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Inequalities Fund (IF) Programme Evaluation 2023/24 and Lessons Learnt

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Issue Statement:

The ICB's now well-established Inequalities Fund Programme is an investment in a range of statutory and voluntary sector partnership projects. Its aim is to improve engagement with and health, well-being and life chances of NCL people living in the 20% most deprived neighbourhoods in England and thus address social gradients in outcomes across NCL's population.

This is the first large-scale programme evaluation in terms of its delivery, outcomes and system impact and what lessons can be drawn that could be applied to other initiatives.

Inequalities Fund

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- Context of Inequalities Fund Programme
- 2023-24 IF Programme Evaluation
- Overview of Programme Results and Impact on Systems
- Some Examples of IF Projects
- Lessons Learnt to Inform Population Health Management

The Inequalities Fund (IF) Programme

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- The Programme was established in 2021/22 in response to **NHS Planning Guidance to tackle inequalities.**

- Programme has a **focus on people living in the 20% most deprived (and often most diverse) neighbourhoods**, i.e. the 'Core20' element of the national Core20Plus5 initiative

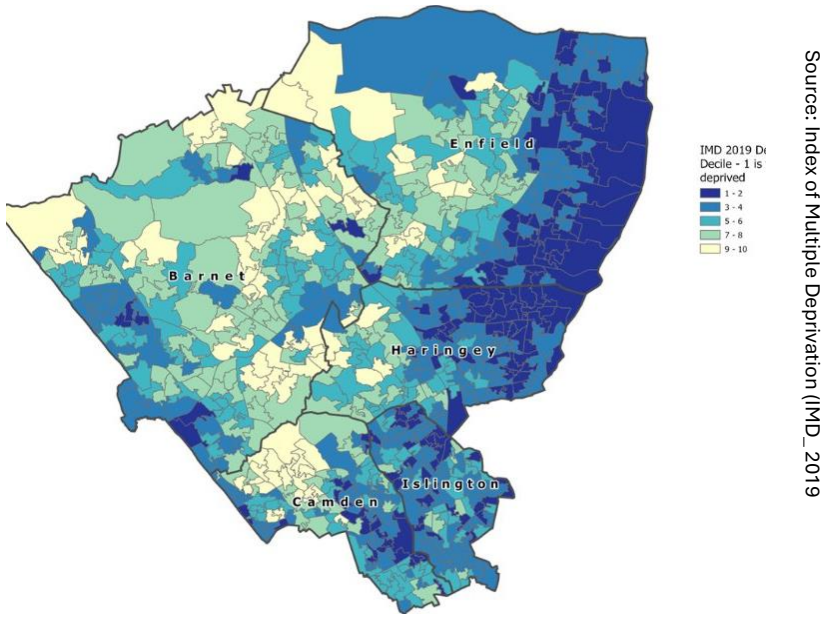
- **The Programme invests £5m per annum in 50+ projects across NCL** to improve engagement, health, well-being and life chances**.** Projects are divided into 5 categories:
  1. Improving empowerment & trust with communities
  2. Tackling wider determinants of health
  3. Helping people adopt a healthy life/improve life chances
  4. Improving physical and mental health management
  5. Supporting more vulnerable people

- **Funding is allocated to each Borough** based on the proportion of their population living in the 20% most deprived areas. **Individual Borough Partnerships decide on project investments.**

- The Government signaled a key focus of its 10-Year NHS Plan in 2025 would be a **'shift left' towards prevention and community-based services; there is learning from the Programme** about how to do so successfully.

Estimated 300,000 NCL residents live in 20% most deprived areas – the size of a Borough. 200,000 of these residents live in Enfield and Haringey.

Deprivation profile of NCL, by lower super output area



Projects align with **NCL's Population Health & Integrated Care Strategy, its Delivery Plan** and its objective to improve equity of access and outcomes. Appendix 1 contains a Borough-based project list.

Context: How the IF Programme Schemes are Categorised

To better understand the expectations of IF projects, **each project aligns with one of five categories** below. Doing so supports understanding population health and system impact of the projects and IF Programme

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	Building Community Power	Address Wider Health Determinants	Adopt Healthy Lifestyles	Health Inclusion of Vulnerable Groups	Promote Active Health Management
Category					
Aim	**Enabler to Build Social Capital** engage with people, groups & communities to 'have their say' & co-design solutions or understand their needs.	**Address Social Issues in Under-Served Communities** work to improve social, working & living conditions affecting health outcomes & life chances.	**Engaging with People to Promote Public Health** encourage people, including those at risk, to adopt behaviours to improve physical or mental health and well-being.	**Work with Vulnerable Groups in Under-Served Areas** to improve access to health and social & health outcomes and improve life changes.	**Proactive LTC Screening/Diagnosis and its Management to Avoid Crises** work with people receive early diagnosis & help with active condition management.
Example	Examples include Community Powered Edmonton scheme; and Haringey Empowering Communities	Projects associated with preventing serious youth violence in Barnet & mentoring into work opportunities.	Projects include ABC Parenting in Enfield/Haringey, Somali Mental Health in Haringey and NCL.	Projects supporting those at risk of homelessness in Islington and Enfield, support for care leavers with mental health issues in Islington	Projects screening, diagnosing & helping patients with specific physical and mental health LTCs in all Boroughs
Impact Type	Foundational building block to engage with communities and groups and build social capital	Promotes life chances & avoid adverse health or social outcomes for people at particular risk. Often 'compresses future need' (sometimes impact longer-term)		Addresses underlying health/social issues currently experienced by specific groups of individuals and aims to improve or maintain outcomes, with system mitigation 'in year'	

Outcomes and impact of each category are different – but so are the specifics of outcomes of individual projects in each category, e.g. those for projects supporting people with severe MH issues differ from those managing LTCs

