NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 30 January, 10:00 a.m.
Enfield Council, Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

Contact: Fola Irikefe, Principal Scrutiny Officer

E-mail: fola.irikefe@haringey.gov.uk

Councillors: Philip Cohen and Paul Edwards (Barnet Council), Larraine Revah **(Vice-Chair)** and Kemi Atolagbe (Camden Council), Chris James and Andy Milne **(Vice-Chair)** (Enfield Council), Pippa Connor **(Chair)** and Matt White (Haringey Council), Tricia Clarke and Joseph Croft (Islington Council).

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

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

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.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

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 - 10)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 21 November 2025 as a correct record.

7. NCL INEQUALITIES FUND (PAGES 11 - 50)

8. PAEDIATRIC SERVICES REVIEW UPDATE

Papers to follow.

9. NORTH MIDDLESEX & ROYAL FREE HOSPITAL MERGER UPDATE

Papers to follow.

10. NCL JHOSC TERMS OF REFERENCE

Papers to follow.

11. WORK PROGRAMME (PAGES 51 - 54)

This paper provides an outline of the 2025-26 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

12. NEW ITEMS OF URGENT BUSINESS

13. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

9 March 2026

Fola Irikefe, Principal Scrutiny Officer
Email: fola.irikefe@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Thursday, 22 January 2026

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Agenda Item 6

MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON Friday 21st November 2025, 10.00am – 13.00pm

IN ATTENDANCE:

Councillors Pippa Connor (Chair), Andy Milne (Vice-Chair), Larraine Revah (Vice-Chair), Kemi Atolagbe, Tricia Clarke, Philip Cohen, Chris James

ALSO IN ATTENDANCE:

- Lizzy Dobres, Deputy Head of Communications and Engagement, NCL ICB
- Clare Hendesron, Director of Place, NCL ICB
- Fola Irikefe, Principal Scrutiny Officer, Haringey Council
- James Johnson, Associate Director of Operations for North Central London
- Jess Lievesley, Chief Operating Officer, North London NHS Foundation Trust
- Elizabeth Ogunoye, Director of System Operations & Assurance, NCL ICB
- Mita Joshi, Head of Operations and Assurance

Attendance Online

- Stephen Heard, Director, Healthwatch Camden
- Dan Rogers, CEO, Public Voice
- Sophie Woodhead, Chair, Haringey Healthwatch

FILMING AT MEETINGS

Members present were referred to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'. The Chair informed those present that the meeting was being recorded for the purpose of accuracy.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Joseph Croft and Matt White.

URGENT BUSINESS

None.

DECLARATIONS OF INTEREST

The Chair declared an interest in that she was a member of the Royal College of Nursing and also that her sister was a GP in Tottenham.

DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The committee received a deputation from Haringey Keep Our NHS Public, Brenda Allen, Alan Morton and Rod Well were in attendance in respect of concerns over the

NHS 10 Year Plan. Haringey Keep Our NHS Public raised points in relation to the 52% reduction in ICB staff without redundancy payment expressing that the cuts will come either from cuts to services or other economies they can make. The concession from the Treasury is they will be this this will be spread over 2 financial years rather than one but feel this is a very false economy.

Concerns over loosing trained staff and the potential use of external private companies being brought in to meet the gap to meet the economic challenges ahead was also highlighted. Along with this, HKONP raised concerns over the democratic oversight detailed in the 10 Year Plan, they felt having Healhwatch move into and internal NHS body will weaken democratic oversight. This effectively means that the NHS will be marking its own homework.

Haringey KONHP expressed that the document from the ICB mentions community advisory groups of 25 plus residents and that borough partnerships have to be strengthened to allow leadership, accountability but this will be compromised when it's all internal. Haringey KONHP stressed that the JHOSC needs to pay a lot of attention to the impending developments.

The impact on social care, and the big risks in the future due to reductions to council budgets and private sector influence was another concern raised. Haringey KONHP expressed that the reduced social care budgets will mean to needs being met through the private sector and especially important because social care budgets are a very big part of council activity and council budgets.

The move to a thirteen borough ICB is likely to also mean further distance will be added to relations between the ICB and local authorities leading to a more powerful and more top-down organisation which mitigates against any effective democracy and more localised care. HKONP lastly raise the issue around health data and the need for caution as there are risks in terms of working with big tech and big pharma, so safeguards need to be implemented to protect public data.

The Chair opened the committee to some questions; Councillor Clarke made the point that she shared the concerns regarding the need to ensure that Healthwatch retain its autonomy. Councillor Clarke expressed it was good to have Healthwatch present and echoed the concerns for the NHS in terms of the privatisation of services. Councillor Clarke asserted that a lot of the concerns raised should be directed at lobbying the government.

The Chair expressed that having Healthwatch colleagues online was helpful as there are concerns around the procurement processes, what been done in terms of the private partnership and data collection how it's being used who has oversight and responsibility. The Chair explained that key points and questions should be raised when we the 10 Year Plan is considered.

NHS 10 YEAR HEALTH PLAN AND NEIGHBOURHOOD HEALTH

Clare Hendesron, Director of Place, NCL ICB gave an overview of the 10 Year Plan explaining that it detailed high-level thinking for the NHS for the next ten years and had been developed with significant engagement, London wide engagement and engagement in individuals' boroughs within North Central London. Concerns raised included people having to repeat their medical history, NHS department's operating in silos, systems being outdated, workforce being undervalued etc. The Director of Place explained that the plan sought to address some of these issues, including introducing a single patient record allowing people to book appointments by bringing teams together and investing in workforce. From NCL residents it was also heard during consultation that carers and family should be involved when a patient is discharged from hospital and there have been numerous conversations on the digital plans.

In terms of the Neighbourhood work, the ICB will reduce running costs by 50% from April 2026. The National Health landscape is also changing with NHS England and the Department of Social Care merging. The committee heard that the ICB will be working on understanding our local populations in terms of needs and context and the nuances in the boroughs in terms of the long-term population health strategy and there will be a strong focus on measuring impact.

The committee heard that following the merger in April 2026, they will be called West and North London ICB with a new executive team that's presently being appointed for the new merged organisation. The Merger Implementation plan currently in development was overseen by a joint Executive Programme Board looking at how to reduce running costs and explored what the new organisation needs to look like in order to carry out the commissioning function. Consultation with staff is planned to begin in December 2025 and a voluntary redundancy scheme is also going to be put in place.

The committee were briefed that neighbourhood health was a core component of how the 10 Year Plan would be implemented and the emphasis of a neighbourhood health approach is to shift to proactive care rather than preventive care driven by data and insight of the communities. There are significant health inequalities across North Central London and forming relationships is key to the neighbourhood approach working closely local authorities and the voluntary sector.

The Chair enquired about the ICB Model in terms of the 52% reduction in staffing budget and expressed she was sceptical about how the ICB will be able to deliver and commission services and where the oversight would come from in terms of the new model. She enquired over how things will work with a reduced budget and covering an increased number of boroughs, from five to thirteen.

The panel heard from the Deputy Head of Communications and Engagement that as a strategic commissioner the ICB will try to develop better understanding of each borough's population health and approach things with a more proactive model of care. There will also be closer working with Public Health colleagues. In terms of understanding the local context, there will be a board and close working will still take place with local authority colleagues. In terms of evaluation and impact, there is

recognition that the skills to really look at evaluation and impact could be improved and in the detail in the 10 Year Plan on a national level there is recognition that Health Economists are required.

Healthwatch

The Chair invited Healthwatch colleagues to put forward their views on the points raised in respect of the deputation and the 10 Year Plan. Sophie Woodhead from Healthwatch Haringey shared her reflections from a Healthwatch perspective explaining that they have been engaging in several conversations about the transformation process and are really supportive of the, the patient experience directorate but were keen to stress the necessity for independence, of patient and resident voice. The Chair of Healthwatch Haringey added that patients speak openly when their voice is separate from that of providers and this is at the core of Healthwatch. The Chair of Healthwatch Haringey also emphasises that there will be more of a focus on health where as Healthwatch had an integrated approach looking at health and social care. Healthwatch's really strong links in with community and are presence on various boards and committees whilst also supporting individual residents helping navigate services was pivotal.

Stephen Heard, Director, Healthwatch Camden re-iterated that he felt one of the most important factors is the issue of the independence of patient voice and resident voice. He explained Healthwatch provided a safe space and objective space for patients and residents to express themselves whether it's for local authority, hospital provider or the ICB. The Director of Healthwatch, Camden stressed the good practise that Healthwatch had provided for years and urged local authorities and ICB's to consult with them as much as possible in order to influence how the next phase of patient representation looks. The Director of Healthwatch, Camden also expressed that the focus on the patient is limited in the 10 Year Plan and it is more about organisational restructure and organisation and this was a concern.

Dan Rogers, CEO, Public Voice echoed everything that was said and asserted that the move to neighbourhood working is more important than ever and they have links to local populations and especially those whose voices are seldom heard, experiencing health inequalities. The CEO, Public Voice emphasised that Healthwatch has offered the independent voice for a significant period so close working on the planning going forward is even more important. The need for the JHOSC to continue acting as an independent voice and critical friend is also crucial.

Councillor Clarke enquired about the harvesting of data with huge international corporate bodies having control of data and expressed that the committee should be lobbying the government about it. Councillor Clarke also raised concerns about the increased use of technology and the likelihood to replace human interaction and enquired about what offline options would be available.

The Director of Place, NCL ICB explained that technology is used to support in primary care, e.g. online booking will continue to be the main way people book appointments but there will still be access for people to phone and walk in. For all services, they are

looking at where technology can make things more efficient for the workforce, for example using technology to task notes during a consultation means the doctor doesn't have to type their notes, freeing up more of their time.

Councillor Milne asked further about whether technology was helping the professionals or patients as presently even getting through to GPs on the phone is a challenge. The Deputy Head of Communications and Engagement expressed that a lot of people in consultation have expressed that they feel the NHS needs to improve in terms of technology whilst ensuring that other means of working still remain. The committee heard that in a survey of people in North Central London showed that 80 to 90% of people get all of their health information online on a phone or on their tablet. In terms of accessibility by phone, there is currently ongoing work with general practise to understand both how they can be better supported with better technology for their phone systems.

