MEETING
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
MONDAY 20TH MARCH, 2023
AT 10.00 AM
VENUE
HENDON TOWN HALL, THE BURROUGHS, HENDON NW4 4BG

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	AGENDA AND REPORT PACK	3 - 80

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NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Dominic O'Brien, Principal Scrutiny Officer

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Monday 20th March 2023, 10.00am.
Committee Room 1, Hendon Town Hall, The Burroughs, London NW4 4BG

Councillors: Philip Cohen and Ann Hutton (Barnet Council), Larraine Revah (Vice-Chair) and Kemi Atolagbe (Camden Council), Kate Anolue and Andy Milne (Enfield Council), Pippa Connor **(Chair)** and John Bevan (Haringey Council), Tricia Clarke **(Vice-Chair)** and Jilani Chowdhury (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

1. FILMING AT MEETINGS

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2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under item 10 below).

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

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Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

6. MINUTES (PAGES 1 - 12)

To approve the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 6th February 2023 as a correct record.

7. WINTER RESILIENCE UPDATE (PAGES 13 - 26)

To provide an overview of the approach to winter resilience in NCL for 2022/23 including the High Impact Winter Action Plan and additional funding for winter demand/capacity and discharge.

8. HEALTH INEQUALITIES FUND (PAGES 27 - 46)

To provide an overview of the £5m health inequalities fund which supports schemes targeted at the most deprived communities in NCL.

9. PRIMARY CARE UPDATE (PAGES 47 - 64)

To provide an update on NCL primary care and an overview of community pharmacy integration in NCL.

10. WORK PROGRAMME (PAGES 65 - 74)

This paper provides an outline of the 2022-23 work programme for the North Central London Joint Health Overview and Scrutiny Committee. This item provides an opportunity for Committee Members to select items for inclusion in the 2023-24 work programme.

11. NEW ITEMS OF URGENT BUSINESS

12. DATES OF FUTURE MEETINGS

Dates for 2023/24 TBC.

Dominic O'Brien, Principal Scrutiny Officer
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Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
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Friday, 10 March 2023

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Agenda Item 6

Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held on Monday, 6th February 2023, 10.00 am - 12.45 pm

PRESENT:

Councillors: Cllr Pippa Connor (Chair), Tricia Clarke (Vice-Chair), Larrine Revah (Vice-Chair), Kate Anolue, Kemi Atolagbe, John Bevan, Jilani Chowdhury, Philip Cohen, Anne Hutton and Andy Milne.

36. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

37. APOLOGIES FOR ABSENCE

None.

38. URGENT BUSINESS

None.

39. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

Cllr Jilani Chowdhury declared an interest by virtue of his son working as a doctor in Margate.

40. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

41. MINUTES

In relation to the action points from the previous meeting, Cllr Bevan requested a further update on the future inspection of GP practices. He noted that, according to the response received, inspections had not yet been carried out in Camden and

Haringey and that this would be dependent on the availability of funding. It was agreed that a further update would be provided from the North Central London Integrated Care Board (NCL ICB). **(ACTION)**

Cllr Clarke noted that, in response to a question from Rod Wells of Haringey Keep Our NHS Public (KONP), it had been confirmed that the St Ann's primary care contract in Haringey would be coming up for renewal, and asked for an update on the timescales for the review and next steps. It was agreed that a further update would be provided from the NCL ICB. **(ACTION)**

The minutes of the previous meeting were approved.

RESOLVED – That the minutes of the meeting held on 23rd November 2022 be approved as an accurate record.

42. NCL COMMUNITY AND MENTAL HEALTH CORE OFFER

Sarah Mansuralli, Chief Development and Population Health Officer for the NCL ICB, introduced the report on the NCL Community and Mental Health core offer, highlighting that the programme was one that aimed to address historical inequities in access to community and mental health services. She said that, as a new statutory body, the North Central London Integrated Care Board (NCL ICB) had a focus on improving population health and reducing inequalities. It was committed to improving outcomes for residents through an outcomes framework and these community and mental health services were seen as building blocks to delivering proactive integrated care and enable earlier intervention and prevention.

Sarah Mansuralli explained that the strategic review in 2020/21 started with a baseline review of services across NCL which identified a number of inequalities in access and also some differentials in outcomes and spend. This review then led to the co-design of the core offer in partnership with service users and in response to what patients said. The core offer aimed to meet different levels of patient need, including the differing needs of various patient cohorts. Multiple benefits were expected from the core offer and implementation was in progress with an ambitious plan of incremental improvement in services over the next five years.

Natalie Fox, Deputy Chief Executive and Chief Operating Officer at Barnet, Enfield & Haringey Mental Health NHS Trust (BEH-MHT) and also Camden & Islington Foundation Trust (C&I), expanded on this, noting that the core offer involved doing more by working in integrated ways in partnership with other statutory agencies and also local communities and voluntary organisations. The core offer for mental health recognised the variations that existed in the NCL area and was developed with input from clinical staff, experts by experience and local communities across the five boroughs. The core offer developed clarity on access, including what service users

could expect from services, what interventions should be provided and the skills and expertise that services should have. The work was linked to the NHS Long Term Plan for Mental Health and placed the service user at the heart of everything that service did. It also aimed to tackle the wider social determinants of mental health which impact on certain patient cohorts, such as the overrepresentation of young black men in mental health services. Through the core offer, services should be developed that people want to engage with and that are accessible for people with physical health conditions or other issues such as learning disabilities. The core offer journey aimed to offer the right care at the right time by the right person. It would also be important to make the workforce more resilient, improve staff satisfaction and offer employment opportunities to the local community through apprenticeships and 'expert by experience' roles.

The core offer was split across children and adolescents, young adults, working-age adults and older people with the various models set out in the agenda pack. For children and adolescents, this was based on the THRIVE model which involved a range of interventions to improve access to advice and support. For young adults (aged 18-25) the focus was on a central point of access with service sensitive to cultural and demographic factors that impact on how young people prefer to access care, such as through the 'Minding the Gap' mental health support service. For working age adults, there was also a central point of access to a range of services and community provision. For older people there was recognition that there were often more co-morbidities which required more support across different services.

Natalie Fox then responded to questions from the Committee:

- Cllr Connor remarked that there were a number of new initiatives involved with this work and asked how these would be delivered with the community and voluntary sector. Natalie Fox explained that some services were being developed with organisations while others were being commissioned with local providers. With investment coming in there was work ongoing across all five boroughs to pool resources to improve the community offer in partnership with local organisations.
- Asked by Cllr Cohen for further details about the finances, Natalie Fox said that there was a combination of new investment but also a recognition of productivity gains that could be made with existing investment. Sarah Mansuralli added that mental health services had benefitted from a stream of national government funding intended to achieve parity between physical and mental health services. In addition, there were specific service development funding initiatives linked to the long-term plan such as mental health support in schools. While this was not the case for community services, there had been a recognition in NCL that reorganising funding to support people outside of hospital could help to reduce demand on hospital services.

- In response to a request from Cllr Cohen for further details about virtual wards, Natalie Fox said that mental health had been a trailblazer area for virtual wards. This involved multi-disciplinary teams providing face-to-face services to people in their own homes as an alternative to hospital treatment.
- In response to a point from Cllr Atolagbe about the issue of cultural experience, Natalie Fox explained that, by working with experts by experience, this could help to understand how the service offer needed to change. There had also been local work carried out on health population needs. Developing the diversity and inclusion of the workforce could also help to improve the cultural sensitivity of services.
- Asked by Cllr Atolagbe about the lack of female long-term inpatient high dependency rehabilitation beds, Natalie Fox said that the data had been reviewed across the NCL area with a view to looking at how investment could be redeployed. A business case was being developed to look at whether further inpatient services could be provided within the NCL area rather than relying on services outside of NCL.
- Cllr Atolagbe asked how the success of the changes resulting from the Reviews would be judged. Natalie Fox said that there was an outcomes framework as well as long term plan metrics which specified what needed to be delivered included greater access to services. There was also an approach to patient care called DIALOG+ which enabled patients to communicate what they felt their needs were and then looking at whether those needs had been met at various points in time. Several ‘experts by experience’ from the Hive service in Camden, who had been invited to join the meeting, said that they were familiar with the DIALOG+ initiative with one saying that it seemed promising as it enabled feedback to be provided and help guide a way forward. Another explained that he was on a lived experience panel looking at DIALOG+ and that it was generally received favourably by the participants though some found the process to be somewhat mechanistic. Patients were asked to rate their satisfaction with 11 different aspects of their life (e.g. medication, housing, etc.) and those with the lowest scores then formed the basis of a discussion with a therapist to ascertain what action could be taken.
- Cllr Anolue asked whether best practice from previous initiatives were being incorporated into the newer projects. Tina Read, Head of CAMHS Transformation at BEH-MHT, responded that there had been examples of recent collaborative work, including learning from best practice in the Minding the Gap model in the young adult pathway in Camden to help inform other areas, such as transitions.
- Asked by Cllr Anolue about employment support for people involved with these initiatives, Natalie Fox confirmed that there had been investment in employment specialists in all five boroughs to support those already in employment to retain it, and to assist those out of work in engaging with employment opportunities.

- Asked by Cllr Anolue about staff representation of people of Black African origin, Natalie Fox said that there had been considerable work on staff diversity in BEH-MHT and C&I, including at Director level, across the five boroughs but accepted that there was more work to do.
- Cllr Revah requested further details about the waiting times to access CAMHS services and the transition to adult services. Tina Read acknowledged that the waiting times for CAMHS services were longer than they would want them to be and work was ongoing to address this, particularly to support young people most at risk in a timely way. She also acknowledged that transition between services could be a particularly difficult time for young people and so the primary focus of Year 1 of the improvement plan for the young adult pathway was the development of transition teams including key workers and clinicians to support young people during this phase. Tina Read said that details of the actual waiting times for transition to adult services could be provided to the Committee in writing. **(ACTION)**

Kay Isaacs, Director of Operations (North Central Division) at the Central London Community Healthcare Trust, presented details about the adult community services review covering the NCL area. She noted that for many years there had been fragmentation of community services across NCL, leading to inequities. The new core offer for all residents aimed to address this and had been co-produced to improve outcomes. The programme would involve working closely across the five boroughs with primary care, secondary care, social services and the voluntary sector to achieve more joined up services. In the first year of the programme there would be specific work on tissue viability, diabetes, virtual wards, rehabilitation beds, frailty models and long-term conditions. Community providers would be reviewing their local offer to build understanding about where the gaps in provision were and where investment may be needed. The most significant gap found so far was with residents with wounds who were not housebound as they did not have a consistent services across NCL – some may be referred to their GP while others may be advised to go to a walk-in centre – and this had an impact on healing rates. The overall intention was to deliver a local service that meets local needs but with more consistency across NCL.

Vanessa Cooke from the Whittington Health NHS Trust spoke about the aim of reducing variation in the core offer for children and young people's (CYP) services. As had been said previously about other services, there were a range of providers across NCL with gaps and inconsistencies in some areas and so practical change to work together was important to make better decisions about investment and areas of change. In general, outer London Boroughs had lower investment but there were demand pressures across NCL that could not be met. Slide 37 in the agenda pack provided a summary of the challenges that had been identified and how services would be developed in response. For example, this included investment in health assessments for looked after children across NCL and this required new money in four of the boroughs to increase provision and reduce variation. By building early

intervention and having good universal support for all children, this could avoid the need for more targeted and specialist support in future, reducing long-term demand pressures.

Seema Islam, Chair of the 'Our Voices' parent carer forum in Enfield, explained that the sooner that intervention and access to services for children with autism/ADHD took place, irrespective of when diagnosis was made, the sooner the quality of life improved for them.

The experts by experience then described their use of the Hive service in Camden, which was described as a dynamic, preventative service. Helena said that she had been visiting the Hive for three years after a recommendation from her GP and had accessed a number of services including one-to-one meetings, a women's group and an LGBT group. She said that the Hive provided a good multi-faceted service but unfortunately this type of service was not available to many people in other boroughs. She also highlighted the higher accessibility of the Hive in comparison to some other NHS mental health services.

Nick explained that following his autism diagnosis, he found that the service offer to him was very limited as he was regarded to be high functioning. He felt that access to informal drop-in support would be very helpful, rather than having to go through his GP for everything, particularly because GP appointments were difficult to obtain at present.

Cllr Connor asked whether this service model could be replicated elsewhere. Sarah Mansuralli said that the overall plan was to recognise where there was good practice, look at the gap analysis and then go through a prioritisation exercise as resources were limited. This meant that, while services like the Hive might not be available across the whole of NCL by next year, services and the workforce required, would be built up incrementally. Natalie Fox added that there had been considerable investment recently in crisis cafes and drop-in centres across all five boroughs, but acknowledged that there was more work to do in reaching people.

Committee Members then asked questions to those present:

- Asked by Cllr Clarke about the definition of prevention, Vanessa Cooke said that prevention was about helping people to stay well and meeting their needs at the point they were at. In the context of CYP services she said that this was about young people being able to access support in a timely way when they need it rather than waiting until their issues became more complex.
- Asked by Cllr Clarke about the use of dialectical behaviour therapy, one of the experts by experience described this as an approach for people with complex emotional needs that included mindfulness and relies on the person getting in touch with their emotions.

- Cllr Revah highlighted the importance of early intervention for people with autism, including because of the difficulties that can be experienced in education settings if it is undiagnosed. Seema Islam responded that there was an ongoing 'autism in schools' project supporting parents and schools to work more closely together. She emphasised that children having their needs met was more important than having a diagnosis. Vanessa Cooke added that other work with schools included joint training and the Senco forums which were attended by representatives of autism services. Sarah Mansuralli added that networking between groups of schools could help to spread learning in this area. Vanessa Cooke acknowledged that long waits for diagnosis was a big issue and said that a significant amount of one-off investment was being provided to increase capacity across NCL, targeted at children and young people who had been waiting the longest.
- In response to a point from Cllr Revah about support for parents, Natalie Fox said that the care packages provided were for the parents as well as the children with an allocated key worker. There were also community navigators that worked with families over a longer period of time.
- Cllr Anolue commented that autism diagnosis was particularly important as parents needed to know what their child needs support for and what services they need to access. Seema Islam responded that it was still important to children to be able to access service before diagnosis in order to prevent deterioration. Vanessa Cooke added that there was a range of support available before diagnosis but it was recognised that more was needed at an earlier stage. Nick added that diagnosis opened a lot of doors in terms of access to certain services and entitlements.
- Asked by Cllr Connor how long the autism/ADHD assessment waiting times currently were, Vanessa Cooke said that this varied across NCL and that there were complexities due to different providers and different types of assessment processes. Although more resources were being provided, referral numbers in the past 6-12 months had risen so this was impacting on waiting times. Some specific data on this could be provided to the Committee in writing. **(ACTION)**
- Asked by Cllr Atolagbe about signposting to mental health support for parents and children, Sarah Mansuralli commented that service users are sometimes concerned on a Friday about accessing support over the weekend and weren't always aware of support available such as crisis cafes. She felt that there was potential to promote this information more widely, including online.

Alex Tambourides, Chief Executive of MIND in Enfield & Barnet, then spoke about the work of the organisation, noting that it sees around 5,000 people with mental health issues per year and for MIND organisations across the NCL area this figure was around 20,000 people per year. He added that 77% of their staff had lived experience of mental health issues. He said that a recent Mental Health Trust document had pointed out that most positive outcomes for mental health issues had a social route.

However, the levels of investment required for such support did not match clinical funding. For MIND, prevention was at the core of their work and they provided a well-being network, with therapy and integrated services provided in partnership with the Mental Health Trust. They also ran a crisis café in Barnet at which around 800 people were supported per year, though more could be done with additional funding and staff. He added that more one-to-one support workers were needed in mental health as opposed to more social prescribers and community navigators.

Lynette Charles, Chief Executive of Mind in Haringey, said that MIND organisations across London recognised that they needed to fill gaps on the ground. She welcomed the core offer and that what was needed on the ground was a needs-led framework to help address issues that people were facing such as problems with the cost of living and the huge demand for housing. There were also concerns with the precarious situation in the voluntary sector waiting to find out whether contracts held with statutory partners would be renewed. Other concerns of residents around services remained basic issues such as the ability to contact home treatment teams or care coordinators and so they were not currently seeing the transformation in services.

Ruth Glover, Clinical Director at Open Door, explained that her organisation provided a voluntary sector mental health service including talking therapies in Haringey for 12-25 year olds and their parents and carers. Most of the team had been trained in the NHS. Their service user issues included autism/ADHD, children in care and involvement in youth violence. The age range of 12 to 25 that they supported meant that the transition stage was covered which could be a challenging time and when young people needed the space and time to talk. About a third of the young adults that used the service were recognised as neurodiverse, though this figure could be significantly higher in reality. Demand and the number of referrals to the service had increased in recent years but this had not been matched by funding and so it had been necessary to close the waiting list for a time. Some new funding had now been received and there were currently around 50 young people on the waiting list. As well as an increase in the overall demand for services there was also an increase in the complexity of need. As this was happening across the sector, this presented recruitment and staff retention challenges.

Committee Members then asked further questions:

- Asked by Cllr Connor about the challenges in stability and funding for voluntary organisations, Natalie Fox said that a large proportion of the investment into the core offer was going to the voluntary and community sector. This included experts by experience and peer support coming into the offer. BEH-MHT and C&I recognised that a partnership strategy with the voluntary sector was needed to improve joint working processes. Alex Tambourides commented that voluntary sector organisations were very small compared to statutory partners and said that it was good to hear about a partnership strategy but it was necessary to work out what each organisation was responsible for. MIND

provided IAPT services in Enfield and Barnet and MIND in London ran services for people on CAMHS waiting lists and this all required funding to keep going. Ruth Glover added that better access to psychiatry was needed due to the increased level of complexity that was being seen.

- Cllr Milne asked what progress was being made to enable service users to only have to provide their information once, as doing so multiple times could be frustrating for people. Natalie Fox said that NCL ICB currently had a project looking at healthy information exchange with providers able to add and access patient information. Sarah Mansuralli added that this brought a variety of data sets together but that it was taking some time for all Trusts to add their data and keep it updated in real time. Alex Tambourides commented that data sharing was moving in the right direction and suggested that wider use of information passports which allows people to transfer their information between organisations, including voluntary sector organisations. Ruth Glover added that trusted joint assessments could help in this area.
- Cllr Hutton raised the wider issue of communications with residents, including how widely available information about services was, including information being provided in a culturally appropriate way. Natalie Fox acknowledged that there was a big piece of work to do on communications and ensuring that people can easily get information about accessing services.
- Referring to the investments on slide 37 (page 49) in the agenda pack, Cllr Cohen asked about the sources of the funding for these and how many years they lasted for. It was agreed that further information on this would be provided to the Committee in writing. **(ACTION)** Cllr Connor noted that there were also requirements for savings on the slides. Kay Isaacs reported that there was an error on page 55 of the agenda pack and that where it stated 211,000 bed days this should actually read 21,000 bed days.
- Cllr Chowdhury raised concerns about the resilience of the workforce and the short-term nature of some funding for service providers. Lynette Charles and Alex Tambourides also highlighted challenges with instability in funding arrangements. Natalie Fox acknowledged that smaller pots of short-term funding could cause difficulties and observed that this was an issue in the statutory sector as well as the voluntary sector. She also referred to the NHS People Promise, recognising that staff across a lot of services had been through a difficult time so there was an issue about resilience, wellbeing and supporting staff.
- Cllr Connor explained that Councillors often experienced issues in local communities with people in mental health crisis who typically came into contact with the Police rather than mental health teams and asked what was being done to address this. Natalie Fox responded that community transformation was about engaging with service users earlier in order to prevent them from reaching crisis point. The other active piece of work was liaising with the Police so that they could contact mental services and direct people to alternative care

options rather than using S136 (under the Mental Health Act). Each Borough also had a mental health liaison officer.

