NCL Population Health Improvement Strategy

Draft Aim and Plan

V1.1 – 14 April 2022

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Summary

We need to start doing things differently to improve the outcomes and wellbeing of our residents, with a core focus to reduce inequalities in health and wellbeing outcomes, as well as experience of and access to health and care services. By following a population health improvement approach, we will:

- connect with communities to make a meaningful difference in how services are planned and delivered so that we can address inequalities of access that lead to poorer outcomes for some of our communities
- use the opportunities that the ICS provides for all partners to work together with communities, as well as within our own organisations to make the necessary changes
- make our health and care system sustainable, focused on early intervention and prevention – thereby reducing and eliminating the escalation of ill health and poor wellbeing

Therefore we have to build on our integration journey so far and take the leap to review the effectiveness of how we currently use and deploy our resources (our money, our workforce, our relationships) – driven by the needs of our residents. This will transform our health and care system that effectively and holistically serves our residents and is focused on prevention and early intervention.

1. Purpose of this document

Integrated Care Systems (ICS) are partnerships between the organisations that meet health and care needs across an area. Their core purpose is to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

In North Central London, the partnerships between health and care organisations have continued to form and grow over many years. As we commence this next phase of our journey as the NCL Integrated Care System, becoming an ICS provides us with an opportunity to make changes in the way we plan and deliver services, integrating even further, widening the levers we can use and maximising impacts of changes, resulting in our residents having longer and healthier lives. This strategy aims to reflect the binding of the work of place and system in a complementary way so that we are using our collective resources, capabilities and connections to improve population health and individual outcomes and experiences for residents in NCL.

This NCL Population Health Improvement Strategy draws together much of the conversations, partnerships and work to date to set out and achieve:

- A single narrative for NCL that is owned and supported by all partners as to why we are building and following a population health improvement strategy
- A shared vision for the future of health and wellbeing of NCL residents, on which to build our strategy

- Support and endorsement for the roadmap as to how we will deliver this vision – recognising the enablers and interdependencies with multiple programmes of work
- A commitment from all partners to be involved and play their part in delivering the roadmap and its detailed plans
- Agreement to build capacity for a population health improvement approach across the places and neighbourhoods that make up the ICS – using data to drive timely clinical and other interventions
- Agreement to apply population health improvement principles not only to health care services but also to other services, including those that impact wider determinants, such as voluntary and community sector, social care services, integrated services, education, housing and employment

Ultimately, we want this strategy and its' supporting plans to be endorsed by residents and their representative organisations, to ensure that we are making the changes that deliver what our residents want.

We know that it takes time to see changes in population level outcomes, however, the aim and rationale for this strategy should endure for the medium term (c. 5+ years), whilst the detailed plans will need to be iterative, being refreshed regularly, to take account of progress and learning. Therefore the "roadmap" element of this document is based on a shorter timeframe (c.1-2 years).

This strategy recognises the importance of the places and neighbourhoods, and the links between them, which make up our ICS – covering the full breadth of the system of the voluntary and charity sector and social care, alongside the traditional "health" domains of primary care, community care, mental health care and acute & tertiary care.

This strategy also considers the importance of understanding the impact of wider socio-economic circumstances on our population, in developing our population health improvement approach. This strategy is being developed at a time of great uncertainty and pressure within public sector services, notably the pressures and impacts (not just health) of the Covid-19 pandemic. This means that it is even more important to optimise our collective capacity to work together on our shared ambitions for NCL residents.

The aim is for this strategy and outline roadmap to be shared with partners, including residents and communities, to achieve the objectives above and for discussions and feedback to shape and refine the subsequent development of detailed plans and activities to support the strategy.

1.1 How this strategy has been developed

This is the first iteration of the NCL Population Health Improvement Strategy and has been developed by a wide range of system and place authors who have come together from a range of partner organisations across the ICS.

This strategy has sought to pull together the ideas, principles and themes from conversations and analysis shared with the NCL PHI Committee. It also pulls on historic and ongoing work at system and in place based partnerships to join up services in a more integrated way, tackle inequalities and consider the overall wellbeing of our residents. This strategy sits alongside local Health and Wellbeing Board strategies and also ongoing organisational and partnership development work to support the transition to an ICS.

1.2 What do we mean by population health improvement?

In NCL, we are defining population health as "an approach aimed at improving the health of an entire population. 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"[1].

By having an NCL Population Health Improvement Strategy – we are describing in the broadest sense the principles, approaches and ways of working that will deliver improvements in the health and care outcomes of the residents of NCL. We are focussing on population health improvement, rather than the dominant language of population health management, because it is more intuitive, ongoing, incremental and participative – reflecting our intention to set out our way forward and progress together over time. The principles, approaches and ways of working will needed to be supported, facilitated and embedded at all levels within the ICS, from hyper local and neighbourhoods, through to place and system, with integration and partnership at the centre.