It was enquired over how much engagement was done face-to-face by Councillor Milne. The Director of Place, NCL ICB explained that the NHS engagement involved face-to-face workshops and they employed a partnership charity in the local area to go out and hold community conversations in community centres all lead by a dedicated engagement team.

The Chair asked Director of Place, NCL ICB to address some of the points raised by Healthwatch colleagues, she responded and explained that there is a commitment from the ICB to continue working with the local Healthwatch's and to use this to think through how the new organisation and patient engagement will be carried out whilst also awaiting further guidance.

Recommendation: The chair summarised that it will be important for the JHOSC to better understand the implications of having a significant number of staff cut from the ICB as it going to impact on services for residents, so it will be key to understand that process.

In terms of oversight, the Chair expressed it will be important to continue working as JHOSC in the format that we currently have as a 13 boroughs JHOSC will not work but at the same time there will need to be collaboration with the NWL JHOSC. The Chair acknowledged and agreed with the concerns raised by Healthwatch colleagues in terms of retaining the independent voice of the residents. Assurance that the new patient voice will also link in with social care and not just health was also pointed out.

The chair would also like clarity on the governance arrangements and how information will be brought forward to the various JHOSC's.

It was also emphasised that service provision and changes in services will need to be clear with data and evidence from the Heath Economists to be brought in to show the rationale behind any changes.

Neighbourhood Health

Councillor Cohen sought clarity about what has been proposed for neighbourhood health and integrated teams whilst at the same time merging the two ICB's. It was heard that the neighbourhood approach was key to ensure the view from the neighbourhoods including residents from each of our five boroughs, the ICB, voluntary sector members from each of our five boroughs are currently represented. Similarly, Northwest London also have their own kind of engagement exercise underway and how the two organisations come together will be considered in the new year.

Councillor Cohen expressed that some of the objectives of neighbourhood health is already being done by existing local health and care networks, borough partnerships and already well-established so it feels like duplication. He expressed he understood the approach to neighbourhood health especially when trying to deal with inequality but there are already structures in place. The ICB explained that rather than reinventing the wheel, the hope is that working relationships will become more integrated with multidisciplinary teams and Neighbourhood Team also including social workers, GPs, district nurses, etc. The aim is to try to bring more connectivity with the resources we currently have. At present Haringey has the most advanced multi-agency model. All the boroughs have elements of multidisciplinary working, but the objective is to scale up.

The committee were briefed that the Neighbourhood Teams will be looking at how they can support people differently as there is a recognition that the population is ageing and ageing less well, so they will be looking at how to cope with the demand and how take more preventative measures.

Councillor Atolagbe enquired over how the Neighbourhood Teams will work with Health and Wellbeing Boards which are also statutory boards. The Chair commented that she noted the integrator arrangements, and it says instead they'll work with borough partnerships and the integrators will provide the leadership infrastructure and coordination needed to support so. ICB colleagues agreed the Integrators will play a leading role in collaborative working.

Councillor Clarke commented that having sat on Islington's health committee for a number of years and the focus has been on prevention, she felt for the NHS prevention shouldn't be a priority over cure. Officers agreed that the role of the NHS was to cure but prevention was also key for Neighbourhood Teams.

Councillor Revah enquired over how they will ensure that the patient and resident involvement is up to task as it was following local authority intervention that the Peckwater Centre engagement in Camden was then carried out more thoroughly. Councillor Revah also emphasised that although quality is key for engagement, it is also important that we are consulting with a reasonable amount of people. The plans for closer working and improved links with social care was also enquired about.

ICB explained that the plan is to work even closer with local authority colleagues in adult social care and borough partnerships. They will be very much involved in

integrated neighbourhood teams whilst also being conscious and mindful of the pressures that adult social care is under.

The Chair stressed concerns over how the borough partnership and the integrator arrangements will work and they needed to be understood better. The chair suggested more detail around how they have the charity, voluntary sector and all the relevant the bodies including Healthwatch and adults social care feeding in. **Follow up:** The chair felt it was necessary to have this as a rolling agenda item coming to the JHOSC. Along with this, a future item on community advisory groups across the whole merged ICB.

WINTER PLANNING 2025/26

NCL ICB

Elizabeth Ogunoye, Director of System Operations & Assurance, NCL ICB and Mita Joshi, Head of Operations and Assurance briefed that in developing the Winter Plan, they develop the plan involving the providers who work in that landscape and local authorities of all the five boroughs. They held an event in September bringing everyone together and developed a dashboard that will be used to monitor impact.

Councillor James enquired about the COVID vaccine rollout and the number of people over 65 who had been invited arriving at surgeries having booked and then being turned away. Councillor James also expressed her concerns over the low take up of the flu jab from NHS staff and welcomed the fact that research to find out why was being carried out. The committee heard about the measures taken to try and get more take up of the flu vaccine including weekly analysis and tracking. In terms of staff, the Director of System Operations & Assurance explained that staff take up the vaccination is low as there is vaccine scepticism and hesitancy and a lot of our energy and attention is taken up dispelling myths around vaccines. The hesitancy is reflective of the population and demographic of many carers. **Follow up:** The Chair agreed that it would be good to be updated on the research and see what the learning is from the research especially as the take up rate seems to be dropping annually.

The Head of Operations and Assurance agreed that they will follow up especially as it very much fits with the focus on prevention as discussed with the 10 Year Plan and so they are trying to increase the uptake of the COVID and flu vaccine, especially amongst the vulnerable groups.

Councillor Clarke enquired about the maximum 45-minute ambulance handover time objective, improve patient discharge time and eliminate internal discharge delays plans and sought assurance over how this be done with no extra funding. In response the committee heard that the plan is to implement measures to improve the flow through hospitals to reduce assessment times and so reducing waste.

Councillor Cohen enquired about corridor care as it should not be seen as a normal practise and that treating patients in the corridor should be a temporary measure and in extreme circumstance, he sought figures on how many patients are treated in corridors.

The committee heard from the Director of System Operations & Assurance that corridor care was not ideal but if there is a surge in patients attending A&E, then at times people are cared for in a corridor setting and they are trying to set up team to manage during those times. The Chair further enquired over the capacity in the system to support the care for people in corridors and what risk assessment has been completed for patients? **Follow up**: details around corridor care.

Councillor Connor enquired about 'virtual wards' which are now called 'hospital at home', she raised concerns that the person who is doing the caring in the home setting and how they are being looked after. She felt some analysis of this needs to be carried out because if there is burnout of carers then the patient is going to come back into hospital. The Director of System Operations & Assurance explained that there is an assessment of the suitability for the 'hospital at home' care carried out by social services in the same way it's carried out when patients are discharged. There is yet to have been an assessment of the impact on carers and the success as these things are currently done on an individual basis.

Mental Health

The chair enquired about the liaison and crisis pathway with high rates of acuity crisis and presentation in the winter planning and without receipt of extra funding, and how this is this managed? Jess Lievesley, Chief Operating Officer, North London NHS Foundation Trust explained that there were no additional funds so they have restructured Trust to meet the challenges of increased demand. As demand is never uniform, they now have the ability to move the resources to where the demand is. In the event that they have a particular surge in North Middlesex for example, they would then align resources for Barnet or with the Whittington. Resources are now more reactive to pressures that might occur within real time.

The Chief Operating Officer, North London NHS Foundation Trust briefed the committee that the mental health challenge in winter is later, so in mental health the surge in demand comes at the end of February and into March, so they plan for that period. From a health science point of view, there is yet to be a full explanation as to why that is but demand peaks at the end of February. At times it can go all the way through March and April, so that is where the balance is necessary for the North London NHS Foundation Trust. The committee heard that one of their big challenges is managing people who are identified as clinically ready for discharge who need to move on into care packages.

A positive step going forward that the committee were briefed on was the establishment of the second mental health A&E. Whittington Hospital has a 24-hour mental health A&E, the first in the country and it's now being rolled out across the whole of the UK. The second one under the Trust will be at Chase Farm Hospital with building works concluding in February and services opening soon after. The Chief Operating Officer explained that the most resilient aspect of the current emergency and urgent care pathway is the mental health A&E as it frees up a significant amount of capacity into the

system. **Follow up**: the committee to receive an update on the progress of the two mental health A&E departments.

London Ambulance Service

James Johnson, Associate Director of Operations for North Central London briefed the committee on the progress that London Ambulance Service had made, explaining that this time last year category two performance was just over 50 minutes and it is now in the low 30s. In relation to corridor care, the committee were informed that have been working closely with hospital colleagues and the ICB to support corridor. The Associate Director of Operations for North Central London also explained that a significant amount of work had been done to try and improve ambulance turn around to make sure the right pathways are employed and reduce some of the burden on A&E. North Central has some of the most challenged hospitals in London for turn around.

The Associate Director of Operations for North Central London then explained that there is a significant strain on staff and a huge incidence of burnout amongst staff and they are currently in the process of addressing these concerns further through a staff survey. It was reported that through recognition of the burnout measures are being taken to resolve the work/life balance and the number of staff off sick was starting to fall.

The Chair acknowledge that everything is looking like it's moving in the right direction, and steps are being actively taken to address the challenges of work/life balance and staff well-being. In respect of the proposed well-being initiatives that were discussed, the chair enquired if the finances were available for it to be sustained. In response, it was heard that some of the measures are very simple, employing process changes and ensuring that people feel valuable. The Associate Director of Operations for North Central London explained that paying sick pay is expensive, so any resources spent on well-being initiatives are offset by the cost of having somebody off and non-productive. There aren't additional resources, but the service is now better at identifying value.

Councillor Cohen enquired why the mental health figured in London were so high and the Associate Director of Operations for North Central London expressed the figures were hight but stressed that we have the benefits of the mental health A&E unit at the Whittington as briefed about by Jess Lievesley of North London NHS Foundation Trust. Councillor James enquired over why in December 2024 they saw the highest number of 999 calls. It was explained perhaps because people were no longer worried about going to hospital anymore following apprehension during and after the pandemic.

