Overview & Scrutiny Committee Business Meeting

NCL Integrated Care Board and Enfield Borough Partnership Update

15th January 2024

Evolution of NHS Commissioning in North Central London

Enfield Clinical Commissioning Group (CCG)

CCGs was established following the Health & Social Care Act in 2012, to replace Primary Care Trusts from 1st April 2013

North Central London Clinical Commissioning Group

Established following the merger of the CCGs in North Central London: Barnet, Camden Enfield, Haringey Islington to form a single NCL CCG from 1st April 2020 in order to ensure:

- Greater strategic commissioning as an Integrated Care System working across larger populations.
- Greater coordination between Boroughs that support improved opportunities for seamless integrated care to deliver by quality and experience for patients and more cost effectiveness.
- Greater alignment of commissioning activities and sharing best practice across disciplines to enable a more consistent co-ordinated approach with our stakeholders and services on care currently provided and in development.
- A move away from transactional contracting and towards a more strategic outcomes approach.
- Improved consistency in planning and decision making in order to underpin our commitment to reducing variation and inequalities.
- Effective utilisation of limited commissioning resource by reducing duplication in effort, inconsistency and fragmentation of approach and the use of financial resources that ensures cost efficiency and value for money.

Evolution of NHS Commissioning in North Central London

North Central London Integrated Care Board

- Established from 1st July 2022 and replacing NCL CCG to take on the NHS planning functions previously held by the CCG, as well as some additional planning roles from NHS England.
- NCL ICB is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area.

Integrated Care Systems (ICSs) will become statutory organisations and will be responsible for strategic commissioning and planning

- ICSs will merge the functions of CCGs alongside some of the existing NHS England functions and with new strategic functions. The primary functions of a future ICS (as described in legislation) will be to arrange for the provision of services for our population for the purposes of the health service in England, supported by additional functions such as:
  - Leading strategic planning and commissioning
  - Allocating financial resources
  - Coordinating and overseeing service delivery
  - Facilitating service transformation and pathway redesign
  - Leading emergency planning and response
  - Stakeholder and public engagement – making sure patient and resident voices are heard

Evolution of NHS Commissioning in North Central London

North Central London Integrated Care Board

The principles informing the work of NCL ICB are:

- **Taking a population health approach:** We need to continue to develop the way we plan services to take into account the needs of people and communities, acknowledging the wider determinants of health. This will support tackling health inequalities across and within the communities we serve.
- **Evolving how we work with communities:** Embedding co-design with partners and communities in planning and designing services and developing systematic approaches to communication and community engagement.
- **Continued focus on boroughs:** Partnership working within boroughs is essential to enable the integration of health and care and to ensure provision of joined up, efficient and accessible services for residents.
- **Learning as a system:** We have learnt a lot as a system throughout both our response to COVID-19 and our efforts to recover. Capturing this learning across primary care, social care, community, mental health and hospital services will guide our next steps for both individual services and system approaches.
- **Acting as a system to deliver a sustainable health and care system:** Providing high quality services enabled by workforce, finance strategy, estates, digital and data.

NCL ICB key responsibilities

NCL ICB is a statutory organisation responsible for specific functions that enable it to deliver against four core functions.

Developing a Plan	Allocating Resources	Establishing joint working arrangements	Establishing Governance arrangements
To meet the health needs of the population within their area, having regard to the Partnership's Strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long-Term Plan commitments are met.	To deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.	With partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.	To support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.

NHS Service providers in North Central London

NHS Providers

- Barnet, Enfield and Haringey Mental Health NHS Trust
- Camden and Islington NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- Central London Community Healthcare NHS Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- North Middlesex University Hospital (including provision of Enfield Community Servcies)
- Royal Free London NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- The Tavistock and Portman NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust

Primary Care

- 209 GP practices across 32 Primary Care Networks (PCNs)
- Enfield Borough –47 GP practices in 5 PCNs

Why do we have ICSs?

