NHS
Enfield
Clinical Commissioning Group

ENFIELD CARE CLOSER TO HOME PROGRAMME

SUMMARY

This paper provides details of the progress made to date on the development and implementation of the Care Closer to Home Integrated Network Agenda and its impact on the wider health & social care system in Enfield.

Care Closer to Home is a flagship programme designed to deliver integrated, community-based healthcare services which support people to stay healthy and live independently for longer. This includes services for both adults and children who have identified health needs. For example, the frail and elderly, people with disabilities and long-term conditions, and those with palliative and end of life care needs.

Enfield CCG, with our partners in health, social coal care and voluntary sector, will be aiming to deliver much more care in the community, either in patients' homes or closer to where they live and work. Committing to a population outcome-based model, aims to reduce the dependence on avoidable and unnecessary hospital attendances and admissions. For those who do need hospital care, our plan ensures there is more support available locally so they can return to their home as quickly as possible Enable earlier interventions and provide more integrated, coordinated support to those most in need, including the frail elderly, children and those with long term conditions.

This programme of work is being jointly designed and progressed with the London Borough of Enfield, Enfield Health, our GP Federation - Enfield Healthcare Co-operative Limited (EHCL), and all relevant stakeholder in full recognition of the need for a coordinated and integrated approach to promote local health and social care delivery in ways which best meet the needs of the residents and registered population of Enfield.

Enfield's vision for Care Closer to Home

To bring together health, social care and voluntary sector organisations to provide better outcomes for our population whilst alleviating the pressure on the system through smarter, more cohesive working arrangements across health and social care within our communities. Our ambition is to create hubs across all localities, shaped to meet the needs of that local area. The hubs will become a focal point in communities to support people to lead happier and healthier lives with a range of organisations and professionals working together to achieve that objective

What does Care Closer to Home Integrated Network mean for the people of Enfield?

- Community and primary care services available for longer during the evening and weekends;
- A single care record, so people only have to tell their story once;
- Greater deployment of technology to provide patients with faster access to support and consultations;
- A single phone number for patients, giving access to a range of community services 24 hours a day, 7 days a week;
- Building further upon our Integrated teams of nurses, therapists, social care, mental health, specialist nurse, primary care;

- Helping patients to manage their own long-term conditions and increase their independence;
- Continuity and coordination of community-based health and social care services for the local population;
- Seven day access to palliative care beds and a 24 hour helpline;
- To increase people's ability to access urgent care more locally when they become unwell, avoiding being admitted to hospital where appropriate.

Background & Context
A collective response to implement Care Closer to Home is one of the fundamental platforms for change in the North Central London STP. This model builds on much of the work already underway across Enfield to develop integrated working and person-centred care.

The high-level objectives of this programme are:

- To establish a place-based system of care delivery which draws together social, community (incl. voluntary sector), primary and specialist services in a seamless, integrated way;
- To ensure the local population gets the right care, at the right time, in the right place;
- To improve access to services and reduce health inequalities;
- To improve the quality of primary care and reduce unwarranted variation without stifling innovation;
- To improve the management and prevention of chronic disease;
- To provide support for people to self-care;

The STP identifies a number of delivery/enabling mechanisms for the enhancement of care closer to home. Collectively, these require an integrated approach across health and social care and strengthened federated working by providers, including primary care. This should include the more flexible deployment of workforce skills across organisations

The three main drivers of change are:

Improved Access to Primary Care
Patients will be able to access consultations with GPs or other Primary Care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm seven days a week.

Planned outcomes are improved patient satisfaction with access to primary care and a reduced number of patients seen in A&E/Urgent Care with a primary care appropriate problem

Care Closer to Home Integrated Networks (CHINs)
CHINS may be virtual or physical. Typically covering populations of c50-80,000, they will be home to a number of services, providing an integrated, holistic, person-centred model of health and social care and support. At the heart of this will be integrated health and social care multi-disciplinary teams, care planning, risk stratification and care coordination. Support from specialist consultants should be accessible to enable GPs and their teams to manage more care closer to home.

Planned outcomes are a reduction in clinical variation, a reduction in secondary (hospital) care activity and cost, a reduction in the number of residents dying prematurely, an enhancement of the quality of life for people with long-term conditions and an increase in the number of patients having a positive experience of care.

Quality Improvement Support Teams (QISTs)
These GP-led teams will be tasked with improving quality in primary care and reducing unwarranted variation. They will play a central role in supporting CHINs, providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer of service. They will help to identify, promote and roll out best practice, clinical innovation and proven technologies in a systematic and consistent way. This will include support to maximise early identification and support and the proactive management of high blood pressure, atrial fibrillation, chronic kidney disease and diabetes.

