Enfield Borough Partnership

Update on the NCL ICS and Borough Partnership Programme

Health Scrutiny Panel

6th December 2022

North Central London Integrated Care System

NCL ICS

Cross Borough Partnership Developments

October 2022

North Central London Integrated Care System

Where have we got to…

- Formed and arrived at agreement on Borough Partnership Decision Framework [document that sets out ambitions, accountabilities, how we'll approach resident and community engagement, resources and capability, neighbourhoods].
- Distilled priorities at place, system and in terms of population health
- Developed thinking about role of chair / leader for place – drafted role description
- Progressing work within ICS about communications and engagement and data task at place level
- Helped shape and adopted outcome framework

Highlights from Framework

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Ambition / Vision

- Borough Partnerships will *reduce health inequalities through dual focus on improving quality and accessibility of health and care and tackling wider determinants*
- Strong relationships between system and place
- Spaces for regular and structured sharing between boroughs, ‘safe space’

Exec Groups

- Will take on a more formal role – joint committee / committee in common
- Overseeing delivery of shared statutory responsibilities
- Manage local risks, operational, strategic and political
- Oversee delivery of borough plan
- Oversee delivery of key transformation programmes

How we will work

- Ensure work is embedded within and informed by local communities
- Drive co-design and co-production with residents and stakeholders
- Shape and refine the operating model for place – bringing together transformation capacity over time
- Neighbourhoods as core priority, key unit for multidisciplinary working and integration on frontline
- Using data and info at neighbourhood level to enable integrated care
- Have a shared set of financial duties including: identifying and delivering efficiency, transparency of budgets and spend, oversight of shared budgets, steering use of investment to support priorities and drive improvement

Outputs

- Publish a local partnership plan, including a core set of actions and deliverables that will work for and are reflective of the local area
- Work to deliver indicators agreed through NCL outcomes framework

Priority focus areas

North Central London Integrated Care System

1 Local priorities

- ✓ Increasing the uptake of Vaccs & Imms. (Childhood Vaccs. & Imms., Flu, Covid19)
- ✓ Improving Mental Health and wellbeing
- ✓ Improving the health and wellbeing of children, young people and families
- ✓ Improving access, discharge & crisis services
- ✓ Developing neighbourhoods – and integrated models of care / pathways for delivery
- ✓ Digital inclusion, and other means of addressing social isolation
- ✓ Joining up health and care workforce development, including employment support & jobs for local people
- ✓ Tackling inequalities – via NCL inequalities fund, other local resources (e.g. community chest)

2 Outputs from population health framework

- ✓ Developing, rolling out and embedding HealtheIntent across frontline delivery
- ✓ Responding to identified priorities from current HealtheIntent analysis e.g.
  - Vaccs & Imms coverage
  - Smoking prevalence
  - Cancer screening
  - Care planning for mental health
  - Flu vaccination coverage
- ✓ Further analyses focussing on population sub-cohorts, geographical disparities

3 System-level health improvements

- ✓ Implementing outputs of strategic commissioning reviews for CYP services, Adult Community Services & Mental Health services
- ✓ Scoping and implementing a response to the Fuller report framework for action
- ✓ Local engagement in the Start Well review
- ✓ Continued vaccination programme support – including Covid19 autumn campaign, polio, and community outreach
- ✓ Embedding an integrated paediatric service model in all neighbourhoods
- ✓ Mobilising the winter plan – ED front of house, supported discharge and virtual ward scaling
- ✓ Actioning reviews around asylum seeker and homelessness health and wellbeing

Enabling functions

- ✓ Developing a more integrated approach to community and civic engagement
- ✓ A joined up approach to planning and delivering new and improved estates in response to system need
- ✓ Sharing and driving our anchor commitments around workforce

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Enfield Borough Partnership:

Place Based Development – National Programme

November 2022

Contents:

Local Context - 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

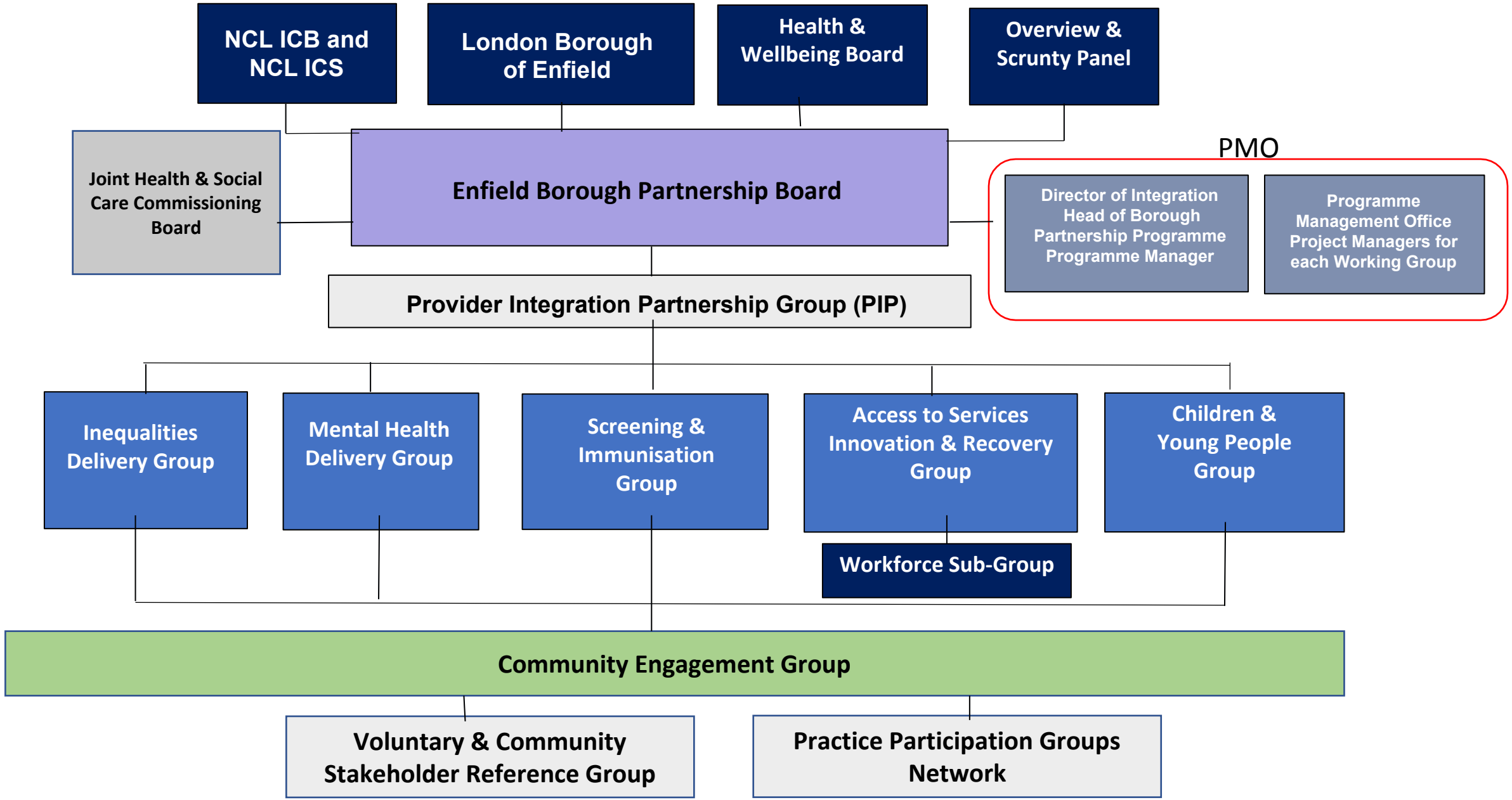
- NEL 12% and Elective 20% higher national average Edmonton Green
- 600+ attendances NMUH A&E with significant unregistered population

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 2020/21. Average reduction of £800 per household for core funded services

Disadvantage generally accumulates through life **– Marmot Review**

Enfield Borough Place based Partnership - Governance Structure July 2022



Place Based Partnership Working & Programme Modules

The statutory members of our partnership are:

- London Borough of Enfield
- Enfield Borough, North Central London CCG
- North Middlesex University Hospital & Royal Free London Hospital (inc. Barnet & Chase Farm Hospitals)
- Barnet, Enfield and Haringey Mental Health Trust (inc. Enfield community Services)
- VCS organisations supporting delivery of front line services (e.g. Enfield Voluntary Action -health champions and social prescribing, Enfield Carers Trust, Age UK)
- Enfield GP Federation and 5 Primary Care Networks (PCNs)

In addition to this work:
Enfield has been working with The Leadership Centre & Traverse to drive the **Strategic Development** work required for the Enfield Borough Partnership.

We have worked hard to ensure that the Enfield Place Based Development work focuses on **Operational Delivery opportunities** and does not duplicate effort.

