NHS
Enfield
Clinical Commissioning Group

Care Closer to Home Integrated Networks

Leading Whole System Transformation

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Sustainability and Transformation Plan (STP)

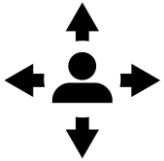
NHS Enfield Clinical Commissioning Group

- NHS 5 year plan - Sustainability & Transformation Plans across 44 area (footprints) in England 2016-2021
- NCL has developed North Central London Plan – Enfield, Haringey, Camden, Islington & Barnet
- Key to plan - Localised Health, Quality of Care , Leadership and Efficiency

Ambition for the STP is built on existing CCG/LA values and strategy

Improve the health of the local population

Reduce health inequalities



Maximise care out of hospital

Sustainability and Transformation Plan (STP)

NHS Enfield Clinical Commissioning Group

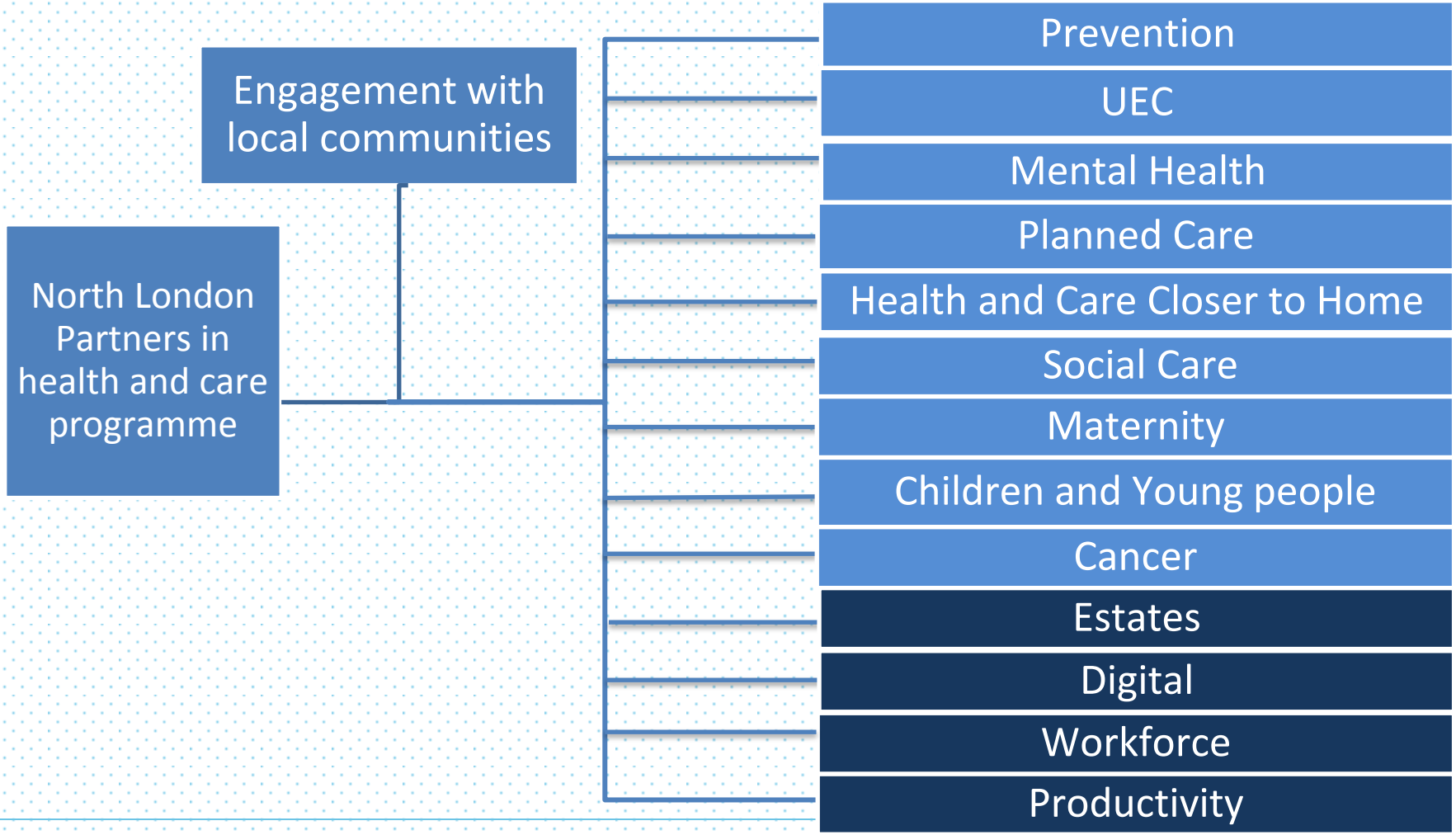
High Level Objectives

- Enhance collaboration and integration between NHS providers, the Voluntary and Community Sector and social care through commissioning place based networks of care
- To improve the quality of primary care and reduce unwarranted variation without stifling innovation;
- Improve access and reduce unwarranted variation in quality and use of healthcare
- Improve management & prevention of chronic disease;
- Support & promote self-care
- Encourage local provider/ commissioner/ social care partnerships which can lead population based health and care planning and strategy

Sustainability and Transformation Plan (STP)

NHS Enfield Clinical Commissioning Group

Overview of Programme



Enfield's Care Closer to Home Integrated Network

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The STP "Health and Care Closer to Home" work stream proposes we develop Care Closer to Home Integrated Networks (CHINs). This model builds on much of the work already underway across Enfield to develop integrated working and person centred care

