Better Care Fund 2016/17

Enfield Narrative Plan – 21st March 2016

NHS
Enfield
Clinical Commissioning Group

1. Local Vision for health and social care services

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

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

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

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

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

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

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

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

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

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

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

2. An evidence base supporting the case for change

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

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

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

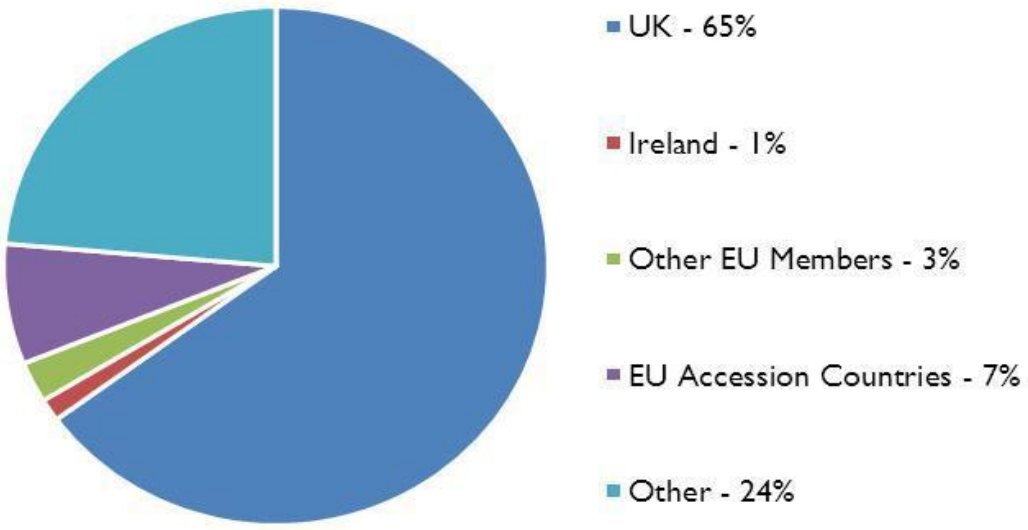
22.6% of Enfield's population are under 16. This is above the average for London (20.2%) and very nearly twice the proportion in the UK (11.5%). Children in Enfield live disproportionately in the less wealthy east of the borough, and this is reflected in