The Chair enquired further about the Southern Ambulance service collaboration. It was explained that it is a memorandum between the Southern ambulance services. It was explained that procurement is currently carried out separately across the ambulance services, ranging from equipment to even software and it has now been recognised that there is an opportunity to join together to have common policies, mutual understanding, common governance and processes. There is an economy of scale and to join together procurement and to share best practise. **Follow up**: the next update

from London Ambulance Service to provide details/ an update on the collaborative work.

NWL JHOSC TERMS OF REFERENCE

The Scrutiny Officer briefed on progress to date in trying to settle on the terms of reference and support arrangements for the NWL JHOSC going forward explaining that some meetings with Heads of Democratic services in other authorities had taken place and that equally, the Chair of the committee had written a letter to other Chief Executives on the JHOSC.

The Chair of the committee emphasised that having resolved to retain the autonomy to appoint the Chair of the panel, the issue of resourcing and supporting the JHOSC still remained. It was acknowledged that all local authorities were under financial constrain but only Camden had responded with a clear agreement to contribute to supporting the NCL JHOSC.

The committee agreed that the JHOSC was even more necessary with all the changes taking place with the ICB and even more important, ensuring the critical friend role with the changes planned for Healthwatch to be internalised in the NHS. Councillor Cohen re-iterated that Barnet was in a difficult financial position. On discussion in terms of the amount to contribute, Councillor James expressed that the figure to contribute individually was not significant to which all members of the committee acknowledged.

The Chair concluded the discussion that the panel was happy to agree the terms of reference, with the caveat and understanding that the finances still needed to be resolved and ideally by the end of this municipal year.

Recommendation: that the finance is split equally by the members of JOSC, including any prospective future increase or decrease in view of the need to have some link with the NWL JHOSC.

WORK PROGRAMME

The committee discussed the work programme for the remaining two meetings in brief including:
<u>30th January 2026</u>
Paediatric service
Royal Free and North Middlesex update

<u>9 March 2026</u>
10 Year Plan
ICB Merger and Reconfiguration update
Including social care and how they will work.

North Central London
Health and Care
Integrated Care System

NHS

Inequalities Fund

2025-2026

An overview of the programme, achievements and future development

Ruth Donaldson, Paul Allen, Priyal Shah
Strategy, Research and Communities Team, NCL ICB

Inequalities Fund - outline

North Central London Health and Care
Integrated Care System

- Context
- Inequalities Fund Programme Overview
- Outcomes Framework and Thematic Review
- Economic Evaluation
- Learning and next steps
- Appendix: Project highlights and list of projects

Context

North Central London Health and Care
Integrated Care System

- Addressing health inequalities is a key ambition of **The Fit for the future: 10 Year HealthPlan for England** through a stronger focus on **prevention** and shifting care and resource into the **community**, particularly targeting socio-economically disadvantaged areas

- The **Inequalities Fund** is £5m per year investment to fund innovative partnerships that address the root causes of health inequalities, focusing on prevention, early help and wider determinants of health by working alongside communities through a co-production approach

- NCL ICB is also leading on the development of **neighbourhoods** to deliver a more preventative model of care through cross-sector partnerships that are rooted in communities, supported by pooled budgets

- The Inequalities Fund represents a pioneering approach to **improve health outcomes** through community-based partnership models that will support **neighbourhoods** and strengthen our focus on prevention

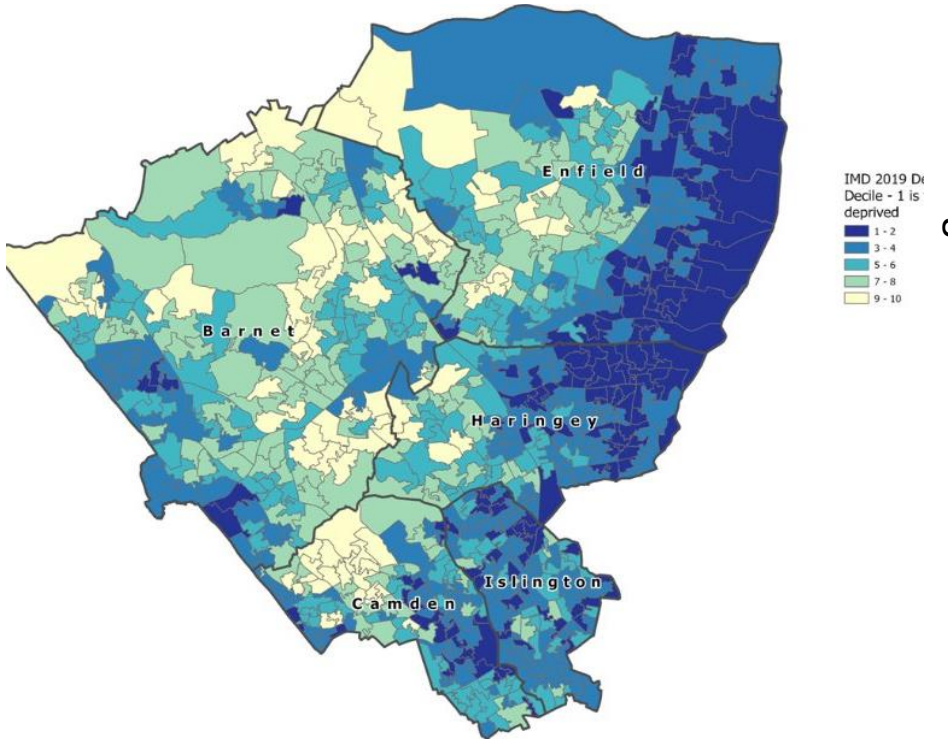
Funding allocation
Indices of Multiple Deprivation 2019

North Central London Health and Care
Integrated Care System

Funding was allocated into two ways:

1. **75% of funding is allocated to individual Boroughs**
   - Funding distribution based on relative number of Borough NCL residents living in England's Indices of Multiple Deprivation 2019 20% most deprived wards
   - Two-thirds of NCL's population in the 20% most deprived IMD2019 areas live in Haringey or Enfield, hence two-thirds of the funding is targeted at these Boroughs
   - Smaller allocations for Camden and Islington and no allocation to Barnet (with no wards in the IMD2019 20% most deprived areas)
2. **25% funding is retained in an 'NCL pool' to fund:**
   - Projects to support non-geographical inequalities and disadvantaged and under-served groups in NCL
   - Projects in Barnet – to recognise 'pockets' of the population in IMD2025 deprivation within specific wards in the Borough that needed some resource

Deprivation profile of NCL, by lower super output area



Source: Index of Multiple Deprivation (IMD_ 2019

Funding allocation
Indices of Multiple Deprivation 2025

North Central London Health and Care
Integrated Care System

Implications of Moving from IMD2019 to IMD2025

- National IMD analysis recently update from 2019 to 2025, with slightly changed methodology
- Implications of IMD2025 for NCL & Programme the ICB & partners are exploring:
  - NCL became relatively more deprived v. England – 28% people living in IMD2025 20% most deprived areas nationally v. 21% in IMD2019
  - Relative increase more noticeable in Haringey & Enfield – already most deprived Boroughs - and to an extent in Barnet & Camden
  - Islington only Borough in which % of population living in 20% most deprived areas improved
  - Further factor to consider is people already living in 10% IMD2019 most deprived areas may have become relatively even less affluent in 2025
- ICB working towards reallocate its fixed Programme budget to reflect IMD2025 without destabilising long-standing projects in impacted Borough

Selection of IF schemes: Borough Partnership process

North Central London Health and Care
Integrated Care System

- Funding is allocated to each Borough based on the proportion of their population living in the 20% most deprived areas.
- Borough Partnerships decide on project investments according to local healthcare inequalities enabling funding to be targeted to hyperlocal communities
- Examples include:
  - Complete Care Communities project targeting Somali and Bengali communities in Camden and the RISE project supporting the Somali community in Haringey
  - Improved management of diabetes and heart failure in east Enfield and Haringey
  - Targeted prevention and lifestyle change support for Healthy Heart among South Asian and Black communities in Barnet
  - Outreach cancer screening and targeted support to improve childhood immunization in Islington
- Borough Partnerships review each project annually to decide on future commissioning, to continue, stop or recommend changes for the project

Inequalities Fund 2025-26 Summary

North Central London Health and Care
Integrated Care System

- **45** Inequalities Fund projects were delivered with many continuing from the previous year achieving greater impact (more people supported, improved models)
- Over 20,000 people supported across all the projects. 75% of project objectives were met
- Range of providers and partnerships including VCSE, Trusts and Primary Care; some match-funded through other sources
- Majority are focussed on wider determinants, prevention and early identification, targeting communities at highest risk
- There was evidence of extensive engagement, service-user feedback and co-production to develop and deliver the projects
- Wide range of data has been collected to demonstrate impact e.g. clinical markers, patient feedback, self-reported outcomes such as behaviour change, extent of unmet need identified, improvement in wider determinants of health (educational achievement)
- The following slides describe the multi-dimensional evaluation:
  1. Outcomes Framework
  2. Thematic review
  3. Economic evaluation
  4. Project highlights

North Central London
Health and Care
Integrated Care System

Population Health Outcomes Framework

Population Health Outcomes

North Central London

Vision

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities & the gap in healthy life expectancy

Start well

Every child has the best start in life and no child is left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and newborn screening coverage
- All children are supported to have good speech, language and communication skills
- Children have improved oral health

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Early identification and improved care for people with mental health conditions

- Improved physical health in people with serious mental health conditions
- Reduced racial and social inequalities in mental health outcomes
- Reduced deaths by suicide

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity
- Improved air quality
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing

- Reduced unemployment and increase in people working in fulfilling employment
- People live in stable and healthy accommodation and are safer within the communities in which they live

Age well

People live as healthy, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier intervention and improved care for people with dementia

