Public Document Pack

HEALTH AND WELLBEING BOARD

Tuesday, 8 October 2024 at 6.30 pm
Virtual/Teams

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PLEASE NOTE: VIRTUAL MEETING
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MEMBERSHIP

Cabinet Member for Health & Social Care – Councillor Alev Cazimoglu (Chair)
Cabinet Member for Children's Services – Councillor Abdul Abdullahi
Councillor Emma Supple – Conservative Member representative
Governing Body (Enfield) NCL CCG – Dr Shakil Alam (Vice Chair)
NHS North Central London ICB – Clare Henderson
Healthwatch Representative – Albie Stadtmiller
NHS England Representative – (Vacancy)
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 (+ Vacancy)

Non-Voting Members

Royal Free London NHS Foundation Trust – (TBA)
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 - 6:35PM)

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. UPDATE ON IMPENDING CQC INSPECTION OF LB ENFIELD ADULT SOCIAL CARE (6:35 - 6:40PM)

Doug Wilson, Director of Adult Social Care, London Borough of Enfield, for noting.

To include brief detail of preparations and possible timelines.

4. DELIVERING POPULATION HEALTH AND INTEGRATED CARE AMBITIONS IN ENFIELD AND JOINT LOCAL HEALTH AND WELLBEING STRATEGY / ACTION PLAN PROGRESS UPDATE (6:40 - 7:05PM) (Pages 1 - 16)

Presenters for the NHS North Central London ICB:
Clare Henderson, Director of Place, East: covering Enfield, Haringey and Islington
Paul Allen, Assistant Director – Strategy, Communities & Inequalities
And
Dudu Sher-Arami, Director of Public Health, Public Health Department LB Enfield, and Victoria Adnan, Policy and Performance Manager, People's Department LB Enfield.

(Paper attached.)

5. STATUS OF INTERNAL REVIEW ON STATUTORY AND OTHER BOARD INTEGRATION IN LONDON BOROUGH OF ENFIELD (7:05 - 7:15PM) (Pages 17 - 24)

Matthew Cagnetta, National Management Trainee, People Department, Public Health LB Enfield.

(Papers attached.)

6. ITEM FROM SEND AND INCLUSION SERVICE (7:15 - 7:35PM)

Trauma Informed Practice and its place within the Successor Health and Wellbeing Strategy, and activity across LB Enfield - Dr Leylla Mulisa, Senior Lead Educational Psychologist for Emotional Wellbeing and Mental Health/ E-TIPPS Programme Lead.

7. I-THRIVE RISK SUPPORT MODULE DELIVERY FOR ENFIELD (7:35 - 7:45PM) (Pages 25 - 34)

Rachel Stephen NCL iThrive Manager, Tavistock and Portman NHS Foundation Trust.

(Paper attached.)

8. LBE / NCL AUTUMN VACCINATION PROGRAMME / INFECTION CONTROL UPDATE (7:45 - 7:55PM)

Gayan Perera, Public Health Intelligence Manager – Public Health Department, LB Enfield. (Papers to follow.)

9. FUTURE SUBJECT ITEMS FOR SPOTLIGHT AND DISCUSSION

i. Board suggested items.
ii. Development session on Wednesday 23 October 2024.

10. ANY OTHER BUSINESS (Pages 35 - 40)

To Note – Better Care Fund/S75 Agreement Status – Doug Wilson, Director of Adult Social Care London Borough of Enfield asks the Board to note the report sent out with papers for information only.

11. MINUTES OF THE MEETING HELD ON 11 JUNE 2024 (Pages 41 - 46)

To receive and agree the minutes of the meeting held on 11 June 2024.

12. NEXT MEETING DATES

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

Tuesday 3 December 2024
Wednesday 5 March 2025

Formal Board meetings proposed to commence at 6:30 pm to 8:00 pm.

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Delivering Population Health and Integrated Care Ambitions in Enfield

Enfield Health and Wellbeing Board

8th October 2024

Draft v3

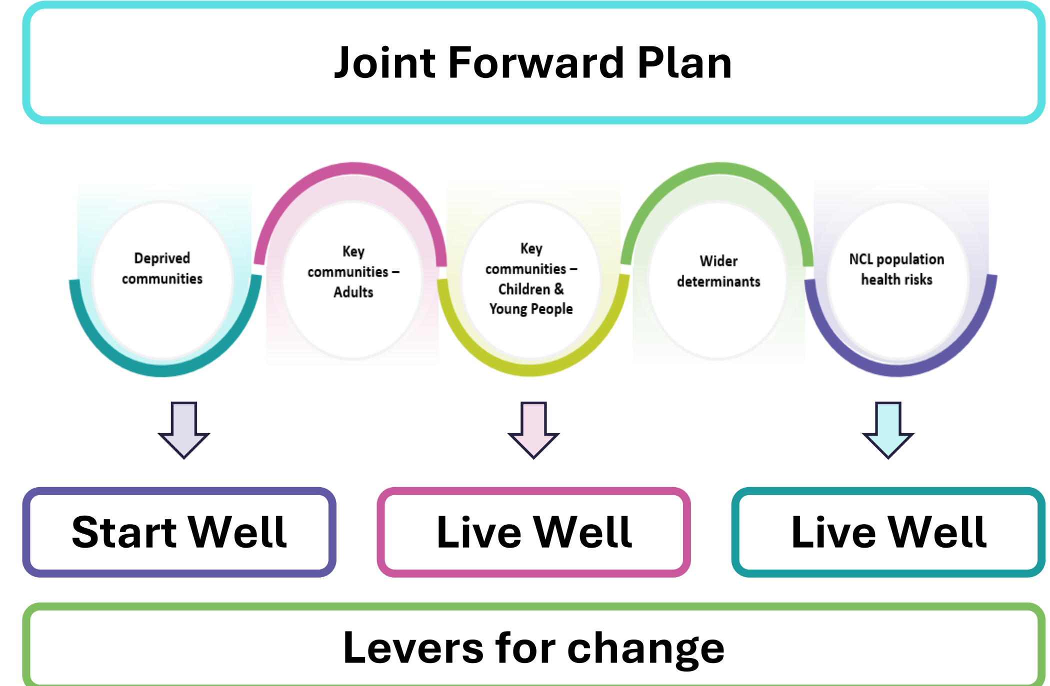
NCL Population Health & Integrated Care Strategy and Delivery Plan overview

Our NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. The Strategy can be found here. It outlines our ambition to **tackle health inequalities** by a **shared emphasis** on **early intervention, prevention and proactive care**.

Since April 2023, significant socialising and planning work across the ICP has culminated in the development of our **NCL Delivery Plan** (which also serves as our Joint Forward Plan (JFP)), which outlines our critical path to **deliver against our PH & IC Strategy**. The NCL Delivery Plan can be found online here.

The Delivery Plan describes progress in implementing the strategy over the last 12 months, our plans for the coming 18 months and how we will monitor delivery using the NCL Outcomes Framework. The plans are aligned to a life course approach and incorporate:

- NCL communities experiencing the poorest outcomes, wider determinants of poor health and 5 key health risk areas
- NCL system transformation programmes, which are aligned to delivering our population health ambitions
- System levers which will create the conditions for population health improvement
- A number of areas within the plan have been identified by the ICP to "**super-charge**" - making the **best use of the collective weight** of the ICP to **accelerate and deepen impact**.



NCL Outcomes Framework

North Central London Health and Care
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
- Children have improved oral health

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

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

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

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

Live well

Early identification and improved care for people with mental health conditions

- 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

Work to develop Population Health approach since April 2023

North Central London Health and Care
Integrated Care System

- **Engaging and socialising** the Delivery Plan with Health & Wellbeing Boards, Trust Boards, Borough Partnerships, forums involving the VCSE and patient representatives. This has culminated in the publishing of resident-focussed content which can be found online here.

- **Developing the NCL Outcomes Framework and launching the online dashboard to support monitoring –** *the dashboard can be found here*. Data in the dashboard are at Borough and NCL level, compared to London and England. There is also an Outcomes Framework annual insights report at NCL and borough level *(Enfield content appearing later in the pack)*.

- **Understanding and starting to align plans across borough and system** to maximise the impact of our joint working.

- **System Progress on Population Health outcomes** is set out in detail in the Delivery Plan. Improvements include:
  - Mental Health – Longer Lives: The proportion of adults with SMI having a physical health check increased by 44%
  - Improved the uptake of Targeted **Lung Health** Checks from 30% to 55%. Over 20,000 people have now had a lung health check.
  - **Inclusion Health** needs assessment completed which has been identified as an example of good practice in national guidance and over £1m invested in integrated homelessness discharge support post hospital

NCL Outcomes Framework Insights Report 23/24 Summary

North Central London Health and Care
Integrated Care System

The NCL Outcomes Framework (OF) annual insights report summarised key insights at NCL and borough level from the NCL OF dashboard. The report demonstrates that while we have made **some progress, the five population health risks identified in the PH&IC remain relevant and require ongoing system and borough focus**, and there are also broader areas requiring focus across the life course (Start Well, Live Well and Age Well).

Childhood immunisations
Although there has been notable, steady improvement in the proportion of children who have been fully vaccinated by age five, 31% of children in NCL were not fully vaccinated by the end of 2022/23

Cancer
Despite steady improvement in bowel cancer screening over recent years, overall cancer screening coverage is poor, with all boroughs except Enfield having lower coverage than London in at least one programme in 2023

Mental health and wellbeing
The proportion of adults with SMI having a physical health check increased by 44% from 2020/21 to 2022/23, but we are not achieving our target of 0–18 year olds receiving at least one contact from an NHS-funded mental health service.

