North Central London
Health and Care
Integrated Care System

NHS

Delivering Population Health and Integrated Care Ambitions in Haringey

Haringey Health and Wellbeing Board

28th November 2024

NCL Population Health & Integrated Care Strategy and Delivery Plan overview

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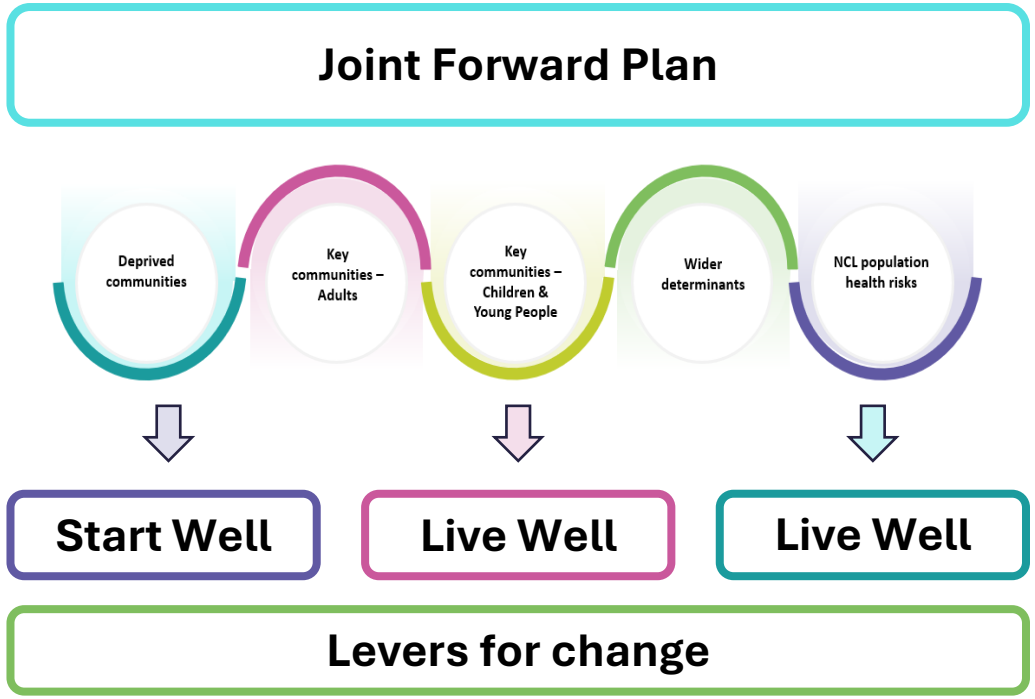
Our NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. The Strategy can be found here. It outlines our ambition to **tackle health inequalities** by a **shared emphasis** on **early intervention, prevention and proactive care**.

Since April 2023, significant socialising and planning work across the ICP has culminated in the development of our **NCL Delivery Plan** (which also serves as our Joint Forward Plan (JFP)), which outlines our critical path to **deliver against our PH & IC Strategy**. The NCL Delivery Plan can be found online here.

The Delivery Plan describes progress in implementing the strategy over the last 12 months, our plans for the coming 18 months and how we will monitor delivery using the NCL Outcomes Framework. The plans are aligned to a life course approach and incorporate:

- NCL communities experiencing the poorest outcomes, wider determinants of poor health and 5 key health risk areas
- NCL system transformation programmes, which are aligned to delivering our population health ambitions
- System levers which will create the conditions for population health improvement
- A number of areas within the plan have been identified by the ICP to "**super-charge**" - making the **best use of the collective weight** of the ICP to **accelerate and deepen impact**.



Work to develop Population Health approach since April 2023

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- **Engaging and socialising** the Delivery Plan with Health & Wellbeing Boards, Trust Boards, Borough Partnerships, forums involving the VCSE and patient representatives. This has culminated in the publishing of resident-focussed content which can be found online here.

- **Developing the NCL Outcomes Framework and launching the online dashboard to support monitoring –** *the dashboard can be found here*. Data in the dashboard are at Borough and NCL level, compared to London and England. There is also an Outcomes Framework annual insights report at NCL and borough level *(Camden content appearing later in the pack)*.

- **Understanding and starting to align plans across borough and system** to maximise the impact of our joint working.

