Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 7 July 2022 at 6.30 pm
Virtual / Teams (See agenda frontsheet for link)

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PLEASE NOTE: VIRTUAL MEETING
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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 Abdul Abdullahi
Councillor Andy Milne – Conservative Member representative
Governing Body (Enfield) NCL CCG – Dr Nitika Silhi (Vice Chair)
NHS North Central London Clinical Commissioning Group – Deborah McBeal
Healthwatch Representative
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

(Note: COVID-19 written update to be circulated.)

2. DECLARATION OF INTERESTS

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

3. NORTH CENTRAL LONDON MENTAL HEALTH AND COMMUNITY SERVICES REVIEW UPDATE (6:40 - 6:55PM) (Pages 1 - 24)

Programme Director for North Central London CCG Strategic Reviews of Community and Mental Health Services.

(Papers attached)

4. "START WELL" INITIATIVE (6:55 - 7:05PM)

Anna Stewart, North Central London CCG, and Chloe Moralesoyarce, North Central London CCG.

(Paper to follow)

5. JOINT HEALTH AND SOCIAL CARE COMMISSIONING BOARD UPDATE AND BETTER CARE FUND UPDATE (7:05 - 7:15PM) (Pages 25 - 38)

Doug Wilson, Head of Strategy, Service Development & Resources, Department for People, LB Enfield.

(Report attached)

6. NORTH CENTRAL LONDON POPULATION HEALTH STRATEGY (7:15 - 7:30PM) (Pages 39 - 60)

Penny Mitchell, North Central London CCG / North London Partners in Health and Care.

(Joint Presentation attached)

7. ENFIELD BOROUGH PARTNERSHIP UPDATE (7:30 - 7:45PM) (Pages 61 - 88)

Stephen Wells, Head of Enfield Borough Partnership Programme Enfield Borough Directorate NHS North Central London CCG.

(Report attached)

8. PHARMACEUTICAL NEEDS ASSESSMENT (7:45 - 7:50PM)

Amna Syed, Public Health Intelligence Specialist.

9. ANY OTHER BUSINESS

Formal thanks from Cllr Caliskan (Chair Enfield Health & Wellbeing Board) to Dr Nitika Silhi, Governing Body Member whose membership of the Board is ending.

10. MINUTES OF THE MEETING HELD ON 10 MARCH 2022 (Pages 89 - 96)

To receive and agree the minutes of the meeting held on 10 March 2022.

11. NEXT MEETING DATES AND DEVELOPMENT SESSIONS

Proposed date of the next meetings of Enfield Health and Wellbeing Board:

Thursday 6 October 2022
Thursday 15 December 2022
Thursday 2 March 2023

Development Sessions to commence at 5:00pm.
Formal Board meetings to commence at 6:30pm.
Unless otherwise advised.

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North Central London's sustainability and transformation partnership

NHS

Enfield Health and Wellbeing Board

Update on Progress of Community and Mental Health Service Reviews and Development of Core Service Offer

7th July 2022

Recap: The journey so far…

Since the initial analysis was completed, extensive stakeholder engagement was conducted through the design phase of the core offer, including patient groups, providers, local authorities, and commissioners. This is set to continue as the programme moves forwards.

Start of review

Agreement was reached for a strategic review of Community Health Services and a case for change was created

Mental Health

A parallel review of Mental Health Services has been conducted concurrently based on a case for change

Design co-production

Co-developed case for change, service offer, inequalities identification, gap analysis against Borough, through interviews, surveys and workshops with a focus on Local Authority

Partners Involved In Design Workshops
Primary Care
Community providers
Local Authority
Acute providers
Commissioner Borough& Strategic
Voluntary Sector
Residents/Users/Carers

Gap analysis

A gap analysis was conducted by Borough against the Core Offer

Core Offer

The purpose of the Core Offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence

Investment principles and KLOEs for prioritisation

Investment priorities and KLOEs agreed at CH and MH programme Boards respectively

Provider collaboration

Areas for provider collaboration have been agreed to improve care and support financial sustainability

Agree investment priorities

Review gap analysis and start to form a shared view on how closing the gaps might be prioritised in Y1, which will subsequently be tested with place

Future Programme Delivery

Programme Governance, Engagement and Co-design

Mental Health Services Review Programme Board Membership

- **CCG** including Accountable Officer, Clinical Responsible Officer, Governing Body GP and Lay member
- **Mental Health Trust** Chief Executives; BEH/C&I, Tavistock and Portland and Whittington Health
- **Local Authority**: Chief Executive, Directors of Adults, Children and Public Health
- Two **Experts By Experience**
- **Voluntary Sector** Representative

Community Services Review Programme Board Membership

- **CCG** including Accountable Officer, Clinical Responsible Officer, Governing Body GP and Lay member
- **Community Trust** Chief Executives; Whittington Health, CNWL, CLCH
- Acute Trust CE Representative
- **Local Authority**: Chief Executive, Directors of Adults, Children and Public Health
- **Voluntary Sector** Representative

Engagement

- Residents Reference Group
- Residents Survey
- Borough Meetings e.g. with Healthwatch In Islington, Bridge Renewal Trust in Haringey
- Specific focused meetings e.g. Mencap in Barnet, Camden Parents of Children with Special Needs

Co-production and co-design

- Core Service Offer developed with Experts By Experience and some Voluntary Sector Reps
- All community providers
- All mental health providers
- Resident Reference Panel input into core service design
- Workstreams for Mental Health Core Service Offer (and Long Term Plan Delivery): service user co design

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in health and care

NHS

There is a powerful case for changing mental health and community health services in NCL

Inequalities

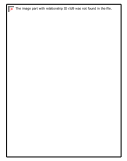
There are stark inequalities in health needs and outcomes across NCL

Provision

There is significant variation and gaps in service provision depending on where you live and this is not aligned to need

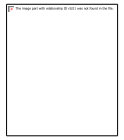
Access

The way you access services and how long you wait is also dependent on where you live



Spend

Different amounts are spent per head in different boroughs and this does not correlate with need



Service user / resident feedback

Services are difficult to navigate and require service users to repeat their stories

Enfield has over **twice the prevalence** of diabetes as Camden; but **half the** diabetes **resource**

NCL is the CCG in England with **the most number of people with a severe and enduring mental illness**

Camden's in-reach to care homes is **25% higher** than Barnet's, despite Barnet having an older population and the most care home beds in NCL

Dementia services in North and South of NCL are very different and services in the North provide less ongoing support

Community: In Haringey **£98 per head** is spent on community health services **vs. £192 per head** in Islington

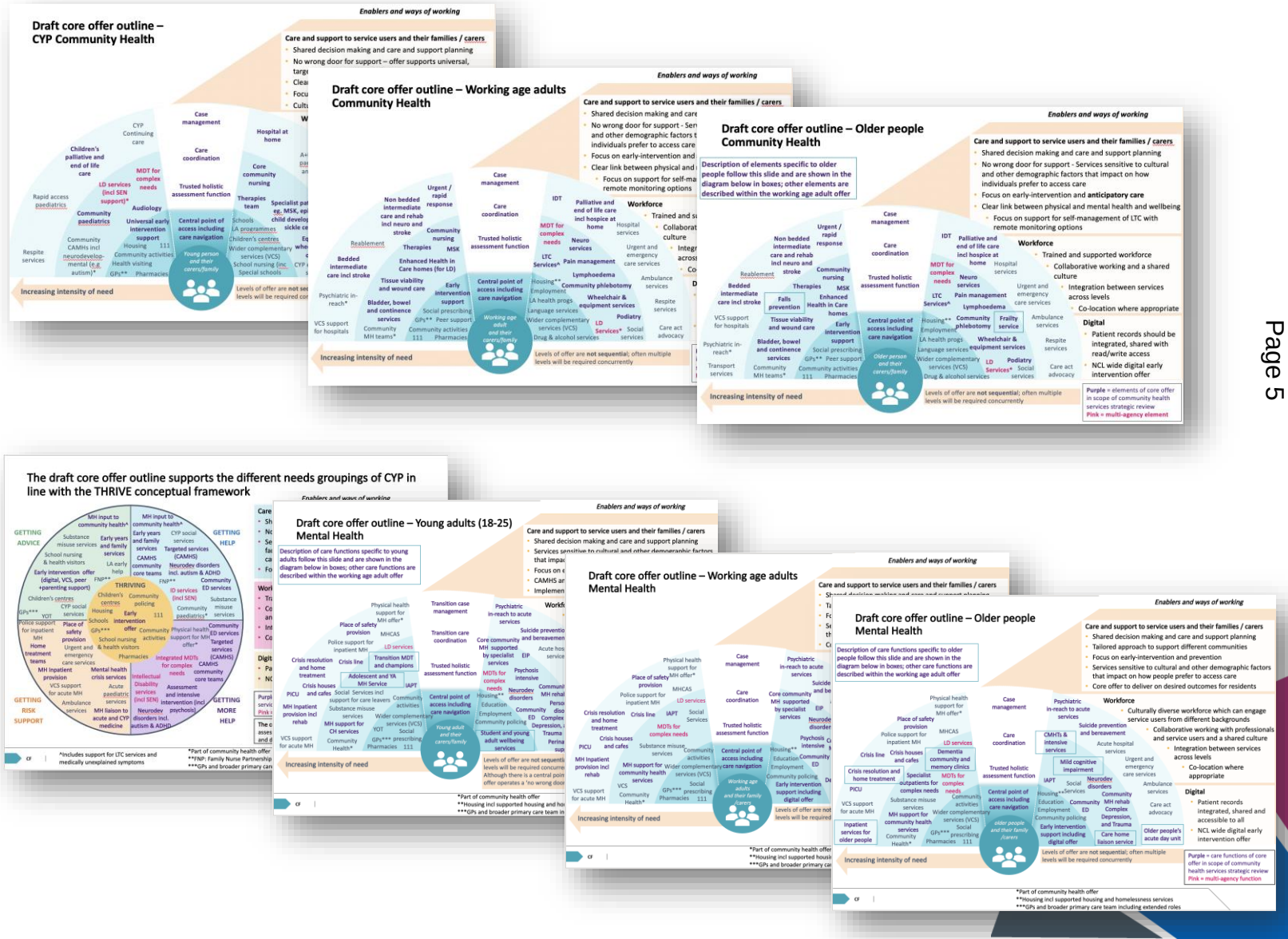
Mental Health: **Barnet £157 per head** vs. **£247 per head in Camden**

Children in Barnet wait **20 more weeks** than children in Camden for initial SLT assessments

Islington has the **highest number of CYP waiting over 18 weeks** from 1st referral to 2nd contact

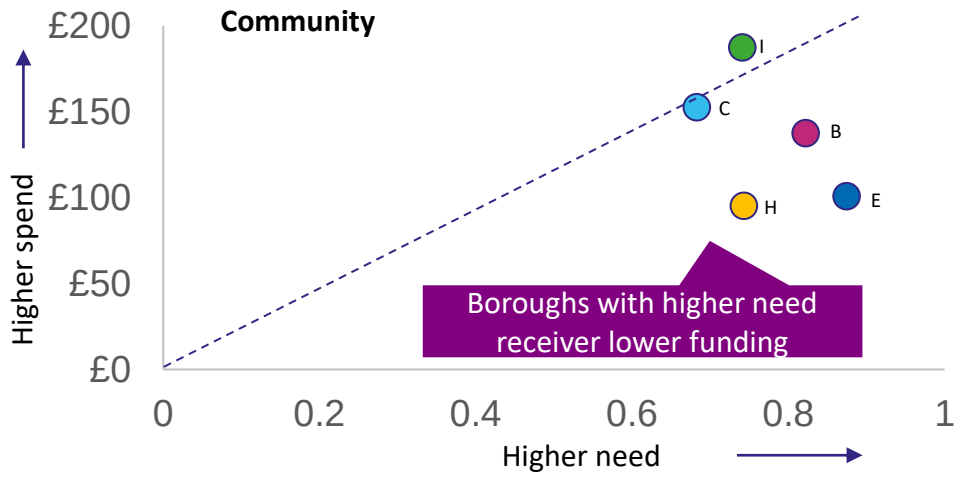
Community and Mental Health Services Core Offer

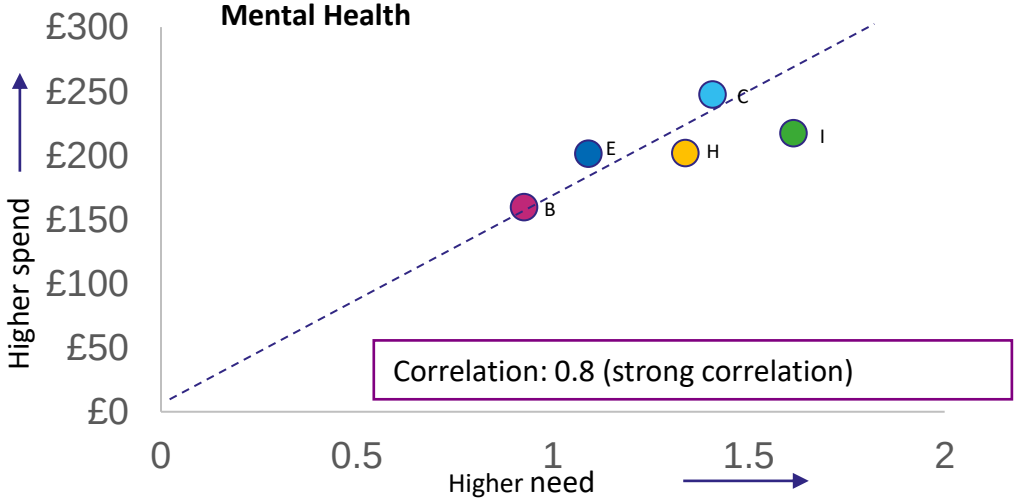
- The Offer represents the desired minimum standard to be delivered for all residents across NCL
- The Community services Core Offer is described in line with the NHS Long Term Plan categories of Start Well, Live Well and Ageing Well
- Additionally, the Mental Health services core offer includes the transition 18-25 service
- The offers are centred around the shared services functions; including, Case Management and Single Point of Access
- The Children and Young Peoples offer is structured differently to align to the THRIVE conceptual framework currently only rolled out in Camden



Comparing the spend vs level of need in each borough, mental health is well correlated and community is not correlated

Correlation between NHSE needs index for Community health services (x axis) and spend per head on community health services (y axis)





This table shows how well spend correlates to need based on the NHS England needs allocation formula.

As noted for community services there is no correlation whereas for mental health the correlation is stronger

In terms of understanding spending based on 2020/21 unweighted per head of population for community services spend is £101 per head in Enfield against a range of £101-£187 per head of population

For Mental Health in Enfield spend is £201 per head unweighted population against a range of £157-247 per head of population

B Barnet C Camden E Enfield H Haringey I Islington

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NHS

In order to sustainably fund the core offer delivery beyond FY22/23, cost savings will be required across the system, both in and out of hospital

C&MH provider savings	Efficiency	Providers **improve productivity and redesign ways of working** to meet system 'best in class' to release funds e.g. reshaping care models, use of technology
	Opportunities of Scale	We seek to deliver some services via **Lead Provider models** or similar to release efficiencies This will also help address workforce issues in smaller or more fragile services.
	Service workforce re-design	Providers change the footprint over which they deliver services and/or share resources to effectively increase investment in areas that are under-invested.
Acute savings	System Savings[1]	We will reinvest savings from elsewhere in the system that our work accrues. For example, via reducing acute demand, this would supports the flow of funds from Acute to Community.
ICS funding	Growth Monies	Growth monies to be allocated asymmetrically with more growth going to areas that have had historic inequities in investment

Mental Health Service Update

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NHS

Moving Mental Health Programmes; From Development to the Start of Implementation

Having agreed a set of NCL ICS core service offers in August 2021, a funding plan has been developed to support Mental Health services. Mental Health colleagues continue to focus on delivering the priorities of the Long Term Plan (LTP), and the White Paper on Health & Social Care Integration with its focus on integration and innovation. Priorities include;

Core Offer Themes	Examples of current challenges in our Mental Health system highlighted through the gap analysis	Examples of service developments being implemented in 22/23.
Prevention and Early Intervention	Prevention and Early Intervention is a key priority for LTP, core services offer highlighted from engagement and discussion with local people	Delivery is linked to the rollout of transformed core MH community teams as well as for CAMHS
NCL Inequalities and Population Health improvement strategy	Recognition of the disproportionate impact that Covid has had on many deprived and marginalized communities	Delivery of the NHSE MH inequalities strategy and NCL inequalities and population health improvement strategy
Long waiting times and access	Addressing long waiting times and access challenges which have worsened as a result of Covid and the increase in referrals especially in CAMHs services	Additional CAMHs staffing to reduce waiting times. Additional capacity in eating disorder specialist and community service and MH support in schools.
Workforce challenges	Addressing workforce challenges including developing new support role as part of developing innovative ways to expand service access	Strengthening MH work closer working with Vol Sector, Local Authorities, wrapped around primary care linked to primary care networks and local communities
Transition from childrens' to adult services	Addressing the issue of transition from children's to adult services. This was highlighted during our engagement events and has led to the development of an 18-25 offer	Strengthening and increasing capacity for transitioning young people and roll out of a young adults model of care.

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Priorities for mental health investment

NHS

Mental Health transformation is a priority for NCL. Additional investment has been received in 22/23 in the following areas to develop and / or increase capacity in 22/23 in line with the LTP and NCL MH Core Offer.

(Borough)	Service	Description	Core Offer "Gap"	Summary system benefits
ALL	**Adult Community**	Services receiving investment delivered in the community inc. Community Transformation	Wide variation in support to Primary Care. Significant secondary care waiting lists, capacity gap in IAPT services	Reduces waiting times, addresses inequalities, pt experience, clinical impact, reduces acute activity Increase average IAPT access by ~40%. ~20k patients receiving transformed community models of care. Opportunity to reduce inpatient length of stay to national av. of 32 days and opportunity to improve position of Out of Area Placements (current position approx. ~1,000 OBDs per day (12 OAP/day).
ALL	**Adult Crisis**	Services receiving investment within the Crisis pathway inc. Crisis Houses / Cafes, MHLS	Limited capacity in admission avoidance and discharge beds. Limited Crisis Alternatives. Variation in MH Liaison Services	Reduction in Adult A&E attendances due to depression of between 274-365 (10-13%) and a reduction in Adult A&E attendances due to psychotic symptoms of 402-535 (15-20%). Improves pt experience and addresses inequalities.
ALL	**Young Adults**	Additional workforce and new roles supporting transition	Long waiting times, inequities in support moving to AMHS	Reduces waiting times, addresses inequalities, pt experience, clinical impact
ALL	**CAMHS Community**	Waiting Times recovery and transformation. New Home Treatment Teams	Long waiting times, variation between boroughs	Reduces waiting times, addresses inequalities, pt experience, clinical impact
ALL	**CAMHS Crisis**	Acute Trust MH nurse educators.	Services capacity / not in place	Average reduction in CAMH crisis admission of between:11-15 (31-41%). Reduction in CYP A&E attendances due to depression of between 101-135 cases (30-40%). Improves Pt experience.
ALL (C & H in 22/23)	**CAMHs MHST**	Embed new MHSTs in 2 boroughs in 22/23 as part of NCL expansion programme	Variation in MH support in schools	Increases access, prevention, improves pt experience
ALL	**Eating Disorders**	Embed Community team and increase specialist Eating Disorder Service capacity	Not enough CYP accessing support in LTP timescales	Reduces waiting times, addresses inequalities, pt experience, clinical impact

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DRAFT: Adult MH programme structure

NHS

With the design principles in mind, the MH programme has been translated into three delivery workstreams, through which the work will be delivered and the planned benefits realised. These delivery workstreams will be aligned with enabling and ongoing workstreams / programmes

Provider/ICS-led delivery

Provider Collaboration / ICS led Transformation

- Crisis – Single Point of Access, THINK 111, MH CAS, Crisis pathways, Liaison and MH JRC.
- Inpatients – Provider Led (inc OAPs and Complex Care Rehab)
- IAPT
- Perinatal

Lead(s): ICS Programme SROs **Support:** Provider programme support

To unlock savings and financial benefits by improving productivity and increasing standardisation of service across the five boroughs for the benefit of NCL patients.

