Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 2 December 2021 at 6.30 pm
Virtual / MS Teams

Contact: Jane Creer
Board Secretary
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Council website: www.enfield.gov.uk

PLEASE NOTE: VIRTUAL MEETING

Join on your computer or mobile app

Click here to join the meeting

MEMBERSHIP

Leader of the Council – Councillor Nesil Caliskan (Chair)
Cabinet Member for Health & Social Care – Councillor Alev Cazimoglu
Cabinet Member for Children's Services – Councillor Mahtab Uddin
Governing Body (Enfield) NCL CCG – Dr Nitika Silhi (Vice Chair)
NHS North Central London Clinical Commissioning Group – Deborah McBeal
Healthwatch Representative – Olivia Clymer
NHS England Representative – Dr Helene Brown
Director of Public Health – Dudu Sher-Arami
Director of Adult Social Care – Bindi Nagra
Executive Director People – Tony Theodoulou
CEO of Enfield Voluntary Action – Jo Ikhelef
Voluntary Sector Representatives: Vivien Giladi, Pamela Burke

Non-Voting Members

Royal Free London NHS Foundation Trust – Dr Alan McGlennan
North Middlesex University Hospital NHS Trust – Dr Nnenna Osuji
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Whittington Hospital – Siobhan Harrington
Enfield Youth Parliament representative

AGENDA – PART 1

1. WELCOME AND APOLOGIES (6:30 - 6:40PM)

Welcome from the Chair and introductions

Confirmation of appointment of Dudu Sher-Arami as Director of Public Health

for LB Enfield.

2. DECLARATION OF INTERESTS

Members are asked to declare any pecuniary, other pecuniary or non-pecuniary interests relating to items on the agenda.

3. COVID-19 AND OTHER WINTER THREATS IN ENFIELD UPDATE (6:40 - 6:50PM) (Pages 1 - 20)

i. Epidemiology and outlook – PH Intelligence Team. Gayan Perera

ii. Care home status, visiting support, and vaccination status – Des O'Donoghue, Brokerage and Market Development Manager, LB Enfield

iii. Vaccination update (COVID and Influenza) – Dudu Sher-Arami, Riyad Karim, Hetul Shah, Belinda Danso-Langley

4. UPDATE FROM BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST (6:50 - 7:05PM) (Pages 21 - 28)

Andrew Wright, Director of Strategic Development, Director of Planning and Partnerships BEH MHT

Natalie Fox, Chief Operating Officer and Deputy Chief Executive BEH MHT

5. UPDATE ON THE BETTER CARE FUND (7:05 - 7:10PM) (Pages 29 - 50)

Doug Wilson, Head of Strategy and Service Development, Health, Housing and Adult Social Care Directorate, LB Enfield

6. ICS WORKSTREAMS UPDATE (7:10 - 7:30PM) (Pages 51 - 108)

i. ICP / Borough Partnership Update

Deborah McBeal, Director of Integration, Enfield Borough Directorate, NCL Commissioning Group and Stephen Wells, Head of Integrated Care Partnership Programme, NHS NCL CCG. Papers attached.

ii. ICS Transition Update

Frances O'Callaghan, NCL CCG Accountable Officer

iii. Inequalities Workstream

Ruth Donaldson, Director of Communities, NCL CCG

7. ANY OTHER BUSINESS

8. MINUTES OF THE MEETING HELD ON 7 OCTOBER 2021 (Pages 109 - 114)

To receive and agree the minutes of the meeting held on 7 October 2021.

9. NEXT MEETING DATES AND DEVELOPMENT SESSIONS

Proposed date of the next meeting:

Thurs 17 March 2022

Development Sessions to commence at 4:30pm.
Formal Board meetings to commence at 6:30pm.
Unless otherwise advised.
Venues to be confirmed.

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Microsoft | Power BI

Enfield COVID19 Dashboard

View in Power BI

Last data refresh:
12/1/2021 3:02:39 PM UTC

Downloaded at:
12/1/2021 3:05:11 PM UTC

Enfield COVID-19 Dashboard (24- 30 Nov 21)

CASES =06 Mar 20 - 30 Nov 21
DEATHS = 30 Mar 20 - 12 Nov 21

TOTAL

CASES = 47,612
DEATHS = 847
(EXCESS# = 732)

20-25 November

NEW CASES

892

Variants of Concern
Delta = 350
Omicron = 0
(For 30 Days till 27/11)

RECENT COVID DEATHS*

3
(3 excess deaths*)

HOSPITALISATIONS

On Oxygen =26
Not on Oxygen =44

INFECTION RATE PER 100,000*

310.37

AGE GROUP

0-29	30-59	60+
308	297	107

23-30 Nov update

TESTS*

7,534.9
per 100,000

PCR = **8,522** tests;

Lateral Flow = **16,629**

28 Nov update

VACCINATIONS

Healtheintent GP registered 12+ Population (now inc. care homes)

195,124 (66.1%) 1st DOSES
179,150 *(65.0%)* 2nd DOSES

PHE resident 12+ Population (inc care homes)

209,616 (66.5%) 1st DOSES
190,825 *(64.8%)* 2nd DOSES

28 Nov update

VACCINATIONS

12-15s Uptake

19,488 (21.5%) 1st DOSES

Boosters (40+ population)

77,109 Doses (45%)

25 Nov update

ADULT SOCIAL CARE

CARE SETTINGS
CARE HOMES = 1
Deaths=0;
Staff=0
Residents=1

CASES IN DAY SERVICES
(24th-30th Nov)
Sites =0
Staff=0
Service users=0

29 Nov update

SCHOOLS/ EARLY YEARS AFFECTED

34

Staff = 44 cases
Students = 187 cases

WARDS WITH HIGHEST INFECTION RATES*

1. **Town (389)**
2. **Grange (364)**
3. **Palmers Green (359)**

*ONS weekly mortality records compared with 2015- 19 deaths.

#North Central London include Camden, Barnet, Enfield, Haringey & Islington

Change since last week of data

Observation Summary

- There were 3 excess COVID-19 deaths in week 45 of 2021 compared to the 2015-19 average.

- Death Returns for the latest 7-day period between 20-Nov to 25-Nov-2021 show 3 COVID-19 death registered in Enfield via Enfield Registry Office.

- As of 30-Nov-2021, the number of cases per 100,000 population per week is 310.37 in Enfield, compared with 711.31 and 701.33 per 100,000 per week in Rutland and Devon, the LTLAs with the highest case rates according to the GOV.UK dashboard.

- According to the GOV.UK dashboard, Enfield is ranked 3rd amongst NCL boroughs. The highest ranked borough in terms infection rate is Barnet with 410.99 cases per 100,000 per week. The lowest ranked borough is Camden at 301.45 cases per 100,000 per week.

- We have seen 10 postcode clusters in the last week including 2 cases in N99EJ and 2 cases in EN20DP based on the latest PHE data.

- Most of the cases this week, according to the latest PHE data, are within the 0-18 age group at 34.8% of cases.

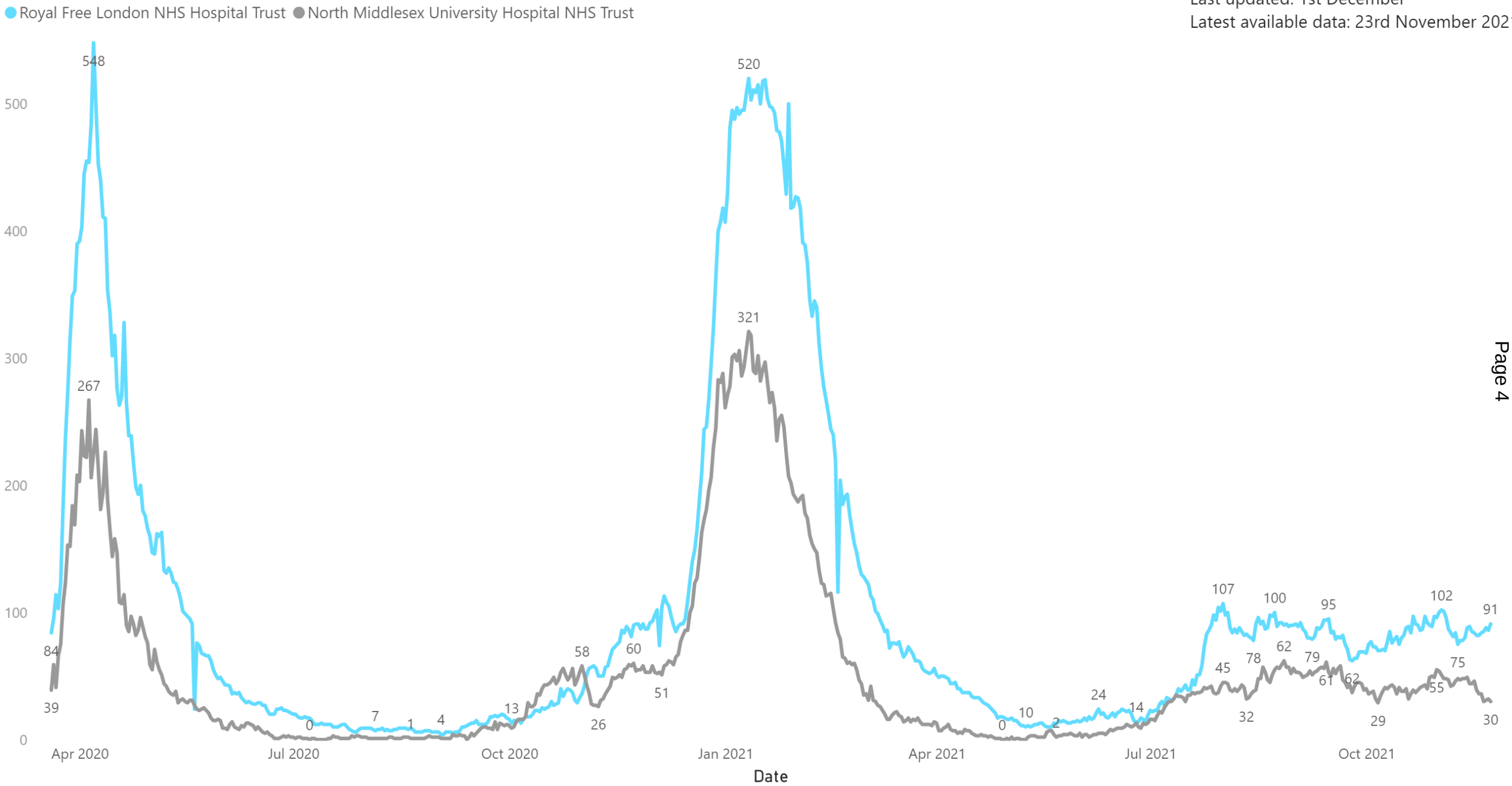
- As of 30-Nov-2021 according to PHE, there are a total of 47,612 confirmed cases of COVID-19 within the borough. There were 892 cases this week, compared to 878 cases in the previous week. This represents a 0% change.

ENFIELD Council

Last Updated: 1st December 2021

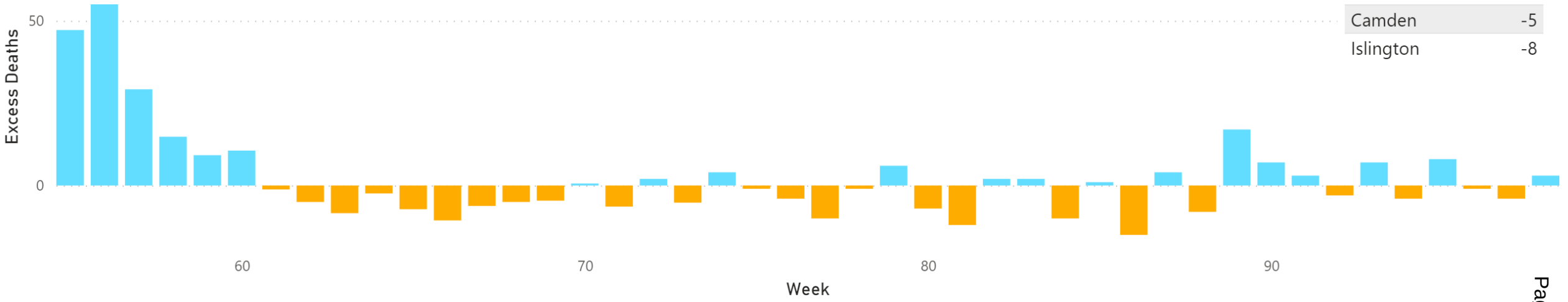
Patients in Hospital - COVID

Last updated: 1st December
Latest available data: 23rd November 2021

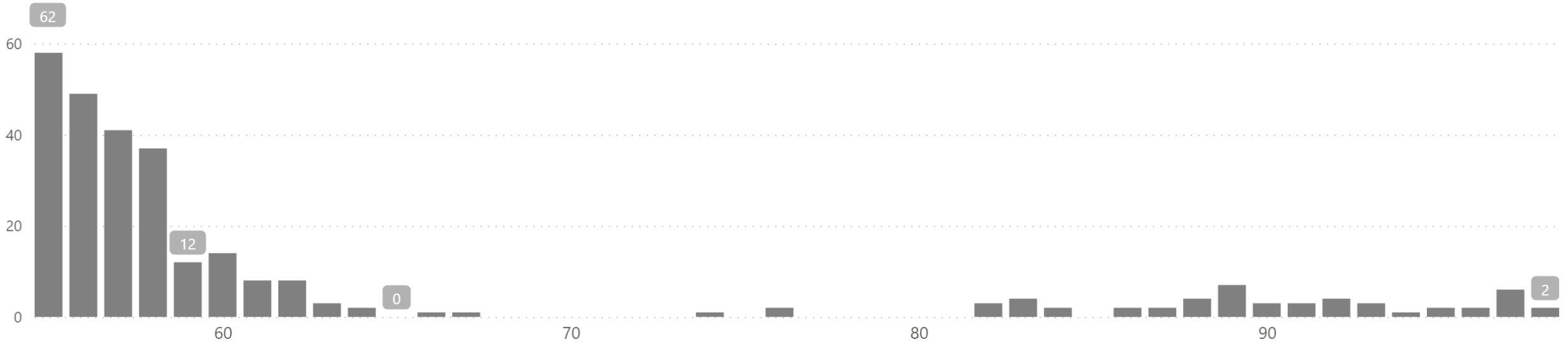


Excess Deaths in Enfield (2021 deaths minus 2015 to 2019 average)

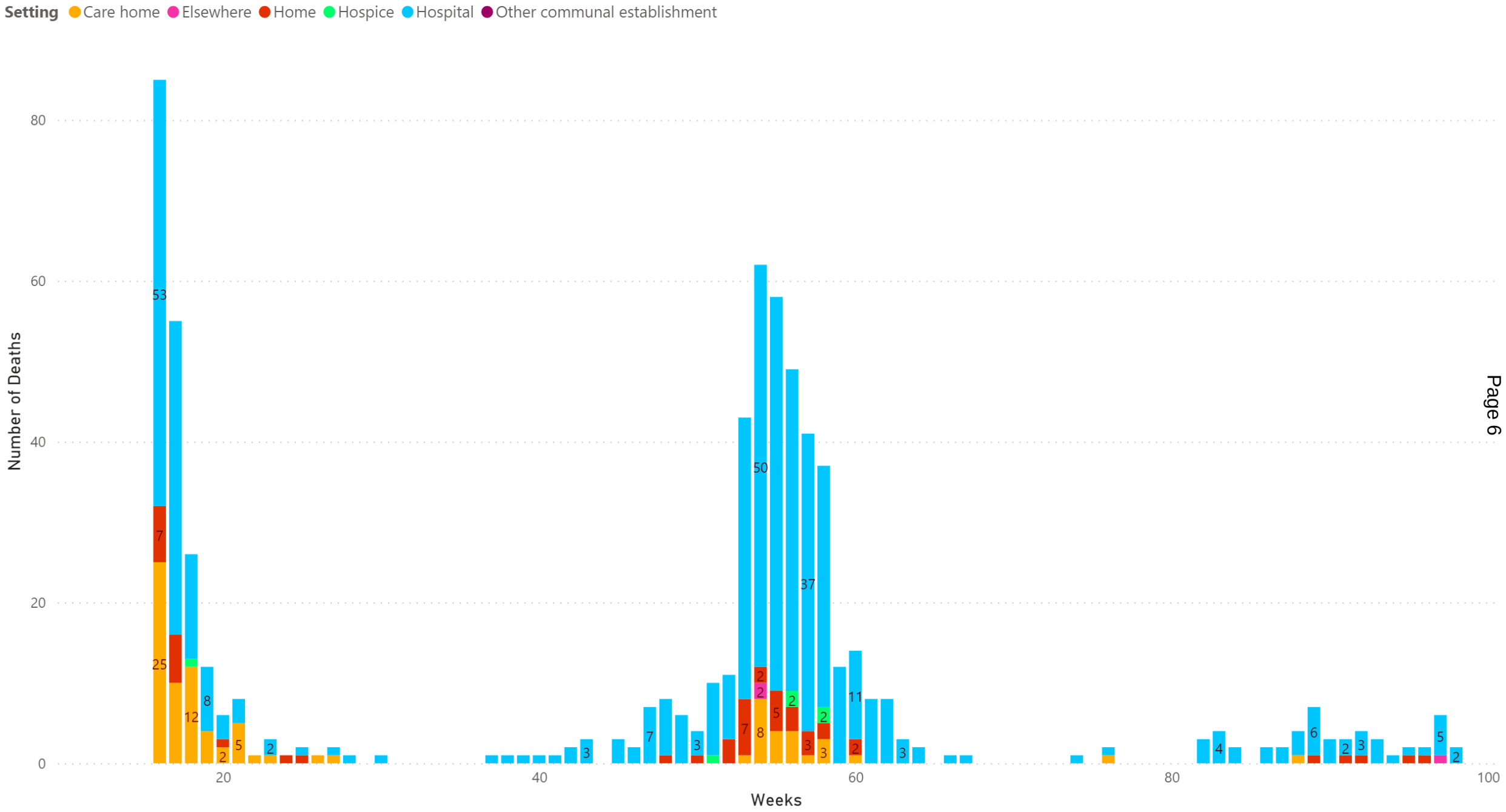
Borough	Excess Deaths
Enfield	3
Haringey	3
Barnet	-5
Camden	-5
Islington	-8



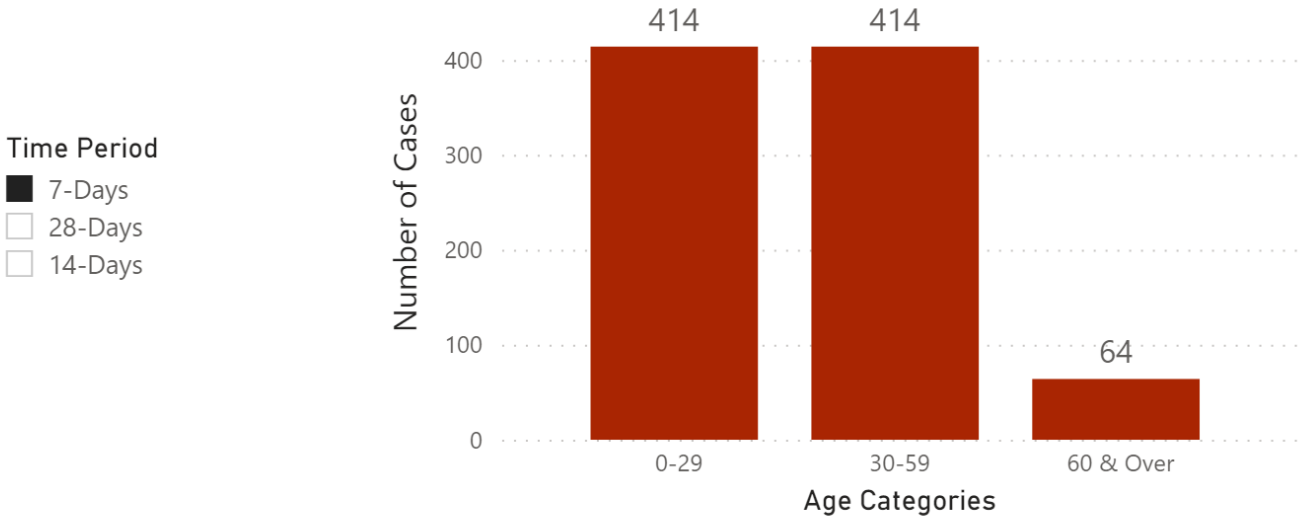
COVID-19 Deaths



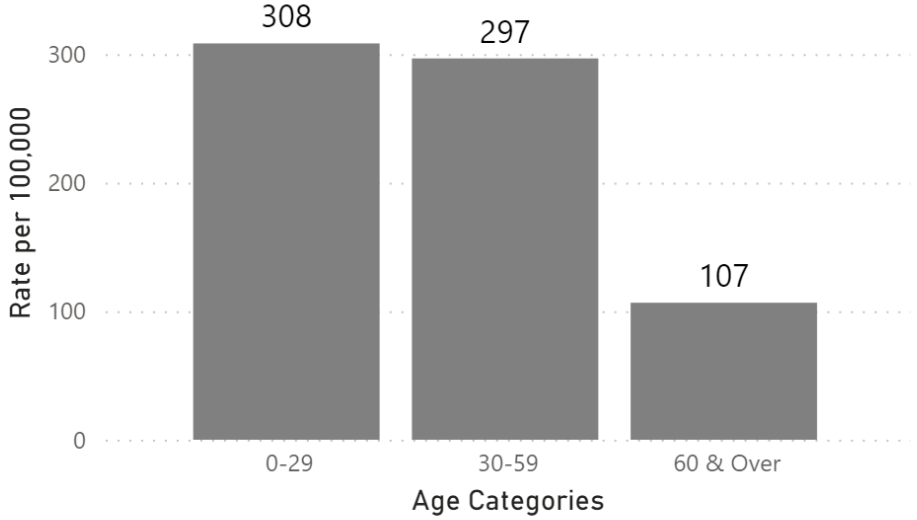
Number of Deaths by Setting



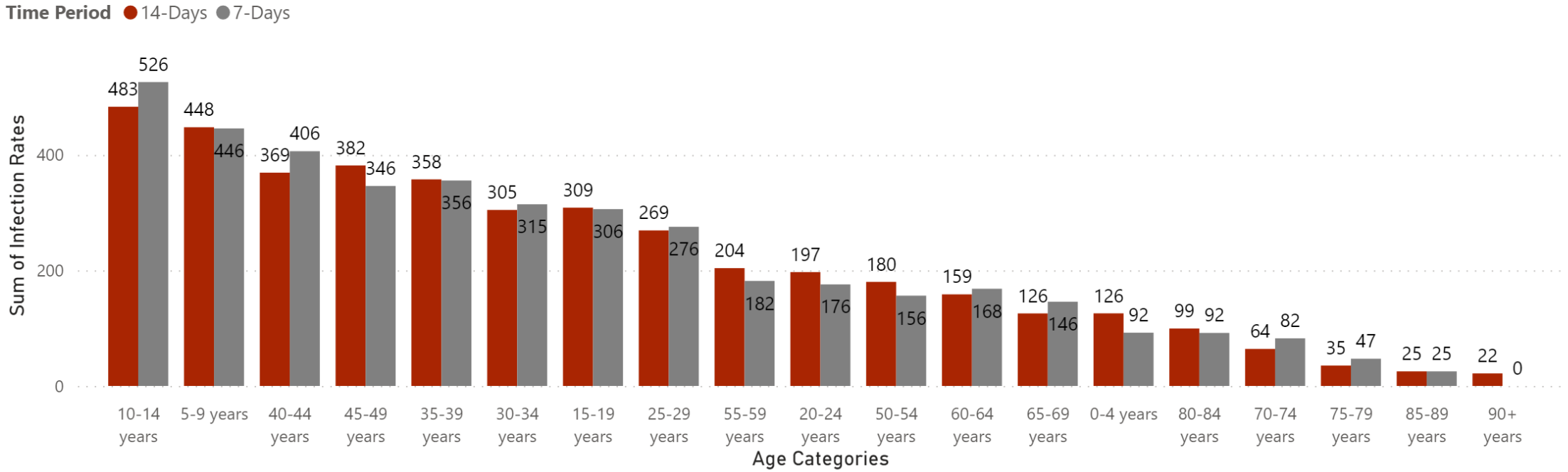
Number of COVID-19 Cases by Broad Age Categories



