Enfield Integrated Care Partnership Progress Update

Enfield Health and Wellbeing Board

Stephen Wells, Senior Programme Manager, NCL CCG

24th June 2021

"Working together, we will change the way we work in order to reduce inequality and to support all people in Enfield to live happy, healthy and rewarding lives"

Equal and inclusive, **Q**uality, **A**ccessible, **L**istening and Responsive, **I**ntegrated, **T**imely

Why are we doing this?

To address the Health and Care Challenges in Enfield:

Growing population and deprivation

- 330,000 – 4th largest London Borough
- 30% increase in population 2001-2025
- Moved from 12th to 9th most deprived London borough
- Language barriers – 100+ languages

Increasing need impacting wider determinants of health

- 1 in 5 workers low paid
- Debt, fuel and food poverty
- 250% increase in homelessness associated with private rental market evictions
- Youth violence +27%

East/West Inequality

- Life expectancy and living in poor health
- Households in poverty & child poverty
- Adult and child obesity
- School readiness and achievement

Differential service use East/West of borough

- NEL 12% and Elective 20% higher national average Edmonton Green
- 600+ attendances NMUH A&E with significant unregistered population

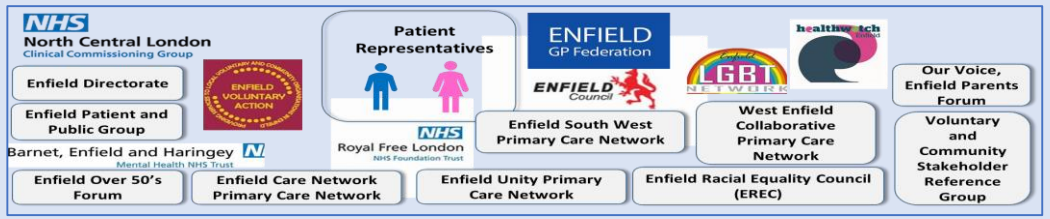
Differential investment

- Historic lack of investment in community and primary care services
- Significantly lower spend on community services per head of population than other NCL boroughs
- Fewer GPs and practice nurses than national average
- Austerity - Enfield Council cuts £178m since 2010 - £13m more in 20/21. Average reduction of £800 per household for core funded services

To address the local and national priorities:

- Delivering **NHSE's 8 tests** for the journey to a new health and care system
- Delivering the **London Vision and Touchstone**
- Supporting delivery of the **12 Expectations** for ICS Programmes
- Local priorities – Enfield HWBB, Enfield Poverty and Inequalities Commission, NCL ICS

To respond to the wide range of stakeholders involved in this process



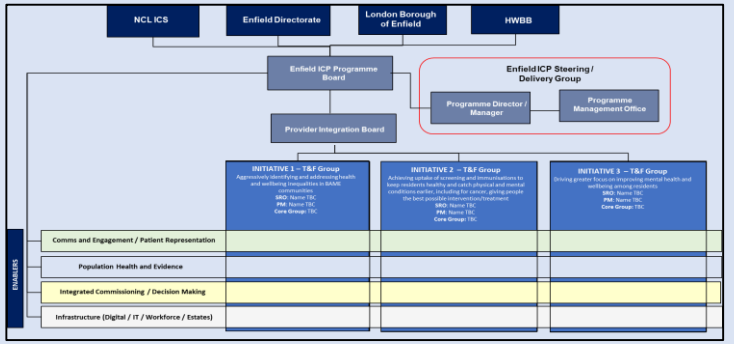
What will we do to achieve this vision?

We've developed a clear set of priorities for the Enfield ICP based on extensive engagement

Identifying and addressing health and wellbeing inequalities in BAME communities	• Improving self-care and management of LTCs • Improve the knowledge and understanding of local services for BAME • Driving up representation of those impacted by inequalities in PPRGs • More engagement with BAME and deprived communities • Measuring the performance and impact of services for all residents and BAME • Ensure ICP members are positive corporate citizens in employment practices
Achieving uptake of screening and immunisations to keep residents healthy and catch physical and mental conditions earlier, including for cancer, giving people the best possible intervention/treatment:	• Exceeding childhood vaccinations targets for all communities • Exceeding flu vaccination targets in winter 20/21 • Driving uptake of and concordance with cancer screening programmes • Developing new and targeted comms/engagement campaigns
Driving greater focus on improving mental health and wellbeing among residents	• Proactively responding to the direct and indirect impact of Covid-19 by providing improved care offers • Improve capacity and capability through local public services by developing networks of support, training and advice to improve the management of lower acuity mental health conditions (e.g. in schools and at work) • Proactively ensure improved understanding of early support and access points for all communities that may need emotional resilience support as a result of covid related anxiety as well as those overrepresented with more severe and complex conditions

How will we deliver these priorities?

Through a clear delivery plan and a robust and inclusive governance structure



- A Provider Integration Partnership Group will bring together providers from across the Health and Care system
- Separate Task and Finish groups will be established for each initiative, responsible for developing and implementing the plan to realise the required outcomes
- The Task and Finish groups will endure for the duration of delivery of the initiative, and will be replaced at the end of the initiative by a new set of T&F Groups
- Key enablers will support each T&F Group, to ensure a common approach to critical aspects of delivery across the system (e.g. Communications and Engagement, Population Health and Evidence etc.)