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

Population Health Outcomes and Inequalities Fund

North Central London Health and Care
Integrated Care System

Start Well	
Increased immunisation	**Childhood immunisations Islington** • Partnership across VCS and primary care. Targeted approach to improve childhood immunisations (joint project across Healthwatch and primary care) • 384 parent/carers engaged • 29 booked appts (from 275 successful call attempts) out of a target list of 530 children
Early identification and proactive support for mental health conditions	**Mental health, arts and sports project Haringey for young people (Open Door)** • Over 1000 hours of support provided: including: 650 Individual psychotherapy/CBT sessions, • 28 active programs and 80 workshops/trainings, including sport, lunch clubs and holiday camps • 82% self-reported progress in 'prosocial 'behaviour (SDQ) • 71% improved quality of relationships (therapist assessment through talking with young people) • 73% started in moderate-severe depression range, 72% reporting improvement (self-rated clinically validated measure- PHQ9) – which is a marker for successful treatment
Reduced prevalence of children and young people who are overweight or obese	**Childhood weight management, Haringey** • 650 children seen out of a target of 850. • On average children were reported to have made 2 diet changes and 1 exercise change. • On average 50% of children either reduced or maintained BMI

NCL Outcomes Framework
https://nclhealthandcare.org.uk/our-working-areas/population-health/ncl-outcomes-framework/

Population Health Outcomes and Inequalities Fund

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Live Well

Reduced racial and social inequalities in mental health outcomes	**Tottenham Talking Haringey** • 48% of the users were from age 40-65 years and 60% from N15 and N17 post codes. Almost 40% were from global majority communities. • Over 206 participants seen and significantly improved self-reported mental wellbeing outcomes (feeling of usefulness, optimism about the future, social connections). • 37.5% of service users (n=?) surveyed reported that they would have had a crisis or hospital admission if they were not engaging with Tottenham Talking
Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity	**VCS & Primary Care based smoking cessation in Enfield** • Turkish and Romanian speaking staff to target Non-English speaking (168 out of 217), entrenched health beliefs, high risk of obesity • 55 out of 217 who joined programme quit (25%) • 134 out of 286 (46%) patients quit (12 week quit rate)
Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease	**Type 2 diabetes (Enfield and Haringey)** • On average 64% of 258 patients (164) had an improvement in HbA1c (target 60-70%) • 70% improved self-management • Reduced A&E attendance by 18-27% (Jan-Sep 2024)

Population Health Outcomes and Inequalities Fund

North Central London Health and Care
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Age Well

People get timely, appropriate and integrated care when they need it and where they need it	**High Intensity Users (Enfield and Haringey)** • 131 individuals with a total of over 2590 A&E attendances since 2022 • A&E attendances for 18 individuals fell by 287 from 2662 to 2375 (11%) over 2 years

People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age	**Enfield Community Hub Outreach**
	• 880 people seen in outreach and social events; providing information, advice and guidance
	• Outreach - 95% of enquiries are related to housing e.g. inadequate housing conditions, evictions, difficulty paying rent
	• Hubs – most queries related to financial assessment followed by housing
	• Events with health services:
	  • 425 people screened for diabetes since August 2023 – 57 people diagnosed as having pre-diabetes
	  • 84 blood pressure checks – 22 of which outside of normal ranges
	  • 10 people spoke to homeless GP outreach service
	  • 20 residents engaged with Cancer screening awareness conversations

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Thematic evaluation

Inequalities Fund Outputs - Themes

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Output themes	Description	Examples and types of metrics
Project 'Reach' into Population	Number of people engaged with project. What % of specific 'targeted population' does projects reach?	• Reach: 20,000+ individuals • % annual reach for project is c. 15+% of targeted groups. but can be higher (examples below).If projects are at this 15% level, likely to have impact at targeted popn level
Community Health checks & screenings	Thousands of community health checks and screenings delivered through the schemes.	• Example – 1,722 enhanced health checks by a health care assistant with enhanced training. (Camden Brondesbury Medical Centre) - % reach c. 13%-15% of target popn. • Example – 425 diabetes screening, 84 blood pressure checks, 20 cancer screening discussion (Enfield Community Hub Outreach) – % reach c. 15% for Community Hub
Training & capacity building	Working with local needs and assets to build capacity in our communities.	• Example – 51 community champions created and trained in mental health first aid (Camden Complete Care Communities). • Example – 45 community champions retained, 12 of which became breastfeeding champions who undertook level 2 BFN peer supporter training (ABC parents).
Mental and physical wellbeing support	Schemes recorded over 16 types of weekly activities across specific under-served communities in NCL	• Example – 296 buddy journeys delivered, with the majority going to access green spaces, shopping or for leisure (hand in hand Islington). • Example – 128 females attended social and physical activities, with scheme working with 350+ individuals (Somali Mental Health) - % annual reach c. 22% of this popn.
Community outreach and engagement	Schemes oversaw multiple pop-up health events and culturally adapted activities.	• Example – Happy Health Halloween event (Healthwatch Islington – Childhood Imms) • Example – 17 Healthy Hearts events totally attendance of 1,361 people and leading to 493 BP checks/lifestyle advice (Healthy Hearts Barnet) - % reach c. 17%

Inequalities Fund Outcomes - Themes

North Central London Health and Care
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Outcome themes	Description	Examples and types of metric to consider
Health & Wellbeing improvements	Schemes consistently reported high levels of improvement in physical and mental health.	• Example – Work with 800 young people - 82% self-reported progress in prosocial behaviour & 78% reduction in self-harm, 67% reduction in violence/aggression and 80% reduction in drug/alcohol misuse. (Haringey Arts and Sports) - % reach c. 31%
Reduction in NEL and A&E attendance	A key theme running through the schemes is that of significant reductions in emergency or avoidable attendances.	• Example – 114 'High Intensity Users' of A&E engaged at NMUH, all needing additional support due to multiple disadvantage or complex needs. Reduction of 20% & 50% in future A&E attendances and hospital admissions for participants (Haringey & Enfield High Impact Users) - % reach c. 21%.
Empowerment & self-management	Empowering our communities to feel confident in taking control of their health & wellbeing.	• Example – 27% increase in patients from the most deprived quintile booking appointments digitally and a 14% increase in this group of patients using online Services such as the NHS App. (Camden Brondesbury Medical Centre).
Social connectedness and participation	The schemes oversaw the bringing together of communities to participate in health & wellbeing activities.	• Example – 70% felt more connected to the community and 81% felt more confident making friends since coming to their Tea & Toast initiative. (Enfield Community Hub Outreach).
Staff empowerment and system change	Many schemes reported positive impact on staff through a combination of training and wellbeing opportunities.	• Example – 100% of staff felt fulfilled to see the impact of their intervention to empowering clients. (WHATIF scheme). • Example – Staff felt more empowered by having structured programmes and clear guidelines to address health inequalities. (Targeted community outreach worker).

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Economic evaluation

System Impact of Inequalities Fund Programme in 2025/26

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- Projects were evaluated in Oct-25. The table estimates the IF Programme impact on health and care system in mitigated activity/costs.
- Projects were divided into 2 groups:
  - **Projects focussed on engagement, healthy lifestyles and primary prevention**, where you might expect the impact to be longer-term. However, as many of the projects are well-established (3+ years), we estimated the extent this mitigation was achieved – and to consider the impact on healthcare activity and costs on a 3-5 year basis
  - Projects focussed on projects to **promote screening, earlier diagnosis and improved planned health management** often with the aim of mitigating demand 'downstream', i.e. reducing demand for typically secondary care/mental health activity.

  For example, the proportion of non-elective acute admissions decreased by 25% amongst people 50+ from these deprived areas in 2025 v. 2019. We estimate the IF Programme contributed c. 20% of this decrease.

Estimated Return on Investment Cost Mitigation for Evaluated Projects in 2025/26

Project Type	Neighbourhood Pillar	No. Participants	Annual Costs	Cost Mitigation*	Net ROI Benefit	Type of Activity Mitigated
Earlier Diagnosis / Health Management	Pillar 3 – Health Management	10,460	£2.0m	£3.0m	+£981k	Includes unplanned care and MH activity (3,086 ED attendances, 470 NEL admissions, 547 MH interventions)
Preventative Solutions	Pillars 1-2 – Community Assets and Early Help	8,770	£1.6m	£2.35m	+£732k	Includes planned and unplanned healthcare activity in primary care, community, acute.
All	**Pillars 1-3**	**19,770**	**£3.6m**	**£5.3m**	**+£1.7m**	

The table shows both project types resulted in positive net ROI cost mitigation – £5.3m mitigation v. £3.6m cost (of projects included in 2025/26 evaluation). ***This means £1.47 activity-based cost mitigation for every £1 spent.***

Summary of Evaluation by Borough 2025/26

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	All Projects	Results from Projects Evaluated in Stock-Take				All Projects
Borough	No. Projects	Amount Invested in Evaluated Projects	Est. No. Participants 2025/26	% of Project Objective Met	Est. Cost Mitigation in Healthcare Utilisation	**Borough Summary:** ✓ Different foci of investment in different Borough portfolios ✓ All Boroughs showed net positive cost-benefit analysis ✓ Opportunity for sharing learning into neighbourhood models
Barnet	2 (1 evaluated in stock-take)	£26k	1,200 (but part of wider project)	100%	£57k	One project, Healthy Hearts, is part of a wider project with the Council and VCSE. The second project mobilised part year.
Camden	10 (4)	£237k	2,880	75%	£454k	Four continuing projects and six projects mobilising in year. All addressing a mix of health and social outcomes and targeting vulnerable groups.
Enfield#	11 (10)	£1,147k	10,250	80%	£2,081k	Continuing VCSE and statutory partnership projects tackling empowerment, long term conditions and health determinants.
Haringey#	13 (10)	£1,514	5,840	90%	£1,955k	Continuing partnership projects across statutory services and VCSE focussing on more complex mental and physical health.
Islington	10 (9)	£676k	1,390	78%	£764k	Greater focus on mental health including those focussed on more vulnerable groups. Most are collaboration with mix of statutory and VCSE projects.

