Health & Wellbeing Board Update Report from the Joint Health & Social Care Commissioning Board

1. Introduction

Enabling people to be safe, independent and well is a key aim within the Health and Wellbeing Strategy. Delivering this requires the right support to be available at the right time and in the right place for people when they need it. It is also really important that people have the right information and advice in order to be able to access what they need. This links to support in the community, whether it is health, social care or universal service provision which helps to ensure that:

- Emergency admissions to hospital are minimized through the provision of good primary care support in the community
- Permanent admissions to residential/nursing care are only made where it is no longer safe or practical to support a person to continue living in the community
- The number of hospital bed days lost due to delayed discharges is minimized recognizing that where people are medically fit, they are able to return to the best possible place to enable recovery or appropriate care to take place outside of a hospital setting.
- People are able to receive enablement services which support them to gain or regain independent living skills
- People are in appropriate and settled accommodation
- Meaningful training and employment opportunities are available
- That where longer-term support is needed, people have as much choice and control over those arrangements as possible.

2. Hospital & Primary Care

A&E Attendance & Non-elective Admissions

Healthwatch Enfield completed a review of A&E attendances at North Middlesex Hospital in January 2018. Some key findings through conversations with 630 attenders in a week of that report:

- 20% attended because they could not get a GP appointment
- 33% knew about the out of hours GP hubs overall reducing to 20% on Saturday and 5% on Sunday with 3% having visited the hub before A&E
- Awareness of the Urgent Care Centre's at NMDDX and CFH hospitals was poor
- 50% would use primary care services if diagnostic services were available.

Enfield CCG has also analysed the A&E attendance and emergency admission rate across hospital for all Enfield residents and found that:

- 33% of people admitted to hospital as an emergency stay there for less than a day
- This varies significantly according to how old the patient is:
    - 0-4 yrs – 58% less than 24hrs and 42% over 1 day
    - 5-12yrs – 53% less than 24 hrs and 47% over a day
    - 13-18yrs – 43% less than 24 hrs and 57% over a day
    - 19-64yrs – 39% less than 24 hrs and 61% over a day
    - 65-84yrs – 24% less than 24 hrs and 76% over a day

- 85 and over – 18% less than 24 hrs and 82% over a day

The table below shows the top 4 presenting medical reasons for attendance by age group:

Table 1

Top 4 Attending Primary Diagnosis By Age Cohort	
Rank	0 - 4
1	Viral infection, unspecified
2	Acute upper respiratory infection, unspecified
3	Acute bronchiolitis, unspecified
4	Acute tonsillitis, unspecified
	5 - 12
1	Asthma, unspecified
2	Viral infection, unspecified
3	Acute tonsillitis, unspecified
4	Acute upper respiratory infection, unspecified
	13 - 18
1	Other and unspecified abdominal pain
2	Pain localized to other parts of lower abdomen
3	Acute appendicitis, other and unspecified
4	Other symptoms and signs involving emotional state
	19 - 64
1	Chest pain, unspecified
2	Pain localized to other parts of lower abdomen
3	Other and unspecified abdominal pain
4	Headache
	65 - 84
1	Urinary tract infection, site not specified
2	Lobar pneumonia, unspecified
3	Pneumonia, unspecified
4	Congestive heart failure
	85 and Over
1	Urinary tract infection, site not specified
2	Lobar pneumonia, unspecified
3	Tendency to fall, not elsewhere classified
4	Congestive heart failure

Primary Care Service Response

Access to Primary Care (GP) Hubs was established to deal with urgent or routine appointments (out of normal GP hours) as well as offering a walk-in service as an alternative to attendance at A&E services. Take up of the new drop in services is now well established and attendance levels are improving with current attendance levels at around 75% of capacity.

It is clear, however, that more needs to be done both to develop an improved awareness of and confidence in the primary care services that are available and the services they are able to provide. Working with Healthwatch and other VCS organisations would provide a valuable avenue of engagement with those groups that are harder to reach.

Enfield CCG currently commissions GP Extended Access Services (EAS), from four geographically located 'hub' sites across Enfield. These services provide same day and pre-bookable appointments with a GP, nurse or healthcare assistant from 6.30pm–8pm Mondays to Fridays and 8am–8pm Saturdays, Sundays and public holidays. This is in line with the NHS Long Term Plan to provide 7 day 8am–8pm access to primary care.

These services operate from:

- Eagle House Surgery – North East
- Evergreen Primary Care Centre – South East
- The Woodberry Practice – South West
- Carlton House Surgery – North West

Enfield CCG receives in the region of £1.7m per year for this provision and this will continue. In addition to this national access funding, Enfield CCG received additional funding during 2017/18 and 2018/19 to provide even more GP and nurse appointments, including walk-in appointments. Enfield is the only north central London CCG that has been providing walk-in access as part of our extended access service, due to our successful application for additional non-recurrent funding from NHS England. As this funding stream is coming to an end, from 1 October 2019 we plan to manage the flow of Enfield residents presenting as walk-in by:

- triaging them and offering them a bookable appointment OR
- advising them to visit their GP practice OR
- directing them to an alternative NHS service OR
- advising them to self-care, if clinically appropriate.

In doing this, we will be developing our local services in line with the national model of care, which is bookable GP, nurse and healthcare assistant appointments at evenings and weekends accessed via the patient's own GP practice or via NHS111. The changes being implemented will:

- Ensure local resources are invested and reserved for the benefit of Enfield residents
- Reduce Did Not Attends (DNAs) rates at hub services
- Improve the overall utilisation of the service
- Improve the retention and sustainability of the workforce
- Fit with wider primary care improvements and core-hour investment
- Link up with the successful national NHS111 campaign and local marketing of the hubs

In response to the NHS Long Term Plan and the new GP Contract, Enfield CCG is working on and progressing with a number of initiatives:

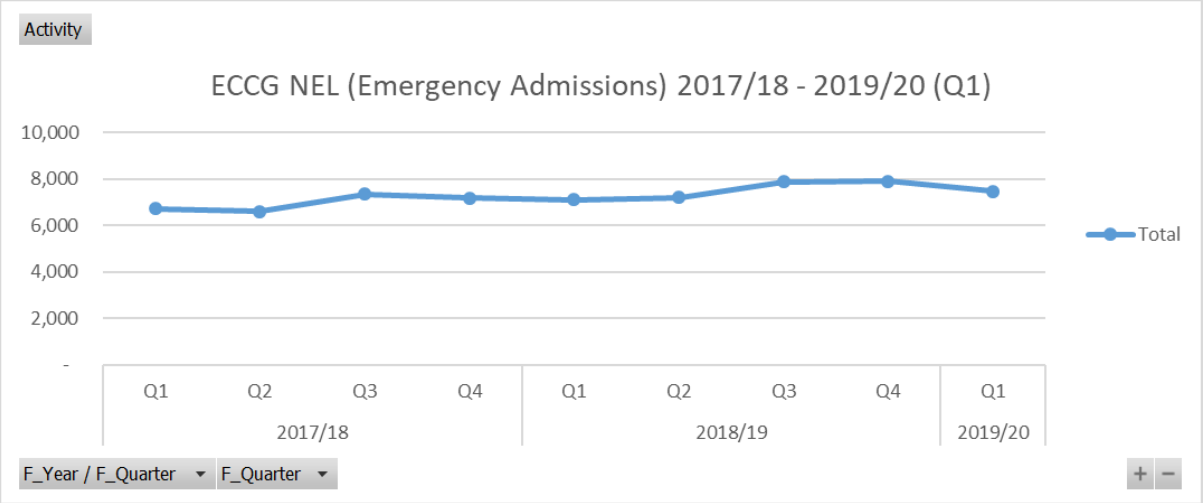
- Maintain the £1.7m investment into Extended Access Services during 2019/2020.
- Since the 1st April 2019, invested an additional £1m into General Practice to increase access to clinical services.
- Since 1st July 2019, expanded the Extended Access DES to 100% of the population
- Working with Enfield's primary care networks to develop the workforce, . such as recruiting to the clinical pharmacy and social care link workers posts in Enfield.

