SUPPLEMENTARY AGENDA

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Fiona Rae / Robert Mack

Friday 19 March 2021, 10:00 a.m.
MS Teams (watch it here)

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Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Christine Hamilton and Edward Smith (Enfield Council), Pippa Connor and Lucia das Neves (Haringey Council), Tricia Clarke, and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Andy Ellis, Robert Mack, and Peter Moore.

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

AGENDA

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS (PAGES 1 - 4)

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

7. INTEGRATED CARE SYSTEMS (ICS) (PAGES 5 - 26)

To consider and discuss Integrated Care Systems (ICS).

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John Jones
Monitoring Officer (Interim)
River Park House, 225 High Road, Wood Green, N22 8HQ

Tuesday, 16 March 2021

JHOSC, 19 March 2021 - Deputation on ICSs - Integration and innovation? *NCL NHS Watch*

Introduction

Since our presentation to JHOSC in January about proposals in NHSE's proposals for ICSs, ***Integrating Care -next steps to building strong and effective care across England,*** the government published a **White Paper (WP), *Integration and innovation: working together to improve health and social care for all*,** proposing legislation this Spring to give Integrated Care Systems (ICSs) a legal basis by 2022. The ICS will bring together primary, secondary, and public health, with social care, under the ICS (i.e. NHS) management, with a single, capped budget.

Omissions, context, over-claiming and the *'new normal'*
Neither document addresses the real keys to improving health outcomes and reducing health inequalities i.e., redressing the ***workforce and funding issues in health,*** relative to comparable countries, (fewer beds, doctors, and nurses), social care and public health. The context is one of ***councils weakened*** by cutbacks and erosion of powers, reductions in all areas impacting the social determinants of health, and a ***developed, private health care sector*** of pre-approved companies.

The White Paper claims that its proposals are essential now. It states '***the response to Covid 19…..has shown us new ways to deliver care using ……. the potential of digital and data instead of needless bureaucracy. We must not go back to the old ways of working. The gains made by these new approaches must be locked in*'**. Yet many of these new ways of working trouble councillors and patients. ***Claims that the proposals will reduce bureaucracy, end competition, and promote collaboration and partnership are not substantiated with detail or evidence.***

Key issues for Councillors and the public *are:*

1. **unequal partnership and lack of representation**
2. **reliance on digitisation and shift to data driven, virtual, remote care**
3. **threats to councils' role and funding for social care and public health**
4. **unscrutinised, wasteful procurement**
5. **Integration – structural and financial - not patient centred**

1.Unequal partnership and lack of representation, accountability, transparency, and engagement for councillors, users, and the public

*'We will work much more closely with local government', y*et ***local government bodies were not involved*** in drawing up the proposals and are still not being involved; the ***LGA*** voiced concerns about the ***unequal partnership between councils and the ICS,*** and the ***BMA*** about the ***risk of reduced clinical involvement in decision making.*** Councils will also ***lose a significant power*** to refer proposed reconfiguration of services to the Secretary of State, used to good effect in recent years.

The new structure includes ***two boards****:*
ICS NHS board responsible for ***spend and performance of the system, to run the ICS***. It will have a chair, CEO and representatives from NHS trusts, primary care and local authorities and 'others'. It will not have the power to direct providers. Currently ***NCL ICS has one LA representative***, the Haringey CEO and the merged CCG only ***non-voting LA representatives***.
ICS Health and Care Partnership Board composed of NHS, local authority and other partners focused mainly on social care, and public health needs of the system, and is subordinate to the ICS NHS Board. Neither NHS bodies nor Local Authorities will be bound by ICS Health and Care Partnership Board policies.