ICP Stakeholder Memebrship

NHS North Central London Clinical Commissioning Group

Enfield Voluntary Action

NHS North Middlesex University Hospital NHS Trust

ENFIELD GP Federation

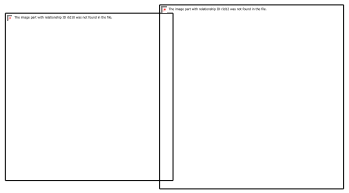
Enfield Directorate

NHS Royal Free London NHS Foundation Trust

ENFIELD Council

Barnet, Enfield and Haringey Mental Health NHS Trust

Patient Representatives



Enfield South West Primary Care Network

Enfield Unity Primary Care Network

Enfield Patient and Public Group

healthwatch Enfield

West Enfield Collaborative Primary Care Network

Enfield Over 50's Forum

Enfield LGBT Network

Enfield Racial Equality Council (EREC)

Enfield Care Network Primary Care Network

Our Voice, Enfield Parents Forum

Voluntary and Community Stakeholder Reference Group

Enfield ICP – Our Key Principles

Through a highly collaborative process the Enfield ICP partners have co-designed priority initiatives on the basis of the following key principles:

- Requiring the energy and support of all partners – the sum of the parts – to maximise success
- Being discrete and deliverable initiatives that can be mobilised to generate early momentum within the Partnership
- Representing the vital programme of work in the next 6-12 months for the public and its anchor institutes
- Working with all stakeholders including voluntary, community, faith groups to support improved outcomes in our endeavours
- Being the start of a new programme of work for the ICP that will soon address many other local priorities

2 Background

- Enfield Integrated Care Partnership was established in 2019 to deliver the national and local vision for integrated health and social care
  - Good progress made between partners in agreeing a vision, principles, governance structure for the ICP, and identifying some initial priorities

- Initial work focused on the frailty pathway
  - Touches on most organisations in the ICP, and therefore a catalyst for joint working

- Work on the ICP paused following the onset of the COVID-19, as partners focused on managing the immediate impact of the pandemic

- Now that the system is focusing on recovery from COVID-19, the Enfield Integrated Care Partnership (ICP) is being re-established

- To support the effective re-establishment of the Enfield ICP a design process was undertaken, with the support of experienced external facilitators, to re-engage all local stakeholders from across health, social care and voluntary and community groups in developing a shared ICP which:
  - Maximises the collective benefits from our ongoing collaboration
  - Improves outcomes and addresses health inequalities for Enfield residents
  - Incorporates learning from the Covid-19 pandemic

Enfield Integrated Care Partnership

ICP Initiatives – Highlight Reports Year end 2020/21:

i. Inequalities

ii. Mental Health Steering Group

iii. Screening & Immunisation:

- *Seasonal Vaccination Programme*
- *COVID Vaccination Programme*

Inequalities Workstream: April 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
Reduce childhood obesity	27% of year 6 children are identified as obese (National Childhood Measurement Programme 2019/20, there is no data available regarding impact of pandemic). Whilst we do not yet have National Childhood Measurement Programme data covering the period, we anticipate that childhood obesity will have increased due to lower levels of physical activity among children.
Reduce childhood obesity among groups where there is evidence of high prevalence in comparison to average for Enfield including; children from Black, Turkish backgrounds and geographic communities experiencing deprivation.	As above
Reduce inequalities by working as an Integrated System to improve wider determinants – improve employment opportunities, educational outcomes, reduce homelessness and improve the built environment in areas of high deprivation.	Currently there has been an increase in numbers of individuals and families who are seeking benefits, using food banks, on furlough and experiencing financial crisis in Enfield. It is possible that there will be a long term worsening/ widening of inequality in Enfield as a result of the pandemic. We will use local intelligence to monitor the impact on the priorities identified.
Commission a programme of Community Participatory Research (CPR), Health Champions and Community Chest to support the above priorities. This will include academic evaluation of the programme.	Some of the meetings of the task and finish group were postponed due to COVID pandemic prioritisation – none the less the key working group continued to enable the procurement to progress resulting in securing a local organisation to deliver HC & Community Chest.

Risk/Issues	RAG*	Mitigating Actions
1. Following a procurement process, we were unable to commission CPR from a local organisation	Amber	We will seek procurement from an appropriate organisation outside of our local system
2. We are yet to secure an academic partner for evaluation of the programme	Amber	We will be approaching appropriate academic organisations over the next few weeks.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	NA
2	NA

The Enfield ICP Mental Health Steering Group: April 2021

ICP MH Steering Group Agreed Priorities (PRE-Covid)	Impact of COVID
We agreed to prioritising the development and delivery of the Long Term plan targets for Mental Health in relation to the Community Framework for MH, this includes but is not limited to developing PCN MH integrated care and holistic support for SMI communities by piloting agreed approaches. We will improve access to physical health care, increase access to SMI health checks, increase access to Individual Placement Support and seek to achieve EIP Level 3 in 21/22	Some meetings of the Steering Group were cancelled due to prioritisation of Covid activity and transformation funding and milestones are yet to be confirmed by NHSE. We have agreed the TOR for the group and what Long Term Plan targets will be prioritised for 21/22 and these are: - Improve SMI health checks by working with primary care to improve targeted uptake of hard to reach group and improve record keeping across all 6 domains - We agreed the PCNs Pioneer sites and selected East borough neighbourhoods across two PCNs (17 GP Practices in the East of the borough). - Increase access to Individual Placement Support (IPS) by joining the Councils contract with the Working Well Trust under Section 75 arrangements - Review EIP services in terms of gap analysis to achieve Level 3
Establish Community Transformation Work streams and Activities	We have established a local Community transformation work stream; the steering group meets monthly and there are sub-groups at NCL level for co-production, contracting & procurement and Needs Assessment. Membership attendance has been sporadic due to the Covid 19 pandemic.
Develop a shared approach for local priorities and modelling	Further development of the operational model, principles, population segmentation and interfaces in readiness for staffing workshops and engagement events that are in planning stage

Risk/Issues	RAG*	Mitigating Actions
1. non-engagement from clinicians and workforce due to Covid and vaccination prioritisation means that we may not stay on track with key deliverables		Increased support through BEH PMO, streamlining communications – need to Review and flex as required
2. NHSE milestones yet to be confirmed – this is partly due to covid		Beyond our control but we will continue to develop projects in the interim

Issues for Escalation to PIP AND/OR ICP BOARD	
1	None at present

Seasonal Vaccination Programme: April 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
Achieve National Flu Target: Over 65s – 75% Under 65s at risk – 55% Pregnant Women – 55% 2/3 year olds – 50% Actual Performance 2020/21 : Over 65s – 73.0%, Under 65s at risk - 45.1%, Pregnant Women – 26.8%, 2/3 years olds – 48.7%	Increased target to 75% across all cohorts Additional 50-64 cohort Services delivered in covid compliant facilities/ increased time to deliver vaccine.

