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North Central London's sustainability and transformation partnership

NHS
Enfield
Clinical Commissioning Group

Enfield ICP update

Enfield Health and Wellbeing Board

19 March 2020

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NHS Enfield





10 key lessons from existing ICS Leaders – King Fund

Establishing a locally-credible, ICS-specific vision and case for change early on is essential. It will provide a guiding framework to maintain commitment and alignment when parties come to discuss more difficult issues later.	**Developing a sense of 'place' provides the key focus for change.** 'Places' are keen to lead local improvements, but desire a clear framework for co-ordination from the 'systems' of which they are part.
The role of 'localities', 'places' and 'the system' is becoming established (with some variation of emphasis). NHS England Guidance confirms this expected 'division of labour.'	**ICS-level programmes *can* provide "top-down" leadership of change.** Systemwide collaboration builds the case for change with staff and stakeholders
An established ICS leadership group should meet regularly. Seniority and breadth of representation matters more than precise configuration. **Chief Executive-level ownership needs to extend into the detail**.	**Financial collaboration has a high profile in some – but not all – systems.** A (difficult) balance between beginning funding discussion early – getting difficult issues out in the open – and ensuring financial reform is led by new care models / improving outcomes.
Effective programme resourcing is essential. Some element of central funding is common to many current ICS areas. A small but dedicated team is required to push forward system re-design work.	**Most – but not all – systems have minimised structural change –** using collaboration agreements / collaborative governance rather than new types of contract or creating new organisations. Bespoke governance arrangements may be needed for specialist providers.
Systems should **use the pre-history of the ICS to their advantage,** and spread best practice locally as well at to/from wider areas. Acute service reviews may be helpful here.	**Non-executive, staff, stakeholder and citizen engagement is growing** as ICSs develop and adapt their structures. Local authority support in particular can't be taken for granted

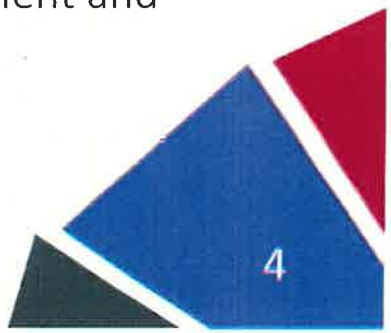
How an ICS might look in North Central London

Following the co-ordinated programme of events exploring potential future arrangements consensus was reached on what a potential integrated care system across North Central London might look like.
This would see a single NCL wide strategic commissioner working with a borough based partnership in each borough supporting frontline integration of services at a community level
This is summarised in the diagram below:

Our design principles

Some of the key principles of this framework are that:

- There should be **strong public/resident voice** at all levels of the structure along with strong clinical and care leadership.
- **Population based approach** and a **focus on prevention** will be a critical feature at all levels.
- The operational relationships between levels and functions is as critical as where the function sits.
- The partnerships and overall system are a **collective initiative of public sector bodies** working together in the public interest.
- The **borough is the dominant level for planning and delivery of health and care services**, underpinned by NCL-wide enablers and longer term collective planning.
- Local authority funding should be managed entirely at borough level, with effective mechanisms for considering the impact of wider determinates of health on residents outcomes There will need to be an **evolving relationship with the current health regulator** to develop new ways of mutual support assessment and development of system responses to cross organisational issues



Our approach

Communities as building blocks of integrated care:

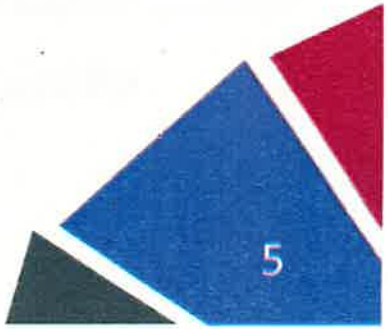
- Neighbourhoods to build on the core of the newly established primary care networks and enable greater provision of proactive, personalised, coordinated and more integrated health and social care through multidisciplinary teams taking a proactive population based approach to care through consistent pathways. 30 PCNs developed across boroughs

Boroughs as the critical point of integration of planning and coordination of services

- Majority services will continue to be planned and coordinated at a borough level
- Boroughs to build local plans based on local population need

Working across NCL where it makes sense

- Those activities where a larger footprint increases the impact or effectiveness of function-
- Enabling elements such as digital and large-scale reconfiguration programmes- e.g. NCL wide PHM platform



