products consistent with the overall clinical models of the Plan
- Test and provide assurance for proposed service changes to understand their appropriateness in meeting the agreed vision for Integration

Membership

Title	**Organisation**
Clinical Director CCG	ECCG
Chief Executive - Health Watch Enfield	HW
Medical Director - Royal Free Hospital NHS FT	NHS
Director – Strategy and partnerships	CCG
Assistant Director – Strategy and Resources	LBE
Medical Director – North Middlesex NHS FTR	NHS
Medical Director – BEH - MHT	NHS
Director of Public Health	LBE
Better Care Fund Programme Manager	CCG/LBE
Senior Practitioner Social Care	LBE
GP Representative (Federation)	NHS
Third Sector Representative	LBE