Enfield Integrated Care Partnership Progress Update

Health & Adult Social Care Scrutiny Panel

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Enfield Borough Directorate, NCL CCG

28th July 2021

"Working together, we will change the way we work in order to reduce inequality and to support all people in Enfield to live happy, healthy and rewarding lives"

Equal and inclusive, **Q**uality, **A**ccessible, **L**istening and Responsive, **I**ntegrated, **T**imely

Why are we doing this?

To address the Health and Care Challenges in Enfield:

Growing population and deprivation

- 330,000 – 4th largest London Borough
- 30% increase in population 2001-2025
- Moved from 12th to 9th most deprived London borough
- Language barriers – 100+ languages

Increasing need impacting wider determinants of health

- 1 in 5 workers low paid
- Debt, fuel and food poverty
- 250% increase in homelessness associated with private rental market evictions
- Youth violence +27%

East/West Inequality

- Life expectancy and living in poor health
- Households in poverty & child poverty
- Adult and child obesity
- School readiness and achievement

Differential service use East/West of borough

- NEL 12% and Elective 20% higher national average Edmonton Green
- 600+ attendances NMUH A&E with significant unregistered population

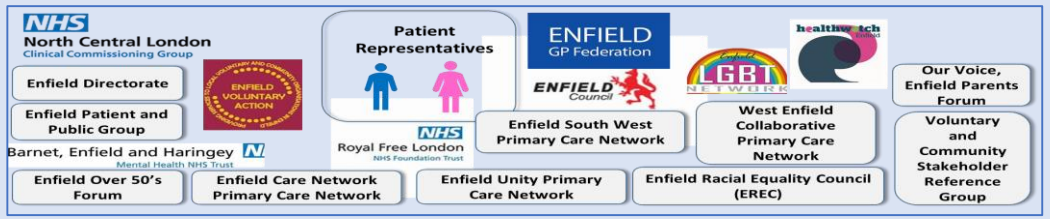
Differential investment

- Historic lack of investment in community and primary care services
- Significantly lower spend on community services per head of population than other NCL boroughs
- Fewer GPs and practice nurses than national average
- Austerity - Enfield Council cuts £178m since 2010 - £13m more in 20/21. Average reduction of £800 per household for core funded services

To address the local and national priorities:

- Delivering **NHSE's 8 tests** for the journey to a new health and care system
- Delivering the **London Vision and Touchstone**
- Supporting delivery of the **12 Expectations** for ICS Programmes
- Local priorities – Enfield HWBB, Enfield Poverty and Inequalities Commission, NCL ICS

To respond to the wide range of stakeholders involved in this process



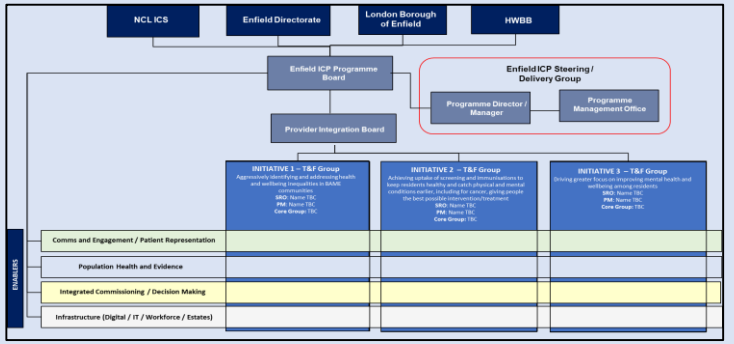
What will we do to achieve this vision?

We've developed a clear set of priorities for the Enfield ICP based on extensive engagement

Identifying and addressing health and wellbeing inequalities in BAME communities	• Improving self-care and management of LTCs • Improve the knowledge and understanding of local services for BAME • Driving up representation of those impacted by inequalities in PPRGs • More engagement with BAME and deprived communities • Measuring the performance and impact of services for all residents and BAME • Ensure ICP members are positive corporate citizens in employment practices
Achieving uptake of screening and immunisations to keep residents healthy and catch physical and mental conditions earlier, including for cancer, giving people the best possible intervention/treatment:	• Exceeding childhood vaccinations targets for all communities • Exceeding flu vaccination targets in winter 20/21 • Driving uptake of and concordance with cancer screening programmes • Developing new and targeted comms/engagement campaigns
Driving greater focus on improving mental health and wellbeing among residents	• Proactively responding to the direct and indirect impact of Covid-19 by providing improved care offers • Improve capacity and capability through local public services by developing networks of support, training and advice to improve the management of lower acuity mental health conditions (e.g. in schools and at work) • Proactively ensure improved understanding of early support and access points for all communities that may need emotional resilience support as a result of covid related anxiety as well as those overrepresented with more severe and complex conditions

How will we deliver these priorities?

Through a clear delivery plan and a robust and inclusive governance structure



- A Provider Integration Partnership Group will bring together providers from across the Health and Care system
- Separate Task and Finish groups will be established for each initiative, responsible for developing and implementing the plan to realise the required outcomes
- The Task and Finish groups will endure for the duration of delivery of the initiative, and will be replaced at the end of the initiative by a new set of T&F Groups
- Key enablers will support each T&F Group, to ensure a common approach to critical aspects of delivery across the system (e.g. Communications and Engagement, Population Health and Evidence etc.)