The core purposes of Integrated Care Systems are to:

- NHS organisations, local councils and other partners have increasingly been working together across North Central London in recent years to improve our population's health and reduce inequalities through greater collaboration.
- Working together, partners have developed better, more coordinated and convenient services.
- We will continue to invest more to keep people healthy and out of hospital and set shared priorities for the future.

Our NCL ICS structure

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

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

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

System

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

Place

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

Neighbourhoods

Building on primary care networks (PCNs), neighbourhoods support multidisciplinary working between frontline teams, population health management and relationships with communities.

Benefits of NCL ICS

Improved outcomes

Enable greater opportunities for working together as 'one public sector system' – ultimately delivering improved patient outcomes for our population

New ways of working

Accelerate our work to build new ways of working across the system to deliver increased productivity and collaboration

Working at borough level

Services will continue to be coordinated and delivered at borough level.

Reduce inequalities

Identify where inequality exists across in outcomes, experience and access and devising strategies to tackle these together with our communities

Efficient and effective

Help us build a more efficient and effective operating model tackling waste and unwarranted variation

System resilience

Help us become an system with much greater resilience to face changes and challenges to meet the needs of our local population by supporting each other

Population health

NCL residents are at the heart of these changes, making sure contracts are built around long term benefits for communities, not activity

Collaboration

Organisations across the health and care sector will come together more often

Reduced bureaucracy

Transactional barriers will be removed to make collaborative working simpler and allow partners to organise themselves

Economies of scale

Help us make better use of our resources for local residents and achieve economies of scale and value for money

Working at borough level

Support the further development of local, borough-based Care Partnerships and Primary Care Networks

North Central London Integrated Care System

Strategic aims

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life. We have identified five strategic aims to deliver our ambition and achieve our purpose.

Start well

By working collaboratively with schools and communities, our children and young people will have:

- tools to manage their own health
- access to high quality specialist care
- safe and supported transitions to adult services.

Live well

Our residents will have early support for health issues including:

- equitable access to high quality 24/7 emergency mental and physical health
- world-class planned and specialist care services
- true parity of esteem between physical and mental health.

Age well

Our residents will:

- be supported to manage their long term conditions and maintain independence in their community
- receive seamless care between organisations
- experience high quality and safe hospital care that ensures they can get in and out of hospital as fast as they can.

Work well

Our workforce will:

- have equal access to rewarding jobs, work in a positive culture, with opportunities to develop their skills
- have support to manage the complex and often stressful nature of delivering health and social care
- strengthen and support good, compassionate and diverse leadership at all levels.

Enablers

We will provide key enablers for success, including:

- digital technologies to connect our health and care providers with our residents and each other
- a fit for purpose estate in each locality
- being a financially balanced health economy driving value for money for the taxpayer.

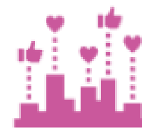
NCL Population Health & Integrated Care Strategy - Delivery Planning

This strategy begins defining how we work best across the whole NCL system, at Borough Partnership and neighbourhood levels to improve population health through a collective focus on **prevention, early intervention and proactive care**. Our shared ambition is:

'As an integrated care partnership of health, care and voluntary sector services, our ambition is to work with residents of all ages of North Central London so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death. We want to achieve this ambition for everyone.'

Our key principles for becoming an integrated population health system

We have identified **ten principles which will guide our news ways of working**, including examples of what that looks like. We will need to make substantial changes to how we work with our residents and communities, and this will involve changing how we prioritise our resources and efforts. The strategy sets out a clear **call to action to our providers** to reflect on how their organisations will look and feel when they align to these principles.



Trust the strengths of individuals and our communities

We listen to our communities and develop care models that are strengths-based and focussed on what communities need, not just what services have always delivered

Break down barriers and make brave decisions that demonstrate our collective accountability for population health

We understand each other's viewpoints and take shared responsibility for achieving our ICS outcomes and our role as anchor institutions

Build from insights

We create digital partnerships and use integrated qualitative and quantitative data to understand need

Strengthen our Borough Partnerships

We build a system approach for local decision making and accountability to support local action on physical and mental health inequalities and wider determinants

Mobilise our system's world class improvement and academic expertise for innovation and learning

We build the evidence base for population health improvement and innovative approaches to improve integrated working

Break new ground in system finance for population health and inequalities

We shift our investment toward prevention and proactive care models and create payment models based on outcomes.