ICB-led delivery

Borough Working & Transition to Place-based Delivery

- Adult Community
- Young Adults
- Early intervention and prevention
- Crisis: Houses and Cafes
- IAPT - local
- Suicide Prevention & Bereavement
- Borough specific projects: e.g. Dementia, Ken Porter, Camden Day Unit, Enfield Wellbeing Centre, rough sleepers

Lead(s): DoI's **Support:** MH Commissioners

To identify and define delivery of the MH core offer, delivered at place, including alignment with borough based partners including primary care networks, LA, VCS and community services. Enabling resident co-production and engagement.

Planning, Investment & Contracting

- Defining Mental Health outcomes framework with PHI strategy
- Strategic Planning, Investment & Contracting
- Performance and outcomes
- Overarching programme management office

Leads: Sarah/Dan/Anthony **Support:** Carolyn/Mary

To oversee the governance of the MH Programme. To determine investment location and priorities, according to likely benefit; invest the additional money available for MH services in NCL and manage any required contracting work.

Enabling workstreams

Data	Finance	Workforce	Digital	Comms and engagement
Lead: Anita Garrick / MH Trusts **Support:** Dhiraj Sardana	**Lead:** Anthony Browne **Support:** Carolyn Piper	**Lead:** Clare Scott **Support:** TBC	**Lead:** Sarah Wilkins **Support:** TBC	**Lead:** Carolyn Piper **Support:** Mary Morgan

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DRAFT: CYP MH implementation programme structure

NHS

With the design principles in mind, the MH programme has been translated into three delivery workstreams, through which the work will be delivered and the planned benefits realised. These delivery workstreams will be aligned with enabling and ongoing workstreams

Provider/ICS-led delivery

Provider Collaboration / ICS led Transformation

Crisis –
- Crisis pathway / SPA
- Crisis Home Treatment / DBT
- Eating Disorders (specialist)

Community –
- Recovery and Transformation
- Eating Disorders (Community, ARFID)
- Digital support options

Lead(s): ICS Programme SROs **Support:** Provider programme support

To unlock savings and financial benefits by improving productivity and increasing standardisation of service across the five boroughs for the benefit of NCL patients.

ICB-led delivery

Borough Working & Transition to Place-based Delivery

- CAMHs
- ASD / ADHD pathways
- Early intervention and prevention
- Integrated Targeted Services *LAC
- CYP MH in Schools / Support Teams
- Young Adults 16-25
- Borough specific projects: e.g. Minding the Gap, VCS provision

Lead(s): Dol's **Support:** MH Commissioners

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Proposed services to be provided at Borough and NCL level for adult and CAMH services

NHS

MH Programmes	CYP	IAPT	Community	Crisis	Inpatients
Borough					
• Borough specific projects (e.g. Barnet Ken Porter Ward) • Rough sleeping • Suicide • Bereavement care • Dementia • Co-production* • Quality* • Health inequalities* • Early intervention and prevention*	• Gap analysis delivery of THRIVE model • LAC borough gaps • WSOA (Haringey) • H@H (exc.Islington)	• GP referrals • LTC development pathways / Covid recovery* • VCS offer • Specific Health Inequalities outreach programme	• SMI Health Checks • Individual Placement Support • Borough co-production and implementation of Community Transformation Prog	• Crisis cafes • Crisis houses	• Integrated discharge teams and flow into LA placements
• Workforce • Digital • Perinatal • NDD	• Provider led review • Therapies accelerator • Autism hub	• NCL digital • HLP system maturity tool • Group sessions / publicity • Staff health and well-being hub	• NCL SMI Physical Health Clinical Network • Overarching Framework for Community Transformation 1. Personality Disorder 2. Rehab 3. Community Eating Disorders 4. EIP 5. Older / Young adults*	• Crisis lines / Think 111 / SPA • MH Joint Response Car • MH Liaison Services	• OAP • Length of stay • Quality • Winter schemes
NCL ICB					

Community Health Service Update

Update on Community Services; Plans to Transform Adult and Childrens Community Services

- Community Providers including BEH and North Middx have agreed a programme of collaborative and transformational work to support working at scale, and the clinical and workforce opportunities this will bring.
- This includes collaborative work on areas such as community beds, the development of virtual wards, diabetes and tissue viability. These were areas identified by Community Providers as areas they wished to work on collaboratively to deliver NCL wide transformation.
- BEH will act as the lead community provider in NCL's development of a system Diabetes strategy with primary care. This will be through NCL's Diabetes and Weight management clinical network. Other Providers are leading different work streams e.g. Central London North West London (CNWL) are leading work on community beds.
- North Middx are supporting work on the rollout of virtual wards and the CEO of North Middx is now the ICS' Community Senior Responsible Officer leading the provider response to the delivery of the community services review and chairing the implementation steering group.
- Work has continued with colleagues from community services including Barnet Enfield and Haringey MHT to deliver the Ageing Well Programme which as resulted in an Enfield investment of £1,672k recurrently for urgent community response and further community health support for anticipatory care.
- Funding is being identified for children and young peoples services and will initially focus on rolling out a children's hospital at home service and reducing waiting times for therapies and autism assessments.
- In terms of next steps we are starting to look a opportunities to reshape some services via a lead provider role. This would allow a focus on workforce which along with funding is the biggest challenge for the health and care system. However point of delivery will remain local i.e. either in a patient's home or locally in a clinic.
- We will also need to agree a series of new projects to provide a pipeline for transformation across NCL to ensure we can generate funding to recycle into community services along with system investment.

The provider collaboration workstream is a significant enabler for creating equitable and accessible community services for the people of NCL.

Areas for provider collaboration have been agreed to improve care and support financial sustainability

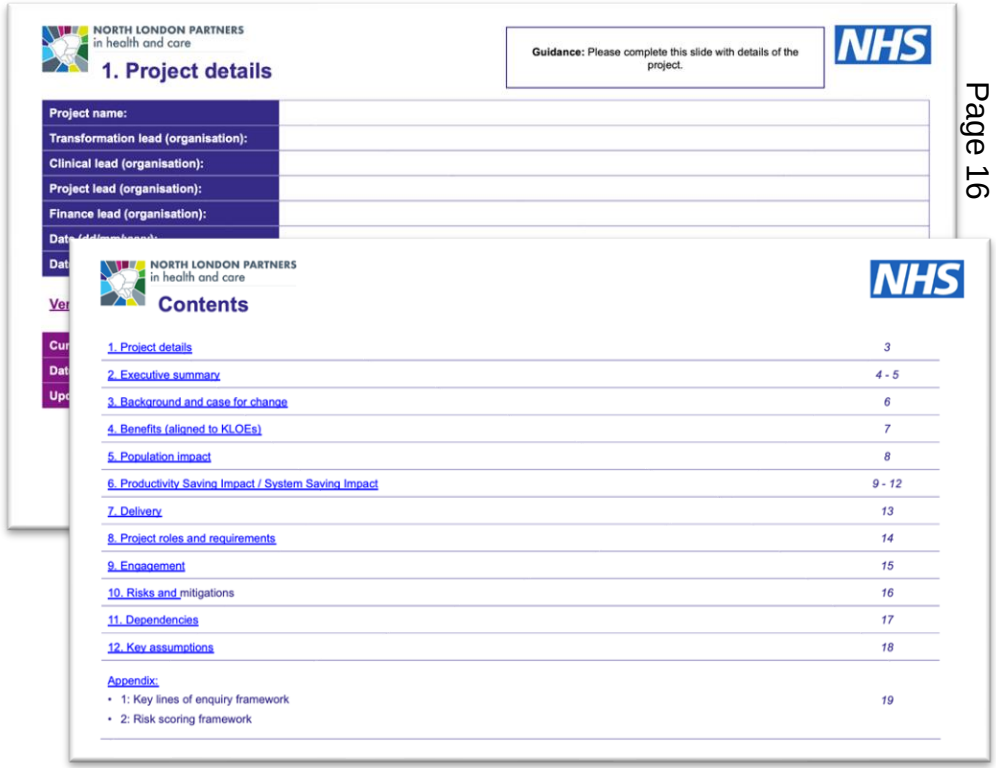
1st tranche

- CYP
- Virtual wards
- P2 Beds
- Single Point of Access (subject to workshop discussion)

2nd tranche

- Diabetes
- Tissue viability

Project documentation is being completed for each of these areas



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1. Project details

Guidance: Please complete this slide with details of the project.

Project name:	
Transformation lead (organisation):	
Clinical lead (organisation):	
Project lead (organisation):	
Finance lead (organisation):	

NORTH LONDON PARTNERS in health and care

Contents

NMUH/BEH/WH Virtual Ward

History

The Virtual Ward was launched on 20/12/21, in operation for 6 months.

The service is provided to residents of Enfield (by BEH) and Haringey (by WH)

Inclusion/exclusion criteria

- Residents of Enfield and Haringey
- Suitable home environment in which to provide care / treatment.
- Interventions within the scope of practice of the team.

Referral pathways

- Strictly from all wards / departments at NMUH only
- Daily case-finding / outreach by VW staff
- Daily site / Ops meeting
- Collaboration with IDT team

Clinical leadership

- The referring consultant retains responsibility
- SDEC consultant provides support to MDT and team
- Daily MDT
- VW GP 4 working days

Capacity

- Currently 20 beds (expanding from 8)
- Service hours are 08:00 – 20:00

Care activities

- Clinical assessment
- Phelobotomy / venepuncture
- Medication administration / review (including IV antibiotics)
- Therapy input

Workforce

- SDEC consultant
- GP
- 4 Nursing staff- band 7 and 6
- 1 admin
- Social care input , limited therapy input

Key interdependent services

- Social Service
- ERAS (RR and D2A)

Patient diagnostic cohorts

- Range of conditions within the inclusion criteria.
- Elderly / Frailty
- Post surgical
- Sepsis

Digital

- Currently none – but see future planning.

Future planning

- Increase to 28 beds 2022/23
- Explore virtual monitoring with digital technology
- Expand the referral criteria / higher acuity cases
- Regular slot on new docs induction program

Evaluation

- The service uses Careflow EPR
- Data collected manually working to pull data electronically.
- Awaiting Service evaluation by UCLP.

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Update on Community Services: Funding Approach to Enfield

NHS

- In terms of funding, the NCL system (System Management Board and ICB Board) have been asked to agree some additional funding to invest in community services, with a particular focus on helping reduce pressures in acute services such as by reducing emergency admissions and better supporting people in their homes. Colleagues will be aware of the pressures being experienced by services and especially at the North Middx where there have been challenges with discharging patients and creating capacity.
- Part of this funding will be allocated asymmetrically to fund core services in the Boroughs with the largest gaps against the core service offer (Enfield, Haringey and Barnet). Included in this report is the draft proposal for investment in adult community services in Enfield. These are subject to a wider NCL system signoff and ICB governance. Recruitment remains a key risk for providers and providers will need to collaborate around innovative recruitment and retention work.
- We have set out the proposed shape of investment in Enfield. This proposal builds on the gap analysis we completed as part of developing the core services offer and is based on a set of system principles agreed with partners. This proposed investment e.g. into community nursing and therapy services has been discussed with some key colleagues in Enfield with whom it resonated and they recognised how it fits with identified gaps against the core services offer.
- A small amount of the funding being identified will be used to develop coordination functions such as a Single Point of Access which enables holistic assessments and case management. We are planning a workshop on June 22nd at which local colleagues will think through the benefits, opportunities and challenges that a Single Point of access might achieve
- Once Provider colleagues have completed their project documentation, which will include the measurable benefits we expect to see for local residents as well as an equalities impact assessment, we will shortly need to discuss with colleagues a further set of projects to ensure we have an agreed pipeline of areas for transformation for future years of the programme.

Plans for Children and Young People for 2022/23 Against Core Services Offer

Progress to date

- Multidisciplinary audit of LAC health services gaps and recommendations developed
- Development of CYP community Services data dashboard to track progress and benchmark across NCL
- Investment in CAMHs services to reduce backlog of referrals
- Investment in Autism Hubs to clear backlog of referrals
- Therapies accelerator to clear back log of assessments
- Increased access to autism diagnosis and assessment
- **Prioritisation of 4 key areas for children's community transformation (ASC/ADHD, Community Nursing, Community Paediatrics and Therapies**)

Plans being developed For Implementation ;

- Roll out Children's Hospital at Home service in Enfield
- Rollout of asthma nursing model (in Haringey & Barnet)
- Looked After Children; building teams to have greater resilience and sustainability
- Reviewing community paediatrics to agree ways to make services more resilient and sustainable
- Review children's community nursing provision and the offer to special schools nursing

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Subject to ICB Governance, the following 'gaps' within the 'core offer' in Enfield will be the focus during year 1.

NHS

	"Gap"	Rational and benefits
1	**Community nursing: skill mix and capacity gaps**	Investment would boost skills and capacity gaps within community nursing to contribute to filling core offer "gaps" associated with case management capacity, IV/PEG/Catheter and TV to keep people well at home, inc. overnight response.
2	**Community rehabilitation service**	Investment would help establish a seven day community rehab service in line with the core offer, potentially filling gaps in neuro therapy capacity, and enabling more people to recover at home
3	**Community Diabetic Services**	Investment would boost skills and capacity gaps in the community diabetes service, to enable it to start to move towards meeting this "core offer" gap in terms of responsiveness.
4	**Silver Line (NCL Wide)**	Expanding our silver triage geriatrician advice line to LAS staff to 8-8pm, 7 dpw, following a successful pilot. This service allows an LAS staff member to gain consultant level advice at the point of potential conveyance from a care home. Our pilot avoided conveyances in over 80% of occasions that the silver triage phone was utilised.

Population Health Outcomes Framework

Proposed NCL Population Health outcomes framework

The proposed public health outcome framework has been agreed by the Programme Boards and will be used to demonstrate how the impact from Community and Mental Health Services Transformation will be measured. A more detailed set of service indicators is being developed in discussion with colleagues e.g. from public health and from discussions as part of public engagement e.g. on transition from children to adults services as that was a key are of feedback from parents and young people

Start well

Every child has the best start in life and no child left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and new born screening coverage
- All children are supported to have good speech language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduction in the number of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Reduction in early death from cancer, cardiovascular disease and respiratory disease

- Reducing prevalence of key risk factors: smoking, alcohol, obesity
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in good jobs

- Support people to stay in jobs, including mental health and musculoskeletal services
- Anchor institutions to employ local people including those with mental health illness, physical disability, and learning disabilities, and to buy locally including by using social value-based commissioning and contracting

Parity of esteem between mental and physical health

- Reducing racial and social inequalities in mental health outcomes
- Improved physical health in people with serious mental health conditions
- Reducing deaths by suicide

Age well

Older people live healthy and independent lives as long as possible

- Ensure that people get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Improved outcomes for older people with long-term conditions, including dementia

Older people are connected and thriving in their local communities

- Older people have fulfilling and meaningful social life
- Older people are informed well and can easily access support for managing financial hardship

Next Steps; Delivery at Borough of Community & Mental Health Core Services Offer

- Whilst the Core Services Offer is designed to provide residents with a consistent experience and increase access to services, it is recognized that boroughs will lead delivery and that this will need to reflect local needs, priorities and wider relationships with partners including the Local Authority, and local voluntary sector colleagues as well as with local people.
- In delivering the core service offer via local delivery plans, further work will be needed to ensure ongoing engagement and communications to ensure local residents continue to be involved in shaping how the core services offer is delivered in their community
- Discussions are commencing with borough partners about the delivery of the core services offer, to think about where in local governance implementation needs to report to and how some of the work that is being undertaken at scale e.g. the community service providers work on community beds or tissue viability is interpreted and aligned with existing work and with work of other colleagues e.g. in primary care to deliver wrap around support for community mental health teams
- Although one of the outcomes from the reviews is to ensure we can better support people with both a mental and physical health need, further work is needed between both community & mental health providers and with primary care to think through how this aspiration will work in practice at a local place level, as the core service offer is delivered
- As part of delivering a community & mental health set of outcomes aligned to the population health outcome framework, local partners may wish to agree some Borough based community & mental health outcomes which can help inform local partners of on progress against the overall population goals.

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

Date of Health and Wellbeing Board: 7th July 2022

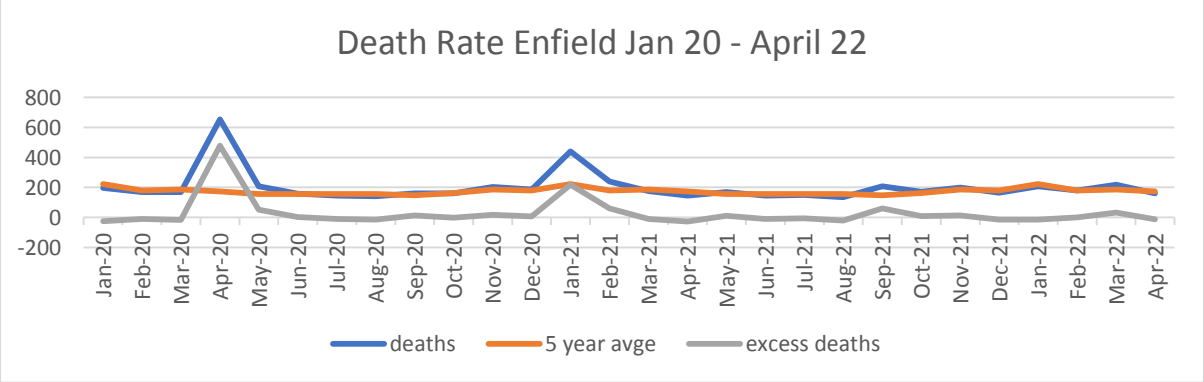
Update prepared by: Doug Wilson, Head of Strategy, Service Development & Resources, People, Enfield Council

1. Introduction & Background

2. The Joint Health & Social Care Commissioning Board is a partnership across Council People services and Health (CCG) commissioners. For the purposes of this update, it oversees the Better Care Fund Delivery Group and has oversight of the delivery of the Better Care Fund joint priorities across Social Care and Health.
3. These priorities are:
    a. Reducing avoidable admissions to hospital
    b. Reducing the proportion of people whose length of stay in an acute hospital bed exceeds both 14 and 21 days
    c. Increasing the proportion of people who are discharged from hospital back to their usual place of residence
    d. Minimising the number of people aged 65 and over who are permanently admitted to residential or nursing care
    e. Maximising the proportion of people who enter the enablement service following discharge from hospital and who are living independently three months following discharge.
4. These have continued to be delivered within the context of the pandemic over the last two years and a significant consequential impact on our local communities and services.
5. The impact of the pandemic with regards to resident deaths has been clear in Enfield with:

- An average number of deaths (over a five-year period to 2019) of 2061 exceeded by 493 (excess deaths) in 2020 and 280 excess deaths in 2021. April 20 and January 21 saw the most significant spikes in excess deaths. The number of excess deaths in 2022 so far is 7.