- Working with NHS111 to release primary care appointments. Current proposals will embargo approximately 100 appointments per day across Enfield for booking unscheduled care activity.
- Commissioning an additional £251k of GP capacity to be reserved for integrated urgent care services.
- Work with Enfield's Voluntary Action (EVA) to target specific groups and improve patient awareness of and appropriate use of primary care medical services.

These initiatives will enable Enfield CCG to commission both high quality and sustainable services for local residents, ensuring primary care can support the wider policy position of joining up the urgent care system.

The chart below shows the number of emergency admissions for Enfield residents between 2017/18 and 2019/20. As stated above, further analysis of the admission data is being done currently to understand any links between improved access to GP hubs and responses to the types of conditions where people continue to present at A&E departments from where they are admitted as emergencies. A further update will come to the next Health & Wellbeing Board once received. The partnership continues to monitor this activity closely, is projecting the target will be met, subject to management of demand over the Winter period.

Chart 1 Emergency Admissions to Hospital Enfield Residents



3. Supporting People to regain their Independence after Hospital

Where admission to hospital is unavoidable, it is essential that, once appropriate care and clinical interventions have taken place, people are discharged in a timely appropriate way back to their usual place of residence.

The Council and Enfield CCG have been working hard to develop new Discharge to Assess services in order to minimise the amount of time people spend in a hospital bed once they are fit for discharge. In the majority of cases, people will be discharged home first where they will be assessed and provided with the appropriate support in order to help them regain independent living skills through LBE Enablement Services.

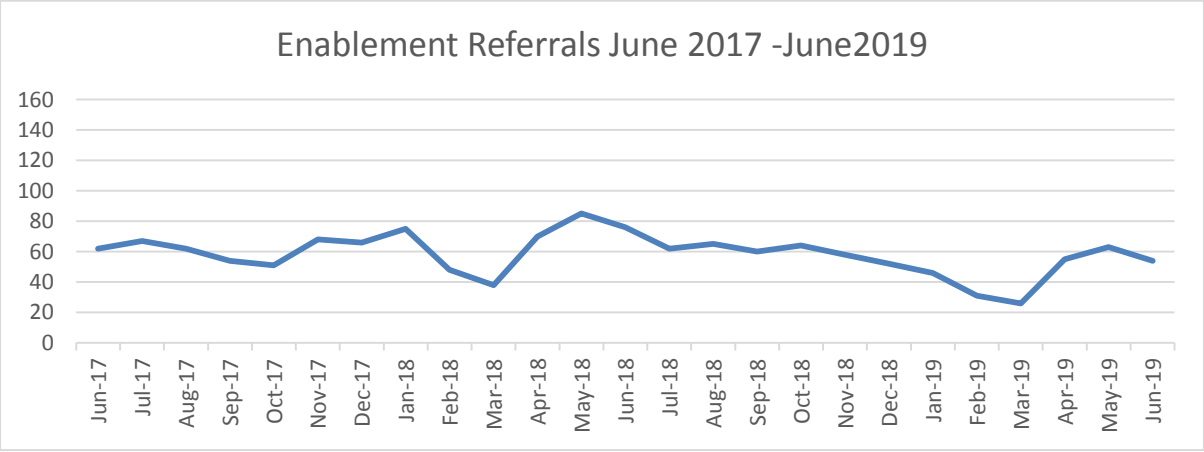
Around 85% of people who enter the Enablement Service are discharged from the service requiring no ongoing support or care. This service is available for up to six weeks (it may be

longer dependent on individual cases). For those people who do have an ongoing need for care and support, support will be provided by the Enablement service until a suitable long term provider is found.

Outcomes so far:

- No. of people discharged via D2A Pathway 1: 1,082
- Estimated average bed days saved per patient: 3.11
- Estimated average savings to the NHS per patient: £1,555
- Total estimated bed days saved: 3,298
- Estimated total cost of savings to the NHS: £1,649,000

Chart 2 – Enablement Referrals



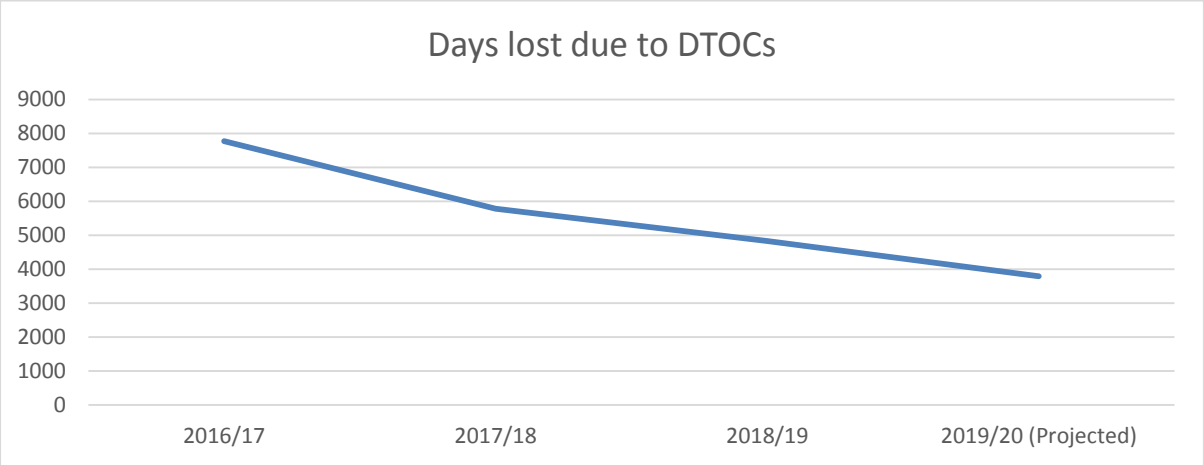
Avoiding Hospital Delays

Where the needs of a person in hospital are particularly complex and 24 hour care is the only safe and appropriate option following discharge, a residential or nursing placement will be considered. Whilst Enfield has a large supply of residential care homes in its area, the number of nursing care homes is smaller and can lead to some unavoidable delays.

As a result the Council has invested in a new purpose built and dual registered care home (Bridgewood House) providing both residential care and nursing care. Plans are being developed to convert more of the existing beds within the home to nursing care and, working across the North Central London region, other options are being considered where further nursing bed capacity within the market can be developed.