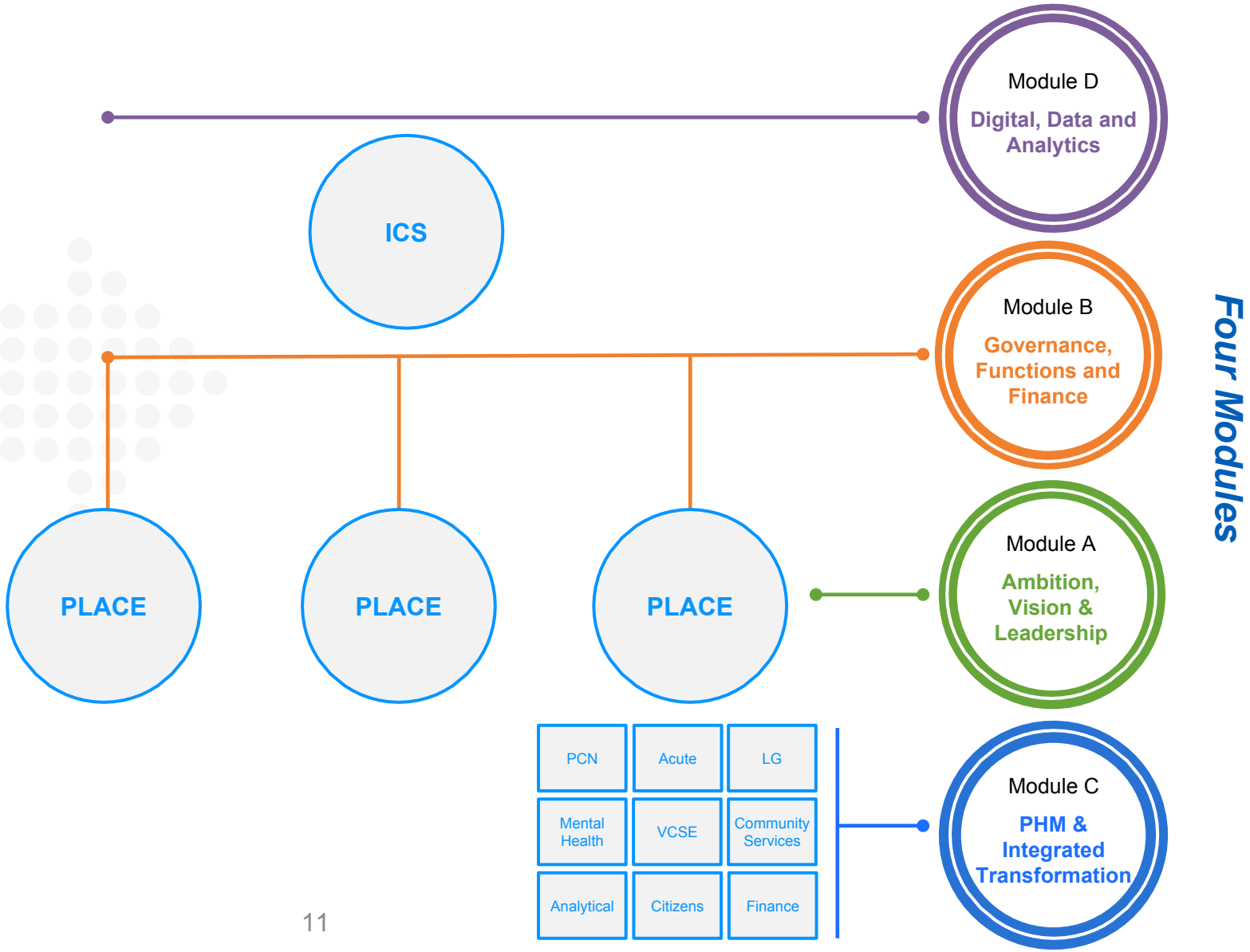
The Place Based design national offer comprises 4 Modules:

Module A - ***Leadership***	Strengthening the local vision through collaborative leadership, focused on outcomes for the population
Module B – ***Governance & Finance***	Sharing resources on a system basis while being Place & Neighbourhood focused to drive effective local decisions
Module C – ***Population Health Management***	Using this approach aims to improve the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population
Module D - ***Digital Development***	Developing a digital approach to help to improve access to health and social care services

ICS Population Health and Place Development Programme

The Programme set out to work in the following way:

- **To work in a joined up way across the different levels of an Integrated Care System.**
- **To respond to our priorities, developed through four core learning modules.**
- **Delivered online through up to 10 sessions per Module**
- **Offer of coaching and mentoring**



ICS Population Health and Place Development Programme

Aim of the Programme

- This has been designed to help Enfield Borough to deliver the best possible population health outcomes for its residents
- The support provided by the national offer will accelerate and embed the adoption of Population Health Management (PHM).

Why is Place based working so important?