- Enfield and Haringey share 2 joint projects cross-border. Est. No. of Participants counted in both Enfield & Haringey rows for these projects, so total number of participants slightly over-estimated. However, split of funding is 50:50 for these projects between the two Boroughs, and est. cost mitigation specific for each Borough

Inequalities Fund and Neighbourhood development

North Central London Health and Care
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- Neighbourhood development will be prioritised in areas of high inequalities, which have been the target areas for the Inequalities Fund
- The partnership approach, insight, learning and reach into the communities through the Inequalities Fund provide the foundations for improving health outcomes
- Majority of the projects are aligned to Neighbourhood pillars 1-3 with a few aligned to pillar 4:

  Pillar 1: Creating community assets for health and wellbeing

  Pillar 2: Outreach and early identification

  Pillar 3: Targeted interventions and secondary prevention

  Pillar 4: Prompt action on rising risk

Inequalities Fund – Learning

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What works

- ✓ IF projects **reached deep into communities** that face highest levels of health inequalities e.g. Bengali, Somali, young black men, people experiencing homelessness and **upskilling** them as community champions
- ✓ **Extensive engagement**, co-production, service user feedback which was then incorporated into delivery approaches
- ✓ **Wide ranging partnerships** especially across statutory services and VCSE and across multiple VCSE organisations and across IF projects (outreach events)
- ✓ Most projects employed a **holistic approach** delivering health promotion, group work and individual support for health and **wider determinants of health** matters
- ✓ Continuing projects for a couple of years have enabled them to **improve delivery models**, expand their reach and collect data

What to improve

- **Commissioning and administering the Programme is complex** in context of changing procurement requirements, provider vulnerabilities and partnership arrangements. However, the IF programme has been led by oversight from Borough Partnerships, shaping projects for place-based delivery.
- **Several successful projects have ended – as their approaches were absorbed into 'business as usual' models.** However, more providers could adopt this approach, improving services and making best use of resources. This is a conversation the ICB is having with several more providers into 2026/27.
- **Data and intelligence recording and reporting** as part of evidencing outcomes and impact has improved over the years, the challenge is how we make greater use of qualitative insights alongside quantitative data to understand benefits. Attribution is complex, particularly for prevention-type interventions, which take longer to materialise. Variety of project types (from increasing participation to improving access and early identification) make evaluation and analysis complex.
- Cost mitigation is considered in this analysis; but one issue is extent to which **'shift left' Return on Investment approaches cashable –** resolving this will be key to progressing 'shift left' and improving sustainability.

Inequalities Fund – next steps

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Over the next year, we will align the Inequalities Fund programme with West and North London ICB's strategic priorities:

- Strengthen **neighbourhoods** by linking place-based Inequalities Fund projects with the emerging borough models and closer working with borough Integrators; majority of projects focus on prevention, early identification and targeted intervention. The deep knowledge of the communities and connections provide a strong basis for proactive population health management at place.
- Focus on **improving outcomes** for key groups: adults with serious mental illness, integrated care for children and young people, people approaching end of life through specific Inequalities Fund projects and by embedding the learning from these into our wider services.
- Target investment towards areas newly identified as highly deprived as per **IMD 2025** with insight from Borough Partnerships (next slide) to improve equity across boroughs.
- Streamline **commissioning arrangements** in partnership with VCSE partners and statutory organisations building on current models, such as lead provider and provider partnership arrangements.
- Embed a **robust data collection and evaluation** approach to help demonstrate the impact of the programme and inform wider commissioning.

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Appendix: Project highlights

1. Healthy Heart, Barnet
2. Complete Care Communities, Camden
3. Health Heroes Unite, Enfield
4. #What If, Enfield
5. Community Diabetes, Haringey
6. Young Black Men and Mental Health, Islington
7. Learning Disability health checks

Healthy Heart, Barnet

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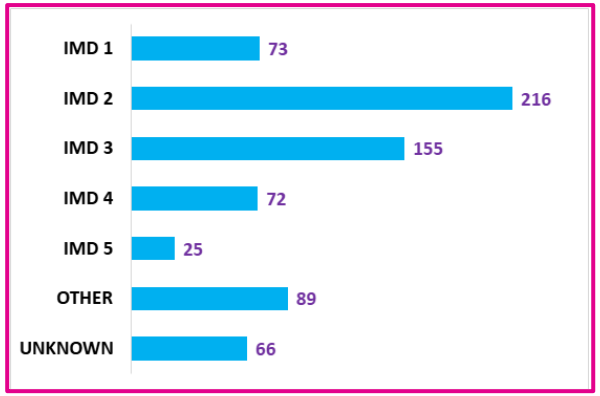
- ➢ Culturally and linguistically targeted information resources, brief and extended advice, courses and workshops to South Asian and global majority communities to encourage and embed healthy lifestyle behaviours
- ✓ Improved understanding and adoption of healthy behaviour and preventative actions

Improve heart health with South Asian and global majority communities in Barnet

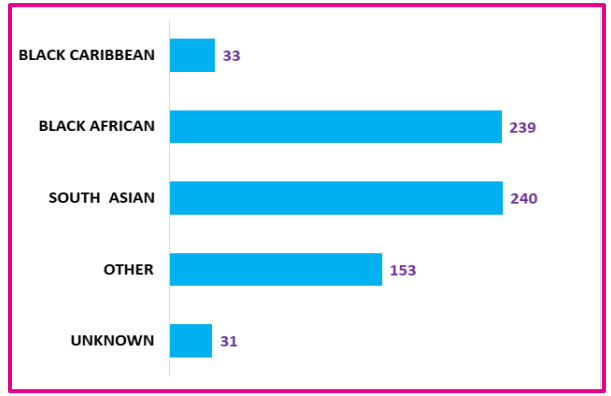
- Partnership with 16 community organisations
- Delivered 696 brief and extended brief interventions to event attendees and 41% from IMD 1 and 2 wards (highest deprivation)
- Provided over 83 in-depth interventions during courses and workshops.
- 176 Resource Packs in English, Somali and Gujarati given out

Behaviour change – intensive course impact (21 attendees)

- Knowledge: 100% understood lifestyle changes to lower high blood pressure.
- Behaviour Plans: 95% planned to adopt healthier habits.
- Confidence: 95% knew to seek help for high blood pressure.
- Healthcare Use: 95% felt more confident accessing local services.



IMD breakdown (interventions)



Ethnicity breakdown (interventions)

A leader in the Nepalese community said:

"Your efforts in educating our members about healthy eating, regular exercise, and lifestyle improvements have been truly inspiring and impactful…thanks for explaining these important concepts in simple Hindi and Urdu, ensuring that everyone could easily understand and apply the advice to lead healthier lives."

Complete Care Communities, Camden

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- ➢ Working with Camden's underserved communities at high risk (Somali and Bengali) to improve physical and mental health
- ➢ Training community champions and taking a culturally informed approach to healthcare
- ✓ Improved engagement with healthcare services including health checks, self-management and peer-support

✅ Aims & Objectives

- Empower mental health resilience and improve physical health in Camden's Bengali & Somali communities.
- Recruit community advocates and pathfinder groups to co-design culturally appropriate interventions.
- Reduce stigma, promote healthy lifestyles, and increase access to mental health and long-term condition care.

👥 Reach into communities

- Target: Bengali (13,116) & Somali (5,398) residents in Camden (IMD 2nd centile – most deprived 20%).
- Majority female; socially isolated carers and mothers identified as inclusion groups.

📋 Activities & Outputs

- Mental Health First Aid training for 51 community champions.
- Over 1,000 community members engaged via workshops, cooking classes, exercise groups, and health checks.
- Estimated unique individuals seen: 590 (plus >2,000 contact episodes).
- WhatsApp support groups formed; advocates co-located in Kentish Town Health Centre.

📈 Outcomes

- 68% Somali participants reported reduced stress/anxiety; 40% women improved wellbeing.
- Uptake of NHS Health Checks and LTC reviews increased (SMI reviews: Somali 73%, Bengali 64%).
- Growing trust and engagement with statutory services.

💬 Quote & Case Study

"I really enjoyed the first session. It has made my understanding of mental health really good. This is something that is missing from the Bengali community and it is not spoken of."

Case Study: Sara, a domestic abuse survivor, rebuilt her life through emotional support, therapy, community integration, and employment—now a Mental Health Champion mentoring others.

Complete Care Communities, Camden

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Mandeeq "Market Place" event.
supporting parents of children with special educational needs (SEN). Event in partnership with SENDIASS Camden, Children and Young People Disability Service (CYPDS) Camden and Nafsiyat . Over 150 attendees.

<u>Mandeeq Programme: Somali Community (Complete Care Communities</u>

Pre-diabetes education event Whole day event including 2 nurses doing pre-booked appointments (BP, BMI and point of care HBA1C testing), Yoga sessions, mental health champion education and drop -in sessions, drug and alcohol councillors and a Somali councillor.

40% of attendees were referred to their GPs for further investigation

47% referred to weight management, diet and/or exercise programs.

39 one to one nurse appointment pre-booked slots were attended plus many on the day also attended. Unfortunately, 20 drops-ins wanting to see the nurses could not be accommodated as maximum capacity reached.

Health Heroes Unite, Enfield

North Central London Health and Care

- ➢ Working with vulnerable groups including care leavers, young people and global majority communities in areas of high deprivation to improve access to healthcare through co-production
- ➢ Multiple models of engagement including events, focus groups and health screening
- ✓ Improved participation and ownership of community-based healthcare

Aims & Objectives

- Improve physical & mental health for Children Looked After (CLA), Care Leavers, and LGBT+.
- Address health inequalities in Black, Asian & Minority Ethnic (BAME) groups using Core20PLUS5.
- Engage youth in co-designing mental health services.
- Build capacity through partnerships and community consultations.
- Deliver actionable projects/events to reduce exclusion and improve health equity.