This work, together with other joint projects undertaken together with NHS Enfield CCG has delivered both additional capacity in the market and new discharge to assess pathways which have led to a reduction in the number of bed days lost due to delayed discharges. It is worth noting that over the four years covered, Enfield's population will have increased by around 14,000 people with one of the largest areas of growth amongst the 85+ years population, the group far more likely to require both hospital admission and social care support. See Chart 3 below:

Chart 3

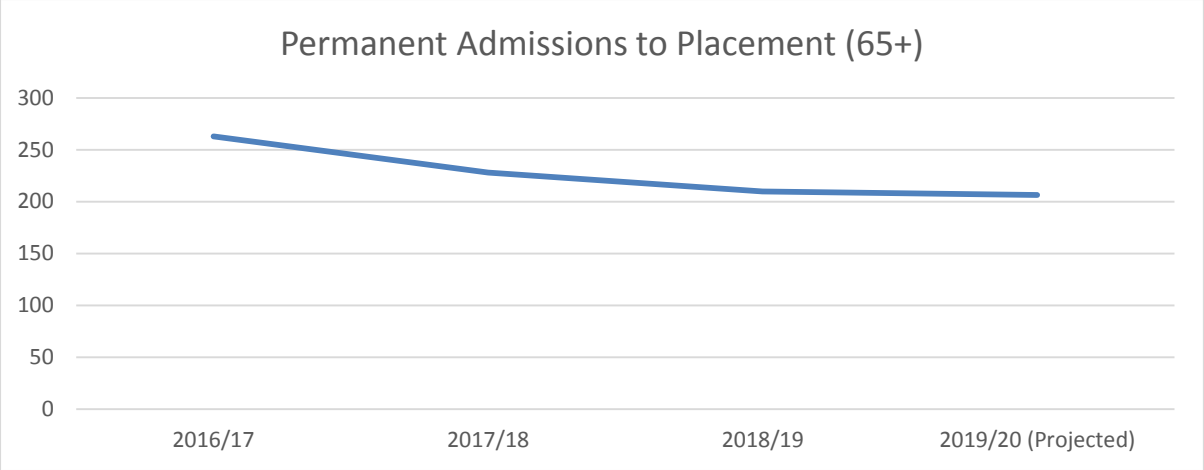


4. Admission to Residential or Nursing Care Homes

Whilst it is always preferable for people to continue to live independently within their own homes, there does come a time where it is no longer practical or safe for some people to do so. A prolonged stay in hospital can reduce people's functional abilities significantly (for example, mobility) or a gradual decrease in cognitive abilities due to dementia can make it unsafe for people to live without 24 hour care and support. This is only possible, in most cases, by working with people to move them on into a residential or nursing care placement.

Older people are by far the largest group represented within residential and nursing care with around 800 in placement at any given time. Around a third of these would be older people with dementia, including some 50+ aged with early onset dementia. The number of new admissions to placements has been decreasing from 2016/17 (from 263), 2017/18 (228) and 2018/19 (210). This decline maybe due to the success of the discharge to access programme. The number of permanent admissions from hospital versus community has shifted from a 50/50 split in 2015/16 to a 60/40 split in 2018/19. Chart 4 below shows the position over the last four years:

Chart 4



Strategically it is the Council's intention to create additional extra care supported living capacity for older people. This would be a viable independent living alternative for people who can no longer live safely on their own but where residential care would not be appropriate. Having successfully secured over £9.4 million development funding from the Greater London Authority earlier this year, Enfield Council has become steps closer to delivering a new Extra Care Housing scheme in the borough following approval to proceed with an innovative housing with care project in Winchmore Hill.

Pending permission from the Local Planning Authority, the new build scheme will provide up to 91 fully accessible, self contained, affordable homes, with 24-hour site based care, for people who wish to live independently, but may require additional support and care to do so.

An array of thoughtfully designed communal facilities, including a hairdressing and treatment room, library/IT suite, lounges and activity rooms shall sit at the heart of the scheme, to facilitate social inclusion and community engagement. Healthy, active and sustainable living shall also be supported through the provision of accessible sensory gardens and allotment space.

Following a local resident information event held at Winchmore Hill Library, work is now underway to progress site plans and enable a full planning submission later in the year.

Individual Service Funds (ISFs) has now been introduced within two Extra Care Schemes within the borough. The benefit of an ISF is that it enables service users and their families to become much more involved in the kind of support services they receive. The current provider of both schemes, which were, chosen by the service users and families themselves, has, and will continue to engage regularly with them to co-design the arrangements they need in a way that suits them best. The service user can make changes to this arrangement at any stage. This arrangement is similar to a group of people with direct payments pooling their personal budgets and exercising more choice and control over the kind of support they get.

For younger adults the number of people living in residential or nursing care is around 350 (learning disability, physical disability and mental ill health). The number of new admissions to residential or nursing care tends to average between 8 to12 per year.

5. Adults with Learning Disabilities

The integrated learning disability service, proportionally, continues to see the largest year on year increase in demand for services with numbers increasing at the rate of between 3.5% to 4% per year. Increased demand notwithstanding, the service continues to deliver excellent outcomes for service users and families:

- 85% of service users living in settled accommodation and numbers in residential care amongst the lowest in London and Nationally. This includes the development of new shared ownership housing options for people with very complex needs and their families;
- Early and successful implementation of the Transforming Care programme with no residents in long stay hospital wards;
- Very low admissions to hospital year on year due to crisis thanks to the work of the Community Intervention Service;
    - NCL TCP admissions data August 2019
        - Barnet 11
        - Camden2
        - Enfield 2
        - Haringey 9
        - Islington 6

- A very successful supported employment service helping people with learning disabilities into paid employment with performance amongst the best nationally;
- 50% of service users using a direct payment to manage their support, London and national leading performance;
- A new Positive Behaviour Support Service funded by the Council and Enfield CCG, working with both children and adults, working with people who have behaviour that challenges, de-escalating these behaviours, improving quality of life and reducing the need for more expensive support. The services are still relatively new and under review but early signs indicate good outcomes for those service users and families with whom services have worked;
- The number of adults and children with a learning disability receiving a health check to improve health and quality of life increased to 80% in 18/19;
- Work is underway to develop a local diagnostic and post diagnostic offer for people with high functioning autism, improving access for local people with high functioning autism to diagnostic services and improved information and advice on the kind of support available in the local community;
- Planning completed for a new respite/crashpad facility locally to support families and service users avoid crisis, carer breakdown and hospital admission.

Housing & Technology Grant

- Following the award of funding from the Department of Health in 2016, the Council has worked in partnership with service users and their carers to roll out a shared ownership pilot for adults with learning disabilities.

- Service users eligible for this pilot have been identified and assessed. Work now continues to identify appropriate properties for purchase, support mortgage applications and facilitate move in.

Carterhatch Transformation

- Following the decant and demolition of outdated accommodation at the Carterhatch Service, Hillman Court has now opened its doors to new tenants.
- The new scheme provides modern and fully accessible self-contained homes for adults with physical and Learning Disabilities, who require 'move-on' accommodation.
- Completion of this service marks one of the final phases of the scheme's service user led modernisation. It will enable those who have developed their independent living skills, to 'step down' from more intensive supported living services, whilst maintaining professional and peer support networks.

6. Adults with Mental ill Health

The integrated Mental Health Service works to support adults with severe and enduring mental ill health to reintegrate back into their community. Enfield CCG, working with the Council, has undertaken to transform care arrangements for people living on long stay hospital wards, supporting moves back into supported community living and access to meaningful activities.