Chart 1



6. Enfield's two acute trusts, Royal Free and North Middlesex have remained in a permanent state of escalation with additional acute beds having to be made available to respond to an increased number of hospitalisations. This is demonstrated below in charts 2 and 3:

Chart 2

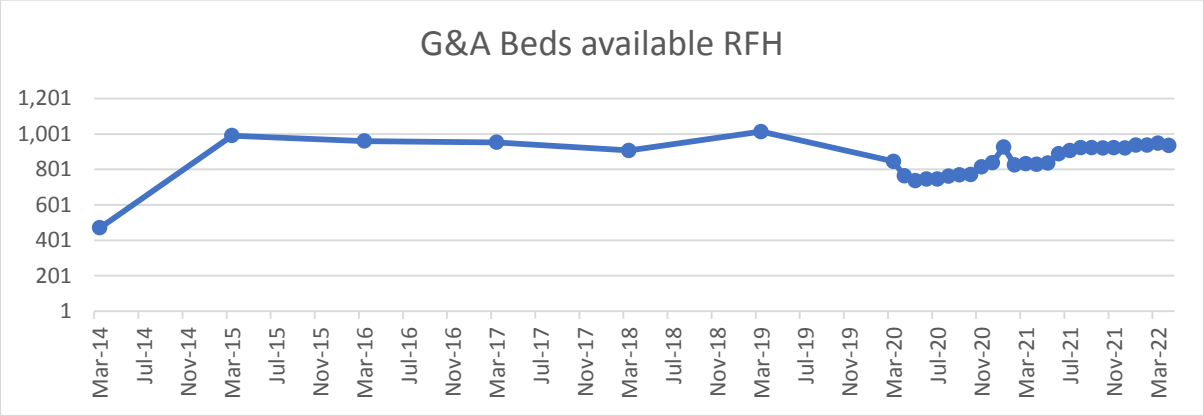
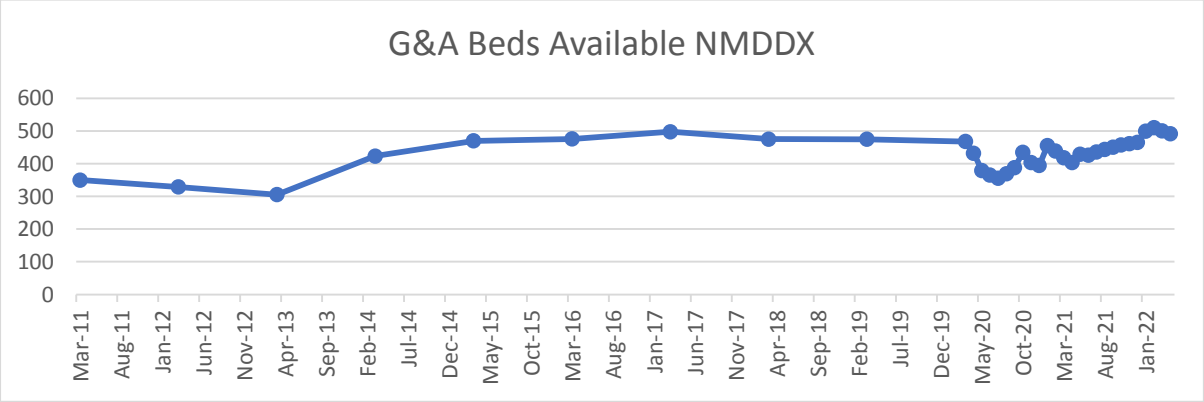


Chart 3



7. Occupancy rates for both Acute Trusts have also been extremely high with both NMDDX and RF Trusts exceeding an average of 95% bed occupancy since December 2020 as shown in charts 4 and 5:

Chart 4

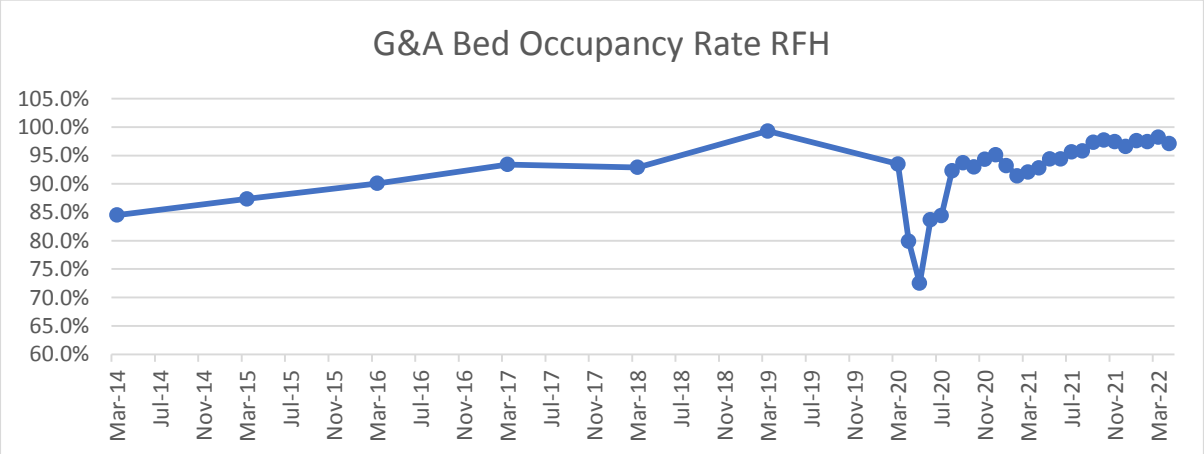
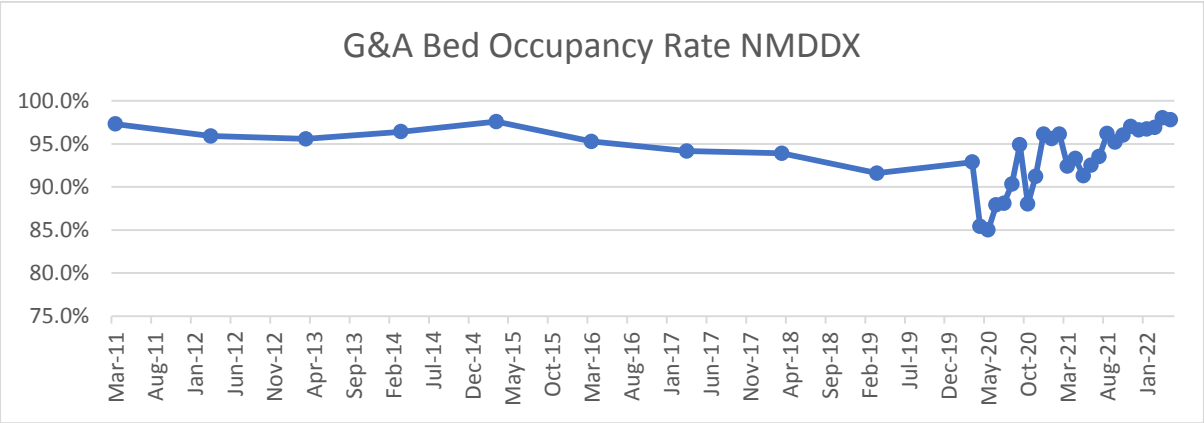
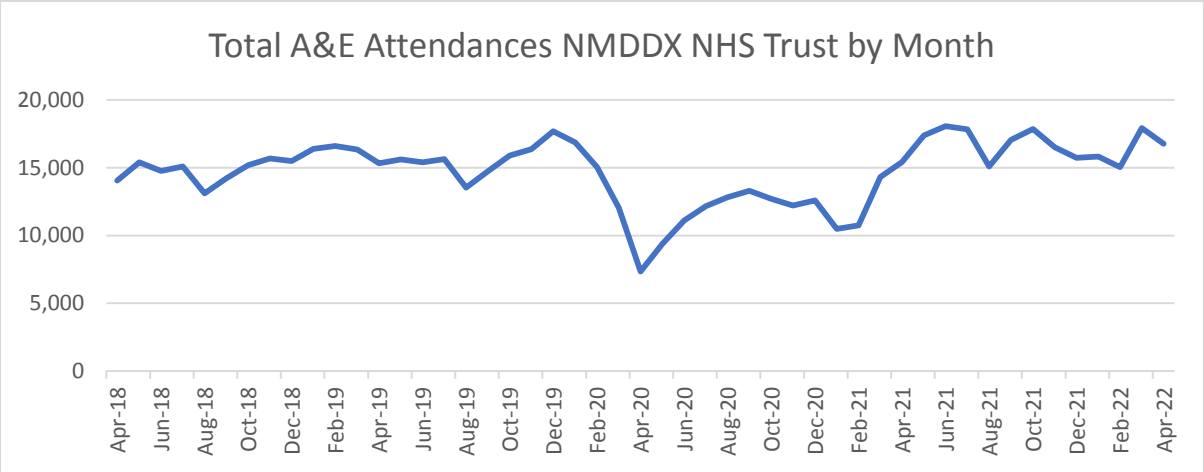


Chart 5



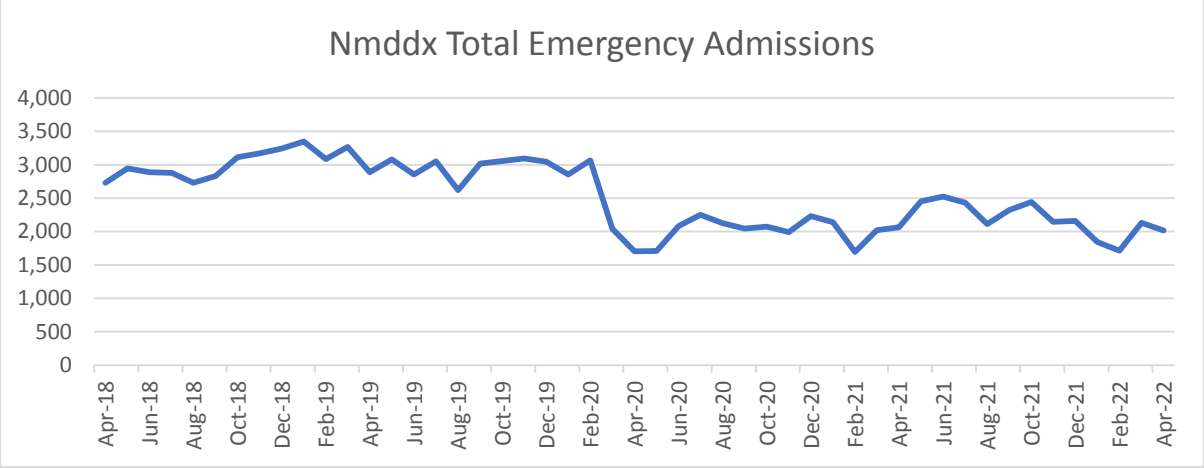
8. The Accident and Emergency department at NMDDX hospital has also been under significant pressure with just under 200,000 A&E attendances in financial year 2021/22. Chart 6 shows the patterns of attendances over time:

Chart 6



9. However, work done has been successful in reducing the number of those A&E attendances which result in an emergency admission to hospital as shown in Chart 7 below with emergency admissions reducing by just under 10,000 per year from 2018/19 to 2021/22:

Chart 7



10. Despite the lower number of emergency admissions our hospitals continue to be busier than ever as already shown above and as demonstrated in charts 8 and 9 below where waiting times to admit from the decision made to admit have increased substantially from the middle of 2019/20:

Chart 8 – Waiting times April 18 to April 22

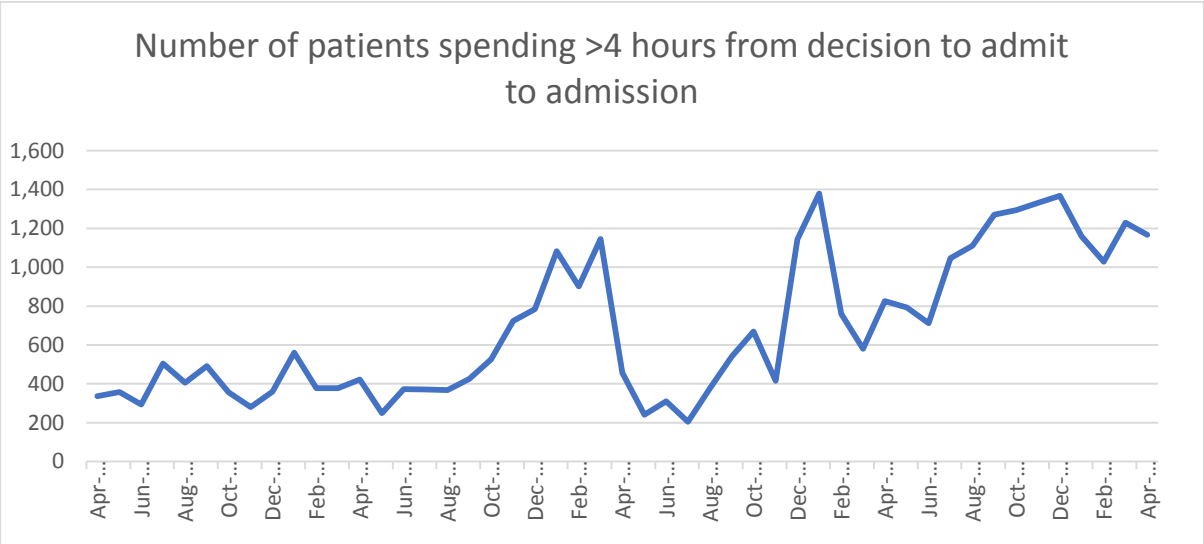
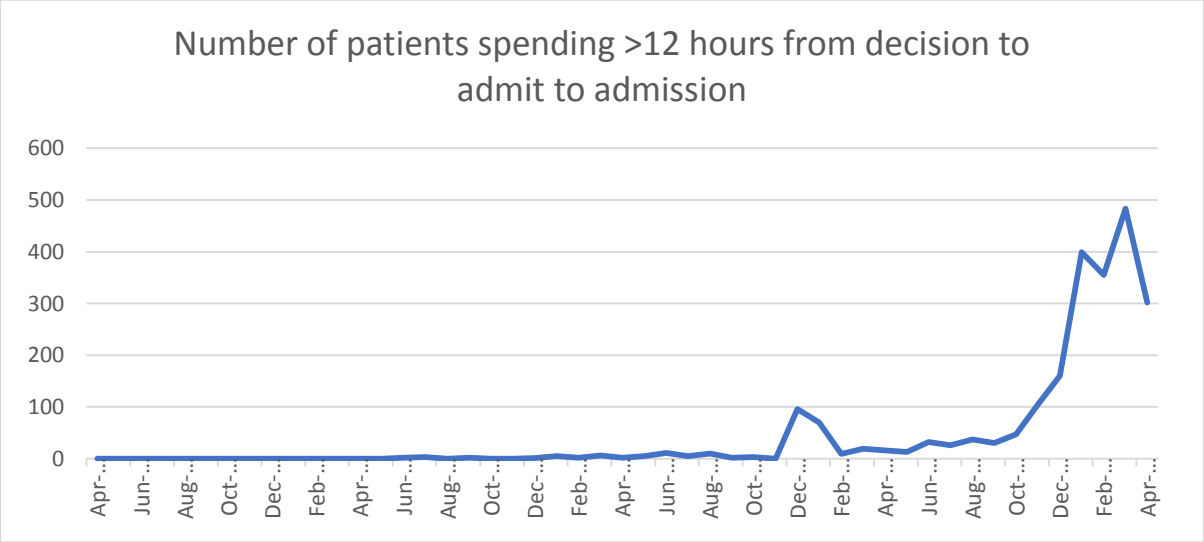


Chart 9 Waiting times from April 18 to April 22



11. Enfield's Partnerships and Better Care Fund

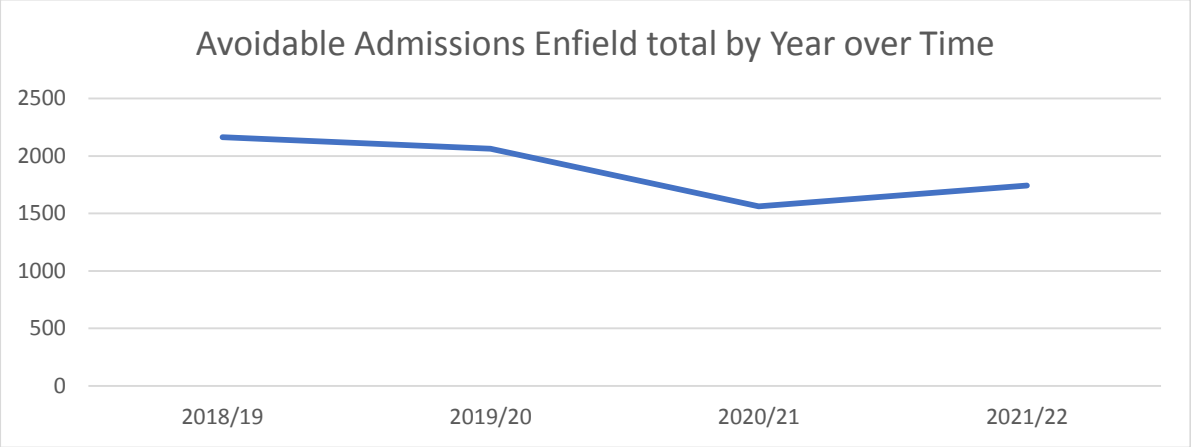
Avoidable Admissions

12. One of the key targets within Enfield's Better Care Fund Plan is the reduction of avoidable admissions. This is measured as a proportion of all emergency admissions. This focuses on chronic conditions where treatment in the community should be available to prevent the need for emergency treatment within a hospital setting. Table 1 and Chart 10 below show the trend over the last four years for conditions known as Ambulatory Care Sensitive (or avoidable):

Table 1

Avoidable Admissions over time	2018/19	2019/20	2020/21	2021/22
Heart Disease And Heart Failure	483	526	491	520
Diabetes	285	276	260	262
COPD	446	347	169	257
Asthma	358	278	124	199
Atrial Fibrilation And FLutter	233	295	203	176
Epilepsy	159	177	145	142
Anaemia	91	85	90	116
Hypertension	29	28	25	25
Angina	31	14	27	24
Dementia	48	37	29	22
total in year	**2163**	**2063**	**1563**	**1,743**

Chart 10



13. Between April 2018 and March 2021 avoidable admissions reduced by 600 but in 2021/22 increased on the 202021 number by 180. Whilst admissions for some conditions remained fairly constant during the four-year period, there are some which reduced significantly, including COPD (emphysema) and Asthma. A corresponding increase in emergency admissions due to Covid19 was seen in the same period and this has added to the acuity or complexity factor being attributed to an increasing number of hospital cases where people are having to remain in hospital for treatment for an extended period of time.

14. The target set in the Better Care Fund Plan was significantly exceeded in 2021/22 (target set per 100,000 of population) for 2021/22 was 697.6 with actual performance at 592.3.

Length of Stay in Acute Hospital Beds -Table 2

Length of Stay in Hospital 14 days and over with primary reason	2018/19	2019/20	2020/21	2021/22
Acute renal failure, unspecified	42	46	34	51
Cerebral infarction due to thrombosis of cerebral arteries	0	0	38	0

15. Table 2 above shows the top 10 main presenting reasons by year for admission to an acute hospital bed where the person stayed in that bed for 14 days or longer.

16. Whilst some main presenting issues have remained fairly constant over the four-year period for people remaining in an acute hospital bed for 14 days or longer, there is a clear impact of Covid19 in 20/21 and 21/22. The appearance of strokes (cerebral infarctions) in 2020/21 when it appears in no other years, does require further investigation but may indicate a shortage of specialist rehab services for strokes in the NCL area.

17. Other infections that have escalated also demonstrate a significant impact on admissions (pneumonia, UTIs, sepsis) as well as falls and fractures. These are admission causes that should be more preventable in nature through community interventions.

18. The length of stay targets within the Better Care Fund Plan are set based on the number of people staying in an acute hospital bed for 14 days or longer as a proportion of all people who have had a hospital stay in an acute bed.

19. The target set for 2021/22 for 12% for 14+ days and 5.25% for 21 days and over. Whilst the target for 14+ days was met at 11.9% the target for 21+ days was missed at 6.1%.

