

# Making Care Closer to Home Work for Enfield



# Contents

Executive summary	3
Background	4
Introduction	5
What could a CHIN in Enfield look like?	6
Enfield CHIN - what should it deliver?	7
Blood tests	8
Provision of mental health support	8
Access to physiotherapy	9
Diabetes check-up	9
Provision of Occupational Therapy	9
The role of patients in self care	10
Commissioning	11
Behavioural change	11
Capability and capacity	12
Conclusion	14
Appendix 1 - Further information on CHINs	15

We would like to thank residents of Enfield who took time to participate on the day; your contributions are greatly appreciated.

Special thanks also go to those who helped us to co-design and facilitate the workshops, including members of NHS Enfield Clinical Commissioning Group, Barnet Enfield and Haringey Mental Health NHS Trust, Enfield Council and local GPs.

# Executive Summary

At Healthwatch Enfield, we have taken an active role in informing the blueprint for Care Closer to Home Integrated Networks<sup>1</sup> (CHINs) and advocating for the need to involve local people; embedding co-production as a preferred method of designing, delivering and evaluating this future delivery model.

To date, work on developing CHINs in Enfield has not involved significant input from local people. Given how essential it is to secure local people's input into this work, in December 2017, Healthwatch Enfield hosted an engagement event where nearly 90 residents and health and care professionals working in the borough participated in workshops to start a discussion on how to make CHINs work for Enfield.

At the workshops, many local residents suggested deploying a physical 'hub and spoke' model for CHINs, that brings several services together in larger centralised settings whilst also ensuring that appropriate interventions can be accessed through community hubs, such as smaller GP surgeries, community centres or shops, to name just a few. For the CHINs, services and facilities such as blood tests, mental health support, physiotherapy, diabetes check-ups, dietetics, wound care management, occupational therapy, and wellbeing services should form the basis of the new integrated delivery model. Naturally, local people told us that all of these should be fully accessible to individuals with additional needs and / or from disadvantaged backgrounds.

With regard to Self-Care, introducing holistic and integrated "Wellbeing Plans", where clear outcomes and strategies could be jointly co-produced and agreed with a care professional, were seen as a potential solution. However, a change in culture and behaviours is required. Part of this is ensuring individuals have access to more appropriate education, information and community support. But, there is also a need for the 'professionals' to change; to listen

and to understand how to support individuals effectively. This could help enable patients and service users to jointly take **'a proactive rather than re-active approach'** that is not limited by the current boundaries of commissioning models.

Through bringing together local residents and professionals, representing a wide cross section of the community, to co-design solutions, Healthwatch Enfield facilitated some real discussions around the potential scope of the CHIN model for Enfield. However, our work, and that of our statutory partners, does not stop here.

We are **asking Enfield Council and NHS Enfield Clinical Commissioning Group to work with local people to co-produce Care Closer to Home Integrated Networks that support the population's needs:**

- ➔ using ideas and suggestions contained within this report as the basis of conversations with local residents;
- ➔ engaging in an ongoing dialogue with the local communities to test and further develop the CHINs model for Enfield through organising targeted outreach, going to where people already 'meet';
- ➔ working across professional and organisational boundaries, involving local people in decisions around commissioning, delivering and evaluating CHINs