Heart health
With 73% of NCL patients with high blood pressure treated to within age-specific target range within the last 12 months, we are falling short of the national target (77% for 2023/24; now 80% for 2024/25)

Lung health
Only 53% of NCL patients with chronic respiratory disease are vaccinated against flu, and only 69% of people aged 65+

Start Well

Poverty - 17% children live in poverty (2021/22 data which is likely to have increased since)
Maternal smoking - More than one in 20 women giving birth in NCL smoke
Newborn hearing screening - NCL boroughs are within the 6 worst performing boroughs in London
Oral health - More than one in four 5-year-olds in NCL have experience of tooth decay
Healthy weight - 38% 11-year-olds are overweight or obese
Communication skills - One in five reception children do not achieve expected communication and language skills
Mental Health - An estimated 1 in 5 11-16 year olds have a mental health disorder. Prevalence estimates for Camden are 33% higher compared to the national average

Live Well

Smoking - More NCL patients aged 15+ years smoke compared to London
Healthy weight - 55% of adults are overweight or obese
Alcohol - Admissions for alcohol-related conditions are higher in three of our boroughs (Islington, Haringey and Enfield) compared to London
Employment - 35% people with a long term physical or mental health condition of working age are not in employment
Diabetes - Only 31% patients with Type 1 diabetes and 43% of patients with Type 2 diabetes in NCL achieved all three treatment targets

Age Well

Loneliness – Only 36% older adult social care users have as much social contact as they would like
Dementia diagnosis - Although rates across NCL were similar to London, Camden, Haringey and Barnet did not meet the national benchmark for dementia diagnoses
Avoidable admissions – Unplanned admissions for older adults with certain long-term conditions have increased across all our boroughs since 2020/21
Intermediate care – On average more than one in ten of NCL's hospital beds per week are occupied by patients who did not meet Criteria to Reside but were not discharged
Carers - The average quality of life score for carers in NCL was 7 out of 12 which, although low, was comparable to London

Key Next Steps

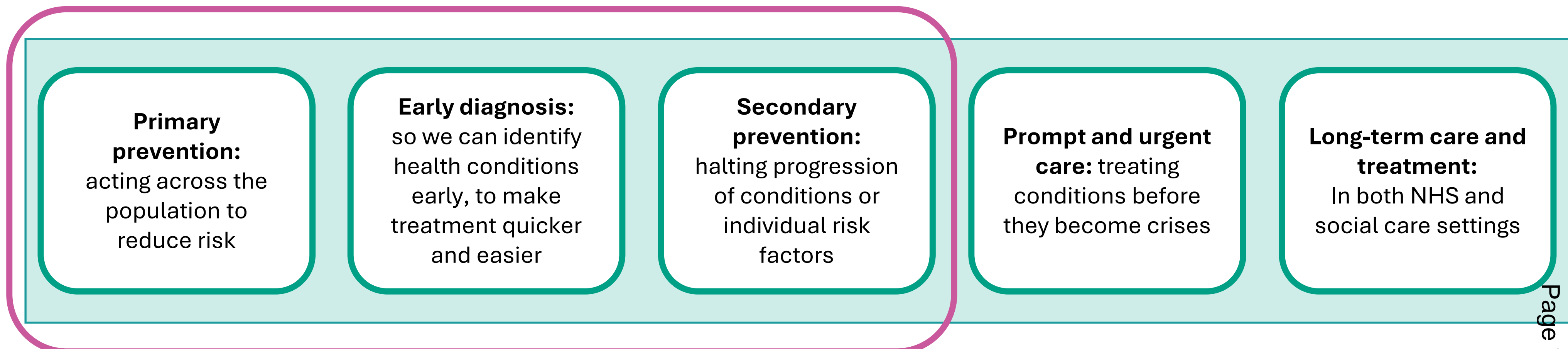
North Central London Health and Care
Integrated Care System

The priorities and indicators in the Population Health Delivery Plan and NCL Outcomes Framework are wide ranging, multiple and complex. We will be tracking progress against all the actions outlined in the Delivery Plan, but it is important that we are able to demonstrate the tangible improvements that we hope to make in population health in the next 18 months.

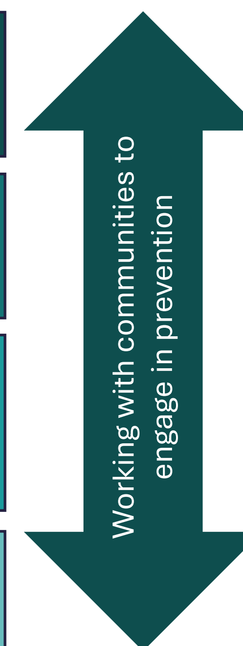
How could we address this?

- We need to identify a smaller sub-set of **key (sentinel) population health metrics** to allow us to demonstrate our impact with which to effectively track and showcase the progress we are making and the benefits of coming together on a multi-geographical footprint across ICS. This will include the key population cohort to be targeted for each metric in order to **improve equity.**
- These metrics should be aligned to existing measures and be supported by a **wider benefits realisation programme**
- This will also clarify roles and responsibilities so that all partners are aware of the contribution they can make – including identifying areas for collaboration. For example, boroughs are best placed to utilise local insights to deliver change.
- The benefits realisation programme will consider how we work differently across partners to make progress on the agreed sentinel measures – this will include a deep dive process that will bring together the worlds of academic research, intelligence and insights and NHS/LA delivery to ensure we are harnessing strengths of all partners to reduce inequalities and improve outcomes.

Benefits Realisation – a worked example for Heart Health



NHS	Making Every Contact Count – tackling health behaviours and lifestyle risks	Optimising management of hypertension and CVD e.g. via the LTC LCS	Case-finding in high-risk patients on GP patient lists and opportunistically in secondary care
Local Authority	Commission primary NHS Health Checks. Population and community workplace screening *in process*	Commission population-based lifestyle services to manage risk factors	Commission NHS Health Checks; population-based community health screening
VCSE & Healthwatch	Deliver targeted primary prevention lifestyle initiatives with local communities; leveraging reach into underserved communities	Deliver targeted population-based lifestyle services/ initiatives to manage risk factors; leveraging reach into underserved communities	Run community awareness campaigns and blood pressure checks
Academic Partners	Research across these areas and putting these into practice through engagement with services and commissioners		



What else does evidence suggest would work?

Are there gaps when we focus on key communities?

Example of aligning plans and strategies across partners to deliver population health outcomes in Enfield

North Central London Health and Care
Integrated Care System

Joint Health & Wellbeing Strategy (2024-30) ***DRAFT***

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

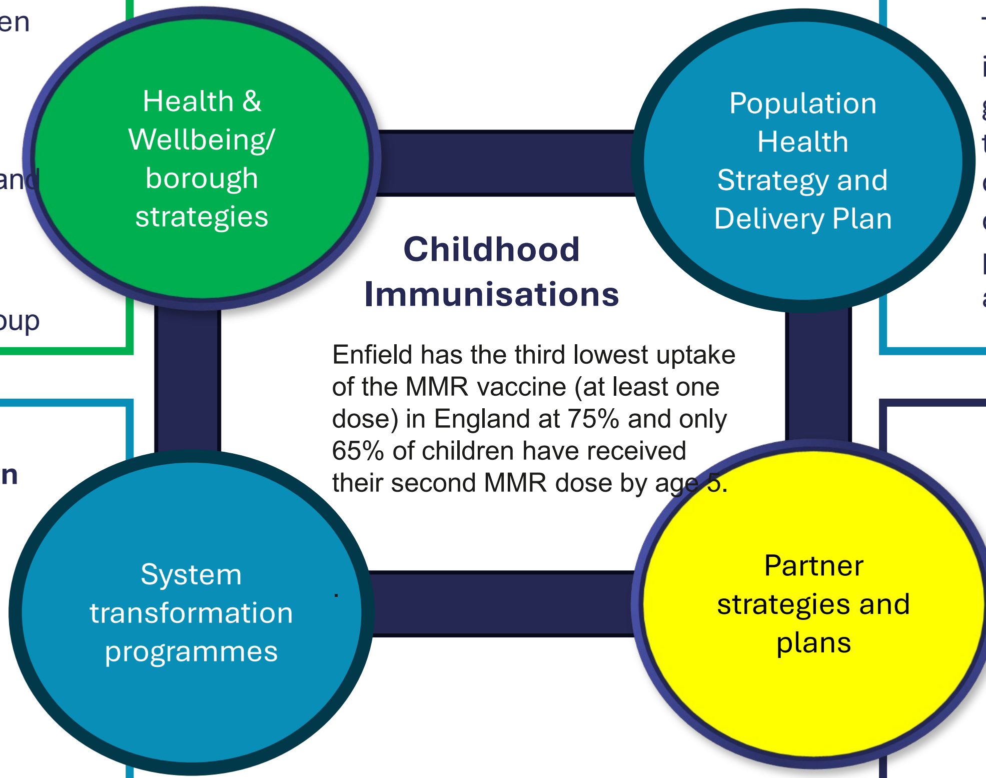
- Upskilling our communities with regular talks and promotion of Childhood immunisation
- Access to drop-ins at our Family hubs and Children centres

Enfield Borough Partnership Board

- Increase routine childhood immunisation vaccine uptake with a focus on most deprived communities and communities with lowest uptake.
- Target 3-5% increase in childhood vaccination by focusing on areas of greatest disparity.
- Deliver the AP of the Enfield Imms and Vacs Subgroup

Our **NCL Delivery Plan** outlines our ambition to increase routine childhood immunisation vaccine uptake with a focus on most deprived communities and communities with lowest uptake.

The Strategy outlines an aim to conduct a gap analysis to identify outcomes across different population sub-groups and geographies to develop focus areas for tackling health inequalities. We also want to develop a common framework to accelerate work across childhood imms, reflecting governance, a focus on prevention, working across partners, including the VCS and success measures



NCL Childhood Immunisation and Vaccination Programme

An ICP-sponsored system-wide programme is overseeing a programme to improve:

- Vaccine conversation competency
- Communications and engagement via new information sources
- Operational processes & quality call/recall
- Workforce training and development
- Data quality
- Enfield Immunisation and Vaccination subgroup interfaces with the ICP delivery plan

ABC Parenting Programme supported by **Enfield inequalities funding** focussing on:

- Training & education to patient champions & community leaders
- Deliver pop-up clinics in GP practices and more community focussed venues to get the conversation going about the importance of proactive immunisation and vaccination Facts
- Deliver comms & patient information in the relevant language.
- Evaluated and upheld as best practice by our partner system

Enfield Borough

North Central London Health and Care
Integrated Care System

- **Physical health and LTCs**: 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. 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.
- **Mental health**: The majority (89.3%) of Enfield adults say they are happy with their life (ONS 2021/22). Two out of 5 people aged 16 and over in Enfield have a common mental disorder (any type of depression or anxiety) (OHID, 2017), which is significantly worse than the England average (16.9%). 2.5% of school aged children in Enfield have social, emotional and mental health needs. This is significantly worse than the England average (PHE, 2018)
- **Immunisations:** Enfield has the third lowest uptake of the MMR vaccine (at least one dose) in England at 75% and only 65% of Children have had their second MMR dose by the age of 5 years old.
- **Homelessness:** Enfield has a highly mobile and transient population. This includes a homeless population, that includes entrenched rough sleepers. This population group experiences multiple disadvantages, including markedly reduced life expectancy, and increased prevalence of substance misuse / mental health dual diagnosis.
- **Respiratory conditions:** Enfield residents breathe polluted air in parts of the borough nearest to inner London. Enfield has a higher prevalence of conditions including asthma, and COPD. In Enfield, 6.4% of deaths are attributable to poor air quality, this compares to 6.5% in London and 5.5% in England.
- **Hospital admissions:** The number of emergency hospital admissions in Enfield was 1,748 per 100,000 in 2022/2023, which is 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. The most common cause of injury resulting in hospital admission for people aged 65 and over is falls.
- **End of Life:** Research suggests that 2 in 3 people want to die at home but in Enfield currently only 38% of people die at home.

