Delivering Population Health and Integrated Care Ambitions in Enfield

Enfield Health and Wellbeing Board

8th October 2024

Draft v3

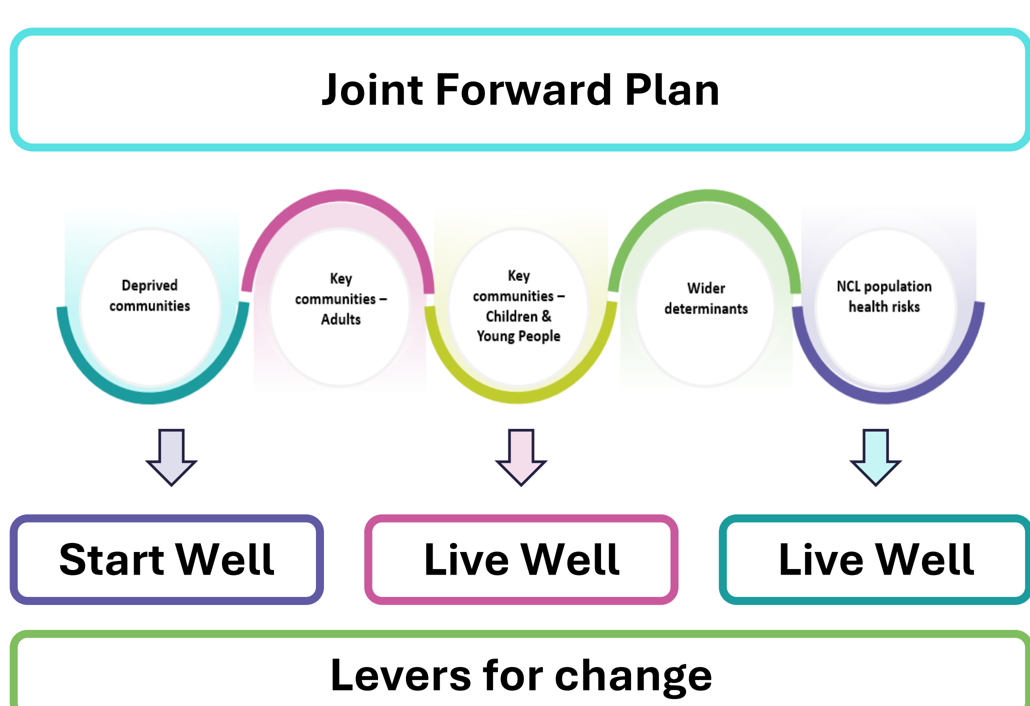
NCL Population Health & Integrated Care Strategy and Delivery Plan overview

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

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

- **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

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

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

Making the shift upstream with more preventative practice and care

Primary prevention: acting across the population to reduce risk	**Early diagnosis:** so we can identify health conditions early, to make treatment quicker and easier	**Secondary prevention:** halting progression of conditions or individual risk factors	**Prompt and urgent care:** treating conditions before they become crises	**Long-term care and treatment:** In both NHS and social care settings

	Primary prevention	Early diagnosis	Secondary prevention
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		

Working with communities to engage in prevention

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

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 VCSE and success measures

Health & Wellbeing/ borough strategies

Population Health Strategy and Delivery Plan

Childhood 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 received their second MMR dose by age 5.

System transformation programmes

Partner strategies and plans

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

- **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?

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?

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?

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?

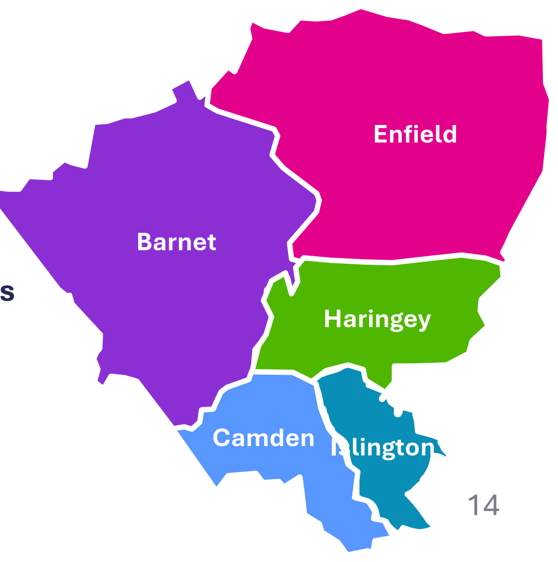
Wider determinants- Working with our Communities and embedding the VCSE.

- 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

Strategy delivery area	Start well	Live well	Age well
Vision	**Inequality in life expectancy for women -** worse than London, and getting worse		
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

- 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?