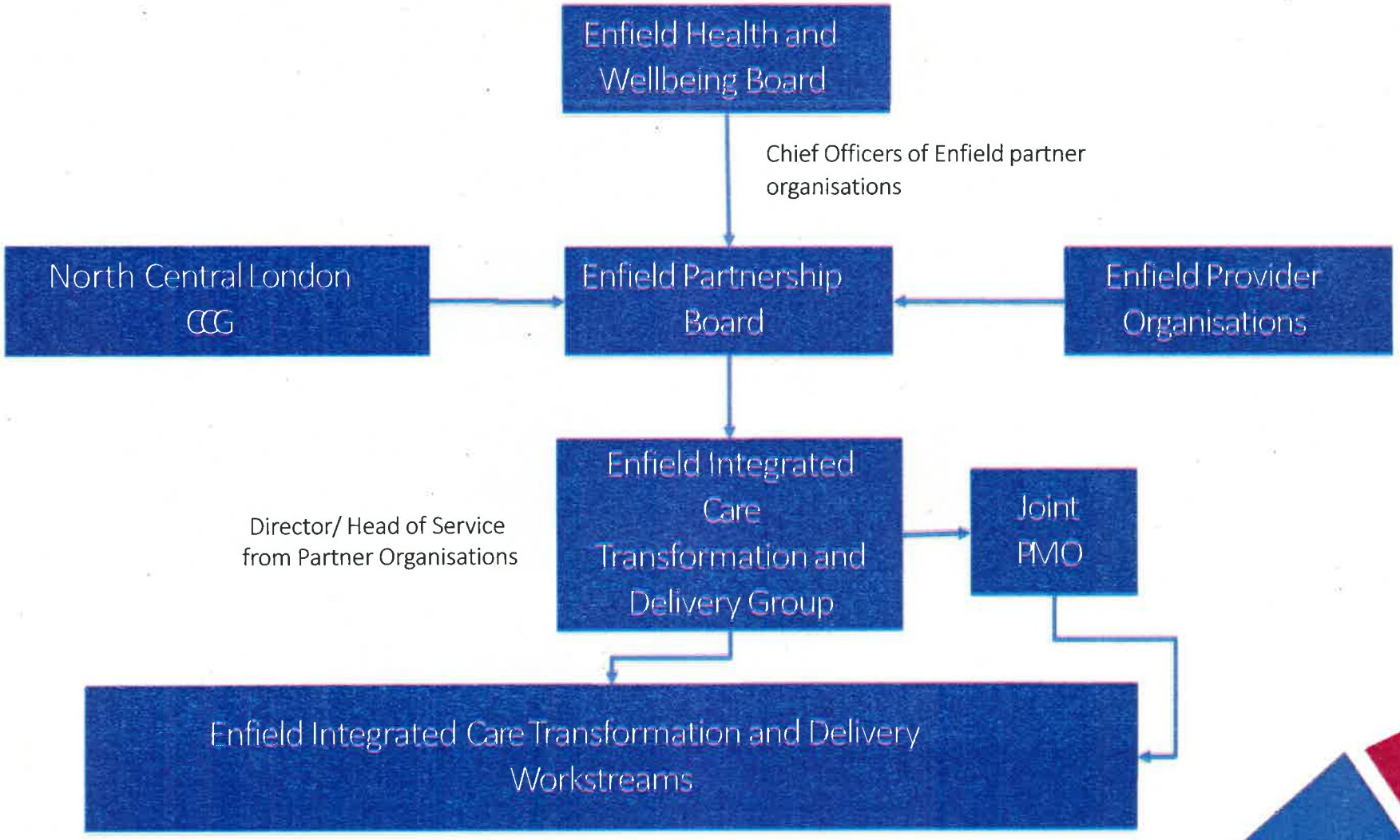
Borough priorities and workstreams

The below table summarises key priorities and workstreams in each borough

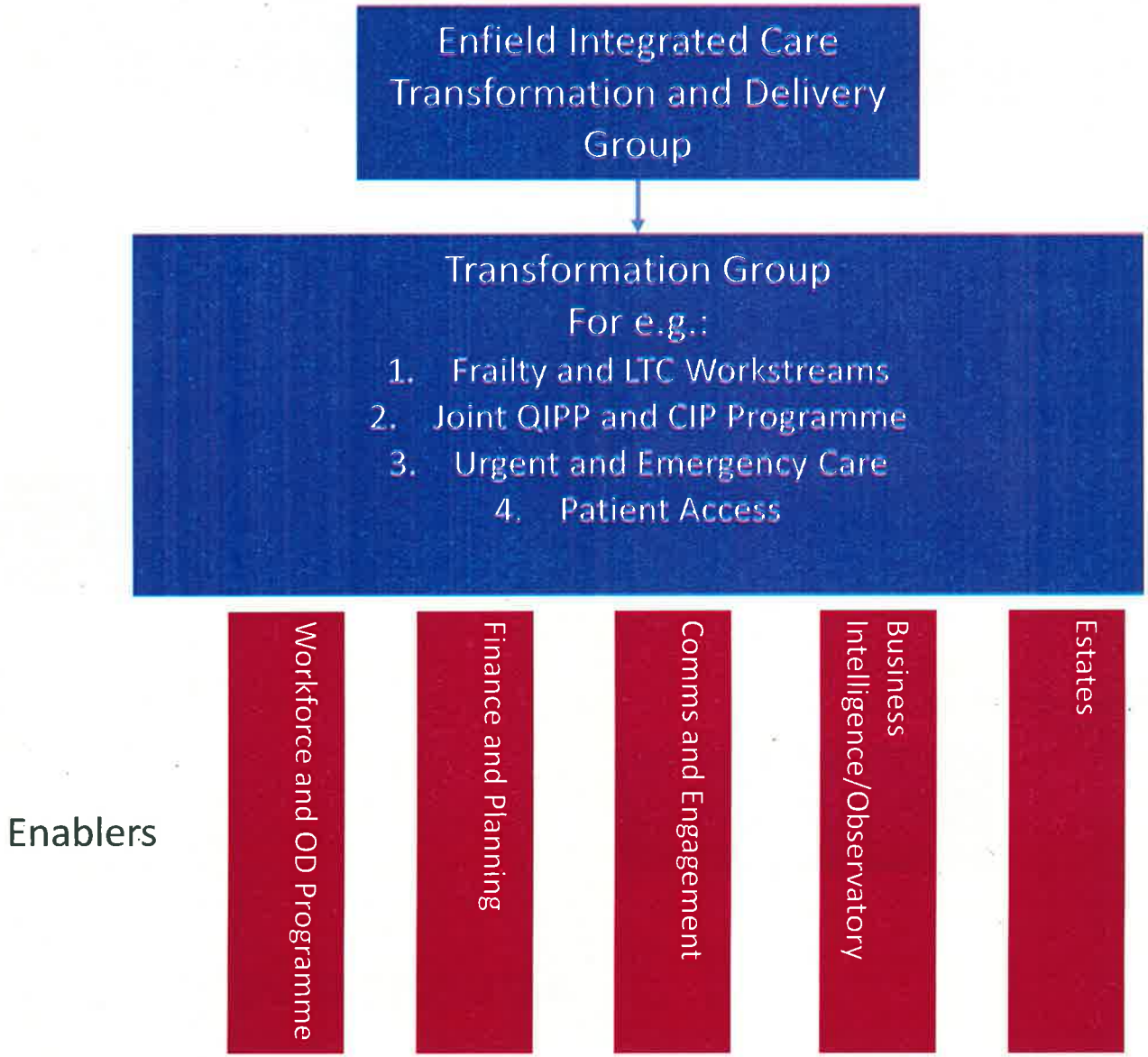
	Barnet	Camden	Enfield	Haringey	Islington
Priorities*	• Development of ICP Governance and whole systems planning • Development of agreed population health management approaches and baseline current integrated pathways across the system	• Consolidation of frailty related contracts • Consolidation of End-of-Life contracts • Consolidation of LTC community contracts • Aligning frailty and LTC community contracts to Universal Offer • Aligning frailty contract to new GP contract	• Development of pan-system governance structure with shared financial structures that support system governance • Development of Frailty care as a proof of concept for integrated care models	• Giving children and young people the best start in life • Improving mental health and wellbeing throughout the life-course • Improving health and wellbeing in groups with additional needs • Ageing well	• Locality working - building on the North Locality prototype • Primary care networks • Joint Strategic Resource Assessment • Governance • Communications and engagement • Workforce/OD
Workstreams	1. Outcomes Framework 2. Strategy and Scope 3. Population Health Management 4. Pathway Development and Priorities 5. Financial Management and Planning 6. Governance/OD 7. Workforce 8. Comms and Engagement	1. Engaging citizens, residents and patients 2. Setting Camden system-wide objectives 3. Developing and implementing the Camden Integrated Care Roadmap 4. Setting commissioning design and delivery principles for the next 2-3 years	1. Governance 2. Joint PMO 3. Focus on population health approach to LTC and Frailty 4. Mapping social care spend across above populations where possible 5. Estates and enablers	1. Strategy development; 2. Ways of Working; 3. Governance; 4. Finance and Performance; and 5. Engagement and Communication.	1. Communications and borough prospectus 2. Joint financial resource assessment 3. Governance 4. Localities development 5. Workforce/OD