Mandated collaboration, joint capped budgets, conflicts of interest and no veto
The ICS will work to a ***single plan and single budget*** and its proposals will be binding with no veto. Partners will have a duty to collaborate and be ***collectively accountable*** for delivering the plan and budget and the ***Triple Aim*** of better patient care, health, and sustainable NHS resource use. The NHS ICS will be able to establish committees and delegate functions to individual or groups of providers and its committees can make legally binding decisions on major resource allocation and service provision. With independent providers on boards, there is potential for major ***conflicts of interest*** and under/***unscrutinised/ lack of due diligence in awarding contracts***. The ***BMA*** highlighted this concern, and the ***lack of an NHS Preferred Provider*** specification.

The ICS board will be ***accountable upwards*** to NHS England and now the Secretary of State, but ***not to the public, patients, carers, or Local Authorities***. There is no detail yet that requires ICS boards to meet in public, publish board papers or minutes, or it seems be the subject to FoI requests. Private providers are not bound by FoIs unless this is included in their contract - which is rare. It has not been made clear what ***powers the ICS NHS would have over local authority assets*** including proposals for the Better Care Fund and powers over local public health.

These mandated powers over the NHS and LAs, with their different funding and accountability mechanisms, ***misses the opportunity t***o foster genuine public accountability and engagement between the NHS, LAs and the public that exists in some areas.

2.Digital, data, and the vanishing doctor/patient relationship

The use of ***digitization*** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care is a ***key plank of ICSs***, and the use of digital technology to reimagine care pathways. *(Integrating Care).* North London Partners (NLP) aim for 2020/21 is that ***'the use of online and video consultation is embedded and normalised across NCL by both patients and GPs.'***

Their only concern is managing or coaching the 'digitally excluded'. There is no recognition that the shift to ***virtual and remote consultations,*** instead of face to face meetings with health professionals, erodes the ***doctor patient relationship,*** which robust evidence indicates is key to better patient outcomes, including diagnosis, treatment compliance, and the importance of ***relationship continuity*** to reducing mortality. *(1)* A blended approach of virtual/ remote and face to face contact, with the latter enshrined as a right *can* offer greater convenience and patient choice, but as an addition, not with f***ace to face increasingly the exception or attracting lengthier wait times.***

Given the chronic shortage of GPs, with no realistic plans to redress this, it is easy to understand the emphasis on increased remote access, the involvement of other health professionals and social prescribing, as cheap, quick means to ***mask the GP shortage***, rather than increasing contact and treatment options for patients.

Data driven, actuarial targets and the vanishing patient
Improving the health of the population and reducing variations within an ICS, will depend on ***data driven planning*** between NHS and LAs, using Population Health Management (PHM). PHM is critical for the ICS model, relying on ***data sharing*** across care settings, the move to ***remote consultation, triaged by algorithms***, and shifting the focus from care for individual patients, to data driven, actuarial health targets for the whole population. However, ***targets set nationally,*** or by an ICS board, particularly one with provider interest, may ***not be good for an individual patient.***

Public health has long produced ***JSNAs,*** and evidence on how to combat health inequalities is not new; what has been lacking is funding and national political will. So, it is unclear how the ICSs PHM

approach can deliver better public health, in the context of an over 33%, and continuing, cut to councils' funding, impacting services, essential to addressing health inequalities.

3.Social care, public health, and council democracy under threat

Major ***social care proposals are deferred*** to later this year. There is no acknowledgment of Social Care's (SC) remit for a wide group of people with a range of need, disability, illness, or frailty, but solely its role in meeting the NHS's hospital discharge targets. The ***Discharge to Assess*** model will be updated, whereby ***assessment take place after an individual is discharged*** from acute care. There is also no acknowledgment of the emphasis in SC of ***co-production*** –and what this would mean for governance arrangements.

The plans for ***Public Health*** (PH) are sparse and mainly relate to restrictions on food advertising and labelling, to tackle obesity.