How We Evaluate Projects in the Programme

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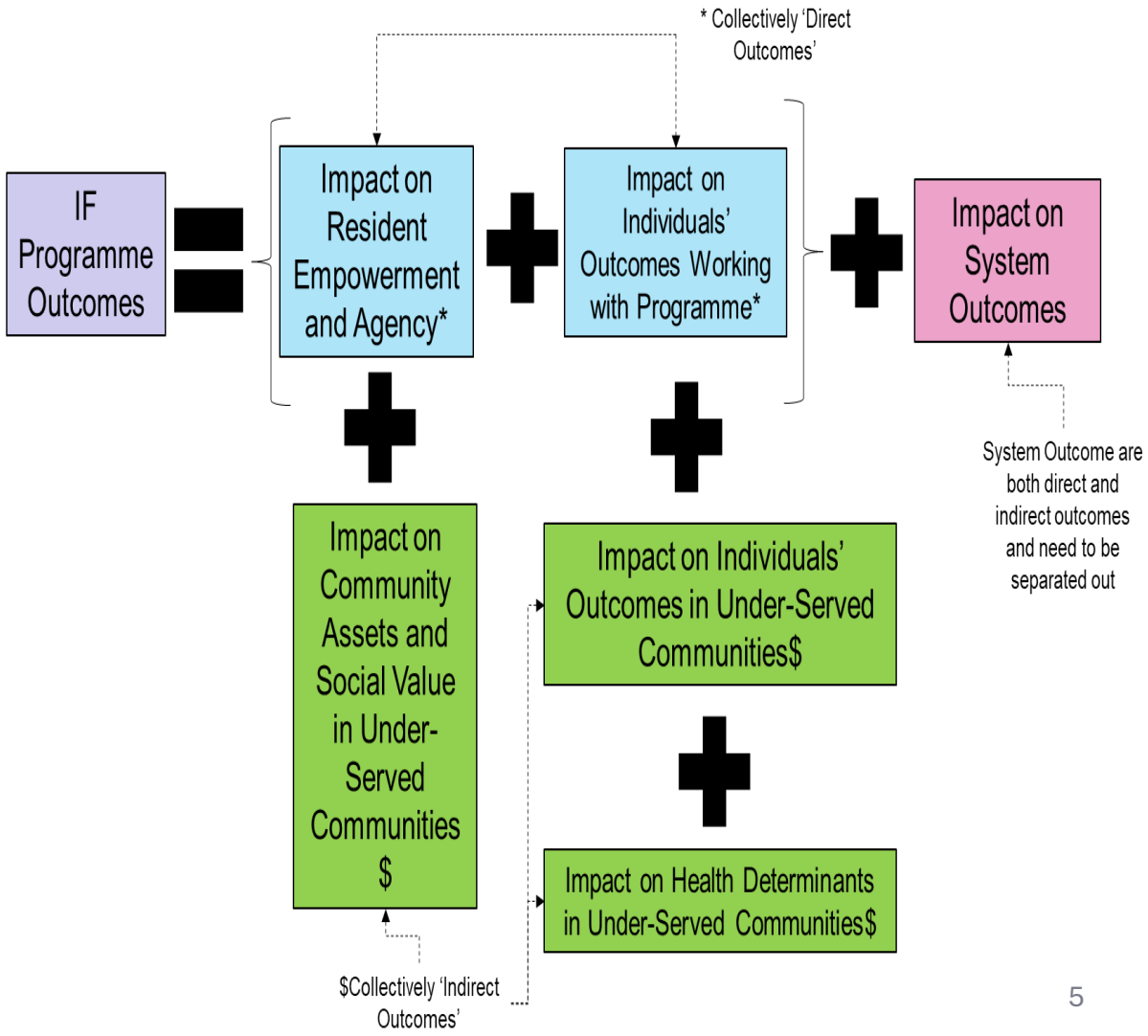
- In Q3 2023/24, **each project was asked to submit a stock-take**:
  - Service delivery and financial utilisation
  - Quantitative and qualitative outcomes for participants
  - Potential impact on mitigating NHS activity for participants
  - Social capital: how the service had developed trust and links with the targeted community or group for that project.
- Stock-take supported Borough Partnerships and NCL to make decisions about funding of projects in 2024/25 – the evaluation further builds an evidence base
- The **evidence base was utilised to determine overall Programme evaluation** (e.g. participant outcomes etc.)
- **Other evidence** – including NHS activity, e.g. hospitalisation rates and primary care results for under-served communities and groups in 2023/24 – **was also utilised to better understand 'indirect outcomes'**
- **The framework for evaluation is shown in the diagram**



Summary of Outcomes of the Programme

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56 projects in the evaluation, each with stated objectives associated with delivery. The table summarises the results, utilising the 5 categories on the previous slide:

- **26,000+ people benefited from a project in the Programme during the year.** This represents c. 9% of the population living in the 20% most deprived areas in NCL
- **Around 75% of project objectives** were successfully delivered, though those projects focusing on wider health determinants were less successful.
- Part of the reason for this may be the issues in engaging with communities. **Middlesex University conducted an evaluation of the Programme approach to coproduction**, with a series of recommendations to strengthen engagement
- **The IF Evaluation suggested projects with robust partner collaboration and engaged with communities and groups were more successful** in delivery – building such capabilities is key feature in developing integrated solutions

Many organisations and individuals across the statutory and voluntary sector contributed to the delivery of schemes which made a real impact on people's lives. **The ICB is very grateful to everyone for their commitment and support in making the Programme successful.**

Summary	Health Determinants	Community Power	Healthy Lifestyles	Active Health Management	Vulnerable Groups
Number of schemes	6	7	13	22	8
Investment	£371,686	£434,958	£1,269,168	£2,190,691	£732,721
Participant numbers	4,405	1,308 people, 90 organisations	9,771	10,389	262
Delivery models	Collaborations: Statutory and VCSE	Collaboration: VCSE and Community	Solo & collaborations: GP, Statutory & VCSE	Solo & collaborations: GP, Statutory & VCSE	Statutory health and local authority led
Outcomes achieved	7%	75%	69%	76%	82%

Outcomes: Understanding 'In Year' System Impact

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The evaluation provided a systematic view of estimated project impact in mitigating NHS activity for:

1. **Project participants**
2. **Targeted population groups** participants drawn from
3. **People in 20% most deprived areas**

- **One area of focus is the impact on NHS Trust activity**, including MH interventions, ED attendances and non-elective admissions.
- **22 projects likely to have measurable impact on NHS activity** – categorised as Health Management, Vulnerable People and, to extent, Healthy Lifestyles
- Remaining projects targeted at health management in primary care, primary prevention, wider social determinants and/or community engagement

A conclusion is that the Programme mitigated participants' healthcare activity, particularly in Haringey and Enfield which received the greatest investment**.** As many projects were sufficient scale, **this led to improvements at population level.**

Mitigating Annual NHS Service Activity for...