- Breaks down institutional silo's and draws together support and services around people and the local population
- Best utilises the shared resources and assets of a Place
- Helps to tackle local problems, drawing on creativity of people from across the Place
- Emphasises the importance of community and citizen involvement in the design/delivery/evaluation of services and support

What role can PHM play in Place based health and wellbeing?

- Considers the wider determinants of health and inequalities, not just health and care
- Improving health inequalities by taking action
- Using data-driven insights and evidence of best practice to inform targeted, proactive interventions to improve the health & wellbeing of specific populations & cohorts
- Making informed judgements - clinical, public health and analysts working together
- Making best use of collective resources – workforce and incentives - to have the best impact
- Acting together – the NHS, local authorities, public services, the VCS, communities, activists & local people. Creating partnerships of equals
- Achieving practical tangible improvements for people & communities

Leadership & PHM Workshops

Priorities from the borough partnership PHM analyses it was agreed to focus on:

- ❑ Preventing & Reducing Tobacco Dependence - vaping vs. tar based
- ❑ Preventing & Reducing Overweight People from becoming Obese

Definitions of Population Health & Population Health Management discussed:

Population Health…
… is an approach aimed at improving the health of an entire population.

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management…
…improves population health by **data driven planning and delivery of proactive anticipatory care to achieve maximum impact within collective resources**.

It includes **segmentation, stratification** and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and **targeting interventions to prevent ill-health** and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

Following in-depth discussions of the partner members, it was agreed:

- ○ **The population cohort we should focus on is:**
  - ❖ **18 – 40 year age group – who smoke and who are obese or at risk of becoming obese**
  - ❖ **Living in the 20% most deprived areas**
  - ❖ **Other determinants of health to be considered , including cost of living crisis and poverty, social deprivation, education, access to fresh food, and access to green spaces**
- ○ **Partner members would identify operational leads to drive the development of the borough delivery plan in their respective organisations**

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'Place-based partnerships should centre their work around a clear, shared vision of what the partnership is trying to achieve for local people and communities. The development of new structures and governance arrangements is secondary to this and must not become the principal focus. (The King's Fund)'

Case for Change:

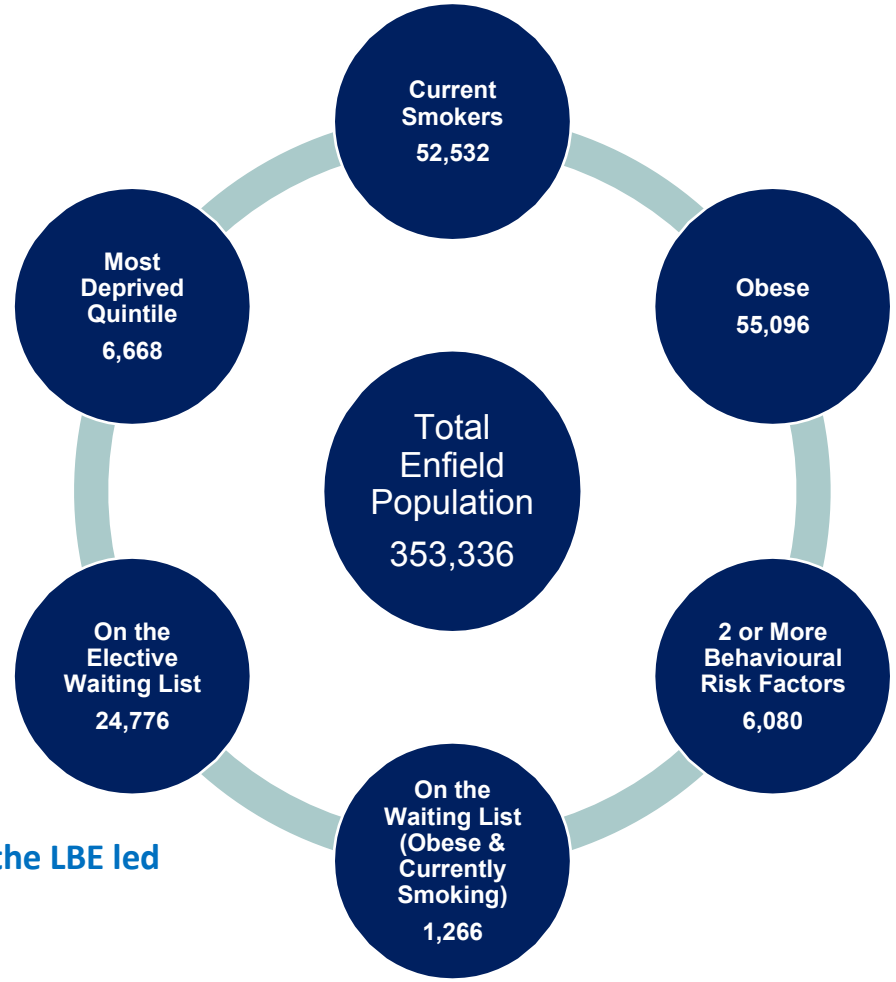
- ❑ 55,107 (20.5%) patients are reported as obese
- ❑ Obesity is high in the most deprived quintile and age 65yr
- ❑ 52,612 (19.6%) patients are current smokers
- ❑ Smoking prevalence is highest in:
  - the most deprived areas of the borough
  - The Turkish, Polish and Irish community groups