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

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

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

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



Source: 2011 Census

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

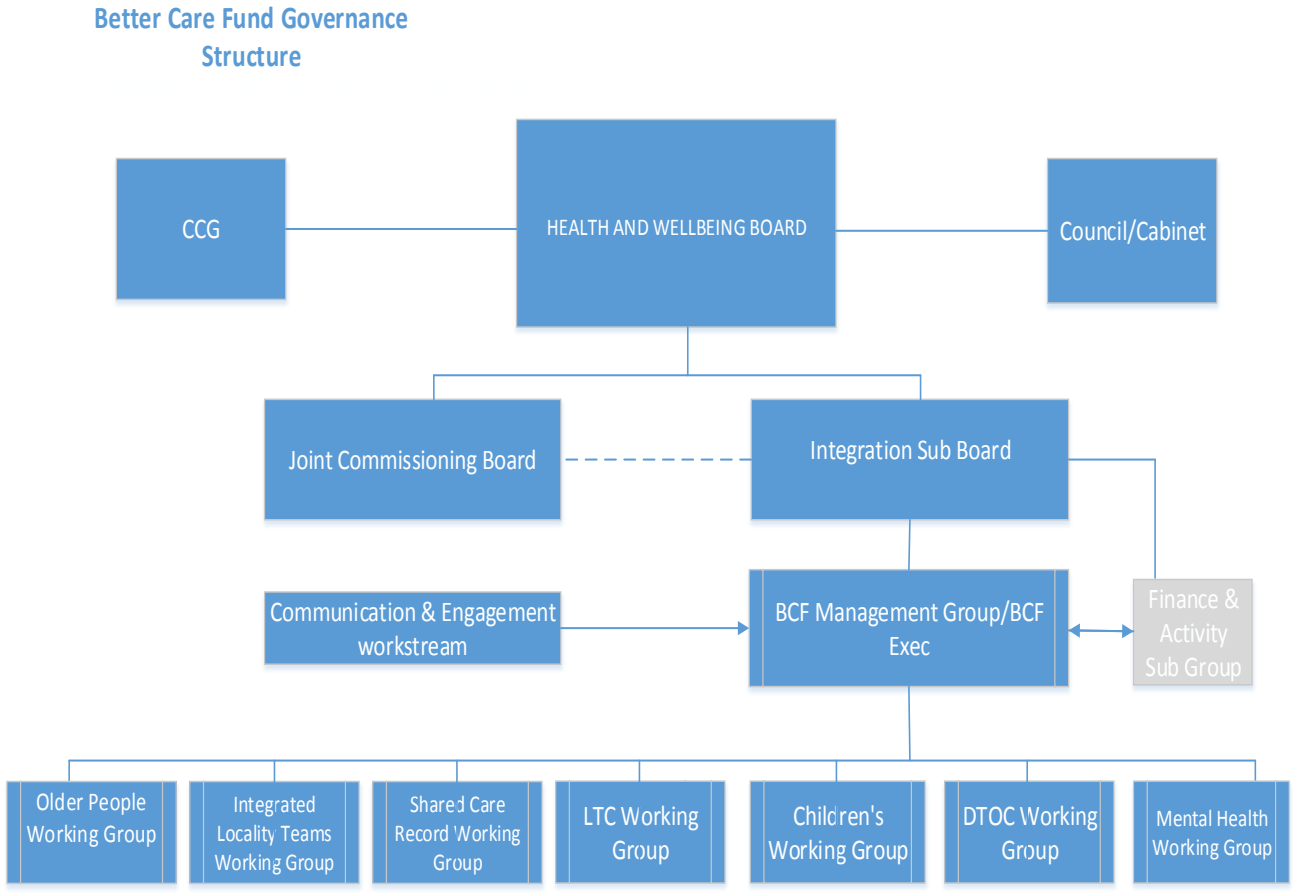
CASE FOR CHANGE ISSUE SUMMARY	**Population Groups**			
	Integrated Care for Older People	**Mental Health**	**Working Age Adults & LTC**	**Children with Health Needs**
	All above have cross-cutting theme: Supporting Carers			
Population Needs: The health of population continues to improve, but there remain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

