Inequalities Fund schemes progress and recommendations

Red = Stopped or completed

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

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

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

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

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

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

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

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

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

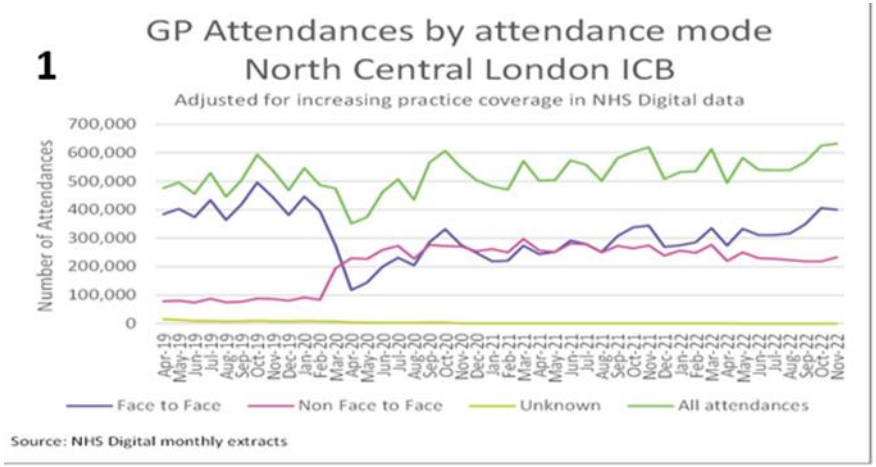
NCL IF 059	Enfield	Family Support model - early intervention therapeutic support – Wellbeing Connect & Edmonton Partnership	WCS Proposed Service outline: Our proposed service will include initial holistic assessment of children and/or their families' needs, support planning, face-to-face (some online)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

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

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

High Performing Schemes and Impact

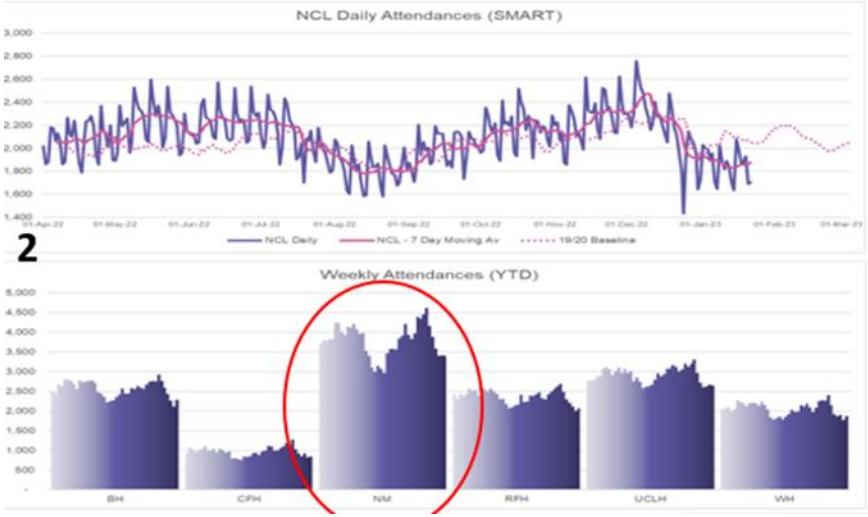
1



GP Activity (Graph 1)

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

2



Acute Activity (Graphs 2)

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

Conclusions

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

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

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

Haringey HF Outcomes and Progress So Far

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

Project Reach and Ripple Effect and System Impact

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

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

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

Its Outcomes and Progress So Far

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

Project Reach and Ripple Effect and System Impact

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

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

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

Its Outcomes and Progress So Far

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

Project Reach and Ripple Effect and System Impact

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

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

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

Project Outcomes and Progress So Far

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

Project Reach and Ripple Effect and System Impact

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

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

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

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

Project Outcomes and Progress So Far

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

Project Reach and Ripple Effect and System Impact

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

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

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

Project Outcomes and Progress So Far

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

Project Reach and Ripple Effect and System Impact

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