Wider determinants of health to consider:

- ❑ Unemployment / poverty
- ❑ Access to healthy food
- ❑ Access to green spaces

Aspects to consider during intervention design:

- ❑ Language, English / Turkish / Polish / Other
- ❑ Children in the household and childhood obesity
- ❑ Cultural co-production
- ❑ Use of social media/community spaces (e.g. libraries, building synergies with the LBE led work including development of community hubs



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Local Priorities

- ❑ **Preventing & Reducing Tobacco Dependence - vaping vs. tar based**
- ❑ **Preventing & Reducing Overweight People from becoming Obese**

Last 100 Days

The following progress has been made to date:

- Have started to articulate a good case for change
- Have gathered evidence to inform and influence the ICB, particularly to secure further resources to help deliver at borough level
- Have reached out to staff on the ground who engage with our patients
- Have engaged with colleagues who's work focuses on our target groups of smoking and obesity
- Agreed the need to develop a standardized approach to access services, and a definitive directory of available resources to aid signposting.

Next 100 Days

As we start to shape our plan for the next 100 days:

- We recognise the scale of the challenge
- Consider how to take forward the learning that emerged in the first 100 days Look at the longer term future
- Use intelligence to help us define intervention
- Ensure local incentives are appropriately aligned to ICS level priorities
- Ensure sufficient infrastructure and capacity supports delivery
- Develop a model in order to track and monitor the impact over time, including metrics and indicators for each outcome.

Looking at holistic interventions that will lead to positive change:

In the short to medium term:

- Work will include looking at wider determinants of health
- Quantified quit rates within a measured time frame
- Looking at eating habits to support the cohort signposting
- Reduce smoking, and the use of tar based products based on NICE recommendations
- Explore the effects of vaping
- Reduce the impact of second-hand smoke on children and families

In the long term:

- Individuals in the cohort will be engaged in their own health care and well-being
- Looking for long term reduction rates of associated co-morbidities such as CBD hypertension, Cancer, COPD etc.
- Reduction in smoking prevalence and obesity.

Local Population Health Improvement priorities in 2022/23

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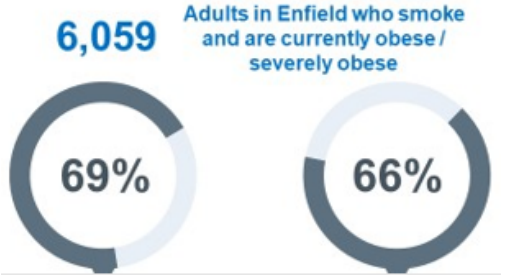
Population characteristics of individuals who smoke and are currently obese/severely obese



- Data is not currently readily available at a level of granularity that allows us to look at the demographic characteristics of individuals aged 19-40 living in the 40% most deprived areas
- We estimate that between 2,767 and 4,170 19 to 49 year olds in Enfield who smoke and are currently obese / severely obese
- The upper bound is the total number of individuals living in the 40% most deprived LSOAs
- The lower bound is 66% of the total
- However, people living in the most deprived areas are more likely to be young; therefore, it is safe to assume that the size of the cohort is closer to ~4,000.