Risk/Issues	RAG*	Mitigating Actions
1. Pregnant women flu uptake in Maternity units below target	R	NCL below target. Engaging with Maternity Departments on recovery plans Engaging with Primary Care Providers to deliver mop up clinics
2. Availability of flu vaccine supplies	A	Ongoing engagement with NHSE/I re: underwriting GP Practice additional flu orders
3. NHSE/I change eligibility cohort mid season	R	Communication and Engagement strategy to be developed as and when required.

*RAG status based on Likelihood & Impact

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Engage Acute Maternity providers to improve flu uptake amongst pregnant women.
2	Patient vaccinations outside of practice registered lists.

COVID Vaccine Inequalities: April 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
(National target) At least 75% coverage for all JCVI cohorts – including health, social care and care home staff	NA
(Aligned to NHSE Local Borough Plan submitted and agreed March 2021) Aspiration of 95% vaccine coverage for all JCVI cohorts	NA
Limit inequality in vaccine uptake between areas of high and low deprivation, different ethnic groups and other groups experiencing deprivation (e.g. GRT, homeless)	NA

Risk/Issues	RAG*	Mitigating Actions
1. Below 75% vaccine coverage (or <95%) in some geographic communities, ethnic groups and other communities experiencing inequality (e.g. homeless, GRT)	amber	ICP Vaccine Workstream activity informed by intelligence provided by Public Health Team ICP Inequalities Workstream working to borough Live communication and engagement plan (including range of communication activities such as multiple community webinars, social media, and direct community with community leaders (aligned to NHSE Local Borough Plan)) Provision of weekly programme of pop ups targeting lower uptake communities
2. Below 75% uptake among care home workforce	amber	Production of improvement plan LBE.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Care home staff uptake
2	

Addressing Inequalities 2021/22
NCL Inequalities £2.5m Investment Fund

NCL CCG Inequalities Fund: Rationale and Principles

NCL CCG have created an Inequalities Fund to address the growing disparity between our most deprived and least deprived communities. In line with 2021/22 Planning Guidance, this will focus on the most deprived 20%, with an aim to improve their access, experience and outcomes.

The objectives of this fund are as follows:

- We are seeking innovative and collaborative approaches to delivering high impact, measurable changes in inequalities across NCL
- We want these solutions to break down barriers between organisations and develop both new and extend existing relationships
- We want to target the most deprived communities and to reach out proactively to our resident black and minority ethnic populations
- We want this to help form Borough, Multi-Borough and NCL wide partnerships to deliver high impact solutions
- We are keen to engage our population, the VCS and our partners across health and care in making a difference to the lives of our people

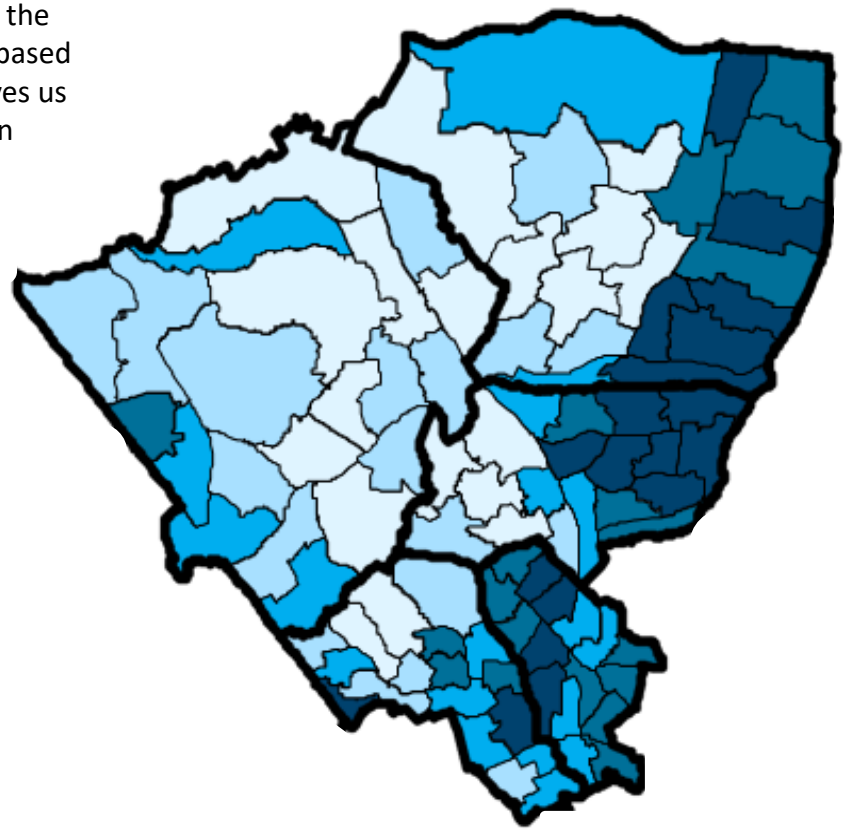
Each ICP will be able to bid for a proportion of the initial £2.5m, with funds relative to needs in each borough. All health and care partners will need to approve the submitted plans, which will be assessed by an NCL wide panel.

Top 20% Most Deprived Wards in NCL

Based on Index of Multiple Deprivation Score 2015, the 20% most deprived Wards in NCL are spread across 19 of the total of 95 Wards. The table below also uses the Deprivation Score to give a weighted investment for each Ward based on an allocation of £2m of the £2.5m Inequalities Fund to address the Planning Guidance Priorities. Using this gives us an indicative value for each Borough of Enfield (£676,781), Haringey (£766,967), Islington (£369.039) and Camden (£187,213). As stated previously none of the 20% most deprived Wards are located in Barnet.