* Priorities summarised from Maturity Matrix returns , PIDs or ICP Updates

Local Governance Structure



Proposed Workstreams and Approach



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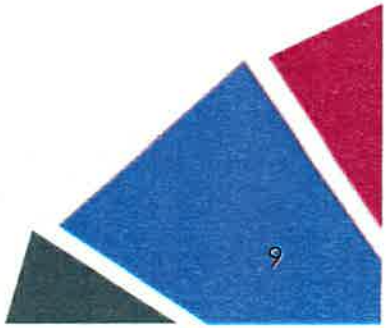
Enfield's Emerging PCN landscape

There are 4 PCN's in Enfield, two of which consist of 3 neighbourhoods:

1. **Enfield Care Network** (100,802)
   - Enfield Care Network Central (33,576)
   - Enfield Care Network North (33,035)
   - Enfield Care Network South (34,191)
2. **Enfield South West** (45,743)
3. **Enfield Unity** (158,121)
   - Enfield Unity Central (57,061)
   - Enfield Unity North East (46,002)
   - Enfield Unity North West (55,058)
4. **West Enfield Collaborative** (40,484)



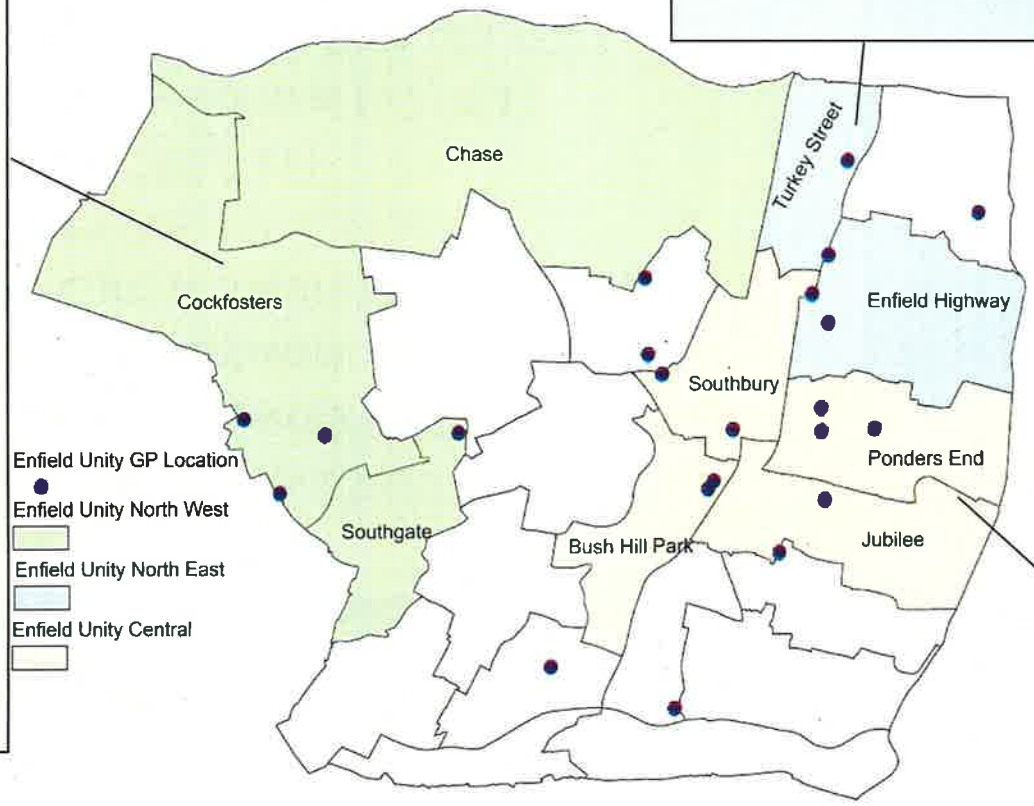
Enfield Unity Networks

North West

- Population has a higher proportion of older people.
- Highest life expectancy (LE) within the PCN, female LE is 84.6 and male LE is 80.7.
- Second highest proportion of white residents (72.3%) in Enfield
- Sig lower prevalence of children in poverty (17.3%) compared to Enfield (22.6%).