<sup>1</sup> Please refer to Appendix 1 for more detail

# Background

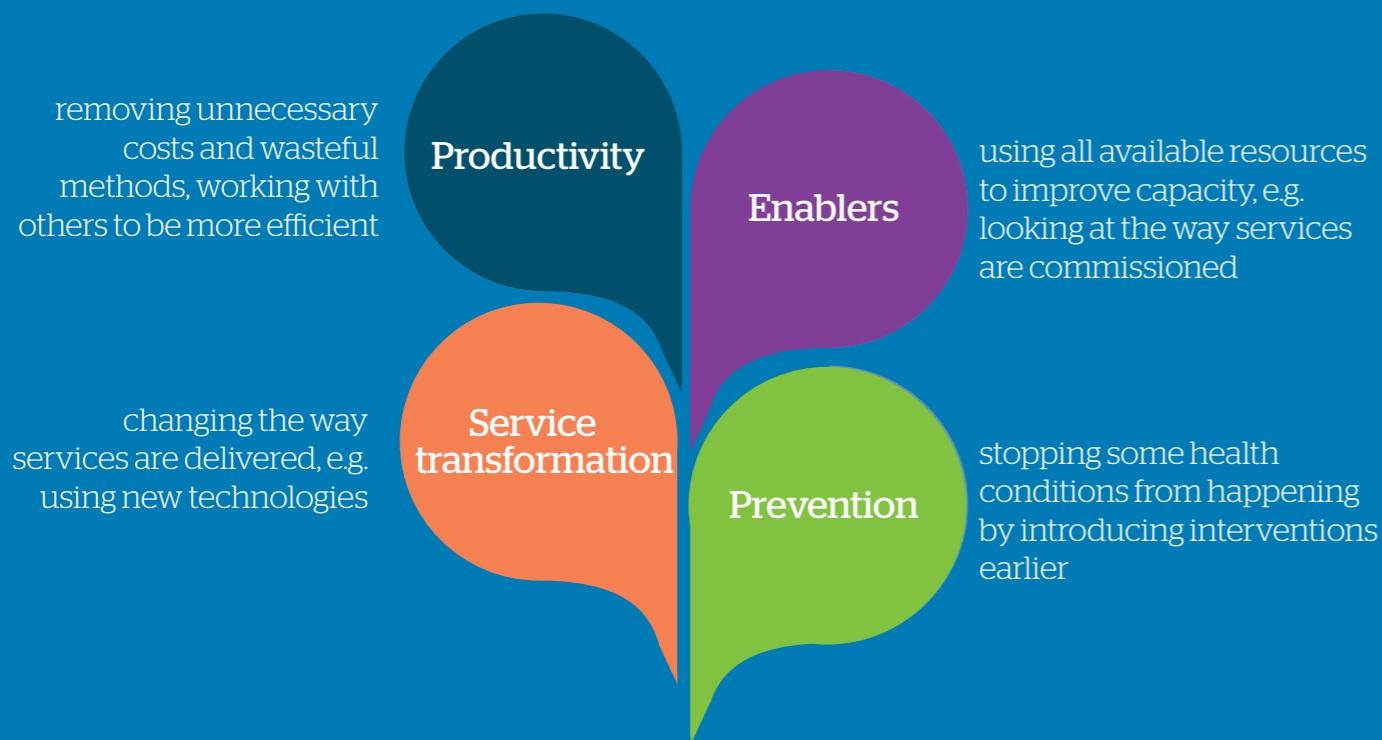
In October 2014, NHS England published the 'NHS Five Year Forward View', which was further supplemented by the 'Five Year Forward View for Mental Health' and the 'General Practice Forward View'. In total almost 200 pages on what the future of our National Health Service (NHS) will look like. Still, how do you put theory into practice? Cue Sustainability and Transformation Plans (STPs).

Sustainability and Transformation Plans, to an extent, are not new apart from the name and some of the terminology they introduce. It's NHS England's newest and latest attempt at ensuring that health providers work together and in different ways:

-  to improve quality of service
-  to improve health outcomes for individuals through providing better quality services
-  to ensure that NHS services are sustainable in the long-term with the main challenge to address the growing deficit within the health service

Across Enfield, Barnet, Haringey, Camden and Islington commissioners, providers and local authority representatives have been working together to shape the North Central London Sustainability and Transformation Plan (NCL STP). A plan that by 2020/2021 is intended to address a financial gap of £811million whilst also ensuring that approximately 1.45million people living within the 5 boroughs receive high quality care that meets their diverse needs. The vision for the NCL STP is for North Central London to be a place with the best possible health and wellbeing, where no one gets left behind.

To deliver this vision, the NCL STP features 4 fundamental aspects:



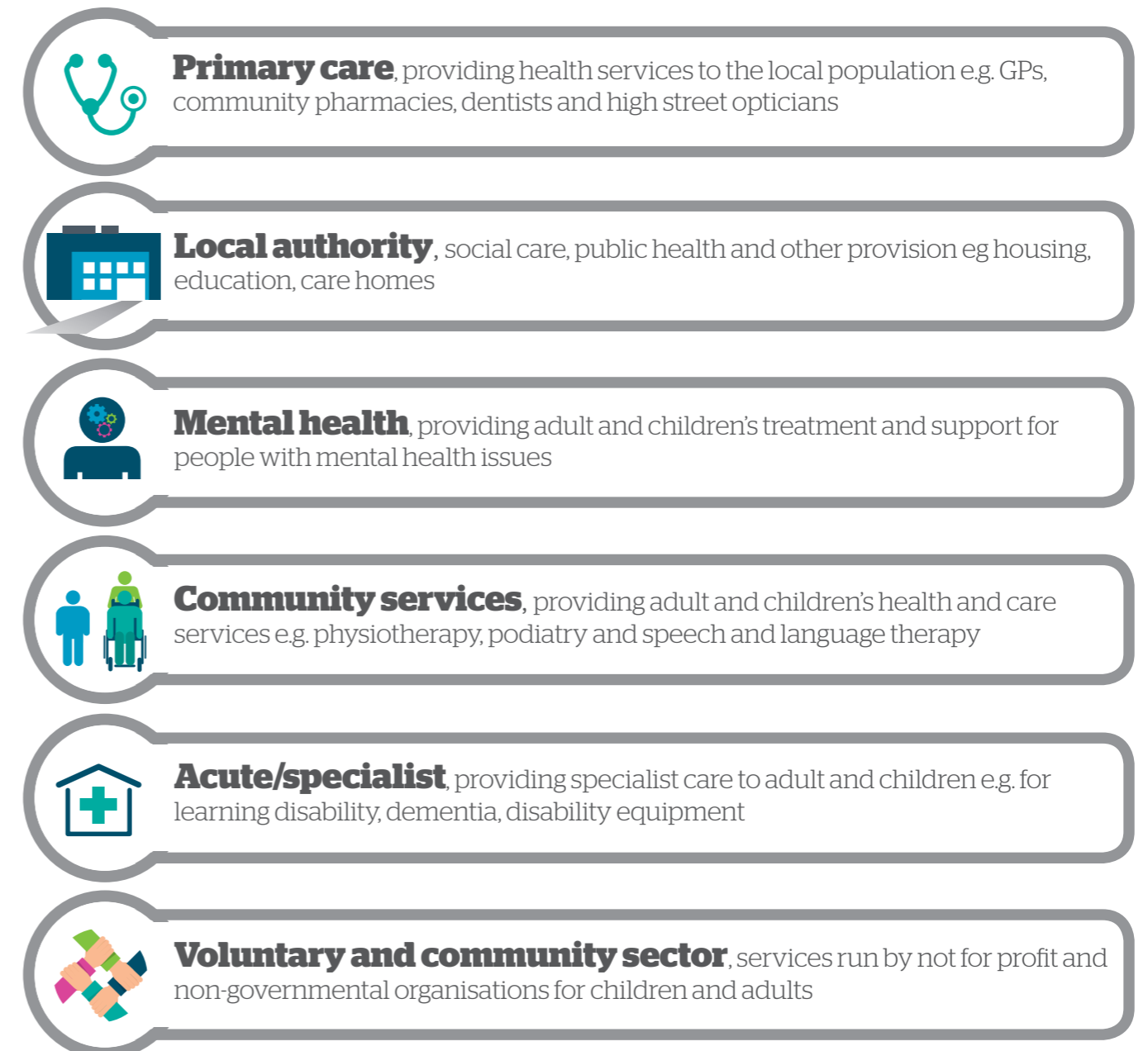
Part of the NCL STP intends to change how health and social care is provided closer to home through the development of CHINs, Care Closer to Home Integrated Networks, building on much of the work already underway across Barnet, Camden, Enfield, Haringey and Islington to develop integrated working and person-centred care.

# Introduction

So, what is a CHIN or a Care Closer to Home Integrated Network? As defined by the NCL STP, a CHIN is a way of working that aims to bring together primary care, local authorities, community services, voluntary and community sector, mental health services, acute and specialist providers and local people to work in partnership to deliver more integrated and holistic care for individuals. A CHIN can be 'virtual', meaning that it has no designated location, or 'physical', meaning that it has a specific location or locations. The CHIN will deliver its services at 'a population level' (to around 50,000 individuals). The make-up of its teams will be tailored to the health and care needs of the communities it is going to serve, based on Public Health data.

What could all of this mean for Enfield? Throughout 2017, Healthwatch Enfield got involved in conversations about delivering a Care Closer to Home Integrated Network model that could work in the borough. We understand that proposals are being considered for four CHINs based within geographical localities (North East, North West, South East and South West).

This report articulates feedback from workshops and discussions that we will seek to utilise to inform the development of Care Closer to Home Integrated Networks in the borough.



# Services in the Community

## What could a CHIN in Enfield look like?

Based on the conversations and feedback from local people, Care Closer to Home Integrated Networks (CHINs) in Enfield should deliver integrated co-produced services that are accessible.

