Public Document Pack

HEALTH AND WELLBEING BOARD

Monday, 4 December 2023 at 6.30 pm
Virtual / Teams

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PLEASE NOTE: VIRTUAL MEETING
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Click here to join the meeting

MEMBERSHIP

Leader of the Council – Councillor Nesil Caliskan
Cabinet Member for Health & Social Care – Councillor Alev Cazimoglu (Chair)
Cabinet Member for Children's Services – Councillor Abdul Abdullahi
Councillor Andy Milne – Conservative Member representative
Governing Body (Enfield) NCL CCG – Dr Shakil Alam (Vice Chair)
NHS North Central London ICB – Deborah McBeal
Healthwatch Representative – Albie Stadtmiller
NHS England Representative –
Director of Public Health – Dudu Sher-Arami
Director of Adult Social Care – Doug Wilson
Executive Director People – Tony Theodoulou
CEO of Enfield Voluntary Action – Jo Ikhelef
Voluntary Sector Representatives: 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 - 6:40 PM)

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. LB ENFIELD WINTER PREPARATION / VACCINATION PROGRESS / INFECTION CONTROL UPDATE (6:40 - 6:55 PM) (Pages 1 - 10)

Mark Tickner, Infection Control Lead, and Gayan Perera, Public Health Intelligence Manager – Public Health Department London Borough of Enfield.

(PAPERS ATTACHED)

Verbal update from Dr Nnenna Osuji, Chief Executive, North Middlesex University Hospital NHS Trust.

4. BETTER CARE FUND - UPDATE (6:55 - 7:05 PM) (Pages 11 - 20)

Doug Wilson, Director of Health and Adult Social Care, London Borough of Enfield and Matt Casey, Head of Strategy and Service Development, People Department London Borough of Enfield.

(PAPERS ATTACHED)

5. NORTH CENTRAL LONDON POPULATION HEALTH STRATEGY UPDATE PROGRESS (7:05 - 7:35 PM) (Pages 21 - 44)

Stephen Wells, Head of Borough Partnership Programme, Enfield Borough Directorate, NHS North Central London. Deborah McBeal Director of Integration Enfield Borough Directorate NHS North Central London Integrated Care Board.

(PAPERS ATTACHED)

6. JOINT HEALTH AND WELLBEING STRATEGY RENEWAL PROGRESS UPDATE (7:35 - 7:45 PM) (Pages 45 - 66)

Dudu Sher-Arami, Director of Public Health LB Enfield, Chad Byworth ST1 Registrar – Public Health Department, LB Enfield, Victoria Adnan, Policy and Performance Manager, Chief Executive's Department, LB Enfield, Mark Tickner, Senior Public Health Strategist, Public Health Department, LB Enfield.

(PAPERS ATTACHED)

7. EARLY YEARS PARTNERSHIP - UPDATE (7:45 - 8:00PM) (Pages 67 - 70)

Andrew Lawrence, Head of Commissioning – Children and Young People, Public Health Department LB Enfield and Francesca Falcini, Schools and Early Years Data Manager, People Department, LB Enfield.

(PAPERS ATTACHED)

8. ANY OTHER BUSINESS

a. **Dudu Sher-Arami –** Intention to hold JHWBS/NCL Population Strategy

Joint Working Scoping Meeting in Jan/Feb 2024.

9. MINUTES OF THE MEETING HELD ON 2 OCTOBER 2023 (Pages 71 - 76)

To receive and agree the minutes of the meeting held on 2 October 2023.

10. NEXT MEETING DATES AND DEVELOPMENT SESSIONS

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

Tuesday 5 March 2024.

Formal Board meetings proposed to commence at time to be confirmed.

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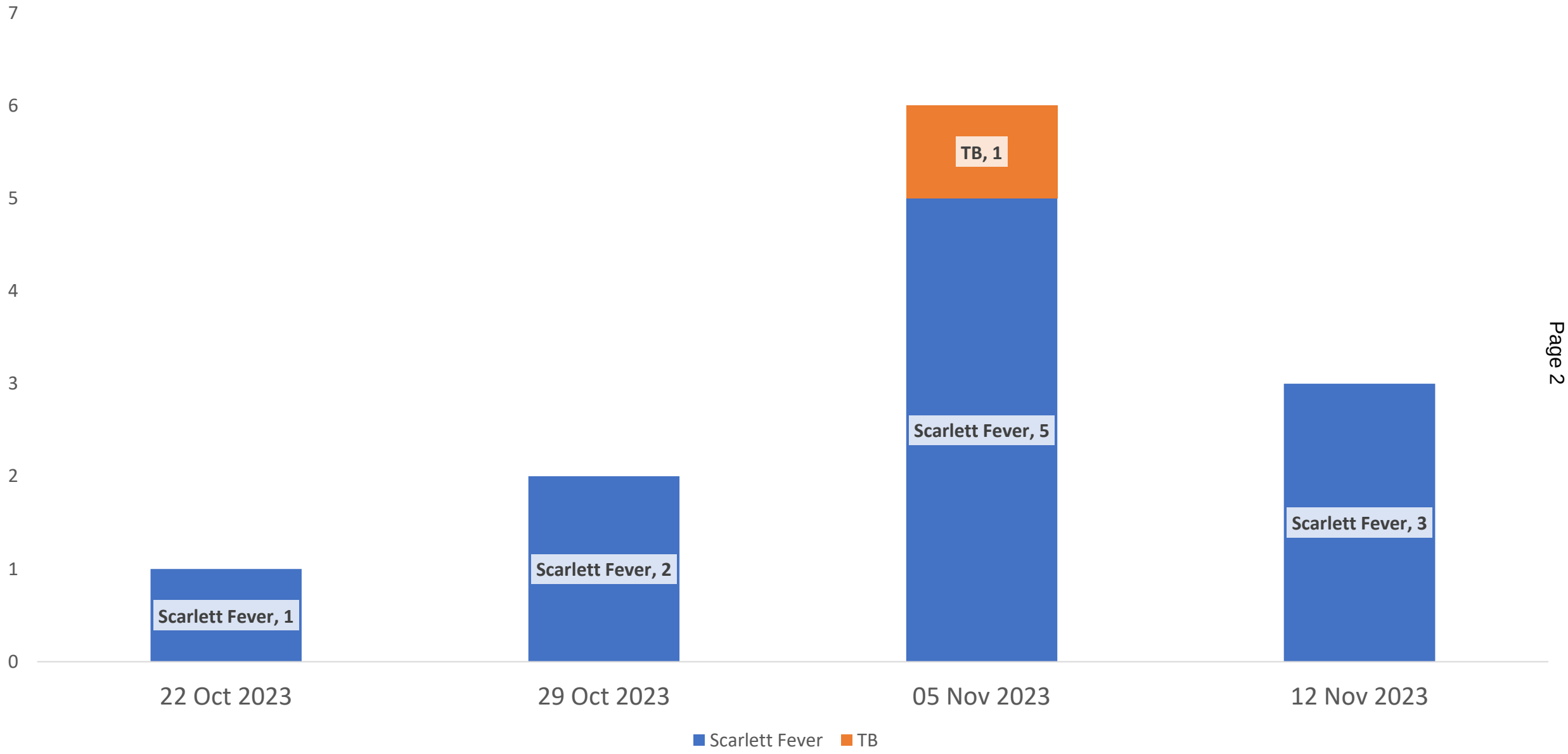
WINTER VACCINATION PROGRESS / INFECTION CONTROL UPDATE

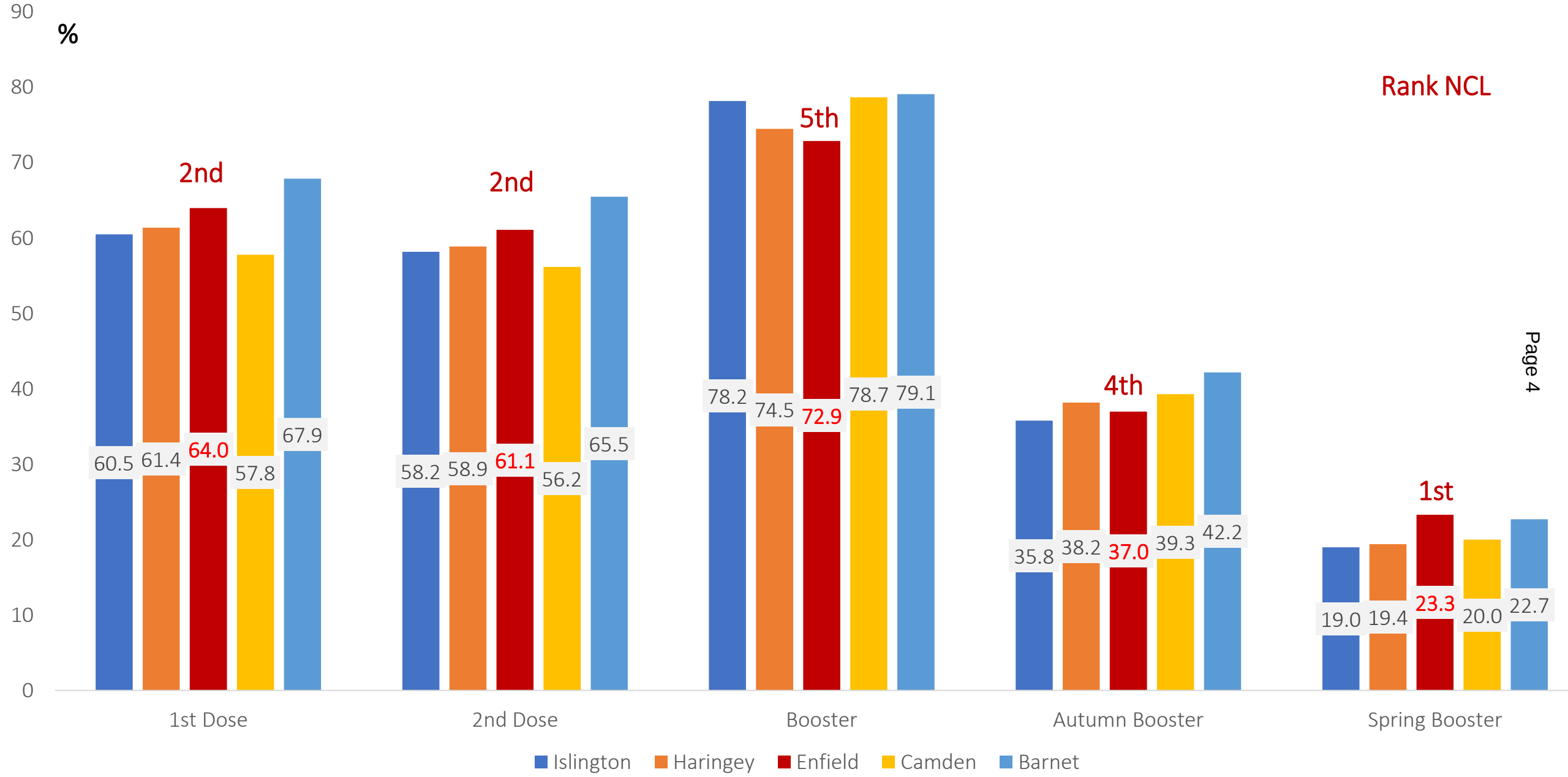
ENFIELD Council

Notifications of infectious disease cases



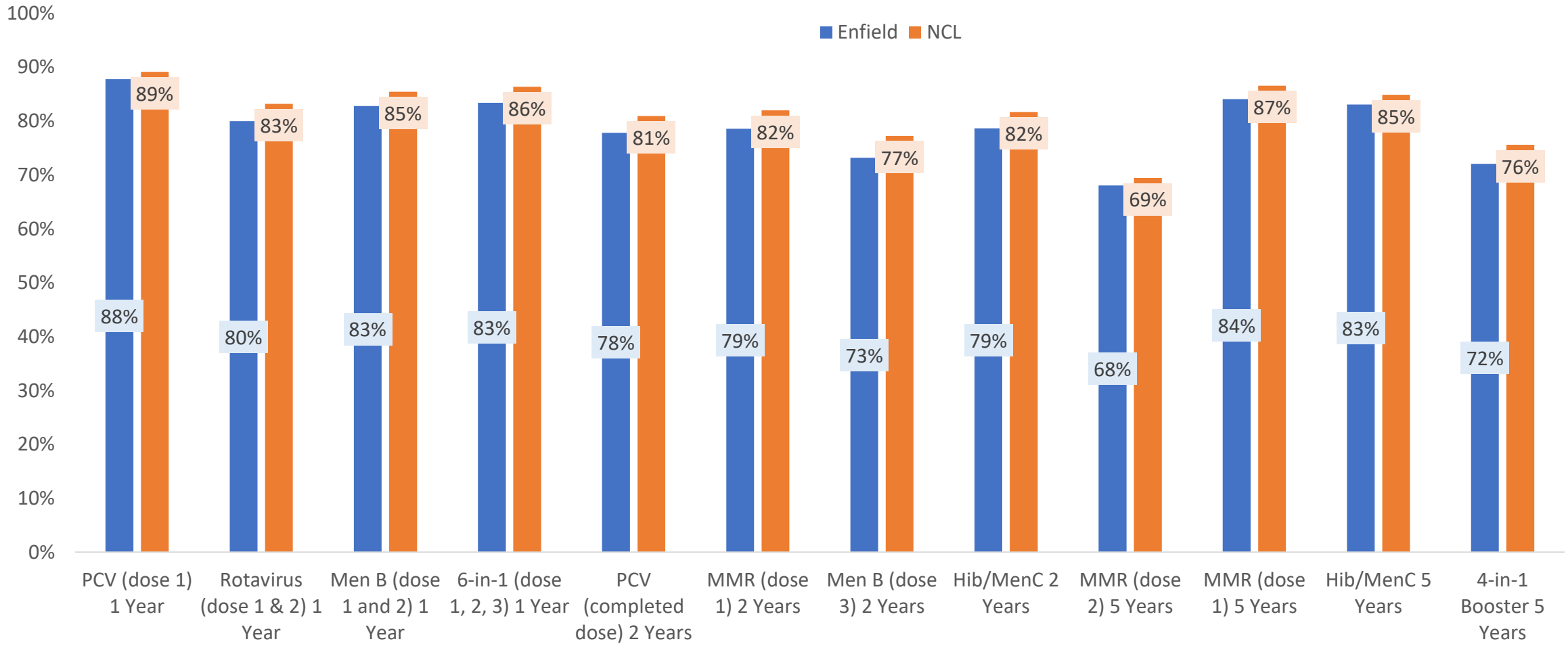
Rolling 7 day COVID cases

NCL Vaccine Uptake



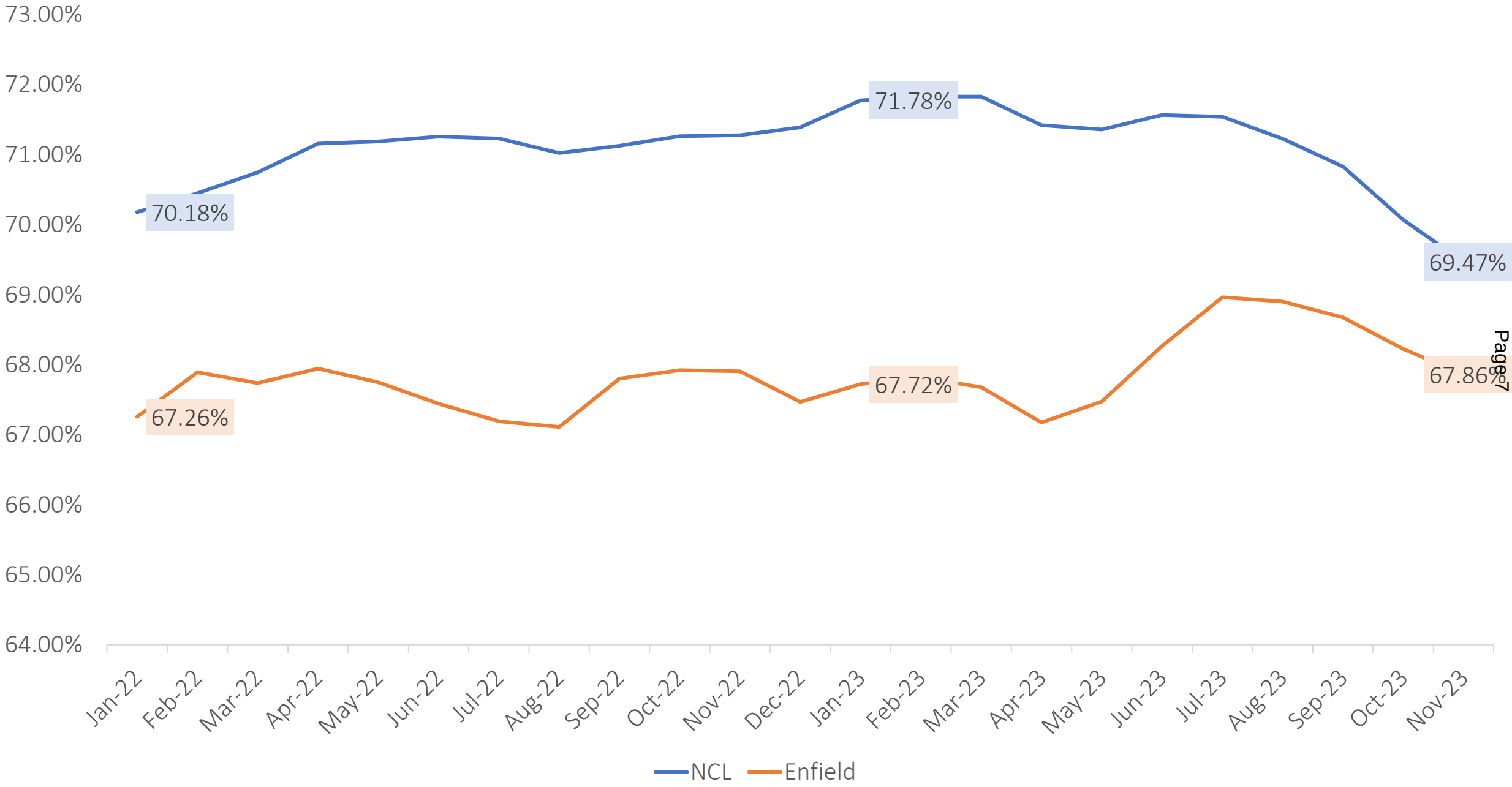
Eligible residents	COVID Autumn 2023 Booster	Flu 2023 vaccine
1021	78.8% (805)	81.9% (836)