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

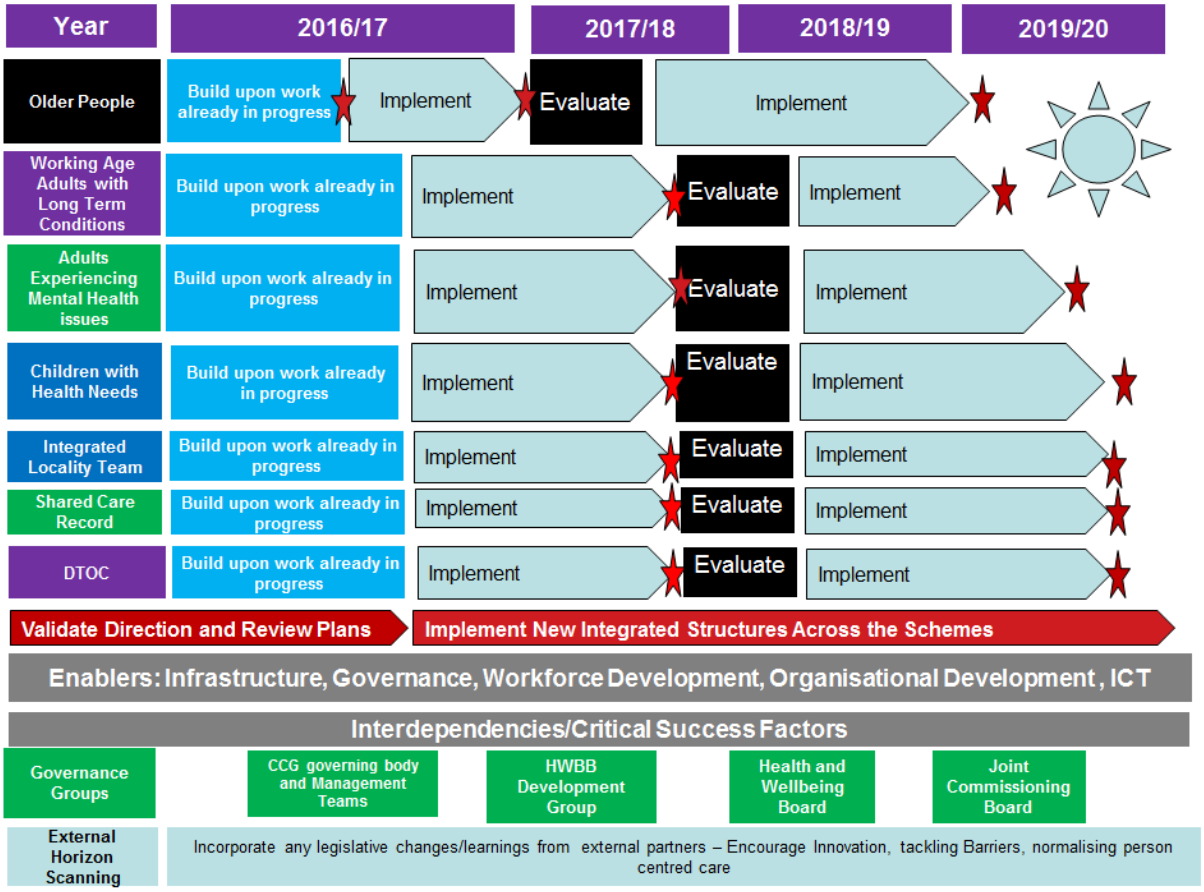
Opportunities to build health and social care partnerships to deliver collective efficiencies and manage more sustainably	✓	✓	✓	✓
Opportunities to develop infrastructure to support and sustain transformation	✓	✓	✓	✓

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

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



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



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

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

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

The Integrated Care Programme

The aim of our integrated care programme is to develop a person-centred response to planning and delivering care to individuals so local people will be able to say: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve outcomes important to me". Our principles are in line with the NHS Five Year Forward View:

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

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

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

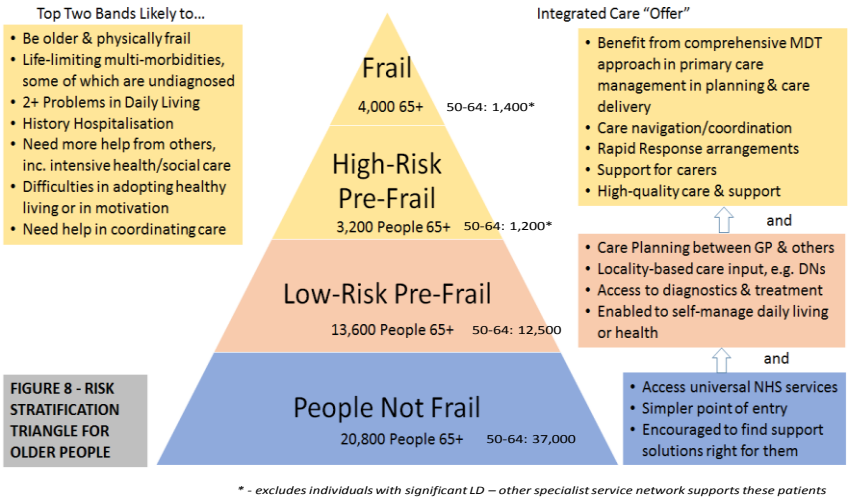


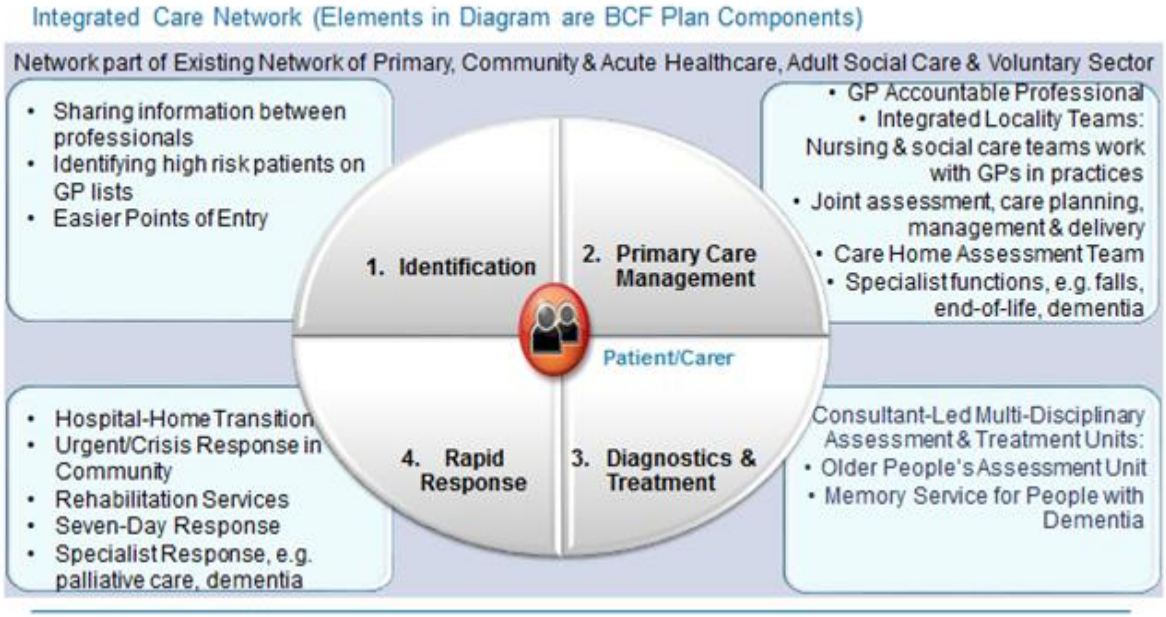
FIGURE 8 - RISK STRATIFICATION TRIANGLE FOR OLDER PEOPLE

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

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

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

Integrated Care Network Model



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

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

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

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

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

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

NHS England National Conditions

1. Plans to be jointly agreed

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

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

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

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

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

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

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

- Moving towards enabling and self-care

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

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

2. Maintain provision of social care services

Within the Better Care Fund £6,055m has been allocated to maintain the provision of social care services in 2016/17 compared to £5,952 for 2015/16. Our plans protect local social care services in three main ways:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