Ward	Borough	Total IMD Score	Total Population	Total ward allocation £*	£ per population
Northumberland Park	Haringey	52.6	16,416	141,161	8.60
Edmonton Green	Enfield	47.0	19,433	149,262	7.68
White Hart Lane	Haringey	45.9	13,485	101,211	7.51
Tottenham Green	Haringey	43.6	16,595	118,119	7.12
Finsbury Park	Islington	42.4	17,258	119,421	6.92
Tottenham Hale	Haringey	41.5	19,202	130,034	6.77
Bruce Grove	Haringey	40.2	15,090	98,998	6.56
Upper Edmonton	Enfield	39.2	19,806	126,874	6.41
St Pancras and Somers Town	Camden	38.6	16,967	107,121	6.31
Noel Park	Haringey	38.3	15,161	94,818	6.25
Turkey Street	Enfield	38.2	15,684	97,984	6.25
Lower Edmonton	Enfield	37.1	17,948	108,896	6.07
Ponders End	Enfield	36.5	15,788	94,058	5.96
West Green	Haringey	36.3	13,918	82,626	5.94
Kilburn	Camden	36.0	13,600	80,092	5.89
Holloway	Islington	35.5	14,983	87,010	5.81
Caledonian	Islington	35.5	13,896	80,521	5.79
Tollington	Islington	35.3	14,220	82,087	5.77
Haselbury	Enfield	34.8	17,539	99,707	5.68

** Calculation: The population was multiplied by IMD score, to give an indicative score on which to base the £2m allocation.*



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher levels of deprivation, based on the IMD deprivation score.

Indicator values range from 9.5 to 52.6.

Original Data Source: Ministry of Housing, Communities and Local Government, Index of Multiple Deprivation 2015

Planning Guidance Alignment (Inequalities)

The 5 Priority Areas related to Inequalities:

Priority 1: Restore NHS services inclusively – use data to plan the inclusive restoration of services guided by local evidence (focused on analysing access, experience and outcomes data)

Priority 2: Mitigate against digital exclusion – provide face-to-face care; identify who is accessing telephone, face-to-face, video consultations breaking this down by relevant protected characteristic and health inclusion group; assess impact of digital consultations channels on patient access.

Priority 3: Ensure datasets are complete and timely - improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes - take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021; preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated (related to management of LTCs, conducting annual health checks for people with LDs and SMI, improving maternity care for Black and Asian women and those from deprived neighbourhoods

Priority 5: Strengthen leadership and accountability

NORTH LONDON PARTNERS
in health and care

NCL ICS Development

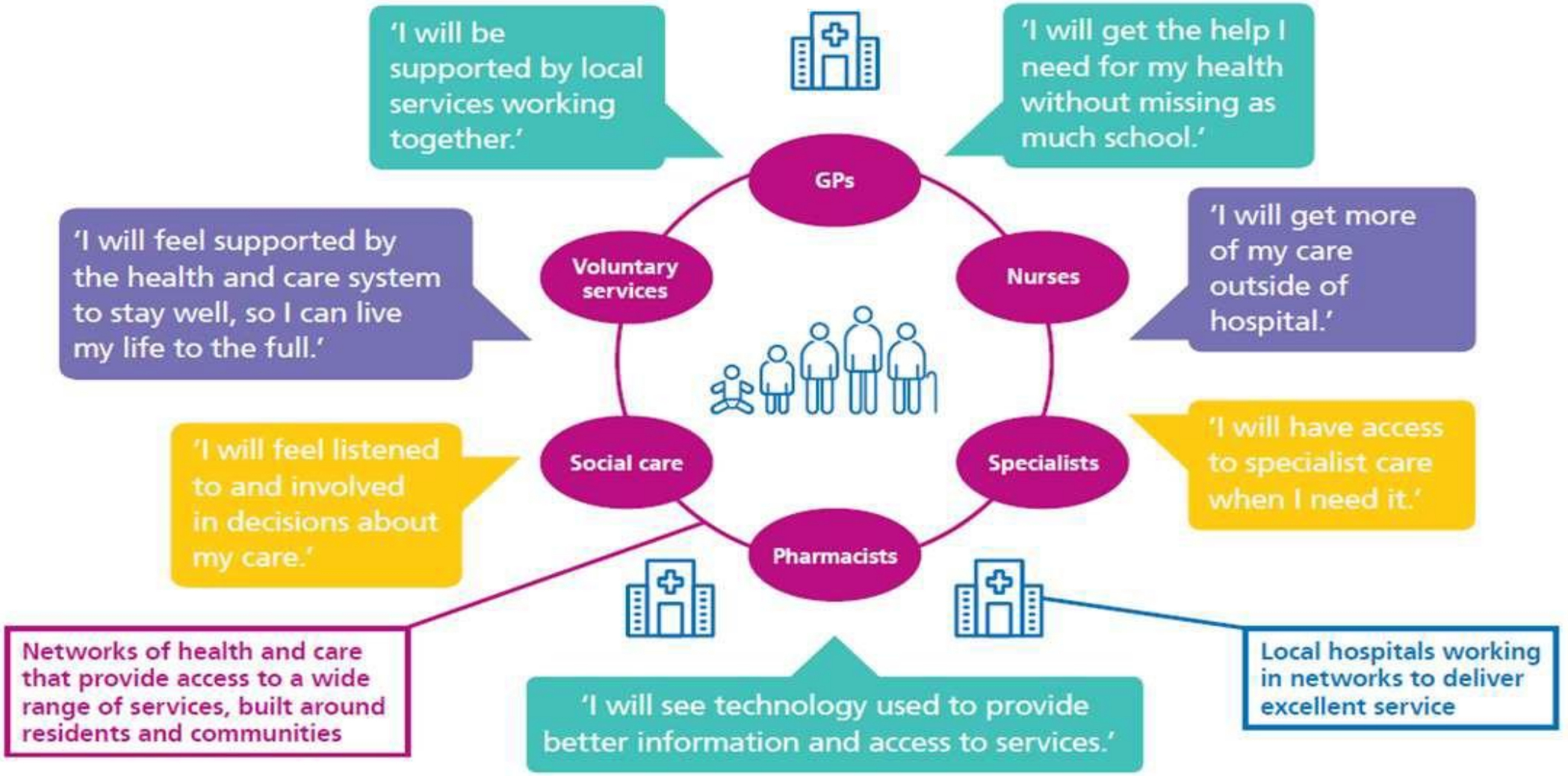
Developing our plans

May 2021

NORTH LONDON PARTNERS in health and care

NHS

Our Vision remains at the heart of everything we do



NORTH LONDON PARTNERS in health and care

NHS

Roadmap to transition

May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April '22

Listening and planning phase

- **Staff and partner engagement in developing the ICS system development plan**
- National guidance issued (over summer)

