North Central London Integrated Care System

North Central London Population Health and Integrated Care Strategy

DRAFT **16th March 2023**

Version **11**

Foreword

North Central London Integrated Care System

This document sets out our approach to improving the health of our population in North Central London. As an integrated care partnership, we are in a unique position to work together to tackle some of our biggest population health challenges – ones that no individual organisation or sector could achieve on its own.

The strategy describes our vision for a more prevention-oriented, proactive, integrated, holistic and person-centred approach to care, as well as our new ways of working to achieve that. We focus on where we can make the biggest improvements in population health by taking a partnership approach. We put more emphasis on earlier interventions where we can transform outcomes by addressing the wider determinants of health, such as housing, air quality and education whilst recognising and working to minimise the impact of the climate emergency on the health of our population. At the heart of this strategy is a belief in the strengths and motivation of our residents, many of whom also work in NCL, often within our health and care sector. We want to celebrate and build on the capabilities of our residents.

This document brings together a number of separate asks into a single document. It covers how we will integrate care (Integrated Care Partnership's Integrated Care Strategy) and our approach to population health improvement (Integrated Care Board's (ICB) Population Health Strategy), creating the context for the NHS ICB 5 year joint forward plan. This document guides what we aim to achieve as a system, with our sectoral and organisational plans then enabling the benefits of an integrated population health improvement system to be realised.

Although this document forms a milestone in our population health journey, we will continue to develop our partnership working as well as our engagement with our communities.

This document will bring to life how we will work together, as an integrated care system to achieve our collective ambition for our population

North Central London Integrated Care System

Our Ambition

As an integrated care partnership of health, care and voluntary sector services, our ambition is to **work with residents of all ages of North Central London so they can have the best start in life, live more years in good health in a sustainable environment, to age within a connected and supportive community and to have a dignified death.**

We want to achieve this ambition for everyone.

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Creating this document has been a collective effort across our partnership in the spirit of system-ownership

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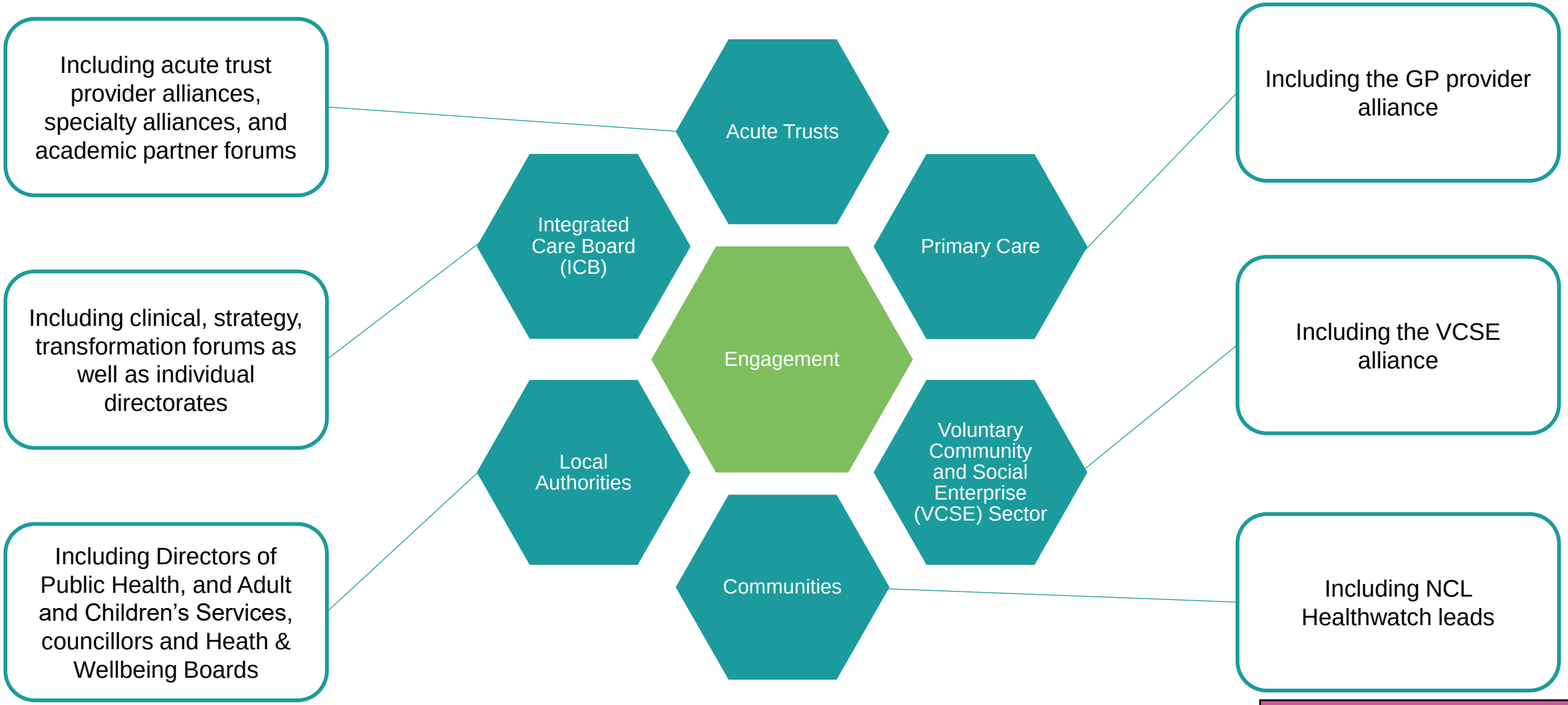

Link to engagement appendix

Our understanding of our population builds on the existing Joint Health and Wellbeing Strategies

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- Each borough in NCL has a statutory Health and Wellbeing Board (HWBB). This is a partnership across the Council, the NHS, local voluntary and community sector organisations and Healthwatch. Each HWBB has a statutory duty to produce a Joint Health and Wellbeing Strategies (JHWS). This sets out how the local system will work together in partnership to improve the health and wellbeing of the local community and reduce health inequalities. The JHWS do not stand alone but are underpinned by a range of other Council, NHS and partner strategies which together give a sense of borough-level health and wellbeing priorities and areas of focus.
- Each of our borough JHWS is on a different cycle, with delivery for many interrupted with COVID. The JHWS for three of our boroughs being refreshed during 2023.

	Priorities and focus areas in current JHWS	
Still current	Barnet (2021-25)*	1) Creating a healthier place and resilient communities 2) Starting, living and ageing well 3) Ensuring delivery of coordinated holistic care, when we need it
	Camden (2022-30)*	Long-term ambitions: 1) Start well - All children and young people have the fair chance to succeed, and no one gets left behind 2) Live well - People live in connected, prosperous and sustainable communities 3) Age well - People live healthier and more independent lives, for longer Short-term priorities for action (for first 2 years, refreshed in 2-yearly cycles): 1. Healthy and ready for school 2. Good work and employment 3. Community connectedness and friendships
Refreshing during 2023	Enfield (2020-23)*	1) Eat well 2) Be active 3) Be smoke free 4) Be socially connected In order to: • Reduce the chances of people developing non-communicable diseases such as cancer, heart disease, Type 2 Diabetes or lung disease • Improve emotional and mental health and wellbeing and reduce the prevalence of mental health conditions • Reduce inequality in health outcomes
	Haringey (2020-24)*	1) Creating a healthy place 2) Start well 3) Live well 4) Age well 5) Violence prevention
	Islington (2017-20)*	1) Ensuring every child has the best start in life 2) Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities 3) Improving mental health and wellbeing

Common themes

- **Life course approach (start well, live well, age well) -** with a clear focus on children and 'giving every child the best start in life'
- **Emphasis on prevention and early intervention** – both in terms of long-term conditions but also intervening early in the life course with children and young people
- **Tackling inequalities**
- **Working with communities**
- **Role of partner organisations as anchor institutions within communities** – in particular in terms of employment and impact on the environment
- **Integration -** role of service integration but also digital integration e.g. through population health management tools
- **Mental health and wellbeing across the ages**
- **Tackling lifestyle risk factors** – in particular physical activity and healthy eating
- **Action on the wider determinants of health** – including in particular housing, employment, environment, violence and social isolation – either expressed directly as JHWS priorities or linked to other borough strategies
- **Making every contact count**
- **Social prescribing**

* Life cycle of current strategies

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We are committed to working differently to give our residents the best possible outcomes

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Through the key elements of the ICS, we will bring together leaders from across the health, care, voluntary and community sectors to drive the delivery of our ambitions and deliver a more joined up approach. These will allow us to remove blockages and more effectively align our objectives across the system. We are embedding a learning approach in our system to enable local innovation, clarify responsibilities and accountabilities, identify best practice and develop our partnership approaches. Through these, we can accelerate the integration of our services and deliver better outcomes for our residents.

The work of our Integrated Care System (ICS) is being developed and supported by:

- **The Integrated Care Board (ICB) -** new NHS statutory bodies responsible for allocating NHS budget and commissioning services with an emphasis on collaboration. The NCL ICB covers all 5 boroughs and all NHS providers working in the geography
- **The Integrated Care Partnership (ICP) -** a joint committee between the councils across the five boroughs, the NHS and voluntary sector partners. Responsible for the planning to meet wider health, public health and social care needs and is the author of this strategy as well as its implementation.
- **The Community Partnership Forum –** a forum to oversee resident engagement and involvement in NCL.

Borough Partnerships local collaborations between health care and the voluntary sector, bringing in wider sector partners such as housing and education to will be the engine room for the delivery and reform of our services.

Integrated neighbourhood teams - multi-disciplinary working teams driving proactive care at hyperlocal levels, with a focus on health inequalities and the wider determinants of health

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To get involved in population health and integrated care, there are six key terms for everyone in our system to know

North Central London Integrated Care System

Population Health

Improving the physical and mental health and wellbeing of people within and across a defined population, while reducing health inequalities.

Integrated care

Joining up the health and care services required by individuals, to deliver care that meets their needs in a personalised and efficient way.

Wider determinants

The range of factors which impact our health and wellbeing, including social, economic and environmental factors.

Integration

Aligning two or more historically autonomous organisations or sectors with the aim of delivering integrated care.

Equity

An environment in which everyone has a fair opportunity to thrive, regardless of who they are.

Aligning resources to need

Focusing our resources and delivery capabilities in proportion to the degree of need.

Link to full glossary

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Contents

North Central London Integrated Care System

Section	What's included
Context	Our population Local challenges and opportunities
Our principles	Our 10 principles Our 'I' statements Our outcomes framework
Delivering on our ambition	Our future state Our vision for BP development
Our five focus delivery areas	Deprivation Adult key communities CYP key communities Wider determinants of health Key pathways
Leveraging the ICS to achieve better outcomes	Making population health everyone's business Aligning resource to need Strengthening integrated delivery Collaborating to tackle the root causes of poor health Becoming a learning system
Moving forward	Our roadmap to iterate our future state via test and learn How this all fits together

Executive summary

North Central London Integrated Care System

This document outlines our response to local growing health needs and widening inequalities as well as system pressures and national opportunities in the form of a new approach to working together. It begins defining how we work best across system, borough partnership and neighbourhood levels to collectively focus on **prevention, early detection and proactive care**.

'As an integrated care partnership of health, care and voluntary sector services, our ambition is to work with residents of all ages of North Central London so they can have the best start in life, live more years in good health in a sustainable environment, to age within a connected and supportive community and to have a dignified death. We want to achieve this ambition for everyone.' – Our ambition in NCL

This document sets out a clear call to action to our providers to reflect on how their organisations will look and feel when they align to the principles and areas outlined in this strategy.

In order to make this approach a reality, we have developed **ten principles** which will guide our news ways of working. This will require us to fundamentally change the way we work, including with our residents and communities, and where we prioritise our resources and efforts.

In order to embed and test our principles, we have outlined **five focus delivery areas** where we can make the greatest impact continue learning about our approach to system, borough partnership and neighbourhood working. Each focus delivery area is accompanied by rationale for its selection in NCL as well as what we plan to do next.

We also acknowledge that NCL as a system is currently not set up to deliver according to these principles in a sustainable way, therefore we have identified **five levers for change** which will help the ICS create the right conditions for sustainable delivery and positive outcomes. Each of these levers consists of system-wide deliverables which will set our system up for long-term success.

Although this document forms a milestone in our population health journey, we will continue to develop our partnership working as well as our engagement with our communities.

North Central London Integrated Care System

Context

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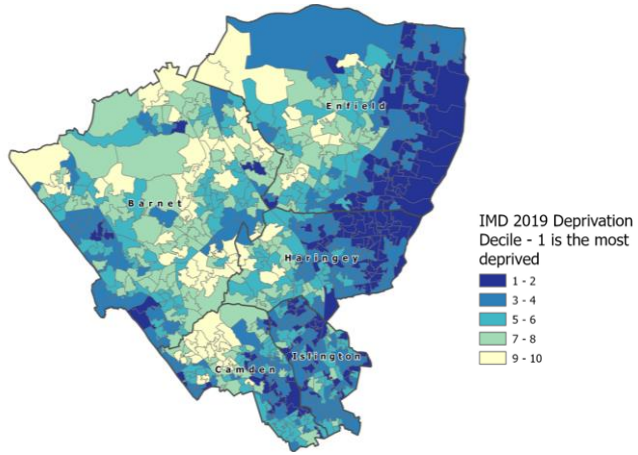
Our population – who do we serve

North Central London Integrated Care System

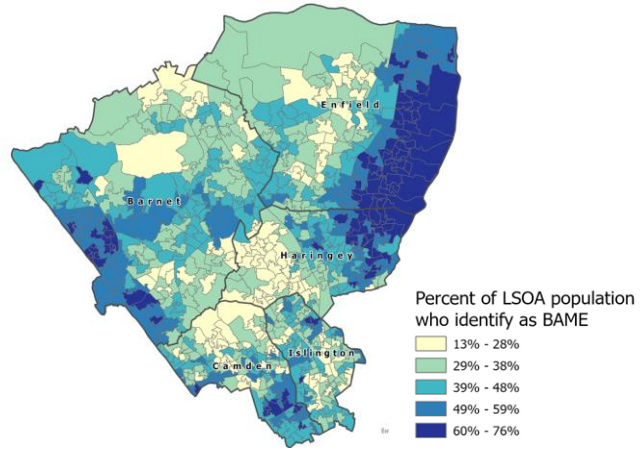
- North Central London (NCL) has a **relatively young resident population of just under 1.8 million people** and a similar number registered with our GPs. Despite large overlap these are not the same populations, and some of our residents remain unregistered anywhere, including from our inclusion health groups.* Alongside our residents, NCL ICS also provides services for people who work, study and visit NCL, as well as people who travel to access our primary and specialist health and care services, particularly tertiary and quaternary services, but do not live within our boroughs.
- Pre-COVID **NCL's resident population was expected to increase by 5% by 2030, with the largest increase in the 65+ year olds** (32% forecast increase overall, ranging from 27% increase in Enfield to 39% in Camden).
- **NCL is the second most deprived ICS in London and there are areas of deprivation across all 5 boroughs, often in close proximity to areas of affluence**. More than 1 in 5 people in NCL live in the 20% most deprived areas nationally, while almost 1 in 3 live in the second most deprived 20% areas. There are distinct spatial patterns of deprivation, with particular concentrations of deprivation towards the east of NCL, with Enfield, Haringey and Islington having on average higher levels of deprivation.
- **Our population is ethnically diverse.** Although, more than half of NCL residents are White, around 20% are of an Asian ethnicity and 20% a Black ethnicity. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.
- **Different communities have very different age structures:** there are higher proportions and numbers of children and young people in Bangladeshi (30%), Black African (28%), Black Somali (32%) and Mixed (39%) communities compared to the NCL average (21%). White British (20%), White Irish (29%), Black Caribbean (19%) and Indian (18%) groups have proportionately more residents aged over 65 in their populations, compared to the NCL average (13%).
- **Across North Central London there is a high level of population health need and inequalities.** Improvements in life expectancy across NCL have stalled in recent years and life expectancy and healthy life expectancy have declined following the pandemic. **Residents in all our boroughs are living for 20 years on average in poor health.**
- **Life expectancy and healthy life expectancy varies within and across our boroughs.** Whilst residents in Barnet and Camden have higher life expectancy than the London average, Islington residents and men in Haringey have lower life expectancies. Life expectancy for men living in Upper Edmonton West in Enfield was around 15 years lower than for men and women living in Frognal and Hampstead Town (in Camden), across the five years before COVID-19. Similarly, there is nearly 20 years variation in healthy life expectancy between most and least affluent areas in NCL. For people experiencing homelessness average life expectancy is 30 years shorter than the general population, from largely preventable conditions.

Deprivation profile of NCL, by lower super output area (LSOA)



Source: Index of Multiple Deprivation (IMD_ 2019

Ethnic profile of NCL, by LSOA



Source: Census 2021

*inclusion health groups include for example: people experiencing homelessness, refugees and asylum seekers, sex workers, Irish Traveller and Gypsy, Roma and Traveller communities, transgender people, and (ex)offenders.

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Population health is why we are here and our shared purpose across the North Central London Integrated Care System

North Central London Integrated Care System

Core purpose of our Integrated Care System (ICS)

NHS Providers

1. Whittington Health NHS Trust
2. University College London Hospitals NHS Foundation Trust (UCLH)
3. North Middlesex University Hospital NHS Trust (NMUH)
4. The Royal Free London NHS Foundation Trust
5. Barnet, Enfield and Haringey Mental Health NHS Trust
6. Camden and Islington NHS Foundation Trust
7. Tavistock and Portman NHS Foundation Trust
8. Central and North West London NHS Foundation Trust (CNWL)
9. Central London Community Healthcare NHS Trust (CLCH)
10. Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)
11. Royal National Orthopaedic Hospital (RNOH)
12. Moorfields Eye Hospital NHS Foundation Trust

Integrated Care Systems (ICS) are partnerships between the organisations that meet health and care needs across an area. Driving improvements in population health and reducing health inequalities is at the heart of our purpose. Our Integrated Care Partnership (ICP) between the Integrated Care Board (ICB) and our borough local authorities creates the opportunity for us to address the fundamentals of poor health and tackle what is preventable. We can become a proactive, rather than reactive system, focussing on health and wellbeing, not just on illness.

North Central London (NCL) is a complex health and care economy with 12 major healthcare providers (many of whom provide specialist services to the rest of London and across England) with a combined income of around £5bn, 5 local authorities, 33 primary care networks (PCNs), more than 280 domiciliary care providers and around 220 care homes and hundreds of voluntary, community and social enterprise (VCSE) organisations. The system is also supported by UCL Partners - our Academic Health Science Network (AHSN) - and a flourishing world-class wider academic community.

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We have worked to understand our population needs, residents' experience and system challenges

North Central London Integrated Care System

Our assessment of our population's needs tells us:

Health needs are growing and **inequalities are widening**. Whilst we still need to drive forward improvement in the quality of care we provide, we need to do more to **intervene earlier** when people start to become unwell and prevent people becoming unwell in the first place, through a greater focus on tackling the **lifestyle and wider determinants** of our health and wellbeing, if we want to improve health outcomes and reduce inequalities across our population.