Enfield residents asked for better co-ordination, between each service and with primary care, particularly in relation to test results and care plans: **‘There should be better joined up working of health and social care services; sharing of test results between primary and secondary care and different hospital trusts’**



In terms of accessibility, local people focussed on the potential for harnessing technology to access information or appointments and ensuring that contacting the CHIN is easy. They also emphasised the requirement that local CHINs need to work to support Enfield's Deaf community and people with Learning Difficulties, producing information in 'type talk' and 'easy read' so that all services could be accessed equally.

*the deaf community*  

 We feel VERY STRONGLY about us getting the right information + BETTER communication

They also asked that health and care professionals have a good understanding of the impact of these conditions to ensure patient-centred care. No doubt targeted co-production events with other specific community groups would similarly highlight the need for services and information to be available in other languages.

And as far as co-production is concerned, Enfield residents were clear that involving people with lived experiences, as well as working with local communities to address cultural differences, were key to designing CHINs and services available within them. The following pages of this report outline several suggestions and ideas which emerged on the day of our workshops however these should be treated neither as fully articulated nor as irrelevant. They are the beginning of a journey to co-produce a Care Closer to Home Integrated Network that works for local people.

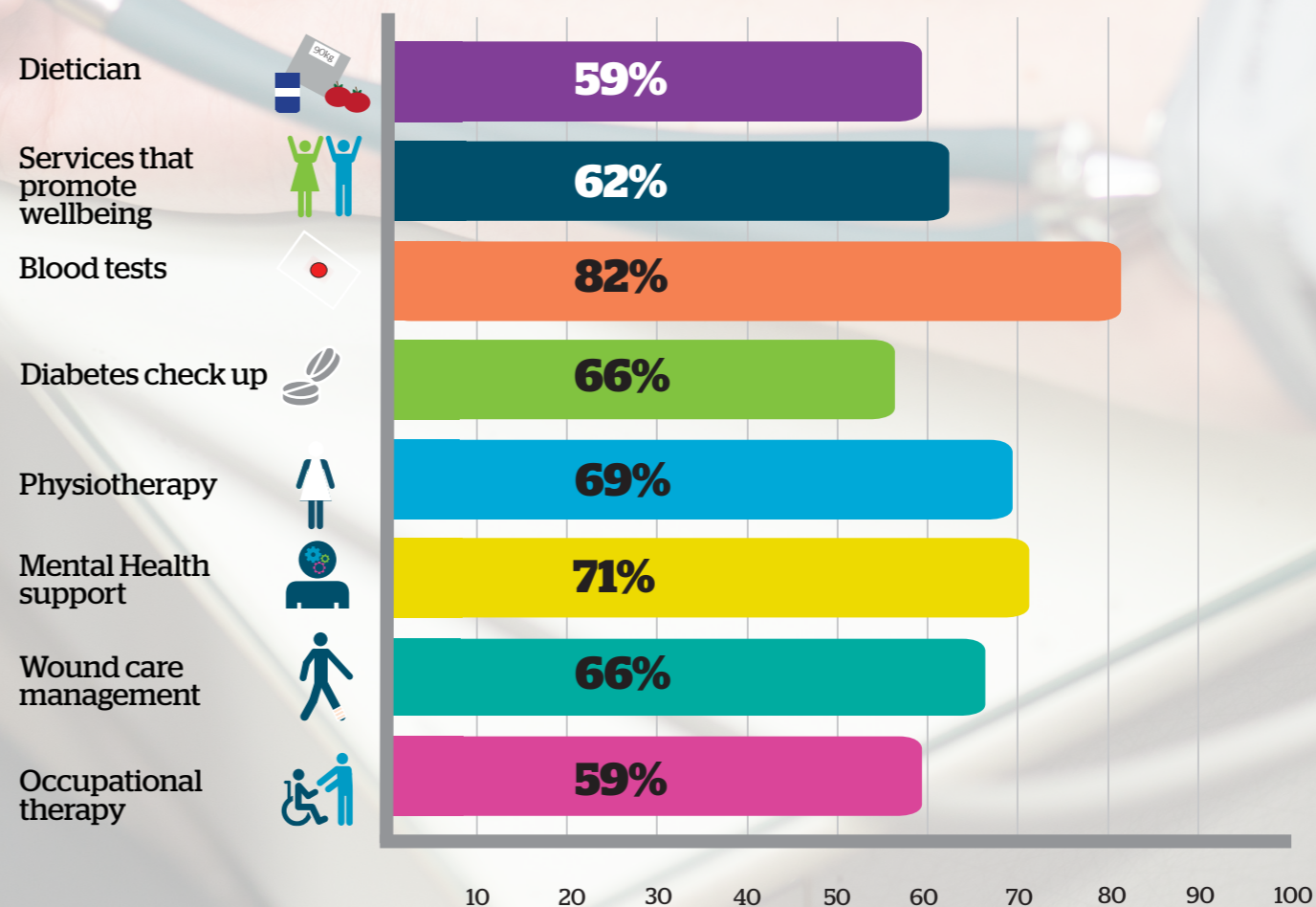
Should Enfield's CHINs be physical or virtual? For Enfield, local people suggested deploying a physical 'hub and spoke' model for CHINs where Care Closer to Home Integrated Networks bring several services together in larger centralised settings whilst also ensuring that appropriate interventions can be accessed through **‘libraries, smaller GP practices, children's centres, community centres, day centres, local VCS organisations, schools, cafes, shops and local employers’**. This attracted support from those present at our event, although further work by the STP partners will be needed to test out the depth of support for this model and to co-design how this, or other models, might work in practice.