10,368 participants in 22 projects mitigating:

- **3,628** ED attendances
- **543 non-elective (NEL) admissions**
- **765** MH community interventions
- **£3.1m** in NHS activity

For every **£1** spent, **£1.45** mitigated in activity

Define **'project reach' as participant numbers as % of targeted group in deprived areas**:

- If its reach c. 15%+, **project likely to result in positive NHS activity/outcomes for group**
- 6 projects had target groups easily identifiable from acute data. **All 6 showed falls in NEL admissions, with 5 having good 'reach'**
- Other projects showed **benefits in improving healthcare**, e.g. improved diagnostic rates

Seen an overall 'shift left' reduction in activity in the 20% most deprived areas, e.g.

- **50+ NEL admissions** in these areas **reduced by 25%** in NCL between 2019/20 & 2023/24
- Translates to £8m cost mitigation in 2023/24 v. 2019/20, IF projects contributes £1.8m
- **50+ NEL admissions fell faster for 20% most deprived areas** (25%) than population (16%)

Some Challenges for the Inequalities Fund Programme

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The evaluation highlighted some common challenges across the Programme:

- **Programme can be difficult to administer and commission** in context of changing procurement requirements and across a range of partners working together. We are currently working with VCSE partners, particularly, to streamline commissioning, procurement and payment arrangements into 2025/26.
- **Several successful projects have ended – as their approaches were absorbed into 'business as usual' models.** However, we suspect 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 2025/26.
- **Importance and impact of good engagement with intended participants is clear.** We found as part of our stock-takes that some projects could improve this engagement; and those that had engaged, could often understand and improve their approach to engagement and coproduction with communities and representative groups
- **Some projects struggled to focus on** their 'target group' – those living in the 20% most deprived communities. This was a particular issue for Boroughs in which deprivation is scattered across Boroughs rather than concentrated in specific geographies.
- **Data and intelligence recording and reporting** as part of evidencing outcomes and impact has improved over the years, but some projects struggled to relate to report on these outcomes despite the support provided.
- **Unlikely any PHM commissioning will have 'perfect analysis'** in attribution of system impact due to networking effects – the projects are one element of a 'support network' for participants. The outcomes are more difficult to understand if their outcomes are longer-term.
- 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.

IF Lessons for Population Health Management (PHM)

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Opportunities to apply lessons from the IF Programme to wider PHM approaches:

- **Moving Towards Holistic Population Health Management:** IF programme segmented investment in different target population groups across life course (e.g. children and young people, those with physical or mental health needs), and then further segments each project according to the level of need and its response, e.g. Adopting Healthy Lifestyles, Health Management etc. We have found a way of describing **the 'reach' of projects** into these segments.

- **Data, intelligence – and successful engagement and partnership working** – is key to understanding success in 'shifting left' in terms of the attribution of impact against a 'do nothing' position

- **'Shift Left' as a concept:** The IF approach is to work with communities to provide a set of planned care & preventative solutions to improve the health and life chances of people across life course and mitigate activity 'upstream'

- **Approach could provide a learning set to inform strategic commissioning approach and delivery**, e.g. to invest systematically with partners in Integrated Neighbourhood Teams. One Programme aim is to test approaches on delivering care and support solutions within projects to then mainstream these approaches across wider populations; this was achieved in several projects over the last 2 years.

- **One opportunity** is to extend the principle of the Inequalities Fund Programme to support people in the 20% most deprived areas to **develop a Thriving Community Zone to focus greater investment in deprived areas of Haringey and Enfield**, Boroughs in which two-thirds of the NCL population living in these deprived neighbourhoods reside.

Thriving Communities Zone Proposal

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- Nationally, and from NCL's population health analysis, we know that **adverse health outcomes and higher levels of crisis interventions** are associated with residents living in more deprived (and often most diverse) areas. Residents also often face barriers to accessing planned healthcare advice and support.

- The Thriving Communities Zone proposal is to focus **a concentrated level of investment in a small geographical area in the most deprived wards, working collaboratively with Councils, statutory and voluntary sector partners and communities,** learning from the IF Programme. If successful, this will result in better healthcare outcomes for residents and help our care system become more sustainable through 'shifting left' towards improved preventative and planned care for these communities.

- These short and longer-term outcomes for residents will include adopting healthy lifestyles, improved diagnosis, better management of physical and mental long-term conditions and longer and healthier lives as well as tackling wider determinants, e.g. supporting people with long-term conditions into work. **It will help address the need for more equitable access, outcomes and experience across our population to 'close the gap' between outcomes in the most deprived and affluent communities**

- As with the IF Evaluation, **measurement of these outcomes – and the impact on our system - will be key to understanding our** Return on Investment against a 'No Change' scenario. The approach aligns with the 'mission-based approach' emerging nationally, regionally and in NCL. We intend to work closely with academic partners locally **understanding the evidence base, evaluating the impact and prompting further research.**

- This approach will lead to optimised use of limited resources and **evidence-based prioritisation of investment** towards issues that are most important to residents and the ICS. We are also hoping to attract external investment from a range of national and London partners for this initiative. We intend to work with Councils and other partners to shape this approach.