How are partners already delivering (an integrated approach to population health) in Enfield?

North Central London Health and Care
Integrated Care System

Start Well Highlights

"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" *(HWB strategy)*

Increasing CYP vaccination coverage – through collaboration across the system and innovation, we have a well-established Enfield Iimmunisation and vaccination group that has developed a targeted action plan over the past 2 years we have seen an incremental increase and there is more work to do as an Enfield partners system with NCL ICS input.

Stood up a multi-agency **Start Well subgroup and also, a Family Hubs Board and themed sub-groups** to oversee and assure our borough ambitions for children, young people and families

Under the auspices of the Start Well Subgroup and its multi-agency T&F, we have developed a *pilot model* for Integrated Paediatric Service **multi-disciplinary integration of acute and primary care plus wider partners** including CAMHS, early help and social services through complex case multi-disciplinary meetings. This is due to be implemented in 2025.

Integrated approach to breast feeding - a programme of work is being taken forward in Family Hubs to increase breastfeeding, which includes but is not limited to – loan pump, BFI accreditation, trained BF supporters.

CYP **Asthma nurses** are embedded within primary care practices focussed on integrated, multi-agency proactive approach focussed on **asthma** care for populations those that are 'high risk' due to complexity factors and those presenting within ED for manageable needs.

Improving support for neurodiverse children and young people including addressing waiting times via the Enfield Autism Steering Group

Mapping our CYP training offer across partners with the support of **Enfield training Hub** leads

How are partners already delivering (an integrated approach to population health) in Enfield?

North Central London
Health and Care
Integrated Care System

Live Well Highlights

"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"
(HWB strategy)

- The primary care long-term conditions LCS is under development which aims to set out a proactive care approach to **LTC management** particularly focussed on **achieving equitable outcomes. Primary Care PCNs** have worked together to develop a **single borough plan** which aims to reduce inequalities. The borough also has established and developed a pilot **MDT** approach referred to as the Enfield Diabetes and Heart failure project hosted in GP practices in the eastern part of the borough.

- Integrated **neighbourhood teams for SMI communities** at Enfield quadrant level. Primary care and NL MH Partners have agreed four new mental health liaison posts working full time within Enfield practices, which is a prototype to support co-location and aligned neighbourhood teams to enable joined up care for residents and enhanced working experience for staff. Recruitment is underway. Development of the Enfield collaborative partner plan to deliver the **Longer lives programme is** underway

- **Learning Disabilities-**Almost all of Enfield's eligible population living with LD having an annual health check (83%) and a collaborative plan is being worked on with the **Enfield Integrated Learning Disabilities service** to target more complex and hard to reach groups

- **Black Health Improvement Programme (BHIP)** is a forum is to support residents to take ownership of health matters and build local connections in order to improve health outcomes by sharing information on health services and providing a forum for discussion on health and wellbeing matters. These sessions are co-ordinated and co-located within **practices and community hubs** to provide relevant and useful information to the wider community

How are partners already delivering (an integrated approach to population health) in Enfield?

North Central London Health and Care
Integrated Care System

Age Well Highlights

"People living healthier and socially connected lives
Communities that nurture and promote independence
The right support at every stage of life" *(HWB strategy)*

- **Enfield Community Services transferred to NMH on 1st April 2023** and our partners and stakeholders see this as an opportunity to embed new joined up practice around developing **pilots of integrated approaches to Ageing Well** in Enfield including a **multi-disciplinary** approach to ageing well with MDMs being established at the beginning of November across NMH community services and LBE care co-ordinators. Internally, NMH Community services have hosted a range of workshops that support both vertical and horizontal developments and proactive care innovation. For example, a new team has been established called the Proactive Care service. As a local system of partners, we are having collaborative discussions about advancement of **workforce training hubs** to prepare our workforce for more integrated way.

- **A Joint review of the Better Care Fund review 23/24** indicated a number of key integrated successes such as the virtual ward implementation and there is ongoing review of expanding consultant led care within the community. Opening of Reardon Court extra Care facility and closer working to identify people living in the community and / or discharged from hospital that might benefit from therapy-led rehabilitation. S**ix training short-stay flats are available on site**. Enfield has a successful and **well-established Integrated Discharge Hub and Enablement service. Our ICEs equipment service** offers a range of integrated services, equipment and aids in a timely fashion to support reductions in deterioration in the community and helps people to remain well at home. A new ICES helpline is being opened for community priority referral requests.

- **Carers** action Plan-Led by the council and co-produced under the auspices of the Enfield Carers Partnership Board with resident Carers and key partners, a framework action plan to support the identification, support, wellbeing and experience of Carers in Enfield.

How are partners delivering (an integrated approach to population health) in Enfield and what is planned?

North Central London Health and Care
Integrated Care System

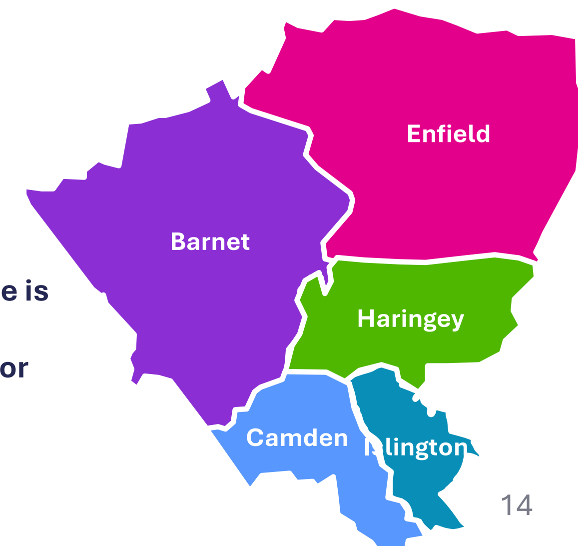
Wider determinants- Working with our Communities and embedding the VCSE.

- Our Enfield inequalities subgroup has designed the **Thriving Community Zones –** focussed on the experiences of ethnic minority residents and those that experience inequalities of access living in more deprived parts of Enfield
- Almost all of Enfield's eligible population living with LD having an annual health check
- Continuing to **tackle entrenched inequalities through a wide range of NCL-funded partnership schemes**, with demonstrated impact around e.g. healthy lifestyles in Edmonton, promoting vaccination and immunisation in under-represented communities, and equality of access.
- Enfield is developing **a Mental Health Hub** that will host integrated MDTs and VCSE organisations that contribute towards improving MH and emotional wellbeing outcomes for Enfield Residents.
- **Homelessness** System Programme-led by the council
- Under the auspices of the Multi-Agency Panel, we were able to access NCL ICB Mental Health Investment Standard funding to ensure that physical and mental health services are commissioned with consideration of the needs of local homeless and rough sleeping residents of Enfield
- Partnership approaches include:
    - Developing an integrated model of physical and mental health and care support;
    - Assertive outreach models and building trusting professional relationships with rough-sleepers
    - Ensuring an appropriate wider primary care offer for homeless residents

Borough summaries

Whereas the last section of the report provided a whole-system focus, this section has a borough focus and highlights indicators where there are potential opportunities for population health improvement within each of our five boroughs (Barnet, Camden, Enfield, Haringey and Islington).

- The focus of this section is to draw attention to indicators where individual boroughs are performing worse than their peers and/or performance appears to be getting worse
- It overlooks the many areas where individual boroughs are doing better than their peers - other sections of this report draw attention to some of these and these can also be seen in the many indicators RAG-rated green in the full data tables in Section 5.
- These borough summaries are intended to signal areas which may warrant further investigation, in the context of what is known about each borough's population and work currently being delivered/current priorities. Within this, for example, as signalled in the executive summary and in Section 4, it is important to note within this that due to the reporting lag for some indicators, more recent work to drive improvement may not yet be reflected in the data
- In this section, indicators of note for each borough have been mapped to delivery areas of the NCL PH&IC Strategy, across the life course. As the insights are tailored to each borough's performance, individual boroughs may not have indicators in the same boxes as other boroughs, but they may include:
  - Our five population health risk areas, including Childhood immunisations, Cancer, Lung Health, Heart Health and Mental Health and Wellbeing at all ages
  - Common risk factors, including smoking and overweight/obesity
  - Health and care, including access, experience and integration
  - Wider determinants, for example loneliness and housing
  - Other including, newborn hearing screening.
- **Indicators have been selected where:**
  - **Boroughs are RAG-rated worse (red) compared to London in the latest time period**
  - **Boroughs are RAG-rated similar (amber) or better (green) compared to London in the latest time period but performance is getting worse**
  - **The indicator was not RAG-rated but the difference in performance is visually substantially different from London and/or other NCL boroughs and/or the NCL average (an assumed difference, not tested by statistical significance)**
- *Please note for space abbreviated titles for the indicators have been used.*



Enfield

Vision

Inequality in life expectancy for women - worse than London, and getting worse

Strategy delivery area	Start well	Live well	Age well
Our five population health risk areas	**MMR vaccine uptake (22/23)** – worse than London **Children fully vaccinated by age 5 (2023)** – worse than NCL peers, but getting better	**Cervical cancer screening (2023)** – better than London, but getting worse **NHS Health Check uptake (2018/19-22/23)** – worse than London, and getting worse **Treatment targets for Type 1 Diabetes (22/23) –** similar to NCL peers, but getting worse	
Common risk factors	**Smoking at delivery (22/23)**- worse than London **Childhood overweight and obesity (22/23)** - worse than London	**Smoking prevalence (22/23) –** worse than London, but getting better **Alcohol-related hospital admissions (21/22) -** worse than London **Active travel (2022)** – worse than London	
Health and care – access, experience and integration			**Avoidable admissions (22/23)** – worse than NCL peers, and getting worse **Length of stay 21+days (22/23)** – similar to NCL peers, but getting worse
Wider determinants	**Reception children's language and communication skills (22/23)** – worse than London	**16- and 17-year-olds NEET (22/23)** – worse than London **Jobs below the London Living Wage (2022)** – worse than London, but getting better	**Adults reporting loneliness (21/22)** – worse than London **Fuel poverty (2021)**– worse than London
Other	**Premature births (19/21)** - worse than London, but getting better **Newborn hearing screening (22/23)** - worse than London		

Considerations for the Health and Wellbeing Board

North Central London Health and Care
Integrated Care System

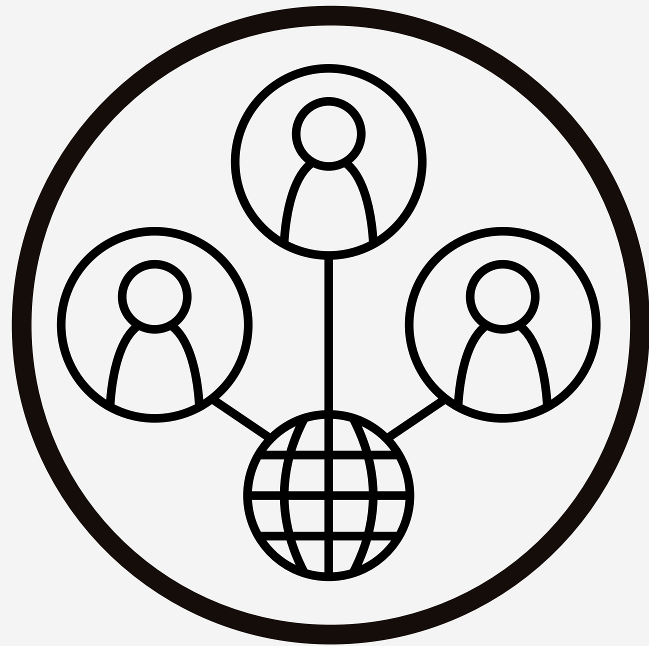
- Is the HWB assured that coherence is being developed between local priorities and system priorities? What further work would strengthen this?

