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

Date of Health and Wellbeing Board: **15th December 2022**

Prepared by: Doug Wilson, Head of Strategy, Service Development & Resources, People Dept.

Introduction & Background

- The Joint Health & Social Care Commissioning Board is a partnership across Council People services and Health (ICB/ICS) commissioners. For the purposes of this update, it oversees the Better Care Fund Delivery Group and has oversight of the delivery of the Better Care Fund joint priorities across Social Care and Health, in line with the key priorities.

  These priorities are:

  a. Reducing avoidable admissions to hospital
  b. Reducing the proportion of people whose length of stay in an acute hospital bed exceeds both 14 and 21 days
  c. Increasing the proportion of people who are discharged from hospital back to their usual place of residence
  d. Minimising the number of people aged 65 and over who are permanently admitted to residential or nursing care
  e. Maximising the proportion of people who enter the enablement service following discharge from hospital and who are living independently three months following discharge.

- These have continued to be delivered within the context of the pandemic over the last two and a half years and a significant consequential impact on our local communities and services.

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A&E Attendances

- Enfield's two acute trusts, Royal Free and North Middlesex, have remained in a permanent state of escalation.
- Occupancy rates for both Acute Trusts have also been extremely high with both NMDDX and RF Trusts exceeding an average of 98-100% bed occupancy as at Nov 2022.
- The Accident and Emergency department at NMDDX hospital remains under significant pressure with just under 200,000 A&E attendances in financial year 2021/22. Chart 1 shows the patterns of attendances in FY 21/22.time
- Activity is starting to rise following a seasonal fall over the summer months. This is particularly visible in some of the more complex categories.
- Nearly 28% of patients attending NMUH A&E were categorised as having no investigation with no significant treatment.

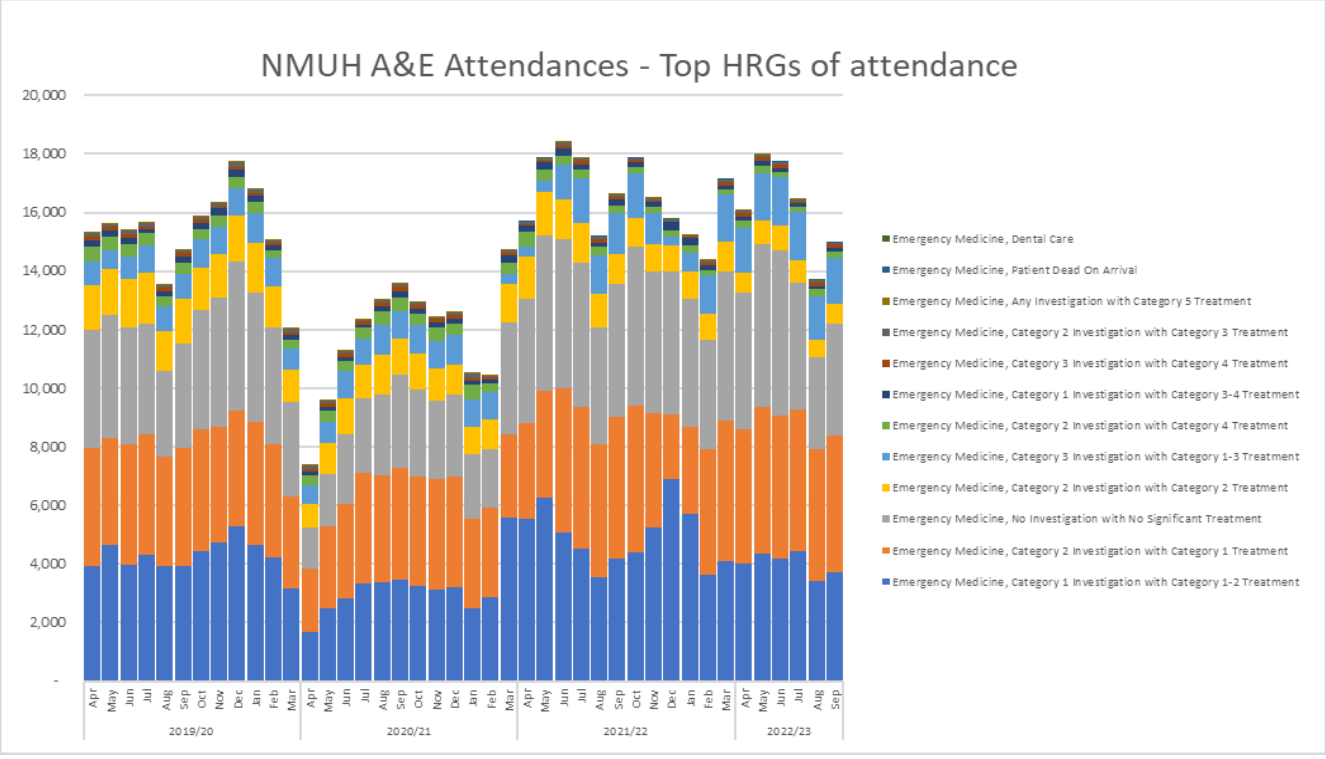


Chart 1

- Enfield residents went to A&E in 2021/22 approximately 183,000 times which is a 4% increase on pre-pandemic levels.
- Activity is starting to rise following a seasonal fall over the summer months. This is particularly seen in some of the more complex categories.

- Nearly 24% of Enfield patients attending A&E were categorised as having no investigation with no significant treatment. Further exploration of the reasons behind this is underway.

Chart 2

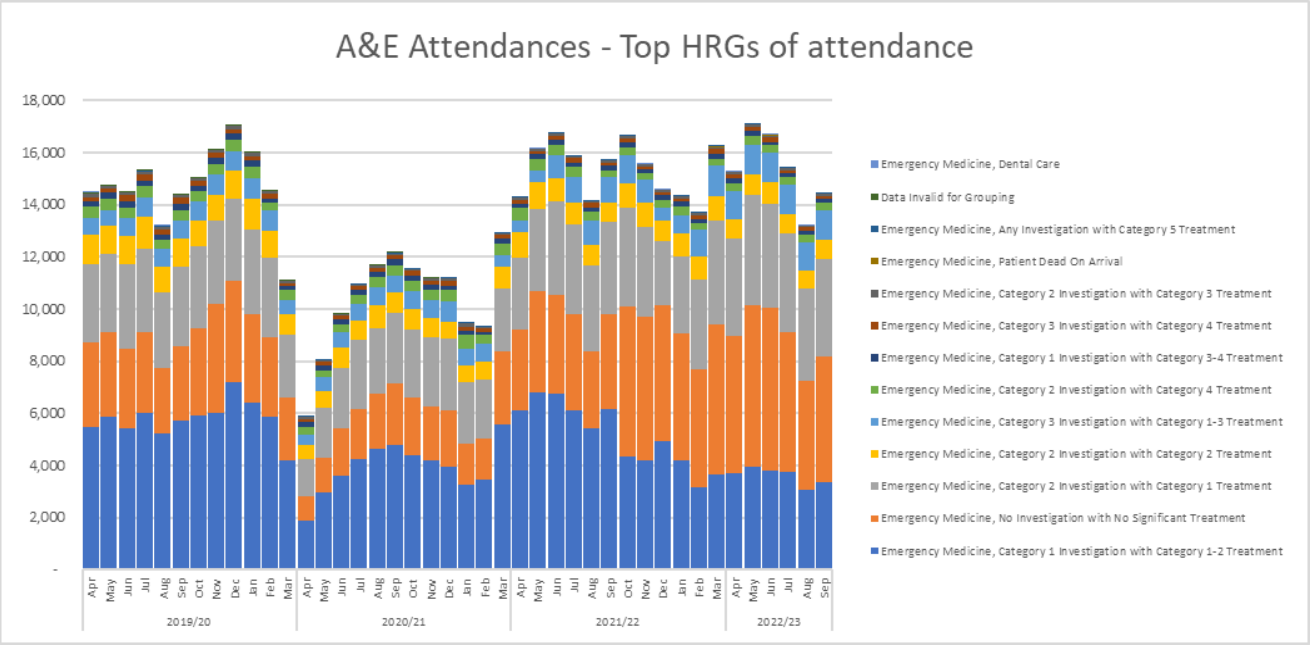
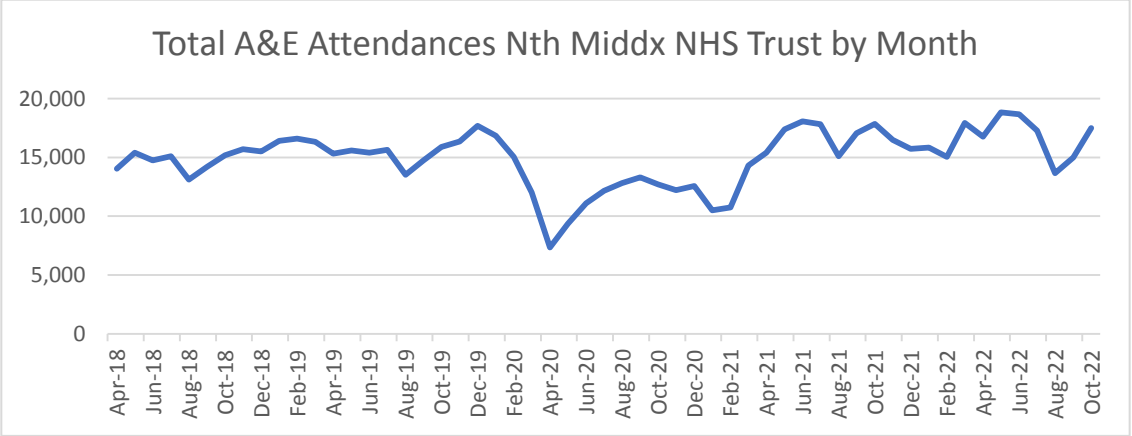