20. The tables and chart below show the trend for length of stay in an acute hospital bed over the last four years.

Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries	0	0	31	0
Chronic obstructive pulmonary disease with acute lower respiratory infection	31	0	0	0
Congestive heart failure	82	78	68	65
Covid-19	0	0	291	134
Fracture of neck of femur (closed)	63	68	45	58
Lobar pneumonia, unspecified	86	80	43	51
Pertrochanteric fracture (closed)	0	48	0	0
Pneumonia, unspecified	54	55	0	0
Pneumonitis due to food and vomit	37	47	31	40
Sepsis, unspecified	49	92	61	52
Tendency to fall, not elsewhere classified	40	41	0	46
Urinary tract infection, site not specified	76	57	39	61
Total	**560**	**612**	**681**	**657**

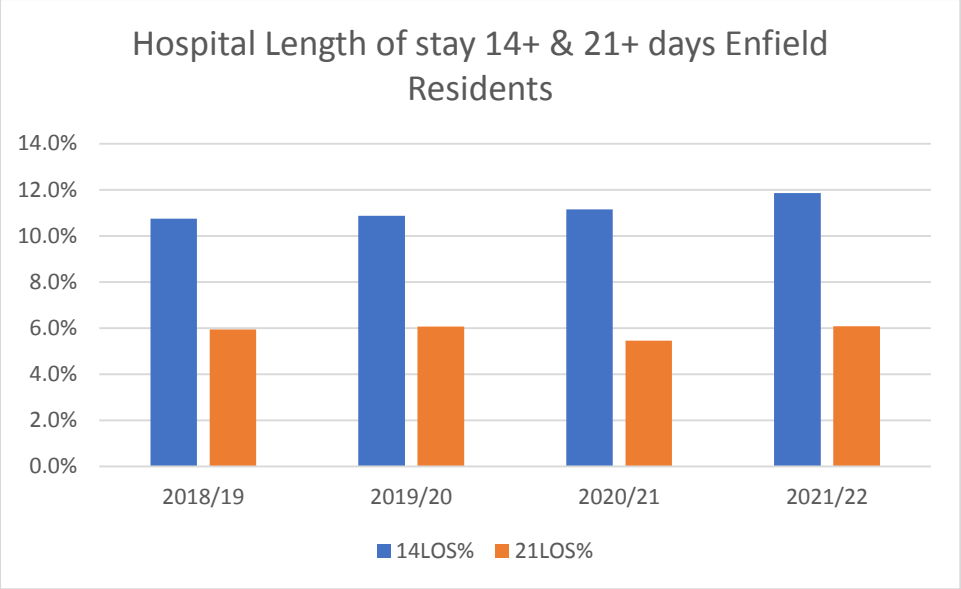
Table 3

Enfield LOS Hospital	All stays	0-13 LOS	14-20 LOS	21+ LOS
2018/19	25976	23186	1247	1543
2019/20	25922	23106	1245	1571
2020/21	20835	18512	1186	1137
2021/22	20549	18112	1189	1248

Table 4

Enfield LOS Hospital	0-13%	14LOS%	21LOS%
2018/19	89.3%	10.7%	5.9%
2019/20	89.1%	10.9%	6.1%
2020/21	88.9%	11.1%	5.5%
2021/22	88.1%	11.9%	6.1%

Chart 11



21. Given the increased bed availability and usage shown in the introduction and background of this report but the reduced number of stays (fewer people occupying the beds) it appears clear that the general upward trend in longer average length of stays in a hospital bed continues to contribute towards pressures on our acute hospital services. The impact of Covid19 (in terms of hospitalisation and primary care focus on the vaccine programme) appears to be the single largest impacting factor in this position (as shown in Table 2 above).

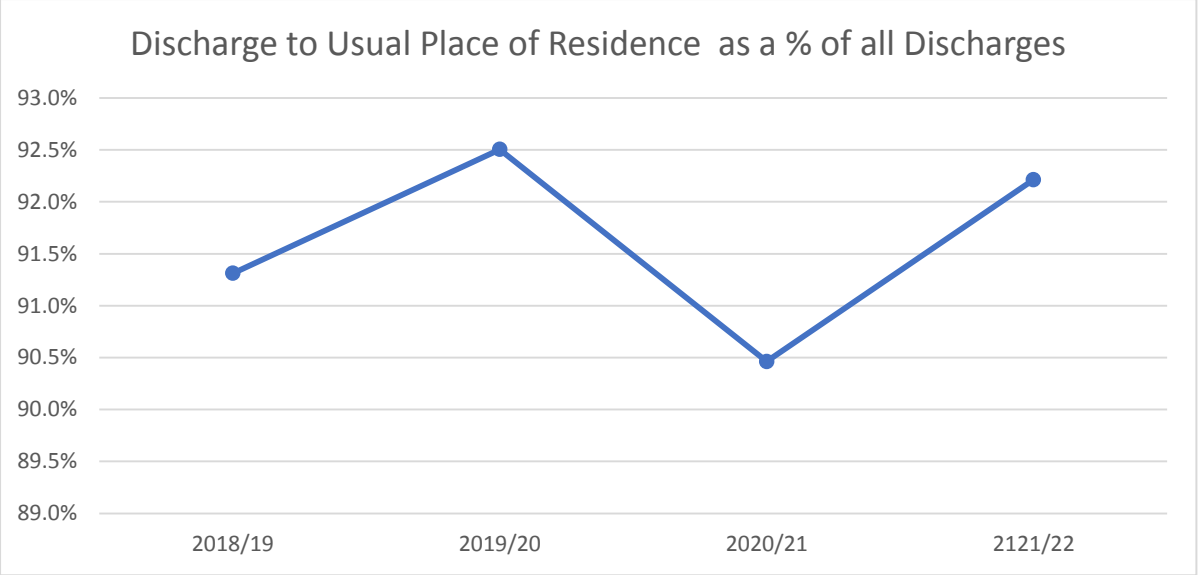
Discharge to Usual Place of Residence

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

Table 5

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

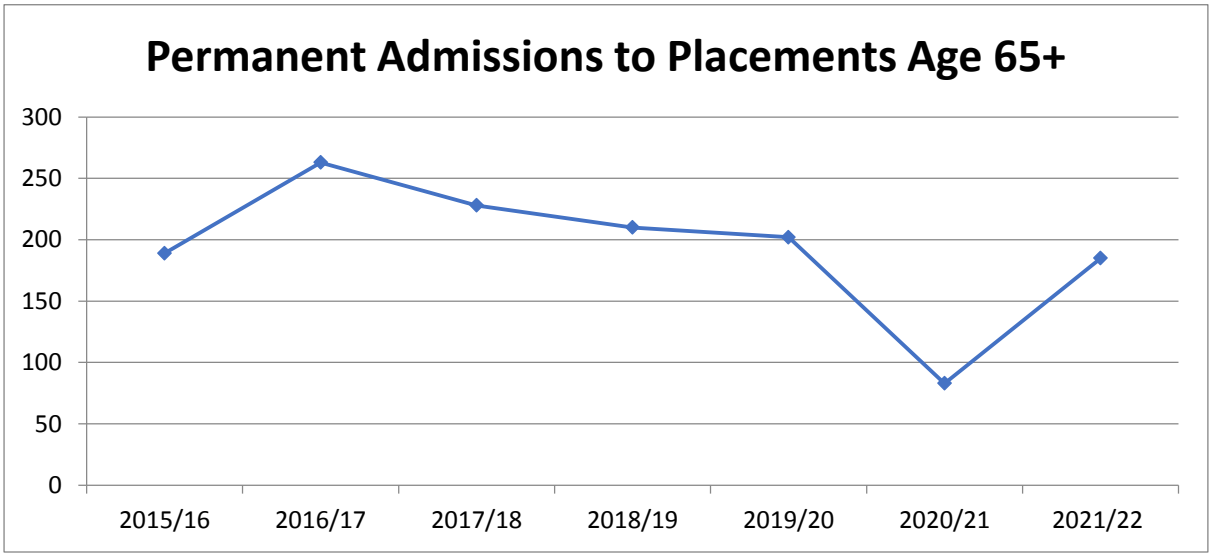
Chart 12



Permanent Admissions to Residential or Nursing Care for Older People

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

Chart 13



Supporting People to regain their Independence after Hospital

24. 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.

25. 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.

26. Around 78% of new people who enter the Enablement Service are discharged from the service requiring no ongoing support or care. This service is available for up to six weeks (it may be longer dependent on individual cases). Of the people who are discharged from hospital and supported by the Enablement service, over 81% of them continue to live independently three months later. Our target for this year is to increase this to 88%.

27. 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.

28. We understand that people want to continue to live in their home for as long as they possibly can. Where this is no longer possible there are alternatives to residential care. The Council has planned to invest over £30m in a new purpose-built extra care facility on the site previously occupied by the Reardon Court Care Home and Extra Care scheme. Extra care provides people 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 2023/24. The scheme, once built will provide 69 self-contained flats, all fully accessible within a state of the art facility providing much needed services for local people with a variety of different support needs. An array of thoughtfully designed communal facilities, including a hairdressing and treatment room, library/IT suite, lounges and activity rooms shall sit at the heart of the scheme, to facilitate social inclusion and community engagement. Healthy, active and sustainable living shall also be supported through the provision of accessible sensory gardens and allotment space.

29. Table 6 below shows the balance of care over the last four years in Adult Social Care in Enfield. The number of people living permanently in residential or nursing care has returned to pre-pandemic levels. This is despite the increasing complexity of hospital

discharge cases and due to an increasing number of people receiving more stepdown/rehab support which enables them to return home to more independent living.

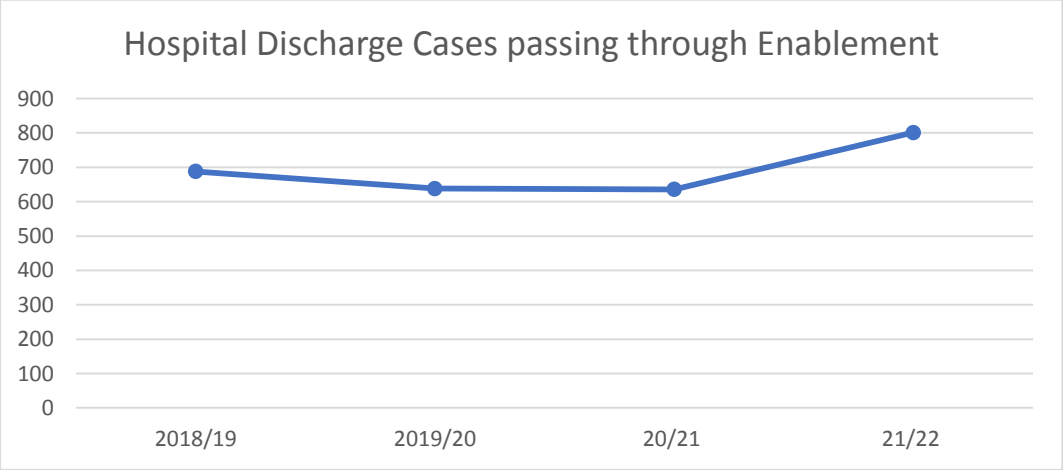
30. The ongoing development of Integrated Discharge Teams (IDTs), consultant-led virtual wards as well as scaled up enablement/community equipment service provision and invaluable support via our Voluntary and Community Sector has contributed to a strengthened health and social care system which actively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

Table 6

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

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

Chart 14



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

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

34. 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

35. Enabling people to be safe, independent and well is an integral part of the Health and Social Care vision for Enfield residents. Delivering this requires the right support to be available at the right time 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.

36. The development of Integrated Care Boards and Integrated Care Partnerships will bring together stakeholders from across the health and social care system. Most importantly, they must have at their heart the voice of local people and what matters most to them.

37. 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

38. There is strong collaboration at a place level with a shared understanding of the most pressing challenges across health and social care. Examples in 2021/22 of joint planning and delivery of commissioned services include:
    - Development and delivery of an ageing well programme of work completed in partnership across Enfield and Haringey Councils/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.

39. The operational planning guidance for the Better Care Fund 2022/23 is not expected until later in the Summer. However, it is expected that there will be little change in terms of the headline metrics used to measure success which are:
    a. Reducing avoidable admissions to hospital
    b. Reducing the proportion of people whose length of stay in an acute hospital bed exceeds both 14 and 21 days

c. Increasing the proportion of people who are discharged from hospital back to their usual place of residence
d. Minimising the number of people aged 65 and over who are permanently admitted to residential or nursing care
e. Maximising the proportion of people who enter the enablement service following discharge from hospital and who are living independently three months following discharge.

40. Work is underway to review the metrics and joint deliverables, agree joint investment plans and produce a new Section 75 agreement for sign off at Council Cabinet and the ICB Governing Body.

41. It is anticipated that this will be completed ready for September Cabinet.

42. A further update to the Health and Wellbeing Board on delivery against the Better Care Fund metrics to be produced in November 2022.

NORTH LONDON PARTNERS in health and care

NHS

NCL Population Health Improvement Strategy

Draft Aim and Plan

V1.1 – 14 April 2022

NORTH LONDON PARTNERS in health and care

NHS

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Summary

We need to start doing things differently to improve the outcomes and wellbeing of our residents, with a core focus to reduce inequalities in health and wellbeing outcomes, as well as experience of and access to health and care services. By following a population health improvement approach, we will:

- connect with communities to make a meaningful difference in how services are planned and delivered so that we can address inequalities of access that lead to poorer outcomes for some of our communities
- use the opportunities that the ICS provides for all partners to work together with communities, as well as within our own organisations to make the necessary changes
- make our health and care system sustainable, focused on early intervention and prevention – thereby reducing and eliminating the escalation of ill health and poor wellbeing

Therefore we have to build on our integration journey so far and take the leap to review the effectiveness of how we currently use and deploy our resources (our money, our workforce, our relationships) – driven by the needs of our residents. This will transform our health and care system that effectively and holistically serves our residents and is focused on prevention and early intervention.

1. Purpose of this document

Integrated Care Systems (ICS) are partnerships between the organisations that meet health and care needs across an area. Their core purpose 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 support broader social and economic development

In North Central London, the partnerships between health and care organisations have continued to form and grow over many years. As we commence this next phase of our journey as the NCL Integrated Care System, becoming an ICS provides us with an opportunity to make changes in the way we plan and deliver services, integrating even further, widening the levers we can use and maximising impacts of changes, resulting in our residents having longer and healthier lives. This strategy aims to reflect the binding of the work of place and system in a complementary way so that we are using our collective resources, capabilities and connections to improve population health and individual outcomes and experiences for residents in NCL.

This NCL Population Health Improvement Strategy draws together much of the conversations, partnerships and work to date to set out and achieve:

- A single narrative for NCL that is owned and supported by all partners as to why we are building and following a population health improvement strategy
- A shared vision for the future of health and wellbeing of NCL residents, on which to build our strategy

- Support and endorsement for the roadmap as to how we will deliver this vision – recognising the enablers and interdependencies with multiple programmes of work
- A commitment from all partners to be involved and play their part in delivering the roadmap and its detailed plans
- Agreement to build capacity for a population health improvement approach across the places and neighbourhoods that make up the ICS – using data to drive timely clinical and other interventions
- Agreement to apply population health improvement principles not only to health care services but also to other services, including those that impact wider determinants, such as voluntary and community sector, social care services, integrated services, education, housing and employment

Ultimately, we want this strategy and its' supporting plans to be endorsed by residents and their representative organisations, to ensure that we are making the changes that deliver what our residents want.

We know that it takes time to see changes in population level outcomes, however, the aim and rationale for this strategy should endure for the medium term (c. 5+ years), whilst the detailed plans will need to be iterative, being refreshed regularly, to take account of progress and learning. Therefore the "roadmap" element of this document is based on a shorter timeframe (c.1-2 years).

This strategy recognises the importance of the places and neighbourhoods, and the links between them, which make up our ICS – covering the full breadth of the system of the voluntary and charity sector and social care, alongside the traditional "health" domains of primary care, community care, mental health care and acute & tertiary care.

This strategy also considers the importance of understanding the impact of wider socio-economic circumstances on our population, in developing our population health improvement approach. This strategy is being developed at a time of great uncertainty and pressure within public sector services, notably the pressures and impacts (not just health) of the Covid-19 pandemic. This means that it is even more important to optimise our collective capacity to work together on our shared ambitions for NCL residents.

The aim is for this strategy and outline roadmap to be shared with partners, including residents and communities, to achieve the objectives above and for discussions and feedback to shape and refine the subsequent development of detailed plans and activities to support the strategy.

1.1 How this strategy has been developed

This is the first iteration of the NCL Population Health Improvement Strategy and has been developed by a wide range of system and place authors who have come together from a range of partner organisations across the ICS.

This strategy has sought to pull together the ideas, principles and themes from conversations and analysis shared with the NCL PHI Committee. It also pulls on historic and ongoing work at system and in place based partnerships to join up services in a more integrated way, tackle inequalities and consider the overall wellbeing of our residents. This strategy sits alongside local Health and Wellbeing Board strategies and also ongoing organisational and partnership development work to support the transition to an ICS.

1.2 What do we mean by population health improvement?

In NCL, we are defining population health as "an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies"[1].

By having an NCL Population Health Improvement Strategy – we are describing in the broadest sense the principles, approaches and ways of working that will deliver improvements in the health and care outcomes of the residents of NCL. We are focussing on population health improvement, rather than the dominant language of population health management, because it is more intuitive, ongoing, incremental and participative – reflecting our intention to set out our way forward and progress together over time. The principles, approaches and ways of working will needed to be supported, facilitated and embedded at all levels within the ICS, from hyper local and neighbourhoods, through to place and system, with integration and partnership at the centre.

2. Why does NCL need a population health improvement strategy?

The case for change is straightforward:

- There is minimal improvement in life expectancy and stagnation or even decline for some residents. Additionally, too many residents are spending the last 15-20 years of life in poor health / wellbeing
- There are stark inequalities across different communities in NCL in terms of health and care access, experience and outcomes
- The system cannot, and will not, keep pace with demand, especially if we don't start taking preventative measures

The main causes of death and ill health in NCL are cardiovascular disease and cancer. Lifestyle factors and behaviours are not improving at a sufficient rate (and in some cases are worsening, particularly for childhood obesity) to forecast a decline in the need for those services. The system is predominantly geared to "fix" or "treat", rather than "prevent".

The direct and indirect impacts of COVID-19 have starkly highlighted the inequalities faced by many residents in NCL, visibly demonstrated by hospitalisations and deaths from COVID-19 during the pandemic, and wider impacts on children living in overcrowded households during lockdowns and differential experiences on employment and income.

These inequalities are longstanding and deeply entrenched among some communities in NCL, driven by high levels of deprivation, affecting all aspects and phases of people's lives including education, employment, income and housing. For some communities, the intersectionality between ethnicity and deprivation compounds the impact on health and wellbeing, including racial discrimination. For example:

[1] King's Fund: A vision for population health, 2018 (p.18). https://www.kingsfund.org.uk/publications/vision-population-health

- Across the five years before COVID-19, life expectancy for men living in Upper Edmonton West in Enfield was around 15 years lower than for men and women living in Frognal and Hampstead Town (in Camden)
- Those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death
- Residents from Black communities are more likely to die prematurely from preventable or treatable causes of cardiovascular disease compared to White residents

Other factors can also be negatively and unfairly linked to poor health and wellbeing outcomes including being disabled, having a learning disability, having a serious mental health condition, being homeless or being from an LGBTQ+ group. Many residents will live with more than one of these factors, with some individuals and communities experiencing severe and multiple forms of disadvantage. Inequalities can also be stark in the ability to access services, resulting in late diagnosis, late access to treatment and subsequently poorer outcomes.

[Placeholder: Include example of inequalities in access]

[Placeholder: Include information on utilisation of services]

3. What is the NCL Population Health Improvement Strategy?

3.1 The aim of the Population Health Improvement Strategy

Our vision for the NCL ICS is to improve outcomes and wellbeing for the residents of NCL, 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.