LA's responsibilities for SC have already been eroded by the Care ***Act Easements 2020,*** and now the Secretary of State (SoS) has powers to directly make payments to SC providers. ***'Not only will the local government voice be relatively weak, but the powers given to the SoS could see councils losing control of their SC and PH services to the priorities of the ICSs. In those circumstances, it would no longer be clear what the purpose of democratic local government might be'.*** *(2)*

4.Unscrutinised and wasteful procurement

Increased data sharing means large contracts for private companies. The White Paper proposals to repeal competition law as it applied in the Health and Social Care Act 2021, and its accompanying system of procurement, increases the prospect of **unregulated direct awarding of contracts, *an even worse prospect than the previous competitive regime.*** This occurred during the pandemic, as highlighted in the ruling of the High Court against the Secretary of State, and locally, the recent renewal of a contract by ***NCLCCG Primary Care Committee***, handing several NCL ***GP practices,*** previously owned by AT Medics, ***to a US company***, Operose, owned by Centene, without transparent due diligence or consultation with local authorities. All five lead members for Health & Social Care in NCL have made a formal protest about this.

There are also 101 global, US and other accountancy, digital technology and health care companies, already signed up in the Health Support Service Framework, a ***pre-approved list of companies*** which can be awarded contracts with no further tendering or competition available to ICSs.

5.Integration -structural and financial – not patient centred

Integration conjures up visions of coordinated, wrap-around patient care, but this is not the plan. ***Structural and financial integration*** is a central goal of the NHS Long-term Plan (2019), as a means of ***saving money*** by reducing hospital bed occupancy, secondary referrals, and GP face to face contacts. The WP claims that integration can only happen with this Bill, but different forms of integration and collaborative, working at patient and local level have developed before, without this legislation and ICSs.

The National Audit Office noted that the *government had* ***not yet established a robust evidence base to show that structural integration leads to better outcomes for patients*** and that there was no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity. (*3)* Previous government ***mandated collaboration imperatives*** have ***foundered*** on the different NHS/LA funding and accountability regimes, which the WP does not successfully address.

Next steps – we urge the JHOSC to:

- ***raise these concerns*** with NCL, the mayor, local government bodies, MPs
- press for full, public ***consultation*** involving all stakeholders before further implementation.
- insist NHS and local authorities have ***parity of representation and voting rights on main ICS board***
- demand measures to ensure ICSs are fully ***accountable to LAs, public,*** users and carers and meetings to be held and papers/minutes etc to be made public
- insist that face to face consultations are enshrined a right, not a rationed exception -***Patient First not Digital First***
- press for ***independent providers to be excluded*** from membership on decision-making/resource allocation boards
- insist ICSs to be prohibited from purchasing services from their board members.
- demand changes that will make a real improvement to ***health outcomes and inequalities***.

References:

1.Pereira Gray DJ, et al, Continuity of care with doctors -a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018. 10.1136/bmjopen-2017-021161)

2. (Hudson R, Short on detail but not on ambition: four problems with the new NHS white paper. British Politics and Policy, LSE, March 7, 2021)

3. https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf .

Brenda Allan, Alan Morton, NCL NHS Watch

NORTH LONDON PARTNERS
in health and care

NHS

North Central London: Integrated Care System

JHOSC – 19 March

Summary

This paper covers recent developments in the national health and care landscape which are expected to lead to a formal legislative framework for Integrated Care Systems (ICSs). We are keen to have a conversation with the JHOSC about our approach in NCL, and to inform that conversation we have provided here some slides, primarily as context and background reading.

Contents

Areas to debate with the JHOSC

1. How can we make this new ICS framework an opportunity in North Central London to make this a true partnership with Councils and communities?

2. What do we need to do differently to start moving towards greater collaboration across health and care?

3. How can we ensure Councils, community/voluntary sector organisations and our local communities are central to how we develop as an ICS?

4. How can we best work with the JHOSC on the development of the ICS over the coming year, bearing in mind that lots of things remain to be shaped and clarified?