A joint project to develop new stepdown services for people leaving hospital wards and residential care settings will seek to provide additional capacity within the community to enable this. It is expected that a tender exercise will take place over the next 3 months with a view to commissioning the new service early in the new financial year. This service will enable people to live more independent lives, with support as needed to prevent relapse from a multi-disciplinary team of staff.

7. Frailty Project

Approximately 50% of Enfield's over 65 population are living with some form of Frailty; of this 50%:

- 35% are considered to have a mild form of frailty (people who are slowing down in older age and may need help with personal activities such as finances, shopping, transportation)
- 12% are moderately frail (people who have difficulties with outdoor activities, may have mobility problems or require help with activities such as washing and dressing)
- 3% have a severe frailty diagnosis (people who are dependent for personal care and have a range of long-term conditions/multi-morbidity) Some within this group will be medically stable but others are unstable and can go into decline quickly. Some people in this group will be at risk of dying within 6-12 months.

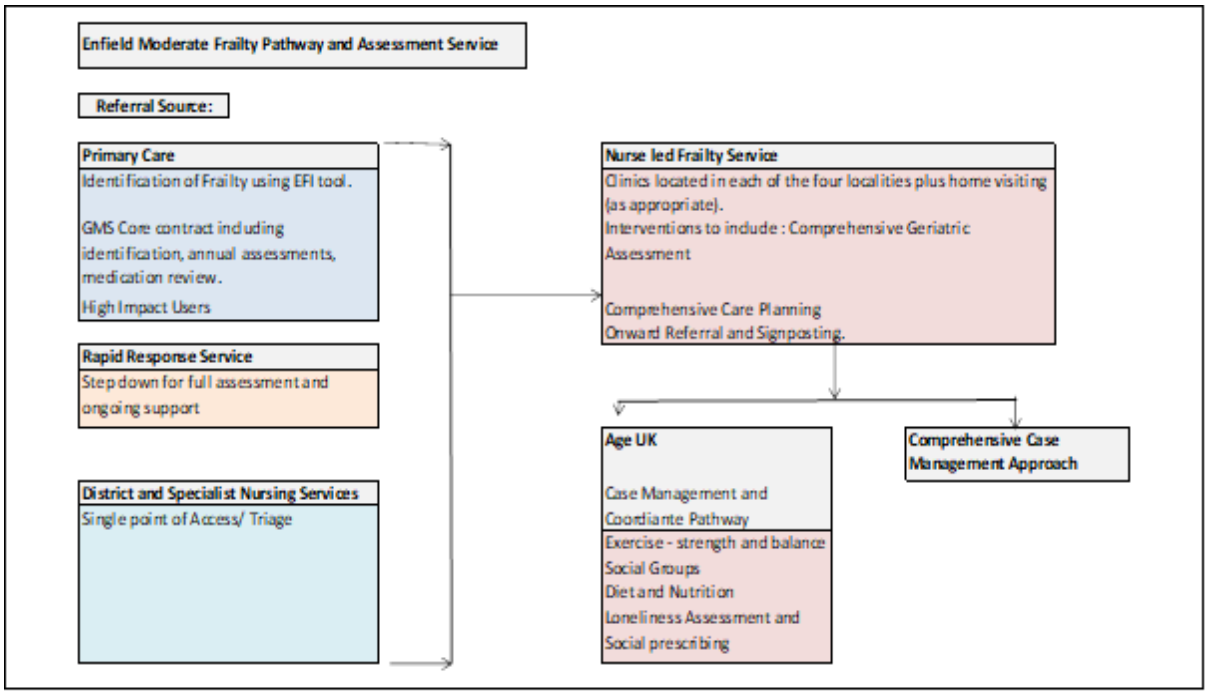
Therefore, circa 21,300 local residents are stratified as frail. These individuals are frequent users of services across health and social care and are particularly vulnerable to adverse outcomes, in particular health outcomes such as unplanned admission to hospital, care home admission, developing additional impairment and death. However, there is evidence that for some in this group, these adverse outcomes could be avoided and their frailty modifiable through proactive case finding, timely and comprehensive assessment, care planning and targeted proactive use of services outside of hospital.

The Enfield Integrated Care Programme is to provide better co-ordinated, holistic health and social care services for older people with frailty emphasising the need for a greater focus on prevention, early identification and assessment, care planning and case management.

Moderately Frail

The CCG is in the process of commissioning a nurse led service to target the moderately frail population. The service will deliver clinics in each Primary Care Network. Patients will be identified through primary care registers using the electronic frailty index and referrals made to the service for a holistic and personalised assessment. Following the assessment, the nurse will agree with the patient any ongoing care, support or signposting required for them to maintain optimum wellbeing and independence and make the required referral. The care plan will be shared with the patient and their GP. Patients at the low end of moderately frail may be followed up by Age UK for care co-ordination and signposting to local community and voluntary services as appropriate.

It is hope that this service will be mobilised in October 2019 and be fully operational by November 2019.



Severely Frail – Rapid Response

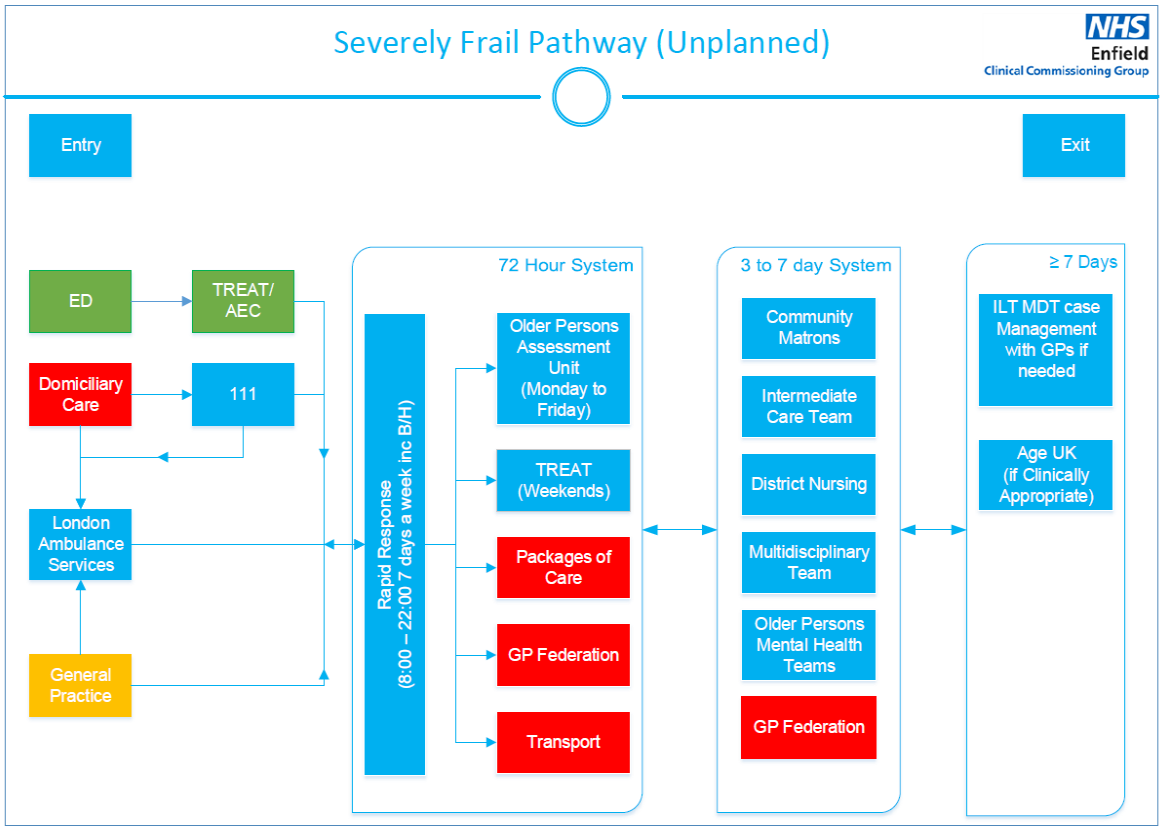
Frailty is a distinctive state of health related to the ageing process, usually characterised by a complex mix of physical, mental health and social care needs. It is a condition where the body's' inbuilt reserves are eroded meaning people are vulnerable to sudden changes in their health triggered by seemingly small events, such as a minor infection or a change in medication. Typically, frailty goes largely unnoticed until a crisis happens which necessitates urgent intervention.