- **System Progress on Population Health outcomes** is set out in detail in the Delivery Plan. Improvements include:
  - Mental Health – Longer Lives: The proportion of adults with SMI having a physical health check increased by 44%
  - Improved the uptake of Targeted **Lung Health** Checks from 30% to 55%. Over 20,000 people have now had a lung health check.
  - **Inclusion Health** needs assessment completed which has been identified as an example of good practice in national guidance and over £1m invested in integrated homelessness discharge support post hospital

NCL Outcomes Framework Insights Report 23/24 Summary

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The NCL Outcomes Framework (OF) annual insights report summarised key insights at NCL and borough level from the NCL OF dashboard. The report demonstrates that while we have made **some progress, the five population health risks identified in the PH&IC remain relevant and require ongoing system and borough focus**, and there are also broader areas requiring focus across the life course (Start Well, Live Well and Age Well).

Childhood immunisations
Although there has been notable, steady improvement in the proportion of children who have been fully vaccinated by age five, 31% of children in NCL were not fully vaccinated by the end of 2022/23

Cancer
Despite steady improvement in bowel cancer screening over recent years, overall cancer screening coverage is poor, with all boroughs except Enfield having lower coverage than London in at least one programme in 2023

Mental health and wellbeing
The proportion of adults with SMI having a physical health check increased by 44% from 2020/21 to 2022/23, but we are not achieving our target of 0–18 year olds receiving at least one contact from an NHS-funded mental health service.

Heart health
With 73% of NCL patients with high blood pressure treated to within age-specific target range within the last 12 months, we are falling short of the national target (77% for 2023/24; now 80% for 2024/25)

Lung health
Only 53% of NCL patients with chronic respiratory disease are vaccinated against flu, and only 69% of people aged 65+

Start Well

Poverty - 17% children live in poverty (2021/22 data which is likely to have increased since)
Maternal smoking - More than one in 20 women giving birth in NCL smoke
Newborn hearing screening - NCL boroughs are within the 6 worst performing boroughs in London
Oral health - More than one in four 5-year-olds in NCL have experience of tooth decay
Healthy weight - 38% 11-year-olds are overweight or obese
Communication skills - One in five reception children do not achieve expected communication and language skills
Mental Health - An estimated 1 in 5 11-16 year olds have a mental health disorder. Prevalence estimates for Camden are 33% higher compared to the national average

Live Well

Smoking - More NCL patients aged 15+ years smoke compared to London
Healthy weight - 55% of adults are overweight or obese
Alcohol - Admissions for alcohol-related conditions are higher in three of our boroughs (Islington, Haringey and Enfield) compared to London
Employment - 35% people with a long term physical or mental health condition of working age are not in employment
Diabetes - Only 31% patients with Type 1 diabetes and 43% of patients with Type 2 diabetes in NCL achieved all three treatment targets

Age Well

Loneliness – Only 36% older adult social care users have as much social contact as they would like
Dementia diagnosis - Although rates across NCL were similar to London, Camden, Haringey and Barnet did not meet the national benchmark for dementia diagnoses
Avoidable admissions – Unplanned admissions for older adults with certain long-term conditions have increased across all our boroughs since 2020/21
Intermediate care – On average more than one in ten of NCL's hospital beds per week are occupied by patients who did not meet Criteria to Reside but were not discharged
Carers - The average quality of life score for carers in NCL was 7 out of 12 which, although low, was comparable to London

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Key Haringey Areas to improve

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- The NCL Report identified a number of areas for each borough where performance was lower than comparators and/or getting worse. These borough summaries are intended to signal areas which may warrant further investigation, in the context of what is known about each borough's population and work. Key areas identified for Haringey are:

Strategy areas	Start Well	Live Well	Age Well
5 population health risks	MMR vaccine uptake	Common MH condition prevalence Cancer screening General heath-check uptake Diabetes Type1 treatment Flu Vaccine uptake in adults with chronic respiratory conditions	Flu Vaccine uptake
Common risk factors	Smoking at delivery	Smoking prevalence Alcohol related hospital admissions	
Health and care			Avoidable admissions Length of hospital stay: 21 days +
Wider determinants	Children in low income families 16 & 17 year olds NEET	Adults with Learning Disability in employment Jobs below London Living Wage Homelessness duties owed	Adults reporting loneliness Social contact for older adult social care users Fuel poverty
Other	Newborn hearing screening		

Key Next Steps

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The priorities and indicators in the Population Health Delivery Plan and NCL Outcomes Framework are wide ranging, multiple and complex. We will be tracking progress against all the actions outlined in the Delivery Plan, but it is important that we are able to demonstrate the tangible improvements that we hope to make in population health in the next 18 months.

