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To: All Members of the North Central London Joint Health Overview and Scrutiny Committee

Dear Member,

North Central London Joint Health Overview and Scrutiny Committee - Monday, 3rd February, 2025

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

**7. HEALTH INEQUALITIES FUND (PAGES 1 - 24)**

To provide an update on the Health Inequalities Fund including details about projects in the community that are supported by the Fund.

**8. WORKFORCE UPDATE (PAGES 25 - 68)**

To provide an update on workforce issues in NCL.

The most recent previous update to the Committee on this issue was on 29th January 2024. To view the minutes from this discussion please see Item 46 at:
https://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=697&MId=10545&Ver=4

Yours sincerely

Dominic O'Brien,
Principal Scrutiny Officer

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Integrated Care System

# 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 addres 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

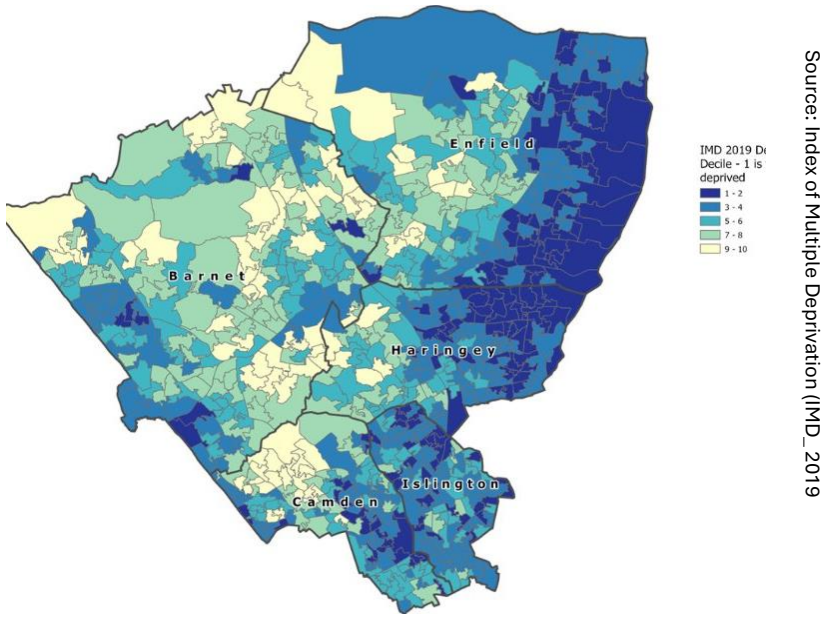
- **The Programme invests £5m per annum in 50+ projects across NCL** to improve engagement, health, well-being and life chances**.** Projects are divided into 5 categories:
  1. Improving empowerment & trust with communities
  2. Tackling wider determinants of health
  3. Helping people adopt a healthy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




Source: Index of Multiple Deprivation (IMD_2019

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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| Category | Building Community Power | Address Wider Health Determinants | Adopt Healthy Lifestyles | Health Inclusion of Vulnerable Groups | Promote Active Health Management |
|---|---|---|---|---|---|
| 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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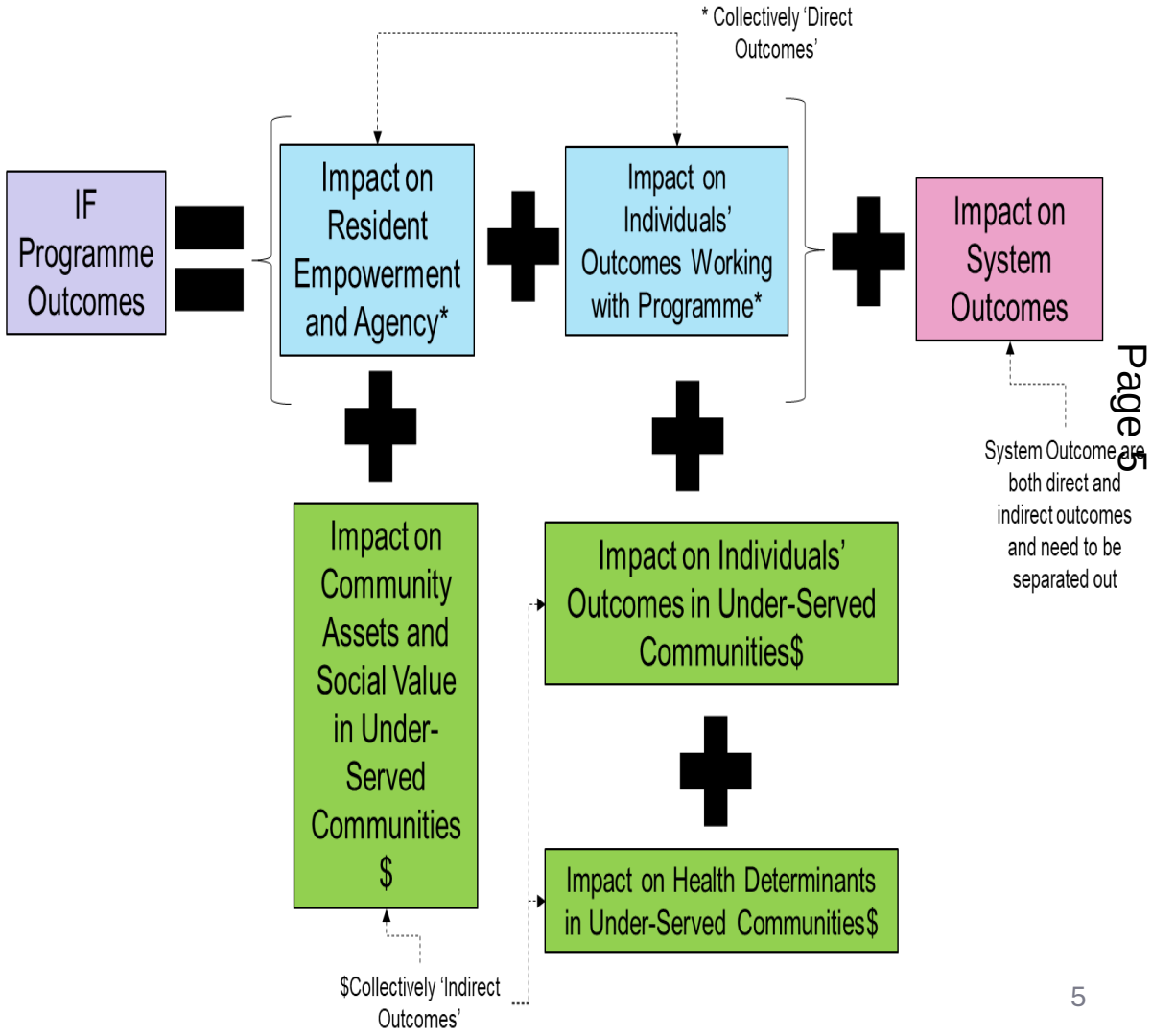
- In Q3 2023/24, **each project was asked to submit a stock-take**:
  - Service delivery and financial utilisation
  - Quantitative and qualitative outcomes for participants
  - Potential impact on mitigating NHS activity for participants
  - Social capital: how the service had developed trust and links 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

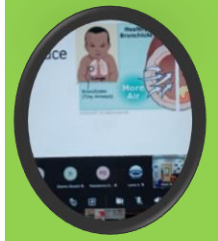
## Who's Uses the Service, its Community Reach & Its Costs

| 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** | | | |

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North Central London
Health and Care
Integrated Care System

NHS

# NCL JHOSC Workforce Update

3 February 2025

Sarah Morgan, Chief People Officer
Shahana Ramsden, Director of System Workforce

# Introduction

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This is our third update to the NCL JHOSC, with our last update being 29 January 2024. This paper will particularly focus on the care leavers programme and the WorkWell programme, including the development of the Work and Health Strategy.