The aim of the Population Health Improvement Strategy is that together, with residents and communities at the centre, we will improve the health and wellbeing of our population and reduce health inequalities by:

- Working in **partnership with our communities**, enabling them to start well, live well and age well, and ensuring that the lived experience plays a central role in the co-design and delivery of services and interventions
- **Using our data systematically and in new ways** to understand need and drive change
- **Focusing our collective resources in the most effective way** to address need and reduce inequality of access, experience and outcomes, including investing upstream to reduce entrenched health inequalities
- **Leveraging the benefits of the ICS** – as planners, providers, partners and employers – to have the greatest impact on the outcomes for the people we serve

3.2 The core principles of the Population Health Improvement Strategy

The following five core principles will underpin all that we do as part of the Population Health Improvement Strategy:

Fig. 1: Core principles of the Population Health Improvement Strategy:

- The wider determinants of health are the single most important driver of health outcomes for our population. **We will use the power of our ICS partnership in NCL to impact, influence and advocate for changes that address the fundamental components of health** – income, employment, housing, education, transport and leisure. This includes our commitment to a greener NCL, a collective focus on social value and strengthening the wider impact of our anchor organisations.
- The healthy behaviours and lifestyles of our population are critical to improving outcomes but this cannot be achieved without a new relationship with our communities that seeks to understand the challenges, what is important to people, speaks to their aspirations and based on their strengths. **We will reset our relationship with local people and communities and shape our support and provision to enable everyone to live their best and healthiest lives.** We understand that this needs to be underpinned by a decision making process which is flexible enough to operate at both place and system level.
- We recognise that the places where people live and the communities they are part of play an important part in sustaining long healthy lives – both mentally and physically. Our borough partnerships and our neighbourhoods are therefore central to realising our system commitment to improving the health of our population. **Borough Partnerships will deploy their expertise built on local relationships to find the right solutions with their communities**. We will enhance and enable the work they do through our work across NCL embodying the principle of subsidiarity.
- We know that people's needs can be complex – as a result of age, frailty or multiple disadvantage. **We will work together as partners to better understand those needs from an individual's point of view, integrate our provision and combine our resources around people** rather than conditions or single issues.
- There are significant differences in access, experience and outcomes across our population. We also know that the way we have historically funded services and investments has not always reflected need. Moreover, these inequalities drive many of our resourcing issues and challenge our future financial sustainability as a system. **Using our data and in partnership**

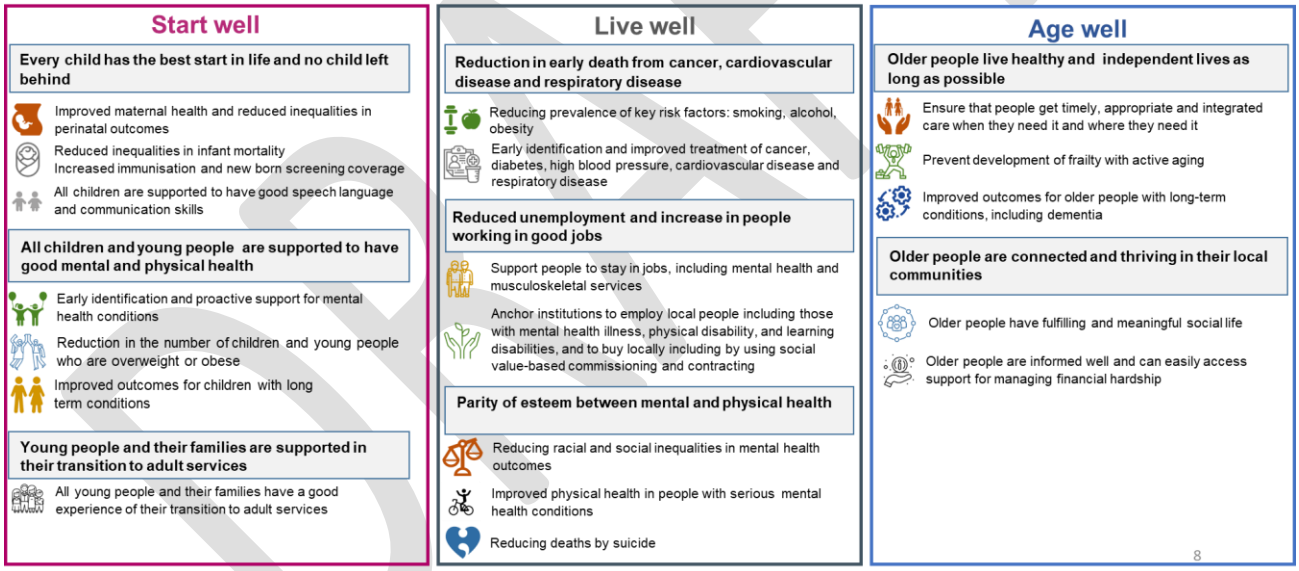
with our communities we will seek to deploy our resources to address the inequalities our residents experience – taking the learning from Covid about different communities needing different levels of support to access care and achieve equitable outcomes and therefore taking this into account as we make decisions about resource allocations for the longer term health of the population and of the system.

3.3 The NCL Population Health Outcomes Framework

We have developed an NCL Population Health Outcomes Framework that provides an overarching view of the outcomes we want our residents to experience, thereby providing a high level sense of where we need to act as ICS. The Outcomes Framework has been developed to underpin the vision for the ICS and the purpose of the Population Health Improvement Strategy, and is complementary to the plans and objectives that sit at system and place based levels. Working together to improve outcomes will drive ever more integration throughout the ICS.

The Outcomes Framework is based on existing priorities and ambitions at system and place (many described in local Health and Wellbeing Board strategies), driven by existing public health evidence (such as in local Joint Strategic Needs Assessments), our population health needs analysis and the progression towards integration.

Fig. 2: Summary of the NCL Population Health Outcomes Framework



The Outcomes Framework will continue to be developed, identifying a core set of indicators, which we will then use to:

- Understand our baseline position, including inequalities
- Develop goals & trajectories, based on our principles
- Build the indicators into our population health improvement platform, HealtheIntent, so that we have a near-real time view of the outcomes for the system, boroughs and care teams

As a result, the full Outcomes Framework (with supporting dashboards) will contribute to our decision making to align resources to address the most stark inequalities or gaps in outcomes, alongside taking account current investment disparities. It will also be central to how we measure progress and monitor impact.

3.4 Roles and responsibilities throughout the ICS

To realise the improvements in outcomes in our communities, every part of the ICS will have to take responsibility for applying the population health improvement principles to what they are doing and how they do it.

The individual and combined roles of the core three levels of the ICS – neighbourhood, place and system – will be vital to the delivery of improved outcomes. We have set out an overarching view of the expected roles and functions of the three main levels within the ICS, to illustrate what "good" will look like as part of our population health improvement journey (see Fig. 3).

We need to do more work to identify, develop and understand the strengths and opportunities that all parts of the ICS will contribute to our population health improvement journey. Included within this is the role of both Provider Alliances and individual providers of services. For example, both *Beyond the Data* from Public Health England and the NHS Race and Health Observatory's *Ethnic Inequalities in Healthcare* highlighted the need for an increased focus on ethnicity data collection. As part of this it would also be beneficial for providers to understand more from their local communities about their lived experiences of access, experience and outcomes, and within this why there may be a reluctance to provide ethnicity information.

Fig. 3: Overview of core functions and responsibilities of Neighbourhood, Place and System in Population Health Improvement in NCL

Neighbourhood

- Individuals and teams using PHM / HealtheIntent as part of everyday care
  - Making every contact count
  - Spotting and resolving gaps in care
  - Identifying inequalities and where other factors / wider determinants might be impacting, e.g. signpost to benefits advice or housing advice
- Resources are organised and deployed to meet both proactive / preventative needs and reactive / episodic needs
- Population risk stratification utilised to identify and manage caseloads
- Teams are multi-disciplinary and horizontally & vertically integrated, embedded in their communities and reflecting their communities
- Wide range of specialist (medical and non-medical) expertise is easily accessible
- Integration of outcomes, incentives and payment mechanisms, with patient reported outcomes and experience measures strongly featured
- Dynamic and interactive community and resident review loop – understanding needs, sharing ideas, monitoring impact and refining approach
- Local planning responsibilities and processes utilised, with discretionary and flexible funding able to support care & pathway transformation (aligned to place & system outcomes)
- Evidence based care models & interventions utilised and adapted for local population needs
- Develop "flexibility" of neighbourhood definition – developing solutions to wrap around communities, not necessarily geography / traditional organisation boundaries

Place

- Optimum understanding of population needs – developing insights, monitoring for change, utilising community relationships to review and respond
  - Systematic review of inequalities and development & implementation of ideas to reduce
- Sets direction of travel and local priorities in light of population needs and place & system outcomes – monitoring for impact and accountable for delivery
- Plan and organise deployment of resources to deliver outcomes – understanding demand, services utilisation, changing needs, changing behaviours
  - Focus on prevention, driven by reducing inequalities, utilising opportunities to maximise benefits from strengths of partnership (tackling wider determinants) and asset / strength based approach in local communities
  - Continuous development of partnership – between and amongst organisations, voluntary and charity sector, communities and individuals
- Shaping and driving transformation – pathways, care models, workforce models, culture & behaviours
- Critical level of interface between and amongst partners – identifying where escalation and additional support required
- Establish environment to enable mutual aid, problem sharing, risk sharing and learning / best practice
- Coordination and support cohesion of neighbourhood plans
- Act as "honest broker" between services and communities – building relationships, developing co-production models and adapting approaches

System

- Population health principles and behaviours are embedded at the heart of the partnership – changing language and leading the new narrative from the top
- Systematic review of the deployment and effectiveness of resources, supported by infrastructure and skills to tackle the "wicked issues"
- Putting in place funding frameworks and payment mechanisms to support proportionate universalism and tackling of wider determinants
- Oversight and assurance of outcomes
- Undertaking delivery where "doing once for all" is most effective
- Develop, implement and monitor system-level strategies, ensuring ongoing review / adaptation / learning throughout system
  - Monitor & consider consistency and equity of offer – offering strategic approach to proportionate universalism
  - Strategic engagement with VCS and communities
- Developing and utilising planning processes focused on tackling inequalities, responding to population needs, supporting identification of problems and determining potential solutions
- Developing & refining principles, frameworks, methodologies to support population health in practice – particularly where "once for all" makes sense
- Senior partnership issue resolution
- Acting as broker between system, regional and national bodies – driving from population and local needs to influence and secure change
- Interactive relationship with academia, AHSNs, research, etc. to utilise full system skills and expertise across the full breadth and depth of the system

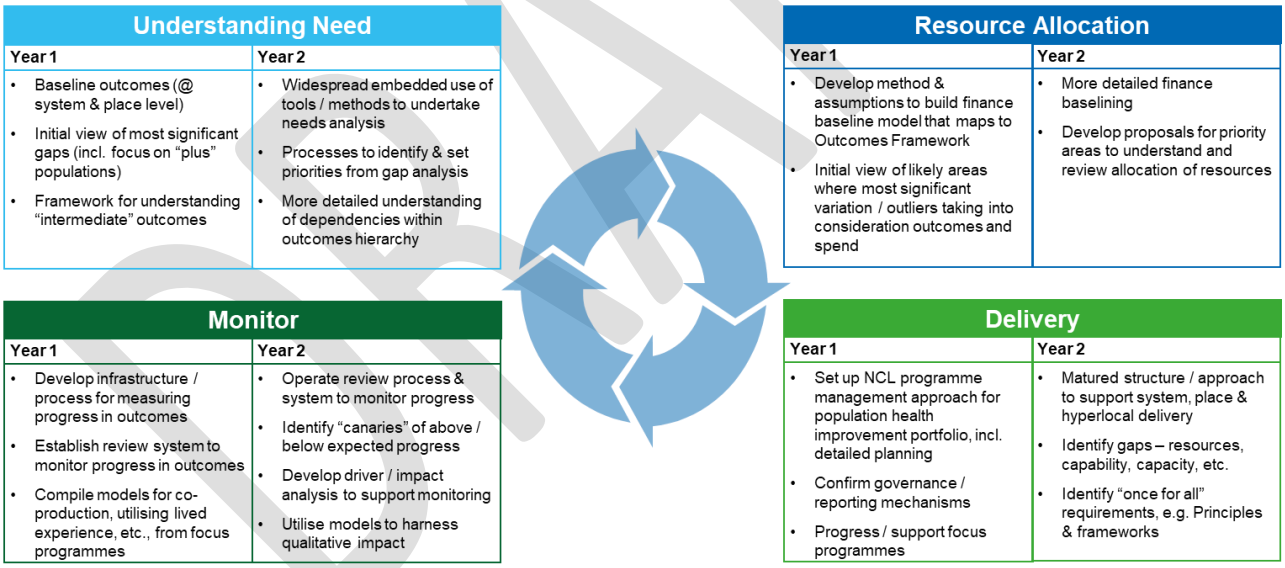
4. Our plans for the next 1-2 years to deliver population health improvement in NCL

We know that some of these outcomes will take time to see improvements at a population level. However, we need to work now to make the changes that will result in those long term improvements, but that will also have an impact at an individual level in the shorter term. For example, it is anticipated that benefits from improved Cardiovascular disease management can be achieved in 1 to 2 years, whereas smoking cessation will realise benefits after c. 5 years, however other interventions such as in tackling childhood obesity will only realise benefits in 10+ years or longer.

We are focusing our planning on the next two years – to create the culture, infrastructure and ways of working that will both provide the foundations for longer term population health improvement as well as have tangible impacts for individual residents in the here and now.

Our initial roadmap is based around the core stages that will enable us to put the population health improvement principles into practice: understand need, resource allocation, delivery and monitor. The initial roadmap is focused at system level, but further planning will enable us to develop roadmaps and plans across the ICS – building a "3D" view.

Fig. 4: Initial 2 year roadmap for population health improvement at NCL level



4.1. The core themes of the NCL Population Health Improvement plan

The core themes of our plan are:

- Support the creation of place-based capacity and capability to deliver population health improvement – understanding local population needs, using data and analytics, listening and working with communities to develop and respond to insights
- Developing our model for putting population health improvement into practice – creating the infrastructure for integrated teams who focus on equity, prevention and proactive care

- Putting co-production and resident involvement at the heart of all our programmes, from development to delivery, for residents, service users and employees
- Embedding population health intelligence to help us understand need, formulate our system problems, address inequities and improve outcomes.
- Rolling out our population health management platform so that frontline health and care teams have access to a near-real time integrated health and care record to identify gaps in care and opportunities to improve the quality of care and reduce inequalities
- Developing new funding models that provide opportunities for testing ways in which we can allocate resources to support those communities with different levels of need to achieve equity of outcomes
- Thinking prevention first in all we do, focusing on keeping people well, using strength-based approaches and tackling wider determinants of health
- Using evidence based interventions and developing proportionate and effective monitoring and effective measurement of impact and improvement (quantitative and qualitative)
- Promoting a system-wide culture of understanding and tackling inequalities through all that we do

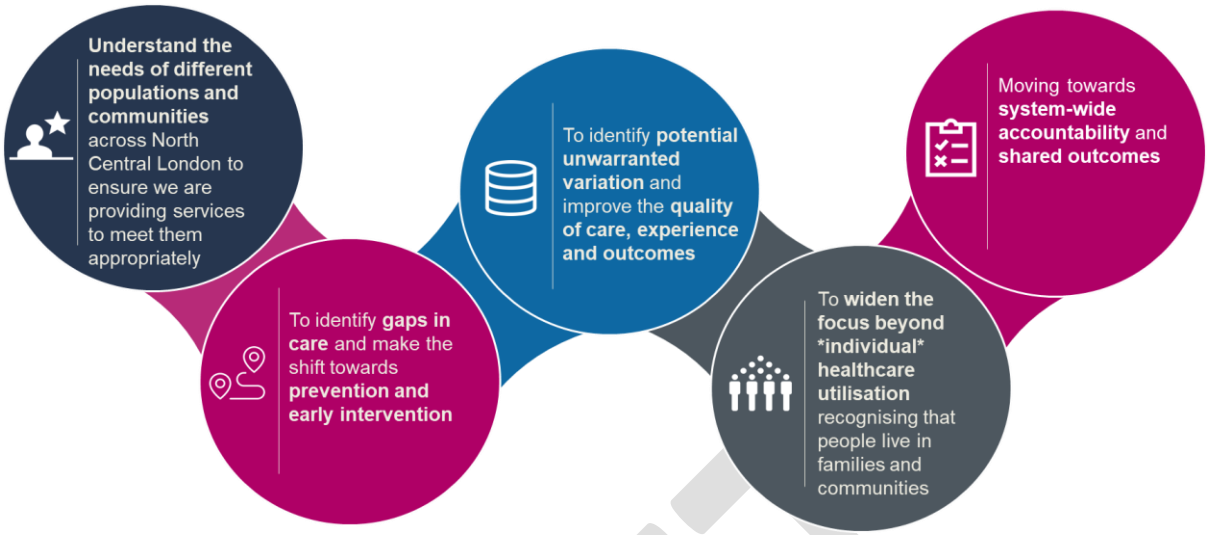
By focusing on these themes, we will making the best use of our skills and resources at all levels in the system – ensuring that the system is providing the environment that will allow places and neighbourhoods the flexibility to develop the local partnerships (including with residents) and ways of working that most effectively will meet the needs of local communities.

Across all of these themes, building a culture that embodies our population health improvement principles and reflects the lived experience of our communities will be central to achieving our outcomes. This includes empowering health and care professionals to work in partnership with the voluntary and charity sector and residents as one team, building on the strengths and aspirations of our residents, supported by the data, to do what is needed.

4.2 Using data for population health improvement

NCL recognises the importance of using data and intelligence to underpin work on population health improvement, and particularly to shine a light on where there are inequities and inequalities.

We have five goals in what we want to achieve with using data:



As a system we are working together to do this by creating a near-real time integrated health and care record in a population health management platform provided by a company called Cerner – HealtheIntent. This will enable our frontline health and care teams to see where patients have gaps in care and create a better understanding of population health needs and inequalities.

[Placeholder: Include information on use of HealtheIntent in PITS]

Key outputs from HealtheIntent include:

- Vaccination dashboards identifying equity gaps. Includes childhood immunisations, flu, and Covid. These dashboards have been used to identify opportunities to improve uptake in specific areas or with specific communities.
- Registries of patients with a condition or issue that flag whether individual patients have 'gaps in care'. For example, if someone with serious mental health illness has not had their physical health check or someone with diabetes does not have their blood pressure under control. These registries will be visible to all frontline health and care staff during 2022/23.
- Quality improvement dashboards which highlight where there is potential unwarranted variation in care for specific conditions and also by equalities groups so that care teams can identify best practice ('bright spots') or areas for improvements.

[Placeholder: Include information on next steps – embedding more and the challenge of moving from the analysis to impacting clinical and care practice and actions]

4.3 Addressing Health Inequalities

A key element of this Population Health Improvement Strategy is an underlying commitment to addressing Health Inequalities. NCL CCG have already demonstrated their commitment to this through the establishment of a dedicated Communities Team, who focus on reducing the variation in access, experience and outcomes for those facing health inequalities. This includes oversight of the NCL Inequalities Fund of £8.75m, the commissioning of inclusion health services, i.e. homeless health and asylum health, overseeing an NCL anchor institutions strategy and developing a Green Plan for the sector.