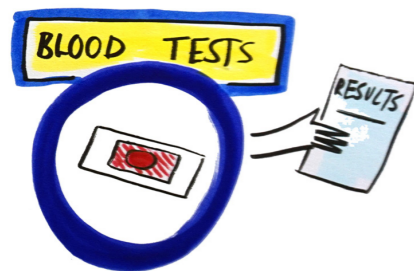


## Enfield CHIN- what should it deliver?

The Care Closer to Home Integrated Network should establish a partnership of primary care, local authorities, community services, voluntary and community sector, mental health services, acute and specialist providers and local people working together to achieve a prescribed set of outcomes. However, the question remains about what services will be available. According to initial feedback from Enfield's residents, the following should be hosted within CHINs in the borough, with more detail given below:

### Percentage of attendees who supported each service:





Participants at the workshop agreed that there should be a uniform offer to provide blood tests closer to home (within 20 minutes walking distance), including access to phlebotomy<sup>2</sup> for children that is currently only available within a hospital setting.

Blood tests could be offered through designated 'day clinics' within GP practices through a potential upskilling of the existing workforce, expanding the capacity to carry out the activity more locally.

Reflecting the integrated nature of service delivery through CHINs, local people have suggested that the results of their blood tests be promptly shared electronically with a range of professionals including the GP, the referrer, community nurses and hospitals, if appropriate. It was felt that this could help to reduce delay and prevent results getting lost.

One of the challenges facing patients currently is that blood test results from North Middlesex University Hospital NHS Trust are seemingly not accessible for appointments at Chase Farm Hospital as patients have been told that **'IT systems don't communicate'**.



Local people recognise the complexity of providing support for mental health, particularly as 'mental health is embarrassing and taboo rather than necessary and important'. Accessing services where 'people feel safe' somewhere where it doesn't feel like a mental health institution' would be an important factor in defining the physical nature of the CHIN

provision. Other ideas put forward by Enfield residents include:

- linking physical and mental health services as individuals **'need to be healthy to be better able to deal with mental health problems'**
- ensuring clear information and pathways are in place as **'information has to be everywhere for people to find out early rather than in crisis', 'GPs and others need to know where they can refer people who are having mental health problems'**
- providing one-to-one peer support and telephone buddies as **'everyone needs to have someone to talk to about problems' and have the ability to 'talk before problem becomes serious'. 'Sometimes GP is not the answer, talking to people in a similar situation, is'**
- providing **'therapy and calming sessions on a drop-in basis'** e.g. through utilising any available space within CHINs and existing GP practices
- embedding a social prescribing framework for mental health to **'prevent mental health by keeping active'** and to enable local people to utilise opportunities that are on offer, for example: **'mindfulness, art therapy, expressive therapies, VCS working in mental health, health trainers and health champions'**

Local people recognised that intervening early is a way of avoiding crisis, however this will require a new way of thinking about a delivery model; **'shouldn't get to this stage, if more local services in the area'**. For a CHIN, this could mean embedding an outreach model, placing **'greater focus on community'**, through specialists engaging with Enfield residents, for example, in schools, through children centres, community centres, day centres, pharmacists and other health care professionals to:

- facilitate mindfulness
- deliver mental health first aid training
- carry out 'mental health check-ups'



As the third most popular service to be made available through CHINs in Enfield, according to local people's feedback, physiotherapy within the Care Closer to Home Integrated Networks should adopt an outreach approach. Ideas from local people included:

- utilising any available space within CHINs and existing GP practices to facilitate access within a locality
- delivering 'physio' appointments at leisure centres
- offering group sessions within any existing community settings

CHINs should also make it more effective and capitalise on technology to make it easier for individuals to book 'physio' appointments where a patient is offered a range of choices as opposed to the current offer which is, receiving a letter or only being able to make a phone call.