Reach into communities

- Target groups: CLA, Care Leavers, LGBT+, BAME communities, Gypsy Roma Traveller (GRT), and youth.
- High deprivation areas in Enfield (IMD lowest quintiles).
- Inclusion of people with disabilities and digitally excluded groups.

Activities & Outputs

- 20+ health & wellbeing events across Edmonton & Enfield
- Services offered: GP registration, mental health checks, ENT, diabetes screening, dementia support, cancer awareness, blood pressure monitoring.
- Youth engagement: mentoring, forums, festivals, mental health focus groups.
- Partnerships with 12 VCSEs and local schools; creation of Community Chest funding programme.

Outcomes

- Increased access to hyper-local health services.
- 68% of surveyed participants reported improved wellbeing.
- Strengthened borough partnerships and co-production models.
- Uptake of health checks and mental health support among underserved groups.

Quote & Case Study

"I have been sitting at home after losing my job and coming to this session has made me realise, I am not alone and I can get the help I need."

Care Leavers Forum 'All About You' project provided mentoring, mental health support, and creative activities, improving confidence and resilience among young care leavers.

Health Heroes Unite, Enfield

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DISPLACED
YOUR BACKGROUND IS YOUR POWER

MAKING ENFIELD HAPPIER

Supported by: Health Heroes Unite
Edmonton Community Partnership · NHS North Central London

The Making Enfield Happier programme aims to develop a shared understanding of the needs of young residents in Enfield, focusing on reducing health inequalities and improving mental wellbeing. The programme created a space to identify key issues and co-produce solutions that address barriers to accessing services. The core of this effort is amplifying the voices of young people, so their insights and experiences can shape the delivery of strategies for tackling local health challenges.

Through capacity-building sessions, practical workshops, and peer research, participants reported that their self-awareness and ability to express increased. This process not only deepened their understanding of their own mental health but also strengthened their ability to support their peers. As a result, participants grew in confidence and are able to begin taking an active role in advocating for change within their community.

IMPACT ON PARTICIPANTS

- **89%** of participants reported speaking to Enfield residents about their experiences of health and wellbeing services.
- **86%** of participants reported a significant increase in self awareness and learning how to talk to others about mental health.
- **70%** of participants reported learning more about the mental health of Enfield's ethnically minoritised residents.
- **57%** of participants reported a significant improvement in their social connectedness.
- **50%** of participants reported learning more about their own mental health.

A **20% increase** from the middle of the programme.

- Participants were **paid** London Living Wage for the interviews they conducted.
- Participants received **AQA accreditations** on Training As A Peer Researcher and Understanding Mental Health.

Impact of the facilitation style:

- **100%** of participants reported strongly agreed to feeling listened to, valued and respected.

WHO ARE THE PEER RESEARCHERS?

- Children and young people who are ranging from 13 - 22 years old.
- From 1st and 2nd generation migrant backgrounds.
- Peer researchers identified as Black African, British Bangladeshi, Black Carribean and Mixed ethnic backgrounds.
- Local residents of Enfield, majority of which are living in Edmonton.

WHO ARE THE INTERVIEWEES?

- **74%** are aged 13-17
- **26%** are aged 18-25
- **20%** from migrant backgrounds
- **20%** from 2nd generation migrant backgrounds
- **68%** live in Enfield
- **17%** live in Haringey
- All interviewees were from ethnically minoritised communities.

#WhatIf project, Enfield

North Central London Health and Care

- ➢ Mentoring, therapeutic and education support for young people and families in areas of high deprivation (addressing wider determinants of health)
- ✓ Improved educational attainment and mental wellbeing for parents and young people

✅ Aims & Objectives

- Provide mental health, well-being, and educational support to Inclusion Health Groups (children aged 8–15 from Eastern European, Black, Asian & Minority Ethnic communities in Edmonton schools).
- Improve access to culturally sensitive mental health services.
- Enhance emotional resilience and educational attainment by addressing mental health barriers.
- Build capacity for families and schools to support mental health.
- Reduce stigma and create safe spaces for mental health discussions.

👥 Reach into communities

- Target: Children & young people (8–15), families, and staff in Edmonton schools.
- High deprivation areas (IMD lowest 20%).
- Majority from BAME and Eastern European backgrounds; 95% pupils with English as an Additional Language (EAL).
- Inclusion of SEND students and families under severe social/economic stress.

📋 Activities & Outputs

- Unique individuals seen 88 (#Whatif project); overall Edmonton Community Partnership engagement: 135
- Partnerships with 11 schools; mentoring and therapeutic support for 445+ young people.
- Literacy & numeracy programmes for 575 children and young people (CYP); 85% pass success in Year 4 multiplication checks.
- 37+ parents accessed talking therapy; 15 staff trained in mental health support.
- Safe spaces and well-being rooms established in schools.

📈 Outcomes

- 68 CYP reported improved mental health and well-being.
- 518 CYP (90%) showed improved educational outcomes.
- 65% increase in referrals to services; stronger family-school engagement.
- 100% staff reported feeling empowered by impact of interventions.

💬 Case Studies

Client KB overcame emotional challenges linked to care experience through 8 therapeutic sessions, improving self-esteem, relationships, and emotional regulation.

Another young person improved literacy and confidence via one-on-one tutoring, passing all exams successfully.

Community Diabetes, Haringey

North Central London Health and Care

- ➢ Proactive identification and early intervention to manage diabetes, including culturally-tailored education, self-help resources and support to change lifestyle for communities in areas of high deprivation
- ✓ Improved diabetes control, dietary changes and adherence to medication reducing risk of complications

Aims & Objectives

- Reduce health inequalities in **Black African, Black Caribbean, Asian, and East European communities** with Type 2 diabetes in Northumberland Park.
- Identify and risk-stratify adults with **HbA1c >75 mmol/mol**.
- Empower self-management through culturally tailored education and behavioural change programmes.
- Promote independent functioning and signpost to community resources.
- Increase engagement and reduce hospital admissions via proactive case finding and MDT collaboration.

👥 Reach into communities

- Target: Adults with Type 2 diabetes in **N15 & N17 (20% most deprived areas)**.
- Ethnicity: Black Caribbean (30), Black African (21), Turkish (9), Other (15).
- Gender split: Male & Female across 6 GP practices.
- 76% from most deprived quintile; includes patients with multiple LTCs and disabilities.

📋 Activities & Outputs

- **434 patients triaged** from GP lists; **136 seen in IDSS clinics**, 298 discussed in MDT.
- **504 patients engaged in 2023/24**; 434 April–Sept 2024.
- **African-Caribbean group education:** 132 invited, 79 attended; 64% improved HbA1c.
- 6 MDT meetings; 3 community health promotion events; culturally tailored dietary sessions.
- Planned reach: 200 patients/year.

📈 Outcomes

- **64 patients** reported positive health impact (medication adherence, self-management).
- **109 patients** improved HbA1c and dietary habits.
- 53 patients improved relationships with carers; 66 increased social engagement.
- 79 group attendees scored high on confidence and motivation.

💬 Quote and Case Study

"I thought nobody cared, they just give you medication. After the session, I understood why it matters. I even agreed to go to A&E for a foot wound that could have led to amputation."

Case Study: Mrs J (65) improved diabetes control and accepted psychological therapy after motivational interviewing; Mr S (52) engaged in culturally relevant education, leading to HbA1c reduction and lifestyle changes.

Young Black Men and Mental Health, Islington

North Central London Health and Care
Integrated Care System

- ➢ In partnership with Islington Council, multiple approaches to improve mental health and wellbeing for young people through mentoring, therapeutic and anti-racist practice training
- ✓ Improved mental wellbeing, social engagement and school attendance with related impact on serious youth violence

Aims & Objectives

- Improve mental health and wellbeing outcomes for young Black men (aged 13–25).
- Reduce Serious Youth Violence and improve life chances.
- Deliver four pillars:
  - **Becoming a Man (BAM):** School-based counselling & mentoring.
  - **Elevate Hub:** Community therapeutic support for high-risk youth.
  - **Barbers Round Chair:** Train barbers as mental health ambassadors.
  - **System Change Training:** Cultural competency & anti-racist practice for professionals.

Reach into communities

- Target: Young Black and mixed-heritage men in Islington (population ~28,743).
- High deprivation: Islington has **2nd highest child poverty rate in London**.
- Cohort includes those affected by trauma, SYV, care experience, and mental health risks.

Activities & Outputs

- **BAM:** 3 schools (Central Foundation, Beacon High, AMSI); 175 young men supported.
- **Elevate:** 97 referrals; 83 active cases; 72–84 receiving 1:1 support per quarter; 29 parents engaged.
- In total, over 200 individuals supported
- Barbers: 15 trained as mental health ambassadors.
- System Change: 20 training sessions; 359 professionals trained in cultural competency.

Outcomes

- 80% reported improved mental & overall health.
- 60% improved relationships; >75% increased social engagement.
- Reduction in Serious Youth Violence (60 → 48 incidents) and knife crime (123 → 86).
- Improved school attendance: Beacon High (71% → 93%), AMSI (76% → 97%).

Quote and Case Study

"Without this programme, these young men would likely have escalated to tier 4 hospital admissions or further criminal justice involvement."

Case Study: *Elevate supported a young man with severe trauma, psychosis, and SYV involvement through long-term therapeutic engagement, advocacy, and housing support—preventing further deterioration and promoting stability.*

Learning Disability
Annual Health Check Quality Improvement, Camden

Inequalities Fund project to enable improvement in quality and uptake of Annual Health Checks by working with people with lived experience, Learning Disability staff and primary care teams through a Health Facilitator in Camden.

Achievements

- ✓ **90.5%** of adults with a learning disability in Camden had their Annual Health Check at their GP practice between April 2024 and March 2025.
- ✓ Additionally, young people aged 14–17 achieved **83.6%** uptake rate, well above the national target of 75% set by NHSE.

Why Annual Health Checks Matter

People with learning disabilities often face significant health inequalities, leading to poorer physical and mental health and lower life expectancy.