2. Why does NCL need a population health improvement strategy?

The case for change is straightforward:

- There is minimal improvement in life expectancy and stagnation or even decline for some residents. Additionally, too many residents are spending the last 15-20 years of life in poor health / wellbeing
- There are stark inequalities across different communities in NCL in terms of health and care access, experience and outcomes
- The system cannot, and will not, keep pace with demand, especially if we don't start taking preventative measures

The main causes of death and ill health in NCL are cardiovascular disease and cancer. Lifestyle factors and behaviours are not improving at a sufficient rate (and in some cases are worsening, particularly for childhood obesity) to forecast a decline in the need for those services. The system is predominantly geared to "fix" or "treat", rather than "prevent".

The direct and indirect impacts of COVID-19 have starkly highlighted the inequalities faced by many residents in NCL, visibly demonstrated by hospitalisations and deaths from COVID-19 during the pandemic, and wider impacts on children living in overcrowded households during lockdowns and differential experiences on employment and income.

These inequalities are longstanding and deeply entrenched among some communities in NCL, driven by high levels of deprivation, affecting all aspects and phases of people's lives including education, employment, income and housing. For some communities, the intersectionality between ethnicity and deprivation compounds the impact on health and wellbeing, including racial discrimination. For example:

[1] King's Fund: A vision for population health, 2018 (p.18). https://www.kingsfund.org.uk/publications/vision-population-health

- Across the five years before COVID-19, 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)
- Those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death
- Residents from Black communities are more likely to die prematurely from preventable or treatable causes of cardiovascular disease compared to White residents

Other factors can also be negatively and unfairly linked to poor health and wellbeing outcomes including being disabled, having a learning disability, having a serious mental health condition, being homeless or being from an LGBTQ+ group. Many residents will live with more than one of these factors, with some individuals and communities experiencing severe and multiple forms of disadvantage. Inequalities can also be stark in the ability to access services, resulting in late diagnosis, late access to treatment and subsequently poorer outcomes.

[Placeholder: Include example of inequalities in access]

[Placeholder: Include information on utilisation of services]

3. What is the NCL Population Health Improvement Strategy?

3.1 The aim of the Population Health Improvement Strategy

Our vision for the NCL ICS is to improve outcomes and wellbeing for the residents of NCL, through delivering equality in health and care services for local people, supporting them to Start Well, Live Well and Age Well. We also want to support the many local people who are employed by health and social care to Work Well.

The aim of the Population Health Improvement Strategy is that together, with residents and communities at the centre, we will improve the health and wellbeing of our population and reduce health inequalities by:

- Working in **partnership with our communities**, enabling them to start well, live well and age well, and ensuring that the lived experience plays a central role in the co-design and delivery of services and interventions
- **Using our data systematically and in new ways** to understand need and drive change
- **Focusing our collective resources in the most effective way** to address need and reduce inequality of access, experience and outcomes, including investing upstream to reduce entrenched health inequalities
- **Leveraging the benefits of the ICS** – as planners, providers, partners and employers – to have the greatest impact on the outcomes for the people we serve

3.2 The core principles of the Population Health Improvement Strategy

The following five core principles will underpin all that we do as part of the Population Health Improvement Strategy:

Fig. 1: Core principles of the Population Health Improvement Strategy:

- The wider determinants of health are the single most important driver of health outcomes for our population. **We will use the power of our ICS partnership in NCL to impact, influence and advocate for changes that address the fundamental components of health** – income, employment, housing, education, transport and leisure. This includes our commitment to a greener NCL, a collective focus on social value and strengthening the wider impact of our anchor organisations.
- The healthy behaviours and lifestyles of our population are critical to improving outcomes but this cannot be achieved without a new relationship with our communities that seeks to understand the challenges, what is important to people, speaks to their aspirations and based on their strengths. **We will reset our relationship with local people and communities and shape our support and provision to enable everyone to live their best and healthiest lives.** We understand that this needs to be underpinned by a decision making process which is flexible enough to operate at both place and system level.
- We recognise that the places where people live and the communities they are part of play an important part in sustaining long healthy lives – both mentally and physically. Our borough partnerships and our neighbourhoods are therefore central to realising our system commitment to improving the health of our population. **Borough Partnerships will deploy their expertise built on local relationships to find the right solutions with their communities**. We will enhance and enable the work they do through our work across NCL embodying the principle of subsidiarity.
- We know that people's needs can be complex – as a result of age, frailty or multiple disadvantage. **We will work together as partners to better understand those needs from an individual's point of view, integrate our provision and combine our resources around people** rather than conditions or single issues.
- There are significant differences in access, experience and outcomes across our population. We also know that the way we have historically funded services and investments has not always reflected need. Moreover, these inequalities drive many of our resourcing issues and challenge our future financial sustainability as a system. **Using our data and in partnership**