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

Development of the Enfield Care Closer to Home

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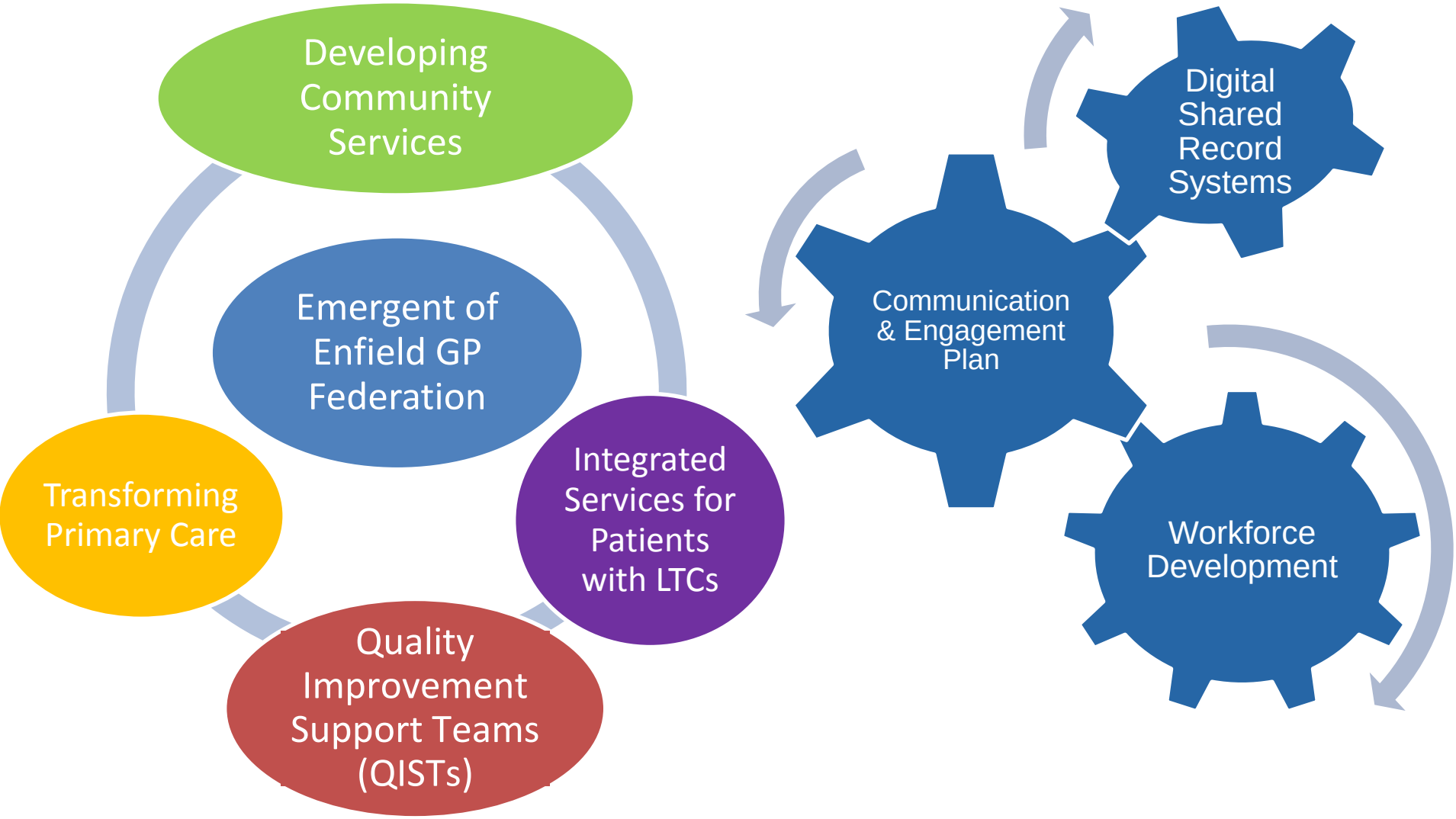
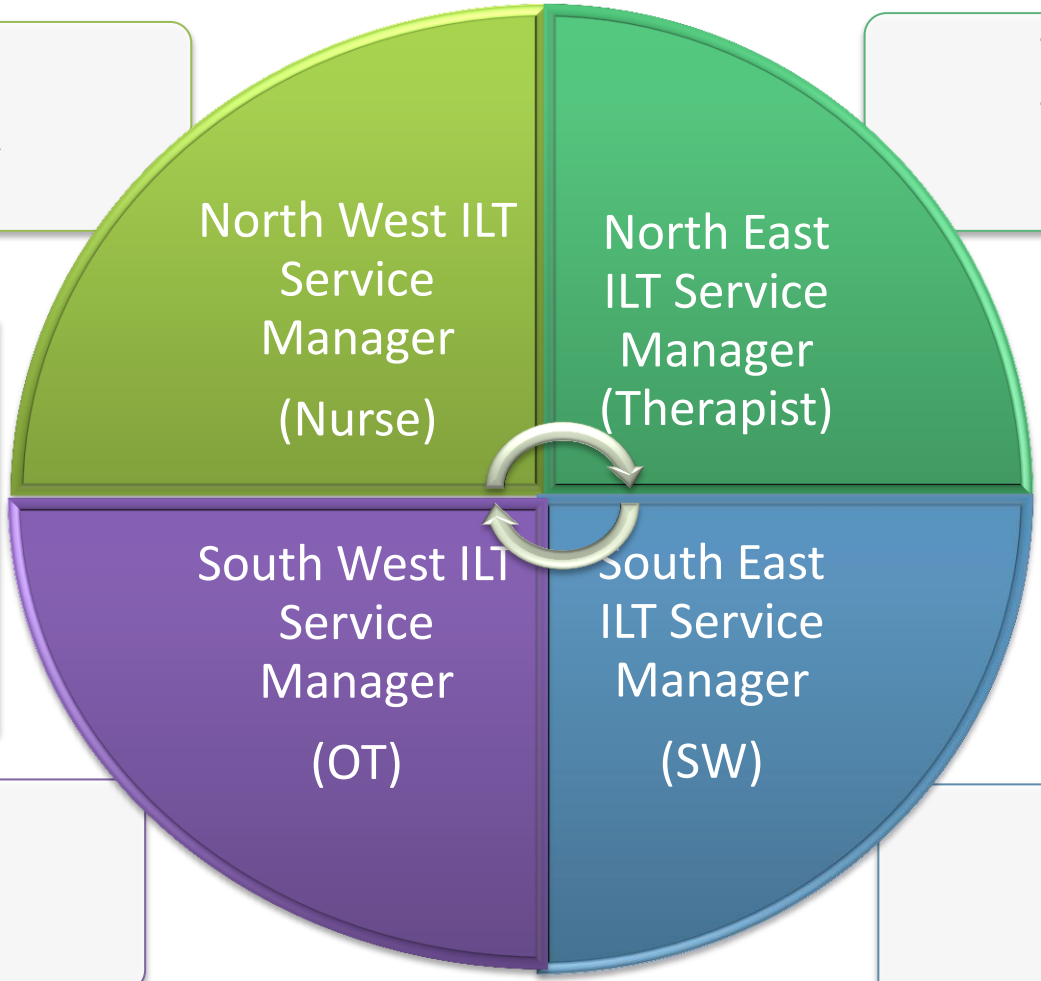