Context

- Following publication of the NHS Long Term in January 2019, it was announced that Sustainability and Transformation Partnerships (STPs) across England would evolve to form integrated care systems (ICSs).
- A potential statutory framework for ICSs was expected to ensure closer collaboration across NHS organisations, including GPs, hospitals, mental health and community trusts, in partnership with local councils, the voluntary sector and other partners.
- ICS leadership is expected to take collective responsibility for managing resources, delivering NHS standards, integrating care and improving the health of the residents of NCL.
- Working together in this way will allow local services to provide better and more joined-up care for local people that is tailored to individual needs.
- During the pandemic the benefits of closer working have been very clear, in particular examples of mutual aid and collaboration across health and care services to tackle large scale challenges created by the pandemic.

Department for Health and Social Care (DHSC): White Paper

Following consultation by NHS England and Improvement on recommendations for the development of integrated care systems, the DHSC White Paper was published on 11 February 2021 with a series of proposals for an ICS legislative framework.

- The White Paper details a specific set of proposals where change to primary legislation is required, which can be grouped under the following themes:
  1. working together and supporting integration
  2. stripping out needless bureaucracy
  3. enhancing public confidence and accountability.
- The government's plan is that legislative proposals for health and care reform outlined in the paper will begin to be implemented in April 2022.
- Draft legislation is expected to be brought to Parliament in May 2021,subject to the parliamentary timetable.

Department for Health and Social Care (DHSC): White Paper

- Focus on integration, and best ways of driving collaboration across the NHS and with Councils, voluntary and community organisations, and local communities.
- Reverses some elements of reforms from the *Health and Social Care Act 2012*, including focus on the market, transactional commissioning, and procurement.
- Functions of CCGs will be transferred to a statutory Integrated Care System, alongside responsibilities for oversight and direct commissioning devolved from NHSE/I.
- Gives to local ICSs the flexibility to develop processes and governance structures which work most effectively for them.
- Two key elements to the ICS, working in collaboration: an NHS statutory body responsible for NHS spending and performance; and the wider health and care partnership to address wider health and wellbeing issues.
- Introduces a formal duty to collaborate, and partners will have responsibility for the system financial position.

Department for Health and Social Care (DHSC): White Paper

- Provider collaboratives / alliances seen as vehicles for change.
- Commitment to be permissive of local development, but coupled with stronger direct accountability of the NHS to the Secretary of State.
- Intention is to proceed at pace, with legislation introduced in May to enable ICSs to become statutory bodies from 1 April 2022.
- Government proposals on social care and public health reform are not included in this White Paper. NHS Providers, a body representing NHS Trusts, have argued that the commissioning of some clinical public health services, such as sexual health and school visiting, should be moved to the NHS.
- Separate consultation is underway on the process for selecting providers of NHS care – running until April 2021.

How does this fit with NCL?

- Move to strategic commissioning at a system level - away from transactional contracting/the current market and procurement model.
- Builds on existing commitment by CCG and partners to focus on population health management and tackling health inequalities.
- Strengthened collaborative working across NCL through the pandemic, including major incident response and planning for recovery.
- Integrated Care Partnerships established in each borough, with local priorities – focal point for delivery.
- Partnership Board in place with local authority leadership representation.
- Extensive arrangements for clinical and professional leadership already in place.
- Work is underway for provider alliance, and for development of primary care provider alliance.

NORTH LONDON PARTNERS in health and care

NHS

Our vision - an integrated care system in NCL

We are working to deliver improvements in outcomes for local people – through changes in the way we plan and deliver health and care services

Our future success depends on the health and wellbeing of local people. We have made good progress in recent years but there are still too many health disparities and inequities within and between North Central London communities that prevent our residents getting the **same opportunities to start well, live well and age well**.

We know that, in particular, we have the need and the opportunity to improve children and young people's health. Focusing on public health and the quality of health and care services for children and young people means we can help **make a real difference to key determinants of good health such as reducing childhood obesity and increasing immunisation rates.**

We know that the economic climate impacts health. Poor health and care, in turn, affects individuals, their quality of life and their ability to contribute to the local economy. Health and care services and the staff and carers that work in them can impact and help break this cycle. This will help reduce urgent or long-term care for problems that could have been **identified earlier, managed better, or prevented altogether.** This upholds our whole purpose to support residents, communities and the economy.