To update the Committee on the progress against the People Strategy, we have included a link to a video that summarises key achievements, as well as the Annual Report that went to the NCL ICB Board meeting in May 2024. The next report is due to be published in May 2025 and is currently under development.

It continued to be a challenging year which started with the continued industrial action, which was not settled from a resident doctor perspective until September 2024, under the new Government. The GP collective action does continue, and we monitor the impact of this on a regular basis. The year ended with a high number of cases of flu, COVID-19 and RSV being seen in Emergency Departments and a huge pressure being felt both in the acute sector and the ambulance sector.

# Introduction

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Again, as with last year, despite the challenging backdrop for colleagues across the health and care sector, we have managed to continue to make progress in the areas of our People Strategy, including being successful in our bid to become one of the 15 WorkWell Vanguards in England.  This will enable us to support 3,000 residents with disabilities, long term conditions and mental health problems back into work.

We are working with local authority and charity colleagues across the sector and successfully launched on 1 October 2024. WorkWell is a joint initiative between DHSC and DWP and we hosted SofS Liz Kendall and SofS Wes Streeting on 6 November 2024, at Junction Medical Practice in Islington, joined by participants on the programme and their work and health coaches. This pack contains our latest performance report, which demonstrates we are 90% on track and one of the best performing Vanguards currently.

We are also co-creating a Work and Health Strategy across NCL which focuses on how we support more people into work and crucially how we work with employers to support them to thrive in work. We are partnering with the Institute of Employment Studies and this is due to be published in our May 2025 ICB Board meeting.

# Introduction

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We continue our Care Leavers programme. Last time we described the programme, and since then we have engaged with over 40 care leavers and offered employment to 10. The NCL Health and Social Care Hub is continuing the programme for us as they have recently had a pause to  undertake some learning.

We have been funded by NHSE to support an additional 25 care leavers between now and March 2025. We are also offering free prescriptions to care leavers across most of and we recently had a focus on what else we could do in partnership to support people better.

Many of our Trusts have been focussing on moving away from agency and recruiting to substantive posts to reduce spend and increase quality. However as our People Strategy sets out, we now need a focus on improving our productivity through transforming how we deliver care and supporting the three shifts set out by the government towards care in the community, with greater deployment of digital and technology, and from treatment to prevention.

It has been a challenging year, but we continue to make progress in our ambitions set out in the People Strategy. It remains directionally correct and we will continue to ensure it aligns with any new policy directions that emerge throughout 2025.

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# Progress against Year 1 of Our People Strategy

# Year 1 progress against our People Strategy

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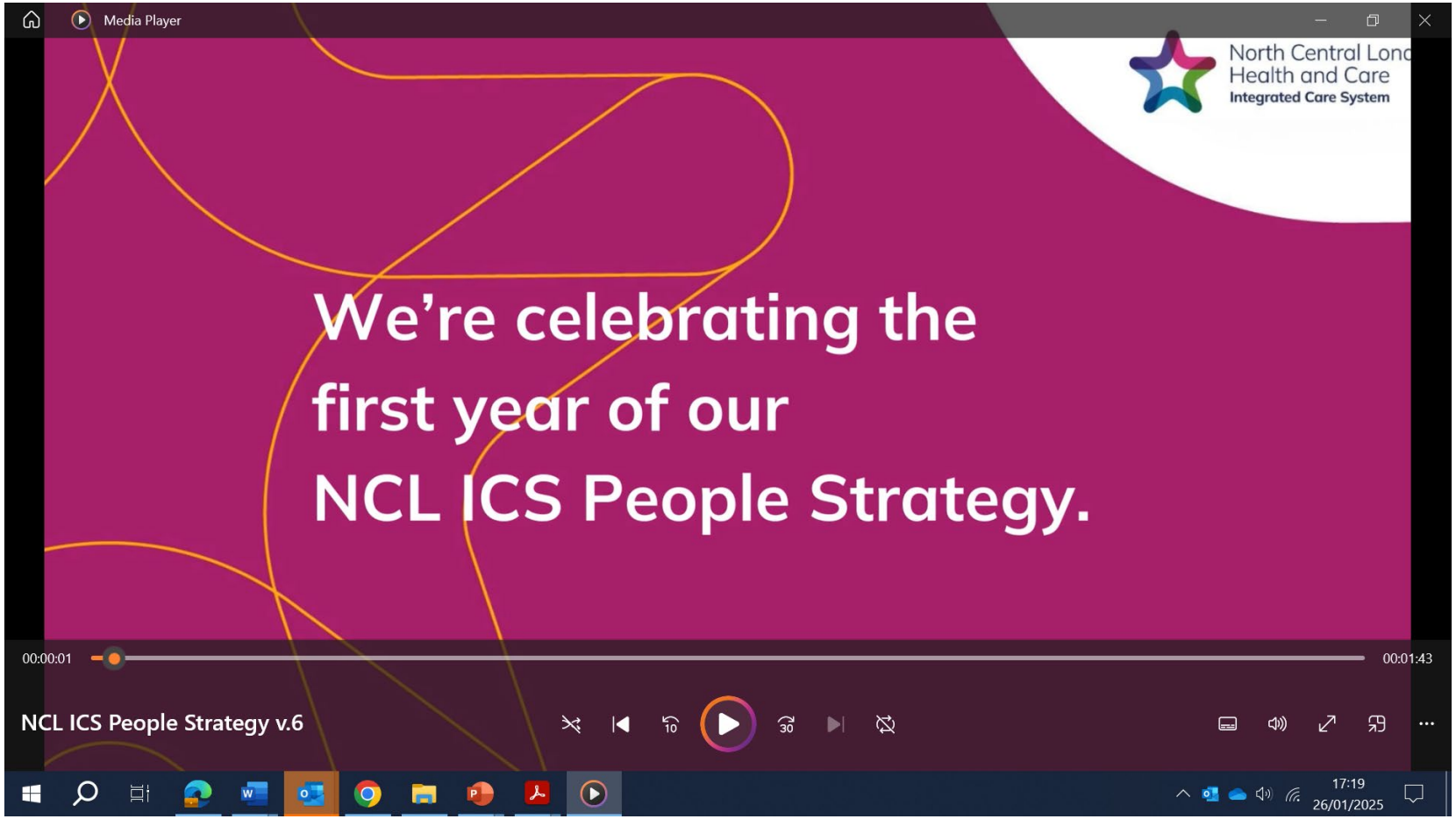


Click to watch our 2 minute video

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# People Priorities and associated Key Performance Indicators

# Our approach to KPIs

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Purpose of year 2 / 3 priorities is to generate a focus and sense of direction for system-wide workforce interventions. Alongside these, the KPIs are designed to ensure we can measure the impact and progress of our collective interventions.

Existing NCL People Board Workforce data pack contains more than 84 data items, charts and graphs – the majority of which focus on NHS Trust workforce data. (1 slide on social care data with 4 data items)

When developing KPIs, key principles were:

- Measure impact across all ICS partners: NHS, Primary Care, Community, Social Care, VCSE
- Start by using data that is already available, can be easily collated and allows benchmarking across organisations and systems
- For some priority areas (e.g. Digital) explore approaches to measuring progress where impact is harder to measure.

The Workforce Team have identified a bespoke number of indicators – that will drive improvements across the whole system. (80/20 Pareto Principle). Operational teams will continue to collate more comprehensive data – although  the KPI Dashboard will focus on 12 core indicators.