The Rapid Response service is an element of the integrated care pathway which provides short term intervention, treatment and rehabilitation for patients experiencing an acute episode of illness or a crisis to maintain the patient in the community and avoid hospital admission. The service provides intensive support for up to 72 hours and manages the onward referral to other services within the integrated care programme.

The service prevents unplanned avoidable admissions/readmissions to hospital by providing care in their own home responding within 2 hours for people having an urgent or immediate crisis and within 2-4 hours for those that are less urgent.

In order to prepare the health and care frailty environment for community service provision the pathway has been redesigned to support the design principles of rapid response and care closer to home. Pathways have been altered so that providers including 111, London Ambulance and Emergency services refer into the community service as a direct replacement for an ED presentation.

Once in the community service, the patient's continuity and co-ordination will be strengthened with access to other community and social care services to support their ongoing care and prevent further crisis.



The service has been phased in April-August 2019, during that time 435 patients have been seen of which 336 severely frail admissions have been avoided; with 70% of referrals from Primary Care, 12% from 111, 12% Barndoc, 7% Ambulance 3% acute. However, the service is not being fully utilised and there are still too many severely frail people attending A&E. The Rapid Response Team will be working closely with partners to raise the profile of the service and to identify patients who are appropriate for rapid response intervention.

System Wide Frailty Work

There are many existing pathways linked to frailty across the wider system and more being created. North Middlesex University Hospital Local Delivery Group (LDG), identified frailty as a priority for joint working and held a workshop to share understanding of areas of work and developments in frailty across the local system. Following this the system made a successful bid to NHSI/E for the Transformational Change through System Leadership (TCSL) which enabled senior leaders across Enfield and Haringey to work on frailty pathways.

The TCSL team have held two Frailty Network Workshops with representation from all partners across Enfield and Haringey including hospital, community services, CCGs, primary care, LAS, social care, voluntary sector and North London Hospice. In workshop 1 the Network created a shared vision and a set of principles for frailty. In workshop 2 partners shared quick wins, identified priority areas, agreed that all organisations would work towards using the Rockwood score as the single tool for measuring frailty and continued to develop relationships across organisations.

There is a 3rd Network event being held on 8th October 2019 to look at how we begin to join pathways up across the system so that we can improve patient care, ongoing management across the system. Building on the priorities identified by the Network we have identified four work streams to focus on:

- Identification - Improve the identification of people with frailty
- Admission Avoidance – Increase the number of people over 65 being treated at home rather than ED
- Integrated Discharge – Improve information flows through the patient journey between acute, community services, primary care, social care
- Home First – Manage patients with higher needs at home

8. Housing Gateway Pilot

The Housing Gateway Pilot is now near completion. Early indicators point to the success of this pilot project, which has enabled people with complex accommodation needs who have limited accommodation options to identify appropriate housing. Work is now underway to identify additional funding opportunities to extend this pilot.

In terms of outcomes for the people with whom the service works:

- Just under 84% of people live in settled accommodation (in the community) with the number of admissions to residential care reduced to 2 this year;
- 30% of people receiving support in the community manage this through a direct payment;
- The number of people being supported to maintain or enter paid employment is increasing. It is still low compared to London and national averages but a new contract is now in place which is already beginning to show improvements in the service. This will be continually monitored to ensure people with mental ill health receive the support they need to get into employment if that is what they choose;
- The mental health enablement service works with around 30 individuals at any one time to help them get their lives back on track and around 90 people in the course of a year. People are supported to have a safe and secure home, develop and maintain their friendships and relationships and to find a role in their life that improves their wellbeing and resilience. 100% of people who work with the Enablement service need no further support services after discharge.
- Working in partnership Enfield CCG and the Council has funded Mental Health Linkworkers attached to GP surgeries. The Primary Care Mental Health Linkworker pilot has three key outcomes:

    - Support people with common mental health issues to remain healthy and well in the community with minimal support and provide access to community wellbeing and universal services to reduce the risk of isolation;

    - Reduce inappropriate referrals to secondary care services by offering person centred interventions to manage common mental issues and reduce the risk of further deterioration and by doing this;

    - To move freed up activity and reinvest in Secondary Mental Health Services to reduce avoidable admissions and support people well in the community

Primary Care has responded very well to the Mental Health professionals and there has been reciprocal upskilling around the Primary Care and Secondary Care environments. There has been very positive feedback from the GP Practices that have not been included in the pilot, requesting a Linkworker for their own surgeries and supporting the full roll-out of the scheme across the Borough.

Between December 2017 and December 2018, the pilot has supported 1333 people. 1056 of people were supported following full roll-out to 24 practices from June 2018.

9. Adult with Physical Disabilities

The Council works with around 1150 adults with physical disabilities with a focus on promoting independent living, flexibility, choice and control through use of direct payments. The number of younger adults in residential placements is low compared to London and national averages with around 35 people in placements at any given time. The plan is to develop more supported living options for this group, including the development of shared ownership housing options. Other supported living accommodation options are currently

being developed in order to provide more safe, appropriate and more independence focused places for people with physical disabilities to live as a viable alternative to residential care.

Jasper Close

Following a successful bid for funding from the Mayors Care & Support Specialist Housing Fund, the development of Jasper Close is now near completion.

The new scheme will provide fully accessible 2 and 3 bed homes for adults with physical disabilities who require additional support and care to live independently, including those who require move-on from a residential care setting.

A multi-disciplinary project group has been established to guide final design decisions and facilitate the transition of service users to their new homes later in the year (December 2019).