Chart 3



Data source:
https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2022-23/

- The Accident and Emergency department at NMDDX hospital is currently (as at October 2022) dealing with between 500 to 600 attendances a day.
- However, work undertaken in the last few years has been successful in reducing the number of A&E attendances that result in an emergency admission to hospital, as shown in Chart 4 below, with emergency admissions reducing by just under 10,000 per year from 2018/19 to October 2022

Chart 4

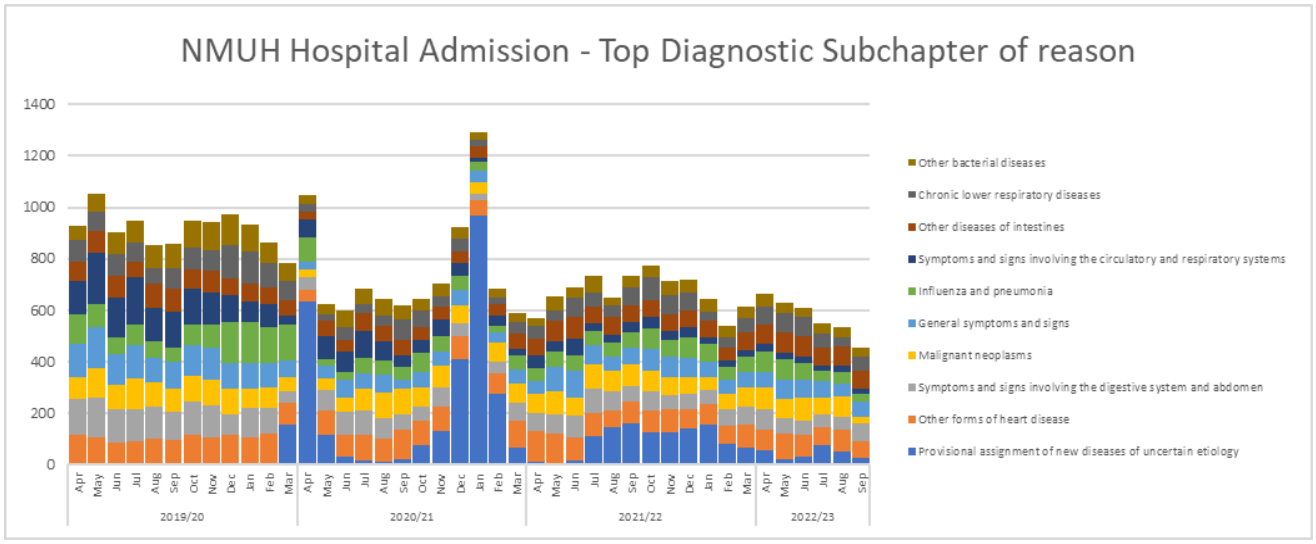
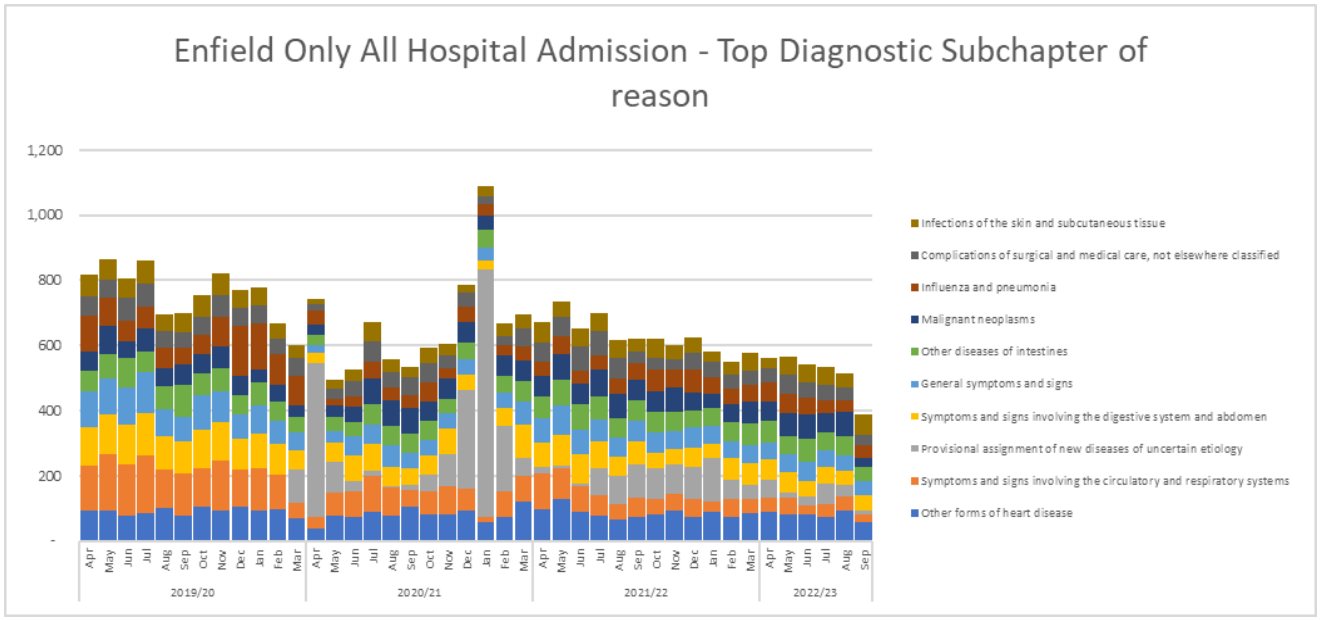


Chart 5 shows the top 10 admissions by HRG sub-chapter for all Enfield patients across all NCL providers. The chart shows a decrease in admissions across the top 10. There has been a particular drop in September due to seasonal effects with activity expected to rise over the coming months.

Chart 5



- Despite the lower number of emergency admissions our hospitals continue to be busier than ever within A&E.