Implement new ways of working

- NCL ICS operating in shadow governance form
- Engage with stakeholders to embed NCL ICS Vision
- Work to implement NCL system development plan

Design phase

- Shadow ICS Governance developed in line with legislation
- New ways of working developed in line with system development plan

Embedding new ways of working

Continue to develop system capabilities to deliver on core ICS vision of a population health based- approach to reducing inequalities, improving access and increasing efficiencies

How to get involved…

- Join the upcoming drop in session and listening sessions (more information in newsletter)
- Email any questions to:
- Share any good system working examples to
- Contribute to system development planning through team discussions…

This is based on what we know now – but could change based on national timelines…

NHS England ICS Design Framework - published 17th June 2021

https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/

Appendices

DAC BEACHCROFT

THE HEALTH AND SOCIAL CARE BILL 2021 FINDING PLACE WITHIN INTEGRATED CARE SYSTEMS

ALISTAIR ROBERTSON
HAMZA DRABU
DAC BEACHCROFT LLP

25 MAY 2021

KEY THEMES

DAC BEACHCROFT

1. Integrated Care Systems will be recognised in statute. They will comprise (a) an Integrated Care Partnership which will bring together parts of the system, including local authorities, primary care, independent sector and voluntary sector; and (b) an Integrated Care Board (ICB) which will be responsible for the day-to-day running of the ICS.

There will be flexibility for the ICS as to how it is structured – this will not be a top-down re-organisation.

ICBs will combine may CCG functions with some existing NHS England functions and new strategic functions.

2. An ICS will be set a financial allocation by NHS England. The ICB will develop a plan to meet the health needs of its population and develop a capital plan for the NHS providers in its geography. The ICB Chief Executive will become the Accounting Officer for the NHS money allocated to the ICS

3. Most services will be designed and delivered at Place level. Places will generally be aligned geographically with local authority boundaries. They will sit within the governance structure of the ICB. Options for Place-Based Partnerships include (joint) committees, place director and lead provider.

4. There will be enhanced duties to collaborate and meet the "triple aim". Common duties across ICB and trusts/FTs to assess impact of activities on health and well-being, quality of service and sustainability of NHS services locally.

5. Reconfigurations. SofS to have extensive powers to "call in" proposals for service change at an early stage and make decisions on service change. Thresholds for notification and considerations that SofS must take into account being developed. How with this relate to public engagement, Public Sector Equality Duty/Health Inequalities and the role of LA Overview & Scrutiny?

6. Procurement and competition burdens removed. The NHS will be able to organise itself without CMA involvement. Health services will be carved out of the Public Contracts Regulations 2015 and Patient Choice Regulations will be repealed. This will be replaced with a bespoke health services provider selection regime, currently being consulted upon.

7. Population health is at the heart of these proposals. Provider collaboratives will have outcomes-based contracts which look at the health of the population at place or ICS level. Changes to the National Tariff will enable it to work more flexibly with population health contracts, rather than focussing on activity-led inputs. Patient choice is still important and NHS bodies will be required to protect this.

KEY THEMES

DAC BEACHCROFT

8. Powers to impose capital spending limits on Foundation Trusts, as it currently does on NHS Trusts. The government will have the power to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts which are not working to prioritise capital expenditure within their ICS.

9. NHS England will formally merge with NHS Improvement and be designated NHS England. The merged entity will be accountable to the Secretary of State, while maintaining operational independence. The Secretary of State will have increased powers of direction.

10. There will be changes to social care and public health changes including ensuring better integration with the NHS through the ICS structure. Mechanisms will be put in place to allow better of integration of social care and public health activities with NHS services. Measures re information sharing, regulation and financial assistance for social care.