These will be approved at the February 2025 People Board

**"What gets measured gets done."** *(Peter Drucker)*


**When you measure something, the probability of acting on the information you gather increases…..**

# NCL People KPIs

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| | |
|---|---|
| **Recruitment, Retention and Turnover** | |
| **1** | We have systems in place to support better recruitment of hard to fill roles |
| **2** | Increased wellbeing at work is demonstrated through reduced sickness absence |
| **3** | We create supportive working environments that lead to improved retention |
| **Population metrics – live well** | |
| **4** | We see increased engagement of NEET 16/17-year-olds |
| **5** | More jobs for local people are created |
| **6** | We generate increased employment opportunities for local people with disabilities and LTCs |
| **Our People Promise** | |
| **7** | We see an increase in people who confirm that NCL system employers are compassionate and inclusive |
| **8** | Development and career progression opportunities are available to people who work in the NCL system |
| **9** | An increased number of people are able to work flexibly |
| **Workforce transformation and planning** | |
| **10** | We align workforce growth and productivity gains, and right size and right skill our workforce |
| **11** | We accelerate digital interventions to maximise the benefits of technological innovation |
| **12** | We work at place and neighbourhood level to maximise workforce integration opportunities |

# NCL Key Performance Indicators – EXAMPLE DASHBOAD November 24 (1/3)

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| | | | | | |
|---|---|---|---|---|---|
| **Recruitment, Retention and Turnover (23/24)** | | | | | |
| | | | **Social Care** | **NHS Trusts** | |
| **1** | **We have systems in place to support better recruitment of hard to fill roles** | Vacancy rates | **9.8%** | **8.4%** | *Expectation: 24/25 data to show reduction of vacancies, sickness and turnover.* |
| **2** | **Increased wellbeing at work demonstrated through reduced sickness absence** | Sickness data | **4.3** (average sick days) | **4.4% average** | |
| **3** | **We create supportive working environments that lead to improved retention** | Turnover | **14.3%** | **12%** | |
| **Population metrics – live well NCL (22/23 data)** | | | | | |
| **4** | **Increased engagement of NEET* 16/17-year-olds** | Percentage of 16/17 yr olds not in employment, education or training | | **3.9%** | *Expectation: 23/24 data to show reduction of NEET and increase of people of working age in employment.* |
| **5** | **More jobs for local people** | Percentage of working age population in employment 16 to 64yrs | | **75%** | |
| **6** | **Increased employment opportunities for local people with disabilities and LTCs** | Percentage of population with a long-term condition in employment (16 to 64yrs) | | **65.1%** | |

*NEET : Not in employment, education or training.*

# NCL Key Performance Indicators – EXAMPLE DASHBOAD November 2024 (2/3)

North Central London Health and Care Integrated Care System

| | Our People promise | | | |
|---|---|---|---|---|
| 7 | **We see an increase in people who confirm that NCL system employers are compassionate and inclusive** | Percentage of staff in senior roles compared with the percentage of staff in the overall workforce. Within WRES and WDES indicators | WRES Indicator 1<br>WDES Metric 1 | *Expectation: aggregated data for trusts in the system demonstrates workforce inequalities for BAME, Disabled staff are reduced.* |
| | | Relative likelihood of staff being appointed from shortlisting across all posts. Within WRES and WDES indicators. | WRES Indicator 7<br>WDES Metric 2 | |
| | | Percentage of staff experiencing harassment, bullying or abuse. Within WRES and WDES indicators | WRES Indicator 6<br>WDES Metric 4 | |
| | | NHS Staff survey compassionate leadership people promise element | NHS staff survey sub-score (workforce data pack) | |
| 8 | **Development and career progression opportunities are available to people who work in the NCL system** | Percentage of staff who agree that their organisation acts fairly with regard to career progression/ promotion regardless of ethnic background, gender, religion, sexual orientation or age. | NHS staff survey Question 15 | *Expectation: System-wide data demonstrated increased participation rates. .* |
| | | Apprenticeship Participation Rate: Assesses the number of NHS staff enrolled in apprenticeship programs, from entry-level to advanced roles. | TBC (data sharing agreement in progress with NHSE) | |
| | | Increasing NCL staff representation across commissioned progammes in 25/26 academic year onwards. | METIP delivery figures | |
| 9 | **An increased number of people are able to work flexibly** | Percentage of staff who confirm they are satisfied with opportunities for Flexible Working Patterns | NHS staff Survey question 4 | *Expectation: Increase in flexible working opportunities* |
| | | Percentage of staff who can approach their manager to talk about flexible working | NHS Staff Survey Question 6 | |

# NCL Key Performance Indicators – EXAMPLE DASHBOAD November 2024 (3/3)

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| Workforce planning and transformation | | | | |
|---|---|---|---|---|
| 10 | **We align workforce growth and productivity gains, and right size and right skill our workforce** | Variance against plan (red confirms we are above plan) | **1.4%** | *Expectation:*<br>*Monthly tracking to confirm that variance is below plan.* |
| | | Use of bank Variance against plan (red confirms we above plan) | **6.5%** | |
| | | Use of agency (green confirms below plan) | **1.6%** | |
| 11 | **We accelerate digital interventions to maximise the benefits of technological innovation** | Currently no national metrics.<br>Within NCL we will track the number of digital innovations and identify impact on workforce growth/ productivity. | TBC | |
| 12 | **We work at place and neighbourhood level to maximise workforce integration opportunities** | Currently no national metrics.<br>Within NCL we will track the extent to which integrated approaches impact on vacancies, turnover and sickness and people promise data. | TBC | |

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# Vacancies and managing the system workforce

# Summary

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- Despite the challenging picture overall, there has been solid progress. The vacancy rates as a % are at their lowest levels, across all staff groups in the past three years
- There were encouraging falls in vacancies in the groups of Nursing, Midwifery and Health Visiting and Scientific, Therapeutic and Technical staff
- The final graph shows our continued growth of the workforce (establishment) overall, with the biggest staff group (Nursing, Midwifery and Health Visiting) now at 15,000 WTE