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Avoidable Admissions

- One of the key targets within Enfield's Better Care Fund Plan is the reduction of avoidable admissions. This is measured as a proportion of all emergency admissions. This focuses on chronic conditions, where treatment in the community should be available to prevent the need for emergency treatment within a hospital setting. Table 1 and Chart 6 below show the trend over the last four years for conditions known as Ambulatory Care Sensitive (or avoidable):

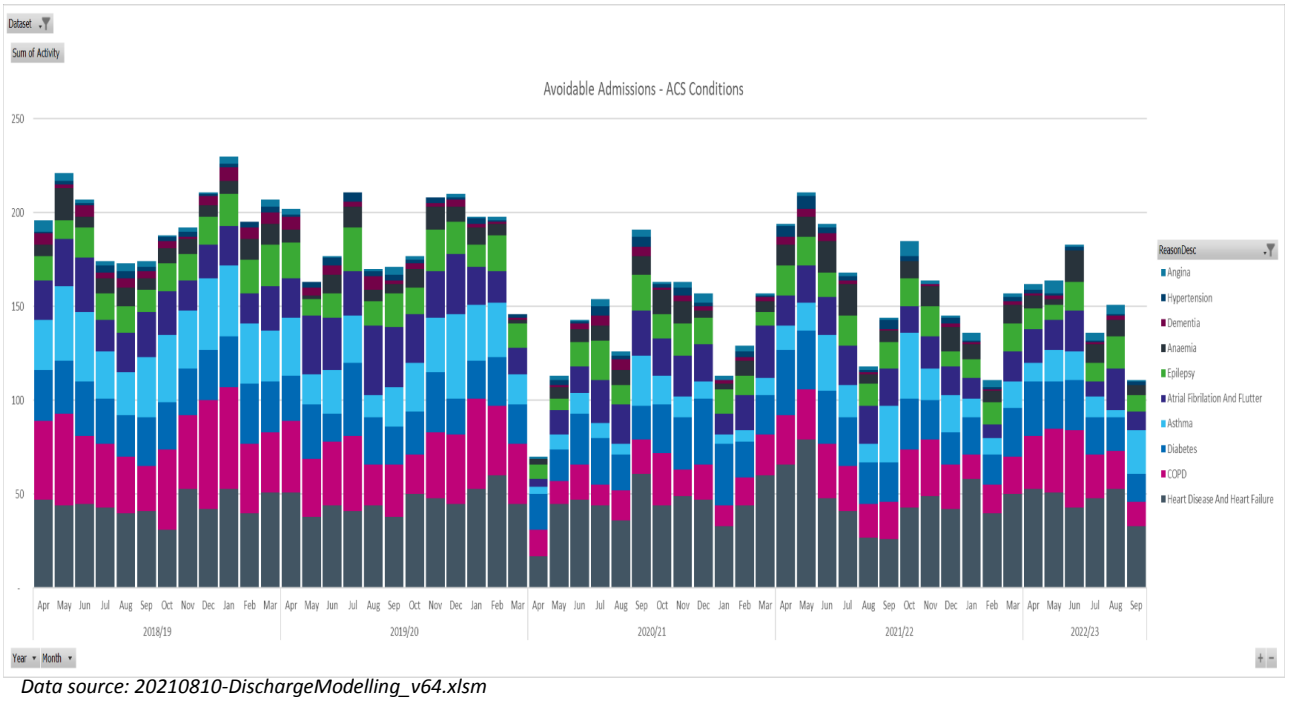
- Despite an overall downward trend across ACS (Acute Coronary Syndrome) conditions, heart disease and heart failure remain consistently high with no improvement.

Table 1

Avoidable Admissions over time	2018/19	2019/20	2020/21	2021/22	to Sept 22
Heart Disease and Heart Failure	530	557	527	569	281
Diabetes	319	293	287	290	134
COPD	478	403	199	277	159
Asthma	386	303	119	220	80
Atrial Fibrillation and Flutter	255	307	219	197	96
Epilepsy	180	192	151	162	70
Anaemia	104	88	88	124	51
Hypertension	28	31	28	34	9
Angina	33	16	29	31	21
Dementia	55	41	32	23	6
total in year	2368	2231	1679	1,927	907

- Whilst Enfield is above NCL average for avoidable admission it is tracking the NCL downward trend seen in ACS avoidable admissions.

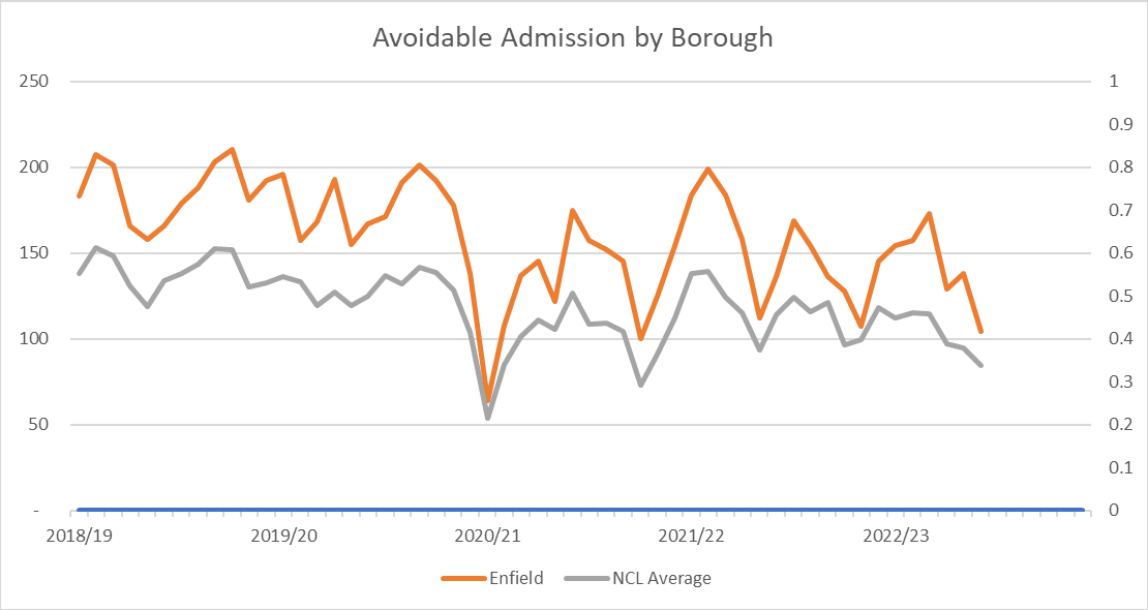
Chart 6



Data source: 20210810-DischargeModelling_v64.xlsm

- Between April 2018 and March 2021 avoidable admissions reduced by 689 but in 2021/22 increased on the 2020/21 number by 248. Whilst admissions for some conditions remained fairly constant during the four-year period, there are some which reduced significantly, including COPD (emphysema) and Asthma. A corresponding increase in emergency admissions due to Covid19 was seen in the same period and this has added to the acuity ,or complexity factor, being attributed to an increasing number of hospital cases where people are having to remain in hospital for treatment for an extended period.

chart 7



Data source: 20210810-DischargeModelling_v64.xlsm

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Length of Stay in Acute Hospital Beds

Table 2

	Column											
	Sum of Activity				Sum of BedDays				Avg LOS			
Row Labels	2019/20	2020/21	2021/22	2022/23	2019/20	2020/21	2021/22	2022/23	2019/20	2020/21	2021/22	2022/23
Other forms of heart disease	415	406	391	183	3,129	2,820	3,151	1,702	7.54	6.95	8.06	9.30
Malignant neoplasms	343	297	339	155	4,186	3,683	4,097	2,143	12.20	12.40	12.09	13.83
Provisional assignment of new diseases of uncertain etiology	31	736	218	81	161	8,060	3,233	864	5.19	10.95	14.83	10.67
Influenza and pneumonia	397	184	229	102	3,684	1,826	2,527	970	9.28	9.92	11.03	9.51
Other bacterial diseases	305	190	197	78	4,353	2,472	2,448	1,146	14.27	13.01	12.43	14.69
Ischaemic heart diseases	153	179	225	83	786	841	1,333	599	5.14	4.70	5.92	7.22
Chronic lower respiratory diseases	251	103	185	99	1,502	597	1,396	718	5.98	5.80	7.55	7.25
Cerebrovascular diseases	157	177	197	88	1,429	1,986	2,297	955	9.10	11.22	11.66	10.85
Other diseases of intestines	191	152	197	72	1,813	1,095	2,037	707	9.49	7.20	10.34	9.82
Other diseases of urinary system	174	118	170	75	1,467	1,034	1,545	817	8.43	8.76	9.09	10.89
Grand Total	**2,417**	**2,542**	**2,348**	**1,016**	**22,510**	**24,414**	**24,064**	**10,621**	**9.31**	**9.60**	**10.25**	**10.45**

- Table 2 above shows the top 10 main presenting reasons by year for admission to an acute hospital bed that have the longest length of stay. The table shows the number of patients admitted, the total number of bed days for those patients and the average length of stay.
- Overall whilst admissions have decreased slightly over the last few years, the overall number of bed-days has increased, this has resulted in an increase in the average LoS (length of stay).
- They key areas where the average LoS has increased are;
  a. Other forms of heart disease
  b. Ischaemic heart disease
  c. Chronic lower respiratory diseases
  d. Other disease of the urinary system