Case Study 1: Improving LTC Theme in Haringey Healthy Neighbourhoods

Two Haringey projects in 'Health Management' which focus on primary care & community health supporting people from more deprived and diverse communities with different conditions – CKD, Hypertension, COPD - & Heart Failure

Aims

- **One project based in Haringey GP Federation**
  - To identify & work with people to **support diagnosis, registration, self-management & avoid hospitalisation**
  - Focused on patients with **CKD, hypertension and COPD**
- **One based in community health (WHT)** with NMUH
  - To work **with people with diagnosis of heart failure** (HF) **to better manage conditions & avoid hospitalisation**
- Both **worked with VCSE** to reach groups & support delivery

Who's Uses the Service, its Community Reach & Its Costs

Characteristic	GP Fed	WHT
No. of Participants / Annum	1,200	303
- % in 20% Most Deprived Areas	54%	86%
- % non-White British	80%+	83%
IF Spend / Full Spend (if relevant)	£194k / £313k	£163.5k
Unit Cost/Patient	£129 / £208	£540
Community 'Reach': Participants as Est. % of All Relevant Patients in 20% Most Deprived Areas	**7%** people with LTCs; **30%** CKD/COPD	**33%** of people with HF

Engaged with Turkish community & VCSE groups to tailor support in community

Results and Impact

- **84% & 93%** of **GP Fed & WHT participants** felt much more confident **in managing their conditions**
- Case-finding in **GP Project contributed to 30% rise** in number of east Haringey PCN patients on CKD register

- **50% fall in ED attendance & NELs for HF participants** in 2 yrs
- Significantly contributed to **30% fall in HF-related NELs** for those living in 20% deprived areas Apr–Aug-23 v. -19
- Contributed to **40% fall in COPD/CKD NELs** in same areas

- **WHT Project significantly contributed to £260+k mitigating acute activity** for people with HF in 20% deprived areas
- **Positive net benefit (+£100k)** from investment in WHT project

What Next?

- **Continued investment in projects in 2024/25 –** potential to mainstream learning to all areas as part of CSR investment?
- **Better engage with black African/Caribbean & east European groups & VCSE** to improve access & delivery
- **Revisit 'fit' of IF project with local & ICS requirements** to support wider groups of people with LTCs & fit with LCS 25/26

I most certainly would recommend this service. You took time to explain what I needed to know about CKD & hypertension, and I felt heard.

Case Study 2: ABC Parenting in and around NMUH

Project with substantial VCSE input to support parents of infant children using NMUH ED or using health services often

Aims

- **Paediatrician-led project delivered n Haringey & Enfield** at NMUH and in community settings around NMUH to:
  - Provide opportunities for parents to learn more about better managing infant health & NHS system via health coaching sessions, e.g. on breast-feeding, co-delivered with parents
  - Encourage parents to form peer networks and/or become health champions in communities to spread knowledge
  - Build confidence to reduce reliance on health services including ED attendances
  - Work with VCSE to help address wider health determinants

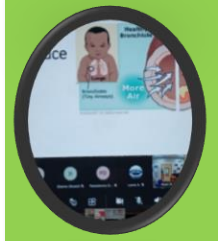
Who's Uses the Service, its Community Reach & Its Costs

Characteristic	Number
No. Participants on Courses in 2 Yrs	1,371 + Events
- % in 20% Most Deprived Areas	67%
- % non-White British	70%
IF Annual Spend / Unit Cost Per Participant	£327k / £238pp
No. Health Champions Recruited H1 2023/24	28, 90% non-WB
NMUH 'Reach': Participants as % 0-3 NMUH ED Attendances from 20% most deprived wds	**c. 40%**
Community 'Reach': Participants as Est. % of Relevant 0-3 Popn. in Deprived Areas in H&E Boroughs	**c. 10%** of all 0-3s in deprived wards

- Partners include Councils, primary & community health, schools & 25+ VCSE orgs

Results and Impact

- **99% participants** confident to use infant care/life-saving skills
- **90+%** stated improved infant health protection, e.g. vaccinations
- **90% participants** stated they had shared knowledge with others



- **Major impact on healthcare utilization** for parents post-course:
  - **90%** reported using online, **80%** primary care, resources
  - **80%** reported no further ED attendances post-course
- Contributed to **24% fall in ED attendances 0-3** living in 20% deprived areas Apr–Aug-23 v. -19

- **Major contribution to c. £300k** per annum mitigating ED attendances alone of 0-3 children

What Next?

- **Increase investment in project in 2024/25 within Thriving Communities –** potential to mainstream learning to other sites?
- Continue to expand scope and function to improve access & delivery, and build social capital amongst communities

ABC Parents
A Achieving a
B Better
C Community

Course has been very insightful and I have left here today very confident should any emergency arise. Teachers have been fantastic and very engaging. I will definitely recommend to my friends.

We attended the first aid course today. WOW we are so happen we went. The best part is how essential it is & how they provide and all for FREE

Case Study 3: Mental Health Arts and Sports

Project to support school age children & young people (CYP) with significant MH and wellbeing issues via arts & sports

Aims

- **VCSE project** working with Haringey schools & MH services to support children with significant mental health issues to::
  - Engage with & mentor children & young people to provide opportunities for sports, arts & other community services
  - Improve engagement with statutory services
  - Improve their mental health and well-being
  - Improve short-term & longer-term life chances, e.g. school attendance, educational attainments & self-actualisation

Who's Uses the Service, its Community Reach & Its Costs

Characteristic	Number
No. Project Participants to end Oct-23	532 CYP+95 Adts
- % on SEND	30%
- % a) depression; b) High emotional difficulty	a) 77%; b) 57%
- % in 20% Most Deprived Areas	73%
- % non-White British	74%
IF Annual Spend / Unit Cost Per CYP	£250k / £270 pp
Community 'Reach': Participants as Est. % of Relevant CYP Popn with MH issues. in 20% Deprived Areas	**c. 20%** of all children 5-16 with MH issues in area

- Partners include LBH, primary care, MH services, schools & VCSE

* Based on calculations of compendium of healthcare costs from and updated to 2023 from: Suhrcke, M., Pillas, D., & Selai, C. (2008). Economic aspects of mental health in children and adolescents, WHO and Clark, AF et al (2005) Children with Complex MH Problems, Needs, Costs & Predictors over Year.