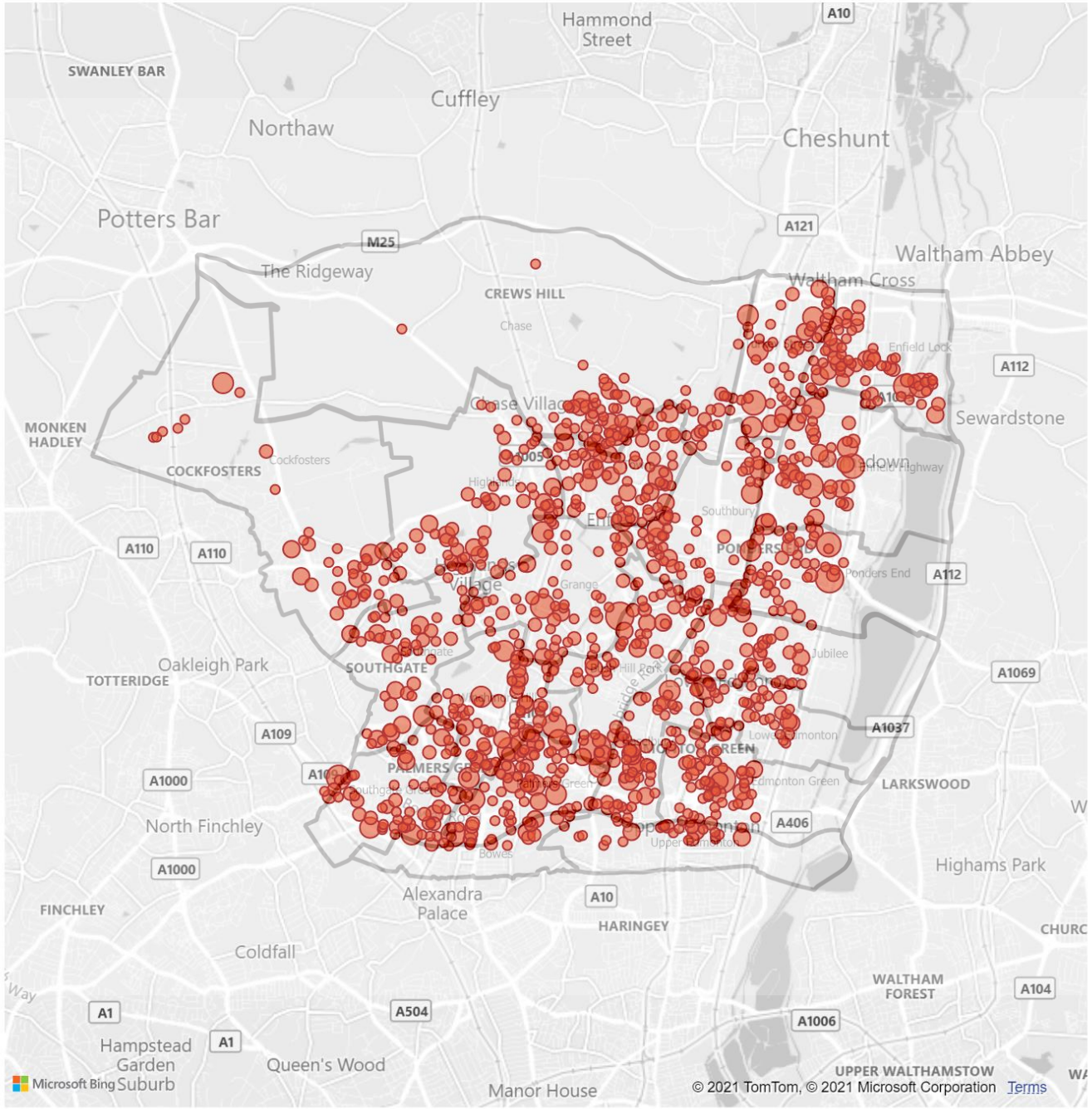
Infection Rate per 100,00 by Broad Age Categories



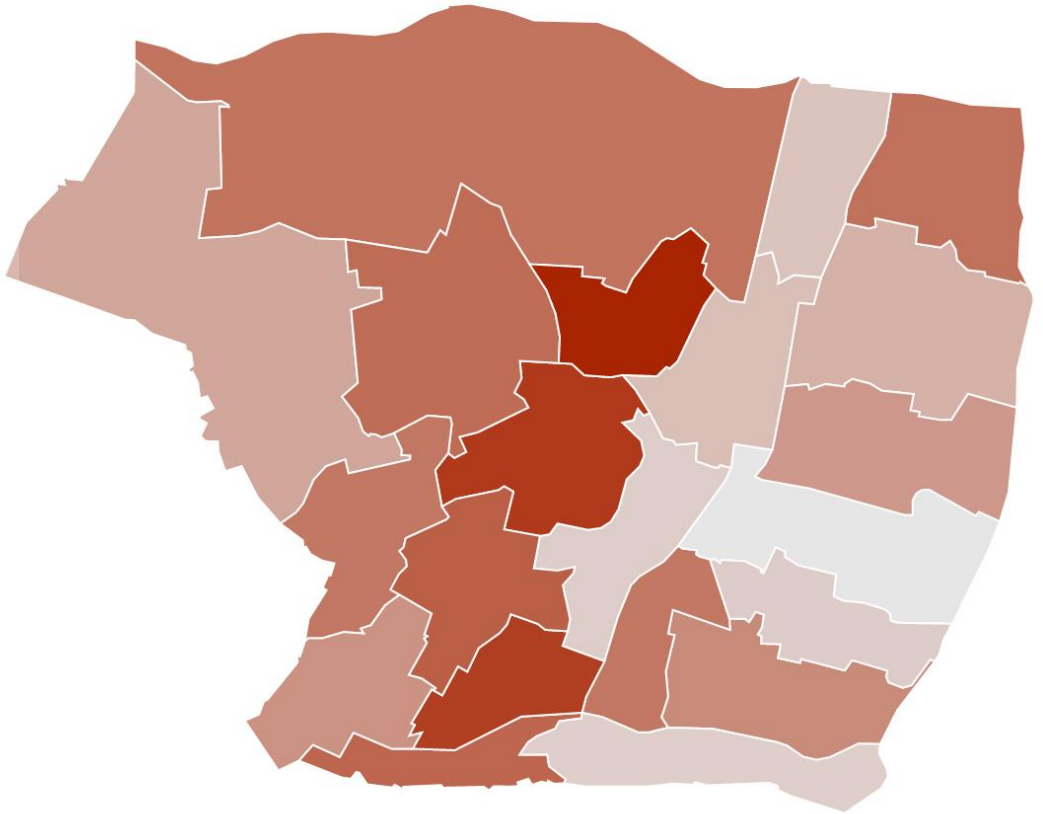
Infection Rate per 100,000 by 5-Year Age Brackets



COVID-19 Cases Lab-Confirmed in the Previous 2-Weeks (16 Nov - 30 Nov)



COVID-19 Cases Lab-Confirmed in the Previous Week (24 Nov - 30 Nov)



Specimen Date

11/24/2021 11/30/2021

Age (Years)

0 121

Patient Gender

- [ ] Female
- [ ] Male
- [ ] Unknown

Test Kit

- [ ]
- [ ] ePCR
- [ ] lft
- [ ] rtPCR

Ethnicity

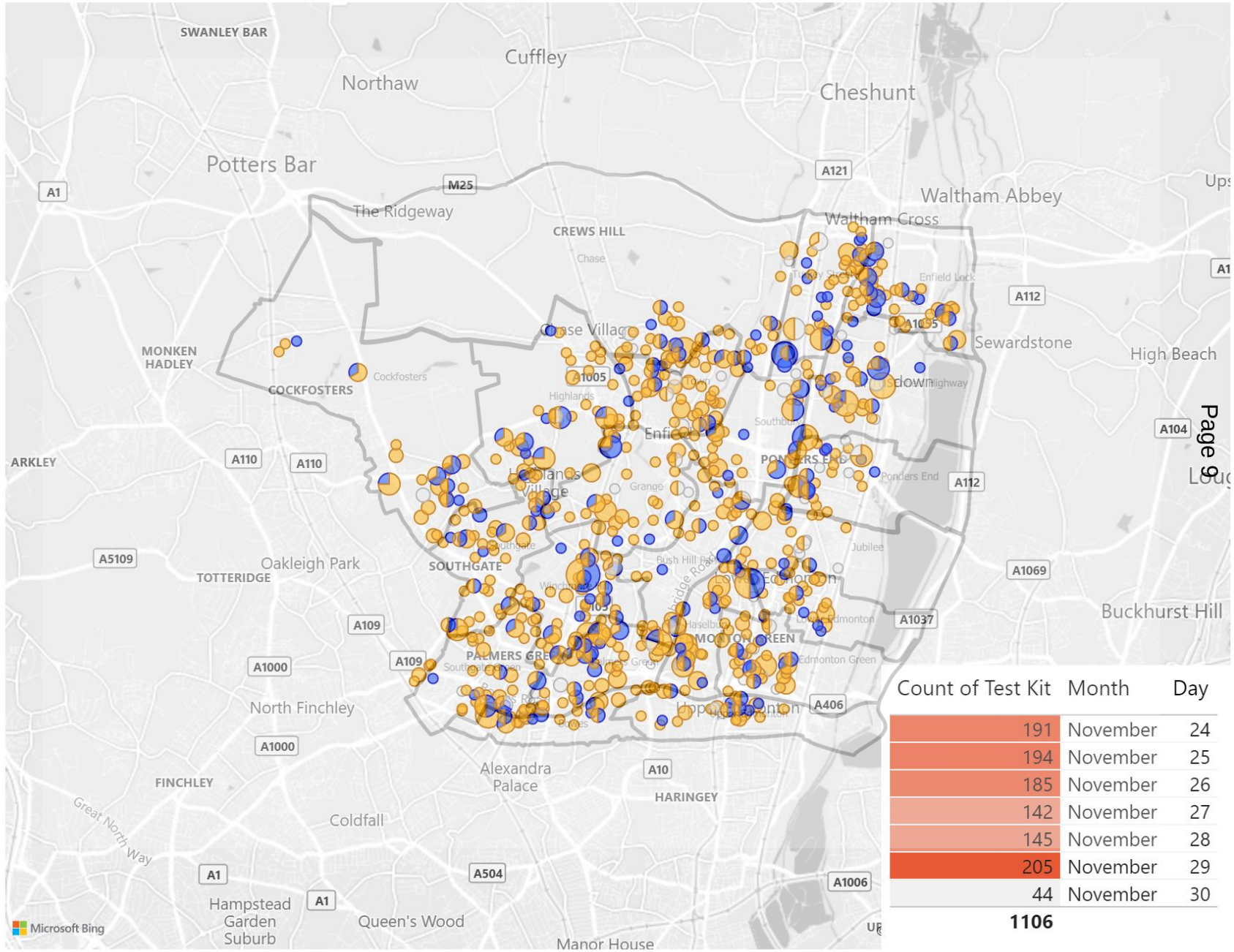
- [ ] African
- [ ] Any other Asian background
- [ ] Any other Black / African / Caribbean background
- [ ] Any other ethnic group
- [ ] Any other Mixed / Multiple ethnic background
- [ ] Any other White background

Asymptomatic

- [ ] N
- [ ] U
- [ ] Y

Map of COVID-19 Positive Tests in the Previous Week (24 Nov - 30 Nov)

Colours LFT PCR



Count of Test Kit	Month	Day
191	November	24
194	November	25
185	November	26
142	November	27
145	November	28
205	November	29
44	November	30
1106		

School LFT Testing – as of 1st December 2021

All LFTs conducted

Week beginning	School	SS	FE	Independent	Other	PRU	New Academy	Weekly total	Cumulative 4 week total
21-Nov-21	4306	2	2	4	0	0	0	4314	15732
14-Nov-21	4068	0	0	4	0	0	0	4072	11418
07-Nov-21	3152	1	1	2	0	0	0	3156	7346
31-Oct-21	4181	0	1	8	0	0	0	4190	4190

Positive LFTs

Week beginning	School	SS	FE	Independent	Other	PRU	New Academy	Weekly total	Cumulative 4 week total	% Positivity
21-Nov-21	138	0	0	0	0	0	0	138	186	3.2
14-Nov-21	48	0	0	0	0	0	0	48	48	1.2
07-Nov-21	0	0	0	0	0	0	0	0	0	0.0
31-Oct-21	0	0	0	0	0	0	0	0	0	0.0

FE, Further Education; SS, Secondary School; PRU, Pupil Referral Unit.

Vaccination Update (latest data as of 28th November)

Eligible Cohort	No. Eligible Persons	Dose 1	Dose 2	% Uptake 1st Dose	% Uptake 2nd Dose	Remaining Dose 1 (to Target)	Remaining Dose 2 (to Target)
12-15	19488	4181	0	21.45	0.00	10,435.00	14,616.00
16-17	8820	3366	1693	38.16	19.20	3,249.00	4,922.00
18-29	48150	25130	21786	52.19	45.25	10,982.50	14,326.50
30-39	46769	26841	24587	57.39	52.57	8,235.75	10,489.75
40-49	42030	29246	27827	69.58	66.21	2,276.50	3,695.50
50-54	17260	13215	12776	76.56	74.02	-270.00	169.00
55-59	14680	11670	11348	79.50	77.30	-660.00	-338.00
60-64	10910	8854	8687	81.15	79.62	-671.50	-504.50
65-69	12050	10275	10092	85.27	83.75	-1,237.50	-1,054.50
70-74	10935	9654	9533	88.29	87.18	-1,452.75	-1,331.75
75-79	8506	7575	7440	89.05	87.47	-1,195.50	-1,060.50

195124
Total 1st Dose

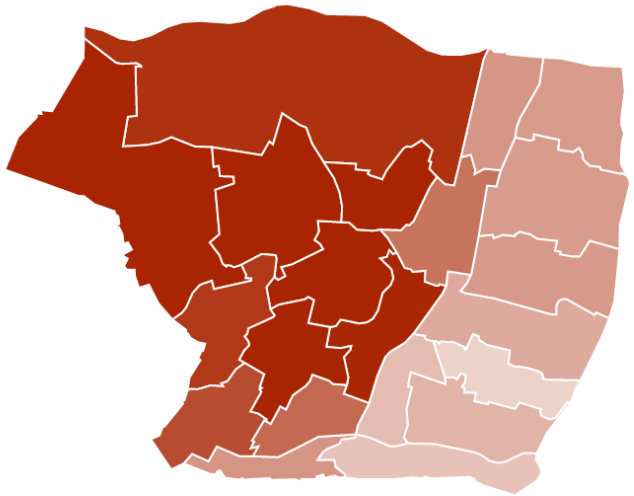
179150
Total 2nd Dose

**Count of 1st/2nd dose vaccinations administered on latest day (of cumulative period); Remaining to target provides the count of individuals remaining of eligible cohort to be vaccinated to reach 75% threshold uptake.*

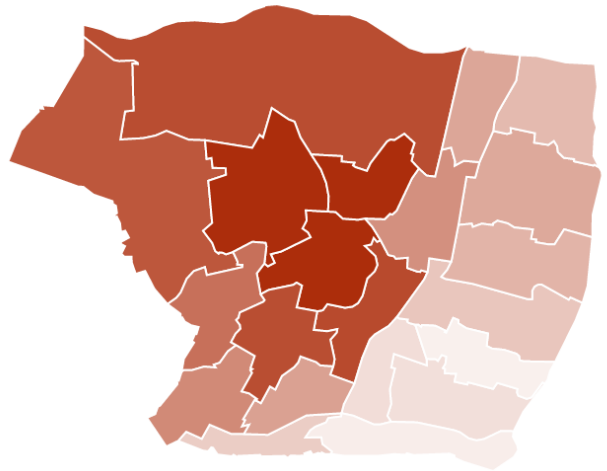
Ward

- Bowes
- Bush Hill Park
- Chase
- Cockfosters
- Edmonton Green
- Enfield Highway
- Enfield Lock
- Grange
- Highlands
- Jubilee
- Lower Edmonton
- Palmers Green
- Ponders End
- Southbury
- Southgate
- Southgate Green
- Town
- Turkey Street
- Upper Edmonton
- Winchmore Hill

%1st Dose Uptake Under 40s

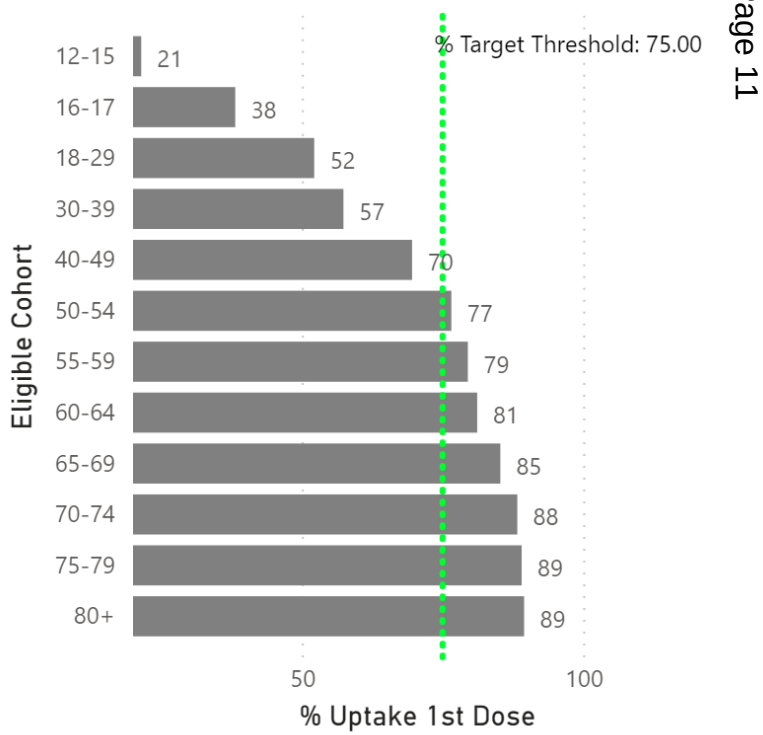


%1st Dose Uptake All Eligible Cohort

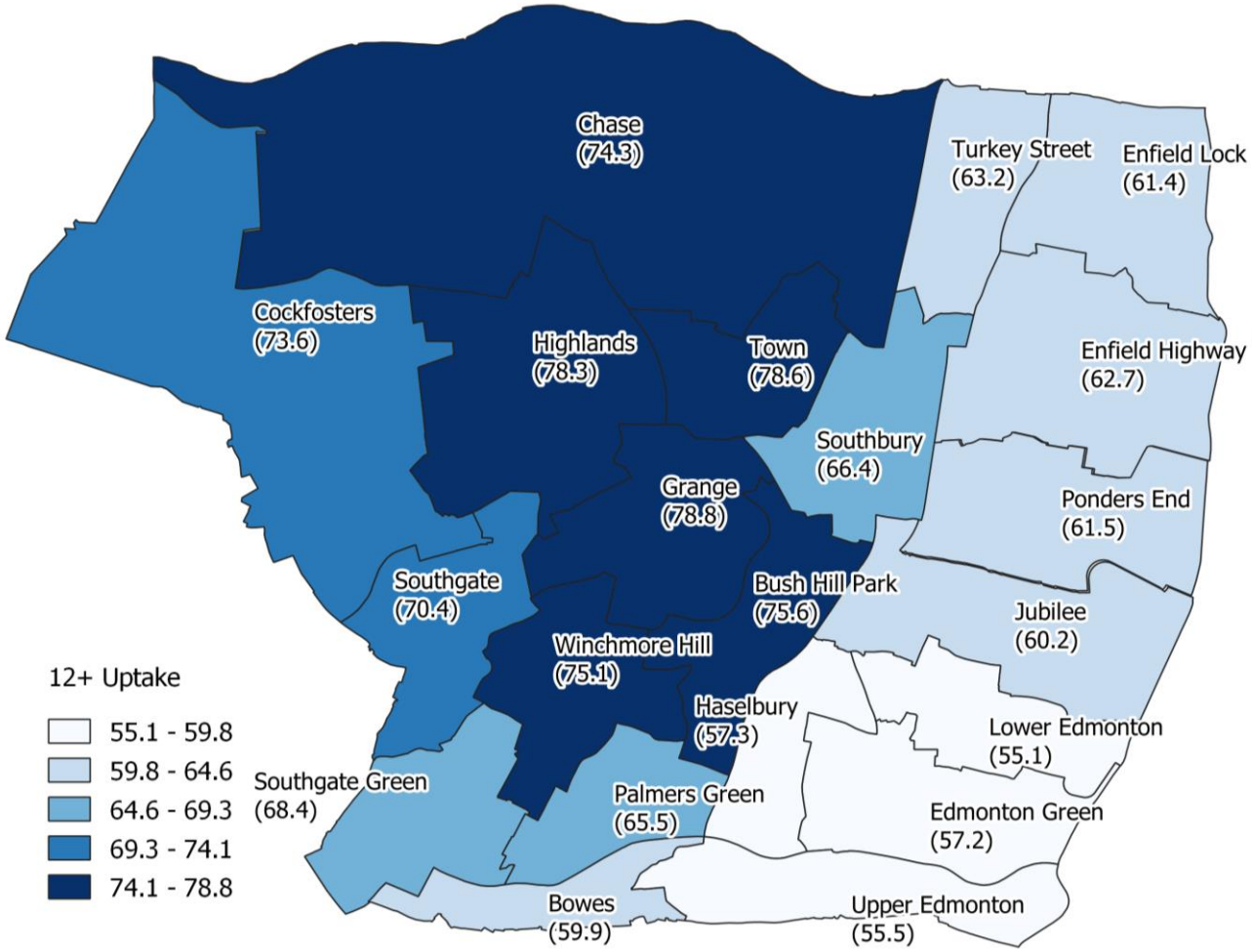


*the 12-15 years cohort is only being offered one dose of the vaccine

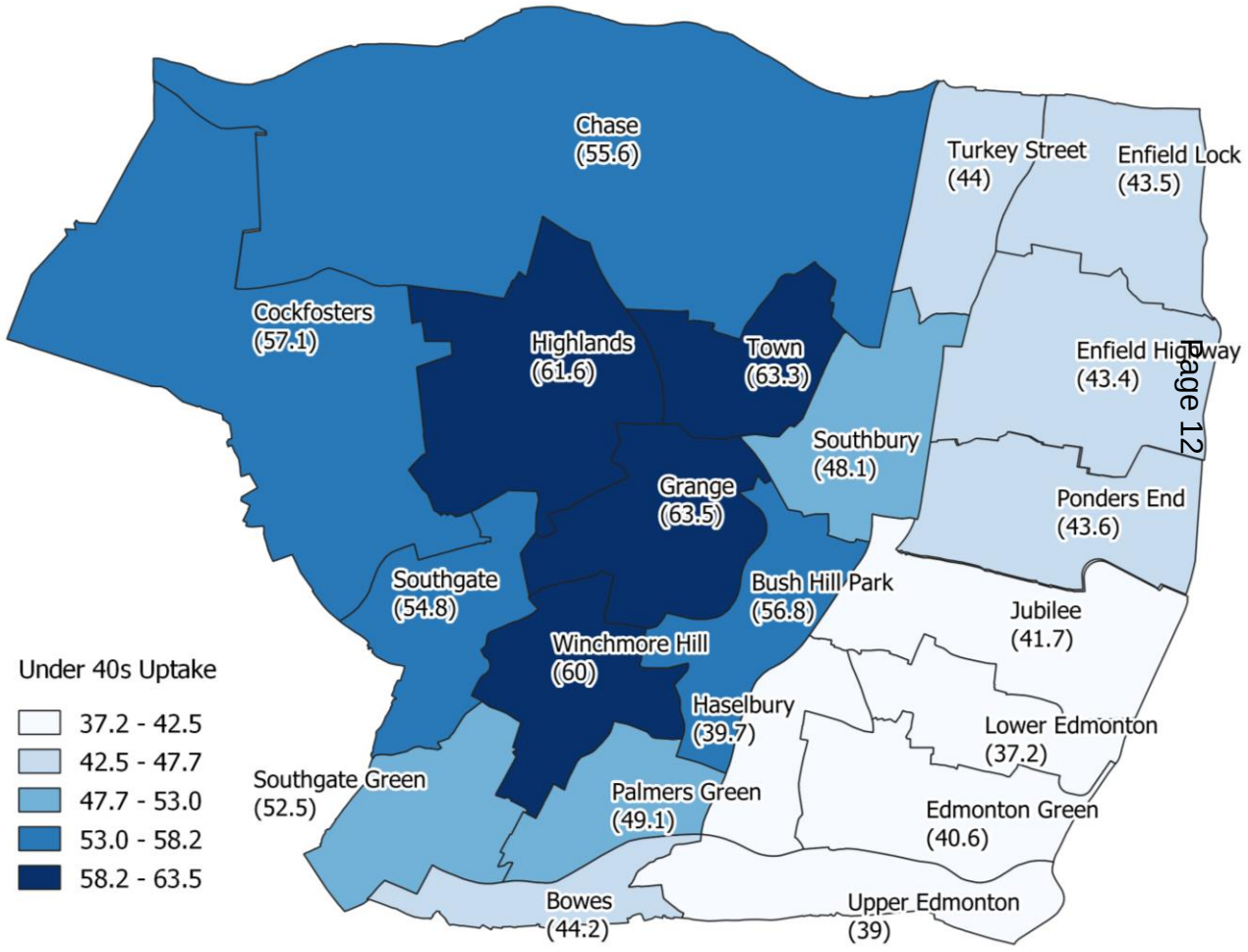
% Uptake 1st Dose by Eligible Cohort



% Uptake first dose of COVID-19 vaccination in all cohorts (12+ years)



