North Central London Integrated Care System

North Central London Population Health and Integrated Care Strategy

DRAFT **6 April 2023**

Version **Final**

Foreword

North Central London Integrated Care System

This document sets out our approach to improving the physical and mental 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, as well as our new ways of working to achieve this**. We will focus on where we can make the biggest improvements to population health outcomes by taking a partnership approach. We will 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 while recognising and working to minimise the impact of climate 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 ambitions into a single document. It covers how we will integrate care (Integrated Care Partnership's (ICP) 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.

Mike Cooke, Chair – NCL ICB and ICP

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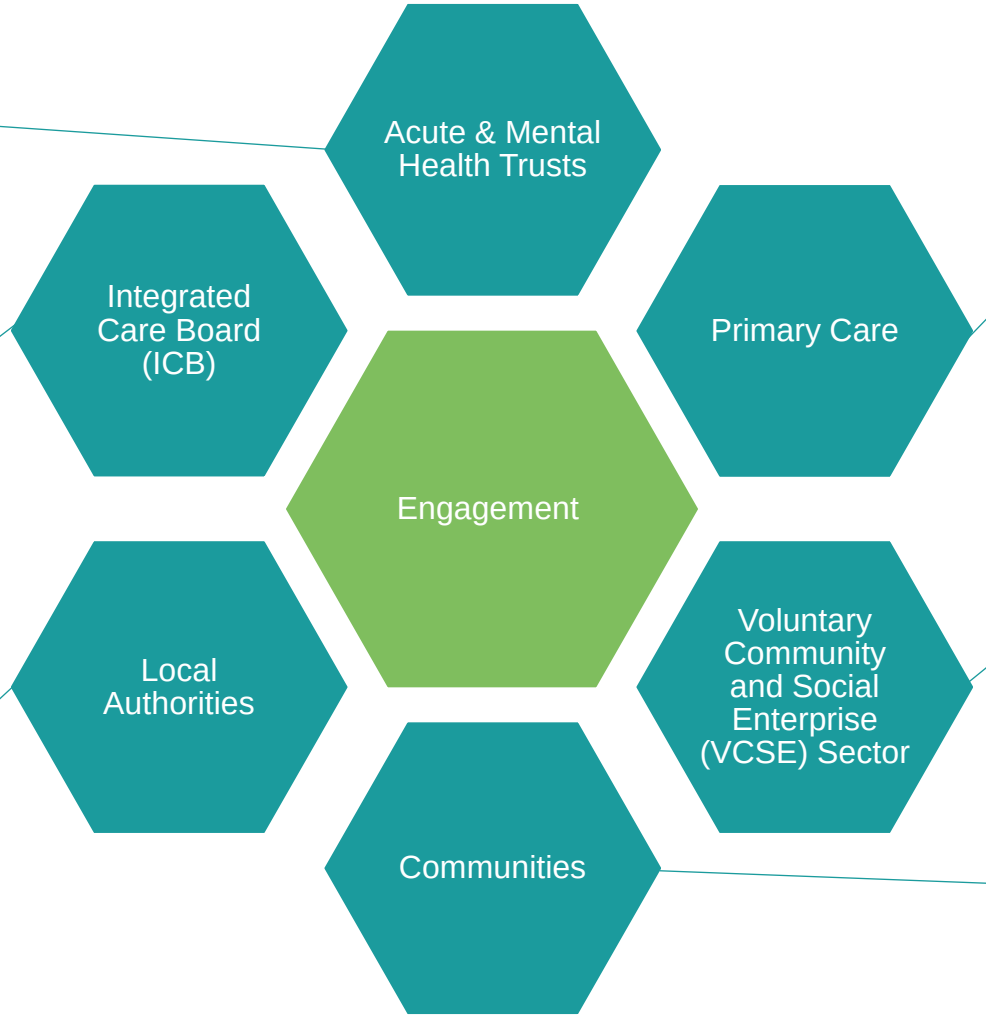
Creating this document has been a collective effort across our partnership in the spirit of system-ownership

North Central London Integrated Care System

Including acute trust provider alliances, specialty alliances, and academic partner forums

Including clinical, strategy, transformation forums as well as individual directorates

Including Directors of Public Health, and Adult and Children's Services, councillors and Heath & Wellbeing Boards



Including the GP provider alliance

Including the VCSE alliance

Including NCL Healthwatch leads

Six key terms for population health and integrated care

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 services 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.

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

Executive summary

North Central London Integrated Care System

This document outlines our response to the growing health needs of our local population in NCL and to evidence of widening inequalities. We take stock of system pressures and opportunities in the national context that support a new approach to collaboration by health, care, the voluntary sector and wider partners. It begins defining how we work best across the whole NCL system, at Borough Partnership and neighbourhood levels to improve population health through a collective focus on **prevention, early intervention and proactive care**. Our shared ambition is:

'As an integrated care partnership of health, care and voluntary sector services, our ambition is to work with residents of all ages of North Central London so they can have the best start in life, live more years in good physical and mental 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.'

This document sets out a clear call to action to our providers to reflect on how their organisations will look and feel when they align to the principles and areas outlined in this strategy.

In order to make this approach a reality, we have developed **principles** which will guide our news ways of working. This will require us to fundamentally change many aspects of the way we work, including with our residents and communities and where we prioritise our resources and efforts. We have also outlined a set of **population health outcomes** that we will work together to improve.

In order to embed and test our principles, we have outlined **delivery areas** where we can make the greatest impact and continue learning about our approach to system, borough partnership and neighbourhood working. Each delivery area describes the rationale for its selection in NCL as well as what we plan to do next.

We know that NCL as a system is not currently set up to deliver according to these principles in a sustainable way, therefore we have identified **levers for change** which will help the ICS create the right conditions for sustainable delivery and improved outcomes. Each of these levers consists of system-wide deliverables which will set our system up for long-term success.

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 to deliver these goals.

North Central London Integrated Care System

Context

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.

Our understanding of our population builds on the existing Joint Health and Wellbeing Strategies

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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 Strategy (JHWS). This sets out how the local system will work together in partnership to improve the health and wellbeing of the local community and reduce health inequalities. The JHWS do not stand alone but are underpinned by a range of other Council, NHS and partner strategies which together give a sense of borough-level health and wellbeing priorities and areas of focus.
- Each of our borough JHWS is on a different cycle, with delivery for many interrupted with COVID. The JHWS for three of our boroughs are being refreshed during 2023.