Our purpose is: To improve to outcomes and wellbeing, through delivering equality in health and care services for local people.
Supporting them to Start Well, Live Well and Age Well. We also want to support the many local people who are employed by health and social care to **Work Well.**

We will be guided by a shared outcomes framework **setting out the difference we will make for the population in NCL** and how we will be monitoring that we are achieving our strategic aims.

Our approach – emerging governance proposals

We need appropriate governance arrangements to support the delivery of our vision and strategies.
The key elements of high level governance we are discussing with Council and NHS colleagues are:

Partnership Board (NCL-wide)

Purpose: to agree the overall ICS ambition, strategy and policies to improve the health and wellbeing of local people and address inequalities.
Membership: ICS Chair, Local Authority leaders, NHS provider Chairs, CCG Chair, Primary Care representation, ICS leaders

Population Health and Inequalities Committee (NCL-wide)

Purpose: to drive strategic approach to population health and health inequalities

ICS Steering Committee (NCL-wide)

Purpose: to oversee integration and development of services and the NCL system
Membership: ICS Chair, ICS leaders, Council CEO and Leader, NHS providers, Primary care

Integrated Care Partnerships (borough-based)

Purpose: to set local priorities, and enable integration of health and care services for residents
Membership: locally decided, including Council, NHS, VCSE

Community Partnership Forum (NCL-wide)

Purpose: to enable residents to be involved in developing strategies
Membership: ICS Chair, Council representation, NHS providers, Healthwatch, VCSE

Our approach – local partnerships to improve care

- Health and care providers need to deliver joined-up support for growing numbers of older people and people living with long-term conditions.
- There are three levels within Integrated Care Systems:

Communities as building blocks of integrated care

- Neighbourhoods to build on the core of the newly established primary care networks and enable greater provision of proactive, personalised, coordinated and more integrated health and social care through multidisciplinary teams taking a proactive population based approach to care through consistent pathways. 30 PCNs developed across boroughs.

Boroughs as the critical point of integration of planning and coordination of services

- Majority services will continue to be planned and coordinated at a borough level.
- Boroughs to build local plans based on local population need.

Working across NCL where it makes sense

- Those activities where a larger footprint increases the impact or effectiveness of function-
- Enabling elements such as digital and large-scale reconfiguration programmes- e.g. NCL wide population health management platform

Our approach - local partnerships to improve care

- NHS organisations and local councils are joining forces to coordinate services around the whole needs of each local person.
- We want residents to live healthier lives and get the care and treatment they need, in the right place, at the right time.
- Our integrated care system will be made up of three main pillars of work:
    1. **Primary Care Networks** enable greater provision of proactive, personalised, coordinated and more integrated health and social care.
    2. **Personalised Care** gives people choice and control over their mental and physical health, as health and social care partners work together to deliver more person-centred care.
    3. **Strategic Population Health Management** overseen through the integrated care partnerships at borough level allow us to use data to design new models of proactive care, set local priorities and deliver improvements in health and wellbeing that makes best use of collective resources.

What does integrated care mean for local people?

"My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes."

My goals and outcomes

- All my needs are assessed and taken into account.
- I am supported to understand my choices and to set and achieve my own goals.
- The needs of my family and carer are recognised and they are also given support.

Information

- I have the information I need, at the right time, and am supported to make decisions about my care.
- I can see my care records .

Care planning

- I work with my care team to agree a care and support plan.
- I have regular reviews of my care so I can plan ahead and stay in control to avoid a crisis.

What does integrated care mean for local people?

Transitions

- When I use a new service my care plan is known in advance and respected.
- When I move between services or settings there is a plan.
- I know where I am going and who is responsible for my care.