Enfield Integrated Care Partnership

ICP Initiatives – Highlight Reports Year end 2020/21:

i. Inequalities

ii. Mental Health Steering Group

iii. Screening & Immunisation:

- *Seasonal Vaccination Programme*
- *COVID Vaccination Programme*

Inequalities Workstream: April 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
Reduce childhood obesity	27% of year 6 children are identified as obese (National Childhood Measurement Programme 2019/20, there is no data available regarding impact of pandemic). Whilst we do not yet have National Childhood Measurement Programme data covering the period, we anticipate that childhood obesity will have increased due to lower levels of physical activity among children.
Reduce childhood obesity among groups where there is evidence of high prevalence in comparison to average for Enfield including; children from Black, Turkish backgrounds and geographic communities experiencing deprivation.	As above
Reduce inequalities by working as an Integrated System to improve wider determinants – improve employment opportunities, educational outcomes, reduce homelessness and improve the built environment in areas of high deprivation.	Currently there has been an increase in numbers of individuals and families who are seeking benefits, using food banks, on furlough and experiencing financial crisis in Enfield. It is possible that there will be a long term worsening/ widening of inequality in Enfield as a result of the pandemic. We will use local intelligence to monitor the impact on the priorities identified.
Commission a programme of Community Participatory Research (CPR), Health Champions and Community Chest to support the above priorities. This will include academic evaluation of the programme.	Some of the meetings of the task and finish group were postponed due to COVID pandemic prioritisation – none the less the key working group continued to enable the procurement to progress resulting in securing a local organisation to deliver HC & Community Chest.

Risk/Issues	RAG*	Mitigating Actions
1. Following a procurement process, we were unable to commission CPR from a local organisation	Amber	We will seek procurement from an appropriate organisation outside of our local system
2. We are yet to secure an academic partner for evaluation of the programme	Amber	We will be approaching appropriate academic organisations over the next few weeks.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	NA
2	NA

Addressing Inequalities 2021/22
NCL Inequalities £2.5m Investment Fund

Planning Guidance 2021/22 Alignment (Inequalities)

The 5 Priority Areas related to Inequalities:

Priority 1: Restore NHS services inclusively – use data to plan the inclusive restoration of services guided by local evidence (focused on analysing access, experience and outcomes data)

Priority 2: Mitigate against digital exclusion – provide face-to-face care; identify who is accessing telephone, face-to-face, video consultations breaking this down by relevant protected characteristic and health inclusion group; assess impact of digital consultations channels on patient access.

Priority 3: Ensure datasets are complete and timely - improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes - take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021; preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated (related to management of LTCs, conducting annual health checks for people with LDs and SMI, improving maternity care for Black and Asian women and those from deprived neighbourhoods

Priority 5: Strengthen leadership and accountability

NCL CCG Inequalities Fund: Rationale and Principles

NCL CCG have created an Inequalities Fund to address the growing disparity between our most deprived and least deprived communities. In line with 2021/22 Planning Guidance, this will focus on the most deprived 20%, with an aim to improve their access, experience and outcomes.

The objectives of this fund are as follows:

- We are seeking innovative and collaborative approaches to delivering high impact, measurable changes in inequalities across NCL
- We want these solutions to break down barriers between organisations and develop both new and extend existing relationships
- We want to target the most deprived communities and to reach out proactively to our resident black and minority ethnic populations
- We want this to help form Borough, Multi-Borough and NCL wide partnerships to deliver high impact solutions
- We are keen to engage our population, the VCS and our partners across health and care in making a difference to the lives of our people

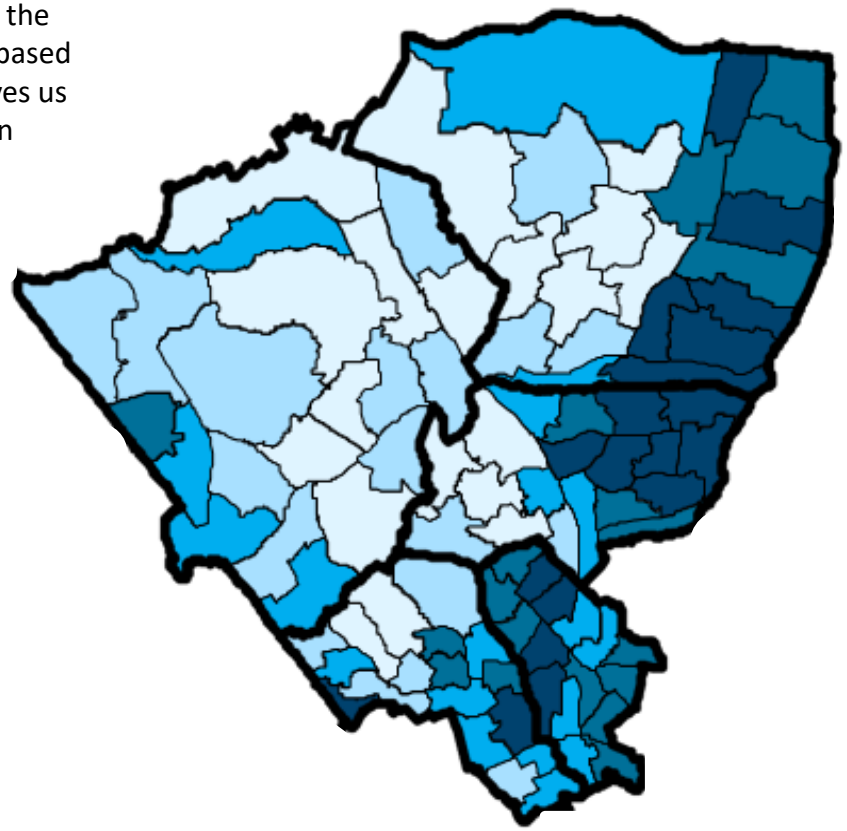
Each ICP will be able to bid for a proportion of the initial £2.5m, with funds relative to needs in each borough. All health and care partners will need to approve the submitted plans, which will be assessed by an NCL wide panel.

Top 20% Most Deprived Wards in NCL

Based on Index of Multiple Deprivation Score 2015, the 20% most deprived Wards in NCL are spread across 19 of the total of 95 Wards. The table below also uses the Deprivation Score to give a weighted investment for each Ward based on an allocation of £2m of the £2.5m Inequalities Fund to address the Planning Guidance Priorities. Using this gives us an indicative value for each Borough of Enfield (£676,781), Haringey (£766,967), Islington (£369.039) and Camden (£187,213). As stated previously none of the 20% most deprived Wards are located in Barnet.