Local residents felt that CHINs should play a vital role in delivering services whilst also supporting prevention of diabetes. To this extent, the Care Closer to Home Integrated Networks should offer:

- diagnostic services, **'provision of blood tests within CHINs should streamline this'**
- weight reduction clinics supported by a social prescribing framework that include links to **'voluntary and private sector'** and can **'direct patients and those with issues**

**that might lead to diabetes to how to improve health and wellbeing'**

- education classes for people who have been identified as at risk and for **'some members of communities (newly arrived people to Enfield) who may not have full information regarding appropriate diets'**

It was proposed that the work of the CHINs is supported through the Public Health initiatives around education, through workplace initiatives (e.g. signing up to the Local Government Declaration on Sugar) and through working more closely with pharmacists, who could play a more active role in engaging with individuals.



Occupational Therapists (OTs) **'help people with daily activities'** their presence within the CHINs in Enfield has been recognised as of crucial importance to improve individual's health and wellbeing.

Local people have suggested that:

- pathways for accessing support from an OT are reviewed and available through the CHIN as it: **'needs to be easier for service users to access OTs themselves, having a direct link would make them feel more independent'**
- OT's could provide **'a face-to-face service within CHINs for a limited time'** whilst also carrying out **'mobile visits and facilitating group activities'**

# Responsibility for self-care

## The role of patients in self-care

According to NHS Choices<sup>3</sup>, 'self-care is about keeping fit and healthy, understanding when you can look after yourself, when a pharmacist can help and when to get advice from your GP or another health professional. If you have a long-term condition, self-care is about understanding that condition and how to live with it'.

When asked the question, all participants of Healthwatch Enfield's workshop recognised that there is a role for patients to take responsibility for self-care. Through people's feedback, self-care for Enfield has been currently defined as a way of living that **'involves individuals looking after themselves; that makes them proactive; taking responsibility and being responsible; that empowers individuals to take action, to be clear about their limits and to ask for help'**.

Unfortunately, embedding a self-care attitude into the 'DNA' of local patients will not happen organically and will require input from all parts of Enfield's health and care economy to:

- review commissioning arrangements
- influence behavioural change
- build capability and capacity

**ENABLE + EMPOWER PEOPLE!**

## Commissioning

When discussing the patient's role in self-care, local people were clear that it is not possible to look at small-scale initiatives in isolation to tackle a single challenge. It was clear to them that **'taking a proactive rather than re-active approach'** to service delivery was necessary and that this could only be achieved through developing new approaches to commissioning health and care services, as currently **'certain things get specific funding meaning that others get discounted'**.

For CHINs and their commissioners, this creates an opportunity to build commissioning and governance frameworks:

- that enable **'services to be taken to people'**;
- that provide an **'annual check-up for those who want it and everyone should be entitled to have it'** to ensure early detection and proactive management of health deterioration; and
- that can capitalise on advantages of modern technology (e.g. Fitbits, app health data) to inform approaches to providing health and care

## Behavioural change

As articulated by local people, **'all this talk is fine but how do you actually encourage people to action?'** The success of a self-care model for Enfield must be rooted in behavioural change that will require input from all relevant stakeholders.

As the CHINs will involve primary care, local authorities, community services, voluntary and community sector, mental health services, acute and specialist providers and local people working together - bringing partners around the table should not be difficult.

And the brief is clear, to build on the evidence and best practice to ensure that professional working within the CHIN are **'motivating people to do this, addressing "learned helplessness"'**. To develop solutions that **'incentivise through ensuring availability, utilising promotion, offering a range of choices, that are local, welcoming and non-judgemental'** whilst also to **'make things less desirable shifting the way we think within our communities'** and take account of **'cultural approaches'**.