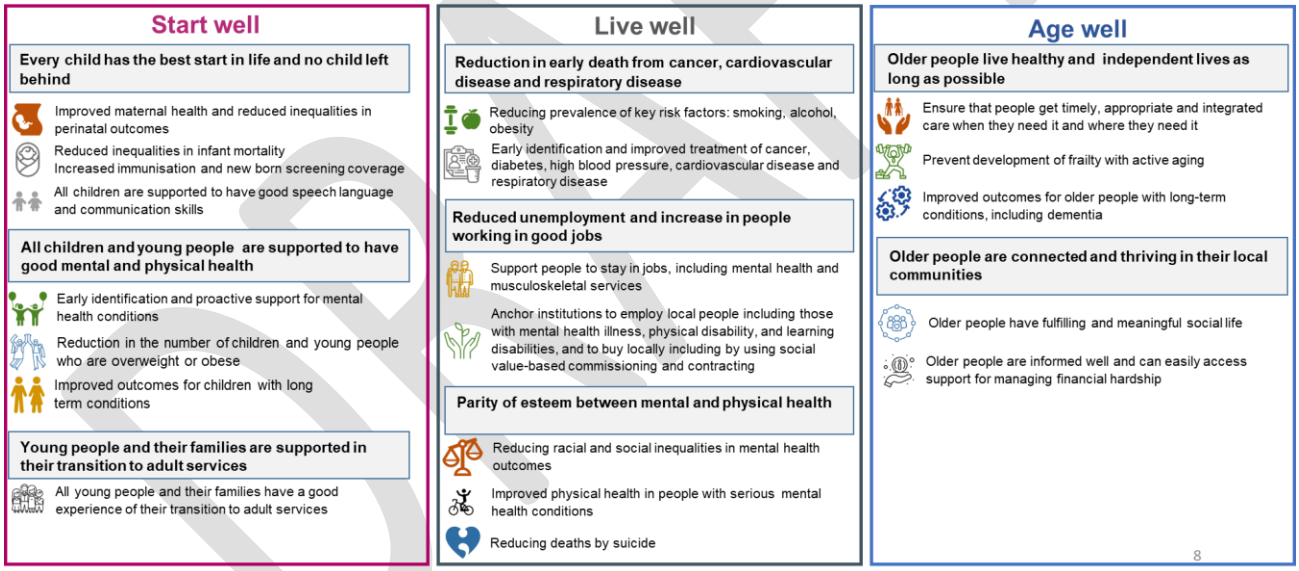
with our communities we will seek to deploy our resources to address the inequalities our residents experience – taking the learning from Covid about different communities needing different levels of support to access care and achieve equitable outcomes and therefore taking this into account as we make decisions about resource allocations for the longer term health of the population and of the system.

3.3 The NCL Population Health Outcomes Framework

We have developed an NCL Population Health Outcomes Framework that provides an overarching view of the outcomes we want our residents to experience, thereby providing a high level sense of where we need to act as ICS. The Outcomes Framework has been developed to underpin the vision for the ICS and the purpose of the Population Health Improvement Strategy, and is complementary to the plans and objectives that sit at system and place based levels. Working together to improve outcomes will drive ever more integration throughout the ICS.

The Outcomes Framework is based on existing priorities and ambitions at system and place (many described in local Health and Wellbeing Board strategies), driven by existing public health evidence (such as in local Joint Strategic Needs Assessments), our population health needs analysis and the progression towards integration.

Fig. 2: Summary of the NCL Population Health Outcomes Framework



The Outcomes Framework will continue to be developed, identifying a core set of indicators, which we will then use to:

- Understand our baseline position, including inequalities
- Develop goals & trajectories, based on our principles
- Build the indicators into our population health improvement platform, HealtheIntent, so that we have a near-real time view of the outcomes for the system, boroughs and care teams

As a result, the full Outcomes Framework (with supporting dashboards) will contribute to our decision making to align resources to address the most stark inequalities or gaps in outcomes, alongside taking account current investment disparities. It will also be central to how we measure progress and monitor impact.

3.4 Roles and responsibilities throughout the ICS

To realise the improvements in outcomes in our communities, every part of the ICS will have to take responsibility for applying the population health improvement principles to what they are doing and how they do it.

The individual and combined roles of the core three levels of the ICS – neighbourhood, place and system – will be vital to the delivery of improved outcomes. We have set out an overarching view of the expected roles and functions of the three main levels within the ICS, to illustrate what "good" will look like as part of our population health improvement journey (see Fig. 3).

We need to do more work to identify, develop and understand the strengths and opportunities that all parts of the ICS will contribute to our population health improvement journey. Included within this is the role of both Provider Alliances and individual providers of services. For example, both *Beyond the Data* from Public Health England and the NHS Race and Health Observatory's *Ethnic Inequalities in Healthcare* highlighted the need for an increased focus on ethnicity data collection. As part of this it would also be beneficial for providers to understand more from their local communities about their lived experiences of access, experience and outcomes, and within this why there may be a reluctance to provide ethnicity information.