Our communities tell us:

Our system is not meeting our communities' needs. Our **services are complex and hard to navigate**, with challenges entering the health system through primary care. Services need to be better integrated and provide **more holistic support, taking account of people's wider needs** e.g. related to issues such as housing or income, making best use of the assets within our voluntary sector. We need to build trust with some of our communities and develop more culturally sensitive services. We need to work with our communities to design person-centred solutions which **take account of differences rather than a 'one-size-fits-all' approach**.

Our system challenges tell us:

Our services and **workforce are straining under increasing complexity and growing demand**, within a **tight financial environment, and our resources are not aligned to our population's needs**. Our system is in parts fragmented and **decision making and accountability at the different system levels is not clear.** We need to understand and **use our strengths and assets across the system more efficiently and effectively** to meet our population's needs and make our system future proof.

To ensure that we can meet the needs of the populations that we serve and achieve our ambition, we need to **fundamentally change the way we work, including with our residents and communities, and where we prioritise our resources and efforts**. We need a new vision that will bring us together around a common purpose and approach.

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To become a population health and integrated care system, we need to change in fundamental ways

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We need to move from being a collection of health and care organisations that…	to become a population health system that…	so that our residents....
are reactive and demand-driven with a high-proportion of resources focused on urgent care	is needs-driven, prioritising prevention and proactive care	stay well and in control of their health
treats individual conditions not the drivers of poor health	sees the whole person and takes action on prevention and the wider determinants of health	feel heard and confident that their care is right for them
are focussed on their services and part of the pathway	integrates care around the person and communities	feel that the system is coordinated and communicates well
are focussed on illness and dependence	works to improve life chances, prevent illness and promote physical and mental well-being	can live more of their life in good health

National legislation and initiatives, such as the Health and Care Act 2022, the Fuller Stocktake and the CORE20PLUS5 framework, have given us an opportunity to develop and act on our ambitions. These are outlined further in Appendix 3

Link to national context

North Central London Integrated Care System

Our vision and principles

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Our ‘I’ statements define what our new system needs to feel like for our residents, our communities and our service users

North Central London Integrated Care System

A whole person

- I am treated as a whole person and you recognise how disempowering being ill is
- I am listened to and respected

Patient choice and effective self-care

- I am involved in decisions regarding my life, my health and the support or care that I need

Feeling empowered

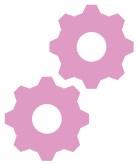
- I have the support that I need to stay healthy and to live as independently as possible
- I am supported by people who see me as a unique person with strengths, abilities and aspirations

Information on services, communication and navigation

- I have the information and advice that I need, when I need it and in a form that I can understand

Housing and community

- I live in a safe place with access to lots of green spaces
- I feel part of a community
- I can easily access and afford local activities / services



Integrated care

- I tell my story once
- My care is coordinated across services
- When I move between services, settings or areas, there is a clear plan and the transition feels seamless

We have developed a population health outcomes framework that reflects where we have significant local disparities across the life course

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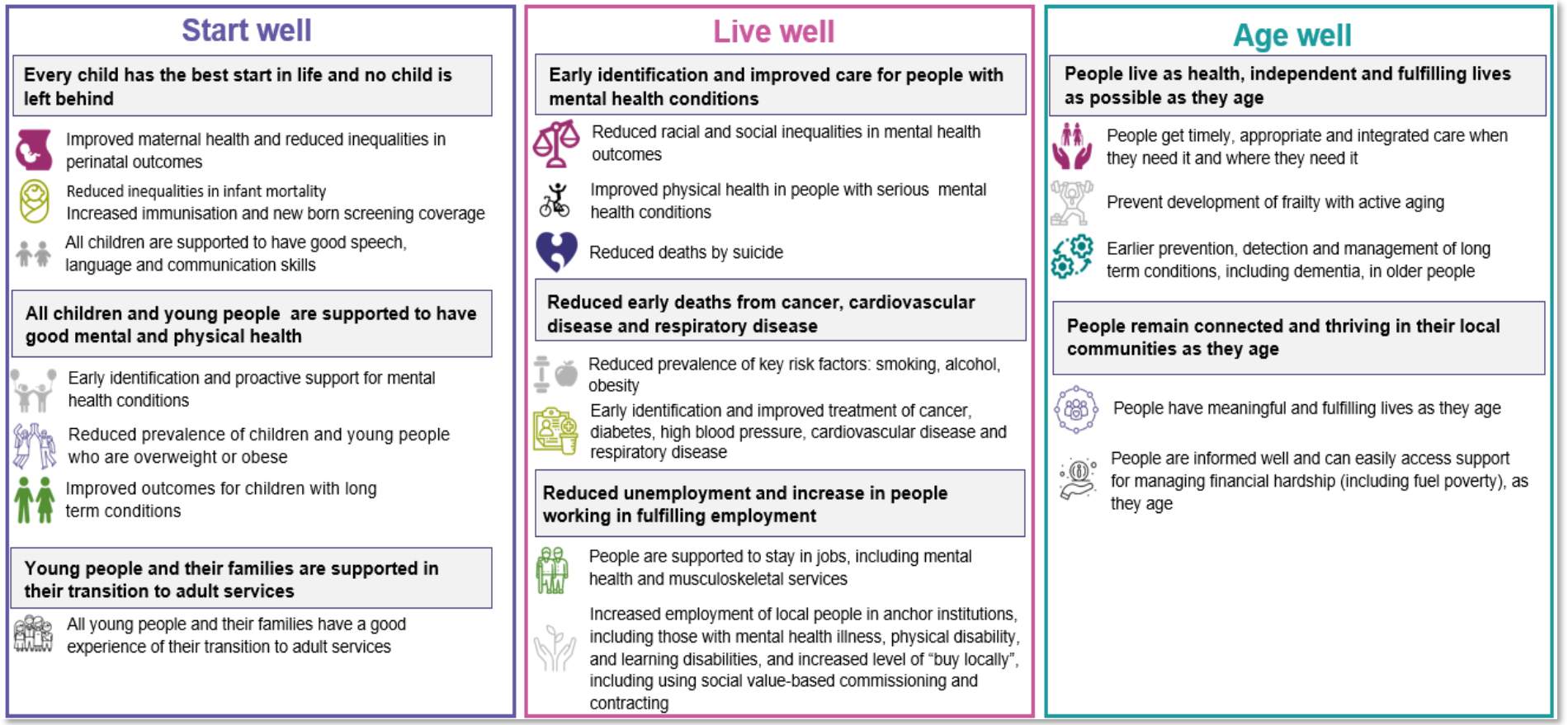
Across our health and care services, we have developed and **agreed a set of outcomes, based on our population needs identified through our NCL needs assessment and our borough JSNAs and Health and Wellbeing Strategies, that reflect our population health ambition** and for which we will collectively hold ourselves to account. The Outcomes Framework **follows the life course.**

An indicator set underpins the outcomes which will be mapped to all our key work programmes and we are aiming to make a significant impact in.

The outcomes framework is **a tool for us to assess variation and need, support prioritisation** and identify where we can make a difference by working together as a system, and areas which require focus at borough and neighbourhood level.

We have used the outcomes framework to identify 5 key population health risks, which will be our first areas for focus at an NCL-level. Borough Partnerships will continue to work across the breadth of the Outcomes Framework and will identify local priorities to sit alongside these.



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We have ten principles which will guide our new ways of working

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To make our transition to a population health and integrated care system that is needs-driven, holistic and integrated, we have identified 10 principles to guide us and examples of what that looks like in terms of changed ways of working.

Trust the strengths of individuals and our communities

We listen to our communities and develop care models that are strengths-based and focussed on what communities need, not just what services have always delivered

Break down barriers and make brave decisions that demonstrate our collective accountability for population health

We understand each other's viewpoints and take shared responsibility for achieving our ICS outcomes and our role as anchor institutions

Build from insights

We create digital partnerships and use integrated qualitative and quantitative data to understand need

Strengthen our Borough Partnerships

We build a system approach for local decision making and accountability to support local action on health inequalities and wider determinants

Mobilise our system's world class improvement and academic expertise for innovation and learning

We build the evidence base for population health improvement and innovative approaches to improve integrated working

Break new ground in system finance for population health and inequalities

We shift our investment toward prevention and proactive care models and create payment models based on outcomes.

Build 'one workforce' to deliver sustainable, integrated health and care services

We maximise our workforce skills, efficiencies and capabilities across the system

Support hyper-local delivery to tackle health inequalities and address wider determinants

We make care more sustainable by creating local integrated teams that coordinate care around the communities they serve

Relentlessly focus on communities with the greatest need

We embed Core20PLUS5 in all our programmes with a particular focus on inclusion health to make sure no-one is left behind

Deliver more environmentally sustainable health and care services

We prioritise activity which impacts our communities' health and environment, such as transport

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Delivering on our ambition

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We will deliver on our vision for NCL by working across three spatial levels

North Central London Integrated Care System

Purpose	Function
System: • Focuses on activities that are better undertaken at an NCL-level where a larger planning footprint increases the impact or effectiveness • Creates conditions for local delivery of population health improvement through borough partnerships	• Understand totality of system health • Integration principles • Delivers system population health priorities • Differentially resource for achievement of population health outcomes • Balance service efficiency with equitable access and outcome • Conditions for population health improvement – workforce, data integration, insights, estates, back-office functions • Establishes and supports improvement collaboratives across priority pathways and services • Interactive relationship with academia, AHSN, research, alliances, collaboratives
Borough Partnership: • Focussed on bringing together partners to develop, integrate and coordinate services based on agreed priorities. • Work with wider sector partners • Drives hyper-local delivery	• Coordinate and oversee neighbourhood delivery and act as interface between sectors • Drive integration across the borough partnership • Accountable for local delivery of placed-based and system priorities • Drive local co-production, insights and transformation • Agree plans for sectoral partnerships and functional integration • Create new spaces and ways of working that enable every-day local integration • Ensures community involvement and insights to improve access, experience and population health gains
Neighbourhood: • Builds on the core of primary care networks through integrated multidisciplinary te ams delivering a proactive population-based approach to care at a community level	• Key unit of integrated care delivery for population health improvement • Balance proactive/preventative and reactive/episodic care • Multidisciplinary working • Close collaboration with voluntary sector partners • Risk stratification, case-finding, care coordination, anticipatory care and making every contact count • Co-produced targeted services and interventions to improve outcomes for communities

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Designing our approach to neighbourhood working

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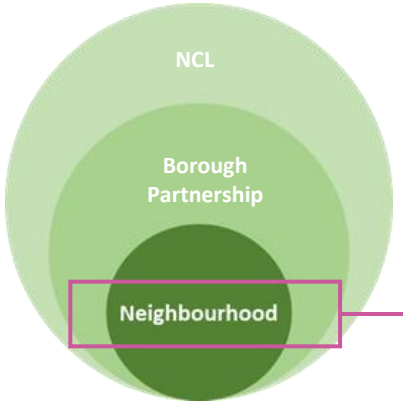

In December 2022, system leaders from 32 organisations from across the ICS came together at an event focused on Delivering Population Health Improvement and the Neighbourhood Model in North Central London, in the context of *Next Steps for Integrating Primary Care: Fuller Stocktake report.*

Consensus was reached on:

There is a need to balance consistency in the offer across NCL, with the ability and necessity to tailor to local need.

Population health improvement, with a focus on prevention, early intervention and proactive care, is critical to improved outcomes and the sustainability of services.

There is a need to meet reactive demand with proactive interventions, and this should be linked to the high risk cohorts in the primary care led Long Term Conditions Locally Commissioned Service (LTC LCS) stratification.

Proactive targeting of key cohorts within a neighbourhood should be data-driven, focused on individuals at high risk of urgent need.

Primary care is at the heart of neighbourhoods but system-wide contribution of critical infrastructure, particularly workforce and data, is critical to neighbourhood development and impact. It cannot be seen solely as primary care transformation. It should be framed and delivered as system transformation.

There is a need to develop a vision for same-day access needs in order to build consensus on the proposed model of care

We agreed to continue working together in order to focus on:

- Required neighbourhood infrastructure, including core functions, key cohorts, workforce, estates and data
- Establish and receive feedback from a panel of residents.
- Work through the balance between a consistent offer across NCL and local flexibility needed in defining each neighbourhood, in response to local context.
- Develop a suite of neighbourhood test and learn demonstrators, by building on where there is resource and appetite to participate.
- Support with unblocking challenges.

We are building on a foundation of integrated care across our five Borough Partnerships

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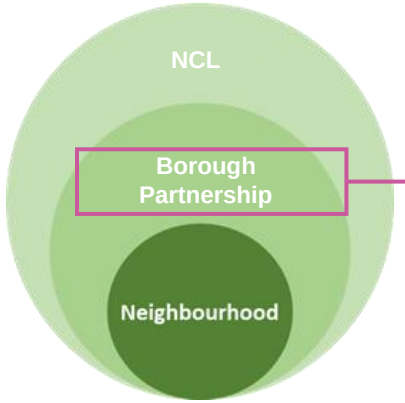

Integrated working already takes place within our boroughs as our BPs have been established – their experience and local programmes have given us a window into their future state. We think this is a defined place within which exists a series of horizontally integrated collaboration of organisations to improve outcomes for their local population. They will support neighbourhoods to address episodic care, long-term conditions, prevention and specific population health focuses. They will also be supported by the NCL system via strategic direction, cross-borough working, and enablers such as data, estates, and workforce.

Local community hubs: Creating a bridge between the Council's Early Help for All Strategy and a range of targeted support for residents in need. This includes in-depth support on health & wellbeing, jobs & skills, housing stability, and money.

Grahame park: Joint working between Council, NHS, Integrated Care Partnership, VCSFEs to develop an evidence-based neighbourhood model. The team focused on identified needs (for example substance misuse outreach services) and co-produced solutions with impacted communities.

Proactive Integrated Teams: Developing a multidisciplinary population health improvement approach to tackle elective recovery. MDTs routed in PCNs with wrap around input from community services and secondary care to reduce the number of patients on waiting lists

Childhood immunisations: Joint, iterative work between ICB, primary care, parent champions and community based organisations to raise awareness through focus groups, animation and pop-up clinics.

Integrated Front Door & Integrated Networks: Bringing together health and social care teams into a joint triage. Further joint working across integrated networks where MDTs of health professionals work across small networks of GP practices to discuss and support patients with complex needs.

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Our vision for Borough Partnerships will develop over time within a shared framework

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Our vision: Borough partnerships in NCL will see partners take a 'helicopter view' of the health and wellbeing of their local population, including delivery at Neighbourhood level - helping reduce inequalities with a dual focus on improving quality and accessibility. They will enable the integration of health & social care and alignment of a broad range of services and community groups to address the wider determinants of health. They will have clear transformation priorities, are innovation spaces, and will 'lead on learning'.

All our Borough Partnerships are building their relationships and approach to local collaboration. Each is at a different point, with their own strengths and priorities for development. Working to the shared vision for Borough Partnerships, we are building a common framework for Borough Partnership development, giving clarity and with the goal of providing the flexibility for delivery according to local need.

The framework comprises nine key elements, however there are additional elements to be added. To develop the whole framework, we will take a 'learn by doing' approach, using a set of integrated projects as demonstrators as well as our key population health risks. These will be underpinned by a shared model for learning. The outputs from these demonstrators will shape the scope, responsibilities, accountabilities and the infrastructure needed for Borough Partnerships. They will also refine and further clarify what is needed at System level.

In the framework already

- Ambition/vision
- Leadership
- Functions, accountability, governance
- Priorities
- Neighbourhoods
- Resident and community engagement
- Commissioning and procurement
- Outcomes and impact
- Resources and capability

Additional elements to consider

- Finance
- VCSE
- Ways of working

Link to framework detail

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There is a call to action for everyone in our system to help deliver our ambition

North Central London Integrated Care System

Community Trust

'The community services we provide will need to be delivered around local neighbourhoods with more focus on multidisciplinary working with primary care teams, not just how we work with hospitals'

'We will focus more on equity of access and outcomes than just counting activity'

Cross-cutting

"There is a commitment to develop an autism centre of excellence/child development centre where families can access a range of services from the same location, to continue to embed the specific programmes to address assessment and diagnosis wait times, and to improve transitions between children and adults services."

Call to action

Throughout this strategy, we refer to principles, focus delivery areas, and levers for change however a key element to making this all a reality is what each of us will think and do differently as a result of them. With that in mind, our call to action is for each organisation in NCL to consider the following questions:

- **How will my organisation look and feel differently when we align to the principles and areas outlined in this strategy?**
- **How do we align with the 10 principles in everything we do?**
- **Are we able to identify and focus on the 5 focus delivery areas?**
- **How do we contribute to what we will do next for each of those?**
- **What is my role in the 5 levers for change? How will this contribute to creating a sustainable system for our new ways of working?**

Acute Trust

'By developing better integration between primary and secondary care, at the neighbourhood level, we have the opportunity to do things differently in service of this aim. We are therefore thinking about how we could reorient the secondary care workforce, for example by systematically aligning secondary care specialists to neighbourhood MDTs across our population.

(Regarding joined-up approach to prevention) 'This means that we are implementing healthy living hubs and embedding prevention in our secondary care pathways by making every contact count.'

GP

My role of a GP is to provide services to my registered patients from cradle to grave, understanding the whole practice population's needs. By working in a system that prioritises population health the focus of my role is enhanced so enabling me to do my job better.

North Central London Integrated Care System

Our five focus delivery areas

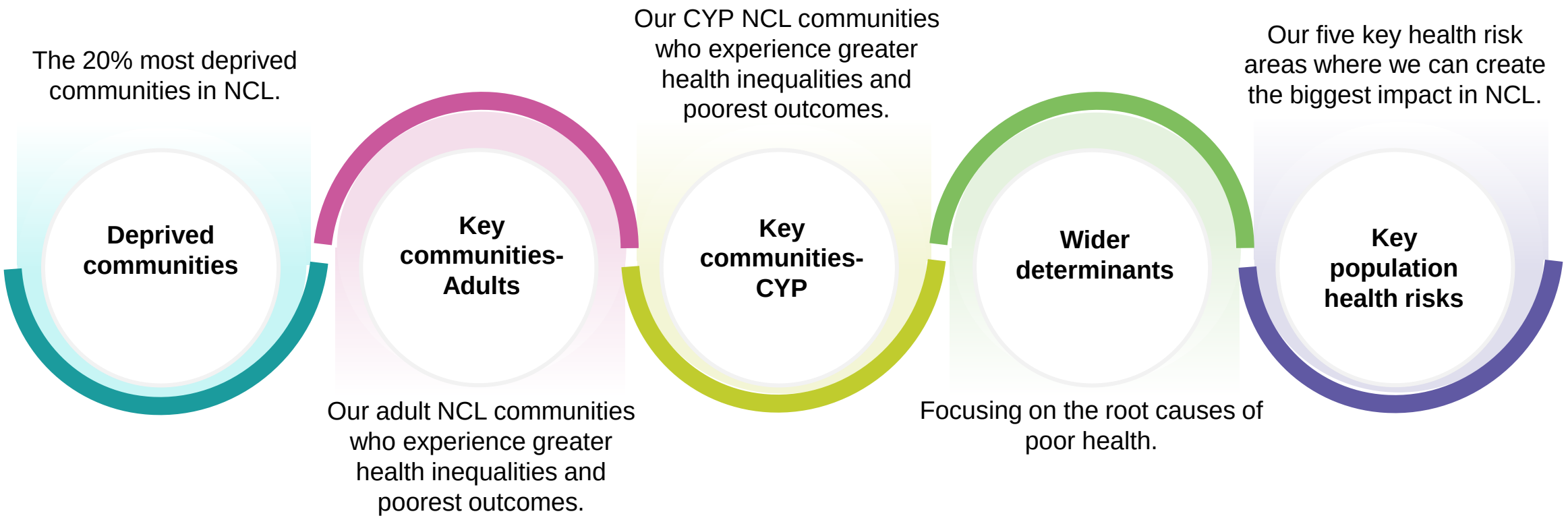
Where we can make the biggest impact

Our five focus delivery areas

North Central London Integrated Care System

Our ten principles guide all of the work we do however we need an approach to focus on areas where we can make the greatest impact. We have identified five focus areas for delivery which will enable us to do this.