Enfield Wide System Supporting the CHINs

- Core team co-located and managed by the NW ILT SM
- Additional services aligned to the NW area team: CHAT; SPA / Access; Matrons

- Core team co-located and managed by the NE ILT SM
- Additional services aligned to the NE area team: ICT; Enablement; Magnolia



Services Supporting Core ILTS

- BEH MHTs
- Geriatricians (NMUH)
- HealthWatch
- C&VS

- Core team co-located
- Additional services aligned to the SW area team: Hospital Discharge; MASH

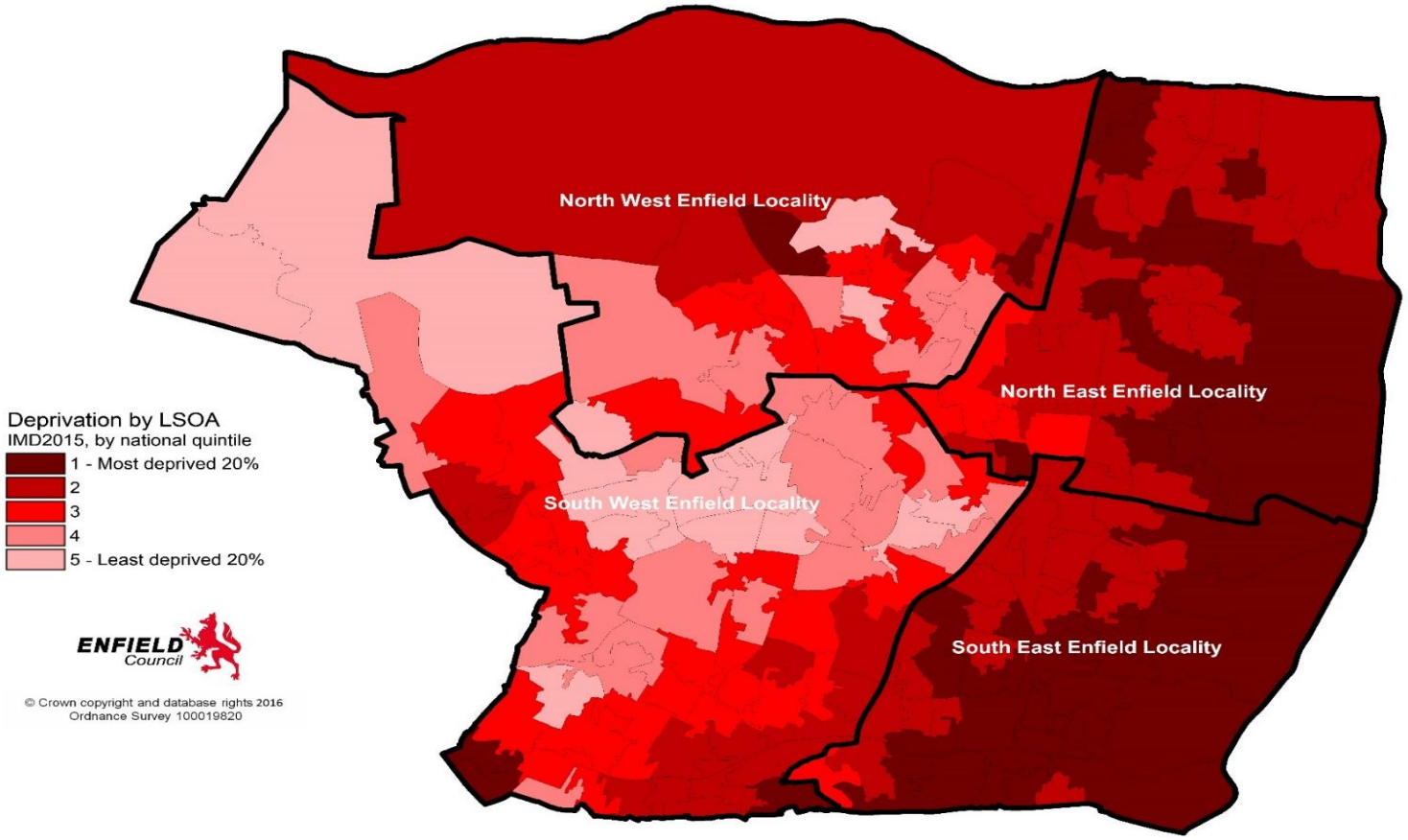
- Core team co-located
- Additional services aligned to the SE area team: Hospital Discharge; Review