		Priorities and focus areas in current JHWS
Still current	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 (for first 2 years, refreshed in 2-yearly cycles): 1. Healthy and ready for school 2. Good work and employment 3. Community connectedness and friendships
Refreshing during 2023	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)*	1) Giving children and young people the best start in life 2) Living well – improving the health and wellbeing of all working age adults 3) Ageing well – working together to support people with frailty to live and age well 4) Creating a healthy place, tackling inequalities and integrating care at a neighbourhood level 5) Reducing violence against women and girls Haringey are refreshing their JHWS but a key area of focus across the partnership will be all age mental health, better health and what it means to Haringey residents and health inclusion.
	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'
- **Emphasis on 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**
- **Working with communities**
- **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 e.g. through population health management tools
- **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 – either expressed directly as JHWS priorities or linked to other borough strategies
- **Making every contact count**
- **Social prescribing**

* Life cycle of current strategies

Our population – who do we serve

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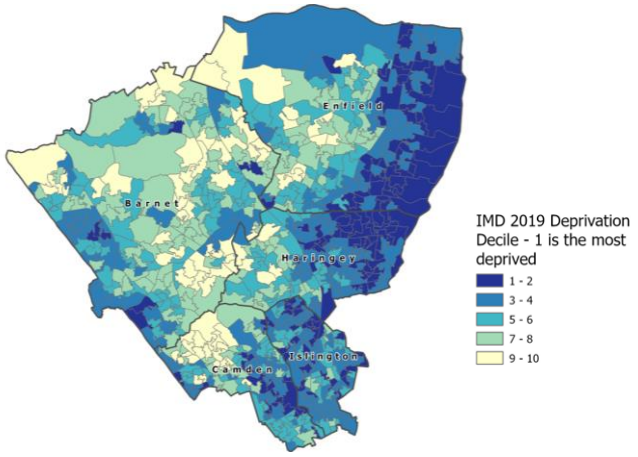
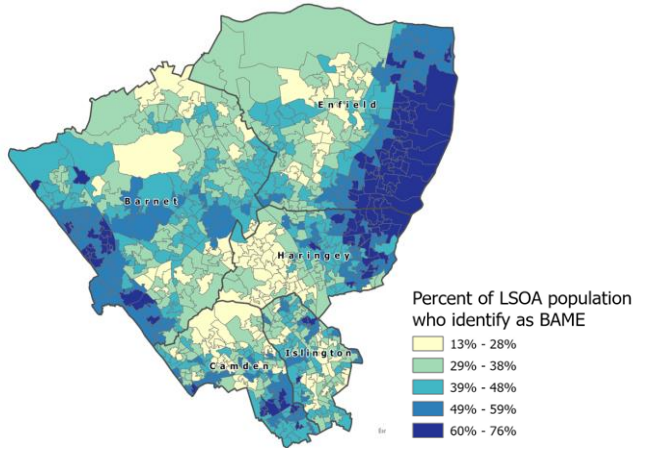
- North Central London (NCL) has a **relatively young resident population of just under 1.8 million people** and a similar number registered with our GPs. Despite large overlap these are not the same populations, and some of our residents remain unregistered anywhere, including from our inclusion health 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 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 and 20% of 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, largely from 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, transgender people, and (ex)offenders.

We have worked to understand our population's 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, physically and mentally, 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.

To become a population health and integrated care 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

National legislation and initiatives, such as the Health and Care Act 2022, the Fuller Stocktake and the CORE20PLUS5 framework, have given us an opportunity to develop and act on our ambitions. These are outlined further in Appendix 2.

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Our ambition, vision and principles

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

Our Ambition

As an integrated care partnership of health, care and voluntary sector services, our ambition is to **work with residents of all ages in North Central London so they can have the best start in life, live more years in good physical and mental 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.

We have worked with residents and partners to develop 'I' statements that define what our new system needs to feel like for our residents, our communities and our service users

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A whole person

- I am treated as a whole person and you recognise how disempowering being ill is
- I am listened to and respected

Patient choice and effective self-care

- I am involved in decisions regarding my life, my health and the support or care that I need

Feeling empowered

- I have the support that I need to stay healthy, both physically and mentally, and to live as independently as possible
- I am supported by people who see me as a unique person with strengths, abilities and aspirations

Information on services, communication and navigation

- I have the information and advice that I need, when I need it and in a form that I can understand

Housing and community

- I live in a safe place with access to lots of green spaces
- I feel part of a community
- I can easily access and afford local activities / services

Integrated care

- I tell my story once
- My care is coordinated across services
- When I move between services, settings or areas, there is a clear plan and the transition feels seamless

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

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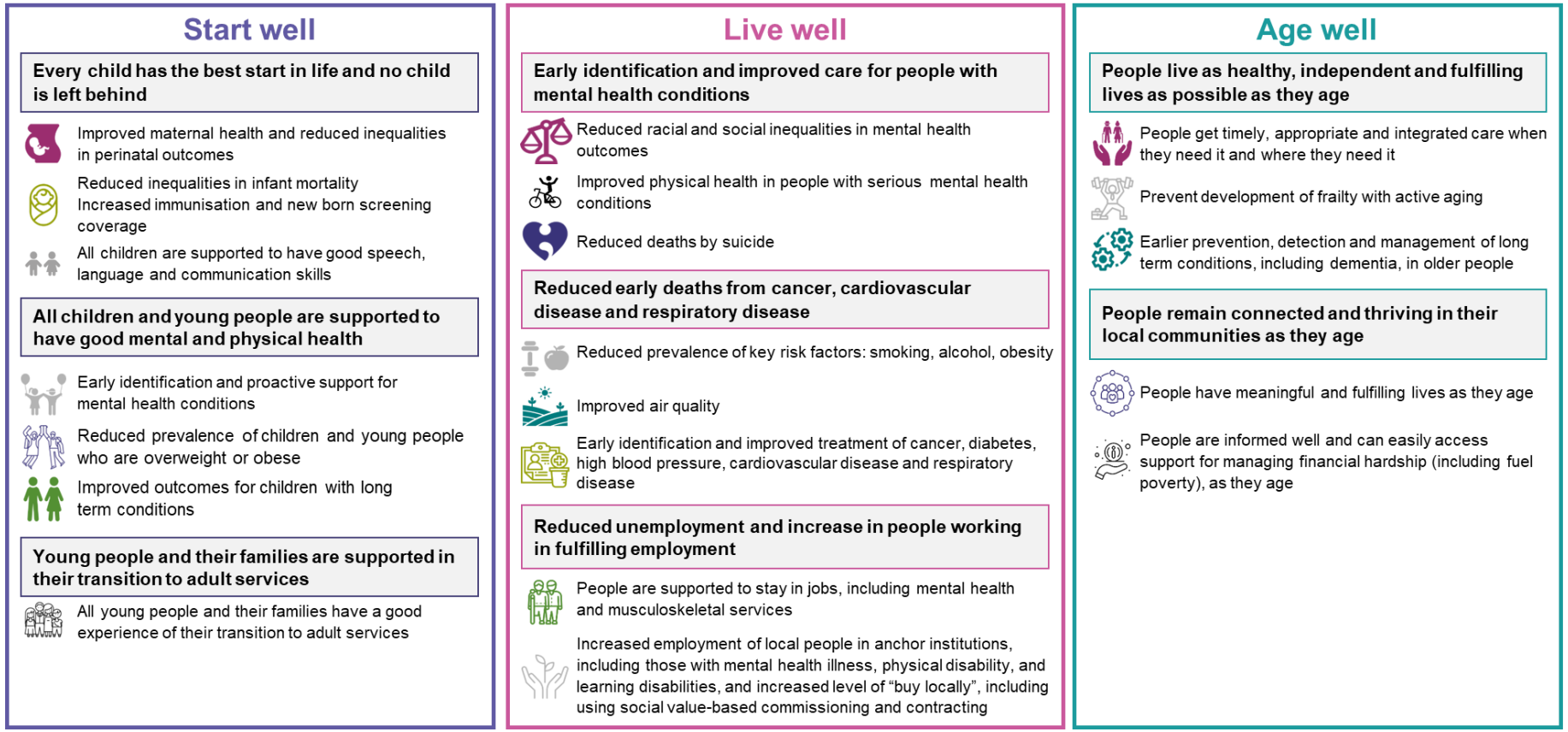
Across our health and care services, we have developed and **agreed a set of outcomes, based on our population needs identified through our NCL needs assessment and our borough Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies, that reflect our population health ambition** 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 and we are aiming to make a significant impact in.