This work is delivered at system, place and neighbourhood level and we will be working with Borough Partnerships to ensure they have the right conditions in place to improve the outcomes of residents.



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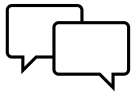
Focus delivery area 1 – Deprived Communities

North Central London Integrated Care System

Around 364,000 NCL residents live in the 20% **most deprived areas** nationally and 30% of children and young people are growing up in poverty. Poverty and deprivation are key determinants of poor health outcomes – for example, those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death compared to the NCL average.

Those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death compared to the NCL average. The prevalence of childhood asthma is almost double in the most deprived areas in NCL. People living in the more deprived areas of NCL have higher rates of GP appointments, A&E admissions and mental health contacts compared to those living in less deprived areas

Snapshot of what we are already doing



Tottenham Talking
This initiative aims to increase the number of young black males accessing lower-level mental health services, and reduce those developing severe mental illness, through identifying need at the prevention stage.
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Tackle mental health inequalities facing young black boys/ men in Islington
This initiative established four pillars (such as “Becoming a Man” initiative in schools and “Round Chair Barbers”), driven by listening to Young Black men’s experiences. Both examples are delivered through the Inequalities Fund.

What we will do

Across NCL, we will have a greater understanding of the needs of our most deprived communities and a shared understanding on how providers will tailor services and approaches to maximise their opportunities of health and wellbeing.

This will include a clear mapping of inequalities, built from data and community insights, to identify gaps where we need to act as a whole system and how we measure progress.

We will continue to use NCL’s Inequalities Fund as a delivery vehicle, consisting of a combination of borough-level and system-wide focussed projects which will focus on our most deprived residents.

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Focus delivery area 2 – Adult key communities (1/2)

North Central London Integrated Care System

- **Inclusion Health Groups**, including people experiencing homelessness, Gypsy, Roma and Traveller communities, sex workers, vulnerable migrants*, and adults with a history of imprisonment. These groups have amongst the poorest health outcomes, both physical and mental ill health, which are often compounded by poverty, trauma, social marginalisation and substance misuse.
- **Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities** (specific groups to be defined as part of Core20PLUS5 and tailored to reflect nuance at Borough level). BAME communities on average experience poorer health outcomes even after controlling for social and economic disadvantage.
- **Adults with severe mental illness and adults with learning disabilities**. These groups have complex social and health needs, often with multi-morbidity, lower incomes with poorer access to employment and lower life expectancy.
- **Family carers** have poorer health and wellbeing outcomes and are disproportionately impacted by the cost of living crisis.

Snapshot of what we are already doing

Collaborative forums on homeless health
Which build on and share learning from borough-based work – in particular the Haringey Homelessness Inclusion Team and the Camden Adult Pathway Partnership which has informed multi-disciplinary team (MDT) thinking in Enfield and Islington.

Healthcare for asylum seekers and migrants
Healthcare solutions at neighbourhood, place and system have been developed following needs identified through our Inclusion Health Needs Assessment and feedback from local care providers and service users e.g. GP practice and Respond (UCLH) service offers

Outcomes based specialist accommodation
Each Local Authority and the ICB is working with specialist accommodation providers to ensure provision is focused on outcomes and sustainably funded (use of Care Cube), promotes independence and that staff are skilled in providing positive behaviour support.

What we will do

Across all our work in NCL we will be embedding a focus on these communities.

We will use the findings of our Inclusion Health Needs Assessment to identify how as a system we can best meet the needs of Inclusion Health Groups, following the recommendations from the review.

We will also build the capability of our population health management platform regarding these communities and improve data recording to better identify these populations with services

We will strengthen wraparound support for adults with care and support needs to ensure that people are supported to maximise their independence, including responsive, flexible support when people's needs increase. We will level up community resource where some boroughs are underserved and explore how we can shift resources from hospital to community settings.

This will also include focusing on identifying carers who are currently hidden from the system to ensure we are supporting them.

* To include children and young people where relevant as part of a family approach to supporting asylum seekers and vulnerable migrants

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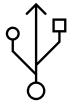
Focus delivery area 2 – Adult key communities (2/2)

North Central London Integrated Care System

- **Older adults with care and support needs.** Our assessment arrangements for older adults are not integrated which means that residents can experience multiple assessments, uncertainty and delays accessing provision. Whilst we have a sub-regional market of care homes our commissioning is fragmented between health and social care, which can result in poorer outcomes and is also driving up system costs unnecessarily. Residents with high physical and mental health needs can struggle to find appropriate care home places.
- **Supporting residents at risk of hospital admission**. Too many residents go into hospital for avoidable reasons, including from groups we know are at risk. Prevention and hospital avoidance support is not consistently well integrated and is sometimes commissioned episodically (VCSE).
- **Supporting residents to recover following hospital admissions.** Generally, residents in NCL are discharged from hospital in a more timely way compared to other areas, however, we are seeing an increase in people's needs when they leave hospital and not all residents receive optimum discharge support to recover.

Snapshot of what we are already doing

Care Home Market Management
The 5 Councils have developed a strategic approach to working with care homes that promotes quality, ensures we pay a fair rate and addresses market gaps. This has supported significant quality improvement in CQC ratings.



Using digital technology to deliver pro-active care
The ICB, NCL Training Hub and Councils have collaborated on a programme of increasing digital technology in social care settings. This is supporting pro-active care to thousands of residents to offer support when someone starts to become unwell or is at risk of falls.

Integrated Discharge Teams
We have developed integrated discharge teams across acute, community and social care provision that support residents to leave hospital in a timely way and to access effective community support. We have recently jointly commissioned work to identify areas for improvement that will drive developments in the next few years.

What we will do

We will strengthen partnership working and integration across all of these services to deliver better outcomes for residents at a sustainable cost. This will include exploring joint market management arrangements for care homes, drawing on the particular strengths the NHS and Councils can bring.

Borough Partnerships will explore opportunities to provide more pro-active care through the development of neighbourhood teams and maximising NHS and LA spend on VCSE organisations.

We will develop a joint programme to improve outcomes for residents leaving hospital by taking forwards improvement recommendations around finance and improved management information, improved coordination of residents leaving hospital and a strengthened core offer of discharge support across all boroughs.

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Focus delivery area 3 – Children and Young People key communities (1/2)

North Central London Integrated Care System

- **Children with Special Educational Needs and Disabilities (SEND).** Pupils with SEND face barriers that make it harder for them to learn than most pupils of the same age. They often experience poorer outcomes than their peers in educational achievement, physical and mental health status, social opportunities, and transition to adulthood.
- **Children Looked After (CLA) and care leavers.** Many children in care are likely to have had experiences which make them more vulnerable, leaving them at risk of poorer health outcomes than their peers.
- **Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities** (specific groups to be defined as part of Core20PLUS5 and tailored to reflect nuance at Borough level). Children from BAME groups on average experience poorer physical and mental health outcomes even after controlling for social and economic disadvantage.

We recognise there is some overlap across these populations, which may result in increased risk of health conditions or further barriers in accessing services – it will be important to recognise this intersectionality and provide support for these groups in a holistic way as part of delivery.

Snapshot of what we are already doing

Enfield Speech and Language Service

Enfield has developed a comprehensive SEND Action Plan for Health. A 0-2 years Speech and Language Early Identification and Intervention Service has been implemented, offering targeted interventions for children with speech, language and communication needs in deprived wards who experience difficulties or barriers in accessing universal therapy provision.

Barnet Care Leavers

Barnet Care Leavers Service is known as the Onwards and Upwards team and they allocate personal advisors (PA's) to support care leavers with all aspects of future independence. All boroughs have a support offer for Children Looked After related to education, employment, keeping healthy, staying safe/accommodation support.

What we will do

Across all our work in NCL we will be embedding a focus on these communities. This will be consistent with the approach for adult communities described in the previous slide.

Furthermore, each Borough is identifying a multi-agency partnership group responsible for developing and overseeing local implementation of the Community Services Review, and part of this is around the core offer for NHS support for CLA.

Finally, we will continue to develop our collaborative approach to supporting the SEND population.

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Focus delivery area 3 – Children and Young People key communities (2/2)

North Central London Integrated Care System

- **Continuing Care for Children and Young People.** The landscape across NCL in relation to continuing care is varied, there is fragmented transition pathways between children's and adults with young people having poor experiences when transitioning.
- **Safeguarding arrangements for designated doctors and nurses for Children and Young People.** NCL are keen to ensure that hospital wards have the right people on them in terms of safeguarding to undertake appropriate medicals when needed.

Snapshot of what we are already doing

Enfield Continuing Care
Enfield has a good model of partnership working for continuing care arrangements with input from local authority and health colleagues in panel decisions. The dynamic support register is used well to prevent breakdown of placements.

Understanding the landscape
We are working to understand the landscape across NCL for continuing care provision and for safeguarding arrangements for designated nurses and doctors.

What we will do

We will work to further understand the landscape across NCL for Safeguarding arrangements and continuing care arrangements in each borough.

For Continuing Care, we will explore a advocacy support network for parents/carers, explore a training package to upskill staff across NCL to reduce the need for placements and ensure families are receiving adequate support and further explore data, best practice and collaboration opportunities.

For Safeguarding arrangements for designated doctors and nurses, we recognise the difference in children protection medicals across NCL boroughs, we will work to ensure medicals are timely, fully considered and assessed, and take a multi-agency approach.

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Focus delivery area 4 – Wider determinants of Health

North Central London Integrated Care System

- **Making every contact count.** There are millions of interactions with residents which happen each day across health and care services, and beyond, which could be used as opportunities to support people's health and wellbeing, prevent disease and tackle the wider determinants of health if staff have the right training and tools to signpost residents to relevant services.
- **Working with our communities.** To be an effective health and care system it is essential that we work with our communities to co-design solutions that prolong good health, prevent avoidable ill health and address health inequalities.
- **Working with the Voluntary, Community and Social Enterprise Sector (VCSE).** to ensure we are embedding the voice of the sector within our governance structures, building the unique skills and knowledge the sector have into our population health and in particular prevention approach & addressing some of the key issues which face the sector including sustainability, long term funding and workforce/resource.
- **Social prescribing.** Many people present to health and care services when what they need is support for an underlying social problem such as support with housing or income issues – social prescribing is about linking people to appropriate services and informal support in their local communities.

We want to embed a focus on tackling the wider determinants as drivers of poor health across our work and the other 4 focus areas – the above are some some examples, but not an exhaustive list of how we might tackle this.

Snapshot of what we are already doing

Community connectors
Working with local HealthWatches to develop a community champions-style programme. This will support communities who face high health inequalities to understand how to stay healthy, symptoms of poor health, and how to access services.

Community research and action programme
The programme focuses on developing strong VCSE partnerships within each Borough, raising local communities' voices, and investment in grass-roots VCSE to help tackle inequalities and barriers to accessing services.

VCSE investment
Each Council makes a range of long term strategic investments in the VCS supporting residents to stay well, address wider determinants of health and have less need for formal health and care services.

What we will do

Working with our VCSE partners to deliver our NCL VCSE strategy which outlines our system-wide approach to working with the VCSE

Focusing on incorporating wider sector partners into our work, including education, road safety, and air quality.

Identify and use opportunities to provide holistic advice to residents regarding wider determinants issues such as benefits and housing.

Health and Social Care Academy – we will support residents with barriers to employment access a range of jobs in health and care services.

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Focus delivery area 5 – Key population health risks

- **Childhood immunisations**. Coverage is below London and far below England for almost all childhood immunisations across NCL as a whole, and in individual boroughs.
- **Heart health, cancer and lung health**. These are the three biggest causes of the life expectancy gap between the most and least deprived communities and have multiple common risk factors – such as smoking, physical inactivity and air quality.
- **Mental health and wellbeing across all ages.** Prevalence of mental disorders amongst adults and children increased due to the pandemic and mental wellbeing is repeatedly highlighted by communities as an area of need within NCL.

A summary of the key population health risks and the rationale for focusing on them is included in Appendix 7 as well as the rationale for agreeing to initially focus on childhood immunisations.

There will be other population health risk areas which we want to explore in the future from an NCL perspective, including those articulated within the Core20PLUS5 frameworks for adults and children - such as maternity and Diabetes, Epilepsy, Oral Health, and Asthma for children and young people.

Snapshot of what we are already doing

Childhood vaccinations
Building on the learning from the COVID vaccine and the pan-London Polio campaign – around communication and community engagement, cross-system working, outreach, IT infrastructure and data flow, workforce and use of alternative providers.

Long Term Conditions (LTC) management
Primary care has developed a model of care that stratifies the LTC population and provides proactive personalised care and support over a year of care.

What we will do

Childhood vaccinations are an embedded as a priority across each local partnership and structures for leadership and delivery are being enhanced, alongside cross-borough working. Each partnership will use data and local learning and community insight to deliver what works with local communities.

We will conduct a gap analysis for each risk area to identify outcomes and spend across different population sub-grounds and geographies to develop focus areas for tackling health inequalities.

We will develop a common framework to accelerate work across each of these 5 population risks reflecting governance, a focus on prevention, working across partners, including the VCSE and success measures. As part of this we will look at how we are tackling the risk factors which are common across these different pathways.

North Central London Integrated Care System

Leveraging the ICS to achieve better outcomes

Our 5 levers for change identify how we will create sustainable conditions for us to deliver on our ambitions

North Central London Integrated Care System

In order to drive progress on our 5 focus delivery areas, we have identified 5 ICS levers for change which will create sustainable conditions for our new ways of working. These represent where the ICS can add value and accelerate equitable achievement of outcomes.

Aligning resources to need

Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap

Becoming a learning system

Working with NCL's world-leading research and improvement expertise to become a system that is evidence-based and evidence-generating to deliver impact, value, scale and spread.

Making population health everyone's business

Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our front-line teams

Strengthening integrated delivery

Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams

Collaborating to tackle the root causes of poor health

Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities

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Lever 1 - Making population health everyone's business

North Central London Integrated Care System

Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our front-line teams

How this helps us create a sustainable system for our new ways of working

Making population health everyone's business means all organisations across NCL taking joint responsibility for promoting and protecting the health and wellbeing of our residents. Each organisation across our system has a unique view of resident experiences and no single organisation alone can achieve holistic improvements in population health outcomes.

In order to create a system that supports our new ways of working, we should be enabling each organisation to embed the fundamentals of population health in what they do. This means:

- **Developing a shared understanding of needs** – If we want to work together, we need to understand and hold a shared vision of resident and community needs. This can be done by ensuring the infrastructure, learning and capacity is in place to share our insights.
- **Build capacity across the system** – We must embed the fundamentals of population health and embark on a cultural shift to ensure all organisations across NCL can build in relevant processes and learning in line with our new ways of working.

Making population health everyone's business

Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our health and care providers

Insights

- Develop and embed system understanding of need
- Build a networked intelligence function across partners, including provider organisations
- Embed data on Key Communities (adults and children/young people) and other population health management (PHM) insights into frontline care
- Add social care, housing, prescribing and other data sources to include wider determinants of health to integrated dataset
- Embed health inequalities indicators across performance metrics
- Deliver on the conditions for adoption of our PHM platform
- Develop information and clinical governance for integrated care
- Develop community and qualitative insights and co-production infrastructure
- Develop and embed a suite of system quality metrics to support Core20PLUS5 for adults and children and young people
- Levers around data quality
- Develop CQUIN financial incentives to address health inequalities

Fundamentals of population health

- Capacity building - build population health fundamentals into induction programmes across partners, including provider organisations
- Build Making Every Contact Count (MECC) culture and processes, including incorporating into all staff personal development reviews (PDRs)
- Establish a population health leadership academy across the ICS and build into role descriptions
- Embed digital inclusion into all programmes
- Governance processes in place at ICB and providers that supports a health inequalities in all approach – e.g. all decisions focus on underlying need and resource

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Lever 2 - Aligning resources to need

North Central London Integrated Care System

Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap

How this helps us create a sustainable system for our new ways of working

Our system is facing significant pressures, which our staff have responded valiantly to. In spite of this, our services need to change to ensure they are able to meet the present and future needs of our population.

By better utilising opportunities to inform and align our decision-making, we can ensure our collective resources go further to most effectively meet our population's needs. This means:

- **Prevention and early intervention –** In order to take a proactive approach to improving whole life outcomes for our residents, we need to identify and act on opportunities to shift our resources towards prevention and early intervention across our services.
- **Decision-making –** By ensuring decisions are informed and can be made at the right time and place, our borough partnerships will have permission to act to shape local services within the framework of our system.

Aligning resources to need

Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap

Understanding variation in outcomes

- Baseline and monitor outcomes framework and setting our ambitions for how our outcomes will change over time.
- Baseline current outcomes and spend by geography and demography and how it compares to data on access, experience and outcomes
- Embed a plan for our key communities that outlines current work in progress on health inequalities focusing on community empowerment, wider determinants, health promotion / prevention, data collection and inclusion health. To be refined post gap analysis above.
- Inter-dependencies identified with related programmes – e.g. anchors, green programme, elective recovery, and agreement of who does what – e.g. individual action vs advice provided
- Define system values and approach to trade-offs to address health inequalities and the wider determinants
- Embed systematic quality outcomes reviews to support proactive identification of areas of variation and develop plans for targeted interventions
- Allocative efficiency programme in place that identifies most effective interventions to address health inequalities, linked to needs identified in gap analysis

Frameworks and measures

- Develop the financial architecture that reflects the differential effort needed to achieve outcomes with different communities, options for movement of resource and investment in prevention
- Agree a prioritisation framework with clear and transparent criteria including health inequalities
- Develop a population health commissioning framework with increased emphasis on equitable outcomes rather than units of activity
- Develop a decision-making framework that balances delegation to Borough Partnerships with system flexibility to support vulnerable populations
- Develop plan for investment in the VCSE to support community engagement, volunteering, co-production and hyper-local delivery
- Agree finance indicators to measure ambition and set trajectories that reflect the shift of resources to need

Lever 3 - Strengthening integrated delivery

North Central London Integrated Care System

Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams

How this helps us create a sustainable system for our new ways of working

Integration is happening at every level of our system, from neighbourhood to system. It enables our services to better understand and meet the needs of the individual, as well as the factors contributing to worse outcomes, so that the care provided can be less episodic and reactive.