Since 2008, GP practices in England have been offering Enhanced Annual Health Checks (AHCs) to individuals with learning disabilities, and in 2014, this was extended to young people aged 14 and above. These checks play a crucial role in early detection and intervention, helping to address previously unidentified health concerns, optimise management of long-term conditions, and provide preventative care.

How CLDS is Supporting Access

The CLDS Health Facilitator collaborates with GP practices to ensure better access to Annual Health Checks. This includes:

- ✅ Considering Reasonable Adjustments under the Equality Act 2010
- ✅ Providing Easy Read Health information via the newly launched CLDS Health Library: www.cldsinfo.net/health.
- ✅ Identifying individuals who haven't yet attended or been supported to their Annual Health Check.

The Power of Co-Production

Community involvement plays a vital role in improving health outcomes. Camden residents with learning disabilities have contributed through:

- 🎥 Creating promotional AHC videos. www.cldsinfo/health
- 🎶 Producing a rap about Annual Health Checks. www.cldsinfo/health
- 💡 Organizing focus groups.
- 🗣️ Co-facilitating training sessions to raise awareness and draw on their knowledge as 'experts by experience'

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 042	NCL	Barnet	London Borough of Barnet	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.	£ 25,732.00
NCL IF 075	NCL	Barnet	Barnet GP Feds / GP practice	Improve health outcomes for people living in Grahame Park with health conditions and access to community & clinical services with a focus on those at risk of or experiencing poor heart and lung health and mental health that are supported by the Holistic Case Workers (HCWs) and reduce demands on statutory health and wellbeing services of the people that are supported.	£ 120,000.00
NCL IF 003	Camden	Camden	South Kentish Town PCN	Complete Care Communities – Facilitating Mental Health Empowerment in Camden's Bengali and Somali Communities	£ 60,000.00
NCL IF 007	Camden	Camden	Brondesbury Medical Centre	Kilburn Ward outreach bus to detect risk factors for Type 2 Diabetes Mellitus	£ 64,800.00
NCL IF 044	Camden	Camden	Camden Health Evolution Ltd (Central Camden PCN)	Patient-centred approach to improving lifestyle behaviours. Improve health and wellbeing through free exercise and nutrition programmes, targeting deprived communities and supporting patients to adopt sustainable healthy behaviours.	£ 55,249.00
NCL IF 047	Camden	Camden	London Borough Camden	Annual Health Check (AHC) Quality Improvement Project. Improve uptake and quality of Annual Health Checks (AHCs) for people with learning disabilities (LD) aged 14+, mitigate health inequalities highlighted in LeDeR reports, strengthen cross-agency collaboration, and amplify the voice of people with LD in AHC development.	£ 56,697.00
NCL IF 078(b)	Camden	Camden	Camden GP Feds	Understanding Populations Living in Deprived Areas in Neighbourhoods. Support for Integrated Neighbourhood Teams (INTs) to work with local VCS organisations and communities to codesign interventions within each neighbourhood footprint to improve understanding of local priorities and need and explore new approaches to help people manage health & well-being, particularly for those with long term conditions.	£ 34,749.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 078(c)*	Camden	Camden	Sub co: Camden GP Feds	Coffee and Care in the Community. Community well-being initiative targeted at isolated and under-served populations in Central Camden. Initiative include health checks, well-being talks, and workshops in collaboration with healthcare professionals, including cardiovascular screening and self-management (HTN & diabetes), addressing social isolation with VCSE groups and a digital CBT solution for frail older adults supported by digital champions.	£ 7,500.00
NCL IF 078(d)	Camden	Camden	Camden GP Feds	Digital Inclusion in West Camden PCN. Digital Inclusion Lead and supporting team to work with specific communities to promote digital inclusion/digital literacy and developing Digital Health Ambassadors within those communities – supporting them in using the NHS app, onward digital signposting, and booking appointments/re-ordering prescriptions.	£ 20,000.00
NCL IF 078(e)	Camden	Camden	Camden GP Feds	Castlehaven Interclude. VCSE offer for personalised physical and mental health activities for those with a neurodivergent diagnosis (ADHD or autism) in partnership with GP practices.	£ 4,012.50
NCL IF 078(f)	Camden	Camden	Camden GP Feds	CamPain-Chronic Pain Care for communities affected by health inequity. Community based chronic pain group - supported by clinicians from UCLH - to explore, develop and evaluate co-designed, co-produced ongoing patient-led pain management support projects to provide peer support, physical activity, advice and promote health and well-being.	£ 9,000.00
NCL IF 078(g)	Camden	Camden	Camden GP Feds	Youth Justice Nurse for comprehensive health check. Employment of a Youth Justice Nurse in Integrated Youth Support Service (IYSS) to provide health screening and a holistic approach to physical, emotional and mental health & well-being in most deprived and global majority populations.	£ 30,000.00
NCL IF 009	Enfield	Enfield	Caribbean and African Health Network	Black Health Improvement Programme (BHIP) for Enfield Primary Care, NHS North Central London CCG and development of Enfield Caribbean and African Community Health Network. To support efforts to improve health outcomes and service engagement for Enfield's Black Caribbean and African community by addressing cultural, religious, language, and racial barriers to primary care access, whilst building community capacity through co-design, outreach, and partnerships between residents, VCFSE organisations, and statutory services.	£ 98,950.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 010 NCL IF 011	Enfield	Enfield	Royal Free London (North Middlesex NHS Trust)	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.	£ 322,186.00
NCL IF 012	Enfield	Enfield	Royal Free London (North Middlesex NHS Trust)	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.	£ 70,000.00
NCL IF 013	Enfield	Enfield	Royal Free London (North Middlesex NHS Trust)	ABC Parenting Programme delivering workshops covering child health, Basic Life Support (BLS), illness prevention, and health services education for young parents to prevent unnecessary childhood A&E attendances.	£ 163,500.00
NCL IF 014	Enfield	Enfield	London Borough of Enfield	DOVE project (Divert and Oppose Violence in Enfield) Public Health approach to reducing Serious Youth Violence. To help young people who are involved in or at risk of youth violence or child sexual exploitation through the Early Help Team in Enfield.	£ 66,186.00
NCL IF 015A	Enfield	Enfield	Enfield GP Federation	Healthy Lifestyles. To provide a structured, equitable, and culturally competent healthy lifestyle and weight management service for Enfield residents aged 18–50 (with an initial focus on 30–50), living with obesity and at least one long-term condition, or at high risk of developing one. The service aims to promote behavioural change, reduce weight, and improve health outcomes and quality of life	£ 90,000.00
NCL IF 035	NCL	Enfield	Enfield GP Federation	Enhanced Homeless Primary Care Health Service. The project aims to provide accessible, comprehensive healthcare to individuals experiencing homelessness in Enfield, addressing their unique needs and barriers to care. By delivering tailored services directly to this vulnerable population, we seek to improve their health outcomes and overall well-being.	£ 75,000.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 056	Enfield	Enfield	Edmonton Community Partnerships	Health Heroes Unite - Drop in events. GP Registration in Enfield. Through active community and youth engagement, we raise awareness of local health services, strengthen links with community providers, and promote physical and social activities, ultimately improving access to care and reducing pressure on GP practices and A&E departments.	£ 130,000.00
NCL IF 057	Enfield	Enfield	Enfield Patient Participation Group (PPG) Network	Enfield Patient Participation Network (PPG). To increase patient participation through out Enfield and the GP surgeries. To enhance the skills of the patients.	£ 60,675.00
NCL IF 059	NCL/ Enfield	Enfield	Well-Being Connect	Family Support model - early intervention therapeutic support – Wellbeing Connect & Edmonton Partnership. to provide mental health, well-being, and educational support to key Inclusion Health Groups, particularly children and young people aged 8-15 from Eastern European, Black, Asian, and Minority Ethnic communities in Edmonton Schools.	£ 80,000.00
NCL IF 077	Enfield	Enfield	Enfield GP Federation	Fore Street Project: Tackling Health Inequalities in Neighbourhoods. Development of a CHWW model in Enfield – to work often intensively with c. 700 households in the 10% most deprived LSOAs in Enfield to better engage, identify and provide a strength-based approach to supporting residents and patients and managing their health needs.	£ 145,000.00
NCL IF 081	NCL	Enfield	Enfield GP Federation	Evaluation of and Support for Thriving Communities Zone (TCZ) and impact of Inequalities Fund Programme. TCZ hypothesis is to test whether concentrated system engagement and investment in a defined very deprived sub-Neighbourhood area, focussing on key population groups leads to accelerated improvements in Core Metric and other health and social outcomes and mitigated demand, utilisation and costs of statutory health and care. This element of investment is to support evaluation of TCZ IF investments included.	£ 60,000.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 020	Haringey	Haringey	Royal Free London (North Middlesex University Hospital NHS Trust)	ABC Parenting Programme delivering workshops covering child health, Basic Life Support (BLS), illness prevention, and health services education for young parents to prevent unnecessary childhood A&E attendances.	£ 163,500.00
NCL IF 021	Haringey	Haringey	Open Door, Young People's Consultation Service	Engaging our most vulnerable Haringey young people with mental health support through creative arts, activities and sports. VCS partnership project that aims to target and to support young people with histories of multiple Adverse Childhood Experiences (ACEs), who would not normally engage with mental health services, through arts, sports, creative ventures, tailored and adapted therapies, mentoring and other activities co-produced and designed with the young people themselves and delivered by people trained in trauma awareness and supported by therapists.	£ 250,000.00
NCL IF 022	Haringey	Haringey	North London NHS Foundation Trust (BEHMHT)	Tottenham Talking. Partnership project between VCS and NLMHT to encourage service users at risk of admission, those needing post-admission support, or individuals living in the community to join groups and activities, support employment, and empower positive life changes.	£ 271,930.00
NCL IF 023	Haringey	Haringey	Whittington Hospital NHS Trust	Enhanced Health Management of People with Long-Term Conditions in east Haringey. To reduce diabetes-related health inequalities for underserved communities in Northumberland Park (East Haringey), focusing on patients with Type 2 diabetes from Black African, Black Caribbean, Asian, and Eastern European backgrounds.	£ 139,561.00
NCL IF 024	Haringey	Haringey	Royal Free London (North Middlesex University Hospital NHS Trust)	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.	£ 70,000.00
NCL IF 063	Haringey	Haringey	Haringey GP Group Ltd	Health Neighbourhoods in our locality (Childhood Weight Management). Proactively identify children at or above the 91st centile for BMI registered in East Haringey and provide culturally sensitive, non-stigmatising support to reduce or maintain BMI. This is achieved through clinical, wellbeing input and personalised interventions that wrap around care for the child and their family.	£ 209,420.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 063	Haringey / NCL	Haringey	Haringey GP Federation	Health Neighbourhoods in our locality (Long Term Conditions). Reduce healthcare inequalities experienced by Turkish, Kurdish and Afro-Caribbean patients residing in the East of Haringey - through early detection, diagnosis and management of the following long-term conditions: Chronic Kidney Disease (CKD), Hypertension (HTN) & Chronic Obstructive Pulmonary Disease (COPD), (Pre-diabetes and Diabetes & raised cholesterol are also picked up as part of the health check).	£ 165,192.00
NCL IF 063	NCL	Haringey	Haringey GP Federation	Health Neighbourhoods in Our Locality (Empowering People) VCS Partnership - Community Empowerment to include Community Involvement in Neighbourhood Development. It aims to meaningfully involve residents and patients from across Central and East Haringey in the design, development and implementation of neighbourhood working with a particular emphasis on addressing health inequalities.	£ 64,000.00
NCL IF 038	NCL	Haringey	RISE PROJECT (VCS)	NCL Somali Mental Health Support. VCS partnership project focussing on three key areas: youth engagement, parental engagement, and community wellbeing. Each area works to support the Somali community in improving mental health and overall wellbeing through culturally sensitive services and by encouraging early access to statutory support.	£ 135,000.00
NCL IF 078(i) and element of NCL IF 077	Haringey	Haringey	Haringey GP Federation	Diabetes structural education project. Scheme to improve referral rates to structured education on diabetes utilising and testing roll out of digital solutions to deprived (and often diverse) communities – funding will support implementation of NHSE-approved dedicated diabetes app to provide an alternatives available to nearly 100 written or verbal languages building on existing work on diabetes in Borough, and with support from a Health Coach for English and non-English speakers.	£ 67,142.00
NCL IF 078(h)	Haringey / NCL	Haringey	Haringey GP Federation	Haringey Community Asset Fund. CSE-related investment pot to support key priority outcomes in 20% more deprived neighbourhoods in Haringey (alongside TCZ which is focussed on even more deprived neighbourhood).	£ 100,154.35
NCL IF 080	NCL	Haringey	Haringey GP Federation	Thriving Communities Zone (Haringey). TCZ hypothesis is to test whether concentrated system engagement and investment in a defined very deprived sub-Neighbourhood area, focussing on key population groups (best start in life, those with MH issues, people 45/50+ at risk of/with LTCs or multi-morbidity, particularly vulnerable groups) leads to accelerated improvements in Core Metric and other health and social outcomes and mitigated demand, utilisation and costs of statutory health and care	£ 230,943.88