- Nick referred to an recent government announcement about 'mental health ambulances' which was based on the idea that these emergency vehicles, staffed by people with mental health training, were better placed than the Police in dealing with an individual in crisis, assessing them and transporting them to the most appropriate location. Natalie Fox confirmed that they were already engaged with this project in NCL. Lynette Charles highlighted the adverse impact on the black community in S135/136 police interactions and reported that MIND has provided training to 192 police officers on mental health awareness to help them in these situations.

The Committee than made recommendations for a follow-up agenda item:

- That an updated report on the mental health and community health service reviews be provided to a meeting of the Committee in approximately 12 months time.
- That the updated report should cover a range of issues of interest to the Committee including:
    - Partnership working with the voluntary sector.
    - How well signposting was working and how the availability of services was being promoted/communicated to residents.
    - What support was provided when voluntary services were not able to cope with demand (such as when Open Door were forced to close their waiting list)
    - The availability of advocacy & patient support and the availability of psychiatric support.
    - Waiting times for autism/ADHD diagnosis.
    - Progress on support for the workforce and recruitment/retention.
    - Challenges with the use of small, limited pots of funding to provide services.
    - The social route of mental health support, such as cost of living and housing issues.
    - The service offer for older people.
    - Police S135/136 interactions and the 'mental health ambulances' project.
    - The cultural sensitivity of services.
    - Support for people with disabilities.

43. WORK PROGRAMME

The Committee discussed possible items for inclusion on the agenda at the March meeting and raised the role of community pharmacies and the difficulties that some residents experienced in obtaining GP appointments.

44. DATES OF FUTURE MEETINGS

- 20th March 2023 (10am) - Barnet

CHAIR:

Signed by Chair ……..

Date ……

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North Central London Integrated Care System

NCL JHOSC

Winter Resilience Update

Contents

North Central London Integrated Care System

Key Messages

North Central London Integrated Care System

- Winter 2022/23 is being experienced in the context of flu and respiratory illness (especially in children) and industrial actions. These have contributed to making this winter more challenging. Impact of the industrial actions on staffing capacity across NCL has been notable, with staff numbers significantly reduced.
- NCL has developed a High Impact Winter Action Plan to support our resilience during winter (Slide 4). The plan focuses on attendance and admission avoidance, improving flow and maximising discharges. Furthermore, we have increased capacity across the key focus areas (avoidance of attendances & admissions, improving flow and maximising discharges. In allocating winter funding, we have targeted additional resources based on analysis of attendance, admissions and delayed discharges across NCL Trusts and Boroughs.
- Moreover, NCL has taken a whole system approach to allocating additional winter demand/capacity funding and discharge funding. For example, we have invested in additional primary care at the front door of district general hospitals that we know experience high levels of emergency admissions – see Appendix 1. In addition, the Adult Social Care Discharge Fund and the Hospital Discharge Fund have funded c 24k hours of home or domiciliary care; c 18k hours of reablement alongside extra step down beds within community and mental health and extra block P3 placements and care packages.
- Additionally, NCL has implemented it's System Control Centres (SCC) as supplementary support for winter pressures. The SCC is a valuable resource in NCL, in that it has visibility of operational pressures and risks across providers and system partners. It takes concerted action across the Integrated Care System (ICS) on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges
- Whilst we have made some notable improvements with hospital discharges e.g. increased our same day discharges, we have also experienced some challenges over winter. Factors contributing to these challenges include industrial actions, workforce challenges within health and social care together with increasing acuity and complexity of admitted patients.
- The ICS has continued to develop services in collaboration with partners to improve patient flow throughout winter and during periods of surge. An Example include the NCL Silver Triage Line - a consultant geriatrician advice and guidance telephone line available to LAS and NHS111 launched in September 2022. Over 400 calls have been made into the Silver Triage line from paramedics on scene and in care homes. Through the consultant geriatrician advice and guidance, 80% of the calls have resulted in patients being managed within the community and did not require conveyance. Other examples of similar projects are detailed further in this report.
- Finally, a review of winter 2022/23 will commence in March through April to identify learnings to help define what we need to continue doing or do differently next winter. Our approach is set out Slide 14. Final outputs will be incorporated into Operating Plan for 2023/24 as appropriate.

NCL High Impact Winter Action Plan

North Central London Integrated Care System

	Key Issues	Key Actions	Oversight Forum	System KPIs
Front Door	Attendance avoidance (Primary care and low acuity A&E walk in)	• Development of regional 111 Single Virtual Contact Centre • A&E front door primary care streaming models implemented (NMUH including paediatrics, BH & RFH sites) • Implementation of revised national UTC/WiC service specification in progress. • Actions to help reduce pressures associated with mental health attendances within emergency departments in place.	NCL Flow Board via NCL Flow Operations Group (FOG)	• 999 Call answering times (BAF) via NHS E • 999 CAT 2 response times (BAF) via NHS E • Hospital handover delays (BAF) via NHS E • No of primary care and mental health A&E redirections • UTC / WiC attendances • 12hr mental breaches in A&E • No. of DTAs in ED @ 08.00 • No. of Section 136 detentions
	Reducing handover delays	• Sites using the new 45mins handover standard as a mitigating action to delays. • All acutes sites have the facility to implement patient Cohorting in conjunction with LAS.		
In Hospital	Improving Flow	• Protocols to support nurse led discharge in place • Development of 7 day infrastructure and weekend handover protocols is being progressed. • Early discharge planning protocols in re-establishment of discharge lounges developed and in use.	NCL Flow Board via FOG	• Adult G&A bed occupancy (BAF) • Delays per pathway P1-P3 • Virtual ward occupancy • 2-hour UCR activity vs plan • No of 2-hour referrals from LAS/111 • No of SDEC referrals from LAS/111 • No of CAT 3/4 conveyances to ED avoided
	Admission avoidance	• Increase referrals to urgent community response service (LAS/111) • Increase referrals to Same Day Emergency Care Services (LAS/111) • Continue to implement SDEC Boost to fully maximise benefits • Increase utilisation of silver triage/enhanced care in care homes		
Out Flow	Optimising P1-P3 capacity & Early supported discharge	• Maximise community referrals via the ICE hub • Fully maximise virtual ward capacity • Further embed use of discharge lounge across all sites. • Patients identified for discharge are fast tracked home or to discharge lounge before midday	NCL Flow Board via FOG	• P2 bed occupancy • Criteria to reside occupancy (BAF) • No. of discharges reported Fri, Sat & Sun • No. of pre-midday discharges • No of pre-5.pm discharges
		• Discharges identified for the following day have patient transport booked		• Discharge lounge throughput activity • No of cancelled patient transport journeys

Increasing winter capacity

North Central London Integrated Care System

NCL has taken a whole system approach to allocating additional winter demand/capacity funding and discharge funding. For example, we have invested in additional primary care at the front door of district general hospitals that we know experience high levels of emergency admissions – see Appendix 1

In allocating winter funding (including the Better Care Fund), we have targeted extra resources based on analysis of attendance, admissions and delayed discharges across NCL Trusts and Boroughs.
The Adult Social Care Discharge Fund and the Hospital Discharge Fund have funded **c 24k hours of home or domiciliary care; c 18k hours of reablement** alongside extra step down beds within community and mental health and extra block P3 placements and care packages.

Adult Social Care Discharge Fund: activity funded

- **Pathway 1 capacity** – block homecare and reablement capacity mobilised across NCL – nearly 24k home or home care (hrs) and 18k reablement (hrs)
- **Pathway 2 capacity** - 17 extra P2 step down beds in Barnet to assist with flow
- **Pathway 3 capacity** – 34 block care home beds mobilised across NCL
- **Homelessness** - 7 extra accommodation units in place to support discharge for homeless patients
- **Mental Health** - 5 extra beds have been commissioned by Enfield and Camden. Other boroughs have the ability to sport purchase up to 5 beds to meet peaks in demand.

£200m Hospital Discharge Fund: activity funded

- **Extra community and mental health step down capacity**: 67 block beds across Community (55) and Mental health (12) and 14 spot beds across NCL
- **Extra packages of care at home and Pathway 3 spot purchases:** the detailed activity breakdown is given below from January.

Virtual Wards (VW)

- **108 Frailty VW beds** open across the system with 80%+ utilisation rates (plan of 96) -> 108 Frailty beds by Feb/March (working to overcome recruitment challenges).
- **10 paediatric hospital@home VW beds** open at Whittington, with a further 12 beds planned within NMUH system.
- **40 remote monitoring pilot beds launched in December** –16 in January, ramping up to 40 in Feb (plan of 50). Pilots will also inform procurement of a single NCL VW remote monitoring solution.
- **118 beds in total by December,** ramping up to 158 in Jan/Feb. Plus 79 Covid VW beds available since pandemic, with clinical redesign underway to convert to General Respiratory VW beds by Q4.

Discharges – challenges this winter and mitigations

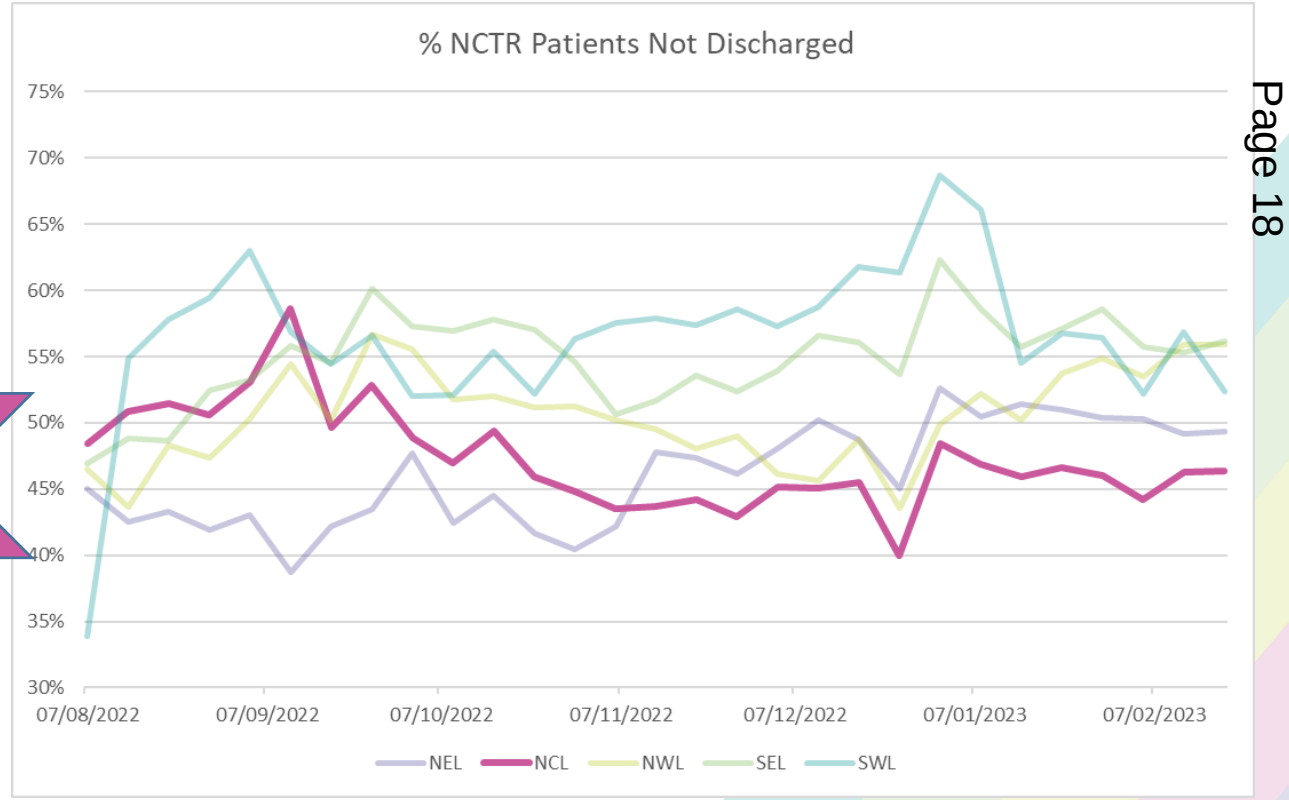
North Central London Integrated Care System

Ensuring timely discharge is a key priority for our system. We know people want to get home as soon as possible, and once acute care is no longer needed residents recover better and face less risk out of hospital. We also know we need to ensure hospital beds are freed up to admit residents in a timely way. Patients who no longer need to be in hospital are referred to as “no criteria to reside” (NCTR). The chart show NCL’s performance compared to London, where we have improved and sustained our performance.

We have faced a number of challenges over this winter. The key challenges and mitigations are outlined below:

- Funding is short term only so doesn’t build capacity
- Impact of strike actions on capacity
- Workforce recruitment remains very challenging and existing staff are pressured and tired
- Capacity for complex care home patients can be limited

- Close integrated working across all partners
- Additional short term funding across the NCL system
- Increasing % of discharges earlier in the day
- New pathways like Virtual Wards out of hospital, and preventing admission from rapid response



Service improvement and innovation

North Central London Integrated Care System

North Central Integrated Care System has continued to develop services in collaboration with partners to increase resilience and improve patient flow throughout winter and during periods of surge. The tables below summarise a number of service improvements and innovations that have been undertaken throughout 2022/23.

Reducing ambulance conveyance and improving hospital handover	**1. Pre-dispatch senior clinical decision maker pilot** A London Ambulance Service (LAS) pre-dispatch senior clinical decision maker pilot was launched in February 2023. The pilot will see 5 NCL clinicians on the LAS clinical hub rota to help ensure patients are being referred into the right service, at the right time and into the right clinician. The aim being to reduce ambulance dispatch to ED and increase referrals to community and alternative pathways. In the short-term, key measurables will focus on referral numbers to alternative pathways, failed referrals, Cat2 conveyances, and ambulance dispatch after clinical assessment, all of which will be assessed through weekly evaluations. **2. New clinical handover protocol** NCL ICS in conjunction with LAS has supported the development of an agreed clinical handover protocol, which was enacted in January 2023 across all provider sites. The protocol outlines the process that will take place where there is not sufficient capacity within the Emergency Department to allow for handover as soon as possible (noting the existing national 15minute standard). A significant element of the process focusses on ensuring Cohorting arrangements are in place . All NCL providers now have Cohorting in place and are operational. The protocol outlines that when cohorting reaches maximum capacity and if there are still patients waiting to be handed over (where expansion of cohorting is not possible), then patient handover / trolley should be cleared at 45 minutes following clinical discussion between the provider and LAS. **3. Transfer of CAT3/4 patients from NHS111 to LAS** A pilot was launched in April 2022 to transfer all CAT 3/4 ambulance dispositions from NHS111 to LAS. Within NHS111, dispatch to LAS is made when waiting time for clinical validation exceeds 30 minutes, which minimises their clinical risk. This a national 111 standard and common across all providers. Once a patient is in the dispatch queue then there is no further opportunity to call or review the patient and they are effectively waiting for an ambulance to arrive. In LAS, the risk is managed on the basis that it is often better for patients to receive a telephone triage, which at times can take longer than 30 minutes, than wait 2-3 hours for an ambulance with no clinical assessment. It is anticipated that this will result in approximately 250 fewer dispatches will be made per week. A review of the pilot will be undertaken in March 2023.

Service improvement and innovation

North Central London Integrated Care System

NHS111

1. Virtual eye pathway

It is recognised that there are several system challenges relating to equitable access to urgent eye care services across London, with calls to NHS111 not always directed to the most appropriate service, which can result in long waits and a poor patient experience. Based on analysis between July 2021 and July 2022, NHSE outline that approximately 70% of NHS111 calls across London that could have been seen in an eye hospital were referred to general Emergency Departments (ED).

Moorfields currently operate a video consultation platform within their A&E department. A pilot was launched in February 2023 to enable direct referral from NHS111 into this model. It is expected that approximately 80% of patients referred will be managed with advice, remote prescription, general practitioner referral, direct referral to hospital subspecialty services or diversion to a local eye unit.

2. Referral to Same Day Emergency Care

NHS111 and Whittington Hospital are undertaking a one month pilot to offer directly bookable appointments from NHS111 to Same Day Emergency Care (SDEC) services from 28 February 2023. The pilot will focus on medical type presentations with the aim of reducing referrals to ED. If successful, the intention would be to expand the pilot across all hospital sites across a greater range of presentations.

3. Increasing staffing levels

Constraints within the NHS111 call handling workforce is a recognised significant national issue, with providers experiencing continually high vacancy and turnover rates. Following conversations between the NCL Covid Vaccination Workforce team and our NHS111 provider, arrangements have been confirmed to utilise the existing pool of reservist staff to support the NHS111 Service Advisor call handling. This role will primarily support the management of minor injury, dental and repeat prescription calls and cover periods of highest pressure, including weekday evenings (16.00 – 23.00), weekends and Monday mornings.

The Covid vaccination workforce team has already identified over 30 reservist staff keen to participate. Training will take place over a 2week period following staff compliance checks. The use of reservist staff within NHS111 offers a number of benefits, including: greater scope and flexibility to support in-year NHS111 staffing constraints; opportunity for bank staff to further develop and broaden their skills and experience; and opportunity for staff to take on substantive Service Advisor roles or, with advanced training, Health Advisor roles.

Service improvement and innovation

North Central London Integrated Care System

NCL Silver Triage line	A silver triage service - consultant geriatrician advice and guidance telephone line available to LAS and NHS111 was launched in September 2022. Over 400 calls have been made into the NCL Silver Triage line from paramedics on scene in care homes. Through the consultant geriatrician advice and guidance, 80% of the calls have resulted in patients being managed within the community and did not require conveyance. The line is currently live 9:00 – 17:00 with agreement to expand the cohort of patients to include those aged 65+ living in their own home (Clinical Frailty Score 6+) from January 2023.
Frailty Pathway	Frailty pathway development focussed on 'frailty cars' as an addition to the current infrastructure. A co-designed proposal has been developed that will include falls, silver triage/care homes, and elements of LAS category 3 and 4 calls through a 'pull' approach. A pilot was launched in February 2023 across Barnet and Enfield with nursing/therapy staff from Urgent Community Response teams for 2 cars to manage up to 14 incidence per day (8:00 – 8:00 7 days a week).
Emergency Department(ED) missed opportunity audit	A missed Opportunity Clinical Audit (supported by NHS England) level was undertaken at North Middlesex University Hospital in January 2023. The audit focused on the aspects of care driven at a system with the aim of identifying patients that are not on the correct pathway and as a result of their attendance at ED. The audit followed the standard Clinical Audit cycle with a focus on measuring current patient care through systematic review of this care given against explicit criteria. The route into the system for the patient on the ED Pathway is variable. Entry points can include Primary Care, NHS111, Urgent Treatment Centre (UTC), 999 or self-referral. The audit results will provide evidence to support improvements such as the development of new pathways, improving access to existing pathways and support feedback to 111. There may also be intelligence to support new pathways being developed. The audit outcome report is expected to be completed by end February 2023. Once finalised, the report will go through the relevant ICB governance for consideration of further roll-out across all providers. The timeline for this process is yet to be confirmed; however it is anticipated to be end April because of the frequency of these meetings.