- The Outcomes Framework Insights Report is part of a data driven approach to improving outcomes – how do we ensure this is reviewed in context with wider data?

- How can we work together most effectively to assure delivery of our joint population aims and ambitions?

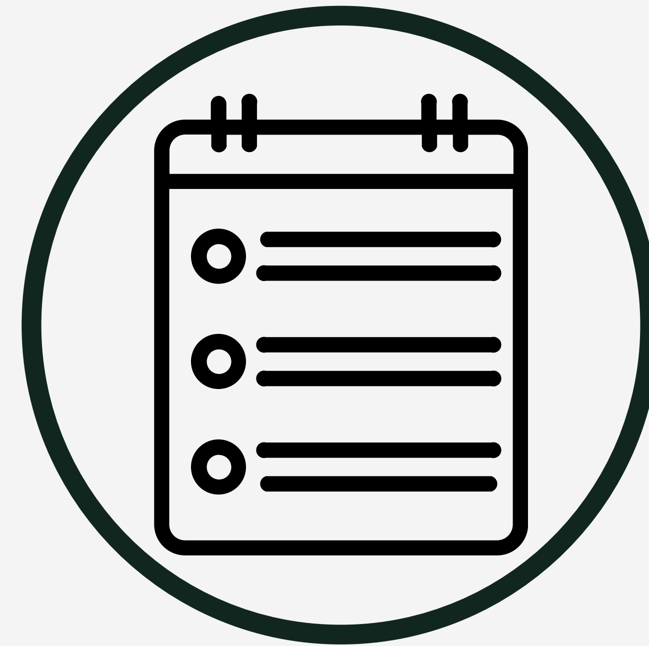
Mapping and Governance Project

Purpose: To identify opportunities to further enhance joint working between the Health and Wellbeing Board (HWB), the Borough Partnership (BP), and their sub-groups.



Identify all sub-groups

To identify all subgroups of the HWB and BP.



Obtain and analyse all ToRs

To obtain and analyse all ToRs, highlighting statutory functions and suggesting opportunities for bringing together groups with overlapping responsibilities.

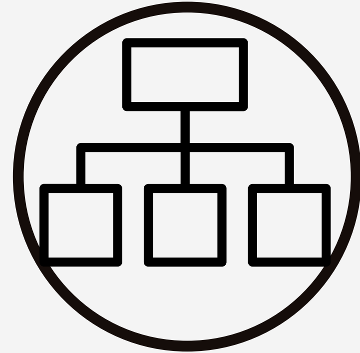
Identify meetings and reporting structure

To identify the frequency and mechanism of meetings and reporting for sub-groups and opportunities to enhance joint working.

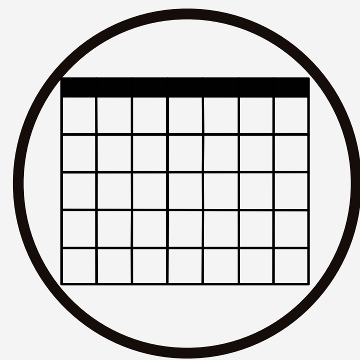
Recommend an enhanced reporting system

To recommend opportunities to enhance the reporting system and joint working to ensure regular and succinct updates are provided to the HWB, including those relating to the Health and Wellbeing Strategy Action Plan.

Mapping and Governance Project



Output 1 : To develop a full governance map of all relevant subgroups



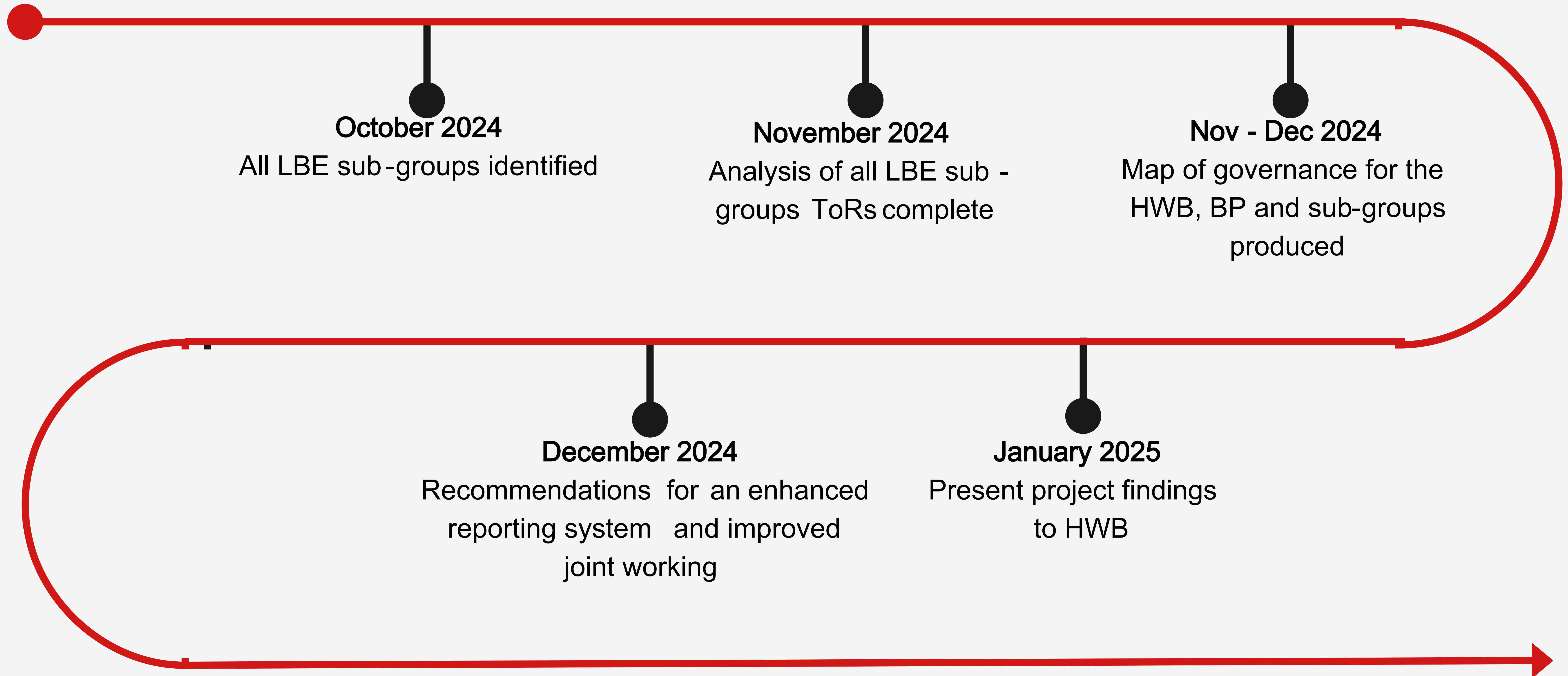
Output 2 : To create a table of governance, which includes the Chair, Administrator, board responsibilities, regularity of meetings and reporting process for each group.

Output 3 : To produce a concise report summarisingthe findings and recommendations based on the agreed objectives.

Out of scope:

- Updating or producing new ToRs on behalf of groups considered as part of this review and mapping exercise.
- Establishing or co-ordinating new or existing groups.
- Producing a public landing page for the partnership boards.

Timeline and milestones



Project Scope

Title	Mapping and Governance Review: Health and Wellbeing Board, Borough Partnership and Sub-groups
To	Dudu Sher-Arami, Director of Public Health (Project Sponsor)
Date of Meeting	10 September 2024
Author	Matthew Cagnetta, National Management Trainee
Project Governance	The project will be delivered by Matthew Cagnetta, National Management Trainee with the support of Victoria Adnan, Policy and Performance Manager. Regular updates will be provided to Dudu Sher-Arami throughout the lifecycle of the project. The final report will be presented to People DMT, the Health and Wellbeing Board and Borough Partnership.

Purpose:

The Director of Public Health has initiated a mapping exercise to identify opportunities to further enhance joint working between the Health and Wellbeing Board (HWB), the Borough Partnership (BP), and their sub-groups.

This project will review all Terms of Reference (ToRs) for these entities to identify core functions, areas of overlap and difference, governance processes; and potential opportunities for improving the effectiveness of partnership working. Additionally, it will propose a streamlined reporting structure to enhance communication and effectiveness.

Objectives:

- To identify all subgroups of the Health and Wellbeing Board and Borough Partnership and their key contacts (including Chair and Administrator).
- To obtain and analyse all ToRs, highlighting which functions are statutory, if there is any overlap and how information is shared between the groups.
- To identify overlap and suggest opportunities for streamlining / bringing together groups with overlapping responsibilities
- To identify how regularly each group meets and if there are opportunities to enhance joint working and reporting, based on scheduling.
- To identify the mechanisms and structures sub-groups currently use to report to the Health and Wellbeing Board and Borough Partnership.
- To recommend opportunities to enhance the reporting system and joint working to ensure regular and succinct updates are provided to the HWB, including those relating to the Health and Wellbeing Strategy Action Plan.

Outputs:

- To develop a full governance map of all relevant subgroups (initial map commenced in 2023/24 is included in appendix 1).
- To create a table of governance, which includes the Chair, Administrator, a brief description of responsibilities, regularity of meetings and reporting process for each group.
- To produce a concise report summarising the findings and recommendations relating to the mapping and review, based on the agreed objectives set out in this scope.

Out of scope:

- Updating or producing new ToRs on behalf of groups considered as part of this review and mapping exercise.
- Establishing or co-ordinating new or existing groups.
- Producing a public landing page for the partnership boards.

Next Steps

- Share a summary of the project's objectives and scope with the chairs of the Health and Wellbeing Board, the Borough Partnership and other key stakeholders.
- Initiate contact with relevant groups to obtain ToRs.
- Deliver a short introduction and presentation to be provided to the Health and Wellbeing Board on Tuesday 8th October 2024 and to the Borough Partnership (meeting TBC).