Charts 8 & 9 – Number and % discharges within 7 and 21 days

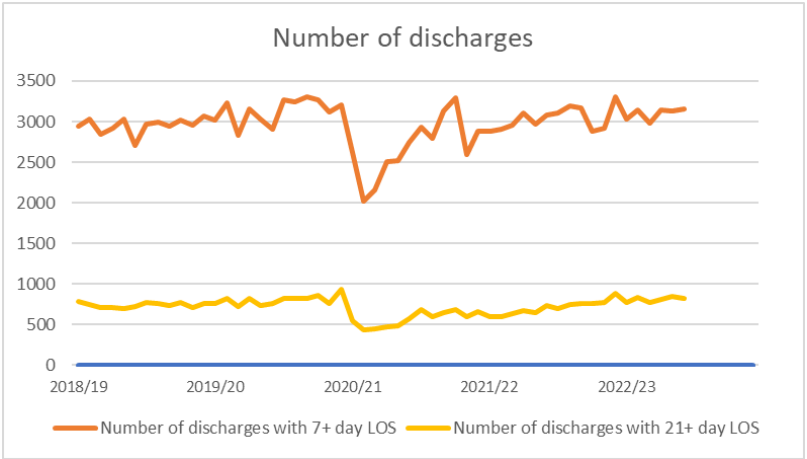

Chart 8

- The number of patients being discharged after 21 days has increased to pre pandemic levels despite an improvement in 2021/22.

- There has been an improvement in the number of patients being discharged at 7+ days.

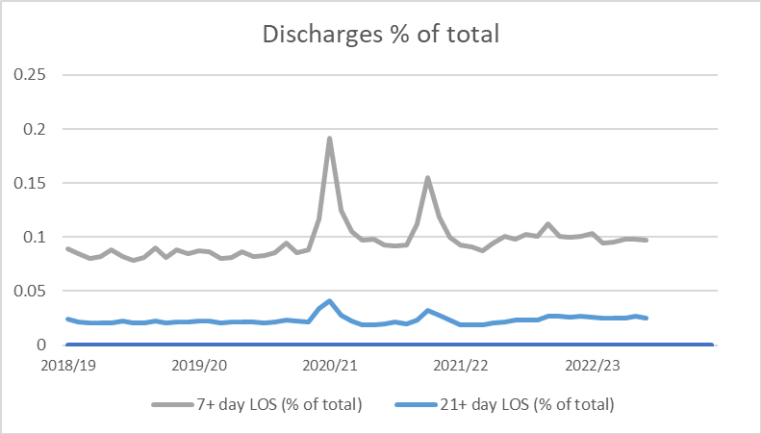

Chart 9

Bed occupancy

Bed occupancy is high across NCL with both Barnet Hospital and NMUH consistently at 98% - 100%.

The number of escalation beds has increased by 94 in NCL of which 32 are at NMUH and 24 at RFH.

Table 3

21st – 27th November 2022	NMUH	RFL	UCLH	WH	NCL	London Average
Adult G&A Occupancy	100%	98%	97%	98%	98%	95%
Bed Occupancy where Patient LOS is 7 Days +	64%	57%	51%	43%	53%	52%
Bed Occupancy where Patient LOS is 14 Days +	38%	33%	31%	26%	32%	31%
Bed Occupancy where Patient LOS is 21 Days +	26%	22%	21%	20%	22%	22%
% of attendances over 12 hours from arrival	7.2% (358)	2.2% (162)	3.4% (119)	6.1% (157)	4.3% (796)	6.2% (6292)

- MO (*medically optimised*) numbers remain high although Enfield continues to exceed target.
- Delays to discharge key issues:
- P1 (*Pathway 1 = the patient has additional care needs that can safely be met at home*) complexity of care required for some patients
- P2 (*Pathway 2 = The patient is unable to return home for a short period of time as they require further rehabilitation*) effective flow and utilisation of capacity. Additional P2 capacity has opened on the Chase Farm site and will provide 17 extra beds.
- P3 (*Pathway 3 = The patient has complex needs and is unable to return home*) ongoing pressure for P3 discharges due to complexity of patients and constraints in the care home market.

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Discharge System	Total MO	MO P1	MO P2	MO P3	System MO Target	Distance from target	P1 Discharges (last week)	P2 Discharges (last week)	P3 Discharges (last week)	Total Discharges (P1-P3)	MO as % of total weekly discharges	Hospital OPEL	Discharge OPEL (proposed)
Barnet	37	7	15	15	31	6	73	20	6	99	37%	3.0	3
Camden	14	3	4	7	14	0	38	8	7	53	26%	2.0	2
Enfield	20	7	4	9	28	-8	47	22	3	72	28%	4.0	1
Haringey	31	11	12	8	22	9	31	7	3	41	76%	3.5	3
Islington	25	11	9	5	15	10	25	4	6	35	71%	2.5	3
Non NCL	49	18	16	15	23	26	42	10	2	54	91%	2.8	4
Total	**176**	**57**	**60**	**59**	**133**	**43**	**256**	**71**	**27**	**354**	-	**2.8**	**3**

Note this excludes P0 delays as they are not counted through IDT's. Delays are system responsibilities, across all providers and local authorities.

OPEL scores are snapshots. MO as of 27-Nov and includes all current referrals (including day-0 referrals).
Hospital OPEL as of 27-Nov (averages of relevant acutes). Weekly discharges as of w/c 18-Nov .

37

Table 4

- Overall, the MO position is stable and Acute remains high. We are now at +43 against the NCL target (+43)
- Acute OPEL pressure remains high but has reduced, NMUH are at OPEL 4, Barnet and WH are OPEL 3 and RFH are OPEL 2
- Enfield continues to report below target and Camden is on target. Barnet, Haringey and Islington are all over target and we propose OPEL 3 for these discharge systems. Non NCL MO remains very high, with +26 (+24)
- We have escalated the work to draw this data from acute patient systems to the COO group, to secure their support in enabling this data flow, and have received the first submission from the Whittington acute
- Supported discharge volumes have decreased slightly at 354 supported P1-P3 discharges in the last week (381) (as at 02-12-2022)
- Both 14+ and 21+ LOS remain stable with the NCL position now nearer to the London averages. The trusts LLOS reviews and subsequent actions continue to deliver on LLOS pressures.
- Average of 45% of patients without criteria to reside not discharged each day - this is an improving trend and lower than the London average of 52%.

Table 5

21st – 27th November 2022	NMUH	RFL	UCLH	WH	NCL	London Average
Total discharges	34	116	103	23	275	1,099
No longer meeting Criteria to Reside (CTR)	69	214	143	56	483	2,269
No longer meeting CTR and not discharged	36	98	40	33	207	1,170
No longer meeting CTR and not discharged (%)	51%	46%	28%	59%	43%	52%

- Just over 50% of discharges across NCL take place before 5.00 pm. There is a continued system focus on pre 12.00 and 5.00pm discharges to help improve flow.