NCL Population Health Improvement Strategy: Enfield Borough

Borough:	**Enfield**	**Where/who PHI Strategy & OF have been socialised:**	• Borough Partnership (PIP/Board) • Health and Wellbeing Board • VCSRG • PCN/Clinical Director Forum
Borough view on outcomes/ focus areas for NCL:	• Addressing Inequalities – Core 20 Plus 5 • Smoking – reducing harm from tobacco • Obesity – Diet, physical activity, environment • Physical & Mental Wellbeing • Wider determinants of health – isolation, debt, housing, employment, education, cost of living, food poverty • Climate change/social responsibility • Integrated workforce, working across organisational boundaries • System cost analysis.	**Borough view on outcomes/ focus areas for Boroughs:**	• Obesity – reducing the risk of people who are overweight from becoming obese • Smoking – reducing harm from tobacco • Inequalities • Access to Services, Recovery & Innovation – to include workforce • Screening & Immunisation • Mental Health (including Community Services Review) • Children & Young People • Communication & Engagement – Community Fund, to improve health literacy and involve local residents to inform local priorities.
Next steps to support population health improvement delivery (over next 12 months): (e.g. further socialisation, programme mapping, deep dive analytics, etc.)		**Suggestions/requirement from NCL to assist with next steps & onward delivery:**	
• Socialisation of the Population Health Strategy • Identification of key actions by groups • Deep dive analytics and interpretation • VCS – Community Participatory Research		• Programme management support • Additional PHM analytics and ICB analytical support – develop borough dashboards for health and care service provision • Shared intelligence, systems and data	

Function	Functions needed at Place level in Enfield		
	For Smoking (& reducing harm from tobacco)	**For Obesity**	**Discussion on Developing Place**
Strategy & Planning	• Lead engagement with local people/residents • Lead the development of a local strategy • Manage the co-production with residents & partners • Identify best practice approaches	• Lead engagement with local residents and HWBB • Appoint a local Obesity Champion and a Food Quality Champion • Focus on obesity and health outcomes at a whole population scale • Define what success looks like for obesity	**KEY POINTS** • Involving wider stakeholders in the Partnership's decision-making • Articulating role and functions, and how they fit with those of the ICB • Confirming and socialising the functions • Considering what this means for how we organise and govern our work **RESOURCES** **Resources we have across the partnership include**: • A borough partnership office with a programme support team • Pooled funding e.g. Community Engagement Fund • Sufficient workforce pan-borough to support priority initiatives • Use residents as a resource & influencers e.g. faith group & networks • Consolidate "Healthy Intent" and other evidence of what has worked • Significant physical assets across organisations • Strong relationships / trust formed across the ICS. **What resources do we need?** • Political will and power to implement these ambitious strategies • All ICS partners being willing to be educated and understand how the ICS impacts them • VCS organisations must see themselves as part of solution • Enfield NHS commissioners must support the development of emerging business cases **How could we close the gap? (including by stopping things…)** • Financial resources /funding need to be unlocked • Identify commissioner skills to support development of business cases • Consolidate evidence to demonstrate the case for change • Clear communications & engagement strategy needed to explain how ICS impacts different groups • Work with head teacher forums to develop avenues into partnership working with schools.
Service Design & Delivery	• Identify innovative initiatives & models to tackle tobacco • Design services & initiatives to prevent young people becoming addicted to tobacco	• Focus on changing behaviours/prevention • Align capacity requirements with service design • Collate local population health data • Signpost obesity services to residents	
Collaborate with Partners	• Lead the development of a local partner collaboration strategy • Collaborate across partners to support delivery of initiatives • Support partners to drive tobacco/smoking cessation through engagement • Collate local intelligence to inform where/how efforts are best targeted • Establish joint working groups to tackle tobacco • Manage engagement with senior stakeholders of organisations	• Collaborate with partners to provide better food options • Develop proactive information based campaign for engaging with partners • Coordinate development of a comprehensive obesity strategy and plan • Drive up advocacy amongst local partners & facilitate exchange of information • Develop an anti Obesity Charter for partners to sign up to • Drive behaviour change in anchor organisations to act as role models • Develop common terminology around obesity	
Performance & Finance	• Develop performance models • Ensure resources are aligned to deliver • Ensure full involvement of holders of community wellbeing council contracts • Define realistic outcome-based targets within the available resources • Monitor performance against targets	• Develop a sustainable regime for reporting performance/finances to the system • Set realistic performance targets • Monitor/report on delivery against obesity initiatives • Disaggregate information/data from system level to more local level • Consolidate information to measure success	
Quality & Risk	• Ensure quality & risk management are aligned to patient/resident experience/stories • Manage escalation/communication on quality/risk to the ICB.		

The Fuller Stocktake Report sets out a vision for integrating primary care

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**
- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

The new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

- **Neighbourhoods of 30-50,000**, incorporating teams from
  - across primary care networks (PCNs),
  - wider primary care providers,
  - secondary care teams,
  - social care teams, and
  - domiciliary and care staff
- **Working together** to:
  - share resources and information and
  - form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and
  - tackling health inequalities.
- **PCNs have already enabled many neighbourhoods to progress** – but limited by lack of infrastructure / support.