Planned outcome is to reduce local variation by identifying patients on a particular specialism in a particular locality and design an integrated service close to home that fits the integrated care needs of the individual

Progress on programmes developed to support Care Closer to Home Agenda in Enfield

Extended Access to Primary Care:
NHS Enfield CCG commissioned three locality-based primary care access hubs to improve patient access across the borough of Enfield. These services support the delivery of access to primary care GP services 8am to 8pm, 7 days per week as set out in the Care Closer to Home Agenda. The service offers both routine and urgent appointments for all patients registered with an Enfield GP practice and offer a skill-mix that includes GP and Nurse appointments. There is also a walk in service in the north east of the borough operating from 8am to 8pm on weekends and Bank Holidays.

Patients can access appointments through a Single Point of Access (SPA) number **03000 333 666.**

CHINs and QISTs
Enfield's newly formed GP Federation, Enfield Healthcare Co-operative Limited, has been commissioned to deliver out of hospital services to the entire patient population of Enfield. Mobilisation of these services have been progressed since 1st December 2017

The CCG has commissioned Phase I of what is known as the Enfield Single Offer Single. These are a range of services that must be offered universally to all patient in Enfield. Phase I services include:

- Atrial Fibrillation & pre-Diabetes;
- The establishment of a diabetes QIST to identify and offer care to those patients requiring support with their care;
- Wound care services offered 7 days per week;
- Medicines Optimisation – to review medication usage;
- Locality Commissioning – to review patients who could be treated closer to home and to avoid unnecessary hospital admissions;
- Latent TB Screening;
- Support to stable prostate cancer patients;
- Supporting patients with online services for booking appointments and ordering medication;

The co-ordinated design and delivery work is being undertaken by local Enfield CHIN Delivery Programme Group, itself overseen by the Joint Health & Social Care Commissioning Board. This ensures that action to promote the delivery of Care Closer to Home is consistent with our broader commitment to improvements in local health and wellbeing.

In regards to QIST development, Enfield's proposal is to have two QISTs providing quality improvement support in the East and West borough building upon the data that already exists within GP practices and Public Health to risk stratify patients with specific conditions so their care can be better planned and co-ordinated.

Development of the Integrated Locality Team (ILT)
A key objective of the Integrated Care Programme is to develop a network of cross-organisational multi-disciplinary care, with the GP at the heart of care planning and care delivery supported through the Integrated Locality Teams composed of community health and social care staff.

The development of Phase I of the ILTs brought together professionals across community health and social care as a virtual team to case manage and deliver services to cases GPs identified as being at risk of hospitalisation. This approach was successful in managing more complex cases of older people at risk of hospitalisation.

Phase 2 of the Integrated Locality Team implementation will be focused on the wider co-location of services, drawing together social workers, occupational therapists, district nurses and community matrons. This work will be undertaken with due regard and alignment to the wider development of the Care Closer to Home Integrated Network (CHIN).

Given the success of Phase I, a proposal has been put forward for a jointly managed, co-located ILT team working across the 4 localities. This development will be through a phased approach:

Other component parts of the Care Closer to Home programme
It is recognised that training and development initiatives will be required to support the development of the care Closer to Home agenda and we will be working with our local Community Education Provider Network (CEPN) to identify and implement aspects of this training.

The CCG and the London Borough of Enfield continuously review the current use and effectiveness of Better Care Funding to ascertain what changes can be made to enhance its effective deployment in support of Care Closer to Home.

With the establishment of CHINs, there is additionally the scope for considering how these can potentially act as a platform for broader working between providers and commissioners and for the development of alternative care models, as encouraged in NHS England's Five Year Forward View.

Key Enablers
Successful delivery of the Care Closer to Home Agenda are dependent on the following key enablers, which are being taken forward as separate system wide work streams

Workforce Development*:* Development of new workforce roles, behaviours and competencies to deliver new care pathways, effective care planning, new cultures and behaviours –

Interoperability of IT: Development of fewer systems and interoperable IT systems which support coordination of care and the ability of people to hold their own personal health record

Estates: Provision of an appropriate estates infrastructure to support increased care in the community.

Next steps for 2018/19:

- To establish formally the CHINs in each locality and the two QISTs in the East and the West of the borough;

- To undertake joint planning and co-ordination of the Care Closer to Home programme through a supported process with UCL Partners working with a key team from the CCG, LBE, North Middlesex University Hospital, BEH Mental Health Trust and the GP Federation;

- To determine the main areas of clinical focus for each of the four localities in Enfield;

- To establish dedicated workstreams around:

    - Workforce development;
    - Premises;
    - IT interoperability;
    - Patient and stakeholder engagement