By strengthening our partnership approach, we can make sure our services are fit for purpose. This is an opportunity to implement transformative changes that radically improve the way we deliver care. This means:

- **'One Workforce'** – A joined up workforce, equipped with the right skills and information, is key to the delivery of our ambitions.
- **Effective Care** – By joining up our clinical teams and social services more, we can deliver more effective care for our residents.
- **Meaningful Partnership** – To succeed, we need our partners to continue engaging and participating in our joint commitments, and we need to facilitate open and honest conversations that enable us to collectively overcome obstacles and inefficiencies across our system.

Strengthening integrated delivery

Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams

Context and conditions for success

- Deliver Borough Partnership Roadmap, including scope, infrastructure and responsibilities/accountabilities
- Deliver key population health risk demonstrators
- Deliver Borough Partnership integration demonstrators

Building local integrated teams

- Shape the neighbourhood offer including role of VCSE
- Establish the delivery infrastructure to deliver integrated neighbourhood teams
- Integrate and scale personalisation approaches (PCSP, PHB, co-production etc)
- Develop a digital supported offer for more proactive care@home and increase levels of digital inclusion
- Align system quality leads to each borough team to support action planning around equality gaps in service provision and delivery

Workforce transformation

- Create the infrastructure and ways of working for a 'One Workforce' approach
- Implement the NCL People Strategy, which will enable NCL to:
    - Optimise the volume of staff with the right skills, attracting more people with more diverse skills and increasing the representation of our local population in our workforce
    - Continually develop our staff, systems and processes to maximise the talent and assets across NCL
    - Utilise technology to ensure our staff have access to the information they need, driving productivity and efficiency by further connecting our workforce with advanced data and analytics

Lever 4 - Collaborating to tackle the root causes of poor health

North Central London Integrated Care System

Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities

How this helps us create a sustainable system for our new ways of working

It was estimated by Public Health England (PHE) that 40-50% of health outcomes are attributed to the so-called 'wider determinants of health' like housing, education and employment and their unequal distribution across the population, a much greater influence than healthcare, lifestyle behaviours or genetics. Addressing the wider socio-economic determinants is a crucial part of preventing ill health and reducing health inequalities.

By addressing the root causes of poor health, we can reduce the likelihood of health problems arising in the first place and thus decrease the demand for healthcare services. This means:

- **Recognising the role of anchor institutions –** Anchor institutions play a key role in strengthening local economies.
- **Promoting sustainable health and care –** By delivering on the NCL Green Plan, we can work towards building a healthier community.
- **Engaging with communities –** By collaborating with our VCSE, we can better understand the needs of our population.

Collaborating to tackle the root causes of poor health

Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities

- **Anchors –** strengthen our anchor network and joint work programme to maximise our assets within our local communities to build local economies, improve the environment, widen access to good quality employment for local people (including through the health and care academy) and increase physical activity
- **Social prescribing -** Ensure social prescribing is visible, accessible and available across all life courses, and is valued by all partners equally.
- **Making every contact count –** consolidate our MECC offer in NCL including around the wider determinants of health
- **Health inequalities fund –** expand the Health Inequalities fund and strengthen scaling of interventions for greater impact
- **Inclusion health -** take forward recommendations from the NCL Inclusion Health Needs Assessment
- **Tackling key population health risks–** coordinate action around the common risk factors for our key population health risks, to include work to tackle tobacco, alcohol and weight as well as the wider determinants of health, such as poor quality housing and air quality.
- **Green plan –** deliver the objectives of our NCL Green Plan
- **Working with our communities –** strengthen our engagement and investment with our VCSE and communities to better understand and act on their needs – taking forward our NCL Working with our Communities and Working with our VCSE Strategies

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Lever 5 - Becoming a learning system

North Central London Integrated Care System

Working with NCL's world-leading research and improvement expertise to become a system that is evidence-based, evidence-generating to deliver impact, value, scale and spread.

How this helps us create a sustainable system for our new ways of working

NCL has a unique position to evolve into a learning system, thanks to its world-renowned academic, research, and healthcare institutions. By fostering our collaboration to become a learning system , we can integrate our data and experiences into practice to better understand the needs of our residents. This means:

- **Adopting a QI approach –** By adopting a consistent Quality Improvement methodology, we can gather insights and learnings from across the system.
- **Acting based on evidence –** Collaborating with our academic forums will enable us to better understand the challenges that our system is facing and allocate resources more efficiently.
- **Generating evidence –** The unique challenges and opportunities of NCL can produce real-world evidence to inform research priorities.

Becoming a learning system

Working with NCL's world-leading research and improvement expertise to become a system that is evidence-based, evidence-generating to deliver impact, value, scale and spread

Quality Improvement
- Shift from transactional quality surveillance to a QI approach with a consistent methodology and greater use of afteraction reviews and appreciative inquiry
- Build system improvement collaboratives across partners, including providers

Evidence-based practice
- Co-ordinate with our various academic forums, including Academic Health Science Network (AHSN), Clinical Research Network (CRN), Applied Research Collaboration (ARC) and Biomedical Research Centres (BRC) to develop a common understanding of what each part of the research infrastructure does and provide a single point of access for the system
- Develop our capabilities for evidence-based system problem formulation

Becoming an evidence-generating system
- Develop our ICS research strategy
- Develop the list of research priorities shared across NCL
- Develop a our approach system-wide research collaboration to steer and scale up evidence-generation and act as a single point of research co-ordination

Build evidence and research
- Use our research networks to grow and apply the evidence base on high value interventions to tackle the wider determinants of health

Benefits realisation
- Collaborate with our AHSN to model and simulate impact of population health interventions on system demand over time
- Build a system evaluation framework to support evidence-based resource reallocation

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There are key programmes already underway which show how we leverage the ICS to create value

North Central London Integrated Care System

Community and mental health services core offer

An innovative Core Offer has been developed, ensuring consistency across NCL and reflecting population need. The core offer includes co-ordination functions to facilitate access to services and better join-up. This will help to reduce health inequalities, improve the quality and consistency of provision across NCL and deliver more proactive, integrated care.

Work is also ongoing to co-develop a shared outcomes framework and KPI dashboard which will be used to track equitable outcomes improvement.

NCL Health and Care Academy

North London Councils, NHS and adult education partners, have secured funding to promote health and care as a workforce of choice to our residents, with a focus on those with barriers to employment, and to work with health and care employers to tailor their employment offer to all of our communities and ensure they are offering good quality roles. This will include direct training for 400+ residents in health and care of which over 240 residents will move into entry level jobs. Once we establish better entry level pathways we will also work with employers to promote a range of flexible progression opportunities.

New model for long term conditions

Developing a consistent proactive care model across NCL, based on the Year of Care approach. It is data driven, realistic and practical and has been co-designed with providers, people with lived experience and the voluntary sector. It's outcomes-focussed, person-centred, stratified, focused on need, evidence-based and clinically-validated, making use of the full range of general practice workforce, and complementing our community core offer. This model will act as a key piece of our neighbourhood model in NCL.

We need to generate evidence of impact and value in these new models and the potential to create additional impact through integrating these programmes around local delivery.

Inequalities fund

The aim of the Inequalities Fund was to develop new approaches to entrenched health inequalities and we currently £5m per annum committed to do this.
To date, the Inequalities Fund has looked out towards local communities working with local authorities to understand their needs and measure the value of developing relationships and co-produced solutions.
An example of this is NCL ICB and LB Islington collaborating to improve mental health in Young Black Men in Islington working within school settings, a community-based hub, barbers, and an anti-racist training programme.

Start well

In November 2021, the partner organisations which now make up NCL's (ICS) formally launched a long-term programme looking at maternity, neonatal, children and young people's services, called the Start Well programme.

The case for change was developed using a combination of engagement and outcomes data and identified areas of variation and inequity where there are significant opportunities to improve care and outcomes for patients.

Moving forward

North Central London Integrated Care System

To address our population health challenges and become a population health system, we will organise delivery around four key elements:

1. Five focus delivery areas
2. Five ICS levers for change
3. Population health development area demonstrators
4. Borough Partnership integration demonstrators

Across our demonstrators we will be willing to remove barriers, create new incentives and protect our teams so they can work more freely in response to what our communities tell us is needed.

We will build on existing learning, draw on and develop the focus areas and levers, prototype delivery models and governance arrangements and work through the practical issues that arise when we work as an integrated care partnership.

This document sets out the broad vision of the test and learn approach, as well describing important delivery elements across our five themes. A more detailed plan (our Joint Forward Plan) with milestones, timelines and trajectories will be closely linked to this document and will describe the detail behind this high-level view.

Moving forward – our model for change and how all the pieces fit together

North Central London Integrated Care System

Resident 'I' statements

North Central London system assets

Population health needs

Existing examples of integration

System challenges

Our ten principles

Our five focus delivery areas

- Deprived communities
- Key communities - Adults
- Key communities - CYP
- Wider determinants
- Key population health risks

Test and Learn Demonstrators

- Key population health risks
- BP Integration Development Areas

Our five ICS levers for change

- Aligning resources to need
- Strengthening local integrated delivery
- Making population health everyone's business
- Becoming a learning system
- Collaborating to tackle the root causes of poor health

More proactive care out of hospital

More hyper-local care targeting health inequalities

Strengthened Borough Partnerships driving integrated local plans

Improved resident experience

Improved equity of access

Improved population health outcomes

Next steps

North Central London Integrated Care System

- This strategy should set the strategic direction for NCL and guide our future ways of working in order to become a population health system. This document has been developed by, with and for the system so there will now be a phase of wide sharing of the concepts, principles, and deliverables with organisations from across the system. We will continue to learn from partners as we move forward with implementation.

- This strategy outlines next steps in the form of deliverables and demonstrators as well as a call to action for providers to reflect on what this strategy means for them. We are developing a more detailed plan (our Joint Forward Plan) with milestones, timelines and trajectories which will describe the detail behind the high level view laid out in this strategy. This will include how and where we will apply our new ways of working and integrate care and support to deliver better outcomes.

- We want to strengthen system leadership to ensure there is a clear function and remit of the ICP and BPs.

North Central London Integrated Care System

Appendix 1: Engagement summary

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Where we have engaged

North Central London Integrated Care System

Area of system	Forum
NCL ICP	• Integrated Care Partnership – Informal • Population Health and Inequalities Committee • Population Health and Inequalities Steering Group • Community Partnership Forum
Borough Partnerships	• Camden Borough Partnership Delivery Group • Camden Borough Partnership • NCL Directors of Integration • Borough Heads and DOI Meeting
NCL ICB	• Performance & Transformation DMT Away Day • Extended Executive Management Team • NCL Clinical Advisory Group • Strategy & Development Committee • Development and population health - Directorate Management Team • Development and Population Health Directorate Briefing • CNOD SMT Business Performance, finance and HR Extended Executive Management Team • Population Health Management Group • Performance and Transformation Directorate briefing • NCL Transformation Board • Communications Leadership meeting • Corporate Affairs Briefing
Providers	• UCLH inequalities programme board • GP Provider Alliance seminar • NCL Long-term Conditions steering group • NCL Mental Health Implementation Steering Group • NCL Cancer Alliance • Cancer leads • NCL Community Health Implementation Steering Group • Royal Free/NMUH population health committee in kind

Area of system	Forum
NCL Councils	• Directors of Public Health • Lead councillors for Health and Care • Haringey Health and Wellbeing Board • Enfield Health and Wellbeing Board • Islington Health and Wellbeing Board • Barnet Health and Wellbeing Board • Director of Children Services • NCL Directors of Adults Social Services • Councillors briefing
Community	• Healthwatch (NCL leads meeting) • VCSE Alliance • Haringey Engagement Network
System Partners	• UCLPartners • CVD network • Quality Operational Group • Adult Community Provider Transformation Programme Group • CYP Community Transformation Programme Group • SMI Network

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North Central London Integrated Care System

Appendix 2: Glossary

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North Central London Integrated Care System

	Definition
Anchor institution	Anchor institutions are large organisations such as NHS trusts and local authorities, which, by their nature, are unlikely to relocate, have a significant stake in their local area, and have sizeable assets which can be used to support local community health and wellbeing, including tackling health inequalities. (NHS Confederation, 2022. Accessed here).
Academic Health Science Network (AHSN)	Academic Health Science Networks (AHSNs) are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members. Some of their aims are to promote economic growth, improve patient safety and putting research into practice. (AHSN. Accessed here).
Borough partnership	Borough Partnerships are partnerships at borough level that include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care. They are responsible for working with local communities to improve health and wellbeing and reduce inequalities. (These are the NCL equivalent to the nationally defined place-based partnerships - (King's Fund, 2022: Accessed here).
Becoming A Man programme	The Becoming a Man (BAM) programme is mental well-being intervention that aims to support young men's personal development by taking into account their lived experience and the often difficult environments they must navigate. (Mental Health Foundation. Accessed here).
Core20PLUS5	Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Core20 refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation the national level. The PLUS population are population groups experiencing inequalities who may not be included in the Core 20 are identified at local level. The '5' national focus clinical areas for adults are: Maternity , Severe Mental illness, Chronic Respiratory disease, Early Cancer diagnosis and Hypertension case-finding and optimal management and lipid optimal management and for children are asthma, diabetes, oral health, epilepsy and mental health. (NHSE. Accessed here).
Co-produced	Co-production refers to an approach that brings together service users, carers and staff to shape and develop services and programmes, rather than staff making decisions alone.
Environmental Sustainability	Environmental sustainability is the ability to maintain an ecological balance in our planet's natural environment and conserve natural resources to support the wellbeing of current and future generations. To support the co-ordination of carbon reduction, the NHS set out the requirement for trusts to develop a Green Plan to detail their approaches to reducing their emissions in line with the national trajectories. Given the pivotal role that integrated care systems (ICSs) play, each system are also required to develop its own Green Plan, based on the strategies of its member organisations. (NHSE. Accessed here).
Fuller Stocktake	The Fuller Stocktake report, published in May 2022, sets out a comprehensive vision for locally integrating primary care with system partners, built around a 'Team of Teams' and an improvement culture. (NHSE, 2022. Accessed here).
Health Equity	Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (for example, sex, gender, ethnicity, disability, or sexual orientation). It is the state in which everyone has a fair and just opportunity to attain their highest level of health. (WHO. Accessed here).
Health inequalities	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. These inequalities are understood and analysed across four, often inter-related, factors: socio-economic factors such as income; geographic factors such as the area where people live; specific characteristics such as ethnicity, disability or sexual orientation; and excluded groups, for example, people experiencing homelessness. (King's Fund, 2022. Accessed here).

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	Definition
HealtheIntent	HealtheIntent is a near-real time integrated health and care record in a population health management platform provided by a company called Cerner. It enables our frontline health and care teams to see where patients have gaps in care and creates a better understanding of population health needs and inequalities. (NCL. Accessed here).
Health and Wellbeing board	Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. (King' Fund, 2016. Accessed here).
Healthy life expectancy	Healthy life expectancy is the average number of years that a person can expect to live in good health.
Inclusion health Groups	Inclusion health groups describes groups of people who are socially excluded and may experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes groups of people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. NHS. Accessed here).
Inequality	Social inequality refers to differential access to and use of resources across various domains (e.g., health, education, occupations) that result in disparities across gender, race, ethnicity, class, and other important social markers.
Inequity	Inequity refers to a lack of equity, which means "justice" or "fairness." Where there's inequity in a community, it means injustice, unfairness, and bias are being perpetuated.
Integrated care	The aim of integrated care is to join up the health and care services required by individuals, to deliver care that meets their personal needs in an efficient way. (Nuffield Trust, 2021. Accessed here).
Integrated Care Board (ICB)	Integrated Care Boards (ICBs) are statutory NHS organisation that are responsible for developing a plan to meet the health needs of the population, managing the NHS budget and arranging for the provision of health services in the area covered by an Integrated Care System (ICS). ICBs replaced Clinical Commissioning Groups (CCGs) in July 2022.
Integrated care partnership (ICP)	Integrated care partnerships (ICPs) are statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop an integrated strategy on how to meet the health and wellbeing needs of their local population.
Integrated care systems (ICS)	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. An ICS is a way of working, not an organisation. Partners within the NCL ICS include: Acute Trusts, Mental Health Trusts, Community Trusts, Local authorities (Barnet, Camden, Enfield, Haringey and Islington), Healthwatch and VCSE (Voluntary, Community and Social Enterprise) sector. (NHSE. Accessed here).
Joint Strategic Needs Assessments (JSNAs)	JSNAs are assessments, produced by health and wellbeing boards, of the current and future health and social care needs of local communities. These are needs that could be met by services commissioned (bought) by the local authority, ICBs, or by NHS England to improve the health and wellbeing results of the local community and reduce inequalities for all ages. (GOV.UK, 2013. Accessed here).

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	Definition
Lower Layer Super Output Area (LSOA)	Small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. They were produced by the Office for National Statistics for the reporting of small area statistics. (GOV.UK: Accessed here).
Middle Layer Super Output Area (MSOA)	Middle Layer Super Output Areas are built from groups of contiguous Lower Layer Super Output Areas with appositely 5000 to 7200 residents. (NHS Data Dictionary. Accessed here).
Making every contact count (MECC)	The Making Every Contact Count (MECC) approach encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have conversations about how they might make positive improvements to their health or wellbeing. (HEE. Accessed here).
Neighbourhood	Neighbourhoods are areas where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (PCNs) and multi-agency neighbourhood teams. (King's Fund, 2022. Accessed here).
Personalised care	Personalised care means that patients have more control and choice when it comes to the way their care is planned and delivered, taking into account individual needs, preferences and circumstances. (Personalised Care Institute. Accessed here).
Personal Health Budget (PHB)	A personal health budget is an amount of money individuals receive to support their health and wellbeing needs, which is planned and agreed between patients and their local NHS team. (NHSE. Accessed here).
Population Health	Population Health refers to the health of an entire population. A population health approach. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies. (King's Fund, 2022. Accessed here).