% Uptake (Under 40) first dose of COVID-19 vaccination



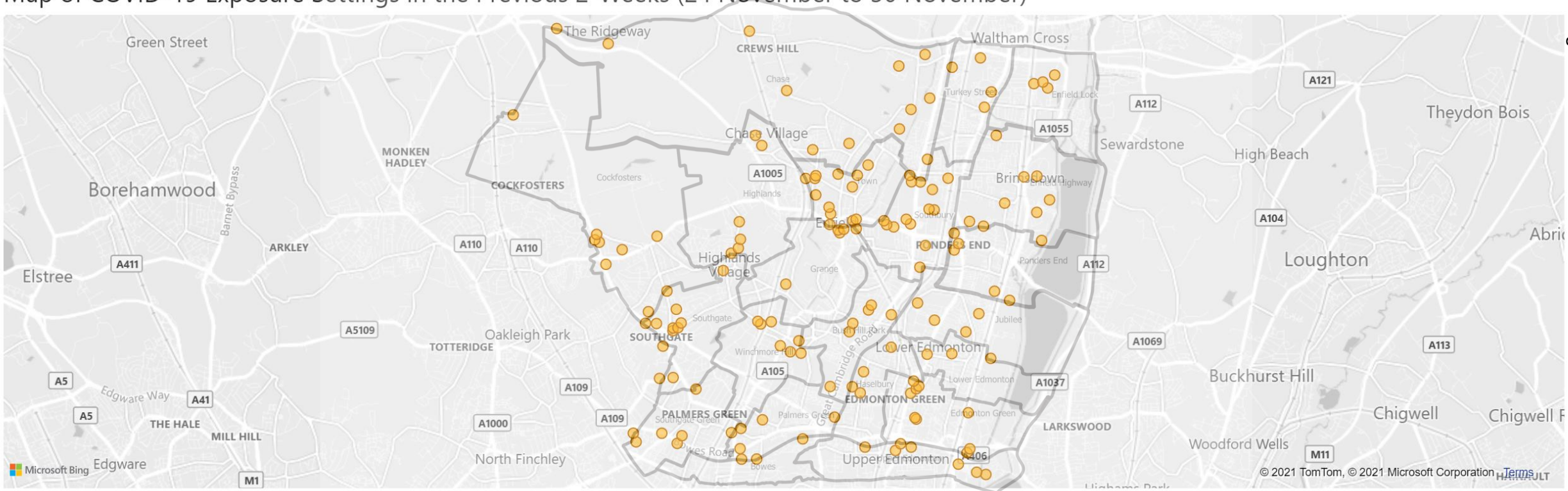
COVID-19 Exposure Settings

Exposure setting	1 Day	Previous 7-Days	Previous 14-Days
Attending_Childcare_Educational_Setting	84	589	1337
Teaching_And_Education	18	43	132
Shopping	4	44	88
Exercising	0	10	44
Healthcare	3	19	28
Warehouse_Or_Distribution	0	11	28
Other	0	4	22
Entertainment_And_Day_Trips	1	11	17
Retail_Sector	0	17	17
Sport_Events	0	4	15
Eating_Out	0	5	9

COVID-19 Exposure Descriptions (Can only display Top 12 exposures please see PBI for more details)

Exposure Count	Description of Exposure Setting
47	Firs farm primary school (Bush Hill Park)
26	AIM North London School (Jubilee)
25	ST. GEORGES CATHOLIC PRIMARY SCHOOL (Town)
24	KINGSMEAD SCHOOL (Southbury)
22	Heron hall academy (Ponders End)
22	Highlands School
20	Bishop Stopford School (Southbury)
19	hillel school
18	EDMONTON COUNTY SCHOOL (Jubilee)
18	st monica's catholic primary school (Southgate Green)
18	The Latymer School (Haselbury)

Map of COVID-19 Exposure Settings in the Previous 2-Weeks (24 November to 30 November)



Hospital admissions due to COVID-19

Last updated: 30th November

indicator	North Middlesex University Hospital NHS Trust (36)	Royal Free Chase Farm NHS Foundation Trust (34)
Number of confirmed COVID-19 patients receiving oxygen at 0800?	16 (5)	10 (-2)
Number of COVID-19 patients not on any form of oxygen at 0800?	20 (4)	24 (2)

Confirmed COVID-19 patients

0-34	7 (5)	0 (-4)
35-64	17 (9)	22 (5)
65+	11 (-6)	12 (-1)

Glossary

Indicator	Definition
Infection rate per 100,000	An infection rate is the probability or risk of an infection in a population. It is used to measure the frequency of occurrence of new instances of infection within a population during a specific time period. Calculation: (lab-confirmed case count/Enfield resident population) *100,000.
Number of tests conducted per 100,000 population	Calculation: (count of Pillar 2 tests conducted/Enfield resident population) *100,000.
Positivity rate of Pillar 2 testing	Calculation: (count of tests with positive Pillar 2 results/count of pillar 2 tests conducted) *100,000.
Number of cases in Pillar 1 & 2	Cases: Lab-confirmed case count; a lab-confirmed case is when a tested specimen is returned positive. Duplicate tests for the same person are removed therefore lab-confirmed cases are counts of people. This is a count of people NOT TESTS. Pillar 1: swab testing in Public Health England (PHE) labs and NHS hospitals for those with a clinical need, and health and care workers. Pillar 2: swab testing for the wider population, as set out in government guidance.
Number of cases with no contacts	Count of COVID-19 cases as identified via NHS Test and Trace that were recorded as having 0 contacts.
Number of cases with contacts	Count of COVID-19 cases as identified via NHS Test and Trace that were recorded as having contacts.
Number of positive Pillar 2 tests	Count of tests with positive Pillar 2 results; this can be duplicate testing.
111/999 triages	Data about the rate of calls to these services relating to coronavirus; this data is based on potential COVID-19 symptoms reported by members of the public to NHS Pathways through NHS 111/999 and is not based on outcomes of tests for coronavirus. This is NOT A COUNT OF PEOPLE.
Exceedance (Observed Vs Expected)	Observed: the observed count of lab-confirmed COVID-19 cases within a given period. Expected: the expected number of lab-confirmed COVID-19 cases within a given period as defined by regression modelling.
Number of Pillar 2 tests conducted	This is a count of the total number of valid tests conducted (positive, negative and void) on a particular specimen where the date the test was taken is available and plausible, where the upper tier local authority is in England, and where valid postcode is recorded.

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NHS
North Central London
Clinical Commissioning Group

COVID 19 & Flu Vaccination Update

HWBB Board

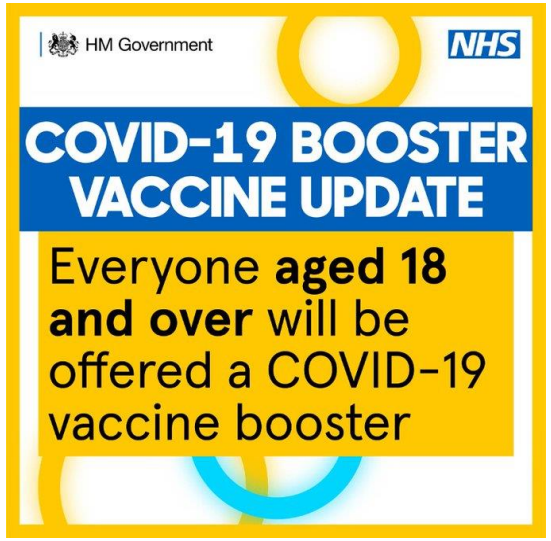
November 2021

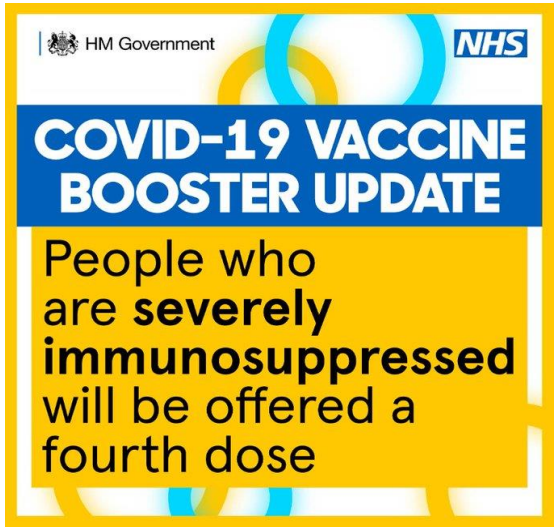
Riyad Karim

Assistant Director of Primary Care

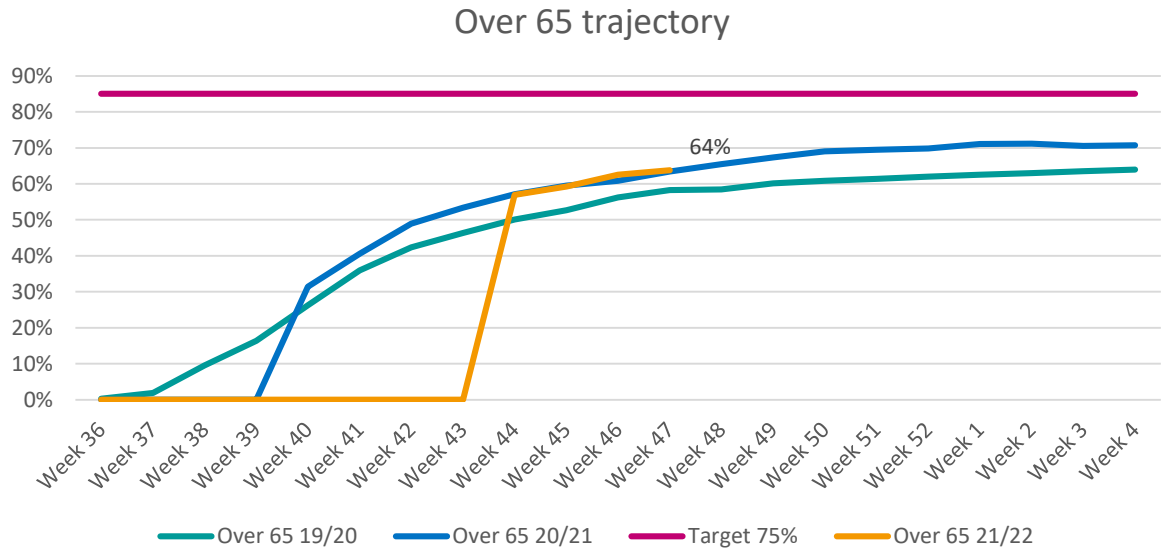
Omicron Variant and COVID 19 Vaccinations

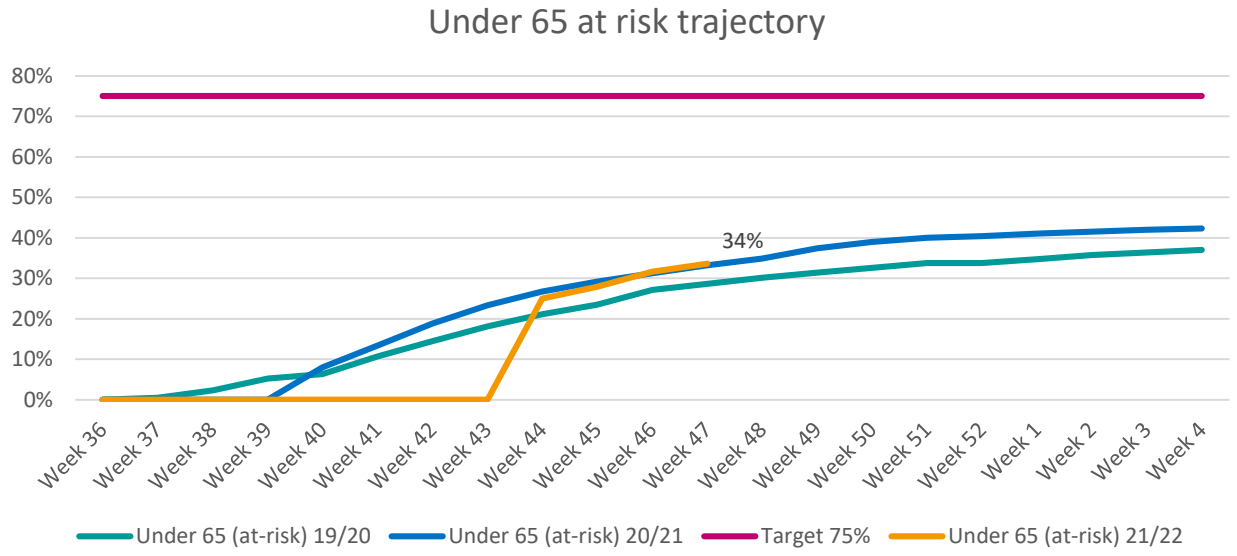
- NHS is expanding and accelerating the COVID19 Vaccination programme
- Following new advice from the Joint Committee on Vaccination and Immunisation (JCVI)
- This will strengthen our defences against the Omicron Variant
- All adults in England will be offered a COVID19 booster doses by the end of January 22
- Further details will follow
- In Enfield we will be working out the plan to deliver on the above at the Phase 3 COVID and Flu ICP meeting next week

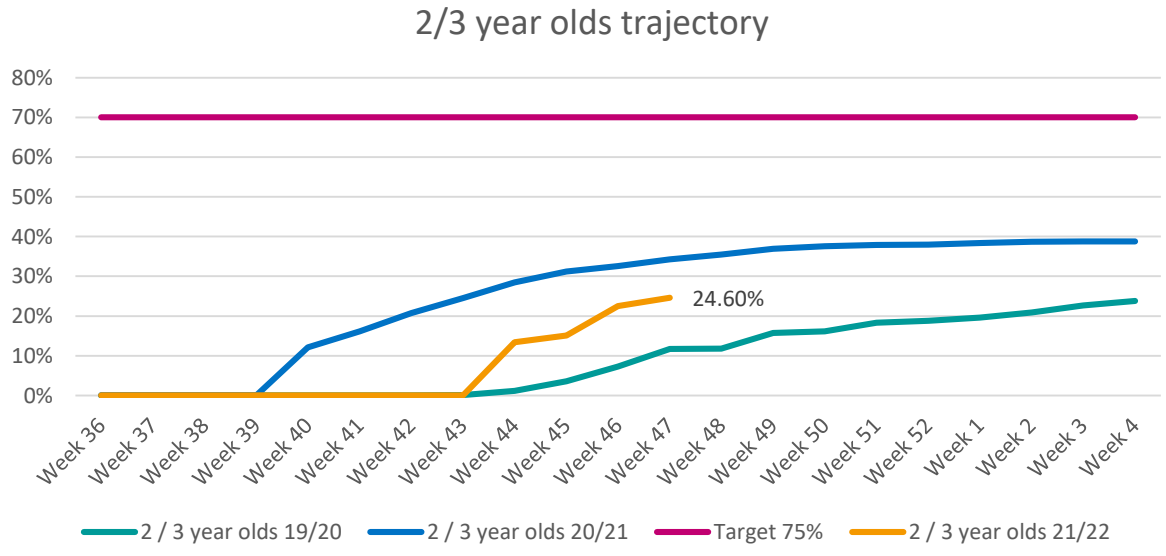


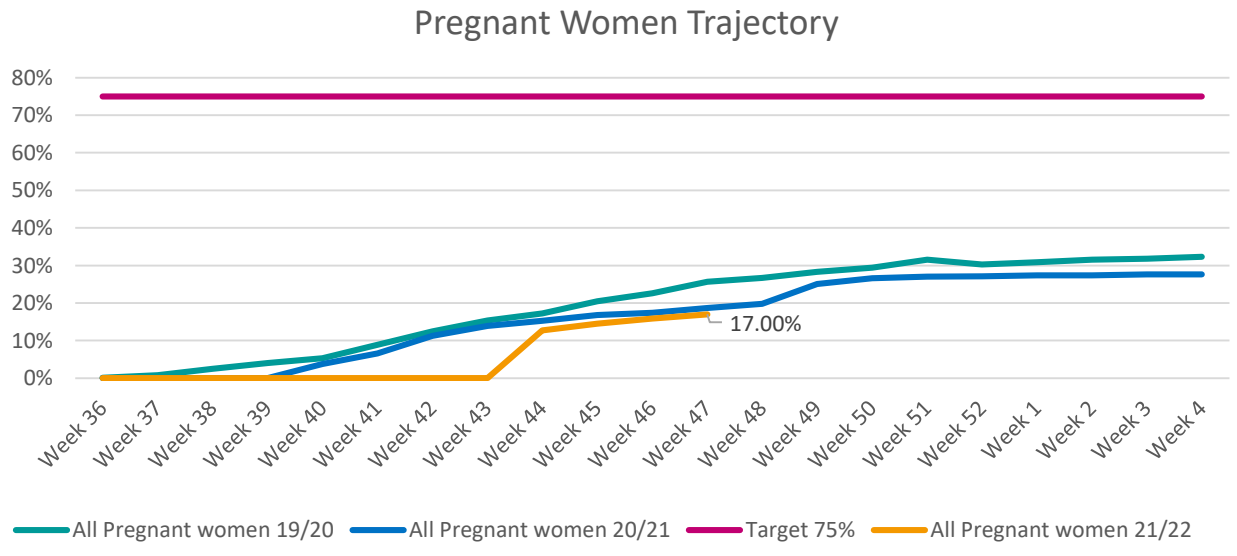


Flu Year on Year performance 2019 - 2021









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Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

BEH MHT update to HWBB - 2 Dec 2021

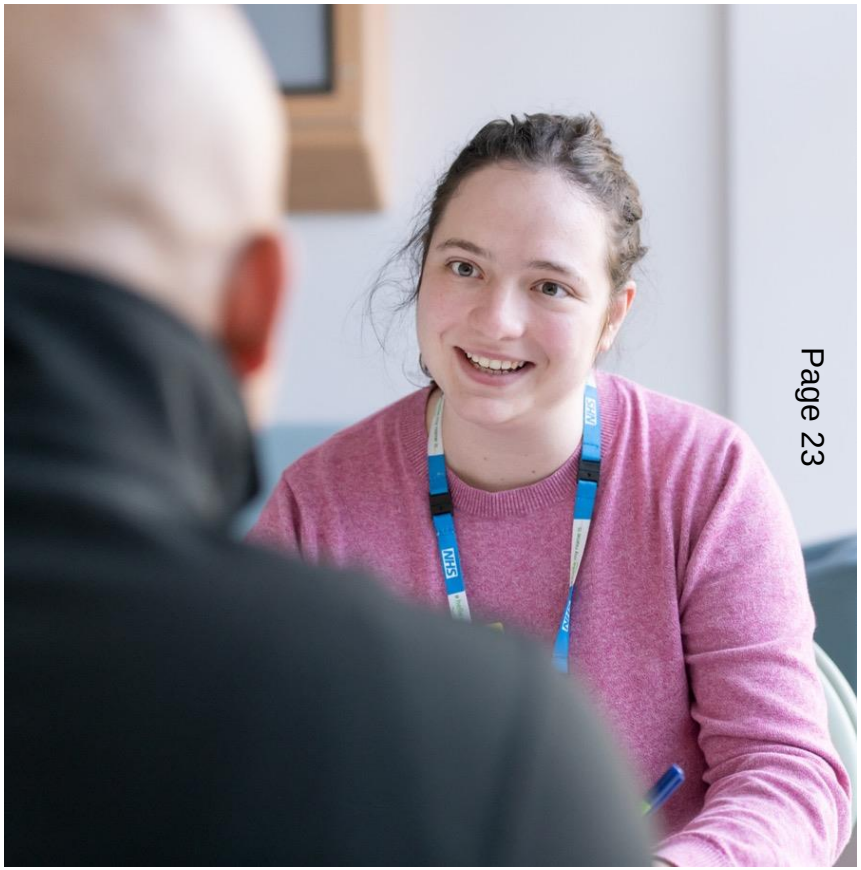
Natalie Fox and Andrew Wright

Responding to COVID-19

- Our priority over the last 20 months has been responding to COVID-19 through:
  - Keeping our patients and staff safe and supporting their wellbeing
  - 2,000 service users supported through wellbeing checks
  - Diversion hubs and all aged crisis helpline
  - Vaccinations to patients, staff, Enfield care homes and in special SMI / LD hub
  - ECS supporting local acute hospitals including additional step down ward
  - Long COVID clinic established
- We have responded well, but sadly lost a number of colleagues to COVID