How could we address this?

- We need to identify a smaller sub-set of **core (sentinel) population health metrics** to allow us to demonstrate our impact with which to effectively track and showcase the progress we are making and the benefits of coming together on a multi-geographical footprint across ICS. This will include the key population cohort to be targeted for each metric in order to **improve equity.**
- These metrics should be aligned to existing measures and be supported by a **wider benefits realisation programme**
- This will also clarify roles and responsibilities so that all partners are aware of the contribution they can make – including identifying areas for collaboration. For example, boroughs are best placed to utilise local insights to deliver change.
- The benefits realisation programme will consider how we work differently across partners to make progress on the agreed sentinel measures – this will include a deep dive process that will bring together the worlds of academic research, intelligence and insights and NHS/LA delivery to ensure we are harnessing strengths of all partners to reduce inequalities and improve outcomes.

Benefits Realisation – a worked example for Heart Health

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Making the shift upstream with more preventative practice and care

	Primary prevention: acting across the population to reduce risk	**Early diagnosis:** so we can identify health conditions early, to make treatment quicker and easier	**Secondary prevention:** halting progression of conditions or individual risk factors	**Prompt and urgent care:** treating conditions before they become crises	**Long-term care and treatment:** In both NHS and social care settings
NHS	Making Every Contact Count – tackling health behaviours and lifestyle risks	Optimising management of hypertension and CVD e.g. via the LTC LCS	Case-finding in high-risk patients on GP patient lists and opportunistically in secondary care		
Local Authority	Commission primary prevention lifestyle services and NHS Health Checks	Commission population-based lifestyle services to manage risk factors	Commission NHS Health Checks; population-based community health screening		
VCSE & Healthwatch	Deliver targeted primary prevention lifestyle initiatives with local communities; leveraging reach into underserved communities	Deliver targeted population-based lifestyle services/ initiatives to manage risk factors; leveraging reach into underserved communities	Run community awareness campaigns and blood pressure checks		
Academic Partners	Research across these areas and putting these into practice through engagement with services and commissioners				

Working with communities to engage in prevention

What else does evidence suggest would work?

Are there gaps when we focus on key communities?

Example of aligning plans and strategies across partners to deliver population health outcomes in Haringey

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Joint Health & Wellbeing Strategy (2024-29) *DRAFT*
Preventative Health and Care services theme:
- Commitment to continue to invest in and develop services for inclusion health groups to support our residents Live Well.

Haringey Corporate Delivery Plan (2024-26)
- Commitment to develop a programme and forward plan for the partnership Health Inclusion Board to contribute to reduce health inequalities to meet our ambition of equitable access, experience and outcomes.

Commissioned an **NCL wide needs assessment** in inclusion health to inform the ICS strategy.

NCL Population Health and Integrated Care Strategy
- Commitment to take forward the recommendations from the NCL Inclusion health Needs Assessment
- Sets out NCL ICBs principles to guide new ways of working. This includes relentlessly focusing on communities with the greatest need, with a particular focus on inclusion health.
- Inclusion Health Groups are identified as a key community in the adult population to support.

Mayor of London's Health Inequalities Strategy recognises the need to address long-standing inequalities in London's most social excluded groups.
- The associated **Implementation Plan** seeks to foster equitable access to services, with a focus on both preventive and responsive care tailored to the needs of socially excluded populations.

ADPH London hosts the Health and Wellbeing of Asylum Seekers and Refugees Community of Practice.

NHSE Core20PLUS5
- The PLUS groups are those groups who may experience poorer access to, experiences of, or outcomes from NHS services. Inclusion health groups are therefore a priority group, and NHSE are calling for improved healthcare provision for this group in their ambition to reduce health inequalities.

NHSE National Framework for Inclusion Health
- Framework developed by NHSE for ICSs to plan, develop and improve health services to meet the needs of people in inclusion health groups

How are partners already delivering (an integrated approach to population health) in Haringey?