Results and Impact

- **82% participants** with made progress v. outcome goals
- **77%** had moderate/severe depression & **86%** improved
- **70%** had improved education/training attendance

- Focus to ensure children & young people can help themselves:
  - **81%** had improved self-care
  - **71%** had improved their independence
  - **63%** reduced risky behaviours, including substance misuse

- **Est. NHS mitigation = £428k +** LBH mitigation* based on conservative estimate of 25% CYP diverted from statutory sector
- If so, **Positive net benefit (+£178k)** from investment in project

What Next?

- **Continue investment in project in 2024/25 –** potential to mainstream learning to MH services
- Further improve reach into community and increase number of participants engaged with projects

I was listened to. Before I felt alone, anxious and like I was in a dream world. Now things feel easier. I know now that what happened, was not my fault. I would recommend Open Door [VCSE lead] to other people highly. It has been a great help to me especially

I went from being suicidal to doing A-levels

Case Study 4: Black Health Improvement Project

Project to promote community engagement within black ethnic communities & build relationship with health system

Aims

- **Enfield VCSE project** working with Haringey's VCSE Black African and Caribbean organisations to:
  - Build local connections in community & with health partners
  - Empower people to take ownership of their health through information & knowledge sharing and confidence building
  - Encourage partners to better listen, understand and shape solutions around needs & preferences of this community

How the Project is Delivered

- Brings together network of VCSE organisations to provide help, e.g. to apply for grants
- Meetings between residents from these communities and statutory sector to build relationships and knowledge on range of social and health-based topics and how systems work
- Activity encourage community members to get involved to shape local policies and how services are delivered; and to share their knowledge with others

Activities and Impact

- Well-attended one-off events & monthly forums on health topics such as CVD, cancer, menopause, HIV/AIDs & mental health attended 50+ different individuals & 41 statutory services
- Improved cultural competence and knowledge of statutory partners, particularly GP practices & health professionals
- Increased involvement of community members in shaping local policies: 35 participants signed up to be part of BHIP network

What Next?

- **Continue investment in project in 2024/25**
- Improve link to other initiatives that could benefit from insight from black African/Caribbean community members

I am really enjoying being part of the forum. I am learning so much and hope that as a lay person I am able to continuously offer community insights

Next Steps

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- We have recently completed our 2024/25 Stock-Take of projects, and **we will re-apply the evaluative methods to refresh the outputs of key evaluation findings** – i.e. increased numbers of participants and impact of schemes.

- This will provide a platform for IF investments in 2025/26, which will align with our Population Health Delivery Plan priorities and Core20Plus5. We will re-emphasise the **importance of partner collaboration and engagement with targeted communities in implementing and delivering new projects successfully. Individual Borough Partnerships will continue to have a key role in deciding on project investment in 2025/26.**

- **With our partners, we will continue to develop our concept of the Thriving Community Zone to expand the learning from the IF Programme into this initiative.** We will explore opportunities to integrate this concept with existing Council-led place-based initiatives in these more deprived areas.

- We will continue to work with partners to mainstream **population health management learning from the IF Programme into our 'shift left' planning towards planned and/or preventative care as part of our response to the 10-Year Plan for the NHS.** With our Borough partners, this will include development of Integrated Neighbourhood Teams, multi-disciplinary, multi-agency teams working with residents within their communities.

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Questions?

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Appendix 1 – List of Projects and Scheme Case Studies

Summary of Projects 2023/24 and Outcomes By Borough

Borough	No. Projects	Amount Invested^	Objectives Met	Borough Summary
Barnet	2	£72,232	89%	Two Borough projects: positive outcomes from the project and clear focus on more deprived communities
Camden	11	£599,269	75%	Broad spectrum of projects, including several in individual PCNs/practices. Potential room for improvement on increasing % of participants in several projects on 20% most deprived areas, including PCN/practice/RFL projects and need to consider 'reach' of several projects. Difficulties in mobilising some projects.
Enfield#	21	£1,580,742	85%	Enfield has greatest number of Borough projects and has a mix of statutory- and VCSE-projects with a span across multiple categories with good reach in some areas. Significant focus on tackling empowerment and wider health determinants than other Boroughs; less on MH services.
Haringey#	14	£1,695,619	79%	Haringey had mix of statutory- and VCSE-projects with a span across multiple categories, but less investment in improving empowerment and more on smaller number of larger projects than Enfield built around Healthy Neighbourhood portfolio, and 'good' reach in number of projects. Most primary care-based projects via GP Federation.
Islington	10	£731,362	100%	Islington had greater focus on number of MH projects with mix of statutory and VCSE projects, several of which focussed on more vulnerable groups and on better understanding populations. Former approach supported a focus on building project 'reach' effectively. Fewer projects associated with primary care and LTCs and as result relatively low 'in year' reductions to acute activity, but more in terms of MH interventions.

- Enfield and Haringey share 5 joint projects in Thriving Community Zone. These are counted in both Haringey and Enfield 'No. of Projects, but the funding for these 5 projects is halved and included in each Borough, as are the cost mitigation estimates for these projects included in the 'Total In Year NHS Cost Mitigation' column

$ - It should be noted that not all 53 projects were expected to contribute directly to NHS in year cost mitigations but could influence this in the longer-term, e.g. community empowerment projects.

