Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 6 October 2022 at 6.30 pm
Virtual / Teams

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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 ICB – Deborah McBeal
Healthwatch Representative – Rikki Garcia
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

2. DECLARATION OF INTERESTS

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

3. LBE INFECTIOUS EPIDEMIOLOGY AND VACCINATION UPDATE (6:40 - 7:00PM)

Gayan Perera, Public Health Intelligence Team Manager.

Including updates on Covid-19, Influenza, Polio, MPX Vaccination Programmes.

4. SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) PARTNERSHIP STRATEGY REPORT (7:00 - 7:15PM) (Pages 1 - 6)

Peter Nathan, Director of Education.

(SENT TO FOLLOW)

5. COMMUNITY POWERED EDMONTON REPORT (7:15 - 7:30PM) (Pages 7 - 34)

Rikki Garcia, Interim CEO Healthwatch Enfield.

This is a partnership project funded by NCL ICB that has engaged Edmonton residents in innovative ways to identify issues and solutions with local services.

6. INCLUSION HEALTH NEEDS ASSESSMENT (7:30 - 7:45PM) (Pages 35 - 46)

Sarah D'Souza, Director of Communities, NHS North Central London ICB.

7. ENFIELD CANCER SCREENING UPDATE (7:45 - 8:00PM) (Pages 47 - 58)

Louisa Bourlet, Community Health Development Officer, Dr Amna Naeem and Dr David Peprah.

Review of current local activity.

8. PHARMACEUTICAL NEEDS ASSESSMENT (8:00 - 8:10PM)

Gayan Perera, Public Health Intelligence Team Manager.

Short Progress Update.

9. ANY OTHER BUSINESS

10. MINUTES OF THE MEETING HELD ON 7 JULY 2022 (Pages 59 - 66)

To receive and agree the minutes of the meeting held on 7 July 2022.

11. NEXT MEETING DATES AND DEVELOPMENT SESSIONS

Next meeting dates and development sessions of Enfield Health and Wellbeing Board:

Enfield Health and Wellbeing Board:

Thursday 15 December 2022, 6:30PM
Thursday 2 March 2023, 6:30PM

Development Sessions (potential dates):

Thursday 15 December 2022, 5:00PM
Thursday 2 March 2023, 5:00PM

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SEND PARTNERSHIP BOARD

Health & Well Being Board – 6/10/22

Agenda Item 4

Board Purpose

- Provides strategic direction & leadership for SEND
- Monitors and Quality Assures local area SEND
- Focus on ensuring needs are identified and met
- Supports inspection preparation

Membership includes senior representatives from education, childrens' and adult social care, health, parents groups.

ENFIELD Council

Board responsibilities

- Ensure that there is an overarching SEND strategy and action plan to ensure statutory duties and met and service improvements are being addressed.
- Ensuring effective joint commissioning from LA and NCL – clinical commissioning groups.
- Ensuring assessment and support pathways are in place and clear on the local offer
- Ensuring impact/progress of CYP SEND (Data dashboard – QA process – parental and CYP feedback)

ENFIELD Council

Board responsibilities

- Receive/evaluate reports from SEND workstreams –eg – Enfield Communication Advisory Service, Autism Service, Nurture groups
- Monitor the financial position of SEND including the High Needs Budget and impact of spend and Delivering Better Value programme.
- Note the impact of legislation such as the recent Green Paper – changes to inspection framework - and ensures the local area takes account and changes as needed.

ENFIELD Council

Examples of recent work of the SEND Partnership Board

- Commissioned review of SEND by Ernst & Young (EY)
- Initiated further investment in preventative services – ECASS, EASA, E-TIPS.
- Focused on improving timeliness of EHCP assessments – now well above national average
- Agreed introduction of SEND units in mainstream schools and increase in number of ARPs

ENFIELD Council

Examples of recent work of the SEND Partnership Board

- Introduction of SEND data dashboard & review of health dashboard
- Focus on addressing autism assessment and mental health assessment waiting lists and proposed mitigation actions.
- Developing SEND parental survey for autumn 2022
- Agreeing SEND strategy for 2023-27
- Reviewing SEF and SEND action plan

ENFIELD Council

Community Powered Edmonton

Using community collaboration to improve services and reduce inequalities

August 2022

EDMONTON COMMUNITY PARTNERSHIP
even better together

NEW LOCAL

healthwatch Enfield
listen to act

NHS
North Central London
Integrated Care Board

CONTENTS

"Healthy behaviours and lifestyles of our population are critical to improving outcomes, but without a new relationship with our communities this cannot be achieved."

Discussion around issues facing Bulgarian GRT communities

INTRODUCTION

Health inequalities in Enfield are long established and create a stark difference in the risk of avoidable death between those living in poverty and those who do not, as well as significant difference between life expectancy and healthy life expectancy. This inequality not only impacts on NHS and local authority resources and service capacity, it has disastrous long term effects on communities and individuals. In 2019 across England, women in the most deprived areas were three times more likely to die from an avoidable cause than those in the least deprived areas. This figure rose to 3.5 times for men.[1]

Health inequalities are also an indicator of a whole range of other negative circumstances that impact on communities, from poor housing and food deserts to a lack of access to education and poor work and job prospects. In Enfield, the local authority, NHS and voluntary sector have long recognised the interrelationship of these issues, the impact of poverty and its resultant strain on local services and poor outcomes for local people. The Health and Wellbeing Strategy 2020 to 2023 explicitly seeks to "prevent the preventable", by taking a system wide approach, using effective partnerships as the primary means to address inequalities and improve health outcomes.[2]

[1] https://www.kingsfund.org.uk/publications/what-are-health-inequalities#:~:text=Inequalities%20in%20avoidable%20mortality,-Deaths%20are%20considered&text=In%20England%2C%20in%202019%2C%20women,in%20the%20least%20deprived%20areas.

[2] https://new.enfield.gov.uk/healthandwellbeing/wp-content/uploads/2020/04/LBE-JHWBS-FINAL-V5.0.pdf

Recently, the advent of the Integrated Care Boards, which bring together health and care services across regions (like North Central London) and at borough level through place based work, has provided an opportunity for the NHS, Enfield Council and local voluntary sector partners to come together, share learning and build on the existing inequalities work. This work seeks to ensure that local people are heard, listened to and included in the development and delivery of services and programmes; this in turn seeks to make sure that services are as effective and relevant as possible.

The NHS North Central London Integrated Care Board (NCL ICB) recognises that Enfield has a long history of working with communities and community groups to improve local services. Resident and patient engagement is being recognised as critical at a regional and local level, and as a result, governance structures have been developed to ensure that engagement is understood and supported from the top down. In addition, specific and dedicated funding is being sourced and distributed, and resources are being applied to engagement activities, researching the patient experience and supporting service redesign.

Enfield Borough Partners recognise that healthy behaviours and lifestyles of our population are critical to improving outcomes, but without a new relationship with our communities this cannot be achieved. In Enfield, the Edmonton area has some of the worst health outcomes and greatest inequalities and as a result, Community Powered Edmonton was created, using local assets to understand the challenges, find out what is important to people, speak to their aspirations and generate outcomes based on their strengths.

Young people's performance from Platinum Arts

COMMUNITY POWERED EDMONTON

HOW WE WORKED

Community Powered Edmonton is a partnership between the NHS, the voluntary sector and the local community led by a collaboration of voluntary sector partners:

New Local is an independent think tank and network with a mission to transform public services and unlock community power.

Edmonton Community Partnership is an alliance of 18 schools and members of the local community managing a range of school enrichment and community projects and events that help improve the lives of children, young people, their families and the wider community in Edmonton.

Healthwatch Enfield delivered by Listen to Act, is an independent statutory organisation that gathers and amplifies the voices of people, patients and users of health and adult social care services in Enfield. **Listen to Act** is a charity specialising in community collaboration, co-design and co-production.

Working as a pathfinder programme for more effective community engagement and collaboration between service providers and service users, each partner brought unique expertise, local connections and understanding. We used an exciting range of engagement methods and techniques to reach out to communities in Edmonton.

WHO'S IN THE ROOM?

Collaboration can only happen if the right people come together. Community Powered Edmonton was designed by the partners to bring together service users and service providers, providing opportunities for creative discussion. Each session allowed all participants to really hear each other and identify common ground, common language and shared solutions.

Each session had representatives from:

- **Enfield Council**: From frontline staff and service leads to the Director of Public Health, elected members and the deputy leader of Enfield Council.
- **The NHS:** Frontline staff, officers and senior managers from the North Central London Integrated Care Board (NCL ICB), primary care clinicians, and staff from local NHS Trusts including North Middlesex University Hospital and Barnet, Enfield and Haringey Mental Health Trust.
- **The voluntary sector:** Volunteers, service users and staff from a range of local community organisations including Enfield Carers Centre, the RNIB, Enfield Citizens Advice Bureau, Voice of Jubilee Park, Caribbean and African Health Network.
- **Local residents:** A wide range of local people from Edmonton were invited, encouraged and supported to attend and participate in the sessions. These included people from several different local communities, young people, people with disabilities, and people representing mental health service users.

OBJECTIVES

Overall, we sought to deliver against the following four objectives:

1. To strengthen the local voluntary and community sector (VCS) infrastructure by addressing current gaps in representation.