Childhood immunisations uptake



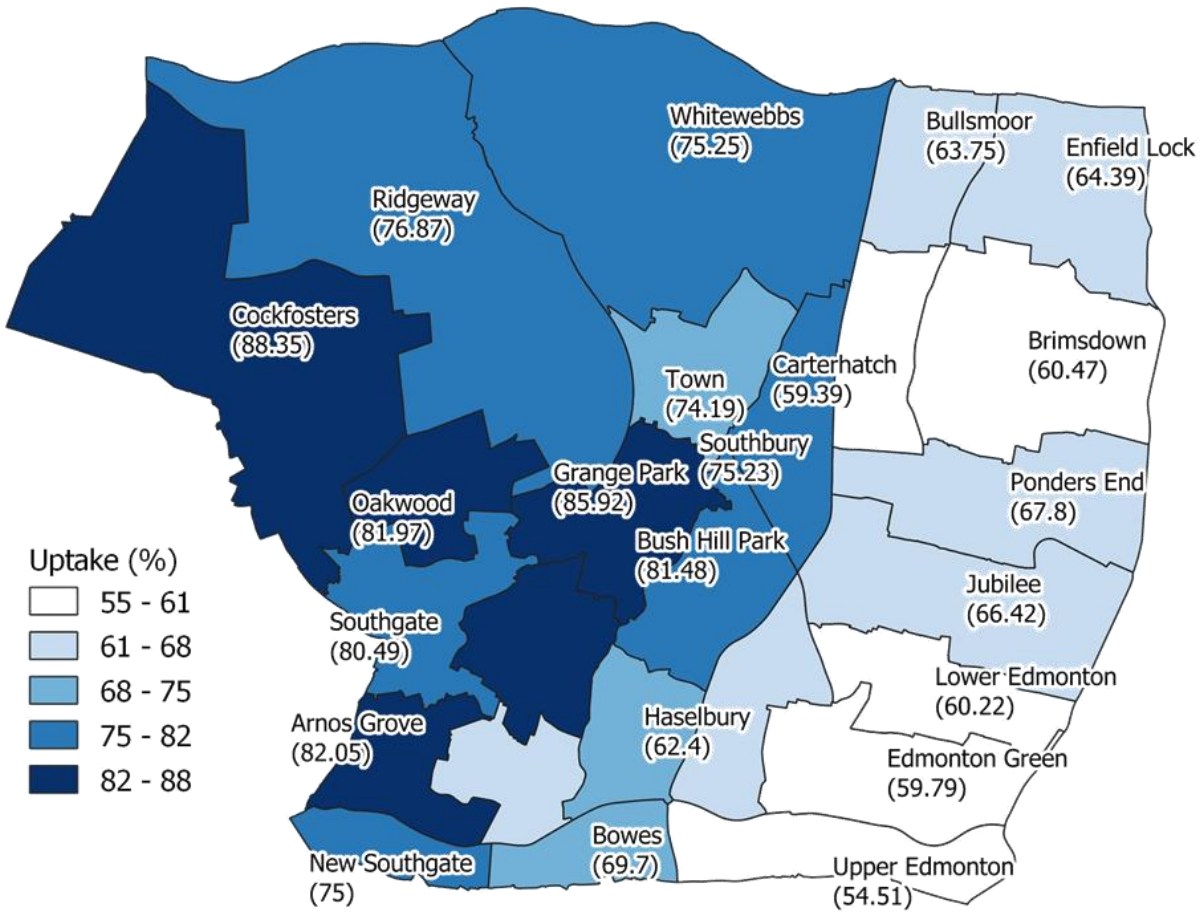
<1 year | *1 year* | *Pre-school*

MMR uptake over time

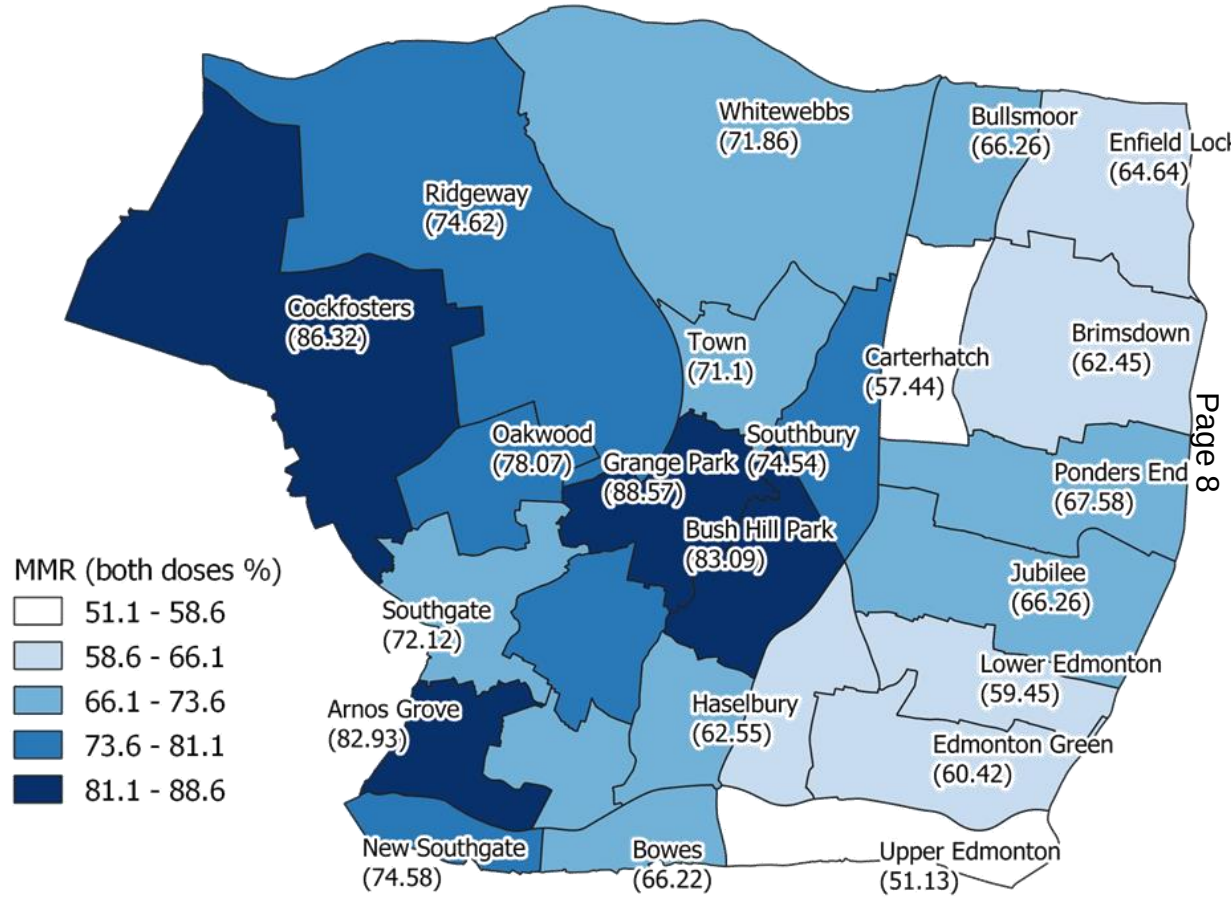


MMR uptake map

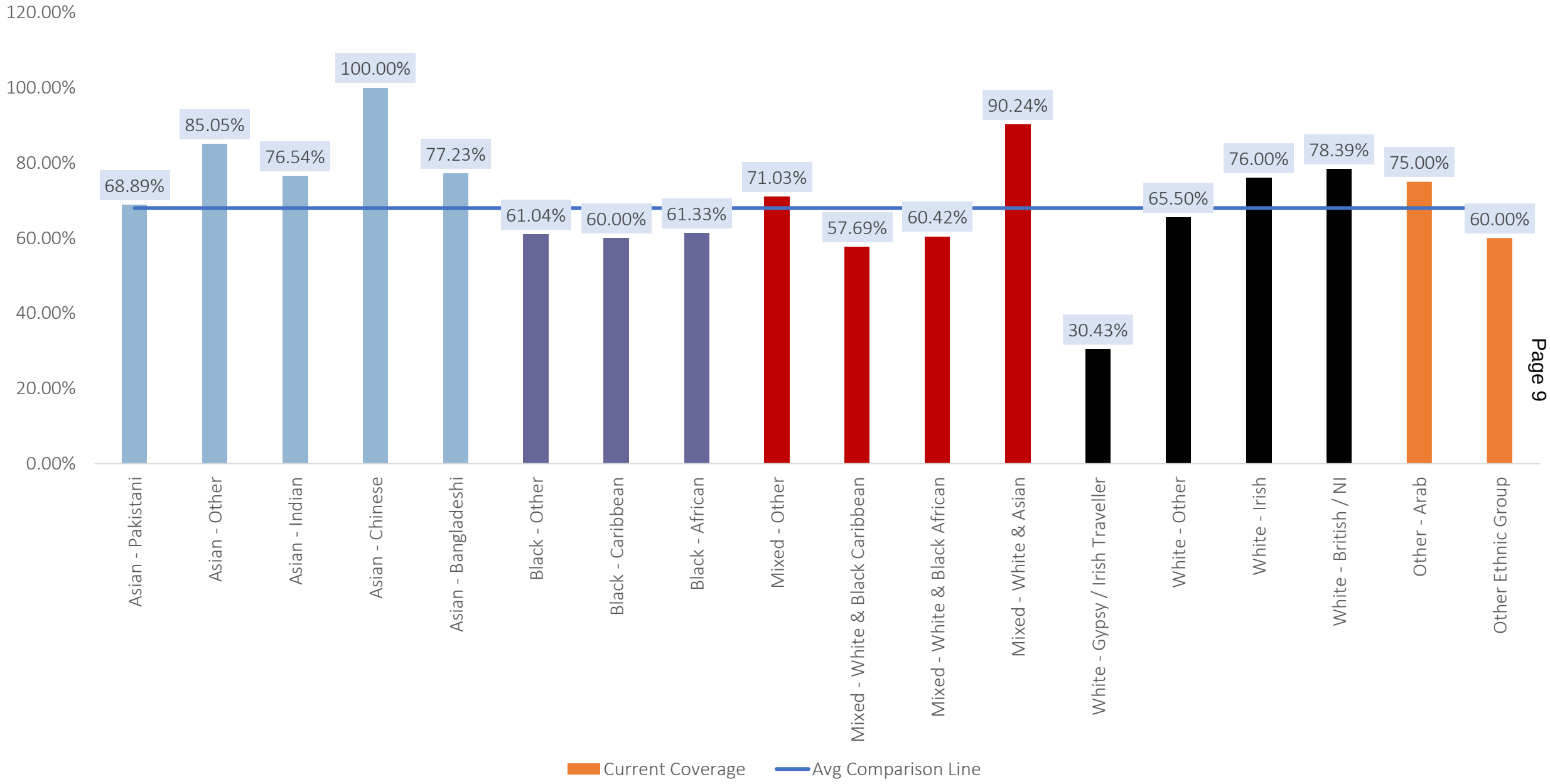
October 2023



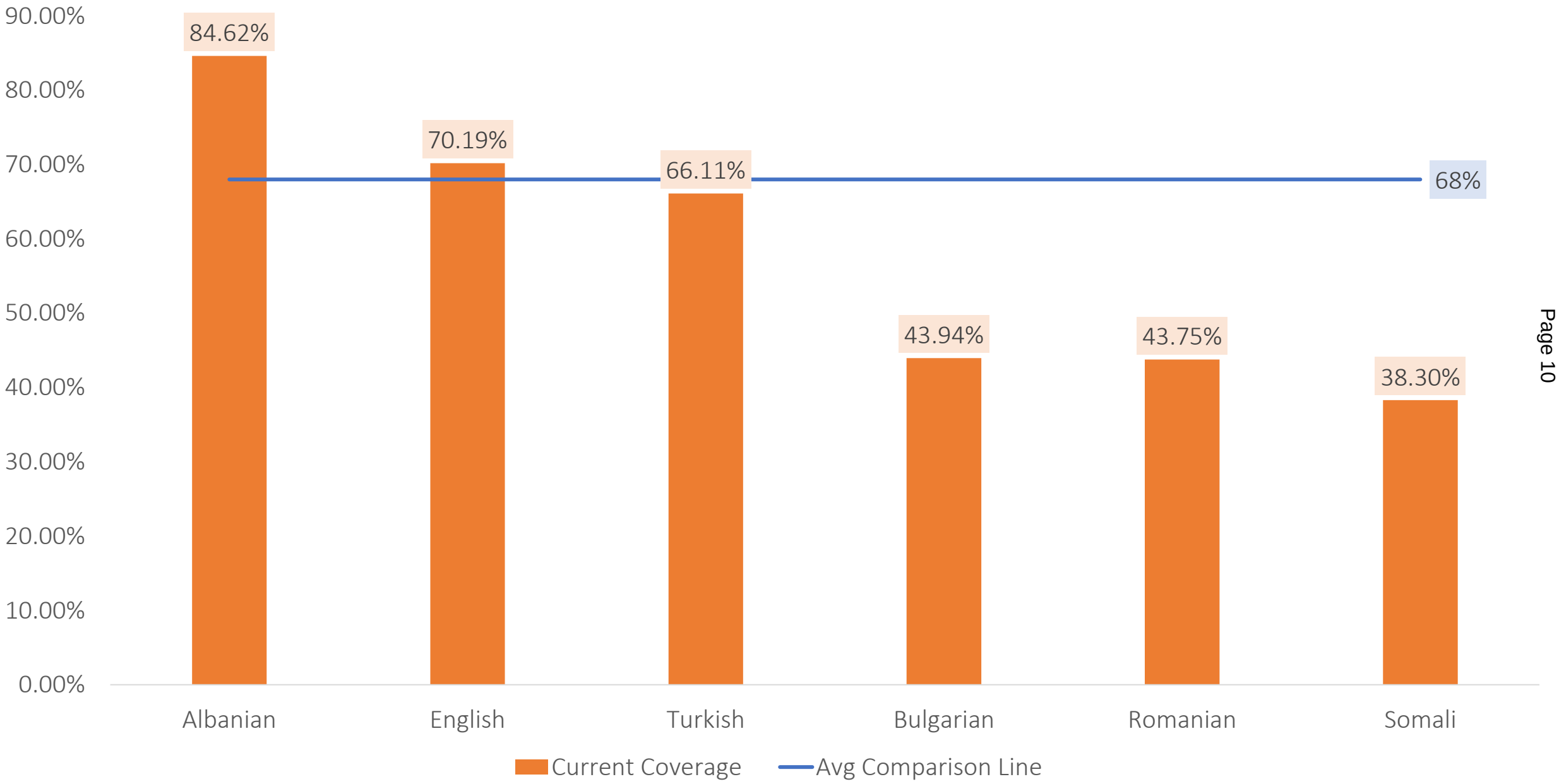
November 2023



MMR uptake ethnicity



MMR uptake language



Health & Wellbeing Board

Update from Joint Health & Social Care Commissioning Board on The 2023 –2025 Better Care Fund
4th December 2023

BCF (Better Care Fund) planning update

- The BCF funding was jointly agreed by Enfield LA/ICB July 2023 in accordance with governance guidelines.
- The BCF plan has been assured and moderated regionally, and calibrated across regions. The plan has now been put forward for approval by NHSE, in consultation with DHSC and DLUHC
- In previous years BCF plans were required for a single year, however, this year a two-year plan is required. For 2023-24 the Enfield BCF Plan is largely a continuation of the expenditure plan for 2022-23 with adjustments for inflation, and new allocations to support improved hospital discharge.

- A narrative plan is attached as an appendix providing details of schemes, capacity and demand, as well as ambitions and delivery plans for BCF metrics

ENFIELD Council

BCF national conditions and metrics for 2023 to 2025

- The national conditions for the BCF in 2023 to 2025 are:

1. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
3. implementing BCF policy objective 2: providing the right care, at the right place, at the right time
4. maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

ENFIELD Council

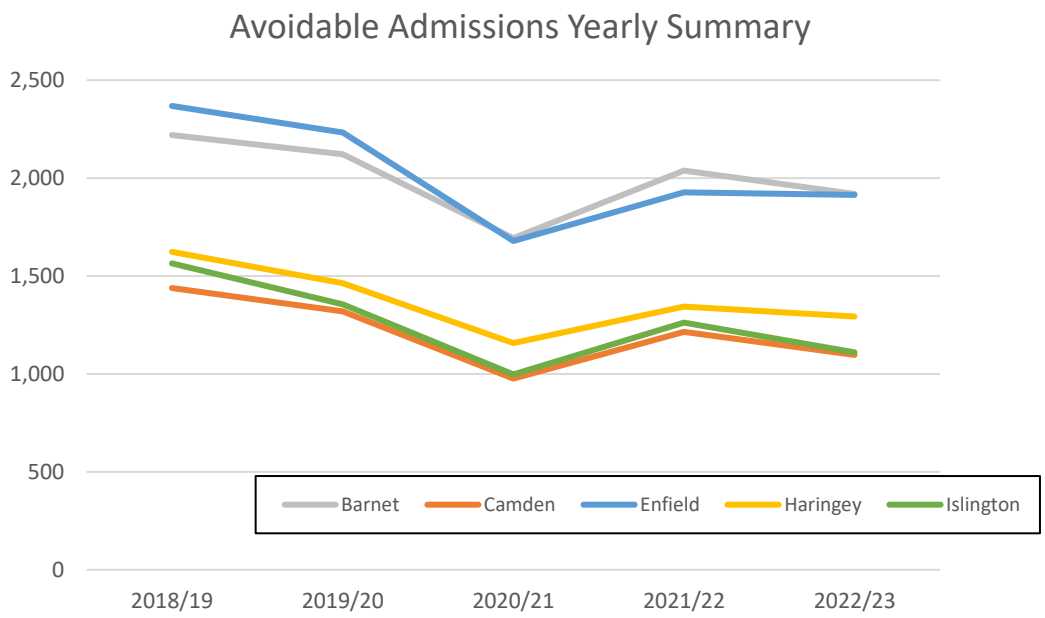
BCF Metrics

- Beyond the four National Conditions, areas have flexibility in how the fund is spent across health, care and housing schemes or services
- Monitor and review Enfield HWB's ambitions on how spending will improve performance against the BCF 2023-2025 metrics set out below.