Decision-making, including budgets

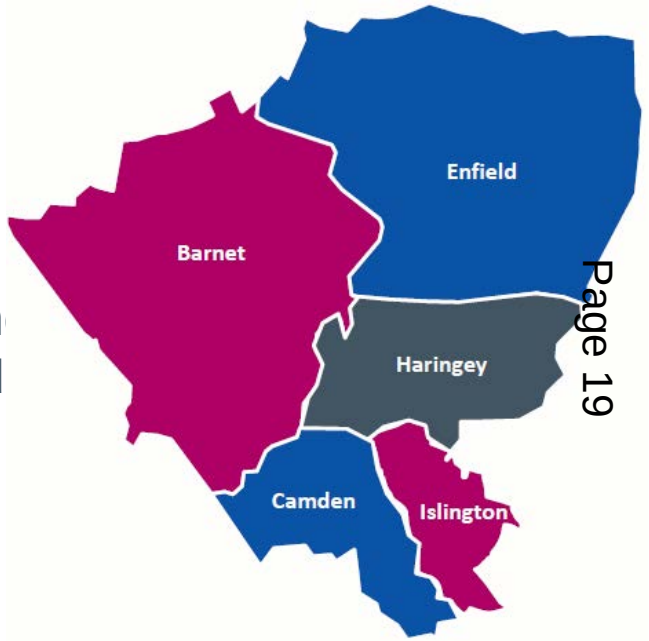
- My carer and I are involved in discussions and decisions about my care and I have help to make informed choices.
- I know how much money is available for my care and I can access this and determine how this is used or get skilled advice about this.

Communication

- I only need to tell my story once.
- I am listened to about what works for me and my life.
- The professionals involved in my care talk to each other and work as a team.
- I know who is coordinating my care, they understand me and I have one point of contact I can go to.

What have we achieved so far?

- We have already started focusing work on a number of areas
  - ✓ A move to single strategic commissioner for health services (NCL CCG).
  - ✓ Ensuring resident voice is heard at all levels of work.
  - ✓ The importance of prevention in all we do, combined with an ambition of partners working together to tackle wider determinates of health
  - ✓ Establishing five borough based integrated care partnerships focused on th coordination, integration and development of out of hospital services based on population needs.
  - ✓ Supporting the development of Primary Care Networks



- Through our response to and recovery from the Covid-19 pandemic we have worked collaboratively through the Clinical Advisory Group and 'GOLD' decision-making executive. We have worked increasingly as a system to tackle challenges and find solutions to meet the needs of local people
- We are building on this to cement our system approach by developing our ICS leadership team

What have we achieved so far? – impact of Covid

- **Accelerated collaboration**
  - single point of access for speedier and safe discharge from hospital to home or care homes
- **Mutual planning and support**
  - system able to respond quickly to a significant increase in demand for intensive care beds
- **Smoothing the transition between primary and secondary care**
  - increased capacity for community step-down beds to ease pressure on hospitals
- **Sharing of good practice**
  - Clinical networks to share best practice and provide learning opportunities
- **Innovative approaches to patient care**
  - pulse oximetry led by primary care and virtual wards led by secondary care to avoid Covid patients' admission to hospital and early discharge where appropriate
- **Clinical and operational collaboration**
  - Ensuring consistent prioritisation across NCL so most urgent patients are treated first
- **Multi-disciplinary approach to pathways of care**
  - Development of post-Covid Syndrome multi-disciplinary teams to support patients

Priority issues for the ICS

- As the ICS develops, it will be fundamental to focus on:
    - population health
    - health outcomes
    - reducing health inequalities
    - unwarranted variation
    - stakeholder and public engagement – making sure patient and resident voices are heard.

Appendices

NHS England: consultation and recommendations

- NHS England consultation document published in December Next Steps to Building Strong and Effective Integrated Care Systems
- Following the consultation, *Legislating for Integrated Care Systems*, makes five recommendations, alongside principles to guide how the Government progresses this work.
  - A series of FAQs explain these recommendations
  - It is proposed that the NHS ICS statutory body will take on the commissioning functions that currently reside with CCGs alongside some of the responsibilities that currently reside with NHSE.
- The DHCS White Paper, *'Integration and Innovation: working together to improve health and social care for all'*, aims to streamline and update the legal framework for health and care, enabling health and care services to be brought closer together, improve care and tackle health inequalities.