ILTs expanded to cover all complex adults
Each SM has responsibility for a borough wide service and local delivery and management of the ILT

Core teams consist of Social Workers, District Nurses and Community Matrons

Over half of Enfield wards within the most deprived 25% in England

The population will increase by nearly 49,000 (15%) between now and 2025 and 20% for age 65+.



Progress to date….

Improved Access to Primary Care

Progress so far:

- NHS Enfield CCG commissioned three locality-based primary care access hubs 8am to 8pm, 7 days per week as set out in the Care Closer to Home Agenda.
- Additional 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
- 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.

Integrated Networks

Development of the Integrated Locality Team

Improving services for people living with long term conditions and frail older people through our Integrated Locality Team

Progress so far…

Phase 1

- Virtual MDT
- Running for 2 years
- Reviewed

Phase II

- Joint role/ further recruitment
- Develop locality teams/service
- Co-location

Phase III*

- Service re-design
- Embed practices
- Learning & Development

QIST

Aim of the QIST is to reduce variations in health by providing better care, reducing disease and extending life

Progress so far…

- Quality Improvement Support Team provided in the West and the East of the borough

Enfield's Integrated Network - Outcomes Achieved in 2017

The Care Home Assessment Team are vital partners in reducing A&E attendance from care providers; they have a strong and collegiate relationship with care homes and are part of the Trusted Assessor implementation locally, creating a relationship where providers feel confident and safe to seek advice. Enabled individuals to choose to die in their preferred place (100% in both October and November 2017); CHAT is measured on percentage of people who having falls go into A&E, which stood at 12% in October and 15% in November

To prevent avoidable admission and provide a response to individuals in the community in crisis, **the Community Crisis Response Team (CCRT)** is funded by the BCF as part of the integrated care programme to assess and treat patients in their own home. The service had a target of seeing patients within 2 hours of receipt of referral, and achieved this in 100% of cases in October, and 99% of cases in November. Importantly, the feedback from those who use the service is a vital indicator of their experience of care; 100% of patients surveyed reported a positive experience of care.

Community Falls prevention prevents is funded through the BCF to reduce fragility fractures and fracture neck of femurs (#NOF) in patients over 65s through improved care pathways and assist navigation from acute to community settings. The service has contributed to an overall reduction in hospital related activity for all fractures (including fractured neck of femurs) in 16/17 by 17% compared to previous year.

The **Older People Assessment Unit** (OPAU) provides unplanned care to patients who need rapid response for assessment and treatment, often to prevent hospital admission. 2017/18 has shown a positive increase in the uptake of this service, which will assist in care outside of an acute in-patient setting. The service is well received by those experiencing care, with 100% of individuals surveyed during October reporting they felt dignity was always respected, and 100% would be extremely likely to use the service again or recommend to family and friends.

Next Steps…

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- Work with all our partners to co-design plans
- Ensure plans are clinically led and evidence based
- Work with UCL Partners on the Placed based Care Network Programme
- Communicate with our stakeholders and communities about the changes ahead
- Align our plans and ensure these contribute to financial sustainability

ANY QUESTIONS?

What other opportunities are there for further developing integrated care closer to home in Enfield ?