Timeline: Proposed Project End Date: Friday 13th December

See Gantt chart below for the split

Borough Partnership & HWBB Governance Review

Public Health

Project lead: Matthew Cagnetta

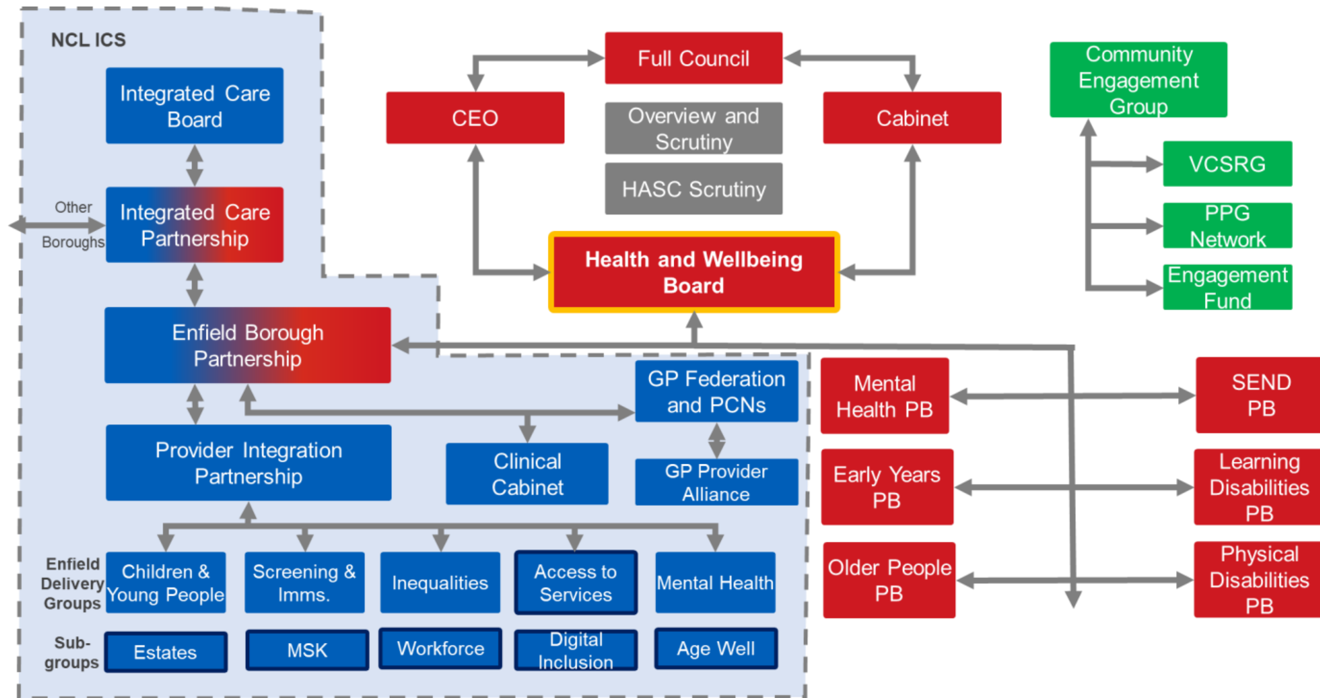
Task
Initiation
Create Project Brief
Review with Dudu Sher Arami, Director of Public Health
Review with Peppa
Finalise proposal and brief Doug Wilson, Director of Health and ASC
Mapping and Review
Sub-groups
Identify all sub-groups key contacts
Analyse the relevance of the sub-groups ToRs
Identify the frequency of meetings for sub-groups
Identify the structure and frequency of reporting into the HWBB and BP
Health and Wellbeing Board and Borough Partnership
Identify statutory requirements and overlap between the HWBB & BP
Identify the frequency of meetings for HWBB & BP
Evaluation
Create
Develop a governance map of the subgroups
Create a table of governance, displaying main points of contact
Produce a concise report on the functions and responsibilities of the PBs
Recommend
Recommend a new reporting system and efficiency changes

Weeks: Sep 9, 2024 | Sep 16, 2024 | Sep 23, 2024 | Sep 30, 2024 | Oct 7, 2024 | Oct 14, 2024 | Oct 21, 2024 | Oct 28, 2024 | Nov 4, 2024 | Nov 11, 2024 | Nov 18, 2024 | Nov 25, 2024 | Dec 2, 2024 | Dec 9, 2024

Project Scope Update to HWBB

Interim project update to Dudu, Doug and Peppa

Appendix 1: Governance Map 2023/24



Drat Proposal – V1 (10 Sep 20204)

i-THRIVE

Planning and Reporting Pack

THRIVE Framework for System Change

October 2024

i-THRIVE in NCL

North Central London
Health and Care
Integrated Care System

What is i-THRIVE?

i-THRIVE is a set of tools and processes that have been developed to implement The THRIVE Framework for Systems Change (Wolpert et al,.. 2019). The framework itself provides a set of principles and a common language for creating local integrated communities of mental health and wellbeing support for CYPF that are shaped by their needs and the ways in which they would like to receive help and support.

NCL i-THRIVE

The intention is to ensure that the THRIVE Principles and common language are implemented across the 5 boroughs in NCL, building on, protecting and strengthening current THRIVE aligned practices and further developing the infrastructure and culture required to enable us all to create NCL communities of mental health and wellbeing support that are uniquely shaped to meet the needs and preferences of our local CYP and their families.

In order to support that process NCL have commissioned the National i-THRIVE Programme to help support the project management of the implementation process across NCL.

How Far Have We Come in NCL?

North Central London Health and Care
Integrated Care System

- i-THRIVE is central to the ambitions of the North Central London CYP MH & EW Transformation Plan
- We have an NCL i-THRIVE Project board which feeds into the NCL CYP MH & EW Integrated Group and the national i-THRIVE programme is represented on the Haringey, Camden, Enfield and Barnet CYP MH & EW Integrated Boards
- The i-THRIVE system Maturity Matrix is offered to each borough on a yearly basis – providing the opportunity to capture existing strengths and alignment to the framework in the systems and an opportunity to identify priorities to form part of local integrated delivery plans.
- We are currently developing a dashboard for NCL which will give accessible overviews of the systems and their progress towards alignment to the framework
- We have delivered Getting Risk Support Training and Managing Difficult Ending Training across 4 of the 5 boroughs and continue to offer training and development opportunities through NCL webinars and an i-THRIVE Community of Practice. Contact rstephen@tavi-port.nhs.uk or more information
- Co-production is an important principle of The THRIVE Framework and there is an NCL co-production Task and Finish Group currently working to increase understanding and opportunities for NCL Stakeholders. We are working with the waiting room to develop co-production pages
- Meeting the needs of the Getting Risk Support grouping is high on the agenda and there are plans to ensure that the conditions for providing relational support that is helpful to the CYP and their family is possible

i-THRIVE 2024/2025 deliverables

North Central London Health and Care
Integrated Care System

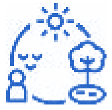
Key Milestones

1. Providing project management support to the system
2. Lead an NCL systemwide co-production working group to map opportunities, develop shared understanding and guidance and develop co-produced/ co-delivered meaningful outputs to maximise the effectiveness and experience of co-production across NCL
3. i-THRIVE Programme Team representation at NCL and borough based CYP MH partnership groups/boards
4. Bi-monthly system wide community of practice to share learning, challenges and innovation
5. Build on the risk support academy module working with stakeholders in each of the 5 boroughs, to develop an implementation plan for the agreed system wide changes that will provide the conditions required for supporting at risk CYP who currently cannot be helped by services as they are currently offered
6. Annual i-THRIVE System Maturity matrix events in each of the 5 boroughs to benchmark and map progress
7. Delivering a programme of webinars open to NCL CYP Mental Health and Emotional Wellbeing Community including CYP and their families to increase understanding of the framework and its relevance to practice
8. Integrating QI into the Risk Support Project
9. Providing a critical friend role to support NCL implementation

Working toward THRIVE Framework maturity

Key Principles:

Common Language: Based around the 5 needs-based groupings, promoting shared language and understanding across system



Integrated whole system approach: With clearly defined roles and responsibilities & shared accountability across agencies to delivering improved outcomes for CYP's MH. Needs-based care across the system is organised and delivered via the 5 needs-based groups

CYP-centred: Based on CYP's needs, choices and preferences. Underpinned by shared decision-making and strengths-based approach. Consideration is given to the family and wider support network

Proactive prevention & promotion: Active promotion of digital & community-focused support to address wider determinants of health, to identify and support those with vulnerabilities, and support whilst awaiting treatment

No wrong door: Timely, accessible and local advice, assistance, treatment and risk support, whereby community providers understand and actively signpost and refer to services and support

Outcome-focused: Outcomes framework underpinning routine use of outcomes data and the integration of QI approaches to improve CYP outcomes. Practice based around evidence-based approaches and measurement of progress towards goals.

Equalities and diversity. System-wide approach to identifying and addressing key inequalities in access, experience and outcomes of CYP, including for those in vulnerable groups and with complex needs.

Co-production and community engagement: Enabling the whole community, and building on strengths, ensuring involvement of CYP and their families from across the population in the development and shaping of services at strategic and operational levels. CYP views and experiences are used to support decision-making.