Clearly, further work is needed with local communities to co-produce just what sort of support and opportunities local people will require in order to bring about behavioural change in the local populations.



## Capability and capacity

Introducing new commissioning arrangements and affecting behaviours of local communities should be possible in the longer-term, however, there are also opportunities available now to accelerate Enfield's progress on a journey to become a self-help borough.

From developing the right skills for professionals working within CHINs, through ensuring access to information and education; to building a wider infrastructure that capitalises on local assets, capability and capacity of the local health and care economy to support prevention initiatives, including self-care; these are at the top of everyone's agenda. Doing further work with local people would help to develop and embed these concepts.



**we face', 'Attitudes of health professionals need to change to let patients be experts using each opportunity to tell people about self-care', 'Need to learn how to empower people and take ownership of issues'**

- introducing 'integrated well-being plans'<sup>4</sup> within CHINs to **'help people to help themselves'** that will be used to work with patients **'to set goals and outcomes not blame and point the finger'**
- upskilling patients e.g. teaching people living with diabetes to self-inject or **'educating for self-management (e.g. "next time do this...")'**



### Patient as the expert

As articulated by local residents, self-care is about taking responsibility, being responsible and feeling empowered to take actions. However, that can be easier said than done when the current delivery model **'makes people more reliant whilst we need to promote what people can do rather than focus on what they can't do'**. Achieving the latter will require a significant shift in the relationship between the care professional and the patient, **'to work with the "expert" patient'**.

According to feedback from people accessing services in Enfield, this could be achieved by:

- upskilling health and care staff: **'They need to listen to the voice of the service user', 'It is about understanding the issues that**

<sup>4</sup> Integrated well-being plans could be based on health action plans widely used for people with learning difficulties. These plans are a one page summary of health outcomes and how an individual is going to work to achieve them

## Community assets

From an individual point of view, self-care needs to be supported by an extensive community offer, accessible through the CHIN, that should, for example, entail:

- Social prescribing<sup>5</sup> including activity groups like exercise or Tai Chi: **'doctors should be able to prescribe gym membership as encouragement is vital'**
- Access to peer support and mentoring, including online forums: **'social groups are good, as patients can hear others' experience, share learning and not feel alone'**. This could take a form of sessions for people managing their own conditions e.g. diabetes, blood pressure or mental health where people suggested that some potential activities on offer could include:
  - inter-generational work to harness technology, discuss different approaches and tackle social isolation
  - taking exercise classes, physical activity monitoring alongside introducing calorie counters
  - hosting cooking 'on a budget' classes
  - facilitating access to healthcare professionals incl. diagnostics and education through a group consultation



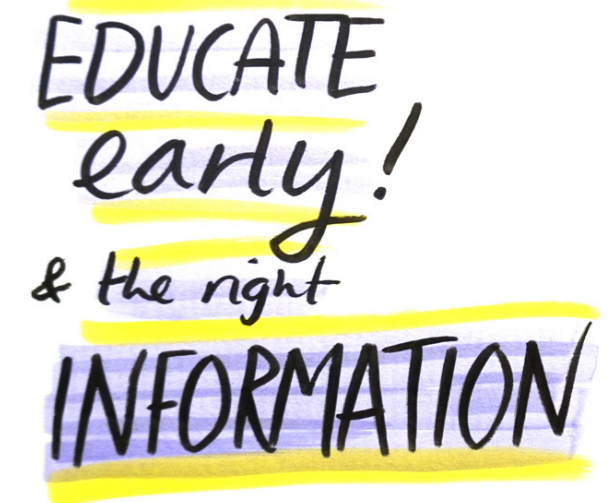
The offer should both utilise and develop community assets; **'create communities to stop people being isolated. Asking people to bring their skills to share with others'**. It was seen as an opportunity for innovation: developing intergenerational work **'in care homes and through schools'; 'growing veg in gardens/train stations - leads to food becoming free. Volunteer involved get benefit of food, get benefits from working in the garden'** or providing support for older people who want to remain independent like **'carrying bags from shops'**.

## Information and education

The role of education and information in enabling individuals to self-care was discussed by almost all conference attendees. Local residents agreed that information should be:

- clear and easy to understand, **'for people with disabilities (LD, hearing, mental, sight impairment) and different community languages'**
- available on a wide range of topics, for example on screening that is age-related
- targeted at different groups: **'carers need information and skills to help the person they care for be more independent e.g. healthy lifestyles (not fizzy drinks/take away food)'**

Education was seen as one of the ways of influencing behavioural change, starting with children of school age. When targeted at those with existing health conditions, it would also enable individuals to become **'expert patients'**.