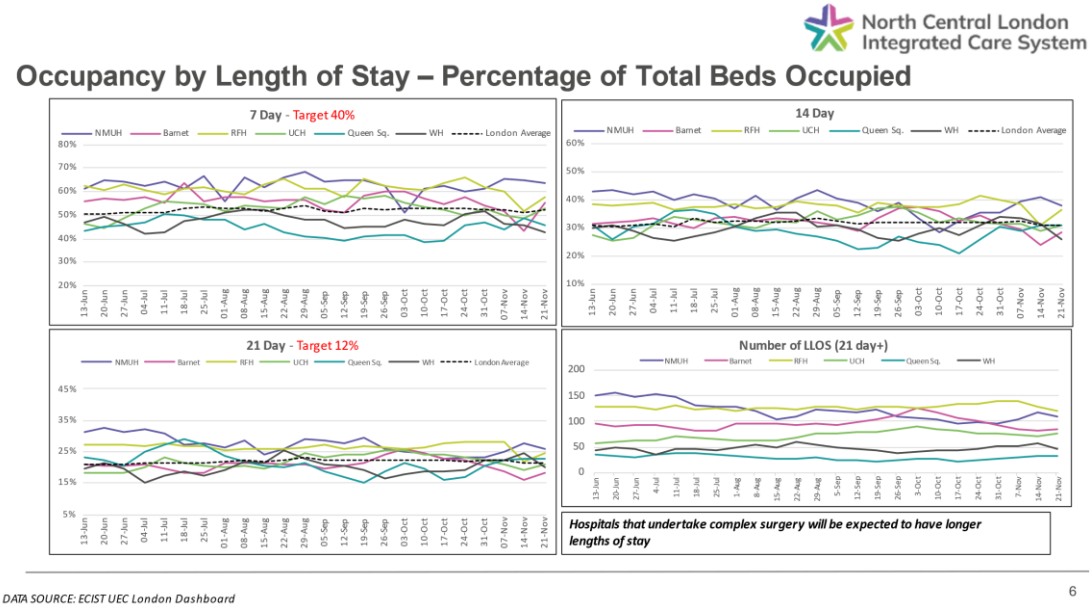
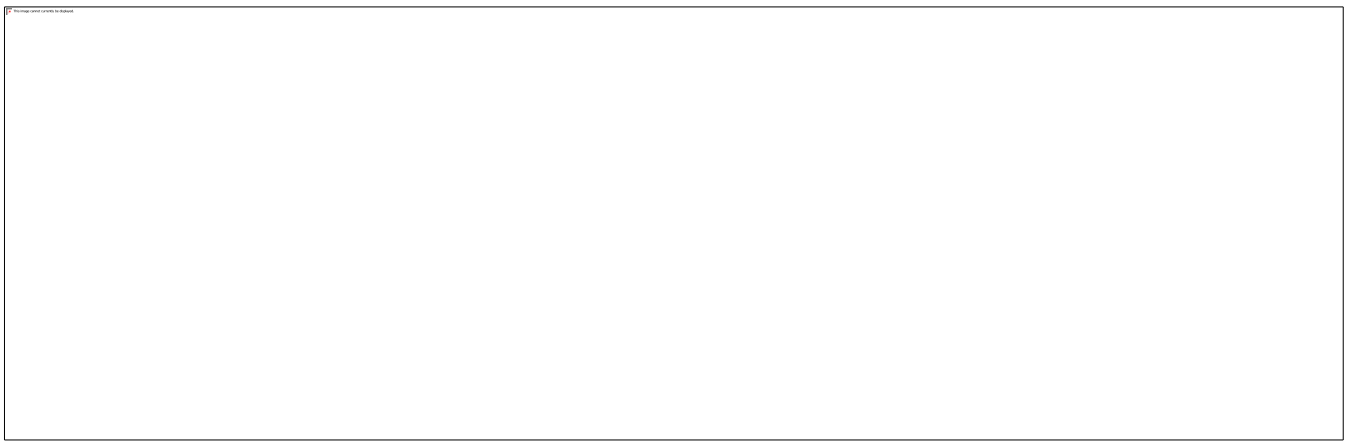


Chart 10

Excess Deaths

- The impact of the pandemic with regards to resident deaths has been clear in Enfield with:
- An average number of deaths (over a five-year period to 2019) of 2061 exceeded by 493 (excess deaths) in 2020 and 280 excess deaths in 2021. April 20 and January 21 saw the most significant spikes in excess deaths.

Chart 11



- excess deaths 2020 493
- excess deaths 2021 280
- excess deaths 2022 70

Discharge to Usual Place of Residence

Chart 12

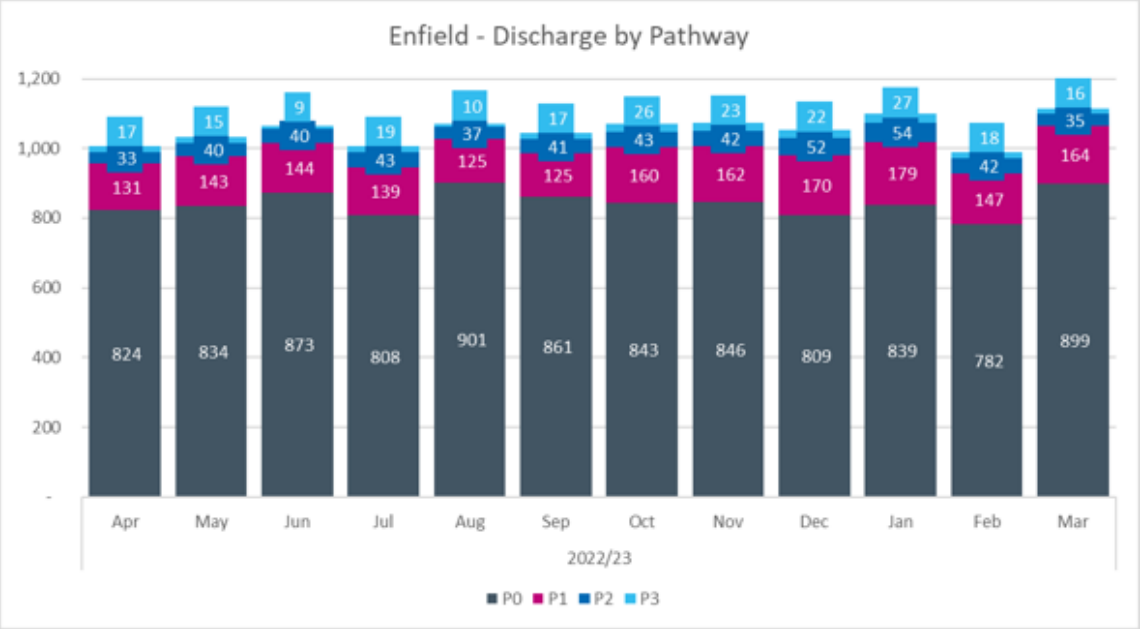


Table 6

	2022/23													
ProviderGroup	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Oct-Mar
Barnet Hospital	309	309	305	320	349	351	365	378	365	362	314	344	4,071	2,128
North Middlesex	1,137	1,276	1,243	1,123	1,160	1,195	1,182	1,088	1,088	1,029	1,036	1,089	13,646	6,513
Royal Free London	136	148	143	157	155	161	169	167	159	159	145	156	1,855	954
UCLH	174	175	209	180	180	193	172	165	178	185	185	184	2,180	1,068
Whittington Health	14	16	18	16	19	16	17	20	26	33	30	26	251	151
Total	**1,770**	**1,925**	**1,918**	**1,797**	**1,864**	**1,915**	**1,905**	**1,817**	**1,816**	**1,768**	**1,710**	**1,799**	**22,002**	**10,814**

	2022/23														
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Oct-Mar	%
P0	1,534	1,611	1,620	1,476	1,626	1,649	1,614	1,553	1,530	1,492	1,426	1,558	18,688	9,173	84.8%
P1	138	189	184	194	143	160	179	166	188	173	187	148	2,049	1,041	9.6%
P2	82	105	103	116	79	85	95	79	82	84	74	80	1,064	494	4.6%
P3	15	20	11	11	16	21	17	19	16	18	22	13	201	107	1.0%
Total	**1,770**	**1,925**	**1,918**	**1,797**	**1,864**	**1,915**	**1,905**	**1,817**	**1,816**	**1,768**	**1,710**	**1,799**	**22,002**	**10,814**	

- The priority for people once their treatment and stay in hospital is completed, is to discharge them to their usual place of residence. The target set within the Better Care Fund for 2021/22 was to achieve this for 93% of Enfield residents who had a stay in hospital. The table and chart below show that although progress was made between 2020/21 and 2021/22, the target was narrowly missed.
- Given the increased acuity or complexity of many of the cases coming through hospital, many residents are being discharged to further specialist services for ongoing treatment or support, which includes placements into residential or nursing care. Homefirst continues to be a priority for the partnership, underpinned by the principles of Discharge to Assess - where people are discharged

initially to wherever is appropriate and safe, with assessment of ongoing needs for care and support carried out in a more appropriate environment (preferably a person's own home).