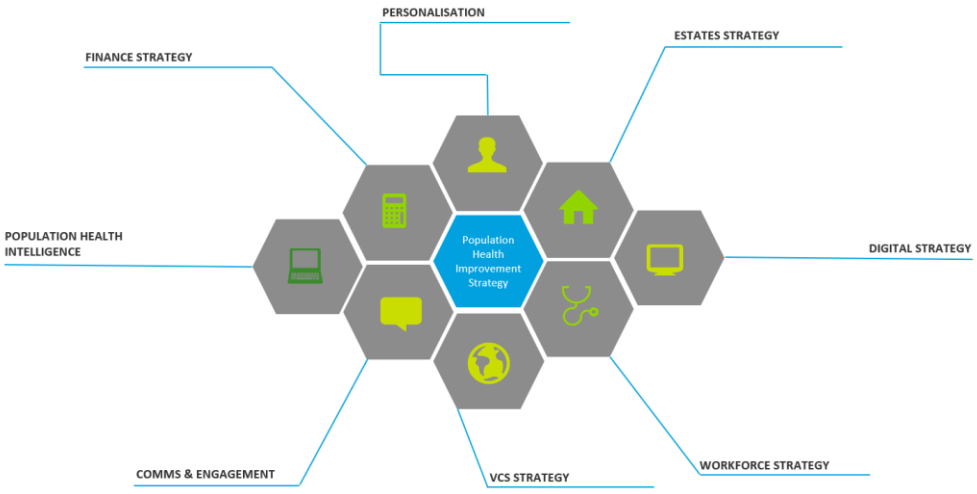
The NCL Inequalities Fund aims to bring together local communities and statutory services to co-design innovative, collaborative approaches to addressing entrenched health inequalities. This includes focusing on the 20% most deprived, as well as other forms of inequality such as learning disability, and is aligned to the wider Core20PLUS5 agenda. Schemes aim to target the underlying root causes of inequality, including the social determinants of health, with examples including schemes addressing severe and multiple disadvantage, food poverty and serious youth violence.

Going forwards, the outputs of the both the Inequalities Fund and the wider health inclusion, green plan and anchor institutions strategy will continue to feed into a Population Health approach across the sector.

4.4 Enablers for our population health improvement plan

We have identified the core enablers that will support the delivery of this Population Health Improvement Strategy. In alignment and combination they will deliver tools, principles, frameworks and methodologies to create the culture, infrastructure and ways of working required to deliver improvements in outcomes.

As part of our plans for the next 1-2 years, we need to work with our enablers to develop the detailed plans – to understand and specify the changes that they will make and contribute to, in order that the aim of this strategy will be achieved.



4.5 Our population health improvement focus programmes

Whilst we have set out our ambition for our Population Health Improvement approach to infiltrate across the planning and delivery of all our services, we also know that we have a number of programmes and initiatives that are acting as forerunners – testing the ways in which we utilise and embed our population health improvement principles, providing us with learning experiences, matured relationships and new skills and models. We recognise the close relationships between these programmes and the mutual learning and sharing of experience that will result as we progress and embed our principles and population improvement delivery themes.

The following list of programmes is not exhaustive, but sets out for those programmes identified, how they align with our population health improvement principles and some outline delivery aims for the next 1-2 years.

Focus programme	Population health improvement approach	Delivery aim in 22/23 and 23/24
Inequalities Fund	• Tackling inequalities • Grass-root / community-focused initiatives • Addressing social determinants of health inequalities	• Demonstration of the value that co-production and use of lived experience can bring to reducing variation in access, experience and outcomes • Development of potential integrated delivery models between the statutory and voluntary sectors
Proactive Integrated Care Teams (PITs)	• Using HealtheIntent to understand needs, identify inequalities & gaps • Tailoring interventions (backed by multi-disciplinary teams) to offer alternative pathway or maintain / improve "readiness" for future care	• Develop provider partnerships for all PITs • Expand Haringey PIT across east locality and develop integrated model with Wood Green CDC • Document core operating model • Evaluate and share learning to inform development of neighbourhood population health improvement model
Start Well programme	• Robust population health needs analysis • Service users and community participation informing programme approach	• Baseline inequalities analysis • Case for change tested through in-depth community engagement • Develop proposals for service user and community engagement and participation in any subsequent phases of programme
Community & Mental Health Services Reviews	• Developing evidence based models of care • Tackling inequalities	• Commence implementing core service offer for both community and mental health based on gap analysis of priority areas

Focus programme	Population health improvement approach	Delivery aim in 22/23 and 23/24
	• Testing models to allocate resources to meet differential needs	• Development of outcomes framework to start to monitor/assess impact of delivering core service offer on inequity of access to services • Provide opportunities for local people to join workforce e.g. with peer support workers in mental health services
Inclusion Health	• Use of population health data to tailor approach to service delivery	• Holistic approach to meeting needs of vulnerable cohorts, e.g. trauma-informed, gender-informed, and delivered in partnership between health and local authorities
Long Term Conditions Locally Commissioned Service (LTC LCS)	• Prioritising prevention and early intervention • Testing new funding models to reallocate resources where differential effort required	• Launch preparatory year for the new model of care, including practice training and readiness • Define and establish supporting infrastructure; • Finalise outcomes framework and goal setting and build dashboard • Finalise funding model, including outcomes-based payment
[Placeholder: Example of pathway that we are improving]	•	•
[Placeholder: Example on prevention]	•	•
[Placeholder: NCL Cancer programme]	•	•
[Placeholder: Specialised commissioning]	•	•

4.6 Alignment with Core20PLUS5

Core20PLUS5, the national approach to tackling healthcare inequalities, will also be integral to delivering improvements in outcomes throughout 22/23 and 23/24. Whilst this does not operate as a stand-alone programme, we will be:

- Prioritising our understanding of the baseline position for the Core20PLUS5 outcomes and where significant gaps, variations, and inequalities exist
- Mapping and aligning the different projects related to Core20PLUS5
- Identifying and developing additional projects / requirements to address any gaps

We will continue to build the action plans against the 5 priority areas:

Maternity Continuity of Care

- Collaborative design of midwifery continuity action plan
- Ensure that women from Black, Asian, minority ethnic and mixed ethnicity backgrounds, as well as vulnerable groups are care for using patient-informed clinical models to improve outcomes and experiences
- Trust action plans that include logistics planning and milestone setting, followed by system-wide introduction, sustainability and launch of new continuity models

SMI – annual health checks

- Specialist primary care teams established across boroughs to provide full SMI coverage and drive improvement against the annual healthcheck KPI (60%)
- NCL has launched a clinical network across primary and secondary care driving clinical change. The network will develop a system wide plan in 2022/23 to improve health outcomes and reduce inequalities in health and social outcomes

Respiratory

- Development of ICS wide multi-disciplinary Respiratory Network
- The Respiratory Network will champion, commission and oversee Proactive Care programmes and transformation initiatives across all Respiratory pathways, including reviewing population health data to understand how services can address health inequalities within the local populations
- Specific priority areas include: introduction of pulmonary rehabilitation roadshows targeting underserved populations; establishment of spirometry hublets in primary care

Cancer diagnosis

- The Cancer Alliance is focusing on four priorities to address known inequalities in cancer access and provision, as well as continue identifying other inequalities:
  - Working with patients, voluntary sector organisations, academia, local authorities, and NCL partners to understand the needs of diverse or marginalised groups
  - Reducing barriers in service provision and increasing access for hard-to-reach groups in NCL
  - Ensuring data analysis and reporting includes inequalities indicators
  - Utilising information from Equality Impact Assessments (EIA) on our programme as a guide to embed further activities in Alliance way of working

Hypertension case finding

- Development of ICS wide multi-disciplinary Cardiovascular Disease (CVD) & Stroke Prevention Network
- The network aims to prevent and reduce the prevalence of Stroke, CVD, Myocardial Infarction (MI), Peripheral Vascular Disease (PVD), heart failure and Vascular dementia by focusing on the management of modifiable risk factors such as hypertension, atrial fibrillation and hypercholesterolaemia
- Case finding for hypertension, AF and hypercholesterolaemia forms part of the key priorities for improvement in the workplan for 22/23, and case finding for hypertension and AF is included in the LTC LCS
- Embedding of risk stratification tools into HealtheIntent and development of a hypertension and lipid management HealtheRegistry to support detection of those at risk, optimisation of care and increasing uptake of NHS health checks

We have started to define the “Plus” population cohorts for NCL, as our analysis shows that unwarranted variations in access, experience and outcomes is much more nuanced than consideration deprivation in isolation. By looking beyond the most 20% deprived of our population, we will design and deliver services to the level of intensity required to close gaps in health needs across the deprivation and ethnicity gradients to maximise health gains and reduce inequalities. Importantly the patterns of deprivation are different for children and young people and also older people compared to the population average. We will tailor our approaches and plans to reflect these differences.

We have also identified three other core groups of population cohorts that we propose to include in our “plus”:

- Ethnic groups with a high percentage of the community living in the 40% most deprived areas:
  - Start Well: Black African, Bangladeshi, Mixed Black ethnicities and Somali communities, noting that the patterns of spatial deprivation are different than adults
  - Live Well: White Turkish communities
  - Age Well: Black Caribbean communities
- People with serious mental illness and learning disabilities – these populations have disproportionately poorer health outcomes, including higher mortality and preventable ill health

- Inclusion health groups – these groups face disproportionately poorer health outcomes, and include the homeless, refugees and asylum seekers, sex workers, Irish Traveller and gypsy communities, transgender people, and (ex)offenders

We will be undertaking an inclusion health needs assessment to better understand the needs and sizes of these populations.

[Placeholder: Further case studies to be captured and appropriately distributed throughout document]

Haringey community COVID vaccine outreach

What did we do?

A partnership between Haringey Council, Local NHS and community groups to increase COVID vaccine uptake, particularly focussing on communities with lower uptake. We set up a vaccine engagement and outreach team integrated with vaccine provision from our GP federation– with staff with a number of community languages. We had a Haringey COVID vaccine bus and used data and listened to communities on where best to go out into the community and provide vaccinations.

What was the impact?

We supported over 80,000 outreach engagements to encourage vaccination take up in low uptake areas, contributing to over 11,000 vaccine appointments and delivered an additional 2850 vaccinations on the vaccine bus. COVID vaccine uptake was increased in particular groups (e.g. rough sleepers, people from Turkish communities). The programme was informed by local initiatives in other NCL boroughs and we were able to share our learning across London.

"Going out into communities with our vaccine bus allowed us to provide 1st COVID vaccinations and vital protection to 100s of local residents who we had not been able to reach previously"

Equitable recovery Programme – Royal Free London

What did we do?

Extensive data analyses of elective procedures and outpatient appointments Do Not Attend (DNA) was performed against ethnicity and deprivation factors that uncovered inequalities in access to services. The equitable recovery programme was set up consisting of various components including data analyses using HealthIntent and hospital data, improved ethnicity recording as well as interventions such as a network of patient navigators and volunteers proactively contacting patients to offer support and understand barriers to access. A partnership is being established with local community and voluntary sector organisations to explore opportunities for joint working.

What was the impact?

A significant number of missed appointments were reduced, patients' satisfaction improved and savings to the system made. These are early impacts of this recent interventions; work is in place to extend its reach across the whole of NCL.

"Intelligence-led interventions made us think differently and support our 'business as usual' with more bespoke interventions that have immediate benefits to both, patients, and the system"

4.7 Next steps

To ensure this Population Health Improvement Strategy is owned and endorsed by the system, we now need to socialise it widely with our key stakeholders. We see this very much as a live and iterative document that will continue to develop, reflecting the feedback that we receive from system partners.

NORTH LONDON PARTNERS in health and care

NHS

Appendix 1: Glossary

Population Health: In NCL, we are defining population health as "an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies"[2].

Population Health Improvement Strategy: We are describing in the broadest sense the principles, approaches and ways of working that will deliver improvements in the health and care outcomes of the residents of NCL.

Population health management (PHM): While the definition of PHM has changed over time, at its heart is the use of integrated data by all health and care professionals to drive improvement and reduce inequalities. This will enable a risk stratified approach to delivering the care that residents need, recognising that there are differing levels of needs amongst our communities and residents.

HealtheIntent: A near-real time integrated health and care record in a population health management platform provided by a company called Cerner. This will enable our frontline health and care teams to see where patients have gaps in care and create a better understanding of population health needs and inequalities.

The 4 pillars of population health: The following four interconnecting pillars form the basis for a population health system:

1. The wider determinants of health
2. Our health behaviours and lifestyles
3. The places and communities with live in, and with
4. An integrated health and care system[3]

Wider determinants of health: The socio-economic circumstances that drive the health outcomes for our population. Income, employment, housing, environment, education, transport and leisure are all examples of wider determinants of health.

Proportionate universalism: The resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. It is the recommended approach to reducing health inequalities, as outlined in the Marmot Review (2010) following extensive consultation with experts in this field, and building on decades of academic research.

Health inequalities: Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. These inequalities are understood and analysed across four, often inter-related, factors: socio-economic factors such as income; geographic factors such as the

[2] King's Fund: A vision for population health, 2018 (p.18). https://www.kingsfund.org.uk/publications/vision-population-health

[3] King's Fund: A vision for population health, 2018 (p.21). https://www.kingsfund.org.uk/publications/vision-population-health

area where people live; specific characteristics such as ethnicity, disability or sexual orientation; and excluded groups, for example, people experiencing homelessness.[4]

Subsidiarity: The principle of subsidiarity is the idea that decisions should be made as close as possible to local communities.[5]

[4] King's Fund: Health inequalities: our position. https://www.kingsfund.org.uk/projects/positions/health-inequalities

[5] King's Fund: Integrated care systems explained. https://www.kingsfund.org.uk/publications/integrated-care-systems-explained

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North Central London Integrated Care System

NCL Population Health Improvement Strategy

Enfield Health & Wellbeing Board

7 July 2022
V0.3

NCL Population Health Improvement Strategy

North Central London Integrated Care System

- Becoming an ICS provides NCL with an opportunity to change the way we plan and deliver services – integrating even further, widening the levers we can use, and maximising impacts of change
- Delivering improvements in residents' outcomes, thereby improving population health, is one of the four objectives for the ICS
- The Draft NCL Population Health Improvement strategy aims to reflect the binding of the work of neighbourhood, place and system in a complementary way so that we use our collective resources, capabilities and connections to improve population health
- The strategy provides the core narrative for the system to share and own
- It will need to delivered fully <u>across</u> and <u>through</u> the system – acting as a framework

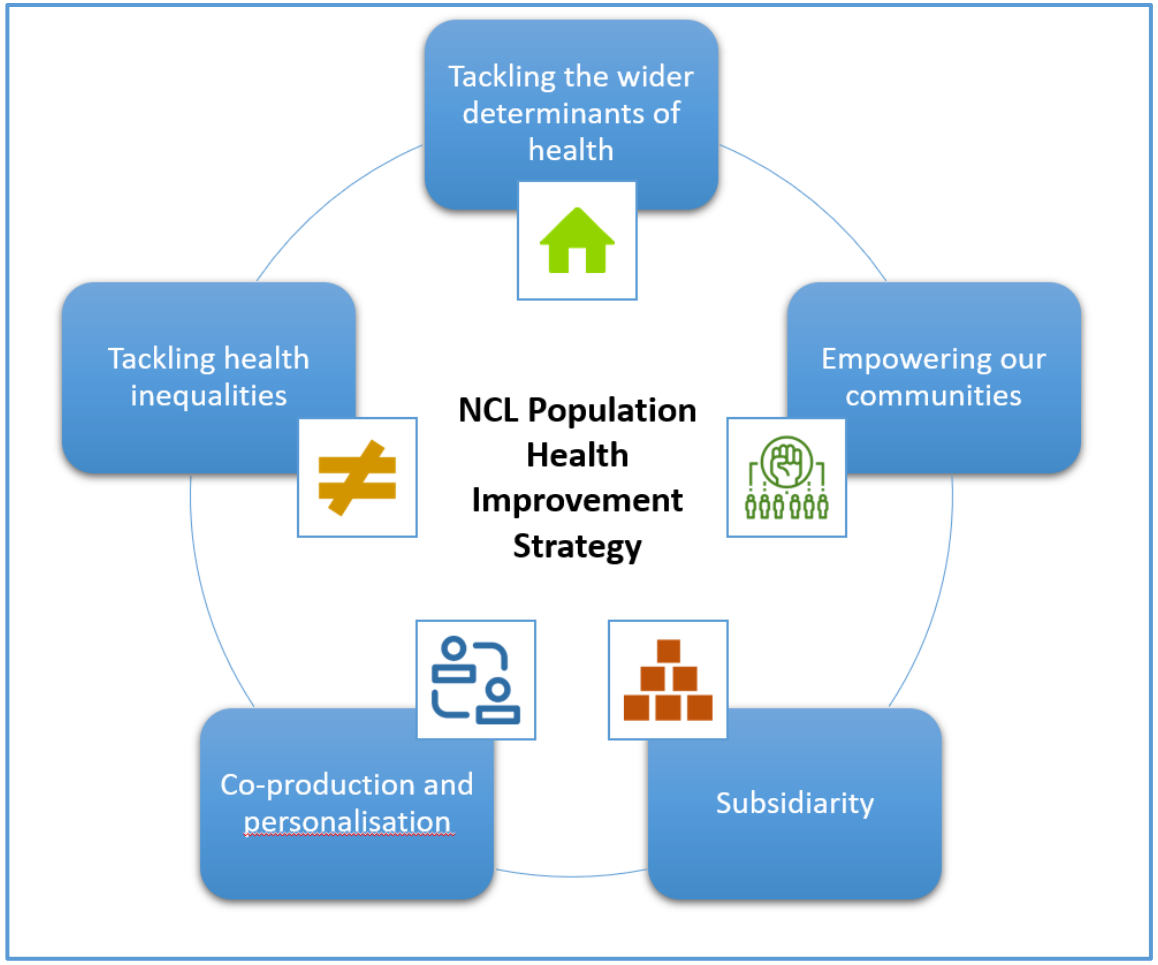
- This is the first iteration of the strategy, which has been developed by a wide range of system and place authors who have come together from across ICS partner organisations
- The strategy is being shared with partners, for discussions and feedback to shape and refine the subsequent development of detailed plans and activities to support the strategy

The Population Health Improvement strategy sets out:

- A single narrative for NCL that is owned and supported by all partners as to why we are building and following a population health improvement strategy
- A shared vision for the future of health and wellbeing of NCL residents, on which to build our strategy
- Support and endorsement for the roadmap as to how we will deliver this vision – recognising the enablers and interdependencies with multiple programmes of work
- A commitment from all partners to be involved and play their part in delivering the roadmap and its detailed plans
- Agreement to build capacity for a population health improvement approach across the places and neighbourhoods that make up the ICS – using data to drive timely clinical and other interventions
- Agreement to apply population health improvement principles not only to health care services but also to other services, including those that impact wider determinants, such as voluntary and community sector, social care services, integrated services, education, housing and employment

Core principles

North Central London Integrated Care System



- The principles and core delivery themes of the strategy need to permeate everything that we do – Population Health Improvement is everyone's business.
- We need to do things differently to improve the outcomes and wellbeing of our residents – and reduce inequalities
- Through our population health improvement approach we will:
  - Connect with communities to make a meaningful difference in how services are planned and delivered
  - Use the opportunities that the ICS provides for all partners to work together with communities
  - Make our health and care system sustainable – focused on early intervention and prevention

NCL Outcomes Framework

North Central London Integrated Care System

Start well

Every child has the best start in life and no child is left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and new born screening coverage
- All children are supported to have good speech, language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Early identification and improved care for people with mental health conditions

- Reduced racial and social inequalities in mental health outcomes
- Improved physical health in people with serious mental health conditions
- Reduced deaths by suicide

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in fulfilling employment

- People are supported to stay in jobs, including mental health and musculoskeletal services
- Increased employment of local people in anchor institutions, including those with mental health illness, physical disability, and learning disabilities, and increased level of "buy locally", including using social value-based commissioning and contracting

Age well

People live as health, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier prevention, detection and management of long term conditions, including dementia, in older people

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

2

Indicators for each outcome are being developed so that we can understand variation, identify opportunities for improvement and monitor progress. We need to consider prioritised outcomes for NCL and for each Borough.