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North Central London Integrated Care System

	Definition
The four pillars of population health:	The four interconnecting pillars of the King's Fund vision for a population health system are the wider determinants of health, our health behaviours and lifestyles, the places and communities with live in, an integrated health and care system. (King's Fund, 2018: Accessed here).
Primary care networks (PCNs)	Network of general practices that work together at scale to support improved practice staff recruitment and retention, management of financial and estates pressures, provision of a wider range of services, and better integration with the wider health and care system. (King's Fund, 2022. Accessed here).
Population health improvement	Population health improvement aims to improve the health of our entire population by improving physical and mental health outcomes and the wellbeing of people, while reducing health inequalities across the life course.
Population Health Management (PHM)	Population Health Management refers to the use of integrated data by health and care professionals to drive improvement and reduce inequalities. This enables a risk stratified approach to delivering the care that residents need, recognising that there are differing levels of needs amongst our communities and residents. (NHSE. Accessed here).
Primary prevention	Primary prevention aims to prevent disease or injury before it occurs. Example of primary preventions are: immunisation, education about healthy habits and legislation to promote healthy practices. (NHS. Accessed here).
Proportionate universalism	Proportionate universalism is an approach that aims at resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. It is the recommended approach to reducing health inequalities, as outlined in the Marmot Review (2010) following extensive consultation with experts in this field, and building on decades of academic research. (GOV.UK, 2010. Accessed here).
Personalised care and support planning (PSCP)	Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation. (NHSE. Accessed here).
Outcomes Framework	The Outcomes Framework provides a set of outcomes that reflect our population health ambitions for NCL across the life course. Organised around the three domains of Start well, Live well and Age well, these outcomes and indicators will enable us to identify areas of variation across the system, track progress and collectively hold ourselves to account.
The Barbers Round Chair Project	The Barbers Round Chair Project is a local Initiative in Islington where the local authority and the NHS partner up with local barbershops to deconstruct barriers to mental health support and create safe pathways into community mental health services . They do this by training local barbers in Islington to become community mental health ambassadors. (Islington Council. Accessed here).
Secondary prevention	Secondary prevention aims at detecting early stages of disease and intervening before full symptoms develop. (NHS. Accessed here).

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North Central London Integrated Care System

	Definition
Severe and multiple disadvantage	Severe and multiple disadvantage represents the most acute of our 20% most deprived, experiencing a complex and compounding set of issues associated with education, health, lifestyle, employment, income, social support, housing and criminal justice. For example, those experiencing homelessness, substance misuse and mental health issues. The nature of severe and multiple disadvantage (SMD) often lies in the multiplicity and interlocking nature of these issues and their cumulative impact, rather than necessarily in the severity of any one of them. SMD is distinct from other types disadvantage due to the degree of dislocation from societal norms these individuals' experience, which can make them reluctant or difficult to engage with services or solutions that could help.
Social prescribing	Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing.
Strengths-based	Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing.
System	System refers to a wide population area where partners in different sectors come together to set strategic direction and to develop economies of scale. The 'system' in NCL covers the population of 5 boroughs. (NHSE, 2019. Accessed here).
Tertiary prevention	Tertiary prevention denotes preventing complications in those who have already developed signs and symptoms of an illness and have been diagnosed. (Local Government Association. Accessed here).
Voluntary, community and social enterprise (VCSE)	The voluntary, community and social enterprise (VCSE) sector is an important partner for statutory health and social care agencies and plays a key role in improving health, well-being and care outcomes. VCSE are made up of charities, not-for-profit enterprises, informal, unregistered groups consisting of volunteers that act collectedly to provide a service to their local community.
Variation	Variation in healthcare is a difference in healthcare processes or outcomes, compared to peers or to a gold standard such as an evidence-based guideline recommendation.
Wider determinants of health	The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. (GOV.UK, 2018. Accessed here).

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North Central London Integrated Care System

Appendix 3: National context

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National context

North Central London Integrated Care System

National Challenges

Historically, health and care services across the country have operated autonomously. This has led to different organisations viewing residents primarily from their own perspective without alignment with other organisations.

However, this approach has resulted in people not always receiving high-quality care or having a positive experience, especially when requiring multiple services.

Furthermore, the COVID-19 pandemic has highlighted health inequalities across the country. Health inequalities are defined as avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions.

Considering these challenges, the Department for Health and Social Care set out national ambitions for more integrated health and care services, specifically:

- Successfully integrating care to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole.
- Aligning different parts of the system to prioritise prevention, early intervention and population health improvement.

New legislation and opportunities

The **Health and Care Act 2022** came into effect in July 2022 creating the statutory bodies that make up the ICS:

- **Integrated Care Boards (ICB) -** NHS bodies, taking on many of the functions previously held by the CCGs as well as some NHS England functions.
- **Integrated Care partnerships (ICPs)** bringing together NHS, local authority, and wider partners to focus on addressing wider determinants of health and developing integrated working.

The legislation also formalises the geographical footprint-based approach of system, place and neighbourhood and provides an opportunity to address our challenges by working together, specifically with the aims to:

- Deliver joined-up health and social care at all levels in the system, creating a less fragmented experience for patients and users.
- Develop a holistic approach to population health and tackle wider determinants through collaboration with public health teams, local authorities, voluntary sectors, and other key system partners.
- Enhance transparency and accountability by supporting engagement with local communities and providing local democratic oversight.

National initiatives

Much of the work we do builds on two national frameworks.

The **Fuller Stocktake** report sets out a comprehensive vision for locally integrating primary care with system partners, built around a 'Team of Teams' and an improvement culture.

At the heart of the stocktake are three core offers:

- **Streamlining access to care and advice**
- **Providing more proactive, personalised care with support from a multidisciplinary team of professionals**
- **Helping people to stay well for longer**

Core20PLUS5 is a national approach from NHS England to support the reduction of health inequalities at both national and system level. It has three areas of focus:

- **Core20** – Our 20% most deprived
- **PLUS** – Locally identified adult and child populations
- **5 clinical priorities** – There are separate Core20PLUS5 frameworks for both children and adults with different clinical areas.

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A key ingredient to change on the ground is how we join up and integrate care around individuals and communities

North Central London Integrated Care System

Joining up services to make care more personalised, holistic, effective and efficient is the goal of integrated care. Integration needs to be vertical and horizontal and work effectively at each level of the system. Our task as a population health system is to make sure that each level has a clear scope, well-defined roles and accountabilities and the infrastructure it needs to deliver

Vertical integration

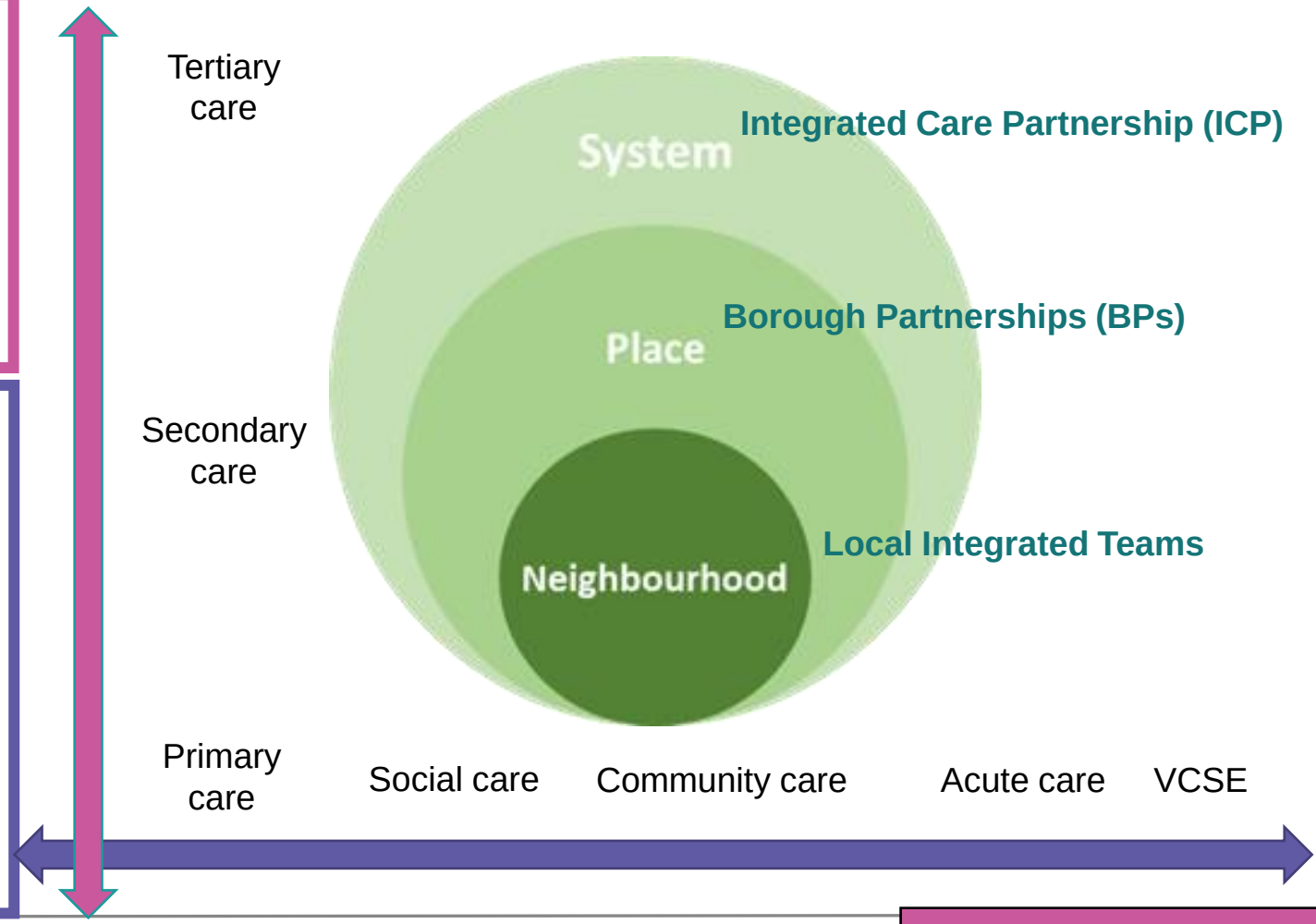
Aligning between healthcare providers to minimise handovers, maximise efficiency, address and incentivise downstream care and work across the whole continuum of need.

Provider collaboratives support vertical integration and can themselves improve the efficiency and effectiveness of horizontal integration (eg Lead Provider models).

Horizontal integration

Aligning across sectors to take a more holistic and hyper-local approach to care and a 'helicopter view' of the health and wellbeing of their local population - taking action on the wider determinants and reducing inequalities with a dual focus on improving quality and access.

The ICP and Borough Partnerships support horizontal integration. Borough Partnerships need infrastructure as well as clear accountabilities and responsibilities to deliver population health improvement. Horizontal integration at place is key for continuity of care as well as coordinated urgent care.



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Appendix 4: Our population health needs

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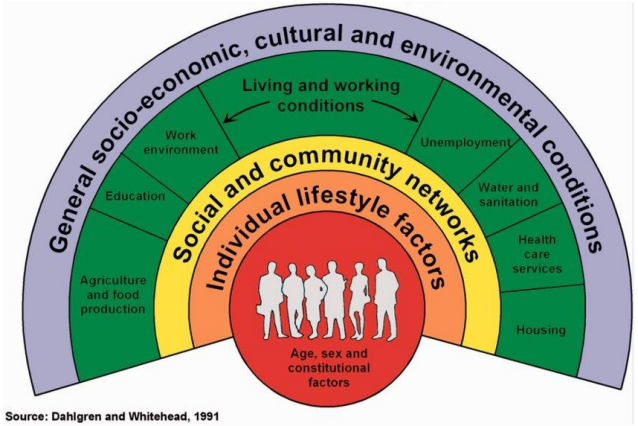
What we mean by population health

North Central London Integrated Care System

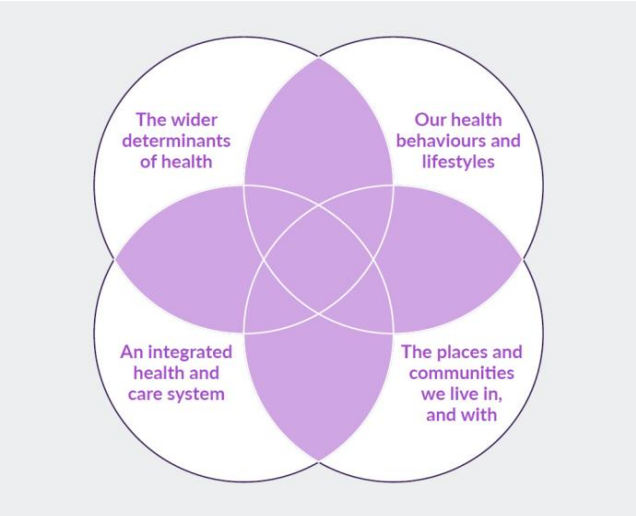
The health and wellbeing of individuals and communities are driven by a range of complex protective and risk factors that interact and accumulate across the life course.

These range from individual characteristics and lifestyle factors, to social and community networks, and the physical, social and economic environments in which we live, work and grow**.**

It was estimated by Public Health England (PHE) that 40-50% of health outcomes are attributed to the so-called 'wider determinants of health' like housing, education and employment and their unequal distribution across the population, a much greater influence than healthcare, lifestyle behaviours or genetics. Addressing the wider socio-economic determinants is a crucial part of preventing ill health and reducing health inequalities.



Source: Dahlgren and Whitehead, 1991



Population health aims to improve the health of our entire population. It is about **improving physical and mental health outcomes and the wellbeing of people, while reducing health inequalities across the life course.**

It includes:

- action to reduce the occurrence of ill health - **prevention**
- action to deliver appropriate health and care services – **early intervention and improvement**
- action on the wider determinants of health – **integrated and holistic support.**

The Kings Fund provides a **vision of a population health system** that achieves maximum impact on the health of a population through coordinated action across four, interconnected pillars:

- Our health behaviours and lifestyles;
- The wider determinants;
- The places and communities we live in and with; and
- An integrated health and care system.

It requires working with communities and partner agencies.

Sources: PHE, Wider determinants of health: An introduction https://fingertips.phe.org.uk/profile/wider-determinants; King's Fund's: A vision for population health, 2018 (p.18), https://www.kingsfund.org.uk/publications/vision-population-health; PHE 2019: Health matters: Prevention - a life course approach, https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach; Da and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.

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Health inequalities

North Central London Integrated Care System

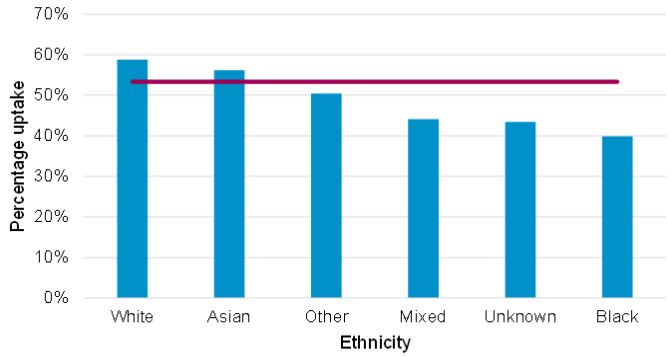
Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Health inequalities can involve differences in:

- health status, for example, life expectancy
- access to care, for example, availability of given services
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.

People may experience different combinations of these factors.

Disadvantage starts before birth and accumulates throughout life and the foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. Therefore it is important to **take a life course approach to improving health and tackling health inequalities**, starting with giving every child the best start in life, including preconception, and continuing through early years and adolescence, working age, and into older age.

Uptake of Covid-19 vaccination, NCL, August 2021



GP records, individuals' registered ethnicity by their GP, snapshot of records

Health inequalities follow a social gradient - the lower one's social and economic status, the poorer one's health is likely to be. As within the social gradient of health, everyone underneath the top has a greater risk of poor health, Marmot et al. (2010) in their first review of health inequalities proposed that resource allocation in healthcare should **follow the principles of proportionate universalism**, whereby health actions are universal but with a scale and intensity that is proportionate to the level of disadvantage. This will have the result of reducing the social gradient in health outcomes thereby reducing health inequalities. If we want to reduce unfair differences in health inequalities it is not enough simply to provide everyone with the same thing (equality) – we need to tailor our interventions and resources according to the needs of different population groups if we want to achieve equal outcomes (equity).

Health inequalities are largely preventable. **There is a strong social justice case for addressing health inequalities, but also a pressing economic case.** It was estimated at the time of the first Marmot review that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS and other services. This is likely to have increased.

As Fenton et al. (2020) showed**, the COVID-19 pandemic highlighted and exacerbated inequalities in health, in particular ethnic inequalities**. The unequal impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, cardiovascular disease and asthma. A key recommendation made by Fenton was the need to improve access, experiences and outcomes of NHS, local government and Integrated Care System-commissioned services and rebuild trust with our communities.

Inequalities are currently being further exacerbated by the rise in cost of living. We also recognise that climate emergency poses a major threat to human health and that **the populations most impacted by health inequalities are often those most impacted by climate breakdown and poor air quality.**

Sources: King's Fund: What are Health Inequalities? Update June 2022 https://www.kingsfund.org.uk/publications/what-are-health-inequalities; Marmot et al. Fair Society, Healthy Lives, 2010, https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf and Marmot et al. Health equity in England: The Marmot Review 10 years on, 2020 https://www.instituteofhealthequity.org/res
marmot-review-10-years-on-full-report.pdf ; Fenton et al (PHE) Beyond the data: Understanding the
impact of COVID-19 on BAME groups, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_th

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Our five boroughs: high level summary

North Central London Integrated Care System

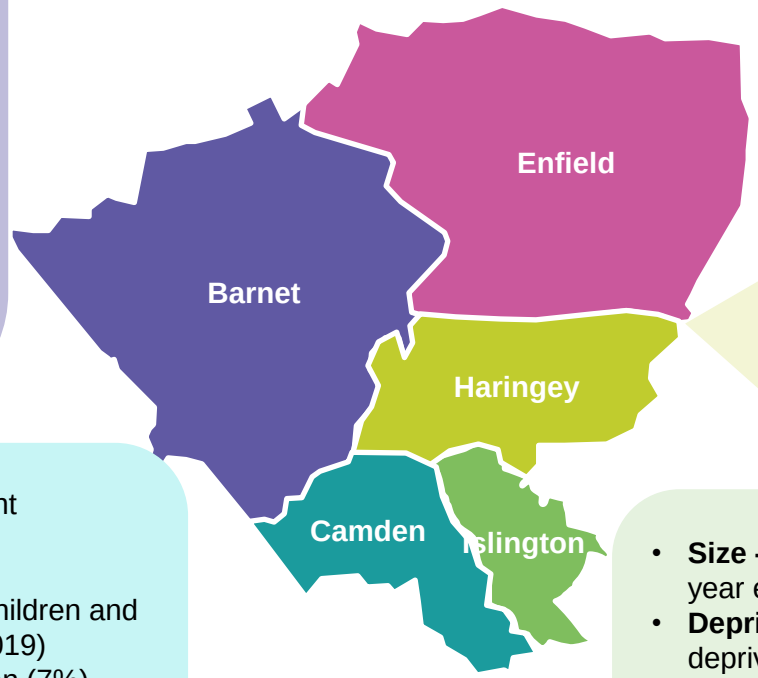
Further detail on each borough's population provided in Appendix 1.

Barnet

- **Size-** 425,395 registered population; 400,064 resident population (GLA mid-year estimate 2020)
- **Significant older population -** 6.8% of the population of is aged 75 years and over, an increase of 11% since 2011 (Census 2021).
- Deprivation **-** 15% of Lower Super Output Areas (LSOAs) in the 30% most deprived nationally (IMD 2019).
- **Ethnicity -** 19.3% of people in Barnet identify as Asian, 7.9% as Black, 5.4% as Mixed, 9.8% as Other and 57.7% as White (Census 2021)
- Barnet has a significantly higher Jewish population (14.5%) compared to the London average of 1.7% (Census 2021), predominantly living in the south of the borough.
- **Some other key needs:** Significantly higher percentage of older people living alone.