2. To understand local needs and the barriers different communities face to accessing local healthcare and support services.

3. To explore ways in which a strengthened communities and VCS network could work alongside statutory agencies to share insights and engage in local decision making.

4. To consider how the local NHS and council could further collaborate with a strengthened communities and VCS network to improve health outcomes, and any changes that might be needed to support this. This includes consideration of the systemic changes required in how local public service organisations work to enable a more community powered approach to become embedded.

Young people's performance from Platinum Arts

WHAT WE DID

Over the course of three months, the partners engaged with more than 150 people using a range of activities, including:

- **Workshops:** Three workshops (a mixture of face to face and online) led by New Local. The workshops focused on bringing together statutory and voluntary service providers and service users to share information and really hear each other.

- **Creative activity:** Including a showcase event led by Edmonton Community Partnership (ECP) and involving Platinum Performing Arts and Ape Media, allowing young people and residents from Bulgarian Gypsy, Roma and Traveller (GRT) communities to share their lived experience and stories through music, poetry, dance, film and panel discussions, captured by a graphic scribe.

- **Focus groups:** A series of focus groups and a survey led by Healthwatch Enfield, capturing the perspectives of particular communities including a Turkish women's group, a group of mental health services users and a group of people with learning disabilities.

- **Open access:** If people were unable to attend one of the workshops, events or focus groups, we provided an opportunity for people to submit online responses and express opinions on the issue being discussed via email.

Focus

Discussions were led around three key areas:

- **Living a healthy life in Edmonton – what do we know:** Our discussions considered what helps people and communities in Edmonton to live a healthy life, and what gets in the way of their health and wellbeing.

- **Talking and listening to improve health and wellbeing:** Public sector staff and residents in Edmonton engaged in a community conversation to better understand what matters to local communities, so that service providers can listen to ideas and co-design changes in the future.

- **Taking action to address health inequalities:** Bringing together residents, VCS, and public sector organisations to focus on practical actions which could be taken to work more collaboratively to address health inequalities in Edmonton.

Discussion around young people's safety and opportunities

Community workshop with local people, voluntary sector and statutory services

WHAT WE HEARD

ISSUES AFFECTING LOCAL PEOPLE

- **Safety**: One of the biggest concerns from people, especially young people, was safety. There was a very clear perception that certain areas of Edmonton were not safe for young people and older members of the community to be around, especially after dark. Young people felt unsafe and expressed worry about gangs, people hanging around in the dark and the lack of street lighting. The lack of available and accessible youth provision across the Borough was flagged as being a particular concern – there are only two youth centres in Edmonton and neither are easily accessible unless you live in the immediate local area. Both youth venues require a walk of at least eight to ten minutes to get to, often through areas that may not be safe for young people to be walking alone in the evening. There are no buses that go direct to each venue.

- **Poverty:** Unsurprisingly, financial hardship was expressed by most groups as on the biggest issues they are facing. The current cost of living crisis has only exacerbated this challenge and runs the risk of undoing some of the positive progress that has taken place in recent years to try and reduce inequalities. A lack of money has a significant negative impact on health and wellbeing, creating feelings of exclusion and barriers to health care access, for example, being unable to afford travel expenses to attend appointments.

- **Social isolation**: Loneliness and social isolation affected everyone we spoke to in one way or another. Older people are well known to suffer from isolation, but it was also expressed

as a concern by younger people from various parts of the community. When asked what the single most important thing was for people to help avoid poor outcomes, it was almost unanimously agreed that positive relationships with the local community, friends, and family are essential for positive health and wellbeing.

- **Mental health:** This was huge concern raised by almost everyone we spoke to. In addition to the great concern over the availability and capacity of mental health services in the area, several sections of the community expressed a mistrust in services, and even a disbelief that poor mental health existed. Members of the Bulgarian community expressed that significant stigma still surrounded mental health in the community and as such, it wasn't spoken about, and people often didn't seek help unless they reached a crisis point.

- **Language barriers, cultural difference and lack of knowledge:** For a large section of the community in Edmonton, and especially those from more recent migrant communities, simply knowing how to access services, and what services are available was expressed as a major problem. Many migrants were dependent on family or community members for translation services and several expressed concern about becoming victims of scams when trying to access primary care – for example, by being inappropriately and unnecessarily charged by third parties to register with a GP. Having no recourse to public funds was also raised as having a potentially significant negative impact on people's health and wellbeing in the area. The timing, cost and delays involved in securing

residency status were also highlighted as having a huge impact on people's mental health.

- **Digital exclusion:** There are three main ways people are digitally excluded: a lack of computer literacy and computer phobia; digital poverty i.e. not being able to afford devices and/or internet access; and being a non-English speaker trying to access services online that are only available in English. Digital exclusion was identified as a major issue in Edmonton, especially as services are increasingly taking place mostly online or are online only. This affects both health care and council provided services and has been exacerbated by Covid-19.[3] It is also an issue that disproportionally affects those on lower incomes and those living in poverty.

- **Trust:** An underlying issue affecting many communities was the lack of trust in services and the providers of services. This lack of trust was caused by several different factors depending on the specific community and individual experiences. Everyone agreed that trust was difficult to build but easy to lose. Participants acknowledged that it is imperative for service providers to set realistic expectations, follow through with commitments made, and spend time on the ground building relationships with people, listening to them and demonstrably acting on what they hear.

[3] https://www.cam.ac.uk/stories/digitaldivide

EDMONTON NEWS

REAL STORIES * REAL LIVES

Local authority, Community health provider families working together to reduce the incidence of Type 2 Diabetes.

WORKING TOGETHER SAVE LIFE, SIGHT AND LIMB!!

Long term conditions prevalence drops for the first time in ~~Enfield~~ Edmonton in 30 years

Healthy life expectancy in ~~Enfield~~ Edmonton increases by 5 years closing the gap from East to West in record time

"My doctor informed me that I was at risk of diabetes. In a conversation with a Care navigator she signposted me to the healthy weight Coach. My diabetes is now in remission and I've attending her sessions. I feel confident to start looking for a

THE REPORT

what, who, when, where, how etc

Trusts VCSE

Local authority, NHS, GPs, Community health services worked with the local community to develop a ground breaking diabetes prevention + management plan.

Partners understand each other's assets and strengths leading to high impact + low duplication. This is a priority for everyone so this is addressed at every opportunities

cont'd...

- People with diabetes have a brilliant service with care navigators, health coaches, direct access to support (not only via ~~easy~~
- Healthy lifestyle is weaved through all services - active travel, parks are overrun with people exercising
- Fried chicken shops go bust
- Local markets record high profits from increasing sales of fruit + veg

'Future positive news headlines' from community workshop

KEY BLOCKS TO COLLABORATION

In addition to the issues raised above, local people and service providers were asked what the blocks and barriers are to engagement. What stops people from coming together, talking through issues and finding shared solutions? These included:

- **Lack of trust:** Trust was identified as a clear barrier to engagement from all sides. Local people, and especially those from more marginalised communities, often don't trust people in a position of authority including those who provide services. On the occasions when services have tried to engage with local people, these have often been poorly attended or mistrusted. This has been caused by several issues, including:

    - Service providers and decision makers not taking the time or investing the resources to speak to people, build relationships, and create trust through consistency.

    - People often feeling 'let down' by the system when they are unable to access the services they should have access to, are not supported effectively, or have negative experiences.

    - Some service providers struggling to see the value of engaging local people in service design and delivery. This is frequently seen as a time consuming requirement, or a legal duty, rather than a positive and essential part of the development process.

- Feedback from service users sometimes being challenging, critical and hard to hear. This can cause service providers to be defensive and put up further barriers.

- Frequent negative stories on social and mainstream media combined with existing prejudices feeding into a sense of apathy. For example, people may not see things change as quickly as they like, they may have a perception that other sections of the community are treated better or have greater access to funding.

- **Knowledge and awareness:** Service providers who have a detailed and in depth knowledge of their own services and the interactions with neighbouring ones, often lose sight of the fact that most people don't have this level of understanding of how to navigate the system. Many people have no knowledge of a service until they need it. This is a particular problem for health care where the complexity of the system means people who don't speak English, or those who have moved to the UK from other countries are at a particular disadvantage. Many don't know where to go, may not be able to easily access information, and frequently don't know which services exist.

Community workshop

- **Language barriers:** Most information is written in English, and whilst translation services are generally offered by most statutory services, these are not always easily accessed. Literature is only usually translated on request (beyond a few key documents and languages), and interpreters for GP and hospitals can be difficult to access even for healthcare professionals, are sometimes not adequate due to the often technical nature of health care, and quite often people are not comfortable using a stranger to discuss very personal issues so rely on family members instead. The language barrier adds additional limits to understanding and communication between providers and users.

- **Engagement practice and expertise**: Effective community engagement is a skilled process that needs to be supported by people who are equipped to do it well. It involves spending adequate time and funding to build trust and develop effective relationships with local people and communities. Sufficient and dedicated resources need to be provided on an ongoing and consistent basis, not just on a one off, ad hoc project basis.