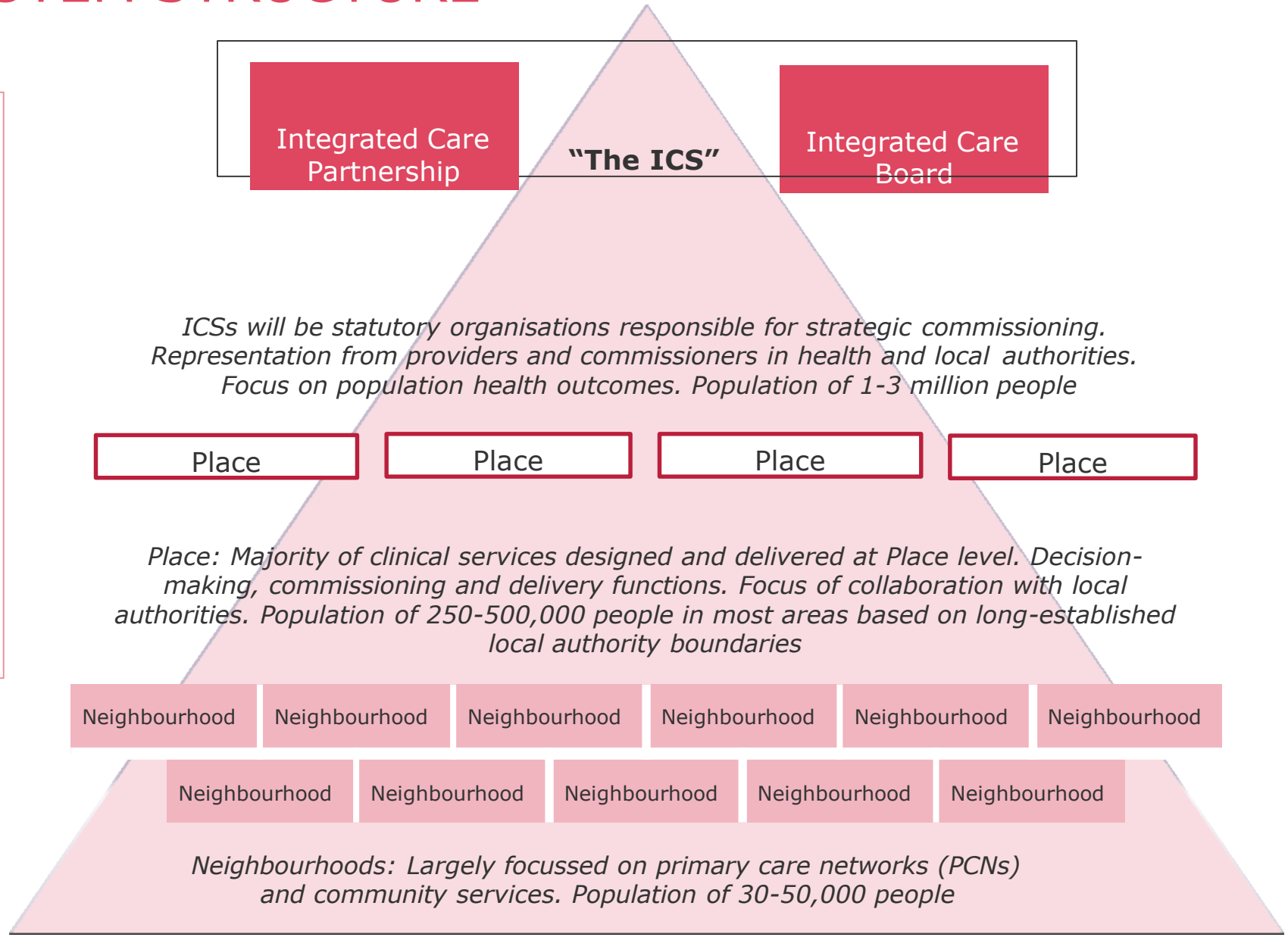
11. Patient Safety and regulatory change. Using the new Health and Care Bill to re-position the existing Health Services Safety Investigations Body (HSSIB) as statutory body, with the notable extension of HSSIB investigative reach to include treatment provided by the independent sector, in addition to changes around the concept of 'safe space' in those investigations. The same Bill will propose establishment in statute for the current Medical Examiners scheme, and restructuring of the regulation of healthcare professionals, by reducing the number of professional bodies. Further regulatory change in landscape will enable the Medicines and Healthcare products Regulatory Agency (MHRA) to set a national medicines registries; and legislation will be put in place to enable the implementation of comprehensive reciprocal healthcare agreements with other countries.

NEW SYSTEM STRUCTURE

Meeting the **Triple Aim Duty** – simultaneously pursuing:

- better health and wellbeing for everyone;
- better quality of health services for all individuals; and
- sustainable use of NHS resources