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 NCL population health risks, 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.



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

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To make our transition to a population health and integrated care system that is needs-driven, holistic and integrated, we have identified 10 principles to guide us and given 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 physical and mental 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 needs

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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Delivering on our ambition

We will deliver on our vision for NCL by working across three levels of the system

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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	• Understands totality of system health • Integration principles • Delivers system population health priorities • Differentially resource for achievement of population health outcomes • Balances 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
Borough Partnership: • Focussed on bringing together partners to develop, integrate and coordinate services based on agreed priorities. • Work with wider sector partners • Drives hyper-local delivery	• Coordinates and oversees neighbourhood delivery and acts as interface between sectors • Drives integration across the borough partnership • Accountable for local delivery of placed-based and system priorities • Drives local co-production, insights and transformation • Agrees plans for sectoral partnerships and functional integration • Creates 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 • Balances 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

Designing our approach to neighbourhood working

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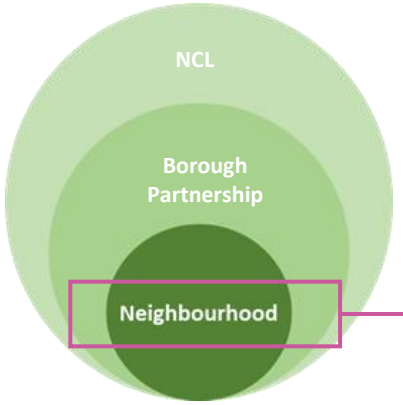

In December 2022, system leaders from 32 organisations from across the ICS came together at an event focused on Delivering Population Health Improvement and the Neighbourhood Model in North Central London, in the context of *Next Steps for Integrating Primary Care: Fuller Stocktake report.*

Consensus was reached on:

There is a need to balance consistency in the offer across NCL, with the ability and necessity to tailor to local need.

Population health improvement, with a focus on prevention, early intervention and proactive care, is critical to improved outcomes and the sustainability of services.

There is a need to meet reactive demand with proactive interventions, and this should be linked to the high risk cohorts in the primary care led Long Term Conditions Locally Commissioned Service (LTC LCS) stratification.

Proactive targeting of key cohorts within a neighbourhood should be data-driven, focused on individuals at high risk of urgent need.

Primary care is at the heart of neighbourhoods but system-wide contribution of critical infrastructure, particularly workforce and data, is critical to neighbourhood development and impact. It cannot be seen solely as primary care transformation. It should be framed and delivered as system transformation.

There is a need to develop a vision for same-day access needs in order to build consensus on the proposed model of care.

We agreed to continue working together in order to focus on:

- Required neighbourhood infrastructure, including core functions, key cohorts, workforce, estates and data.
- Establish and receive feedback from a panel of residents.
- Work through the balance between a consistent offer across NCL and local flexibility needed in defining each neighbourhood, in response to local context.
- Develop a suite of neighbourhood test and learn demonstrators, by building on where there is resource and appetite to participate.
- Support with unblocking challenges.

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

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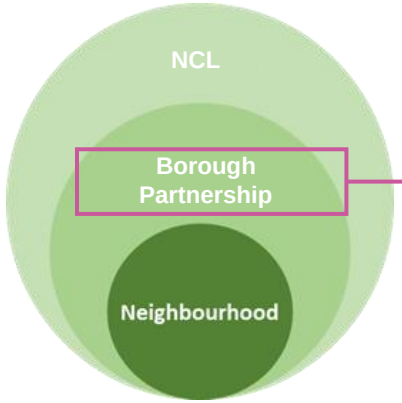

Integrated working already takes place within our boroughs as our Borough Partnerships have been established – their experience and local programmes have given us a window into their future state. We think this is a defined place within which exists a series of horizontally integrated collaboration of 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. Multi-disciplinary Teams (MDTs) routed in Primary Care Networks (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.

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

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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 and 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, will be 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 key population health risks. 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

Borough Partnership integration demonstrator priorities for 23/24

North Central London Integrated Care System

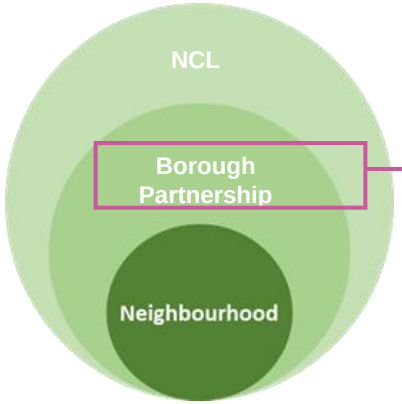
Barnet

Care market: Initial aim to join up spend and strategically commission to secure more supply, gain more support for complex residents, streamline assessments and strengthen partnership working with care providers. This should improve resident experience and outcomes around admission and quality of life within care homes.

Autism diagnosis and therapies co-design – Work together with providers to reduce waiting list for autism by tackling fragmentation. Opportunity to do this through co-design services with residents, families, and VCSE.

Enfield

Population health: There is a joint commitment to focus on areas that fit under the CORE20PLUS5 banner where we can make the most meaningful difference to our population, such as smoking, heart health and obesity. In developing our approach we will be guided by our communities and we will have a significant focus on intersectionality, including with homelessness. This aligns with the focus on implementing Fuller/neighbourhoods.



Our plan is to develop our borough partnerships through identifying a series of demonstrators where we work collectively to address longstanding challenges that make a tangible difference to our residents. One set of demonstrators will relate to the population health risks (delivery area 5), which has started with childhood vaccinations as a priority in all boroughs. A second set of demonstrators relates to areas where we can deliver better outcomes through integration, which have been identified in each borough. These are summarised in the borough boxes.

As we deliver these demonstrators we will also learn about what capacity, resources and responsibility we need to embed improvements and to strengthen borough partnerships in the medium term. We will develop new demonstrators regularly according to local need and capacity.