Table 7

Discharge to usual place of residence	total	Usual place	%
2018/19	25976	23719	91.3%
2019/20	25922	23979	92.5%
2020/21	20835	18848	90.5%
2121/22	20549	18949	92.2%

Adult Social Care Discharge Fund

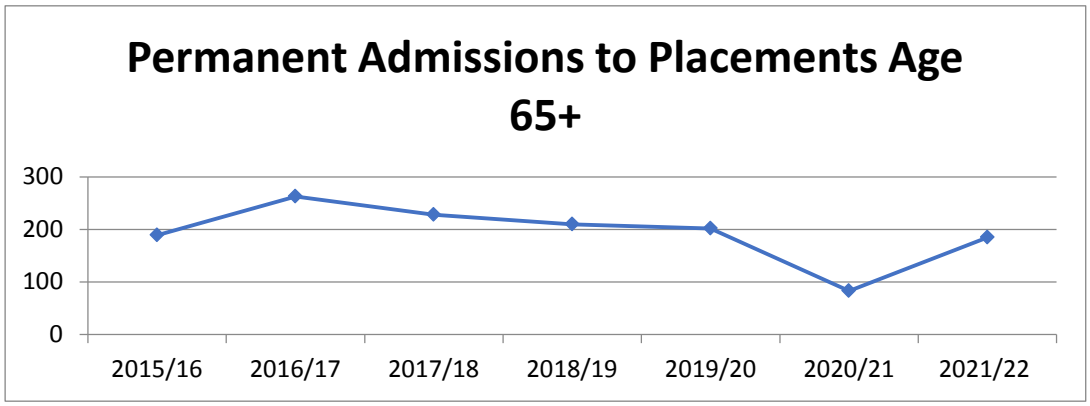
The ICB and LBE have received additional funding to support with the discharge of residents within the borough through this winter. This funding has only just been announced and we are working with ICB colleagues on plans on how this should be best spent. The following areas are what we will be focussing on

- Assistive Technologies and Equipment,
- Home Care or Domiciliary Care
- Bed Based Intermediate Care Services
- Reablement in a Person's Own Home
- Residential Placements

Permanent Admissions to Residential or Nursing Care for Older People

- The Council's priority, working in partnership across the health and VCS sector, is to reduce the number of people admitted permanently to residential or nursing care. Whilst there will always be a need for 24-hour care and support in settings such as these, improved support in the community which promotes independent living, is a priority for the partnership. This would include more supported living options (such as extra care support for older people), increased use of telecare as part of a wider support offer and early interventions which support family carers, ensuring accommodation is safe and fit for purpose to reduce social isolation and the risk of falls. The Better Care Fund Plan target for permanent admissions in 2021/22 was 230, a significant increase on the previous year in anticipation of a Covid bounce-back. The successful work undertaken has seen more people temporarily admitted to residential stepdown care for rehabilitative support and a return home to the community. At year end the actual number of permanent admissions was 185 significantly exceeding the target set. Chart 13 below shows the trajectory over time with a significant dip in 2020/21 with an increase in 2021/22.

Chart 13



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 their partners have been working hard to continue to develop Discharge to Assess services to minimise the amount of time people spend in a hospital bed once they are fit for discharge. In most cases (over 92%), people will be discharged home first where they will be assessed and provided with the appropriate support to help them regain independent living skills including through LBE Enablement Services.

- Around 78% of new 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). Of the people who are discharged from hospital and supported by the Enablement service, over 81% of them continue to live independently three months later. Our target for this year is to increase this to 88%.

- Enablement have worked with 953 residents between April-November 2022. Of those 953 people 759 have gone through pathway 1 D2A hospital discharge process. D2A and Enablement work closely together to support hospital discharge and enable people to return to their own home. Safe and Connected is offered to all people going through D2A and Enablement following hospital discharge to enhance their support at home. (From Anna)

- Hospitals cancelling a significant number of discharges, continues to be challenging, over this period there have been 219 cancellations. Strategies have been put in place to try and address this with the hospital teams.

- For those people who do have an ongoing need for care and support, this will be provided by the Enablement service until a suitable long-term provider is found. Where long terms support is needed, this can be arranged in a variety of different ways. Enfield leads the way nationally in the roll out of direct payments (number one in England) with over 54% of people who receive community services doing so through a direct payment. This offers people who use services and their families more flexibility, choice, and control in getting the right services for them.

Table 8

OP/PD ASC Service Profile	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
People in Year (excluding Enablement)	3427	3595	3553	3558	3483	3546	3741
People in Year (across services including enablement)	4494	4344	4198	4246	4121	4182	4346
People in year under 65	825	880	864	904	899	840	970
People in year 65 and over	3669	3464	3334	3342	3222	3342	3376

- Within our Older People and Younger People pathway we have seen an increase of 9% in the last 6 years. This has been a gradual increase over this period and is also in line with Enfield's growing older population.

- We understand that people want to continue to live in their home for as long as they possibly can. Where this is no longer possible there are alternatives to residential care. The Council has planned to invest over £30m in a new purpose-built extra care facility on the site previously occupied by the Reardon Court Care Home and Extra Care scheme. Extra care provides people, usually aged 55 and over, with their own accessible flats (either 1 or 2 bed) where care and support is available 24-hours a day, 7 days a week. Demolition of the existing site has already taken place and construction is planned to begin this financial year with completion in 2023/24. The scheme, once built, will provide 69 self-contained flats, all fully accessible within a state-of-the-art facility providing much needed services for local people with a variety of different support needs. 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 an allotment space.

- Table 9 below shows the balance of care over the last four years in Adult Social Care in Enfield. The number of people living permanently in residential or nursing care has returned to pre-pandemic levels. This is despite the increasing complexity of hospital discharge cases and due to an increasing number of people receiving more stepdown/rehab support which enables them to return home to more independent living.

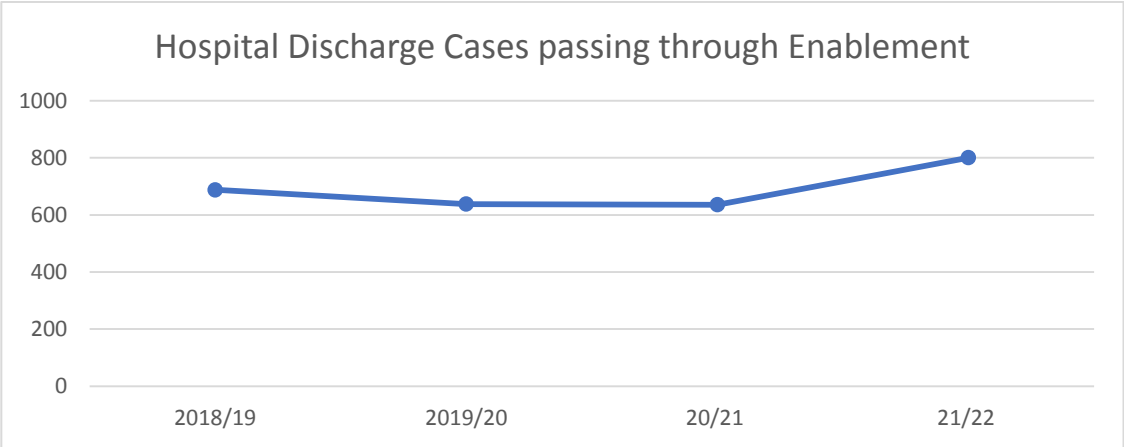
- The ongoing development of Integrated Discharge Teams (IDTs), consultant-led virtual wards as well as scaled up enablement/community equipment service provision and invaluable support via our Voluntary and Community Sector, has contributed to a strengthened health and social care system which actively promotes and delivers independent living options for our older vulnerable people in Enfield.

Table 9

Older People services over time (year-end snapshot)	**Mar-19**	**Mar-20**	**Mar-21**	**Mar-22**	**Sep-22**
Residential/Nursing	722	725	591	720	763
Community	4918	4844	4649	4851	4508
Total	5640	5569	5240	5571	5271
OP services over time	**Mar-19**	**Mar-20**	**Mar-21**	**Mar-22**	**Sept-22**
Residential/Nursing	13%	13%	11%	13%	14%
Community	87%	87%	89%	87%	86%

- Chart 14 below shows how the Council's Enablement Service has developed over time, with the capacity to support hospital discharges having increased in 2021/22 by 26% to meet increased demand over the last year.

Chart 14



- The Better Care Fund Plan for supporting people to continue to live independently three months following discharge from hospital, set a target of 87.9% for 2021/22. The outturn for this service was 81%. Given the volatility of many cases following discharge from hospital and the significant increase in cases seen, this is good performance.