# Vacancy rates %

North Central London Health and Care
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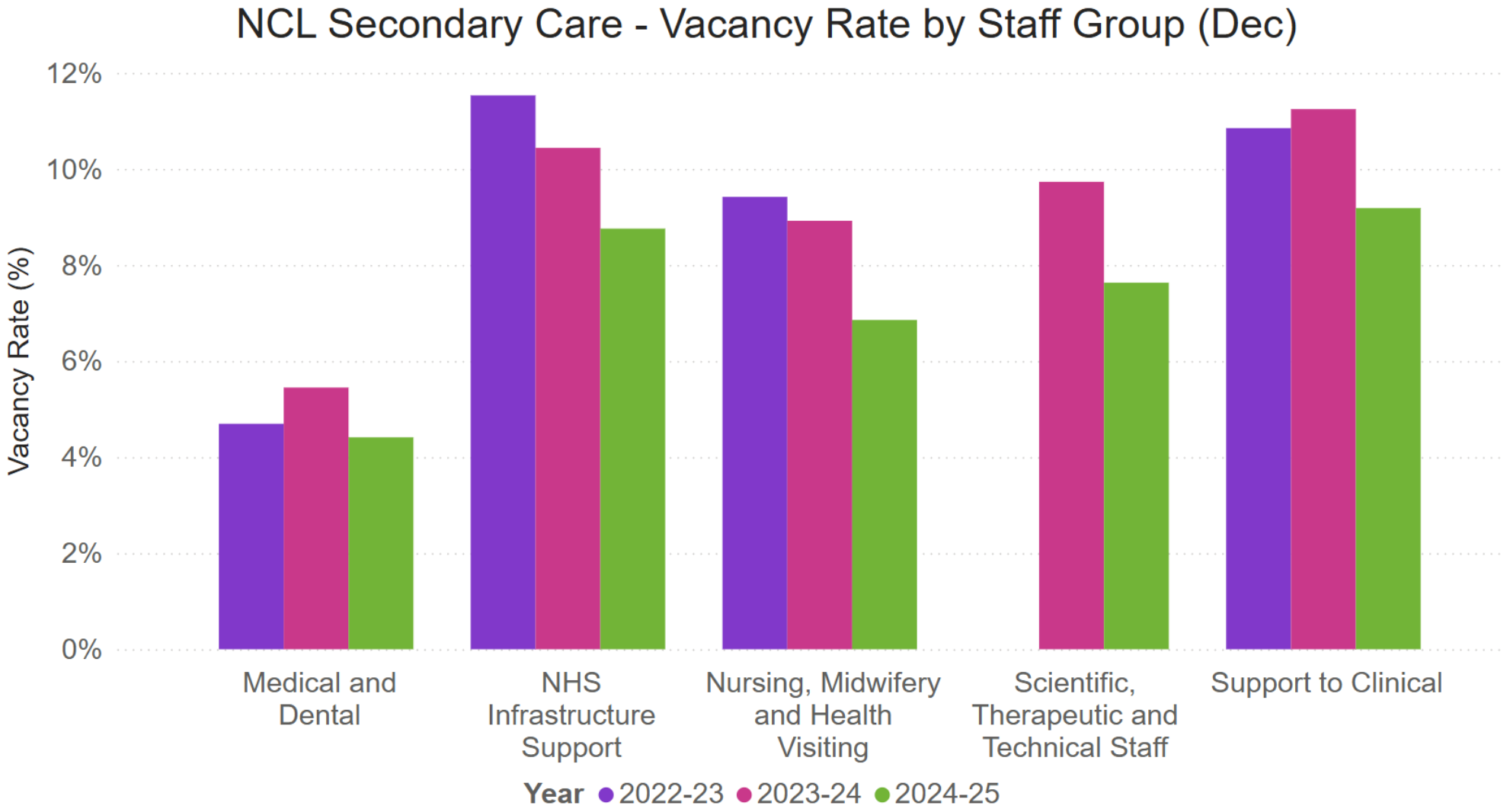
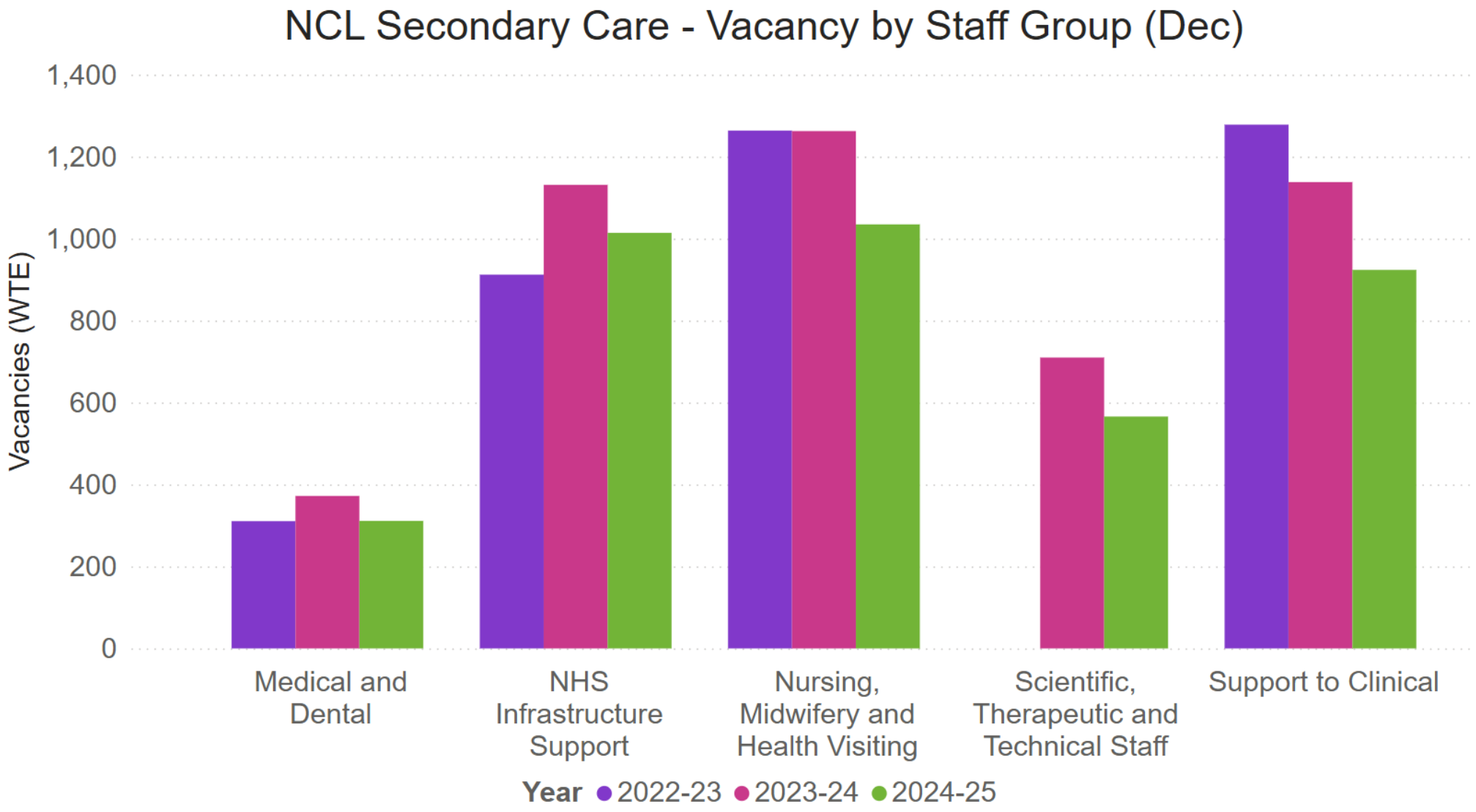