Ward	Borough	Total IMD Score	Total Population	Total ward allocation £*	£ per population
Northumberland Park	Haringey	52.6	16,416	141,161	8.60
Edmonton Green	Enfield	47.0	19,433	149,262	7.68
White Hart Lane	Haringey	45.9	13,485	101,211	7.51
Tottenham Green	Haringey	43.6	16,595	118,119	7.12
Finsbury Park	Islington	42.4	17,258	119,421	6.92
Tottenham Hale	Haringey	41.5	19,202	130,034	6.77
Bruce Grove	Haringey	40.2	15,090	98,998	6.56
Upper Edmonton	Enfield	39.2	19,806	126,874	6.41
St Pancras and Somers Town	Camden	38.6	16,967	107,121	6.31
Noel Park	Haringey	38.3	15,161	94,818	6.25
Turkey Street	Enfield	38.2	15,684	97,984	6.25
Lower Edmonton	Enfield	37.1	17,948	108,896	6.07
Ponders End	Enfield	36.5	15,788	94,058	5.96
West Green	Haringey	36.3	13,918	82,626	5.94
Kilburn	Camden	36.0	13,600	80,092	5.89
Holloway	Islington	35.5	14,983	87,010	5.81
Caledonian	Islington	35.5	13,896	80,521	5.79
Tollington	Islington	35.3	14,220	82,087	5.77
Haselbury	Enfield	34.8	17,539	99,707	5.68

** Calculation: The population was multiplied by IMD score, to give an indicative score on which to base the £2m allocation.*



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher levels of deprivation, based on the IMD deprivation score.

Indicator values range from 9.5 to 52.6.

Original Data Source: Ministry of Housing, Communities and Local Government, Index of Multiple Deprivation 2015

Enfield ICP Inequalities proposals funded in 2021/22

NCL CCG received 32 proposals from the five boroughs and these were reviewed by a panel led by lay/patient representatives with public health and NCL CCG executive team input. The decisions were ratified by the NCL Population Health & Inequalities Committee. The successful schemes in Enfield are outline below:

Inequalities Proposal	Funding in 2021/22 (part year effect) £
Black Health Improvement Programme (BHIP) for Enfield Primary Care, NHS North Central London CCG and development of Enfield Caribbean and African Community Health Network	£ 37,000
Enhanced Health Management of People with Long-Term Conditions in Deprived Communities in Enfield	£159,000
Enfield Connections at North Middlesex University Hospital	£ 72,000
Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services	£ 41,000
Parentcraft Programme	£ 87,970
DOVE project (Divert and Oppose Violence in Enfield) Public Health approach to reducing Serious Youth Violence	£ 55,186
VCS & Primary Care based smoking cessation	£200,000
Joint proposal with Haringey Supporting earlier cancer presentation through community development	£ 36,384

The Enfield ICP Mental Health Steering Group: April 2021

ICP MH Steering Group Agreed Priorities (PRE-Covid)	Impact of COVID
We agreed to prioritising the development and delivery of the Long Term plan targets for Mental Health in relation to the Community Framework for MH, this includes but is not limited to developing PCN MH integrated care and holistic support for SMI communities by piloting agreed approaches. We will improve access to physical health care, increase access to SMI health checks, increase access to Individual Placement Support and seek to achieve EIP Level 3 in 21/22	Some meetings of the Steering Group were cancelled due to prioritisation of Covid activity and transformation funding and milestones are yet to be confirmed by NHSE. We have agreed the TOR for the group and what Long Term Plan targets will be prioritised for 21/22 and these are: - Improve SMI health checks by working with primary care to improve targeted uptake of hard to reach group and improve record keeping across all 6 domains - We agreed the PCNs Pioneer sites and selected East borough neighbourhoods across two PCNs (17 GP Practices in the East of the borough). - Increase access to Individual Placement Support (IPS) by joining the Councils contract with the Working Well Trust under Section 75 arrangements - Review EIP services in terms of gap analysis to achieve Level 3
Establish Community Transformation Work streams and Activities	We have established a local Community transformation work stream; the steering group meets monthly and there are sub-groups at NCL level for co-production, contracting & procurement and Needs Assessment. Membership attendance has been sporadic due to the Covid 19 pandemic.
Develop a shared approach for local priorities and modelling	Further development of the operational model, principles, population segmentation and interfaces in readiness for staffing workshops and engagement events that are in planning stage

Risk/Issues	RAG*	Mitigating Actions
1. non-engagement from clinicians and workforce due to Covid and vaccination prioritisation means that we may not stay on track with key deliverables		Increased support through BEH PMO, streamlining communications – need to Review and flex as required
2. NHSE milestones yet to be confirmed – this is partly due to covid		Beyond our control but we will continue to develop projects in the interim

Issues for Escalation to PIP AND/OR ICP BOARD	
1	None at present

Seasonal Vaccination Programme: April 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
Achieve National Flu Target: Over 65s – 75% Under 65s at risk – 55% Pregnant Women – 55% 2/3 year olds – 50% Actual Performance 2020/21 : Over 65s – 73.0%, Under 65s at risk - 45.1%, Pregnant Women – 26.8%, 2/3 years olds – 48.7%	Increased target to 75% across all cohorts Additional 50-64 cohort Services delivered in covid compliant facilities/ increased time to deliver vaccine.

Risk/Issues	RAG*	Mitigating Actions
1. Pregnant women flu uptake in Maternity units below target	R	NCL below target. Engaging with Maternity Departments on recovery plans Engaging with Primary Care Providers to deliver mop up clinics
2. Availability of flu vaccine supplies	A	Ongoing engagement with NHSE/I re: underwriting GP Practice additional flu orders
3. NHSE/I change eligibility cohort mid season	R	Communication and Engagement strategy to be developed as and when required.

*RAG status based on Likelihood & Impact

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Engage Acute Maternity providers to improve flu uptake amongst pregnant women.
2	Patient vaccinations outside of practice registered lists.