^ Figures exclude programme overheads and additional funding of NCL homelessness projects

List of Projects in Inequalities Fund Programme 2023/24

The tables list the projects by Borough, their funding levels and project alignment between the Core20Plus5, NCL Outcomes Framework metrics and Delivery Place Topic

(colours indicate levels of broad alignment between project aims and alignment)

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Project	Description	Lead	2023/24 Investment	Aligns with		
				NCL Outcome Framework Metrics	Delivery Plan Topic	'5' in Core20Plus5
Barnet						
Peer Support for CVD Prevention	Support for adults particularly those from non-White backgrounds with potential or diagnosed HTN to screen and support self-management	London Borough of Barnet	£25,732	**Y** - HTN Diagnosis & Mgt	**Y** - Heart Health	**Y** - Hypertension Case-Finding & Management
Arts Against Knives	Multi-agency VCS-led collaboration to support young black men identified at risk of MH, trauma or disadvantage to access arts-based projects to improve health and life-chances	Arts Against Knives	£46,500	**Y** - MH Prevalence & Treatment; NELs for Violent Crime	**Y** - Adult & CYP Mental Health	**Y** - CYP Mental Health
Camden						
Childhood Immunisation Programme	Multi-agency project to improve uptake of childhood immunisations in under-served communities and group	NCL ICB & Community Matters	£28,500	**Y** - Childhood Immunisation Rates	**Y** - Childhood Immunisation	**N**
Complete Care Communities	PCN project to empower and help build resilience in local Somali and Bengali residents at risk of MH issues	South Kentish Town PCN	£25,000	**Y** - MH Prevalence & Treatment	**Y** - Adult & CYP Mental Health	**Y** - CYP Mental Health
Kilburn Outreach	Practice based project to improve take up of health checks and promote healthy lifestyles for 40-74 (particularly non-white British) and other groups (e.g. those with LD/Severe MH)	Brondesbury Medical Centre	£64,800	**Y** - Health Checks 40-74	**Y** - LTCs and Prevention	**Y** - Hypertension Case-Finding & Management
Health Equalities Programme	Practice project to mitigate against digital exclusion amongst under-served groups and promote healthy lifestyles	Brondesbury Medical Centre	£43,800	**N**	**N**	**N**
Targeted Community Outreach	Practice-Based Care Coordinator to support prevention, detection and active physical health management of people with SMI, diabetes, hypertension and obesity	Abbey Road Medical Practice	£46,367	**Y** - SMI Physical Activation; HTN/HbA1c Mgt; Obesity	**Y** - LTCs/Heart Health, Prevention & Adult MH	**Y** - Hypertension Case-Finding & Management; SMI Physical Health
Patient-centred approach to improving lifestyle behaviours	PCN project to promote Healthy Lifestyles for people with SMI, diabetes and hypertension	Central Camden PCN	£43,249	**Y** - SMI Physical Activation; HTN/HbA1c Mgt; Obesity	**Y** - LTCs/Heart Health, Prevention & Adult MH	**Y** - Hypertension Case-Finding & Management; SMI Physical Health
Lifestyle Hubs at RFL	Project to implement Prevention Hub to Promote Healthy Lifestyles within RFL	Royal Free London NHS Trust	£152,000	**Y** - Smoking Cessation; Weight Management; Physical Activation	**Y** - Prevention	**Y** - Smoking Cessation
Pathways for under-represented communities to access dementia diagnosis	Project to identify and engage with South Asian Women to raise dementia awareness, improve diagnostic rates and support	Camden and Islington MH Foundation Trust	£71,710	**Y** - Dementia Prevalence & Treatment	**N**	**N**
Primrose A	Project to support SMI patients to improve physical health and activation in primary care settings	Camden and Islington MH Foundation Trust	£57,317	**Y** - SMI Physical Activation	**Y** - Adult MH	**Y** - SMI Physical Health
Annual Health Check Quality Improvement Project	Funds Strategic Health Facilitator to undertake audit of practice in relation to health checks for people with learning disabilities	London Borough of Camden	£36,526	**Y** - LD Measures relating to work & housing	**Y** - LD & Autism	**N**
Camden Adult Prevention Pathway	Contributes to Camden Adult Pathway Partnership to provide patient-centred support for residents at risk of homelessness	London Borough of Camden	£30,000	**Y** - Homelessness Outcomes	**Y** - Inclusion Health	**N**