North East

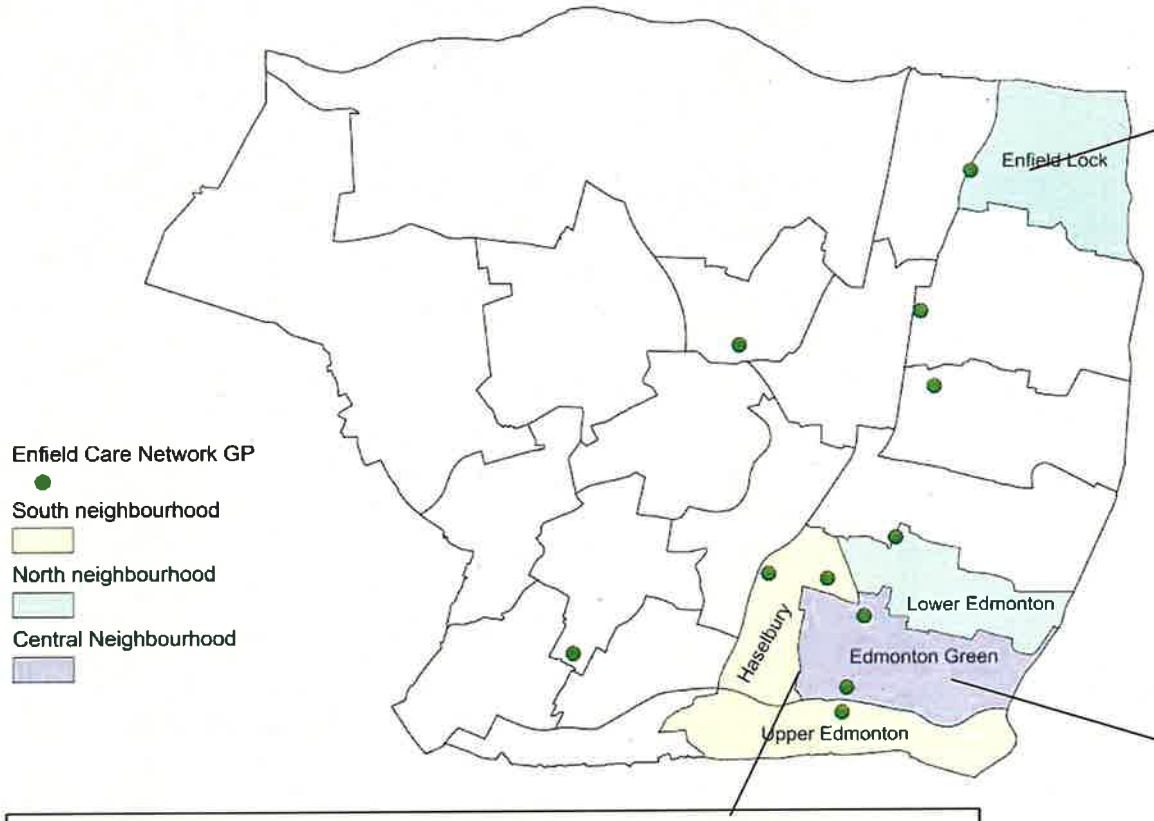
- Higher proportion of children and young people aged 0-19
- Lowest life expectancy (LE) within the PCN, females LE is 83.2 and males 79.2
- Sig higher proportion of black residents (23.8%) compared to Enfield (17.2%).
- One of the highest prevalence's of child poverty in Enfield (29.3%), sig higher than Enfield (22.6%).



Central

- Similar population structure to Enfield
- Life expectancy of females is 84.2 and males 79.7, similar to Enfield.
- Similar ethnic break down of residents to Enfield.
- Similar prevalence of child poverty (23.2%) to Enfield (22.6%).

Enfield Care Network Neighbourhoods



North

- Higher proportion of children and young people aged 0-19
- Both male (80.5 years) and female (82.8 years) life expectancies at birth are similar to Enfield (80.3 and 84.2 respectively).
- One of the highest prevalence's of people receiving out of work benefits in the borough (4.2%), sig higher than the Enfield average (3.2%)

Central

- Higher proportion of children and young people aged 0-19 and working age adults (aged 25-34).
- Highest proportion of black residents in Enfield (35.2%).
- Both male (79.4 years) and female (84.9 years) life expectancies at birth are similar to Enfield (80.3 and 84.2 respectively).
- Highest prevalence of child poverty in the borough (30.0%), sig higher than Enfield (22.6%).