# Vacancies as WTE

North Central London Health and Care
Integrated Care System



# Overall workforce by group

North Central London Health and Care
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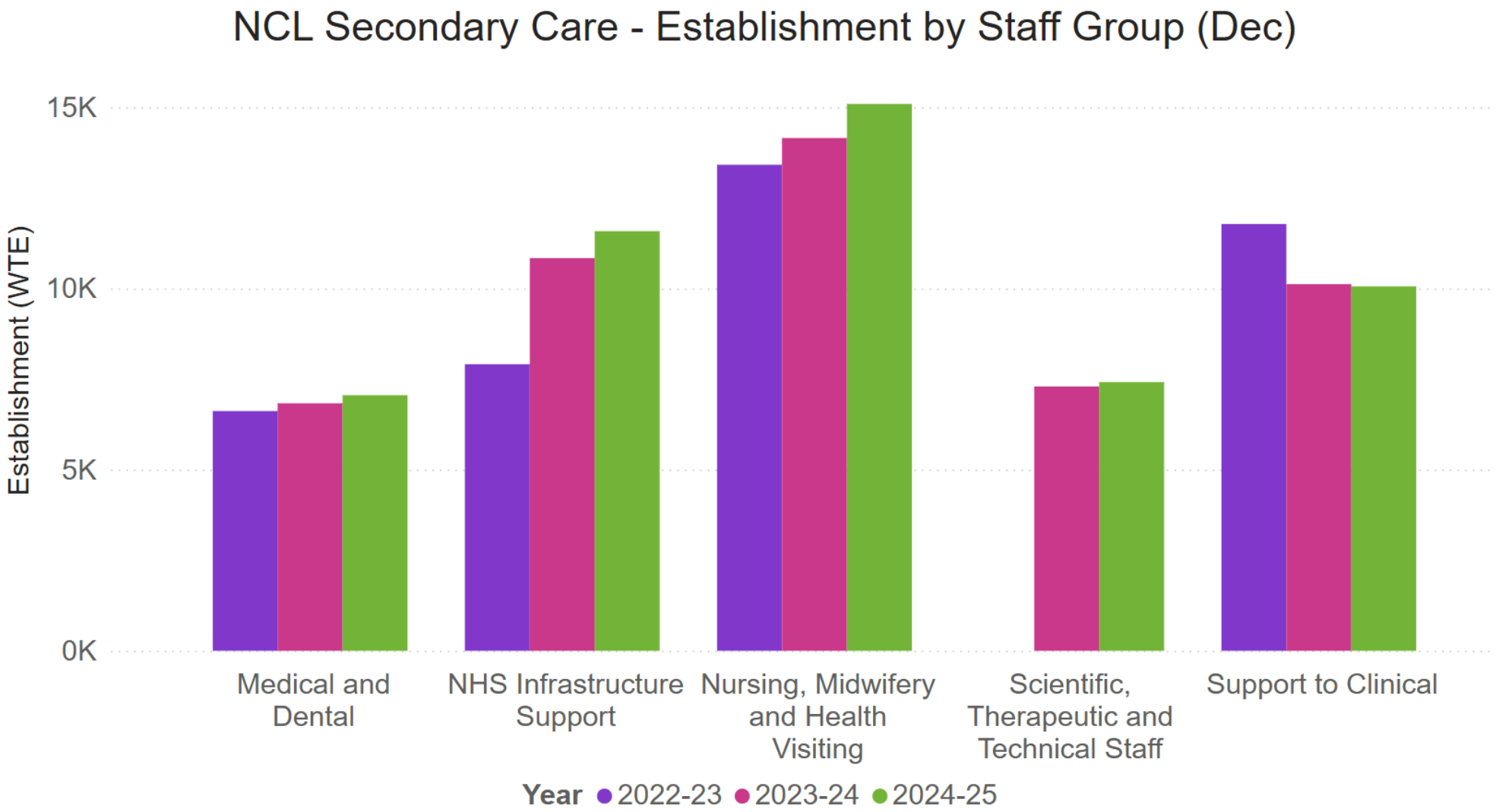

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# Overall strategic approach to Work and Health and the WorkWell Programme

# Why focus on work and health?

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- Good work has a positive effect on physical and mental health, while unemployment and long-term sickness often have a harmful impact
- Long-term sickness has become the most common reason for economic inactivity, in the region of **2.6 million people**
- The biggest factor in the rise of economic inactivity since the start of the pandemic – now around **490,000 higher**
- Reversing this trend cannot be achieved by services acting in siloes - it requires an **integrated whole-systems approach** at a local level
- The challenges in the **Get Britain Working** white paper for the wider economy are profound and need a cross-government approach to solving them
- Health, **working together with local government and local employers**, plays a pivotal part in supporting people being able to work and have a better quality of life and more opportunities.

# Developing a Work and Health Strategy

North Central London Health and Care
Integrated Care System

1. Foster a **proactive** approach to greater integration between health and care, employment and wider community place-based services
2. Ensure **engagement** of the Jobcentre network, NHS, local authorities, employers, VCS services, and residents
3. Understand the **demographics of cohorts** to ensure groups are not disadvantaged
4. Explore **other place-based initiatives** in the area
5. Ensure **continuous improvement** of integrated services
6. Develop an **Action Plan** to implement the strategy

# What NCL wants from the joint strategy

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**How will the Strategy contribute to ICS core purposes and wider Government aims?**

1. How will the Strategy help health and care services to support broader social and economic development, and on tackling inequalities in outcomes, experience, and access in health and employment services?

**What should be the scope of a Work & Health Strategy?**

2. What are the views of partners on the aims, objectives and scope of a Work & Health strategy?
3. How will the Strategy fit with other local plans and strategies?
4. To what extent should employers (of all sizes) be a focus of the Strategy?

**How can the Strategy improve integration, co-ordination and services?**

5. What actions can improve co-ordination between health services and employment services?
6. What actions can partners deliver that will reduce economic inactivity due to ill health?
7. Should there be consistent messages on employment through all appropriate NHS channels?

**Impact**

8. How should we measure the impact of stronger co-operation and new actions taken by partners?

# Approach and timeline

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1. A series of group and bi-lateral interviews (Nov 24 -Jan 25) with the full range of partners in health and employment services
2. Interviews and/or focus groups with residents and employers
3. Two Partner Workshops (March 2025) to develop and test ideas
4. A review of local existing and planned work, health and skills strategies
5. Some data and desk research to inform priorities for action
6. Submit draft strategy to Board in May 2025

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# The WorkWell programme

# What is the WorkWell programme?

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- Partners in NCL were successful in bidding to become one of 15 **WorkWell Vanguard** programmes in England. DWP and DHSC has funded NCL to:
    1. Provide a **WorkWell Service** – a path to Health and Work Support in North Central London. This is now live – see NCL website
    2. Take forward an **integrated work and health strategy** – a strategic approach to work and health services
    3. Be part of a **national learning programme** - provide a bank of delivery experience and expertise that ensures all areas can benefit
- The **Institute for Employment Studies** have been commissioned to lead the development of the work and health strategy
- In addition, **Connect to Work** will launch in London in 2025 – this is for people with health conditions and complex barriers to work who are further from work.

# WorkWell Launch

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We were pleased to be chosen to support the launch with a visit from two Secretaries of State – Liz Kendall and Wes Streeting.



The Government release is here. This led to a positive piece on BBC London featuring service users and our leaders.

There was further coverage in the Evening Standard alongside figures of increased numbers of benefit claimers, with pick up in THIIS magazine for mobility and access professionals. There was also a great video produced by the DWP on Instagram.


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Designed to support people with a disability or health condition to:

- ✓Start work if unemployed
- ✓Stay at work if they have been/ or are at risk of being on sick leave
- ✓Thrive at work

Participants receive 1 to 1 support from a work and health coach.

# Co-designed key principles

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As a local partnership we are collectively signed up to and have a commitment to work to a common set of principles:

- ✓ The service will be place-based
- ✓ We will use a relational model to engage economically inactive residents.
- ✓ The service should scale up and build on what already exists.
- ✓ We will link to the NCL Population Health Outcomes Framework.
- ✓ We will utilise data to inform our model, including Fit Note data within Primary Care.
- ✓ We will seek to address Health Inequalities through the work, focussing on supporting those most disadvantaged
- ✓ The service will be person centred supporting people to address health, employment and wider needs in a co-ordinated way.
- ✓ The service will seek to share information between agencies by default.

Our WorkWell model has been designed in line with these principles and in full collaboration with our partners.

The WorkWell programme aligns with the NCL Population Health Strategy which sees access to meaningful employment as a population health intervention. A key population health outcome within the strategy is to increase the number of people with Long Term Conditions, Mental Health Learning disabilities and Health Conditions back into work.