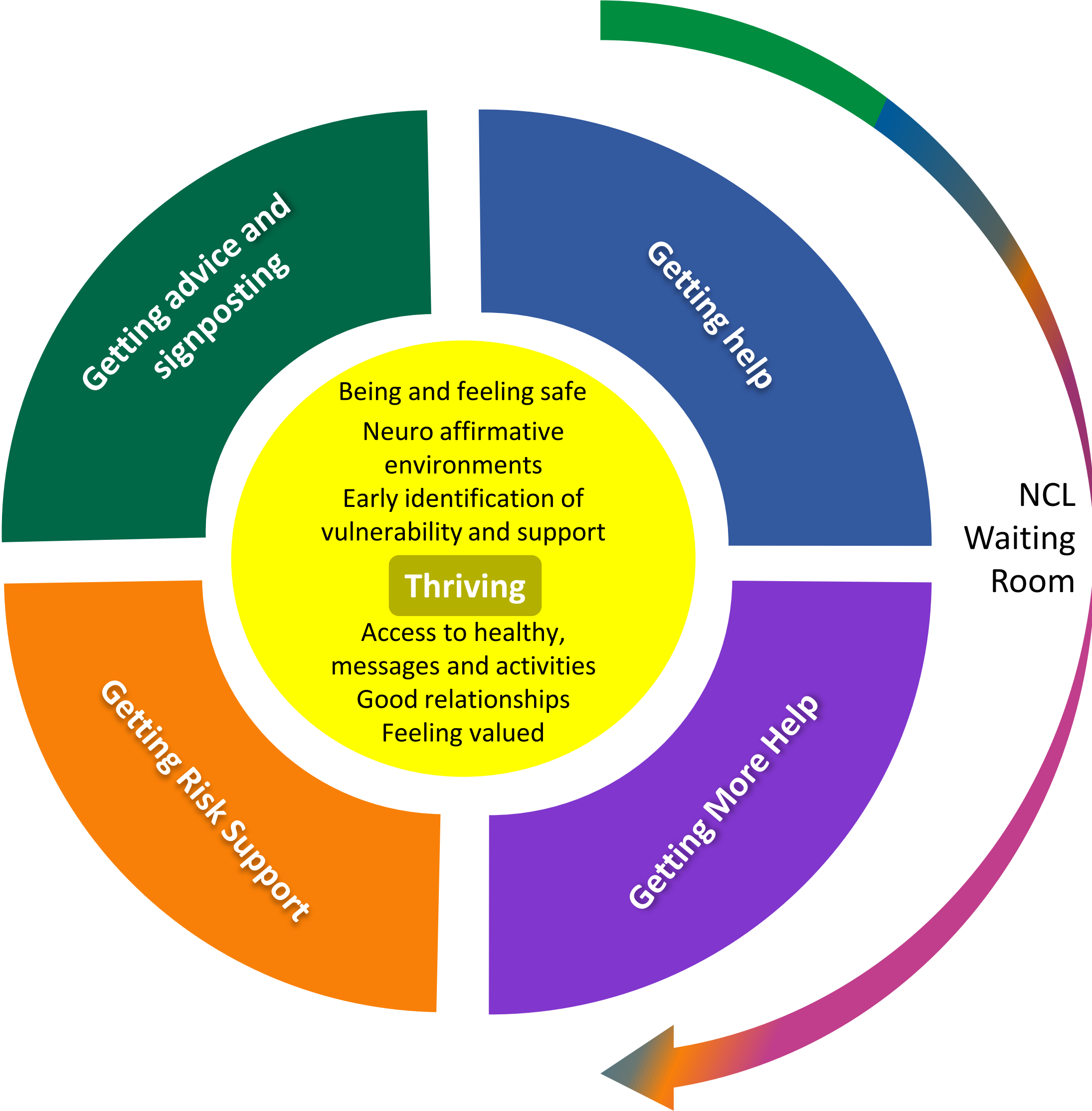
Needs based groupings:

BARNET LONDON BOROUGH
ENFIELD Council
ISLINGTON
Haringey LONDON
Camden

NCL ICS is introducing the language of the THRIVE needs based groupings to build shared understanding and meet the needs of children and young people across the community in a way that is easy to navigate

CYP has easy access to informed consultation with a skilled and experienced professional who is able to help them decide if and what help they need and where to get it

Working flexibly to manage risk by working with CYP and family in a way that is helpful to them. Identifying trusted adult and scaffolding professional support around the trusted adult. Reducing multiple referrals and sharing accountability



A range of psychologically informed goal based interventions that CYP can choose from – e.g one to one, groups, online or activity based

Integrated package of psychologically informed intervention and support that meets the MH needs and goals of the CYP e.g school, family, GP and Eating Disorders Team working together

Annual Cycle

Complete i-THRIVE System maturity self-assessment

Setting local Priorities based on the assessment results

Agreed local priorities incorporated into local implementation/ delivery plan

Priorities and delivery plan fed into NCL ICB and borough governance group

Annual cycle

i-THRIVE facilitates 90min sessions yearly (online or face to face) incorporating individuals from across the Borough MH CYPF Partnership (strategic, operational and staff working with CYP and service users)

i-THRIVE synthesize the results and present and benchmark results so the strengths and weaknesses of current system, in terms of alignment to the THRIVE Framework, can be identified and inform local planning

NCL Assurance

North Central London
Health and Care
Integrated Care System

NCL i-THRIVE System Maturity Matrix			
Borough	**22/23**	**23/24**	**24/25**
Haringey	June 2022	Not Completed	September 2024
Islington	July 2022	Not Completed	October 2024
Enfield	January 2023	Not Completed	
Barnet	January 2023	Not Completed	
Camden	June 2023	January 2024	Planned for NY

- Some detail about scoring and scoring dashboard?

Reporting and monitoring process chart

What we do

- Provide i-THRIVE representation and consultancy to your CYP MH & EW Integrated Partnership Board
- Provide facilitated cross system events yearly to map your sysem maturity in relation to the framework
- Support to identify whole system strengths and priorities together with i-THRIVE strategies for addressing priorities
- i-THRIVE training and learning opportunities
- Co-production resources and support for individual projects
- Opportunitues for shared learning

What you do

- Use your borough knowledge to support the organisation of i-THRIVE events to ensure maximum impact
- Demonstrate your support and committment to whole systems transformation using the i-THRIVE process by prioritising attendance and engagement yourself- leading by example
- Comit to completing the i-THRIVE system maturity matrix yearly
- Consistant use of the langauage of i-THRIVE
- Encouage attendance at i-THRIVE learning events
- Guided consultation through system transformation process

What you gain

- Support and services for CYPF that is relevant and helpful to them
- Improved outcomes and waiting times for CYP and families
- Support and access to the evidence based tools and processes required to being about a process of whole system change
- Flexibility and craetivity in your system
- Greater system integration

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London Borough of Enfield

Report Title	Health & Wellbeing Board update
Report to:	Health & Wellbeing Board
Date of Meeting:	6th October 2024
Report Author:	Matt Casey, Head of Service, Strategy & Service Development, Adult Social Care

Summary
This report is to update Health and Wellbeing Board on the Enfield 2023-25 Better Care Fund (BCF) plan.

The report has been consulted with the Chair of HWB prior to the HWB meeting.

Under the BCF, local authorities and NHS Integrated Care Boards are required to enter into annual pooled budget arrangements and agree an integrated spending plan for the BCF funding.

Details for the minimum contributions to the BCF for 2023 to 2025 are set out below. This includes the additional £1.6 billion funding for supporting hospital discharge.
Table 1: minimum contributions to the BCF in 2023 to 2024 and 2024 to 2025

BCF funding contributions	2023 to 2024 (£m)	2024 to 2025 (£m)
Minimum NHS contribution	4,759	5,029
Improved Better Care Fund (iBCF)	2,140	2,140
Disabled Facilities Grant (DFG)	573	573
Discharge funding	600	1,000
Grand total	8,072 (+4.6%)	8,741 (+8.3%)

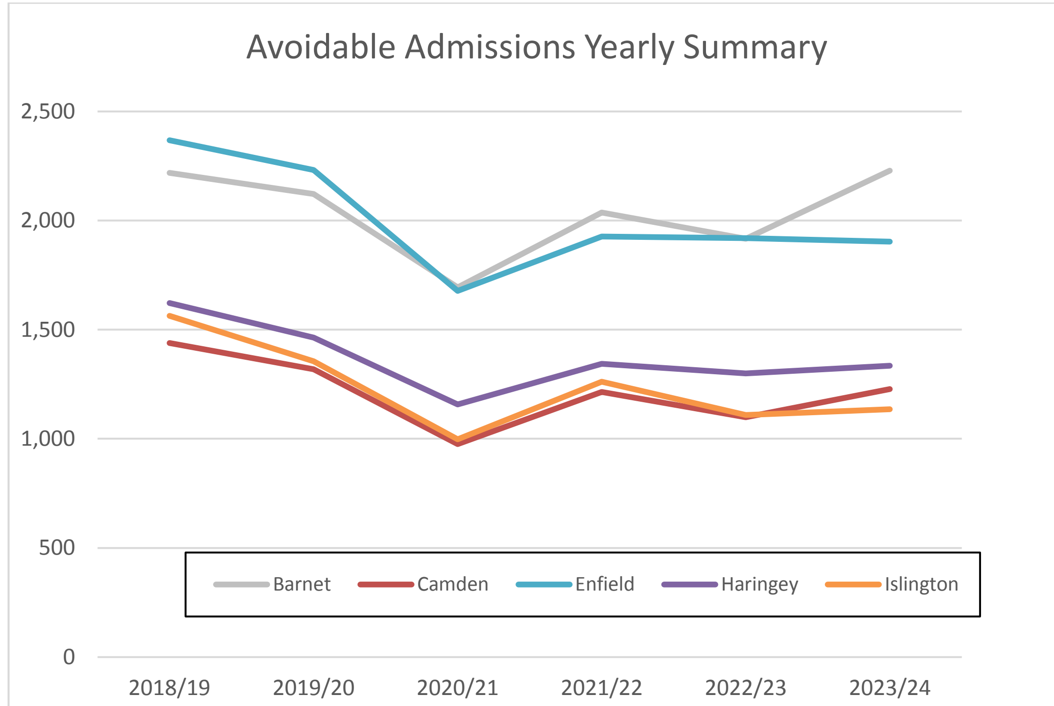
Table 1

The total allocation for Enfield BCF in 2024-25	£ 49 million

This report provides an overview of the two-year (2023-25) BCF Plan, which continues to act as a strategic enabler in the development of the Enfield Integrated Care Partnership (ICP).

The plan includes proposed local targets for the national BCF metrics that measure the performance of the integrated health and care system. The targets represent an ambitious aim to continue with the post-pandemic recovery and have been developed in partnership with social care and ICB colleagues. Below is an update on the metrics achieved for 2023 /2024