Key current challenges

- Staff recruitment and retention – working with partners on wider solutions, e.g. new roles
- Significant increases in demand:
  - 28% increase in mental health referrals in 2021 compared to last two years
  - 10% increase in Enfield Community Services referrals in 2021 compared to last two years
- Significant increases in the acuity of patients (more seriously ill)
- Pressures on inpatient mental health beds

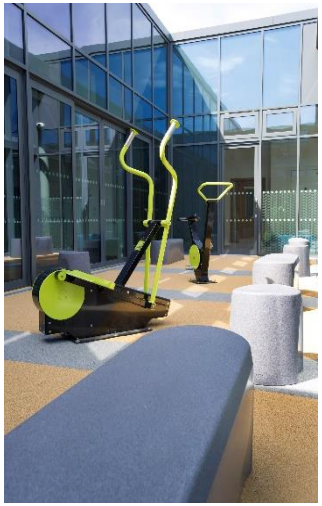


Improving inclusion and equalities

- Trust Inclusion Programme creating a fairer and more just culture
- Working with partners to help address local health inequalities
- Addressing low levels of funding for mental health and community health services in Enfield

Improving our Estate

- Blossom Court opened at St Ann's Hospital in 2020 and we are progressing improvements to the rest of the site
- Eliminated all shared bedrooms across all our wards
- Developed business case to improve the rest of our estate
- Ongoing improvements to therapeutic environments for our patients

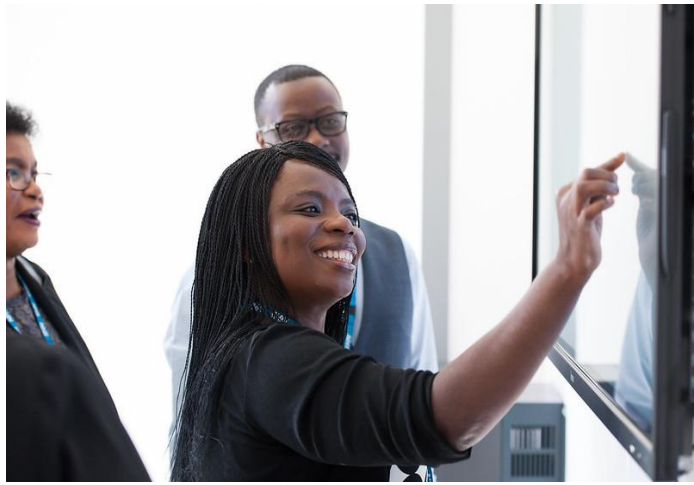


Transforming our services

Our service users have told us they want:

- Care delivered closer to home
- Improvements in our environments
- Equitable access to high quality care
- Support with jobs, housing, physical health

To help achieve these improvements, we are investing £50m in changing our services over the next four years



Our Transformation Programme

- Developing our **mental health crisis services** to provide quick, effective care at home or in the community and reducing A & E attendances
- Strengthening **community mental health services** to provide early treatment and personalised care
- Improving **CAMHS services** to ensure rapid, equitable access and immediate support for young people in crisis
- Transforming **Enfield Community Services** through improved access to services for local people, development of care home support, more agile working for staff and improving care environments

Partnership with C&I

Increasing our partnership with Camden & Islington, focusing on:

- Reducing health inequalities
- Eliminating unwarranted variation and inconsistencies
- Creating a sustainable workforce
- Improving outcomes for patients and carers

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

Date of Health and Wellbeing Board: 2nd December 2021

Update prepared by: Doug Wilson, Head of Strategy, Service Development & Resources, People, Enfield Council

1. Introduction & Background

2. The Joint Health & Social Care Commissioning Board is a partnership across Council People services and Health, represented by CCG colleagues. For the purposes of this update, it oversees the development and delivery of key priorities across Adult Social Care and Health.
3. The priorities jointly developed and agreed across health and social care build on the good work done in previous years and, in particular, focus on the learning from the period of the Covid-19 pandemic.
4. The impact of the pandemic has been clear in Enfield with:
    - excess deaths increasing by 375% in April 20 alone with care homes proportionally hardest hit
    - significant reductions in emergency admissions to hospital and permanent admissions into care homes.
    - By February 21 over 80% of acute hospital beds occupied by people with Covid
    - Access to virtual GP appointments increased from 20% pre-pandemic to almost 50% by June 2021.
    - Increased referrals to Social Care for support in the community
    - Increased referrals for support from informal carers looking after family members
    - An increased use of technology facilitated by the health and social care partnership to enable more vulnerable residents to engage with family members
    - an increased deployment and take up of assistive technology to provide targeted support where needed.
5. However, the impact of the pandemic has also impacted on the mental health and wellbeing of many of our residents with
    - significantly increased referrals to local voluntary and community sector groups focused on mental health and practical support
    - increased mental health inpatient admissions, particularly amongst the BAME communities
    - increased admissions to assessment and treatment for people with learning disabilities
6. Across the Integrated Care Partnership our priorities seek to address these most pressing of challenges by:

- Proactively identifying and addressing inequalities in BAME communities including: Mental Health; Long Term Conditions (LTCs);
- Education and engagement to support self-care and access;
- Driving up representation of those impacted by inequalities in Patient Participation Groups and Partnership Boards;
- Greater engagement with BAME, hard to reach, and deprived communities particularly through our voluntary and community sector;
- Driving increased uptake of screening and immunisations to keep residents healthy and catch conditions earlier, including for cancer, giving people the best possible intervention/treatment;
- Driving greater focus on improving mental health among residents: Focus on proactively preparing for post Covid MH; Proactively identifying and addressing lower level MH issues; addressing the Disproportionate impact on BAME communities;

7. These priorities are addressed in our Better Care Fund Plan with increased joint investment in:
    - Hospital avoidance and discharge capacity – increased capacity in Integrated Discharge Teams, older people and mental health enablement services and a virtual ward model of delivery;
    - New complex mental health stepdown service delivered to support hospital avoidance and to support timely discharge;
    - Increased voluntary and community sector provision to address mental ill health, to support better self-management of long-term conditions and expand the levels of support available to people recovering from mental ill health to access employment;
    - Planned capital investment in a new integrated mental health and wellbeing hub, adapted community accommodation options for people with complex learning disabilities;
    - An enhanced community equipment and assistive technology offer able to flex up to 7 days services as required
    - Digital and telehealth/assistive technology solutions in partnership with the GP Federation
    - Support for informal carers through increased investment in the voluntary and community sector
    - Increased support for people with sensory impairments through our voluntary and community sector
    - Targeted work on our hardest hit BAME communities, particularly in mental health and substance misuse services
8. The planned net impact of this joint work and investment is:
    - A 5% reduction (compared to the 19/20 baseline) in avoidable admissions
    - A 2% reduction in patients whose discharge is delayed by 14 days or more (compared to winter 19/20 and 20/21 averages)

- A 2% reduction in patients whose discharge is delayed by 21 days or more (compared to winter 19/20 and 20/21 averages)
- A continued focus on home first with 93% of patients able to return home following discharge
- A planned but short-term increase in residential admissions to ensure appropriate levels of support in the right care setting
- Enablement capacity increased by 20% to support home from hospital 88% of those people living independently 3-months following discharge

9. Enfield's local Acute A&E Hospital, North Middlesex has been particularly challenged during the pandemic period. Serving mainly local communities in both Enfield and Haringey there are very active partnerships in place which bring together both boroughs, CCG and trust representation with access to regularly updated and joined up data. As a result of this partnership length of stay of Enfield residents ready for discharge in acute hospital beds have reduced across all areas (7+, 14+, 21+ days) supported by increased BCF investment in additional capacity across Pathways 0, 1, 2 and 3. The ambition for this year 21/22 is to reduce length of stay delays further still by 2% for 14+ days and 2% for 21+ days.

10. Mutual aid arrangements developed during the pandemic continue to be in place (availability of placements, community support cover and community equipment where needed. With a significant proportion of each borough unregistered with a GP a new GP registration service has been established in partnership with the local VCS and situated in the hospital. The outcome of this project will be monitored carefully and will contribute towards the ambitious targets that have been set to help people continue to live safely and independently within their own homes.

11. Adult Social Care has worked well with partners including Voluntary and Community Sector organisations, Health and our providers across community and residential care settings to respond to the volatile and fluctuating patterns of demand that the pandemic has created. Overall demand has increased but with a shift to more community-based support both in the statutory sector and in the VCS/early intervention and universal service provision sector.

12. Our partnership has remained resilient with partners working really well together to deliver good outcomes for local people with a focus on work to help people to continue to live independently and safely in their own homes, preventing hospital admissions where possible and supporting safe, timely and appropriate discharge from hospital when in-patient treatment is necessary.

13. Overall, for this year we expect a period of volatility to continue given that we are not out of the pandemic yet. However, the success of the vaccine roll out and other initiatives to prevent the spread of the Coronavirus to our more vulnerable populations together with the end of furlough arrangements for many families looking after vulnerable loved ones has seen a gradual shift of activity resulting in, for example, an increase in permanent and short term placements in care homes. This bounce effect is not unexpected and whilst a placement in a care home is a last resort, we do make sure that other community alternatives are safe or viable before we do this.

14. This report provides a variety of information about how things are going across the health and adult social care sector, as well as signalling our plans both immediate and medium term given the significant legislative changes currently making their way through parliament which will bring Integrated Care System and Partnerships, a new regulatory framework for Councils with Adult Social Care responsibilities and Adult Social Care Funding Reforms.

15. Our Vision for Health & Social Care Services in the Borough

16. 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

17. Enabling people to be safe, independent and well is a 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 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:

    - 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 is well supported and equipped to deliver support and services which put families and people who use services at their very heart.

18. Integrated Services and what this means for local residents

19. The development of Integrated Care Systems (ICS) and Integrated Care Partnerships 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.

20. Our Joint priorities as a place system are:
    - Improve outcomes in population health, health and social care services with a focus on health inequalities, immunisations and cancer screening programmes
    - Supporting our workforce, including our wider provider workforce, to deliver inclusive, person centred practice
    - Tackle inequalities in outcomes, experience and access
    - Delivering a system review in partnership with all stakeholders of community and mental health services in order to establish a consistent core offer across the five north central london boroughs whilst building on good practice particular to each individual place
    - Further develop a health and social care system which enables people to live independently, avoiding hospital where possible and supporting timely and appropriate discharge where admission is necessary
    - Delivering an enhanced health management and improvement offer to Care homes in the borough
    - Enhancing productivity and delivering value for money
21. There is strong collaboration at a place level with a shared understanding of the most pressing challenges across health and social care. Examples in this year 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/CCGs
    - 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 CCG 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.
22. Our balance of care data shows that over the last three years the balance of people living at home versus those living in residential and nursing placements has shifted from 84% (community) and 16% (residential/nursing care) to 86% and 14% respectively. This excludes 20/21 which was heavily impacted by the pandemic.

Hospital avoidance, improved step down/rehab capacity has supported more people to either remain in their own homes or to return home after a hospital stay.

23. Enfield's hospital delays, according to regular benchmarking, are the lowest in the north-central London sub-region both for acute hospitals, mental health in-patient wards and learning disability assessment and treatment units.
24. We are building on this good work by delivering this year a joint Independent Living Strategy and will encapsulate the key learning from the pandemic period which includes:
    - Further embedding and broadening across the system the strength-based approach to working with people
    - An enhanced VCS offer focused on early support and proactive interventions to reduce falls and social isolation
    - Further development of the digital offer to include telehealth and assistive technology with a focus on risk stratifying and regular vital signs monitoring jointly with GPs
    - Better joined up information, building on the Health Information Exchange project to support more joined up and holistic approaches to supporting people
    - Roll out of the Healtheintent project to support improved and more joined up data to support commissioning needs assessments and service development
    - A continued focus on homefirst with graduated levels of support which can be stepped down or up as needed quickly to help people return home safely and appropriately from hospital
    - Joint market management and service development approaches to support our care market remain resilient and stable
25. Our collaborative approach to supporting and training our staff, including our wider care market provider workforce has resulted in a health and social care workforce that has continued to demonstrate resilience, compassion, innovation, flexibility and professionalism throughout the pandemic. An increase focus on asset or strength-based approaches to working with people has resulted in over 92% of people who are admitted to hospital being able to return home with an appropriate level of support.
26. We have staff across a variety of disciplines, including VCS staff, co-located and working collaboratively to ensure that people who need our help are engaged with at the earliest opportunity. Using strength-based approaches we have seen the number of people entering long term services reduce which has contributed to the partnership's management of demographic pressures across the system.
27. Better Care Fund funded services represent a relatively small proportion of the overall system. However, the principles of early intervention, innovation, positive risk taking and robust monitoring of data and outcomes clearly demonstrate that, while the system in Enfield has been challenged, particularly over the period of the pandemic, the collaborative approach supported by the Better Care Fund has delivered real benefits with:
    - Increased investment in early intervention services
    - Development of capital projects which will deliver long term benefits
    - An improving shared understanding of pressures and opportunities across the health and social care system
    - Improved resilience around planning for periods of pressure, including Winter

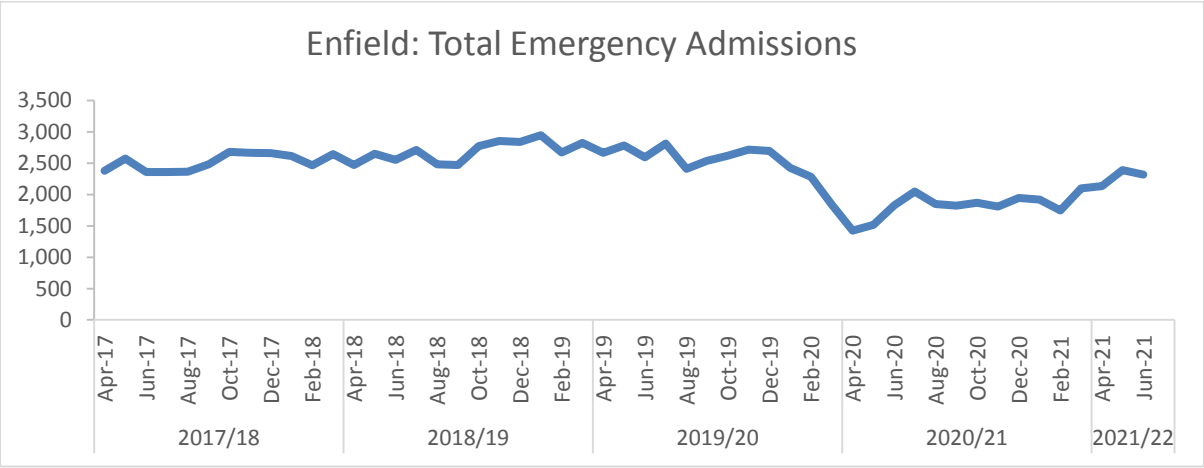
28. Strong governance arrangements with good engagement at all levels of the system have resulted in a shared understanding of the challenges and opportunities in Enfield as a place, a shared commitment to deliver key priority areas based on a good understanding of our intelligence which translates into good planning, clear and deliverable objectives and robust monitoring of timely data enabling decision making at all levels to be made.

29. The key measure of the success of any health and social care system, however, is how people in the community experience it when they need support. We are planning a collaborative approach in partnership with Healthwatch Enfield to deliver a Local Account which will focus on how health and social care services have delivered in 2021/22. This will include feedback from all of our stakeholders, including the people who use our services and their families. Discussions and planning are underway to deliver this as early in the next financial year as possible and it is our intention to bring this report to the Health and Wellbeing Board.

30. Hospital Care & Community Services

31. North Middlesex Hospital is our local NHS Trust delivering Accident and Emergency (A&E) services. It has faced significant challenges with daily attendances at the A&E department 600 people on a regular basis. Whilst the number of people with Covid19 occupying beds has significantly reduced with the successful roll out of the vaccine programme from its height in January/February 21 the hospital is still treating between 30-50 patients at this point in Time (December 2021) who are Covid positive. It is clearly important, therefore, that people are supported to avoid hospital, where possible and to remain in an acute bed for only as long as is appropriate. The following charts show activity over time:

Chart 1

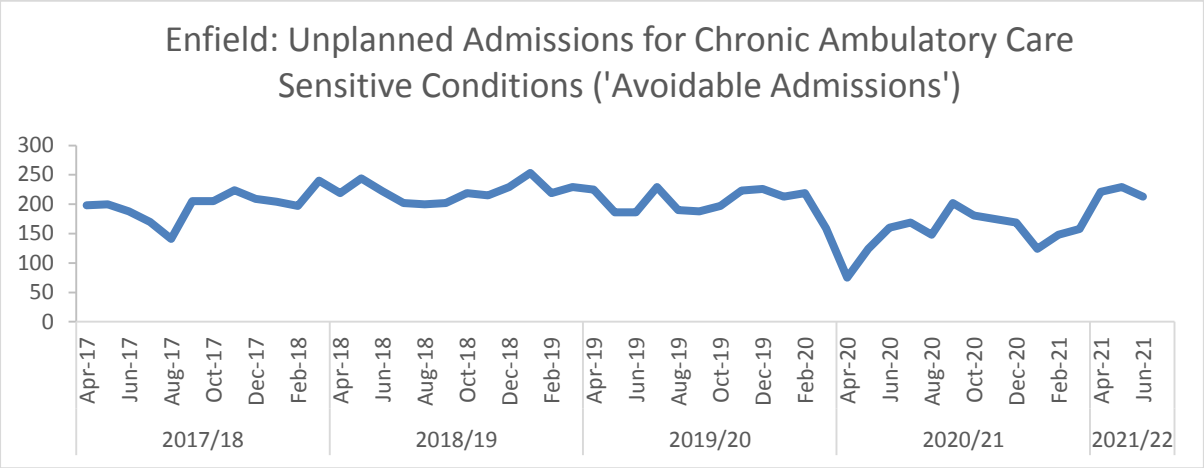


32. Whilst there is a noticeable dip in emergency admissions during the period of the pandemic indications are that these are beginning to increase to pre-pandemic levels. The impact of Covid19 and the reduced access to elective or planned treatments as a result of the pandemic has contributed to this. There are plans in place to reduce the number of what are called Ambulatory Care Sensitive (or

avoidable) admissions. Ambulatory Care Sensitive Conditions (ACSCs) are **health conditions-diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalization** by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease.

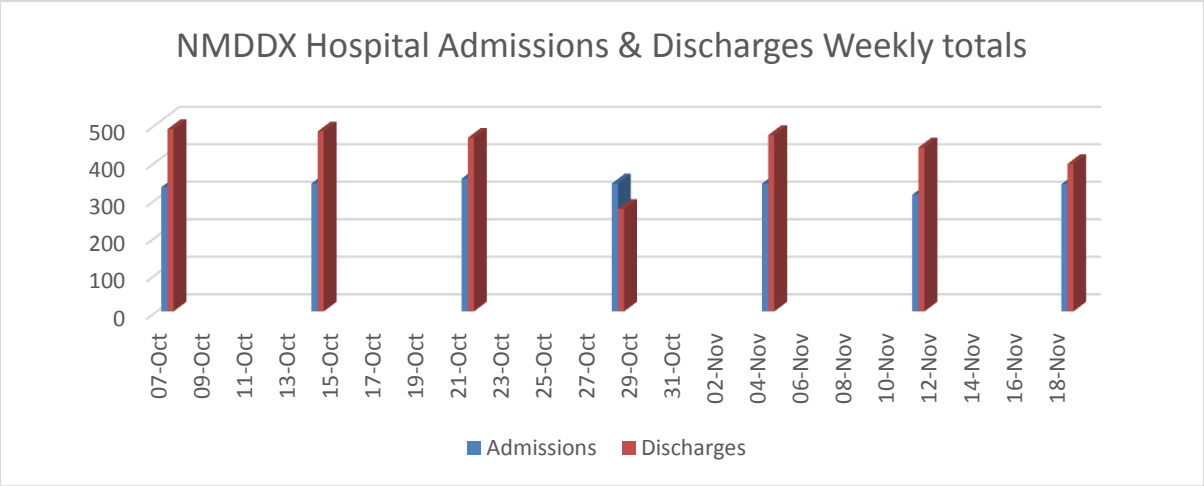
The chart below shows these over time:

Chart 2



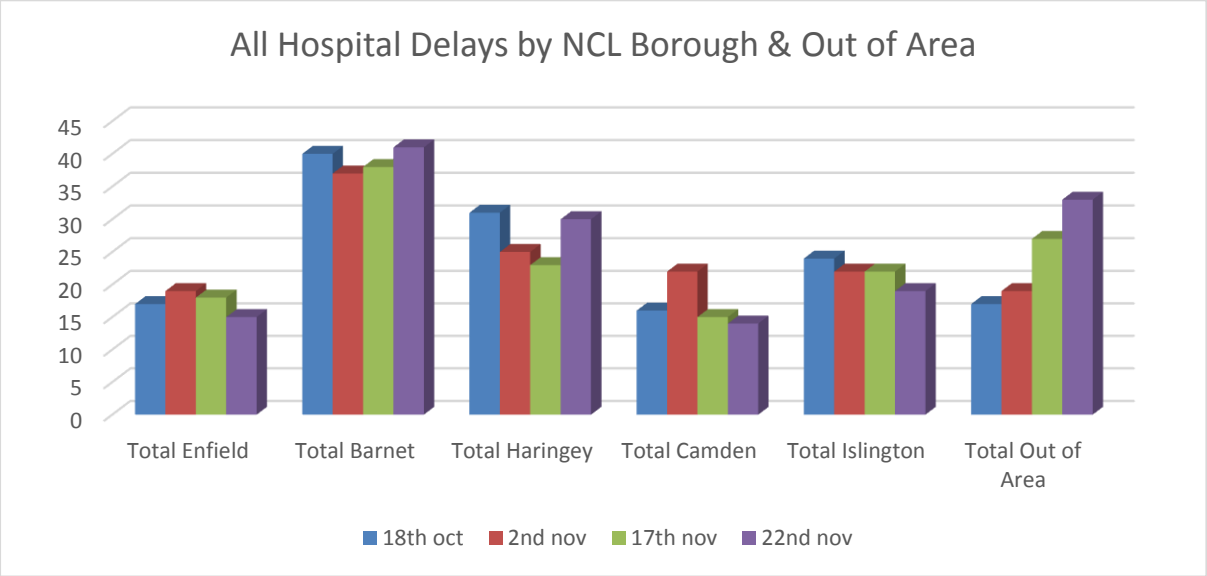
33. Again, the dip in activity over the period of the pandemic is evident but with levels increasing once again to pre-pandemic levels. There are plans in place to reduce these in 21/22 by 5% (compared to the pre-pandemic 2019/20 baseline) so approximately 125 fewer admissions to hospital. The plan is to deliver this by:
    - Working to increase capacity in the Rapid Response service ensuring full geographic coverage of two-hour crisis response care across system.
    - Increasing referrals from all providers, including LAS, 111 and A&E.
    - Improve access to support from a range of clinicians including GP, Consultant, Mental Health and Learning Disabilities.
    - Introduce access to diagnostics within Rapid Response teams. In addition to this the Care Home Assessment Team has been expanded to cover all care homes in the borough and will be working with the primary care networks to introduce an anticipatory care service identifying moderately frail patients providing assessment and case management where appropriate.
    - Additional investment in early intervention services working across the VCS, Council and Health services to support people to better self-manage chronic long-term conditions.
34. Of course, there will always be times when admission to hospital is not avoidable and it is then critical that people who are admitted are treated and discharged in a timely and appropriate way. The chart below shows over the last two months the balance of admissions and discharges from North Middlesex hospital:

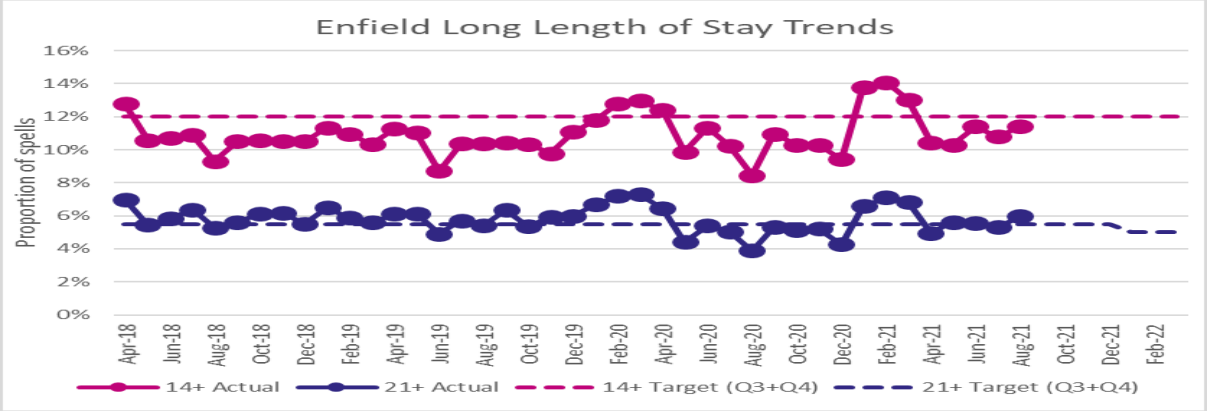
Chart 3



35. Enfield as a Health & Social Care system has robust partnership arrangements in place. The chart below shows Enfield compared to other North Central London boroughs where discharges are delayed for the months of October and November 2021:

Charts 4 & 5

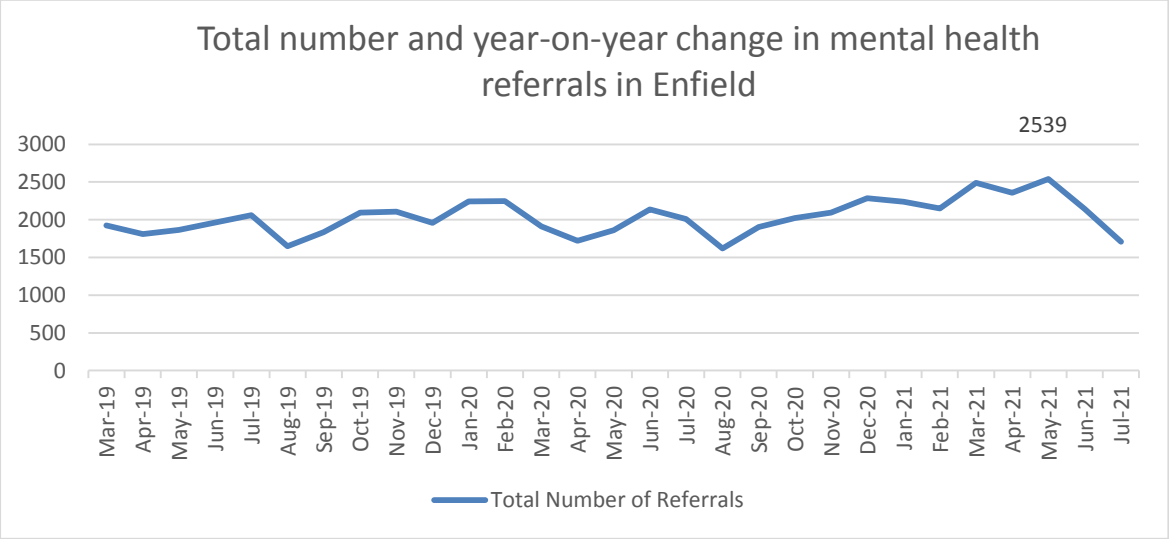


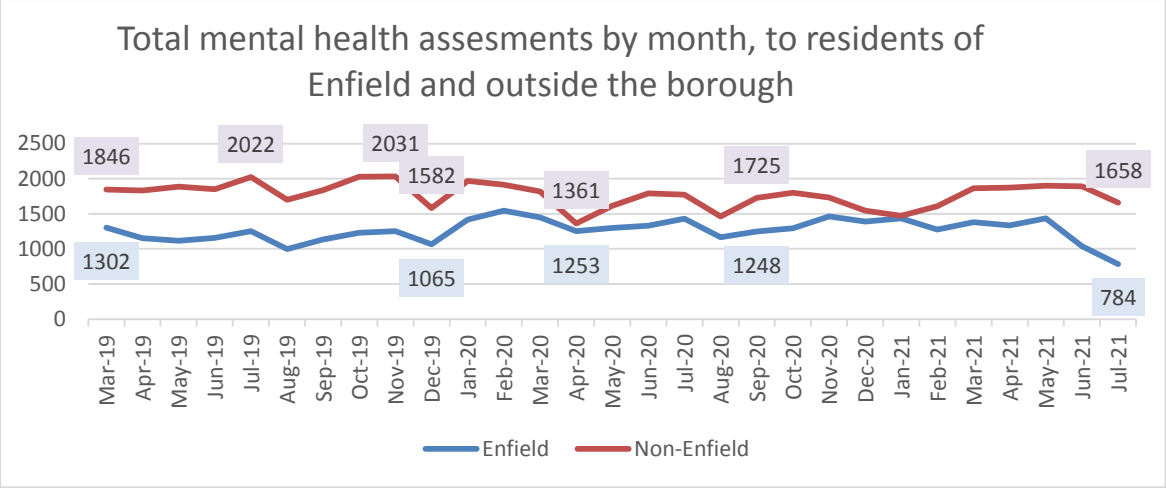


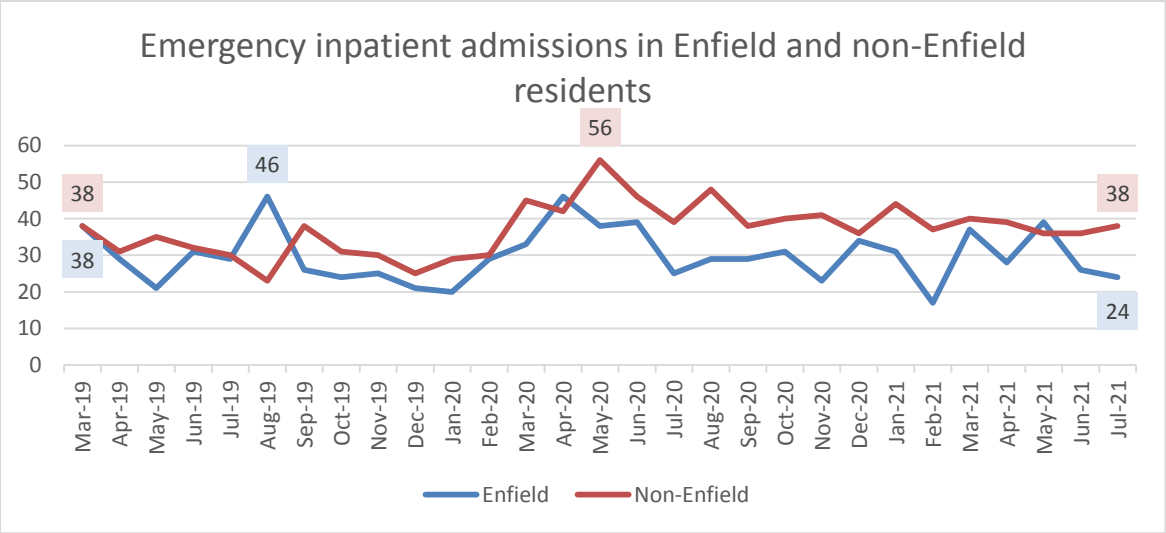
36. Twice weekly Silver meetings are held across the health and social care partnership to review hospital activity and any delays. Any delays tend to be focused on areas where specialist activity is required (for example specialist neuro/rehab services) which require consultant-led therapeutic interventions including for people who have experienced brain injury (like strokes).

37. The onset of the pandemic did also create an additional spike in demand for mental health inpatient services and the chart below shows referrals to Mental Health Services and inpatient admissions to mental health wards over time within Barnet Enfield and Haringey Mental Health Trust. Emergency inpatient admissions for Enfield residents peaked in May 2020 with 46 admissions and 56 admissions for non-Enfield residents. Emergency inpatient admissions to the BEH Trust have consistently been lower in Enfield than in non-Enfield residents. No significant spikes in referrals rates were seen with the exception of a slight upward trend from August 20 to May 21 decreasing into June and July 21. The work of community services (including our VCS) to continue to support people in the community has prevented many people from reaching crisis point.

Charts 6, 7 & 8







38. For many more vulnerable older people the consequence of declining health and hospital admission can mean permanent admission to a care home. Although the overall trend has been downward over the past few years, there has been a significant drop in permanent admissions during the period of the pandemic. Lockdown, with more families at home has seen an increase in family support maintaining family members in the community with a resultant drop in admissions. However, 2021/22, we project, will see a return to 2019/20 levels of admissions.

Chart 10

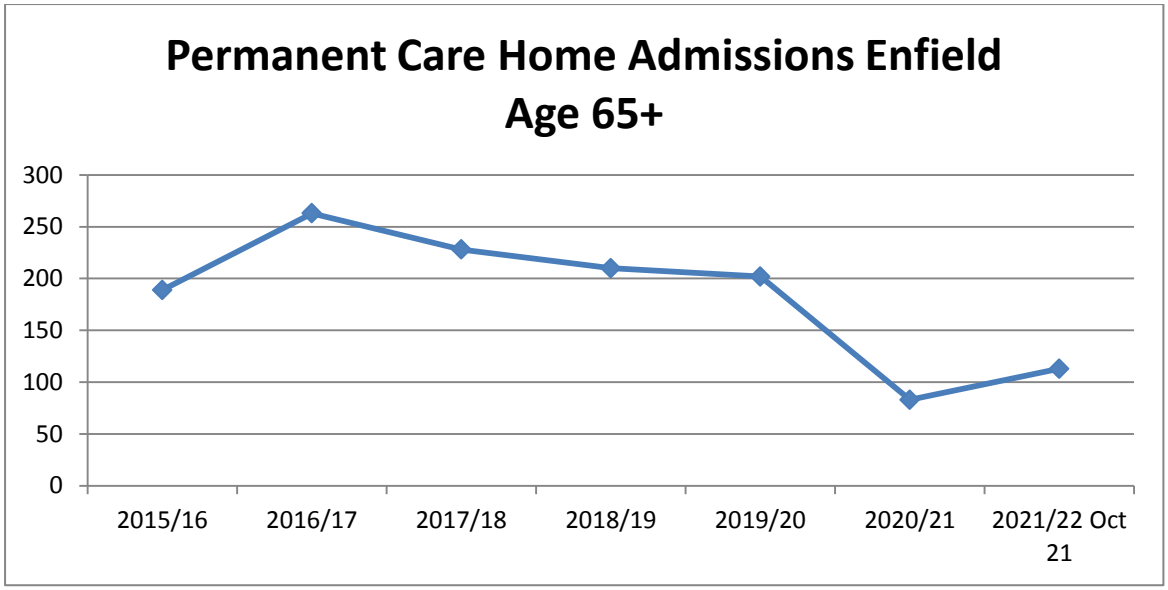
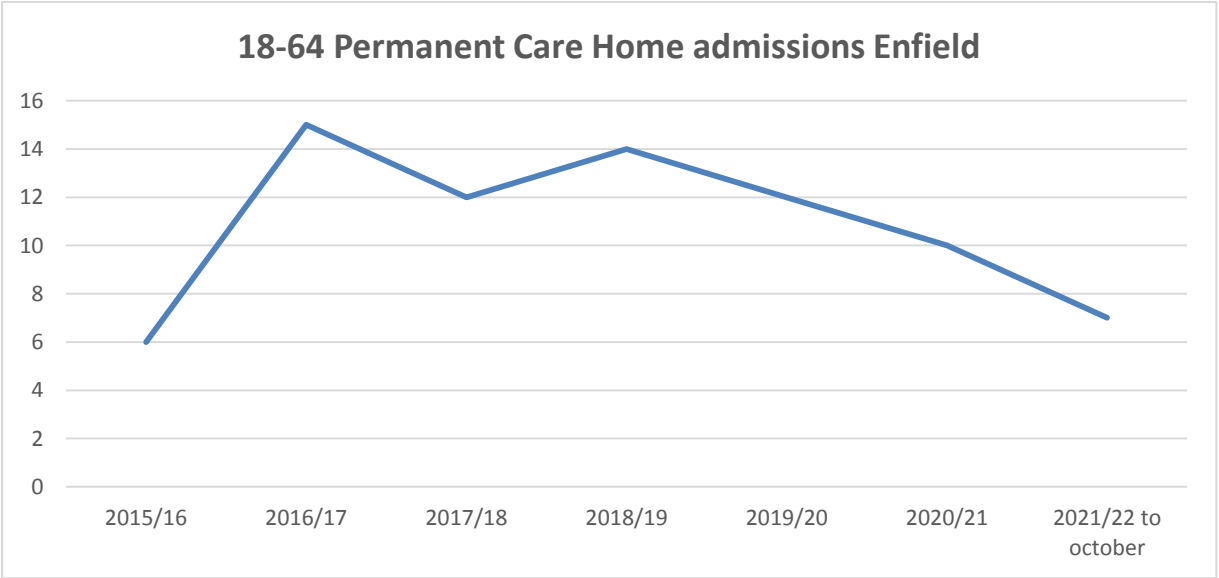


Chart 11

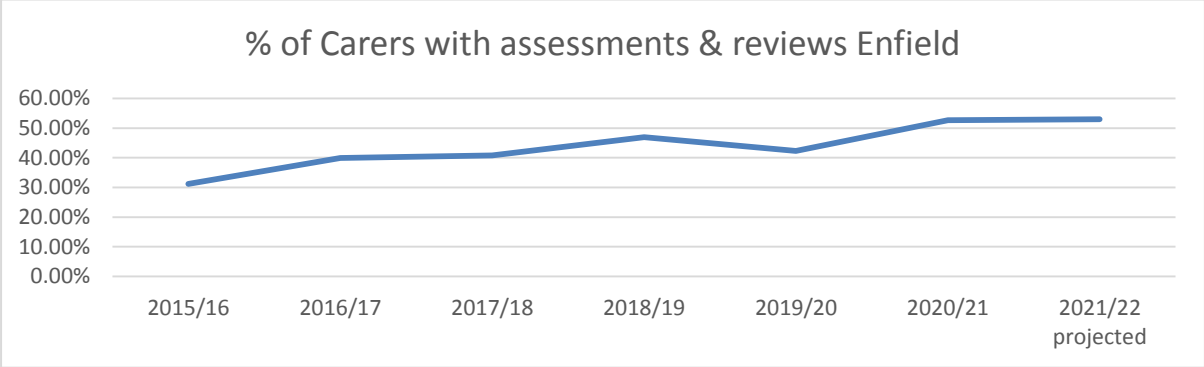


39. Permanent admission to a care home is much less frequent in the younger age group with the majority of placements in this age group attributable to early onset dementia cases in people under 65. Whilst the general trend since 2018/19 has been downward it is anticipated that permanent placement numbers this year will reflect pre-pandemic 2019/20 numbers.

40. Our plans across health and social care are very much focused on providing more enabling and independent living support in the community in order to reduce the number of permanent admissions to care homes and emergency admissions to hospital across all ages. These ambitions are reflected in what we have achieved so far and in our plans for this year and beyond.

41. Chart 12 below shows the work done by the Council in partnership with Enfield Carers Centre to support carers (unpaid family members/friends) to access assessments and reviews, either separately or together with the person for whom they are caring, and reviews of the support they receive. The period of the pandemic has placed enormous pressure on families and friends caring for loved ones and our partnership across health, social care and the voluntary and community sector has provided much needed support to more people to help them to continue caring both safely and appropriately.

Chart 12



42. Services available range from practical information, advice and support for carers themselves and for the person or people for whom they care and are available both on-line and face to face, situations and government regulations permitting. Information about the services and support available is available here: https://mylife.enfield.gov.uk/homepage

Supporting People to regain their Independence after Hospital

43. 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.

44. The Council and the CCG have been working hard to continue to develop 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 (over 92%), 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 including through LBE Enablement Services.

45. 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 77% of them continue to live independently three months later. Our target for this year is to increase this to 88%.

46. 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.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.

47. 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 £20m 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 generally 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. 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 allotment space.

Adults with Learning Disabilities

48. 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:
    - 87% 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;
    - A very successful supported employment service (EQUALS) helping over 130 people with learning disabilities into paid employment with performance amongst the best nationally;
    - Over 54% of service users using a direct payment to manage their support, London and national leading performance;
    - Shared ownership accommodation options available to people who use services;

- Bespoke Covid testing and vaccine facilities developed to support people with complex needs and challenging behaviour to access the support they need to stay as safe as possible.

Adults with Mental ill Health

49. The integrated Mental Health Service works to support adults with severe and enduring mental ill health to reintegrate back into their community. Integrated services work with just under 1,100 people per year. This year has been:
    - A joint health and social care project to develop new stepdown services for people leaving hospital wards and residential care settings is now providing much needed additional capacity within the community to enable this. This service enables people to live more independent lives, with support as needed to prevent relapse, from a multi-disciplinary team of staff;
    - A new and expanded employment support service has been jointly commissioned by the Council and the CCG which has already supported more than 50 people to gain paid employment this year. This service works with people who have been discharged from hospital and with people referred by their GP;
    - Low numbers of people admitted to permanent residential care year on year with over 78% of people known to mental health services living in settled accommodation.
    - Additional Council and CCG investment in enablement service capacity to work with people in the community, to support rapid and appropriate hospital discharge and to provide more people with the practical support skills they need to live independently.
    - Additional joint investment in community support services focused on reducing the number of younger black men admitted under section to inpatient units;
    - Planned Council investment in a new mental health and wellbeing hub delivering a wide variety of services for local people, including a planned community café open outside of normal working hours to provide people with practical support.
    - A planned review of Mental Health services is nearing completion with a focus on Enfield as a place and the system is simplified, treating people as individuals rather than illnesses or diagnoses.

Adult with Physical Disabilities

50. 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.
    - Delivery of new fully accessible 2 and 3 bed homes for younger adults with physical disabilities at Jasper Close providing more supported living and shared ownership options;
    - 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 works with 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 also enables volunteer work opportunities for people with disabilities

Voluntary & Community Sector

51. The Council delivers its main early intervention and prevention initiatives through seven 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
    - People are supported to better self-manage long term conditions
    - Vulnerable people are given a voice in our community
    - Supporting appropriate discharge from hospital
    - Improved information and advice
    - Access to practical advice, information and support to maintain tenancies and manage finances

52. Additional one-off investment to establish luncheon clubs in those parts of the borough which are most deprived and where levels of social isolation and falls are most prevalent has been made. This will link in with the Council's Safe and Connected service providing 24/7 lifeline support and developing a new service focused on reducing the incidence of falls amongst our most at risk population

53. Headline statistics across our new VCS contracts include:
    - An increase of 8% in registrations for carers
    - 38 training workshops and 48 carer forums delivered to support carers in their role
    - 452 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
    - 91% 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
    - 12 information sessions held for people living with Long Term Conditions across the borough.
    - 279 direct face to face support with claiming disability benefits
    - LBE ASC VCS organisations working in partnership with Haringey Council and NMH have set up a advise NMH operating Monday – Friday.

- 2502 welfare calls to support residents

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

Public Health Commissioned Services

Young People Misuse Contract

51. The current Young People's Substance Misuse Contract runs until March 2023, as is due shortly to be re-commissiond. This offer is comprises 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. Performance continues to be good.

Indicator	2020/21	
	Value	Target
PH002n Substance Misuse: Number of Young People in treatment for the latest 12 months rolling period	197	
PH002o Substance Misuse: Proportion of Young People exiting treatment in a planned way of all treatment exits (EMT)	**92%**	77%

Substance Misuse Services Andrew and Fulya to update and include data

51. 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 Behavioral 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.

52. 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;

53. 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.

54. The current contract expires in 2025.

Indicator	2020/21	
	Value	Target
DAAT-001 NDTMS Partnership Successful Completion Rate (%) for all Drug users in treatment (aged 18+), excluding alcohol-only users:	**21.40%**	20.0%
DAAT-003 NDTMS Partnership Numbers in Treatment - All Drug Users in treatment (aged 18+), excluding alcohol-only users:	912	

Sexual Health Services

51. 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.

52. The service, through its Hub & Spoke model, delivers treatment and support at Silverpoint (Upper Edmonton, N18) and The Town Clinic (Enfield Town, EN2).
53. During 2021 an independent review of the service has been carried out, and a number of recommendations made ahead of service recommissioning, the current contract expiring in 2023. A high level steering group and operational delivery group has been set up to oversee the review and will now transition to overseeing the

implementation of the action plan, with all actions to be completed by 2023. Plans for recommissioning are being developed and will be brought to the attention of the board in due course.

Indicator	2020/21	
	Value	Target
PH003i % completed treatment within a month of diagnosis at Enfield Sexual Health Clinics	**98%**	90%

Oral Health Provision

51. 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.

52. On 31st of March 2019 contractual arrangements with the Whittington came to an end. In order to continue to benefit from a substantially reduced cost of delivery, the Council has now agreed in principle a 3-way agreement with Whittington and NHS England, through use of a contract and separate memorandum of understanding (MoU). Arrangements are being finalised with plans for the contract in place to cover until 2027.

53. The service has three main agreed objectives:
    - 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.

54. 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.

Indicator	2020/21	
	Value	Target
PH003x Number of Children that received at least one Fluoride Varnish	**1,419** *(this was severely impacted by the pandemic, as delivery is through schools, which moved to remote learning for a significant part of the year)*	2,444

Health Visitors

The 0-19 Service comprises Health Visiting (0-4 years old) and mainstream School Nursing (5-19 years old), and delivers the Health Child Programme, including mandated checks from pre-birth to age 2.

In October 2020 the service transitioned from BEH-MHT to North Middlesex University Hospital (NMUH) under a Section 75 arrangement. This included a physical move of office staff to the Civic Centre.

The move also necessitated a change to some delivery sites. Delivery through Children's Centres remained and additional library sites were brought online to ensure coverage.

Commissioners are now working with NMUH to develop a skills mix model for future delivery and to implement an up-to-date IT solution using RiO.

The pandemic significantly impacted on the service's ability to deliver in person face-to-face contacts, and, as these have started to be re-introduced, certain limitations remain in place e.g. the need to social distance for NHS services has meant that open access clinics are not yet restored.

The majority of mandated checks are now back as face-to-face and this trajectory should continue.