# How does it work?

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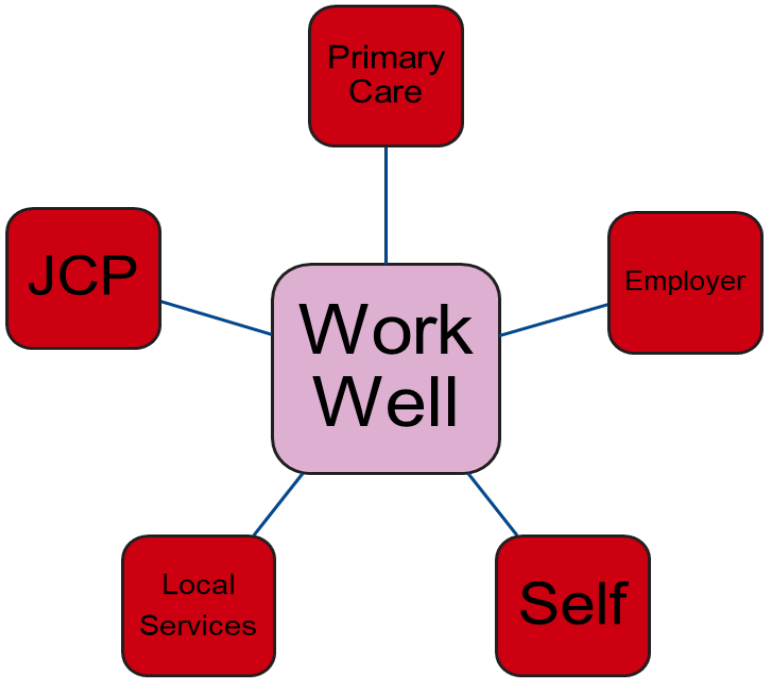
- Participants can either self-refer to the programme or be referred by their employer or a health professional.
- The Shaw Trust have a ‘no wrong door’ policy so if people are referred to WorkWell but would be better supported through an alternative programme, they will be signposted to the appropriate support offer.
- We have proactively engaged Job Centre Plus Partners in enabling referrals to WorkWell.



# Wider support

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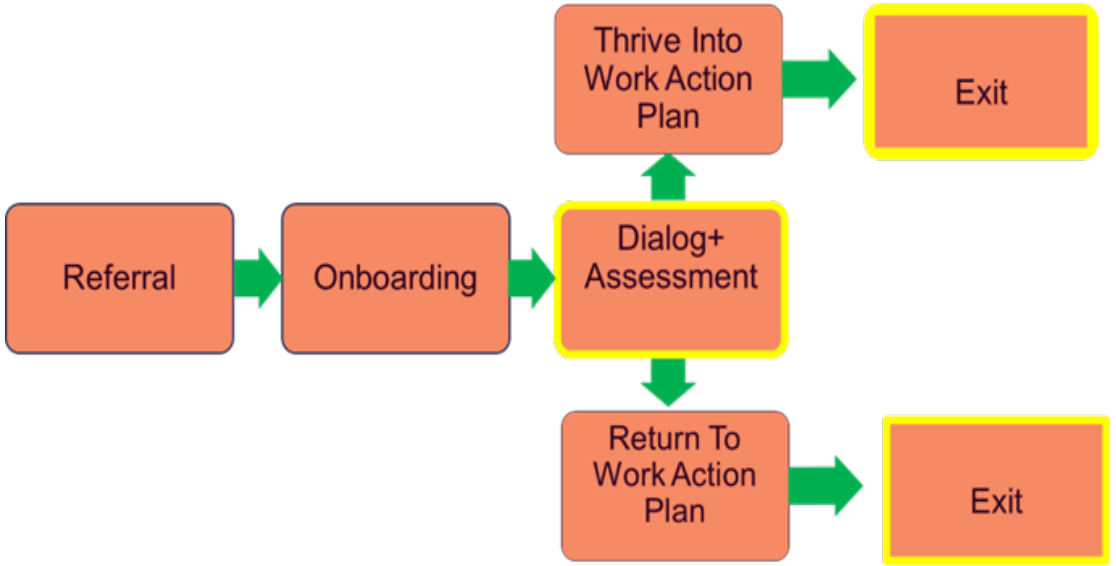
In addition to a team of 15 Work and Health Coaches, a Multi-disciplinary team is in place. The team employs an Occupational Health Practitioner, Mental Health Practitioner and Employment Retention Practitioner. This ensures that WorkWell coaches have an expert resource who they can turn to for advice.

Regular meetings between Coaches and specialist MDT members ensures that cases are regularly discussed so that the coaches are equipped with expert advice where it is needed. For very complex cases, members of the MDT may provide direct advice to a small number of participants.



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# WorkWell programme progress December 2024

# How are we doing?

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| Contract to Date | Target | Actual | Percentage |
|---|---|---|---|
| Referrals | 570 | 385 | 68% |
| Programme Starts | 400 | 359 | 90% |
| Conversion Rate | 70% | 93% | - |
| Programme Exits | N/A | 27 | 8% |

| In – Month (Dec-24) | Target | Actual | Percentage |
|---|---|---|---|
| Referrals | 190 | 189 | 99% |
| Programme Starts | 150 | 185 | 123% |
| Conversion Rate | 70% | 98% | - |
| Programme Exits | N/A | 14 | 7% |

# Who are we helping?

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| Population | | |
|---|---|---|
| **Borough** | **Value** | **%** |
| Barnet | 388,600 | **28%** |
| Camden | 210,400 | **15%** |
| Enfield | 329,600 | **23%** |
| Haringey | 264,100 | **19%** |
| Islington | 216,800 | **15%** |
| **Total** | **1,409,500** | |

| Referrals | | |
|---|---|---|
| **Borough** | **Value** | **%** |
| Barnet | 70 | **18%** |
| Camden | 47 | **12%** |
| Enfield | 75 | **19%** |
| Haringey | 140 | **37%** |
| Islington | 53 | **14%** |
| **Total** | **385** | |

| Starts | | |
|---|---|---|
| **Borough** | **Value** | **%** |
| Barnet | 66 | **18%** |
| Camden | 41 | **11%** |
| Enfield | 69 | **19%** |
| Haringey | 136 | **39%** |
| Islington | 47 | **13%** |
| **Total** | **359** | |

| Conversion | |
|---|---|
| **Borough** | **Percentage** |
| Barnet | **94%** |
| Camden | **87%** |
| Enfield | **92%** |
| Haringey | **96%** |
| Islington | **89%** |

# What are their demographics?

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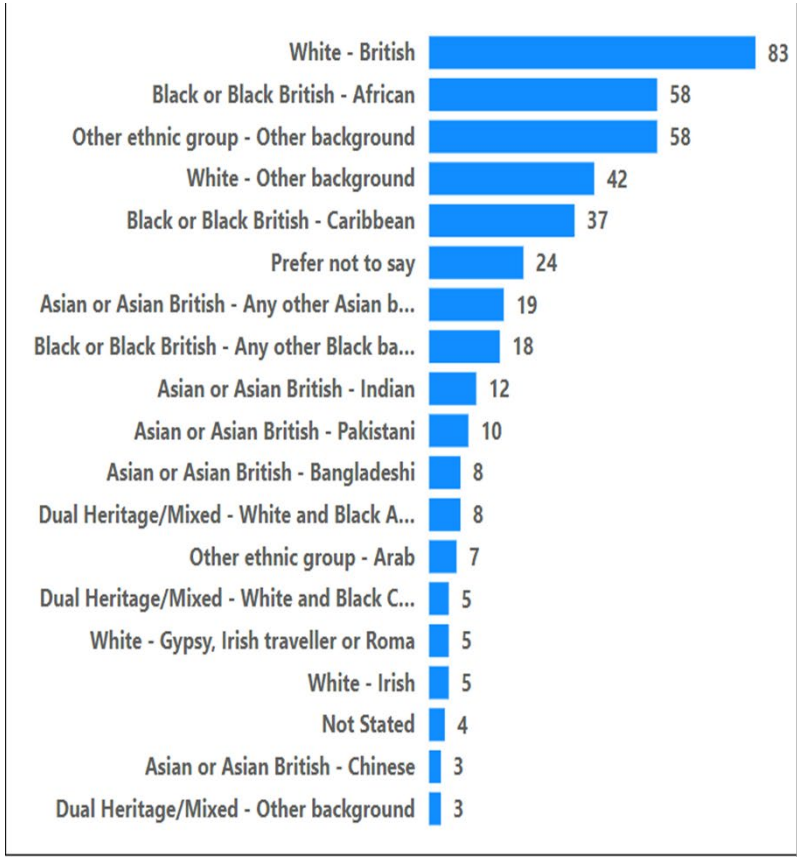