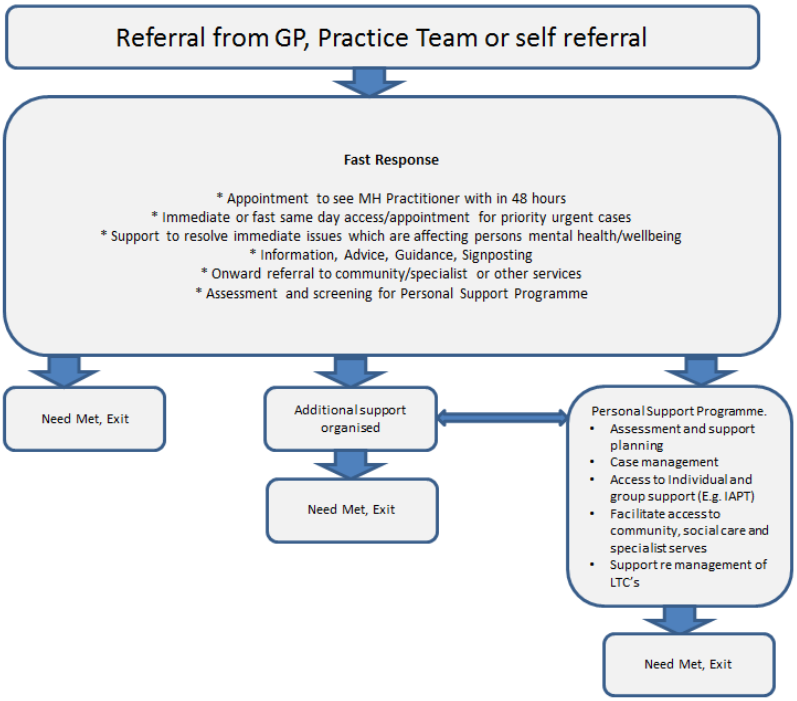
- *GP Urgent Access Hub* established in 2015/16 to enable professionals to schedule GP appointments for patients with clinical needs who need to be seen quickly in the evening or at the weekend at a local practice;
- *Re-commissioned 111 and GP Out-of-Hours Service* to be implemented Oct-16 which will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

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

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

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

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



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

In Hospital Settings

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

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

Direct Access GP Pilot

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

Hospital Discharge

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

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

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

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

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

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

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

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

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

9. An agreed approach to financial risk sharing and contingency

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

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

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

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

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

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

10. Detailed Plans

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

Appendix

Better Care Fund Better Care Fund Related documentation
Information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Enfield JSNA	Setting out our changing demographic pressures and arranged according to a series of themes, in order to make it accessible. www.enfield.gov.uk/healthandwellbeing/info/3/joint_strategic_needs_assessment_jsna
Enfield JHWS (for link to consultation survey)	Setting out our agreed priorities for the area. www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy
Enfield CCG – Plan on a Page	Providing the basis for our strategic planning and work with neighbouring CCGs. www.enfieldccg.nhs.uk/Downloads/Policies/ECCG%20Plan%20FINAL%204%20280313.pdf
North Central London Primary Care Strategy	Setting out the acute commissioning landscape and changes agreed across Boroughs. www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf
Enfield's Joint Commissioning Strategy for End of Life Care 2012-16	Our priorities and plans for this important group. www.enfield.gov.uk/downloads/file/8457/enfields_joint_commissioning_strategy_for_end_of_life_care_2012-16
Enfield's Joint Stroke Strategy, 2011-2016	Explaining our priorities in this condition-specific area. www.enfield.gov.uk/downloads/download/2627/enfield_joint_stroke_strategy_2011-16
Enfield's Joint Dementia Strategy, 2011-2016	Setting out our initial plans for dementia sufferers in the Borough. http://www.enfield.gov.uk/downloads/download/1317/joint_dementia_strategy_2011__2016
Enfield's Joint Carers Strategy, 2013-2016	Explaining our joint plans for carers, working across health and social care. www.enfield.gov.uk/downloads/download/2429/enfield_joint_carers_strategy_2013-2016
Enfield's Joint Intermediate Care and Reablement Strategy, 2011-2014	This important strategy sets out our approach to increasing the numbers of people supported through our intermediate care work as well as continually improving outcomes as a result of our interventions. www.enfield.gov.uk/downloads/download/1319/joint_intermediate_care_and_re-ablement_strategy_2011-2014
Adult Social Care - Voluntary and Community Sector Strategic Commissioning Framework 2013-2016	This document has been shaped by our partners in the voluntary and community sector and explains our plans for supporting them to meet need in the community. www.enfield.gov.uk/downloads/file/8459/voluntary_and_community_sector_strategic_commissioning_framework_2013-2016
JSNA Older People with Complex Needs Factsheet	http://www.enfield.gov.uk/healthandwellbeing/info/18/the_health_and_wellbeing_of_older_people/57/older_people_with_complex_needs

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