Haringey

Community Mental Health – We are focusing on improving short and long term outcomes with a focus on early intervention and prevention. We are initially mapping the range of statutory and non statutory MH support in the borough so we focus on maximising our existing assets. This will give us an opportunity to assess our strengths and weaknesses and identify where there are opportunities to build more pro-active responsive support for residents.

Camden

Review of s75 agreements: There is a wide range of partner spend covered in s75 arrangements that hasn't been reviewed alongside the Borough Partnership priorities. There is the opportunity to re-imagine these and think about how greater integration and increased focus on prevention and upstream intervention can deliver better outcomes and provide a stronger strategic framework for our borough partnership to operate within.

Islington

Strengthening Integrated Teams: Our Borough Partnership has a number of major change initiatives where we are developing stronger integrated teams that make services simpler to access for residents and ensure that they receive a well coordinated joined up response. This includes developing an integrated front door, integrated crisis response, and landing MDT locality teams providing statutory and non statutory support.

Putting population health into practice – how providers see the future

North Central London Integrated Care System

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'

Cross-cutting

"There is a commitment to develop an autism centre of excellence/child development centre where families can access a range of services from the same location, to continue to embed the specific programmes to address assessment and diagnosis wait times, and to improve transitions between children and adults services."

Call to action

Throughout this strategy, we refer to principles, focus delivery areas, and levers for change however a key element to making this all a reality is what each of us will think and do differently as a result of them. With that in mind, our call to action is for each organisation in NCL to consider the following questions:

- **How will my organisation look and feel differently when we align to the principles and areas outlined in this strategy?**
- **How do we align with the 10 principles in everything we do?**
- **Are we able to identify and focus on the 5 delivery areas?**
- **How do we contribute to what we will do next for each of those?**
- **What is my role in the 6 levers for change? How will this contribute to creating a sustainable system for our new ways of working?**

Acute Trust

'By developing better integration between primary and secondary care, at the neighbourhood level, we have the opportunity to do things differently in service of this aim. We are therefore thinking about how we could reorient the secondary care workforce, for example by systematically aligning secondary care specialists to neighbourhood MDTs across our population.

(Regarding joined-up approach to prevention) 'This means that we are implementing healthy living hubs and embedding prevention in our secondary care pathways by making every contact count.'

GP

My role of a GP is to provide services to my registered patients from cradle to grave, understanding the whole practice population's needs. By working in a system that prioritises population health the focus of my role is enhanced so enabling me to do my job better.

North Central London Integrated Care System

Our delivery areas
Where we can make the biggest impact

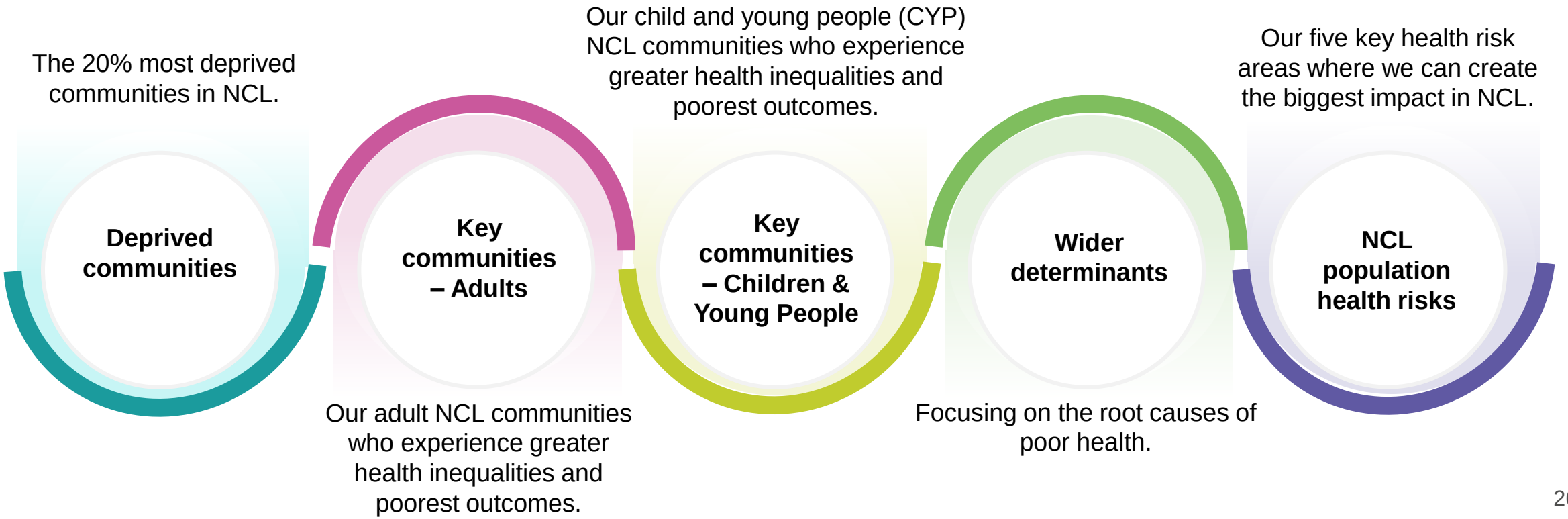
Our delivery areas

North Central London Integrated Care System

Our principles guide all of the work we do however we need an approach to focus on areas where we can make the greatest impact. We have identified areas for delivery which will enable us to do this.

This work is delivered at system, place and neighbourhood level and we will be working with Borough Partnerships to ensure they have the right conditions in place to improve the outcomes of residents.

We have key programmes of work that have already commenced as early foundations of population health improvement and we have agreed new delivery areas that will have the greatest impact on population health outcomes.



Inflight programmes of work that are foundations for population health improvement

North Central London Integrated Care System

Community and mental health services core offer

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 key performance indicator (KPI) dashboard which will be used to track equitable outcomes improvement.

NCL Health and Care Academy

North London Councils, NHS and adult education partners, have secured funding to promote health and care as a workforce of choice to our residents, with a focus on those with barriers to employment, and to work with health and care employers to tailor their employment offer to all of our communities and ensure they are offering good quality roles. This will include direct training for 400+ residents in health and care of which over 240 residents will move into entry level jobs. Once we establish better entry level pathways we will also work with employers to promote a range of flexible progression opportunities.

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.

New 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. This model will act as a key piece of our neighbourhood model in NCL.

Inequalities fund

The aim of the Inequalities Fund was to develop new approaches to entrenched health inequalities and we currently £5m per annum committed to do this.
To date, the Inequalities Fund has looked out towards local communities working with local authorities to understand their needs and measure the value of developing relationships and co-produced solutions.
An example of this is NCL ICB and Islington Council collaborating to improve mental health in Young Black Men in Islington working within school settings, a community-based hub, barbers, and an anti-racist training programme.

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.