Build 'one workforce' to deliver sustainable, integrated health and care services

We maximise our workforce skills, efficiencies and capabilities across the system

Support hyper-local delivery to tackle health inequalities and address wider determinants

We make care more sustainable by creating local integrated teams that coordinate care around the communities

Relentlessly focus on communities with the greatest needs

We embed Core20PLUS5 in all our programmes with a particular focus on inclusion health to make sure no-one is left behind

Deliver more environmentally sustainable health and care services

We prioritise activity which impacts our communities' health and environment, such as transport

Levers for change

To deliver on our ambition, there are six levers for change that will help us create the right conditions for sustainable delivery. We will need to work across the integrated partnership to make these real.

Making population health everyone's business

Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our front-line teams

Strengthening integrated delivery

Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams

Collaborating to tackle the root causes of poor health

Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities

Aligning resources to need

Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap

Becoming a learning system

Working with NCL's world-leading research and improvement expertise to become a system that is evidence-based and evidence-generating to deliver impact, value, scale and spread

Creating 'one workforce'

'One Workforce' across our health and care providers to provision a sustainable model that enables us to pivot towards a model that focuses on population health improvement

Start Well, Live Well, Age Well

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

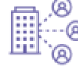
Reduced early deaths from cancer, cardiovascular disease and respiratory disease

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.

Deprived communities

Key communities – Adults

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

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

Key communities – Children & Young People

Wider determinants

Focusing on the root causes of poor health.

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

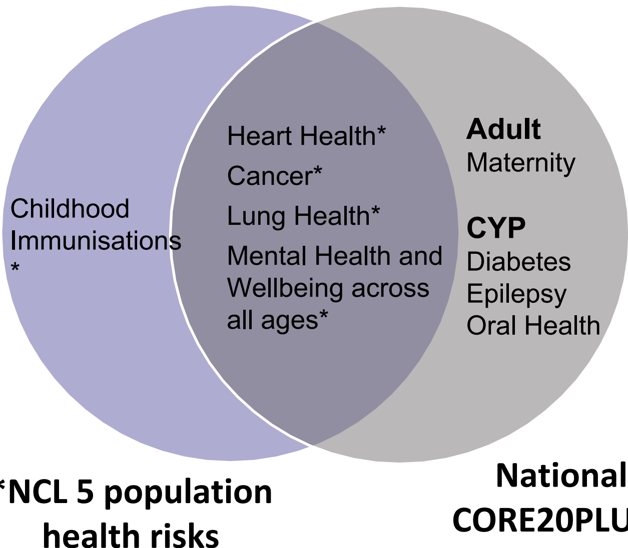
NCL population health risks

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



What will this mean for residents?

Integrated care and communities

What will be different?

"Joan is 80 years old and lives in Camden. She has heart disease and diabetes, and recently has been forgetting to take her medication. She has found it more difficult to manage over the last six months but wants to keep living at home. Joan's GP and social worker have developed a Care Plan in discussion with Joan. This means that the GP practice, district nursing and social care know how to work together to help Joan stay well and at home safely. If Joan's GP becomes concerned about something, he uses the 'Rapid Response' service to assess her the same day at home, which helps avoid trips to A&E. When Joan did fall last year and needed to be seen in hospital, she was assessed within 2 hours and a plan was in place quickly to get her home as soon as she was ready. Joan was supported to stay at home with a care package provided by social care, her domiciliary care workers were increasingly concerned about her forgetfulness so referred her to the memory clinic for a dementia assessment."