Focus on population health



Provider collaborative(s) working across places and within place

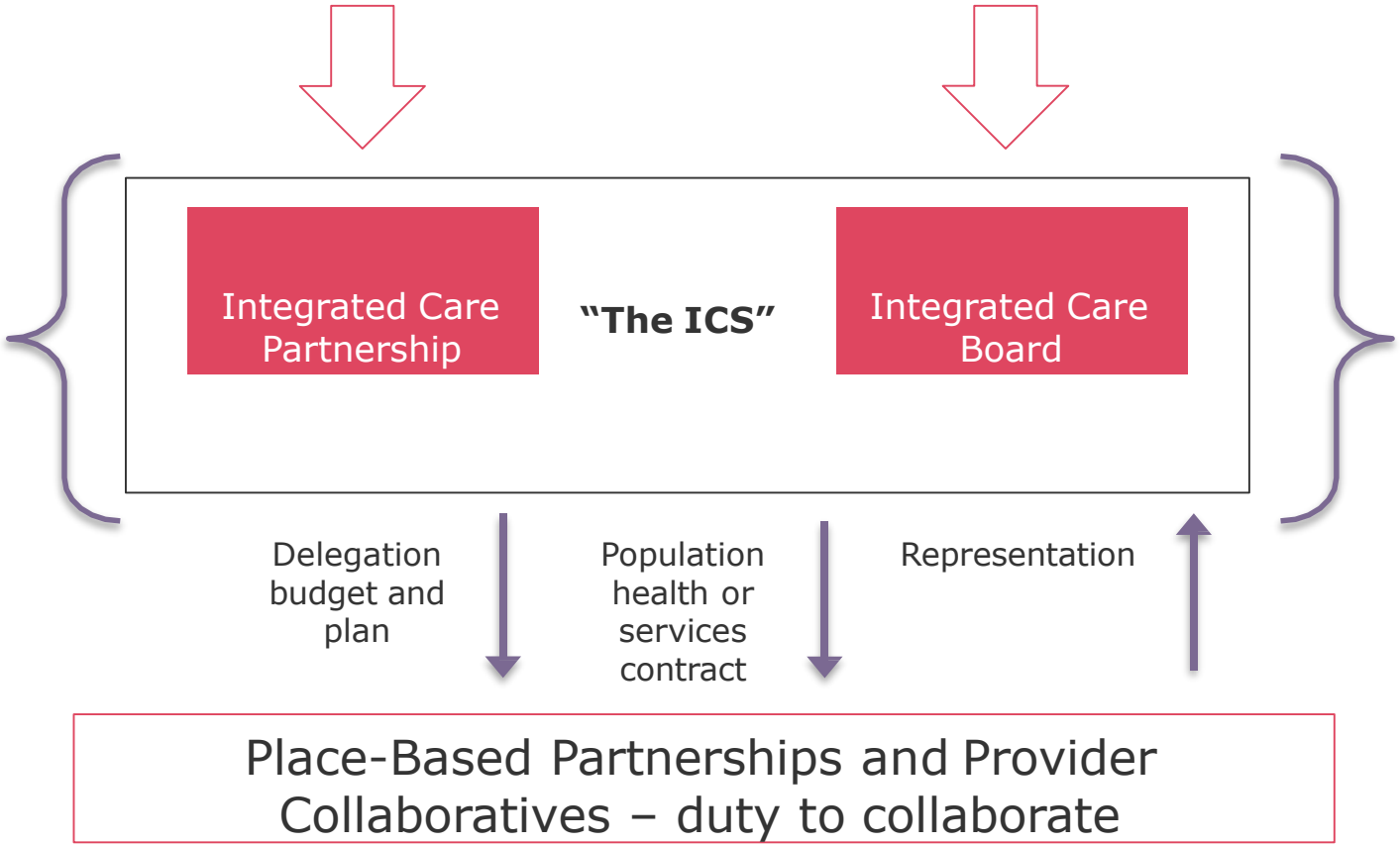
ICS STRUCTURE AND GOVERNANCE

Integrated Care Partnership will promote partnership arrangements and develop a strategy to address the health, social care and public health needs of their system. Integrated Care Board and local authorities need to have regard to this strategy.

The ICB will have responsibility for the day to day running of ICS. It will develop a plan to meet health needs of its population and a capital plan for NHS providers. It will have functions from merged/re-purposed CCGs and some from NHS England within its boundaries.

Representation from:

- Local government
- ICB
- Health, social care and public health as determined locally (including, where appropriate, representatives from the wider public space, e.g. social care and housing providers)



ICB board will include:

- Chair
- CEO (Accounting Officer)
- Representatives from NHS trusts, general practice and local authorities
- As determined locally or by NHSE guidance – e.g. medical and nurse reps, representatives from mental health, community health services, NEDs

GOVERNANCE AND HOW PLACE FITS INTO THE ICS

- Emerging models – Place ‘Design Framework’ expected soon
- Questions to resolve:
  - Role of the LA
  - Representatives – not every organisation can have a representative in every forum
  - Role of health and wellbeing boards
- Conflicts
- Relationships
- Direct Commissioning

MODELS FOR THE PROVISION OF SERVICES

Intra-NHS and NHS/local authority collaboration

Memorandum of understanding

Documents
MoU
Service Contracts

Prime contracting/ alliance arrangements

Documents
Heads of Terms/Bidding Agreement
Head Contract/Service Contracts
Sub-contract(s)/ Alliance Agreement

Contractual joint venture

Documents
Heads of terms/Bidding Agreement
Collaboration Agreement

Full merger / establish new Trust

Documents
Due diligence
Business Transfer Agreement
Statutory Transfer Orders (where relevant)
Contract Novations (where relevant)

Informal partnerships → Full integration

Integrated governance

Documents
Integrated Management Board Terms
Multi party unincorporated arrangements
Joint committees ToR / scheme of delegation
Joint appointments

Section 75 arrangements expanded

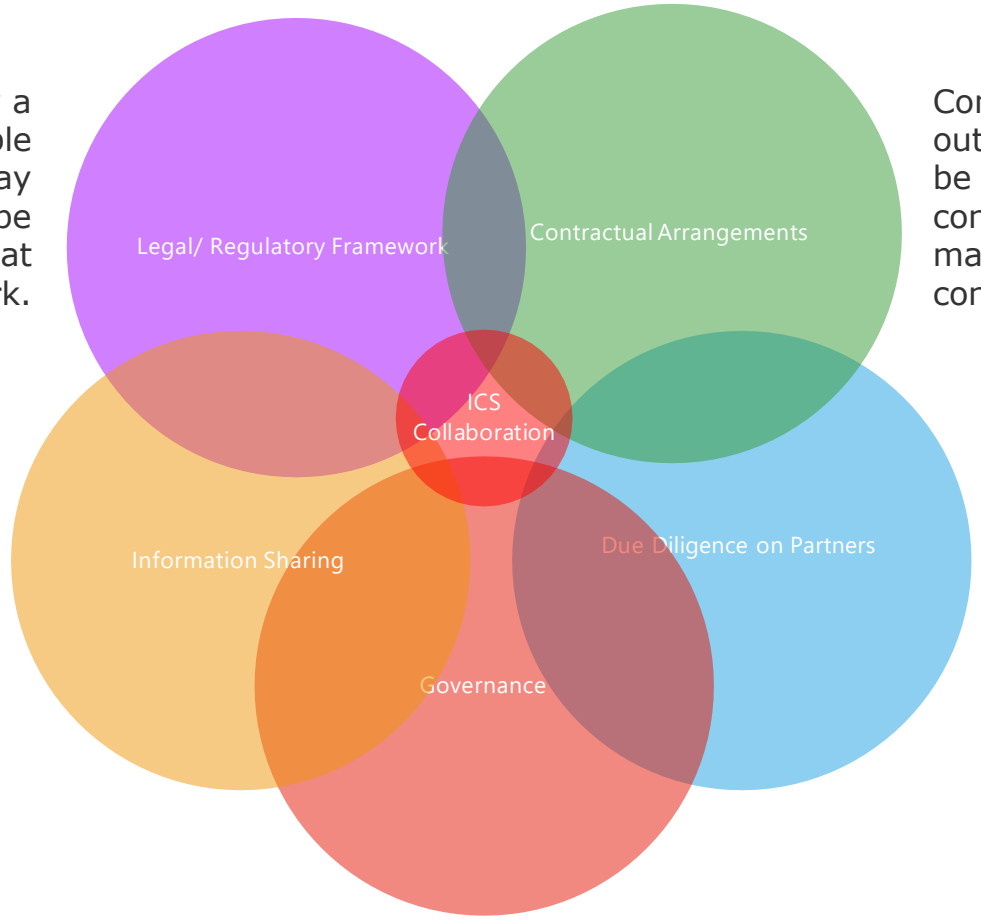
Documents
Section 75 Agreement
Service Specification
Lead commissioning/ pooled funds

Corporate Joint Venture

Documents
Options advice on corporate vehicles
Heads of Terms
Articles of Association/LLP Agreement/Constitution
Members' Agreement
Service Agreements

KEY CONSIDERATIONS

Is the collaboration governed by a statutory framework, for example s75 arrangements. If so, there may be specific matters that need to be included to comply with that framework.