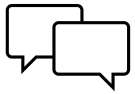
Delivery area 1 – Deprived Communities

North Central London Integrated Care System

Around 364,000 NCL residents live in the 20% **most deprived areas** nationally and 30% of children and young people are growing up in poverty. Poverty and deprivation are key determinants of poor health outcomes

For example, 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

Snapshot of what we are already doing



Tottenham Talking
This initiative aims to increase the number of young black males accessing lower-level mental health services, and reduce those developing severe mental illness, through identifying need at the prevention stage.
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Tackle mental health inequalities facing young black boys/ men in Islington
This initiative established four pillars (such as “Becoming a Man” initiative in schools and “Round Chair Barbers”), driven by listening to Young Black men’s experiences. Both examples are delivered through the Inequalities Fund.

What we will do

Across NCL, we will have a greater understanding of the needs of our most deprived communities and a shared understanding on how providers will tailor services and approaches to maximise their opportunities of health and wellbeing. We will look to strengthen links between statutory health and care services and wider support to address inequalities.

This will include a clear mapping of inequalities, built from data and community insights, to identify gaps where we need to act as a whole system and how we measure progress.

We will continue to use NCL’s Inequalities Fund as a delivery vehicle, consisting of a combination of borough-level and system-wide focussed projects which will focus on our most deprived residents.

Delivery area 2 – Key communities – adults (1/2)

North Central London Integrated Care System

- **Inclusion Health Groups**, including people experiencing homelessness, Gypsy, Roma and Traveller communities, sex workers, disadvantaged migrants*, and adults with a history of imprisonment. These groups have amongst the poorest health outcomes, both physical and mental ill health, which are often compounded by poverty, trauma, social marginalisation and substance misuse.
- **Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities** (specific groups to be defined as part of Core20PLUS5 and tailored to reflect nuance at Borough level). BAME communities on average experience poorer health outcomes even after controlling for social and economic disadvantage.
- **Adults with severe mental illness and adults with learning disabilities**. These groups have complex social and health needs, often with multi-morbidity, lower incomes, with poorer access to employment and lower life expectancy.
- **Family carers** have poorer health and wellbeing outcomes and are disproportionately impacted by the cost of living crisis.

Snapshot of what we are already doing

Collaborative forums on homeless health
Which build on and share learning from borough-based work – in particular the Haringey Homelessness Inclusion Team and the Camden Adult Pathway Partnership which has informed multi-disciplinary team (MDT) thinking in Enfield and Islington.

Healthcare for asylum seekers and migrants
Healthcare solutions at neighbourhood, place and system have been developed following needs identified through our Inclusion Health Needs Assessment and feedback from local care providers and service users e.g. GP practice and Respond (UCLH) service offers

Outcomes based specialist accommodation
Each Local Authority and the ICB is working with specialist accommodation providers to ensure provision is focused on outcomes and sustainably funded (use of Care Cube), promotes independence and that staff are skilled in providing positive behaviour support.

What we will do

Across all our work in NCL we will be embedding a focus on these communities.

We will use the findings of our Inclusion Health Needs Assessment to identify how as a system we can best meet the needs of Inclusion Health Groups, following the recommendations from the review.

We will also build the capability of our population health management platform regarding these communities and improve data recording to better identify these populations with services

We will strengthen wraparound support for adults with care and support needs to ensure that people are supported to maximise their independence, including responsive, flexible support when people's needs increase. We will level up community resource where some boroughs are underserved and develop ways to shift resources from hospital to community settings.

This will also include focusing on identifying carers who are currently hidden from the system to ensure we are supporting them.

* To include children and young people where relevant as part of a family approach to supporting asylum seekers and disadvantaged migrants

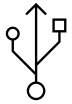
Delivery area 2 – Key communities – adults (2/2)

North Central London Integrated Care System

- **Older adults with care and support needs.** Our assessment arrangements for older adults are not integrated which means that residents can experience multiple assessments, uncertainty and delays accessing provision. Whilst we have a sub-regional market of care homes our commissioning is fragmented between health and social care, which can result in poorer outcomes and is also driving up system costs unnecessarily. Residents with high physical and mental health needs can struggle to find appropriate care home places.
- **Supporting residents at risk of hospital admission**. Too many residents go into hospital for avoidable reasons, including from groups we know are at risk. Prevention and hospital avoidance support is not consistently well integrated and is sometimes commissioned episodically (VCSE).
- **Supporting residents to recover following hospital admissions.** Generally, residents in NCL are discharged from hospital in a more timely way compared to other areas, however, we are seeing an increase in people's needs when they leave hospital and not all residents receive optimum discharge support to recover.

Snapshot of what we are already doing

Care Home Market Management
The 5 Councils have developed a strategic approach to working with care homes that promotes quality, ensures we pay a fair rate and addresses market gaps. This has supported significant quality improvement in Care Quality Commission (CQC) ratings.



Using digital technology to deliver pro-active care
The ICB, NCL Training Hub and Councils have collaborated on a programme of increasing digital technology in social care settings. This is supporting pro-active care to thousands of residents to offer support when someone starts to become unwell or is at risk of falls.

Integrated Discharge Teams
We have developed integrated discharge teams across acute, mental health, community and social care provision that support residents to leave hospital in a timely way and to access effective community support. We have recently jointly commissioned work to identify areas for improvement that will drive developments in the next few years.

What we will do

We will strengthen partnership working and integration across all of these services to deliver better outcomes for residents at a sustainable cost. This will include progressing joint market management arrangements for care homes, drawing on the particular strengths the NHS and Councils can bring.

Borough Partnerships will provide more pro-active care through the development of neighbourhood teams and maximising NHS and local authority spend on VCSE organisations.

We will develop a joint programme to improve outcomes for residents leaving hospital by taking forwards improvement recommendations around finance and improved management information, improved coordination of residents leaving hospital and a strengthened core offer of discharge support across all boroughs.

Delivery area 3 – Key communities – Children and Young People (1/2)

North Central London Integrated Care System

- **Children with Special Educational Needs and Disabilities (SEND).** Pupils with SEND face barriers that make it harder for them to learn than most pupils of the same age. They often experience poorer outcomes than their peers in educational achievement, physical and mental health status, social opportunities, and transition to adulthood.
- **Children Looked After (CLA) and care leavers.** Many children in care are likely to have had experiences which make them more at risk of poorer health outcomes than their peers.
- **Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities** (specific groups to be defined as part of Core20PLUS5 and tailored to reflect nuance at Borough level). Children from BAME groups on average experience poorer physical and mental health outcomes even after controlling for social and economic disadvantage.

We recognise there is some overlap across these populations, which may result in increased risk of health conditions or further barriers in accessing services – it will be important to recognise this intersectionality and provide support for these groups in a holistic way as part of delivery.

Snapshot of what we are already doing

Enfield Speech and Language Service

Enfield has developed a comprehensive SEND Action Plan for Health. A 0-2 years Speech and Language Early Identification and Intervention Service has been implemented, offering targeted interventions for children with speech, language and communication needs in deprived wards who experience difficulties or barriers in accessing universal therapy provision.

Barnet Care Leavers

Barnet Care Leavers Service is known as the Onwards and Upwards team and they allocate personal advisors (PA's) to support care leavers with all aspects of future independence. All boroughs have a support offer for Children Looked After related to education, employment, keeping healthy, staying safe/accommodation support.

What we will do

Across all our work in NCL we will be embedding a focus on these communities. This will be consistent with the approach for adult communities described in the previous slide.

Furthermore, each Borough is identifying a multi-agency partnership group responsible for developing and overseeing local implementation of the Community Services Review, and part of this is around the core offer for NHS support for CLA.

Finally, we will continue to develop our collaborative approach to supporting the SEND population.

Delivery area 3 – Key communities – Children and Young People (2/2)

North Central London Integrated Care System

- **Continuing Care for Children and Young People.** The landscape across NCL in relation to continuing care is varied, there are fragmented transition pathways between children's and adults services with young people having poor experiences when transitioning.
- **Safeguarding arrangements for designated doctors and nurses for Children and Young People.** NCL are keen to ensure that hospital wards have the right people on them in terms of safeguarding to undertake appropriate medicals when needed.

Snapshot of what we are already doing

Enfield Continuing Care
Enfield has a good model of partnership working for continuing care arrangements with input from local authority and health colleagues in panel decisions. The dynamic support register is used well to prevent breakdown of placements.

Understanding the landscape
We are working to understand the landscape across NCL for continuing care provision and for safeguarding arrangements for designated nurses and doctors.

What we will do

We will work to further understand the landscape across NCL for Safeguarding arrangements and continuing care arrangements in each borough.

For Continuing Care, we will establish an advocacy support network for parents/carers, develop a training package to upskill staff across NCL to reduce the need for placements and ensure families are receiving adequate support and further scrutinise the data, best practice and collaboration opportunities.

For Safeguarding arrangements for designated doctors and nurses, we recognise the difference in children protection medicals across NCL boroughs, we will work to ensure medicals are timely, fully considered and assessed, and take a multi-agency approach.

Delivery area 4 – Wider determinants of Health

North Central London Integrated Care System

- **Working with our communities.** To be an effective health and care system it is essential that we work with our communities to co-design solutions that prolong good health, prevent avoidable ill health and address health inequalities.
- **Working with the Voluntary, Community and Social Enterprise Sector (VCSE)** to ensure we are embedding the voice of the sector within our governance structures, building the unique skills and knowledge the sector have into our population health, and in particular, prevention approaches and addressing some of the key issues which face the sector including sustainability, long term funding and workforce/resource.
- **Social prescribing.** Many people present to health and care services when what they need is support for an underlying social problem such as support with housing or income issues – social prescribing is about linking people to appropriate services and informal support in their local communities.
- We want to embed a focus on tackling the wider determinants as drivers of poor health across our work and the other 4 focus areas – the above are some examples, but not an exhaustive list of how we might tackle this.

Snapshot of what we are already doing

Community connectors
Working with local HealthWatches to develop a community champions-style programme. This will support communities who face high health inequalities to understand how to stay healthy, symptoms of poor health, and how to access services.

Community research and action programme
The programme focuses on developing strong VCSE partnerships within each Borough, raising local communities' voices, and investment in grass-roots VCSE to help tackle inequalities and barriers to accessing services.

VCSE investment
Each Council makes a range of long term strategic investments in the VCSE supporting residents to stay well, address wider determinants of health and have less need for formal health and care services.

What we will do

Working with our VCSE partners to deliver our NCL VCSE strategy which outlines our system-wide approach to working with the VCSE

Focusing on incorporating wider sector partners into our work, including education, housing, employment, leisure, road safety, and air quality.

Identify and use opportunities to provide holistic advice to residents regarding wider determinants issues such as benefits and housing.

Health and Social Care Academy – we will support residents with barriers to employment access a range of jobs in health and care services.

Delivery area 5 – NCL population health risks

- **Childhood immunisations**. Coverage is below London and far below England for almost all childhood immunisations across NCL as a whole, and in individual boroughs.
- **Heart health, cancer and lung health**. These are the three biggest causes of the life expectancy gap between the most and least deprived communities and have multiple common risk factors – such as smoking, physical inactivity and poor air quality.
- **Mental health and wellbeing across all ages.** Prevalence of mental disorders amongst adults and children increased due to the pandemic and mental wellbeing is repeatedly highlighted by communities as an area of need within NCL.

A summary of the NCL population health risks and the rationale for focusing on them is included in Appendix 6 as well as the rationale for agreeing to initially focus on childhood immunisations.

There will be other population health risk areas which we want to identify in the future from an NCL perspective, including those articulated within the Core20PLUS5 frameworks for adults and children - such as maternity and Diabetes, Epilepsy, Oral Health, and Asthma for children and young people.

Snapshot of what we are already doing

Childhood vaccinations
Building on the 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.

Long Term Conditions (LTC) management
Primary care has developed a model of care that stratifies the LTC population and provides proactive personalised care and support over a year of care.

What we will do

Childhood vaccinations are embedded as a priority across each local partnership and structures for leadership and delivery are being enhanced, alongside cross-borough working. Each partnership will use data and local learning and community insight to deliver what works with local communities.

We will conduct a gap analysis for each risk area to identify outcomes and spend across different population sub-groups and geographies to develop focus areas for tackling health inequalities.

We will develop a common framework to accelerate work across each of these 5 population risks reflecting governance, a focus on prevention, working across partners, including the VCSE and success measures. As part of this we will look at how we are tackling the risk factors which are common across these different pathways.

North Central London Integrated Care System

Levers for sustainable improvements

Our levers for change identify how we will create sustainable conditions for us to deliver on our ambitions

North Central London Integrated Care System

In order to drive progress on our delivery areas, we have identified ICS levers for change which will create sustainable conditions for our new ways of working. These represent where the ICS can add value and accelerate equitable achievement of outcomes.

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

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

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

Becoming a learning system

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

Creating 'one workforce'

'One Workforce' across our health and care providers to provision a sustainable model that enables us to pivot towards a model that focuses on population health improvement

Lever 1 - Making population health everyone's business

North Central London Integrated Care System

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.

How this helps us create a sustainable system for our new ways of working

Making population health everyone's business means all organisations across NCL taking joint responsibility for promoting and protecting the physical and mental health and wellbeing of our residents. Each organisation across our system has a unique view of resident experiences and no single organisation alone can achieve holistic improvements in population health outcomes.

In order to create a system that supports our new ways of working, we should be enabling each organisation to embed the fundamentals of population health in what they do. This means:

- **Developing a shared understanding of needs** – If we want to work together, we need to understand and hold a shared vision of resident and community needs. This can be done by ensuring the infrastructure, learning and capacity is in place to share our insights.
- **Build capacity across the system** – We must embed the fundamentals of population health and embark on a cultural shift to ensure all organisations across NCL can build in relevant processes and learning in line with our new ways of working.

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 health and care providers

Insights

- Develop and embed system understanding of need
- Build a networked intelligence function across partners, including provider organisations
- Embed data on Key Communities (adults and children/young people) and other population health management (PHM) insights into frontline care
- Add social care, housing, prescribing 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
- Develop and embed a suite of system quality metrics to support Core20PLUS5 for adults and children and young people
- Levers around data quality
- Develop CQUIN financial incentives to address health inequalities

Fundamentals of population health

- Capacity building - build population health fundamentals into induction programmes across partners, including provider organisations
- Build Making Every Contact Count (MECC) culture and processes, including incorporating into all staff personal development reviews (PDRs)
- Establish a population health leadership academy across the ICS and build into role descriptions
- Embed digital inclusion into all programmes
- Governance processes in place at ICB and providers that supports a health inequalities in all approach – e.g. all decisions focus on underlying need and resource

Lever 2 - Strengthening integrated delivery

North Central London Integrated Care System

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.

How this helps us create a sustainable system for our new ways of working

Integration is happening at every level of our system, from neighbourhood to system. It enables our services to better understand and meet the needs of the individual, as well as the factors contributing to worse outcomes, so that the care provided can be less episodic and reactive.

By strengthening our partnership approach, we can make sure our services are fit for purpose. This is an opportunity to implement transformative changes that radically improve the way we deliver care. This means:

- **'One Workforce'** – A joined up workforce, equipped with the right skills and information, is key to the delivery of our ambitions.
- **Effective Care** – By joining up our clinical teams, social services and wider support more, we can deliver more effective care for our residents.
- **Meaningful Partnership** – To succeed, we need our partners to continue engaging and participating in our joint commitments, and we need to facilitate open and honest conversations that enable us to collectively overcome obstacles and inefficiencies across our system.

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

Context and conditions for success

- Deliver Borough Partnership Roadmap, including scope, infrastructure and responsibilities/accountabilities
- Deliver key population health risk demonstrators
- Deliver Borough Partnership integration demonstrators

Building local integrated teams

- Shape the neighbourhood offer including role of VCSE
- Establish the delivery infrastructure to deliver integrated neighbourhood teams
- Integrate and scale personalisation approaches (Personalised Care & Support Planning, Personal Health Budgets, co-production etc)
- Develop a digital supported offer for more proactive care@home and increase levels of digital inclusion
- Align system quality leads to each borough team to support action planning around equality gaps in service provision and delivery

Lever 3 - Collaborating to tackle the root causes of poor health

North Central London Integrated Care System

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.

How this helps us create a sustainable system for our new ways of working

It was estimated by Public Health England (PHE) that 40-50% of health outcomes are attributed to the so-called 'wider determinants of health' like housing, education and employment and their unequal distribution across the population, a much greater influence than healthcare, lifestyle behaviours or genetics. Addressing the wider socio-economic determinants is a crucial part of preventing ill health and reducing health inequalities.

By addressing the root causes of poor health, we can reduce the likelihood of health problems arising in the first place and thus decrease the demand for healthcare services. This means:

- **Recognising the role of anchor institutions –** Anchor institutions play a key role in strengthening local economies.
- **Promoting sustainable health and care –** By delivering on the NCL Green Plan, we can work towards building a healthier community.
- **Engaging with communities –** By collaborating with our VCSE, we can better understand the needs of our population.

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

- **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 (including through the health and care academy) and increase physical activity
- **Social prescribing -** Ensure social prescribing is visible, accessible and available across all life courses, and is valued by all partners equally.
- **Making every contact count –** consolidate our MECC offer in NCL including around the wider determinants of health
- **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
- **Tackling key population health risks–** coordinate action around the common risk factors for our key population health risks, to include work to tackle tobacco, alcohol and weight as well as the 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 – taking forward our NCL Working with our Communities and Working with our VCSE Strategies

Lever 4 - Aligning resources to need

North Central London Integrated Care System

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.

How this helps us create a sustainable system for our new ways of working

Our system is facing significant pressures, which our staff have responded valiantly to. In spite of this, our services need to change to ensure they are able to meet the present and future needs of our population.

By better utilising opportunities to inform and align our decision-making, we can ensure our collective resources go further to most effectively meet our population's needs. This means:

- **Prevention and early intervention –** In order to take a proactive approach to improving whole life outcomes for our residents, we need to identify and act on opportunities to shift our resources towards prevention and early intervention across our services.
- **Decision-making –** By ensuring decisions are informed and can be made at the right time and place, our borough partnerships will have permission to act to shape local services within the framework of our 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

Understanding variation in outcomes

- Baseline and monitor outcomes framework and setting our ambitions for how our outcomes will change over time.
- Baseline current outcomes and spend by geography and demography and how it compares to data on access, experience and outcomes
- Embed a plan for our key communities that outlines current work in progress on health inequalities focusing on community empowerment, wider determinants, health promotion / prevention, data collection and inclusion health.
- Inter-dependencies identified with related programmes – e.g. anchors, green programme, elective recovery, and agreement of who does what – e.g. individual action vs advice provided
- Define system values and approach to trade-offs to address health inequalities and the wider determinants
- Embed systematic quality outcomes reviews to support proactive identification of areas of variation and develop plans for targeted interventions
- Allocative efficiency programme in place that identifies most effective interventions to address health inequalities, linked to needs identified in gap analysis

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 populations in need
- 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

Lever 5 - Becoming a learning system

North Central London Integrated Care 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.

How this helps us create a sustainable system for our new ways of working

NCL has a unique position to evolve into a learning system, thanks to its world-renowned academic, research, and healthcare institutions. By fostering our collaboration to become a learning system, we can integrate our data and experiences into practice to better understand the needs of our residents. This means:

- **Adopting a QI approach –** By adopting a consistent Quality Improvement (QI) methodology, we can gather insights and learnings from across the system.
- **Acting based on evidence –** Collaborating with our academic forums will enable us to better understand the challenges that our system is facing and allocate resources more efficiently.
- **Generating evidence –** The unique challenges and opportunities of NCL can produce real-world evidence to inform research priorities.

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 (QI)
- Shift from transactional quality surveillance to a QI approach with a consistent methodology and greater use of after action 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 system-wide research collaboration to steer, simplify 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, prevention and upstream intervention
- Promote participation in research so it reflects communities in NCL

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.

Lever 6 – Creating ‘one workforce’

North Central London Integrated Care System

‘One Workforce’ across our health and care providers to provision a sustainable model that enables us to pivot towards a model that focuses on population health improvement.

How this helps us create a sustainable system for our new ways of working

We want to, in line with our people strategy, ensure our workforce is integrated and focuses on population health improvement. This means:

- **Workforce supply** – Closing the workforce gap through improved workforce planning across all the sectors to better understand the types of skills required within each sector in the future.
- **Workforce development** – Supporting the development of meaningful careers, particularly for the ‘poly-potential’ entry level roles such as physicians associate thereby increasing retention rates.
- **Workforce transformation** – Embracing new ways of working including through technological advancement, creation of holistic roles across the health and care boundaries, that provide support for the population we serve.

Creating ‘one workforce’

‘One Workforce’ across our health and care providers to provision a sustainable model that enables us to pivot towards a model that focuses on population health improvement.

Workforce supply

- Data: the ICS has a unique opportunity and role to generate visibility of roles, opportunities and capabilities and used an evidence-based approach to support strategic workforce planning and coordinate planning activities across the system
- Supply routes: we need to broaden where we attract staff from and ensure we have the right number of staff with the right skills in the right place to achieve our population health improvement outcomes sustainably.

Workforce development

- Flexibility: designing the right policies and process to enable staff the opportunity to have a portfolio career; a second career or to offer an approach to work that overcomes the barriers that prevent people with long term conditions or caring responsibilities, joining the workforce.
- Enhanced capability: increasing capability across the system, maximising the talent we have and therefore reinforcing and increasing workforce flexibility

Workforce transformation

- Innovation: piloting initiatives and designing an ecosystem that provides a clear route to scaling and enabling workforce transformation impact at scale; maximising the datasets and advanced technologies within the system (and explore new ones) to increase access, efficiency and continuously evolve our workforce and operating model.
- Ways of working: embracing new ways of working including through technological advancement, creation of holistic roles that provide support for patients across the health and care boundaries; increasing productivity through the introduction of digitally augmented pathways and development of new career pathways to attract and retain staff.

North Central London Integrated Care System

Moving forward and next steps

As we transition to delivery, we will sequence and prioritise our deliverables

North Central London Integrated Care System

The levers and delivery areas in this strategy, alongside our existing programmes of work, allow us to frame the delivery of this strategy around clear deliverables and cohorts.

Not everything should be delivered at the same time as some are dependant on others therefore, as we move forward into delivery, we are sequencing our delivery according to three horizons. We will be working to define the end state for each horizon and how we measure success.

Horizon 1 – 0-18 months

- Tangible action plan and progress for each delivery area
- Prioritisation and sequencing of the deliverables under each of our levers
- Ensure progress on foundational lever pieces are in place to make the progress on our delivery areas sustainable

Horizon 2 – 18-36 months

- Our intermediate pieces of work that build on the foundations and early learning
- This horizon will require updating and further detailed planning in the first annual refresh.

Horizon 3 – 36+ months

- Our longer-term pieces of work which are dependent on deliverables in horizons 1 and 2.
- These will reflect consolidation of learning and greater depth of system partnership and collaboration.

Horizon 1 future state

Horizon 2 future state

Horizon 3 future state

2023/24 is the first year of horizon 1, where we will lay the foundations for delivery

North Central London Integrated Care System

Horizon 1 – 0-18 months

- Tangible action plan and progress for each delivery area
- Prioritisation and sequencing of the deliverables under each of our levers
- Ensure progress on foundational lever pieces are in place to make the progress on our delivery areas sustainable

Setting the foundations during 23/24

Sequencing and prioritisation

- Clear sequencing and prioritisation of our deliverables, including our inflight transformation programmes.
- Define future end state for each Horizon to plot transition to system vision
- Defining how we measure success

Outcomes framework

- Plan for setting ambitions for priority population health outcomes, sub-outcomes and indicators
- Complete the population health outcomes baselining
- Map outcomes to population health risks and inflight transformation programmes

Oversight and measurement

- Establishing oversight and monitoring arrangements with clear accountabilities
- Building the delivery infrastructure and capacity

Delivery

- Granular delivery plans
- Tangible progress against agreed action plans for each delivery areas

We will establish oversight and monitoring arrangements that will use our outcomes framework to guide our work

North Central London Integrated Care System

Oversight and monitoring arrangements
Ensuring all parts of the system are clear about their role in delivering the strategy, the outcomes and indicators that they support, how they will track progress and how that will contribute to the overall system view. This will help support mutual accountability for population health outcomes.

NCL Population Health Outcomes Framework

All population outcomes are baselined and prioritised, and we have agreed ambitions to drive improvements and reduce inequalities.

Delivery cycle
Working at system, borough partnership, neighbourhood and providers

Identifying opportunities for intervention
Assessing variation and need to identify where we can make a difference by working together as a system, and areas which require focus at borough and neighbourhood level.

Discussing, learning and unblocking

Discussing key outcomes shifts, as well as opportunities and challenges, across all levels of our system to allow us to come together for learning and solutions.

Insights, dashboards and tools

Ensure insights are feeding in at NCL, borough, neighbourhood and provider level which can also be viewed through the lens of key communities

Moving forward and next steps

North Central London Integrated Care System

- This document described the system's strategic intent for population health improvements and integrated care which will guide our future ways of working. It has been developed by and with system partners.

- This strategy outlines next steps in the form of deliverables as well as a call to action for system partners working in a system that prioritises population health improvement and delivery of integrated care.

- We will be developing a more detailed plan with milestones, timelines and trajectories which will describe the detail behind the high level view described in this strategy.

- This will include how and where we will apply our new ways of working and integrate care and support to deliver better outcomes.

- We will continue to implement our foundations for population health improvement through our inflight programmes of work and co-produce delivery plans with system partners for new delivery areas that will have the greatest impact on population health.

- We want to strengthen system leadership to ensure there is a clear understanding about the role and remit of each component part of our system infrastructure and the integral role they play. E.g. Borough Partnerships, Integrated Care Partnership.

Our strategy will be owned and delivered across the system

Through the key elements of the ICS, we will bring together leaders from across the health, care, voluntary and community sectors to drive the delivery of our ambitions and deliver a more joined up approach. These will allow us to remove blockages and more effectively align our objectives across the system. We are embedding a learning approach in our system to enable local innovation, clarify responsibilities and accountabilities, identify best practice and develop our partnership approaches. Through these, we can accelerate the integration of our services and deliver better outcomes for our residents.

The work of our Integrated Care System (ICS) is being developed and supported by:

- **The Integrated Care Board (ICB) -** new NHS statutory bodies responsible for allocating NHS budget and commissioning services with an emphasis on collaboration. The NCL ICB covers all 5 boroughs and all NHS providers working in the geography
- **The Integrated Care Partnership (ICP) -** a joint committee between the councils across the five boroughs, the NHS and voluntary sector partners. Responsible for the planning to meet wider health, public health and social care needs and is the author of this strategy as well as its implementation.
- **The Community Partnership Forum –** a forum to oversee resident engagement and involvement in NCL.

Borough Partnerships local collaborations between health care and the voluntary sector, bringing in wider sector partners such as housing and education to will be the engine room for the delivery and reform of our services.

Integrated neighbourhood teams - multi-disciplinary working teams driving proactive care at hyperlocal levels, with a focus on health inequalities and the wider determinants of health