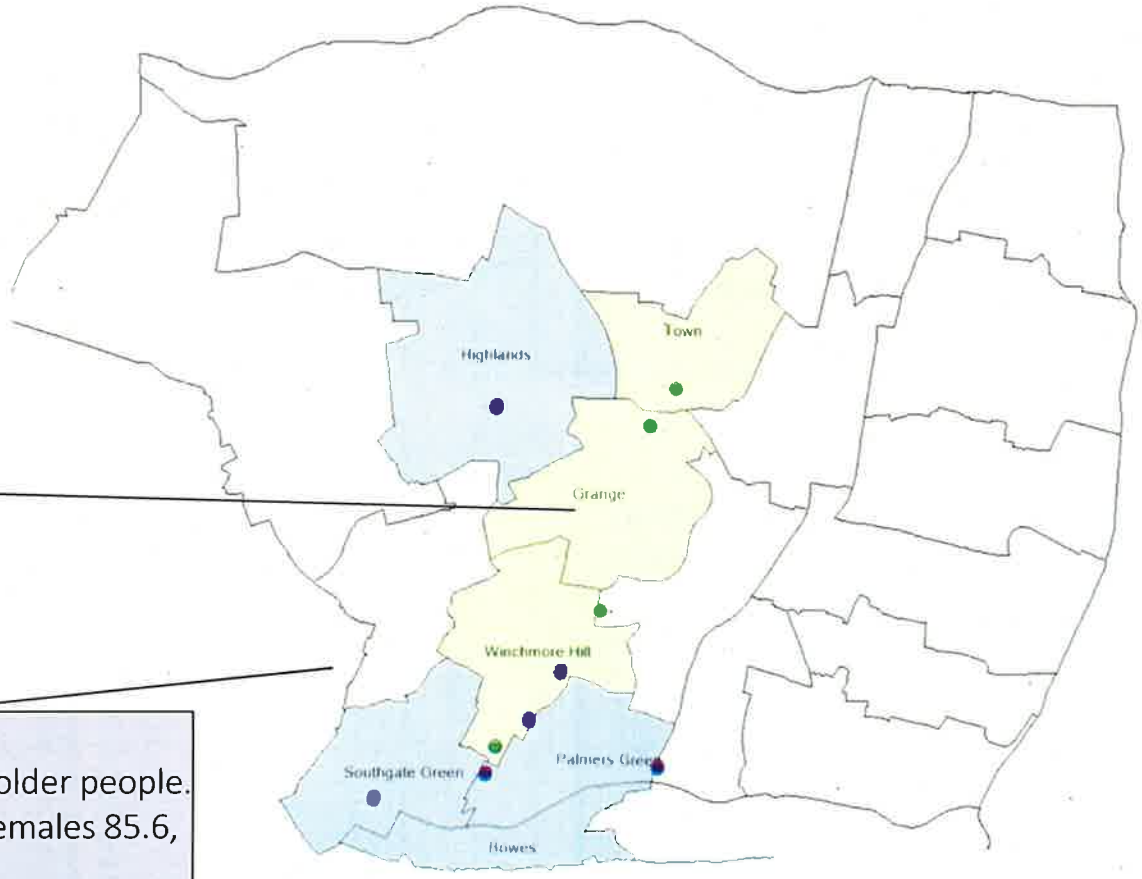
South

- Higher proportion of children and young people.
- The male life expectancy at birth in the South neighbourhood (77.6 years) is significantly lower than the Enfield average (80.3 year). Female life expectancy at birth (83.2 years) is similar to Enfield (84.2 years).
- Significantly lower percentage of people economically active (61.1%) compared to Enfield (63.6%)

Enfield South West and West Enfield Collaborative

West Enfield Collaborative

- Population has a higher proportion of older people.
- Highest proportion of white residents in Enfield
- Males life expectancy 82.3 years and females 85.1, both similar to the Enfield life expectancy.
- Affluent area – low levels of poverty, out of work benefits, social housing etc.



Enfield South West

- Population has a higher proportion of older people.
- Males life expectancy 82.1 years and females 85.6, similar to the Enfield life expectancy.
- From all PCN's females in the Enfield South West PCN on average live longest.
- Affluent area – low levels of poverty, out of work benefits, social housing etc.