Enfield

- **Size -** 338,201 registered population; 334,710 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 7% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 17% for income deprivation affecting older people (2019)
- **Ethnicity - 33.1**% of people in Enfield identify as White British or Irish, 18.6% as White other, 18.3% as Black, 12.1% as Other and 11.5% as Asian (Census 2021). Significantly high proportion of Turkish, Greek and Cypriot communities residing in Enfield.
- **Some other key needs**: 42.2% Year 6 pupils are overweight or obese (2021/22) significantly higher than London; significant high level of GP-diagnosed diabetes in Enfield (8.4%) compared with London (6.8%).



Haringey

- **Size -** 298,418 registered population; 269,506 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 11% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 44% for income deprivation affecting older people (2019)
- **Key ethnicities -** Black African (9%) and Black Caribbean (6%) (Census 2021)
- **Other key communities:** Orthodox Jewish community in Seven Sisters and South Tottenham wards; and Turkish speaking and Eastern European communities
- **Other key needs -** 1.3% population have a severe mental illness (significantly higher than national average).

Camden

- **Size -** 303,267 registered population; 274,695 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 10% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 24% for income deprivation affecting older people (2019)
- **Key ethnicities** - Bangladeshi (7%) and Black African (7%) (Census 2021)
- **Some other key needs -** 6% of the population 18+ are diagnosed with depression (2020/21) compared to 4% NCL average and 1.4% have a severe mental illness (significantly higher than national average).

Islington

- **Size -** 257,135 registered population; 245,320 resident population (GLA mid-year estimate 2020)
- **Deprivation -** 29% LSOAs in the 10% most deprived nationally for income deprivation affecting children and 50% for income deprivation affecting older people (2019)
- **Key ethnicities:** Black African (8% of population) and Black Caribbean (3%) – particularly Somali (Census 2021)
- **Some other key needs -** 7% of the population 18+ are diagnosed with depression (2020/21) compared to 4% NCL average and 1.4% have a severe mental illness (significantly higher than national average).

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Our population's health needs (1)

North Central London Integrated Care System

To inform our strategy and outcomes framework we are starting a high-level NCL needs assessment to complement the borough Joint Strategic Needs Assessments (JSNAs). Some of our key population needs and challenges highlighted by our Outcomes framework, our borough JSNAs, our NCL needs assessment, our inclusion health needs assessment or major service transformations are shown here:

Poor health accumulates throughout the life-course

Start well	Live well	Age well

Key population drivers compound and lead to poor health outcomes and inequalities

Health outcomes

Pre-natal - There were 238 still births in NCL between 2018-20; Haringey has a significantly higher rate of stillbirths than the England average.

Infancy - Newborn hearing screening coverage across NCL is lower than London & England.

Early years - NCL has the lowest 2 year old MMR coverage in England.

Childhood - Hospital admissions for asthma are higher than average for children and young people in Islington and for epilepsy, Barnet has a higher rate.

The prevalence of mental illness in under 18s in NCL is almost double London average.

Hospital admissions for self-harm among young people are higher in Barnet and Islington compared to London.

Increasing mental and physical health needs and multi-morbidity - More than 1 in 4 people in NCL have a long-term condition (LTC). A quarter of those with LTCs have 3 or more conditions. 21% more people have 3 or more LTCs since the pandemic.

Nearly 6,000 new cancers are diagnosed each year, with rates higher in Enfield than London average.

Around 1 in 5 residents have a common mental health illness. Rates in Haringey and Islington exceed London rates.

NCL has the highest prevalence of severe mental illness (SMI), among ICS in England. Fewer than half of those with an SMI have a comprehensive care plan.

Missed opportunities for prevention and early intervention - Fewer than 1 in 3 people have an NHS Health Check, considerably lower than the London average.

Fewer than 3 in 4 people with Chronic obstructive pulmonary disease (COPD) have the flu vaccine, with coverage lower than London.

Cancer screening coverage in NCL is significantly lower than London - half of women do not get breast cancer screening.

All NCL boroughs fall short of the national standard that 60% of people with SMI should have a full physical health check in primary care.

Increasing needs – Haringey, Islington and Camden have among highest levels of frailty for 50+ in London. 65+ year olds with moderate/severe frailty are estimated to have increased by 15% due to the pandemic.

NCL has a higher prevalence of Dementia than London average but only 39% of people with dementia have had their care plan reviewed in the past 12 months.

Missed opportunities for prevention and early intervention - 24% early deaths in NCL (from cardiovascular disease, cancer and respiratory diseases) are thought to be avoidable (preventable and/or treatable).

65+ flu vaccination coverage is lower than London and England averages. Uptake is particularly low in Haringey.

1 in 5 older people went back hospital within 3 months of discharge into rehabilitation in NCL, higher than the London and England averages (2019/20)

Lifestyle risk factors

Smoking - 1 in 20 mothers are smokers at time of delivery, above London and England averages

Obesity - 37% pupils in NCL leave primary school overweight/obese, rising to 42% in Enfield. Obesity prevalence more than doubles from Reception to Y6.

Smoking - More adults smoke in NCL (16%) compared to London, with higher rates in the more deprived boroughs. Smoking cessation is lower in NCL than London

Obesity - While adult overweight/obesity levels are lower or no different than the London average, in Barnet and Enfield, nearly 60% are overweight/obese

Alcohol - While overall NCL has lower than average alcohol-related admissions, there are high rates in the most deprived boroughs, particularly Islington.

Health inequalities

Wider determinants

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Our population's health needs (2)

North Central London Integrated Care System

To inform our strategy and outcomes framework we are starting a high-level NCL needs assessment to complement the borough Joint Strategic Needs Assessments (JSNAs). Some of our key population needs and challenges highlighted by our Outcomes framework, our borough JSNAs, our NCL needs assessment, our inclusion health needs assessment or major service transformations are shown here:

Poor health accumulates throughout the life-course

Start well	Live well	Age well

Key population drivers compound and lead to poor health outcomes and inequalities

Health outcomes

Lifestyle risk factors

Health inequalities

Deprivation - Those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death compared to the NCL average. The prevalence of childhood asthma is almost double in the most deprived areas in NCL. People living in the more deprived areas of NCL have higher rates of GP appointments, A&E admissions and mental health contacts compared to those living in less deprived areas.

Ethnicity - Black communities in NCL are more likely to die prematurely from preventable (e.g. smoking cessation) or treatable (e.g. atrial fibrillation detection) causes of cardiovascular disease and are higher users of acute mental health services, with 27% of admitted patients being Black, compared to representing 11% of the NCL population.

Severe and multiple disadvantage and inclusion health groups - The average life expectancy of someone experiencing homelessness is only 45 years. The most acute of our 20% most deprived, experience a complex and compounding set of issues associated with education, health, lifestyle, employment, income, social support, housing and criminal justice and often fall through the gaps in service provision. They cost the system 10x that of an average resident.

Wider determinants

Education - Significantly fewer children in Enfield have good development at the end of Reception. Camden & Enfield have significantly fewer children achieving 5 or more GCSEs than the London average, only Barnet has more.

Poverty - Almost 1 in 5 under 16s live in poverty - Islington has the highest rate of child poverty in London.

Every borough in NCL has a higher percentage of older people living in poverty compared to the England average, equating to about 51,000 older adults.

Over a third of 60+ year olds in Islington live in poverty. A higher proportion of residents in Enfield (12.4%) and Haringey (14%) are in fuel poverty than the London average (2020).

These rates are likely to increase with the cost of living crisis.

Housing - Haringey has significantly higher levels of homelessness (22 per 1.000 households in 2020/21) compared to London and also overcrowding - at the time of the last census 16% households were overcrowded in Haringey, the 4th highest in London.

Employment - Significantly fewer residents are employed (71%) compared to London, with particularly low rates in Enfield. Only a third of people with severe mental health illness or a learning disability are in employment compared to nearly half in London.

Environment - Air quality (e.g. concentrations of PM2.5) is significantly poorer in Camden, Haringey and Islington than London, and poorer in all boroughs compared to England; air pollution accounts for 1 in 20 deaths. Between 2000-2019 there were 170 excess deaths attributable to heat in London each year.

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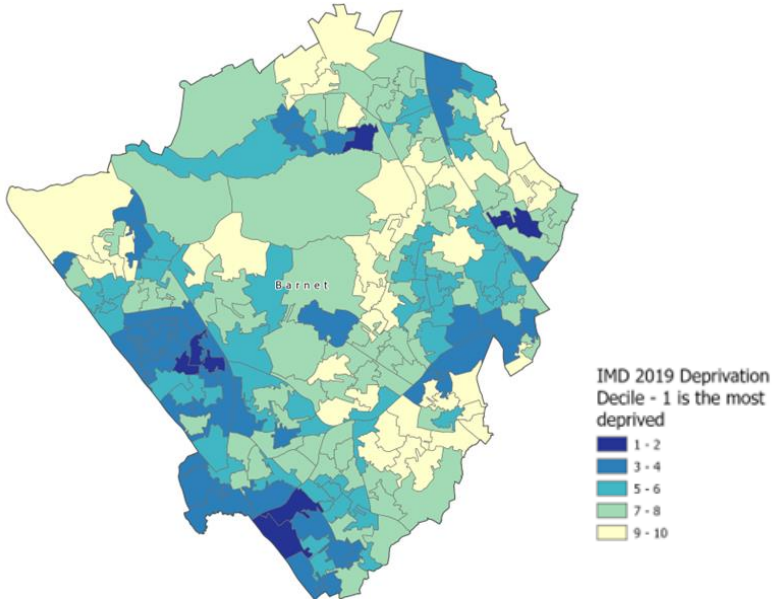
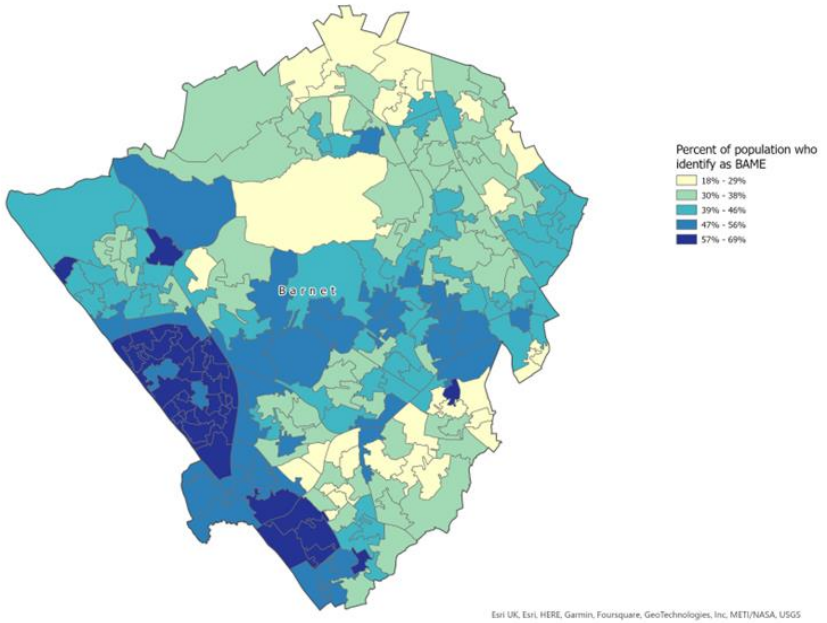
Barnet's population

North Central London Integrated Care System

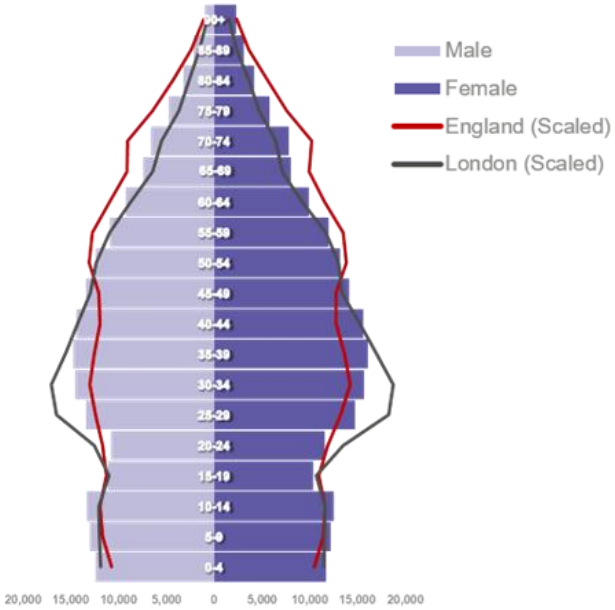
Deprivation profile by LSOA (IMD 2019)



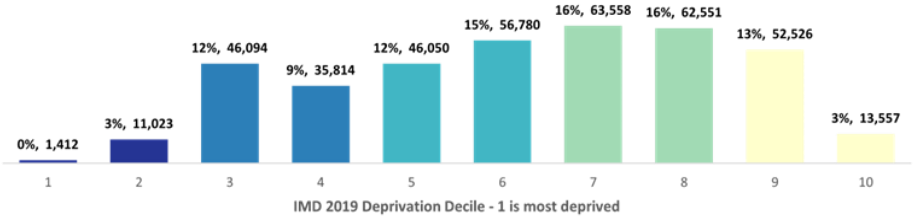
Ethnicity profile by LSOA (Census 2021)



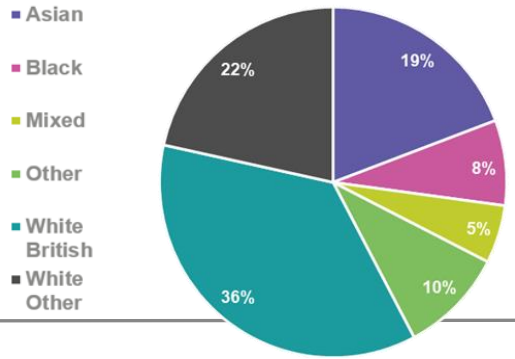
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- 14.5% of people in Barnet are Jewish (Census 2021), significantly higher compared to the London average of 1.7%. The top three middle super output areas (MSOAs) in Barnet having the largest population of Jewish residents are in the south of the borough; Golders Green North (53.1%), Hendon Park (43.9%) and Hampstead Garden Suburb (42.9%) which, aside from Garden Suburb, are amongst the most deprived areas of Barnet.
- Ethnic groups with high proportion living in most deprived 40% - 0-18s of Black African ethnicity

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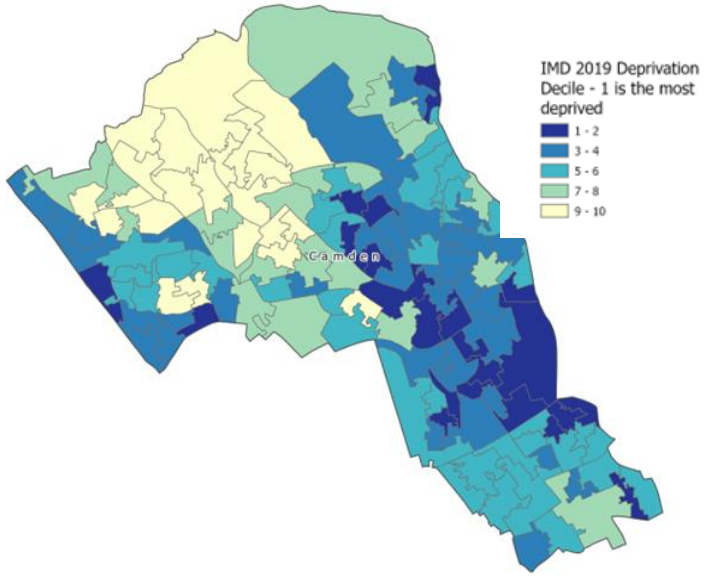
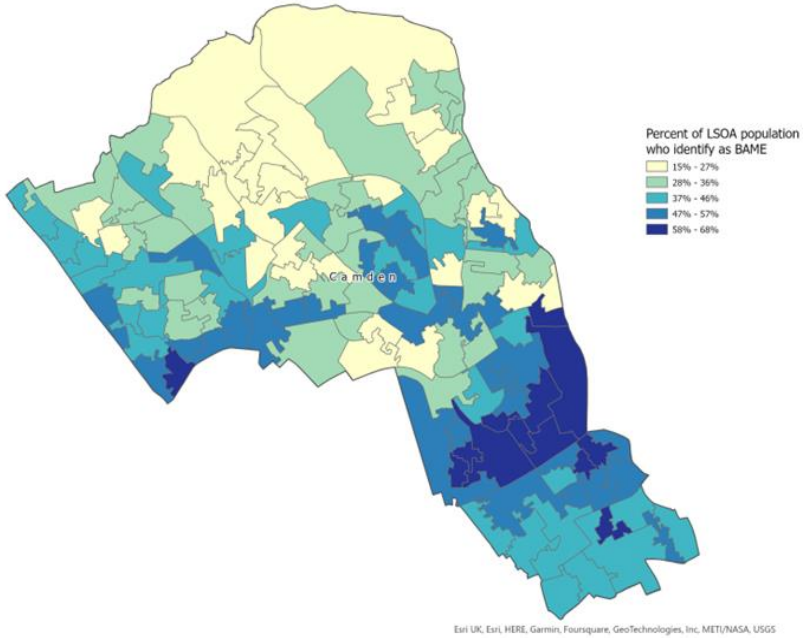
Camden's population

North Central London Integrated Care System

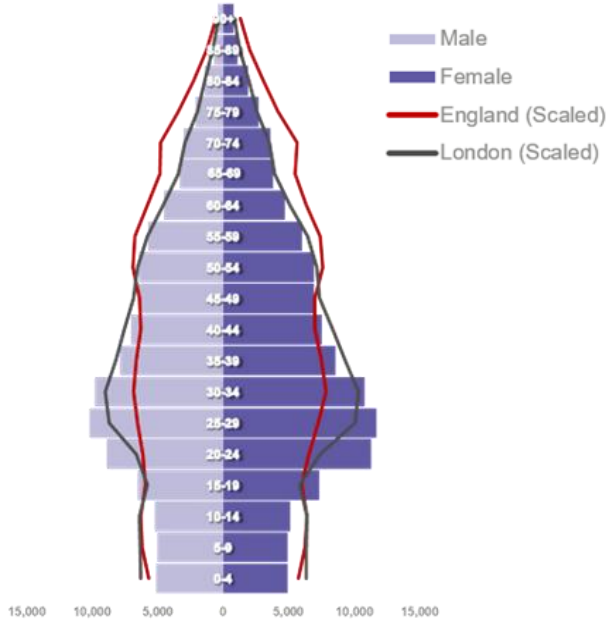
Deprivation profile by LSOA (IMD 2019)



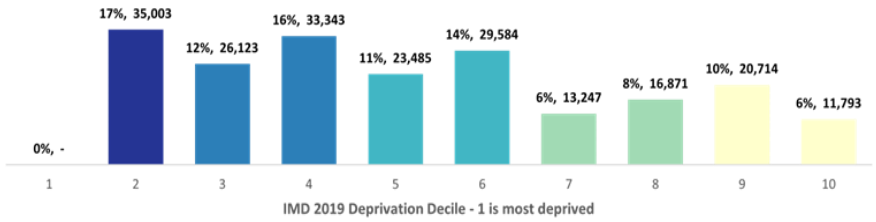
Ethnicity profile by LSOA (Census 2021)