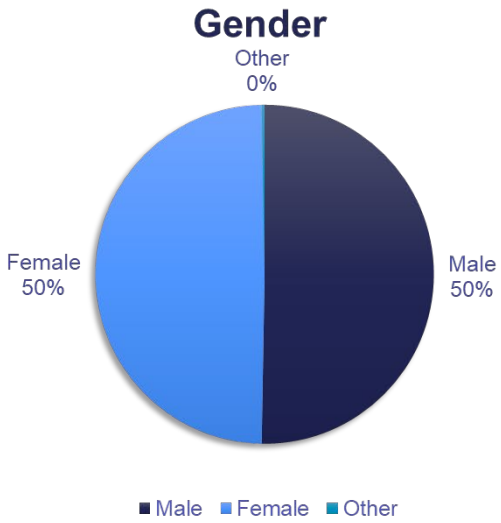


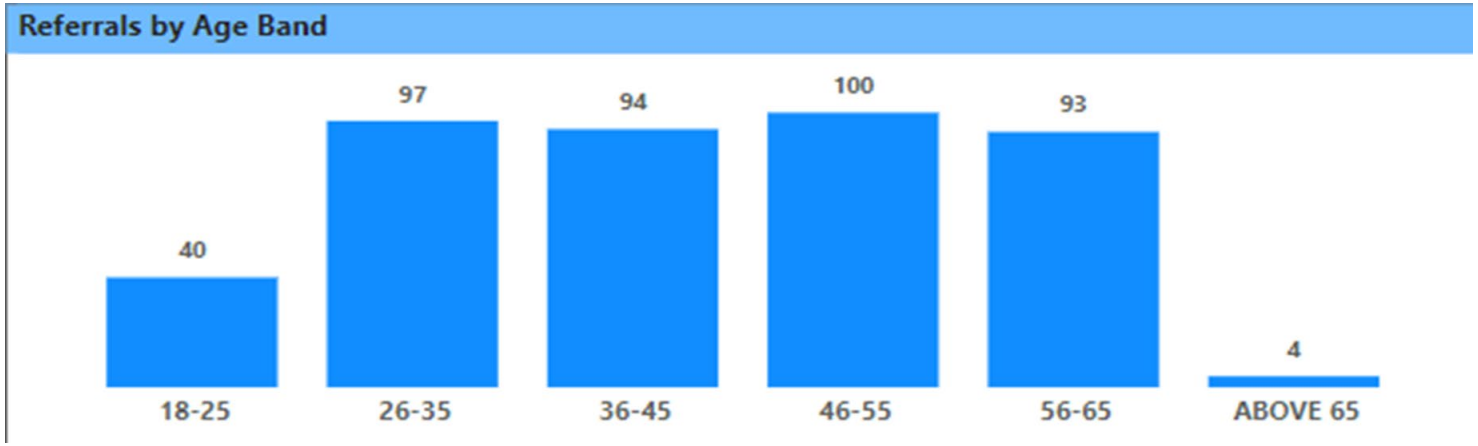

# How do we find them?

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| Referral Source | | | | |
|---|---|---|---|---|
| **Route** | **Number – In Month** | **%** | **Number- CTD** | **%** |
| GP Including Social Prescriber | 18 | **10%** | 39 | **10%** |
| Local Authority | - | - | - | - |
| Voluntary / Community | - | - | - | - |
| Local Health Services | - | - | - | - |
| Employer | - | - | - | - |
| Job Centre Plus | 32 | **17%** | 107 | **28%** |
| Self-Referral | 100 | **53%** | 152 | **40%** |
| Other *(IPS PC, Family, Job Fair, Social Media)* | 39 | **21%** | 87 | **22%** |

| Outcome of Referral | |
|---|---|
| **Outcome of Referral** | **Number of Participants** |
| Issued Thrive in Work Plan | **45** |
| Issued Return to Work Plan | **314** |
| Did Not Start | **26** |
| Ineligible | **0** |
| Other | **0** |
| **Total** | **385** |

# What challenges do they face?

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| Non-Health Related Barriers | |
|---|---|
| **Barrier** | **Value** |
| Transport | 2 |
| Childcare | 2 |
| Skills | 15 |
| Caring Responsibilities | 3 |
| Confidence, Motivation | 24 |
| Fatigue | 0 |
| Language | 0 |
| Suitable Jobs | 57 |
| Other | 4 |
| Not Applicable | 70 |
| **Total** | **177** |

| Health Conditions | | | |
|---|---|---|---|
| **Health Condition** | **Value** | **Health Condition** | **Value** |
| Problems with arms or hands | 10 | Autism | 13 |
| Problems with legs or feet | 14 | Severe / specific Learning Difficulties | 13 |
| Problems with back or neck | 3 | Mental illness, or suffers from phobias, panics or other nervous disorders | 24 |
| Difficulty hearing | 2 | Progressive illness not included elsewhere | 4 |
| Speech Impediment | - | Other | 40 |
| Severe Disfigurement, Skin Condition or Allergies | - | Heart, Blood Pressure, Blood Circulation | 6 |
| Chest / Breathing problems | 8 | Stomach, Liver, Kidney, Digestive problems | 6 |
| Diabetes | 13 | Epilepsy | 3 |
| Depression, Bad Nerves or Anxiety | 156 | ***(Conditions based on MI template options)*** | |

# What difference are we making?

Christine* is a single parent who has just come out of an abusive relationship. She has been receiving mental health/ wellbeing support from her work and health coach, supporting her to re integrate into her community as she has been isolating herself.

Supported to gain specialised mental support (therapy from her GP). Supported to sharpen soft skills such as, time management, confidence and CV writing.

She has been referred to further support to upskill herself through various courses related to her industry of interest. So far, her work and health coach is seeing a significant improvement in her mental health and mood. She is developing a more open and optimistic mindset.

# What difference are we making?

Fiona* was feeling very anxious and couldn't leave the house alone. She lost all her confidence when she got ill, suffering from Lymphoma in 2021 and since then has struggled with health anxiety

She joined WorkWell as she felt that finding a job would force her to leave the house and get into a routine.  She said she doesn't like to talk about her illnesses, and it causes her a lot of anxiety. She advised she would rather not disclose to an employer. We completed a health disclosure form together to break down the pros and cons of disclosing.

Fiona is participating in support groups for her anxiety.  She has made significant improvements building on her soft skills and social interactions recently managing to use public transport independently. She was really pleased with this and thanked WorkWell for all the support and is continuing the programme.