Impact of Industrial Actions

North Central London Integrated Care System

To date, NCL has been affected by a total of 8 industrial actions involving the London Ambulance Service (LAS) , Great Ormond Street Hospital as well as University College London Hospital on account of Royal College of Nurses (RCN) and Physiotherapists on account of Chartered Society of Physiotherapists. In preparation, NCL devised a plan to facilitate coordination of actions to ensure safety of patients and staff during the strike period. Planning focused on the following key elements:

- Additional capacity was in place across all services lines (acutes, community, mental health, primary care, NHS 111 & maternity) on the day of the strike
- Command & Control structures were implemented for all services with senior Gold clinicians on the shop floor of hospital sites
- NCL operational and Gold executive level meetings to assess the on-going impact of agreed actions with decisions taken to refine as required with support from system leaders

Impacts and key learning points from these strike actions can be summarised as follows:

- Demand/activity increased in the subsequent 24 hours following the strikes rather than the day of the strike for all services with the exception of mental health.
- Increases in LAS 'hear and treat' rates on strike days (an average of 14% to 40% on 21st December strike) driven by adjustments to existing operational protocols as part of mitigation planning.
- LAS pre-dispatch senior clinical decision maker pilot launched in February 2023 was initiated as a result of the enhanced LAS/111/GP integration on strike days. As described in previous slides, the pilot will see 5 NCL clinicians on the LAS clinical hub rota to help ensure patients are being referred into the right service, at the right time and into the right clinician.
- Intensity of planning meetings and it's impact on staff. For example, there were 5 check ins throughout the strike days (0830, 1000, 1230, 1600 and 2030), to ensure the agreed minimum staffing levels were maintained and that patients were safe.
- Lack of adequate staffing numbers to run services fully has contributed to low performance in areas such as hospital discharge.
- The system was well prepared for all the strikes, however there is concern that the exercise is not sustainable for staff well-being or from a cost perspective.

There is further LAS strike action planned for 8 March 2023 and a BMA junior doctors strike from 13 to 16 March. The ICS will enact the NCL system industrial action plan with a focus on increasing capacity across all services.

UEC Recovery Plan

North Central London Integrated Care System

The recently published Operating Plan incorporates a delivery plan for recovering urgent and emergency care and focusses on:

1. Increasing capacity (additional beds and new ambulances)
2. Growing the workforce
3. Speeding up discharges from hospitals
4. Expanding new services in the community including virtual wards
5. Helping people access the right care, first time.

NCL is responding to the priority areas in the Operating Plan by taking these initial first steps:

- All providers have submitted plans to deliver the 76% A&E 4 hour standard by March 2024.
- Developed plans for additional capacity (General & Acute beds)
- Developing virtual ward capacity to support admission avoidance and timely discharges. NCL is working towards:
  - Increasing the daily number of over-night admissions avoided from an estimated 8 per day in April 2023 to 17 per day by December 2023.
  - Increasing utilisation of virtual wards to a minimum of 80% by September 2023

- Improved quality and consistency of Urgent Community Response services, with a minimum standard of 70% against the 2 hour response standard being achieved
- Set out a Care Homes Programme which aims to reduce non-elective admissions by 30 per month

- As next steps, we are undertaking a gap analysis. This will be followed by the development of a detailed delivery plan which will be monitored via the NCL Flow Operations Group (FOG) and overseen by the NCL Flow Board.

Review of Winter 2022/23

North Central London Integrated Care System

The approach and timeline for reviewing winter 2022/23 is outlined below.

March – April 2023

Winter reviews session by AEDBS and Silver Cells to include evaluation of winter schemes monitored via BAF

- What went well and what were the enablers of the schemes?
- What didn't work well and what were the barriers for implementation ?
- Learnings - What will we continue, stop or change?

May – June 2023

Consolidate reviews, share learnings and clarify priorities for winter 2023/24

- Identify common themes, risks and opportunities and risks
- Agree priority actions/areas of focus
- Understand interdependencies

June – September 2023

Implementing priorities for winter including consolidation of existing schemes

- Working through actions and developing schemes for winter 2023/24
- Agree timescales, risks and mitigations
- Clarify financial envelope as appropriate

Assurance Process

Individual Silver Cell and A&E Delivery Board reviews → Consolidation via NCL Flow Operational Group → NCL Flow Board to ratify / NCL Clinical Advisory Group to assess risks

North Central London Integrated Care System

Appendices

Appendix 1 – Winter BAF investment in capacity

North Central London Integrated Care System

		Funding Source (£k)		
A&E Delivery Board	**Scheme Description**	**Demand & Capacity**	**Virtual Ward**	**Total (£k)**
NMUH	Escalation Beds / Improving Flow Infrastructure	2,400		2,400
NMUH	Paeds Discharge at NMUH	295		295
NMUH	Additional Community Capacity (P1-P3)	884		884
NMUH	Virtual Ward		1,236	1,236
NMUH	Primary Care system support (type 3 cpaacity, Frequent attendees etc.)	553		553
Total NMUH A&E System Support		**4,132**	**1,236**	**5,368**
RF	Escalation Beds / Improving Flow Infrastructure	2,250		2,250
RF	Barnet Site Weekend Discharge Support (therapy, pharmacy, DC doctors, porters, SW)	500		500
RF	Additional Community Capacity (P1-P3)	1,458		1,458
RF	Virtual Ward		1,001	1,001
RF	Primary Care system support (type 3 cpaacity, Frequent attendees etc.)	845		845
Total RF A&E System Support		**5,053**	**1,001**	**6,054**
UCLH	Escalation Beds / Improving Flow Infrastructure	700		700
UCLH	Additional Community Capacity (P1-P3)	585		585
UCLH	Virtual Ward		1,513	1,513
UCLH	Primary Care system support (type 3 cpaacity, Frequent attendees etc.)	285		285
Total UCLH System Support		**1,570**	**1,513**	**3,083**
WH	Escalation Beds / Improving Flow Infrastructure	500		500
WH	Additional Community Capacity (P1-P3)	380		380
WH	Virtual Ward		673	673
WH	Primary Care system support (type 3 cpaacity, Frequent attendees etc.)	317		317
Total WH System Support		**1,197**	**673**	**1,870**
NCL Wide	Virtual Ward		440	440
Grand Total		**11,952**	**4,863**	**16,815**

North Central London
Integrated Care Board

Cllr Connor has raised the following points re JHOSC

- Concern about process for first tranche and then sustainability of this
- Second tranche and process to be described
- How community involvement shaped and influenced who got funding
- Evidence of what has been impacted from first set of projects
- Numbers and percentages for well performing projects
- How many projects have been funded and who was involved in co-designing these projects

Process for 21/22 and 22/23

The Inequalities Fund was introduced in June 2021. Its objectives were to:

- Develop innovative and collaborative approaches to delivering high-impact, measurable changes in inequalities across NCL, and addressing the underlying causes of health inequalities;
- Create solutions which break down barriers between organisations and both develop new and extend existing relationships within boroughs, multi-borough and NCL-wide partnerships;
- Target the most deprived communities and reaching out proactively to our resident black and minority ethnic populations, in line with the aims of Core20PLUS5; and
- Work alongside our population, the VCSE and our partners across health and care in making a difference to the lives of our people.

The majority of the fund (70%) is weighted towards the 20% most deprived wards in NCL, with the remainder utilised for NCL wide schemes. This NCL element was increased in 2022/23 allocations, due to the recognition that there are pockets of deprivation at sub-ward level.

Table 1 Inequalities Fund 2021/22 and 2022/23 allocations

Allocations to areas	2021/22	2022/23
Barnet	£0	£0
Camden	£381,881	£447,269
Enfield	£1,004,921	£1,406,658
Haringey	£964,963	£1,384,930
Islington	£547,465	£681,166
NCL (includes Barnet)	£818,666	£1,054,030
Total	£3,717,896	£4,974,053

The deprivation-based allocations to Boroughs were considered and schemes developed through Borough Partnerships. NCL wide schemes were developed from a range of sources but with the requirement that Borough Partnerships considered the fit with their local work where relevant. The NCL schemes were considered by a panel comprising Non-Executive Directors supported by Public Health input. ICB Executive Management Team and Strategic Commissioning Committee provided internal governance route to enable spend.

Sustainability

Funding for schemes was non-recurrent because the funding source available to the ICB was non-recurrent. However, as national health inequalities funding is now within the recurrent baseline of

the ICB the aim is to move to longer term contracting arrangements which provides a level of certainty for planning and delivery, particularly for VCSE providers. There is still a strong focus on match funding, identifying alternative funding and moving schemes into BAU. Some schemes are non-recurrent in nature. This provides ongoing seed money for further development work in this space.

Community Involvement

Community involvement is a key principle that underpins the Inequalities Fund and informs prioritisation of schemes for funding. Middlesex University are conducting an evaluation that focuses specifically on the efficacy of schemes which have community empowerment as core part of the scheme so that we can understand the wider impact of working in this way. This is due to report in the Spring. The table below sets out the proportion of schemes where funding has gone direct to VCSE organisations.

Table 2 Percentage of schemes per areas delivered entirely by third party sector or in collaboration:

	Organisations involved
Barnet (in NCL)	ABC Parenting, Age UK, Assunnah Islamic Centre, Bridge Renewal Trust, British Somali Community Centre, Caribbean & African Health Network, Centro Hispano UK, Citizens Advice, Community cook up, Cooperation Town, Cypriots of Enfield/Cypriot Community Centre, Deep Black, Diverse Community Health Voices, Diversity Living Services, Edmonton Community Partnership, Enfield Carer's Centre, Enfield Connections, Enfield Food Pantries, Enfield Voluntary Action, Finding Your Feet, Free Space Project, Healthwatch, Hopscotch Women's Centre, House of Polish & European Community, Inclusion Barnet, Interstelar, Kurdish Advice Centre, Listen to Act, Manor Gardens Welfare Trust, Mayday Trust, Mental Health Foundation, MIND, New Local, Open Door, Polish and Eastern European Christian Family Centre, Public Voice, RISE Projects, Riverside Enfield, Sewn Together, Somali Youth Development Resource Centre, Somers Town Living Centre, Talk for Health, Tottenham Hotspurs Foundation, Turkish Cypriot Community Association, Turkish Cypriot Women's Project, Wellbeing Connect Services, YouvsYou
Camden 42%	
Enfield 58%	
Haringey 73%	
Islington 43%	
NCL 41%	

Evidence of impact

The aim of the Inequalities Fund was to develop new approaches to address entrenched health inequalities. As part of this approach, the Inequalities Fund aims to take Public Health evidence, for example Kevin Fenton[1] and Michael Marmot's[2] research, and apply this to live issues within health and care services.

The rationale for an approach that addresses the root causes of health inequalities is twofold; firstly this improves patient outcomes, but it is also the most cost effective use of resource. The latest *Recovery Plan for Urgent and Emergency Care Services*[3] highlighted that people in the 10% most deprived areas are twice as likely to go to A&E as those in the 10% least deprived areas, and therefore use a disproportionate amount of resource. Whilst interventions that focus on the end point of the patient pathway are important, the inequalities fund schemes aim to demonstrate that delivering a range of interventions at different stages of the pathway, which consider the wider determinants of health, can offer the best value for money.

A number of the schemes were experimental in nature, with the expectation that not all schemes would result in an immediate return on investment. This was in part due to the wealth of evidence which shows the importance of getting to the root causes of inequalities – for example, building relationships and trust with underserved populations. This requires ongoing commitment to produce results.

In addition to the Middlesex University evaluation of community informed/developed schemes, all schemes have been reviewed either through Borough Partnerships or through NCL review process to understand their impact using a “reach and ripple effect” approach.

Below are some examples of high performing Inequalities Fund schemes demonstrating that investment in under-served communities, which cost the ICB a disproportionate amount, result in savings to the system:

- Reduction of approx. 800 A&E attendances for people with Severe and Multiple Disadvantage (Haringey) – can project this would have resulted in 80 emergency admissions (project reach was 120 people)
- Blood pressure reduction in 50% of those participating in the peer support cardiovascular scheme for those from South Asian, African and Caribbean heritage (Barnet)
- 5% reduction in A&E admissions for other forms of heart conditions in Haringey
- Overwhelmingly positive reception to Black Health Improvement Programme cultural competency training for GP practices (Enfield)
- Funding in Enfield distributed to wide range of VCSE organisations who represent under-served populations and had not previously engaged with the NHS
- In Haringey, % reduction in emergency admissions is greater for those 50+ in 20% deprived than 20% affluent areas – this group singled out as many IF projects associated with people at risk (continuing to review causality in more detail)
- NMUH saw highest % reduction (33%) in emergency admissions for those 50+ in 20% most deprived communities**.** NMUH serves mostly Haringey & Enfield’s deprived populations, boroughs received highest % of IF funding

The attached appendix provides greater detail regarding all schemes funded and their impact to date, as well as specific outcomes for high performing schemes. This also describes the co-production element where applicable. In addition to the evaluation carried out by Borough team and the Communities Team, Middlesex University have been commissioned to undertake an analysis of the level of co-production within schemes, and the impact this has had in terms of delivering outcomes. This is a qualitative piece of research, with one to one interviews carried out with VCSE partners. This is due to be completed in April 2023.

To date, learning from the Inequalities Fund has identified some emerging common themes that may be applied across the wider system going forwards.

- Partnership working – All borough teams reported that the Inequalities Fund provided a good test in terms of how they could most effectively operate in partnership across multiple stakeholders, both in strategic terms but also in practical terms in relation to how they prioritise schemes, allocate funding and problem solve. It created opportunities for further discussion with the voluntary and community sector, and enabled a two way conversation between statutory and voluntary organisations that allowed both sides a greater understanding of their strengths, and how all can contribute to addressing health inequalities. **Wider application:** ***A Population Health model can build on the principles of subsidiarity that the Inequalities Fund successfully introduced***
- Community Empowerment – engaging with our communities, in order to put lived experience at the heart of co-designed solutions and to build relationships and trust. The Community Powered Edmonton scheme is a showcase example of how local community VCSE organisations worked alongside statutory services to understand the needs of our under-served communities, what it means to live a healthy life, and the barriers people face. This included some of our most under-served populations, including the Gypsy Roma Traveller community. **Wider application**: ***All system partners to embrace the lived experience through a Core20PLUS5 framework.*** This builds on the approach laid out in Working with our People and Communities and Working

with our VCSE Strategies, and we are working with the Engagement Team to develop and embed, community engagement and empowerment approaches.

- Collaboration with diverse communities and an outward looking approach – the Inequalities Fund schemes encouraged collaboration not just at a borough partnership level, but within the VCSE and across communities. For example, at the Enfield Inequalities Delivery Group, over thirty local organisations are represented, covering issues as diverse as youth violence and youth justice, food poverty, specific ethnic under-served groups, and representatives from primary, community and acute health services. This produces stimulating debate, and encourages an approach where the ICB looks outwards for solutions. The Communities Team are building on this by continuing to share resource in different ways – for example sharing skills around bid submissions and how organisations demonstrate value in their interventions. This approach links in with our VCSE Strategy and the table below shows the range of VCSE engaged within in each borough. A recent NHS Confederation report Unlocking the NHS's social and economic potential uses level of resources spent by NHS with this sector as a key measure of a system's anchor maturity. **Wider application**: ***The outward looking approach to communities and local authorities is expanded to all system partners***

References

[1] Public Health England (2020i) *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups*.

[2] Marmot M. (2020) *Health equity in England: the Marmot review 10 years on*. BMJ, 693. doi: 10.1136/bmj.m693.

[3] Public Health England. London, UK NHS England (2023) *Delivery plan for recovering urgent and emergency care services* [Online]. Available: https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf

Inequalities Fund schemes progress and recommendations

Red = Stopped or completed

ID	Lead Borough	Proposal Name	Description	Progress
NCL IF 001	Camden	Barriers to Accessing Post-Covid Syndrome Services in NCL	Healthwatch Camden collaborating with the voluntary sector, Camden Council and NCL ICB to identify the groups most at risk of not coming forward to access post Covid Services. The programme will be focussed on Camden's two most deprived wards, St Pancras & Somers Town and Kilburn.	Programme undertook a number of structured interviews and focus groups with people with lived experience of access Long Covid services in Camden. The programme in Camden aligned with Healthwatch across the ICS to publish an NCL wide report 'Living with long Covid' alongside a series of Camden specific case studies which were published on Healthwatch Camden's website. The report alongside recommendations were brought to the Camden Local Care Partnership Board in April 2022 and actions followed up with the borough clinical lead for post covid. Recommendations were also taken to the Camden Health and Wellbeing board and NCL ICB fora. The project ceased in March 2022 and met its expectations and delivered on all expected outcomes.
NCL IF 002	Camden	Camden Childhood Immunisation Programme	This proposal seeks to address the inequalities in the uptake rate of childhood Immunisations in Camden	Delays to programme mobilisation due to difficulties identifying an organisation to hold and administered funding, agreement that Camden based organisation Community Matters would hold the funds and provide the programme management. A promotional, language sensitive, animation has been created to be show in waiting rooms and a number of pop-up clinics have been delivered in areas of deprivation and low immunisations uptake. The programme has worked with parent champions to shape language being used and the delivery of awareness session. Initial findings are suggesting that there has been an increase in immunisation uptake. Project leads are looking to focus 23/24 funding on an animation focussing on older children and to deliver more pop-ups in areas. Camden is still an outlier in terms of uptake and as such it was agreed that the aspirations of the project are in line with Camden's priorities and have supported a further year of funding for the project with the expectation that learning and best practice is spread wider and a comms and engagement strategy be produced.
NCL IF 003	Camden	Complete Care Communities – Facilitating Mental Health Empowerment in Camden's Bengali and Somali Communities	Empower mental health resilience in Camden's Somali and Bengali residents, by their community for their community. Using and enhancing the community's assets by engaging them in designing a self-sustaining model to reduce stigma, engender resilience and increase access to mental health support.	This project is a demonstrator site for the national Complete Care Communities programme which is "designed to support health systems to utilise Primary Care Networks in tackling health inequalities". The project focusses on a population (Somali and Bengali residents) known to experience high levels of inequality in NW5. The funding has enabled the PCN to engage with communities in a different way and has increased an understanding of different ways to talk about mental health. The project team have asked for an additional 6 months of funding to finalise the work that they are undertaking and have agreed to share learning with the other HI projects looking at MH. The board agreed to the additional 6 months of running for 23/24 as it is meeting its expected outputs.
NCL IF 004	Camden	LD Annual Health Check Quality Audit	The programme will audit the quality of Annual Health Checks (AHCs) and Health Action Plans (HAPs) in Camden. It is designed as a supportive tool to enable joint working to improve outcomes for people with Learning Disabilities (LD). It will focus on the GP practices in Camden's most deprived wards (St Pancras and Somers Town, and Kilburn wards).	*project completed March 2021 - second year of funding agreed due to bid for wave 2 funding - see NCL IF 047 for details*