e.g. Causes of Death – PCNs

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West Enfield Collaborative

Enfield South West

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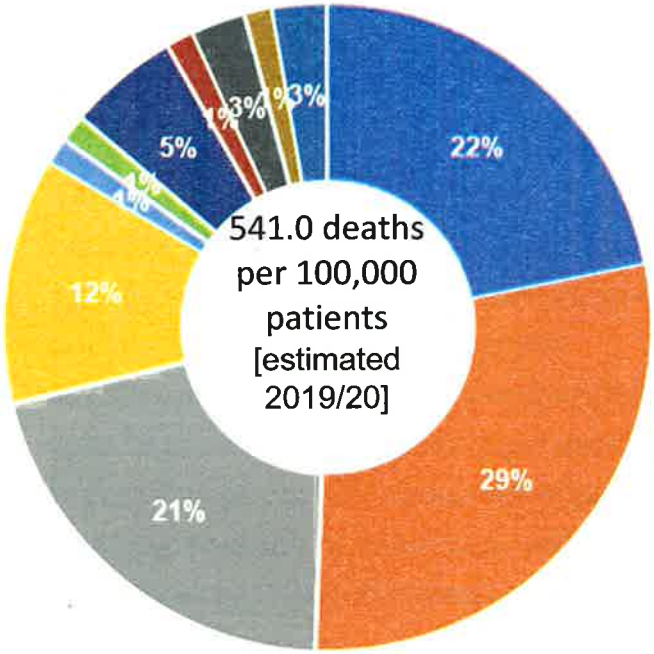

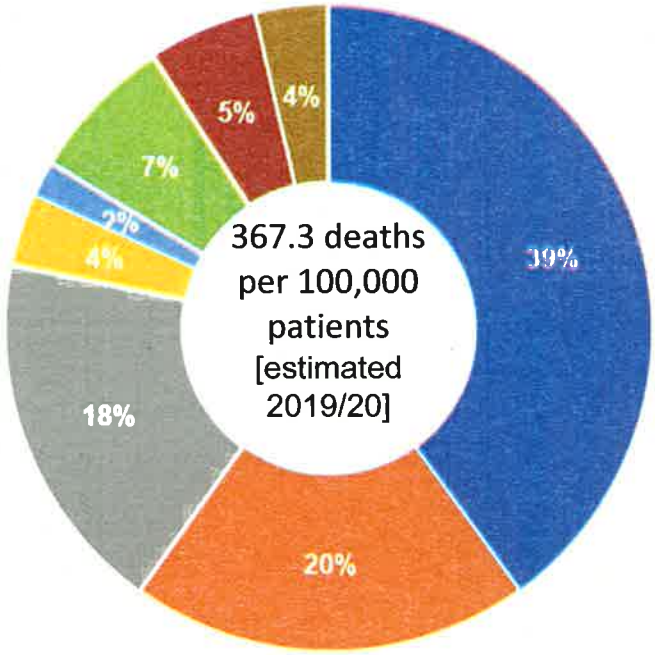

- Diseases of the circulatory system
- Neoplasms
- Diseases of the respiratory system
- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- Infectious and parasitic diseases
- Diseases of the digestive system
- Diseases of the genitourinary system
- Diseases of the nervous system
- Mental and behavioural disorders
- Injury, poisoning and certain other consequences of external causes
- Other

Data from Civil Registration – 3 months worth April, May and June 2019, modelling used to estimate for the year of 2019/20

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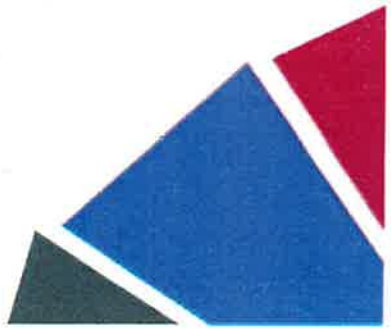
LONG TERM CONDITIONS

We aim to:

1. Diagnose our undiagnosed to give them the best possible chance of living with early disease and potentially reversing some aspects of disease
2. Robustly treat our patients who have one or more LTC to maximise clinical impact and substantially reduce complications and co-morbidities
3. Significantly enhance our prevention offer across primary, secondary and tertiary modalities to reduce the care and treatment burden



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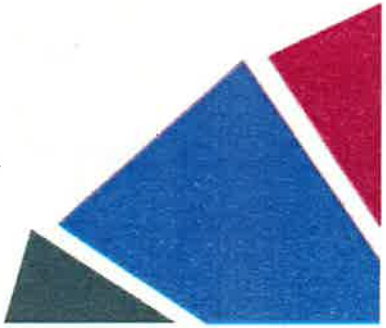
Long Term Conditions in Enfield

The Detection Gap

- In addition to the numbers presented in QoF, a number of unidentified patients are likely to be present. Based on national figures, there may be:
  - **2,270** undiagnosed with AF
  - **3,732** undiagnosed with diabetes
  - **1,887** undiagnosed with Heart Failure
  - **26,000** undiagnosed with Hypertension

Source: Public Health England Cardiovascular Disease Report (2019) https://fingertips.phe.org.uk/profile/cardiovascular-disease-primary-care/area-search-results/E39000018?search_type=list-child-areas&place_name=London