COVID Vaccine Inequalities: April 2021

ICP Agreed Priorities (PRE-Covid)	Impact of COVID
(National target) At least 75% coverage for all JCVI cohorts – including health, social care and care home staff	NA
(Aligned to NHSE Local Borough Plan submitted and agreed March 2021) Aspiration of 95% vaccine coverage for all JCVI cohorts	NA
Limit inequality in vaccine uptake between areas of high and low deprivation, different ethnic groups and other groups experiencing deprivation (e.g. GRT, homeless)	NA

Risk/Issues	RAG*	Mitigating Actions
1. Below 75% vaccine coverage (or <95%) in some geographic communities, ethnic groups and other communities experiencing inequality (e.g. homeless, GRT)	amber	ICP Vaccine Workstream activity informed by intelligence provided by Public Health Team ICP Inequalities Workstream working to borough Live communication and engagement plan (including range of communication activities such as multiple community webinars, social media, and direct community with community leaders (aligned to NHSE Local Borough Plan)) Provision of weekly programme of pop ups targeting lower uptake communities
2. Below 75% uptake among care home workforce	amber	Production of improvement plan LBE.

Issues for Escalation to PIP AND/OR ICP BOARD	
1	Care home staff uptake
2	

NORTH LONDON PARTNERS
in health and care

This ICS System Development Plan is a work-in-progress draft and we will continue to update it every quarter through engagement with stakeholders from across the system to reflect our progress.
Please email comments and feedback to:
northcentrallondonics@nhs.net

NCL ICS System Development Plan

Refreshed Plan

DRAFT for Submission to NHSE/I
v1.0
30th June 2021

Health and Care Bill

1. Government has published a bill setting out it intends to reform the delivery of health services and promote integration between health and care in England

2. The bill is structured in six parts, focuses largely on the detail of a new health and care system based on integration will be structured in England

Integration Care Systems (ICSs) will merge the functions of CCGs alongside some of the existing NHS England functions and with new strategic functions. The primary functions of a future ICS (as described in legislation) will be to arrange for the provision of services for our population for the purposes of the health service in England, supported by additional functions such as:

- Leading strategic planning and commissioning
- Allocating financial resources
- Coordinating and overseeing service delivery
- Facilitating service transformation and pathway redesign
- Leading emergency planning and response
- Stakeholder and public engagement – making sure patient and resident voices are heard

In terms of changes to the formal governance:

(a) an ICS Health and Care Partnership which will bring together parts of the system, including local authorities, primary care, independent sector and voluntary sector.

(b) an ICS NHS Body which will be responsible for the day-to-day running of the ICS.

High Level Changes proposed (1)

1. **Integrated Care Systems (ICSs) will become statutory organisations and will be responsible for strategic commissioning and planning**

- ICSs will merge the functions of CCGs alongside some of the existing NHS England functions and with new strategic functions. The primary functions of a future ICS (as described in legislation) will be to arrange for the provision of services for our population for the purposes of the health service in England, supported by additional functions such as:
  - Leading strategic planning and commissioning
  - Allocating financial resources
  - Coordinating and overseeing service delivery
  - Facilitating service transformation and pathway redesign
  - Leading emergency planning and response
  - Stakeholder and public engagement – making sure patient and resident voices are heard

In terms of changes to the formal governance:

(a) an ICS Health and Care Partnership which will bring together parts of the system, including local authorities, primary care, independent sector and voluntary sector.

(b) an ICS NHS Body which will be responsible for the day-to-day running of the ICS.

High Level Changes proposed (2)

2. **An ICS will be set a financial allocation by NHS England**. The ICS NHS Body will develop a plan to meet the health needs of its population and develop a capital plan for the NHS providers in its geography.
3. **Services will continue to be delivered at Place level**. Places will generally be aligned geographically with local authority boundaries and there must be joint decision-making with local authorities. However, places are not legal entities. This is where providers of primary care, community and mental health, social care, care will work together.
4. **There will be a duty to collaborate**. NHS providers will be told to work together in provider collaborative and organisations across the health and care sector will have a duty to collaborate.
5. **Population health is at the heart of these proposals**. Changes to the National Tariff will enable it to work more flexibly with longer term population health contracts, rather than focussing on activity-led inputs.
6. **The government will have the power to impose capital spending limits on Foundation Trusts, as it currently does on NHS Trusts**. The government will have the power to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts which are not working to prioritise capital expenditure within their ICS.
7. **NHS England will formally merge with NHS Improvement and be designated NHS England**. The merged entity will be accountable to the Secretary of State, while maintaining operational independence.

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Next Steps	Sections
Strategic Direction & Measure of Success: There is a clear post-Covid narrative for health and care which partners and stakeholders support	**In Place and Ongoing** We have made significant progress towards embedding a post-Covid narrative in our system through our recovery programme across acute, mental health, community and primary care.	• Work with our partners to embed both the findings from our resident engagement as well as an evidence-based understanding of our population's post-Covid health needs	*Our Local Population and Population Health Approaches*
Strategic Direction & Measure of Success: There are appropriate measures and metrics of success with which we can measure progress and hold ourselves to account for continuous improvement	**In Place and Ongoing** We have developed in-depth life course analysis of the residents of our 5 boroughs and established the Population Health and Inequalities Committee.	• Developing an Outcomes Framework as a key measure of our success in reducing population health inequities. • Building an inequalities lens into our regular system performance metrics; such as waiting lists.	*Our Local Population and Population Health Approaches*
Place Based Elements of the ICS: Health and care resources at a neighbourhood/LCN/ PCN level are well developed, integrated and resourced to be effective in providing high quality local care	**Well developed** With 32 PCNs and six established GP Federations, primary care representation in the Provider Alliance and in ICS Senior Leadership; our Primary Care Networks are well embedded in our ICS	• Establishing a sector-wide GP Alliance. • In-depth primary care commissioning review to inform next steps of PCN development	*Partnerships in Place and Provider Collaborative/ Governance*
Place Based Elements of the ICS: Borough based integrated care partnerships are up and running and delivering intended benefits, community and primary care are integrated with local acute care	**Well developed** Five effective borough based partnerships that agree local priorities in partnership with local acute, community, mental health trusts, local authorities and primary care.	• Developing ICP interface with ICS • Comprehensive OD programme to help further strengthen these borough partnerships.	*Partnerships in Place and Provider Collaborative*
Place Based Elements of the ICS: Provider collaboratives are up and running and delivering the benefits and outcomes we expect of them as pan borough vehicles (and not becoming additional layers or provider monopolies).	**In Place and Ongoing** All NCL providers (acute, mental health and community trusts, primary care) have established a single provider alliance; and appointed a Managing Director to move into delivery of priroty programmes.	• Progress programmes of work with agreed outcomes across four priorities identified- Waiting times, Workforce, Research to Action and Lead Provider models • Establishing a sector-wide GP Alliance.	*Partnerships in Place and Provider Collaborative*
Place Based Elements of the ICS: The existing statutory institutions of health and care systems (e.g. NHS Trusts, FTs, Governors, HWBBs) are delivering positive benefit of focus on institutions without disbenefit on lack of focus across the system	**Well developed** We have role-modelled effective balancing of institutional and system focus via decision making through our GOLD arrangements and Covid Vaccination programme throughout the pandemic.	• Continue to stress test through ICS Steering Committee and Partnership Council, forerunners of ICS Governance • Embed System Oversight Framework • Develop place-based oversight into our framework	*Governance*