How integrated care can help

- ✓ Clearer information about local services and how to use them will be available to help residents access the right support.
- ✓ Better access to mental health care, with residents given more support to find the help they need.
- ✓ Patients ready to leave hospital will be discharged, through hospitals, community services and social care working together.
- ✓ Ensuring all people have their mental health care needs met, and providing interim support for when people are on waiting lists for complex care treatment.

Listening to our people and communities

Continuing to engage with and listen to our residents will inform the work of NCL ICS.

Patients involved in discussions and shared decisions about their care

Children and young people with epilepsy and their families being involved in the development of local epilepsy services

Use of technology both to increase access to services and to health information

Residents having access to online and video consultations and supported to feel digitally included

Better access to services

Introducing care navigators to signpost people to the right services

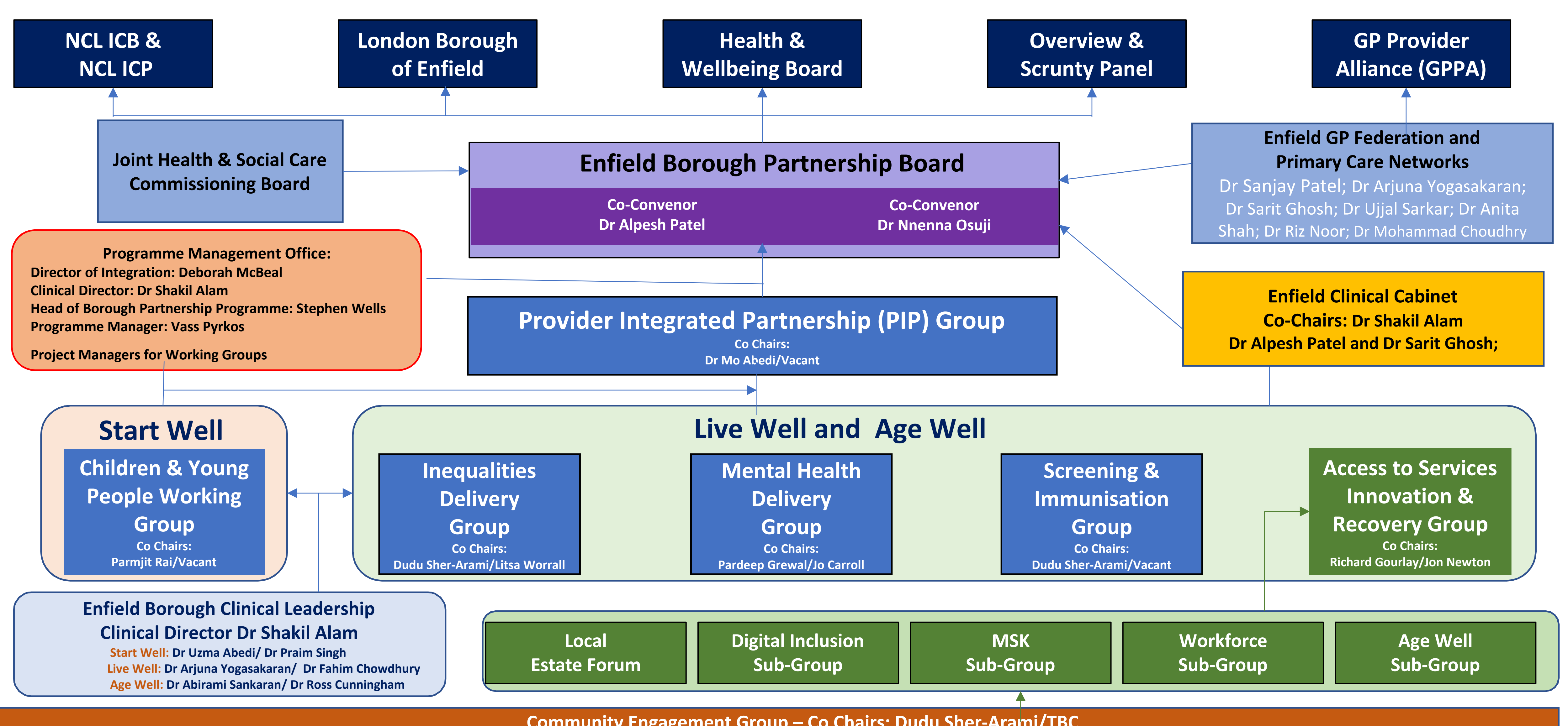
Empathy and understanding around cultural or disability-related needs