- Just under 60% of adults with a physical disability use a direct payment to pay for their care and support;
- There have been no new residential placements made this year and historically numbers have been extremely low;
- The Council has engaged a national charitable organisation called AccessAble to review over 500 locations within the Council area in order to assess the accessibility of local facilities and services. This includes both health and social care facilities, recognising that access to these can be even more critical for people with illness or disability. The project will also enable volunteer work opportunities for people with disabilities and AccessAble are linking in with HealthwatchEnfield to facilitate further opportunities

10. <u>Innovation Hub and New Structure of Older People and Physical Disabilities.</u>

Linking Together is Enfield's first Innovation Site and seeks to develop a Social Care Prevention Service, based on the 3-conversation and the Strengths Based approach, which ultimately extends upon people's existing capabilities and assets, promoting independence and building resilience. They provide early intervention and offer enhanced information and advice, focussing on strengths and assets within the community and therefore enabling people to be more self-sufficient and thus delaying the need to long-term care and support. Community engagement, co-production and working close to the person is a key principle underlying this approach. The hub has been in place for just over 11 weeks now, has worked with over 180 people in the N9, N18 and EN1 postal code areas and through our work with people to identify wider community assets they can link into, none so far have needed an ongoing service from the Council. We will be fully evaluating the impact of the new service in the coming months and will seek to replicate and scale up this approach for our wider population.

Adopting a strength-based approach and with the aim of working more closely with the community ASC serves, the Older People & Physical disability services is changing the way it manages its work in other ways. The Service is moving to a more locality based,

neighbourhood approach to managing the work it does with people who require long term support. The current Care Management Service will be split into East and West team and will allow us to move to a more locality-based way of working. Alongside this change, the Service is amalgamating its 'Access' and 'Enablement' teams so that it has the resources to manage the approach to working with people explained above plus prepare it for integration with adult community health services. Any integration is expected to include both a single point of access (SPA) across health and social care for individuals, their families and professionals to refer into, an integrated rehabilitation/enablement service and the provision of 4 integrated community teams providing a seamless service to those with health and/or social care needs.

11. Voluntary & Community Sector

The Council and the CCG have worked in partnership to deliver five new contracts within the Voluntary sector with a focus on the following outcome areas:

- Carers are supported to continue caring
- People are supported to live independent lives
- Vulnerable people are given a voice in our community
- Supporting appropriate discharge from hospital
- Improved information and advice

A sixth contract is currently under development which will focus on supporting people with long term health conditions to better self-manage. This will have an increased focus on mental ill health.

A full review of the impact of the new contracts will be completed by the end of February 2020 and the results of that review will come to a future health and wellbeing board as part of the Joint Commissioning Board's update.

VCS organisations currently funded by Enfield CCG as part of the joint Section 75 agreement with the Council are being supported, where they work with people who have mental health issues, to seek IAPT accreditation in order to increase the available capacity available to deliver psychological therapies to local people who need them. MIND in Enfield has already been successful in achieving this.

Time limited funding for small projects delivered by VCS organisations (up to £5,000 for a year for a maximum of 20 organisations) has also been made available this year. The outcome being sought is to encourage new and innovative thinking within the voluntary sector which focuses on working with people to develop the skills they need to manage and improve their health and wellbeing. The Council is interested in any new developments which use assistive technology as part of a wider offer to help people develop greater personal resilience, either individually or as part of peer support networks.

The Council has delivered a new floating support service with a local provider with a focus on independent living and flexibility. Riverside work with around 700 people at any given time with a range of needs including mental health issues, learning disability and physical disability, offer a flexible 8am until 8pm service with out of hours support available if needed. Referrals can be made through GPs, Council Staff and other VCS organisations and the

tailored support is available for up to 2 years or as and when required. This is the new service's first year of operation and a 12 month review will be completed by September 2019.

Headline statistics across our new VCS contracts include:

- A 10% increase (an extra 572 carers registered in 2018/19) in registrations for carers
- 3 Carer Ambassadors recruited to represent different service areas (target is 6)
- 20 training workshops and 4 carer forums delivered to support carers in their role
- 472 carers supported through counselling or emotional support sessions
- 560 people supported to access support to help them live independent lives through navigator service
- 4 events held for harder to reach groups within the community – signposting to independent living support options
- 4 peer support groups established focused on independent living
- 400 people supported to leave hospital and return home
- 76% of people discharged home report being more confident taking care of themselves
- 100% of carers involved state that this service has helped them to have a life outside of caring
- Over 2,500 people contacted the new information/advice service
- Over 160 emotional healthchecks done with onward referrals to appropriate support services, including IAPT services

Work currently underway to develop services further include:

- Further work being done with EVA to develop volunteering opportunities across our VCS
- Creating links between floating support services to support more people to learn independent living skills
- Work with public health to embed Making Every Contact Count practice within VCS activity with the public including a focus on smoking cessation, physical activity, healthy diet

12 . <u>High Functioning Autism Self-Assessment</u>

- Self-assessment completed and submitted to PHE with key actions included in action plan below:

Area	Actions	Timescales	Who
Planning			
	Ensure the needs of people with HFA are reflected in the local JSNA	Check when the next review for LD/Autism is due	LD Commissioner Public Health
	Ensure that the new MPS reflects local data and needs of autistic people	Completed	LD Commissioner
	Develop a clear Council policy covering reasonable adjustments to statutory and other wider public services to	January – February 2020	LD Commissioner Head of Customer

	ensure that reasonable adjustments are made to general council services to improve access and support for autistic people		Services
	Encourage and support autistic people to take part in culture or leisure activities, or physical fitness programmes and private sector services such as shopping	Ongoing	One – to – One Autism Steering Group
	Ensure that needs assessment, data and service planning for autistic adults **aged 65** and over and included in the new strategy.	Ongoing / To be included in the new Strategy	LD Commissioner One – to – One Autism Steering Group Older People's Services
	Ensure that planning and implementation of the new joint health and social care priorities document take into account the particular needs of **autistic women**	Ongoing / To be included in the new Strategy	LD Commissioner One – to – One Autism Steering Group
	Ensure that planning and implementation of the new joint health and social care priorities document autistic adults in **BME communities**	Ongoing / To be included in the new Strategy	LD Commissioner One – to – One
	Make sure that the local hate crime statistics specifically identify autistic people.	2019	Sujeevan Ponnampalam
Training	Ensure that autism training includes the needs autistic adults over the **age of 65**	2019	One – to – One
	Offer autism awareness training to the local police service	2019	One – to – One Autism Steering Group
	Offer autism awareness training to the local court service	2019	One – to – One Autism Steering Group
	Offer autism awareness training to the local probation service	2019	One – to – One Autism Steering Group
Diagnostic Pathway	Established a local autism diagnostic pathway	2019	LD Commissioner
	To ensure that mental health crisis services routinely anticipate and provide for the	Ongoing	MH Commissioner – CCG

	mental health crisis needs of autistic people incl. specific training about the needs of autistic people and specialised mental health support		
Care and Support	Check that all advocates working with autistic people have training in their specific requirements (EDA, POhWER and Voiceability contracts)	2019	Commissioning leads
	Develop a comprehensive resource of information about mainstream support services available for autistic people locally	By the end of December 2019	One-to-One Autism Steering Group My Life
Housing and Accommodation	Develop a policy to ensure that the frontline service of social housing providers all have at least one staff member who has training in autism to help people make applications and fill in necessary forms	TBC	Tania Sanger
Employment	Support people with autism access meaningful work activities	Ongoing	One-to-One Autism Steering Group (strategic direction) Operational Services
Criminal Justice System	Engage with the Criminal Justice Services (police, probation and, if relevant, court services) when planning for autistic adults / developing a new strategy	Ongoing / To be included in the new Strategy	One – to – One Autism Steering Group