ENFIELD Council

Metric 1

Reducing avoidable admissions to hospital



Yearly Summary

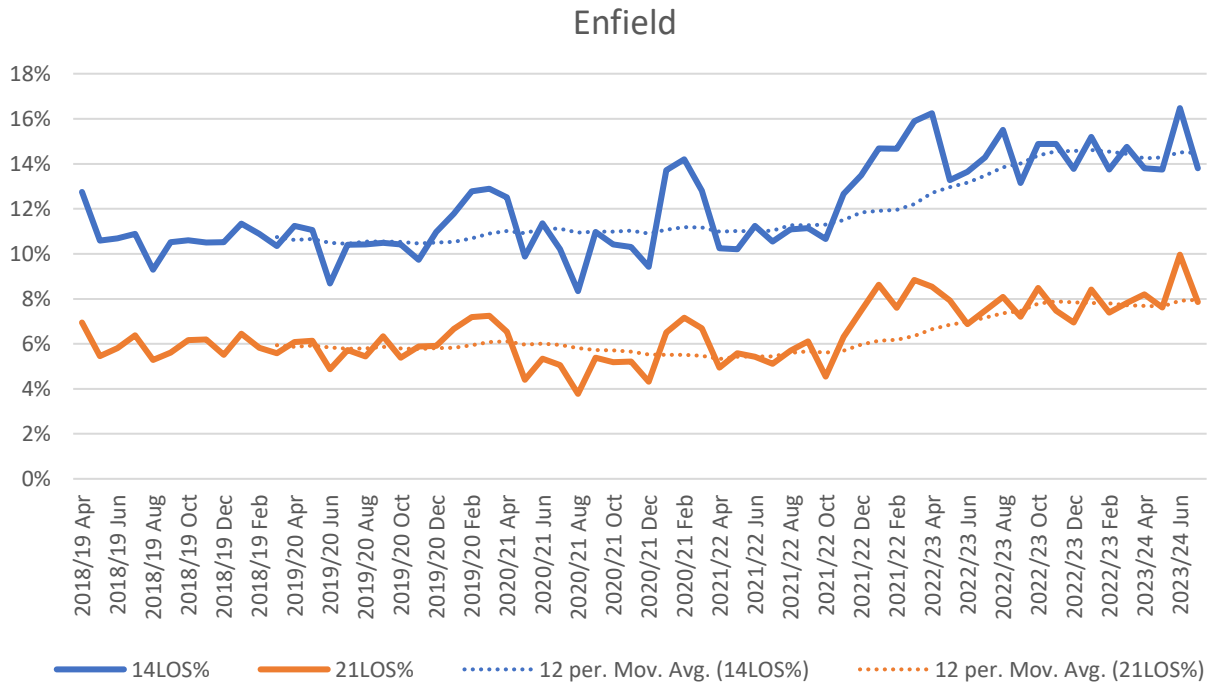
Local Authority	2018/19	2019/20	2020/21	2021/22	2022/23
Barnet	2,219	2,121	1,693	2,037	1,919
Camden	1,438	1,319	975	1,214	1,097
Enfield	2,368	2,232	1,678	1,926	1,913
Haringey	1,622	1,463	1,157	1,343	1,293
Islington	1,564	1,355	997	1,261	1,109

- Avoidable Admissions are on a downward trend within Enfield, although at nearly 2,000 in 2022-23 are still too high. The trend in Enfield reflects that of the NCL generally, although we have seen a fall in recent months whereas the NCL is rising. As you would expect, Enfield and Barnet have the most avoidable admissions across the NCL (being the two boroughs with the largest populations), although Enfield now has similar levels to Barnet whereas in previous years, we have been the higher borough

ENFIELD Council

Metric 2

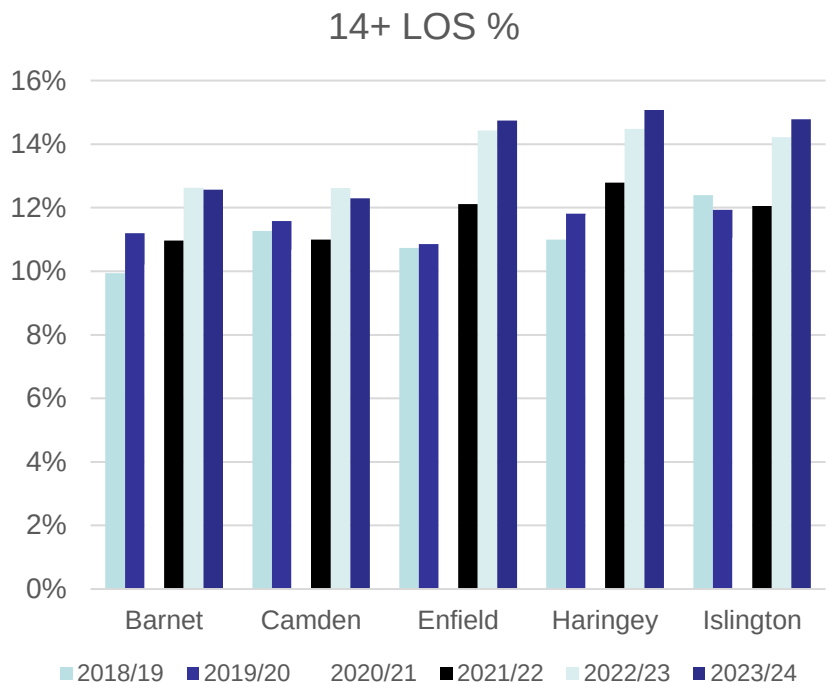
Reducing the proportion of people whose length of stay in an acute hospital bed exceeds both 14 and 21 days

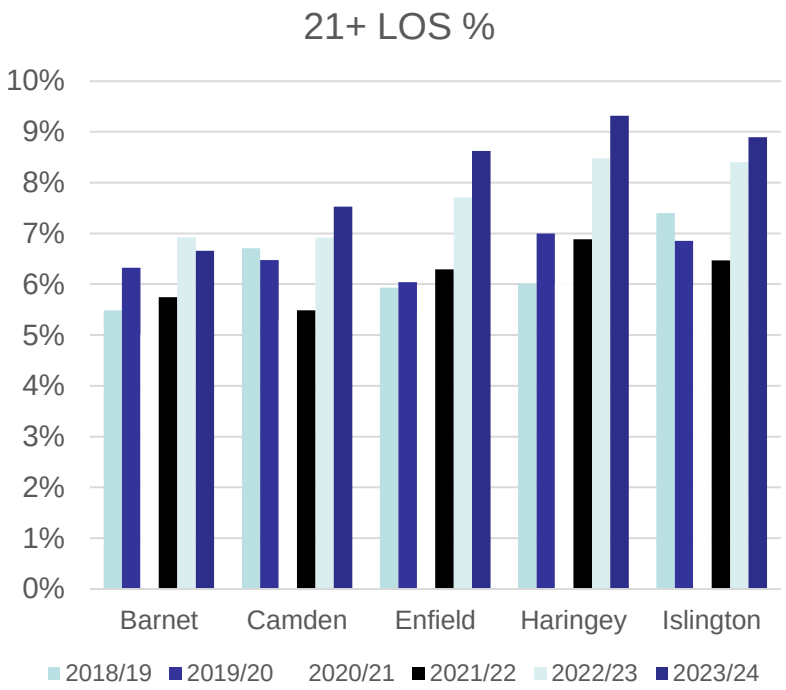


The length of stay in hospital beds that exceeds 14 and 21 days is increasing across the NCL, particularly since the end of 2021-22, with similar trends seen in all five boroughs. Enfield consistently ranks third of the five boroughs, having higher rates that Barnet and Camden, and lower than Haringey and Islington.

Metric 2

Reducing the proportion of people whose length of stay in an acute hospital bed exceeds both 14 and 21 days

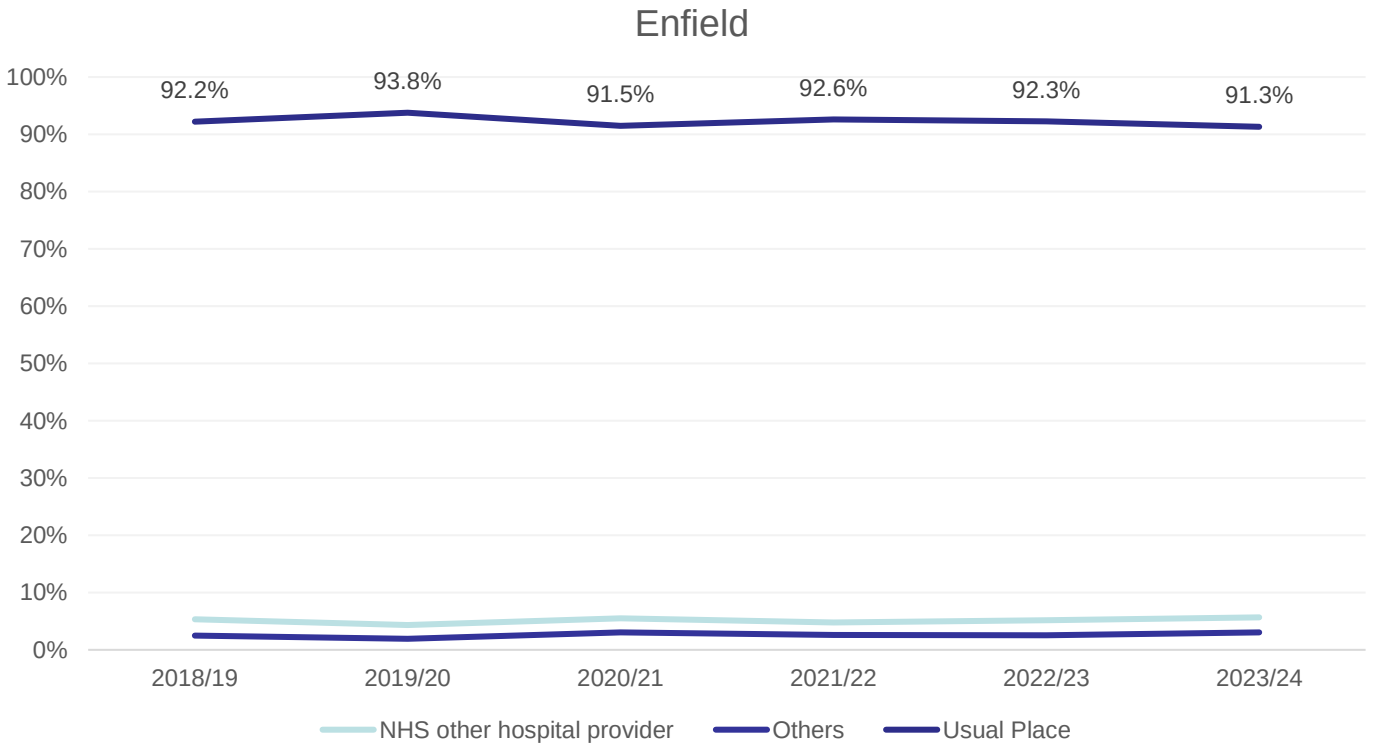




The charts above show a comparison across the NCL.

Metric 3

Increasing the proportion of people who are discharged from hospital back to their usual place of residence



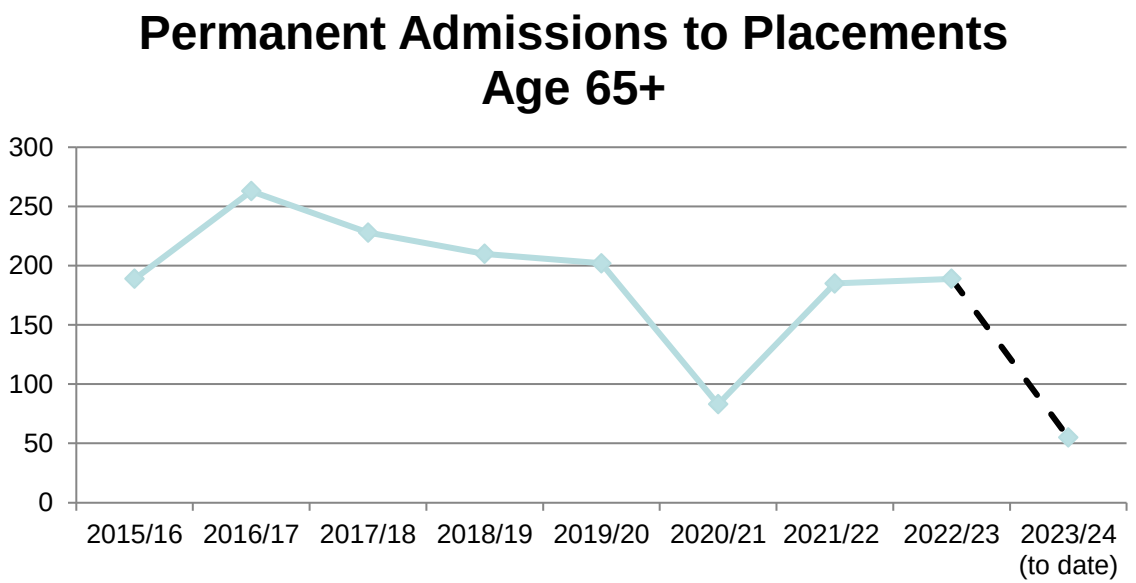
- Discharge to the usual place of residence has hovered around the 92% mark for several years now, although the trend over the last few years has been slightly downward. Enfield broadly mirrors the NCL average with end of year figures for 2022-23 of 92.3% (Enfield) and 92.4% (NCL)

Metric 4

Minimising the number of people aged 65 and over who are permanently admitted to residential or nursing care

The number of permanent admissions to residential homes for those aged 65+ has generally been falling steadily since 2016-17 (excluding the covid impacted figures of 2020-21). However, current pressures and trends have started to see increasing demand on these services

Year	Permanent Admissions to Placement
2015/16	189
2016/17	263
2017/18	228
2018/19	210
2019/20	202
2020/21	83
2021/22	185
2022/23	189
2023/24 (to date)	68

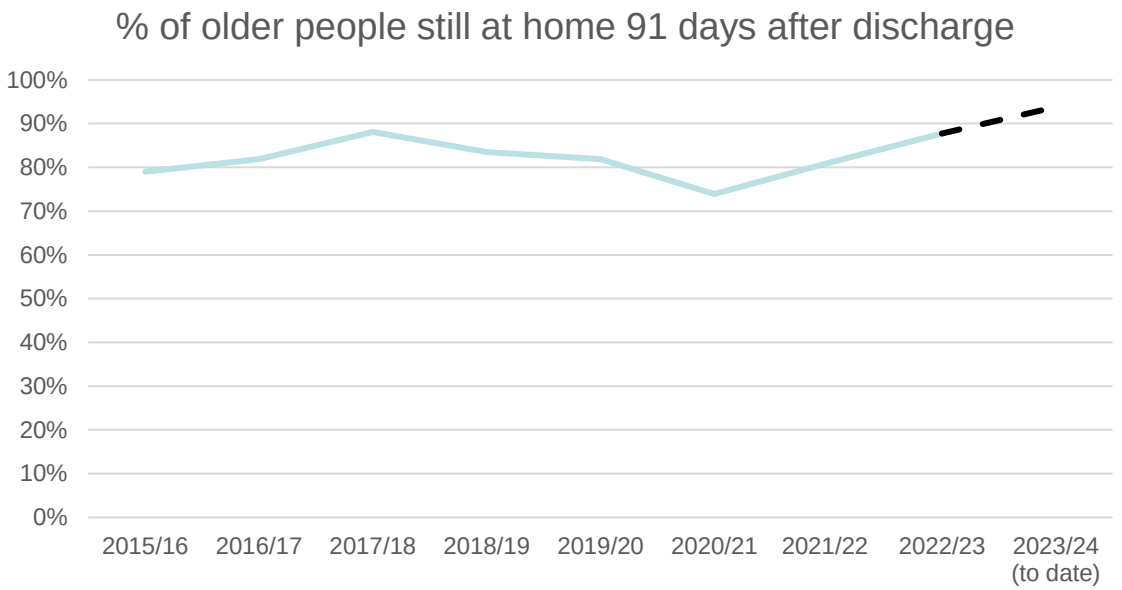


ENFIELD Council

Metric 5

Maximising the proportion of people who enter the enablement service following discharge from hospital and who are living independently three months following discharge

Year	% of older people still at home 91 days after discharge
2015/16	79.0%
2016/17	81.9%
2017/18	88.1%
2018/19	83.5%
2019/20	81.9%
2020/21	73.9%
2021/22	81.0%
2022/23	87.7%
2023/24 (to date)	90.9%



- The percentage of people still at home 91 days after discharge into reablement services is on an upward trend and has been for several years now, especially when you take out the impact of covid on 2020-21 data. Current data for Q1 2023-24 suggests that this improvement will continue into this year

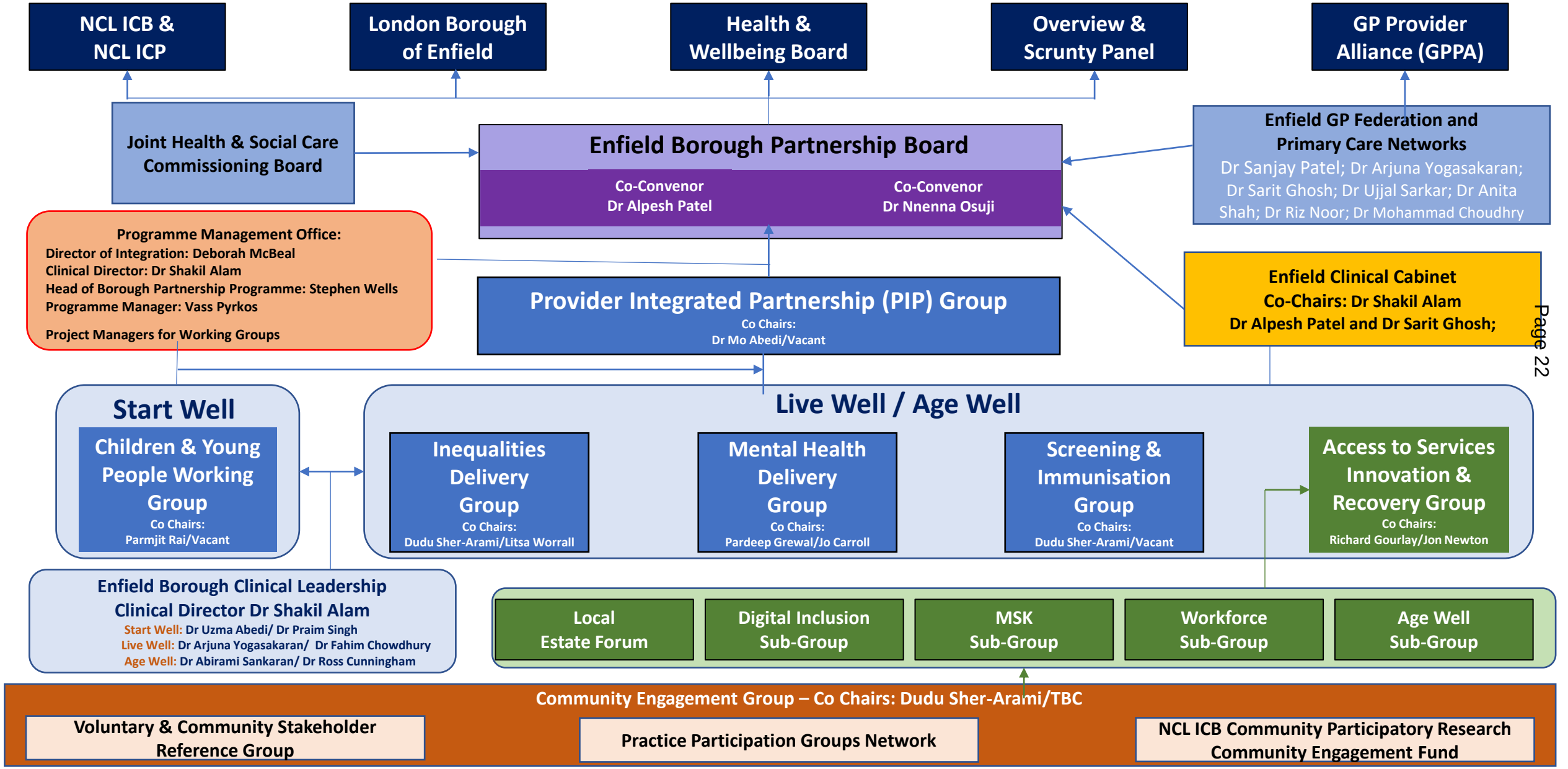
North Central London Integrated Care System

Health & Wellbeing Board

Enfield Borough Partnership Update

4th December 2023

Enfield Borough Place based Partnership - Governance structure April 2023 [Under Review]



Enfield Borough Partnership

Borough Clinical Leadership and Primary Care Clinical Cabinet

Clinical Leadership Enfield Borough

Clinical Director for Place, Enfield	**Dr Shakil Alam**
Clinical Leads for Place - Start Well / Live Well / Age Well ***[See next slide for details of the clinical lead roles]***	**Dr Uzma Abedi** **Dr Praim Singh** **Dr Fahim Chowdhury** **Dr Arjuna Yogasakaran** **Dr Abirame Sambasivan** **Dr Ross Cunningham**
Executive Director, Co-Chair, Enfield GP Federation (Co-Chair)	**Dr Alpesh Patel**
Co-Chair, Director Enfield GP Federation, Clinical Director, Enfield Unity PCN (Co Chair)	**Dr Sarit Ghosh**
Clinical Directors, Enfield Primary Care Networks (PCNs)	**Dr Sanjay Patel** **Dr Harry Grewal** **Dr Anita Shah** **Dr Sarit Ghosh** **Dr Ujjal Sarkar** **Dr Mohammad Choudhry** **Dr Riz Noor** **Dr Arjuna Yogasakaran**
Enfield GP Federation Director of Operations	**Renata Chavda**
Local Medical Committee, Enfield	**Dr Pippa Vincent**

Enfield Borough Clinical Leads – Start Wells, Live Well, Age Well

Clinical Director	Start Well	Live Well	Age Well
Dr Shakil Alam	Dr Uzma Abedi Dr Praim Singh	Dr Fahim Chowdhury Dr Arjuna Yogasakaran	Dr Abirame Sambasivan Dr Ross Cunningham

23/24 focus

- Chair ICB clinical leads monthly meetings
- ICB leadership at the Enfield primary care clinical cabinet
- Rotational chair at the Pan NCL Thursday GP webinar,
- Enfield ICB clinical representative at the Primary care clinical cabinet and the HWBB
- Enfield ICB clinical representative at the NMUH Primary & Secondary Interface Steering Group Meeting.
- Attend Clinical Directors/CMO/CNO /Deputies meetings.
- Supporting 6 Enfield clinical leads across the Start Well/ Live Well and Age well portfolios with regular touch points.
- Enfield ICB clinical representative at the Enfield Borough partnerships PIP meeting.
- Enfield ICB clinical representative at the Enfield Borough partnership meetings.
- Paediatric Low Acuity NMUH Attendance
- Supporting with Clinical DOS sign off from a clinical governance perspective for NHS 111.
- Providing Clinical leadership over the mobilisation of the NCL NHS 111 contract.