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Next Steps	Section
▪**Strong Partnerships:** The role of local councils as critical partners in achieving long-term aims for prevention and health and wellbeing is fully recognised and reflected in the approach to strengthening health and care partnerships at all levels of the ICS	**Well developed** NCL Councils are critical partners in our ICS Steering Committee, NCL Population Health & Inequalities Committee, part of the exec chair of our Borough Partnerships (jointly chaired), and members of the ICS Partnership Council. They also play a key role in helping develop and embed our population health approach.	• Engage with our local councils on embedding a shared understanding about the role of an Integrated Care System; • Ensure local council involvement in transformational programmes of work such as our mental health and community services review	*Governance*
Strong Partnerships: A strong set of clinical leaders and clinical networks within the ICS who are sufficiently empowered to improve system performance	**Well developed** The emerging ICS Leadership has well established roles for clinical leadership- such as those of a Primary and Secondary Care Chief Medical Officer and a Chief Nurse. NCL has successfully developed Clinical Networks, and our Clinical Advisory Group has provided essential oversight and scrutiny to our decision making during our Covid response.	• Engagement across clinical and multiprofessional leadership during this summer to design a framework for clinical leadership at system, place and neighbourhood level in our ICS building from our current clinical leadership	*See slide 44 for further details*
Strong Partnerships: Resident and patient engagement is strong at all levels of the local system and supports decision making quality and legitimacy	**Well developed** We are committed to embedding our resident voice in defining the role and purpose of our Integrated Care System. Our borough partnerships have close links with their local HealthWatch and we continue to engage with residents through multiple forums including an Engagement Advisory Board.	• Establishing a Community Partnership Forum to make resident voice more integral to our plans. • Embedding patient voice in Population health approach • Looking at new ways to work with our communities as evidenced in the recent vaccine roll out	*Listening to our communities*
Strong Partnerships: Health and care staff are supported by workforce strategies, cultures and plans which help them to operate effectively at institution, ICS and regional levels as appropriate	**Well developed** This can be evidenced through the NCL People Plan, and ICS level workforce mission and vision, our commitment to staff wellbeing as part of our recovery plans, and ongoing programmes of OD at all levels.	• As next steps, our NCL People Board will continue to work together to co-design and promote the strategic vision for workforce across the ICS and amongst its member organisations and staff. Examples of system working include the Redeployment Hub.	*See Enablers: Workforce* *See slide 46 on ongoing OD interventions*