Core themes for delivery

North Central London Integrated Care System

- The core themes will help us to put population health improvement into practice
- The themes will help us make the best use of our skills and resources at all levels in the system
- We need to ensure the system provides the environment that will allow places and neighbourhoods the flexibility to develop the local partnerships (including with residents)
- The focus needs to be on those ways of working that will most effectively meet the needs of local communities
- We need to build on what we already have in place – we don't need to start from scratch

Alignment with Enfield plans

North Central London Integrated Care System

- The Population Health Improvement Strategy will inform the update of our Enfield Health and Wellbeing Strategy.
- Population Health Management can also inform delivery within our ICS Borough Partnership Delivery Groups (e.g. Inequalities Delivery Group and Screening & Immunisation Delivery Group)

- The Population Health Improvement Strategy also links well to other local council and NHS strategies and delivery plans, such as:
  - Council Plan
  - Local Plan
  - Early Help Strategy
  - Smoking and Obesity Plans (in development)

Priorities from the PHM analyses – it was agreed to focus on:

- Preventing & reducing tobacco dependence – vaping vs. tar based
- Preventing & reducing overweight people from becoming obese

- Population cohort of those who smoke/or are at risk of becoming obese, with the agreed outcome to focus on the 18 – 40 year age group – who are smoking and obese:
  - living in top 20% most deprived areas of the borough
  - other determinants of health, including social deprivation, education, poverty, housing
  - access to fresh food and access to green spaces should also be considered as part of this work
  - impact of mental health
  - consider homelessness

Intervention design for the local population health priorities will also review other important aspects including:

- Language spoken- English / Turkish / Polish / Other
- Children in the household and childhood obesity
- Cultural co-production
- Use of social media / community spaces (e.g. libraries, building synergies with the LBE led work including development of community hubs

Questions for discussion & next steps

North Central London Integrated Care System

- How is your population health improvement journey going? What does it look and feel like?
- What are your priorities? Are there specific outcomes or areas of inequality you are focused on addressing?
- Where are you already doing things that contribute to population health improvement? How do these align with principles and / or core themes of delivery? E.g. analysis to understand patient needs? Co-production of service model with communities?
- What would help you with the work you are already doing or planning to do? For example; more analytical / intelligence capacity and expertise to understand need better? Ideas for how to get communities more involved in service design? A framework / approach to use to get social workers to use HealtheIntent on a daily basis?
- Boroughs will now need to develop the processes and infrastructure to delivery this strategy. What have you got in place already that will act as your foundation? What support do you need from the system in order to do this?

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Agenda Item 7

MUNICIPAL YEAR 2022/23	

MEETING TITLE AND DATE **Health and Wellbeing Board** **7th July 2022**	**Agenda – Part 1**	**Item:**
	Subject: **Progress Update: Development of North Central London Integrated Care System and Enfield Borough Partnership**	
	Wards: All	
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:

- Purpose of the Integrated Care System and developing the NCL Integrated Care System and it means for our residents in the future delivery of person-centred care
- Overview of the NCL Integrated Care Board (ICB) wef 1st July 2022 and membership of the NCL ICB Executive Management Team

1.2 Progress Update - Enfield Borough Partnership

The attached slide deck summarises:

- Developing Enfield Place based partnership – national programme offer from NHS England & Local Government Association:
    - Leadership, Governance & Finance, Population Health Management and Digital development

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- Note the progress update for the transition to the North Central London Integrated Care System and establishment of the NCL integrated Care Board from 1st July 2022, informed by the presentation slides attached.
- Note the progress update for the Enfield Borough Partnership and the national programme offer to support the development of local priorities and a plan to inform operational delivery in 2022/23, informed by the presentation slides attached.

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Update on NCL ICS Transition

Presentation to Enfield Health & Wellbeing Board 7 July 2022

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The North Central London population

- North Central London is made up of five boroughs – Barnet, Camden, Enfield, Haringey and Islington.
- Around 1.6 million residents live in North Central London, with a relatively young population in some boroughs compared to the 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

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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
- A wide range of voluntary, community and social enterprise (VCSE) sector organisations and groups providing essential care

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Overview

- ✓ The Health and Care Bill received royal assent on 28 April 2022, becoming the Health and Care Act.
- ✓ NCL CCG will continue as statutory body until 30 June.
- ✓ The CCG's current system accountability, functions and responsibilities will transfer to the new NCL ICB on 1 July.
- ✓ Work has progressed well in key areas of ICS development including the development of a clinical and care leadership model and the development of borough partnerships.
- ✓ The NHS North Central London ICB Executive Management Team has been established.
- ✓ Work is underway to appoint Non-Executive Members and Partner Members to the NHS North Central London ICB Board.
- ✓ Key next steps include continued and strengthened engagement with our partners and residents and agreeing partnership ambitions for the next few years, including short term priorities and core principles for working together.

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Purpose of an Integrated Care System

- The core purpose of an Integrated Care System (ICS) 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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The 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 borough level

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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in health and care

Our developing system

North Central London Integrated Care System (ICS) is the name of the NCL system as a whole. An ICS is a way of working, not an organisation.
Partners within the NCL ICS include: Acute Trusts, Mental Health Trusts, Community Trusts, Local authorities (Barnet, Camden, Enfield, Haringey and Islington), Healthwatch and VCSE (Voluntary, Community and Social Enterprise) sector

NHS North Central London Integrated Care Board (or ICB) allocates NHS budget and commissions services. This is the organisation that NCL CCG staff will transfer to, and will be chaired by Mike Cooke, with Frances O'Callaghan named Chief Executive.

The **North Central London Health and Care Partnership**, is the Integrated Care Partnership, a joint committee with the councils across the five boroughs. This committee is responsible for the planning to meet wider health, public health and social care needs and will lead the development and implementation of the integrated care strategy.

System

Provider collaboratives involve NHS trusts and primary care (including acute, specialist and mental health) working together. UCL Health Alliance incorporates all NHS trusts and primary care in NCL.

Place

Place-based partnerships or **borough partnerships** include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care.

Neighbourhoods

Building on PCNs, Neighbourhoods support multidisciplinary working between frontline teams, population health management and relationships with communities.

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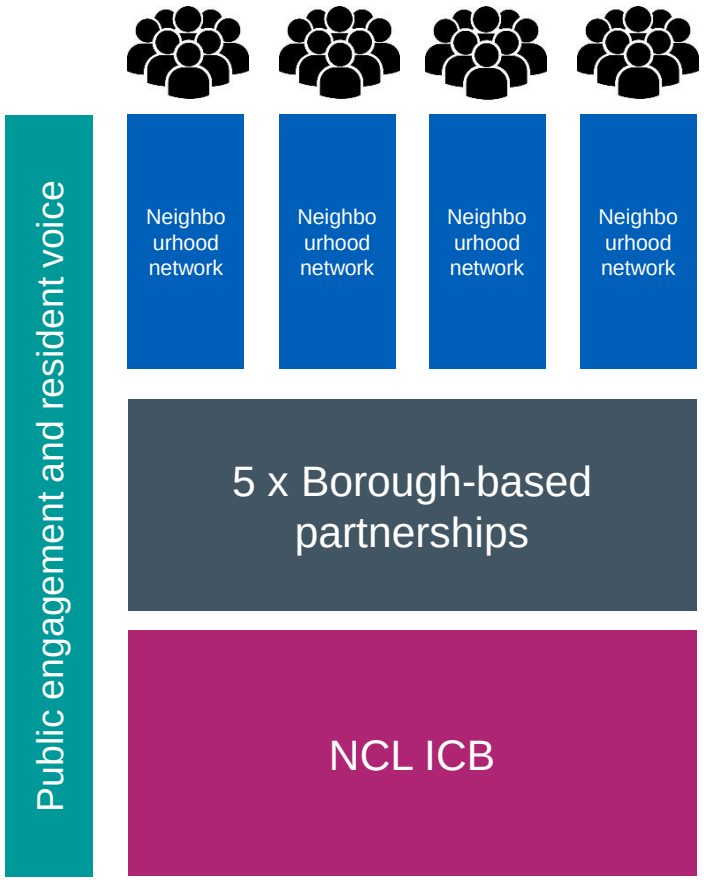
Where we are now

Together with system partners, we are designing what the North Central London Integrated Care System (NCL ICS) will look like at neighbourhood, place (borough) and system-level.



The core purpose of an Integrated Care System (ICS) 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.

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The NHS North Central London ICB Executive Management Team has been established

Board Member

Board Attendee

Chief Executive Officer
Frances O'Callaghan

Chief Development and Population Health Officer
Sarah Mansuralli

Chief Finance Officer
Phill Wells (in post TBC)

Chief Medical Officer
Dr Jo Sauvage

Chief Nursing Officer
Chris Caldwell (in post May '22)

Executive Director of Places
Sarah McDonnell-Davies

Chief People Officer
Sarah Morgan (in post July '22)

Executive Director of Performance and Transformation
Richard Dale

Executive Director of Corporate Affairs
Ian Porter

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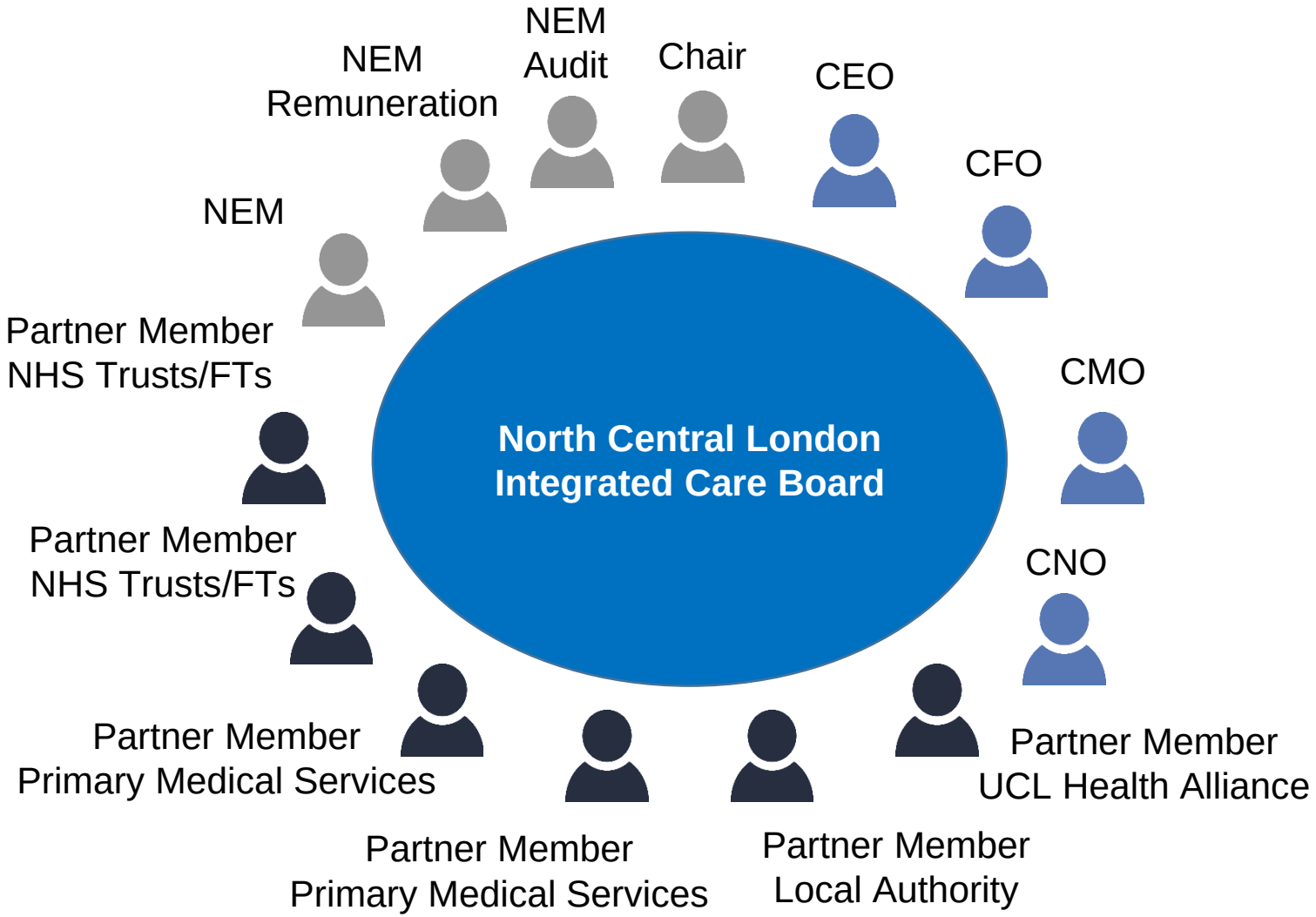
Membership of NCL Integrated Care Board



Non-Executive Members

Executive Members

Partner Members

NCL ICB has proposed 14 Board Members with voting rights within the Constitution.

To date, the Chair designate and the four designate Executive Members have been appointed to the NCL Board.

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Developing the NCL ICS will deliver benefits to residents, patients and staff working across NCL.

- **Reduce inequalities**: Identify where inequality exists across populations, outcomes, experience and access. Devise strategies to tackle these together with our communities.
- **Improved outcomes**: Enable greater opportunities for working together as ‘one public sector system’ – ultimately delivering improved patient outcomes for our population.
- **Working at borough level**: Support the further development of local, borough-based partnerships and Primary Care Networks.
- **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**: Make better use of our resources for local residents and achieve economies of scale and value for money.
- **System resilience**: Improve our resilience to face changes and challenges to meet the needs of our local population by supporting each other.

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Opportunities for change across the system

- Enabling population health approaches to tackle inequalities and wider determinants of health
- Driving new ways of planning and delivering across organisations
- Developing and supporting primary care networks
- Integration of care at neighbourhood and place level
- Supporting and developing our staff to ensure we have the workforce to meet the demands of a changing health and care system
- Create a health and care system that evaluates, learns and improves

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in health and care

What we want to achieve with population health in NCL

Understand the needs of different populations and communities across North Central London to ensure we are providing services to meet them appropriately

To identify **gaps in care** and make the shift towards **prevention and early intervention**

To identify **potential unwarranted variation** and improve the **quality of care, experience and outcomes**

To **widen the focus beyond *individual* healthcare utilisation** recognising that people live in families and communities

Moving towards **system-wide accountability** and **shared outcomes**

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Driving new ways of planning and delivering across organisations

Clinical leadership will need to evolve: with shared responsibilities for outcomes across pathways. If we succeed we will harness the world leading specialist knowledge we have in our specialist trusts and have a greater impact for the health of our population.

Proactive care: across NCL, multidisciplinary teams (made up of social services, acute, primary care, mental health and VCSE) are coming together to manage patients with multiple long term conditions proactively, using population health tools to understand elements of care that would most support them.

Single elective waiting list across organisations: Working with providers we have effectively started to manage a single waiting list across the system. Putting in place demand management initiatives to match capacity and reduce waiting times. This is combined with active mutual aid across sites to treat those in need much quicker.

Taking a pathway approach to recovery: We need to challenge the inverse care law, and invest outside of the normal large acute sites to drive improvements in outcomes. Accelerator money has been invested across the pathway from diagnosis and point of referral through to support in the community.

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in health and care

Key next steps

- ✓ Co-producing a population health outcomes framework and strategy – with input from across the system.
- ✓ Establish a board membership for the ICB including non-executive and partner members (council, NHS Provider and Primary Care).
- ✓ Engagement meetings between the NCL ICS Chair, NCL ICS Chief Executive and partners to consult on next steps in evolving NCL health and care partnerships and borough partnerships.
- ✓ By the end of June 2022, the Partnership will agree ambitions for the next few years, short term priorities and core principles for working together.
- ✓ Begin working with Local Authorities and other system partners to think through the implications of the recently published Integration White Paper ‘Joining up care for people, places and populations’.

Enfield Borough Partnership

Progress Update
Enfield Health & Wellbeing Board

7th July 2022

NCL CCG - Enfield Borough Partnership

Place Based Design: National Offer

Update

Place Based Partnership Working & National Programme Modules

The statutory members of our partnership are:

- London Borough of Enfield
- Enfield Borough, North Central London CCG
- North Middlesex University Hospital & Royal Free London Hospital (inc. Barnet & Chase Farm Hospitals)
- Barnet, Enfield and Haringey Mental Health Trust (inc. Enfield community Services)
- VCS organisations supporting delivery of front line services (e.g. Enfield Voluntary Action -health champions and social prescribing, Enfield Carers Trust, Age UK)
- Enfield GP Federation and 5 Primary Care Networks (PCNs)

In addition to this work:

Enfield has been working with The Leadership Centre & Traverse to drive the **Strategic Development** work required for the Enfield Borough Partnership.

We have worked hard to ensure that the Enfield Place Based Development work focuses on **Operational Delivery opportunities** and does not duplicate effort.

The Place Based design national offer comprises 4 Modules:

Module A - *Leadership*	Strengthening the local vision through collaborative leadership, focused on outcomes for the population
Module B – *Governance & Finance*	Sharing resources on a system basis while being Place & Neighbourhood focused to drive effective local decisions
Module C – *Population Health Management*	Using this approach aims to improve the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population
Module D - *Digital Development*	Developing a digital approach to help to improve access to health and social care services

ICS Population Health and Place Development Programme

Aim of the Programme

- This has been designed to help Enfield Borough to deliver the best possible population health outcomes for its residents
- The support provided by the national offer will accelerate and embed the adoption of Population Health Management (PHM).

Why is Place based working so important?

- Breaks down institutional silo's and draws together support and services around people and the local population
- Best utilises the shared resources and assets of a Place
- Helps to tackle 'wicked' problems, drawing on creativity of people from across the Place
- Emphasises the importance of community and citizen involvement in the design/delivery/evaluation of services and support

What role can PHM play in Place based health and wellbeing?

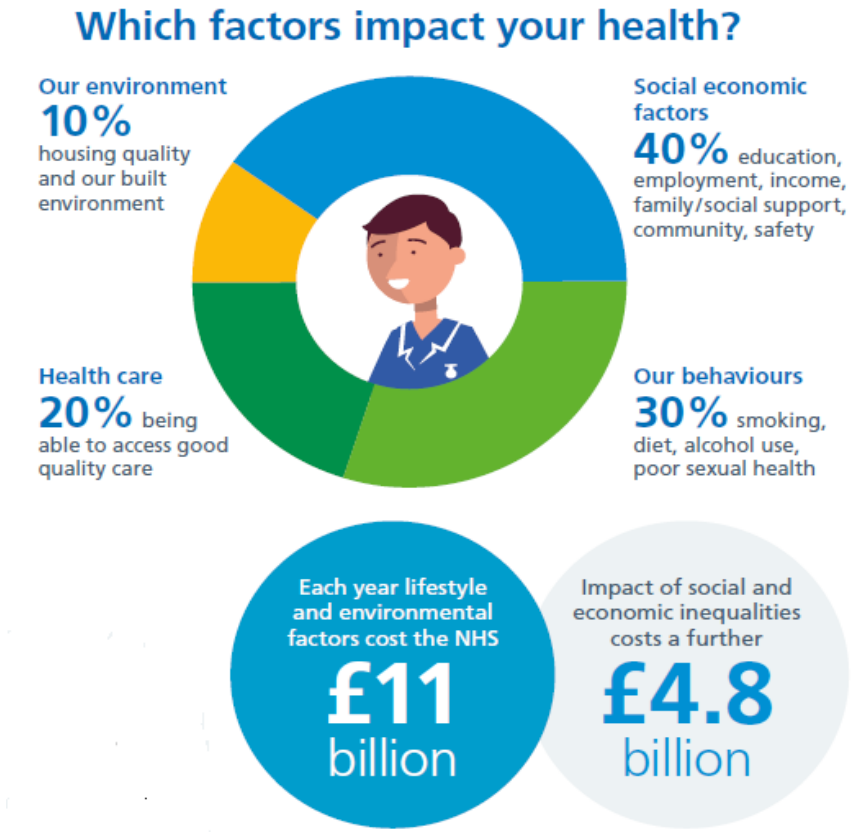
- Considers the wider determinants of health and inequalities
- Improving health inequalities by taking action
- Using data-driven insights and evidence of best practice to inform targeted, proactive interventions to improve the health & wellbeing of specific populations & cohorts
- The wider determinants of health, not just health & care
- Making informed judgements - clinical, public health and analysts working together
- Best use of collective resources – workforce and incentives - to have the best impact
- Acting together – the NHS, local authorities, public services, the VCS, communities, activists & local people. Creating partnerships of equals
- Achieving practical tangible improvements for people & communities

What is Population Health Management?