The report also highlights the need to build integrated teams in every neighbourhood

Integrated neighbourhood 'teams of teams'

- **Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks** (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population.
- **They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.**
- **Cultural shifts needed to enable this**:
  - Move towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community;
  - Realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams.
- **Leadership is also a key ingredient** – fostering an improvement culture and a safe environment for people to learn and experiment

Delivering integrated neighbourhood teams of teams

Requires a step-change in progress, with a **systematic cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods.** This will unlock improvements in patient care and help individual PCNs and teams to better manage demand and capacity, building resilience and sustainability. For example:

- **full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints'**, working alongside dedicated, named specialist teams from acute and mental health trusts, particularly their community mental health teams
- **making available 'back-office' and transformation functions for PCNs,** including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (e.g. GP federations, supra-PCNs, NHS trusts)
- **a shared, system-wide approach to estates**, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

Community Hubs:

Creating a 'bridge' between the Council's Early Help for All Strategy and a range of targeted support for residents in need

Four Pillars – current support & referral pathways

Health & Wellbeing	Jobs & Skills	Housing Stability	Money
• Food Pantries (Appendix 2) • ABC Parents • Enfield Community Psychological team • Age UK • NHS Digital First Programme • NMUH Midwifery Service • Enfield Food Alliance • EVA • NMUH Health & Wellbeing Hub	• Local Employment Team (New) • 50+ Job club • Informed Families/ • Training • EVA • Community Development Team	Housing & Immigration Service Street Homeless service Floating Housing Team Link to Homelessness Team	• Welfare & Debt Advice • CAB • Informed Families • Enfield Connections

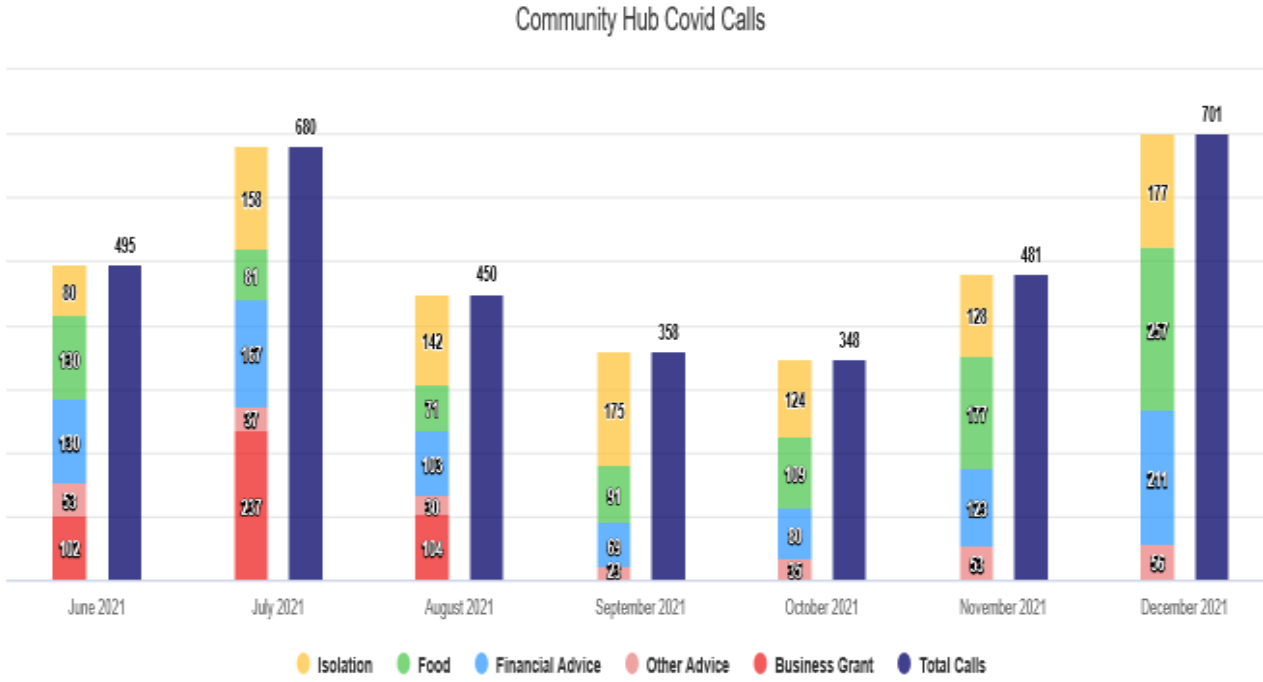
Community Hubs contact with customers 2021/22

Our Community Pantry

- **Strictly a referral-based model, with bespoke customer action plans.**
- **Provision by Enfield Foodbanks, Felix Project and ASDA so far…**
- **Cheaper and healthier alternatives to mainstream shopping for people who are in poverty.**
- **Promoting self-esteem**

Lead by the creation of a Food Action Plan for Enfield to ensure that all families have access to healthy food as per Enfield Poverty Inequality Plan 2020.

