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Update on NCL ICS Transition

Presentation to Enfield Health & Wellbeing Board 7 July 2022

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The North Central London population

- North Central London is made up of five boroughs – Barnet, Camden, Enfield, Haringey and Islington.
- Around 1.6 million residents live in North Central London, with a relatively young population in some boroughs compared to the London average.
- Diverse population with historic high migration – from within UK and abroad; around 25% of people do not have English as their main language.
- Higher rates of deprivation than some London areas, with pockets of deprivation across all boroughs.
- Significant variation in life expectancy between most affluent and most deprived areas.
- Approx. 200,000 people in NCL are living with a disability.

[1] Index of Multiple Deprivation, 2019

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The North Central London health and care system

- 12 hospital trusts
- 5 local authorities
- One clinical commissioning group
- 200+ general practices
- 300+ pharmacies
- 200+ care homes
- A wide range of voluntary, community and social enterprise (VCSE) sector organisations and groups providing essential care

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Overview

- ✓ The Health and Care Bill received royal assent on 28 April 2022, becoming the Health and Care Act.
- ✓ NCL CCG will continue as statutory body until 30 June.
- ✓ The CCG's current system accountability, functions and responsibilities will transfer to the new NCL ICB on 1 July.
- ✓ Work has progressed well in key areas of ICS development including the development of a clinical and care leadership model and the development of borough partnerships.
- ✓ The NHS North Central London ICB Executive Management Team has been established.
- ✓ Work is underway to appoint Non-Executive Members and Partner Members to the NHS North Central London ICB Board.
- ✓ Key next steps include continued and strengthened engagement with our partners and residents and agreeing partnership ambitions for the next few years, including short term priorities and core principles for working together.

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Purpose of an Integrated Care System

- The core purpose of an Integrated Care System (ICS) 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 to support broader social and economic development.
- Each ICS will have a responsibility to coordinate services and plan health and care in a way that improves population health and reduces inequalities between different groups.
- This way of working closely reflects how the NHS and Councils in North Central London have already been working together in recent years, to improve our population's health and reduce inequalities through greater collaboration.

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The benefits of forming an ICS in North Central London

Improved outcomes

Enable greater opportunities for working together as 'one public sector system' – ultimately delivering improved patient outcomes for our population

Working at borough level

Support the further development of local, borough-based Care Partnerships and Primary Care Networks

Reduce inequalities

Identify where inequality exists across in outcomes, experience and access and devising strategies to tackle these together with our communities

Efficient and effective

Help us build a more efficient and effective operating model tackling waste and unwarranted variation

New ways of working

Accelerate our work to build new ways of working across the system to deliver increased productivity and collaboration

Economies of scale

Help us make better use of our resources for local residents and achieve economies of scale and value for money

System resilience

Help us become an system with much greater resilience to face changes and challenges to meet the needs of our local population by supporting each other

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Our developing system

North Central London Integrated Care System (ICS) is the name of the NCL system as a whole. An ICS is a way of working, not an organisation.
Partners within the NCL ICS include: Acute Trusts, Mental Health Trusts, Community Trusts, Local authorities (Barnet, Camden, Enfield, Haringey and Islington), Healthwatch and VCSE (Voluntary, Community and Social Enterprise) sector

NHS North Central London Integrated Care Board (or ICB) allocates NHS budget and commissions services. This is the organisation that NCL CCG staff will transfer to, and will be chaired by Mike Cooke, with Frances O'Callaghan named Chief Executive.

The **North Central London Health and Care Partnership**, is the Integrated Care Partnership, a joint committee with the councils across the five boroughs. This committee is responsible for the planning to meet wider health, public health and social care needs and will lead the development and implementation of the integrated care strategy.

System

Provider collaboratives involve NHS trusts and primary care (including acute, specialist and mental health) working together. UCL Health Alliance incorporates all NHS trusts and primary care in NCL.

Place

Place-based partnerships or **borough partnerships** include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care.

Neighbourhoods

Building on PCNs, Neighbourhoods support multidisciplinary working between frontline teams, population health management and relationships with communities.

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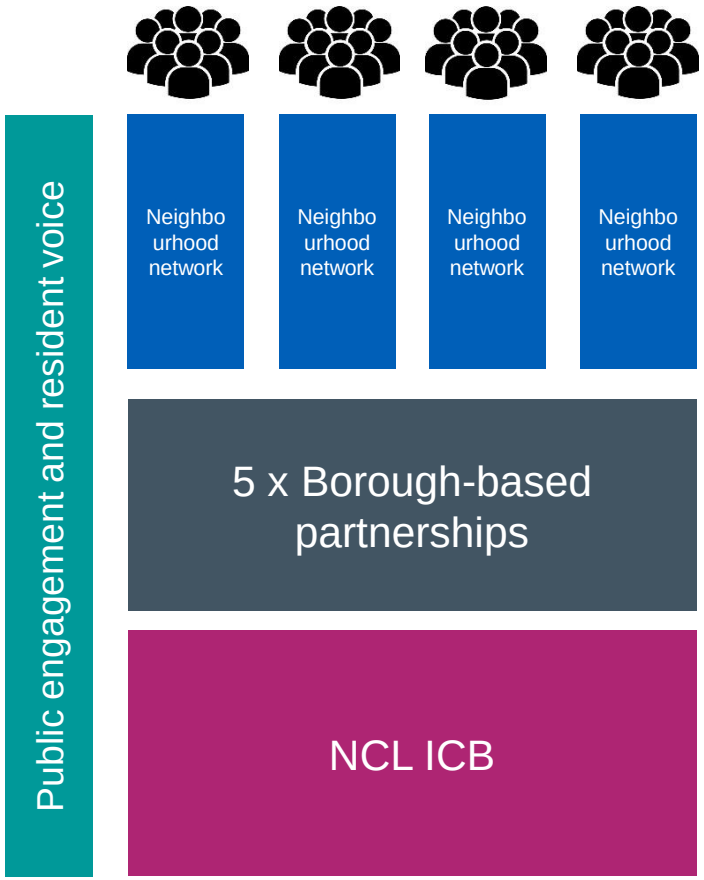
Where we are now

Together with system partners, we are designing what the North Central London Integrated Care System (NCL ICS) will look like at neighbourhood, place (borough) and system-level.



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The NHS North Central London ICB Executive Management Team has been established

Board Member

Board Attendee

Chief Executive Officer
Frances O'Callaghan

Chief Development and Population Health Officer
Sarah Mansuralli

Chief Finance Officer
Phill Wells (in post TBC)

Chief Medical Officer
Dr Jo Sauvage

Chief Nursing Officer
Chris Caldwell (in post May '22)

Executive Director of Places
Sarah McDonnell-Davies

Chief People Officer
Sarah Morgan (in post July '22)

Executive Director of Performance and Transformation
Richard Dale

Executive Director of Corporate Affairs
Ian Porter

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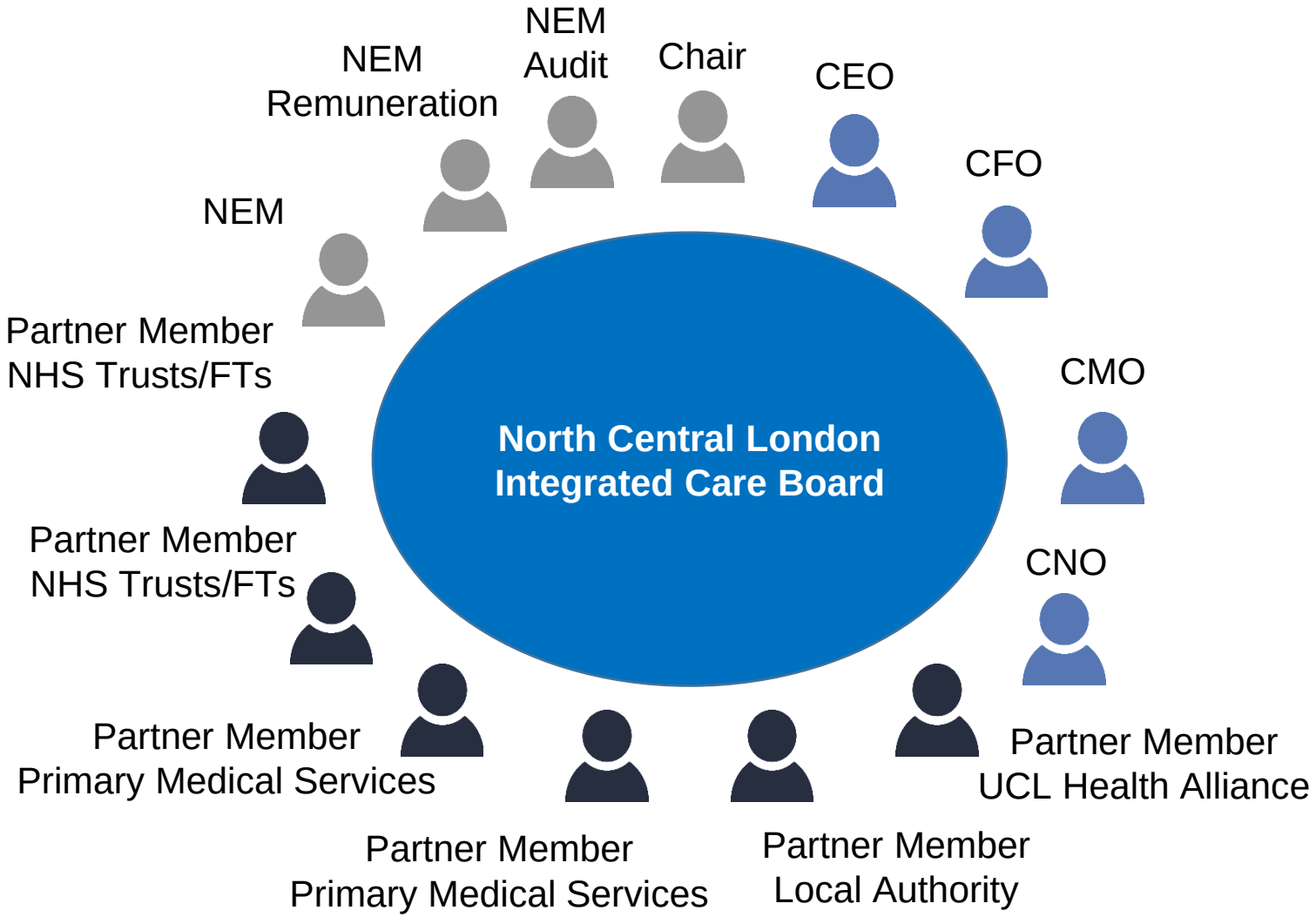
Membership of NCL Integrated Care Board



Non-Executive Members

Executive Members

Partner Members

NCL ICB has proposed 14 Board Members with voting rights within the Constitution.

To date, the Chair designate and the four designate Executive Members have been appointed to the NCL Board.

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Developing the NCL ICS will deliver benefits to residents, patients and staff working across NCL.

- **Reduce inequalities**: Identify where inequality exists across populations, outcomes, experience and access. Devise strategies to tackle these together with our communities.
- **Improved outcomes**: Enable greater opportunities for working together as ‘one public sector system’ – ultimately delivering improved patient outcomes for our population.
- **Working at borough level**: Support the further development of local, borough-based partnerships and Primary Care Networks.
- **Efficient and effective**: Help us build a more efficient and effective operating model tackling waste and unwarranted variation.
- **New ways of working**: Accelerate our work to build new ways of working across the system to deliver increased productivity and collaboration.
- **Economies of scale**: Make better use of our resources for local residents and achieve economies of scale and value for money.
- **System resilience**: Improve our resilience to face changes and challenges to meet the needs of our local population by supporting each other.

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Opportunities for change across the system

- Enabling population health approaches to tackle inequalities and wider determinants of health
- Driving new ways of planning and delivering across organisations
- Developing and supporting primary care networks
- Integration of care at neighbourhood and place level
- Supporting and developing our staff to ensure we have the workforce to meet the demands of a changing health and care system
- Create a health and care system that evaluates, learns and improves

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What we want to achieve with population health in NCL

Understand the needs of different populations and communities across North Central London to ensure we are providing services to meet them appropriately

To identify **gaps in care** and make the shift towards **prevention and early intervention**

To identify **potential unwarranted variation** and improve the **quality of care, experience and outcomes**

To **widen the focus beyond *individual* healthcare utilisation** recognising that people live in families and communities

Moving towards **system-wide accountability** and **shared outcomes**

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Driving new ways of planning and delivering across organisations

Clinical leadership will need to evolve: with shared responsibilities for outcomes across pathways. If we succeed we will harness the world leading specialist knowledge we have in our specialist trusts and have a greater impact for the health of our population.

Proactive care: across NCL, multidisciplinary teams (made up of social services, acute, primary care, mental health and VCSE) are coming together to manage patients with multiple long term conditions proactively, using population health tools to understand elements of care that would most support them.

Single elective waiting list across organisations: Working with providers we have effectively started to manage a single waiting list across the system. Putting in place demand management initiatives to match capacity and reduce waiting times. This is combined with active mutual aid across sites to treat those in need much quicker.

Taking a pathway approach to recovery: We need to challenge the inverse care law, and invest outside of the normal large acute sites to drive improvements in outcomes. Accelerator money has been invested across the pathway from diagnosis and point of referral through to support in the community.

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Key next steps

- ✓ Co-producing a population health outcomes framework and strategy – with input from across the system.
- ✓ Establish a board membership for the ICB including non-executive and partner members (council, NHS Provider and Primary Care).
- ✓ Engagement meetings between the NCL ICS Chair, NCL ICS Chief Executive and partners to consult on next steps in evolving NCL health and care partnerships and borough partnerships.
- ✓ By the end of June 2022, the Partnership will agree ambitions for the next few years, short term priorities and core principles for working together.
- ✓ Begin working with Local Authorities and other system partners to think through the implications of the recently published Integration White Paper ‘Joining up care for people, places and populations’.

Enfield Borough Partnership

Progress Update
Enfield Health & Wellbeing Board

7th July 2022

NCL CCG - Enfield Borough Partnership

Place Based Design: National Offer

Update

Place Based Partnership Working & National Programme Modules

The statutory members of our partnership are:

- London Borough of Enfield
- Enfield Borough, North Central London CCG
- North Middlesex University Hospital & Royal Free London Hospital (inc. Barnet & Chase Farm Hospitals)
- Barnet, Enfield and Haringey Mental Health Trust (inc. Enfield community Services)
- VCS organisations supporting delivery of front line services (e.g. Enfield Voluntary Action -health champions and social prescribing, Enfield Carers Trust, Age UK)
- Enfield GP Federation and 5 Primary Care Networks (PCNs)

In addition to this work:

Enfield has been working with The Leadership Centre & Traverse to drive the **Strategic Development** work required for the Enfield Borough Partnership.

We have worked hard to ensure that the Enfield Place Based Development work focuses on **Operational Delivery opportunities** and does not duplicate effort.

The Place Based design national offer comprises 4 Modules:

Module A - *Leadership*	Strengthening the local vision through collaborative leadership, focused on outcomes for the population
Module B – *Governance & Finance*	Sharing resources on a system basis while being Place & Neighbourhood focused to drive effective local decisions
Module C – *Population Health Management*	Using this approach aims to improve the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population
Module D - *Digital Development*	Developing a digital approach to help to improve access to health and social care services

ICS Population Health and Place Development Programme

Aim of the Programme

- This has been designed to help Enfield Borough to deliver the best possible population health outcomes for its residents
- The support provided by the national offer will accelerate and embed the adoption of Population Health Management (PHM).

Why is Place based working so important?

- Breaks down institutional silo's and draws together support and services around people and the local population
- Best utilises the shared resources and assets of a Place
- Helps to tackle 'wicked' problems, drawing on creativity of people from across the Place
- Emphasises the importance of community and citizen involvement in the design/delivery/evaluation of services and support

What role can PHM play in Place based health and wellbeing?

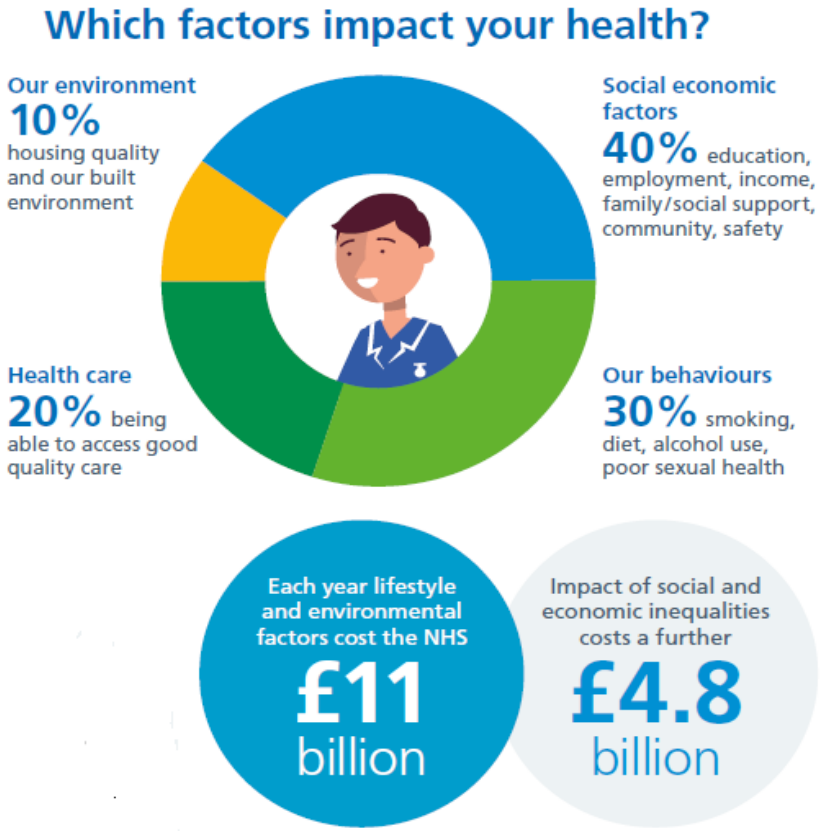
- Considers the wider determinants of health and inequalities
- Improving health inequalities by taking action
- Using data-driven insights and evidence of best practice to inform targeted, proactive interventions to improve the health & wellbeing of specific populations & cohorts
- The wider determinants of health, not just health & care
- Making informed judgements - clinical, public health and analysts working together
- Best use of collective resources – workforce and incentives - to have the best impact
- Acting together – the NHS, local authorities, public services, the VCS, communities, activists & local people. Creating partnerships of equals
- Achieving practical tangible improvements for people & communities

What is Population Health Management?

Population Health Management is an approach aimed at improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population.

Population Health Management is about:

- **Improving health and removing inequalities** by taking actions to reduce the occurrence of ill-health
- **Using data-driven insights and evidence of best practice** to inform, plan and deliver targeted, proactive anticipatory care interventions
- **Addressing wider determinants of health,** not just health & care, by working with communities and partner agencies.
- **Making informed judgements** – clinical, public health and analysts working together
- **Best use of collective resources** – workforce and incentives – for maximum impact
- **Acting together** – the NHS, local authorities, public services, the VCS, communities, activists & local people – **by creating partnerships of equals**
- **Identifying local 'at risk' cohorts by segmentation, stratification and impactability modelling** - and, in turn, designing and **targeting interventions** to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes
- **Achieving practical tangible improvements for people and communities**



Leadership & PHM 2nd Workshop - 16th May 2022

First workshop of Modules A & C (26th April 2022) – Priorities from the borough partnership PHM analyses it was agreed to focus on:

- ❑ **Preventing & Reducing Tobacco Dependence - vaping vs. tar based**
- ❑ **Preventing & Reducing Overweight People from becoming Obese**

Second workshop Modules A & C 2 (16th May 2022)- Definitions of Population Health & Population Health Management discussed:

Population Health…
… is 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, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management…
…improves population health by **data driven planning and delivery of proactive anticipatory care to achieve maximum impact within collective resources**.

It includes **segmentation, stratification** and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and **targeting interventions to prevent ill-health** and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

- **An in-depth discussion of the population cohort of those who smoke/or are at risk of becoming obese, with the agreed outcome, that the population cohort should consist of:**
  - **18 – 40 year age group – who are smoking and obese**
  - **Living in the 40% most deprived areas**
  - **Other determinants of health, including social deprivation, education, poverty, access to fresh food and access to green spaces should also be considered as part of this work**
- **Partner members would identify operational leads to lead the development of the borough delivery plan for their respective organisations**

End goal: Selection of the Enfield population cohort

We have selected a cohort of people/families/places who…. because…

Our cohort selection criteria are:

- **18-40 years old**
- **Smoking and obese / severely obese**
- **Living in the 40% most deprived areas**

Thoughts on the wider determinants and health inequalities for this cohort:

A. Unemployment / Poverty
B. Access to healthy food
C. Access to green spaces
D. Impact of Mental Health
E. Consider homelessness

Aspects to consider during intervention design:

A. Language, English / Turkish / Polish / Other

B. Children in the household and childhood obesity

C. Cultural co-production

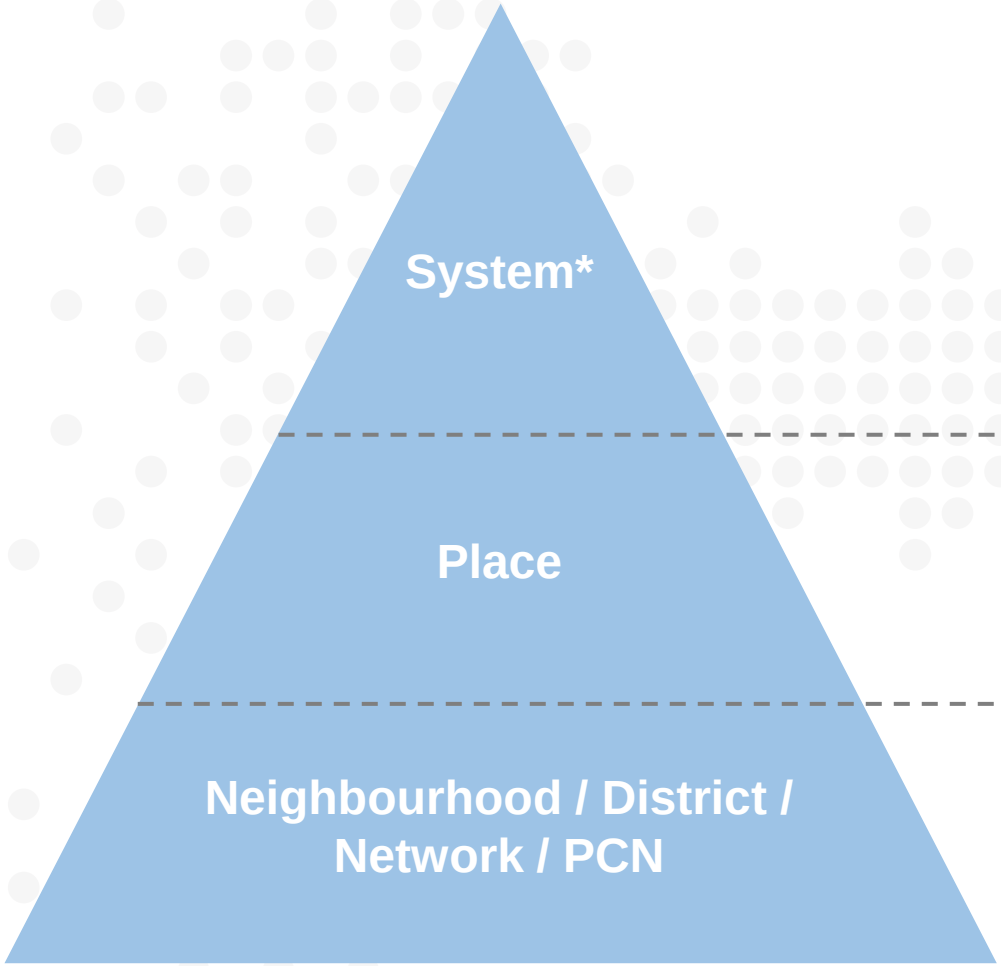
D. Use of social media / community spaces (e.g. libraries, building synergies with the LBE led work including development of community hubs

The national position on the functions of Place Partnerships

From the 'Thriving Places' guidance..

Health and care strategy and planning at Place	• The place-based partnership has a common understanding of its population, and has agreed a shared vision and local delivery priorities. • Building on its vision and priorities, the place-based partnership will have a role in developing the integrated care strategy agreed by all partners in the ICP, and inform the NHS plan developed by the ICB. • Partners at place will also be responsible for delivering these system-wide plans where relevant.
Service planning	• The place-based partnership has agreed approaches to align the commissioning of NHS and local government services around shared objectives and outcomes. Where agreed locally, this includes formal joint commissioning arrangements. • The place-based partnership may look to providers of health and care to play an active role in parts of the commissioning process. In particular, partners should consider approaches to collaboratively monitor the delivery and performance of services.
Service delivery and transformation	• The place-based partnership continues to integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population. • It is important that each place-based partnership fosters a culture of innovation, enabling the sharing of best practice between organisations, and promoting adoption of proven innovation. This includes fostering closer working between sectors to ensure that transitions in care are managed effectively and issues are resolved.
Population health management	• The place-based partnership has agreed with wider system partners plans to establish population health intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally. • This typically includes segmentation and modelling to understand future demand across population groups and care settings, understanding population risk factors, and supporting the implementation of anticipatory care models.
Connect support in the community	• The place-based partnership works with a wide range of community partners to leverage and invest in community assets. • Partnerships should work with VCSE partners to understand where there are opportunities to develop service provision to support communities. This may include working with (for example) housing associations, education providers and local businesses.
Promote health and wellbeing	• The place-based partnership proactively works with local agencies and partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability. • The NHS and local government may consider opportunities to leverage their role as 'anchor institutions' to support economic opportunity and skills development in their communities.
Align management support	• Place-based partners agree options to align and share resources. For example, some places have arranged operational support to PCNs, including data and analytics, as well as HR support. • PCN clinical directors should be supported to build their working relationships to lead on service transformation, and represent primary care in the place partnership.

Thinking about the ‘functions’ of a Place – and how they relate to those exercised more locally and across the whole system



- There is a **statutory or regulatory requirement** to organise them at System or above
- The function is **strategic**, i.e. helps to define objectives/priorities for the whole system
- Represents **best use of resources** to organise the function at system level, balanced with effectiveness of approach
- The function requires **highly specialist or scarce resources** which either cannot easily be sourced at Place, or may risk Places competing with each other for resource

Functions exercised at **Place**, unless…..

- Function requires a **deep understanding of specific local health and care needs.**
- Function involves a **high level of local engagement/relationship building.**
- There is a **statutory or regulatory requirement** to organise them at sub-Place.
- Function is **readily prevalent and accessible** at sub-Place layer.

* Some capabilities may need to be organised beyond System, e.g. at Regional, or Regional Cluster layer but for simplicity we are not focussing on these today

NCL CCG - Enfield Borough Partnership

NCL Cross-Borough Partnership development

NCL Cross Borough Partnership development

Series of Workshops supported by The Leadership Centre and Traverse

- Engages with the 5 borough partnerships in NCL
- To inform and develop place based partnerships and identify the key challenges and opportunities to allow place and neighbourhoods to shape their local ambition, plans and outcomes working with all partners

Focus of this work includes:

- Ambition and Vision
- Leadership at place to shape the cultural change required fro integrated working
- Functions, accountabilities and governance and recognising the interface between the NCL ICB, place and provider alliances as well as recognising the role of Health & well Being Boards and Health Overview Scrutiny Committees
- Development of Primary Care Networks and Neighbourhoods
- NCL ICS/ NCL ICB priorities and borough partnership priorities
- Resident and Community engagement including co-production with local communities and VCS organisations
- Resources and capabilities required at borough partnership level