Trialling a new pathway for self-sampling smear tests

Access to clear and accessible information, including easy read versions and access to interpreters

Healthy Futures providing clear, accessible information for people with diabetes on how to look after their condition

Enfield Borough Partnership Update



Enfield Borough Place based Partnership - Governance structure April 2023 [Under Review]
NCL ICB & NCL ICP
London Borough of Enfield
Health & Wellbeing Board
Overview & Scrunty Panel
GP Provider Alliance (GPPA)
Joint Health & Social Care Commissioning Board
Enfield Borough Partnership Board
Co-Convenor Dr Alpesh Patel
Co-Convenor Dr Nnenna Osuji
Enfield GP Federation and Primary Care Networks
Dr Sanjay Patel; Dr Arjuna Yogasakaran; Dr Sarit Ghosh; Dr Ujjal Sarkar; Dr Anita Shah; Dr Riz Noor; Dr Mohammad Choudhry
Programme Management Office:
Director of Integration: Deborah McBeal
Clinical Director: Dr Shakil Alam
Head of Borough Partnership Programme: Stephen Wells
Programme Manager: Vass Pyrkos
Project Managers for Working Groups
Provider Integrated Partnership (PIP) Group
Co Chairs:
Dr Mo Abedi/Vacant
Enfield Clinical Cabinet
Co-Chairs: Dr Shakil Alam
Dr Alpesh Patel and Dr Sarit Ghosh;
Start Well
Children & Young People Working Group
Co Chairs:
Parmjit Rai/Vacant
Live Well and Age Well
Inequalities Delivery Group
Co Chairs:
Dudu Sher-Arami/Litsa Worrall
Mental Health Delivery Group
Co Chairs:
Pardeep Grewal/Jo Carroll
Screening & Immunisation Group
Co Chairs:
Dudu Sher-Arami/Vacant
Access to Services Innovation & Recovery Group
Co Chairs:
Richard Gourlay/Jon Newton
Enfield Borough Clinical Leadership
Clinical Director Dr Shakil Alam
Start Well: Dr Uzma Abedi/ Dr Praim Singh
Live Well: Dr Arjuna Yogasakaran/ Dr Fahim Chowdhury
Age Well: Dr Abirami Sankaran/ Dr Ross Cunningham
Local Estate Forum
Digital Inclusion Sub-Group
MSK Sub-Group
Workforce Sub-Group
Age Well Sub-Group
Community Engagement Group – Co Chairs: Dudu Sher-Arami/TBC
Voluntary & Community Stakeholder Reference Group
Practice Participation Groups Network
NCL ICB Community Participatory Research Community Engagement Fund

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

Clinical Director

- 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.

Start Well

- 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

Live Well

- 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

Age Well

- 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

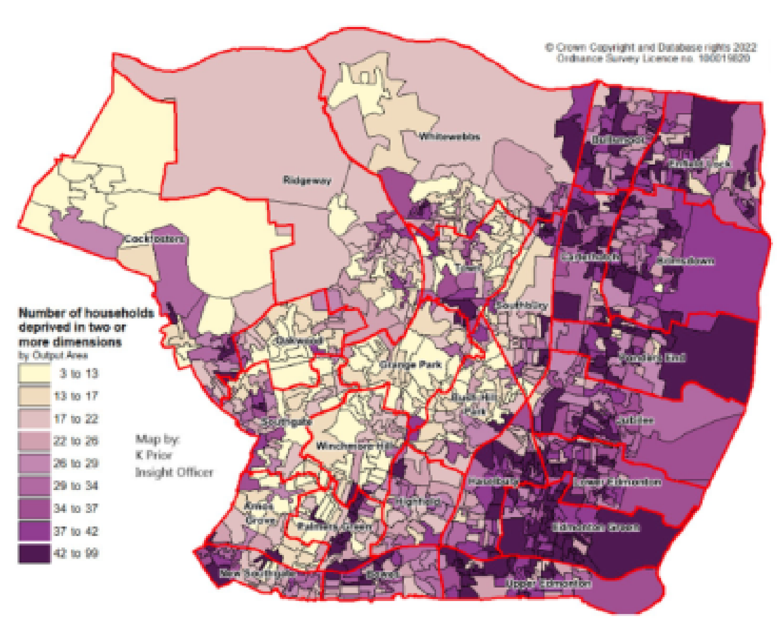
The priority areas of the group include:

- **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

CORE20 PLUS 5 A FOCUSED APPROACH TO TACKLING HEALTH

NCL ICB and Enfield Borough Partnership - Core20PLUS 5 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

Region	Theme, Aim & Objective
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.

Enfield Healthy Communities Zone

1. Purpose of a Healthy Communities Zone (HCZ)

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

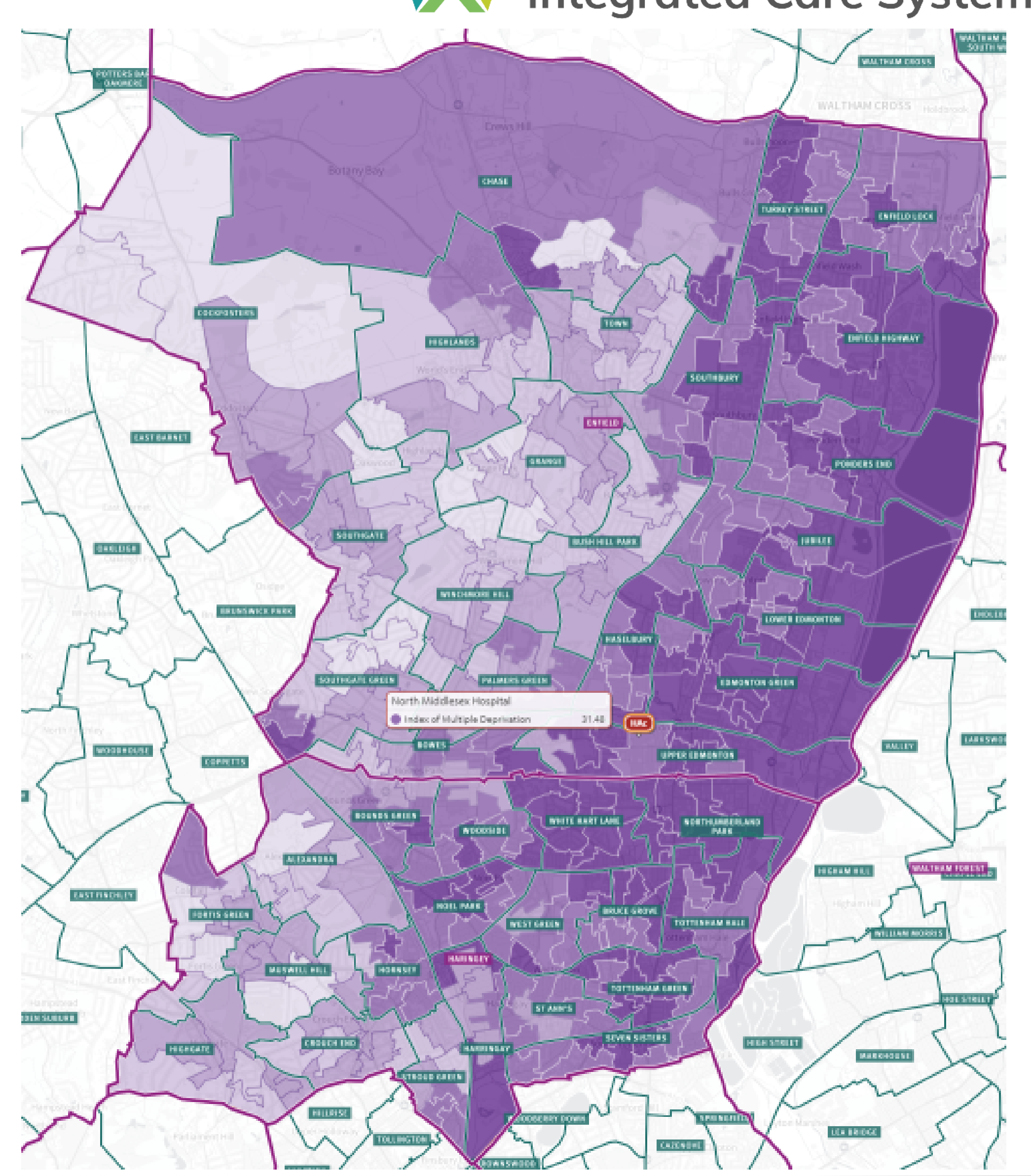
To maximise limited resources there will be a focus on particular segments of the population, in particular young children, underserved ethnic communities, severe multiple disadvantage (including working age), and older people