Contracts (and where applicable, outcomes) between organisations need to be aligned with each other, e.g. a sub-contract needs to be aligned with the main services agreement in a lead contractor model.

Data access and interoperability is essential for collaborative working. Arrangements must be made for the safe, lawful sharing of data.

Depending on the extent of the collaboration, due diligence may include: clinical, financial, legal, operational (including HR, IT and estates matters) and commercial due diligence.

NHS/LA joint committees will require carefully drafted schemes of delegation to be clear on decision making authority and accountability. Joint appointments will also be possible. Whilst governance will remain complex, the need for complex workarounds within the current restrictive framework will be removed.

Enfield ICP Board: Membership

ATTENDEES

Bindi Nagra (BN)	Director of Health & Adult Social Care, LBE and co-chair
Dr Chitra Sankaran (CS)	NCL Governing Body GP, Enfield Borough and Local GP, NCL CCG and co-chair
Deborah McBeal (DMcB)	Director of Integration, Enfield Borough, NCL CCG
Dr Alpesh Patel (AP)	Director, GP Federation/Enfield Healthcare Cooperative Limited (EHCL)
Dr Hetul Shah (HS)	Meds Optimisation & ICP Clinical Lead, Enfield Borough, NCL CCG
Dr Nitika Silhi (NS)	NCL GB GP, Enfield Borough & Local GP, NCL CCG
Richard Gourlay (RG)	Director of Strategic Development, NMUH
Vivien Giladi (VG)	Over Fifties Forum
Chandra Bhatia (CB)	Chief Executive, Enfield Racial Equality Council
Helen Price (HP)	Enfield Voluntary Action
Litsa Worrell (LW)	Patient & Public Group (PPG) Chair & CEO Alpha Care Specialists
Noelle Skivington (NS)	Acting CEO, Healthwatch Enfield
Stephen Wells (SW)	ICP Programme Manager, Enfield Borough, NCL CCG
Sarah D'Souza (SDS)	NCL Director of Communities and Equalities
Laura Andrews (LA)	Senior Engagement Manager, Corporate Services Directorate, NCL CCG
Keith Spratt (KS)	Head of Contracts, NCL CCG
Vass Pyrkos (VP)	Programme Manager, Enfield ICP
Sarah McDonnell-Davies	NCL CCG, Director of Borough Partnerships
Dr Mo Abedi (MA)	Co Chair PIP and Clinical Director, Enfield Community Services, BEH
Alan McGlennan (AMG)	Acting CEO and Medical Director, RFL (Chase Farm Hospital)
David Griffiths (DG)	Director of Finance, BEH MHT
Natalie Fox (NF)	Chief Operating Officer, BEH MHT
Dr Sarit Ghosh (SG)	Enfield PCNs Clinical Director
Vanessa Connolly (VC)	Board Secretariat (Minutes)

ICP Provider Integration Participation Group - Membership

Members:

Alpesh Patel (AP)	Co-Chair, Enfield GP, Executive Director Enfield GP Federation, Adults/LTCs/ Prevention Clinical Lead
Mo Abedi (MA)	Co-Chair, Enfield GP, Clinical Director, Enfield Comm. Services, BEH MHT
Bindi Nagra (BN)	Director of Health & Adult Social Care, London Borough Enfield
Deborah McBeal (DMc)	ICP Director & Director of Integration, NCL CCG, Enfield Borough
Stephen Wells (SW)	Senior & ICP Programme Manager, NCL CCG, Enfield Borough
Keith Spratt (KS)	Head of Contracts, NCL CCG, Enfield Borough
Doug Wilson (DW)	Head of Strategy & Service Development, London Borough Enfield
Dr Sarit Ghosh (SG)	Enfield GP, Enfield Community Network
Alan McGlennan (AM)	Medical Director of Chase Farm Hospital, Royal Free Hospital Trust
Richard Gourlay (RG)	Director of Strategic Development, NMUH
David Cheesman (DC)	Executive Director of Strategy & Transformation BEH MHT
Aalaa Jawad (AJ)	Imperial College Healthcare NHS Trust
Amy Bowen (AB)	Director of System Improvement, NCL CCG
Dudu Sher Arami (DSA)	Public Health Consultant, LB Enfield
Ruth Donaldson (RD)	Director of Communities, NCL CCG
Helen Price (HP)	Business Manager, BEH MHT Enfield Voluntary Action (EVA)
Parmjit Rai (PR)	Enfield Community Services Director, BHE MHT
Riyad Karim (RK)	ICP Inequalities Project Manager & Interim Head of Primary Care, NCL CCG, Enfield Borough
Emdad Rahman (ED)	Primary Care Development Manager, NCL CCG, Enfield Borough
Peter Lathlean (PL)	ICP Screening & Immunisations Project Manager & Deputy Head of Primary Care, NCL CCG, Enfield Borough
Vass Pyrkos (VP)	Enfield ICP Programme Manager
Andy Heeps (AH)	Deputy Chief Executive Officer & Chief Operating Officer at NMUH
Jinjer Kandola (JK)	Chief Executive Officer, BEH MHT
Natalie Fox (NF)	Chief Operating Officer, BEH MHT
Peppa Aubyn (PA)	ICP Mental Health Joint SRO & Assistant Director of Commissioning, NCL CCG, Enfield Borough