NCL IF 005	Camden	Primrose A	The ambition of this programme is based on the Primrose study led by UCL, which found that a primary care intervention focussed on physical health, led to a large reduction in psychiatric hospital admission costs and significantly reduced total healthcare costs.	Project successfully recruited population health nurses however there has been a significant reduction in the number of SMI patients engaged due to a number of factors not least the complexity of the target population but also the training needs of primary care staff. 10 practices are now engaged and the panel agreed to a further years funding for 23/24 as there is recognition of the time it takes to embed a new approach and this would also allow the project to look at longer term sustainable funding and the process to embed the offer of Primrose at scale across Camden.
NCL IF 006	Camden	Self-Care Community Champions	The proposed programme aims to empower those at risk of health inequality with confidence in self-care through locally identified Champions who will cascade self-care information and resources to the diverse communities of Camden in the target areas.	Programme was due to end in March 2021 but due to significant difficulties with recruiting schools and VCS organisations to take part in the programme it was agreed with the project lead that the programme could continue in to 2022 in order to ensure an output was delivered. Awareness sessions are planned with primary and secondary schools and a website is being developed. This project was not in consideration for 23/24 funding as it technically finished March 2022 - an end of year evaluation will be produced and currently the awareness session planning has linked to the childhood imms project to deliver aligned self care messaging.
NCL IF 007	Camden	Kilburn Ward outreach	The aim of the programme is to reduce the barrier of access to healthcare for people in this region by Partnering with our colleagues Camden council. Camden have commissioned a second vaccine bus for outreach to under-represented population who speak little/no English, are sometimes illiterate or have no digital literacy.	Project is successfully delivering awareness sessions via the Camden Mobile Health bus - an initiative match funded with Camden Council. A report has initially been published and further work needs to be undertake to look further at recording information and tracking the outcomes from the residents that engage with the bus. Residents are indicating that the bu is useful and it is being used in known areas of deprivation - the panel agreed that a further year of finding will enable a more robust approach to monitoring as well as the time needed to look at longer term funding.
NCL IF 008	Camden	Health Equalities Programme	The aim of the programme is to mitigate against digital exclusion, ensure datasets are complete and timely and accelerate Preventative programmes that proactively engage those at greatest risk of poor health outcomes..	The project have experienced difficulties with recruitment and in particular a healthcare worker that can speak multiple languages, this initially delayed the roll out of the health checks but over time the volume has increased. The panel agreed to a forward year of funding as it aligns to Camden priorities of a proactive, preventative approach as well as addressing Core20PLUS5 by addressing CVD and Diabetes risks. However, as this is a practice based project there is an expectation that for the forward year the programme will go beyond its boundaries to share best practice with the PCN and wider to inform neighbourhood working.
NCL IF 009	Enfield	Black Health Improvement Programme (BHIP) and Enfield Caribbean and African Community Health Network	BHIP provides ways to improve engagement between the Black service user and the professional and is used to highlight a number of pertinent challenges for Black people including how we communicate and understand Black people. The programme acknowledges bias within individuals and helps professionals to recognise that health interventions that lead to better outcomes for all will only happen when we begin to tackle those biases.	The project successfully delivered cultural competence training targeting GP practices and primary care staff, with positive feedback, but has not achieved it's training targets and would need to develop a plan to increase uptake BHIP 1-hour session of Cultural Competency Training and GP engagement across the borough. The Enfield Black Community Health Forum which is co-chaired community leaders with membership consisting of black community leaders, faith leaders and health system partners and has received substantive interest from NHS England
NCL IF 009a	NCL	Black Health Improvement Programme (BHIP) for Enfield - Additional Investment	Additional funding (from NCL pot) for Enfield Borough Partnership scheme NCL IF 009	The project successfully delivered cultural competence training targeting GP practices and primary care staff, with positive feedback, but has not achieved it's training targets and would need to develop a plan to increase uptake BHIP 1-hour session of Cultural Competency Training and GP engagement across the borough. The Enfield Black Community Health Forum which is co-chaired community leaders with membership consisting of black community leaders, faith leaders and health system partners and has received substantive interest from NHS England. No funding from NCL pot required for 2023/24

NCL IF 010	Enfield	Enhanced Health Management of People with Long-Term Conditions in Deprived Communities in Enfield	This involves identification, management and interventions for adults at risk of developing/with LTCs targeted in Enfield's eastern deprived neighbourhoods. A focus on CHD/CVD, diabetes, COPD/respiratory and multi-morbidity is particularly relevant to underlying need and associated with high NEL admissions/complications, in these communities.	The project has successfully engaged with Primary Care in order to share and collect data. GP and A&E admission list identified in East Enfield and sending patient to discussed at MDT. The project should consider undertaking a service review in conjunction with the local NCL LTC services to determine how it can best align, hence its integration into BUA
NCL IF 011	Enfield	Enfield Connections at North Mid	This proposal requests funding for Enfield to match Haringey's offer at NMUH. In an expansion of the successful model with Haringey, two workers based within 'Enfield Connections' will support patients at North Mid to access support for what is important to the resident's good life whilst tackling known factors in health inequalities.	The project successfully recruited outreach workers for full training and regular outreach sites at the North Middlesex Community Advisory Hub and Evergreen GP Surgery. The project implemented a Customer Relationship Management (CRM)system staff feedback . The project should consider raising the profile of the role of Enfield Community Hubs to residents. The Project needs to demonstrate how the outreach approach is adding value (over and above Councils hubs).
NCL IF 012	Enfield	Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services	This involves multi-agency identification, intensive management and coordinated interventions for predominantly working age adults with SMD in east Haringey & Enfield who are primary and secondary care HIUs. It aims to improve health, well-being, independence and life-chances of its clients and reduce their utilisation of healthcare and other services.	The Project has increased in number of patients being supported within the community by MIND Care Coordinators. Strong links made with the MACC Team- Multi- Agency Care and Coordination Team with regular attendance at monthly MDT. System data indicates significant reduction in HIU in the most recent dataset presented at AEDB. Strong partnership and targeted interventions from Psychiatric Team at BEH with in situ assessment and intervention for case management patients
NCL IF 013	Enfield	ABC Parenting	The ambition of the program is to roll out the pilot in the most deprived wards in both boroughs, aiming to increase parent confidence, create networks of peer-to-peer support for parents and improve appropriate use of services across health and social care (reducing A&E visits).	The programme has successfully delivered 33 courses to 414 beneficiaries and recruited ethnically diverse and multilingual parents/carers to become trained volunteers and are on track to delivery in 23/24. The project has struggled with staff retention and recruiting, which has caused delays in planning and execution, particularly with regard to the delivery of seminars, breastfeeding drop-in groups, and peer support.
NCL IF 014	Enfield	DOVE project (Divert and Oppose Violence in Enfield) Public Health approach to reducing Serious Youth Violence	Funding for a Violence Reduction Social prescribing case worker based in primary care settings, supporting children and young people identified at risk of serious youth violence through case work and signposting to wider Early Help services providing advice, support and access to family and youth support.	As part of the Social Prescribing Pathway for children and young people in the Borough of Enfield who are vulnerable to or at risk of violence, the initiative quickly and effectively hired a specialist case worker post. As a result, their level of engagement throughout the intervention is improved as trust is built. Relationships with Social Care services and the Youth Offending Team have improved because to this programme.
NCL IF 015A	Enfield	VCS & Primary Care based smoking cessation	To reduce the number of residents experiencing severe and multiple disadvantage in the east of Enfield. To reduce the prevalence of smoking among Enfield residents in 20% most deprived wards and communities with evidence of higher than average prevalence. To reduce smoking related mortality. To improve healthy life expectancy experienced by residents in wards of highest deprivation compared to least deprived wards.	Despite initial difficulties, the project was able to recruit 2x Healthy Lifestyle Advisors. The project is delivering smoking cessation services to each of the four surgeries in the Evergreen Group (Ordnance Unity, Evergreen Surgery, Boundary Court Surgery, and Chalfont Surgery), and it has reached out to a nearby primary school (One Degree Academy at Chase Farm) to work on developing a healthy lifestyle outreach programme for elementary school children and their parents/caregivers.

NCL IF 015B	Enfield	VCS & Primary Care based smoking cessation	To reduce the number of residents experiencing severe and multiple disadvantage in the east of Enfield. To reduce the prevalence of smoking among Enfield residents in 20% most deprived wards and communities with evidence of higher than average prevalence. To reduce smoking related mortality. To improve healthy life expectancy experienced by residents in wards of highest deprivation compared to least deprived wards.	Despite initial difficulties, the project was able to recruit 2x Healthy Lifestyle Advisors. The project is delivering smoking cessation services to each of the four surgeries in the Evergreen Group (Ordnance Unity, Evergreen Surgery, Boundary Court Surgery, and Chalfont Surgery), and it has reached out to a nearby primary school (One Degree Academy at Chase Farm) to work on developing a healthy lifestyle outreach programme for elementary school children and their parents/caregivers.
NCL IF 016	Islington	The Islington Respiratory Wellness Programme	The service identifies patients with COPD and high emergency admissions across Whittington and UCLH and links them with peer coaches and community resources. C&I Peer coaches work with patients to encourage appropriate healthcare access, support treatment of tobacco dependence and other high value interventions and build patient confidence to self-manage and identify goals.	The project has experienced significant information governance (IG) issues relating to acute data and recurring recruitment challenges. With only 6 patients supported by peer coaches to date, the service pathway has not been adequately piloted. The board acknowledged the significant IG issues and noted the challenges of engaging with the specific cohort of respiratory patients. The overlap with other projects and services offering peer coaching support was highlighted. The board was not assured that the project would be able to deliver outcomes in 23/24.
NCL IF 017	Islington	Early Prevention Programme – Black Males & Mental Health	A three-year programme, aiming to support mental health issues among young black boys and men in Islington - improving personal mental health and wellbeing, aspirations, and life opportunities.	The four pillars of the programme are on track for delivery in 23/24. Learning from the programmes approach to engagement and co-production have been shared across NCL demonstrating good practice. The programme will continue to receive matched funding from Islington Council and the Violence Reduction Unit (VRU) in 23/24. The project is currently very local authority facing and requires more co-ownership with NHS partners and integration with health pathways. For example, C&I linked into school psychologist support.
NCL IF 018	Islington	Primrose A	Delivery of Primrose A - a primary care intervention focussed on physical health, for patients with serious mental illness (SMI). Delivered by population health nurses and peer coaches, service users will supported to improve the physical and mental health of people and develop relapse prevention strategies through supporting behavioural change and goal setting.	The project initially struggled with primary care engagement due to lack of capacity in practice nursing teams, but re-aligned project resources to ensure delivery of the Primrose A intervention by C&I population health nurses. Although 3 Islington practices have signed up to deliver Primrose A in collaboration with C&I, engagement with patients has been low, with only 3 patients supported to date (as of Sept 22). C&I plan for the Primrose A intervention to become sustainable in 23/24 via delivery within the mental health Core teams.
NCL IF 019	Islington	Population Health Management	To embed and further develop the use of a population health management (PHM) approach within Islington's most deprived wards and housing estates to reduce inequalities.	The housing element of the project has successfully created the housing data set but is yet to develop the HealtheIntent dashboard to provide access to users. The HealtheIntent user training component has struggled due to delays in provider data being available in the tool and therefore had low engagement with primary care teams. There is a rationale for an NCL programme to be supporting HealtheIntent implementation and IG processes in partnership with boroughs, opposed to being borough led.
NCL IF 020	Haringey	ABC Parenting	The ambition of the program is to roll out the pilot in the most deprived wards in both boroughs, aiming to increase parent confidence, create networks of peer-to-peer support for parents and improve appropriate use of services across health and social care (reducing A&E visits).	The programme has successfully delivered 33 courses to 414 beneficiaries and recruited ethnically diverse and multilingual parents/carers to become trained volunteers and are on track to delivery in 23/24. The project has struggled with staff retention and recruiting, which has caused delays in planning and execution, particularly with regard to the delivery of seminars, breastfeeding drop-in groups, and peer support.

NCL IF 021	Haringey	Engaging our most vulnerable Haringey young people with mental health support through creative arts, activities and sports	The project aims to support young people with histories of multiple Adverse Childhood Experiences (ACEs), who would not normally engage with mental health services, through the arts, sports, creative ventures or other activities co-produced and designed by the young people themselves and delivered by people trained in trauma awareness and supported by therapists	This project has experienced some delivery challenges due to funding flow from lead provider to VCS partners, and with recruitment challenges. Two elements of the project are underway. It is recommended that this project requires a review to unblock the delivery challenges and reprofile it offer.
NCL IF 022	Haringey	Tottenham Talking	Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) and The Bridge Renewal Trust (Bridge) have formed the Talking Tottenham project partnership to support service users at risk of admission, or needing support following admission, with access to a variety of groups and activities in order to reduce isolation, develop resilience and effective crisis management strategies The project, which was initially funded through using short term winter pressures funding up until May 2021, is based at the Chestnuts Community Centre. It offers a community, social, mental health and recovery, strength-based focus for beneficiaries (and their families as appropriate building on the Triangle of Care model). The project plans to have activity based in a variety of locations across the borough for face to face and offer online sessions extending to the south Tottenham area	This project is delivering above expected activity, with 127 welcome calls and conversations, 45 currently engaged with weekly groups and 33 have completed the three month weekly groups courses. 4 users are now in volunteer positions within the programme.
NCL IF 023	Haringey	Enhanced Health Manage-ment of People with Long-Term Conditions in east Haringey	Building on existing infrastructure to provide multi-disciplinary proactive support to people with LTCs in east Haringey. This includes in-reach, triage and co-work between NHS, LB Haringey, east PCNs and voluntary sector with adults 'at risk' of acquiring, or who have, specific LTCs (CHD/CVD/diabetes) in under-served communities. Funding for: voluntary sector engagement/support, Community Health specialists, consultant PAs	This project supporting both Heart Failure and Diabetics have successfully identified the target underserved ethnic minority population and outreached to these populations, offering targeted interventions and optimisations of treatment. Future work will focus on wider partnership working and pathways with VCS, within the existing funding envelop.
NCL IF 024	Haringey	Supporting People with Severe & Multiple Disadvantage (SMD)1 who are High Impact Users (HIUs)2 in Healthcare Services	This involves multi-agency identification, intensive management and coordinated interventions for predominantly working age adults with SMD in east Haringey who are primary and secondary care HIUs. It aims to improve health, well-being, independence and life-chances of its clients and reduce their utilisation of healthcare and other services. Hosted at NMUH, it builds on good practice (Blackpool/RightCare model) and current support within NMUH (extends existing ED MDT and Haringey's Making Every Adult Matter approach). The Haringey/Enfield service will work with >100 clients/year, and provides coordinated support with, and across, voluntary and statutory partners.	The Project is successfully providing an MDT approach to identified users and reduced the number of A&E attendances and admissions withing 15 patients who were high users (predicted to be 800 attendances avoided). Strong partnerships developed with users are being supported/cased managed by MIND Care Coordinators, MACC Team- Multi- Agency Care and Coordination Team, and targeted interventions from Psychiatric Team at BEH with in situ assessment and intervention for case management patients

NCL IF 025	NCL	NCL & integrated approach to prevention: Lifestyle Hubs	This structured pilot aims to deliver a prevention approach across three years, to deliver an integrated living hub offer as proof of concept for NCL. Specifically addressing smoking, alcohol and obesity. For Royal Free London patients and staff	It has mapped NCL system prevention offers, establishing a baseline, and set up or aligned networks for smoking, alcohol and weight management across NCL. It has established a smoking cessation offer for their patients. KPIs and an evaluation framework has been set up which will start capturing data. The project will explore how this offer can work with discharge pathways and how it can be imbedded in wider pieces of work to enable sustainability. It will continue to work with partners to take an asset based community development approach.
NCL IF 026	NCL	Supporting earlier cancer presentation through community development	This proposal is for a Community Development Worker in the most deprived areas in Haringey and Enfield to improve earlier diagnosis.	Project successfully rolled with 10 Cancer Champions recruited and embedded within community and VCSE to support cervical and breast cancer conversations. Lower than expected activity, resources have been developed and relationships established. Project is developing options to align existing community resource opportunities, reprofiled offer based on existing 2022/23 funding levels and exploring alternate funding sources, and to ensure sustainability after 2023/24.
NCL IF 027	NCL	Early Years Oral Health	Reduce inequalities and the burden of children's preventable oral disease through the introduction of a targeted supervised toothbrushing programme in Early Years' (EY) settings in the most deprived areas of the London Borough of Barnet (LBB).	Resources developed and a number of sites with staff trained up, including 32 of the 40 sites in deprived areas originally identified. No updated activity evidence available but preliminary evidence previously shared indicated that participant uptake was low in those from BAME backgrounds, one of the project's key aims, whether uptake in White British was high. Panel was not assured of this project for 2023/24.
NCL IF 028	NCL	Focused autism and race equality project	The aim of this project is to incorporate race equality specialism, lived experience expertise and the engagement of a range of partners that will inform the development of an Autism Partnership Board race equality action plan.	Project completed in March 2022, and is a example of how an expected output (development of a race equality action plan) has the unexpected benefit of helping Camden to hear the experience of people in an accessible way that is coproduced, meaningful and as a borough partnership we will continue to learn and be informed by local voices. These lived experiences were shared through photography, music, song, poetry and art to highlight the importance of understanding and listening and how representation truly matters.
NCL IF 029	NCL	Haringey Complex Autism pathway	multi-disciplinary team to support autistic young people and adults who have complex needs	Successfully transitioned 2 people from long term specialist acute care, with one person flourishing in the community and the other is now on a discharge pathway. The offer is partly funded from MH mainstream allocations and the project is exploring opportunities as part of it's transition to MHIS funding for 2023/24.
NCL IF 030	NCL	Ambulatory outreach interventions on marginalised and hard-to-reach groups for health screening, disease prevention, case-finding and improving medicines use.	Led by Archway Medical Centre and collaborating with local providers, Whittington Health and C&I, the premise of the project is provision of drop-in health check clinics in deprived wards of Islington. The clinics plan to deliver screening, disease prevention and treatment interventions to local communities with high levels of deprivation who are less likely to engage with traditional NHS services.	Although the board decided to stop the project in July 22, due to conflicts of interest and lack of clarity around decision-making processes, the project will continue this financial year. The board members initial concerns for the project were clinical governance relating to access to patient records.
NCL IF 034	NCL	Lifestyle hub model	By focussing on prevention and early intervention, the proposed programme will both reduce the ill health and poor outcomes associated with these lifestyle factors and reduce the associated health inequalities e.g. smoking is the biggest single cause of health inequalities and smoking related illness are a major contributor to multi-morbidity – which leads to escalation of health and care costs.	This holistic offer with community partners in the Community Access Hub addresses the wider determinants of health, for NMUH patients and visitors. It has provided training to clinical and department staff. Investment spend addressed increasing estates to enable this integrated offer and 23/24 work will focus on expanding the HLH offer and implement learning from the RFL offer.