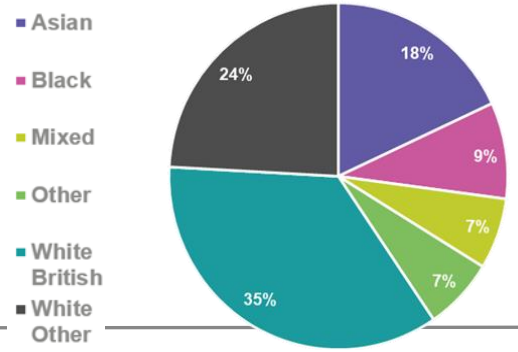
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Bangladeshi (7%) and Black African (7%) (Census 2021)
- Ethnic groups with high proportion living in most deprived 40% - 0-18s of Bangladeshi and Mixed Black ethnicities

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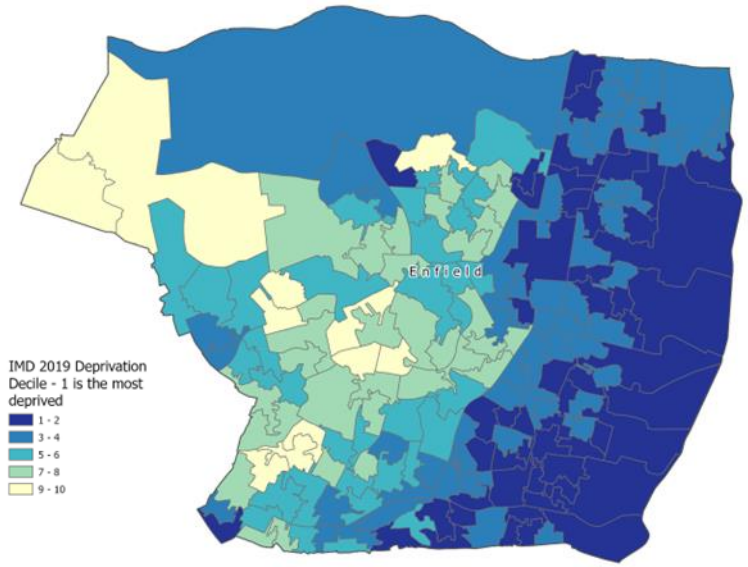
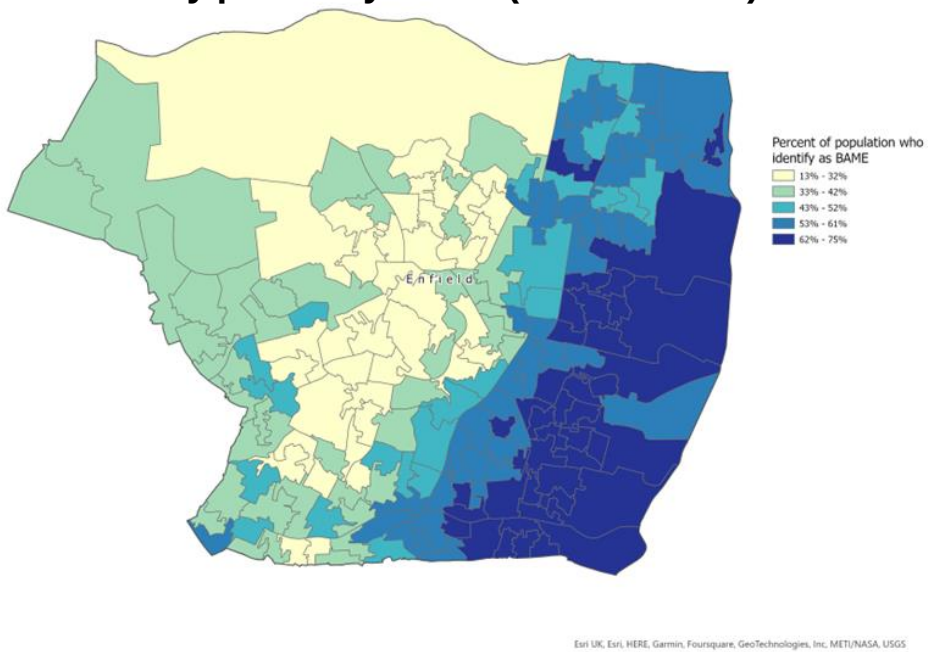
Enfield's population

North Central London Integrated Care System

Deprivation profile by LSOA (IMD 2019)

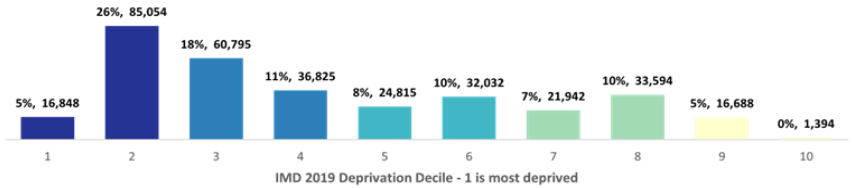


Ethnicity profile by LSOA (Census 2021)

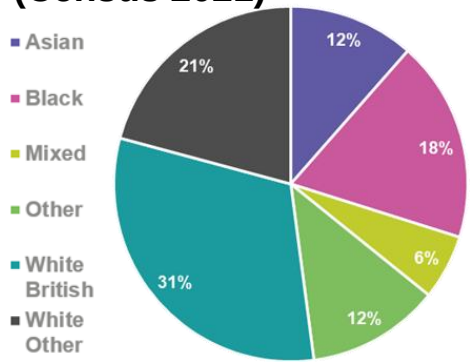


Age and sex profile (Census 2021)

Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Bangladeshi (7%) and Black African (7%) (Census 2021)
- Ethnic groups with high proportion living in most deprived 40% -
  - 0-18s - Black African, Black Somali, Bangladeshi
  - 19-64 – White Turkish and White Bulgarian
  - 65+ - Black Caribbean

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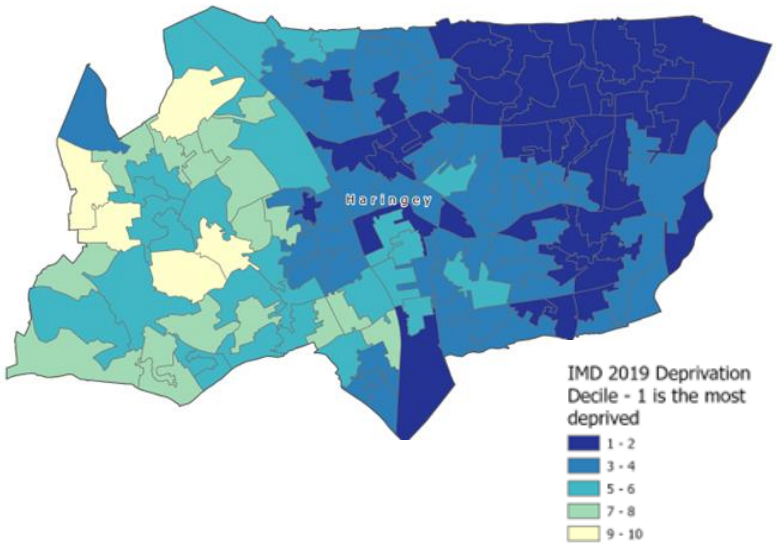
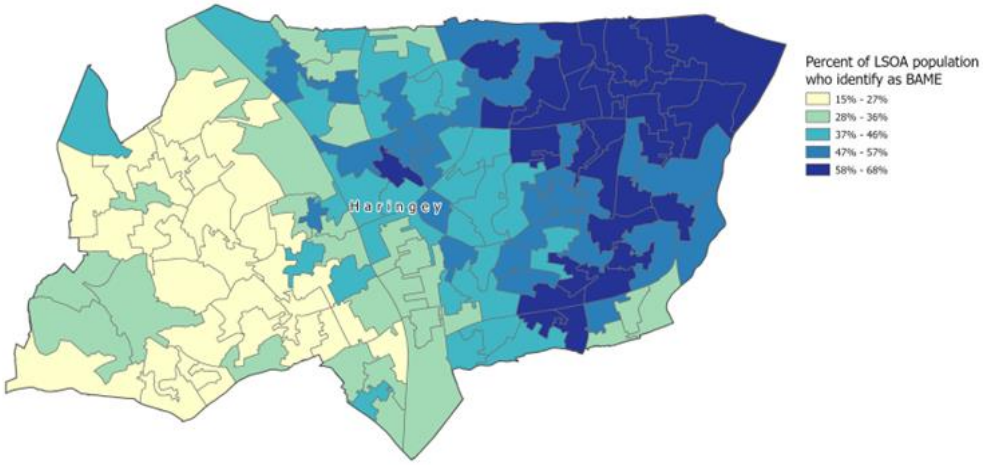
Haringey's population

North Central London Integrated Care System

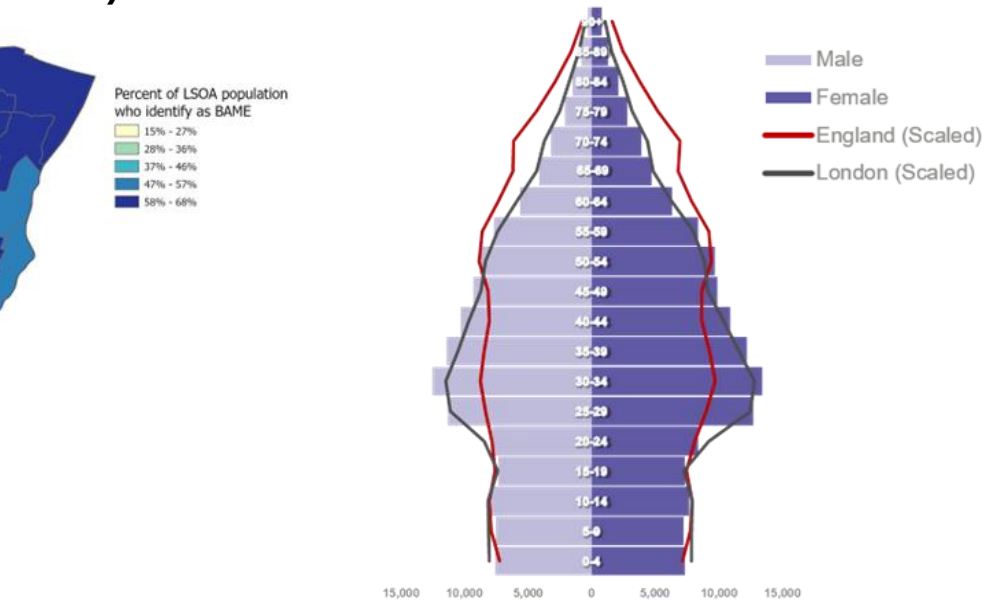
Deprivation profile by LSOA (IMD 2019)



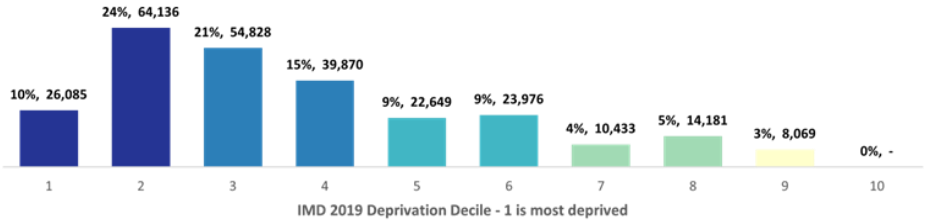
Ethnicity profile by LSOA (Census 2021)



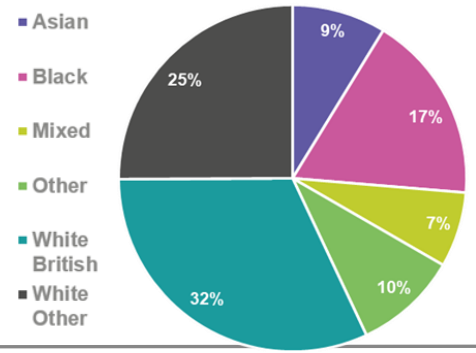
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Black African (9%) and Black Caribbean (6%) (Census 2021)
- Other key communities: Orthodox Jewish community in Seven Sisters and South Tottenham wards; and Turkish speaking and Eastern European communities
- Ethnic groups with high proportion living in most deprived 40% -
  - 0-18s - Black African, Black Somali,
  - 19-64 – White Turkish and White Bulgarian
  - 65+ - Black Caribbean

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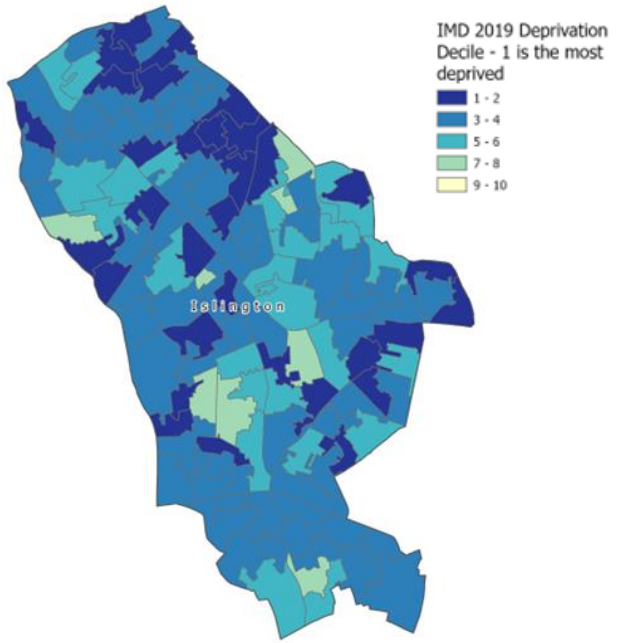
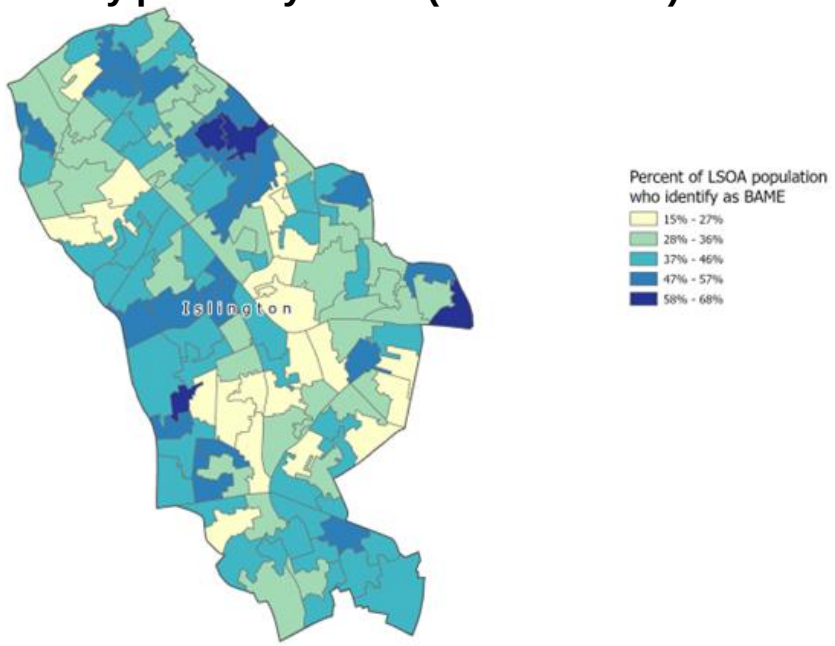
Islington's population

North Central London Integrated Care System

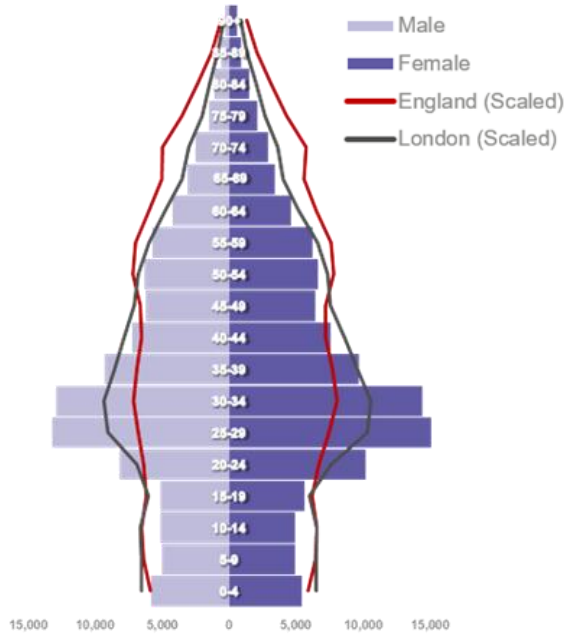
Deprivation profile by LSOA (IMD 2019)



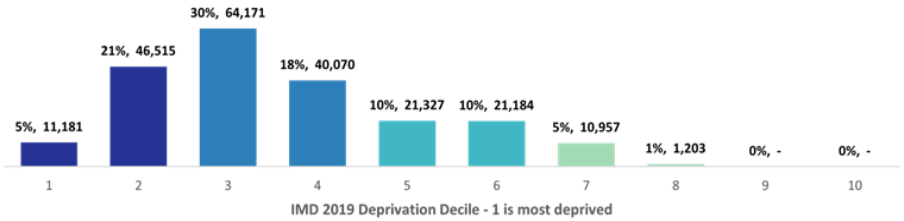
Ethnicity profile by LSOA (Census 2021)



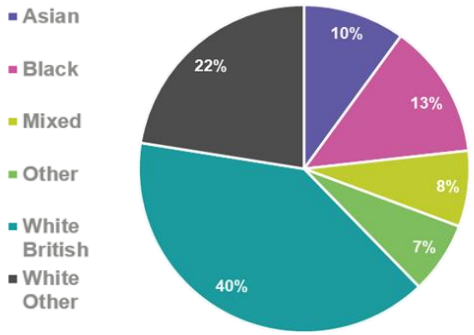
Age and sex profile (Census 2021)



Number and proportion of population in each deprivation decile (national ranking) (IMD 2019)



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

- Key ethnicities: Black African (8% of population) and Black Caribbean (3%) – particularly Somali (Census 2021)
- Ethnic groups with high proportion living in most deprived 40% - 0-18s of Black African, Black Somali and Mixed Black ethnicities

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North Central London Integrated Care System

Appendix 5: What our communities tell us

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What do our communities say?

North Central London Integrated Care System

A snapshot of some of the recent feedback from our communities is captured below, but we will continue to engage, work with and listen to our residents and communities about what is important to them, what is working well and what needs improvement.