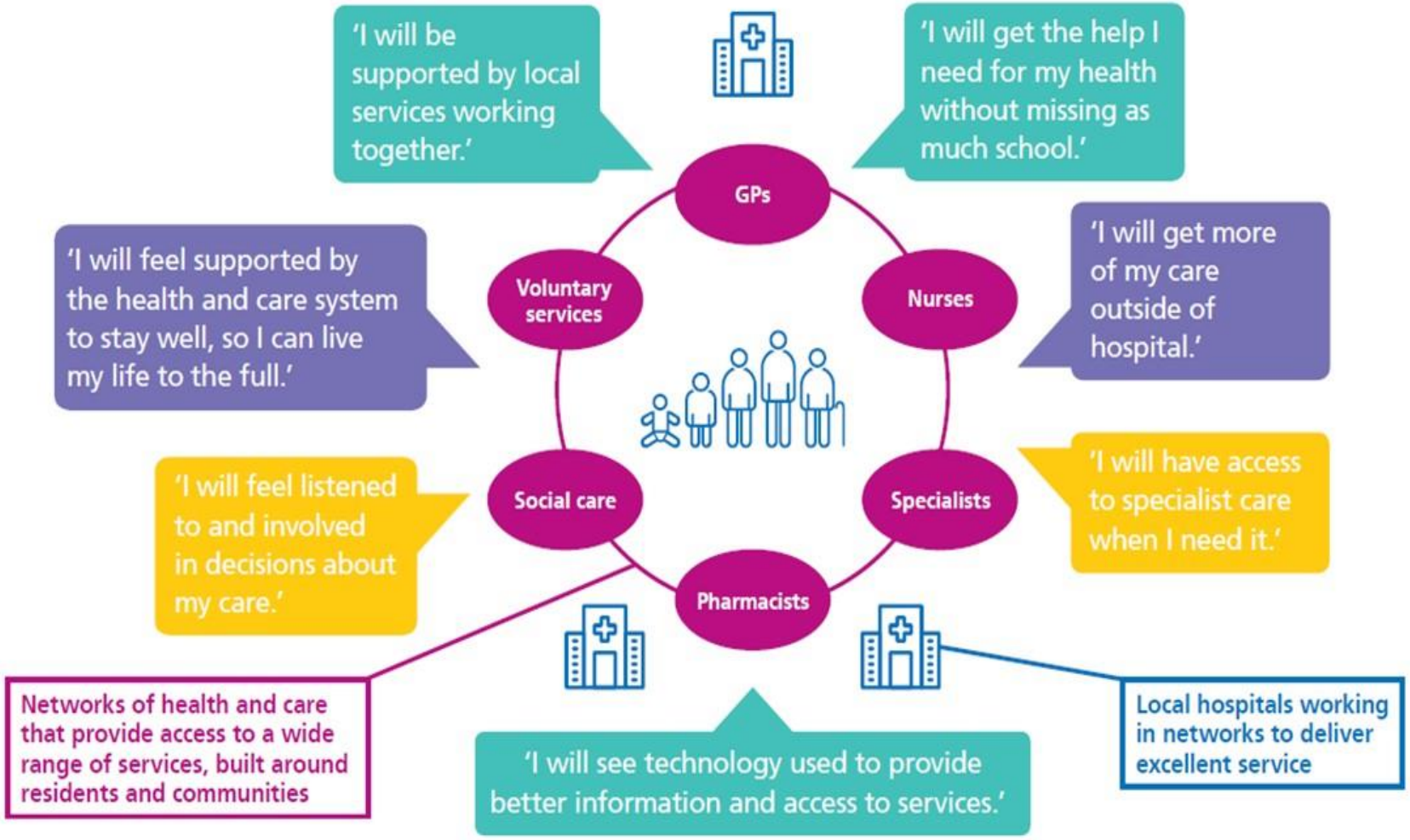
London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Next Steps	Section:
Effective ICS Governance & Decision Making: The formal governance of the ICS is lean and fit for the purpose of it's legislative function and system leadership mission (whilst avoiding becoming a "super CCG")	**In Place and Ongoing** We have established a NCL Partnership Council and ICS Steering Committee as a forerunner of future ICS Governance that works across the health and care system.	• Continue to adapt in line with emerging guidance; ensuring a whole system approach to partnership working, as we move towards ICS shadow governance	*Governance*
Effective ICS Governance & Decision Making: There is increased freedom to move money around the health and care system to support sustainability through improving quality, reducing costs and increasing equality	**In Place and Ongoing** We have agreed financial principles and system ways of working; piloted a financial approach to tackle health inequalities through the Health Inequalities Fund; and supported innovative ways of working across the system through the Accelerated System Recovery Fund	• Embed a whole system comprehensive financial strategy • Determine approach towards areas where less clarity is available such as specialised commissioning (that constitutes a significant share of NCL health services)	*Finance*
Effective ICS Governance & Decision Making: There are effective cultures, mechanisms and support for mutual aid and holding each other to account for continuous improvement in system performance and reduction in unwarranted variation	**Well developed** Our principles of mutual aid- role modelled through the pandemic across acute, community, mental health and primary care – have played a critical role in pandemic response and elective recovery across the system.	• Work through our Operational Implementation Group to ensure a system-wide framework for elective recovery. • As an accelerator site, work towards a "One NCL" approach to our waiting list.	*Enablers Mutual Aid Principles, Governance*
Effective ICS Governance & Decision Making: Decision making at all levels is supported by excellent population health data and management supporting improving health outcomes and reducing health inequalities	**In Place and Ongoing** We have embedded population health data in programmes such as Covid vaccination through HealtheIntent (PHM system); and also established a Health Inequalities Fund as a step towards supporting a population health approach.	• Continue to work with wider system partners to onboard onto HIE/HealtheIntent • OD to embed a population health approach into ongoing programmes of work, helping our workforce to use data for effective decision making.	*Our Local Population and Population Health Approaches*
Regional Added Value: *There is sufficient standardisation of ICS governance approaches, specifically in core structures and mandated performance metrics, which allows for London-level sharing, line of sight and accountability*		*These two conditions of success have been earmarked as those for which a "single regional approach would be necessary".* *The NCL ICS Executive Leadership and ICS Transition team continues to engage with the regional team to feed into regional thinking and respond to emerging guidance.*	
Regional Added Value: *The regional role and operating model has a clear focus centred on added-value to ICSs plus holding them to account; and the respective roles for region and ICS are clear and appropriate*			

Our Vision for an Integrated Care System in NCL

We want to enable our residents to Start Well, Live Well and Age Well

We asked our residents what Integrated Care means for them; and this is what they told us…



What will the integrated care system mean for our residents?

Our Integrated Care system can not just focus on how healthcare services operate. Evidence shows that as little as 10% of a population's health and wellbeing is linked to access to healthcare.

Therefore we need to work with partners to look at the bigger picture, including:

- Fulfilling work
- Education and skills
- Our surroundings
- The food we eat
- Money and resources
- Transport
- Housing
- The support of family, friends and communities

What will be different?

"Joan is 80 years old and lives in Camden. She has heart disease and diabetes, and recently has been forgetting to take her medication. She has found it more difficult to manage over the last six months but wants to keep living at home. Joan's GP and social worker have developed a Care Plan in discussion with Joan. This means that the GP practice, district nursing and social care know how to work together to help Joan stay well and at home safely. If Joan's GP becomes concerned about something, he uses the 'Rapid Response' service to assess her the same day at home, which helps avoid trips to A&E. When Joan did fall last year and needed to be seen in hospital, she was assessed within 2 hours and a plan was in place quickly to get her home as soon as she was ready. Joan was supported to stay at home with *a care package provided by social care, her domiciliary care* workers were increasingly concerned about her forgetfulness so referred her to the memory clinic for a dementia assessment."

How integrated care can help

- ✓ Clearer information about local services and how to use them will be available to help residents access the right support.
- ✓ Better access to mental health care, with residents given more support to find the help they need.
- ✓ Patients ready to leave hospital will be discharged, through hospitals, community services and social care working together.
- ✓ Ensuring all people have their mental health care needs met, and providing interim support for when people are on waiting lists for complex care treatment.