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 079	NCL	Haringey	Haringey GP Federation	Thriving Communities Zone (Haringey). Part of this funding and approach will be used to tackle some of the wider determinants and work with particularly vulnerable individuals, e.g. those who are carers, with disabilities or other health inclusion groups.	£ 240,000.00
NCL IF 017	Islington	Islington	Islington Council	Early Prevention Programme – Black Males & Mental Health. Multi-agency collaboration to engage with & provide earlier support to young black men with MH issues, particularly those living with trauma, to improve health & social outcomes	£ 130,000.00
NCL IF 040 NCL IF 040a	NCL	Islington	Islington GP Group Ltd	Islington Homelessness Health Inclusion Programme – Physical Health Needs. Identify and treat the physical health needs of PEH in Islington using a combination of engagement, diagnostic tools, health navigation, outreach nursing, and the provision of flexible GP appointments in at least one surgery in the four most deprived wards.	£ 111,013.00
NCL IF 060	Islington	Islington	North London NHS Foundation Trust (Camden and Islington Foundation Trust)	Hand in Hand Islington – A Volunteer Peer Buddy Scheme. Project to establish Peer Buddy scheme of volunteers with experience of mental health issues to accompany vulnerable residents to appointments and events	£ 100,552.72
NCL IF 061	Islington	Islington	Healthwatch Islington	Community Research & Support Programme. Project to build community empowerment amongst residents/patients from under-served groups vis to take part in community participatory research and build trust.	£ 72,056.74
NCL IF 066	Islington	Islington	Brandon Centre	Leaving Care Counselling & Psychotherapy Service (Suicide Prevention). VCSE project to provide intensive therapeutic interventions to targeted care leavers thought to be at risk of SMI or suicide	£ 19,570.00
NCL IF 067	Islington	Islington	Brandon Centre	Progression to adulthood. VCSE-led collaboration to provide therapeutic interventions to targeted young people at risk of SMI/suicide.	£ 66,950.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 069a	Islington	Islington	Healthwatch Islington	Mental health inequalities tool kit. VCSE led collaboration to develop toolkit with people with experience of MH issues and professionals to improve access, experience & outcomes in services for under-served groups.	£ 14,641.45
NCL IF 069b	Islington	Islington	MIND	Mental health inequalities tool kit. VCSE led collaboration to develop toolkit with people with experience of MH issues and professionals to improve access, experience & outcomes in services for under-served groups.	£ 21,408.55
NCL IF 070a	Islington	Islington	Healthwatch Islington	Childhood Immunisations. Multi-agency project to improve uptake of childhood immunisations in under-served communities	£ 48,713.79
NCL IF 070b	Islington	Islington	Islington GP Group Ltd	Childhood Immunisations. Multi-agency project to improve uptake of childhood immunisations in under-served communities	£ 21,344.38
NCL IF 070c	Islington	Islington	North2 Islington Primary Care Network	Childhood Immunisations. Multi-agency project to improve uptake of childhood immunisations in under-served communities	£ 13,371.83
NCL IF 071a	Islington	Islington	Healthwatch Islington	Cancer Screening. Project to fund community participation research into improving cancer screening of patients from non-White British backgrounds to inform future cancer screening developments	£ 33,990.00
NCL IF 071b	Islington	Islington	Islington GP Froup Ltd	Cancer Screening. Project to fund community participation research into improving cancer screening of patients from non-White British backgrounds to inform future cancer screening developments	£ 22,864.85

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Appendix A – 2025/26 NCL JHOSC work programme

Friday 11 July 2025 – LB Barnet, Hendon Town Hall

Item	Purpose	Lead Organisation
TBC	Community Pharmacy Update	NCL - ICB
TBC	NCL Estates & Infrastructure strategy	NCL - ICB
TBC	JHOSC ToR	JHOSC

Friday 12 September 2025 – Islington Council

Item	Purpose	Lead Organisation
TBC	St Pancras Hospital Programme Update	NCL - ICB
TBC	NCL Finance Update	NCL - ICB
TBC	ICB Restructure	NCL - ICB

Friday 21 November 2025 – Camden Council

Item	Purpose	Lead Organisation
	Winter Planning Update	NCL - ICB
	NHS 10 Year Plan	NCL - ICB
	London Ambulance Service Update	NHS LAS
	JHOSC ToR	JHOSC

Friday 30 January 2026 – Enfield Council

Item	Purpose	Lead Organisation
TBC	Paediatric Services Review	NCL - ICB

TBC	NCL Inequalities Fund	NCL - ICB
TBC	North Middlesex & Royal Free Hospital Merger Update	

Monday 9 March 2026 – Haringey Council

Item	Purpose	Lead Organisation
TBC	10 Year Health Plan	ICB
TBC	NWL and NCL Merger and Restructure	ICB
TBC	Directors of Adult Social Care	

Usual standing items each year:

- **Estates Strategy Update**
- **Workforce Update**
- **Finance Update -** The Committee requested that the next financial report should include:
  - Details on acute care and community services and on overview of any associated pressures and risks.
  - Details on the distribution of funds to voluntary sector organisations.
  - Details of the lines of communication between Departments and how financial decisions are reached.
- **Winter Planning Update.** The Committee requested that the next winter planning report should include details on progress relating to:
  - High Impact Interventions.
  - Bringing down waiting times for patient discharges to A&E from ambulances.

Possible items for inclusion in future meetings

- Terms of Reference – revised version for JHOSC ToR to be discussed/approved by Committee – July 2025
- St Pancras Hospital update – July 2025
- Health Inequalities Fund – Last item heard in Feb 2025. It was suggested that the community groups involved in delivering local projects could provide an update to the Committee in a year or two. To be reviewed in Feb 2026.
- NMUH/Royal Free merger – Last item heard in Sep 2024. Possible follow-up areas: a) For the Committee to examine a case study into a less prominent area of care to ascertain how it was monitored before and after changes to the service, what the local priorities were

and their impact on how clinical decisions were made. b) For further discussion on financial risk and, including how the debts of the Royal Free Group when be held within the merged Trust.

- Smoking cessation & vaping.
- The efficacy of online GP consultations (including 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.)
- Developing technology and its role in the management of long-term chronic conditions.
- Strategic role of GP Federations.
- Vaccination initiatives tailored to specific local needs in each NCL Borough including outreach work with community pharmacies.
- Paediatric service review.
- Primary care commissioning and the monitoring of private corporations operating in this area.
- 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).
- Mental Health & Community/Voluntary Sector – In August 2024, the ICB/Mental Health Trusts provided an update on Community & Voluntary Sector contract terms. In the meeting of April 2025 it was requested that a further update should be provided to the Committee on how the contracts with the voluntary and community sector fits in with the SPA
- Whittington Hospital merger

2025/26 Meeting Dates and Venues

- 11 July 2025 – LB Barnet
- 12 September 2025 – Islington Council
- 21 November 2025 – Camden Council
- 30 January 2026 – Enfield Council
- 9 March 2026 – Haringey Council

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