Indicator	2020/21	
	Value	Target
PH002c New Baby Reviews completed (10-14 days after birth)	**99%**	92%
PH002d Percentage of 2-2½ year reviews completed	**68%**	50%
PH002g 6-8 week checks Delivered by Health Visitors	**46%**	59%
PH002x Antenatal contact at 28 weeks gestation or above	25.7%	No target
PH002y 12 months review completed by 12 months old	**43%**	63.7%

Update on Children and Families Priorities & Progress Andrew to update

55. 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
56. Below are the current priority areas that are supported by the Children's commissioning team:
    - Implement recommendations from public health approach needs analysis to Serious Youth Violence and aligning to all key strategies and action plans
    - Deliver on the Early Help for All Strategy action plan – 3 workstreams supported
    - Review the strategic and operational domestic abuse response across the Council
    - Review of Parenting Programmes delivered across services to strengthen the offer
    - Develop Trauma Informed Practice programme with schools
    - Re-commission the Children's Centre programme for 2024
    - Maximise take-up of 2-, 3- and 4-year-old early education, aiming to reach the national average.
    - The development of additional SEND provision including:
        - the opening of a new SEMH school for 70 secondary aged pupils at Salmons Brook
        - the provision of an additional 40 places at Durants
        - additional provision for West Lea School at the Swan Centre
        - the provision of up to an additional 5 ARPs and specialist units
        - Review of the Education, Health and Care Plan application process to include a redesign of the SEND service
    - Implement the SALT and Autism provision as funded by the HNB and agreed by Cabinet
    - Increase availability of meaningful employment, education and training opportunities for learners with SEND
    - Develop the strategic approach to pupil place planning to create a system able to meet demand for SEND and reduction in primary school place numbers.
    - Review of transition pathways
    - Deliver Inequalities fund projects
    - Develop and implement the new SEND Strategy
    - Management plan to address High Needs Block overspend position

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Agenda Item 6

MUNICIPAL YEAR 2021/22 - REPORT NO.	

MEETING TITLE AND DATE **Health and Wellbeing Board** **2nd December 2021**	**Agenda - Part:** | **Item:** **Subject:** **Progress update: Development of North Central London Integrated Care System and Enfield Place Based Partnership – Progress Update** **Wards: All**
Frances O'Callaghan, Designate Chief Executive for the North Central London Integrated Care Board **Deborah McBeal, Director of Integration, Enfield Borough Directorate, NCL CCG and Stephen Wells, Head of Enfield Borough Partnership Programme Enfield Borough Directorate, NCL CCG**	**Cabinet Member consulted:**
Contact officer - Stephen Wells **Telephone number**: 0203 688 2874 **Email**: stephen.wells6@nhs.net	

1. EXECUTIVE SUMMARY

This report provides the Health and Wellbeing Board with an update relating to:

1.1 Update on developing the North Central London Integrated Care System (ICS)

The attached slide deck summarises:

- The core purpose of an Integrated Care System and what the Integrated Care System means for our residents in the future delivery of person-centred care
- Building on the strong NCL partnership foundations to form the future ICS
- NCL Integrated Care System: our vision and principles including the work to tackle health inequalities and the programme of work in 2021/22
- Governance and structures of the NCL Integrated Care System including the pace based partnerships in each borough
- Building resident and community voices at the heart of our ICS and Community involvement and representation at both an Integrated Care System and Borough Partnership level

1.2 Progress Update - Enfield Borough Partnership in 2021/22

The attached slide deck summarises:

- Revised programme structure for the borough partnership in 2021/22
- Preparation for workshops in early 2022, to inform the transition to the borough partnership from April 2022, informed by the development of the NCL Integrated Care System
- Continued progress by the Initiative Working Groups - Mental Health, Inequalities, Screening & Immunisation and Access to Services, Recovery & Innovation).

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- Note the progress update for the development of the North Central London Integrated Care System informed by the presentation including the communication and engagement with all stakeholders and local communities and residents planned at both an NCL Integrated System level and in each of the five borough partnerships.
- Note the progress update for the Enfield Borough Partnership in 2021/ 22 including the preparation of for future workshops in supporting the transition towards a Borough Partnership under the new NCL Integrated Care System from April 2022 and the associated Initiative Working Groups (Mental Health, Inequalities, Screening & Immunisation and Access to Services, Recovery & Innovation).

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Update to
Enfield Health & Wellbeing Board
2nd December 2021

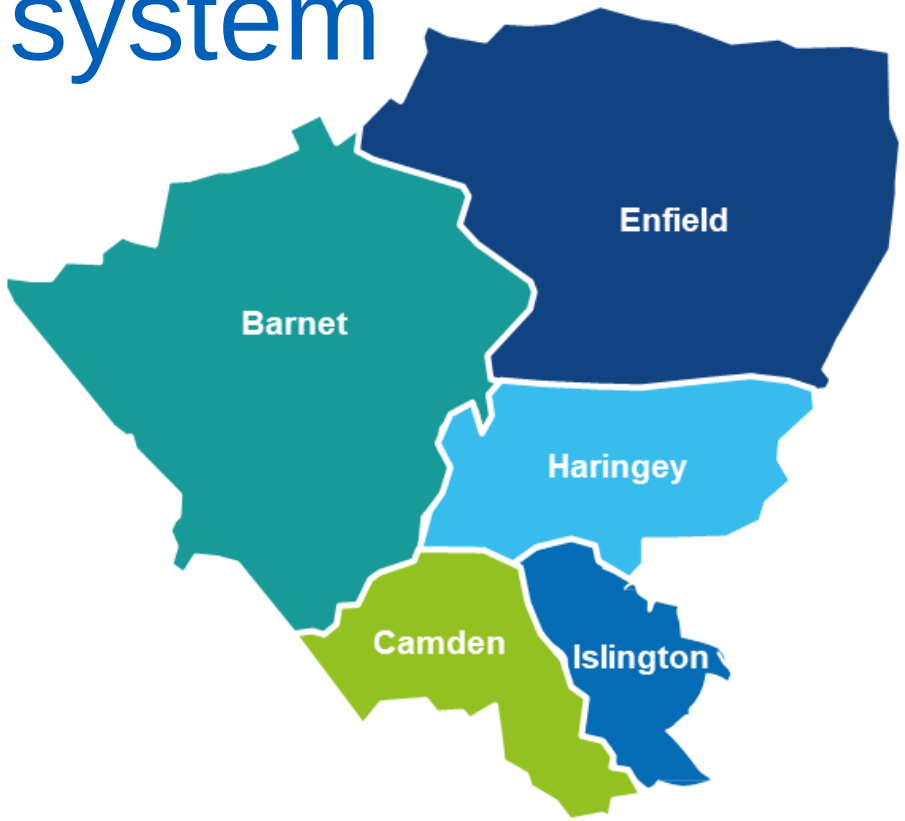
Developing the North Central London Integrated Care System

The North Central London population

- Around 1.6 million residents, with a relatively young population in some boroughs compared to London average
- Diverse population with historic high migration – from within UK and abroad; around 25% of people do not have English as their main language
- Higher rates of deprivation than some London areas, with pockets of deprivation across all boroughs
- Significant variation in life expectancy between most affluent and most deprived areas
- Approx. 200,000 people in NCL are living with a disability

[1] Index of Multiple Deprivation, 2019

The North Central London health and care system



- 12 hospital trusts
- 5 local authorities
- One clinical commissioning group
- 200+ general practices
- 300+ pharmacies
- 200+ care homes
- Countless voluntary sector organisations and community groups providing essential care

[1] Index of Multiple Deprivation, 2019

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Building on strong NCL partnership foundations to form our ICS

The formation of Integrated Care Systems (ICS)

- The NHS Long Term Plan committed to delivering Integrated Care Systems (ICSs) across England by April 2021, to build on the lessons learnt and good work carried out by Sustainability and Transformation Partnerships (STPs).

- Integrated Care Systems (ICS) are a new form of partnership between organisations that support the health and wellbeing of local communities. Partners include the NHS and local councils alongside voluntary, community and social enterprise sector organisations

- In April, the Department of Health and Social Care published a White Paper (February 2021): *'Integration and Innovation: working together to improve health and social care for all'*.

- Government and Parliament will establish ICSs in law and remove legal barriers to integrated care for patients and communities. Decisions on legislation will be for Government and Parliament to make.

- From 1 April 2022, Integrated Care Systems (ICSs) will become fully operational as statutory organisations responsible for strategic commissioning, with a financial allocation set by NHS England. In North Central London, our ICS will operate in shadow form this financial year.

The core purpose of an Integrated Care System

- The core purpose of an Integrated Care System is to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - help the NHS to support broader social and economic development.
- Each ICS will have a responsibility to coordinate services and plan health and care in a way that improves population health and reduces inequalities between different groups.
- This way of working closely reflects how the NHS and Councils in North Central London have already been working together in recent years, to improve our population's health and reduce inequalities through greater collaboration.

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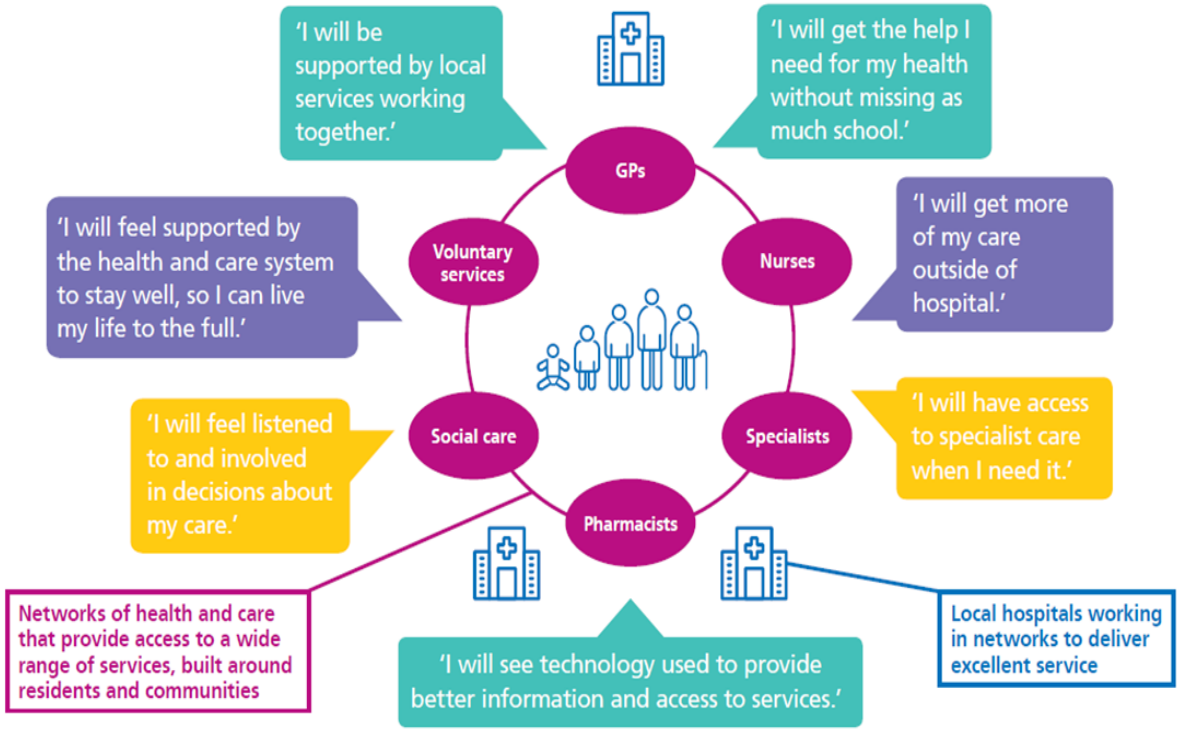
What will this mean for residents?

Faster progress towards what residents have told us they want from local services:



And an increased system-focus on the wider determinants of health and wellbeing:

- Fulfilling work
- Education and skills
- Our surroundings
- The food we eat
- Money and resources
- Transport
- Housing
- The support of family, friends and communities

Building on strong foundations in NCL

- Whilst ICSs are new statutory organisations, we have a track record of close working between partners, NHS and LA, through the STP and other collaborative programmes of work.
- In April 2020 the five Clinical Commissioning Groups in North Central London (NCL CCGs) – Barnet, Camden, Enfield, Haringey and Islington – merged to form one CCG.
- We have strong partnerships already formed in each borough to support working at a ‘place’ level
- Alongside this, we have 33 thriving primary care networks across the area.
- Over the last year system partners have worked closely together, with the CCG, Councils, NHS providers, general practices, voluntary and community organisations, working to respond to the pandemic.
- There has been continued progress towards a more strategic approach to health commissioning at NCL-level, and within our borough partnerships.

Building on strong foundations in NCL

- The new legislation will mean the NHS moves away from the current way of planning and paying for healthcare.
- In the current system NHS hospitals were encouraged to compete with each other to provide the best care possible.
- This improved quality, but has meant it is harder to move money to prioritise prevention.
- The new way of working will support more collaboration and joint planning between NHS organisations with the aim of both improving quality and investing in preventative and proactive care.

Building on strong foundations in NCL

Responding to the Covid-19 pandemic has accelerated, and consolidated, ways the system worked together to deliver for residents. Acting like an ICS already in many ways:

- **Innovative approaches to patient care -** pulse oximetry led by primary care and virtual wards led by secondary care to avoid Covid patients' admission to hospital and early discharge where appropriate
- **Accelerated collaboration -** single point of access for speedier and safe discharge from hospital to home or care homes; development of post-Covid Syndrome multi-disciplinary teams to support patients
- **Mutual planning and support -** system able to respond quickly to a significant increase in demand for intensive care beds
- **Smoothing the transition between primary and secondary care -** increased capacity for community step-down beds to ease pressure on hospitals
- **Sharing of good practice -** clinical networks to share best practice and provide learning opportunities
- **Clinical and operational collaboration -** Ensuring consistent prioritisation across NCL so most urgent patients are treated first

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Benefits of forming an ICS in North Central London

Improved Outcomes

Enable greater opportunities for working together as 'one public sector system' – ultimately delivering improved patient outcomes for our population

Working at Place

Support the further development of local, borough-based Care Partnerships and Primary Care Networks

Reduce inequalities

Identify where inequality exists across in outcomes, experience and access and devising strategies to tackle these together with our communities

Efficient and Effective

Help us build a more efficient and effective operating model tackling waste and unwarranted variation.

New Ways of Working

Accelerate our work to build new ways of working across the system to deliver increased productivity and collaboration

Economies of Scale

Help us make better use of our resources for local residents and achieve economies of scale and value for money

System Resilience

Help us become an system with much greater resilience to face changes and challenges to meet the needs of our local population by supporting each other.

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NCL Integrated Care System: our vision and principles

Our ICS purpose: To improve outcomes and wellbeing, through delivering equality in health and care services for local people. **Supporting them to Start Well, Live Well and Age Well.** We also want to support the many local people who are employed by health and social care to **Work Well.**

Our Principles:

- We will work as one system to benefit the whole population of NCL and work together to drive health equality.
- We will retain the local patient, resident and clinical voice in the commissioning and delivery of health and care, by working effectively together at the three levels of our system.
- We will value our staff, our partners and their expertise to deliver the best health and care possible for the patients and residents of North Central London.
- We will work on a population health basis, planning for population needs as a system, and through local partnerships and neighbourhoods/networks.
- We will work to deliver joined-up care for our population planning around residents not organisations
- We will emphasise the value of subsidiarity, working as locally as is feasible whilst retaining strategic, effective commissioning for North Central London

We will be guided by a shared set of objectives (an 'Outcomes Framework'), setting out the difference we will make for the population in NCL and how we will be monitoring that we are achieving our strategic aims.

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NCL focus on tackling health inequalities

Restore NHS services inclusively	• Ensuring that all analysis undertaken in relation to the restoration of NHS services specifically considers equalities dimensions, including ethnicity and deprivation E.g. in our elective recovery and waiting lists, and community diagnostics hubs • Continuing to build up our population health management platform, HealtheIntent. In six months' time, we plan to have all acute and mental health trusts on HealtheIntent, alongside GPs and Royal Free that are there now. We will have also started onboarding community trust and adult social care data.
Mitigate against digital exclusion	• Commissioning an Equalities Impact Assessment report into the causes and contributing factors to digital exclusion, views from local stakeholders, the impact of Covid, and recommendations for action to address digital exclusion. • Establishing a pilot in Haringey, as a joint initiative with North Middlesex and the local Haringey ICP, that focuses on practical steps that can reduce digital exclusion for those already in the system, i.e. purchasing of hardware. • Prioritising digital exclusion in our most deprived wards through the utilisation of NHS Charities funding.
Ensure datasets are complete and timely	• Use of our population health management platform, HealtheIntent, to understand where care teams can make improvements in recording of equalities data. • System-wide audit on the use of "other" category in ethnicity data
Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes	• Ongoing work with NHSE/PHE to encourage commissioning and delivery of a more culturally and socially competent flu vaccination programme, with appropriate equity monitoring during the coming winter. • Using HealtheIntent for : Deploying a registry for physical health checks among people with serious mental illness, Developing a similar registry for learning disabilities, Deploying our registries for COPD, diabetes, childhood asthma and atrial fibrillation, and dashboards on population health needs, childhood immunisations, frailty and quality improvement for long term conditions. • Working closely with PHE as part of our ICPS, to identify key priorities and implement changes in line with national guidance and the recommendations of publications including Beyond the Data. For example, Enfield is focusing on their most deprived communities, and is jointly funding (with the local authority) community participatory research and community engagement to look childhood obesity.
Strengthen leadership and accountability	• A Population Health Management and Health Inequalities Committee has been established, led by our ICS Chair and with broad stakeholder engagement across local authorities, primary, community and acute services. The aim of this Committee is to embed a population health approach across the system, including a focus on reducing health inequalities.

Priority NCL ICS Programmes for 2021/22

We have defined 9 clinical and care priorities plus four enabler programme priorities:

Elective Recovery	Mental Health	Community/ Local Care
Urgent & Emergency Care	Children, Young People & Maternity	Primary Care Recovery
Cancer Alliance	Diagnostics	Social Care

+

- Estates
- Workforce
- Digital
- Corporate

Our **Clinical and Care priorities** focus on **tackling health inequalities** and improving the **overall quality of care for our residents through service improvement and transformation -** an integral component being **recovery of services to pre-pandemic levels** in an equitable manner .

Our **enabler programmes** help establish the foundation of a truly integrated care system, and contribute to **releasing system efficiencies** that strengthen our health and care system.

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Governance and structures of the NCL ICS

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Working towards an NCL ICS

Together, system partners are designing what our Integrated Care System (ICS) will look like at neighbourhood, place and system-level

Neighbourhoods build on the core of the primary care networks and **enable greater provision of proactive, personalised, coordinated and more integrated health and social care** through multidisciplinary teams taking a proactive population based approach to care at a community level.

Boroughs are the **critical point of integration and coordination of services**. All boroughs have a **strong sense of defined population being coterminous with local authorities**. The work at borough partnerships is focussed on bringing together partners **develop and coordinate services based on agreed outcomes.**

The NCL ICS will focus on activities that are better undertaken at an NCL level **where a larger planning footprint increase the impact or effectiveness** of these functions. It will also be responsible for **system planning,** towards our goals of reducing inequalities and improving health outcomes.

Core components of NCL ICS Governance

- There are some elements of system wide governance we will need to set up and implement to support the formation of an ICS. This is subject to legislation and further work locally on how these will work. These are set out below.
- Integrated Care will not just be at system-level but also within our boroughs, or at 'Place'.
- System partners will work together to confirm the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.

Integrated Care Partnership

Guidance to be issued by DHSC in September.

Responsible for developing integrated care strategy for whole population across partners in NCL

Forerunner of this in NCL: **Quarterly Partnership Council**

Integrated Care Boards (ICB)

Unitary (single) Boards to lead integration within the NHS.

Board membership to be outlined in legislation.

Forerunner of this in NCL: **Steering Committee**

Community Partnership Forum

Will bring together NHS, Healthwatch, local authority, VCSE and community representatives for strategic discussions.

Builds on work of the Engagement Advisory Board, established for the North Central London STP

Place-based partnerships

Functions to be exercised and decisions to be made, by or with place-based partnerships at a borough level.

ICB will remain accountable for NHS resources deployed at place-level.

All boroughs have partnerships in place

Provider Collaborative

Will agree specific objectives with one or more ICB, to contribute to the delivery of that system's strategic priorities.

NCL Provider Alliance forming with all providers and Primary Care as members

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North Central London's sustainability and transformation partnership

NHS

Clinicians at the heart of our NCL ICS

Future clinical leadership

- Clinical leadership will remain at the centre of the NCL ICS - at system, place and neighbourhood level
- Must reflect the multidisciplinary nature of an ICS, and the diversity of our population
- Continued need for primary care clinical leadership
- Setting objectives for effective partnership working between clinical and professional leaders, officers and system partners to provide high quality health and care for NCL patients and residents

Our clinical workforce

- COVID has made us think and act in a more integrated way, aiming to deliver the best care for our population
- Development of the North Central London ICS will build on the good work done to support staff throughout the pandemic
- We are looking at the possibility of having some NHS staff based across multiple sites, to manage the demand on the system
- Working together offers the opportunity to reduce duplication, learn best practice and learn from / teach each other

Our 5 Borough Partnerships: key features

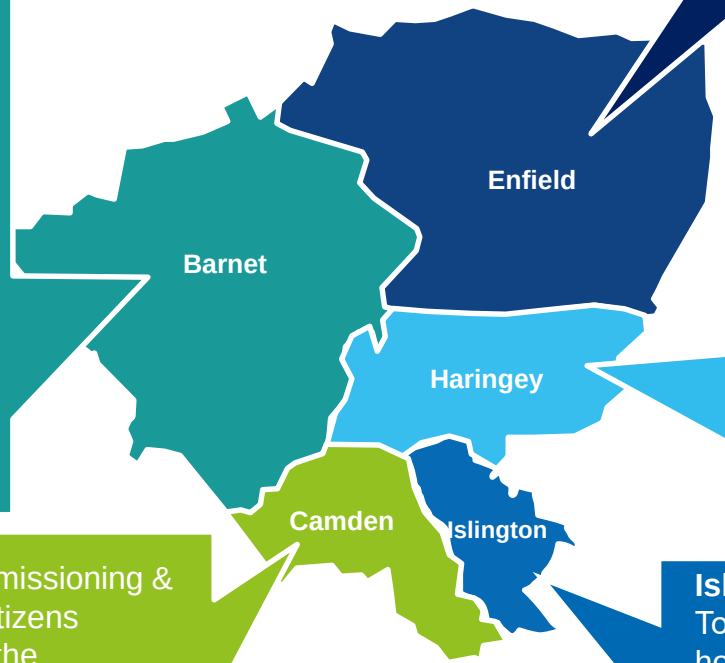
- Partnerships continue to mature locally. COVID and the acceleration of the ICS has enabled us to build on the foundations for partnership working in NCL.
- Place-based leaders are working together to shape the Borough Partnership role, priorities, local structures, core & wider teams and ways of working.
- There are common features but local nuances within each partnership.

Enfield – Borough Partnership Plan established in 2019/20 and the integrated working has accelerated during 2021/22. Four priority work-streams are well established and expanding with excellent collaboration including CVS organisations and Community & Resident engagement. A Provider Integration Partnership Group (chaired by Mo Abedi and Alpesh Patel) oversees delivery of all work-streams.

- 338,201 registered population
- 16+ 'organisations' represented (25+ members on Borough Partnership Board board)
- 4 PCNs (geographical and with neighbourhoods)
- Chair's Exec: Binda Nagra, (Council), Dr Chitra Sankaran (CCG)

Barnet - Significant NHS engagement plus strong community engagement & local govt. leadership. Older population gives rise to focus on proactive care, same day urgent care and support to remain independent. Cross cutting priorities include addressing health inequalities and enablers include co-production and engagement, neighbourhood model working and new governance workstream.