List of Projects in Inequalities Fund Programme 2023/24

Project	Description	Lead	2023/24 Investment	Aligns with		
				NCL Outcome Framework Metrics	Delivery Plan Topic	'5' in Core20Plus5
NMUH Thriving Community Zone						
Enfield						
Black Health Improvement Programme	VCSE engagement project to build connections between primary care, NHS& statutory sector and people from black ethnic groups	Caribbean and African Health Network	£50,000	N	Y - Strengthening integrated delivery	N
Enhanced Health Management of People with Long-Term Conditions	Collaboration between primary care and community and secondary care to target and improve health management of adults with diabetes/heart failure at risk of adverse outcomes	North Middlesex University NHS Trust	£274,000	Y - QOF CVD & HbA1c diagnosis & mgt; admission avoidance	Y - LTCs/Heart Health/Supporting People At Risk of Hospitalisation/ Community Health	N
Community Hub Outreach	Multi-agency collaboration to support residents to address social issues, e.g. income maximisation/finances, food poverty, housing advice, that impact on health and well-being	London Borough of Enfield	£25,000	Y - Employment, Income & Fuel Poverty	Y - Root causes of health outcomes; Prevention	N
DOVE (Divert and Oppose Violence in Enfield) to reduce Serious Youth Violence	Multi-agency collaboration to advise and support young people identified at risk from serious youth violence to access family and youth support to improve life-chances	London Borough of Enfield	£55,186	Y - MH Diagnostic & Treatment; NELs for Violent Crime	Y - CYP Mental Health	Y - CYP Mental Health
VCS & Primary Care based smoking cessation	Project to promote smoking cessation in under-served communities and groups with higher smoking rates	Enfield GP Federation	£156,386	Y - Smoking Cessation	Y - Prevention	Y - Smoking Cessation
Lifestyle hub model	Multi-agency project based in NMUH to promote and advice healthy lifestyles for patients and visitors to hospital	North Middlesex University NHS Trust	£20,000	Y - Smoking Cessation; Physical Activation; Obesity	Y - Prevention	Y - Smoking Cessation
Enhanced Homeless Primary Care Health Service	Project to promote health outcomes and access to primary and community services for people who are at risk of homelessness or rough sleeping who live with multiple disadvantage	Enfield GP Federation	£40,000	Y - Homelessness Outcomes	Y - Inclusion Health; LTCs	N
Social and Emotional support to recover from pandemic	Funds dedicated VCSE caseworker providing advice on income maximisation, debt, housing, mental well-being etc. to under-served communities and groups	Citizens Advice Enfield	£50,000	Y - Adult MH Prevalence; Low Income; Fuel Poverty;	Y - Root causes of health outcomes	N
Community approach to address childhood obesity	Establishment of a small grants programme to support VCSE to work on childhood obesity and its causes	Enfield Voluntary Action	£160,000	Y - Childhood obesity; Physical Activation	Y - Root causes of health outcomes	N
Access to healthier food and financial support in community settings	Multi-agency collaboration to reduce to address underlying causes of food poverty through income maximisation and access to affordable healthy food at foodbanks	London Borough of Enfield	£25,000	Y - Low Income; Fuel Poverty; Employment	Y - Root causes of health outcomes;	N
0-2 Years Speech & Language Early Identification and Intervention Service	Contribution to project to provide support for children aged 0-2 with SLCN (or at risk of SLCN) in under-served communities	North Middlesex University NHS Trust	£50,000	Y - Speech & Language Milestones	Y - Family Help in Early Years	N
Interestelar Twalking Challenge	Practice-based VCSE project to improve patient activation, physical activation and social networking amongst at risk patients with LTCs through walking programme	INTERESTELAR Charity	£33,750	Y - Physical Activation; Specific LTC Mgt	Y - LTCs; Prevention	Y - HTN Management
GP Registration in Enfield	VCSE collaboration with primary care to improve GP registration rates amongst under-served groups	Edmonton Community Partnerships	£160,000	N	Y - Strengthening integrated delivery	N
Enfield Patient Participation Networks (PPG)	Project to improve diversity of membership of PPGs	Enfield PPG Network	£40,000	N	Y - Strengthening integrated delivery	N
Family early intervention therapeutic support	VCSE project to support children & families with MH issues via earlier therapeutic interventions	Wellbeing Connect & Edmonton Partnership	£75,000	Y - MH Prevalence & Treatment	Y - Adult & CYP Mental Health	Y - CYP Mental Health
Empowering Enfield Carers [TCZ]	VCSE-led multi-agency project for carers to manage basic health and nursing skills to better manage the needs of those they care for & navigate hospital discharge processrd	Enfield Carers Centre	£40,000	Y - Carer Reported Quality of Life	Y - Carers	N

List of Projects in Inequalities Fund Programme 2023/24

Project	Description	Lead	2023/24 Investment	Aligns with		
				NCL Outcome Framework Metrics	Delivery Plan Topic	'5' in Core20Plus5
NMUH Thriving Community Zone						
Haringey						
Engaging young people with mental health needs through creative arts, activities and sports	Multi-agency VCSE-led collaboration to target and support young people with emotional and behavioural issues via arts and sports early to improve health and life chances	Open Door	£250,500	**Y** - CYP MH Prevalence & Treatment	**Y** - CYP Mental Health	**Y** - CYP Mental Health
Tottenham Talking	Statutory and VCSE sector collaboration to work with adults with SMI at risk of adverse MH episodes to improve or maintain MH via group arts and culture based activities and support	Barnet, Enfield and Haringey MH Trust	£216,930	**Y** - SMI Mgt, Physical Activation and Life Chances	**Y** - Adult MH	**Y** - SMI Physical Health
Enhanced Health Management of People with Long-Term Conditions	Collaboration between primary care and community and secondary care to target and improve health management of adults with diabetes/heart failure at risk of adverse outcomes	Whittington Hospital NHS Trust	£274,000	**Y** - QOF CVD & HbA1c diagnosis & mgt; admission avoidance	**Y** - LTCs/Heart Health/Supporting People At Risk of Hospitalisation/ Community Health	**N**
Cancer Link Workers	VCSE led collaboration to provide emotional, social and practical support for people diagnosed with cancer to navigate system, support self-management & improve quality of life *(23/24 funding conmmitted from 22/23 & funded in 24/25)*	NCL Cancer Alliance / Public Voice	£0	**Y** - Cancer Survival & Mortality Rates	**Y** - Cancer	**Y** - Cancer
Supporting earlier cancer diagnosis	VCSE project to fund Community Development Worker to improve screening uptake and earlier cancer diagnosis in under-served communities	NCL Cancer Alliance / Bridge Renewal Trust	£42,769	**Y** - Cancer Screening Rates	**Y** - Cancer	**Y** - Cancer
NCL Somali Mental Health Support	VCSE project with NHS to reach into Somali community across Haringey/NCL to improve residents mental health and well-being, navigate system, improve patient activation and support those at particular risk, e.g. due to trauma	RISE	£135,000	**Y** - MH Prevalence & Treatment	**Y** - Adult & CYP Mental Health	**Y** - CYP Mental Health
Health Neighbourhoods - People with Multiple Disadvantage	VCSE project in HN portfolio to work with people living with multiple disadvantage in community to improve health and social outcomes and life chances	Mayday Trust	£60,000	**Y** - Homelessness Outcomes	**Y** - Inclusion Health; LTCs	**N**
Health Neighbourhoods Programme - LTCs; Start Well; Mental Well-Being and Sickle Cell Patients	Partnership portfolio programme with Council BCF funding to support: improve management of patients with COPD, CVD, CKD; tackle childhood weight management; improve mental well-being amongst vulnerable groups; and improve holistic support for people with sickle cell	Haringey GP Federation, MIND, Disabililty Action Haringey	£350,000	**Y** - CYP Weight Management; CYP & Adult Physical Activation; Specific LTC Diagnosis & Mgt; Adult MH Prevalence including SMI	**Y** - LTCs/Heart Health/Supporting People Needing Support & At Risk of Hospitalisation/ Community Health/Adult MH Prevalence	**Y** - Hypertension Case-Finding & Management; Respiratory Conditions
Healthy Neighbourhoods Programme - Empowering People [TCZ]	VCSE project to support community engagement / empowerment in IF projects & under-served communities	Haringey GP Fed / Public Voice	£40,000	**N**	**Y** - Root causes of health outcomes;	**N**