<sup>5</sup> <https://www.kingsfund.org.uk/publications/social-prescribing>

# Conclusion

When considering a CHINs framework that talks about a virtual or physical way of working that supports a population of around 50,000 residents, it can be difficult to imagine what this future service will deliver; what difference it will make to local people. It is an abstract statement on a piece of paper that outlines suggestions and assumptions - we believe that the most effective way to bring a CHIN to life is by asking its future users how they envisage care closer to home working for them.

In Enfield, we have made a start on co-producing a model for CHINs. Utilising Healthwatch Enfield's unique role as one of only a few statutory bodies straddling both health and social care, as well as people of all ages, abilities and communities, we have begun to bring CHINs to life by facilitating conversations between patients, service users, providers and commissioners to articulate a joint vision for the future. For a co-produced CHIN that delivers integrated services that are:



- **accessible**
- **based on a physical 'hub and spoke' model**
- **offer services and facilities such as blood tests, provision of mental health support, access to physiotherapy, diabetes check-up, provision of wound care management, services that promote wellbeing, access to dieticians, and provision of occupational therapy**

A CHIN that supports and furthers the Self-Care agenda and sees the patient as the expert who is enabled to take a proactive approach within a flexible service delivery model that is reinforced by a new commissioning framework seems to be what people in Enfield are seeking.

In Enfield, we have made a start! However, our work, and that of our statutory partners, does not stop here. We are asking **Enfield Council and NHS Enfield Clinical Commissioning Group to work with local people to co-produce Care Closer to Home Integrated Networks that support the population's needs:**

- using ideas and suggestions contained within this report as the basis of conversations with local residents;
- engaging in an ongoing dialogue with the local communities to test and further develop the CHINs model for Enfield through organising targeted outreach, going to where people already 'meet';
- working across professional and organisational boundaries, involving local people in decisions around commissioning, delivering and evaluating CHINs

## Appendix 1 - Further information on CHINS

The North Central London Sustainability and Transformation Plan is intended to deliver the NHS services of the future, to improve the quality of services, to improve health outcomes for individuals and to ensure financial sustainability by 2021. For the last 18 months, commissioners, providers and local authority representatives across Barnet, Camden, Enfield, Haringey and Islington have been working together to develop initiatives to try and achieve these aims. One of the flagship developments is seeing the introduction of Care Closer to Home Integrated Networks (CHINs).

According to plans, CHINs are intended to move services into the community, providing them in a holistic, person-centred and integrated way, whilst co-producing the planning, delivery and monitoring of CHINs with local people. In Enfield, the development of CHINs has been supported by Enfield Council and NHS Enfield Clinical Commissioning Group; building on the existing approach of Integrated Locality Teams and a

Multi-Disciplinary Team model whilst also seeing the introduction of an Enfield Single Offer for primary care.

Based on the NCL STP model, the CHIN should:

- deliver shared, locally-agreed, outcomes within a fully integrated approach including: named, accessible and responsive contacts, shared assessment, shared information, shared training where relevant and shared reporting of progress against objectives
- through its partnership approach, proactively identify patients at risk of a deterioration in health and, utilising clinical leadership, work with these individuals to respond quickly to support and advise about appropriate resources to prevent an emergency hospital admission
- move activity from hospitals into the community with specialists providing support to GPs

## Outcomes for CHINS

### Improving health and wellbeing through:

- reducing health inequalities due to social class
- reducing premature mortality: from cancer, heart disease, hypertension, COPD, liver disease; for people with severe mental illness and learning disability
- reducing complication rates for people with diabetes
- improving cancer survival rate at one year
- reducing obesity rates in adults and children
- improving identification and management of patients with: diabetes; cardiovascular disease/stroke/atrial fibrillation; chronic obstructive pulmonary disease and asthma; chronic kidney disease; dementia; other severe mental health problems; learning disabilities

### Improving patient experience through:

- delivering services that ensure continuity of care (not being passed around), person-centred approach and are responsive (easier to contact a GP and make an appointment)
- supporting individuals to self-care
- improving quality of life for users of adult social care and carers

### Delivering system efficiency (saving money) through:

- reducing emergency admissions, particularly for people with two or more chronic conditions
- reducing unwarranted variation in general practice
- reducing social care packages - new and cost of existing packages of care



