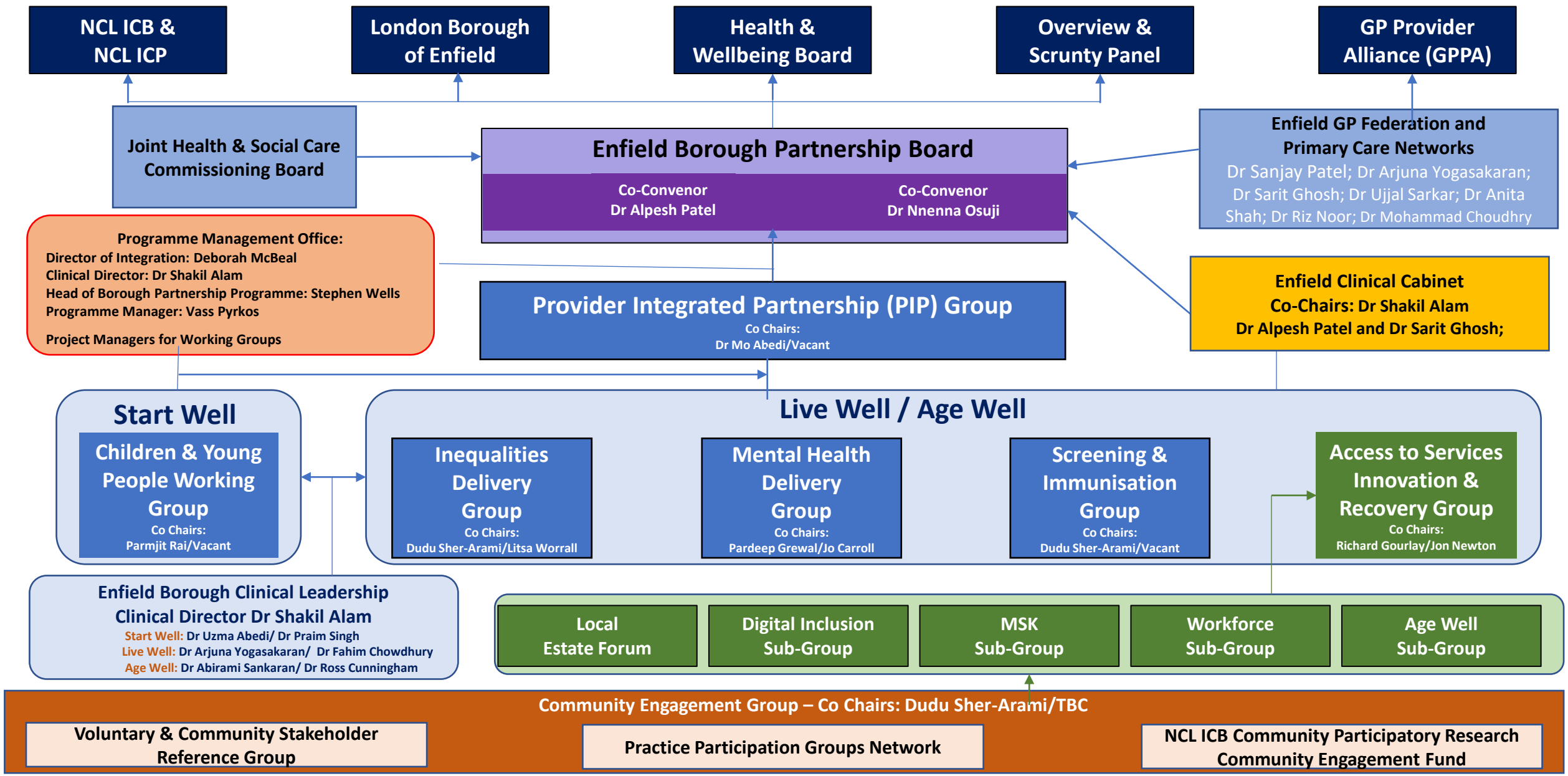
North Central London Integrated Care System

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

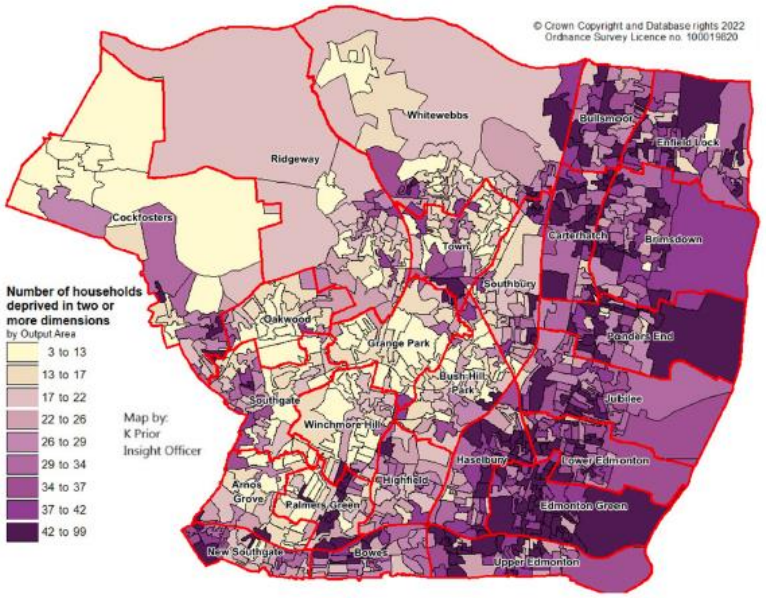
The priority areas of the group include:

- 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

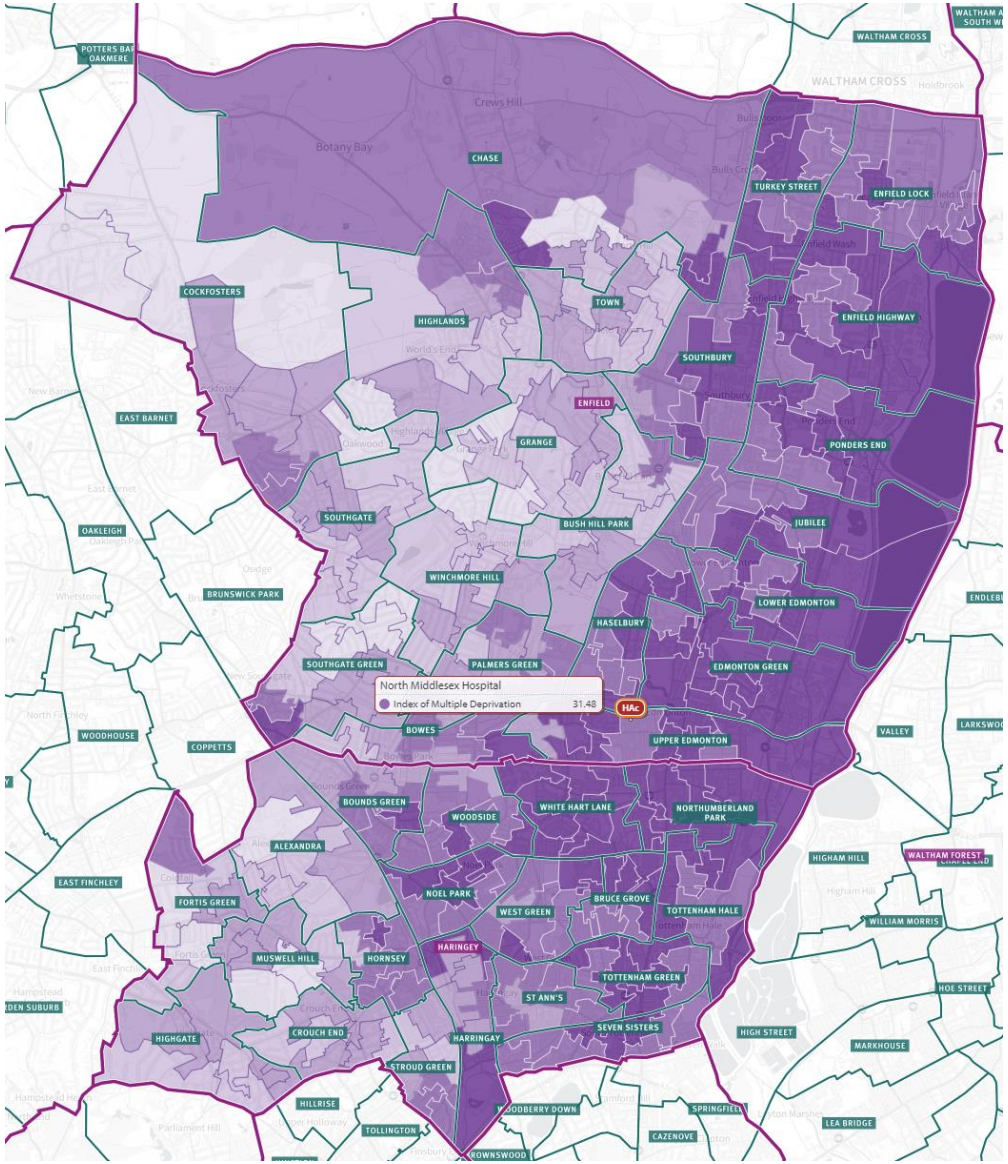
Wards which are included within the Healthy Community Zones are those across Enfield and Haringey which are made up of the 20% most deprived LSOAs as defined by the IMD (2019)

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

	Address Wider Health Determinants	Building Community Power	Adopt Healthy Lifestyles	Health Inclusion of Vulnerable Groups	Promote Active Health Management
Category					
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**