Metric 1
Reducing avoidable admissions to hospital

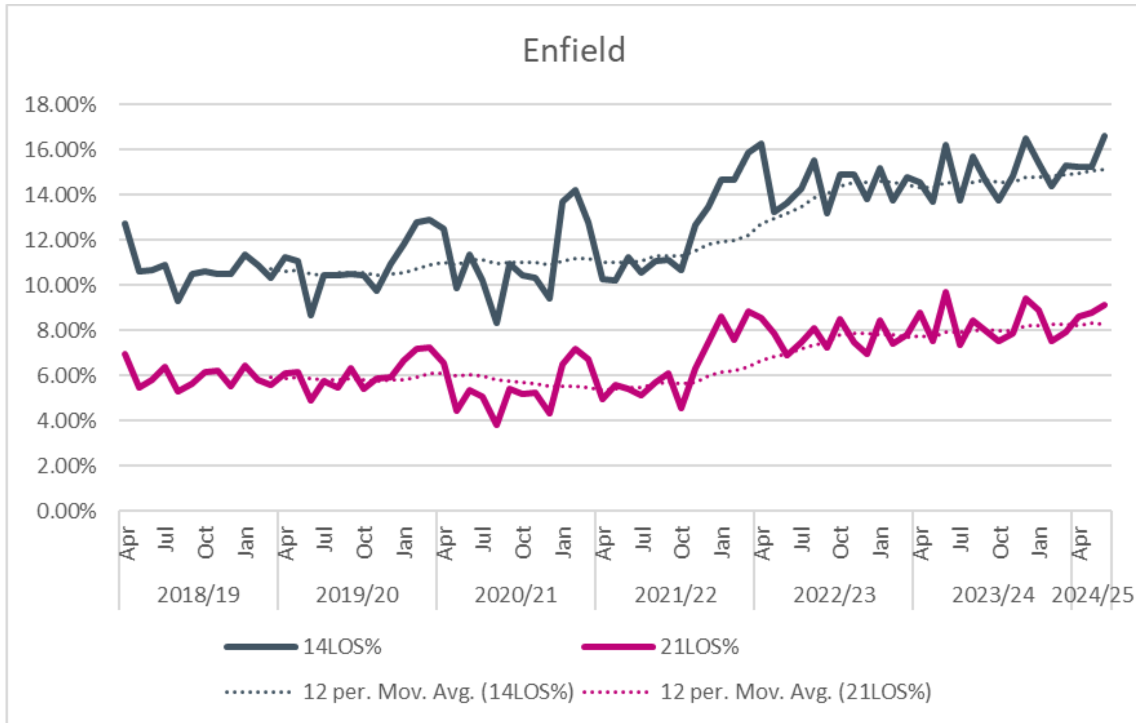


Yearly Summary

Local Authority	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Barnet	2,219	2,121	1,693	2,037	1,917	2,228
Camden	1,438	1,319	975	1,214	1,099	1,228
Enfield	2,368	2,232	1,678	1,926	1,920	1,903
Haringey	1,622	1,463	1,157	1,343	1,300	1,334
Islington	1,564	1,355	997	1,261	1,109	1,135

Avoidable Admissions are on a downward trend within Enfield, although at nearly 2,000 in 2023-24 are still too high. The trend in Enfield reflects that of the NCL generally. 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 smaller levels than Barnet whereas in previous years, we have been the higher borough.

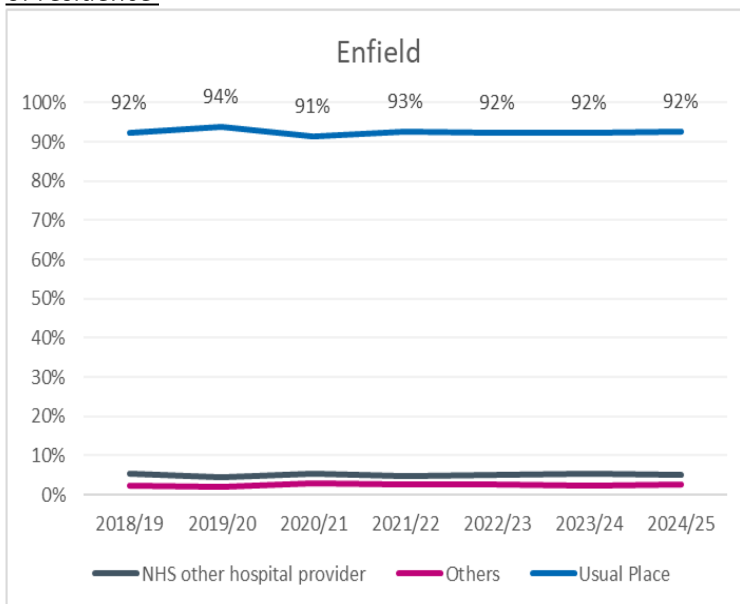
Metric 2
Reducing the proportion of people whose length of stay in an acute hospital bed exceeds both 14 and 21 days



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.

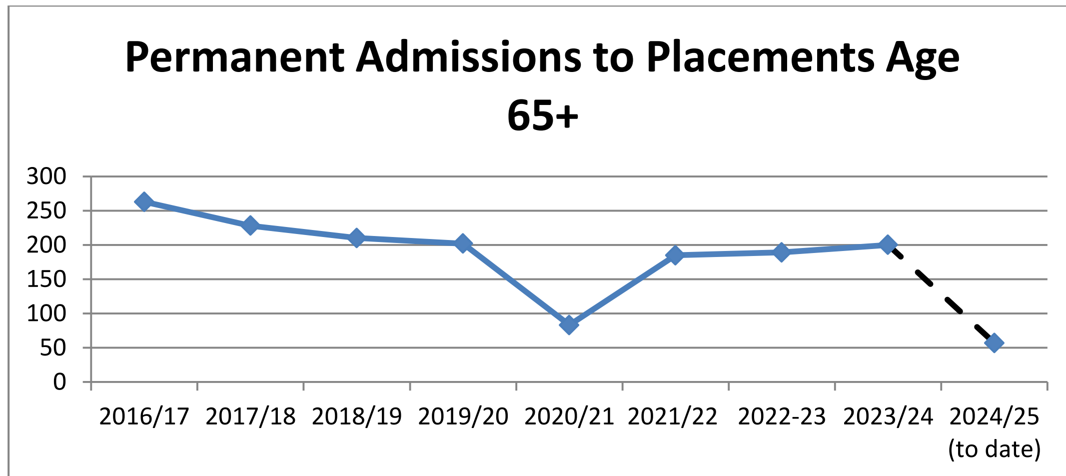
Metric 3

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



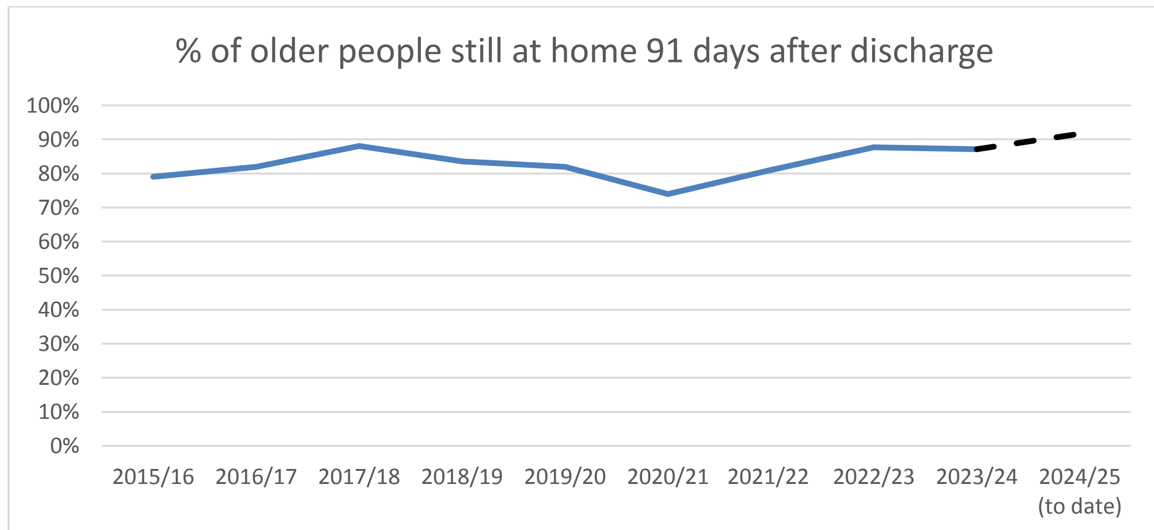
Discharge to the usual place of residence has hovered around the 92% mark for several years now, although the trend over the last few years has been slightly downward. Enfield broadly mirrors the NCL average with end of year figures for 2022-23 of 92.3% (Enfield) and 92.5% (NCL)

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+ had generally been falling steadily since 2016-17 (excluding the covid impacted figures of 2020-21). However, post covid, current pressures and trends have started to see increasing demand on these services.

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



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.

The Enfield BCF Plan is largely a continuation of the expenditure plan for 2023-24 with adjustments for inflation, and new allocations to support improved hospital discharge.

Recommendations

- the HWB note:
  - That proposals for distribution of the BCF 2024-2025 are agreed by the Health & Wellbeing Board (HWB), following consultation and agreement with the Chair of HWB.
  - BCF plans are developed locally in HWB areas by the relevant local authority and health commissioners.
  - BCF plans have been agreed by the ICB (in accordance with ICB governance rules) and the Director of Health & Adult Social Care, prior to being signed off by the HWB. BCF partners have submitted a narrative plan and a planning template, providing details of expenditure from BCF funding sources, capacity and demand, as well as ambitions and delivery plans for BCF metrics that require to be signed off by (or on behalf of) the HWB
  - The Enfield BCF 2023-25 plan has been reviewed for 2024/25 assured and moderated regionally. The plan has now been put forward for approval by Better Care Fund England, in consultation with DHSC (Department for Health & Social Care) and DLUHC (Department for Levelling Up, Housing & Communities).
  - To grant delegated authority to the Director of Health & Adult Social Care, and Director of Integration NCL ICB to make further decisions relating to Enfield's BCF Plan and associated national reporting within the parameters set out in this report, in consultation and agreement with the Chair of HWB.

Background: The Better Care Fund (BCF)

- Since 2015, the BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by 2 core objectives, to:
  - enable people to stay well, safe, and independent at home for longer
  - provide people with the right care, at the right place, at the right time
- The BCF achieves this by requiring integrated care boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under Section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.
- The BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services, as well as supporting the delivery of next steps to put People at the Heart of Care. The BCF facilitates the smooth transition of people out of hospital, reduces the chances of re-admission, and supports people to avoid long-term residential care. The BCF is also a vehicle for wider joining up of services across health and local government, such as support for unpaid carers, housing support, and public health

- Better Care Funding has increased by 5.66 % in 2024/25 and this increase has been applied to all BCF schemes. Improved Better Care Fund (iBCF) funding by 5% 2023-24 and Disabled Facilities Grant (DFG) funding increased by 1%.

- Schemes proposed for inclusion within the Section 75 Agreement for 2024/2025 are broadly aligned to schemes included within the Section 75 Agreement of 2023/2024. Proposed changes since 2023/2024 include additional funding to support hospital discharge.

- Funding shall be distributed in 2024-2025 to support safe and timely discharge from hospital to home or an appropriate community setting. This builds on funding included within the BCF of 2023-2024, to speed up the safe discharge of individuals over the winter period.

- In 2024 to 2025, the discharge fund will focus on growing social care capacity in ways that have the greatest possible impact on:

  - reducing delayed hospital discharges
  - planning services sufficiently far in advance to enable providers to make appropriate workforce capacity plans
  - learning from evaluation of the impact of previous discharge funding
  - improving collaboration and information sharing across health and social care services

Governance and Monitoring

- The schemes within the Better Care Fund are discussed at the Joint Health and Social Care Commissioning Board and approved by the Director of Adult Social Care for Enfield Council and the Director of Integration (Enfield), NCL ICB.

- The schemes are monitored by the Better Care Fund Delivery Group, who report to the Joint Health and Social Care Commissioning Board, the Better Care Fund Executive and the Health and Wellbeing Board. A quarterly return to NHS England is completed which evaluates delivery against jointly agreed priorities, as well as end-of-year returns.