Enfield Integrated Learning Disabilities Service's Community Intervention Service (CIS)

Table 10

LD service ASC profile over time	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
LD People in Year (across services)	738	799	820	826	830	860	872
LD people in year under 65	663	721	739	743	751	776	795
LD people in year 65 and over	75	78	81	83	79	84	77

- As you will see in table 10 above, ILDS have seen an increase of 18% over the last 6 years in residents receiving direct support from ASC. Looking at our transition cases this is directly related to children already receiving services entering adulthood. We believe this will significantly increase over the next three years putting pressure on the budget
- CIS (Community Intervention Service) have implemented a Dynamic Support Register (DSR) where those adults with high needs, including adults in receipt of s.117 aftercare and those known to the CIS, are risk rated under a Red, Amber, Green (RAG) rating system. This formalised process enables professionals to understand needs and recognise early signs, such as changes in behaviours or presentation that may lead to a crisis and therefore enables additional support to be considered. This proactive monitoring is an effective way of avoiding an escalation or risk which could result in an unnecessary admission.
- Adults with complex needs continue to be placed in services within the borough without ILDS knowledge. Such placements are often made without any prior notification or referral for specialist health input from the ILDS. As a result, the opportunity for effective community-based interventions is missed. We often find out about such circumstances at a very late stage, for example, once the adult has presented at A&E.
- An exercise is underway to understand how many adults are placed within Enfield supported living providers from out of area and whether referrals have been made to Enfield ILDS. This exercise will enable us to quantify the issue, identify placing authorities and develop a strategy to ensure that appropriate referrals are made with the aim of reducing risks.
- The ILDS Psychiatry Team have reported an increase in referrals due to people's mental health deteriorating and an increase in people's anxieties, most likely because of the effects of the Covid-19 pandemic. In response to this, the service has contacted supported living and residential care providers in the borough to offer support as a multi-disciplinary service for any adults for whom providers have concerns, or where it has been identified that there is a change in behaviours. This is aimed at ensuring adults with changing needs are supported to receive intervention from the different parts of the integrated service, to prevent an escalation in needs and risks which may result in a hospital presentation.

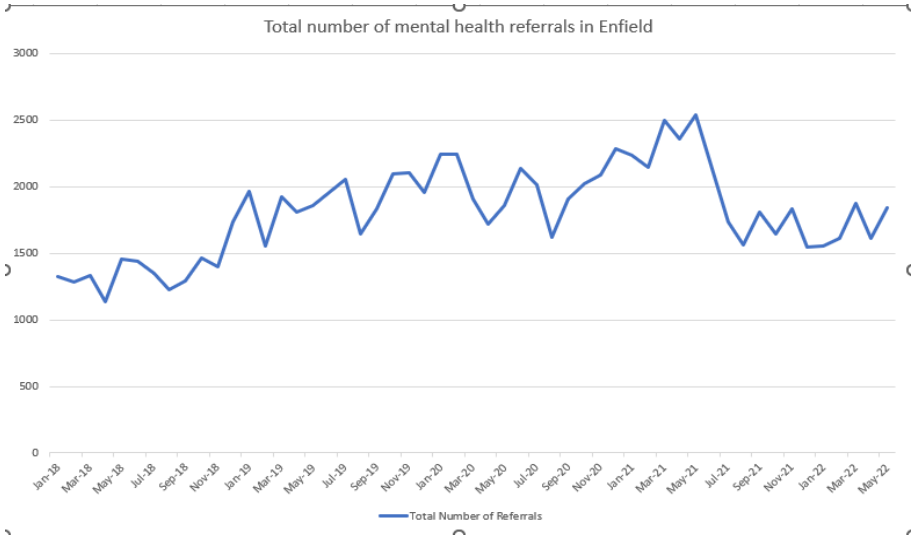
Mental Health Services – Barnet/Enfield/Haringey Mental Health Team (BEH MHT)

Table 11

MH Service profile over time	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
People in Year	376	353	343	366	383	403	372
People in year under 65	323	300	286	308	318	344	308
People in year 65 and over	53	53	57	58	65	59	64

- ASC Mental Health service have remained quite static over the last 6 years. We believe a contributor in this is our successful enablement team reaching residents before going into crisis or supporting them following a period of crisis

Chart 15



- The total number of referrals to mental health services at the BEH trust is on a general upward trend
- April 2020 recorded 1719 mental health referrals, increasing by 37% to 2356 referrals by the same time in 2021.
- EH MHT has continued to see a high demand for services. The NCL Mental health Trusts have reviewed the best practice of High Intensity Users model, provided by the South London and Maudsley (SLAM) and adopted its approach within community teams. The aim of the High Intensity Users project is to identify frequent users of the MH system via an algorithm and provide proactive support in order to reduce crisis episodes. The model includes pharmacy support in Core Teams and engaging with the community teams to support residents.

- Since April the LBE Mental Health Enablement service has received a large increase in new referrals, 210 to date, in addition to the 144 existing service users currently being supported from the previous year. Enablement workers are present on the ward twice weekly, Monday and Friday, attending the ward rounds and the Delay Transfer of care weekly meetings on Thursdays. They are working closely with Crisis resolution & Home Treatment Team and Suffolk House to promote good mental health, prevent admissions to hospital and reduce delayed discharge from hospital, as well as reducing the need for further mental health services. They are also picking up referrals at the earliest point and fast tracking to prevent delayed discharge.

- Penrose is a community based Mental Health Service 24/7 rehab service, jointly funded between the Council and the ICB. It provides 9 high support beds and 12 further step-down beds. There is an MDT that supports the service. The provider has a management team that contains a nurse to undertake and review medication audits and issues. This service works closely with the hospital teams to support discharge and prevent delayed admissions.

Community Café

- BEH MHT jointly with the Council, has commissioned Mind in Enfield to develop a community café out of hours that offers short-term mental health and wellbeing support service. Their trained mental health support workers specialise in crisis de-escalation and prevention. The café opened in July 2022 and practitioners are using it to support residents who may be at risk of crisis, as a place to go in an attempt to decrease the risk of hospitalisation.

Carers

Carers in receipt of direct payments

18/19	19/20	20/21	21/22	22/23 as at Nov
162	150	178	263	286

Table 12

- In Enfield we commission Enfield Carers Centre (ECC) to improve the lives of carers in Enfield by championing their right to have choice about how their needs are met and to have a voice in shaping how services are developed for those they care for.
- ECC provide support to Carers by providing training, information, a variety of support groups, counselling, complementary therapy, and respite activities.
- As you can see from table 12 above, there has been an increase in carers receiving a direct payment by 56% over the last five years. This is in line with our joint vision in identifying and reaching out to more carers in the borough.

Health & Wellbeing Board Update Report
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Providers

Fair Cost of Care

- In September 2021, the government announced plans to reform how people pay for adult social care in England. This was to be funded through a new Health and Social Care Levy and due to be introduced by October 2023.
- To plan for preparations towards this timeline, we have engaged with providers to understand how much it costs them to deliver a service; we then submitted our Fair Cost of Care exercises, provisional Market Sustainability Plans and spend reports to DHSC in October for an analytical review. We expect to be informed from Government on how much funding will be made available for us, approx. Nov/Dec 2022.
- We are continuing to work on engaging Providers to complete returns for the Final Submission in February 2023. The Market Sustainability plan showed we have good relationships with providers and the Market within Enfield is robust. We will continue to support the Providers to maintain this status.
- The Fair Cost of Care (FCC) exercise is currently limited to care homes / Dom Care 18+ .

Market Facilitation Framework

- Our Market Facilitation Framework is a fundamental part of the Strategic Commissioning Plan and considers how we will develop our services to be fit for the future and to improve the planning and delivery of health and social care services through better engagement with providers, service users and carers. This will help us improve and get better at analysis and use of information on needs, costs, quality of services and their impact on people's lives.
- The Market Facilitation Framework represents the start of a dialogue between Enfield Adult Social Care, our stakeholders and Partnerships, including service providers, service users, carers, and other stakeholders about the future shape of our local social care market and how, together, we can ensure this is responsive to the changing needs and aspirations of our residents and carers
- Under the Care Act 2014, local authorities in England have a responsibility to ensure that there is a wide variety of good quality care services available for people who need them. Older people with illness or frailty, people with disabilities, people using mental health services and people with caring responsibilities should have access to information about what services are available, including good information and advice services. Those services should be good quality, accessible, person-centred and strength based.
- To deliver on our commitment we need to make sure people can choose from a variety of providers and a range of support options. They must also understand what support is available and be able to make informed choices, by having easy access to information about the quality, flexibility, safety and cost of services. Our framework sets out to complement and add value to the business planning and development activities of current and potential providers.
- The purpose of this framework is to set out our approach to facilitating the market to support the delivery of our overarching Health & Adult Social Care priorities to support adults and older people with support and care needs in Enfield over the next 3 years (2022-2025).