- **Lack of personalisation**: In an area as diverse as Edmonton, a one-size-fits-all approach is unlikely to work. People and communities will need different things at different times depending on the circumstances. The system often doesn't allow for this level of personalisation and can inadvertently exclude or create additional barriers for people. This is particularly difficult for clinical services, but twice as important if health inequalities are to be effectively reduced.

- **Lack of safe spaces for collaboration**: Many current structures and public access mechanisms can be exclusionary, adversarial or time constrained. Both the NHS and Enfield Council hold many meetings in public, however, the papers for these meetings often run to several hundred pages, are often not distributed soon enough and are not available in other formats. Meetings can be filled with jargon and very technical in focus. Service providers don't bring people together with less formal, more accessible methods on a regular basis.

Presenting back to the group

Ruth Donaldson from NCL ICB closes the showcase event

WHAT WE RECOMMEND

The depth and scale of conversation within the collaborative workshops, events and focus groups produced a huge number of ideas and solutions to many of the issues explored above, supporting the original hypothesis: that problems can be solved when people work together effectively. Many of these ideas would benefit from further exploration and action planning.

Of all the ideas and actions raised and discussed, the following five recommendations not only had clear consensus across statutory and voluntary professionals, local people and service users, they were considered to be the most urgent and most readily actionable.

- **Ongoing community conversations:** Service providers should have ongoing open conversations which bring together residents, the VCSE, and public sector. There is a demand for it within the community and it will contribute to a shared understanding, trust and sense of ownership of local services. These events should be frequent, accessible, held in different venues and formats and feed directly into regular service level feedback. It would be helpful for NCL ICB and Enfield Borough Partnership to identify a lead to coordinate and resource these community conversations.

- **Longer term voluntary, community and social enterprise (VCSE) partnerships and resourcing:** VCSE organisations play a critical role in expanding the reach of the public sector into diverse communities, helping to build greater understanding and reduce current barriers to collaboration and healthcare access (e.g. knowledge of available services, language

barriers, targeting of services). This takes time and resource so more consistent partnerships, and resourcing are needed.

- **Shared accountability:** North Central London ICB should report back on the findings and outcomes of this work and, working collaboratively with the Enfield Borough Partnership, explore ways to develop the 'working together' commitment displayed throughout this project. This would ideally involve a public commitment from decision makers to longer-term and better resourced engagement and collaboration, with clear accountabilities for public sector organisations, VCS organisations, people and communities in taking action forward.

- **Test and learn approach:** The NHS and local authority should identify one thematic priority or targeted community with whom to initially apply the learning and recommendations of this work including active listening, collaboration with community partners, involvement in decision making, learning by doing, while sharing the lessons with the wider system. There is scope to grasp the opportunity to use this new way of working to also address the economic, workforce and general wellbeing of local residents; especially young people and marginalised parents.

- **Training and development:** Professionals, front line staff and anyone involved in the design, development and delivery of community and health services should receive training in active listening, empathy, and different forms of engagement. This should have a particular focus on community facing roles in the public sector.

How do you feel about…? Red/amber/green voting at showcase event

CONCLUSION

Throughout the programme, three areas became increasingly apparent with regards to addressing health inequalities:

- The importance of wider determinants in identifying and causing health inequalities, like poverty, culture, and access to education.

- Gaps in knowledge and barriers to gaining knowledge, especially around what services are available to individuals and communities.

- Blocks to service access, including physical barriers like geography, digital exclusion and language barriers, plus issues which may take more thorough and collaborative work to overcome, such as trust and cultural differences.

Building trust between local people and service providers was a consistently raised as a key priority, with better and more consistent collaboration seen as the best way to achieve this.

Service providers will need to allocate adequate time and resources to have conversations with those most likely to suffer as a result of inequalities. Local people and communities will need to engage with service providers and are best supported by an effective and well-resourced voluntary sector.

The findings of this programme have been presented to the Enfield Partnership Board and the NHS NCL ICB. They will be shared other key strategic bodies including Enfield Health and Wellbeing Board. Overall the response so far has been very positive. Service providers

understand the need to source consistent funds and resources to ensure the work can continue. The NCL ICB has identified £150,000 for a Community Collaboration Fund which will be primarily led and distributed by and via the local voluntary sector. All have agreed to accept the recommendations set out in this report and look at ways to put them into action.

Edmonton Community Partnership

Email: info@edmontoncommunitypartnership.org

www.edmontoncommunitypartnership.org

New Local

Email: info@newlocal.org.uk

www.newlocal.org.uk

Healthwatch Enfield delivered by **listen to act**

Email: admin@healthwatchenfield.co.uk

www.healthwatchenfield.co.uk

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North Central London Integrated Care System

Overview of Inclusion Health in Enfield and North Central London

Public Health, London Borough of Enfield

Communities Team, North Central London ICB

October 2022

Contents

North Central London Integrated Care System

1. Background and context
2. Focus on specific health inclusion groups in Enfield within an NCL picture:
   - People with a history of imprisonment
   - Sex workers
   - Gypsy, Roma and Traveller communities
   - Vulnerable migrants
   - People experiencing homelessness
3. Discussion and next steps

NCL Inclusion Health Needs Assessment

North Central London Integrated Care System

The needs assessment aims to synthesize evidence on the health needs of targeted populations across the five boroughs, identifying the size and demographic profile, health needs, services and gaps in order to inform the ICS commissioning strategy and articulate need for sustainable funding.

Rapid Evidence Review for Inclusion Health groups

Phase 1

Phase 2

Lived Experience interviews person journeys

Strategic insight through interviews with key senior stakeholders

Frontline staff experience via staff survey

Estimating severe multiple disadvantage using existing data sources

Engagement and workshop with partners and people with lived experience

Recommendations

ICS plan for homelessness and inclusion health

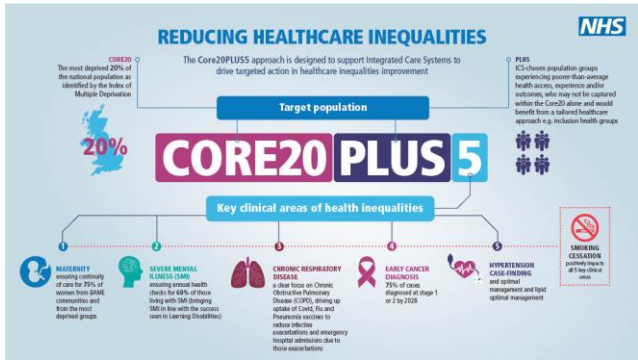
Developed with DsPH across NCL

Scope - People experiencing homelessness, Gypsy, Roma and Traveller communities, sex workers, vulnerable migrants and those with a history of imprisonment.

Context

North Central London Integrated Care System

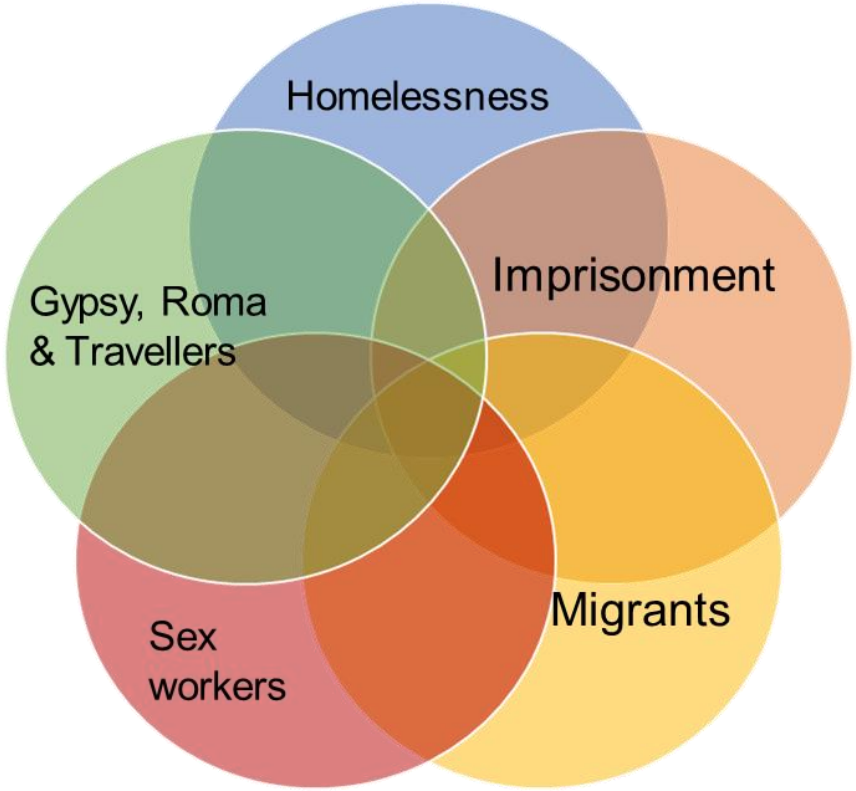
- The Inclusion Health Needs Assessment supports the **Enfield Joint Health and Wellbeing Strategy 2020-2023** to improve the health and wellbeing of the local community and reduce health inequalities for all.
- The Inclusion Health Needs Assessment also aligns with a range of Council strategies:
  - Preventing Homelessness and Rough Sleeping Strategy
  - Children and Young People Plan
  - Violence against Women and Girls (VAWG) Strategy
  - Safeguarding Adolescents from Exploitation and Abuse Strategy
  - Enfield Poverty and Inequality Commission Report 2020
  - Fairer Enfield, Equality, Diversity and Inclusion Policy 2021-2025
  - Enfield Early Help for all Strategy 2021-2025