Fig. 3: Overview of core functions and responsibilities of Neighbourhood, Place and System in Population Health Improvement in NCL

Neighbourhood

- Individuals and teams using PHM / HealtheIntent as part of everyday care
  - Making every contact count
  - Spotting and resolving gaps in care
  - Identifying inequalities and where other factors / wider determinants might be impacting, e.g. signpost to benefits advice or housing advice
- Resources are organised and deployed to meet both proactive / preventative needs and reactive / episodic needs
- Population risk stratification utilised to identify and manage caseloads
- Teams are multi-disciplinary and horizontally & vertically integrated, embedded in their communities and reflecting their communities
- Wide range of specialist (medical and non-medical) expertise is easily accessible
- Integration of outcomes, incentives and payment mechanisms, with patient reported outcomes and experience measures strongly featured
- Dynamic and interactive community and resident review loop – understanding needs, sharing ideas, monitoring impact and refining approach
- Local planning responsibilities and processes utilised, with discretionary and flexible funding able to support care & pathway transformation (aligned to place & system outcomes)
- Evidence based care models & interventions utilised and adapted for local population needs
- Develop "flexibility" of neighbourhood definition – developing solutions to wrap around communities, not necessarily geography / traditional organisation boundaries

Place

- Optimum understanding of population needs – developing insights, monitoring for change, utilising community relationships to review and respond
  - Systematic review of inequalities and development & implementation of ideas to reduce
- Sets direction of travel and local priorities in light of population needs and place & system outcomes – monitoring for impact and accountable for delivery
- Plan and organise deployment of resources to deliver outcomes – understanding demand, services utilisation, changing needs, changing behaviours
  - Focus on prevention, driven by reducing inequalities, utilising opportunities to maximise benefits from strengths of partnership (tackling wider determinants) and asset / strength based approach in local communities
  - Continuous development of partnership – between and amongst organisations, voluntary and charity sector, communities and individuals
- Shaping and driving transformation – pathways, care models, workforce models, culture & behaviours
- Critical level of interface between and amongst partners – identifying where escalation and additional support required
- Establish environment to enable mutual aid, problem sharing, risk sharing and learning / best practice
- Coordination and support cohesion of neighbourhood plans
- Act as "honest broker" between services and communities – building relationships, developing co-production models and adapting approaches

System

- Population health principles and behaviours are embedded at the heart of the partnership – changing language and leading the new narrative from the top
- Systematic review of the deployment and effectiveness of resources, supported by infrastructure and skills to tackle the "wicked issues"
- Putting in place funding frameworks and payment mechanisms to support proportionate universalism and tackling of wider determinants
- Oversight and assurance of outcomes
- Undertaking delivery where "doing once for all" is most effective
- Develop, implement and monitor system-level strategies, ensuring ongoing review / adaptation / learning throughout system
  - Monitor & consider consistency and equity of offer – offering strategic approach to proportionate universalism
  - Strategic engagement with VCS and communities
- Developing and utilising planning processes focused on tackling inequalities, responding to population needs, supporting identification of problems and determining potential solutions
- Developing & refining principles, frameworks, methodologies to support population health in practice – particularly where "once for all" makes sense
- Senior partnership issue resolution
- Acting as broker between system, regional and national bodies – driving from population and local needs to influence and secure change
- Interactive relationship with academia, AHSNs, research, etc. to utilise full system skills and expertise across the full breadth and depth of the system

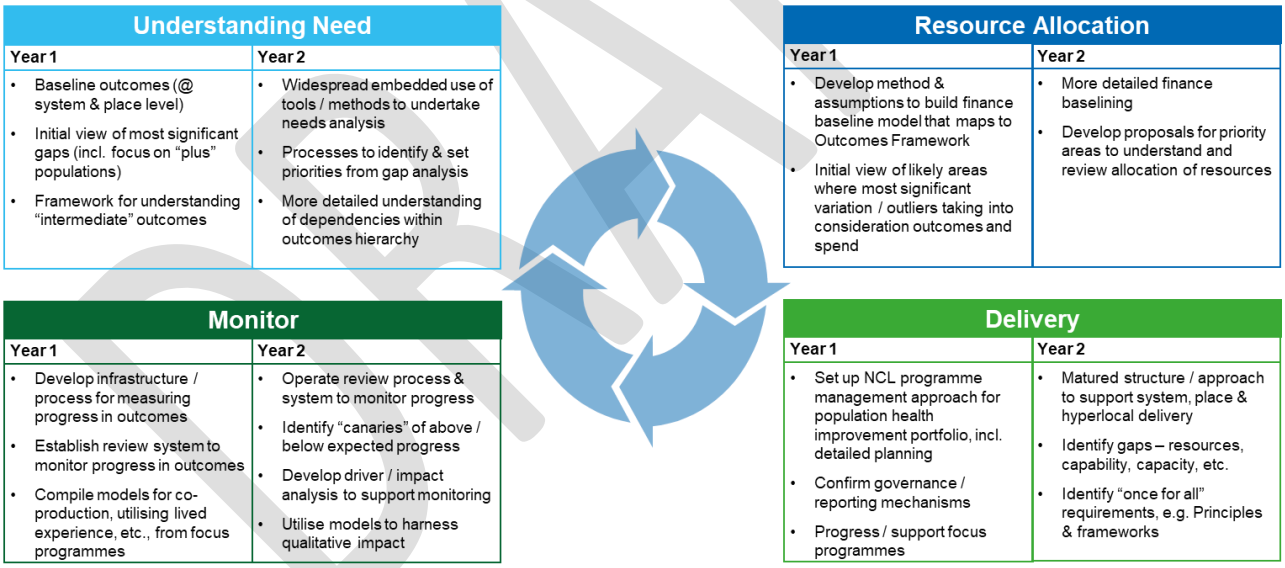
4. Our plans for the next 1-2 years to deliver population health improvement in NCL

We know that some of these outcomes will take time to see improvements at a population level. However, we need to work now to make the changes that will result in those long term improvements, but that will also have an impact at an individual level in the shorter term. For example, it is anticipated that benefits from improved Cardiovascular disease management can be achieved in 1 to 2 years, whereas smoking cessation will realise benefits after c. 5 years, however other interventions such as in tackling childhood obesity will only realise benefits in 10+ years or longer.