List of Projects in Inequalities Fund Programme 2023/24

North Central London Health and Care
Integrated Care System

Project	Description	Lead	2023/24 Investment	Aligns with		
				NCL Outcome Framework Metrics	Delivery Plan Topic	'5' in Core20Plus5
NMUH Thriving Community Zone						
Jointly Funded across Haringey and Enfield						
Supporting People with Severe & Multiple Disadvantage who are High Impact Users at NMUH	Multi-agency identification, intensive management and coordinated interventions for adults living with disadvantage who are frequent attenders to secondary care to improve health, well-being, independence and life-chances and reduce their utilisation of services	North Middlesex University NHS Trust	£140,000	**Y** - Homelessness Outcomes	**Y** - Inclusion Health; LTCs; Supporting People at Risk of Hospitalisation	**N**
ABC Parenting Programme	Multi-agency project to work with parents of babies and infants from broad range of under-served communities whose children are at risk/repeat risk of attending ED avoidably to improve knowledge of children's health and interventions and become ambassadors in community	North Middlesex University NHS Trust	£327,000	**Y** - Birth outcomes; Speech & Language; Childhood Immunisations; Low Income	**Y** - Maternity; Family Help in Early Years; Childhood Immunisation; Prevention; Root Causes	**Y** - Maternity
NHS mentoring and support for young people	NHS based project to coordinate and expand employment anchor activities amongst under-served groups including pathways into NHS	North Middlesex University NHS Trust	£40,000	**Y** - Employment, Income & Fuel Poverty	**Y** - Root causes of health outcomes	**N**
0-2 Years' Speech and Language Early Identification and Intervention Service	Contribution to project to provide support for children aged 0-2 with SLCN (or at risk of developing SLCN) in under-served communities across Barnet, Enfield and Haringey	London Borough of Haringey / NMUH / WHT	£45,840	**Y** - Speech & Language Milestones	**Y** - Family Help in Early Years	**N**
Healthy Commmunity Zone - Primary Care Access [TCZ]	Primary care based project to improve patient access to admission avoidance services and improve primary care access for under-served groups in Haringey and Enfield	Haringey GP Fed (as host for individual practices)	£100,000	**Y** - Admission Avoidance	**Y** - Supporting People At Risk of Hospitalisation	**N**

List of Projects in Inequalities Fund Programme 2023/24

North Central London

Project	Description	Lead	2023/24 Investment	Aligns with		
				NCL Outcome Framework Metrics	Delivery Plan Topic	'5' in Core20Plus5
Islington						
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	London Borough of Islington	£130,000	**Y** - MH Prevalence & Treatment including SMI outcomes	**Y** - Adult & CYP Mental Health	**Y** - CYP Mental Health
Homelessness Health Inclusion Programme	Multi-agency project to promote health outcomes and access to primary and community care services for people who are at risk of homelessness or rough sleeping	Islington GP Federation	£107,780	**Y** - Homelessness Outcomes	**Y** - Inclusion Health; LTCs	**N**
Hand in Hand Islington – A Volunteer Peer Buddy Scheme	Project to establish Peer Buddy scheme of volunteers with experience of MH issues to accompany vulnerable residents to appointments and events	Camden & Islington MH Trust	£97,624	**N**	**N**	**N**
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	Healthwatch Islington	£69,958	**N**	**Y** - Becoming a Learning System	**N**
Leaving Care Counselling & Psychotherapy Service	VCSE project to provide intensive therapeutic interventions to targeted care leavers thought to be at risk of SMI or suicide	Brandon Centre	£19,000	**Y -** CYP MH Prevalence & Management including SMI	**Y -** CYP Mental Health; Child Looked After & Care Leavers	**Y** - CYP Mental Health
Progression to Adulthood	VCSE-led collaboration to provide therapeutic interventions to targeted young people at risk of SMI/suicide	Brandon Centre	£65,000	**Y -** CYP MH Prevalence & Management including SMI	**Y -** CYP Mental Health	**Y** - CYP Mental Health
LD & SMI health cafes	Project to support cafes for people with LD and SMI to promote health checks, healthy lifestyles, social inclusion and empowerment to improve health and social outcomes	Islington GP Federation	£60,000	**Y** - SMI Mgt, Physical Activation and Life Chances	**Y -** Adult MH; LD & Autism; Prevention	**Y** - CYP Mental Health
Mental Health inequalities Toolkit	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	Healthwatch Islington / MIND	£35,000	**Y -** Adult MH Prevalence & Management including SMI	**Y -** Adult Mental Health; Becoming A Learning System	**N**
Childhood Immunisation Programme	Multi-agency project to improve uptake of childhood immunisations in under-served communities	Islington GP Fed / Healthwatch Islington	£81,000	**Y** - Childhood Immunisation Rates	**Y** - Childhood Immunisation	**N**
Cancer Screening Research Project	Project to fund community participation research into improving cancer screening of patients from non-White British backgrounds to inform future cancer screening developments	Islington GP Fed / Healthwatch Islington	£66,000	**Y** - Cancer Screening Rates	**Y -** Cancer; Becoming A Learning System	**Y** - Cancer
OTHER						
IF Programme Management & Evaluation and Other NCL Health Inclusion Initiatives		**NCL ICB**	£424,776			
TOTAL			**£5,104,000**			