Our community-led model; with community volunteers operating the pantry, nudges people who can self-help, away from complete dependency on food banks, so those in most need can access the support.



Community Powered Edmonton

Partnership: NCL Integrated Care Board, Edmonton Community Partnership, Healthwatch Enfield, and New Local

What we did

- Three workshop discussions bringing together residents, VCSE groups, and public sector (NHS and local authority) led by New Local
- A showcase event led by ECP and involving Platinum Performing Arts, allowing young people and residents from GRT Bulgarian and Roma communities to share their lived experience and stories through music, poetry, dance, film and panel discussions, captured by a graphic scribe.
- A series of focus groups and a survey led by Healthwatch Enfield, capturing the perspectives of particular communities (e.g. mental health service users, Turkish women's group)

Living a healthy life in Edmonton – what do we know

- This workshop discussed what helps people and communities in Edmonton to live a healthy life, and what gets in the way of their health and wellbeing.

Talking and listening to improve health and wellbeing

- Public sector staff and residents in Edmonton engaged in a community conversation to better understand what matters to local communities, so that local public service providers can listen to ideas and co-design changes.

Taking action to address health inequalities

- Bringing together residents, VCSE organisations, and public sector organisations to focus on practical actions which could be taken to work more collaboratively to address health inequalities in Edmonton.

What we heard

Biggest issues affecting people & communities' health & wellbeing in Edmonton:

- **Safety:** for young people and the wider community
- **Poverty:** facing financial hardship which has a negative impact on health, wellbeing and feelings of exclusion
- **Social isolation:** even though community, friends, and family are highly rated factors to support health and wellbeing locally
- **Mental health:** an issue affecting many communities, heightened in some due to stigma or mistrust of treatment options e.g. Bulgarian
- **Language barriers & lack of knowledge and confidence:** to access services
- **Digital exclusion:** not always being IT literate to be able to access available information and support

Blocks to effective collaboration between communities and service providers:

- **Lack of trust:** because the time hasn't been taken to build relationships, or people feel 'let down' by the system
- **Knowledge and awareness:** people don't always know where to go or what services exist (e.g. if different in their host country)
- **Language barriers:** limits understanding and communication
- **Engagement skills:** professionals need to be supported to collaborate well with people and communities
- **Lack of personalisation:** people and communities will need different things, sometimes the system doesn't allow for this
- **Lack of safe spaces for collaboration:** not enough bringing together of the public sector with people and communities

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Next Steps

Summary of Key Actions/Priorities

1.	**Winter Community Resilience Forum**	We will drive this via the Access to Services, Innovation & Recovery Group, and through other meetings across the borough partnership.
2.	**Data and information**	To be used to understand trends and think about how we work collectively as a place partnership to make change happen, not just for 6 months, but for ongoing resilience as a place, and as part of the Integrated Care Board, Integrated Care System.
3.	**Strengthen our relationships**	In order to cement our structures
4.	**Think about our resources**	What additional resource do we have within the Borough Partnership programme. We have established new Children & Younger People Group, and due to set up the Enfield BP Engagement & Communication Group
5.	**Convener and clinical director roles**	How they will help us develop our leadership model for Enfield
6.	**Leadership around population health**	Including the LTC programme across NCL and work we're doing locally, and ensure we get the right level of support for Enfield.
7.	**Next 100 Days**	As we shape the care model, articulate what we must do in the short > medium > long term
8.	**Develop a lifestyle network**	Model based around a population health perspective, by resource mapping (in the next three months), and establishing a Task & Finish Group to shape and drive this work in partnership with our residents.
9.	**Become a Core20Plus5 Accelerator Site**	Take forward this opportunity to gain further resource to help us take this programme of work forward.
10.	**Develop our Digital Inclusion work**	Via the Access Group. Consider the ICB Digital Inclusion Plan & the challenges our residents have in terms of accessing solutions.
11.	**Governance**	• Crucial to have sufficient support to manage this programme of work: 18+ projects currently in the programme of work that must be managed; including taking stock of what our inequalities programme of work is achieving and establish strategic oversight. • Source analytical support around population health, and build on collaborative partnership working with public health • Work with the GP Federation and PCN clinical directors to look at our Borough Partnership governance, and our neighbourhood based multidisciplinary structures going forward, between now and April next year.
12.	**Embed the VCS into all aspects of this programme**	Consider how we resource them, in terms of our leadership model and our financial model, and how we ensure they have time to meaningfully participate and contribute to this important work.