We are focusing our planning on the next two years – to create the culture, infrastructure and ways of working that will both provide the foundations for longer term population health improvement as well as have tangible impacts for individual residents in the here and now.

Our initial roadmap is based around the core stages that will enable us to put the population health improvement principles into practice: understand need, resource allocation, delivery and monitor. The initial roadmap is focused at system level, but further planning will enable us to develop roadmaps and plans across the ICS – building a "3D" view.

Fig. 4: Initial 2 year roadmap for population health improvement at NCL level



4.1. The core themes of the NCL Population Health Improvement plan

The core themes of our plan are:

- Support the creation of place-based capacity and capability to deliver population health improvement – understanding local population needs, using data and analytics, listening and working with communities to develop and respond to insights
- Developing our model for putting population health improvement into practice – creating the infrastructure for integrated teams who focus on equity, prevention and proactive care

- Putting co-production and resident involvement at the heart of all our programmes, from development to delivery, for residents, service users and employees
- Embedding population health intelligence to help us understand need, formulate our system problems, address inequities and improve outcomes.
- Rolling out our population health management platform so that frontline health and care teams have access to a near-real time integrated health and care record to identify gaps in care and opportunities to improve the quality of care and reduce inequalities
- Developing new funding models that provide opportunities for testing ways in which we can allocate resources to support those communities with different levels of need to achieve equity of outcomes
- Thinking prevention first in all we do, focusing on keeping people well, using strength-based approaches and tackling wider determinants of health
- Using evidence based interventions and developing proportionate and effective monitoring and effective measurement of impact and improvement (quantitative and qualitative)
- Promoting a system-wide culture of understanding and tackling inequalities through all that we do

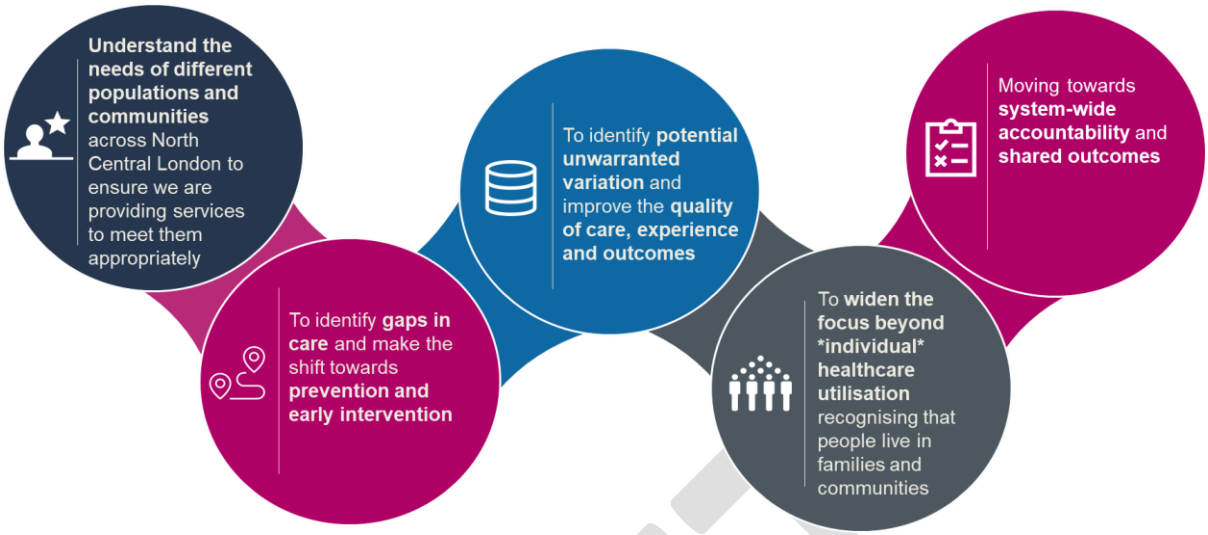
By focusing on these themes, we will making the best use of our skills and resources at all levels in the system – ensuring that the system is providing the environment that will allow places and neighbourhoods the flexibility to develop the local partnerships (including with residents) and ways of working that most effectively will meet the needs of local communities.

Across all of these themes, building a culture that embodies our population health improvement principles and reflects the lived experience of our communities will be central to achieving our outcomes. This includes empowering health and care professionals to work in partnership with the voluntary and charity sector and residents as one team, building on the strengths and aspirations of our residents, supported by the data, to do what is needed.

4.2 Using data for population health improvement

NCL recognises the importance of using data and intelligence to underpin work on population health improvement, and particularly to shine a light on where there are inequities and inequalities.

We have five goals in what we want to achieve with using data:



As a system we are working together to do this by creating a near-real time integrated health and care record in a population health management platform provided by a company called Cerner – HealtheIntent. This will enable our frontline health and care teams to see where patients have gaps in care and create a better understanding of population health needs and inequalities.

[Placeholder: Include information on use of HealtheIntent in PITS]

Key outputs from HealtheIntent include:

- Vaccination dashboards identifying equity gaps. Includes childhood immunisations, flu, and Covid. These dashboards have been used to identify opportunities to improve uptake in specific areas or with specific communities.
- Registries of patients with a condition or issue that flag whether individual patients have 'gaps in care'. For example, if someone with serious mental health illness has not had their physical health check or someone with diabetes does not have their blood pressure under control. These registries will be visible to all frontline health and care staff during 2022/23.
- Quality improvement dashboards which highlight where there is potential unwarranted variation in care for specific conditions and also by equalities groups so that care teams can identify best practice ('bright spots') or areas for improvements.

[Placeholder: Include information on next steps – embedding more and the challenge of moving from the analysis to impacting clinical and care practice and actions]

4.3 Addressing Health Inequalities

A key element of this Population Health Improvement Strategy is an underlying commitment to addressing Health Inequalities. NCL CCG have already demonstrated their commitment to this through the establishment of a dedicated Communities Team, who focus on reducing the variation in access, experience and outcomes for those facing health inequalities. This includes oversight of the NCL Inequalities Fund of £8.75m, the commissioning of inclusion health services, i.e. homeless health and asylum health, overseeing an NCL anchor institutions strategy and developing a Green Plan for the sector.

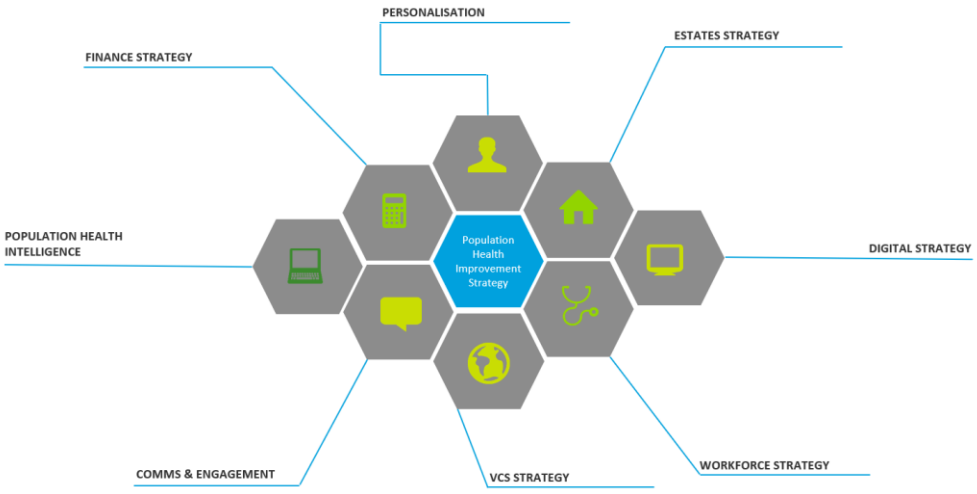
The NCL Inequalities Fund aims to bring together local communities and statutory services to co-design innovative, collaborative approaches to addressing entrenched health inequalities. This includes focusing on the 20% most deprived, as well as other forms of inequality such as learning disability, and is aligned to the wider Core20PLUS5 agenda. Schemes aim to target the underlying root causes of inequality, including the social determinants of health, with examples including schemes addressing severe and multiple disadvantage, food poverty and serious youth violence.

Going forwards, the outputs of the both the Inequalities Fund and the wider health inclusion, green plan and anchor institutions strategy will continue to feed into a Population Health approach across the sector.

4.4 Enablers for our population health improvement plan

We have identified the core enablers that will support the delivery of this Population Health Improvement Strategy. In alignment and combination they will deliver tools, principles, frameworks and methodologies to create the culture, infrastructure and ways of working required to deliver improvements in outcomes.

As part of our plans for the next 1-2 years, we need to work with our enablers to develop the detailed plans – to understand and specify the changes that they will make and contribute to, in order that the aim of this strategy will be achieved.



4.5 Our population health improvement focus programmes

Whilst we have set out our ambition for our Population Health Improvement approach to infiltrate across the planning and delivery of all our services, we also know that we have a number of programmes and initiatives that are acting as forerunners – testing the ways in which we utilise and embed our population health improvement principles, providing us with learning experiences, matured relationships and new skills and models. We recognise the close relationships between these programmes and the mutual learning and sharing of experience that will result as we progress and embed our principles and population improvement delivery themes.

The following list of programmes is not exhaustive, but sets out for those programmes identified, how they align with our population health improvement principles and some outline delivery aims for the next 1-2 years.

Focus programme	Population health improvement approach	Delivery aim in 22/23 and 23/24
Inequalities Fund	• Tackling inequalities • Grass-root / community-focused initiatives • Addressing social determinants of health inequalities	• Demonstration of the value that co-production and use of lived experience can bring to reducing variation in access, experience and outcomes • Development of potential integrated delivery models between the statutory and voluntary sectors
Proactive Integrated Care Teams (PITs)	• Using HealtheIntent to understand needs, identify inequalities & gaps • Tailoring interventions (backed by multi-disciplinary teams) to offer alternative pathway or maintain / improve "readiness" for future care	• Develop provider partnerships for all PITs • Expand Haringey PIT across east locality and develop integrated model with Wood Green CDC • Document core operating model • Evaluate and share learning to inform development of neighbourhood population health improvement model
Start Well programme	• Robust population health needs analysis • Service users and community participation informing programme approach	• Baseline inequalities analysis • Case for change tested through in-depth community engagement • Develop proposals for service user and community engagement and participation in any subsequent phases of programme
Community & Mental Health Services Reviews	• Developing evidence based models of care • Tackling inequalities	• Commence implementing core service offer for both community and mental health based on gap analysis of priority areas

Focus programme	Population health improvement approach	Delivery aim in 22/23 and 23/24
	• Testing models to allocate resources to meet differential needs	• Development of outcomes framework to start to monitor/assess impact of delivering core service offer on inequity of access to services • Provide opportunities for local people to join workforce e.g. with peer support workers in mental health services
Inclusion Health	• Use of population health data to tailor approach to service delivery	• Holistic approach to meeting needs of vulnerable cohorts, e.g. trauma-informed, gender-informed, and delivered in partnership between health and local authorities
Long Term Conditions Locally Commissioned Service (LTC LCS)	• Prioritising prevention and early intervention • Testing new funding models to reallocate resources where differential effort required	• Launch preparatory year for the new model of care, including practice training and readiness • Define and establish supporting infrastructure; • Finalise outcomes framework and goal setting and build dashboard • Finalise funding model, including outcomes-based payment
[Placeholder: Example of pathway that we are improving]	•	•
[Placeholder: Example on prevention]	•	•
[Placeholder: NCL Cancer programme]	•	•
[Placeholder: Specialised commissioning]	•	•

4.6 Alignment with Core20PLUS5

Core20PLUS5, the national approach to tackling healthcare inequalities, will also be integral to delivering improvements in outcomes throughout 22/23 and 23/24. Whilst this does not operate as a stand-alone programme, we will be:

- Prioritising our understanding of the baseline position for the Core20PLUS5 outcomes and where significant gaps, variations, and inequalities exist
- Mapping and aligning the different projects related to Core20PLUS5
- Identifying and developing additional projects / requirements to address any gaps

We will continue to build the action plans against the 5 priority areas:

Maternity Continuity of Care

- Collaborative design of midwifery continuity action plan
- Ensure that women from Black, Asian, minority ethnic and mixed ethnicity backgrounds, as well as vulnerable groups are care for using patient-informed clinical models to improve outcomes and experiences
- Trust action plans that include logistics planning and milestone setting, followed by system-wide introduction, sustainability and launch of new continuity models

SMI – annual health checks

- Specialist primary care teams established across boroughs to provide full SMI coverage and drive improvement against the annual healthcheck KPI (60%)
- NCL has launched a clinical network across primary and secondary care driving clinical change. The network will develop a system wide plan in 2022/23 to improve health outcomes and reduce inequalities in health and social outcomes

Respiratory

- Development of ICS wide multi-disciplinary Respiratory Network
- The Respiratory Network will champion, commission and oversee Proactive Care programmes and transformation initiatives across all Respiratory pathways, including reviewing population health data to understand how services can address health inequalities within the local populations
- Specific priority areas include: introduction of pulmonary rehabilitation roadshows targeting underserved populations; establishment of spirometry hublets in primary care

Cancer diagnosis

- The Cancer Alliance is focusing on four priorities to address known inequalities in cancer access and provision, as well as continue identifying other inequalities:
  - Working with patients, voluntary sector organisations, academia, local authorities, and NCL partners to understand the needs of diverse or marginalised groups
  - Reducing barriers in service provision and increasing access for hard-to-reach groups in NCL
  - Ensuring data analysis and reporting includes inequalities indicators
  - Utilising information from Equality Impact Assessments (EIA) on our programme as a guide to embed further activities in Alliance way of working

Hypertension case finding

- Development of ICS wide multi-disciplinary Cardiovascular Disease (CVD) & Stroke Prevention Network
- The network aims to prevent and reduce the prevalence of Stroke, CVD, Myocardial Infarction (MI), Peripheral Vascular Disease (PVD), heart failure and Vascular dementia by focusing on the management of modifiable risk factors such as hypertension, atrial fibrillation and hypercholesterolaemia
- Case finding for hypertension, AF and hypercholesterolaemia forms part of the key priorities for improvement in the workplan for 22/23, and case finding for hypertension and AF is included in the LTC LCS
- Embedding of risk stratification tools into HealtheIntent and development of a hypertension and lipid management HealtheRegistry to support detection of those at risk, optimisation of care and increasing uptake of NHS health checks

We have started to define the "Plus" population cohorts for NCL, as our analysis shows that unwarranted variations in access, experience and outcomes is much more nuanced than consideration deprivation in isolation. By looking beyond the most 20% deprived of our population, we will design and deliver services to the level of intensity required to close gaps in health needs across the deprivation and ethnicity gradients to maximise health gains and reduce inequalities. Importantly the patterns of deprivation are different for children and young people and also older people compared to the population average. We will tailor our approaches and plans to reflect these differences.