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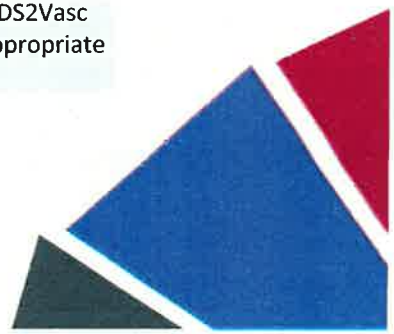
Enfield CCG Long Term Conditions Outcomes Framework			
DISEASE	OUTCOMES MEASURE	2020/21 PERFORMANCE	2021/22 PERFORMANCE
Pre-Diabetes	Improved monitoring of pre-diabetics - Patients to be offered annual HbA1c	85% pre-diabetic (HbA1c 42-47) maintained within pre-diabetic range	15% pre-diabetic (HbA1c 42-47) returned to normal range (below 42)
	Prevention of Type 2 Diabetes	95% pre-diabetics offered NDPP	95% pre-diabetics offered NDPP
	Prevention of Type 2 Diabetes Currently there are 18,750 patients in this group based on the search in EMIS.	10% pre-diabetic patients offered group consultation who do not undertake NDPP	12% pre-diabetic patients offered group consultation who do not undertake NDPP
Diabetes	Diagnose the undiagnosed	640 newly diagnosed diabetic patients (a decrease in undiagnosed of 15%)	TBC newly diagnosed diabetic patients (or decrease in undiagnosed of 15%)
	3 Treatment Targets (3TTs)	2% increase from baseline 46% or at 31/3/2020 if higher	2% Increase from baseline 48% or at 31/3/2021 if higher
	Improve outcomes towards Type 2 for those with HbA1c between 58-70mmol	10% patients completed locally commissioned course (Baseline 3,250) and brought back into control (<58)	12% patients completed locally commissioned course (Baseline TBC) and brought back into control (<58)
Atrial Fibrillation (from single offer)	Diagnose the undiagnosed	304 number of newly diagnosed AF patients (or 15% decrease in undiagnosed)	TBC number of newly diagnosed AF patients (or 15% decrease in undiagnosed)
		86%-patients with a CHA2DS2Vasc score greater than 2 on appropriate anticoagulants	88% patients with a CHA2DS2Vasc score greater than 2 on appropriate anticoagulants



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Prevention	Stop smoking	2% Increase in 4 week quitters (baseline against national online cessation portal number of quitters)	2% Increase in 4 week quitters (baseline against national online cessation portal number of quitters)
Commissioning VCS	Memorandum of Understanding with VCS in place to reduce health inequalities	Actions from Memorandum of Understanding implemented	Actions from Memorandum of Understanding implemented
COPD	Diagnose the undiagnosed	NIL in 2020/21	X number newly diagnosed patients with COPD (or X% decrease in undiagnosed)
	Reduction of Exacerbations	NIL in 2020/21	X number of COPD patients with crisis plan and reduction of X number of COPD diagnosed patients attending ED
CVD (Rightcare /NICE Prevention Pathway)	Hypertension	NIL in 2020/21	X number newly diagnosed Hypertension patients -Baseline QoF 2019/20 (or decrease in undiagnosed of 10%)
	Hypertension	82% patients within clinically therapeutic treatment range (Cohort age <79)	84% patients within clinically therapeutic treatment range (Cohort age <79)
	Heart Failure	NIL in 2020/21	X number newly diagnosed HF patients -Baseline QoF 2019/20 (or decrease in undiagnosed of 10%)
	CKD	NIL in 2020/21	X% newly diagnosed CKD (or decrease in undiagnosed of X%)
	CKD	NIL in 2020/21	60% (increase by 5% each year thereafter: lower target as much harder to achieve). patients within clinically therapeutic treatment range.

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Frailty

1. Currently work in individual organisations but needs to be brought together to develop system response
2. Enfield Borough Partnership has agreed modelling work looking at population breakdown across mild, moderate and severe frailty, and health and social care activity and spend across the population to inform future provision towards prevention
3. Providers currently using, or about to use, Rockwood frailty score to ensure picture of frailty across the older population of Enfield

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Rockwood Frailty Scores NMUH Emergency Department, Apr 19 – Feb 20		
SCORE	NUMBER	PERCENTAGE
1 – Very Fit	113	2%
2 - Well	397	7%
3 – Managing Well	1678	30%
4 - Vulnerable	1103	20%
5 – Mildly Frail	1058	19%
6 – Moderately Frail	792	14%
7 - Severely Frail	382	6%
8 – Very Severely Frail	67	1%
9 – Terminally Ill	15	1%
Total	5,605