13. <u>NHS Long Term Plan Summary</u>

1. Improving quality and outcomes
   - **a.** Waiting time targets and access standards for emergency mental health services from 2020
   - **b.** Increased focus from Care Quality Commission on system-wide quality
   - **c.** New rapid diagnostic centres for cancer from 2019

2. Prevention:

   a. Funding for new evidence-based prevention programmes focused on smoking, obesity, diabetes, alcohol related A&E admissions and air quality
   b. A focus on reducing health inequalities over the next decade

3. New Service Models:
   a. Introduction of new primary care network contracts to extend scope of primary/community services
   b. A focus on social prescribing and personal health budgets and support for improved self-management of long term conditions
   c. Same day emergency care model increasing same day discharge from 20% to 33%
   d. New clinical assessment service as a single point of access for patients, cares and professionals
   e. Reforms to diagnostic services including investment in CT and MRI scanners
4. Digital Care
   a. Availability of choice of GP via Digital First primary care offer
   b. Availability of video consultations
   c. Full digitisation for all trusts by 2024 with Chief Clinical Information Officers in place by 2022
5. Workforce
   a. Potential introduction of formal regulation of senior NHS managers and NHS leadership code outlining cultural/leadership values of NHS
   b. More doctors encouraged to be generalists
   c. Mandatory introduction of flexible rostering
   d. Apprenticeships introduced and £2.3m investment in volunteers
6. Finance
   a. 3.4% funding growth over the next 5 years
   b. Increased funding for primary and community care of £4.5billion and mental health care of £2.3billion more a year
   c. Worst financially performing NHS trusts subject to NHS improvement-led accelerated turnaround process
   d. Finance recovery fund to be set up, accessible to Trusts with identified financial risks
   e. NHS expected to save £700million from admin costs in the next 5 years (£290million from commissioners and £400million from providers)
7. Structural Reforms
   a. Integrated care systems in two years time with a single CCG for each ICS
   b. ICS will have legal shared duties and ability to create joint CCG/Provider committees
   c. Legislative change requested to free commissioners from procurement rules and remove the role of Competition and Markets Authority in NHS merger and acquisitions
   d. Explore opportunities to fund public health services through NHS budget
   e. NHS England and NHS Improvement empowered to establish joint committees

14. Update on Children and Families Priorities & Progress

The children's element of Strategy and Service Development has specialisms in the following areas:

- Early years and education
- Special Educational Needs and Disability
- Children & Families on the edge of and in the Social Care system, CAMHS/Mental Health & Voluntary Sector

Below are the current priority areas that are supported by the Children's commissioning team:

- Finalising the commissioning outcomes framework for children and families
- Raising attainment at all Key Stages through effective commissioning of training and support to schools and in the early years
- Ensuring sufficient in-borough provision, particularly for SEN children and young people
- Meeting the needs of children in our schools (improving SEN provision in mainstream settings etc.)
- Exploring potential for joined-up delivery of SEND services
- A holistic review of domestic abuse services across the People Directorate (including Children's Centre, Change and Challenge, Community Safety and Refuge)
- Exploring opportunities for colocation to further enhance provision of advice and support for families through early help services by looking to funding opportunities provided by the Homelessness Reduction Act
- Recommissioning speech & language and other therapies (joint review of current service with BEH-MHT, CCG and LBE – working group to convene in Autumn 2019)
- Embedding phases 2 and 3 of the children's portal
- Embedding the children and young people's mental health local transformation plan through the work of the THRIVE partnership
- Refresh the Family Resilience Strategy for 2020-2023 (regular multi-agency collaboration events being held to inform co-production)
- Improved collaboration with voluntary and community sector agencies to deliver the Early Help Family Hub
- Reconfiguring/recommissioning VCS Children's Safeguarding contract in line with Early Help Family Hub and Working Together. COMPLETED April 2019.
- Reviewing and decommissioning homecare services in line with the introduction of in-house services
- Explore opportunities to further develop PBS
- Recommissioning the Young Carers service – tender being advertised in October 2019
- Develop action plan for Best Start in Life
- Exploring further opportunities to develop a trading model (already in place for Education) for certain children and families' services, e.g. Speech and Language Therapy
- Explore opportunities for traded services to break the cycle of repeat pregnancies and 24-hour specialist PBS peripatetic service
- Commission single service provision for mediation (preventing homeless 16-17 year olds becoming LAC)
- Review and re-commission therapeutic mentoring service
- Develop Education strategy

- Review the cohort of young people currently accessing the 16-17 provision at Theresa House – COMPLETED July 2019
- Fundamental review of services to vulnerable young people with regard to housing options – the aim is to reduce both demand and cost
- Develop the Play and Communication invest to save model
- Continue to explore bidding opportunities to enable the LA to expand its early help offer
- Review the effectiveness of the joined-up adults/children's appropriate adults service across multiple LAs
- Explore traded service options for contact and assessment
- Tender for semi-independent provision for LAC

15. <u>Implementation of the STAY project:</u>

- A Better Care Fund supported project has been approved an implemented delivering an Intensive Behaviour Support Service, known locally as the STAY (Supporting Team Around You). The project works with young people with special needs and behaviour challenges and for whom there is a risk of home or special school breakdown and admission to hospital or a residential school/placement. Small scale community-based services are more likely to bring about positive outcomes for this group of young people rather than isolated out-of-area services (Jones, 2013), and a similar model in Ealing, which combined intensive behaviour support with respite, was able to demonstrate reduced levels of behaviour that challenge, and a reduction in use of residential schools/placements. The service is delivered by the Integrated Adult Learning Disability Service. This has meant closer working relationships between children's and adults services, including a joint monthly meeting to review the at-risk register, and improved decision making around transition. The STAY project works closely with the CAMHS SCAN (Social Communication and Neuro-disabilities) service, and there are obvious synergies between the two services.
- The impact of STAY has been immediate in terms of meeting an identified gap in provision and case working what are very complex cases involving a number of agencies/professionals. The existence of STAY has already prevented the admission of at least one young person to a residential school, and there is concrete evidence through the regular meetings to review the at risk register that the risk of admission in other cases has been reduced. Funding has been approved for a second Positive Behaviour Support Worker. In addition, North Central London STP is an accelerator area for Transforming Care and funding has been agreed for a key worker/support worker role and a parent worker, which will further increase the capacity of the STAY Project. Both the accelerator pilot and the STAY project will be externally evaluated.

- The STAY Team and SCAN service work as part of network of services including special schools, mainstream schools, children with disabilities services and children's community health services and it an extensive training and support programme is underway. The network has been named the Enfield Transforming Care and Enhanced Family Support network (ETCEFS) to emphasize the importance of collaboration, and the multiagency steering group that supported the establishment of STAY is now supporting the network.
- In addition to the above scheme the BCF also contributes to adolescent outreach and crisis intervention. The SAFE (our adolescent outreach service) and Alliance teams together provide a highly responsive service for adolescents at risk and Enfield has

the lowest Tier 4 admission rate in NCL. Since April 2015, SAFE has successfully trialled an urgent assessment service for children and young people admitted to paediatric wards at the North Middlesex and Barnet Hospitals with presentations of deliberate self-harm (DSH). Going forward it is our intention to implement a whole service response to children and young people's needs, through implementation of a THRIVE type model, accessed via a single point of entry (SPoE).