NCL IF 035	NCL	Enhanced Homeless Primary Care Health Service	Improved health outcomes for people experiencing	There has been a significant amount of collaboration and service mobilisation preparation for this service. to overcome a number of challenges that have delayed implementation which commenced in December 22. The panel were of the consensus that this scheme should continue in 23/24 to demonstrate benefit and impact but consider what funding can be rolled over from 22/23 given slippage, with 23/24 investment reduced accordingly.
NCL IF 036	NCL	Cancer Link Workers	Support for people with more advanced cancers (received phase 1 £ for detection) NCL. Improved outcomes for people in deprived area. Proposal for Haringey & Enfield Cancer Link Workers within voluntary sector. People living with cancer in under-served communities to navigate systems and support self-management	This project has had a delayed start but all is now in place to continue to support the underserved community in Haringey with managing cancer and meeting it's aims. No funding for 23/24 was required for the Haringey component but the Panel's recommendation were for an Enfield offer (which wasn't able to be funded in 202/23) be developed for possible investment consideration. Work is underway by the Cancer Alliance who have identified a Macmillan investment opportunity for the Enfield proposal.
NCL IF 037	NCL	NHS mentoring and support for young people	The scope will include a community mentoring programme for 13-19 year olds, and outreach work with schools and young people with the aim of: • Improving the knowledge of the variety of careers and career pathways in the NHS • Increasing aspirations • To increase resilience and strengthen protective factors • To support goal setting and to encourage young people to take responsibility and work to improve key areas of their life	This project is now established and supports the NHS Trusts (NMUH, BEH, RFL and WH) in being anchor institutions, providing mentoring opportunities for young people from BAME communities across Enfield and Haringey. Work is underway to explore how trusts can fund this from their allocations to ensure longer term sustainability and will include a transition period for 23/24 IF funding (proposed to reduced)
NCL IF 038	NCL	NCL Somali Mental Health Support	This project has three core areas of focus, namely – youth engagement activities, parental engagement, and community wellbeing. Each of these areas are focused on delivering interventions that will support the Somali community to improve mental health/wellbeing by providing culturally appropriate services as well as support with accessing statutory services early	Delivering to core target community but opportunity to increase scale and activity, maximising on activities with most impact. It contributes to wellbeing (activities) and has wider social and community benefits but the evidence around the main purpose to support mental health is limited, though there is reference to IAPT collaboration and some sessions delivered about drugs and alcohol. Panel recommendations for scheme to explore how it can become sustainable without ongoing IF investment, with 2023/24 being a transition year.
NCL IF 040	NCL	Islington Homelessness Health Inclusion Programme – Physical Health Needs	Identification and treatment of physical health needs of people experiencing homelessness (PEH) using a combination of engagement, diagnostic tools, health navigation, outreach nursing, and the provision of flexible GP appointments.	The project is successfully delivering the proposed primary care outreach service across 15 sites and supporting people experiencing homelessness (PEH) accessing healthcare. The service is linking with UCLH ambulatory care offer to provide direct access where required to secondary care consultant support. It aligns with local priorities and the Borough Partnership has agreed to fund the increased 2023/24 investment ask difference.
NCL IF 042	NCL	Peer Support for Cardiovascular Disease Prevention in Barnet	Empower local residents from South Asian, African, or Caribbean heritage to better manage their own cardiovascular disease through the provision of outreach, systematic peer support and culturally competent resources in order to reduce health inequalities in CVD disease outcomes.	This project has demonstrated wider community and system engagement in implementing the project. Resources have been developed and sessions revised so that the participants can still benefit if they are not able to attend all sessions. Demonstrating health impact will take longer, and there is opportunity for more people from the underserved Black and Asian communities to be reached and benefit from this project in 23/24. The project should explore how they can transition off the IF funding for 24/24 onwards and be sustainable ongoing.
NCL IF 043	Camden	Targeted Community Outreach Worker: for BAME, focussing on SMI, DM, Hypertension and Obesity	Community care coordinator to reach out to the BAME patients and especially those with Diabetes, Hypertension, SMI and obesity. This link worker would coordinate patient recalls in the practice, see patients in the surgery, at home or virtually	This project had delays in recruitment to their outreach worker which has meant it has not yet been fully operational for a full year and the panel agreed that it needs more time to realise it's ambitions and agreed to a further year worth of funding. The similarities to NCL IF 008 were highlighted in that they are practice based projects based in the same neighbourhood - however they have different local demographics but it was agreed that the projects are to share learning within their respective PCNs then look to wider neighbourhood rollout.

NCL IF 044	Camden	Patient-centred approach to improving lifestyle behaviours	Provide a joined up holistic approach to lifestyle changes working in deprived communities and allows signposting to other free resources once residents are motivated to maintain physical activity and a healthy diet.	This project has successfully delivered on a number of its expectations and is delivering an intervention within a local community centre that is being well received. Prep and post evaluation measures are in place as is the recording of physical health changes. The panel agreed to funding for 23/24 to continue to deliver the intervention and give the project time to look at sustainable funding as well as to widen their communications on the project to other neighbourhoods.
NCL IF 046	Camden	Pathways for under-represented communities in Camden to access dementia diagnosis and support	Project worker to identify and engage with South Asian Women in Camden - project will place workers in community resources to bridge local people into Camden Memory Service for diagnosis	The project experienced initial delays in recruiting a member of staff to work on the project t however the relationship building with a local VCS organisation began in earnest from day one. The project is improving pathways based on resident feedback and is building a sustainable way of engaging with the VCS and local residents in areas of know deprivation. The panel agreed to a forward year of funding for 23/24 as the project aligns to Camden priorities and is providing insight into ways to improve working between NHS Trusts and the VCS as well as benefitting local residents in terms of understanding dementia and mental health more widely.
NCL IF 047	Camden	Annual Health Check (AHC) Quality Improvement Project	Recruitment of Strategic Health Facilitator for LD for additional 8 months to undertake audit of practice originally proposed in Phase I.	The project was significantly delayed in recruiting an LD nurse in order to deliver the project. A health facilitator is now in place who is proactively working with practice across Camden not just to audit plans but to build confidence and awareness in practices of the reasonable adjustments needed to support people with LD and their families. This project has sustainability built in and the panel felt that another year of funding would enable more practices to be reached and to ensure an offer for all people with LD across Camden.
NCL IF 048	Enfield	Social and Emotional support to recover from the COVID pandemic (previously Life After Loss) - Additional Investment	Dedicated caseworker providing advice in multiple areas of welfare benefits (income maximisation), debt, housing and employment and onward connection to other services, including Mind. Continuation of existing scheme	The project's Mind component has been successful in increasing the number of young black men who use mental health care despite low referral rate initially. It was acknowledged the project needs to show how both service elements are providing both value for money and additional value and to assess financial arrangements in light of the aforementioned.
NCL IF 048a	NCL	Social and Emotional support to recover from the COVID pandemic (previously Life After Loss) - Additional Investment	As NCL IF 048, dedicated caseworker providing advice in multiple areas of welfare benefits (income maximisation), debt, housing and employment and onward connection to other services, including Mind. Continuation of existing scheme.	The project's Mind component has been successful in increasing the number of young black men who use mental health care despite low referral rate initially. It was acknowledged the project needs to show how both service elements are providing both value for money and additional value and to assess financial arrangements in light of the aforementioned. TBC NCL pot funding required for 23/24
NCL IF 049	Enfield	Addressing childhood obesity through community led activity	Funds to be put into established Community Chest for a small grants programme open to local grass roots community organisations to support small scale VCS work focusing on childhood obesity and wider determinants.	The project has made good progress delivering phase 1 of the childhood obesity community chest component and reporting positive results for the community developed initiatives.
NCL IF 050	Enfield	Increasing access to healthier food and financial support in community settings	Proposal aims to offer a solution to reducing the reliance on food banks within Enfield by addressing some of the underlying causes of food poverty with a focus on income maximisation and access to affordable healthy food - through dedicated training of staff and alternatives to food bank utilisation	The service has delivered the operational groundwork for delivery and establishment of provision of fresh and culturally appropriate food through Enfield Pantries, co-operation town and community engagement.
NCL IF 051	Enfield	Analysis – system costs, PH analysis	To reduce the frustration and tension being experienced by both GP practice staff and patients by providing time and space to capture and address experiences of local residents - listen, provide context, signposting and information.	System costs, PH analysis work provided insight into the relationship between ethnicity, deprivation and services usage and tackle the wider determinants of health to address health inequalities. This was a useful one-off project which supported a number of workstreams.

NCL IF 052	Enfield	Diversity Living Services Programme	Project aimed at community engagement, awareness raising of health related issues and supporting service users to access services and enable self-management of care conditions or to gain employment	The project should use underspend for the remainder of the financial year. To improve data collection and approach for gathering impact data. To explore opportunities for partnerships with other organisations for better support with data and service delivery. The consensus were there were not assured that the project would be able to deliver outcomes in 23/24
NCL IF 053	Enfield	Enfield 0-2 Years' Speech and Language Early Identification and Intervention Service	Provide enhanced universal and targeted support offers for children aged 0-2 with SLCN (or at risk of developing SLCN) in deprived areas in Enfield who experience difficulties in accessing existing universal SLT provision in Children's Centres and the core service due to social deprivation factors and other vulnerabilities	The project's outreach support made significant progress, focusing on the SLCN at-risk cohorts in Enfield's deprived areas, both in their homes and in alternative community settings. Partnerships with existing services will be strengthened, and the referral pathway will remain open, accepting referrals for children 18 months and older who are identified as "at risk" of developing SLCN due to factors such as family income, maternal mental health, and family history.
NCL IF 054	Enfield	Interestelar Twalking Challenge	Initiative is walking challenge, designed for patients at risk of social isolation and/or with LTCs, participating in teams that include health professionals and others to improve physical activation socialisation, awareness of condition and mental wellbeing.	Although the project had a strong start, it quickly recognised the importance of networking and formed a formal partnership with PPG and the Enfield GP Federation, which resulted in increased participation from health professionals, social workers, and charity workers.
NCL IF 055	Enfield	Enfield paediatric asthma nursing service – Healthy London Partnership asthma-friendly schools pilot	Pilot an 'asthma-friendly school' specialist paediatric nursing service for children with severe asthma whose condition remains poorly controlled	The Panel was unable to evaluate project as the evaluation report had not been submitted despite several email reminders. It was commented that there was not assured that the project would be able to deliver outcomes in 23/24.
NCL IF 056	Enfield	Drop in events - GP Registration in Enfield	The project will deliver a series of three 'wrap around the GP practice' drop in events for each of the 41 Enfield GP practices.	The project delivered a ground-breaking community outreach event in Enfield to develop community-led solutions. A community engagement session, interviews, and a stakeholder event were held. The collaboration created the Community Powered Edmonton report, which was presented and well received at the borough partnership and wellbeing board meetings.
NCL IF 057	Enfield	Enfield Patient Participation Network (PPG) #2	Project aimed at increasing diversity of membership of PPGs and supporting its administration	So far, the project's main focus has been on conducting an audit of Enfield practises to determine how they are currently operating and what support they require. We recognise that the development of PCNs and the merger/relocation of some Enfield practises has resulted in significant changes in primary care over the last few years.
NCL IF 058	Enfield	NHS mentoring and support for young people	aims to bring together NHS Trusts in Enfield and Haringey to coordinate and expand their efforts with regards to employment anchor activities in the most deprived wards of the two boroughs. • Improving the knowledge of the variety of careers and career pathways in the NHS • Increasing aspirations • To increase resilience and strengthen protective factors • To support goal setting and to encourage young people to take responsibility and work to improve key areas of their life	The project has finished laying the groundwork for the project steering group, governance, and processes. And have recruited and trained 26 new mentors across three NCL trusts, and we received 33 new mentee applications from young local residents. Sixteen young people have been matched with mentors and have begun or completed their mentoring journey.

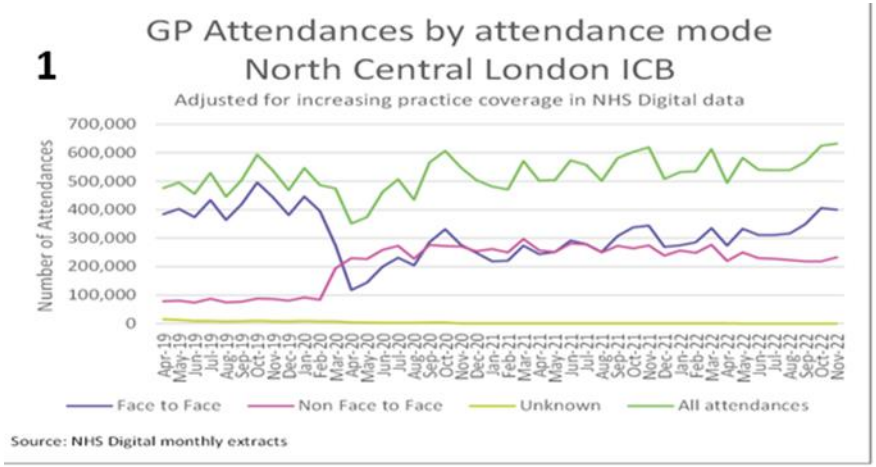
NCL IF 059	Enfield	Family Support model - early intervention therapeutic support – Wellbeing Connect & Edmonton Partnership	WCS Proposed Service outline: Our proposed service will include initial holistic assessment of children and/or their families' needs, support planning, face-to-face (some online) therapeutic support via talking therapies, working with individuals and groups to develop coping strategies, peer & group support mechanisms and resilience. ECP Proposed Service summary: 2 mentors who will each have a caseload of 20 young people from 3 ECP schools (St John & St James, Eldon School and Edmonton County School). Mentors will provide pastoral support as well 1:1 sessions and group sessions within schools and out of school. Mentors will also signpost (and accompany where required) C&YP to after-school extra curriculum activities / catch-up-supplementary education (weekends).	The Edmonton Community Partnership component of the project has outperformed expectations in terms of supporting, enhancing, and mentoring young people at school. The Wellbeing Connect component has hosted two community engagement events and struggles to provide tangible outcome data.
NCL IF 060	Islington	Hand in Hand Islington – A Volunteer Peer Buddy Scheme	A volunteer peer travel buddy scheme that recruits and trains local volunteers with lived experience of mental ill-health to accompany vulnerable residents to other locations in the borough for appointments, courses, services, etc. The service aims to improve access to Islington's health and social care opportunities for residents who experience substantial levels of inequality, stigma, and isolation.	The project is successfully delivering the proposed service and reporting positive outcomes for multi-disadvantaged and at-risk Islington residents in deprived areas. The service plans to enhance delivery in 23/24 and adapt support for specific communities.
NCL IF 061	Islington	Community Research & Support Programme	A community engagement project, talking to residents about their experiences of cancer screening and COPD services. The aim is to help services and commissioners to better understand barriers to uptake within specific communities where uptake is lower.	The project has completed the groundwork of fully scoped engagement topics and trained VCSE partners. Engagement has commenced with a total of 30 residents engaged to date (Oct 22). Routes for engagement with- and provision of support for residents on key priorities and areas of inequality within the borough partnership should be a priority in 23/34 as the partnership continues to develop.
NCL IF 062	Islington	Locality Virtual Spirometry Hubs	Establish a spirometry hub in the North locality to ensure efficient access to quality-assured spirometry.	The service has delivered the operational groundwork for delivery of a spirometry hub service in the North locality; however, due to recruitment issues, the service has not launched. Provision of spirometry as a hub model aligns with national recommendations. NCL LTC clinical networks are in the process of sourcing central funding to also test spirometry hubs in boroughs.
NCL IF 063	Haringey	Haringey - Health Neighbourhoods in Our Locality (Severe Multiple Disadvantage)	Joint Place Board bid to work in east locality on collaboration between statutory and voluntary sector on a number of agreed themes - across population and workforce. Consolidated model of engagement and support	This scheme has empowered 121 users who experience severe multiple disadvantages, to identify themselves what their needs are and solutions that they may want to access, using a trauma and relational approach. Significant outcomes for these people have included the use of a personalised budget for a course of talking therapies or alternate therapies, resulting in them no longer needing mainstream CMHT services, as well as the formation of various peer support groups, including a peer group for black bereaved mothers.
NCL IF 063	Haringey	Haringey - Health Neighbourhoods in Our Locality (LTC)	Joint Place Board bid to work in east locality on collaboration between statutory and voluntary sector on a number of agreed themes - across population and workforce. Consolidated model of engagement and support	This project has experienced challenges in implementation with risk stratification searches now complete and clinics for some conditions now set up. Work is underway to reprofile this project to overcome existing barriers and challenges to enable delivery in Q4 and in 23/24.

NCL IF 063	Haringey	Haringey - Health Neighbourhoods in Our Locality (Empowering Local People)	Joint Place Board bid to work in east locality on collaboration between statutory and voluntary sector on a number of agreed themes - across population and workforce. Consolidated model of engagement and support	This project has been delayed but now has a mapped delivery plan, enabling it's objectives of grass roots group development and community and resident engagement.
NCL IF 063	Haringey	Haringey - Health Neighbourhoods in Our Locality (Childhood Weight Management)	Joint Place Board bid to work in east locality on collaboration between statutory and voluntary sector on a number of agreed themes - across population and workforce. Consolidated model of engagement and support	This project is progressing well with good utilisation of the clinical offer by underserved groups, as well as the educational Grow Tottenham offer for gardening, cycling and physical exercise activities. The Henry offer has experienced implementations challenges, with changes made to better meet parent and user needs. It is under review and may not form part of future delivery
NCL IF 063	Haringey	Haringey - Health Neighbourhoods in Our Locality (Wellbeing Project-MIND)	Joint Place Board bid to work in east locality on collaboration between statutory and voluntary sector on a number of agreed themes - across population and workforce. Consolidated model of engagement and support	This project is performing well, with wide grass root group involvement building community assets and is delivering a range of wellbeing regular activities and bespoke events which are successfully being utilised and supporting Haringey's underserved communities.
NCL IF 063	Haringey	Haringey - Health Neighbourhoods in Our Locality (Sickle cell)	Joint Place Board bid to work in east locality on collaboration between statutory and voluntary sector on a number of agreed themes - across population and workforce. Consolidated model of engagement and support	This project is part of the wider NCL Sickle Cell network work and has made some progress with five priorities identified from patient engagement and the benefits advice priority now delivered. The remaining four priorities are being progressed.
NCL IF 063i	NCL	Haringey - Health Neighbourhoods in Our Locality - Additional Investment	Healthy Neighbourhoods programme	This additional investment from the NCL pot was used to support the following Haringey Borough Partnership projects: Empowering Local People; Childhood Weight Management; LTC (COPD, CVD, CKD); Wellbeing Project; Sickle Cell Project; Severe Multiple Disadvantage. A number of projects are delivering successfully, whilst others experience challenges and delays. This funding invests in a portfolio of healthy neighbourhoods projects that are committed in Haringey for 23/24
NCL IF 063iii	NCL	Haringey - Health Neighbourhoods in Our Locality - Additional Investment GP Federation	As 063, but this is additional investment in Improving LTCs/VCS delivery & infrastructure in Haringey and across NCL as whole.	This additional investment from the NCL pot was used to support the following Haringey Borough Partnership projects: Empowering Local People; Childhood Weight Management; LTC (COPD, CVD, CKD); Wellbeing Project; Sickle Cell Project; Severe Multiple Disadvantage. A number of projects are delivering successfully, whilst others experience challenges and delays. This funding invests in a portfolio of healthy neighbourhoods projects that are committed in Haringey for 23/24
NCL IF 064i	NCL	0-2 Years' Speech and Language Early Identification and Intervention Service (in Barnet, Enfield & Haringey)	Provide enhanced universal and targeted support offers for children aged 0-2 with SLCN (or at risk of developing SLCN) in deprived areas in Barnet, Enfield & Haringey who experience difficulties in accessing existing universal SLT provision in Children's Centres and the core service due to social deprivation factors and other vulnerabilities	This is additional NCL pot funding to support Enfield BP NCL IF 053, which supports a core offer as well as the development of community based SLT assets in children's care centres. The panel queried whether this project was part of the Start Well or core Children's offer. Project may be sufficiently funded from BP pot and NCL transformation programme will flag this project as part of their workflow review.
NCL IF 064i	NCL	0-2 Years' Speech and Language Early Identification and Intervention Service (in Barnet, Enfield & Haringey)	Provide enhanced universal and targeted support offers for children aged 0-2 with SLCN (or at risk of developing SLCN) in deprived areas in Barnet, Enfield & Haringey who experience difficulties in accessing existing universal SLT provision in Children's Centres and the core service due to social deprivation factors and other vulnerabilities	This Barnet model offers community asset building but delayed start and will require 23/24 to develop and build this asset. No funding is required for 23/24. The panel queried whether this project was part of the Start Well or core Children's offer and NCL transformation programme will flag this project as part of their workflow review.