- **Health and Wellbeing Board guidance:** Inclusion Health is included in guidance for Health and Wellbeing Boards https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement.
- **Integrated Care Strategy**: Inclusion Health is specifically mentioned within the statutory guidance for developing ICS Integrated Care Strategy; https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies.
- **CORE20PLUS5:** Inclusion health groups feature in the 'PLUS' element to support the reduction of health inequalities at both national and system level.
- **NICE Guidance (214)** on Integrated health and social care for people experiencing homelessness recognise the additional and specialist care required by this population to improve health outcomes:

Phase 1 overview

North Central London Integrated Care System



- There are overlaps among inclusion health groups, with many individuals facing severe **multiple disadvantage** and common drivers of social exclusion that push people into homelessness, sex work and prison.
- There are **overlaps among inclusion health groups**, with many individuals facing severe multiple disadvantage and common drivers of social exclusion that push people into homelessness, sex work and prison.
- Inclusion health groups often have many similar **health needs**, particularly related to mental health, substance abuse, TB and STIs and untreated long-term conditions, leading to higher mortality.
- Within the 5 broad inclusion health categories, there is also **substantial diversity** : people with a history of imprisonment; those engaged in direct (on and off street), survival and indirect sex work; Romany Gypsies, Irish travellers, Roma people, travelling show people, new travellers and liveaboard boaters; asylum seekers, refugees and undocumented migrants; rough sleepers, statutory, single and hidden homelessness.

Gypsy, Roma and Traveller community

North Central London Integrated Care System

Romany Gypsies, Irish Travellers and Roma People are recognised in law as being an ethnic group protected against discrimination by the Equality Act 2010. Additionally Travelling show people, New Travellers and Liveaboard boaters may have a nomadic lifestyle.

Barriers in accessing healthcare

Nationally, among Gypsy and Traveller communities:

- GP registration rates are low – between 50-91% – with some evidence of higher rates of use of A&E services
- This is often related to lack of proof of identity and permanent address, low literacy, language barriers and fear of stigma and discrimination.
- Compared to the general population, they are less likely to visit the practice nurse, a counsellor, chiropodist, dentist, optician or alternative medical workers, or to contact NHS Direct or visit walk-in centres than their counterparts.

Among Bulgarian Roma communities in Edmonton:

- 33% of households had a family member who was not registered with a GP. The most prominent reason for this was a lack of trust and language barrier, followed by being unable to provide a proof of address.
- 80% reported they would reject an opportunity to have the Covid-19 vaccine.
- They would like better access to children's health services and sexual health services; however, respondents also reported that they were most reluctant to access sexual health services.
- Barriers to health services included language, lack of knowledge of services, lack of trust, low digital literacy and access to digital equipment. Respondents indicated that information campaigns in their own language, presence of frontline workers representing their community and a telephone line in Bulgarian/Roma would help to improve access.

Mental health	Physical health
Anxiety, depression Suicide	Lower life expectancy, fewer years in good health LTC or disability Poor birth outcomes & maternal health Low childhood immunization

Gypsy and traveller population

Borough	2011 Census	GP Registered	Traveller caravan count (2018 – 2021) MHCLG
Barnet	151	421	11
Camden	167	69	39
Enfield	344	784	0
Haringey	370	1,113	43
Islington	163	82	0

- In NCL, the majority are aged between 20-44 and compared to London, there is a higher proportion of under 19s in all boroughs apart from Islington.
- There are no current estimates of the Roma population in NCL, although the 2021 census will have this information.

Service landscape

- Edmonton Community Partnership and Healthwatch Enfield – supporting the Bulgarian/Roma community in Edmonton
- Enfield Council Doctors of the world mobile clinics - weekly mobile health clinics offering GP registration, health assessments, dental, sexual health and pregnancy services and advice on health costs

Vulnerable migrants

North Central London Integrated Care System

- Migrant: who leaves their country of origin to reside in another for the purpose of work, study or closer family ties.
- Forced migrants: who has been forced to leave their country of origin due to war, conflict, persecution or natural disaster.
- Asylum seeker: have applied for asylum under the 1951 Refugee Convention on the Status of Refugees on the grounds that they have a well-founded fear of persecution should they return to their home country.
- Refugee: status of refugee has been conferred under the 1951 Refugee Convention on the Status of Refugees.
- Undocumented migrant: who has entered the UK in a forced or unforced manner but has lost or never obtained the right to residence.

Barriers in accessing healthcare nationally

In the UK, all asylum seekers, refugees and victims of modern slavery/human trafficking are entitled to primary care NHS services free of charge. However many face barriers to access including:

- Denial of GP registration if applicant does not have identification or proof of address
- Transport costs
- Language barriers and digital exclusion
- Lack of understanding or knowledge of their health rights and healthcare system
- Fear of arrest or immigration enforcement if they access healthcare services.
- Trauma triggers that may not be considered when providing healthcare.

Mental health	Physical health
• Depression, anxiety, PTSD, psychotic disorders	• TB, Hep B & C, HIV; other communicable diseases • Diabetes • Cancer diagnosed at later stage • Poor perinatal outcomes

Service landscape in Enfield

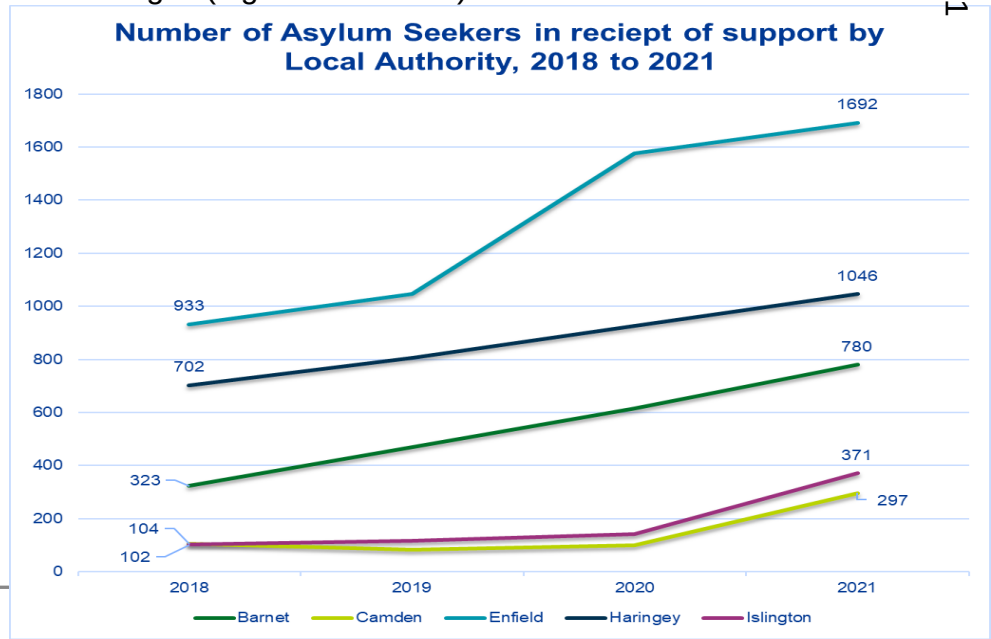
- Promotion of Safe Surgeries that welcome migrants and allow individuals to register with a GP without asking for documents
- Primary care holistic assessment for adults and children arriving from Ukraine

Migrants comprise 31-47% of borough populations

Borough	Non-UK born residents	% of total resident population
Barnet	164,000	41%
Camden	124,000	47%
Enfield	**122,000**	**36%**
Haringey	87,000	31%
Islington	90,000	37%

Source: Annual Population Survey

The number of asylum seekers in receipt of LA support has risen in all NCL boroughs (highest in Enfield).



Source: MHCLG Resettlement Statistics

Homelessness

North Central London Integrated Care System

Includes
- Rough sleepers
- Statutory homelessness people meeting specific criteria to whom LA has a duty,
- Single homelessness
- Hidden homelessness

Insight into lived experience and COVID response

- **Women's homelessness** is unique and often 'hidden' compared to men. Women have high levels of support needs and experienced sustained homelessness. Contact with child protection systems were widespread, as were experiences of domestic abuse and poor health[10].
- **Families with children under 5 living in temporary accommodation** faced a range of health impacts during the pandemic including limited access to primary care, higher hospital admission, poor nutrition, substance use, suicide risk, and other mental health impacts[12].
- **Barriers to healthcare** include stigma and discriminatory practices by healthcare professionals, lack of trauma informed approaches, limited integration of health and social care services, particularly for people facing multiple disadvantage, fixed appointment times and lack of awareness around GP registration and entitlement to healthcare[13-16].
- **During Covid**, people experienced isolation and loneliness, digital exclusion and a lack of meaningful activities to keep them engaged; there was also a need for supported accommodation and additional increased emotional support[8].

Health service landscape

- Specialist GP service for rough sleepers and people experiencing homelessness with complex needs based at Somewhere Safe to Stay Hub (in mobilisation) – Inequalities Fund
- Promotion of Safe Surgeries that welcome migrants and allow individuals to register with a GP without asking for documents
- Move on coordination following hospital discharge, part of the NCL Out of Hospital Care Model for improving discharge care and support for people experiencing homelessness
- Appendix 1 describes the NCL vision for homeless health

Borough	Rough Sleepers (CHAIN 2020/21)	Statutory Homelessness (2020/21)	HealtheIntent (GP)	NCL LA** (Oct-Nov 2021)
Barnet	282	2,030	77	282
Camden	630	1,098	916	847
Enfield	**326**	**1,905**	**64**	**550**
Haringey	405	2,383	113	633
Islington	388	1,623	155	533

* LA estimates based on RS, single homelessness and those in temporary accommodation

Crisis estimates that **62%** of homeless people are **hidden homeless** and 75% have never stayed in temporary accommodation organised by the local authority, nor stayed in a hostel (57%)[1].

Mental health	Physical health
• Suicide • Bipolar disorder, personality disorder, schizophrenia, PTSD, major depression • Substance misuse	• Lower average age of death • Average age of death is 30 years lower than the national average; 46 overall and 43 for homeless women. • Joint & muscular problems, dental issues, chest pain, breathing problems, eye problems, skin and wound conditions • Asthma, TB, heart disease and Hep C

Sex workers

North Central London Integrated Care System

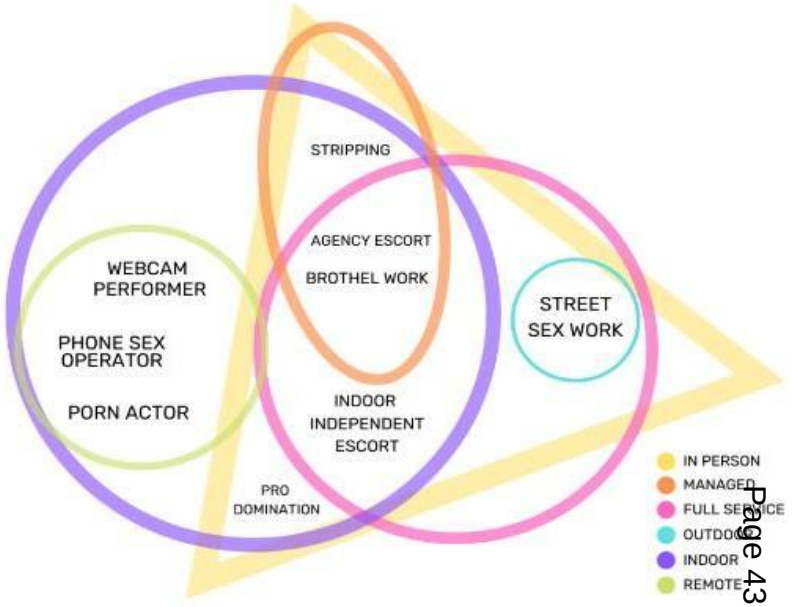
The term “sex worker” refers to any person who provides sexual services in exchange for money or other basic necessities such as food or shelter**.** This includes direct sex work, survival sex work and indirect sex work.

Demographics

No local estimates available

London demographics show that

- Approximately 32,000 of sex workers are estimated to work in London. London has a higher proportion (30-40%) of male and trans sex workers. Many are from Latin America and are more likely to have completed higher education.
- The Open Doors service for sex workers found that the majority of the sex workers they engage with are 18-40 years old and come from a mix of ethnic backgrounds, though more of their service users are British-born.
- A study conducted by the Hackney Open Doors service found:
  - **On-street workers**: Mostly female of white, black, or mixed UK heritage; local borough residents, age 25-45, often struggle with homelessness, substance misuse, and poor mental health.
  - **On street migrant workers:** Mostly female Eastern European, mobile across London, living in HMOs, age 19-35, less likely to struggle with drugs, but often experience immigration issues and language barriers
  - **Off-street:** Mostly migrant, more likely to be male or trans compared on on-street workers, mix of nationalities depending on changes in visa restrictions.



Intersections across types of sex work.

Barriers in accessing healthcare nationally

- Fear of stigma and discrimination leading to avoidance of care or not disclosing their work status.
- Fear of prosecution and zero-tolerance policies
- Gender insensitivity, particularly for trans sex workers
- Lack of flexibility around appointment times
- GP registration. Data on GP registration varies, with some services reporting low-levels of registration (especially among sex workers experiencing homelessness), while others point to relatively high GP registration
- Sexual health and substance misuse services were perceived to be the most accessible, and mainstream general practice and mental health services less accessible.6 Sex workers are likely to present with severe health needs in A&E settings

Mental health	Physical health
• PTSD, anxiety, depression and eating disorders • Substance misuse (alcohol & drug use, chemsex amongst males)	• TB and other respiratory illnesses, Hep B & C, STIs • Untreated LTCs • Terminated pregnancy • Injuries & violence

People with a history of imprisonment

North Central London Integrated Care System

- A person with a history of imprisonment, or a person with a history of contact with the criminal justice system are preferred terms for individuals who have spent time in dentation or custody.
- Individuals with experiences of a variety of criminal justice institutions, including
  - Prisons (both private and public)
  - Young offenders institutions
  - Secure colleges or secure training centres
  - Parole or probation protocols
  - IRCs (Immigration Removal Centres)

Demographics

No local estimates available

National demographics data shows that:

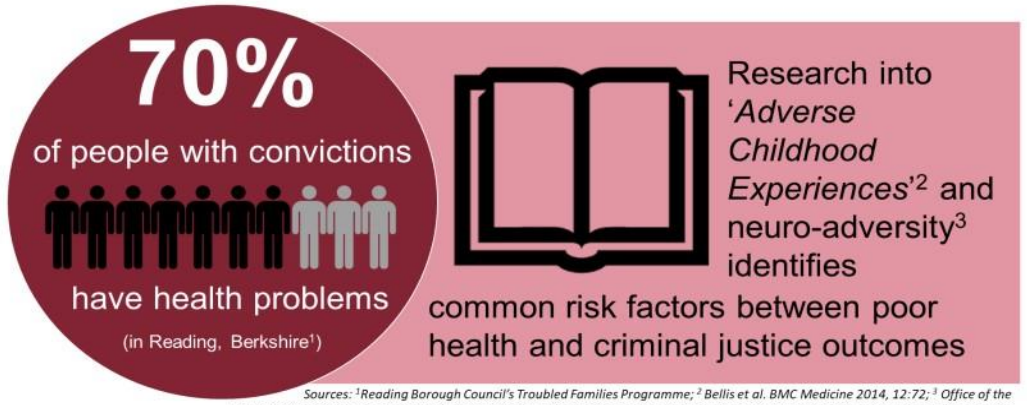
- 96% are male
- Nearly a third are 30-39 years old (32.7%), however older people are the fastest growing group among the prison population, with 17% already being over 50 years old.
- 46% re-offend within a year of release
- Most are sentenced for less than 12 months (74%), with almost half (43%) sentenced for less than 6 months, though they will still experience the negative effects of incarceration on health.
- Compared to the general population, those with a history of imprisonment are:

20x more likely to have been excluded from school
13x more likely to have been in local authority care
13x more likely to be unemployed
And 50% have low literacy levels

Mental health	Physical health
• Suicide, suicide attempt and self-harm rates • Personality & psychotic disorders • Substance misuse	• Mortality • TB, Hep A, B, C, syphilis, HIV • Chronic illness

Barriers in accessing healthcare nationally

- **Fear of stigma and discrimination**
- **GP registration**, with 50% lacking a GP on release[10]
- Inadequate **mental health services** both in and post prison
- **Lack of continuity of care** once leaving prison:
  - Particularly for drug treatment, methadone maintenance and dental health
  - Because of this gap in care and the huge level of vulnerability post-prison, in terms of physical health, time in prison may almost act as a protective factor, with health likely to deteriorate further upon release[3]
  - Sexual health is an exception, with robust pathways between prison and specialized services leading to an uptake of STI testing and treatment



Sources: [1] Reading Borough Council's Troubled Families Programme; [2] Bellis et al. BMC Medicine 2014, 12:72; [3] Office of the Children's Commissioner for England, 2012. Nobody Made the Connection: The prevalence of neurodisability in the youth justice system

Discussion and next steps

North Central London Integrated Care System

Questions

- How does the insight from Phase 1 support Enfield's plan for addressing health inequalities?
- What are the key priorities for Enfield for Phase 2 of the Inclusion Health Needs Assessment?

Next steps

- Complete engagement for Phase 2 of the Inclusion HNA
- Co-produce a set of recommendations for Enfield Borough Partnership, Enfield Health and Wellbeing Board and NCL Integrated Care Partnership (ICP)
- Co-produce an Enfield and an ICP plan for health improvement for Inclusion Health Groups
- Plan presented and discussed at Enfield HWBB in the new year

Appendix 1: NCL vision for people experiencing homelessness

North Central London Integrated Care System

NCL vision for people and families affected by homelessness

To support rough sleepers, multiple exclusion homeless, those in encampments, vulnerable people, families in temporary accommodation and hidden homeless by providing access to integrated housing, health, care, employment and community support to transition into a sustained recovery from homelessness.

Developed with borough homelessness leads – used as format for borough planning/priorities

Infrastructure/Enablers
- Data & evidence
- Contract management
- Info Sharing Agreements
- IT Systems
- Joint Commissioning

Governance

Borough Health & Wellbeing Board
Borough Partnerships
Rough Sleeping Strategic Board/MEAM Strategic Board
ICB Strategic Commissioning Committee

VALUES embedded through training

- psychologically informed
- gender informed
- trauma informed
- strengths-based
- co-produced
- accessible and inclusive services

Healthcare

- Mainstream services

GP registration
Dentistry, Optometry
Community Health
Mental health
Specialist nursing
Health peer advocacy

- Primary and integrated care

Specialist GP and LCS
Dedicated / specialist MDT - mental health, substance misuse, physical health
Health peer advocacy
Children's services
Safeguarding

- Out of Hospital Care

Dedicated Intermediate Care
Move on coordination and system coordination
Health peer advocacy
End of Life Care
NHS 111

Drug & Alcohol

- Ongoing stabilisation
- Substitute prescribing
- Care planning / Detox support / Dual diagnosis support

Prevention

- BBV testing
- Sexual health
- Smoking cessation
- Immunisation and vaccination
- Cancer screening
- Nutrition

Income, employment, education

- Range of education, employment and training opportunities in each borough
- Benefits and immigration support, legal advice

Social Care

- Safeguarding for vulnerable groups (including DV and modern slavery)
- Dedicated social workers and care act assessments where appropriate

Benefits, legal and other specialist advice

- Benefits support
- NRPF
- immigration support
- Other legal advice

Accommodation

Supported Housing, Social Letting Quotas
Night Shelters with support from Housing First

Floating / peer / keyworker support to connect up the system of health, care, housing and other support including engagement in social connections and meaningful activities

- Interdependencies
- Violence Against Women and Girls
- Adult and child Safeguarding
- COVID-19 response
- Staff health and wellbeing

Cancer screening awareness campaign

Health and Wellbeing Board

October 2022

Collaboration

- Enfield Council
- NCL ICB
- NCL Cancer Alliance
- NHSE
- VCS
- PCNs

Snapshot of screening awareness work

ENFIELD Council

NHS North Central London Integrated Care Board

Cervical screening survey shared with 7 European communities across Enfield & Haringey

Cervical cancer prevention training for non-clinical staff

People experiencing homelessness

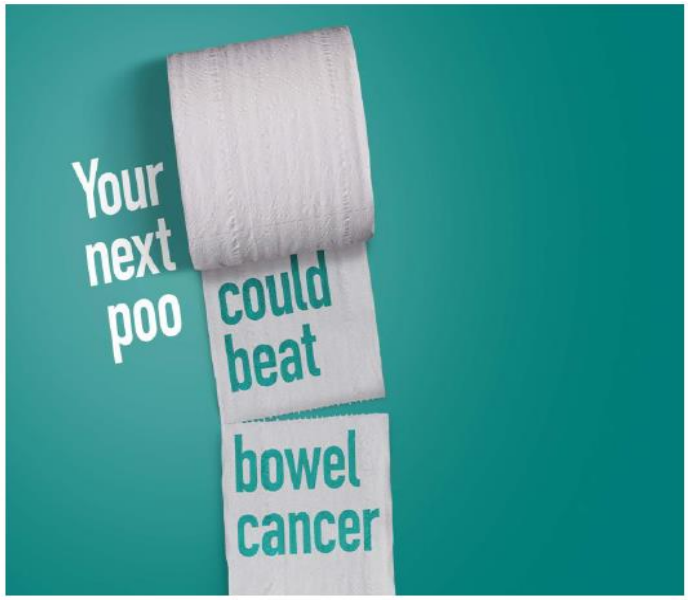
Screening workshops for adults with learning disabilities

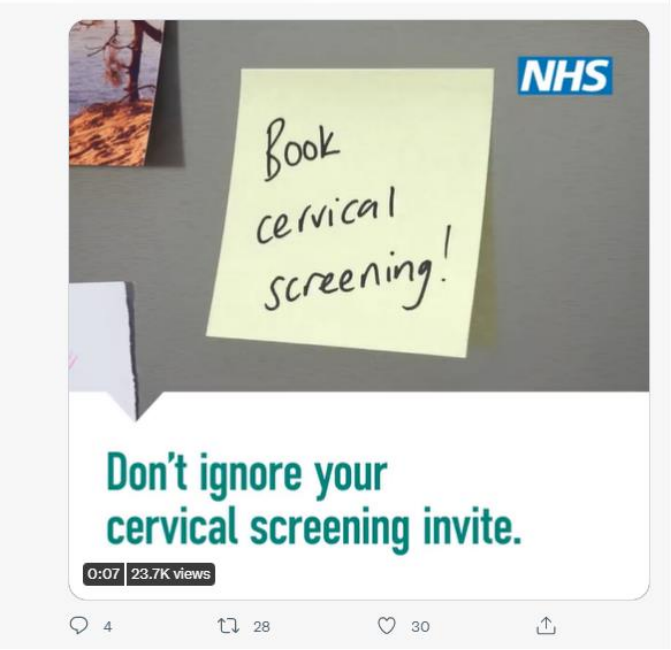
Targeted primary care approach for cervical screening

Breast screening mobile unit at NMUH and Forest Road (fixed site)

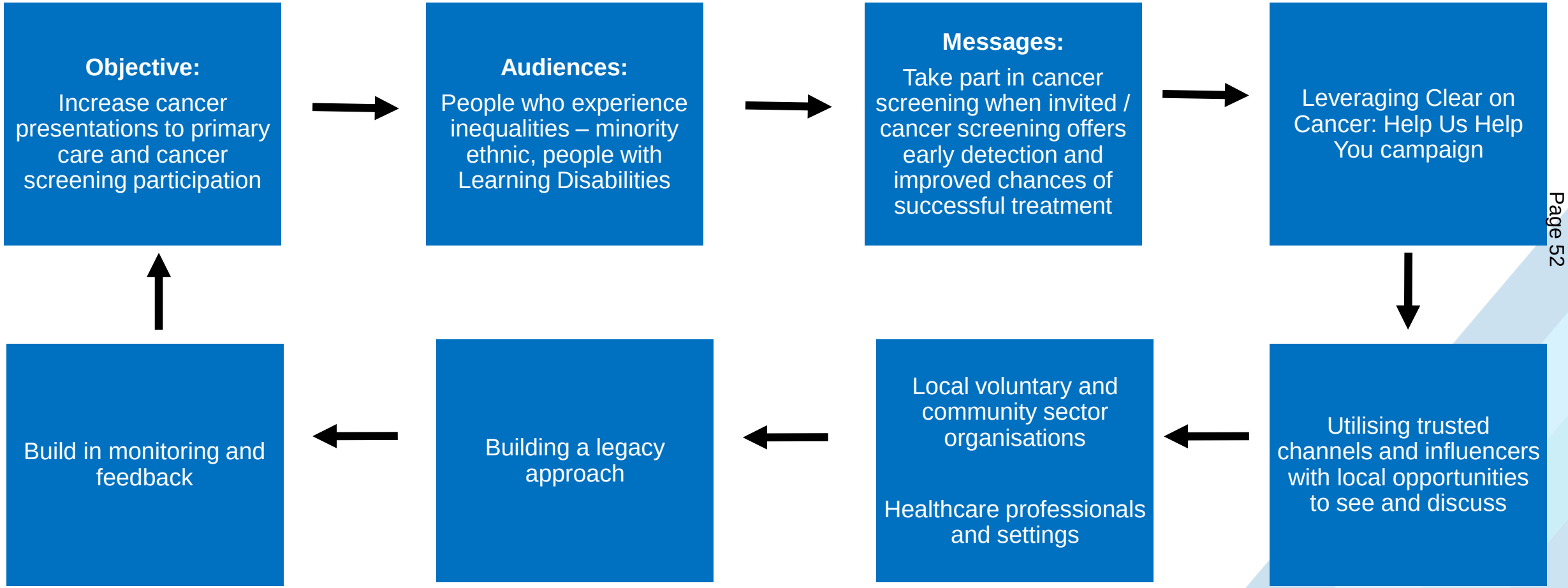
Comms and engagement

Hyperlocal campaign to build on national messaging





Enfield campaign - plan on a page



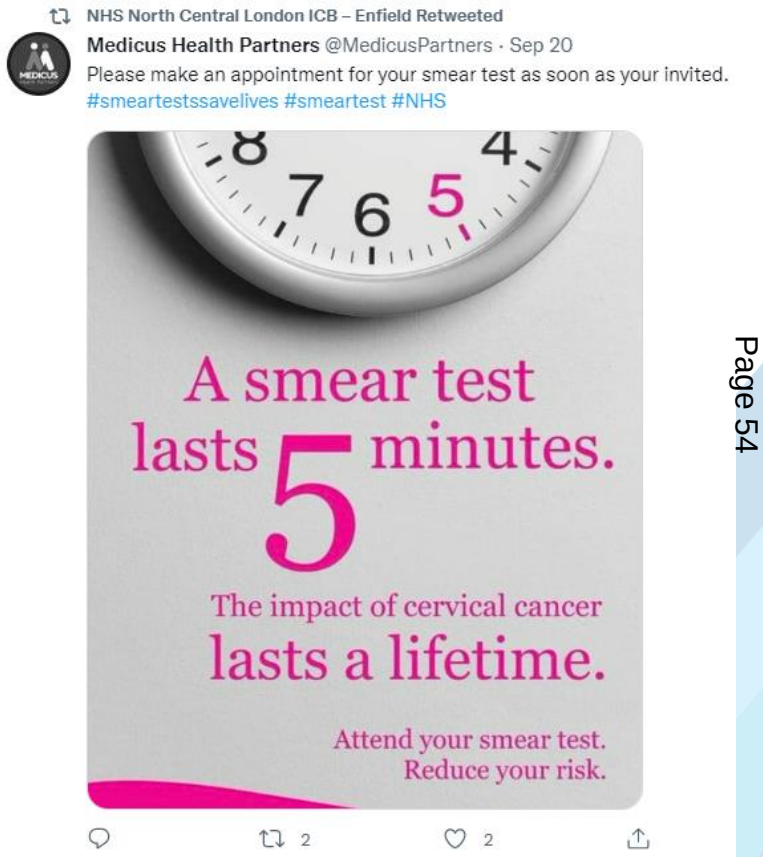
Communication channels

- Social media featuring trusted voices / GPs
- Posters for healthcare settings – GPs and pharmacies
- Online events/webinars
- Channels in ICS organisations – websites, newsletters, waiting rooms
- Council and other organisational screensavers

Social media support

ENFIELD Council

NHS North Central London Integrated Care Board



Events

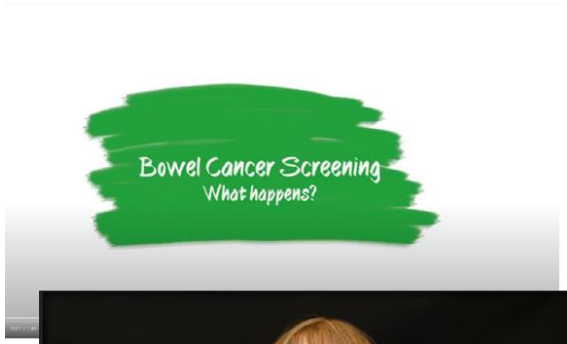
Presentation to the Enfield Black Community Health Forum on 27 September by Dr Nitika Silhi

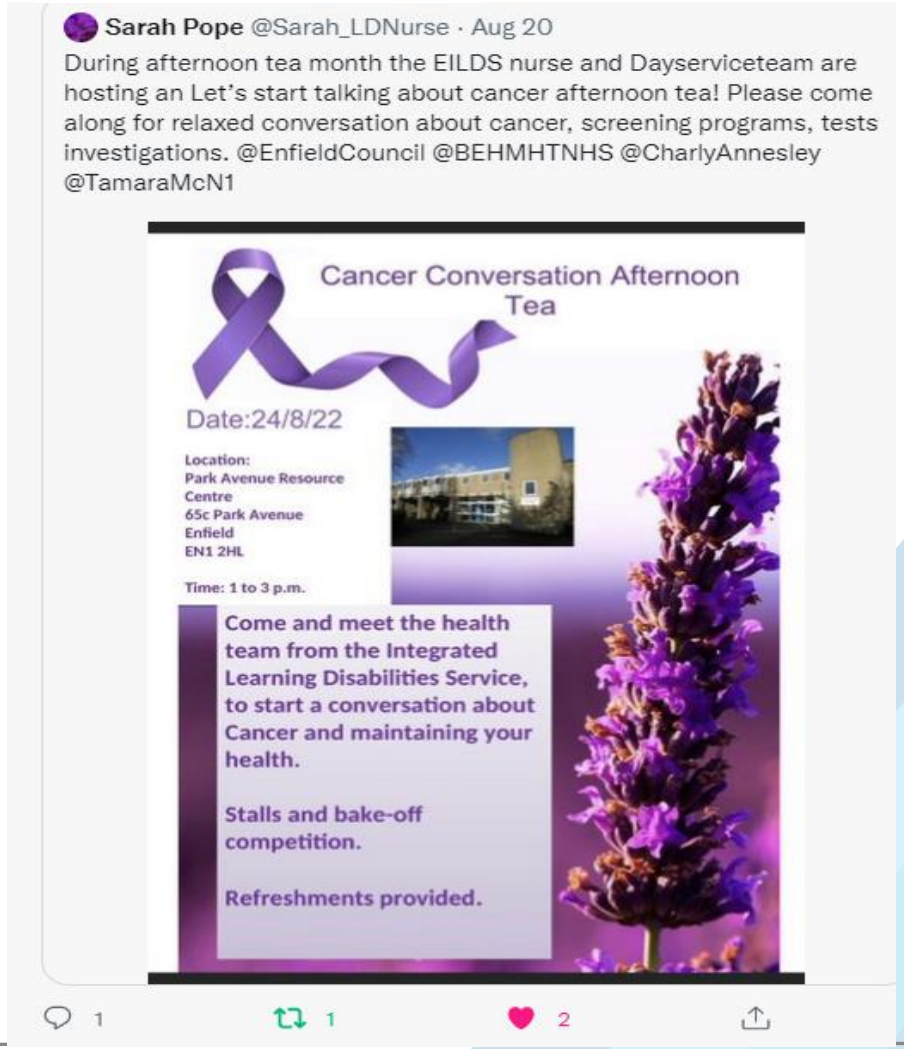
Taking part in cancer screening in Enfield

Dr Nitika Silhi
North Central London Cancer Alliance GP Lead

Partnership working

- Working with Enfield LD team and service user groups to inform and participate in co-production /ensure wide distribution of existing easy-read resources





Coming up

North Central London
Integrated Care Board

- Translated materials for distribution at community venues
- Recruiting trusted voices for promotional materials
- Community Champions / Leaders from Revival Christian Church Enfield taking part in Black History Month celebrations on 16th and 30th October in Enfield with cancer screening resources
- Presentation to the next Faith Forum

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 7 JULY 2022

MEMBERSHIP

PRESENT Cllr Nesil Caliskan (Leader of the Council), Cllr Abdul Abdullahi (Cabinet Member for Children's Services), Cllr Andy Milne, Dr Nitika Silhi (Governing Body Member, NHS NCL CCG), Dudu Sher-Arami (Director of Public Health), Bindi Nagra (Director of Adult Social Care), Tony Theodoulou (Executive Director of Children's Services), Jo Ikhelef (CEO of Enfield Voluntary Action) and Vivien Giladi (Voluntary Sector)

ABSENT Cllr Alev Cazimoglu (Cabinet Member for Health & Social Care), Deborah McBeal (NCL CCG), Olivia Clymer (Healthwatch Central West London), Dr Helene Brown (NHS England Representative), Pamela Burke (Voluntary Sector), Dr Alan McGlennan (Chief Executive, Chase Farm Hospital, Royal Free Group), Dr Nnenna Osuji (Chief Executive, North Middlesex University Hospital NHS Trust), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust) and Siobhan Harrington (Whittington Hospital)

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

Also Attending: Dr Jo Sauvage (Chief Medical Officer NHS NCL ICB), Jo Carroll (Managing Director, Enfield Mental Health Division, BEH NHS Trust), Alex Smith (Director of Transformation, NHS NCL ICB), Dan Morgan (Interim Director of Aligned Commissioning, NHS NCL ICB), Sonia Amos (Senior Communications Manager, NHS NCL ICB), Laura Andrews (NHS NCL CCG), Doug Wilson (LBE Health, Housing & Adult Social Care), Chloe Morales Oyarce (North London Partners in Health and Care), Anna Stewart (Start Well Programme Director), Emma Whicher (Start Well Programme Senior Responsible Officer), Penny Mitchell (Director of Population Health Commissioning, NHS NCL ICB), Stephen Wells (Head of Enfield Borough Partnership Programme, NHS NCL CCG), Dr Fahim Chowdhury GP (Primary Care Lead), Rikki Garcia (Healthwatch), Debbie Gates (Community Development Officer, LBE), Helen Baeckstroem (Strategy & Policy Team Manager, LBE), Jon Newton (Head of Service Integrated Care, LBE)

1
WELCOME AND APOLOGIES

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

Apologies for absence were received from Councillor Alev Cazimoglu, Deborah McBeal (substituted by Stephen Wells), Dr Helene Brown, Pamela Burke, Dr Alan McGlennan, Dr Nnenna Osuji, Andrew Wright, Siobhan Harrington, and Dr Chitra Sankaran.

2
DECLARATION OF INTERESTS

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

3
NORTH CENTRAL LONDON (NCL) MENTAL HEALTH AND COMMUNITY SERVICES REVIEW UPDATE

RECEIVED the slide presentation and introduction by Alex Smith (Director of Transformation, NCL Integrated Care Board (ICB)).

NOTED

1. Further to the report to the previous meeting, an overview was provided of progress. Following definition of the core offer, and baseline reviews, the priorities had been identified.
2. The intention was to continue supporting boroughs which had experienced less investment per head of population in previous years.
3. The challenges were appreciable, particularly around national skills shortages.
4. More detailed information was provided by Jo Carroll (Managing Director, Enfield Mental Health Division, BEH MH NHS Trust) and Dan Morgan, (Interim Director of Aligned Commissioning (MH, Learning Disabilities, Autism & Children Young People), NCL ICB). Most investment had been in crisis services, and there was a need to put more emphasis on prevention and to target long waiting times and to prioritise gap areas.
5. A further update would be brought to the next Board meeting.

IN RESPONSE

6. In response to queries regarding timelines, it was confirmed that transformation work would carry on through the next two years and a longer term plan would be coming on stream. Recovery work started in the last financial year. The Autism hub would start in September.
7. In response to queries regarding attracting workforce to the area and assistance that partners could offer, it was advised there was ongoing work with the voluntary sector, and interest-raising and showcasing in universities and schools, and development of training hubs. There were opportunities to signpost people into meaningful employment. The Chair also highlighted the Council's long term regeneration plans and place-making role, and that the borough already had a large workforce of care workers which could be utilised and built on.

4
"START WELL" INITIATIVE

RECEIVED a verbal update from Anna Stewart (Start Well Programme Director) with Chloe Morales Oyarce (Head of Communications and Engagement, North London Partners in Health and Care) and Emma Whicher (Joint Senior Responsible Officer for the Start Well Programme).

NOTED

1. The Start Well programme will link into the work already done in the Mental Health and Community Services Reviews. It is a long term review of services for pregnant women and people, babies, children, young people and their families.
2. Further to the update to the previous meeting, insights had been sought, engagement planned, and the case for change built.
3. The key themes were described, around the delivery of safe care and opportunities to improve care.
4. The 10 week period of engagement had begun this week, and would include engagement with staff, stakeholders, patients, and local residents to ask about what was considered most important in respect of care and check that other findings reflected people's experiences. A summary version of the Case for Change and a patient leaflet had been produced. The engagement link was shared: https://nclhealthandcare.org.uk/get-involved/start-well/
   There would also be an online residents' panel, gathering of children and young people's opinions, reverse mentoring and a youth summit.
5. Feedback from Board members would be welcomed, along with promotion of the engagement, and an opportunity to return and update the Board on the next steps for the programme.

IN RESPONSE

6. In response to the Director of Public Health's queries, it was confirmed that population health data across North London was being examined, and that variations were apparent. Offers of assistance from the Council and from the voluntary sector were appreciated, and the team would be happy to come and talk to community groups, mother and baby groups, etc.
7. Vivien Giladi, representing the voluntary sector, welcomed the programme and wished to assist. She raised that the country had lost its Measles-free status, and that Enfield had seriously sub-optimal levels of vaccination of children across the borough: she appealed that inequalities funding for uplift should be directed to reversing this situation. The Director of Public Health commented that immunisation uptake was a priority and that there was an ICB delivery group working on the whole schedule, and more information could be brought to a future Board meeting. The Council could also offer sharper communications to raise vaccination awareness.
8. The Director of Adult Social Care raised the importance of health visitor services, and recent concerns in respect of midwife-led units not attached

to acute hospitals. The Chair also raised the concerns of residents around lack of access to health clinics and their wish for more face-to-face opportunities. There were also long-standing inequalities in that national data highlighted that women of colour had higher rates of complications and deaths in pregnancy and childbirth.

9. The points were noted, and that it had become apparent that a lot of the care that happened in hospital could be done in the community, and that large numbers of children were presenting at hospital emergency departments. It was confirmed that the Ockenden maternity review principles underpinned the improvements being made. The requirements from the first part of the Ockenden review were already being met, and the Trust would continue to meet the next steps and take them forward as best practice. In NCL, there was only one stand-alone midwifery led birth unit at Edgware Birth Centre, which had a low number of births. In respect of data relating to experiences of Black women in pregnancy and childbirth, there were clear inequalities at the national level. Where possible this had also been reviewed at an NCL level, however for some areas with low numbers of cases it is not possible to make a robust statement for individual boroughs and the case for change has drawn on the national evidence base.
10. The next steps were to hear from a representative range of voices and to publish the reflections towards the end of September. The ICB would be asked to decide on actions regarding the next steps, working with system partners.

5

JOINT HEALTH AND SOCIAL CARE COMMISSIONING BOARD UPDATE AND BETTER CARE FUND UPDATE

RECEIVED the written update, introduced by Doug Wilson (LBE Head of Strategy, Service Development & Resources, People Department).

NOTED

1. The plans were detailed, but the Better Care Fund purpose was clear: to help people avoid admission to hospital, to reduce long hospital stays and minimise numbers who were permanently admitted to residential or nursing care, to increase the proportion of people returning to their normal place of residence, and to enable people to regain their independence where possible.
2. Performance updates in the report were largely positive. The baseline of 2019/20 was used. Avoidable admissions had gone down, but hospitals and adult social services remained busy. However, more people were staying in an acute hospital bed for longer and the target for 21+ days was missed. When people were going into hospital they were more ill and staying longer, and Covid-19 had played a significant role in this. In testament to Adult Social Care in Enfield, the number of people living permanently in residential or nursing care had returned to pre-pandemic levels. The Council had invested in the Enablement service, which helped people to continue to live independently.

3. The Better Care Fund plans for this year were yet to be finalised, but it was expected that the priorities of the last year would continue. An update would be provided to the Board in the Autumn once the plans were agreed for this year.

IN RESPONSE

4. The Chair noted that pressures were high at all times, and differentiation could no longer be made between seasons. Ambulance service pressures were frequent. It was confirmed that the next report would provide an update on ambitions, and be clear in respect of the challenges and the collaborative work going on to alleviate those.

6
NORTH CENTRAL LONDON POPULATION HEALTH STRATEGY

RECEIVED the NCL Population Health Improvement Strategy Draft Aim and Plan, and slide presentation, introduced by Penny Mitchell, Director of Population Health Commissioning, NCL Integrated Care Board (ICB).

NOTED

1. The first draft of the NCL Population Health Improvement Strategy had been included in the agenda pack, and Penny was happy to receive feedback and questions outside of this meeting also.
2. Action was needed to improve the outcomes and wellbeing of residents, and to reduce inequalities.
3. The NCL Population Health Committee provided a strategic senior steer in respect of achieving the aims.
4. The strategy provided the core narrative for the system, and would need to be delivered fully across and through the system, affecting the whole way or working.
5. The outcomes framework set out the ambitions that were aimed to be achieved.
6. The core themes for delivery were set out. There would be evidence-based interventions and deployment of resources.

IN RESPONSE

7. The Director of Public Health noted that the core priorities fitted with the strategic direction of work already ongoing in the borough, and that this strategy would also inform the update of the Health and Wellbeing Strategy. It was confirmed that conversations would continue in respect of continuation of work, priorities, and data.
8. The Chair would like there to be more pilot projects to demonstrate what the Local Authority and other partners could do to make an impact, for example pop-up cancer screening opportunities on estates. Jo Ikhelef also confirmed that Enfield Voluntary Action funded projects could be fed in and upscaled. Dr Fahim Chowdhury, GP and Primary Care Lead for the borough, confirmed he would like to see closer links with the Council and

would support sessions for health checks in areas of inequalities to identify patients and bring them into the health care system to be managed appropriately. The Chair suggested Joyce and Snells Estate as a recommended location.

ACTION: LBE / Dr Chowdhury

7
ENFIELD BOROUGH PARTNERSHIP UPDATE

RECEIVED a covering report and slides, providing an update on developing the NCL Integrated Care System (ICS) and progress update on the Enfield Borough Partnership, presented by Stephen Wells (Head of Enfield Borough Partnership Programme, NCL CCG).

NOTED

1. The CCG's current system of accountability, functions and responsibilities transferred to the new NCL Integrated Care Board (ICB) on 1 July 2022.
2. The ICS was a new system of provider collaboratives. It would take a place-based approach, and drive new ways of delivering primary care to neighbourhoods.
3. The Executive Management Team was in place. The ICB Board had a constitution and met for the first time this week.
4. The responsibilities of the ICB were set out, as were the new ways of planning and delivering across organisations. There would be integration of care at neighbourhood and place level.
5. Working together as a system would enable the delivery of the Population Health Strategy.
6. The Borough Partnership's most recent work was around the National Programme Modules, and the Population Health Management approach. The National Programme offer supported the development of local priorities and a plan to inform operational delivery in 2022/23.

8
PHARMACEUTICAL NEEDS ASSESSMENT

RECEIVED a verbal update by Dudu Sher-Arami, Director of Public Health.

NOTED

1. Further to the presentation to the previous Board meeting, it was reminded that there was a statutory responsibility of the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA) at least every three years, and that 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 the 5 NCL boroughs. Soar Beyond were managing the project on our behalf.
3. A draft of the PNA was out to public consultation. The link was Consultation on Enfield Council's Pharmaceutical Needs Assessment

2022 – Enfield Health and Wellbeing . Board Members' support was requested in distributing this online survey and encouraging their networks to contribute.

4. The PNA would be completed on time in October. The post-consultation document would be brought to Health and Wellbeing Board to ratify.

9
MINUTES OF THE MEETING HELD ON 10 MARCH 2022

AGREED the minutes of the meeting held on 10 March 2022.

10
NEXT MEETING DATES AND DEVELOPMENT SESSIONS

NOTED the next Board meeting date was scheduled for Thursday 6 October 2022.

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