- 425,395 registered population
- 10 + 'organisations' represented (25+ members of delivery board)
- 7 PCNs
- Chair of Exec: John Hooton (Council);



Haringey – Established and ambitious partnership with strong relationships. Work is structured through partnership boards, start well, live well, age well and place – each addressing poverty, inequality, early health, prevention and responsive and accessible care.

- 298,418 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs
- Chair Exec: Zina Etheridge (Council), Siobhan Harrington (Whittington Health)

Camden – Long partnership history with integrated commissioning & integrated delivery models. Strong focus on CYP, MH, citizens assemblies & dialogue with families & communities and the Neighbourhood model. Focus is accelerating provider joint working at PCN and borough level and connecting communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of delivery board)
- 7 PCNs
- Chair Exec: Martin Pratt

Islington – Active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (incl. police, fire, housing). Senior leadership from Islington Council & CCG. Emphasises joint commissioning, operational joint working & expansion of locality level delivery.

- 257,135 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 5 PCNs
- Chair Exec: Dr Jo Sauvage (CCG) Kaya Comer-Schwartz, Cllr (Council)

Place-Based Partnership priorities

- Covid-19 and flu vaccine programme
- Tackling Inequalities: in outcome, in access, in experience, for deprived communities, for BAME communities
- Mental health and mental wellbeing – for all but especially population groups historically less engaged
- Community joint working and the voluntary and community sector (VCS)
- Health inclusion groups – homeless, asylum and refugee
- Children, Young People and families – support to deliver key outcomes and address the impact of the pandemic 20/21
- Access – inclusive, appropriate, timely – focus on specific groups e.g. people with learning disabilities, serious mental illness, refugees
- Digital inclusion/exclusion
- Wider determinants including employment and housing
- Priority outcomes and populations, including those groups at risk of disadvantage/worse outcomes during the pandemic
- Proactive and Personalised care in the community – including use of technology, expansion of social prescribing models
- Urgent community response – in particular joint working across primary, community and social care supported by VCS

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Building resident and community voices at the heart of our ICS

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Community involvement and representation

Health and Wellbeing Boards

Health and Wellbeing Boards are linked to all borough partnerships:

- Most boroughs have updated their Health and Wellbeing Board ToR to include a link to the Borough Partnerships.
- Cllrs are largely engaged through the HWBB although there is increasing interest in direct involvement.
- HASCs also regularly request reports on the development of integrated care locally.

Patient & resident involvement & engagement

Patient and resident engagement is being undertaken in different forms across borough partnerships:

- All partnerships have their local Healthwatch as members on their partnership groups.
- Some Healthwatch members leads on specific areas of focus/priorities within the partnership.
- Most ICPs have engagement groups (e.g. Haringey Citizen Health & Care Advisory Board, Camden Citizens Assembly, Islington conducts regular community engagement events).
- Some CCG borough teams also support a patient engagement forum, with resident and VCS representation.
- CCG Community Members sit on many of our committees and support wider engagement work.

Engaging the VCS

Voluntary & community sector organisations play a role in all partnerships:

- VCS is represented on all partnership groups across all boroughs. In some, VCS leads on priorities areas (for example MIND in Camden alongside CIFT).
- In all others they are “plugged into” the work and have played an increasingly significant role in delivery of partnership plans (social prescribing, mental health and wellbeing support, delivery of equipment, support to access services, support to comms campaigns such as flu).

Principles for communication and engagement

Effective communication and engagement across partnerships will be key to the ICS development and implementation. The key principles we will work to are included below.

Shape a programme of collaborative work between CCG, Council and Provider comms and engagement team – to build shared processes and ways of working for the future ICS, focused on:

- Building shared approaches to engagement, co-production etc.
- Models to bring together resource (staff and budgets) from across partner organisations
- Regular opportunities to share practice and make connections on engagement work across organisations
- Processes to centrally collect and report on insights to inform plans and decisions
- Shared evaluation models to demonstrate impact of engagement / community involvement
- Workforce training – develop skills to work with communities and VCSE, and build understanding that this is part of everyone's role in tackling health inequalities.

ICS Community Partnership Forum

- Established to oversee ICS resident engagement and involvement – to be aligned strategically with the ICS Quarterly Partnership Council and ICS Steering Committee.
- An expert reference group on community engagement as well as a forum for discussion and debate on emerging proposals and strategies.
- The Forum met for the first time in October 2021, and will meet quarterly.
- Current membership includes:
  - North Central London ICS Chair
  - North Central London Provider Alliance Chair
  - North Central London Executive Director of Strategic Commissioning
  - North Central London Executive Director of ICS Transition
  - Healthwatch representatives from the five boroughs
  - Council of Voluntary Services representatives from the five boroughs
  - Patient representatives from the five boroughs
  - Communication and Engagement reps from NCL Clinical Commissioning Group

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Community involvement and representation

Strong resident, patient and VCS involvement (at system, place and neighbourhood level) is critical. Over the next six months we will seek views, including the below areas of focus - from the ICS Community Partnership Forum, CCG Patient Public Engagement and Equalities Committee, Council Leaders, elected members, our Healthwatches and VCS, and wider audiences.

Ongoing Work to do at System-Level:

- Ensure transparent governance – public board meetings; resident, service user and carer representatives in governance etc.
- Developing shared principles and methods for involving people and communities, and co-production
- Capturing insights to build a picture of resident priorities and needs, and acting on this as a system
- Develop a shared approach to involvement / decision making with VCSE, supporting a resilient third sector

Ongoing Work to do at Place-Level

- Develop place-based partnership approaches on engagement and involvement, linked to ICS framework
- Ensure partnership links with HOSCs, HWBB, Healthwatch and VCSE sector are strong and effective
- Support Primary Care Networks and neighbourhood team links into communities
- Make every contact count to signpost residents to services and support

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Key stakeholders

Organisation	Stakeholder group
North Central London CCG	Governing Body, Executive Management team, Extended Executive Management team, Clinical Leads, union reps, all staff
Local authority (Barnet, Camden, Enfield, Haringey and Islington)	Council leaders, Chief executives, health and social care leads, Directors of adult social care / services, directors of public health, directors of children's social care / services, comms leads, council staff
NHS providers (incl mental health trusts, acute trusts and community trusts)	Chairs, Chief executives, Chief operating officers, Medical directors, nursing leads, comms leads, Trust staff
Primary care	LMC, Federation leads (chairs / chief execs / chief operating officers), PCN clinical directors, GPs, practice managers, practice staff
Cross-cutting groups	Health and Wellbeing Board representatives, Joint Health Overview and Scrutiny Committee members, borough Health Overview Scrutiny committees (HASC / HOSC)
Elected members	MPs (x 12); Councillors
VCSE	Healthwatch (x5) – Chief executives, Chairs, comms leads; NHS charities; VCSE organisations aligned to priorities (including but not limited to): mental health, children and young people, aged care and ageing, long term conditions; cancer; maternity and women's health
Patient / resident groups	Resident health panel, CCG patient groups (organised by borough), strategic review reference groups, Trust patient reference groups, Council patient reference groups, VCSE groups

Barnet, Camden, Enfield, Haringey and Islington residents and communities

If you have a question about our transition to an Integrated Care System in North Central London, please contact us at northcentrallondonics@nhs.net in the first instance.

Enfield Integrated Care Partnership

Progress Update to Enfield Health & Wellbeing Board

2nd December 2021

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

What next for Borough Partnerships?

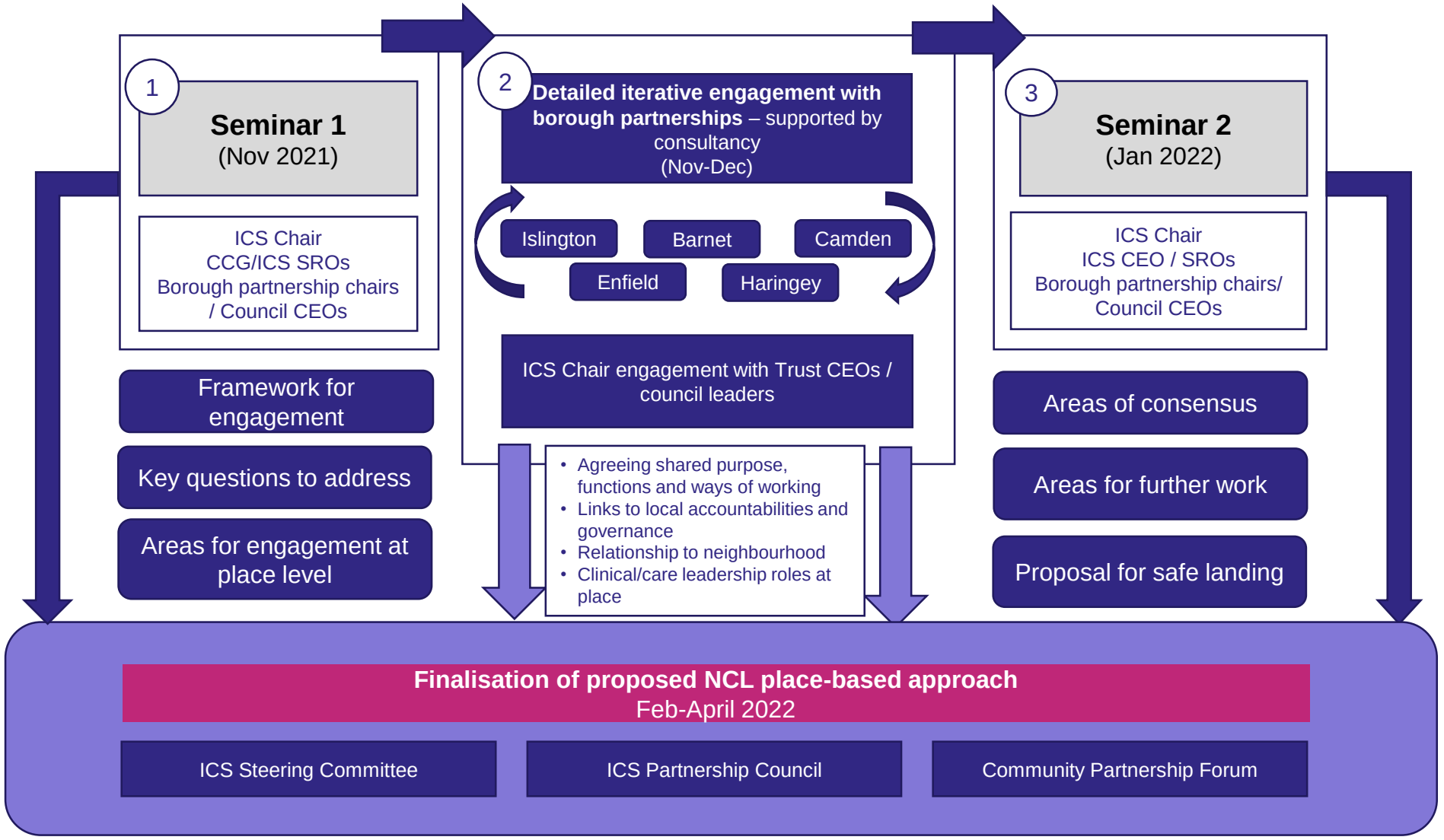
Place based design work

- Leadership Centre and Traverse have been commissioned to support each borough with place-based design and ongoing development of partnership working locally.

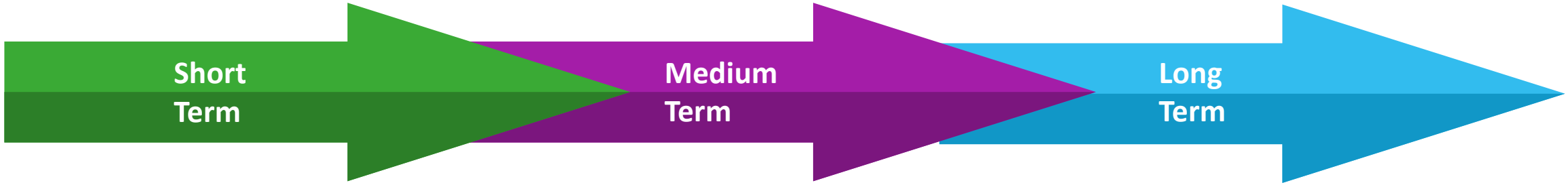
- The programme of work aims to support place-based partnerships to:
  - Articulate the role of Borough Partnerships within the NCL ICS
  - Confirm local models and approaches
  - Capture individual and collective responsibilities to residents/patients, staff, each other and the system/ICS
  - Link the above to local accountabilities and governance, with a view on how this might work in practice from April 22 and beyond, with due regard to the interface with ICS structures
  - Manage the different identities members of partnership might have within place and system

- Key questions for place-based partnerships will include:
  - What do place-based partnerships become post COVID & as we journey into the ICS?
  - What accountabilities do we expect to hold at place and what decisions do we expect to take together? Is this the same/different for all partners?
  - What does a high functioning borough partnership look like?
  - What is the role of place in population health?

The role of place in NCL: Setting out the roadmap to consensus (Oct 2021-April 2022)



Opportunities 21/22 and beyond



Short Term

- Partnership development
- Streamline strategies and plans and set scope for borough partnerships
- Communication & engagement

Medium Term

- Cross-borough partnership working
- Refine and develop Population Health approaches & OD

Long Term

- Estates & Infrastructure
- Integrated workforce plans and models

ENABLERS

Refine and develop approaches to oversight and accountability locally at Place and Neighbourhood

- Oversight of delivery
- Monitoring of impact and outcomes
- Operational oversight and clinical governance for integrated delivery
- Defining place and neighbourhood

Enfield Borough Partnership Board Meeting

Proposal to Support the Transition Towards a Borough Partnership

Bernie Brooks
(The Leadership Centre & Traverse)

Purpose of the Proposal

- Agree a process to progress the ambitions of Enfield Borough Partnership
- Build on the successes and development work to date
- Identify and address emerging challenges as a Borough Partnership
- Respond to patient and citizen needs
- Consolidate partnership working founded on trust and respect
- Deliver on the Enfield priorities
- Engage stakeholders collaboratively using co-design etc.
- Support the covid recovery process and innovation
- Influence cross Borough and broader NCL development

Building on Existing Developments

- Extensive stakeholder engagement process in Summer 2020
- Production of agreed Enfield BP Plan September 2020 - built on clear principles and purpose
- Identified four priority Enfield initiatives, workstreams and sub-groups
- Emerging governance and delivery structure within an overall BP architecture
- Foundation of community and stakeholder engagement, collaboration, and co-design

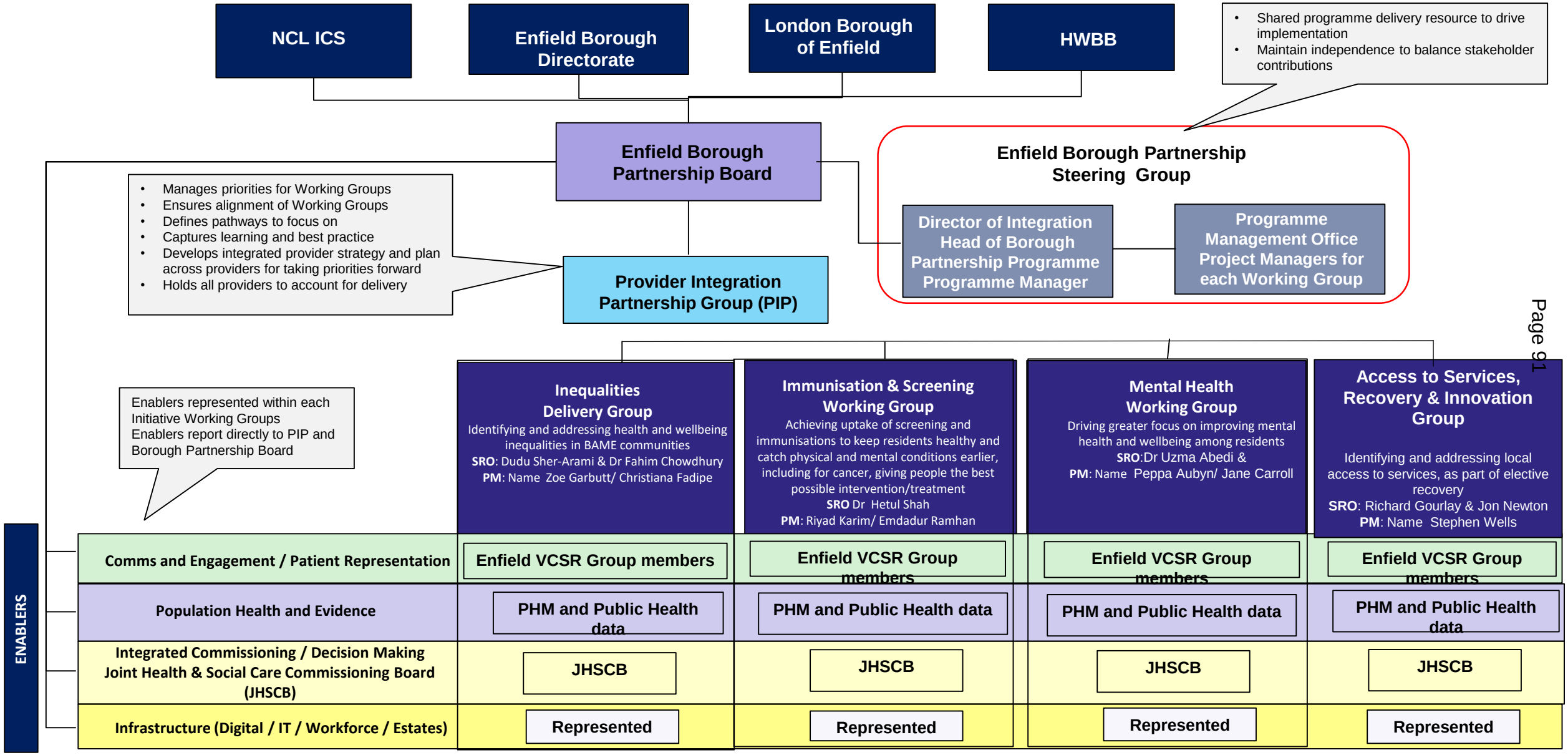
Proposed Development Work

- Robust diagnostic process over next four weeks using existing fora and individual and group conversations with wide cross section of stakeholders
- Use outcomes from diagnostic process to plan and convene a series of workshops in early 2022
- Focus of these likely to include; ambition of the BP, delivery process of priorities, governance, funding, leadership, roles and relationships of partners
- Themes will also feed into other work taking place on cross-Borough development and the relationship between Boroughs and the ICS
- Process will be collaborative, iterative and engaging

Questions

1. What, from your perspective, are the key issues that need to be focused on to progress the integration agenda in Enfield?
2. What are the main barriers to doing this both within the Borough and in the wider ICS?
3. How can we ensure maximum engagement from stakeholders in the process?
4. Are there methods other than workshops that we should consider using?
5. Are there common issues across the Boroughs that we can collaborate on or influence?

Enfield Borough Partnership Programme Structure 2021/22



Enfield Borough Partnership Priorities 2021/ 22

Partnership Priority outcomes

1. Achieving screening and imms uptake
2. Identifying and reducing inequalities where they exist
3. Improved mental health outcomes
4. Improving access to services, recovery from COVID and innovation

Wider Partnership Working

- Access to Services, Recovery & innovation inc. Collaboration with RNOH to develop MSK services on the High Street proof of concept pilot
- Long Term Conditions Programme inc. GP Federation/ PCNs with CVS organisations i.e. Enfield Voluntary Action and Health Champions,
- Enfield Joint Health & Social Care Commissioning Board – focus on Adults & CYP, Mental Health, LD, SEND, Better care Fund and Section 75 priorities
- Flu and Covid Vaccination Programme – multi-organisational approach involving All Borough Partnership stakeholders
- Key enablers: Estates, workforce and IT/ Digital

Core Projects

- Mental Health - developing community integrated mental health pilot in SE Enfield
- Inequalities - childhood obesity and community participatory research
- Access to Services, Recovery & Innovation – identifying where the Borough Partnership can support improvement in local access to services i.e. primary care
- Screening & Immunisation Uptake - including national cancer screening programmes, Childhood immunisations, flu and Covid

Enfield Integrated Care Partnership

Access to Services, Recovery & Innovation

Developing Communication material for local residents

Primary Care Access - Developing communications and engagement materials for local residents: Key Themes – Update November 2021

1. **Valuing the primary care workforce** – abuse of staff is increasing across health and social care. NCL CCG has adopted Leeds CCG campaign on abuse. Resources have now been sent out to member practices. There is a further primary care access campaign under development looking at promoting new workforce roles, explaining new methods of access, how to give feedback to your practice etc. We will be involving patient representatives in the development of campaign materials.

2. **New Primary care estates –** We are developing proactive communications about new premises in Enfield including the Alma Road development and White Lodge Medical Practice. During the pandemic, primary care has not only been working very hard but also developing and planning for the future. By showcasing these new buildings, we will be able to demonstrate the investment and commitment of GP practices to the health of our local population.

3. **Access Case study –** The Communications and Engagement team is working with Enfield practices to develop a case study explaining how member practices are listening to feedback and improving access for patients – particularly around telephone access**.**

4. **PPGs –** Enfield's PPG chair Litsa Worrall and the PPGs will be leading on a piece of work supporting member practices and patients around access. We are currently in the planning phase for this project, with potential funding from the Communities directorate (bid in progress).

5. **System recovery** – We continue to promote messaging around accessing the first appointments offered to you whether that is for elective care at a different site or your flu jab. It's important that patients make their planned appointments and contact the NHS as soon as they know they cannot. We are working with community groups e.g. the Over 50s forum to get these messages out.

6. **Covid** – Covid hasn't gone away and it's important that patients do not attend appointments with symptoms, unless asked to by a clinician and wear masks on NHS premises. We will be working with community groups to promote this message as well as explaining how the NHS continues to keep patients and staff safe (e.g. cleaning between appointments and social distancing).

7. **NCL winter resilience communications and engagement plan –** The plan has been circulated. We will be promoting all national NHS campaigns and are at the early stage of developing local campaigns. Each borough is also currently considering local engagement activities to support winter messaging targeted at key populations across all the NHS campaigns e.g. flu, Covid-19 vaccine, appropriate point of access. This group will receive a report of planned activity at the next meeting.

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Winter resilience

Communication and Engagement plan Autumn/Winter 2021/22

Campaign overview

Our ICS strategic vision is to provide high quality health and care services to support local people to ‘Start well, live well, age well and work well’. As we prepare for what is likely to be another challenging winter, there remains significant pressure on NCL services, alongside a need to maintain elective care, continue to vaccinate local people against Covid and flu and provide routine and emergency care.

We will deliver an integrated communications and engagement programme to support residents, patients and health and care workers stay well and to access care in the right place at the right time.

National campaigns (Winter, vaccine) will be tailored for North Central London. Building on the success of the Covid-19 vaccine work to date, a partnership delivery model is envisaged - with the CCG, NHS provider and Council communications and engagement teams working collaboratively.

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Campaign focus

Focus on building **confidence** in all NHS services ('NHS is Open') and NHS staff (including 'Respect' messaging)

Reduce **health anxiety** overall with positive health and wellbeing messaging

Promote **immunisation as best way to protect** against flu and Covid (build confidence, drive uptake)

Promote **self management and self-care** where possible to stay well and prepare for winter

Promote appropriate **point of access** - encourage everyone to seek the right care

- Clear offer for alternatives to A&E/UTC –111, Extended Access Hubs, SDEC, WICs
- Prioritise frequent attenders – parents, respiratory, mental health service users.
- Manage expectations/timing when A&E particularly busy – plan for escalation/incidents
- Encourage people to seek care when needed – e.g. cancer, paediatric conditions.