NCL IF 064ii	NCL	Additional investment in 0-2 Years' Speech and Language Early Identification and Intervention Service (in Barnet, Enfield & Haringey)	As 064a, but this is additional investment in SLT from the Contingencies as part of Phase II distribution	This NCL Haringey model offer consists of three elements, which are progressing well. External funding has been identified to support one element of this work, and Haringey BP will fund £4k requirements of this project for 23/24. NCL transformation programme will flag this project as part of their workflow review.
NCL IF 065	NCL	Investment in Support for IF Programme Evaluation	Funding to third-party academic institute to better understand delivery & impact of IF Programme projects, with particular emphasis on community empowerment & coproduction	This project has completed the project engagement surveys and currently is undertaking community-based interviews with projects. There has been some slippage with outputs but these are still on track to be delivered and no funding for 23/24 is required.
NCL IF 099	NCL	Programme Management	ICB staff programme management	The panel recognised the value and benefit to programme management to support systems understanding of this programme and synthesis and share benefits and learning from IF investment for system. Recommendation for 23/24 investment.

High Performing Schemes and Impact

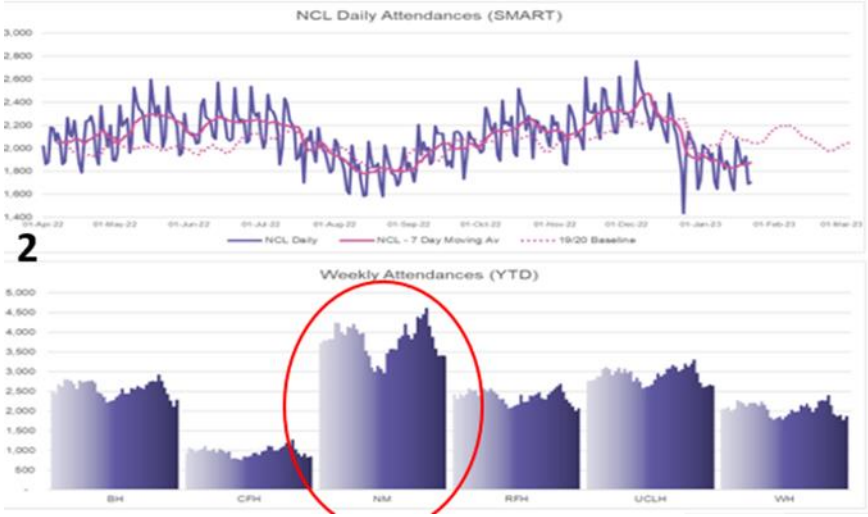
1



GP Activity (Graph 1)

- **More NCL patients than ever seeking GP consultations**. GP attendance rates per head of NCL population increased by 13% pre-pandemic to Jun-22 (and continued to increase)
- **Greatest increase in Haringey** rates (30% rise), with Enfield rates increasing by 7%
- In most Boroughs, **GP consultations for patients in 20% most deprived areas increased** at rate only slightly less than population as a whole (e.g. Haringey 27%)
- **Increases in NCL consultations** across age range, but most notable **for <5, 20-44 (particularly) and 65+** (10%); **Haringey increases more significant for 45+**
- **% of NCL GP patients with LTCs increased by 3.4%**, those with **3+ LTCs by c. 20% to 5.1%** of registered population. **Outer has smaller % of 3+ LTCs than inner London Boroughs** and suggests continued under-diagnoses for level of need in outer London

2



Acute Activity (Graphs 2)

- **NCL ED attendances higher in 2022/23** than 2020/21, **now at 19/20 levels. NMUH attendance shows greatest changes** over last year, **& Dec-22 figures 8% higher than -19**
- **Increase largely due to changes in <65** attendances to ED
- Despite this, **17% decrease in number of NCL 1+ day NEL admissions Apr-Oct-22 v. -19**
- **Nearly 50% were for patients aged 65+ in NCL and rising**, i.e. well over half aged 50+
- **NEL patients now typically more acutely ill with longer LOS** (Table 1, next page)

Conclusions

- **Improvements in primary care & community solutions** – such as anticipatory (proactive) care – **and Inequalities Fund projects made difference to deprived areas…**
- **…And mitigated system and 'legacy of pandemic' changes in need for health & care**

Heart Failure & Diabetes Management (Haringey/Enfield, £274k/Annum)

- **WHT/BEHMHT collaboration with NMUH to improve management and self-management** of people in 20% most deprived communities with these LTCs
- For HF, **aim is to identify people diagnosed with condition, starting with focus on those admitted to NMUH and support them with MDT** in community
- **Work with VCSE to improve self-management** and engage with community, and encourage people with symptoms to come forward for diagnosis/help
- **Focus on Haringey HF outputs as illustration**

Haringey HF Outcomes and Progress So Far

- **149 patients with HF had MDT to Nov-21-Oct-22**, vast majority of whom live in 20% most deprived communities/have GP practices in these areas
- **80% of patients successfully enrolled** on project post-MDT
- **Outcomes** for patients include **engagement with them on treatment optimisation, improved self-management & knowledge** about condition, and knowing what to do and who to contact if their conditions worsen
- **Promising improvements in outcomes** from 25% of patients reviewed
- **Set-up peer support network** amongst patients & helped patients **access health & well-being opportunities**, e.g. One You Haringey, **or improve their social situations**
- **Focussed work with specific communities** on ensuring support 'offer' culturally sensitive, e.g. with Black African/Caribbean, Turkish etc. – this is just beginning

Project Reach and Ripple Effect and System Impact

- c. 0.9% of population with HF, 30% more cases in deprived than affluent Haringey areas
- **Equates to c. 750-800 cases of HF in 20% most deprived areas in Haringey**
- **Current 'project reach' thus equates to 20-25% of cases per annum in deprived areas**
- In addition, focus is on those at **greatest risk of re-admission to secondary care**
- Estimated **22% reduction in hospitalisation for participants** already (part year)
- Likely **project made significant contribution to 5% fall in Haringey NELs related to 'Other Forms of Heart Conditions'** for patients from deprived areas Apr-Nov-22 v. -19
- Latter figure results in **£112k annual cost mitigation** in Haringey

High-Impact Users: Multiple Disadvantage (Haringey/Enfield, £140k/Year)

- **NMUH-based** collaboration with other statutory & VCSE partners **to identify & manage cases of individuals who are frequent ED attenders**, with particular focus on those with severe & multiple disadvantage (SMD), **majority live in 20% most deprived areas**
- **Individual cases managed in community following MDT** via Anticipatory Care Team for older people or via **active care coordination as part of project** to bring together LAS, Council, MH & Substance Misuse Services, Housing, primary & community care & VCSE
- Focus on **improving physical & mental health outcomes** and self-management of people and **their life chances – and reduce ED attendances**

Its Outcomes and Progress So Far

- Engaged with **120 frequent ED attenders at NMUH** and held MDTs for individuals
- Function included as **part of anticipatory care approaches** in development across NCL
- People seen broadly representative of frequent attenders – 70% participants were working age adults with SMD, vast majority from deprived neighbourhoods
- **Positive improvements in some individuals' social, health & environmental outcomes**, including improved self-management of conditions & improved life chances (e.g. reduced risk of homelessness, debt management) – and positive comments about support
- **15% of participants had reduced (800+) ED attendances** – this could improved to 35-40%

Project Reach and Ripple Effect and System Impact

- Estimated 800 reduction in ED attendances could result in 80 NEL admissions during year
- **Annual acute NHS cost mitigations with ED attendances/NELs = £184k, i.e. positive ROI**
- **Plus** savings for LAS, primary & community care, Council, criminal justice & housing – people with significant SMD utilise 6-10x more resources than average citizen. **National modelling suggests working with 85 people with SMD result in non-NHS £450k savings**
- c. 2.000 people with significant multiple disadvantage in Haringey & Enfield
- Majority based in 20% more deprived neighbourhoods (6x more)
- **HIU Project 'reach' therefore represents 5%-10% of people with SMD**
- Second IF project in Haringey works with those with multiple disadvantage in community

ABC Parentcraft (Haringey/Enfield, £327k/Annum both Boroughs)

- NMUH project focussed on **parent(s) from most deprived & diverse neighbourhoods whose young children 0-2 had frequent and/or avoidance ED presentation**
- Engages & provides **training courses for parents to be better able to manage early years child health, well-being & development & to better utilise community services**
- Project works with **parents for some of them to become champions** in their local community networks – enhancing the cultural sensitive nature of delivery

Its Outcomes and Progress So Far

- **420 participants** up to end Sep-22 & forecast to hit **target of 1,100 by Mar-23**
- **Network of courses & local venues in more deprived areas** and work with Council & VCSE organisations to improve 'reach' into community – this network is expanding as new courses, e.g. on mental health & coping with stress are added
- **65% of participants from non-White British backgrounds** – but need to increase numbers from some specific communities, e.g. Somali, & this being addressed
- **All participants** said knowledge of child health, well-being & development improved – several reported utilising skills in life-saving skills
- **Third of participants engaged with self-sustaining peer support networks** established
- Small number of champions on specific areas who support networks
- **94% of participants reported** no onward use of ED as result of course

Project Reach and Ripple Effect and System Impact

- **c. 3,000 children 0-2 from 20% most deprived areas to NMUH per annum**, estimated at 5,200 ED presentations and 770 NEL admissions
- **'Project reach' equates to 35% of these children/parents presenting during year**
- At face value, **£440k annual mitigated costs of future ED/NELs, positive ROI**
- (Likely to be over-estimate, as around only half participants had multiple EDs)
- Project also likely to have **ripple effect** to reach families in under-served communities **without prior ED attendance –** this is being built on & will improve mitigated costs
- Project likely to have contributed to a **37% fall** in number of NEL admissions for children & young people <18 living in Haringey & Enfield's more deprived areas Apr-Jun-22 v. -19

Homeless Health Inclusion Project (Islington, £51k Per Annum)

- **LB Islington/GP Fed project** to improve access to primary & community care solutions for homeless/at risk of homeless population in Islington & known to LBI
- Project provides **access to planned GP & nursing care** in multiple settings for patients to provide **diagnosis, treatment, interventions & help with self-management** as part of holistic support for individuals to support their economic, social & housing outcomes
- Also anticipated to **reduce crises and managing escalating risk of conditions**

Project Outcomes and Progress So Far

- Slow start to mobilise project but now up and running
- **250 projected to be seen by 2022/23**, majority live in 20% most deprived communities
- **C. 50% of patients** with physical long-term conditions, with only one-third diagnosed
- **50% of individuals attended planned appointments** – increase on baseline
- **Some good outcomes** for patients including **engagement with** VCSE groups to promote access, health improvement opportunities and wider social issues people face
- Outcomes for project still being collated

Project Reach and Ripple Effect and System Impact

- Islington homeless/at risk of homeless population known to LBI = 530 people
- **Much more likely to have LTCs than general population**: 7x with MH issues, 21% have multi-morbidity – but less likely to be diagnosed with other physical LTCs than need
- Project **'forecast reach' equates to 45%-50% of homelessness population**
- Research[1] suggests ED attendances associated with homeless population equates to c. 50% of population of homelessness, of these, 30% conveyed by ambulance and 15% would result in NEL admission. **Would equate to 265 EDs & 40 NELs**
- **Assume 40% of participant ED attendances avoided** (in line with HIU expectations) equates to **£52k/year** in cost mitigation from acute & LAS i.e. **likely at least break-even**
- **Plus additional savings associated with primary & planned care**, e.g. mitigation associated with missed GP & outpatient appointments (not included above)

1. Queen AB *et al* (2017) *BJGP Open*, Multimorbidity, disadvantage & patient engagement in a specialist homeless health service in the UK: an in-depth study of general practice data https://doi.org/10.3399/bjgpopen17X100941

Abbey Road Screening Project (Camden, £21.5k Per Annum)

- **Activities** centred around Abbey Road Medical Practice **in deprived Kilburn**
- **Funding for part-time care coordinator** to provide **health screening, reviews & encourage self-management to non-White ethnic patients of** the **practice** in deprived Kilburn, particularly those already known to be at risk due diabetes, obesity, SMI etc.
- **Care coordinator will also engage with communities** to provide advice & information and connect & **support people to adopt healthy lifestyles**, e.g. smoking cessation etc.

Project Outcomes and Progress So Far

- **c. 150 patients** with diabetes reviewed, majority from deprived areas and increase in take-up of diabetes management programme amongst under-served patients
- **Significant increase in number of health checks** amongst SMI registered patients
- **SMI patients better screened for particular conditions** including: diabetes (H1BA1c testing increased by 43%, Lipid profiling by 50%, BP monitoring by one-third)
- **Some positive outcomes** for patients include **engagement with people on healthy lifestyles** and healthy eating and exercise
- Good engagement with local community representatives and facilities

Project Reach and Ripple Effect and System Impact

- **Practice list size (all ages) 12,400** in April 2022, **40% from non-White background**
- 175 patients with SMI, 600+ with diabetes, 700 patients with BMI>30, 1,600 with HTN (all ethnicities). Project largely focussed on these groups – likely to be some overlaps
- Project likely to engage with c. 250 per annum from non-White backgrounds
- If assume at least 40% of patients on disease registers from non-White backgrounds…
- **…'Project reach' is c. 30% of non-White British patients on registers** (not all these patients will necessarily be in the 20% most deprived neighbourhoods)
- Kilburn ward contains c. 20-25% of Camden population in 20% most deprived wards
- Project potentially contributed to 12% fall in patients from 20% deprived areas NEL admitted with circulatory, vascular, renal or SMI conditions Apr-Jun 22 v. -19
- Reduction in these NELs for non-White groups equates **c. £18k yearly mitigation of secondary care NEL/ED activity for those in Kilburn** to which project contributed

Health Inequalities Programme (Camden, £68k Per Annum)

- **Funding for healthcare assistant supported** by pharmacist to provide **health checks & self-management to 40-74 patients** of Brondesbury Medical Practice **in deprived Kilburn**
- **Aim to engage with under-served & diverse communities,** e.g. Somali or Arabic speaking communities **with focus on screening for COVID vaccination, diabetes, CVD & cancer screening & immunisations; and** provide advice & information to connect & **support people to adopt healthy lifestyles**, e.g. smoking cessation, eating/drinking well etc.
- **Screening results in further interventions**, sometimes simple, e.g. GP registration, sometimes **identify & support high-risk patients with abnormal readings**

Project Outcomes and Progress So Far

- **639 patients** seen in project at end Sep, with **1,200 forecast by Mar-23**, majority live in 20% most deprived communities
- **Additional 500 patients registered with practice** as a result of interaction
- **23% increase to 1,550 at end Sep-22 in patients identified as obese**
- 23% increase in BP checks; **4% rise in number of people diagnosed with hypertension**
- **9% & 6% increases to 1,128 & 962 in people identified with pre-diabetes & diabetes**
- **6% increase to 900+ in cervical smears** for women as part of cancer screening
- **14%/3% of patients (total: 21%, 131) identified as intermediate/high risk of stroke/CVD**
- **Positive comments from patients** about convenience and cultural fit of service

Project Reach and Ripple Effect and System Impact

- **Practice list size (all ages) 21,105** in April 2022, and c. 4,750 people 40-74 in Kilburn
- Likely at least 65% **of participants screened live in 20%** most deprived Kilburn ward...
- **. Project reach' equates to screening at least 16%-20% of Kilburn patients 40-74/annum**
- **Project work with high-risk CVD 50-74 patients contributed to 18% fall in Camden NELs for circulatory or vascular conditions of** patients from deprived areas Apr-Nov-22 v. -19
- Reduction in NELs via project likely to equate to **£22k-£24k yearly mitigation of secondary care NEL/ED activity** but mitigation of just 1 stroke patients £45k in first year

North Central London
Integrated Care Board

Primary Care Update to JHOSC

Clare Henderson, Director of Integration (Islington)

March 2023

Contents

North Central London
Integrated Care Board

Primary care challenges going into winter 2022/23
- Summary of primary care access challenges going into winter
- Latest position on primary care appointments (from December 2022 data).

Summary of primary care winter plans
- High-level summary of what has been funded to support General Practice through winter 2022-23. A full evaluation of winter plans will be carried out once the schemes finish at the end of March 2023.

Primary care access – next steps
- Summary of future developments around GP access the ICB will be considering going into 2023/24.

Update on community pharmacy schemes

Update on primary care estates

Primary care challenges going into winter 22/23

North Central London
Integrated Care Board

Primary care position – winter 22/23

- In November 2022, JHOSC invited an update on General Practice. The discussion covered access to GP appointments, development of the primary care workforce, and use of data on GP appointments to inform our work. It also acknowledged the need to ensure that practices were able to deliver a balance of urgent and proactive care to meet residents' needs.
- Comprehensive plans were developed to progress this approach, including dedicated schemes to support primary care in winter. However, primary care has since experienced one of the most challenging winters on record, due to:
- Increase in respiratory infections, with a significant spike in invasive Group A Strep presentations requiring additional for face to face capacity for symptomatic children and young people, with mandated Acute Respiratory Hubs mobilised in each borough.
- Additional demand created by industrial action across the system, reducing urgent capacity elsewhere in the system, more ill people presenting to general practice, and making it harder for practices to convey patients to hospital in emergencies.
- Recruitment and retention challenges for General Practice staff and greater levels of staff sickness, including flu and covid, putting pressure on capacity and stretching workforce.
- GP Practices as smaller providers have less resilience to respond to these challenges than larger organisations.