- The NCL ICB is invoiced on a quarterly basis in arrears after the agreement has been signed and finalised.

- Monthly meetings are held between senior officers of the NCL ICB and Enfield Council to discuss and agree on funding amendments.

- Spend from the Better Care Fund and improved Better Care Fund has been utilised to meet increased demand and cost for services across health and social care and to deliver some stability within existing service provision following a significant period of austerity and much reduced central government funding across the health and social care system. This funding enables the health and social care system to continue to deliver services which meet statutory requirements. It has also been used to fund new service developments which prevent escalation of need/crisis and admission to hospital and which facilitate timely hospital discharge

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Report Author: Matt Casey
Head of Service: Strategy & Service Development, Adult Social Care
Matt.casey@enfield.gov.uk
Tel. 020 8132 2456

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 11 JUNE 2024

MEMBERSHIP

PRESENT (Chair) Cllr Alev Cazimoglu (Cabinet Member for Health & Social Care), Cllr Abdul Abdullahi (Cabinet Member for Children's Services), Cllr Emma Supple (Conservative Member representative), Dr Shakil Alam (NHS North Central London Integrated Care Board), Albie Stadtmiller (Healthwatch), 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 Pamela Burke (Voluntary Sector)

OFFICERS: Glenn Stewart (Consultant in Public Health), Jane Creer (Secretary)

Also Attending: Peppa Aubyn (NHS NCL ICB – Assistant Director (Enfield)), Jose Acuyo (Head of Policy & Research, ICB), Dr Alpesh Patel (NHS NCL), Gayan Perera (Public Health Intelligence Manager, LBE), Dr Chad Byworth (Public Health Team, LBE), Victoria Adnan (Policy & Performance Manager, LBE)

1
WELCOME AND APOLOGIES

Cllr Alev Cazimoglu, Chair, welcomed everyone to the virtual meeting and invited attendees to introduce themselves.

Apologies for absence were received from Clare Henderson, Andrew Wright, Debbie Gates, and Mark Tickner.

2
DECLARATION OF INTERESTS

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

3
STATEMENT ON JHWBB PURPOSE, POWERS AND RELATIONSHIP IN ICB/ICS ERA

RECEIVED the slide presentation, introduced by Dudu Sher-Arami, Director of Public Health, providing a useful update on key responsibilities of the Health and Wellbeing Board and how it relates to the ICS and population health and integrated care strategy.

1. Legislation in 2012 brought in health and wellbeing boards and identified their key responsibilities: to produce a joint strategic needs assessment, to produce a pharmaceutical needs assessment, and to produce a joint local health and wellbeing strategy.
2. The joint local health and wellbeing strategy (JLHWS) was a local borough strategy identifying priorities for the health and wellbeing of Enfield residents.
3. ICSs must produce integrated care strategies: ours covered North Central London (NCL). These complemented each of the health and wellbeing strategies.
4. The purpose of population health and integrated care strategies was to identify the needs that could be addressed better at ICS level.
5. New government guidance was published in February 2024 relating to the preparation of integrated care strategies.
6. The integrated care strategy should reflect and complement, not supersede, any other place-based (borough) plans and strategies.
7. The 5-year joint forward plan was under the governance of the ICB but was co-produced with local authorities, partner Trusts and stakeholders.

IN RESPONSE

8. In response to the Chair's queries on the complexity of the structure, and accessibility of strategies to the public, it was advised that the Joint Strategic Needs Assessment (JSNA) was a public document and the JLHWS would be published once approved. The JLHWS was written to be easy to use and to enable accessibility to the public. The JSNA website contained a lot of information and was accessible to the public. Feedback was sought on the JSNA and partners were encouraged to collect feedback and for this to be brought into the document. There was synergy between these strategies and population health and they were purposely aligned across the life course approach. The core offer for NCL set out the five year programme of change to bring all five boroughs up to the core offer.
The Chair highlighted the importance of reviewing governance structures and reducing duplication and making the structure simpler, and that this should be an action for Health and Wellbeing Board.

ACTION: Dudu Sher Arami / Peppa Aubyn

9. Pamela Burke raised that the Carers Partnership Board did not appear on the slides. The Director of Public Heath confirmed that groups needed to be added in. It was raised also that on the Borough Partnership Board there was no-one yet appointed with responsibility of Carers Lead and this appointment was crucial. In response, the NCL community engagement alliance was highlighted, and the current scoping of how members were elected onto the Borough Partnership Board.

4

LBE / NCL VACCINATION / INFECTION CONTROL UPDATE WITH SPECIFIC MEASLES / CHILDHOOD INFECTIOUS DISEASE STATUS REPORT

RECEIVED the slide presentations Statutory Notifications of Infectious Diseases and Childhood Vaccine Update, and the Immunisation Plan,

introduced by Gayan Perera, Public Health Intelligence Manager and Dudu Sher-Arami, Director of Public Health.

1. The latest weekly figures across NCL boroughs showed numbers of measles and whooping cough cases increasing, particularly in Enfield. This was part of a national increase in cases since the start of the year. The majority of cases had been among unvaccinated young people. Illness suffered by break through cases to those immunised was noted to be much less severe.
2. The MMR dose 2 vaccine uptake was around 72% in Enfield. Generally Enfield's uptake figures were lower than NCL averages. Differences in uptake rates by deprivation quintile, by ethnicity, and by language spoken were highlighted.
3. With reference to whooping cough, uptake of the 6-in-1 and the 4-in-1 vaccine in Enfield was lower than the NCL average.
4. The Immunisation Plan had involved a sustained programme of work over recent years, but remained challenging.
5. Enfield had an immunisation action plan starting from pregnancy to older adulthood with activities to improve vaccine uptake, and a huge amount of capacity had been built into primary care for delivery of immunisation.

IN RESPONSE

6. In response to the Chair's queries, it was confirmed that changes in uptake over time were monitored, but were difficult to quantify. However, it was still important to continue this work and to disseminate accurate information. General reduction in immunisation take-up was a national trend and multi-factorial problem, and continued to be an issue.
7. The Chair asked about targeting specific communities with low uptake, such as traveller communities. It was advised that some of the most important work done was in training officers working in family hubs how to have positive vaccination conversations with families. Catch-up clinics and school visits and community health events were run, and there was a significant amount of community focussing. An opportunistic immunisation pilot project at North Mid Hospital was also highlighted.
8. It was confirmed that children's immunisation data was captured as long as they received vaccination at a school, pharmacy, or GP practice.

5
CURRENT ICB RESTRUCTURING STATUS

NOTED that this item was deferred to the next meeting of the Board, as the process was still ongoing. It was confirmed this was not affecting operational services.

The Chair requested an update from the ICB in respect of the restructure before October. Peppa Aubyn would circulate an action and a timeline.

ACTION: NCL ICB

6

JOINT HEALTH AND WELLBEING STRATEGY RENEWAL PROGRESS UPDATE

NOTED that all Board members had received the draft Enfield Joint Local Health and Wellbeing Strategy 2024-2030.

Victoria Adnan, Policy and Performance Manager and Chad Byworth, Registrar, provided a verbal update on progress.

1. The JLHWS was in its final stages of development.
2. Following the joint development event between the Health and Wellbeing Board and the Borough Partnership in February, focus areas for the first biennial action plan were selected. These are:

- Start Well – Priority 3: Support children and young people to maintain good emotional wellbeing and mental health.
- Live Well – Priority 2: Support residents to manage their major conditions.
- Age Well – Priority 2: Help every Enfield resident prevent the risks of age-related ill health.

3. Within each priority, a set of indicators drawn from the NCL Population Health Outcomes Framework would enable progress to be tracked. At six-month intervals, partners would be asked to identify and update internal progress measures.
4. The proposed action plan template had been circulated to all partners.
5. LBE officers will host several action planning clinics over the summer with members of the Board, to support joint development of the action plan.
6. The JLHWS would be presented to the Council in September, with final approval of the action plan by the Board in October.

IN RESPONSE

7. Pamela Burke raised that there should be specific inclusion of young carers in the strategy, as discussed at the previous Board meeting. Also, unpaid carers should be meaningfully mentioned in the action plan. The Carers Partnership Board would like to work with the authorities in a joint action plan for carers. Dudu Sher-Arami would take this feedback forward.
8. The Chair welcomed the progress made and the proposed action planning.

7
UPDATE ON IMPENDING CQC INSPECTION OF LB ENFIIELD ADULT SOCIAL CARE

RECEIVED a verbal update with presentation slides by Doug Wilson, Director of Adult Social Care.

1. The Adult Social Care Service in Enfield was last inspected in 2009/10, but the forthcoming Care Quality Commission (CQC) inspection would be a different process.
2. The inspection would focus on four areas:

How we are working with People; Providing Support; Ensuring Safety; Leadership and Workforce.
3. The CQC would look at a variety of evidence.
4. The letter of notification was received three weeks ago, and the written submission was due on 12 June 2024. Over 90 pieces of supporting evidence would be submitted.
5. The inspection could take place within six months.
6. The ratings were Inadequate; Requires Improvement; Good; Outstanding.
7. The department would engage with stakeholders and partners, especially with those people likely to be seen by CQC.
8. The Adult Social Care Service was well prepared and welcomed the inspection.

IN RESPONSE

9. The Chair expressed thanks to all the officers working hard to prepare for the inspection, and she knew that Enfield had a good story to tell.
10. Cllr Supple also welcomed the good evidence which would be submitted by the service.

8
FUTURE SUBJECT ITEMS FOR SPOTLIGHT AND DISCUSSION

1. The next Board meeting in October would receive the JLHWS and action plans.
2. Cllr Abdullahi confirmed he had requested an agenda item from SEND and Inclusion Service, and a discussion regarding the challenges around autism diagnoses.
3. In response to queries on behalf of Enfield Voluntary Action in respect of voluntary sector organisations' concerns for their future, Doug Wilson confirmed that proper discussions would take place between the Council and the organisations involved, outside of the Board's remit.

9
ANY OTHER BUSINESS - DR CHAD BYWORTH

1. An update on progress on the Suicide Prevention Plan would be brought to the Board in October.
2. The Chair recorded thanks on behalf of Health and Wellbeing Board to Dr Chad Byworth, ST1 Registrar, for the contributions he made to the Suicide Prevention Plan. The Director of Public Health echoed the thanks to Dr Chad Byworth as he would shortly be moving from Enfield to his next placement and he had also done a lot of work on the JLHWS and action plans.

10
MINUTES OF THE MEETING HELD ON 4 DECEMBER 2023

AGREED the minutes of the meeting held on 4 December 2023.

11

NEXT MEETING DATES

NOTED the next Board meeting date: Tuesday 8 October 2024, 6:30pm on Teams.