Our Strategic Aims

We have identified five strategic aims to deliver our ambition and achieve our purpose. We have mapped life courses for residents from all our boroughs (see appendix) and are in the process of developing a set of outcomes that will enable us to track our progress towards achieving these aims. We continue to refine and further develop these aims with our system partners and residents.

Start well

Strategic Aim 1:

By working collaboratively with schools and communities, our children and young people will have:

- tools to manage their own health
- access to high quality specialist care
- safe and supported transitions to adult services.

Live well

Strategic Aim 2:

Our residents will have early support for health issues including:

- equitable access to high quality 24/7 emergency mental and physical health
- world-class planned and specialist care services
- true parity of esteem between physical and mental health.

Age well

Strategic Aim 3:

Our residents will:

- be supported to manage their long term conditions and maintain independence in their community
- receive seamless care between organisations
- experience high quality and safe hospital care that ensures they can get in and out of hospital as fast as they can.

Work well

Strategic Aim 4:

Our workforce will:

- have equal access to rewarding jobs, work in a positive culture, with opportunities to develop their skills
- have support to manage the complex and often stressful nature of delivering health and social care
- strengthen and support good, compassionate and diverse leadership at all levels.

Enablers

Strategic Aim 5:

We will provide key enablers for success, including:

- digital technologies to connect our health and care providers with our residents and each other
- a fit for purpose estate in each locality
- being a financially balanced health economy driving value for money for the taxpayer.

Foundations of the NCL ICS

Our vision for integrated care is enabled by a focus on three key pillars which will represent a shift-change in that we work together to plan, deliver, and monitor health and care services:

a) Tackling Health Inequalities will make a measurable impact on health disparities by addressing the wider determinants of health and adopting 'person and community centred' approaches in all that we do.

b) Whole-person Personalised Care gives people choice and control over their mental and physical health, and means health and social care partners working together to deliver more person-centred care.

c) Population Health Management allows our partnership to use data to design new models of proactive care and deliver improvements in health and well being that makes best use of the collective resources.

NORTH LONDON PARTNERS in health and care

NHS

Roadmap to transition to ICS

May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April '22

Listening and planning phase

- **Staff and partner engagement in developing the ICS system development plan**
- National guidance issued (over summer)

Design phase

- Shadow ICS Governance developed in line with legislation
- New ways of working developed in line with system development plan

Implement new ways of working

- NCL ICS operating in shadow governance form
- Engage with stakeholders to embed NCL ICS Vision
- Work to implement NCL system development plan

Embedding new ways of working

Continue to develop system capabilities to deliver on core ICS vision of a population health based- approach to reducing inequalities, improving access and increasing efficiencies

How to get involved…

- Join the upcoming drop in session and listening sessions (more information in newsletter)
- Email any questions to:
- Share any good system working examples to
- Contribute to system development planning through team discussions…

This is based on what we know now – but could change based on national timelines…

Key areas where we are working together with partners to develop

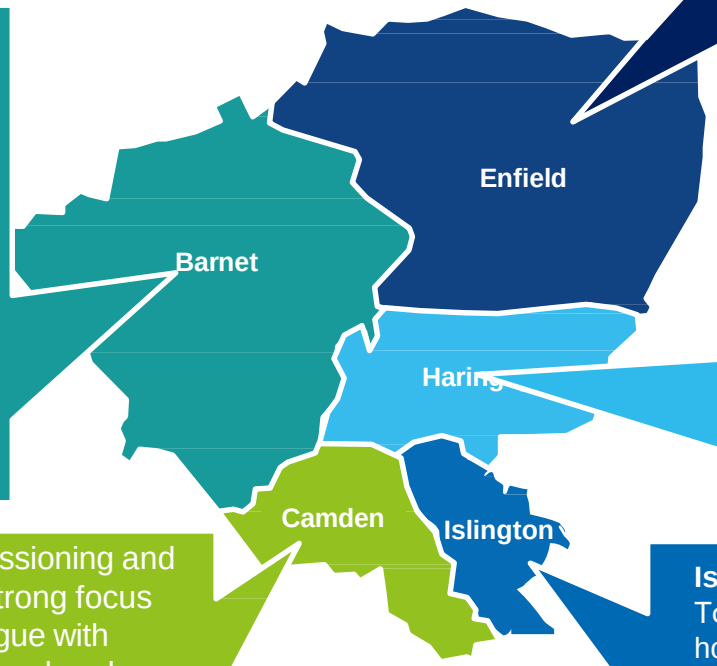
Area	System forum	Working with…	Example questions to explore with partners…
The impacts and benefits of becoming an ICS	ICS Steering Committee	• ICP meetings • LA meetings • CCG Governing Body • Trust boards	• What does the change to a statutory ICS mean we could do differently for residents to improve outcomes/reduce health inequalities? • What does this mean to your organisation – what would work differently? • What changes are needed between now and April 2022 to get us closer to our vision?
NCL's Population Health & Inequalities Strategy	NCL Population Health and Inequalities Committee	• Local Care Forum • ICP Meetings • NCL Finance Groups	• How should we adapt to embed a population health approach? • What are the key areas of variance in outcomes across NCL? • Where are the common areas we should work together? • What might we do at a borough level? • What should we do as a system over the next nine months to embed a Population Health Approach?
Principles for collectively agreeing priorities at a place level	ICS Steering Committee	• NCL Population Health Committee • Local Care Forum • ICP Meetings	• How will each place / borough partnership agree priorities? • How do we work to the principle of subsidiarity? • What should the interface between ICS and ICP priorities look like?
Impact of system oversight framework	System Recovery Executive	• System Recovery Executive • Trust Boards • ICP meetings • NCL Finance Groups	• Do we have transparency of process, shared accountability and joint decision-making? • How do we continue to embed that across the system? • What is our approach to aligning system-wide operational and strategic plans?
ICS Financial Framework	NCL Finance Groups	• NCL Finance Groups • NCL Population Health and Inequalities Committee • ICP Meetings	• How do we best spend the NCL pound? • What is our plan for sharing financial risk and opportunity? • How do we balance system financial sustainability with organisational sustainability?
Clinical Leadership Development	NCL People Board	• NCL People Board • NCL Clinical Advisory Group • CCG Governing Body • Trust boards	• How do we establish appropriate clinical and professional leadership? • What is the role of leadership within system, place and provider collaboratives? • What is our approach to achieving multi-professional leadership including primary care and speciality representation?
Role of Strategic Commissioning	CCG Governing Body	• CCG Governing Body • Local Care Forum • ICP Meetings	• How can strategic commissioning lead to better outcomes for our residents and patients? • What changes are needed in the way we engage with local authorities and other system partners? • What additional skills and competencies should commissioners have to embed a strategic commissioning approach?