- NCL Clinical leads and Commissioners Integration Improvement
- Development of Hospital @ Home pilot
- NCL Integrated Paediatric Steering Group & Asthma Network
- Enfield Primary Care Clinical Cabinet
- Mental Health Partnership Board Steering Group & Enfield Mental Health & Children's Commissioner
- Individual Placement support (IPS) for people on the SMI QOF Register
- Enfield SEND Action Plan overview
- Enfield IPS T&F group (stakeholders from LBE, Early help, Asthma nurses, Mental health etc)
- CAMHS referral / one contact discharges.
- Enfield ASTHMA / Development of LCS
- Clinical Directors and Clinical Leaders ICB Clinical and Care Leadership
- Paediatric Low Acuity NMUH Attendance
- NCL Royal Free Interface Steering Group Meeting

- Improve patient access to PC
- Work with secondary care teams to review and manage referrals
- Clinical guidance on the Enfield Single Offer
- Contribute to planning NCL primary care development workflows obo Enfield Borough
- Chair the NCL ICP Inequalities Workshop
- Work with local trust to improving access and pathway communications and integration.
- Provide clinical advice & guidance to long-term care homes planning & implementation.
- Contribute to the development of learning needs for Enfield GPs
- Attend the NMUH Primary & Secondary Interface Steering Group Meeting
- Ensure readiness for service delivery start date of Oct 2023 by providing clinical & digital advice on: Service specifications, indicators/outcomes; Training Spec/support materials: Support GP practices in prep. period; LCS mobilisation; Development of LTC LCS GP IT infrastructure Chairing of regular NCL GP IT infrastructure meetings – bringing a wider number of stakeholders across NCL together and ensuring progression along agreed timelines

- Clinical leadership to the development of care pathways, improving clinical outcomes & service delivery; GP practice training; engage with Community Matrons; inform development of local Neighbourhood model
- Meet with the Borough Head of PC to provide programme and operational clinical updates/escalate any risks and mitigations
- Clinical leadership to the development of services for older people (incl. falls prevention; urgent care response)
- Attend ICB Frail Elderly Group and LBE older people partnership board; and meetings with Providers, Social Care and VCS partners i.e. Age UK, Dementia UK, Healthwatch Enfield
- Co-chair /clinical leadership to the NCL ICB CVD Prevent Network; and to pathway developments (Heart Failure, Cardiology, BP@Home; input to the GP website
- Attend NMUH A&E Delivery Board & HIU Users Group, and inform the clinical leadership to the ICB Urgent Care Review

Access to Services, Innovation & Recovery Working Group

Co-Chairs: Richard Gourlay, Director of Strategic Development, NMUH and Jon Newton, Director of Integration, Older People & Physical Disabilities, LBE

- To ensure access to health care, social care, and VCSE services for the residents of Enfield, engaging with all local stakeholders to inform the delivery of agreed local priorities
- Ensure we are looking at innovation and measures that support commitment to change the way we deliver services and make a real difference the patient's experience
- Ensure resident views and patients experience is feeding into the work of the group i.e. access to services, development of MSK services, etc.
- We recognise as a group we represent a range of different providers/ settings/ capacity, and we must ensure we have an open culture that builds trust, openness and respect to enable everyone to contribute, respect their and to encourage genuine contribution to shape the way we can work effectively by collaboration
- To make best use of effort, resources etc. and ensuring that each partner plays it part to maximise the success of the Borough Partnership
- To accept that each stakeholder has different drivers, targets and frameworks, and acknowledging how these can complement each other, enabling services to go forward in a different way

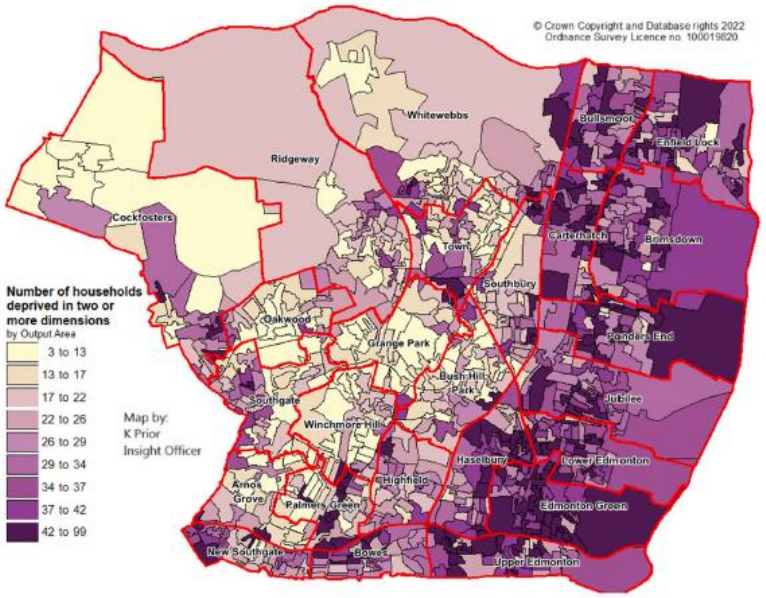
The priority areas of the group include:

- Access to services, System resilience and enhanced access (primary care)
- Development of Lifestyle Hubs (as part of joint work with LBE Public Health, RFL Public Health and the borough partnership local priorities of smoking and obesity
- MSK on the High Street – working with RNOH, to pilot an enhanced community MSK service delivered in partnership with RFL, NMUH, BEH and RNOH to improve local access by those with MSK conditions in our most deprived communities
- Review and co-develop the implementation plans following the NCL strategic services reviews of Community Services (inc. CYP) and Mental Health services reviews
- Development of Social Prescribing working with VCSE partners
- Future development of Neighbourhoods (informed by work in NCL ICB with borough partnerships, GP Fed/ PCNs).

Inequalities Delivery Group

Co-Chairs: Dudu Sher-Arami, Director of Public Health, LBE and
Litsa Worrell, Chair, Enfield PPG Network

- Enfield is a diverse borough with over 150 languages spoken and the census data 2021 has seen large increases in Albanians and Bulgarians and is now home to the largest populations nationally.
- Barnet is the 10th least deprived borough in London. This hides pockets of deprivation in the borough where around 12,000 people lived in the 20% most deprived parts of England.
- In Enfield, 28.7% of residents were estimated to be earning below the Living Wage in 2021 This was worse than the average London Borough.



Work In Progress

- 21 Inequalities Projects including community participatory research funded by NCL ICB in Enfield, in 2022/23 and 2023/24
- CORE 20 PLUS 5 –CORE 20 PLUS 5 Accelerator site (1 of 7 in England funded by NHS England and Institute of Healthcare Improvement) looking at improving the uptake of Targeted Lung Health Checks (working with NCL Cancer Alliance) in 20% most deprived areas of Enfield.
- Community Engagement - Empowering Community Engagement in Edmonton – to identify new approaches through co-production to engage with local communities and improve relationships with partner organisations and local community groups
- Neighbourhood Development – inform the work with local PCNs and GP Federation to develop a neighbourhood model that improves same day access to services and develop proactive care approaches to address health inequalities.

Enfield Inequalities Fund: List of Enfield Projects

Project number	Project title
9	Black Health Improvement Programme (BHIP)
10	Enhanced Health Management of People with Long-Term Conditions (LTC) in Deprived Communities
11	Community Hubs Outreach
12	Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services
13	ABC Parenting Programme
14	Divert and Oppose Violence in Enfield (DOVE)
15	Smoking cessation (Enfield GP Federation)
48	Social and Emotional support to recover from the COVID pandemic
49	Addressing childhood obesity through community led activity
50	Increasing access to healthier food and financial support in community settings
51	Analysis – system costs, PH analysis
52	Diversity Living Services Programme
53	Enfield 0-2 Years' Speech and Language (SLT) Early Identification and Intervention Service
54	Interestelar Twalking Challenge
55	Enfield paediatric asthma nursing service – Healthy London Partnership asthma-friendly schools pilot
56	Community Powered Edmonton -Drop in events
57	Enfield Patient Participation Network (PPG)
59	#WhatIf Project Wellbeing Connect & Edmonton Partnership
NCL projects	
35	Enfield Homelessness LCS
36	(NCL scheme) Cancer community development project
37	Community Mentoring Programme

North Central London Integrated Care System

CORE20PLUS5 A FOCUSED APPROACH TO TACKLING HEALTH INEQUALITIES

NCL ICB Enfield Borough Partnership A Core20PLUS Accelerator Site (1 of 7 sites in England)

NHS England & Institute of Healthcare Improvement Core20Plus 5 Accelerator sites in England 2023/24:

Core20Plus Region Themes, Aims & Objectives

Cornwall	Early cancer diagnosis rates among the GRT community in Cornwall
Humber & North Yorkshire	Develop an assessment, planning and care co-ordinated model, for integrated neighbourhoods, supported by a practice culture that is teamwork orientated and person centred.
Mid & South Essex	Increase life expectancy for people with Severe Mental Illness (SMI) in South Essex
North Central London (Enfield)	To help improve early diagnosis of lung cancer by identifying key insights into the reasons for low uptake of the Targeted Lung Health Checks amongst deprived communities in Enfield by 2027, with a view to designing targeted activities, to help meet the programme's national target of 50%. This contributes towards the national ambition of diagnosing 75% of cancers at stage 1 or 2 by June 2028.
Surrey Heartlands	Increase cancer screening uptake and coverage for those with learning disabilities. Test within the cervical screening programme in the Guildford and Waverley place of Surrey Heartlands
Nottingham	Proportion of people dying early due to CVD in the most deprived areas of Nottingham and Nottinghamshire will be more similar to those in the least deprived areas
Lancashire & South Cumbria	Improve access to cancer screening and earlier care with the aim of achieving 75% of cancers identified at stage 1 and stage 2 in specified cancers by 31st October 2023.

CORE20 PLUS 5
NCL ICS Enfield Borough

Enfield Targeted Lung Health Checks: Timeline

North Central London Integrated Care System

COHORT GROUP	**Age:** 55 – 74 years	**Smoking Status:** Current & previous smokers	**Ethnicity:** Black African (Black/Caribbean), Turkish, Bulgarian, Bangladeshi	**Post Code:** From areas of greatest deprivation in Enfield (East of the Borough)

Key Note: The target cohort for the Enfield TLHC project broadly mirrors that of the similar NCL programme, so the initiatives developed as a result of the local project will likely be suitable to be upscaled pan NCL and National

1. Devise approach and agree cohort group	• Market researchers to identify volunteer participants (using social media and those signed up) • Devise the insights tests documentation (schedule and focus group questions) • Map out insights test process, draft schedule and questions for focus groups • Meet with local partners to identify cohort group	May 2023
2. Insights Test	• Undertake insights test of at least 20 participants, plus volunteers from local community, faith and Public and Patient group (5th to 19th June) • Analyse insights test, draft and share report (by end June)	June 2023
3. Solutions	• Devise solutions to incentivise cohort population uptake of TLHC (incl. forums in community/faith centres, leaflets in target languages etc.) – informed by insights test findings • Agree pilot initiatives	July 2023
4. Rollout	• Commence roll-out of initiatives to improve uptake of TLHC	August 2023
5. Impact analysis and upscale	• Undertake 3-month impact analysis of the initiatives to increase the uptake of TLHC • Identify barriers to improving care delivery in cohort population that need could be upscaled • Work with the NCL TLHC team to Identify new pathways and solutions to reducing inequalities in the cohort population for the uptake of TLHC to share at NCL and National level	October 2023
Demonstrate initial improvement in the uptake of TLHC in the cohort population		December 2023

North Central London Integrated Care System

Enfield Healthy Communities Zone

November 2023

1. Purpose of a Healthy Communities Zone (HCZ)

North Central London Integrated Care System

Aims

To build on the success of the Inequalities Fund schemes in Haringey and Enfield by the creation of a Healthy Communities Zone in wards around NMUH

- Funding: £300k across Enfield and Haringey (£150k / year / borough)

To act as a demonstrator site for the regional Anti-Racism Framework (Kevin Fenton)

To bring an equity lens to wider system performance, spend and outcomes, in order to illustrate how making health inequalities everyone's business is more cost effective for the system as a whole

To demonstrate that the involvement of local communities in identifying needs and co-designing solutions improves cost effectiveness

To act as a magnet for new investment (repurpose/ refocus / prioritise activity) and to broaden the number of stakeholders involved in promoting economic and social gain – for example through working closely with Royal Free Charity to gain input from local business and third sector organisations

To act as a delivery vehicle for the Population Health Improvement Strategy / Health and Wellbeing Strategy

Hypotheses

Impact of Community Empowerment That additional investment led to an improvement in the following:

a. Reported social connectiveness to a community
b. Being in control over your life and/or condition
c. Being better able to manage my own and my families physical and mental wellbeing

Impact on Crisis reduction That additional investment led to a reduction in the number of people from the defined community reaching crisis. This may be expressed as:

a. A&E admissions
b. A&E attendances
c. Self reported crisis

Improving planning and resource allocation A focus on the data underpinning disproportionate outcomes by deprivation and ethnicity improves system understanding and enables better planning and use of resource – e.g. system / place conversations about where resource is currently placed and how we work together to change this

To maximise limited resources there will be a focus on particular segments of the population, in particular young children, underserved ethnic communities, severe multiple disadvantage (including working age), and older people

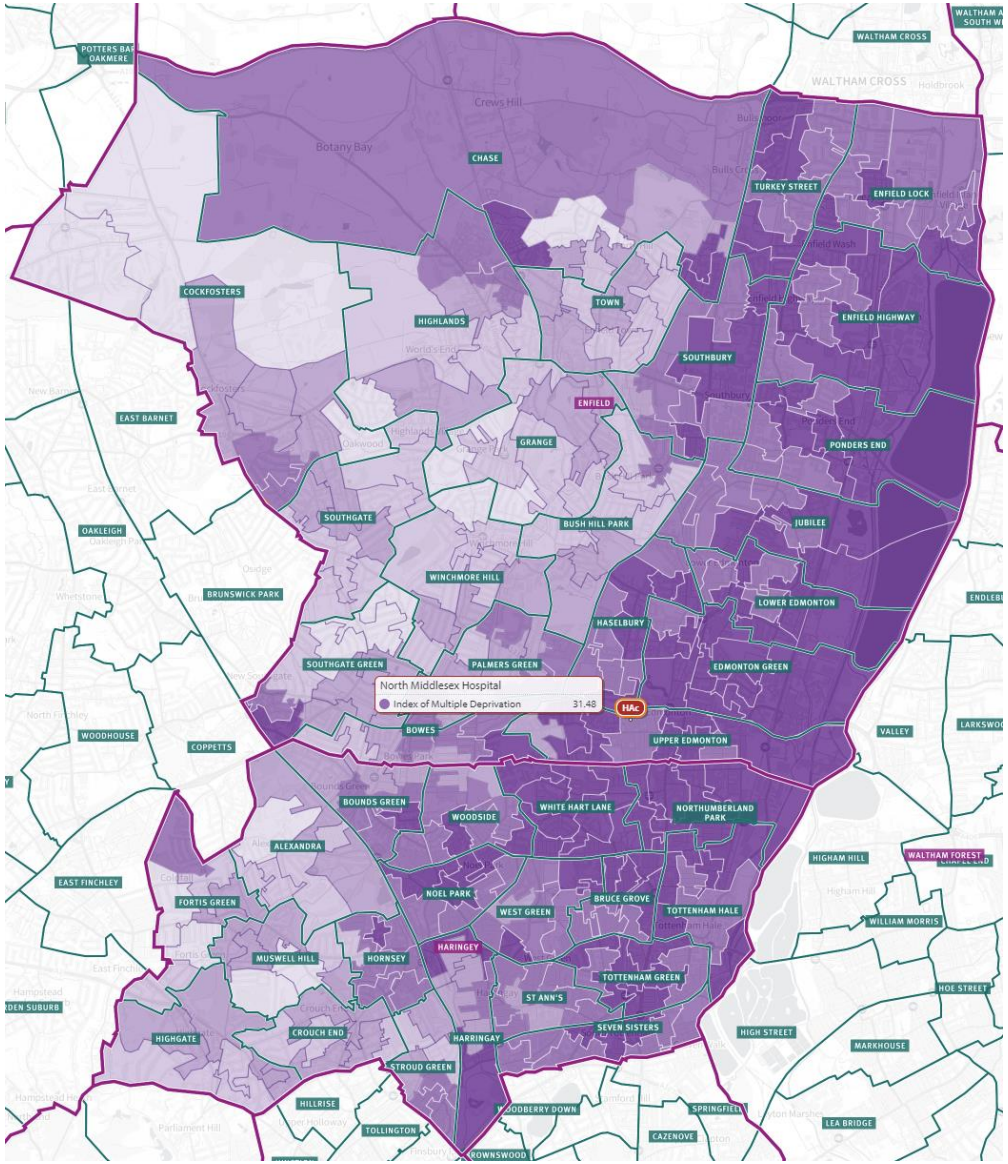
2. Healthy Community Zone Wards

North Central London Integrated Care System

Wards which are included within the Healthy Community Zones are those across Enfield and Haringey which are made up of the 20% most deprived LSOAs as defined by the IMD (2019)

Enfield
Bowes
Chase
Edmonton Green
Enfield Highway
Enfield Lock
Haselbury
Jubilee
Lower Edmonton
Ponders End
Southbury
Southgate Green
Turkey Street
Upper Edmonton

Haringey
Bounds Green
Bruce Grove
Harringay
Hornsey
Noel Park
Northumberland Park
Seven Sisters
Tottenham Green
Tottenham Hale
West Green
White Hart Lane
Woodside



Proposed expanded and new schemes in HCZ (1)

North Central London Integrated Care System

- The following proposed schemes have been identified through collaboration with borough partnerships and stakeholders and are proposed for expansion and inclusion (where new) in the Enfield and Haringey HCZ.
- They support Enfield and/or Haringey residents, with a particular focus on the 20% most deprived (IMD) LSOA and wards - aligning with Health Inequalities Principles (Appendix), with matched investment (where possible) maximising impact and value for our residents.