2. Healthy Community Zone Wards

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)

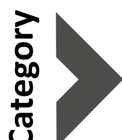
Enfield
Bowes
Chase
Edmonton Green
Enfield Highway
Enfield Lock
Haselbury
Jubilee
Lower Edmonton
Ponders End
Southbury
Southgate Green
Turkey Street
Upper Edmonton

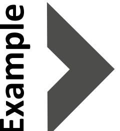
Haringey
Bounds Green
Bruce Grove
Harringay
Hornsey
Noel Park
Northumberland Park
Seven Sisters
Tottenham Green
Tottenham Hale
West Green
White Hart Lane
Woodside



3. All schemes in HCZ

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





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

Impact Size

Likelihood of Immediate Impact on Healthcare Utilisation

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

Screening & Immunisation Working Group

<u>Co-Chairs</u>: 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).

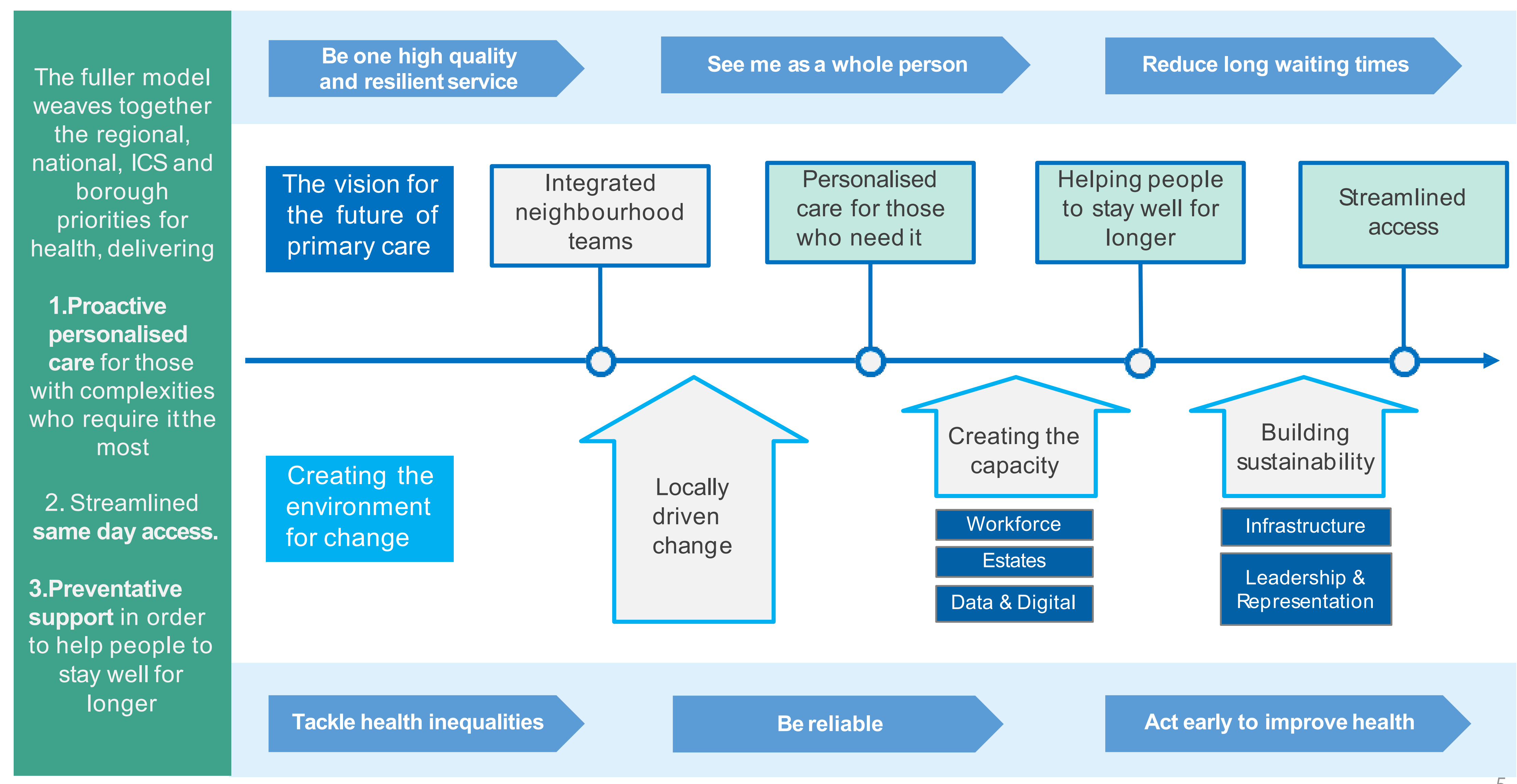
Key Focus of the Group is to:

- **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
Developing the Neighbourhood model

Fuller stocktake report –a priority for systems



Neighbourhood Development: Fuller Matrix

There are generally three types of people:

1. Those who are generally well, who don't have long term conditions. Need to risk stratify this cohort in terms of their risks of developing long term conditions, deprivation it, etc. The offer from public services is more preventative to keep them well with high levels of physical and mental wellbeing and keep them productive in society

2. Those people with one or more long term conditions who require ongoing care, not only from health service but from other organisations to help them self-manage their long-term conditions; and support them to prevent those conditions deteriorating and preventing them from getting new conditions.

	Generally well (lower continuity)	Long Term Conditions (medium continuity)	Complex Needs (high continuity)
Primary Prevention	Primary prevention – vaccination, screening, health-checks, smoking cessation…		
Ongoing Care (with prevention)		Long Term Condition Management with primary and secondary prevention	Highly personalised holistic care and support, including LTC management with primary, secondary and tertiary prevention
Reactive Care	Same-Day Care for new concerns	Same-Day Care for new concerns and exacerbations	Same-Day Care for new concerns and crises

17/01/2023 | Dr Steve Laitner 2022 - Free to use for NHS with source quoted

3. Those with complex needs including frail elderly, end of life dementia, children with complex needs, and working age adults with a mixture of mental health, drug and alcohol problems, who require a primary prevention model of care.

- Primary care struggles with providing same day care for people with new concerns, exacerbations of long-term conditions, and those with complexities, however there are some groups in society who need more continuity than others so we **need to focus on where our scarce resources should be**.

The matrix informs shaping the neighbourhood model in terms of the:

- **Who** – population health - the hierarchy of patient need in terms of health and wellbeing
- **What** we can do differently
- **How** - to include self-management, peer-to-peer support, i.e. find a different way of delivering, and therefore protect in terms of health inequalities
- **Identify our priorities including workforce requirements –develop a skilled workforce and the use of care navigators**

Roadmap to deliver the model of care

Proactive Anticipatory Care & Same Day Access