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North Central London Integrated Care System

Appendix 6: Our system challenges

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Our system challenges

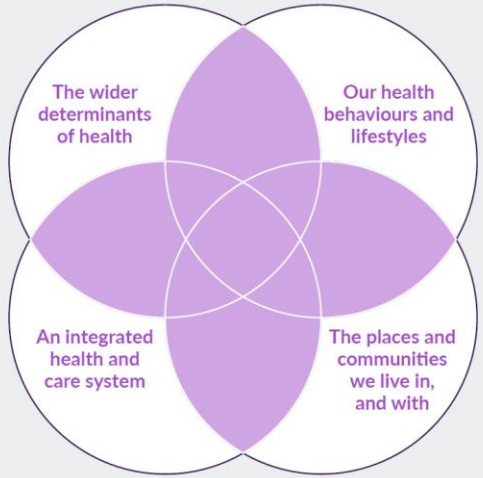
North Central London Integrated Care System

We know our population needs, outcomes and priorities but we also know that working in the way we always have will not be enough to achieve change

Our health and care system is fragile and beset with big challenges.

We have worked across health, care and voluntary sector partners to agree what we see as our system challenges.

We will meet these challenges through describing the change we need to make and the 10 key principles that will help us get there



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Our system challenges (1)

North Central London Integrated Care System

While we are driving efficiencies across the system, we are struggling to meet the growing and increasingly complex needs of our population	**For example:** • Primary care appointments across NCL increased by 23% from February 2020 to February 2022 • NCL outpatient appointment rates (pre-Covid) almost doubled for each condition a patient has, reaching an average of 7 appointments per year for those with 3 or more LTCs, while emergency admission rates increased more than tenfold (3.5 patient events per year per 100 population for those with no LTCs, compared to 38.5 patient events per year per 100 population for those 3 or more LTCs) • NCL has reduced our long waiting cohort (patient waiting over a year) by just under one third (32%) since Jan 2022, by far the largest reduction in London (average 10% growth) • However, 260,000 patients in NCL are waiting on an acute treatment pathway, a 30% increase on pre-covid levels • Increased demand and costs of services led to a 6% increased net spend on adult social care across North London Councils between 2019/20 and 2020/21 • Councils are delivering significantly more 24-hour packages and double up care for adult social care, while care home placement costs are rising close to the rate of inflation. • There has been a 24% increase in rough sleeping in the London overall in 22/23 (CHAIN report) with a 35% rise in those new to the streets compared with the same period last year" as example of impact we are already seeing re cost of living
Alongside historic differences in funding across the system, we are facing relentless financial pressures compounded by the cost-of-living crisis	**For example:** • The NHS in NCL is currently operating a £45m deficit • From 2017-18 to 2019-20, there was considerable variation in place-based allocations for community health services across NCL, with Enfield receiving the least and between 16% and 20% less funding per weighted capita compared to Camden with the highest allocation. • The average savings targets for local authorities in London for 2023/24 is forecast to be double the targets for 2022/23, level of greater than at any time since 2016
Our health and social care pathways are fragmented, acute-focused and demand-driven which leads to poorer outcomes for our population as well as inefficiencies, duplication and waste across the system	**For example:** • Acute health services accounted for more than half of (52%) of NCL's £1,493.6m of spend in 2020/21, even though primary care makes up 80-90% of health care contacts. • Between April 2018 and December 2020, nearly half of all adult admissions to Barnet, Enfield and Haringey Mental Health Trust were not under the care of any community mental health service at the point of admission. • Fragmentation and complexity in children's health and care service commissioning and delivery can delay and disrupt care impacting patient experiences and outcomes, as well as increasing the risk of children, particularly those with complex needs, falling through the gaps.
We have inequity and variation in service access, delivery and investment across NCL, which does not always reflect our population and their needs	**For example:** • Enfield's prevalence of diabetes is twice that of Camden (10% compared to 4%) yet the community diabetes resource is less than half the size 1.6fte compared to 3.5fte diabetes team staff per 100,000 weighted population • In Haringey children and young people have higher mental health needs relative to other boroughs, with highest number of children and young people presenting at A&E with mental health issues, but the spend per head is lower than NCL average
We do not operate as one system, and do not always understand the drivers, challenges and strengths of our partners	**For example:** • Divergent governance, funding mechanisms and capacity across the system can limit the ability of organisations to effectively plan, design and deliver collaborative initiatives • The statutory sector can both overestimate (short lead-in time for projects; misalignment between referrals and resource) and underestimate (underutilisation given the scale and reach on specific issues, with specific communities, often at hyper-local level) the capacity within the VCSE.

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Our system challenges (2)

North Central London Integrated Care System

Our workforce is stretched, we have rising levels of staff vacancies and falling retention across health and social care provision, and our senior staffing does not reflect our local population	**For example:** • Current staff vacancies stand at 11% for NHS staff and 12.7% for adult social care, the latter more than doubling since between 2020/21 and 2021/22 although still below the London average. • With just under one third of social care workers aged over 55 years, approximately 10,000 care staff in NCL will retire in the next 10 years. For NHS providers in NCL this figure is 14.4% of workers, equal to 6,400 staff • Average pay in the independent caring sector is £9.93 per hour, well below the London Living Wage of £11.95 per hour • The VCSE sector is also facing recruitment and retention issues, including reduced volunteer numbers, limited capacity to pay staff more competitively resulting in loss of staff to similar but better paid roles in partner organisations, exacerbated by current rising costs and unpredictability of contracts. • The proportion of NCL staff from Black Asian and minority ethnic backgrounds increased by from 42% in 2019 to 46% in Jun 2022. However, there were significant differences by band: for example, 57% of Band 5 staff in NCL were from Black, Asian, compared to only 27% of Band 8 and 9 (London average 27%, national average 14%)
We do not always recognise and utilise the broad expertise, knowledge and strengths of our communities and voluntary sector	**For example:** • Insufficient funding and resourcing for wider engagement and collaboration, including capacity and infrastructure for strategic thinking conversations - production of work tends to be within allocated block • Fragmented short-term funding cycles, with a lack of alignment of funding and resourcing across NCL, which creates inefficiencies and instability and limits the reach of the sector • Not involving the sector in system solution-solving discussions and not giving them a 'seat around the table' as plans are developed and decisions are made • Although we have a strong VCSE Alliance in NCL, it remains challenging to capture the input and share feedback to such a broad and diverse sector - particularly for smaller organisations with less visibility • Complex ICB processes limit smaller grass roots organisations from fully engaging in our work, which in turn may limit representation of under served communities.
The climate crisis and ecological emergency pose serious threats to our system and our population, via direct impacts on health and wellbeing, impacts on the wider determinants and disruptions to health and social care delivery	**For example:** • In England, the NHS responsible for an estimated 4% of the country's carbon footprint, and 40% of the total public sector footprint. • Between 2000-2019 there were 170 excess deaths attributable to heat in London each year • All five NCL boroughs have declared climate emergencies • A London Councils poll in September 2022 showed 62% Londoners felt their day-to-day life had been impacted by climate change, compared to 55% last year
Our estates and facilities are not fit for purpose, future proofed, and are not conducive to integrated and collaborative working	**For example:** • While 56% of Camden and Islington GP practices received a Quality rating of Raw Grade B, just under 40% were rated Raw Grade C • There is an opportunity to improve maternity and neonatal facilities within NCL, ensuring that the estate does not detract from the care or birth experience – for example we know that current the maternity and neonatal estate at the Whittington Hospital does not meet agreed modern standards.
While digital innovation has supported improved service access and experience for some groups, this is not universal and issues related to digital exclusion and online safety remain	**For example:** • Issues related digital inclusion affects around one in seven people in the UK; • Digital exclusion exacerbates existing inequalities – digital exclusion is 4x more likely in those from low-income households; those digitally excluded are 8x more likely to be aged over-65 years ; 56% of adult 'non-internet' users are disabled

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Appendix 7: Key pathways rationale

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Our five key pathways are mapped across the life course

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Key risk areas

NCL population health improvement key risks

START WELL

Childhood immunisations

LIVE, WORK AND AGE WELL

Heart health - preventing heart disease and strokes

Cancer - prevention, early detection and good quality care for all

Lung health – e.g. asthma and COPD (chronic obstructive pulmonary disease)

WHOLE LIFECOURSE

Mental health and wellbeing (all ages)

Focus on communities and population cohorts experiencing severe and multiple disadvantage across all the priority areas.

RATIONALE

Multiple common risk and protective factors that provide opportunities for influence across the life course

Lifestyle factors such as smoking, alcohol, diet and physical activity

Wider determinants such as deprivation, housing, and air quality

Key contributors to health inequalities, and early and avoidable death across NCL

NCL is an outlier in London for coverage

Biggest causes of avoidable death (largely preventable and treatable)

Next highest cause of avoidable mortality and long term health problems

Increasing prevalence and underpins other aspects of wellbeing

- Inequalities in opportunity, access, experience, outcomes
- Drivers of high health and social care use, poor quality of life and number of years of life lived in poor health
- Affect large (and increasing) numbers of people - so potential for large population health gain

Opportunities for improvement across the pathway with contributions from partners across NCL, and advantages of tackling at an NCL-level

- Opportunities to rebalance the system - greater focus on prevention, early intervention and self-management, reducing future need
- Work already underway – to incorporate population health approach; and start to identify improvement ambitions and levers and some quick wins
- Overlap with the 5 clinical areas in Core20PLUS5.

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Rationale for starting with childhood immunisation

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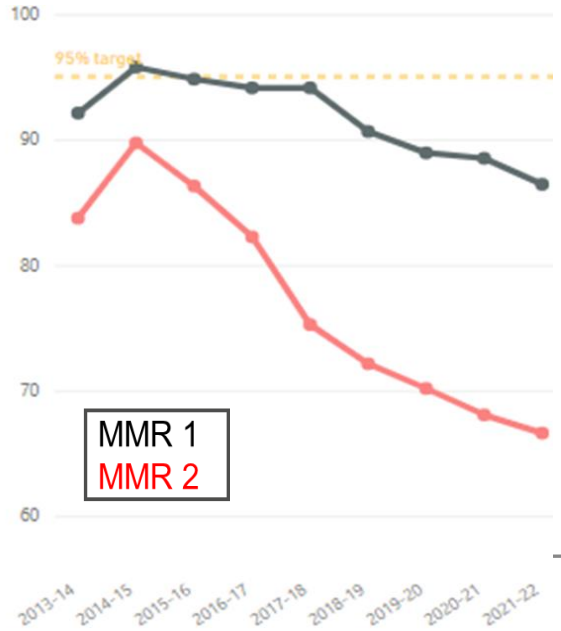
Contributes to meeting the following population health outcome within the Outcomes Framework:
Every child has the best start in life and no child is left behind: Increased immunisation and newborn screening coverage

NCL is an outlier in terms of vaccination coverage:

- Coverage is below London and far below England for almost all childhood immunisations across NCL as a whole, and in individual boroughs
- Coverage for Measles, Mumps and Rubella combined vaccine (MMR) by age 5 (69% in 2020/21) is far below the level for herd immunity and to achieve and sustain measles eradication (95%)
- NCL is the worst ICB in London for MMR first dose coverage.

MMR by age 5, Islington (% coverage), Cover data



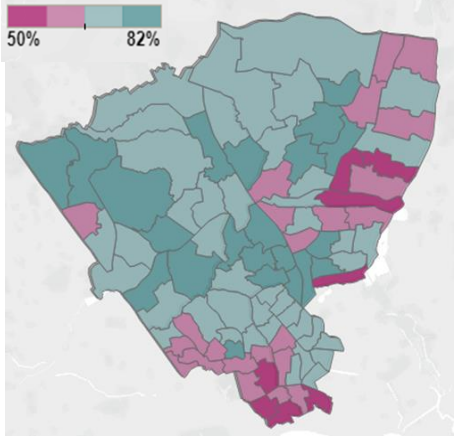
Population health fit and key inequalities:

- Proven, cost-effective, preventative intervention to improve public health - vaccinations have transformed the health of children across the world to prevent disease, long term disability, reduce deaths and rates of related illnesses and complications as well as build and develop 'herd immunity' which is essential to protect those who are unable to be immunised or vulnerable
- Uptake is lower amongst some communities– with lower routine childhood immunisation uptake in areas with high level of deprivation and a correlation between low uptake and some ethnicities and languages spoken
- We need to understand and work with communities who have low uptake through a hyperlocal approach.

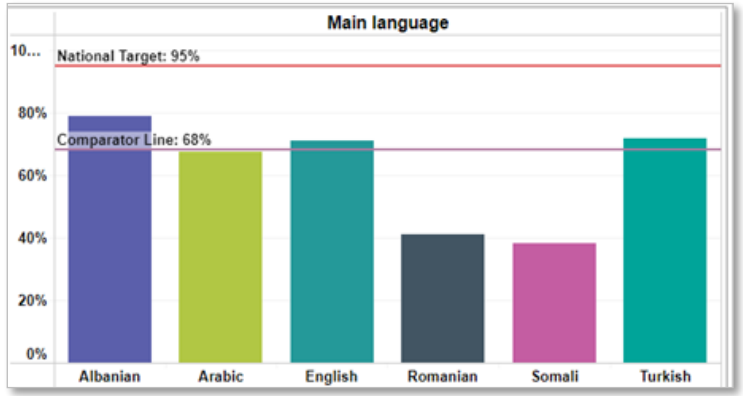
Key local levers:

- Build on learning from the COVID vaccine and the pan-London Polio campaign – around communication and community engagement, cross-system working, outreach, IT infrastructure and data flow, workforce and use of alternative providers.
- Insight from borough-based Parent / Carer Surveys to help us understand the barriers, motives and opportunities towards childhood immunisations - Barnet & Enfield completed in 2022; Islington, Camden & Haringey planned 2023

% population having all routine childhood immunisations at age 5, HealtheIntent



% population having all routine childhood immunisations at age 5, by the six most commonly spoken languages, HealtheIntent



Comparator line shows NCL coverage

Opportunities to improve performance and reduce variation with input across our ICS:

- Learning from Covid vaccination and areas with higher coverage, both within and across boroughs
- Since 2018-19, with the exception of Barnet, there has been a general decline in coverage across childhood immunisations, although coverage has picked up in Camden in 2020-21
- There are opportunities for improvement through patient education at key touchpoints before birth and throughout childhood; community engagement using a cross-system approach; as well as for improved process through service providers e.g. improved call recall and access.
- Improvement requires a whole-system approach, by those providing vaccinations (primary care, school nurses) and utilising opportunities through wider system partners including early years settings, health visitors etc.

Other drivers:

- Key indicator of primary health care performance
- Opportunity to improve how we engage with our communities across a range of healthcare issues and build trust in the health system more generally
- Provides a key infrastructure for encounters with medical professionals as a children grow and develops.

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Overview of Core20PLUS5 (adults and children)

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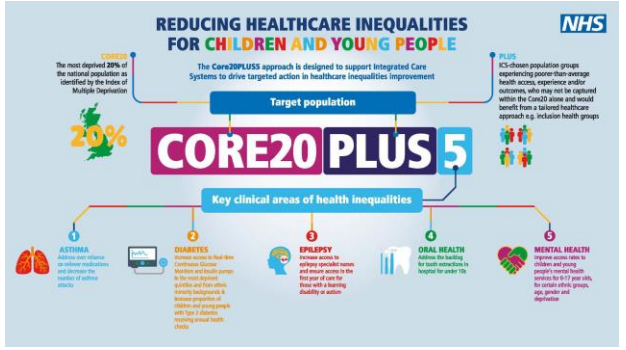
- **Core20PLUS5** is a national approach from NHS England to support the **reduction of health inequalities** at both national and system level, which we are implementing in NCL. It has three areas of focus:

CHILDREN & YOUNG PEOPLE

ADULTS

Core20 population
Our 20% most deprived

5 Clinical priorities
Asthma
Diabetes
Epilepsy
Oral health
Mental health



5 Clinical priorities
Maternity
Cancer
Severe Mental Illness
COPD
Hypertension

PLUS populations
Children with special educational needs and disabilities (SEND)

Children Looked After (CLA) and care leavers

Children and young people from select Black, Asian and Minority Ethnic groups (to be defined and tailored to reflect nuance at Borough level)

PLUS populations
Inclusion health groups:
- People experiencing homelessness
- Gypsy, Roma and Traveller communities
- Sex workers
- Vulnerable migrants*
- Adults with a history of imprisonment

Select Black, Asian and Minority Ethnic groups (to be defined and tailored to reflect nuance at Borough level)

Adults with learning disabilities

Adults with severe mental illness

* To include children and young people where relevant as part of a family approach to supporting asylum seekers and vulnerable migrants

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Appendix 8: Borough Partnerships Decision Framework

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DRAFT FOR DEVELOPMENT

Our existing framework – key questions to consider

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Ambition/ vision	• How do we address issues like poverty and exclusion in the context of shrinking budgets? • There are differing levels of deprivation – how will areas with significant inequalities receive [as much] focus, funding and support as other parts of NCL? • How do we engage residents and who does what?
Leadership	• Who has what responsibilities and how does it play into our accountability (individually and collectively)? • How do collaborative leaders lead people from different organisations? Who has the power to direct actions? • What is the leadership role of provider organisations? Voluntary sector leaders? • In the absence of formal designated roles how will the borough partnership and neighbourhoods provide effective clinical & professional leadership? If formalised how does that ensure engagement and 'buy-in' from the constituency?
Functions, accountability and governance	• What is the role of the borough partnerships in quality improvement and performance? Where do regulatory powers sit? How is this changing across health and local gov? • How do we hold each other to account? Who are the decision makers? Do all partners have equal accountability, responsibility and rights? • Who is the BP accountable to? And who is accountable to it? • What is the role of and interface with the provider alliance(s)? • What steps might be taken to move towards a single accountable person / single point of accountability for place? Might this look different across the 5 partnerships?
Priorities	• We need to explore 'what trumps what' – when do collective priorities trump individual organisational responsibilities or vice versa? • What process will we follow to understand the extent to which these align or don't?
Neighbourho-ods	• What are we expecting from neighbourhoods? • Are they delivery units for more than General Practice? • How much is this about self-organisation? Are they top down, or bottom up – or both? Why have we not landed this in the past? • What counts as good & how would we identify a neighbourhood that was struggling? • Infrastructure - what do we need and how is this achieved?

Commissioni-ng and procurement	• Do we still follow some / all of the commissioning cycle? Do we still follow an annual process? • Local authorities and the ICB still have substantial commissioning and procurement roles, but these are shifting significantly in health. • Is joint commissioning 'old world'? If so, what is new? What does this mean for the Borough Partnerships and how does it work in practical terms?
Resident and community engagement	• How do we communicate who we are and why we exist? • Do BPs need branding? What should that look like? • Do BPs need individual websites? What should that look like?
Outcomes and impact	• A lot of work has already been done on outcomes at place – is the origin and process understood? Will this be unravelled? • Is it clear how this reflects NCL residents needs and priorities and how understanding of this will be dynamic and maintained? • Do borough partnerships feel ownership of these outcomes? • Should the ICS protect local priorities, and bridge between these and national objectives where they are in conflict?
Resources and capability	• Does each borough have an engine room? Who is in it? are these full time posts? Secondments? • What skills are needed? • Do all Council and Health teams and capabilities contribute e.g. for councils more than care and public health? • What does this mean for resourcing models, for staff engagement and for leadership and management? • How are resources prioritised in line with shared priorities – for example S106/CIL to support primary care, competing with affordable housing, community centres etc • How do other teams engage in & support the borough partnerships?

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