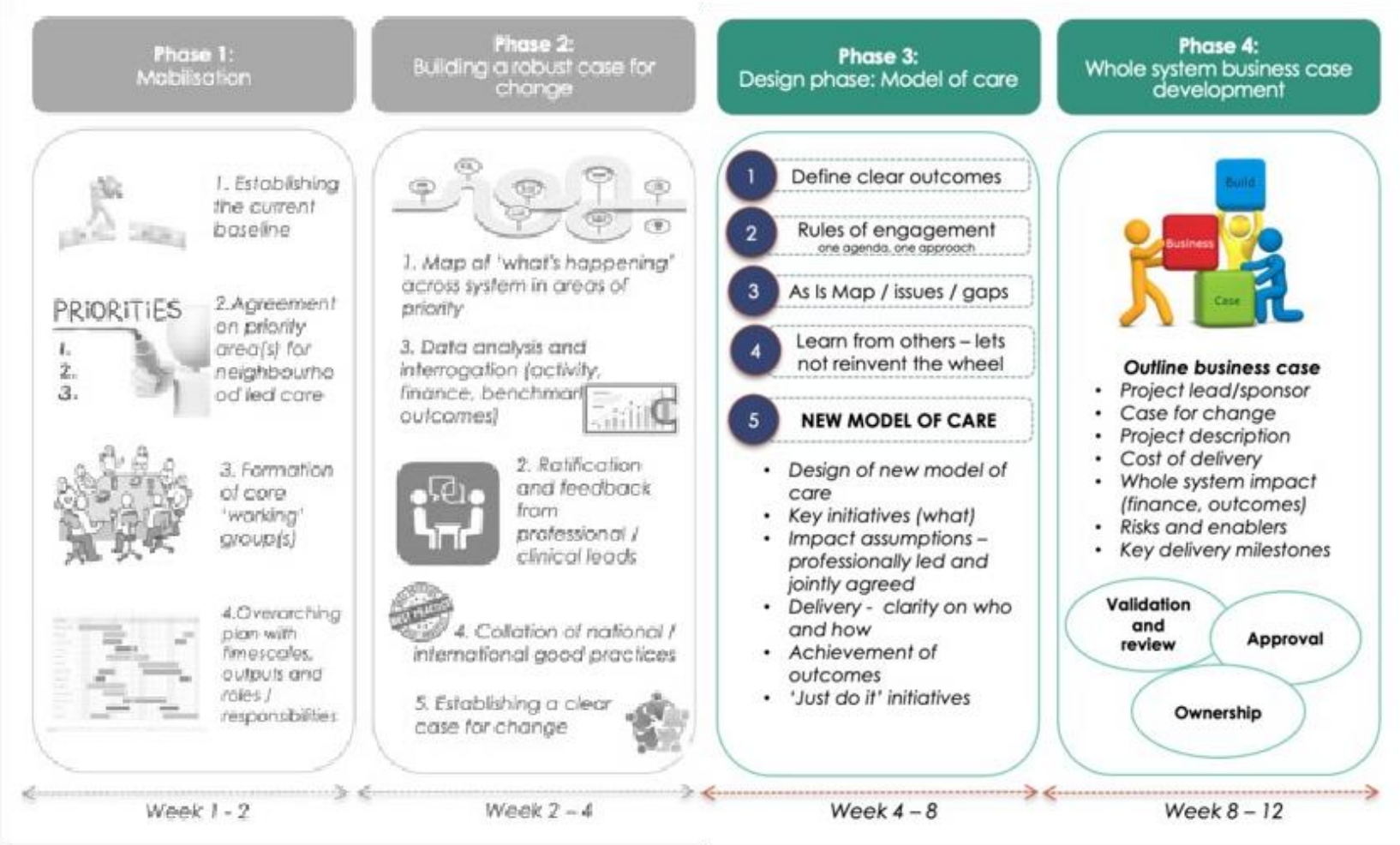
Enfield Borough Partnership

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.

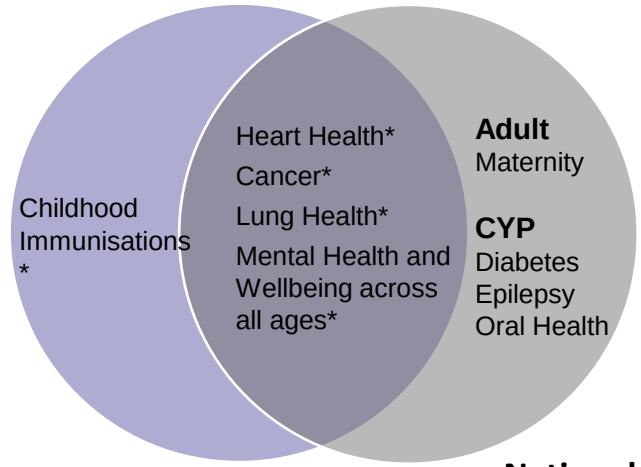
Focusing on the root causes of poor health.

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)