Response from national organisations

A number of national bodies have commented publicly on the DHSC White Paper and made comment about what this could mean for health and care systems:

- https://www.local.gov.uk/parliament/briefings-and-responses/lga-briefing-health-and-social-care-bill-white-paper (LGA)
- https://www.kingsfund.org.uk/press/press-releases/DHSC-integration-innovation-white-paper-response (King's Fund)
- https://adph.org.uk/networks/london/wp-content/uploads/2021/01/Integrating-Care-Consultation-London-Association-of-Directors-of-Public-Health-response.pdf Response of Association of Directors of Public Health

The King's Fund has also looked recently at ICS development in London: https://www.kingsfund.org.uk/publications/integrated-care-systems-london

Borough partnership – Key groups

- Each borough has an Executive / senior oversight board in place
- Every borough has a Delivery Board with Clinical, Officer and Director / Heads.
- Supported in all Boroughs by working groups to deliver their borough partnership priorities
- “Enabling” workstreams in most partnerships. These include local work around: estates, workforce & training, IT/digital, patient and public comms & engagement, use of data & population health

	Barnet	Camden	Enfield	Haringey	Islington
Executive	**Barnet Integrated Care Partnership Executive Board** Rotating chair: Dr Charlotte Benjamin (CCG); John Hooton (Council); Mike Whitworth (GP Fed), Debbie Sanders (Barnet Hosp)	**Camden Integrated Care Executive** Chair: Martin Pratt (Council). Vice Chair: Kate Slemeck (RFH)	**Enfield ICP Programme Board** Co-chair: Bindi Nagra (Council); Dr Chitra Sankaran (CCG)	**Haringey Borough Partnership Executive Management Group** Co-chair: Zina Etheridge (Council) Siobhan Harrington (Whittington Health)	**Fairer Together Partnership Board** Co-chair: Richard Watts (Leader of Council), Dr Jo Sauvage (CCG)
Oversight	**ICP Delivery Board** Chair: Dawn Wakeling (Council). Vice chair: Colette Wood (CCG)	**Local Care Partnership Group** Chair: Dr Neel Gupta (CCG) transitioning to provider chair in Apr 21	**Provider Integration Partnership Group** Co-chair: Dr Alpesh Patel (PCN), Dr Mo Abedi (BEH)	**Haringey Borough Partnership Board Leads** Chair: Rachel Lissaur (CCG)	**Core Group Leads** Chair: Clare Henderson (CCG), Amy Buxton Jennings (Council), Carmel Littleton (Council)
Delivery	4 “delivery groups”	5 “focus area groups”	3 “task and finish groups”	4 “partnership boards” (place, start well, live well, age well)	7 “workstream groups”

Borough Partnerships - Priorities at a glance

Priorities across the partnerships:

- **Inequalities:**
  - Rapidly accelerated via the Flu and COVID vaccine campaigns – building relationships with and working closely with communities and the VCS.
  - Health inclusion (homeless, asylum, traveller etc).
  - Also on the wider determinants of health, in particular the impact of deprivation and unemployment (exacerbated post COVID)

- **Digital access, delivery & inclusion** – learning from the use of technology over the pandemic.

- **Proactive care (incl early intervention & prevention)** – partnerships are focused on the shift more proactive care and population health management (e.g. risk stratification, care planning, case management, virtual wards, remote monitoring etc).

- **Cross sector workforce planning and development** – partnerships have identified the need to develop collective workforce plans, to address recruitment/retention/skills development & wellbeing.

- **Supporting care homes/providers** – all partnerships are focused on providing enhanced support to care homes (nursing & residential).