Health & Wellbeing Board Update Report
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Quality Assurance Team

- The role of the Quality Assurance Team is to ensure that the Council purchases services that are appropriate to need and quality and which represent value for money to the Council. This supports the Council's and People Department's strategic objectives of procuring best value quality services and meeting residents' identified needs appropriately and safely. The role of the team is to complement, rather than duplicate, the role of regulatory Organisation like the Care Quality Commission.

- The Quality Assurance Team make scheduled visits to providers to monitor the services being delivered using a range of monitoring tools to gather evidence to determine the risk level of the service. The visits are pre-arranged, and providers conduct a self-assessment tool which is then used to make meaningful comparisons when the visit takes place. All key aspects of the service are reviewed, including a degree of health and safety checks, review of policies and procedures and internal auditing and management oversight processes. At the time of the visit, people that use the service and their supporters are engaged to give feedback which is used to support the evaluation of the service. The Quality Assurance Team work with new social care providers and make initial visits to check for compliance for the borough's Direct Purchasing System to support safe placements to be made to meet the support needs of people in the borough requiring care and support. Unannounced visits to providers can be made, if requested by higher management and on occasion, to support the boroughs Provider Concerns process.

Quality Checkers

The Quality Checkers are volunteers who have experience of receiving a social care service and therefore have a lived experience from a service user's perspective. Volunteers are involved in projects to review social care services and make realistic recommendations to improve services for residents, working closely with CQC. The volunteers have developed 'a mum test' and a 'small changes make big differences' motto which they apply when working on their chosen projects and will record meaningful service user and carer experiences about services.

Visits will focus on the collection of direct customer experience feedback, together with an overview of the volunteer's perception of the care environment and the care provided, evidenced by examples of observations and quotes from service users and carers.

Feedback is formulated in a report that is submitted as supporting evidence of a care provider's overall performance. This type of information is recognised as a type of 'soft intelligence'.

Chart 16 below outlines the CQC ratings for registered providers currently in Enfield (this does not include unregulated services).

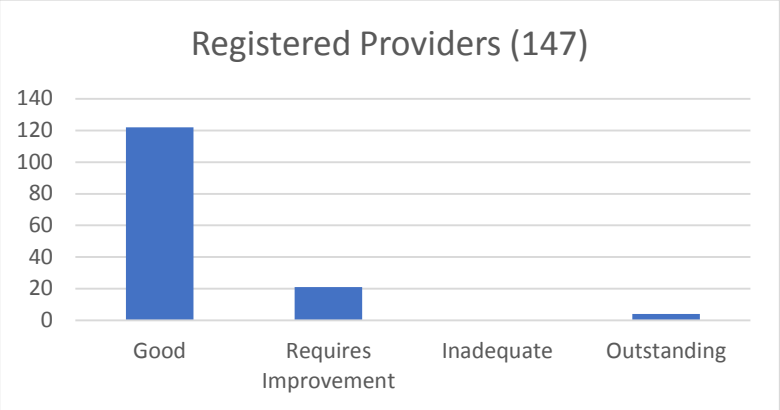

Chart 16

Our Vision and Better Care Fund Planning Cycle for 2022/23

- Our shared vision is: "We want to enable our residents to Start Well, Live Well and Age Well." We asked our residents what Integrated Care means for them; and this is what they told us…
- I will be supported by local services working together
- I will get more of the help I need outside of hospital
- I will have access to specialist care when I need it
- I will feel listened to and involved in decisions about my care
- I will be supported by the health and care system to stay well so I can live my life to the full
- Enabling people to be safe, independent and well is an integral part of the Health and Social Care vision for Enfield residents. Delivering this requires the right support to be available at the right time, in the right place for people when they need it. It is also really important that people have the right information and advice 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:

- We work with people to help safeguard them from abuse
- Emergency admissions to hospital are minimized through the provision of good levels of support in the community including primary care, social care and access to VCS and universal service provision;
- 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;
- Where a hospital admission is necessary, people are able to leave when they are medically fit with the right support in place to enable a return home

- People are able to receive enabling services which support them to gain, or regain, independent living skills
- People are in appropriate and settled accommodation with access to the right support at the right time to help them sustain their accommodation
- Meaningful training and employment opportunities are available
- Where longer-term support is needed, people have as much choice and control over those arrangements as possible
- People have access to information/advice and support at the right place and time and are able to have their voice heard to contribute to and drive changes where these are needed across the Health and Social Care Sector.
- Our wider health and social care workforce are well supported and equipped to deliver support and services which put families and people who use these services at their very heart.
- The ongoing development of Integrated Care Boards and Integrated Care Partnerships will bring together stakeholders from across the health and social care system. Most importantly, they must have at their heart, the voice of local people and what matters most to them.

- Our system challenges are big, too big to assume more of the same will deliver the change we need. To achieve our ambition and address our most urgent challenges, we need to change the way we work with our communities and design our services with them.

- The draft NCL Population Health Improvement Strategy has therefore identified the following priorities.

chart 17

- Additionally, the (draft) NCL PHIS focuses on shifting from a reactive system to one which prioritises prevention and proactive care and support. Takes action on the wider determinants of health and integrates care around the person and communities.
- There is also strong collaboration at a place level with a shared understanding of the most pressing challenges across health and social care. Examples in 2021/22 of joint planning and delivery of commissioned services include:
- Development and delivery of an ageing well programme of work, completed in partnership across Enfield and Haringey Councils and the ICB. Joint planning for future delivery of a new Mental Health and Wellbeing Hub which will include a community/twilight café.
- Jointly planned and delivered stepdown service for people with complex mental ill health to reduce hospital admissions and support timely discharge.

- Jointly planned and delivered Voluntary and Community Sector contracts to support improved access to mental health and wellbeing support and improved self-management of long-term conditions.
- Increased joint investment in mental health support for employment and mental health enablement services.
- Joint investment in Voluntary and Community Sector capacity located in the heart of our local Acute Hospital to support community resilience through active support and signposting to GPs, including GP registration for non-registered patients.
- Joint planning and investment in bespoke support for people with learning disabilities to improve uptake of health checks, immunisations.
- Joint co-ordination of the NCL ICB inequalities fund, targeted on the most deprived wards in the five NCL boroughs with a focus on tackling health inequalities.
- Joint increased investment in development of the virtual ward approach, in integrated discharge team capacity as well as winter planning capacity.
- Increased joint investment in digital technology, integrated community equipment services, including telehealth and assistive technology.
- A joint programme of strength-based training and development rolled out across the Council, health and VCS partners.
- The operational planning guidance for the Better Care Fund 2022/23 was published on 19th July 2022 and the Better Care Fund planning requirements 2022-23 document was published on the same date. There were some practical changes in terms of the headline metrics used to measure success which are now:

a. [1]Metric 1: That the long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes per 100,000 population. Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions.

b. [2]Metric 2: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services. There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, to minimise their need for ongoing support and dependence on public services.

c. [3]Metric 3: Unplanned hospitalisations for chronic ambulatory care sensitive conditions. This indicator measures the number of times people with specific long-term conditions which should not normally require hospitalisation, are admitted to hospital in an emergency.

d. [4]Metric 4: Discharge rates to usual place of residence. Improving the proportion of people discharged from hospital to their own home is vital and using data on discharge to their usual place of residence is

[1] Data source: This data is taken from SALT collected by NHS Digital / Adult Social Care Outcomes Framework. The collection of the denominator will be between 1 October and 31 December

[2] Data source: NHS Outcomes Framework. Data will be extracted monthly by the BCF team Quarterly and annual data from 2003-04 Q1 for all breakdowns

[4] Data source: NHS Secondary Uses Service (SUS).

an important marker of the effective joint working of local partners. This is also a measure of the effectiveness of the interface between health and social care services. Maximising the proportion of people who return to their usual place of residence at the point of discharge, enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person's usual place of residence.

A BCF plan which reviewed the metrics and joint deliverables, agreed joint investment plans, and produced a new Section 75 agreement, was signed off at Cabinet and the ICB Governing Body in October 2022. This is being presented to HWB on 15th December 2022 for final approval.

A further update to the Health and Wellbeing Board to be produced in June 2023.

Monthly. Data is extracted by the BCF team and updated monthly on the Better Care Exchange. SQL codes are available for systems on the Better Care Exchange. Monthly data from 2018-19 Q1 for all breakdowns.