Developing primary care winter plans

- Despite these challenges, overall NCL primary care appointment numbers continue to rise. Demand for primary care appointments continues to rise, with a spotlight on provision of both same-day and F2F appointments – meeting this demand needs to be balanced against the need to protect capacity for proactive care and long-term condition management.
- Rates of face to face appointments are slightly lower than the national average, while NCL is one of the best performers nationally for % same day appointments.
- For winter 2022-23 specific funding was allocated to develop Primary Care winter plans, with the majority of schemes developed at place, based on local needs, with some projects and capacity boosts agreed across NCL. Plans built on learning from our 2021-22 primary care winter response. The high-level winter plan is summarised on the next slide.
- Looking ahead, the ICB has approved a business case for significant investment into primary care to launch a consistent approach to the management of long term conditions in primary care, to be delivered through a Locally Commissioned Service. This will protect capacity for proactive LTC management, alongside ongoing work to meet urgent demand, working with other primary care stakeholders including 111 and community pharmacy.

Summary of primary care winter plans 2022/23

NHS
North Central London
Integrated Care Board

Focus area	Description	Evaluation plan
Increasing hub capacity	ICB funded hub appointments on Saturday evenings, Sundays, Bank Holidays and 111 bookings to provide additional out of hours primary care appointments in all boroughs. Dedicated Acute Respiratory Infection Hub capacity has also been mobilised in all boroughs.	Track number and spread of additional appointments.
Additional primary care appointments	• Primary Care support to provide additional capacity for low-acuity presentations at the front door at our most challenged Emergency Department: North Middlesex. • Contingency plans / funding for spikes in demand including: responding to 111 demand, extra primary care capacity on an ad hoc basis to cover winter pressures and strike action, pulse oximetry services to all patients.	Track number and spread of additional appointments.
Place-based primary care improvement work	• Accelerating PCN models for Integrated Urgent Care in line with Fuller – prioritising specific pathways e.g. respiratory, palliative care rapid response; • High intensity users (established model in Camden); • Dedicated paediatric clinics to manage urgent 0-5 demand in Enfield and Haringey • Sustainable model of proactive care for clinically and socially vulnerable patients – data driven approach • Telephone triage at PCN level; • Implementation of digital tools and PCN online consultation hubs; • Community pharmacy developments; • Targeted capacity increases (e.g. admin, HCA, locum, social prescribing link worker)	Scheme-specific including: tracking number and spread of appointments provided / patients seen, number of additional staff sessions added to primary care, qualitative evaluation of impact on patient care.

Primary care access review	• Further development of weekly practice SITREP process to capture quantitative and qualitative data providing more in depth reflections on patterns of demand and activity, includes:
	  • impact of advice and guidance on primary care
	  • understanding demand - what prevents today's work being done today?
	  • Note Secretary of State priorities includes general practice SITREPs and telephone access audit
	• Response to access recommendations from HealthWatch and wider public engagement – models and principles of primary care access
	• General Practice Impact assessment of Advice and Guidance
		Outputs and findings of the work including better data about primary care demand and capacity and recommendations for further improvement work

Update on General Practice access

North Central London
Integrated Care Board

Latest data on primary care appointments (Dec 2022)

- December data shows the number of core primary care appointments offered in NCL continues an upward trajectory with further growth expected in 2023-24.
- A seasonal dip was seen in December (as expected based on previous years), and provision of face to face appointments dipped in December to accommodate an increase in the number of same-day appointments offered.

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Core Primary Care Appointments	635734	697242	700259	590561	658821
% Face to Face Appointments	63%	67%	65%	56%	64%
% Same Day Appointments	47%	45%	48%	53%	51%

- Core primary care capacity in December was supplemented by a significant boost to hub capacity funded to cover additional bank holidays and LAS strike action. Some areas used hubs to add targeted winter capacity e.g. face to face appointments for young children or for the frail elderly.

- Beginning in Jan, hubs are also providing additional nationally directed Acute Respiratory Infection (ARI) hub capacity.
- At practice level, appointment data quality continues to offer opportunity for improvement; the ICB is exploring how we support practices to improve data quality. We are also working with primary care networks on accessing data on their evening and Saturday appointments to provide a fuller picture of primary care appointments

Forthcoming access changes

- At a national level, access to General Practice remains a priority, with a national GP access recovery plan expected imminently.
- In NCL there has been an increase in the number of practices participating in the national NHS England's "accelerate" programme.
- The ICB will also need to consider the urgent care provision in primary care, in the context of the final year of the PCN DES contract.
- Nationally and within NCL we are working to roll out cloud-based telephony to all practices to improve patient experience of phoning their practices.

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Community Pharmacy Integration in NCL

Kristina Petrou

NCL Community Pharmacy Clinical Lead (CPCL)

March 2023

NCL Community pharmacy contractors

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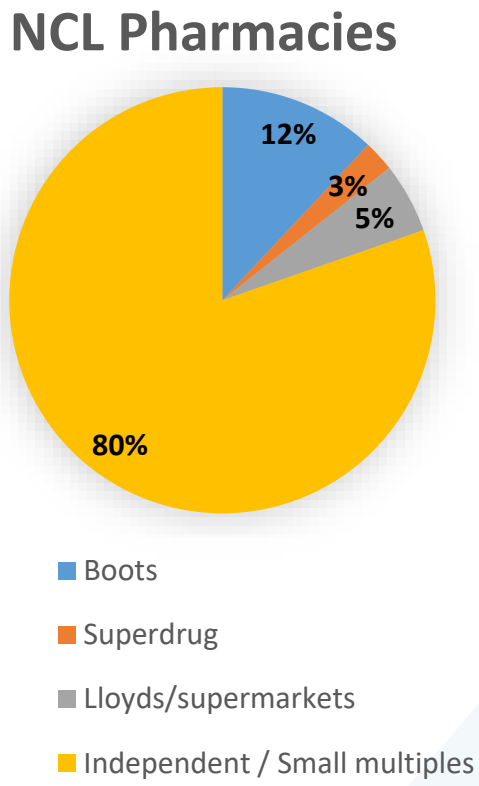
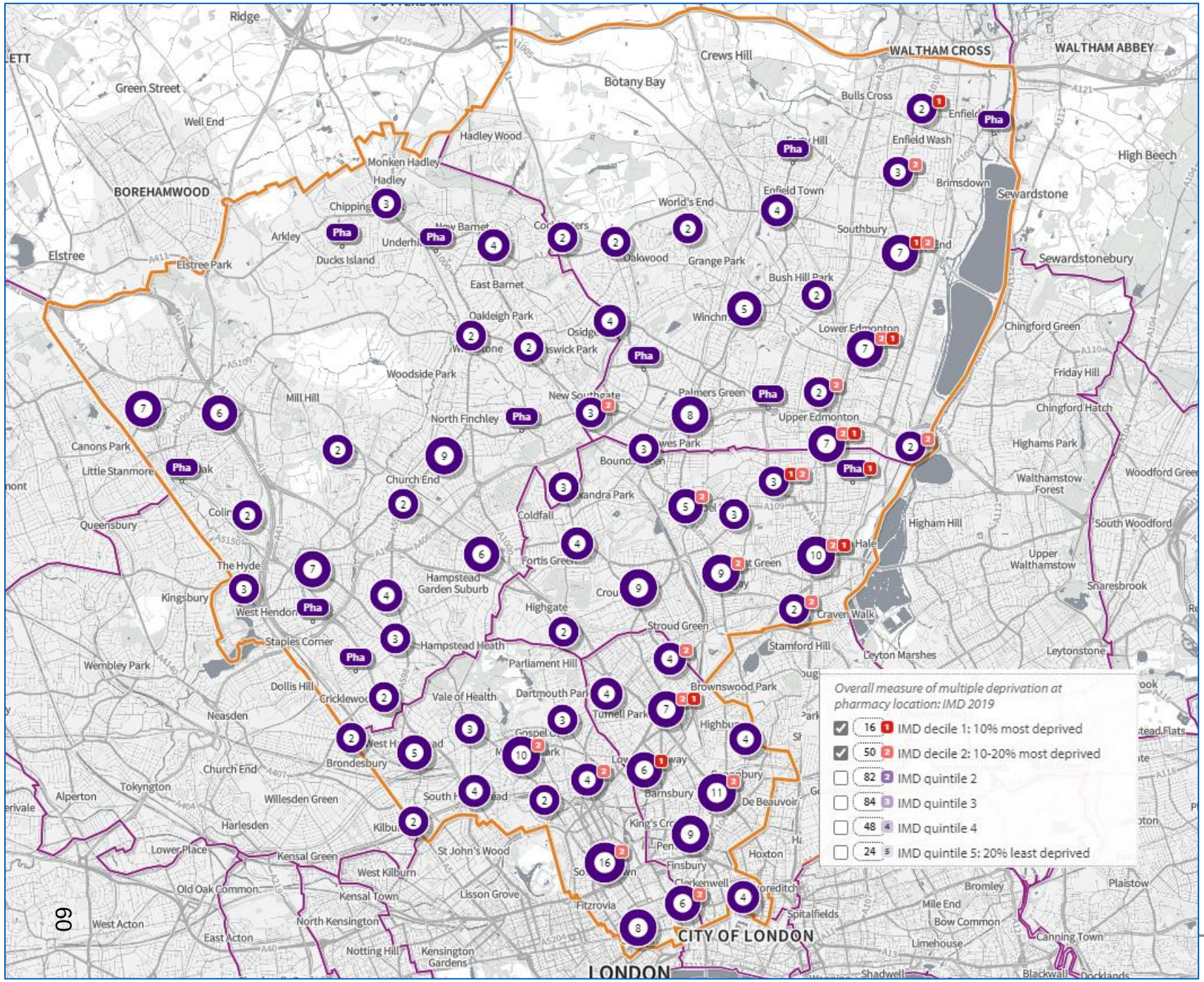
Borough	Pharmacies (Dec22)	Registered Population (Dec22)	pharmacies per 100k registered population
Barnet	75	444k	16.9
Enfield	60	360k	18.9
Haringey	56	338k	16.7
Camden	65	344k	16.6
Islington	48	292k	16.4
NCL	**304**	**1.778m**	**17.1**





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Data Feb'23

Source: SHAPE
https://app.shapeatlas.net/place/

Pharmacy Integration Programme

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- Ensure good clinical leadership and support for the implementation of community pharmacy clinical services.
- Commitment for community pharmacy to be more fully integrated in the NHS
- Range of clinical services
- Vision for community pharmacy to be the first port of call for healthy living advice and for managing minor illness, and staying well
- Support for managing demand in general practice and urgent care settings

Community pharmacy services

North Central London
Integrated Care Board

NATIONAL		REGIONAL	NCL ICB/PH
Essential Services	**Advanced Services**	**Enhanced Services**	**Locally Commissioned Services**
1. Dispensing Medicines 2. Repeat Dispensing and eRD 3. Dispensing Appliances 4. Disposal of unwanted medicines 5. Support for Self Care 6. Signposting 7. Healthy Living Pharmacies 8. Public Health (Promotion of Healthy Lifestyles) **9. Discharge Medicines Service (DMS)**	1. Flu vaccination service **2. Community Pharmacist Consultation Service (CPCS)** **3. Hypertension case-finding service** 4. New Medicine Service (NMS) 5. Appliance Use Review (AUR) 6. Stoma Appliance Customisation (SAC) **7. Smoking Cessation Advanced Service** 8. Hepatitis C testing service	1. London Vaccination Service 2. COVID-19 vaccination (national) 3. Bank holiday rota	PH • Needle Exchange • Supervised self-administration • Stop Smoking Service • Emergency Hormonal Contraception(EHC) • Condom Distribution ICB • Supply of End of Life (EoL) • Medicine Reminder Device (MRD) • Self-Care Pharmacy First (SCPF)

62

Pharmaceutical Services Negotiating Committee https://psnc.org.uk/national-pharmacy-services/

What is GP CPCS?

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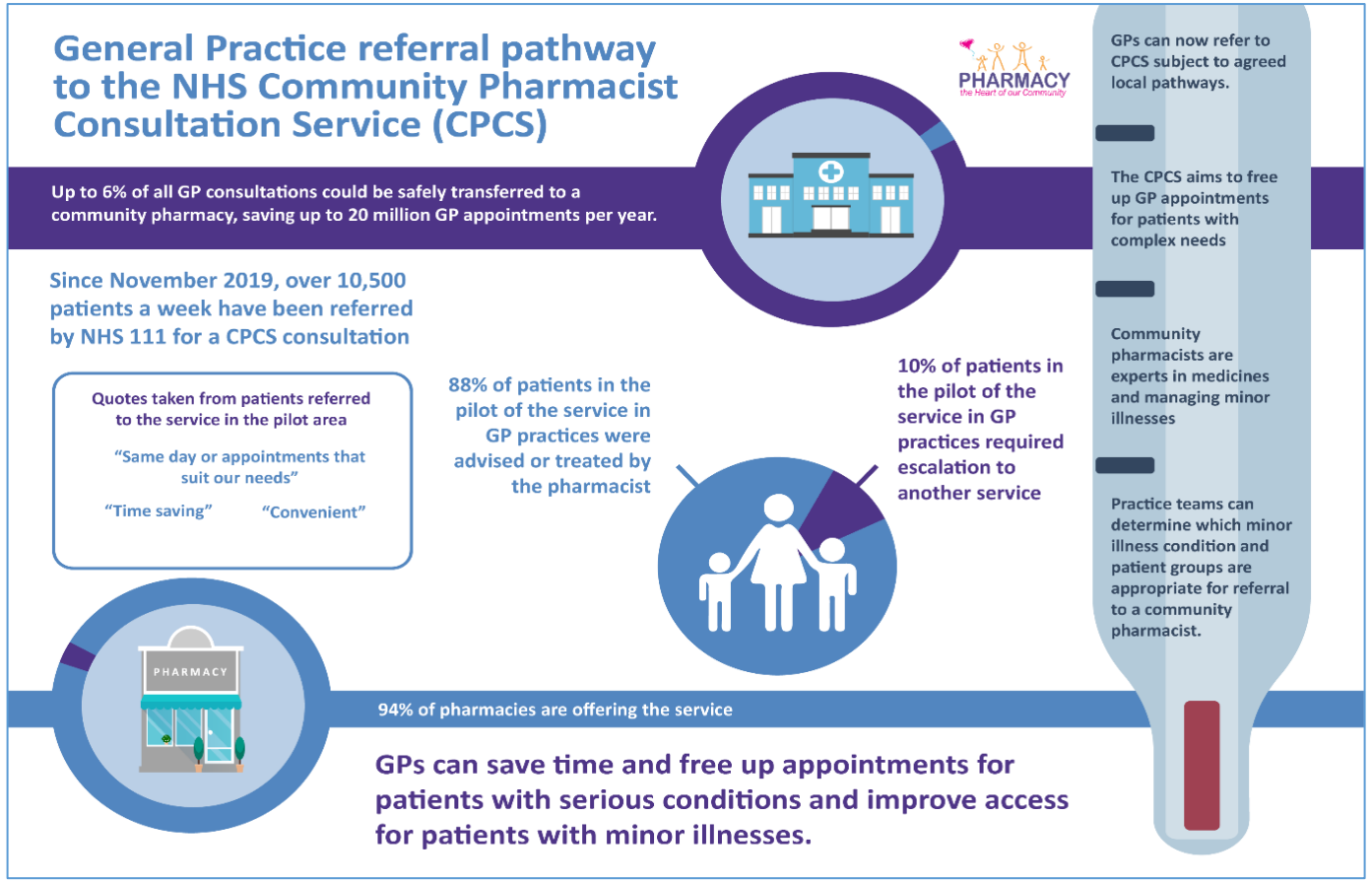

Implementation is locally led but nationally supported

Key aims include:

- Help to alleviate pressure on general practice
- Improve access for patients
- Promote self-care
- Strengthen relationships between general practice and pharmacy

psnc.org.uk/GPCPCSanimation

63

Example minor illnesses

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CONDITIONS	What conditions are SUITABLE for referral to pharmacists?			Do NOT refer in these circumstances	
BITES / STINGS	•Bee sting •Wasp sting	•Stings with minor redness	•Stings with minor swelling	•Drowsy / fever •Fast heart rate	•Severe swellings or cramps
COLDS	•Cold sores •Coughs	•Flu-like symptoms	•Sore throat	•Lasted +3 weeks •Shortness of breath	•Chest pain •Unable to swallow
CONGESTION	•Blocked or runny nose	•Constant need to clear their throat	•Excess mucus •Hay fever	•Lasted +3 weeks •Shortness of breath	•1 side obstruction •Facial swelling
EAR	•Earache	•Ear wax •Blocked ear	•Hearing problems	•Something may be in the ear canal •Discharge	•Severe pain. •Deafness •Vertigo
EYE	•Conjunctivitis •Dry/sore tired eyes •Eye, red or Irritable	•Eye, sticky •Eyelid problems	•Watery / runny eyes	•Severe pain •Pain 1 side only	•Light sensitivity •Reduced vision
GASTRIC / BOWEL	•Constipation •Diarrhoea •Infant colic	•Heartburn •Indigestion	•Haemorrhoids •Rectal pain, •Vomiting or nausea	•Severe / on-going •Lasted +6 weeks	•Patient +55 years •Blood / Weight loss
GENERAL	•Hay fever	•Sleep difficulties	•Tiredness	•Severe / on-going	
GYNAE / THRUSH	•Cystitis •Vaginal discharge	•Vaginal itch or soreness		•Diabetic / Pregnant •Under 16 / over 60 •Unexplained bleeding	•Pharmacy treatment not worked •Had thrush 2x in last 6 months
PAIN	•Acute pain •Ankle or foot pain •Headache •Hip pain or swelling •Knee or leg pain	•Lower back pain •Lower limb pain •Migraine •Shoulder pain	•Sprains and strains •Thigh or buttock pain •Wrist, hand or finger pain	•Condition described as severe or urgent •Conditions have been on-going for +3 weeks	•Chest pain / pain radiating into the shoulder •Pharmacy treatment not worked •Sudden onset
SKIN	•Acne, spots and pimples •Athlete's foot •Blisters on foot •Dermatitis / dry skin •Hair loss	•Hay fever •Nappy rash •Oral thrush •Rash - allergy •Ringworm/ threadworm	•Scabies •Skin dressings •Skin rash •Warts/verrucae •Wound problems	•Condition described as severe or urgent •Conditions have been on-going for +3 weeks	•Pharmacy treatment not worked •Skin lesions / blisters with discharge •Diabetes related?
MOUTH / THROAT	•Cold sore blisters •Flu-like symptoms •Hoarseness	•Mouth ulcers •Sore mouth •Sore throat	•Oral thrush •Teething •Toothache	•Lasted +10 days •Swollen painful gums •Sores inside mouth	•Unable to swallow •Patient has poor immune system •Voice change
SWELLING	•Ankle or foot swelling •Lower limb swelling	•Thigh or buttock swelling •Toe pain or swelling	•Wrist, hand or finger swelling	•Condition described as severe or urgent •Condition ongoing for +3 weeks	•Discolouration to skin •Pharmacy treatment not worked •Recent travel abroad

64

- Minor illnesses often treated with advice and/or over the counter medicines.
- Practices and PCNs can determine specific exclusions/ inclusions within service parameters

GP CPCS patient pathway

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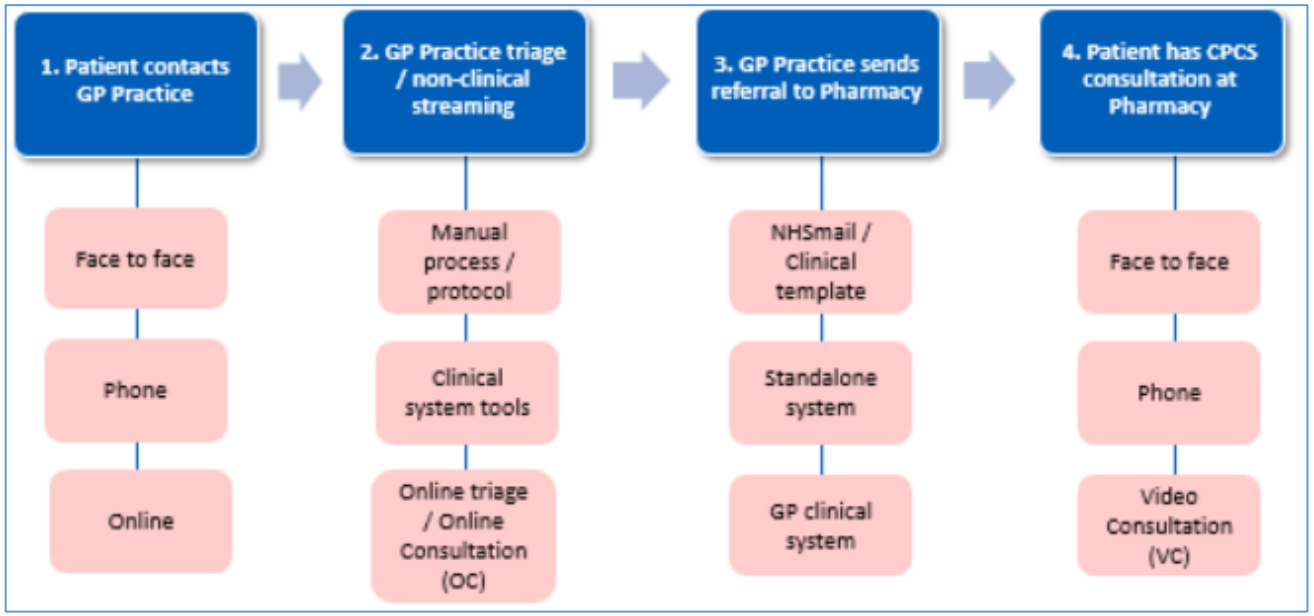
Integrated Care Board



From **March 2023**, the CPCS will expand to enable Urgent and Emergency Care settings (hospital Emergency Departments and Urgent Treatment Centres) to refer patients to the service for a consultation for minor illness or urgent medicine supply.