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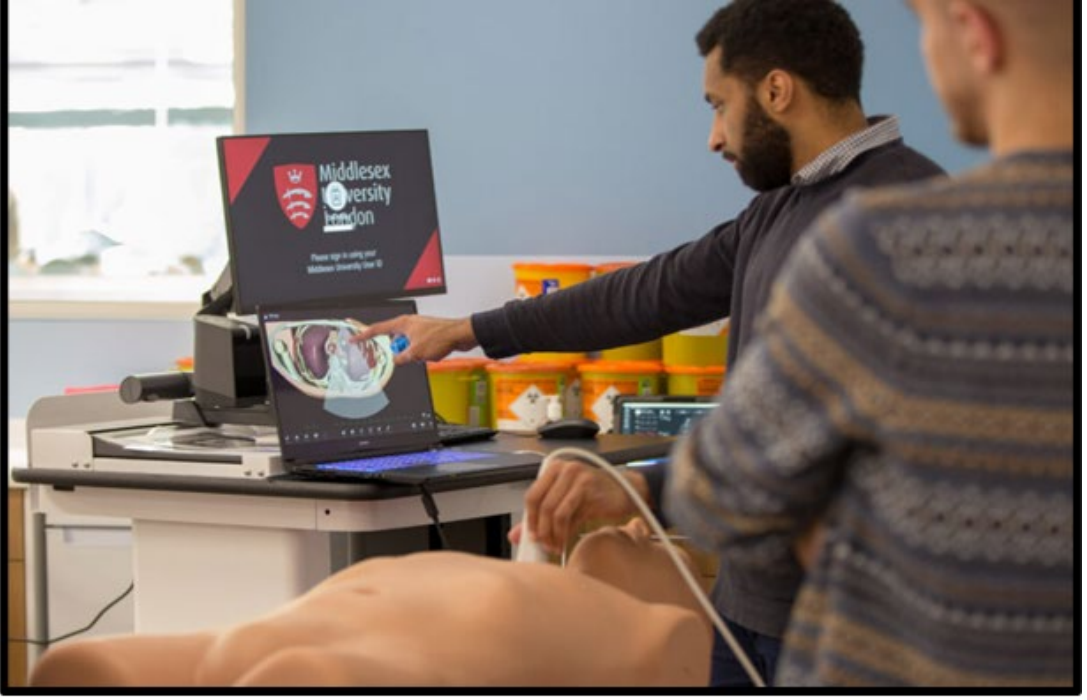
# Next phase in the care leavers programme

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# Our care leavers programme

- Launched as one of the 10 pilots for the NHS Care Covenant (NHS Universal Family) programme
- Aim to support up to 25 care leavers in year 1
- Engaged with over 40 care leavers with 10 being offered employment opportunities (25% success rate)
- Moved to being part of the Health and Social Care Academy
- Paused to learn from the year 1 experience
- Relaunching the mission in 2025 and aim to support 25 young care leavers between January and March 2025 in a new approach funded by NHS England
- Re-stated our mission to embed this as a partnership approach to supporting young care leavers into work on a more systematic basis

# Our original approach

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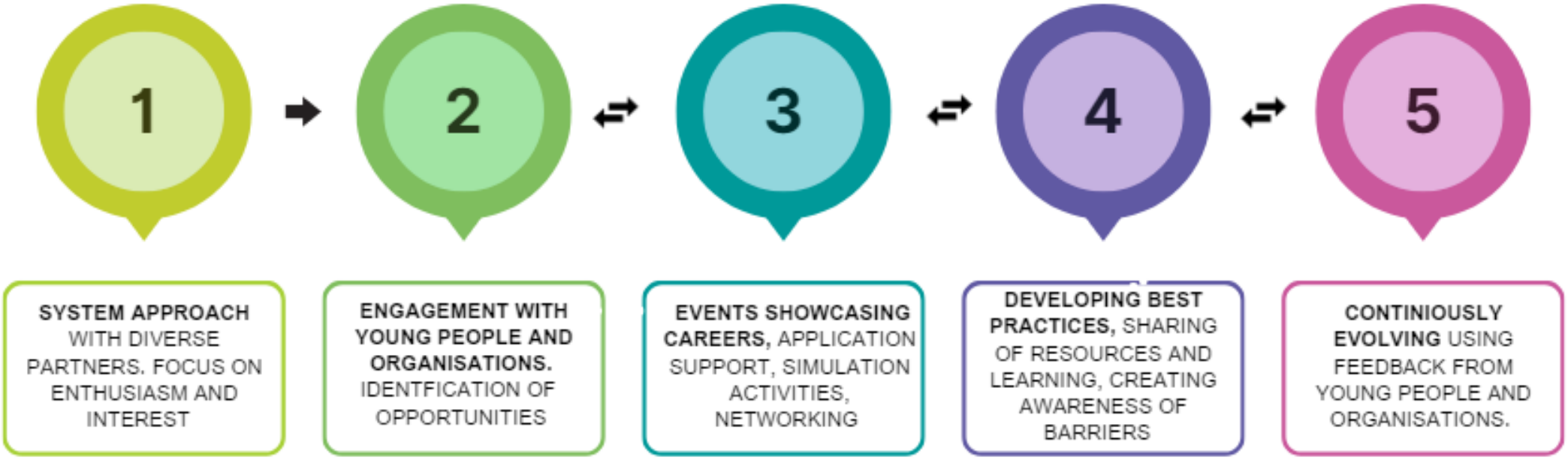




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Better Mental Health. Better Lives. Better Communities.
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ISLINGTON For a more equal future
DRIVE FORWARD MOMENTUM MADE BY YOU
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North Central London Health and Social Care ACADEMY
Middlesex University London

# Our renewed mission

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A focus on providing each Care Leaver the support they need to remove barriers to work – addressing complex needs

Ensuring Care Leavers are job ready and have the skills and tools to sustain work and thrive

Appropriately matching Care Leavers to job roles sourced by employers committed to the CL programme

To continue to deliver events specifically for care experienced young people

Develop a collaborative, NCL system approach; utilise existing assets, tackle barriers in recruitment processes

Engage with care experienced young people; recognise how they add value in our organisations

Showcase the diverse range of opportunities in health and social care

Develop a community of best practice, connect with other pathfinders, utilise feedback, develop case studies



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# Summary and next steps

# Summary and next steps

North Central London Health and Care
Integrated Care System

As this pack, the annual report and the people priorities set out, there is a significant amount of work being undertaken across the system to ensure we continue to have a sustainable health and care workforce as well as offer opportunities to the residents of the five boroughs across NCL.

There will be a lot more requirement for health to support the work and health agenda over the next few years and we are keen to particularly work with employers to ensure our residents with long term conditions, disabilities and mental health challenges are able to access and stay in good work.

Currently the ONS data (March 2024) shows NCL in the bottom quartile for supporting people with only 6.6% of residents with multiple long term conditions in work. This continues to align with our WorkWell programme and our Care Leavers programme.

The elective recovery plan and the need to improve the flow through our hospitals for our patients who require urgent treatment will be a priority for the remainder of the winter and beyond.

# Summary and next steps

North Central London Health and Care
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We are currently working with our community voices groups to continue to support the Change NHS programme and we look forward to the 10 year plan being published in the Spring/ early Summer of this year.  There is a people workstream and we will ensure our priorities align with its requirements.

We will be supporting the development of Integrated Neighbourhood Teams and looking at how we support the transformation of ways of working; including the development of more digital interventions.

Our main challenge will be ensuring that we are delivering efficient and effective services and that our health and care workforce have the right skills and capabilities at all levels to continue to deliver the high quality health and care that our residents and our patients deserve.