Our five Borough Partnerships (ICPs): Key Features

- Partnerships are maturing locally. COVID and the acceleration of the ICS has furthered existing partnership working.
- Place-based leaders are working together to shape the ICP role, priorities, local structures & teams and ways of working.
- There are common features, but local nuances within each partnership.

Barnet – partnership accelerated in last 18 months. Significant NHS engagement plus strong community and co-production focus and local govt leadership. Older population gives rise to focus on proactive care, same day urgent care and support to remain independent. Strong focus also on MH & Dementia and CYP, as well as developing a 'Neighbourhood' model.

- 425,395 registered population
- 10 + 'organisations' represented (25+ members of delivery board)
- 7 PCNs
- Chair of Exec: rotating (CCG, Council, Barnet Hospital, GP Federation)
- Co-chairs of ICP: Dawn Wakeling (DASS), Colette Wood (CCG Director of Integration)



Enfield – Newly formed partnership. COVID has helped accelerate integrated working. Priorities have been expanded from an initial focus areas following success around flu and Covid vaccs. Provider Integration Partnership (PIP) oversees delivery.

- 425,395 registered population
- 10 'organisations' represented (25+ members of delivery board)
- 4 PCNs (not geographical – neighbourhoods within @ 50k)
- Chair Exec: Bindi Nagra and Dr Chitra Sankaran
- Co-Chairs of ICP – Mo Abedi BEH and Alpesh Patel Enfield GP Federation

Haringey – established and ambitious partnership with strong relationships. Focused on expansion of community based care models, MH, wider determinants and inequalities and a local strengths based approach that also addresses risks driven by deprivation.

- 298,418 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs
- Chair Execs: Zina Etheridge, Siobhan Harrington
- Chair of ICP: Rachel Lissaeur (Director of Integration)

Camden – long partnership history with integrated commissioning and partnership development of integrated delivery models. Strong focus on CYP, MH, citizen's engagement/coproduction and dialogue with families and communities, as well as a developing Neighbourhood model. New areas of focus include accelerating provider developments at PCN and borough level and connecting with local communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of ICP/8 PCNs)
- Chair Exec: Martin Pratt, Deputy Chair Kate Slemeck
- Chair of ICP: Graeme Caul, CNWL

Islington – active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (including police, fire, housing). Senior leadership from Islington Council and CCG. Emphasises joint commissioning, operational joint working and expansion of neighbourhood level delivery. New Delivery Board established to drive key workstreams:

- 257,135 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 5 PCNs
- Chair Exec: Dr Jo Sauvage (CCG), Cllr Kaya Comer-Schwartz (Leader)
- Co-Chairs of ICP John McGrath (CCG GB) and Stephen Taylor(Islington Borough)

Summary – Borough Priorities at a Glance

All five partnerships:

- **Shift to proactive care (early intervention and prevention)** – partnerships are focused on how they can make the move to delivering more proactive care through the use of population health management tools (e.g. risk stratification, case management, etc).
- **Inequalities and deprivation** – all boroughs are gathering data related to inequalities are working towards addressing them as part their priority areas of work.
- **Cross-sector workforce planning and skills development** – partnerships have identified the need to develop collective workforce plans.
- **Supporting care homes/providers**– all partnerships are focused on providing enhanced and integrated support to care homes and their residents
- **Digital inclusion** – partnerships have acknowledged the need to emphasise digital inclusion and learn from resident experiences related to the use of technology over the pandemic.
- **Vaccinations and Immunisations** – partnerships are working together to deliver COVID vacs and delivered and highly successful flu campaign.

Appendix

NHS England Integrated Care System Design Framework

https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/

ICS Partnership

- Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The ICS Partnership will be a committee, rather than a corporate body.
- Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body).
- The Partnership will need to be transparent with formal sessions held in public.

ICS NHS Body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- Developing a plan to meet the health needs of the population within their area;
- Allocating resources to deliver the plan across the system;
- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities within the plan;
- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance;
- Arranging for the provision of health services;
- Leading system implementation of the People Plan;
- Leading system-wide action on data and digital;
- Driving joint work on estates, procurement, supply chain and commercial strategies;
- Planning for, responding to and leading recovery from incidents.

NHSE/I will be delegating commissioning of primary care and appropriate specialised Services to the ICS Body.

Integrated Care Systems core purpose

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long- established local authority boundaries), incorporating a number of neighbourhoods

- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale

Governance and management arrangements

The statutory governance requirements for the NHS ICS body will be set out in legislation including the statutory minimum membership of the board – it is likely to include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors;
- Executive roles: chief executive, director of finance, director of nursing and medical director;
- A minimum of three additional board members, including at least:
  - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
  - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
  - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body

Financial allocations and funding flows

NHSE/I will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies. This will include the budgets for:

- acute, community and mental health services (currently CCG commissioned)
- primary medical care (general practice) services (currently delegated to CCGs)
- running cost allowances for the ICS NHS body

This may also include the allocations for a range of functions currently held by NHS England/ NHS Improvement, including:

- other primary care budgets;
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services);
- the allocations for certain other directly commissioned services;
- a significant proportion of nationally held transformation funding and service development funding;
- the Financial Recovery Fund;
- funding for digital and data services;

NB, Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced