North Central London Integrated Care System

North Central London Population Health and Integrated Care Strategy

DRAFT **16th February 2023**

Version **10**

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Engagement has been core to our iterative process

North Central London Integrated Care System

What we heard

Inequalities – We must be able to emphasise that hyper-local delivery is key to reaching communities effectively and tackling health inequalities, as well as how inequalities impact different population groups

Language: The strategy needs to be inclusive in its language to allow a wider audience to understand it

Integration: The strategy needs to define how different stakeholders will work together to deliver the strategy.

Sustainability: The strategy needs to highlightg how the NHS is going to act as anchor institution and its contribution to climate change

Prevention: Balancing addressing population health improvement in our current services and pathways along with shifting more focus and resource toward proactive care and prevention

Financial implications: Provide health economic data to quantify the problem and provide economic argument to tackle inequality

Impact on residents : The report to be more explicit regarding the impact on residents

Education: Education for residents about how things are changing

Impact on providers: The strategy should describe what it means for the providers

Digital : Strengthen approach to how we will use data to support and drive innovation and improvement

Collaboration with VCSE : Strengthen approach to how we will work in collaboration with VCSE

What we did about it

Inequalities: Our future state outlines the close working at place and neighbourhood level. We are focusing on our CORE20PLUS5 populations to ensure we are identifying and tackling inequalities.

Language: We have been iterating our themes and development areas to make them more accessible – we have also tested language throughout engagement.

Integration: Our integrated care content outlines what we believe the future state to be, draws on examples of existing integration and a roadmap for further integration and delegation

Sustainability: Linking in to the 'Collaborating to tackle the root causes of poor health' theme which we describe our aim to strengthen our anchor network and deliver the NCL green plan

Prevention: Our 5 priority areas will encourage holistic thinking and innovation – facilitating linkages across existing programmes and greater investment in improving prevention and early intervention.

Financial implications: Although this strategy does not outline specific cost-benefit analyses, we have identified the importance of engaging with the CFO community in NCL.

Impact on residents : We have developed a series of 'I' statements, linked to what our communities have told us, to describe what integrated care will look like for our residents and communities.

Education: We have worked with communities to gather insight on our system challenges. Our Joint forward Plan (JFP) will be a public-facing document that outlines the delivery of our strategy.

Impact on providers: Our integrated care section describes the future state of integrated care across NCL as well as what this will mean for different organisations, including providers.

Digital : Central to our 'making population health everyone's business' delivery theme is improving our insights across NCL, including how digital will enable us to better community insights.

Collaboration with VCSE: Our integrated care section describes the horizontal integration with VCSE

Executive summary (titles of each slide)

North Central London Integrated Care System

- This document will bring to life how we will work together, as an integrated care system to achieve our collective ambition for our population
- Creating this document has been a collective effort across our partnership in the spirit of system-ownership
- To get involved in population health and integrated care, there are six key terms for everyone in our system to know
- Population health is why we are here and our shared purpose across the North Central London Integrated Care System
- We have a shared ambition across our partnership
- We are building on the existing Health and Wellbeing strategies, with common themes and principles
- We have worked to understand our population needs, residents' experience and system challenges
- Our 'I' statements define what integrated care needs to look like for our residents, our communities and our service users
- To become a population health system, we need to change in fundamental ways
- We have ten principles which will guide our new ways of working
- We have tailored the national NHS framework for health inequalities to the needs of our population
- We have developed a population health outcomes framework that reflects where we have significant local disparities across the life course
- Our outcomes framework has helped us identify five development areas for population health improvement in NCL
- Our five population health improvement development areas where system focus will deliver greatest impact
- What it looks like to take action on wider determinants of health
- There are key programmes already underway which are taking a population health approach
- NCL is uniquely rich in world class expertise in research, evaluation and improvement
- A key ingredient to change on the ground is how we join up and integrate care around individuals and communities
- Our future state – how integrated care will look at system, place and neighbourhood
- All partner organisations will look and feel different in our future state
- Integrated care is already happening across NCL – spotlight on children's health and well-being
- We are building on a foundation of integrated care across our five Borough Partnerships
- Our vision for Borough Partnerships will develop over time within a shared framework
- Our Roadmap for developing Borough Partnerships lays out the way forward over the coming 18 months
- Moving forward
- We will coordinate delivery around five themes
- Our key deliverables for each theme
- Moving forward – our model for change and how all the pieces fit together
- Next steps

Foreword

North Central London Integrated Care System

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

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

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

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

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

North Central London Integrated Care System

Our Ambition

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

We want to achieve this ambition for everyone.

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

North Central London Integrated Care System

Link to engagement appendix

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

North Central London Integrated Care System

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

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

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

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

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

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

Link to glossary appendix

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

North Central London Integrated Care System

Core purpose of our Integrated Care System (ICS)

NHS Providers

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

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

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

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We have a shared ambition across our partnership

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New legislation

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

- **Integrated Care Boards (ICB) -** NHS bodies, taking on many of the functions previously held by the CCGs as well as some NHS England functions.

Health and Care Act 2022

- **Integrated Care partnerships (ICPs)** bringing together NHS, local authority, and wider partners to focus on addressing wider determinants of health and developing integrated working.

The legislation also formalises the geographical footprint-based approach of system, place and neighbourhood to partnership and delivery structures outlined in the next section.

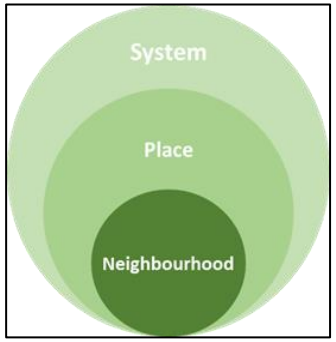
At the time of writing, we are awaiting the findings from the **Hewitt review**, led by Patricia Hewitt, which will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed.

We are expecting specific recommendations on:

- How to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- The scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- How the role of the Care Quality Commission (CQC) can be enhanced in system oversight

Clear Responsibilities

Improvements in population health will happen over three broad levels. How services integrate, where responsibilities and accountabilities are located and how resources are distributed across these levels is key to how the ICS will operate.



Neighbourhood (covering populations of around 30,000 to 50,000 people): where networks of GP practices (PCNs) work with NHS community services, social care, voluntary sector and other providers to deliver more targeted co-ordinated and proactive care.
Place (covering the geography of each of the five boroughs of NCL): where Borough Partnerships of health and care organisations, including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services.
System (covering the whole population of NCL): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.

Integrated Local Delivery

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

At the heart of this report is a new vision that, if delivered well, will create the local structures for integrating care. Fuller focusses on 3 key offers:

- **streamlining access to care and advice** for those who use services infrequently, with more local options
- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including those with multiple long-term conditions
- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

We are building on the existing Health and Wellbeing strategies across our five boroughs

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- Each borough in NCL has a statutory Health and Wellbeing Board (HWBB). This is a partnership across the Council, the NHS, local voluntary and community sector organisations and Healthwatch. Each HWBB has a statutory duty to produce a Joint Health and Wellbeing Strategies (JHWS). This sets out how the local system will work together to improve the health and wellbeing of the local community and reduce health inequalities.
- Each of our borough Joint Health and Wellbeing Strategies is on a different cycle, with strategies for three of our boroughs being refreshed during 2023.

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

Common themes

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

* Life cycle of current strategies

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

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Our assessment of our population's needs tells us:

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

Our communities tell us:

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

Our system challenges tell us:

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

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

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Our ‘I’ statements define what integrated care needs to look like for our residents, our communities and our service users

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I live in a safe, sustainable and health-promoting environments and communities, with timely access to the services and support that I need to keep safe and well, to stay healthy and to live as independently as possible

I have the information and advice that I need, when I need it and in a form that meets my needs, to make choices and decisions about my life and my health, the way that I live, as well as my care and support

I am supported to live a healthy life by people and professionals who I trust, who listen to me, respect me and involve me in decisions regarding my life, my health and the support or care that I need

My care and the support that I receive across different services is coordinated, timely and meets my needs, treating me as a whole person and helping me to live the life that I want to the best of my ability

When I move between services, settings or areas, there is a clear plan for what happens next, how information will be shared and who will do what, with all practical arrangements in place before change happens

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

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

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

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

Trust the strengths of individuals and our communities

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

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

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

Build from insights

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

Strengthen our Borough Partnerships

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

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

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

Break new ground in system finance for population health and inequalities

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

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

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

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

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

Relentlessly focus on communities with the greatest need

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

Deliver more environmentally sustainable health and care services

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

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We have tailored the national NHS framework for health inequalities to the needs of our population

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Across our population we know there are some communities who experience greater inequalities and poorer health outcomes, including shorter life expectancy and healthy life expectancy for a complex range of reasons. These groups are not mutually exclusive – for example many of our PLUS populations may also be amongst our 20% most deprived - and there are a multitude of ways the needs of these groups intersect with common inequalities in access, experience and outcomes.

The PLUS element of Core20PLUS5 provides a framework for us to look at some of these key population groups for our population in NCL as a whole, supported by our Inclusion Health Needs assessment and Joint Strategic Needs Assessments (JSNAs) in each of our boroughs, which identify additional population groups at a borough level.

Some of these groups may be comparatively small in number, compared to other populations, but their needs are disproportionate and often complex. We need to build our understanding of their health needs, working with these communities and better deliver services that meet those needs.

Core20 **Our 20% most deprived**	21% of people in NCL (around 364,000) live in the 20% most deprived areas nationally (index of multiple deprivation).	For example: in Enfield female child mortality is 2.7% greater in most compared to least deprived areas.

Our PLUS populations

Children and young people

Place holder for Children and young people's PLUS population

Adults

Black and minority ethnic groups experiencing greatest inequality	Inclusion health groups	People with severe mental illness	People with learning disabilities
Groups who experience inequalities due to the intersectionality between ethnicity and deprivation. • Start Well (0-18s): Black African Bangladeshi, Mixed Black communities Black Somali • Live Well (18-65s)): White Turkish and Bulgarian • Age Well (65+): Black Caribbean	• People experiencing homelessness, • Gypsy, Roma and Traveller communities • Sex workers • Vulnerable migrants • Those with a history of imprisonment.	These groups often have complex social and health needs and experience multi-morbidity and have lower incomes and lower rates of employment.	
For example: during 2020/21, in NCL twice as many Black pregnant women were obese compared to white women (24% vs. 12%)	For example: Gypsy, Roma and Traveller communities have the shortest life-expectancy of any ethnicity.	For example: The death rate for those with severe mental illness in Camden and Islington is 3x higher than the rest of the population.	

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

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

An indicator set underpins the outcomes which will be mapped to all our key work programmes.

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

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

Start well

Every child has the best start in life and no child is left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and new born screening coverage
- All children are supported to have good speech, language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Early identification and improved care for people with mental health conditions

- Reduced racial and social inequalities in mental health outcomes
- Improved physical health in people with serious mental health conditions
- Reduced deaths by suicide

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in fulfilling employment

- People are supported to stay in jobs, including mental health and musculoskeletal services
- Increased employment of local people in anchor institutions, including those with mental health illness, physical disability, and learning disabilities, and increased level of "buy locally", including using social value-based commissioning and contracting

Age well

People live as health, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier prevention, detection and management of long term conditions, including dementia, in older people

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

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Our five population health improvement development areas where system focus will deliver greatest impact

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- Overseen by our Population Health and Inequalities Committee, we undertook an exercise to look across our population needs, outcomes framework, Core20PLUS5, borough priorities and community insights to identify five development areas for population health improvement to work together on as a system. These do not replace borough or sectoral priorities (for example, the five priorities for children set by the Directors of Children's Services. Rather, they represent opportunities to develop our work as an integrated care partnership and test and learn on key aspects of integration.

- **Setting these priorities will:**
  - encourage holistic thinking and innovation – facilitating linkages across existing programmes and greater investment in improving prevention and early intervention
  - drive improvement in areas which will have a large population impact
  - provide a practical test bed for learning about delegation, decision-making and accountability at all levels of the system
  - provide opportunity to understand and tackle inequalities at local and hyper-local level – through data segmentation and community insight
  - enable us to test and learn through the application of a population health approach in practice
  - enable us to focus measurement of success.

- Seeing improvements in access, experience and outcomes across these development areas will help reduce inequalities and contribute to the improvements required in current “pressure” areas in the health and care system, such as ambulance demand and elective backlog, improving quality of care.
- We will work to further refine these areas through insights work and involvement of residents and those delivering services.
- We have agreed as a system that within these 5 priorities we will begin with working on **childhood immunisations.**
- **These 5 demonstrators will, alongside our integrated projects, lead the ‘learn by doing’ approach in our roadmap.**

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Our five population health improvement development areas are mapped across the life course

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Development Areas

NCL population health improvement development areas

START WELL

Childhood immunisations

LIVE, WORK AND AGE WELL

Heart health - preventing heart disease and strokes

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

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

WHOLE LIFECOURSE

Mental health and wellbeing (all ages)

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

RATIONALE

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

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

Wider determinants such as deprivation, housing, and air quality

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

NCL is an outlier in London for coverage

Biggest causes of avoidable death (largely preventable and treatable)

Next highest cause of avoidable mortality and long term health problems

Increasing prevalence and underpins other aspects of wellbeing

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

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

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

Link to rationale for childhood imms start

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What it looks like to take action on wider determinants of health

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The Health Foundation outlines five ways an **Anchor institution** can make a holistic impact on local communities

Thinking ethically about how we purchase goods and services

Using buildings and spaces to support communities

Reducing our environmental impact (by delivering our NCL green plan)

Widening access to quality work

Spread learning with our local partners

The principles of '**Making Every Contact Count**' can be hardwired into all of our services, this holistic thinking can include:

Offering lifestyle advice on smoking and alcohol during eye checks

Community pharmacy playing a more active role in signposting eligible people to screening

Working with nurseries to tackle dental caries in the under-5s and improve MMR vaccine delivery

Closing gaps in care using our Population Health Management platform

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There are key programmes already underway which are taking a population health approach

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

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

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

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

A system approach to enablers
We are working toward using our system strengths and assets in a more coordinated way, reducing duplication of effort and working toward our shared vision for how the system will work. This may mean some organisations providing system leadership or sharing capacity where it is more efficient to do so.. This approach will be further outlined in respective strategies, including people, finance, quality improvement, digital, data,corporate, surgical and the capital plan.

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

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

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NCL is uniquely rich in world class expertise in research, evaluation and improvement

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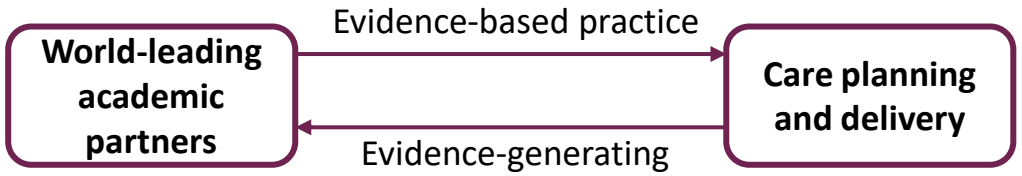
Evidence focus



Evidence-based practice

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

Evidence-generating

Developing a system-wide set of research priorities will enable us to bring unique perspectives from each organisation into a topic.

With that in mind, we envisage a single process to identify, agree, re-visit them to ensure a shared set of priorities.

We also envisage leveraging our world-leading academic assets to build collaborations for new research, specifically to generate evidence and scale up existing evidence

System improvement approach

There are many different change approaches in use in NCL, each with their own strengths. Harnessing the improvement expertise and assets working in the system will key to delivering the priorities in our Population Health Improvement Strategy.

We will build a system improvement approach that balances consistent application of evidence-based methodology with the flexibility to empower place-based leadership of improvement work by frontline staff working together with local communities.

The principles our approach will embody are:

Consistent use of evidence-based improvement methods

Change will be locally led and draw on local assets and strengths

An open, participative theory of change that values all contributions

System-wide collaboration to share and scale-up success

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

North Central London Integrated Care System

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

Vertical integration

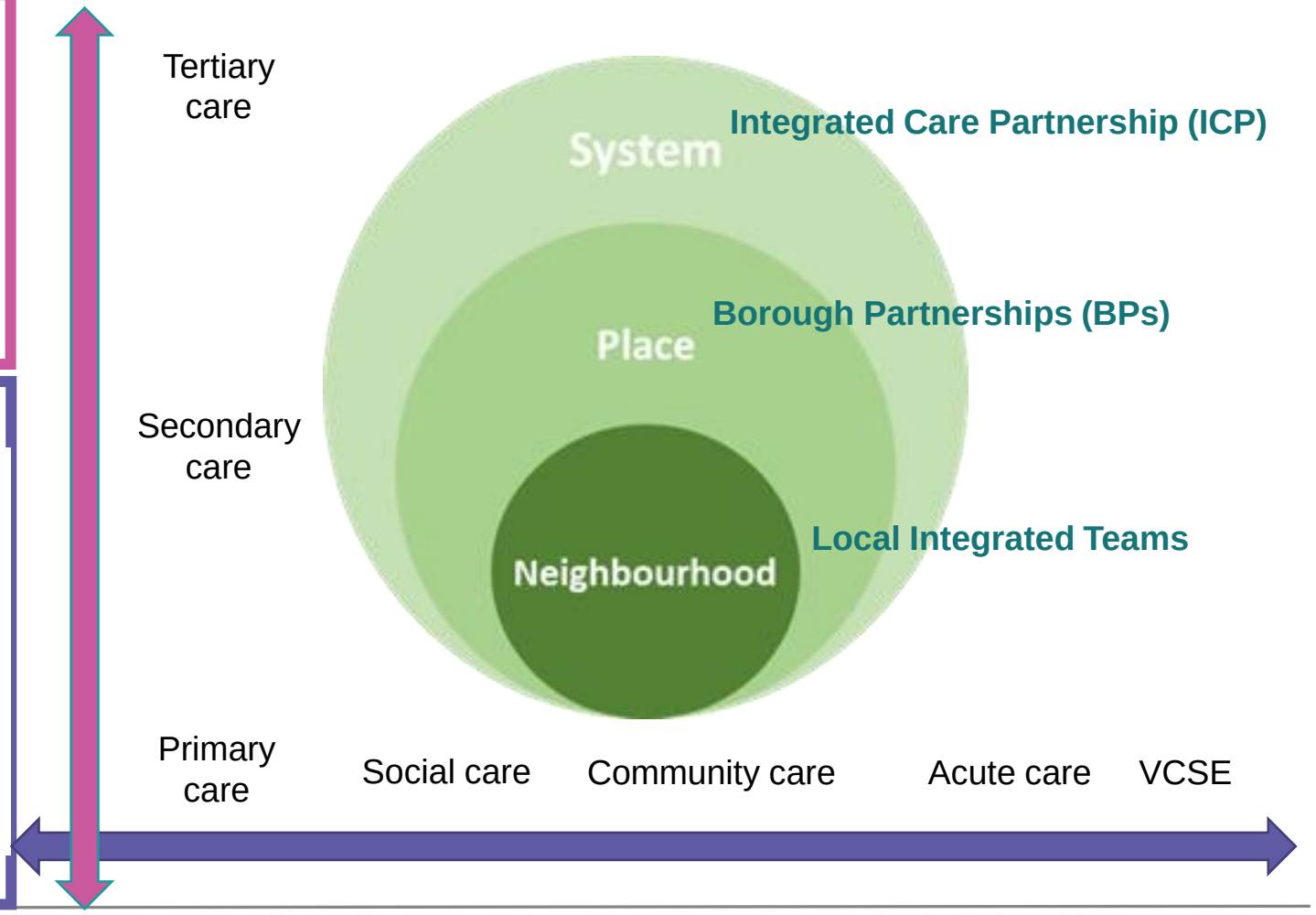
Aligning between healthcare providers to minimise handovers, maximise efficiency, address and incentivise downstream care and work across the whole continuum of need.

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

Horizontal integration

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

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



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Our future state – how integrated care will look at system, place and neighbourhood

North Central London Integrated Care System

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

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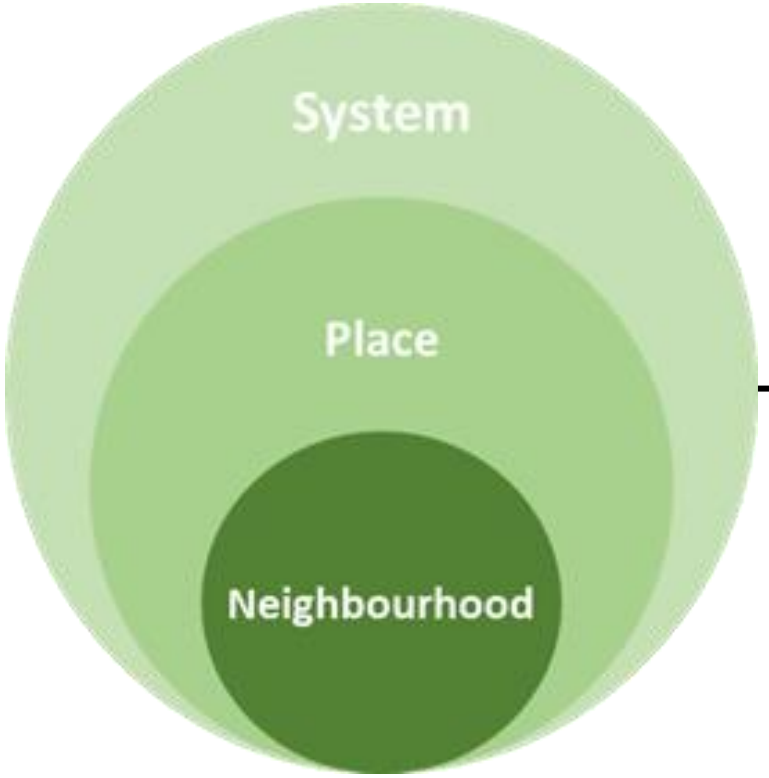
Working at our future state will look differently for each organisation across NCL

North Central London Integrated Care System



How our future state will look for:

Community Trust

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

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

Acute Trust

Awaiting content

Mental Health Trust

Awaiting content

GP

Awaiting content

Integrated care is already happening across NCL – spotlight on children's health and well-being

North Central London Integrated Care System

Integrated care for Children and Young People across NCL includes:

Awaiting content

DRAFT

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

North Central London Integrated Care System

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

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

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

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

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

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

Link to case studies

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

North Central London Integrated Care System

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

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

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

In the framework already

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

Additional elements to consider

- Finance
- VCSE
- Ways of working

Link to framework detail

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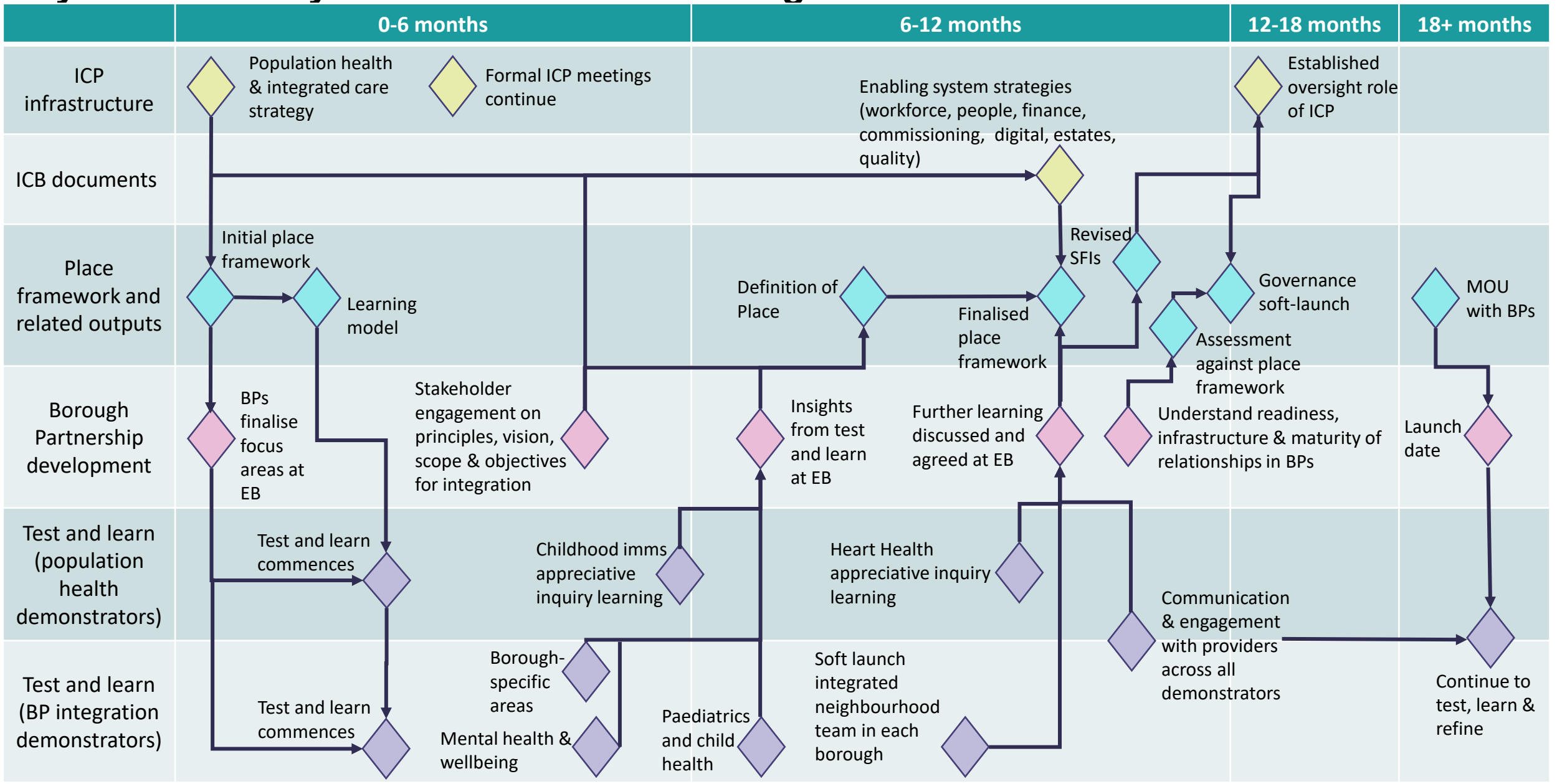
Our Roadmap for developing Borough Partnerships lays out the way forward over the coming 18 months

North Central London Integrated Care System



Moving forward

North Central London Integrated Care System

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

1. Five delivery themes
2. Population health development area demonstrators
3. Borough Partnership integration demonstrators

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

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

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

We will coordinate delivery around five themes

North Central London Integrated Care System

Aligning resources to need

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

Making population health everyone's business

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

Strengthening integrated delivery

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

Becoming a learning system

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

Collaborating to tackle the root causes of poor health

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

Test and Learn Demonstrators

Population Health Development Areas

BP Integration Development Areas

Our key deliverables for each theme

North Central London Integrated Care System

Making population health everyone's business	Strengthening integrated delivery
Developing and improving system-wide access to population health insights and embedding the fundamentals of population health at all levels of our system, including our health and care providers	***Further developing our approach to integrated delivery in the Borough Partnerships by creating the context and conditions for success and support building our local integrated teams***
Insights • Develop and embed system understanding of need • Build a networked intelligence function across partners, including provider organisations • Embed Core20PLUS5 (adults and children/young people) and other PHM insights into frontline care • Add social care, housing and other data sources to include wider determinants of health to integrated dataset • Embed health inequalities indicators across performance metrics • Deliver on the conditions for adoption of our PHM platform • Develop information and clinical governance for integrated care • Develop community and qualitative insights and co-production infrastructure **Fundamentals of population health** • Capacity building - build population health fundamentals into induction programmes across partners, includig provider organisations • Build MECC culture and processes, including incorporating into all staff PDRs • Establish pop health leadership academy across the ICS and build into role descriptions • Embed digital inclusion into all programmes	**Context and conditions for success** • Deliver Borough Partnership Roadmap, including scope, infrastructure and responsibilities/accountabilities • Deliver population health development area demonstrators • Deliver Borough Partnership integration demonstrators **Building local integrated teams** • Shape the neighbourhood offer including role of VCSE • Establish the deliver infrastructure to deliver integrated neighbourhood teams • Integrate and scale personalisation approaches (PCSP, PHB, co-production etc) • Develop a digital supported offer for more proactive care@home and increase levels of digital inclusion • Create the infrastructure and ways of working for one-workforce, one-team approach • Establish the flexible workforce, working to top of license, additional roles, greater use of wider workforce

Our key deliverables for each theme

North Central London Integrated Care System

Aligning resources to need	Collaborating to tackle the root causes of poor health
Transforming how we make decisions about the use of resources by understanding where we have variation in outcomes and creating the frameworks and measures that redirect resources to close the gap	***Creating a better context for good health and well-being for everyone in NCL by collaborating to address the root causes of poor health outcomes and investing locally and responsibly in our communities***
Understanding variation in outcomes • Baseline and monitor outcomes framework • Baseline current spend by geography and demography and how it compares to data on access, experience and outcomes • Define system values and approach to trade-offs to address health inequalities and the wider determinants **Frameworks and measures** • Develop the financial architecture that reflects the differential effort needed to achieve outcomes with different communities, options for movement of resource and investment in prevention • Agree a prioritisation framework with clear and transparent criteria including health inequalities • Develop a population health commissioning framework with increased emphasis on equitable outcomes rather than units of activity • Develop a decision-making framework that balances delegation to Borough Partnerships with system flexibility to support vulnerable populations • Develop plan for investment in the VCSE to support community engagement, volunteering, co-production and hyper-local delivery • Agree finance indicators to measure ambition and set trajectories that reflect the shift of resources to need	• **Anchors –** strengthen our anchor network and joint work programme to maximise our assets within our local communities to build local economies, improve the environment, widen access to good quality employment for local people and increase physical activity • **Social prescribing -** strengthening our social prescribing offer and reach • **Making every contact count –** consolidate our MECC offer in NCL building the wider determinants of health into the brief intervention model alongside lifestyle advice • **Health inequalities fund –** expand the Health Inequalities fund and strengthen scaling of interventions for greater impact • **Inclusion health -** take forward recommendations from the NCL Inclusion Health Needs Assessment • **Development areas –** coordinate action around the common risk factors for our population health development areas, to include both lifestyle risk factors as well as wider determinants of health, such as poor quality housing and air quality • **Green plan –** deliver the objectives of our NCL Green Plan • **Working with our communities –** strengthen our engagement and investment with our VCSE and communities to better understand and act on their needs

Our key deliverables for each theme

North Central London Integrated Care System

Becoming a learning system

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

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

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

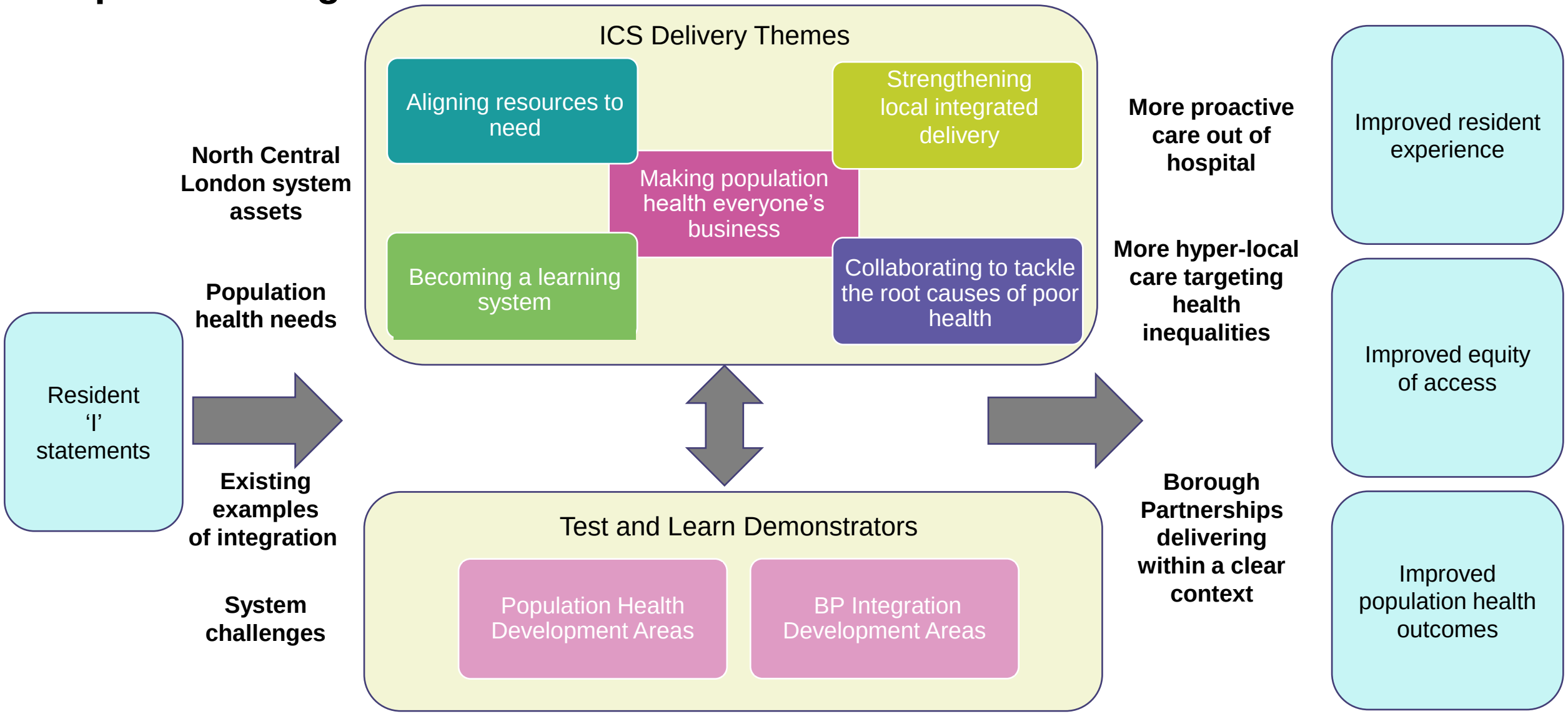
Becoming an evidence-generating system
- Develop our ICS research strategy
- Develop the list of research priorities shared across NCL
- Develop a our approach system-wide research collaboration to steer and scale up evidence-generation and act as a single point of research co-ordination

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

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

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

North Central London Integrated Care System



Next steps

North Central London Integrated Care System

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

- Mentioned within the strategy are next steps in the form of deliverables and demonstrators. We are developing a more detailed plan (our Joint Forward Plan) with milestones, timelines and trajectories which will describe the detail behind the high level view laid out in this strategy.

North Central London Integrated Care System

Appendix 1: Engagement summary

Back to main document

Where we have engaged

North Central London Integrated Care System

PLACEHOLDER SLIDE:
Content in development

Back to main document

North Central London Integrated Care System

Appendix 2: Glossary

Back to main document

DRAFT

Glossary

North Central London Integrated Care System

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

Back to main document

DRAFT

Glossary

North Central London Integrated Care System

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

Back to main document

DRAFT

Glossary

North Central London Integrated Care System

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

Back to main document

DRAFT

Glossary

North Central London Integrated Care System

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

Back to main document

DRAFT

Glossary

North Central London Integrated Care System

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

Back to main document

North Central London Integrated Care System

Appendix 3: Our population health needs

Back to main document

DRAFT

Health inequalities

North Central London Integrated Care System

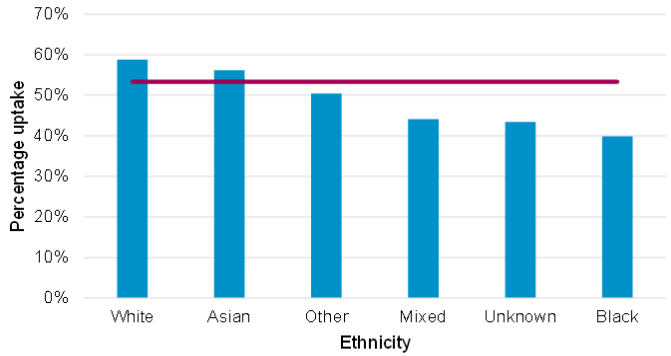
Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Health inequalities can involve differences in:

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

People may experience different combinations of these factors.

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

Uptake of Covid-19 vaccination, NCL, August 2021



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

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

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

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

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

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

Back to main document

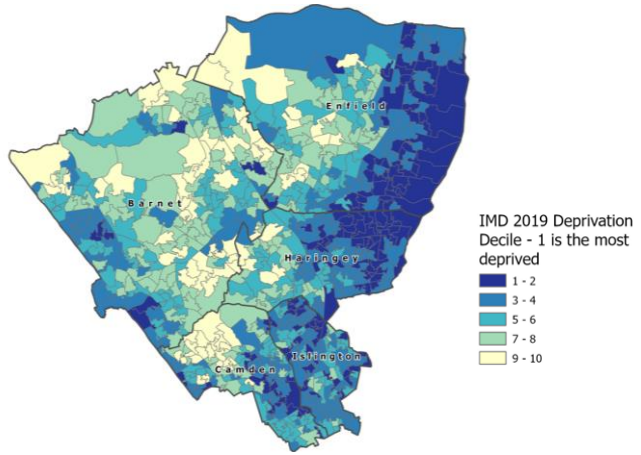
DRAFT

Our population – who do we serve

North Central London Integrated Care System

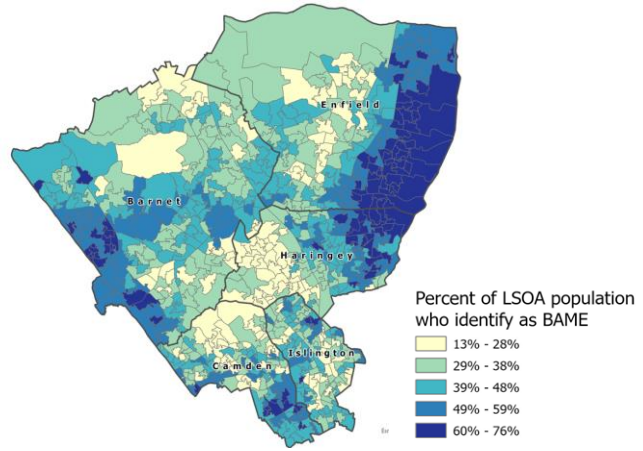
- North Central London (NCL) has a **relatively young resident population of just under 1.8 million people** and a similar number registered with our GPs. Despite large overlap these are not the same populations, and some of our residents remain unregistered anywhere, including from our inclusion health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

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



Source: Index of Multiple Deprivation (IMD_ 2019

Ethnic profile of NCL, by LSOA



Source: Census 2021

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

Back to main document

DRAFT

Our five boroughs: high level summary

North Central London Integrated Care System

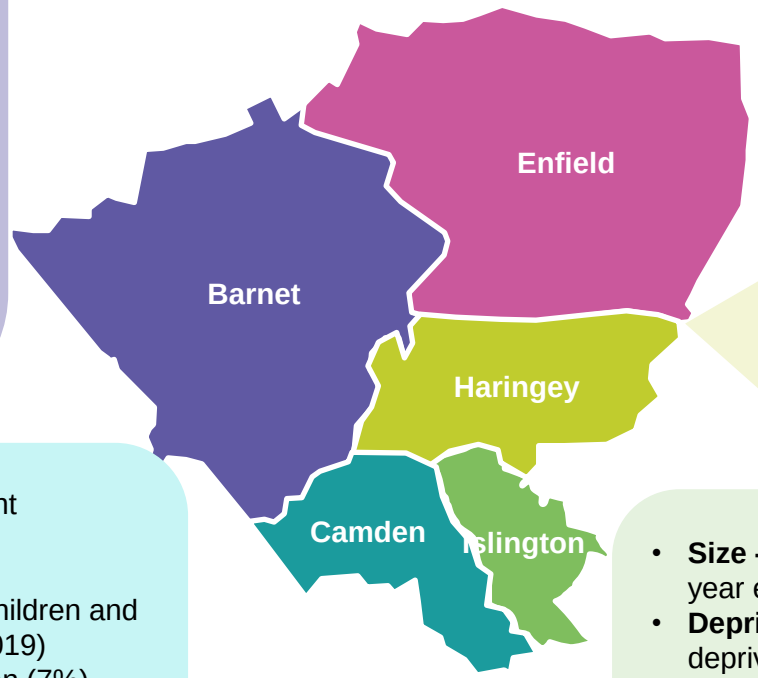
Further detail on each borough's population provided in Appendix 1.

Barnet

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

Enfield

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



Haringey

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

Camden

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

Islington

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

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Our population's health needs (1)

North Central London Integrated Care System

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

Poor health accumulates throughout the life-course

	Start well	Live well	Age well
Key population drivers compound and lead to poor health outcomes and inequalities			
Health outcomes	**Pre-natal -** There were 238 still births in NCL between 2018-20; Haringey has a significantly higher rate of stillbirths than the England average. **Infancy -** Newborn hearing screening coverage across NCL is lower than London & England. **Early years -** NCL has the lowest 2 year old MMR coverage in England. **Childhood -** Hospital admissions for asthma are higher than average for children and young people in Islington and for epilepsy, Barnet has a higher rate. The prevalence of mental illness in under 18s in NCL is almost double London average. Hosptial admissions for self-harm among young people are higher in Barnet and Islington compared to London.	**Increasing mental and physical health needs and multi-morbidity -** More than 1 in 4 people in NCL have a long-term condition (LTC). A quarter of those with LTCs have 3 or more conditions. 21% more people have 3 or more LTCs since the pandemic. Nearly 6,000 new cancers are diagnosed each year, with rates higher in Enfield than London average. Around 1 in 5 residents have a common mental health illness. Rates in Haringey and Islington exceed London rates. NCL has the highest prevalence of severe mental illness (SMI), among ICS in England. Fewer than half of those with an SMI have a comprehensive care plan. **Missed opportunities for prevention and early intervention -** Fewer than 1 in 3 people have an NHS Health Check, considerably lower than the London average. Fewer than 3 in 4 people with Chronic obstructive pulmonary disease (COPD) have the flu vaccine, with coverage lower than London. Cancer screening coverage in NCL is significantly lower than London - half of women do not get breast cancer screening. All NCL boroughs fall short of the national standard that 60% of people with SMI should have a full physical health check in primary care.	**Increasing needs –** Haringey, Islington and Camden have among highest levels of frailty for 50+ in London. 65+ year olds with moderate/severe frailty are estimated to have increased by 15% due to the pandemic. NCL has a higher prevalence of Dementia than London average but only 39% of people with dementia have had their care plan reviewed in the past 12 months. **Missed opportunities for prevention and early intervention -** 24% early deaths in NCL (from cardiovascular disease, cancer and respiratory diseases) are thought to be avoidable (preventable and/or treatable). 65+ flu vaccination coverage is lower than London and England averages. Uptake is particularly low in Haringey. 1 in 5 older people went back hospital within 3 months of discharge into rehabilitation in NCL, higher than the London and England averages (2019/20)
Lifestyle risk factors	**Smoking -** 1 in 20 mothers are smokers at time of delivery, above London and England averages **Obesity -** 37% pupils in NCL leave primary school overweight/obese, rising to 42% in Enfield. Obesity prevalence more than doubles from Reception to Y6.	**Smoking** - More adults smoke in NCL (16%) compared to London, with higher rates in the more deprived boroughs. Smoking cessation is lower in NCL than London **Obesity** - While adult overweight/obesity levels are lower or no different than the London average, in Barnet and Enfield, nearly 60% are overweight/obese **Alcohol -** While overall NCL has lower than average alcohol-related admissions, there are high rates in the most deprived boroughs, particularly Islington.	
Health inequalities			
Wider determinants			

Back to main document

DRAFT

Our population's health needs (2)

North Central London Integrated Care System

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

Poor health accumulates throughout the life-course

Start well	Live well	Age well

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

Health outcomes

Lifestyle risk factors

Health inequalities

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

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

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

Wider determinants

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

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

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

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

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

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

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

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

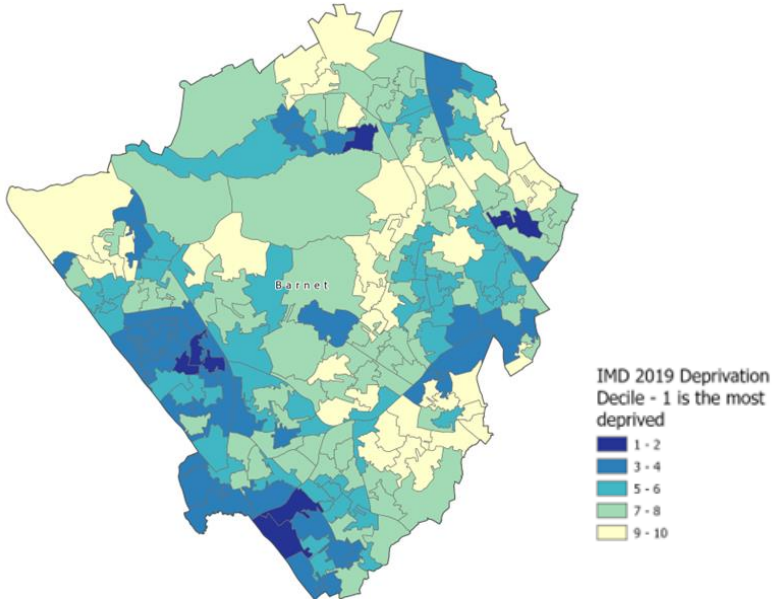
Back to main document

DRAFT

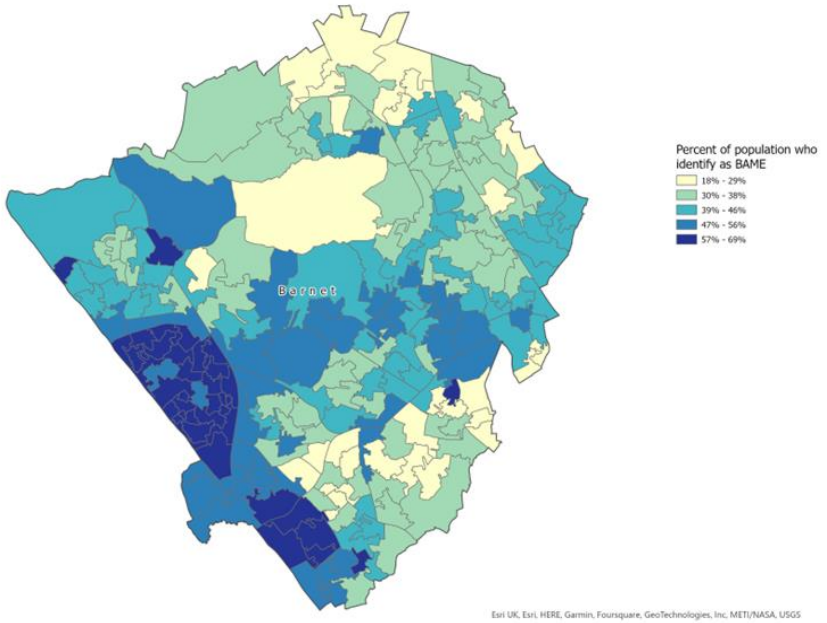
Barnet's population

North Central London Integrated Care System

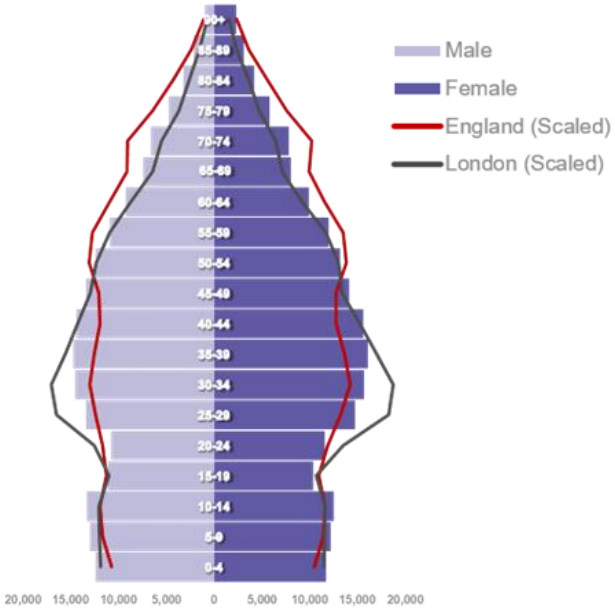
Deprivation profile by LSOA (IMD 2019)



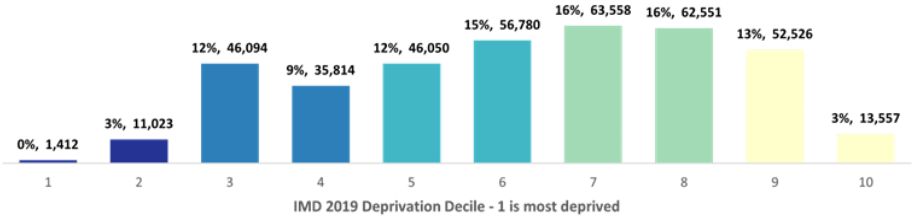
Ethnicity profile by LSOA (Census 2021)



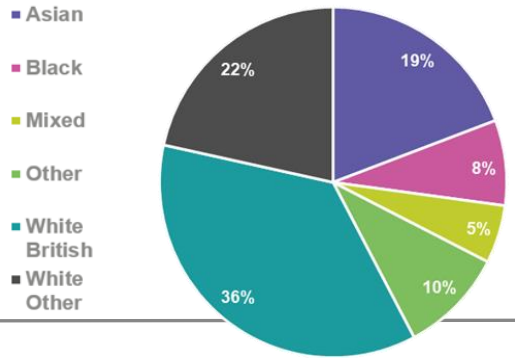
Age and sex profile (Census 2021)



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



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

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

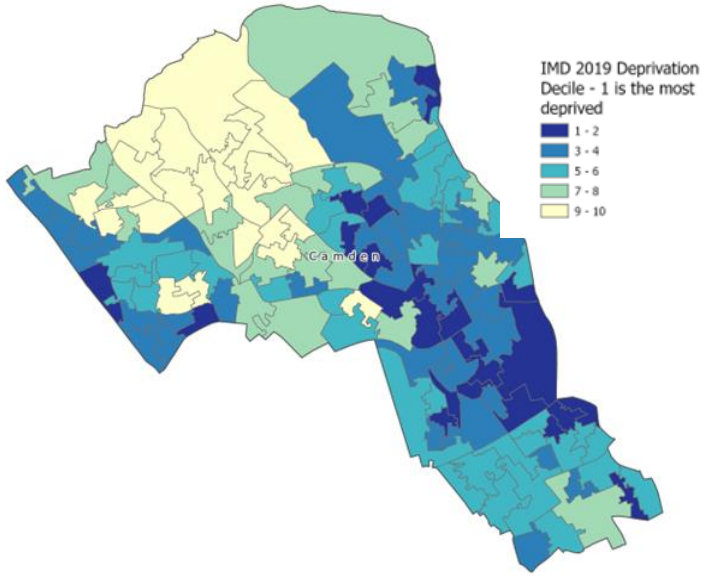
Back to main document

DRAFT

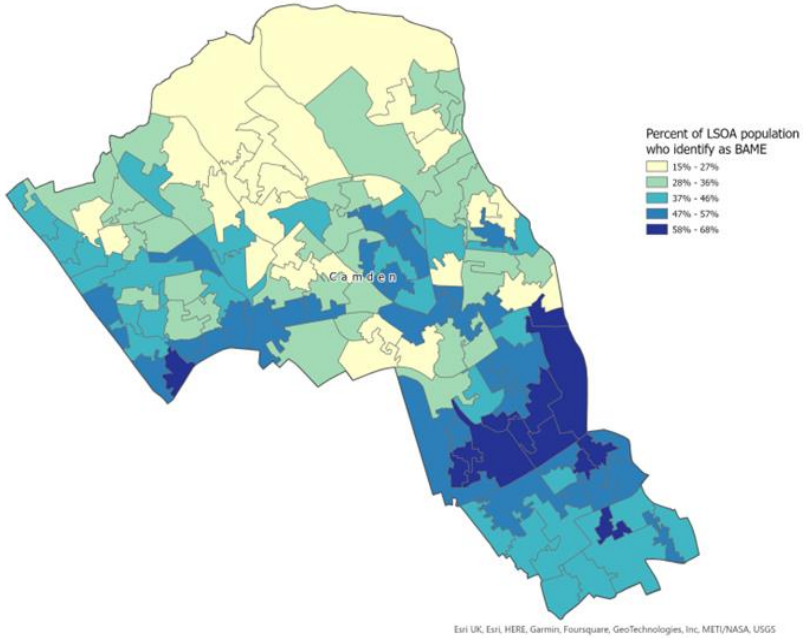
Camden's population

North Central London Integrated Care System

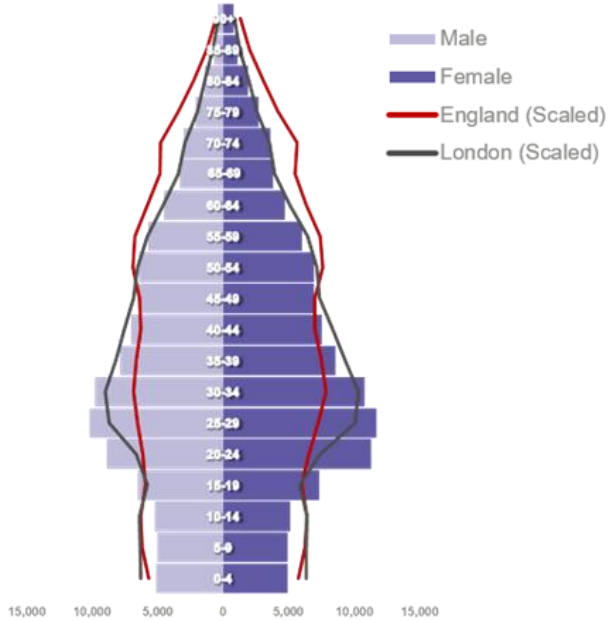
Deprivation profile by LSOA (IMD 2019)



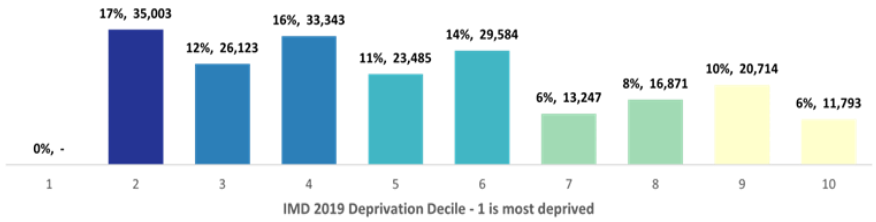
Ethnicity profile by LSOA (Census 2021)



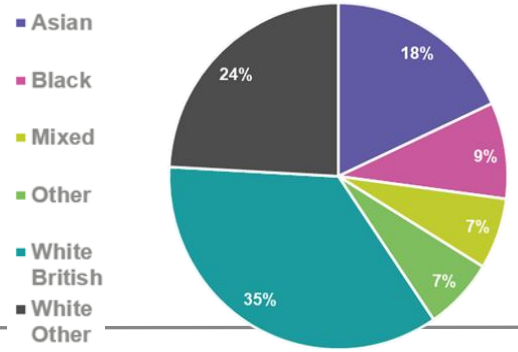
Age and sex profile (Census 2021)



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



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

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

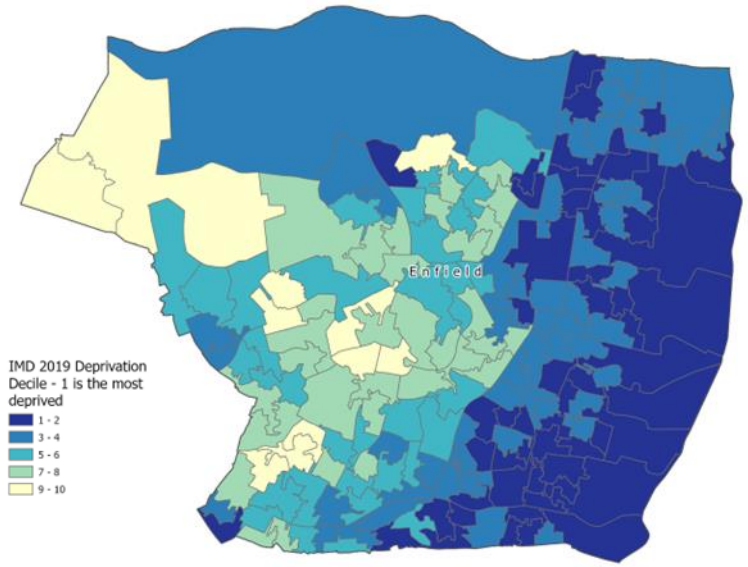
Back to main document

DRAFT

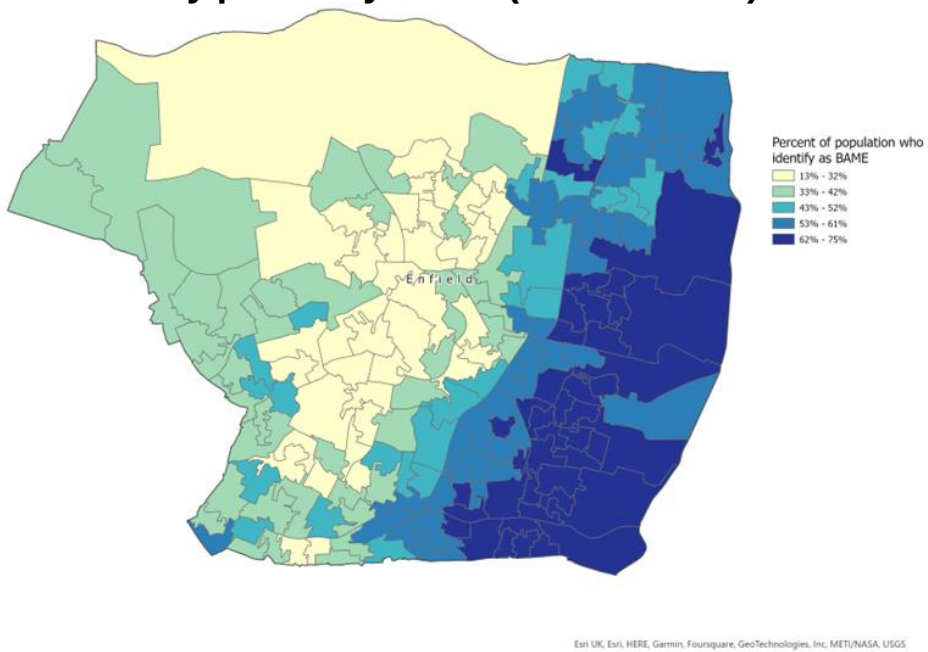
Enfield's population

North Central London Integrated Care System

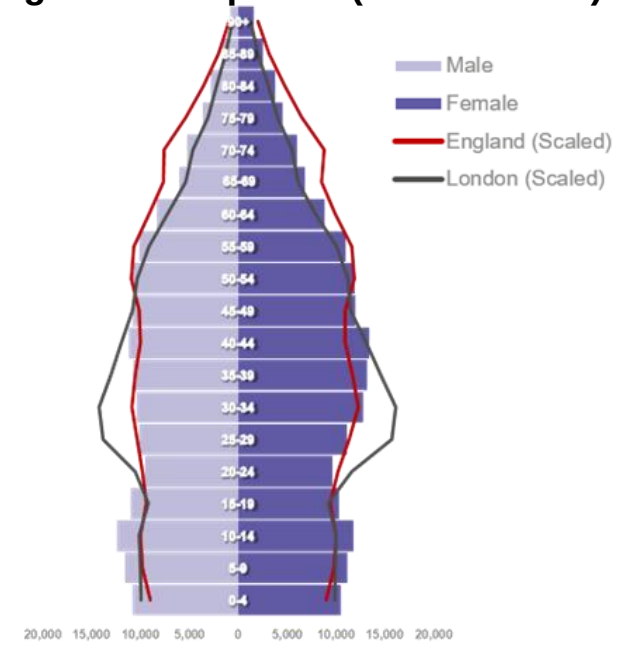
Deprivation profile by LSOA (IMD 2019)



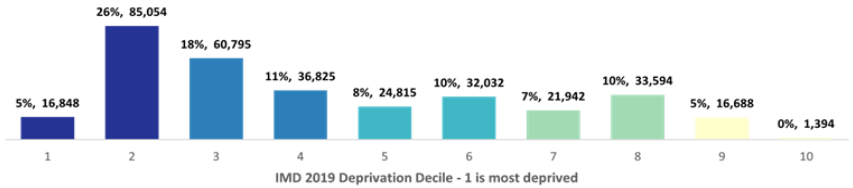
Ethnicity profile by LSOA (Census 2021)



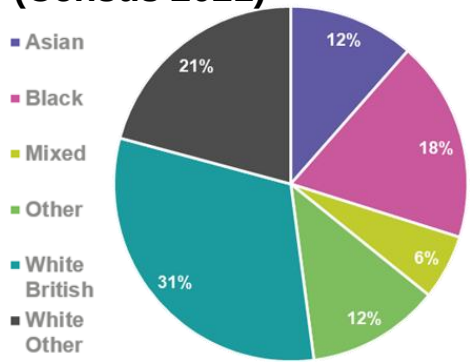
Age and sex profile (Census 2021)



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



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

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

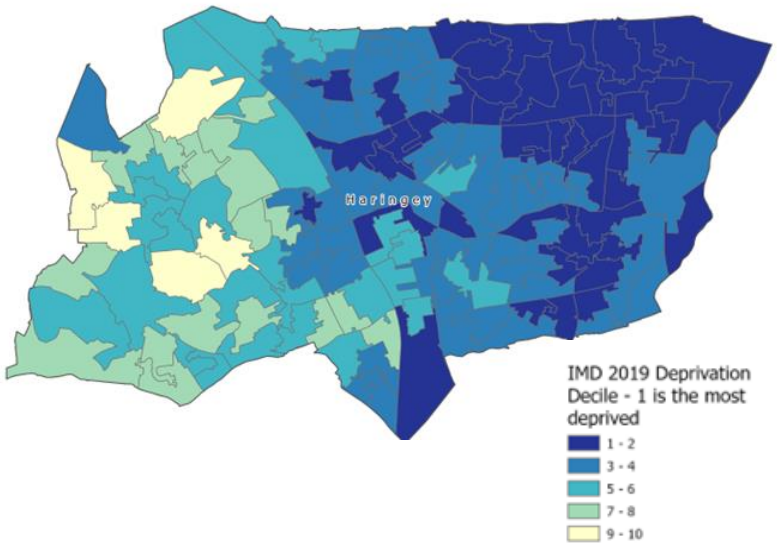
Back to main document

DRAFT

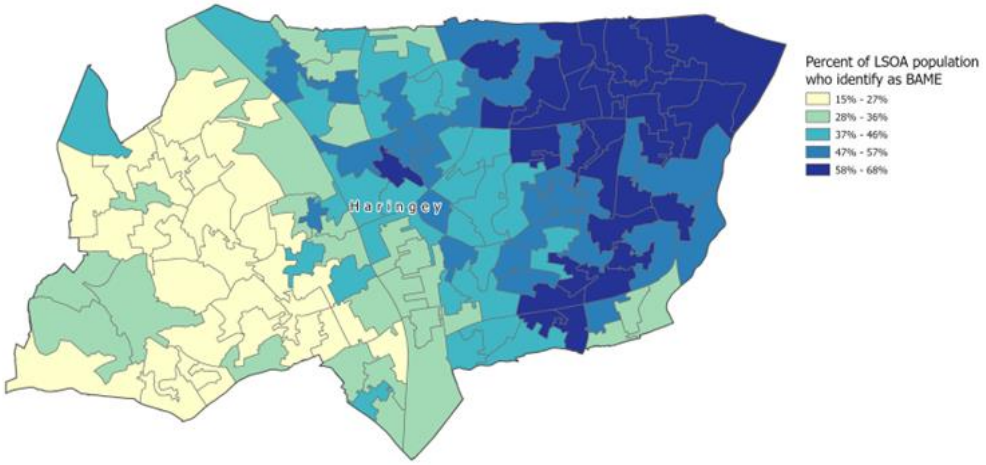
Haringey's population

North Central London Integrated Care System

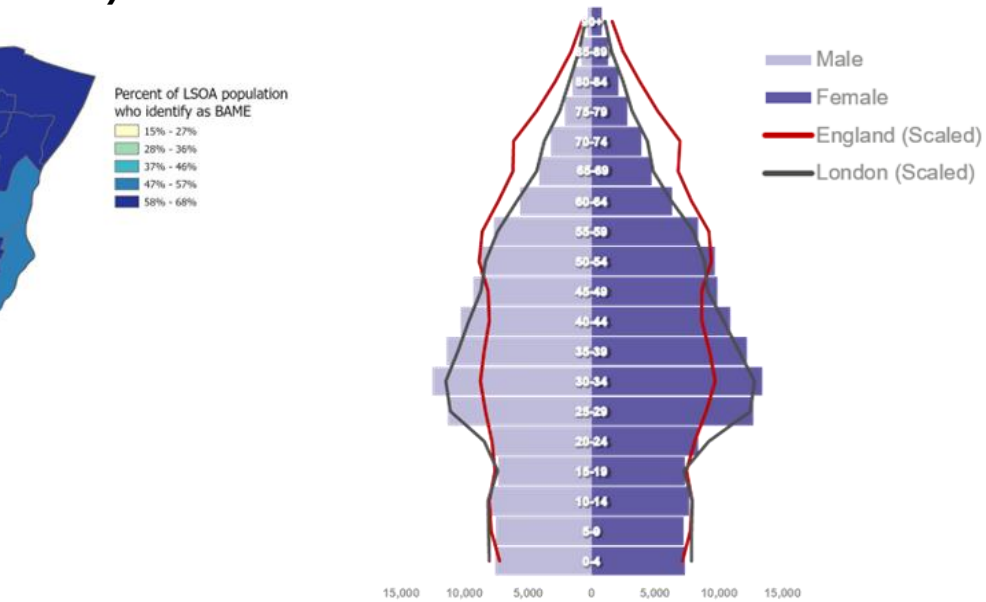
Deprivation profile by LSOA (IMD 2019)



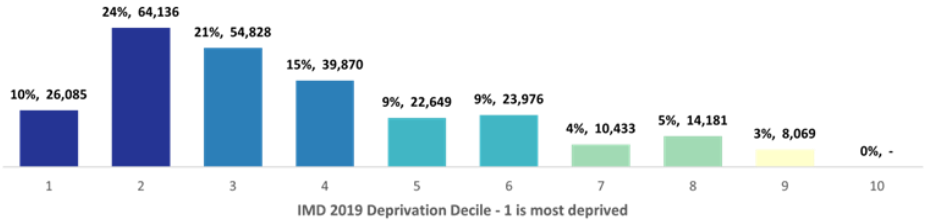
Ethnicity profile by LSOA (Census 2021)



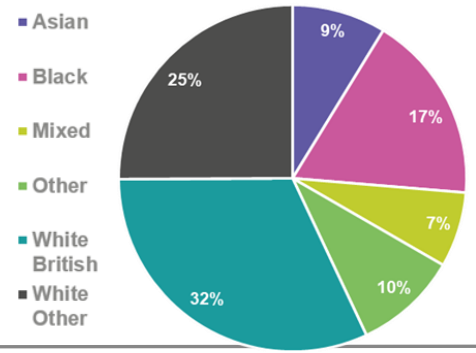
Age and sex profile (Census 2021)



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



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

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

Back to main document

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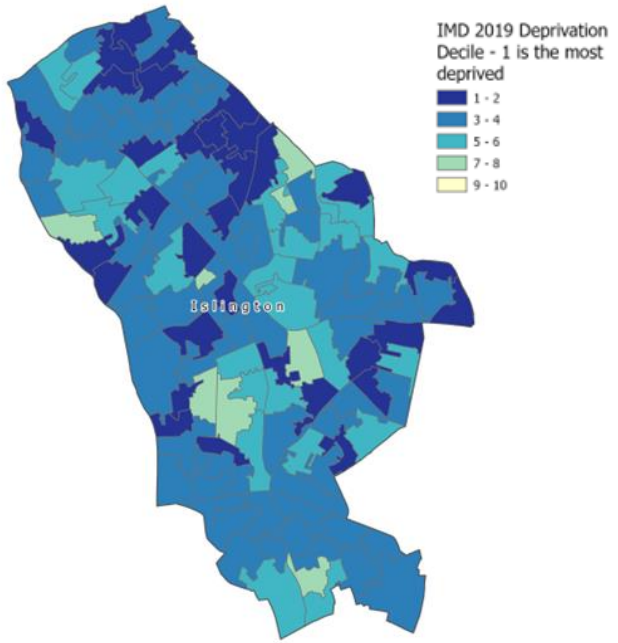
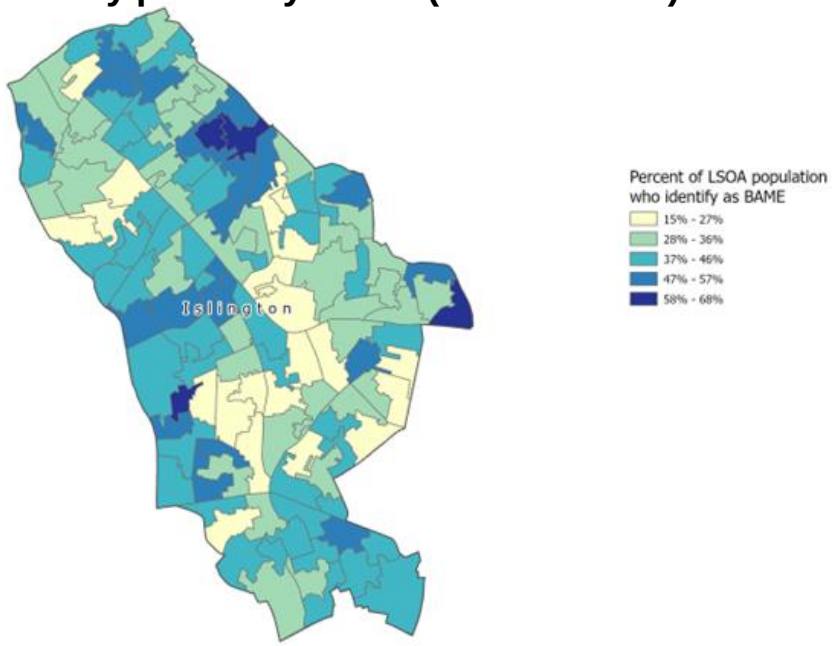
Islington's population

North Central London Integrated Care System

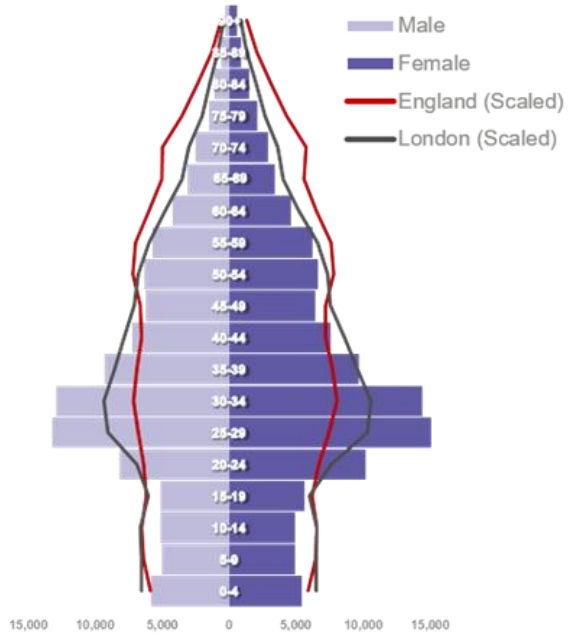
Deprivation profile by LSOA (IMD 2019)



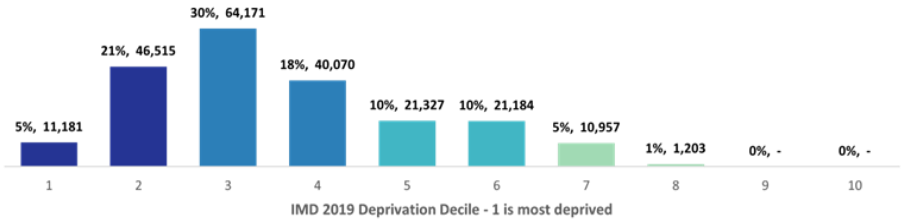
Ethnicity profile by LSOA (Census 2021)



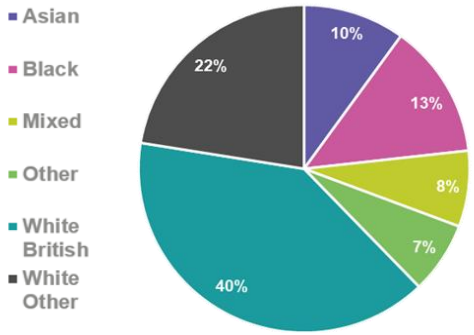
Age and sex profile (Census 2021)



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



Proportion of population by broad ethnic group (Census 2021)



Key population groups experiencing inequalities

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

Back to main document

North Central London Integrated Care System

Appendix 4: What our communities tell us

Back to main document

DRAFT

What do our communities say?

North Central London Integrated Care System

While engaging and working with our residents and communities, we have consistently heard feedback and insights across several key themes;

No choice but to attend A&E

- Unable to get GP appointments (hard to get through on the phone, difficulties with online booking systems)
- Other drivers; poor experience of primary care services, life barriers such as zero hours contracts or not understanding how to navigate the system
- NHS 111 not reliable for support & advice
- Narrow eligibility criteria and/or limited access to services outside business hours or on weekends, mean people turn to A&E as health deteriorates

Lack of resourcing for VCSE partners who provide important community support and advocacy

- Community support enables local people to overcome the barriers to services, address the wider determinants and health inequalities
- Lack of funding for 'general' advice & support
- Residents value receiving information in their own language and having the opportunity check their understanding and go over important points with VCSE partners

More holistic, person-centred care

- Treat a whole person rather than a health condition, particularly when managing a long term condition
- Poor integration and communication between services, patients distressed at having to repeat their stories
- Better integration with wider services that impact health, such as housing and domestic violence services
- More shared discussions and involvement in decision making, empowerment to manage conditions and stay well

Lack of trust impacting on engagement, and use of services

- Building relationships and creating trust through consistency requires time, skills and resources to engage with communities
- Organisations don't always see the value, instead viewing engagement as time consuming requirement or legal duty

Lack of good quality and affordable housing, resources and green spaces that promote health

- Overcrowding and poor quality housing contributing to poor health
- More work needed on air pollution
- Importance of green spaces, and the need to make active travel accessible

System is complex & difficult to navigate

- Poor signposting, lack of and/or conflicting information about services available, how to access appointments etc.
- Reliance on services/staff to support system navigation doesn't support self management

Poor access to interpreters, lack of empathy for cultural and/or disability-related needs

- Difficulty accessing interpreting and translation support, particularly in primary care
- Residents from non-English speaking backgrounds feeling 'less than' when trying to access care
- Can result in people dropping out of care or avoiding engaging with clinical services at all
- Lack of cultural understanding or sensitivity, and culturally relevant or sensitive materials/ resources
- Language, communication and cultural understanding important for front of house and reception staff who support access and navigation of services

Mental health care

- Better transition from child to adult services
- More peer support, lived experience models of care
- Many experiencing isolation and loneliness

Keeping well

- More emphasis on & access to prevention support
- More consistency in services regardless of where you live

Digital exclusion, IT literacy and online safety remain key concerns for many

- Access to digital services may also be limited by availability of private spaces, access to laptop devices, smart phones, and wifi or data
- Existing challenges further exacerbated by the pandemic, particularly for accessing primary care
- Can be particularly difficult for people from non-English speaking backgrounds and/or with sensory impairments – may disrupt access completely
- Online settings can pose safeguarding challenges for those at risk of abuse

Constant worry about staying afloat as we move from the hardships of COVID-19 into the cost of living crisis

- Combined challenges of COVID-19, staying warm, affording food and accessing health services overwhelming
- Concerns around affording basic food and energy costs, losing homes, and maintaining access to benefits and other services that require digital or phone

Back to main document

North Central London Integrated Care System

Appendix 5: Our system challenges

Back to main document

DRAFT

Our system challenges

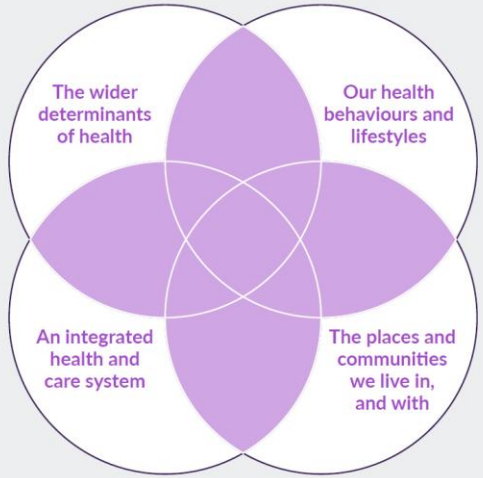
North Central London Integrated Care System

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

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

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

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



Back to main document

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Our system challenges (1)

North Central London Integrated Care System

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

Back to main document

DRAFT

Our system challenges (2)

North Central London Integrated Care System

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

Back to main document

North Central London Integrated Care System

Appendix 6: Childhood immunisations rationale

Back to main document

DRAFT

Rationale for starting with childhood immunisation

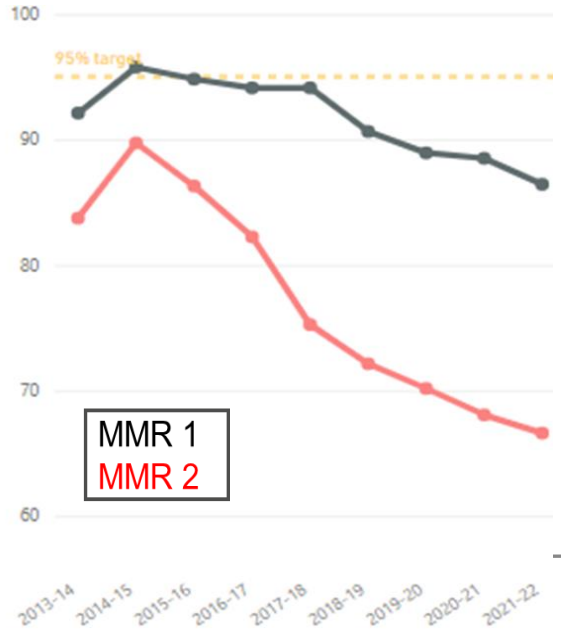
North Central London Integrated Care System

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

NCL is an outlier in terms of vaccination coverage:

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

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



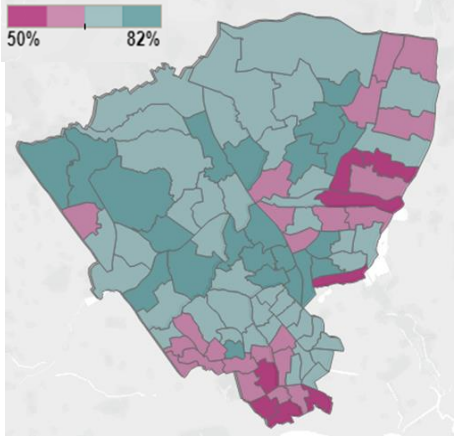
Population health fit and key inequalities:

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

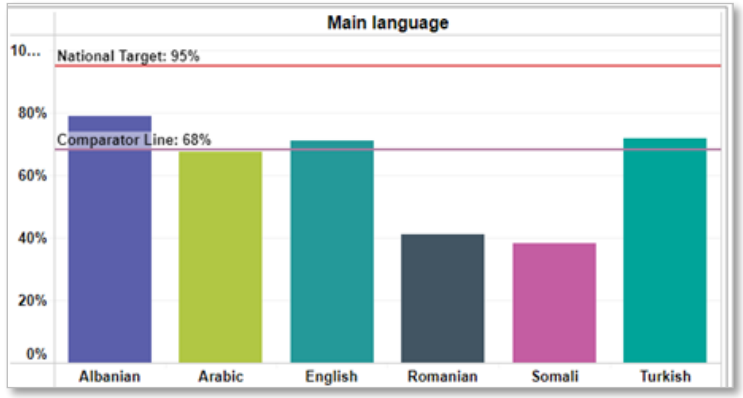
Key local levers:

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

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



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



Comparator line shows NCL coverage

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

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

Other drivers:

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

Back to main document

North Central London Integrated Care System

Appendix 7: Integrated Care case studies

Back to main document

Detailed case studies

North Central London Integrated Care System

PLACEHOLDER SLIDE:
Content in development

Back to main document

North Central London Integrated Care System

Appendix 8: Borough Partnerships Decision Framework

Back to main document

DRAFT FOR DEVELOPMENT

Our existing framework – key questions to consider

North Central London Integrated Care System

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

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

Back to main document