Page 59

65

GP and A&E referrals into the Community Pharmacist Consultation Service (CPCS)

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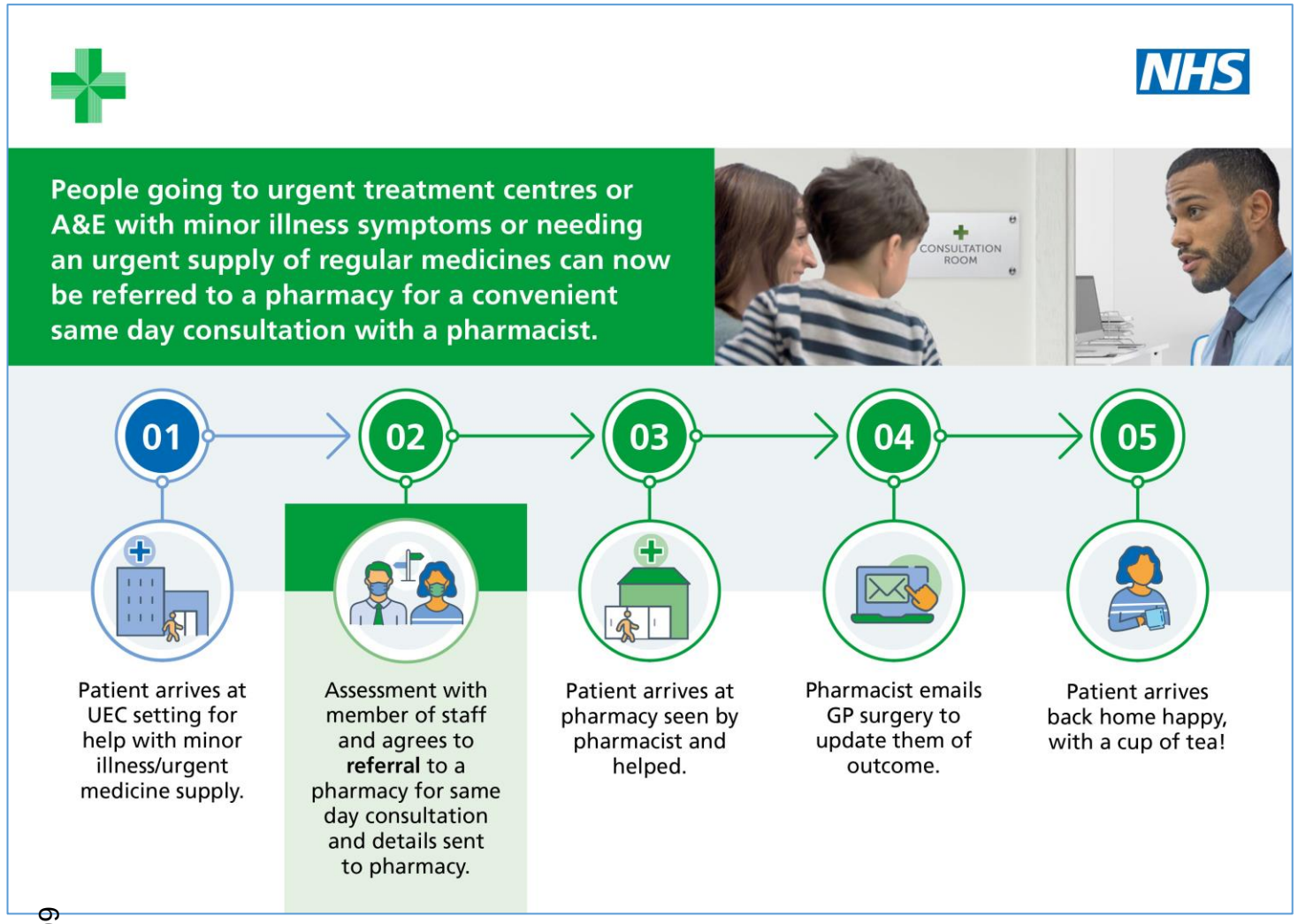
Integrated Care Board



Hypertension Case-Finding

North Central London
Integrated Care Board

- High blood pressure is a major risk factor for cardiovascular disease (CVD) and significantly increases the risk of having a heart attack or stroke, but early detection and treatment can help people live longer, healthier lives.
- Cardiovascular disease (CVD) is the second most common cause of premature death in England, after cancer, affecting seven million people. One in four premature deaths are caused by CVD and it is and a leading cause of disability.
- Participating community pharmacies across England are offering a blood pressure check service to people over 40, as an easy and convenient way for people to get their blood pressure checked.
- The service can be offered opportunistically or at the person's request.
- Checking the blood pressure of people over the age of 40 who have previously not been diagnosed with hypertension (high blood pressure)
- All blood pressure readings are sent to the practice from the community pharmacy.
- General practices can also refer patients to a participating community pharmacy for a clinic blood pressure reading, or for 24-hour ambulatory blood pressure monitoring.

Discharge Medicines Service (DMS)

North Central London
Integrated Care Board

It is estimated that **60% of patients** have **three or more changes** made to their medicines during a hospital stay

30-70% of patients experience **unintentional changes** to their treatment, or an error is made because of a lack of communication or miscommunication on discharge

Only 10% of older patients will be **discharged on the same medication** that they were admitted to hospital on

20% of patients have been reported to experience **adverse events** within three weeks of discharge, 60% of which could have been managed or avoided

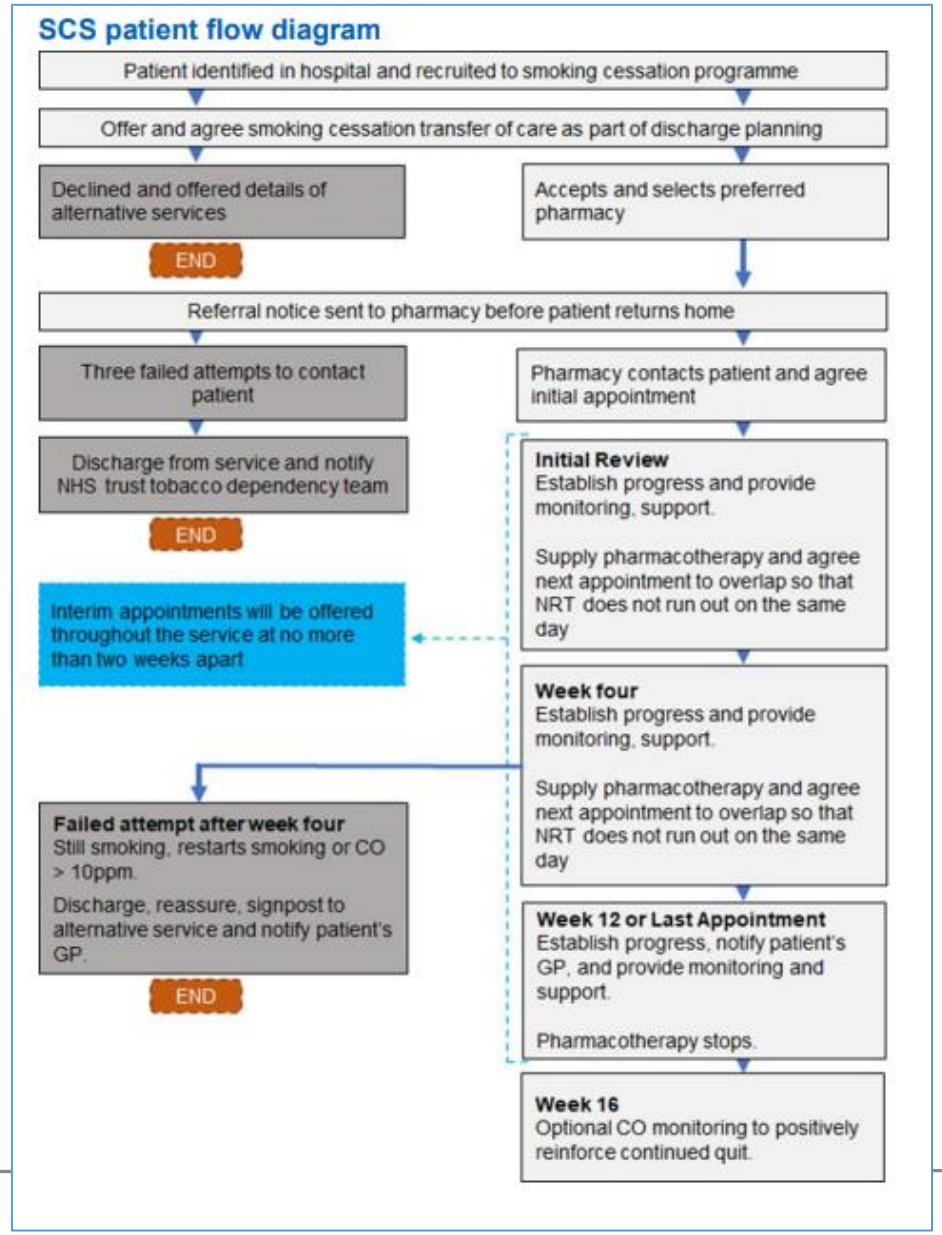
Discharge Medicines Service (DMS)

North Central London
Integrated Care Board

- Discharge from hospital is associated with an increased risk of harm due to medicines, but this can be avoided.
- When people are discharged from hospital, there are frequently changes to their medicines, which can result in confusion about what medicines they should be using.
- Sometimes errors are made when new prescriptions are issued following a stay in hospital, as there may be communications problems between the hospital and the patient's general practice.
- NICE recommends communication systems about medicines should be put in place when patients move from one care setting to another.
- The DMS is an essential service which all pharmacies in England have to provide.
- NHS Trusts (hospitals) refer patients who would benefit from extra support with their medicines after they are discharged from hospital, to their community pharmacy.

Smoking cessation service (SCS)

North Central London
Integrated Care Board



- NHS trusts are responsible for promoting this service to their eligible patients.
- The service should not be actively promoted to the public by contractors.
- The service is specifically for patients referred from NHS trusts who choose to continue their tobacco dependence treatment in community pharmacy following discharge from hospital, by committing to participate in the SCS.
- The service may not otherwise be used as an alternative to existing, locally commissioned specialist stop smoking support.

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme 2022-2023	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 20 March 2023

SUMMARY OF REPORT

This paper reports on the 2022-23 work programme of the North Central London Joint Health Overview & Scrutiny Committee and also requests proposals for reports to be included in the 2023/24 work programme.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

a) Note the work plan for 2022-23;

b) Propose agenda items for the 2023-24 work programme.

1. Purpose of Report

1.1 This item outlines the areas that the Committee has chosen to focus on for 2022-23.

1.2 Meetings of the JHOSC will be scheduled to take place in June 2023, September 2023, November 2023, January 2024 and March 2024. The Committee is requested to consider possible items for inclusion in the 2023-24 work programme.

1.3 Full details of the JHOSC's work programme for 2022/23 are listed in **Appendix A**. A list of items on which the Committee had previously indicated that it wishes to receive further updates in 2023/24 is also provided in **Appendix A.**

2. Terms of Reference

2.1 In considering suitable topics for the JHOSC, the Committee should have regard to its Terms of Reference:

- "To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the areas of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

- The joint committee will aim to work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people."

3. Appendices

Appendix A –2022/23 NCL JHOSC Work Programme

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Appendix A – 2022/23 NCL JHOSC work programme

15 July 2022

Item	Purpose	Lead Organisation
Start Well programme	• For the Committee to receive an overview of Start Well, a strategic programme for children and young people's services.	NCL partners
Update on Fertility Services Review	• For the Committee to scrutinise the final version of the Fertility Services Review.	NCL partners
Enhanced Access to General Practice	• An update on upcoming national changes to 'enhanced access' to general practice (the additional provision of appointments outside of core hours).	NCL partners

30 September 2022

Item	Purpose	Lead Organisation
Finance Update	• For a detailed finance update to include latest figures from each Hospital Trust in NCL, the overall strategic direction of travel and responses to the Committee's supplementary questions published in the March 2022 agenda papers.	NCL partners
Workforce Update	• An update on workforce issues in NCL.	NCL partners

23 November 2022

Item	Purpose	Lead Organisation
Estates Strategy Update	To receive an update on the Estates Strategy including finance issues. This follows on from the discussion on the Estates Strategy at the meeting held on 28th Jan 2022. The specific points to be addressed are: • Vision and priorities; • Context (an overview of the NCL health and care landscape); • The state of the current estate;	NCL partners

	• Drivers of change – clinical requirements, population change and efficiency; • The potential scale of estates change; • Barriers to achieving change; • A summary of devolution asks – drawing from our emerging devolution case for change which is being prepared to a slower timescale and will include options analysis; (for this paper the new ICB Estates strategy) • Timeline; • Governance; • Risks and dependencies – including risks to capital due to current economic circumstances (e.g. higher building costs, general inflationary pressures, higher borrowing rates); • The Targeted Improvement Fund.	
Primary Care Services	To receive a report on the current issues with GP services including: • Difficulties that patients are experiencing in accessing services; • Workforce issues; • Signposting of patients to alternative services such as out-of-hours hubs when GP Practices have limited availability of appointment slots; • An explanation of the current primary care commissioning process including Alternative Provider Medical Services (APMS) contracts and the changes made following the lessons learned from the recent issues relating to Operose Health.	NCL partners
St Pancras Hospital	To provide responses to questions concerning the moving of mental health patients from St Pancras Hospital to facilities elsewhere in London due to construction delays to Camden & Islington Foundation Trust's new Highgate East hospital. The St Pancras site was reportedly due to be used instead by operations transferred from Moorfields Eye Hospital. The specific questions were: 1) Why couldn't Moorfields wait to move their operations to St Pancras so that patients would only need to be moved once (from St Pancras to Highgate East)? 2) Why were Camden & Islington Foundation Trust having to pay for the additional costs incurred by temporarily moving patients rather than Moorfields?	Camden & Islington Foundation Trust Board and Moorfields Eye Hospital Board

6 February 2023

Item	Purpose	Lead Organisation
Mental Health Services Review	Update on the progress of the Review following the previous agenda items on this topic at the meeting in March 2022 including: • How information on available services is communicated to residents; • How co-design/co-production is embedded, with examples of how this was working in practice; • Child & Adolescent mental health services and how the fragmentation of services (as referred to in the report) was being addressed; • The closer working relationship between BEH-MHT and C&I NHS Trust; • A single point of communication for queries relating to service users with complex needs.	NCL partners
Community Health Services Review	Update on the progress of the Review following the previous agenda items on this topic at the meeting in March 2022 including: • The funding mechanisms to support community health services; • The local offer and delivery through the Borough Partnerships; • How the priorities of the local population and specific communities would be identified and addressed; • How co-production would be embedded in the provision of community health services; • How the required workforce would be recruited.	

20 March 2023

Item	Purpose	Lead Organisation
Winter Resilience update	To provide an overview of the approach to winter resilience in NCL including the High Impact Winter Action Plan and additional funding for winter demand/capacity and discharge.	NCL ICB
Health Inequalities fund	To provide details of the £5m health inequalities fund supported by all the Trusts in the NCL area and the impact that this has had.	NCL ICB
Primary Care update	To provide an update on primary care and an overview of community pharmacy integration.	NCL ICB

Possible items for inclusion in 2023/24 work programme

- Further update on Mental Health and Community Health core offer. Last update in March 2023. Next update scheduled for March 2023.
- Further update on Start Well programme to be scheduled. Last update in July 2022.
- Fertility policy review. Last update in July 2022. Next update scheduled for January 2024.
- ICB finance update report. Last update in September 2022. Next update scheduled for late summer 2023. Next update to include further information about the funding to address health inequalities and evidence on how this was working. Risks to services or capital projects associated with inflation/energy costs should also be included.
- ICB workforce update report. Last update in September 2022. Next update not yet scheduled but likely to be in 2023/24. Next update to include Future update report on workforce issues to include a discussion on the need for a strong understanding at senior level of the realities on hospital wards where there are staff shortages and whether sufficient safety levels were being met for staff and patients. A staff representative to be invited to speak at the meeting.

Possible items for inclusion in future meetings

- Strategic role of GP Federations.
- Vaccination initiatives tailored to specific local needs in each NCL Borough including outreach work with community pharmacies.
- Ambulance waiting times and pressures across the system including A&E Departments.
- Pediatric service review.
- Primary care commissioning and the monitoring of private corporations operating in this area.
- The efficacy of online GP consultations, how the disconnect between the public and the medical profession could be addressed, how the public could be reassured that outcomes would be equally as high as face-to-face consultations and how capacity can be improved in this way.
- Increases in number of people being charged for services that they were previously able to access free of charge through the NHS (e.g. dentistry/ear wax syringing)
- Update on funding for NHS dentistry for both adults and children.

2022/23 Meeting Dates and Venues

- 15 July 2022 - Camden

- 30 September 2022 - Haringey
- 23 November 2022 - Islington
- 6 February 2023 – Haringey
- 20 March 2023 – Barnet

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