We have also identified three other core groups of population cohorts that we propose to include in our "plus":

- Ethnic groups with a high percentage of the community living in the 40% most deprived areas:
  - Start Well: Black African, Bangladeshi, Mixed Black ethnicities and Somali communities, noting that the patterns of spatial deprivation are different than adults
  - Live Well: White Turkish communities
  - Age Well: Black Caribbean communities
- People with serious mental illness and learning disabilities – these populations have disproportionately poorer health outcomes, including higher mortality and preventable ill health

- Inclusion health groups – these groups face disproportionately poorer health outcomes, and include the homeless, refugees and asylum seekers, sex workers, Irish Traveller and gypsy communities, transgender people, and (ex)offenders

We will be undertaking an inclusion health needs assessment to better understand the needs and sizes of these populations.

[Placeholder: Further case studies to be captured and appropriately distributed throughout document]

Haringey community COVID vaccine outreach

What did we do?

A partnership between Haringey Council, Local NHS and community groups to increase COVID vaccine uptake, particularly focussing on communities with lower uptake. We set up a vaccine engagement and outreach team integrated with vaccine provision from our GP federation– with staff with a number of community languages. We had a Haringey COVID vaccine bus and used data and listened to communities on where best to go out into the community and provide vaccinations.

What was the impact?

We supported over 80,000 outreach engagements to encourage vaccination take up in low uptake areas, contributing to over 11,000 vaccine appointments and delivered an additional 2850 vaccinations on the vaccine bus. COVID vaccine uptake was increased in particular groups (e.g. rough sleepers, people from Turkish communities). The programme was informed by local initiatives in other NCL boroughs and we were able to share our learning across London.

"Going out into communities with our vaccine bus allowed us to provide 1st COVID vaccinations and vital protection to 100s of local residents who we had not been able to reach previously"

Equitable recovery Programme – Royal Free London

What did we do?

Extensive data analyses of elective procedures and outpatient appointments Do Not Attend (DNA) was performed against ethnicity and deprivation factors that uncovered inequalities in access to services. The equitable recovery programme was set up consisting of various components including data analyses using HealthIntent and hospital data, improved ethnicity recording as well as interventions such as a network of patient navigators and volunteers proactively contacting patients to offer support and understand barriers to access. A partnership is being established with local community and voluntary sector organisations to explore opportunities for joint working.

What was the impact?

A significant number of missed appointments were reduced, patients' satisfaction improved and savings to the system made. These are early impacts of this recent interventions; work is in place to extend its reach across the whole of NCL.

"Intelligence-led interventions made us think differently and support our 'business as usual' with more bespoke interventions that have immediate benefits to both, patients, and the system"

4.7 Next steps

To ensure this Population Health Improvement Strategy is owned and endorsed by the system, we now need to socialise it widely with our key stakeholders. We see this very much as a live and iterative document that will continue to develop, reflecting the feedback that we receive from system partners.

Appendix 1: Glossary

Population Health: In NCL, we are defining population health as "an approach aimed at improving the health of an entire population. 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"[2].

Population Health Improvement Strategy: We are describing in the broadest sense the principles, approaches and ways of working that will deliver improvements in the health and care outcomes of the residents of NCL.

Population health management (PHM): While the definition of PHM has changed over time, at its heart is the use of integrated data by all health and care professionals to drive improvement and reduce inequalities. This will enable a risk stratified approach to delivering the care that residents need, recognising that there are differing levels of needs amongst our communities and residents.

HealtheIntent: A near-real time integrated health and care record in a population health management platform provided by a company called Cerner. This will enable our frontline health and care teams to see where patients have gaps in care and create a better understanding of population health needs and inequalities.

The 4 pillars of population health: The following four interconnecting pillars form the basis for a population health system:

1. The wider determinants of health
2. Our health behaviours and lifestyles
3. The places and communities with live in, and with
4. An integrated health and care system[3]

Wider determinants of health: The socio-economic circumstances that drive the health outcomes for our population. Income, employment, housing, environment, education, transport and leisure are all examples of wider determinants of health.

Proportionate universalism: The 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.

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

[2] King's Fund: A vision for population health, 2018 (p.18). https://www.kingsfund.org.uk/publications/vision-population-health

[3] King's Fund: A vision for population health, 2018 (p.21). https://www.kingsfund.org.uk/publications/vision-population-health

area where people live; specific characteristics such as ethnicity, disability or sexual orientation; and excluded groups, for example, people experiencing homelessness.[4]

Subsidiarity: The principle of subsidiarity is the idea that decisions should be made as close as possible to local communities.[5]

[4] King's Fund: Health inequalities: our position. https://www.kingsfund.org.uk/projects/positions/health-inequalities

[5] King's Fund: Integrated care systems explained. https://www.kingsfund.org.uk/publications/integrated-care-systems-explained