Scheme	Offer	Enfield	Haringey	Why Chosen
ABC Parenting – focus on infants & families	Project to mitigate frequent ED attendances of infants. Investment expands collaborative offer between VCS and NMUH introducing stretch target and to increase immunisation uptake	Y	Y	Existing NMUH-centred collaboration performing well with good reach into under-served communities. Supports Start Well NCL PH objectives
High-Impact Users – focus on those with multiple disadvantage	Project to mitigate frequent ED attendances of people with severe & multiple disadvantage by working to resolve issues with them. Investment expands collaborative offer between VCS & NMUH introducing stretch target & implement new activities	Y	Y	Existing NMUH-centred collaborative project performing well with good reach across range of partners and already supporting people with multiple disadvantage into under-served communities. Supports Live Well NCL PH objectives, including those relating to mental health
Improving Primary Care Access and for Avoidable Hospitalisation	New project to work with communities, PCNs and VCSE to: • Increase utilisation of Rapid Response, SDEC and Virtual Ward by working with primary care • Work with communities/VCSE to better shape/utilise services to respond to escalating LTC needs • Work with communities/VCSE to better shape/support self-management of avoidable hospitalisation, including testing at NMUH or falls prevention risks, and link with LTC LCS	Y	Y	Although new investment, project will build on existing LTC initiatives in IF projects in primary care to develop a NMUH-centred collaboration between acute, primary care, community health & voluntary sector to identify practices operating in 20% most deprived communities potentially under-utilising existing planned care/admission avoidance services and work with practices and under-served communities in the short- and medium-term to better tailor & utilise these services. Supports Live Well NCL PH objectives
Inclusion Health initiatives	Priming resilience in offer and prevent cliff edge funding challenges to offer	Y	Y	People in inclusion health groups, such as those experiencing homelessness or severe multiple disadvantages, require specialist care that is co-designed with lived experience. This funding will enable continuation of engagement and delivery of those services.
Community Empowerment	Overarching community engagement and empowerment function for Haringey schemes	-	Y	Represents continued funding of VCSE for community engagement to support the IF projects in Haringey in 2023/24 – seen as foundation block within IF Programme from which to build HCZ schemes
Programme management	Supporting evaluation of HCZ and engagement/empowerment* (* To be funded next year)	-	-	Funding to be reviewed in H2 2023/24 with view to invest for 2024/25

5. Proposed expanded and new schemes in HCZ (2)

North Central London Integrated Care System

- The following proposed schemes have been identified through collaboration with borough partnerships and stakeholders and are proposed for expansion and inclusion (where new) in the Enfield and Haringey HCZ.
- They support Enfield and/or Haringey residents, with a particular focus on the 20% most deprived (IMD) LSOA and wards - aligning with Health Inequalities Principles (Appendix), with matched investment (where possible) maximising impact and value for our residents.

Scheme	Offer	Enfield	Haringey	Why Chosen
'Empowering Enfield Carers'	Enfield Carers Centre (ECC) has already established a Carers Discharge Project at North Middlesex Hospital University Trust. NHS England London has supported the development of the Carers Discharge Toolkit, which is informing the development of this project and adoption by ICBs across London.	Y	-	The project involves educating family Carers in discharge planning procedures, how to prepare for the discharge date and training carers in basic nursing skills that help them to: 1. identify signs of urine infections 2. prevent dehydration 3. spot and care for skin ulcers (bedsores) 4. care for breathing issues 5. care for and prevent swallowing difficulties (dysphagia, 6. manage medication safely and recognise/deal with side effects 7. find medical support in the community and out of hours 8. recognise the importance of looking after themselves A 4-minute video specially developed for NHS staff has been part of bitesize training sessions, provided by ECC, which promoted the benefits of carer recognition and carer involvement in discharge planning.

3. All schemes in HCZ

North Central London Integrated Care System

- The Enfield and Haringey Healthy Community Zone consists of schemes across both boroughs which covers five health inequalities programme areas

Category	Address Wider Health Determinants	Building Community Power	Adopt Healthy Lifestyles	Health Inclusion of Vulnerable Groups	Promote Active Health Management
Aim	**Address Social Issues in Under-Served Communities** work to improve social, working & living conditions affecting health outcomes & life chances.	**Enabler to Build Social Capital** engage with people, groups & communities to 'have their say' & co-design solutions or understand their needs.	**Engaging with People to Promote Public Health** encourage people, including those at risk, to adopt behaviours to improve physical or mental health and well-being.	**Work with Vulnerable Groups in Under-Served Areas** to improve access to health and social & health outcomes and improve life changes.	**Proactive LTC Screening/Diagnosis and its Management to Avoid Crises** work with people receive early diagnosis & help with active condition management.
Example	Projects associated with preventing serious youth violence & mentoring into employment opportunities.	Examples include Community Powered Edmonton scheme; Haringey Healthy Neighbourhoods.	Projects include ABC Parenting, Somali Mental Health.	Projects which support people at risk of homelessness, those with complex multiple disadvantage, Gypsy and Traveller community, sickle cell.	In both Boroughs screening, diagnosing & helping patients with specific physical and mental health LTCs, including those in Core20Plus5

Impact Size

Likelihood of Immediate Impact on Healthcare Utilisation

Likelihood of Longer-Term **impact** on Population Health Inequalities & Future Healthcare Utilisation

Screening & Immunisation Working Group

Co-Chairs: Dudu Sher-Arami, Director of Public Health, LBE and
Riyad Karim, NCL ICB, Assistant Director of Primary Ccare (Enfield)

Ensures the delivery of adult and childhood national Immunisation programmes, in Primary Care and schools is supported, planned, monitored and evaluated in collaboration with all local partners; and local screening programmes. It supports the planning of immunisation delivery in General Practices, Schools, Pharmacies, Care Homes and other community settings; co-ordinates comms to support immunisation uptake and informs partners of the communications needed in their respective settings; and develops specific services to increase uptake amongst vulnerable and targeted population's such At Risk Groups, Over 65s and Pregnant Women.

Of note: the group carefully oversaw the rollout of COVID vaccinations, is driving and monitoring Polio, MMR and Whooping Cough vaccination campaigns. The group is actively embarking on the 23/24 winter flu planning; as well as focusing on cervical, breast cancer screening and targeted lung health checks screening (as part of the NHS England Core 20 Plus5 accelerator site). work).

Key Focus of the Group is to:

- **To improve the uptake of national cancer screening programmes and Adult and Childhood immunisations by Enfield residents**
- **Ensure we are looking at innovation and measures that support commitment to change the way we deliver services and make a real difference the patient's experience**
- **Ensure resident views and patients experience is feeding into the work of the group informed by work undertaken by other working groups**
- **We recognise as a group we represent a range of different providers/ settings/ capacity, and we must ensure we have an open culture that builds trust, openness and respect to enable everyone to contribute, respect their and to encourage genuine contribution to shape the way we can work effectively by collaboration**
- **To make best use of effort, resources etc. and ensuring that each partner plays it part to maximise the success of the Borough Partnership**
- **To accept that each stakeholder has different drivers, targets and frameworks, and acknowledging how these can complement each other, enabling services to go forward in a different way**

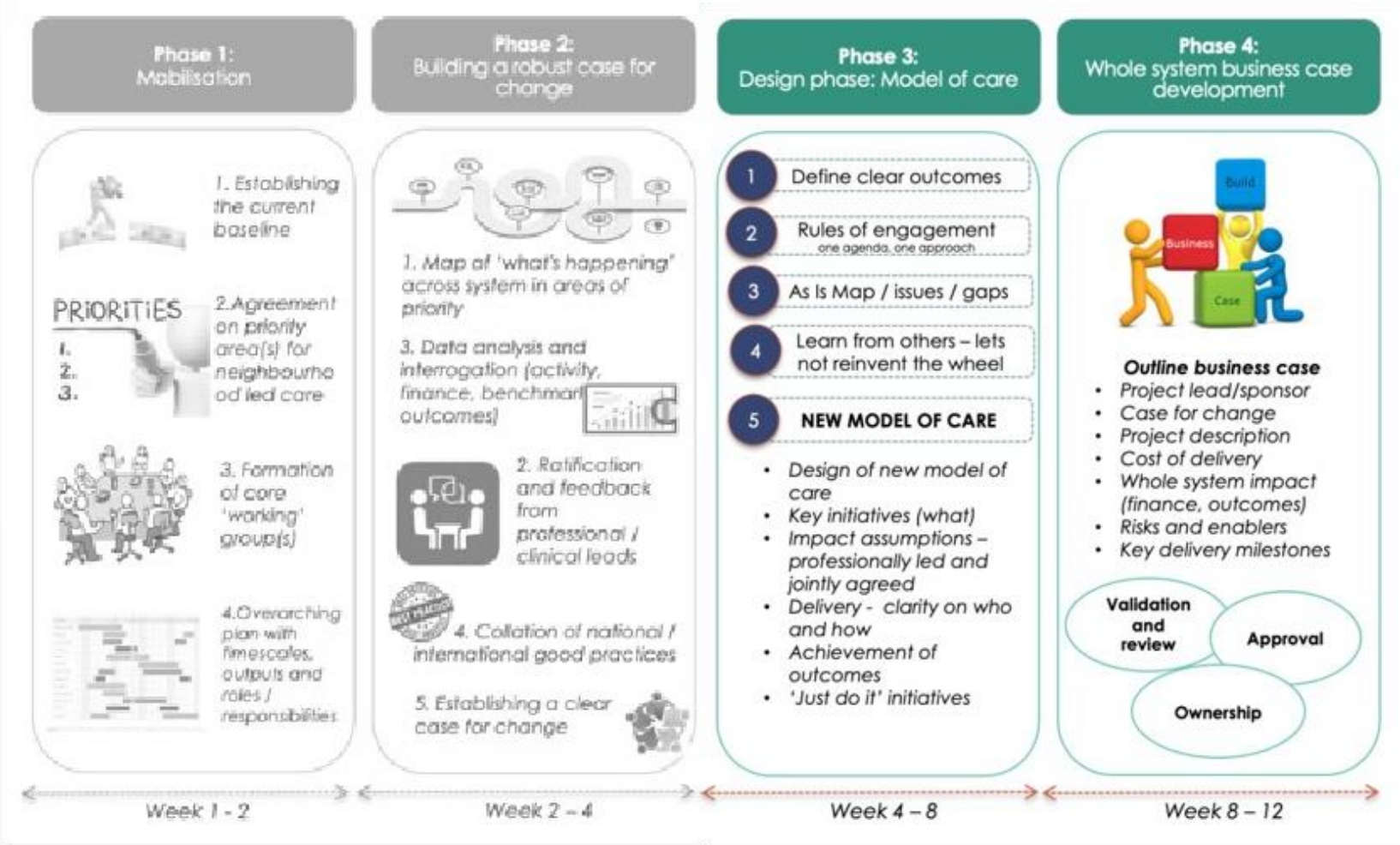
Enfield Borough Partnership

Putting Fuller into Practice
Neighbourhood Development

Roadmap to deliver the model of care

Proactive Anticipatory Care & Same Day Access

1. Co-design the model
2. Demand and capacity model to understand movement in activity and capacity
3. Trigger a business case with clear KPIs
4. Develop an implementation plan
5. Trigger quality improvement (QI) cycles



Case studies: same day access

How is the ability to access care impacting our population?

CASE	NEEDS	KEY ISSUES	HOW CAN FULLER HELP?
	**Marina, 33** - Migrated from Poland - English as second language - 3 young children - 2 year old is sick and she wants him to be seen - Can not afford OTC meds	• Likely to have 6-8 touchpoints a year • Deprivation level, digital exclusion • No network of support for reassurance • Language barrier + extended consultations • Understanding of where to access help • Positive reinforcement at UCC (meds received) • Positive reinforcement at GP (meds received)	• Utilise social prescribing and voluntary care sector for support groups in native language to reinforce good behaviours • Family hubs with health visitor, co-located near pharmacy to access appropriate care • A dedicated line to call for advice and guidance
	**Hassan, 28** - Turkish young male from high deprivation ward - Heavy smoker (20-30/day) - Has asthma & hypertension Does not attend LTC reviews - Overusing salbutamol and poor inhaler technique	• Likely to have 2-3 A&E attendances a year • Reactively seeking support for LTCs • Symptoms deteriorate before accessing primary care, poor management • Lack of understanding for proactively managing care, does not use brown inhaler • Positive reinforcement at A&E (bloods, x-rays, nebuliser vs spacer in General Practice) and relays to family and friends.	• Fuller hub means access is there, in a similar way to A&E, where you can turn up and wait • Time spent on technique and proactive management through targeted support • Education groups with similar age group and ethnicity through community-based health coaches
	**Tony, 53** - Works as a locksmith, so moving around daily - Water feels like it 'passes straight through him' so he avoids hydrating all day - Has a mark on skin he is worried is cancer	• Repeatedly told no availability, and therefore deprioritises his health • Constantly dehydrated as unable to drink water through the day, and worried about his prostate and potentially diabetes • Was told to take a picture of skin mark and send to surgery, and told it is fine • Feels lack of reassurance and nowhere to turn	• A dedicated line to call for advice and guidance to ensure better understanding of why teledermatology is a new way of working and how to re-access care if he still has concerns • A drop-in environment means that access is there and provides a face to face which in some cases is invaluable where reassurance is an underlying issue.

Case studies: proactive care

How is the the gap in proactive care impacting our population?

CASE	NEEDS	KEY ISSUES	HOW CAN FULLER HELP?

	**Joan, 77**
	- Lives alone and due to leg wound has found it more challenging to leave the house.
	- Has been ordering more magazine subscriptions which she enjoys, and are in piles across her home –which has turned into hoarding.
	- She is a diabetic and is becoming more forgetful when it comes to taking her medication, including her antibiotics.
	- She does not like to bother anyone with her problems, which then become urgent and she has to seek emergency treatment.
		• Needs multiagency multidisciplinary support.
		• Frequent infections of a leg wound in a diabetic patient, high risk of complications.
		• Hoarder, who is socially isolated.
		• Memory decline, and possible dementia.
		• Loss of trust in health professionals
		• Reactively accessing emergency care
		• Likely to need intensive social care package if she continues to decline.
			• PCN integrated teams provide relationship and continuity, including RRT and community matrons.
			• Mental Health care coordinator to build trust with Joan. She is then linked in with:
			  • Social services for hoarding
			  • Memory clinic
			  • MH support for mood.
			• Social isolation support through social prescribing to Age Concern.
			• Could have a SPA that could link into all the services that Joan will need. This will prevent future episodes, and support her wellbeing.
			• Better diabetes control via PCN & community diabetes team, and her wound heals.

	**Nigel, 65** - Afro-Caribbean - Has been urinating more at night, and felt dizzy and collapsed one night - Ended up at Chase Farm UCC where they did a urine dipstick which was clear and the patient is not diabetic. - Outcome micturition, discharged to GP - Has UTI symptoms and visits GP, where urine dipstick is clear and PSA is ordered - Nigel is diagnosed with Prostate Cancer, and he is very shocked and upset	• Is in an at-risk group for prostate cancer and could have had prostate cancer for many years with no symptoms • Is unaware of the additional risks presented by ethnicity and therefore did not request any tests • Was not proactively identified in an at risk group or asked any questions that may have supported identifying the cancer earlier	• Having mechanisms to proactively support people, beyond reactive care in vulnerable groups is very important. • Earlier identification, diagnosis planning and multidisciplinary support in a neighbourhood setting. • Information and education for at risk groups based on ethnicity via community based health coaches.

North Central London Integrated Care System

NCL Population Health & Integrated Care Strategy - Delivery Planning

Borough Partnership approach

Start Well, Live Well, Age Well

North Central London Integrated Care System

Vision

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities & the gap in healthy life expectancy

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 newborn 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
- Children have improved oral health

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

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

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

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

Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing

- Reduced unemployment and increase in people working in fulfilling employment
- People live in stable and healthy accommodation and are safer within the communities in which they live

Age well

People live as healthy, 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 intervention and improved care for people with dementia

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

The 20% most deprived communities in NCL.

Our child and young people (CYP) NCL communities who experience greater health inequalities and poorest outcomes.

Our five key health risk areas where we can create the biggest impact in NCL.

Deprived communities

Key communities – Adults

Key communities – Children & Young People

Wider determinants

NCL population health risks

Our adult NCL communities who experience greater health inequalities and poorest outcomes.

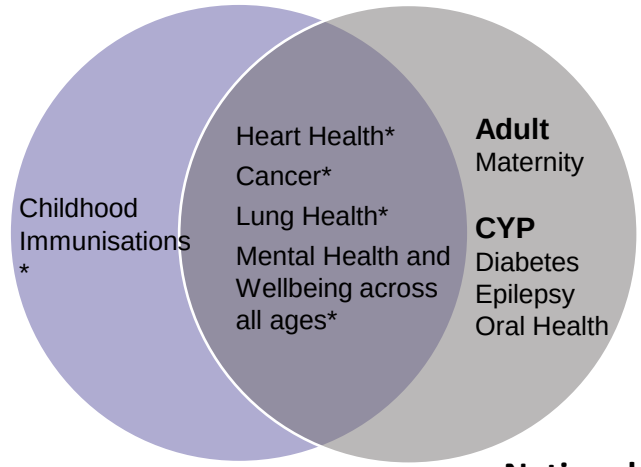
Focusing on the root causes of poor health.

PLUS priorities

- Inclusion Health Groups
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Adults with severe mental illness and adults with learning disabilities
- Family carers
- Older adults with care and support needs
- Supporting residents at risk of hospital admission
- Supporting residents to recover following hospital admissions

PLUS priorities

- Children with Special Educational Needs and Disabilities (SEND)
- Children Looked After (CLA) and care leavers.
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Continuing Care for Children and Young People
- Safeguarding arrangements for designated doctors and nurses for Children and Young People



***NCL 5 population health risks**

National CORE20PLUS5 framework (not part of NCL strategy)

DRAFT

Enfield's Joint Local Health and Wellbeing Strategy 2024-2030

www.enfield.gov.uk

Healthy Enfield: eat well, don't smoke, keep active

North Central London Integrated Care System

ENFIELD Council

Contents

Foreword

Our vision is to empower every Enfield resident to live healthier for longer.

Good health takes resources, but good health is also a vital resource both for individuals and communities. As our partnership publish this strategy, Enfield, the rest of London and the UK, are facing challenges from the impacts of inflation, rising interest rates and the cost-of-living crisis. As residents, businesses, local authorities, the NHS, and voluntary and community sector organisations – this affects us all.

We are also facing unprecedented demands on health and social care services at a time of rising childhood and adult obesity rates, stagnating life expectancy and widening health inequalities. In Enfield, far too many of our residents do not have fair and equal opportunities, and health inequalities are contributing to shorter lives with more years spent in ill health. In our borough, over 30% of children live in poverty; and residents living in our most deprived wards are likely to live seven years fewer than their wealthier neighbours, and over 15 years fewer in good health. Each year thousands of residents remain unregistered with a GP, which can further drive and contribute to health inequalities.

Enfield's Joint Local Health and Wellbeing Strategy sets out our ambition for every resident to ***Start Well, Live Well and Age Well***. It outlines our commitments to supporting every child to have the best start in life and to thrive as they grow up; helping our communities to live active, healthy, and socially connected lives; and supporting residents to maintain independence well into older age. An important element of this journey is supporting the health and care workforce to empower our residents to identify and navigate information, advice, and support services. This enables our residents to take an active role in their own health and wellbeing, participate in their care, and to navigate local health and social care systems.[1]

This strategy builds on the important work already happening locally to tackle inequalities and to join up services and support in our community and across health and social care. In implementing our strategy, we are committed to both improving the health and wellbeing of Enfield residents, but also to ensuring the services and support we provide are cost-effective, accessible, and sustainable.

Working with communities to prevent ill health takes time, but evidence shows that public health interventions can save money in the long-term, by reducing demand on the wider health and social care system.[2] [3]

We pledge to work together across our local partnership and with our community to tackle inequality and to deliver the best possible services, so that every Enfield resident can live healthier for longer.

Cllr Alev Cazimoglu
Cabinet Member for Health and Social Care

1 https://www.healthliteracyplace.org.uk/why-health-literacy/
2 The cost-effectiveness of public health interventions
3 Promoting health, preventing disease: is there an economic case?

Introduction

Our vision is to empower every Enfield resident to live healthier for longer.

Enfield's Joint Local Health and Wellbeing Strategy (HWBS) sets our shared vision, ambition, and priorities for the next six years.

Enfield is home to an estimated 330,000 people and our long-term ambition is for every resident to ***Start Well, Live Well and Age Well***. Our strategy groups together a series of important priorities based on each of these different stages of our lives.

START WELL

Thriving children and young people

Support every child to have the best start in life and thrive from conception to the age of 19 or 25 for young people with special education needs and disabilities (SEND)

LIVE WELL

Strong, healthy and safe communities

Support our communities to live active, healthy lives and work with our partners to provide high quality and accessible health services

AGE WELL

Healthier, more independent and longer lives

Support people to maintain good health and independence well into older age, ensuring every stage of life is valued and spent in the best possible health

The role of our Health and Wellbeing Board

Enfield's Health and Wellbeing Board (HWB) plays a key role in improving the health and wellbeing of our local population. The HWB is a forum in which the Council Leader, Councillors and key leaders from the local health and care system, including the voluntary and community sector, provide strategic direction to improve health and wellbeing in the borough.

The HWB is responsible for assessing the needs of the population and publishing this strategy, which identifies and agrees the health and wellbeing needs of Enfield's population. This directly informs the joint commissioning arrangements for different services and support provided locally.

As a board, our actions are guided by five, equally important, principles:

- **Tackle inequalities and promote equitable outcomes.**
- **Prioritise prevention and early intervention to help residents stay healthy and treat health problems before they become serious.**
- **Empower our residents to maximise their health knowledge and maintain independence.**
- **Ensure clear communication and effective team-working with partner organisations and residents.**
- **Develop and provide sustainable and cost-effective services that are person-centred and fit for the future.**

In applying our principles we consider health in its fullest definition – this means working to improve physical health, mental health, and social wellbeing.

Over the next six years, the HWB will oversee the development and delivery of biennial action plans (every two years), based on the priorities set out in this strategy. Each action plan will include:

- What we need to do to deliver on our priorities and what success looks like.
- The organisations and lead individuals responsible for managing and delivering the work.
- When the actions need to be completed and any milestones along the way.
- What progress has been made and other considerations such as funding or potential risks that might impact the completion of the action.

The action plan will be a dynamic document, which is regularly reviewed and updated, to make sure it responds to local, regional and national developments.

A "Population Health" approach

The foundations of our strategy are built on a population health approach.

Population health is an approach aimed at improving the health and wellbeing of our entire population, while reducing health inequalities. As an approach it recognises that there are lots of factors (or determinants) that effect our health and wellbeing, many of which are outside of the reach of health and care services.[4]

There are **four interconnected pillars** to a population health approach:

Wider determinants of health | **Lifestyle and behaviours** | **Integrated health and care systems** | **Places and communities we live in**

Pillar 1: Wider determinants of health

In 2010, the Marmot Review highlighted the relationship between social and economic inequalities and inequalities in our health outcomes.

A large proportion of these differences arise due to the wider determinants of health – these are factors such as income, education and housing. They affect people differently, based on factors like our age, gender, ethnicity, sexuality, and disability, and people will often experience multiple social inequalities that further reinforce the differences in their health outcomes.[5]

The message today is still clear – the distribution of power and resources have a profound impact on how we start life, live and age. The wider determinants influence our access to and interaction with opportunities and resources, and ultimately, our health and wellbeing.[6]

Acting on these wider determinants will require us to work with partner organisations across the whole of society – this includes organisations like schools and education settings, housing organisations and landlords, police and fire services, and private sector companies like shops, restaurants and cafes, alongside our existing partners in the health, social care and voluntary sectors.

- **The percentage of pupils eligible for Free School Meals has increased in Enfield by 50% from 19.4% in 2019/20 to 29.1% in 2022/23 (an increase by 9.7 percentage points).**
- **Enfield has an acute shortage of social and affordable homes, with over 6,000 households on the Housing Register and over 3,000 households living in temporary accommodation.**
- **The median household income in Enfield is £41,100. This is the 10th lowest of the London boroughs.**
- **10,000 (4.5%) people in Enfield do not have any qualifications. This is lower than the London and national average.**

4 King's Fund (2022) What is a Population Health Approach?
5 The Health Foundation (2018) What makes us healthy
6 Health Equity in England: The Marmot Review 10 Years On

Pillar 2: Lifestyle and behaviours

Our lifestyle can have a significant impact on our overall health and wellbeing. Behaviours such as inactivity, smoking, consuming too much alcohol, eating an unhealthy diet, and not protecting our skin from excessive sun exposure, can have a negative impact; and behaviours such as regular exercise or activity, good sleep quality, and developing skills to manage stress, can have a positive impact.

The wider determinants of health can influence the opportunities we have to make healthy choices.[7] For example, income inequality increasingly prevents many people from accessing a healthy, balanced diet – food poverty is on the rise in Enfield and more of our residents are having to use food banks. Locally, two community-run food pantries have been set up in Edmonton Green and Enfield Town library.

- **62.7% of adults in Enfield are physically active, doing at least 150 minutes of moderate intensity activity each week compared with 66.8% in London and 67.3% in England (2021/22).**
- **13.5% of Enfield adults smoke (more than 35.400 residents), this is higher than the London and England average of 11.7% and 12.7%. 5.4% of Enfield mothers are still smokers at the time of delivering their baby. This is higher than the London average (4.6%) but lower than the England average (8.8%).**
- **59.7% of Enfield adults are overweight or obese compared with 55.9% the London average.**
- **8.4% of Enfield residents are living with diabetes, higher than London and England averages.**

Pillar 3: Integrated health and care systems

In recent years there have been significant changes to how public health and healthcare organisations work together. In 2021, the Government abolished Public Health England and established two new agencies, the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID). Locally and regionally, there have been new organisations established to co-ordinate and plan sustainable health and social care provision to improve population health outcomes, together these form elements of the new Integrated Care Systems.

Following the introduction of the Health and Care Bill (2022) the local authorities, NHS institutions and voluntary sector organisations of the five boroughs in North Central London (NCL) partnered to form an Integrated Care System (ICS). The NCL ICS is responsible for planning health and care services across North Central London and aims to: tackle inequalities; enhance productivity and value for money; and help the NHS support broader social and economic development.

The ICS is led in partnership by two committees. The Integrated Care Partnership (known as the NCL Health and Care Partnership) comprises the five NCL local authorities and the executive team of the NCL Integrated Care Board (ICB); the ICP is responsible for setting the strategic direction and aspiration for health and care across North Central London. The Integrated Care Partnership (ICP) develops local plans through Borough Partnerships – for Enfield this is an alliance of local organisations that include Enfield Council, North Middlesex University Hospital, local mental health services, social care services, community care, voluntary sector and primary care networks (these are groups of primary care practices). The committee works together to collaborate and co-ordinate care in the borough by responding to local borough needs.

7 The Health Foundation (2018) What makes us healthy

The ICB (which replaced the NCL Clinical Commissioning Group) is the local NHS organisation responsible for commissioning and spending on healthcare in the borough and is responsible for developing NHS services that align with the priorities set by the ICP.

An effective and integrated health and care system requires a joined-up and sustainable approach to working with our population, particularly as we manage the growing number of patients with multiple long-term conditions. In April 2023, the North Central London Population Health and Integrated Care Strategy was published, and sets the ICS' strategic vision for health and care integration, and actions to improve population health and to tackle inequalities across North Central London.

NCL Population Health and Integrated Care Strategy

We currently focus a high proportion of resources on urgent care and the existing healthcare system treats individual conditions but not always the underlying drivers of poor health. The NCL Population Health and Integrated Care Strategy aims to move the partnership away from being a collection of health and care organisations that are often reactive, demand-driven and focused on their part of the pathway (or services).

Instead, to become a population health system, the NCL ICS will focus on prevention and proactive care, and work together to act on the wider determinants of health. Our system needs to improve life chances, prevent illness, and promote physical and mental well-being. We want our residents to stay well and be in control of their health, feel heard, and be confident that the system is working and that their care is right for them. This will help our population to live more of their life in good health.

- **The number of emergency hospital admissions in Enfield was 1,748 per 100,000 in 2022/2023. This was higher than the London average.**
- **The rate of delayed transfers of care from hospitals to adult social care in Enfield was 5.5 per 100,000 in 2019/20. This is below the London average.**
- **Between April 2018 and March 2023, 14.8% of Enfield adults eligible for a health check were offered one (aged 40-74), this is the lowest rate in London for this time period.**

Pillar 4: Places and communities we live in

The places and spaces we use such as town centres, libraries and leisure centres can influence our health and how we feel. For example, well maintained and accessible public areas like parks and green spaces can help us to be more physically active and socially connected.[8] Locally, we are investing in the biodiversity of our borough through the introduction of new wetlands, wildlife programmes and green spaces. This is providing more people with access to nature and the associated health and wellbeing benefits this brings, while also helping to mitigate climate change and protecting residents and businesses from the impacts of changing and extreme weather that we are starting to experience.

We know that opportunities to socially connect play a vital role in influencing people's physical and mental health and wellbeing. Social connection, including community, friends and family help us to live longer, healthier, and happier lives. Evidence shows that loneliness and social isolation are associated with a 30% increased risk of heart disease and stroke.[9]

8 The Health Foundation (2018) What makes us healthy
9 The Health Foundation (2018) What makes us healthy

Across the borough, we are nurturing and celebrating our arts, heritage and creative sectors, enabling more people to experience culture and connect with one another in our town centres, museums, theatres and libraries. Our libraries provide a range of services for local people and opportunities to socially connect. This includes books and digital access, makerspaces (where people can engage in crafts and other activities), support groups for all ages and access to skills and training, health and wellbeing support. The library service has developed partnerships with over 100 organisations to provide a range of universal services.

The new Council Plan: Investing In Enfield, sets out our priorities for investing in the places and communities we live in. These are summarised below:

Priorities

- Clean and green places
- Strong, healthy and safe communities
- Thriving children and young people
- More and better homes
- An economy that works for everyone

Principles

- Fairer Enfield
- Accessible and responsive services
- Financial resilience
- Collaboration and early help
- Climate conscious

Future outcomes

- Residents live happy, healthy and safe lives
- Residents earn enough to support themselves and their families
- Children and young people do well at all levels of learning
- Residents age well
- Residents live in good quality homes they can afford
- Residents live in a carbon neutral borough

- **In 2022/23 12,636 young people engaged in our local youth offer (including our universal youth services and Inspiring Young Enfield).**
- **Enfield's crime rate was 111.2 offences per 1,000 residents, lower than the London average of 123.6, in the past 12 months (ending October 2023). This is a decrease of 1.4% from the previous 12 months (ending October 2022).**
- **Enfield has 1,030 hectares of parks and open spaces, attracting 13 million visitors each year.**
- **During the year 2022/23 there were over 1 million visitors to Enfield libraries.**

Addressing health inequalities

What are health inequalities?

Health inequalities are avoidable differences in health between individuals, communities, or populations.

Health inequalities contribute to shorter lives with more years spent in ill health. Evidence shows that individual factors like our genetics only contribute to a small portion of our overall health – the greatest contribution comes from the wider determinants which contribute to at least 50% of our health outcomes.[10]

What this means for most people is that our health outcomes are not predetermined. It is therefore vital we work to reduce health inequalities by acting on the wider determinants and that we take collective action across every part of our society. [11]

To inform our work, we take insights from both our *Joint Strategic Needs Assessment*, *Equality Impact Assessments*, research, and community and partner engagement. This helps us to inform all decisions and action across the pillars of population health. Our goal is to develop and provide universal services but with a focus on reducing barriers to good health for those most in need**.**

Action to reduce health inequalities is a core commitment of our strategy

As we provide and develop services alongside our partners, we will always ensure that the actions we take will contribute to reducing inequalities. Alongside work to make sure that our universal services offer helps to reduce health inequalities, we will also ensure that the right bespoke support is available for people from the most vulnerable groups in society. These groups will have varied and unique needs and we will need to provide focused support to achieve the aspirations set within our priority areas. Our biennial action plans will set out the specific groups of people, and the actions to help improve their health, in detail.

Core20PLUS5

As part of our commitment to tackling health inequalities, Enfield Council is currently working with our local healthcare partners on the **Core20PLUS5** initiatives. This is a national approach that aims to target action at those groups most vulnerable to health inequalities – the **Core20**, who are the most deprived 20% of the total population[12] and the **PLUS** groups.

The **PLUS** population groups are groups of people that face substantial barriers to accessing care and are underserved by existing services.

This includes people from 'inclusion health groups' who are especially vulnerable, including people experiencing homelessness, Gypsy, Roma and Traveller communities and victims of modern slavery.

The approach identifies **5** key clinical areas of health inequalities for adults and **5** key areas for children and young people:

Adults:

- Maternity care
- Physical health checks for people living with severe mental illness
- Seasonal vaccines for people living with COPD
- Early cancer diagnosis
- Hypertension and high cholesterol

Children and Young People:

- Asthma
- Diabetes
- Epilepsy
- Oral Health
- Mental Health

We also want our work to address local priorities and to achieve this North Middlesex University Hospital have expanded **Core20PLUS5** with our local **+2** – HIV and sickle cell anaemia. Two important conditions that are more common in Enfield when compared to the rest of the UK.

10 The King's Fund (2018). 'A vision for population health: Towards a healthier future' page 16
11 Barr B and others (2017). 'Investigating the impact of the English health inequalities strategy: time trend analysis' British Medical Journal: volume 358, issue 8116
12 Based on a measure called 'Index of Multiple Deprivation'

The effects of COVID-19

The COVID-19 pandemic had a profound impact on our lives and on our health. Lockdown helped to keep us all safe whilst the COVID-19 vaccines were developed, but we cannot ignore the harms it caused. People's lives were upended and many of us lost loved ones and friends, jobs, and vital connections with our support networks. Children and young people faced substantial challenges and disruption.

Alongside the direct challenges that caring for people with COVID-19 presented, our communities have also had to deal with disruption across the wider healthcare system. There were significant reductions in capacity for long-term condition care and there is now a sizeable backlog of people waiting longer for care. During the pandemic people were also less likely to seek help for non-COVID-19 illnesses, and this has led to health problems being diagnosed later, when they are typically both more severe and less treatable.

Exacerbating risk factors for poor health[13]

Over the course of the pandemic, we saw an increase by nearly 10 percentage points in the number of adults drinking with "increasing" or "higher" risk. The consequences of heavy drinking are far reaching, and alcohol causes many diseases including liver disease, hypertension and stroke, cancers, and mental ill health.[14] The greatest increase in drinking was observed in the most deprived groups[15] and evidence shows that more deprived groups are at greater risk of harm than less deprived groups even when the amount of alcohol consumed is similar. As a result, the differences in COVID-19-related alcohol use between communities will likely worsen inequalities in the development of alcohol related diseases.

Additionally, between 2020 and 2022 the uptake of screening services (which aim to catch disease early whilst it is more treatable) also reduced. Nationally, the proportion of eligible women who undergo breast cancer screening within six months of invitation fell from nearly 70% to 55% and in 2022 only 65% of eligible women had a screening examination in the prior three years. In Enfield this figure is 60%.[16]

Our mental health was also impacted and in Enfield, referrals to NHS mental health services for anxiety increased three-fold between 2019 to 2022.[17]

Harnessing the lessons learnt

The pandemic challenged us all and has highlighted the profound health inequity in our society. It is vital that we commit to tackling these inequalities and we must also ensure that we continue to harness the power of the positive changes we made to the way we work.

We built strong partnerships with our local voluntary and community sector and strengthened our commitment to working with our partner organisations in the health system across North Central London. We also harnessed the power of technology to utilise new ways of working, with the transformation of services to digital and hybrid models. Across Enfield we are continuing to provide opportunities for people to socially connect through volunteering, mentoring, and befriending initiatives. This builds on the good practice of local organisations, and volunteer networks established during the pandemic and on the legacy of our *Enfield Stands Together* initiative. Our local partnerships will be vital to tackling the new and ongoing challenges we face.

We also saw the success of public health measures and crucially, vaccination.

13 Office for Health Improvement and Disparities. 'Wider Impacts of COVID-19 on Health (WICH) monitoring tool' accessed: 31st August 2023
14 Lopez AD and others (2014). 'Remembering the forgotten non-communicable diseases' BMC Medicine: volume 12, article 2008
15 Institute of Alcohol Studies (2022). 'The COVID hangover: Addressing long-term health impacts of changes in alcohol consumption during the pandemic' page 10
16 Office for Health Improvement and Disparities. 'Public Health Outcome Framework' accessed: 8th September 2023
17 NHS Digital. 'Mental Health Services Data Set (MHSDS)' accessed: 12th September 2022

START WELL

Thriving children and young people

The best start in life for children and young people
Families are empowered and informed about health and wellbeing
The right support, in the right place, at the right time

- **By the age of five, 4% of children in Enfield have had a tooth removed due to decay. This is the worst rate for dental extraction in 5-year-olds in London.**
- **Enfield has the third lowest uptake of the MMR vaccine (at least one dose) in England at 75% and only 65% of cjildren have received their second MMR dose by age 5.**
- **In 2022/23, 43% of year 6 children in Enfield were overweight or obese, this is higher than the London average of 39% and England average of 37%.**
- **In 2021/22, 170 young people in Enfield received treatment for cannabis use disorder compared with 95 in 2009/10.**
- **4,041 children and young people with special educational needs and disabilities (SEND) have an Education, Health and Care Plan (EHCP) maintained by Enfield Council as of 1 May 2022.**
- **In Enfield, 24% of children do not meet the expected level of communication and language skills at the end of reception, compared to the London average of 21%.**

We want every child and young person in Enfield to thrive. The first 1,001 days of their lives (from conception up until the age of 2), can have a significant impact on their development and their life chances; including how well they build relationships, achieve at school and their future job prospects, to their overall health and wellbeing. However, their development and their life chances can also be impacted by different factors, such as early relationships and the care they receive, living in poverty or becoming looked after.

Throughout the COVID-19 pandemic, children and young people faced substantial challenges and disruption, which deepened existing inequalities. The pandemic had a disproportionate impact on children from deprived backgrounds[18] and those with special educational needs and disabilities (SEND).[19] COVID-19 impacted every stage of our children and young people's education, including in the critical early years, when interaction with others is a key factor in the development of speech, language, and social skills. Education outcomes are one of the key drivers of health outcomes in later life with high quality education known to reduce health inequalities.[20]

Locally, with the support of grant funding, we are investing in new Community Hubs, Family Hubs and Children's Centres; improving take up of funded early years education places; and helping families access the right information, advice, and support for their children as early as possible. We are also further developing the range of inclusive play, leisure, social and informal learning opportunities available in the community. This will support children and young people to engage in positive activities which enable them to learn new skills and build healthy relationships and confidence. Importantly, it will enable them to have fun and boost their physical health, mental health and emotional wellbeing.

Young people have a crucial and leading role to play in supporting their own health and wellbeing and that of their peers. We believe in empowering young people to seek out preventive

18 Centre for Evidence and Implementation (2022). 'Implications of COVID for Early Childhood Education and Care in England' page 14
19 https://www.gov.uk/government/news/children-and-young-people-with-send-disproportionately-affected-by-pandemic
20 The King's Fund. 'Healthy schools and pupils' accessed: 11th September 2023

healthcare and to make informed choices about their health and wellbeing. Locally, young people have been working together with the Council to campaign, raise awareness and to empower their peers around health and wellbeing. This includes "How are you?" a film about emotional wellbeing by Enfield's Young Mayor and Youth Parliament, and the launch of the "Looking after your mental health and emotional wellbeing" online guide.

Finally, we are working with our partners in Enfield to create places and spaces where children and young people can be healthy and feel physically and emotionally safe. This includes reducing the number of vehicles on our roads and improving air quality, and we are working together with our partners such as the Police to tackle violence and exploitation affecting children and young people under the age of 25.

Project Spotlight: Youth and Family Hubs

In 2022, Enfield was selected as one of 75 local authorities to receive grant funding for 3 years to develop and implement Family Hubs.

We are transforming our delivery of early help and will be providing Start for Life services from two brand new Youth and Family Hubs at Ponders End and Craig Park, in addition to satellites across the borough. Enfield's Youth and Family Hubs bring together lots of different services for children and families, making it easier to get the help at the right time. This will include parenting support, infant feeding through development of a breastfeeding peer support programme, sessions and resources to help parents and carers provide a thriving home learning environment, and perinatal mental health support with a focus on promoting positive early relationships.

Our Youth and Family Hubs programme will provide support to parents and carers, contribute to a reduction in inequality in health and education outcomes, and help build the evidence base for what works when it comes to improving outcomes for babies, children, and families.

Our Priorities

Priority 1

Support children to thrive in the early years and to be ready for their school or education setting

Becoming a new parent can be an exciting and hopeful time for many people. It can also be a time of heightened anxiety and worry. We want to support all parents to feel empowered, to do the best for their babies, and to establish a strong and secure relationships with their infants through our integrated Start for Life offer.

During these crucial first years, early education opportunities including communication and language, personal, social, and emotional development, and physical development, provide the crucial foundations for learning, health and wellbeing and later independence into adulthood.

We are committed to improving the take-up of funded high-quality early education. We will also be working hard to support our early years workforce to develop the skills they need to implement and embed trauma-informed practice in their day-to-day work, and to identify and provide the right support to children with additional needs including speech, language and communication needs (SLCN) as early as possible.

Priority 2

Improve nutrition, oral health and physical activity among children and young people

According to the National Child Measurement Programme (NCMP) 2021/22 data, the prevalence of childhood obesity in Enfield remains above the national average, and there is a notable increase in obesity between Reception and Year 6.

Childhood obesity is a health inequality which puts children and young people at risk of worse health outcomes as they grow up, including tooth decay, poor mental health and type 2 diabetes.[21] Childhood obesity increases the risk of long-term conditions in adulthood.[22] Obesity is driven by multiple factors including the food our

21 North Central London Whole System Approach to Obesity Mapping
22 Public Health England (2021) Guidance, early years high impact area 4: Supporting healthy weight and nutrition

children and young people consume, physical activity levels, the environment we live in and social norms.[23]

Locally, we are committed to supporting children, young people and their families to access healthy food, maintain a healthy weight, and to be more physically active. This includes by delivering the HENRY (Health, Exercise, Nutrition for the Really Young) programme; the Holiday Activities and Food Programme (HAF); and increasing the range of inclusive play and leisure activities available in the borough. We are also promoting the benefits of active travel and making it easier to choose.

Improving oral health remains an important focus and we are continuing to promote oral health in schools and early years settings through our local dental health advocates, as well as providing the fluoride varnish service in early years settings to help prevent tooth decay.

Priority 3

Support children and young people to maintain good emotional wellbeing and mental health

We all need good emotional wellbeing and mental health so that we can live happy and healthy lives. Physical activity and eating well is important for us to stay healthy; looking after our mental health is as important. It helps us to be ready to do the things we want to do with our friends and family and to make healthy life choices. We want 'mental health' and 'mental health help' to be talked about using a common language that everyone understands, and we want young people to be informed to make decisions about the support they need.

Locally, we are developing a new approach to emotional health and wellbeing services for children and young people in Enfield, focusing on prevention and early intervention. The THRIVE Framework[24] is a way of organising mental health support for all children and young people aged 0-25 (and their families). It involves thinking about the needs of the child or young person rather than focusing on a diagnosis.

Priority 4

Deliver early interventions and empower young people and families to seek out preventative healthcare

Access and confidence in seeking out preventative healthcare and early interventions is crucial as we empower young people with the information, advice, and support they need. Locally we are focusing on 4 key areas:

- **Vaccinations:** we are committed to significantly increasing the take up of early years and childhood vaccinations including the MMR vaccine (which protects against measles, mumps and rubella) and the 6-in-1 vaccine.
- **Sexual and reproductive health:** we are continuing to work in partnership to deliver a comprehensive range of sexual and reproductive health services for adolescents, including access to education, advice, and support; and addressing barriers to prevention, testing and treatment.
- **Drugs and excessive alcohol:** we are continuing to deliver substance misuse support to young people and their families including the delivery of information, advice, guidance and access to treatment services.
- **Smoking and vaping:** we are working with our schools and in our community to implement the "don't smoke outside our school gates" initiative and smoke free zones to de-normalise smoking as a behaviour and to protect children and young people from second-hand smoke.

Our partnership's key strategies include:

- Empowering Young Enfield
- Looked after Children Strategy
- SEND Partnership Strategy
- Tackling Child Neglect Strategy
- Youth Justice Plan
- Enfield Inclusion Charter
- NCL Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan
- NCL Start Well: Opportunities for improvement in maternity, neonatal, children and young people's services in North Central London

23 North Central London Whole System Approach to Obesity Mapping
24 THRIVE Framework for System Change

LIVE WELL

Strong, healthy and safe communities

People with the knowledge and confidence to live healthy lives
An environment and community that keeps us healthy
Health services that support and empower residents

- **Just 20.7% of Enfield residents stated they 'definitely' had enough support from local services to manage their long-term condition compared to 25.2% of North Central London residents.**
- **In Enfield, 6.4% of deaths are attributable to poor air quality, this compares to 6.5% in London and 5.5% in England.**
- **Nearly two-thirds of Enfield adults are now physically active but only 1.4% of people in Enfield cycle to work and only 5.7% travel on foot compared to the 32.5% who travel by car or van.**
- **In Enfield, 8.1% of our residents aged over 16 feel lonely *'often'* or *'always'* compared to 6.5% of London and England residents.**

In Enfield we are committed to working with our residents and partners to build and maintain strong, healthy and safe communities where people lead active lifestyles, have access to healthy food, are smoke-free, feel safe in and connected to their community, and live in good health for as long as possible.

Making *"the healthy choice, the easiest choice"* has been an aspiration in many parts of the UK for some time and was a core focus of Enfield's previous Joint Health and Wellbeing Strategy. Supporting and empowering our residents to make healthy choices and to lead an active life could not only lead to fewer hospitalisations and deaths each year, but also reduce the financial demand on services.

Physical activity is a significant factor in determining people's health, with inactivity increasing the risk of long-term conditions including heart disease, diabetes and other obesity-related illnesses. People in Enfield are less likely to be physically active and our rates of obesity are higher than London averages.

Access to healthy food is another important determinant of health. Income inequality is increasingly preventing many people from accessing a healthy, balanced diet – food poverty is on the rise in Enfield and more of our residents are having to use food banks. We are continuing to work with our partners to help residents experiencing financial hardship to access low cost, sustainable and healthy food in community-run pantries across the borough, and we have already set up two food pantries in Edmonton Green and Enfield Town library.

As with all life stages, to live well, we need to also address the wider determinants of physical and mental health including housing, education, welfare, work and poverty – and contribute to reducing health inequalities.

Our Priorities

Priority 1

Empower residents to grow their 'Health Literacy' to make healthy choices

It has been estimated that health literacy related problems may account for up to 5% of all NHS spending, and there is a close link between socio-economic deprivation and lower health literacy.

The NHS defines health literacy as *"…a person's ability to understand and use information to make decisions about their health."*[25] Important elements of health literacy include *"having enough knowledge, understanding, skills and confidence to use health information."* This enables us to take an active role in our own health and wellbeing, participate in our care, and to navigate our local health and social care systems.[26]

Locally, we are committed to supporting the health and care workforce to empower our residents to identify and navigate information, advice and support services. This includes promoting registration with a GP, enhancing local signposting schemes to support informed decision making and improved outcomes, and raising awareness of support in the community such as from our Community Hubs and Family Hubs, our libraries, and from voluntary and community sector groups and organisations across the borough.

We also want to explore opportunities to work in partnership with our communities to empower them to be providers and champions of information to help us to address the health literacy challenge, including through *Community Health Checks.*

Priority 2

Support residents to manage their long-term conditions

Improvements in healthy lifestyle have stalled nationally, particularly amongst more deprived communities, further exacerbating health and other inequalities.[27] A proportion of our residents have or will develop long-term conditions. These include conditions like cardiovascular disease, chronic respiratory disorders and diabetes.

Alongside our commitment to promoting good health literacy (that empowers individuals to make the daily decisions that support the good management of their long-term conditions, such as stopping smoking, being active and maintaining a healthy weight) we are also developing a programme of *Community Health Checks.* By working with our voluntary and community sector partners we can provide easy opportunities for routine monitoring for things like blood pressure. We will also ensure our targeted NHS Health Checks continue to provide support to those eligible, to help identify and reduce the risk of certain health problems such as heart disease, diabetes, kidney disease and stroke. This enables people to review their health with a professional, catch hidden problems early, and discuss health positive changes they can make to their lives.

By catching these common problems early, we will be more likely to prevent people from developing complications associated with the condition – this is known as *'secondary prevention'* and it is a key measure to enabling people to live longer, healthier lives.

Priority 3

Build a healthy environment that protects and promotes good health and an active lifestyle

Places and spaces, including public buildings, the homes we live in, and parks and green spaces, are major determinants of our health and wellbeing.

Locally, we are making our roads safer and more pleasant environments for walking or cycling, to encourage active travel and improve air quality. And we are also continuing to invest in improving everyone's access to sport, including new opportunities for activity in our parks and improving the activity offer inside our leisure centres.

We are working toward a vision of more and better homes for Enfield in the context of unprecedented financial challenges, with rising inflation, significant interest rate increases, a cost-of-living crisis and insufficient funding to support the increasing number of households in need of affordable housing. We know that too many Enfield residents do not have access to a home they can afford, and we need to work as a partnership to minimise the negative impact of this in the short and medium term, while continuing to work toward our longer-term vision of more and better homes for Enfield.

25 NHS Health Literacy Definition
26 https://www.healthliteracyplace.org.uk/why-health-literacy/
27 https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/

In our role as a landlord, Enfield Council is investing in and improving our council homes in partnership with our tenants and leaseholders, so that homes are safe, secure and comfortable, both now and for the future. This means people can live with sufficient space and in thermal comfort, free from the negative impacts of damp or mould, extremes of temperature, and poor air quality. We also want people to live in mixed-income neighbourhoods where they feel a sense of belonging, can access healthy and nutritious food, green spaces, leisure facilities and community services.

As the local population grows and their health needs change, we also need to work together as a partnership to identify and secure the facilities needed for primary, secondary and tertiary care and the wider health and care system, so that there is sufficient healthcare provision in the places where it's needed.[28]

Priority 4

Create connected communities that support good mental health, emotional wellbeing and resilience

The communities we live in really matter for our emotional wellbeing and mental health. Sustainable employment, good quality homes, strong social networks and a sense of belonging play a big role in ensuring we live a happy life in good health. On the other hand, isolation, whether defined in social, physical or psychological terms is well known to have adverse health impacts, both physically and emotionally.[29]

Locally, we are supporting our communities to be well-connected and digitally included, tackling the harmful impacts of social isolation through activities like our Tea and Toast sessions that run in our libraries. Furthermore, we are committed to tackling the stigma that continues to pervade how our society talks about mental health and we will continue to support the most vulnerable in society – a key focus must be on preventing and supporting people in crisis and we are committed to leading local efforts on suicide prevention through the ongoing development of our local *'Suicide Prevention Plan.'*

Equally, we recognise that traditional service offers across health and non-health sectors do not meet the needs of people living with mental ill health. Because of this, we will continue to explore innovate new work areas with our partner organisations, such as the NHS Core20PLUS5 approach of offering an annual physical health check to people living with severe mental illness.

Our partnership's key strategies include:

- Enfield Early Help for All Strategy
- Climate Action Plan
- Blue and Green Strategy
- Enfield's Local Plan
- Community Safety Plan
- Safeguarding Adults Strategy
- Violence Against Women and Girls Strategy
- Housing and Growth Strategy
- Enfield Housing Allocation Scheme
- Economic Development Strategy
- Tenancy Strategy
- Preventing Homelessness and Rough Sleeping Strategy
- North Central London Green Plan 2022-2025
- NCL Joint Plan Summary 2023-24
- NCL Learning Disabilities and Autism Programme Plan
- NCL Working with our People and Communities Strategy 2022/23 to 2025/26
- North London Mental Health Partnership Strategy
- North Middlesex University Hospital Trust Strategic Vision
- Royal Free London NHS Foundation Trust Strategic Vision

28 https://www.gov.uk/guidance/health-and-wellbeing
29 https://heart.bmj.com/content/102/13/1009

AGE WELL

Healthier, more independent and longer lives

People living healthier and socially connected lives
Communities that nurture and promote independence
The right support at every stage of life

- There are currently 44,500 people aged 65 and over living in Enfield – this is set to increase to 50,200 by 2025.
- In 2021, 36% of people aged 65 and over living in Enfield lived alone.
- The most common cause of injury resulting in hospital admission for people aged 65 and over is falls.
- The average life expectancy at birth in Enfield is 84.1 years in females and 78.9 years in males.
- In 2021/22, 225 Enfield residents suffered a hip fracture.
- Only 68% of older people living in Enfield have their flu vaccine each winter.
- It is estimated that only 66.8% of people living with dementia in Enfield have been diagnosed and seen a specialist.
- Research suggests that 2 in 3 people want to die at home but in Enfield currently only 38% of people die at home.
- Enfield has one of the largest numbers of care providers in London, including 82 care homes.

The key to healthy ageing is to nurture positive health behaviours early in life. Eating well, keeping active, maintaining a healthy weight, and avoiding health harming behaviours like smoking and drinking too much alcohol all reduce the risk of developing long-term conditions and of having poorer health later in life.

But even if you don't start early, it's never too late to make a health improving change and for this reason it's important we target action early but continue to promote health positive behaviours throughout the life course. It is equally vital that we provide high quality care and work collaboratively with our partners across the health and care system, to create joined-up services that support those living with long-term conditions so that they can maximise their independence and live life to the fullest.

At every step we will ensure our work provides the right help for all but prioritises support to those with the greatest need so we can reduce inequalities and give every Enfield resident the opportunity to live a healthier, longer, and more independent life well into old age.

Project Spotlight: PainChek® and SMART Living Projects

In 2021, Enfield became the first local authority in the UK to introduce AI-powered **PainChek®** technology in care homes to better identify and support residents who may be experiencing pain but are unable to express this verbally.

Moreover, our **SMART Living Project** aims to reduce social isolation through introducing digital technology into care homes to connect service users with friends and family. This innovative project was selected as a 2023 MJ Awards Finalist in the 'Digital Transformation' category.

Projects like this help to ensure that people stay happier, healthier, and independent for longer through the introduction of next generation technology in our current social care offer. Looking ahead, we will continue to harness the power of the communities we live in to tackle social isolation and support independence.

Our Priorities

Priority 1

Assist every Enfield resident to have the social network they need to support their wellbeing

Social isolation and loneliness are an all-too-common feature of older age, but they are not inevitable. Loneliness can lead to poor physical and mental health, and it is estimated that loneliness is as bad for our health as smoking 15 cigarettes a day.[30]

Locally, we will be working in partnership to identify those at greatest risk of isolation, such as people living with severe frailty and unpaid carers, and helping them to prevent loneliness, by encouraging community engagement and signposting to support. This includes working with our voluntary and community sector organisations to provide opportunities for volunteering, hobbies and social interaction. We will also be exploring opportunities to tackling age-related stereotypes and stigma by promoting intergenerational programmes that bring together older people and younger generations.

Priority 2

Help every Enfield resident prevent the risks of age-related ill-health

There are many health problems that we are more likely to develop with age, from infections like shingles and pneumonia, through to long-term problems like osteoarthritis, loss of eyesight and hearing, and dementia. Each of these problems has an impact in different ways, but there are things we can do to prevent and mitigate the harm from all of them.

Looking ahead, we are continuing to work in partnership to support people to maintain their independence by encouraging early access to vision and hearing care; helping people to understand and access vaccinations to prevent infections; and supporting people to maintain a healthy weight to reduce the impact of osteoarthritis.

We are also working hard to ensure access to specialist dementia services, so that people get the timely diagnosis and treatments that help to keep them well for as long as possible. Additionally, we are supporting our communities to reduce the impact of dementia by encouraging people to live *'brain stimulating lives'* with local opportunities for high quality education, employment, and community activity.

Priority 3

Enable every Enfield resident to live a resilient and independent life into older age

Frailty reduces the ability of people to maintain their physical and mental independence and increases the risk of even minor illnesses. Preventing older people from developing frailty is a key action to help residents maintain their independence and live happy and healthy lives.

Our existing services are designed to maximise opportunities for maintaining independence with a focus on early intervention and support before people lose vital abilities. We aim to empower

30 Holt-Lunstad J and others (2010). 'Social Relationships and Mortality Risk: A Meta-analytic Review' PLOS Medicine: volume 7, issue 7

people to act on the risk factors for developing frailty by making positive health changes earlier in life and raise awareness of the simple exercises that older people can do from home to maintain strength and balance.

We recognise the crucial role of unpaid carers, in supporting loved ones to live their lives in the setting that's right for them – it is equally vital that we also provide the right support that keeps them well.

Priority 4

Ensure every Enfield resident receives world class care at the end of life that makes the last stages of life as valued as every other

At the end of life most people want a good death: comfortable, dignified and with seamless support for them and their loved ones. But many people are scared to talk about death and dying and worry about the impact on their friends and family. Good care takes good planning and alongside providing compassionate end of life care services we also need to tackle the stigma surrounding talking about death and dying. Only this can help us achieve good wellbeing at every stage of life.

In Enfield, we will seek to break down barriers and empower people to talk about dying and the end-of-life process, so that they can plan and prepare for this important stage of life. We will also be working in partnership to develop processes that help people to take control of their care; and supporting loved ones and communities by working with our NHS, voluntary and community sector partners to provide high-quality bereavement care.

Our partnership's key strategies include:

- Supporting Independence: A Local Prevention Strategy
- Market Position Statement Addendum 2021-2026: Older Person Specialist Accommodation
- Respite Care Policy
- Provider Concerns Policy
- Self Neglect and Hoarding Policy
- Mental Capacity and Deprivation of Liberty Safeguards (DoLS)
- HASC Strength based Supervision Policy

Our Governance Framework

Led by:	The Health and Wellbeing Board are responsible for providing strategic direction and leadership throughout the borough to deliver our vision and ambition, principles, and priorities. The Board are also responsible for developing and monitoring our action plan. The associated action plan will be kept up-to-date and will be regularly reviewed throughout the 6-year lifecycle of the strategy. On a biennial basis the strategy can be reviewed and refreshed as required, to respond to local, NCL or national updates. Any updates to the strategy are subject to agreement by the Health and Wellbeing Board and the Council's Executive Management Team.
Supported by:	The Health and Wellbeing Board is part of a wider network of boards and groups which are responsible for overseeing the successful implementation of the action plan. This includes partnerships such as the Enfield Borough Partnership, the Mental Health Partnership Board, and the SEND Partnership Board which bring together representatives from our community, statutory partners and the Voluntary and Community Sector.
Delivered by:	Individual actions are the responsibility of the named partner within the workforce. This could include the Local Authority, NHS, Voluntary and Community sector, schools and education settings, and commissioned services. These partners report on progress through their relevant internal governance structures which will feedback to the Health and Wellbeing Board.

Thank you for reading our Joint Local Health and Wellbeing Strategy 2024-2030.

If you would like to find out more about our plans and services, how we're doing and how to get involved, please visit our website www.enfield.gov.uk

EnfieldCouncil EnfieldCouncil

Early Years Partnership Board Data Set					
Population					**Comments 12/10/2023**
	ONS (2021 Census based)	**© GLA 2020-based demographic projections**		**Enfield Trend**	
Population Estimate 2023 0-4	21.3K	20.4K		last 3 years	No update since last meeting
	ONS (2018 Based)				
Population Projections in 5 years 0-4 (2028)	20.5K	19.3K		last 3 years	No update since last meeting
Live Births ONS	**2020**	**2021**	**2022**		
	4086	3936	3921	last 3 years	Reduction has slowed
Year on Year Change		150	15		
Deprivation					
	ONS (Mid 2020)			**Enfield Trend**	
Deprivation Children living in bottom 30% IMD 0-4	12.7K (54%)			No update since 2021	No update since last meeting
Families with Child Dependants (Under 16) in Receipt of Housing Benefit (*at May 2023*)	23.3K			Since Feb 2023	Stable since February 2023
	Enfield	**London**	**National**	**Enfield Trend**	
Out of Work Claimants as a proportion of resident population aged 16-64 (August 23)	5.9	4.9	3.7	Since Aug 2022	Still higher than August last year after peak in April 2023
School Demographics					
as at Jan 23 (school census)	**Enfield**	**London**	**National**	**Enfield Trend**	
Free School Meals (% FSM - Primary)	29.2%	24.9%	24.0%	Since Jan 2021	No update since last meeting
English as an Additional Language (EAL - Primary)	51.3%	48.0%	22.0%	since Jan 2021	No update since last meeting
SEN EHCP - (% Primary)	3.8%	3.3%	2.5%	Since Jan 2021	No update since last meeting
SEN Support - (% Primary)	11.1%	12.6%	13.5%	Since Jan 2021	No update since last meeting
Children's Centre Registration and Engagement	Update from Zinat Ismail				
Early Years Entitlement Take Up Jan 2023 ***(includes 4 year olds in infant classes in primary schools)***					
	Enfield	**London**	**National**	**Enfield Trend**	
2 Year Olds	62%	65%	74%	Overall trend since Jan 2020	Enfield Increased from 59% in 2022, Gap from London remains at 3%
3 & 4 Year Olds	84%	84%	94%	Overall trend since Jan 2020	Enfield Increased from 82% in 2022. DfE acknowledges that population statistics at LA level could be distorting these percentages.
SEN EHCP - 2 year olds in provision	0.1%	0.4%	0.7%	Overall trend since Jan 2021	Following a rise in 2022 Enfield is now at the same level as 2021, remaining below London.
SEN Support - 2 year olds in provision	3.5%	5.0%	4.2%	Since Jan 2021	Enfield small rise since 2022 of 0.1% , remaining below London.
SEN EHCP - 3&4 year olds in provision	1.9%	1.4%	1.3%	Since Jan 2021	Enfield has shown a small fall since 2022, but still above 2021, remains above London
SEN Support - 3&4 year olds in provision	8.3%	7.5%	6.7%	Overall trend since Jan 2021	Enfield has increased since 2021 by more than London and National
Pupil Premium and Early Years Pupil Premium	17.0%	13.0%	16.0%	Since Jan 2021	Remains consistently higher than London
Ofsted Outcomes					
	Enfield	**London**	**National**	**Enfield Trend**	
PVI's (% Good or Outstanding) *at June 23*	98%	95%	96%	Overall trend since Aug 2020	2 of 92 less than good (Now 100% both have since received Good)

Childminders (% Good or Outstanding) *at June 23*	94%	95%	97%	Overall trend since Aug 2020 ↑	8 of 135 less than good
Primary Schools with pre school provision *as at Oct 2023*	100%	-	-	Since Mar 2021 ↑	No schools with a nursery now less than good
Early Years Foundation Stage Profile (EYFSP) 2023					
Source NCER	**Enfield**	**London**	**National**	**Enfield Trend**	
Good Level of Development (GLD)	65.2%	69.1%	67.2%	Only 2022 and 2023 data compariable	Enfield GLD fell slightly by 0.2% since 2022, London and National increased
Free School Meals GLD	55.5%	57.8%	51.6%	"	Enfield FSM GLD has improved 0.5% from 2022
Non Free School Meals GLD	69.6%	72.9%	71.5%	"	
Gap	14.1%	15.1%	19.9%	"	Enfield FSM v NON FSM Gap remains below London and National
Communication and Language	75.0%	79.1%	79.5%	"	Enfield 1% fall in Comm and Lang , London and National up slightly
Health					
	Enfield	**London**	**National**	**Enfield Trend**	
Children Obese (including severely obese) (Reception) 21/22	13.4%	10.8%	10.1%	Based on the most recent 5 points →	No update since last meeting
Infant Mortality Rate per 1000 (2019 - 21)	4.4	3.5	3.9	Recent trend can not be calculated	No update since last meeting
Low Birth Weight of Term Babies (2021)	3.5%	3.3%	2.8%	Based on the most recent 5 points →	No update since last meeting
Smoking Status at Delivery (2021/22)	5.4%	4.5%	9.1%	Based on the most recent 5 points ↓	No update since last meeting
Percentage of 5 year olds with experience of visually obvious dental decay 2021/22	28.8%	25.8%	23.7%	New Indicator	No update since last meeting
A&E Attendances *per 1000* - 0-4 Years (2021/22)	1156.2	854.5	762.8	Recent trend can not be calculated	No update since last meeting
Immunisation - MMR 2 dose by 5 years old (2021/22)	66.5%	74.2%	85.7%	Based on the most recent 5 points ↓	No update since last meeting
Polio vaccination @12 months (Jan to Mar 2023 - % of cohort)	84.2%	87.0%	91.6%	over last 3 qtrs ↑	Enfield has shown a 0.8% increase since last qtr.
Seasonal Flu Vaccine Uptake Pregnant Women (GP) 2022/2023 - Data On GP registered patients 1st Sept 2022 to Feb 2023	18.5%	29.9%	35.0%	No trend available	No change from last published data
General Fertility Rate *per 1000 women 15-44* (2021)	56.2	52.9	54.3	Recent trend can not be calculated	No update since last meeting
Teenage Mothers (2021/22)	0.8%	0.3%	0.6%	Based on the most recent 5 points →	No update since last meeting
Substance Misuse	**21/22**	**22/23**	**23/24 QTR 1 Only**	**Enfield Trend**	
Parents in the adult substance misuse services , where child lives with parent	**213** (18% of treatment population)	190 (15.6% of treatment population)	115 (16.3% of treatment population)		Number will increase through the year as new patients present to treatment but % is likely to remain stable as numerator of new presentations to treatment will increase and so will the denominator which is total number of people in treatment.
	21/22	**22/23**	**23/24 QTR 1 Only**		
Health Visiting Data					
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above	450	105	25		
Total % of infants who received a face-to-face New Birth Visit (NBV) within 14 days from birth, by a Health Visitor with mother (and ideally father)	98%	96%	96%		Based on Qtr I 23/24 still below 21/22

Total % of children who received a 6-8 weeks review by the time they turned 8 weeks	62%	67%	70%		Based on Qtr I 23/24 showing consistent improvement
Total % of children who received a 12 month review, by the age of 12 months	40%	35%	49%		Based on Qtr I 23/24 showing consistent improvement
Total % of children who received a 2-2½ year review, by the age of 2½ years	58%	48%	67%		Based on Qtr I 23/24 now above 21/22
Breastfeeding prevalence at 6-8 weeks (Families who report baby is fully or partially breastfed at the 6-8 week check)	49%	46%	58%		Based on Qtr I 23/24 now above 21/22
Perinatal Mental Health					
Family Support					
Early Help Referrals to Children's Centres 0 - 4 year olds	**21/22 (End March)**	**22/23 (End March)**	**23/24 (End Sept 23)**	**Enfield Trend**	
Total Referrals	281	225	76	Since 2021/22	
Top 5 Presenting Issues					
Domestic Violence / Abuse	7%	11%	14%		Top 3 issues remain the same
Parenting	35%	31%	20%		
Mental Health	13%	12%	14%		
Other	18%	13%	3%		Some issues have been extracted from Other into own category e.g. Housing
Learning, or Physical Disability or Illness	13%	4%	9%		
Behaviour	4%	7%	7%		
Neglect	7%	8%	7%		
Asylum Seeker or Refugee			8%		
Housing			8%		
MASH Referrals 0 - 4 years olds	**21/22 (End Mar)**	**22/23 (End March)**	**23/24 (End Sept 23)**		
Total Referrals	1128	1154	383		Based on April to Sep 23/24 25% lower than same period 22/23
Top 5 Refering Agencies (% Referrals)					
Police	30%	30%	33%		
School	20%	18%	17%		
Hospital	9%	9%	7%		
Other Social Services Dept	5%	-	-		
LA Service External (Other LA) e.g. SC , EH	-	6%	7%		
Other Agencies	8%	6%	5%		
Internal Social Services	5%	5%	4%		
Top 5 Outcomes (% Referrals)					
Child & Families (C&F) Assessment	45%	55%	59%		Based on April to Sep 23/24 continues to rise
Strategy Discussion & C&F Assessment	17%	16%	13%		
Provision of Information and Advice	4%	3%	5%		
Strategy Discussion	22%	16%	11%		Based on April to Sep 23/24 continues to fall
No Further Action	6%	6%	7%		
Total Contacts	15344	14404	4540		Based on April to Sep 23/24 39% lower than same period 22/23
Presenting Issues Top 6 (% of All Contacts)					
Other	30%	Not available	Not available		
Domestic Abuse	18%	Not available	Not available		
Blank	9%	Not available	Not available		
Neglect	6%	Not available	Not available		
Adolescent Support	5%	Not available	Not available		

Parental Mental Health	4%	Not available	Not available		
Joint Service for Disabled Children Referrals	**21/22 (End Mar)**	**22/23 (End Mar)**	**23/24 (April to Sept)**		
Total Referrals	174	162	80		Based on April to Sep 23/24 Number are in line with 22/23
Age at Referral 0	18%	12%	13%		
1	17%	24%	24%		
2	37%	27%	34%		
3	13%	15%	13%		
4	14%	22%	18%		
Presenting Need Top 5					
Social Communication Difficulties	37%	50%	56%		Based on April to Sep 23/24 the proportion of referals with social comms difficulties is increasing
ASD (diagnosed)	21%	17%	20%		
Complex Health Needs	17%	14%	5%		
Developmental Delay	13%	6%	3%		
Down Syndrome	6%	4%	3%		
Physical Disability	2%	6%	11%		
Referrers Top 5					
Speech & Langauage Therapist (SLT)	34%	39%	30%		
Other	21%	16%	11%		
Health Visitor	20%	17%	35%		Based on April to Sep 23/24 the proportion refered by a health visitor has increased
Paediatrician /GP/ Medical Consultant	9%	2%	10%		
Social Worker	6%	10%	10%		
School	5%	7%	3%		
Physio	1%	4%			
Panel (ESRAP - Early Support Resource Allocation Panel & SSP) Outcome Top 5					
Pre-School Support (PSS)	45%	41%	48%		
Short breaks agreed	10%	13%	6%		
Early Support & Pre-school Support	9%	10%	13%		
Further information requested/sought	9%	14%	10%		
Did not meet criteria (DNMC)	8%	2%	9%		
NFA	1%	4%	4%		
Other	-	5%	5%		
Temporary Accommodation April 2022	**Apr-21**	**Apr-22**	**May-23**		
Number Families	593	437	353	last 3 years	
Number Children	719	510	413		
Age 0	55	16	26		
Age 1	135	70	46		
Age 2	152	129	68		
Age 3	174	132	127		
Age 4	203	163	146		
Place Out Borough 0-4	320	303	301		

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON MONDAY, 2 OCTOBER 2023

MEMBERSHIP

PRESENT Alev Cazimoglu (Cabinet Member for Health & Social Care), Andy Milne, Dr Shakil Alam (NHS North Central London Integrated Care Board), Albie Stadtmiller (Healthwatch Central West London / Listen to Act), Deborah McBeal (NCL CCG), Dudu Sher-Arami (Director of Public Health), Doug Wilson (Director of Adult Social Care), Tony Theodoulou (Executive Director of Children's Services), Jo Ikhelef (CEO of Enfield Voluntary Action) and Dr Nnenna Osuji (Chief Executive, North Middlesex University Hospital NHS Trust)

ABSENT Nesil Caliskan (Leader of the Council), Abdul Abdullahi (Cabinet Member for Children's Services), Dr Helene Brown (NHS England Representative) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

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

Also Attending: Roseanna Kennedy-Smith (Senior Public Health Intelligence Specialist, LBE), Doug Wilson (Director of Health and Adult Social Care, LBE), Richard Gourlay (Director of Strategic Projects, North Middlesex University Hospital), Dr Chad Byworth (Public Health Team, LBE), Victoria Adnan (Policy & Performance Manager, LBE), Debbie Gates (Community Development Officer, LBE), Tim Hellings (Enfield Carers Centre), Dr Alpesh Patel (NHS NCL ICB)

1 WELCOME AND APOLOGIES

Cllr Alev Cazimoglu, Chair, welcomed everyone to the virtual meeting.

Apologies for absence were received from Cllr Nesil Caliskan, Andrew Wright, Dr Helene Brown, and Stephen Wells.

It was noted that Vivien Giladi had stepped down from the Board. She had been a Voluntary Sector representative and the Chair wished to record thanks for all her work over the years.

The Chair raised that she understood there had been a removal of the Mental Health Services ‘Place of Safety’ at Chase Farm Hospital site and relocation of the facility to Highgate which had led to challenges for officers, Police, and

patients. For the next meeting, the Chair requested an item on the agenda in relation to seeking reinstating of that service.

2
DECLARATION OF INTERESTS

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

3
LB ENFIELD WINTER VACCINATION PROGRESS / INFECTION CONTROL UPDATE

RECEIVED the slide presentation, introduced by Mark Tickner, Health and Wellbeing Board Partnership Manager, and Roseanna Kennedy-Smith, Senior Public Health Intelligence Specialist.

NOTED

1. There were concerns regarding emergence of a new variant (BA.2.86) of Covid-19 in the UK. It had been detected in low numbers so far, but there had been one care home outbreak.
2. Measles was also currently causing concern. Across Enfield the uptake of MMR vaccination was lower than it should be, considerably so in some areas of the borough. Measles was more dangerous than some people thought, and the only way to control it was by vaccination. UK Health Security Agency predicted a measles outbreak in London this year. In preparation, our ability to vaccinate at short notice was being increased.
3. Notifications of infectious disease cases recently in Enfield were shown, which were mostly in line with the expected number of cases for this period.
4. Covid-19 cases to September were shown. There had been a slight increase recently, in the context of testing being much less now, and zero Covid-19 deaths in the latest data.
5. Latest Covid Autumn booster and flu vaccination numbers were shown.
6. Childhood immunisation uptake was reported. The lowest uptake within the programme was in MMR, at 69% for both doses in Enfield. Despite a lot of work, it was proving quite difficult to get an increase in uptake.
7. Disparity in MMR uptake was shown by ward, by ethnicity, and by language spoken.

IN RESPONSE

8. The Chair confirmed that Council on 27 September agreed a motion calling on all councillors to write to the Secretary of State for Health expressing their concern at the low uptake of childhood immunisations and calling for actions to be taken.
9. The Health and Adult Social Care Scrutiny Panel on 20 September received a detailed report on ‘Vaccination and immunisation: childhood immunisations focus’. Dudu Sher-Arami would share this report with Board members as it would give a good understanding of the work going on in the local authority and primary care.

ACTION: Dudu Sher-Arami

10. Glenn Stewart advised that an emergency planning exercise was to be held in respect of measles.

4
BETTER CARE FUND - REVIEW OF AGREEMENT

Doug Wilson, Director of Health and Adult Social Care, provided a verbal update that there had been delays with the initiative, but a report providing a fully formed picture would be provided to the Board at its December meeting.

5
NORTH MIDDLESEX UNIVERSITY HOSPITAL UPDATE

RECEIVED the slide presentation, introduced by Richard Gourlay, Director of Strategic Projects, North Middlesex University Hospital (NMUH).

NOTED

1. The development of a population-based integrated care model was set out. There was a desire for a joined up partnership approach with voluntary and community services as well.
2. Focus on outcomes was strengthened. There would be increased early intervention and preventative activities.
3. Utilisation of their sites would be optimised.
4. Reducing vacancy rate had been made a priority.
5. Main priority areas were highlighted and included developing a consistent community model in Enfield, and preventing hospital admissions.

IN RESPONSE

6. Development of local neighbourhood teams and transitions to benefit patients' experience were welcomed. It was advised that the next update would include patient stories, and the action plan / vision for developments over the next six to 12 months.
7. In response to the Chair's queries regarding recent strike action, it was advised that the situation had been safe. There had been robust planning, and regular briefings through the day. The most urgent treatments had been prioritised and continued. The hospital had been able to recover as quickly as hoped in respect of its elective programme. There was a financial impact around income and payments to cover shifts. No adverse harm in relation to delays had been picked up, but there had been disruption for patients and their understanding was appreciated for rescheduling at short notice. Waiting lists were being managed, and priority given to more clinically urgent cases.
8. It was confirmed there was still pressure in A&E, which was still seeing 550 to 600 patients a day, compounded by challenges in patient flow and high bed occupancy. The executive team had met earlier today to discuss winter planning.

6

JOINT HEALTH AND WELLBEING STRATEGY REFRESH AND REVIEW - PROGRESS

RECEIVED the slide presentation, introduced by Dudu Sher-Arami, Director of Public Health, Victoria Adnan, Policy and Performance Manager, and Dr Chad Byworth, Public Health Team.

NOTED

1. Officers had been engaging with stakeholders and updating the proposed strategy on the basis of the recent development session.
2. There was time for partners to invite officers to forums and meetings to have conversations about the proposed strategy. They wanted to speak to as many in Voluntary Services and communities as possible.
3. As advised, the approach would be evidence informed and have a relatable structure using a population health approach with a life course model. The five principles guiding the actions were re-iterated.
4. Within each of the life course themes were four specific priorities.
5. Further feedback was sought from the Board at this stage on those priorities. Members were welcome to provide written feedback after this meeting.

IN RESPONSE

6. In response to the Chair's queries, it was anticipated that under each priority area there would be an action plan that this Board would oversee. Progress made on each of the priorities would be demonstrated over the course of the strategy. Short term realistic goals should be worked to.
7. It was suggested that, with limited resources, focus on a small number of deliverable actions was preferable. The Chair considered the immediate urgent challenges to be around 'Age Well' and older people.
8. It was confirmed that consultation and engagement would run from 6 November 2023 to 15 January 2024 and would include a public questionnaire. The Chair raised the importance of consultation with under-represented and diverse groups to ensure their views were reflected.
9. It was confirmed that the strategy was aligned with ICB work and priorities, and also Council strategies and NMUH plans. The action plan should also act as part of the delivery plan for some of the priorities in the population health and integration strategy.

7
ICB CHANGE PROGRAMME UPDATE

RECEIVED a verbal update from Deborah McBeal on behalf of NHS North Central London Integrated Care Board.

NOTED

1. There had been a formal consultation with staff in July and August, and the outcome was published on 28 September. All staff had now received a letter

in respect of their status. A timeline had been put in place and all staff would be affected. Partners were requested to bear with them during this period.
2. There would be borough integration units so boroughs would be consistent.

IN RESPONSE

3. In response to the Chair's queries on what this would mean for Enfield, assurance was given that arrangements for the change programme were fair, equitable and well thought through. Decisions would be made on utilising resources across the system.
4. An update on the programme was requested to the next Board meeting.

ACTION: Deborah McBeal / Stephen Wells

8
MINUTES OF THE MEETING HELD ON 6 JUNE 2023

AGREED the minutes of the meeting held on 6 June 2023.

9
NEXT MEETING DATES AND DEVELOPMENT SESSIONS

NOTED the next Board meeting date: Monday 4 December 2023 on Teams.

For future meetings, the Chair proposed an earlier start time in the afternoon, potentially 4.30pm. If any Board member had an objection they should please send a message.

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