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Haringey Start Well priorities	Examples of key projects	NCL Pop Health Delivery plan alignment
Developing our autism pathway	• Investment into autism and ADHD diagnostic capacity • Support from Open Door and Markfield for CYP and families • Expansion of school support in autism from Haringey LAST team and of school places capacity for autistic children	*Improvement of care pathway for children and young people with neuro developmental needs*
Transforming our Speech, Language and Communication pathway	• Collaboration between LBH, ICB, Whittington and education/early years partners to deliver an integrated universal, targeted and specialist pathway. • Haringey has seen a 35% fall in the number of CYP waiting for SLT assessment between Aug 23 – Aug 24, the best performing borough in NCL and compared to a total NCL increase of 4%.	*Identifying evidence-based approaches and investment opportunities to support improved outcomes*
Childhood immunisations	• Innovative project to improve uptake through new digital process via a QR code, with flexible appointment booking. Being rolled out now with initial positive feedback from residents.	*Increase routine childhood immunisation vaccine uptake with a focus on most deprived communities and communities with lowest uptake.*
CYP Mental health	• Aligned action plan across partners in development to improve early intervention offer in schools, referral pathway to CAMHS providers with reduced waiting times.	*Improvements in waiting times for mental health assessment.*

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Live Well	Examples of key projects	NCL Pop Health Delivery plan alignment
Roger Sylvester Centre	• Delivering a flagship integrated crisis prevention, support and recovery service for adults living with mental illness opening February 25	*Improving home treatment for people in crisis and strengthening proactive community support at home.*
Inclusion Health	• Co-ordinating action across housing, social care and NHS services to support people rough sleeping and experiencing homelessness, centred around Mulberry Junction. • New Inclusion Health delivery plan in development • Review of Haringey Homeless Health and Inclusion Team underway	*Improve healthcare equity, access, experience, and outcomes for people in inclusion health groups across boroughs.*
Employment and health	• Long established collaboration with Inclusive Economy team to run embedded employment support in NHS MH services, around primary care / MSK teams and now rolling out work well. E.g. Thrive to Work our scheme for people with health conditions, which is linked to primary care the wider VCSE, has supported 227 residents to start work in 2024 to date.	*Enhanced employment opportunities*

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Age Well	Examples of key projects	NCL Pop Health Delivery plan alignment
Long Term Conditions	• Pilot underway at Welbourne PCN of Hospital Consultant doctor supporting neighbourhood teams & GPs on care for people with complex long-term conditions	*Develop the vision, aims and case for a proactive care function and design an approach to this function that optimises resources, skills and assets in NCL.*
Haringey Multi-agency Care and Coordination Team	• A comprehensive multi-agency team across partners providing pro-active care and support to older and frailer residents to help them sustain independence	
Heart Failure	• Haringey's Community Heart Failure service proactively manages heart failure registers with GP surgeries. Delivered through collaboration, a multidisciplinary team offers home visits, clinic appointments, and interventions. The service proactively ensures timely follow-ups in community and discharge pathways. Enhanced approach targeting under-served communities funded by the Inequality Fund is now being mainstreamed	*Develop borough-based action plans to support identification and management of high blood pressure.*

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Neighbourhoods and inequalities	Examples of key projects	NCL Pop Health Delivery plan alignment
Development of neighbourhood based teams	• Northumberland Park Resource Centre has been developed as an integrated hub hosting a wide range of partners. • Family Hubs hosting wide range of partner services for children • Key statutory adults' health and care teams are now aligned to the same locality geography.	*Develop Neighbourhood Teams as core integrated population health management delivery vehicles.*
Tackling inequalities and supporting communities	• Investment in community delivered interventions tackling health inequalities and supporting health literacy through the Inequalities Fund and aligned schemes from Haringey Council, e.g. Haringey Health Champions	*Extend the impact of Inequalities Fund schemes in areas of greatest deprivation using this as a vehicle for attracting shared investment funding and building an evidence base.*

Considerations for the Health and Wellbeing Board

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- Is the HWB assured that coherence is being developed between local priorities and system priorities? What further work would strengthen this?

- The Outcomes Framework Insights Report is part of a data driven approach to improving outcomes – how do we ensure this is reviewed in context with wider data?

- How can we work together most effectively to assure delivery of our joint population aims and ambitions?