Population Health Management is an approach aimed at improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population.

Population Health Management is about:

- **Improving health and removing inequalities** by taking actions to reduce the occurrence of ill-health
- **Using data-driven insights and evidence of best practice** to inform, plan and deliver targeted, proactive anticipatory care interventions
- **Addressing wider determinants of health,** not just health & care, by working with communities and partner agencies.
- **Making informed judgements** – clinical, public health and analysts working together
- **Best use of collective resources** – workforce and incentives – for maximum impact
- **Acting together** – the NHS, local authorities, public services, the VCS, communities, activists & local people – **by creating partnerships of equals**
- **Identifying local 'at risk' cohorts by segmentation, stratification and impactability modelling** - and, in turn, designing and **targeting interventions** to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes
- **Achieving practical tangible improvements for people and communities**



Leadership & PHM 2nd Workshop - 16th May 2022

First workshop of Modules A & C (26th April 2022) – Priorities from the borough partnership PHM analyses it was agreed to focus on:

- ❑ **Preventing & Reducing Tobacco Dependence - vaping vs. tar based**
- ❑ **Preventing & Reducing Overweight People from becoming Obese**

Second workshop Modules A & C 2 (16th May 2022)- Definitions of Population Health & Population Health Management discussed:

Population Health…
… is an approach aimed at improving the health of an entire population.

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management…
…improves population health by **data driven planning and delivery of proactive anticipatory care to achieve maximum impact within collective resources**.

It includes **segmentation, stratification** and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and **targeting interventions to prevent ill-health** and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

- **An in-depth discussion of the population cohort of those who smoke/or are at risk of becoming obese, with the agreed outcome, that the population cohort should consist of:**
  - **18 – 40 year age group – who are smoking and obese**
  - **Living in the 40% most deprived areas**
  - **Other determinants of health, including social deprivation, education, poverty, access to fresh food and access to green spaces should also be considered as part of this work**
- **Partner members would identify operational leads to lead the development of the borough delivery plan for their respective organisations**

End goal: Selection of the Enfield population cohort

We have selected a cohort of people/families/places who…. because…

Our cohort selection criteria are:

- **18-40 years old**
- **Smoking and obese / severely obese**
- **Living in the 40% most deprived areas**

Thoughts on the wider determinants and health inequalities for this cohort:

A. Unemployment / Poverty
B. Access to healthy food
C. Access to green spaces
D. Impact of Mental Health
E. Consider homelessness

Aspects to consider during intervention design:

A. Language, English / Turkish / Polish / Other

B. Children in the household and childhood obesity

C. Cultural co-production

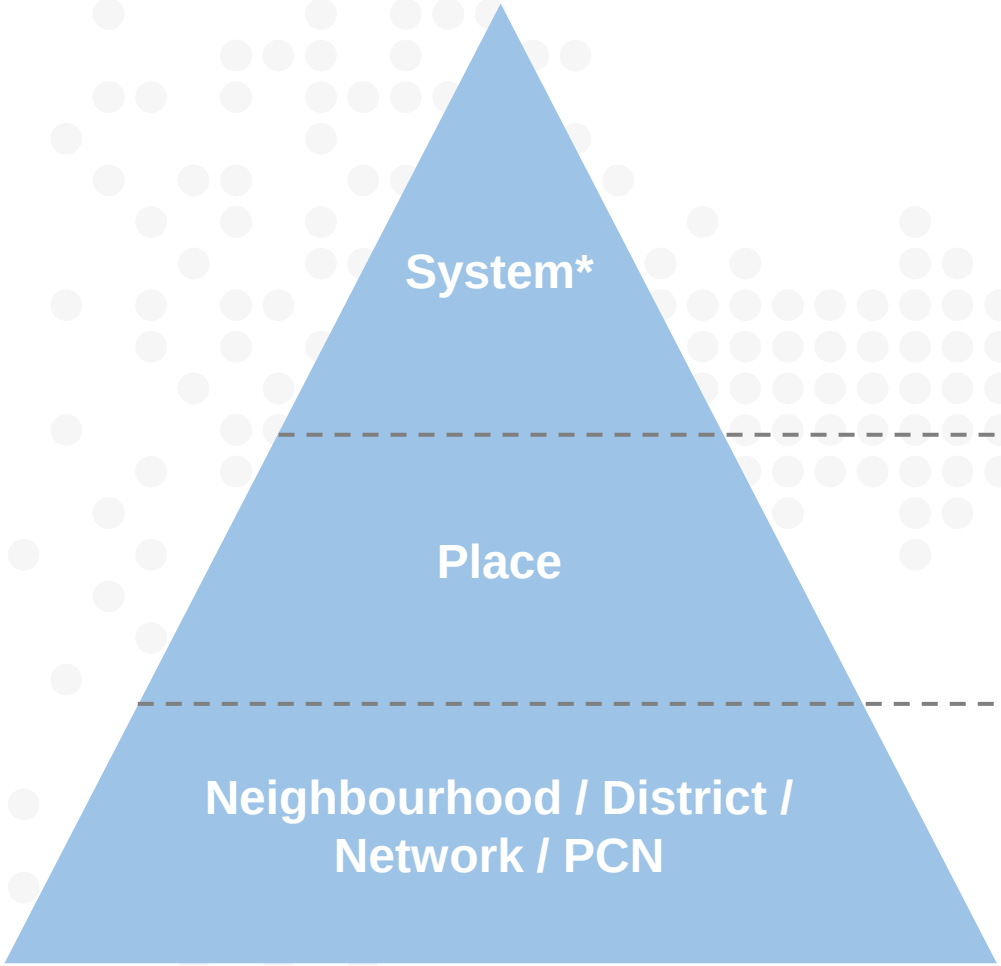
D. Use of social media / community spaces (e.g. libraries, building synergies with the LBE led work including development of community hubs

The national position on the functions of Place Partnerships

From the 'Thriving Places' guidance..

Health and care strategy and planning at Place	• The place-based partnership has a common understanding of its population, and has agreed a shared vision and local delivery priorities. • Building on its vision and priorities, the place-based partnership will have a role in developing the integrated care strategy agreed by all partners in the ICP, and inform the NHS plan developed by the ICB. • Partners at place will also be responsible for delivering these system-wide plans where relevant.
Service planning	• The place-based partnership has agreed approaches to align the commissioning of NHS and local government services around shared objectives and outcomes. Where agreed locally, this includes formal joint commissioning arrangements. • The place-based partnership may look to providers of health and care to play an active role in parts of the commissioning process. In particular, partners should consider approaches to collaboratively monitor the delivery and performance of services.
Service delivery and transformation	• The place-based partnership continues to integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population. • It is important that each place-based partnership fosters a culture of innovation, enabling the sharing of best practice between organisations, and promoting adoption of proven innovation. This includes fostering closer working between sectors to ensure that transitions in care are managed effectively and issues are resolved.
Population health management	• The place-based partnership has agreed with wider system partners plans to establish population health intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally. • This typically includes segmentation and modelling to understand future demand across population groups and care settings, understanding population risk factors, and supporting the implementation of anticipatory care models.
Connect support in the community	• The place-based partnership works with a wide range of community partners to leverage and invest in community assets. • Partnerships should work with VCSE partners to understand where there are opportunities to develop service provision to support communities. This may include working with (for example) housing associations, education providers and local businesses.
Promote health and wellbeing	• The place-based partnership proactively works with local agencies and partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability. • The NHS and local government may consider opportunities to leverage their role as 'anchor institutions' to support economic opportunity and skills development in their communities.
Align management support	• Place-based partners agree options to align and share resources. For example, some places have arranged operational support to PCNs, including data and analytics, as well as HR support. • PCN clinical directors should be supported to build their working relationships to lead on service transformation, and represent primary care in the place partnership.

Thinking about the ‘functions’ of a Place – and how they relate to those exercised more locally and across the whole system



- There is a **statutory or regulatory requirement** to organise them at System or above
- The function is **strategic**, i.e. helps to define objectives/priorities for the whole system
- Represents **best use of resources** to organise the function at system level, balanced with effectiveness of approach
- The function requires **highly specialist or scarce resources** which either cannot easily be sourced at Place, or may risk Places competing with each other for resource

Functions exercised at **Place**, unless…..

- Function requires a **deep understanding of specific local health and care needs.**
- Function involves a **high level of local engagement/relationship building.**
- There is a **statutory or regulatory requirement** to organise them at sub-Place.
- Function is **readily prevalent and accessible** at sub-Place layer.

* Some capabilities may need to be organised beyond System, e.g. at Regional, or Regional Cluster layer but for simplicity we are not focussing on these today

NCL CCG - Enfield Borough Partnership

NCL Cross-Borough Partnership development

NCL Cross Borough Partnership development

Series of Workshops supported by The Leadership Centre and Traverse

- Engages with the 5 borough partnerships in NCL
- To inform and develop place based partnerships and identify the key challenges and opportunities to allow place and neighbourhoods to shape their local ambition, plans and outcomes working with all partners

Focus of this work includes:

- Ambition and Vision
- Leadership at place to shape the cultural change required fro integrated working
- Functions, accountabilities and governance and recognising the interface between the NCL ICB, place and provider alliances as well as recognising the role of Health & well Being Boards and Health Overview Scrutiny Committees
- Development of Primary Care Networks and Neighbourhoods
- NCL ICS/ NCL ICB priorities and borough partnership priorities
- Resident and Community engagement including co-production with local communities and VCS organisations
- Resources and capabilities required at borough partnership level

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 10 MARCH 2022

MEMBERSHIP

PRESENT Nesil Caliskan (Leader of the Council), Alev Cazimoglu (Cabinet Member for Health & Social Care), Mahtab Uddin (Cabinet Member for Children's Services), Dr Nitika Silhi (Governing Body Member, NHS NCL CCG), Deborah McBeal (NCL CCG), Olivia Clymer (Healthwatch Central West London), Jo Ikhelef (CEO of Enfield Voluntary Action), Vivien Giladi (Voluntary Sector), Pamela Burke (Voluntary Sector) and Siobhan Harrington (Whittington Hospital)

ABSENT Dr Helene Brown (NHS England Representative), Bindi Nagra (Director of Adult Social Care), Tony Theodoulou (Executive Director of Children's Services), Dr Alan McGlennan (Chief Executive, Chase Farm Hospital, Royal Free Group) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

OFFICERS: Dudu Sher-Arami (Director of Public Health), 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), Dr Emdadur Rahman (GP), Richard Gourlay (NMUH Director of Strategic Development), Chloe Moralesoyarce (North London Partners in Health and Care), Anna Stewart (Start Well Programme Director), Emma Whicher (Start Well Programme Senior Responsible Officer), Deborah McBeal (Director of Integration, NCL CCG), Richard Dale (Executive Director of Transition, NCL CCG), Debbie Gates (Community Development Officer, LBE), Megan Roberts (Cabinet Support Officer, People Dept, LBE), Harriet Potemkin (Head of Policy and Strategy LBE)

1 WELCOME AND APOLOGIES

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

Apologies for absence were received from Tony Theodoulou, Bindi Nagra, Doug Wilkinson, Dr Helene Brown, Dr Alan McGlennan, and Andrew Wright.

2
DECLARATION OF INTERESTS

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

3
PHARMACEUTICAL NEEDS ASSESSMENT

RECEIVED the slide presentation and introduction by Gayan Perera, Public Health Intelligence Team Manager.

NOTED

1. There was a statutory duty to publish a Pharmaceutical Needs Assessment (PNA) at least every three years. Due to the pandemic related postponement, the revised publication date for the PNA was October 2022.
2. Enfield's Public Health Commissioning team led the procurement of the PNA production on behalf of all 5 North Central London boroughs.
3. Soar Beyond would manage the project. They have previously produced 22 PNAs throughout England and their project team includes pharmacists with regulatory and commissioning expertise.
4. Views of stakeholders were sought. As of yesterday, 110 responses had been received. Consultation would run for 60 days.
5. An update would be provided to each meeting of Health and Wellbeing Board.

IN RESPONSE

6. The benefits to communities from local pharmacies during the pandemic were highlighted.
7. When the recommendations from the assessment were known, the Health and Wellbeing Board may wish to coordinate an action plan to take them forward with relevant organisations.

4
COVID-19 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.

2. Concern remained focussed around new variants. The most common variant at the moment Enfield was Omicron, but the numbers in respect of subvariant BA.2 were up recently.
3. Hospitalisation numbers had gone down significantly.
4. Most recent information set out on deaths, hospitalisations, testing, cases in schools, and vaccination numbers. Emerging themes included re-infections.

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

RECEIVED an update on care home vaccination status.

NOTED

5. The update by Des O'Donoghue, LBE Service Manager – Community Services, of numbers of care home residents and staff vaccinated, and numbers who had received the booster.

iii. Vaccination Update

RECEIVED the vaccination updates (flu and Covid) presented by Dudu Sher-Arami, Director of Public Health, LBE and Dr Emdadur Rahman, GP.

NOTED

6. Targets were focussed on lower vaccination uptake groups and on young people. Offer of Covid vaccination continued for first, second and third doses, with good availability and accessibility in Enfield. Social media and communications activity continued, and funding had been sought for innovative projects and interventions to increase uptake.
7. The next step in the Covid vaccination programme was vaccination of 5 – 11 year olds, from primary care sites, and offering the Spring booster to those eligible.
8. GPs and pharmacies continued to offer flu jabs, and these could be administered at the same time as Covid vaccination.
9. 2021/22 performance for over-65s' flu vaccine uptake was close to the best ever. There had also been an improvement in uptake by pregnant women.
10. Next season, the 50 – 64 year-old cohort and primary school children would not be included in flu vaccine plans.

IN RESPONSE

11. In response to the Chair's queries, it was confirmed that the planned exclusion of the 50 – 64 year-old cohort for flu vaccination 2022/23 was a national directive and a return to the pre-pandemic offer. It was not expected to have a significant impact.
12. It was confirmed that comparable groups showed low uptake of all vaccines, and other healthcare testing and cancer screening. Work with those groups would be taken forward.

13. It was advised that the date for the Spring boosters would be directed by national protocol. Also, planning had begun for Autumn / Winter and preparation for vaccinations.
14. The Council was producing a review report on the impact of Covid-19 on Enfield, to include facts around care homes, testing, communications, logistical support etc, and lessons learned. The report would be submitted to a Scrutiny Panel and would be circulated to Board Members.

ACTION: Governance & Scrutiny

Post Meeting Note: The report 'Managing the Covid-19 Pandemic: Interim Summary Report' was submitted to Overview and Scrutiny Committee 21/03/22 (Item 4) and the link is Overview & Scrutiny Committee | Enfield Council

5
UPDATE FROM NORTH MIDDLESEX UNIVERSITY HOSPITAL (NMUH)

RECEIVED the verbal update, introduced by Richard Gourlay, NMUH Director of Strategic Development.

NOTED

1. The numbers of Covid-19 in-patients had risen slightly, but were much lower than in January and February. The numbers in critical care with Covid-19 were low, and tended to be unvaccinated people. There had been messaging to staff on the importance of vaccination. Messaging continued in respect of social distancing and mask wearing when visiting the hospital.
2. Winter pressures had seen an increase in attendance to Emergency Department. Ambulance attendances were also up. Assessment was rapid, but there had been problematic times. A pilot had been run to provide primary care at the hospital door.
3. BEH Mental Health Trust had test run virtual wards which had been a help.
4. The elective programme had been accelerated, and a ring-fenced ward re-established, to begin clearing the backlog.
5. Improvements had started to be seen where there had been some dips in performance.

IN RESPONSE

6. In response to the Chair's queries regarding the virtual ward, it was confirmed that patients could be appropriately managed outside hospital but continue to have an overview from a hospital consultant. At an appropriate time, discharge would be agreed to their GP or from the health system, and the patient was not in an acute hospital bed. The virtual ward could expand to 15 to 20 patients at any one time. A lot had been learned about what could be successfully managed in the community, and the ways in which primary and secondary colleagues could wrap care around the patient.

6

NCL START WELL PROGRAMME

RECEIVED the verbal update introduced by Chloe Moralesoyarce (Head of Communications and Engagement, North London Partners in Health and Care), Anna Stewart (Start Well Programme Director) and Emma Whicher (Senior Responsible Officer for the Start Well Programme).

NOTED

1. The programme was about ways of working together to provide the best care to pregnant women, babies, young people and families.
2. It was recognised that health inequalities started at the beginning of life. Inequalities in provision were reflected in health outcomes.
3. The programme was responding and learning from national best standards and guidelines.
4. Three workstreams covered acute, emergency, and pregnant and neonatal.
5. Engagement with the public was central. They were keen to hear from those who used the services, including from children and young people.
6. Plans for the engagement and collation of existing data were being worked on now. An online panel was being developed of around 100 people for targeted discussions.
7. Insights would be sought from staff and clinicians and areas identified where there was potential to do things differently / improve. These would be tested through deeper engagement over the summer, and a final report produced by September.

IN RESPONSE

8. Councillor Cazimoglu asked about engagement with harder to reach communities. Olivia Clymer also asked about openness of engagement. It was confirmed that those seldom heard would be reached through partnership with voluntary and community organisations, and suggestions of groups to engage with were welcomed. The local maternity and neonatal system did work with harder to reach groups and those relationships would be used. There would also be ongoing dialogue and further presentations to Health and Wellbeing Board.
9. Dudu Sher-Arami offered the opportunity to engage with Directors of Public Health via the regional meeting and it was confirmed the offer would be taken up.
10. The Chair advised that as a local authority leader she would like to see targeted programmes to demonstrate improvement in maternity experience for mothers and babies; early years services and advice; and Child and Adolescent Mental Health Service. It was confirmed that the programme board included CAMHS and Director of Public Health representation, as well as local authority Chief Executive and Director of Children's Services representation.

7
ICP PARTNERSHIP UPDATE

RECEIVED the report and presentation from the Director of Integration, Enfield Borough Directorate, NCL CCG.

NOTED

1. Introduction by Deborah McBeal (Director of Integration) and Richard Dale (Executive Director of Transition), NCL CCG and Dr Chitra Sankaran (co-chair of Board for Enfield Borough Partnership).
2. An overview was provided of progress towards transitioning to an Integrated Care System (ICS), and an update on the Enfield Borough Partnership.
3. The establishment of the ICS was subject to passage of the Health and Care Bill.
4. The community involvement and representation was set out. There was also engagement with all CCG staff.
5. Tackling inequalities and wider determinants of health were highlighted.

IN RESPONSE

6. The Chair asked about the next big steps in the process. It was advised that from 1 July 2022 there would be an Integrated Care Board (IBC). Focus would be on what could be done to improve health and wellbeing of residents. Health and social care support would be person-centred and holistic. There would be some changes to the technical ways of commissioning, and a move to a more collaborative model, and a more nimble way of working with providers.
7. The Chair welcomed the changes and raised that expectations would be high and there was a need to be honest with residents and patients.

8
MINUTES OF THE MEETING HELD ON 2 DECEMBER 2021

AGREED the minutes of the meeting held on 2 December 2021.

MATTERS ARISING

The expansion of the North London Waste Authority Eco Park had been raised by Board Members at the last meeting. The Chair confirmed the decision making process by NLWA and the Secretary of State, and that there was publicly available information on discussion and questions at Enfield Council. The issue of air quality in the borough was important and the administration had ambitions to seek improvements to air quality and reduction in carbon emissions.

9
NEXT MEETING DATES AND DEVELOPMENT SESSIONS

NOTED the next Board meeting dates would be confirmed following Annual Council Meeting.

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