Provide reassurance around **recovery narrative** - remind of work to maintain elective care, reduce waits and increase capacity

Encourage **longer term behaviour change** through using digital, where appropriate, (NHS 111, 111 online, telephone and video appointments).

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Developing local comms assets

- We will ensure our messaging is aligned to and complements national campaigns such as ‘Help Us Help You’, ‘Catch it, Bin it, kill it’, ‘Stay well this winter’, ‘Boost your immunity this winter’, ‘NHS 111 First’

- We will develop local assets that align with national materials
- We will reuse local assets from last year, such as the flu animations: https://conversation.northlondonpartners.org.uk/flu-season-2020/
- We will use local insight to tailor messages and are currently running an attitudinal survey
- We will analyse local data to ensure we are reaching out to the communities where uptake of vaccines is low [or where there may be hesitancy
- We will seek clinical and operational input to guide messaging
- We will undertake evaluation and monitoring throughout the campaign. This will allow us to be flexible during campaign delivery to ensure opportunities are created and exploited.

Appendix A

Enfield Borough Partnership

Health and Wellbeing Board

FOR INFORMATION ONLY

Highlight Reports for October 2021:

Mental Health
Inequalities
Seasonal Vaccination
COVID Vaccination Inequalities

The Enfield ICP Mental Health Steering Group: October21

ICP MH Steering Group Agreed Priorities	ICP MH Steering Group Agreed Priorities (Cont.)
Strengthened Governance ICP Sub group meetings continue to maintain a firm engagement as a forum to address key priorities and focus. Additional workshops planned to support: Co-production, collaboration development on key population segments across primary and secondary care alongside, caseloads and hub structure. Review of meeting agenda and attendees completed 15th Oct. **SOP (Standard Operating Policy)** Development of SOP for the community teams which will incorporate the VCS pathways and is iterative process as we progress the Co-production with partners. First draft complete and share with partners for review. Involvement of partners with clinical pathways development ongoing. Planned Persona's workshops expected to take place in end of October. **Clinical Pathway Development** First draft of Co-production clinical pathway (EIS, Recovery College and front door/ Personality Disorder Therapy / CRT PH/ SM Substances / Mental Health Service for Older People) is completed, with next steps to invite further stakeholder feedback. Pathway presentation to wider audience with Service Users, Carers, VCS and PCN Clinical Directors expected in November. **Early intervention in psychosis** Ongoing reviews of EIP services to support actions and development trajectory to achieve level 3.	**Staffing/ Recruitment** The Trust is continuing to recruit for the new core teams. Enfield recruiting additional 34 posts to support core functions through transformation programme. Currently 9 posts have been recruited, 7 under offer and 20 posts currently in the recruitment stage. VCS posts in recruitment stage. **ARRs roles** ARRS attracted 12 application, with offers to 3 candidates made. Start date pending. **VCS Tender** Ongoing regular Mobilisation meeting with lead VCS partner MIND (supported by EVA, Enfield Saheli and Alphacare). New VCS JDs agreed with partners. Communication Plan under review. Discussion and agreement on staff location and induction process to be firmed up in November. **KPI and Outcome** Ongoing review of and implementing KPIs which would be signed off by BEH and NHSI. Progress update will be shared with the ICP steering group shortly. **Community Asset Mapping** Asset mapping (Enfield Borough wide Mental Health service) complied by clinical project lead and shared with ICP partners. Asset mapping to compliment the Council's directory of mapped the local contracted offers.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	None at present

Risk/Issues	RAG*	Mitigating Actions
1. Engagement with clinicians, staff, public	At Risk	Enfield continued excellent comms support with an interactive approach to support staff involvement and programme roll out. Additional support provided to the borough by OD lead.
2. Ongoing pressures/challenges re resourcing and operational pressures	At Risk	Continued prioritisation of programme plus additional support. 1 x PMO support and 1 x Divisional Clinical PM 8a in post. Borough sub-structures focussed.
3. Incurring significant recruitment challenges	At Risk	Recruitment strategy ongoing

Mental Health Steering Group: October 2021

NEXT KEY MILESTONES

MH Steering Group	Milestone / product	Due date	RAG Status
PCN led proposal to improve SMI health checks	PCN/ Federation led proposal to improve SMI health checks that provides outreach and targets hard to reach group commenced on 26th of April. KPIs have been agreed and we will develop an evaluation to test outcomes achieved. The pilot is currently being evaluated. High level outcomes are that there has been a 29% improvement in uptake of health checks and 93% satisfaction rate during the pilot reporting period. The Pilot has been extended for the remainder of 21/22.	Mid April	
	NCL MH ICS Board has agreed commissioning arrangement for 21/22 and funding placed under the CCG Single Offer Framework. KPIs and outcomes are being agreed as part of the evaluation process; agreed that as a minimum the LTP target will be achieved and we will strive to increase uptake of hard to reach groups; those that have not engaged within the last 12-24 months, EIP and Wellbeing Clinic cohort.	July	
Procurement for Enablement under MDT model	VCS provider onboard, with MIND as lead partner in collaboration with EVA, Enfield Saheli and Alphacare. Mobilisation meeting ongoing on regular basis.	October	
	Next steps are to devise workforce model at PCN level and agree co-location of Multi-Agency Teams. Including IPS employment support services for SMI cohort	November	
Continue to develop new model of care for the Enfield Community Framework	Via Steering Group and sub groups with continuous input from the NCL Community Framework Steering Group . Focus is on whole person care which means moving beyond secondary caseloads to review SMI population needs. Steering group and sub-groups co-production of access to services, referrals and interfaces first draft completed. Service Users and partners review expected in November.	November	
Dialog /+ Development	Enfield has trained four Dialog + leaders in the pioneering Core Community team. Two training session undertaken. Following slippage of installation on system of device, activation of account, piloting of system with three staff and five service user each is underway with feedback expected in November.	November	

Enablers: Areas for Consideration	
	The NCL Mental Health Service Review
	NCL Community Framework Steering Group and Core Offer development

The Enfield ICP Inequalities T&FG: September 2021

ICP Agreed Priorities	Impact of COVID
Governance The Delivery Group met in October. Regular attendance at VCS Reference Group which has improve engagement by extending meeting invitation to smaller organisations and coproduction of inequalities work. Governance was established for the inequalities group to hold other ICP work streams to account around inequalities. Also, continue to working on a series of events with the VCS around wider determinants that will feed into the ICP programme. **Inequalities Fund phase 1** Overall good progress are being made on the seven bids with a total of £652,156 were approved. Schemes are now being mobilised. Development of MOU and STW are underway. Will develop Inequalities evaluation methodology with an academic partner **Inequalities Fund phase 2** Further funds are available for schemes to the end of March 2023, VCS engagement workshop to develop bids. Membership of VCS meeting in September was expanded to ensure full representation by all stakeholders. Bids to be reviewed at Delivery Group in October finalised early November. Worked with ICP programme lead and organised ICP engagement to sign off of bids. **Inequalities Programme** Enfield Council have commissioned community participatory research to provide insights for the community health champions and community chest. Steering groups for the programmes took place in October. Successfully awarded funding for NHS Charities Together Grant £700k that will be spent across the boroughs of Enfield and Haringey in view of the higher deprivation and health inequalities in those areas.	Inequalities exposed and experienced through covid has informed the programme of work of this work stream. The inequalities fund phase 2 will further consider the impact of covid for example opportunities for local employment.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	None at present

Risk/Issues	RAG*	Mitigating Actions
1. Delays in confirmation of funding for inequalities schemes will delay delivery	At Risk	CCG in communication and reassurance to all leads. Formal confirmation due mid-November .
2. Ongoing pressures/challenges re resourcing and operational pressures	At Risk	Continued prioritisation of programme plus additional support from communities team.

Highlight Report: September 2021

NEXT KEY MILESTONES Workstream	Milestone / product	Due date	RAG Status
Clinical Governance	Dr Fahim Choudhury will provide clinical input and leadership of the programme (co-chair)	Complete	G
	Inequalities Delivery Group to be set up	Complete	G
Inequities fund phase 1	Mobilisation plans completed	Complete	G
	Begin implementation of schemes	Ongoing	Amber
Inequalities fund phase 2	Arrangements for the launch of phase 2 in progress	Ongoing	Amber
Childhood obesity and Community Participatory Research	Continue implementation of Health Champions programme	Complete	G
	Begin implementation of Community Participatory Research (delayed procurement has led to delayed start)	Ongoing	Amber

Priorities for next month	
1	Communication and reassurance to all leads. Formal confirmation regarding phase 2 due mid- November .
2	Mobilisation of Community Participatory Research
3	Meeting of the Inequalities Delivery Group to review mobilisation of inequalities schemes and programme for the inequalities fund phase 2.

Enablers: Areas for Consideration	

Seasonal Vaccination Programme: October 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
Achieve National Flu Target: Over 65s – 75% Under 65s at risk – 55% Pregnant Women – 55% 2/3 year olds – 50% Actual Performance 2020/21 : Over 65s – 73.0%, Under 65s at risk - 45.1%, Pregnant Women – 26.8%, 2/3 years olds – 48.7%	Increased target to 75% across all cohorts Additional 50-64 cohort Services delivered in covid compliant facilities/ increased time to deliver vaccine.

Risk/Issues	RAG*	Mitigating Actions
1. Pregnant women flu uptake in Maternity units below target	R	NCL below target. Engaging with Maternity Departments on recovery plans
2. Failed EMIS data extractions (no metrics supplied by Immform till further notice)	R	Managed by NHS England
3. Supplier Vaccine delivery delays	R	National Stock coming online for under 65s cohort

*RAG status based on Likelihood & Impact

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Engage Acute Maternity providers to improve flu uptake amongst pregnant women.
2	

Highlight Report: October 2021

NEXT KEY MILESTONES Workstream	Milestone / product	Due date	RAG Status
Clinical Governance	Dr Hetul Shah, Dr Fahim Choudhury will provide clinical input and leadership during the seasonal programme.	Ongoing	G
NCL Committee Sign off	Not Applicable as National Programme determines service delivery.		
Implementation in primary care		Quarter 3 2021	G
Implementation in secondary care		Quarter 3 2021	G
Go live		**Quarter 3 2021**	**G**

Priorities for next month	
1	Roll out of national stock ordering process, liaising with providers for mutual aid.
2	Maternity plans update
3	Review of co-administration.

Enablers: **Areas for Consideration**	Support from Health Inequality group to support hard to access cohorts Support from ICP to access maternity cohort.

Highlight Report: October 2021

Develop Immunisation & Screening programme	Set up of Flu Task and Finish Group following release of National Flu Letter. Review lessons learned with PCNs by May 2021 and preparation for 2021/22 seasonal flu vaccination.	Date June 2021 Completed
	• Agree approach to improving flu uptake by patient cohort groups informed by 2020/21 position and work towards national target of 75%. • Continued commissioning of 2/3 year children Flu LCS via the Enfield Single Offer. • Working with Maternity services to improve flu uptake amongst pregnant women. • Reporting monthly commences from September onwards through to March - delayed • Continued use of Healthentent to support work targeting hard to reach groups and identify additional cohorts with low uptake - delayed	Date June - September 2021 Ongoing
PCN engagement	Work with national programmes, to align resources and support flu uptake, in addition to enhanced services in GP Contract.	Date : Ongoing
100 Day Plan	To develop a 100-day plan to: a) Implement a pre-seasonal task and finish group to plan for the flu season; Updates to be included with Covid inequalities group b) Review acute maternity mums to be recovery plan with NMUH; c) National Stock being made available ordering from 18/10/2021; d) Clarify changes in vaccines eligible for reimbursement by the NHS, in particular aTIV changing to aQIV vaccine; confirm whether children are eligible for QIVc/e on non clinical grounds (i.e. porcine); - **Confirmed QIVc eligible for those opposing nasal spray but providers are requested to order supplies from Immform for this batch: Flu poster** 2021382 Flu vaccines for the 2021 to 2022 season poster - Health Publications e) Complete a NCL communication and engagement project request form to enlist NCL communications resources for the flu programme.	Date June - August 2021 a) Completed b) In progress c) Ongoing d)Completed e)Completed

COVID Vaccine Inequalities: Oct 2021 [See also, Appendix A for further info] Page 1

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
(National target) At least 75% coverage for all JCVI cohorts – including health, social care and care home staff • Overall uptake in over 12s = 64% - second in North Central London after Barnet at 68% • 96% of care home staff are now vaccinated with at least one dose, 93 of 2,160 care staff not vaccinated – all need to be fully vaccinated by 11 Nov • Higher than 75% uptake in all cohorts above 50s • Higher than 75% uptake in all over 12s in Highlands, Grange and Town	NA
(Aligned to NHSE Local Borough Plan submitted and agreed March 2021) Aspiration of 95% vaccine coverage for all JCVI cohorts	NA
Limit inequality in vaccine uptake between areas of high and low deprivation, different ethnic groups, Under 40s and other groups experiencing deprivation (e.g. GRT, Black African and Caribbean, homeless)	NA

Risk/Issues	RAG*	Mitigating Actions
1.Below 75% vaccine coverage (or <95%) in some geographic communities, ethnic groups and other communities experiencing inequality (e.g. homeless, GRT) • Age group: Uptake not yet at target in younger populations: 12% in 12-15s, 34% in 16-17s, 51% in 18-29s, 56% in 30-39, 69% in 40-49 • Wards: Uptake (over 12) particularly low in Lower Edmonton (53%), Upper Edmonton (53%) and Edmonton Green (55%) • Ethnicity: Low uptake in White Gypsy Traveller residents (30%), Black African (52%) and Black Caribbean (49%) in over 12s • Language spoken – low uptake Bulgarian (21%), Romanian (27%) and Polish (39%)	amber	• Culturally competent conversations in hesitant areas • Tailored social media engagement campaigns • Partnership working with local authorities and the voluntary sector • ICP Vaccine Workstream activity informed by intelligence provided by Public Health Team. (Fortnightly **Phase 3 COVID and Flu Vaccination Group** continues this work and includes PCN and community pharmacy sites and stakeholders) • Ongoing communication and engagement for communities with sub optimal uptake and Under 40s cohort • Continued targeted comms in low uptake areas • Black African & Caribbean targeted work; Eastern European communities

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Continued integrated focus on sub optimal vaccine uptake in Black African and Caribbean, Eastern European and GRT communities and under 40s cohort incl schools

COVID Vaccine Inequalities: Oct 2021

NEXT KEY MILESTONES Workstream	Milestone / product	Due date	RAG Status
Clinical Governance	Dr Hetul Shah ICP Clinical Lead will provide clinical input and leadership (Public Health Co Chair of Phase 3 Group is Dudu Sher-Arami).		
NCL Committee Sign off			
Implementation in primary care	N/A as not operational (strategic group looking at vaccine inequalities)		
Implementation in secondary care			
Go live			

Priorities for next month	
1	Continuation of engagement activities and coordination informed by local intelligence via multistakeholder Phase 3 Covid and Flu vaccination group
2	• Build on what we have learned in Phases one and two • Seek additional insights • Address new challenges relating to the school-age cohort

Enablers: **Areas for Consideration**	Support from Health Inequality workstream to support hard to access cohorts

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 7 OCTOBER 2021

MEMBERSHIP

PRESENT Nesil Caliskan (Leader of the Council), Alev Cazimoglu (Cabinet Member for Health & Social Care), Dr Nitika Silhi (Governing Body Member, NHS NCL CCG), Deborah McBeal (Director of Integration, NCL CCG), Olivia Clymer (Healthwatch Central West London), Dudu Sher-Arami (Interim Director of Public Health), Bindi Nagra (Director of Adult Social Care), Jo Ikhelef (CEO of Enfield Voluntary Action), Vivien Giladi (Voluntary Sector), Pamela Burke (Voluntary Sector), Dr Nnenna Osuji (Chief Executive, North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

ABSENT Mahtab Uddin (Cabinet Member for Children's Services), Dr Helene Brown (NHS England Representative), Tony Theodoulou (Executive Director of Children's Services) and Siobhan Harrington (Whittington Hospital)

OFFICERS: Mark Tickner (Health and Wellbeing Board Partnership Manager) and Dr Glenn Stewart (Assistant Director, Public Health), Jane Creer (Secretary)

Also Attending: Dr Chitra Sankaran (Governing Body (Enfield) NCL CCG), Dr Hetul Shah (NCL CCG), Gayan Perera (LBE Public Health Intelligence), Doug Wilson (LBE Health, Housing & Adult Social Care), Riyad Karim (NCL CCG Assistant Director of Primary Care), Des O'Donoghue (LBE Service Manager – Community Services), Stephen Wells (Senior Programme Manager, NCL CCG), Ruth Donaldson (NCL CCG)

1
WELCOME AND APOLOGIES

Councillor Nesil Caliskan, Chair, welcomed everyone to the virtual meeting.

Apologies for absence were received from Dr Helene Brown, Tony Theodoulou, Debbie Gates and Siobhan Harrington.

Apologies for lateness were received from Dr Nnenna Osuji and Olivia Clymer.

2
DECLARATION OF INTERESTS

There were no declarations of interest in respect of any items on the agenda.

3
COVID-19 AND OTHER WINTER THREATS IN ENFIELD UPDATE

i. Epidemiology and Outlook

RECEIVED the presentation, Enfield Covid-19 Dashboard, providing an update and analysis of Covid-19 related data in Enfield from LBE Public Health Intelligence.

NOTED

1. Introduction by Gayan Perera, LBE Public Health Intelligence Team, on the latest infection rates in Enfield. In the last week or so there had been a slightly increasing number of cases, mainly Delta variant, but hospitalisations and deaths were staying low.
2. Most recent information on deaths, hospitalisations, cases in schools, and vaccination numbers. The main cohort currently at risk was the 0 – 29 age group.

ii. Care home status, visiting support, and vaccination status

RECEIVED the update presentation on care home vaccination status.

NOTED

3. Introduction by Des O'Donoghue, LBE Service Manager – Community Services, of numbers of care home residents and staff vaccinated.
4. Work was being done to support care homes and facilitate staff vaccinations by the Government deadline. It was confirmed that the rollout was on track and plans were in place to ensure homes were appropriately staffed.

iii. Vaccination Update

RECEIVED the Covid vaccination update presented by Dr Hetul Shah, GP and Riyad Karim, Assistant Director of Primary Care, Enfield Borough NCL CCG.

NOTED

5. Vaccination coverage in Enfield was good in the older population. Uptake was not yet at target in younger populations, some geographic communities, ethnic groups, and other communities experiencing inequality.
6. Collaborative work continued on the flu, Covid-19, and booster vaccination campaigns. There had been an increase in the number of vaccination sites. The Enfield Phase 3 Covid and Flu Group were meeting every two weeks.

IN RESPONSE

7. In response to Councillor Cazimoglu's queries, assurance was given of the focus on both flu and Covid-19 vaccinations. There had been some logistical issues leading to some rearranged appointments, but GP practices and pharmacies were now giving flu jabs as soon as possible even if that meant patients going back again for Covid-19 boosters. It was important for the protection from flu to build. Covid-19 booster vaccinations could be given six months after the second dose. Where possible, both vaccinations could be safely given at the same time. The Chair also raised the importance of not leaving behind any vulnerable groups, including the housebound.
8. It was confirmed that vaccination rates in 12 – 15 year olds were fairly low at the moment across the whole country. There was hesitancy in this group, and an impact from levels of sickness absence and isolation among school children. Further guidance was awaited on the 12 – 15 programme. Engagement work was being undertaken with parents and families. Catch-up clinics were planned during half term, at evenings and weekends.
9. Andrew Wright on behalf of BEH agreed to circulate an update briefing to Board members to provide the latest assurance on access to the vaccines for key groups.

4
PUBLIC HEALTH ENGLAND (PHE) SUCCESSOR ORGANISATIONS UPDATE - IMPLICATIONS FOR ENFIELD

RECEIVED the presentation, introduced by Dudu Sher-Arami, Interim Director of Public Health.

NOTED

1. The context of the setting up of PHE in 2013, and the transfer of all its health protection and health improvement functions from 1 October 2021 to two new entities: The UK Health Security Agency and The Office for Health Improvement and Disparities. A synopsis was given of where responsibilities now lay.
2. There would be little change in functions locally, but the local authority would be working with both organisations as they evolved, and the Board would be kept updated.

IN RESPONSE

3. The remarks of Councillor Cazimoglu and the Chair expressing concern at the abolition of PHE in a pandemic, and the risk of losing focus on prevention.
4. Clarification of governance, and that there were no specific local implications at this stage.
5. The Chair requested an update to the Board in two months' time.

5

UPDATE ON THE JOINT HEALTH AND SOCIAL CARE COMMISSIONING BOARD

RECEIVED a verbal update from Doug Wilson, Head of Strategy and Service Development, Health, Housing & Adult Social Care Directorate, LBE, advising of the effective partnership working and the impact of the pandemic and that a detailed report would be brought to the next Board meeting.

6
ICS WORKSTREAMS UPDATE

RECEIVED the progress update presentation, introduced by Stephen Wells, Head of Integrated Care Partnership Programme, and Deborah McBeal, Director of Integration, NCL CCG.

NOTED

1. Work was highlighted of the four working groups, plus the new working group in respect of Access to Services, Recovery & Innovation, which was jointly chaired by Richard Gourlay (North Middlesex University Hospital) and Jon Newton (LB Enfield)

IN RESPONSE

2. Discussion of concerns and experiences of residents relating to access to GPs and health services for all, noting the pressures on service providers and the provision of significantly more appointments as well as delivering vaccination programmes. The potential for streaming patients away from A&E to appropriate hubs with capacity was being explored. It was difficult to meet current patient demand and a system wide response was needed. The value of communication was also stressed. The new working group would press for solutions.
3. The second phase of the Inequalities Fund was highlighted and the upcoming deadline for submissions. Members should contact Ruth Donaldson or Dudu Sher-Arami with any further ideas.

7
UPDATE FROM ROYAL FREE HOSPITAL AND NORTH MIDDLESEX UNIVERSITY HOSPITAL

The Chair extended a warm welcome to Dr Nnenna Osuji, Chief Executive at North Middlesex University Hospital NHS Trust, to her first Enfield Health and Wellbeing Board meeting.

RECEIVED a verbal update from Dr Nnenna Osuji, including on staff continuing to work hard managing the challenges of the pandemic and the backlogs, high A&E attendance numbers experienced this autumn, upcoming patient feedback and surveys and benchmarking information, collaborative working, continued delivery of elective services, and necessity of communication work around cancer risk signs.

IN RESPONSE

1. The Chair gained clarification around incidental diagnosis of cancer.
2. It was advised that the hospital had been placed in the top ten most improved trusts, but areas for improvement continued to be waiting times and communication, which both linked to the high numbers of people attending and needing to be managed.
3. The introduction of a live feed of information on current attendance and wait time at A&E on the hospital website was suggested.
4. The use of Chase Farm hospital for elective Covid protected surgery was confirmed, and management of patient flow and discharge.
5. Members offered support in cancer awareness raising.

8
MINUTES OF THE MEETING HELD ON 24 JUNE 2021

AGREED the minutes of the meeting held on 24 June 2021.

9
NEXT MEETING DATES AND DEVELOPMENT SESSIONS

NOTED the next Board meeting was scheduled for Thursday 2 December 2021.

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