16. Young People Misuse Contract

In July 2019 the current Young People's Substance Misuse Contract was extended for a two year period. This offer is comprised of two service elements; Support to children and young people who misuse substances including the delivery of health promotion and prevention messages, early interventions and treatment; and, non-treatment support to parents who misuse substances, this includes a 12 week parent recovery programme, one to one support and coordination of support across this service, the adults treatment service and children's services for parents & families where there are substance misuse needs. The current contract has been in place since July 2014 and the final two year extension was granted due to local need and ongoing excellent performance.

In July 2019 the current Young People's Substance Misuse Contract was extended for a two year period. This offer is comprised of two service elements; Support to children and young people who misuse substances including the delivery of health promotion and prevention messages, early interventions and treatment; and, non-treatment support to parents who misuse substances, this includes a 12 week parent recovery programme, one to one support and coordination of support across this service, the adults treatment service and children's services for parents & families where there are substance misuse needs. The current contract has been in place since July 2014 and the final two year extension was granted due to local need and ongoing excellent performance.

17. Substance Misuse Services

The Enfield Drug & Alcohol Services are currently being provided by Barnet, Enfield & Haringey Mental Health NHS Trust (BEH-MHT). Since its inception in April 2017 the service has been providing a range of clinical, therapeutic and recovery interventions across two sites within Enfield. The majority of the clinical interventions, including substitute prescribing, community detox and access to Blood Borne Virus interventions and Hep C treatment are delivered from the Clavering Site in Edmonton, N9 with Vincent House, EN3 providing a wide range of therapeutic and recovery focused interventions. These include counselling, Cognitive Behavioural Therapy based interventions, access to 'Improving Access to Psychological Therapies' (IAPT), groupwork programmes, family-based therapy and access to peer mentoring, mutual aid and Education, Training and Employment (ETE) interventions.

Overall the key deliverables for substance misuse treatment are:

- Treatment for drug misuse in adults;
- Treatment for alcohol misuse in adults;
- Preventing and reducing harm from drug misuse in adults;
- Preventing and reducing harm from alcohol misuse in adults;

Together with the young people's substance misuse service, the adult service aims to minimise the impact that substance misuse has not only on individuals but the wider community. This is turn positively contributes to addressing health inequalities within the Borough as well as the crime reduction priorities for the Safer & Stronger Communities Board.

Since April of this year Enfield Council has been working with the Provider to reconfigure the service to improve performance and quality within service provision. This has included the establishment of alcohol hubs in primary care, improved pathways between the service and the acute sector, dedicated outreach in the community as well as a more joined up approach with community safety teams, probation services and mental health providers. Furthermore a Service Improvement Plan was drawn up which is now monitored on a monthly basis to further aid the evaluation of referral pathways, treatment uptake and throughput as well as treatment exits.

18. <u>Sexual Health Services</u>

Sexual Health Service provision has been delivered through an integrated approach since November 2015 through North Middlesex University Hospital NHS Trust (NMUH). The service has three key elements which support the sexual health needs of young people and adults within the borough: GUM & STI treatment, Family Planning & Contraception and Young Peoples Outreach.

The service, through its Hub & Spoke model, delivers treatment and support at Silverpoint (Upper Edmonton, N18) and The Town Clinic (Enfield Town, EN2). Satellite provision once a week is also delivered at Enfield Island Surgery as part of this model.

Whilst the Provider is working towards achieving its service targets for GUM presentations at Enfield Clinics, there is ongoing partnership working with Enfield Council to reduce out-of-borough GUM presentations for Enfield residents accessing other clinics across London. A joint communications plan has been developed to target 18-30 years to increase STI testing and treatment in Enfield, targeted promotion of clinics to the west of the borough, improved access to online appointments in borough and walk-in attendances as well as utilisation of the E-Service for asymptomatic patients to access postal kits for chlamydia, gonorrhoea, syphilis and HIV. This work will be further complemented by promoting local access to LARC via trained GPs and EHC provision for 18-24 years through pharmacy access.

19. <u>Oral Health Provision</u>

With the transfer of previously held NHS Public Health contractual and financial responsibilities as part of the Health and Social Care Act (2012), Oral Health Improvement became the responsibility of Local Authorities as of 1 April 2013. Since then, Oral Health

Promotion in Enfield has been provided by the Whittington NHS Trust to an agreed service specification.

On 31st of March 2019 contractual arrangements with the Whittington came to an end. Whilst the provider agreed to continue the provision of services, the Council has been exploring the possibilities of a potential partnership agreement between Enfield Council and Whittington NHS Trust in accordance with Section 75 of the National Health Service Act (2006).

Over the recent months Public Health England, NHS England, Enfield Council and Whittington NHS Trust have been working together to improve Enfield's oral health offer and a new delivery plan has been devised with the three main objectives for the years to come:

- Mainstreaming of good oral health approaches across services for children and young people through the delivery of training to professionals and the distribution of brush for life packs.

- Mainstreaming of good oral health approaches across community services for older people by specifically targeting older people in the community setting who are not currently in receipt of statutory services.

- Delivery of preventative treatments to children at risk of poor oral health, which includes the delivery of the fluoride varnish programme to identified targeted groups of children in nursery settings attached to identified schools, reception and year 1.

Whittington NHS Trust also delivers the Community Dental Services Contract across North West London and North Central London commissioned by NHS England. Aligning our Oral Health Promotion service with the Whittington NHS Trust's wider service offers Enfield access to the expertise and specialisms afforded by the much larger Community Dental Services contract. It enables us to integrate the oral health agenda into the wider children's services offer provided by Enfield Council and thus leading to improvements in service quality and performance.

20. Health Visitors

On the 17th July 2019 Cabinet gave approval for the Council to explore a potential partnership agreement between Enfield Council and North Middlesex University Hospital NHS Trust (NMUH), in accordance with Section 75 of the National Health Service Act (2006). This agreement is designed to facilitate the delivery of the Enfield 0-19 Service consisting of Health Visiting and School Nursing.

Enfield's 0-19 Service is currently provided by Barnet Enfield Haringey Mental Health Trust (BEH MHT) under an arrangement which expired on the 31st March 2019 and continues until alternative arrangements have been agreed.

Over the last 12 months Enfield Council and BEH MHT have been in discussions around future delivery of the 0-19 Health Visiting and School Nursing Service following the end of the current arrangement. Unfortunately, BEH MHT and Enfield Council have been unable to find a mutually agreeable conclusion to these discussions which has left Enfield Council with no option other than to seek an alternative provider. BEH MHT have agreed to

continue to deliver the Health Visiting and School Nursing Service on an interim bases until an alternative provider is secured.

A potential Section 75 Agreement between Enfield Council and NMUH can support partnership working allowing service redesign and modernisation to improve our local health offer, deliver value for money and improve performance and quality.

The development of this Section 75 Agreement will improve health and well-being outcomes for children, young people and their families. It will support wider delivery and integration of health care services, early years provision and community services to children, young people and their families.

Work is currently underway to explore new accommodation and IT options, supporting mobile working, an improved skills mix and delivering through a service model discussed and validated by Public Health England. We are confident that a new service will be ready to deliver from 1st April 2020.