NHS
North Central London
Integrated Care Board

Change NHS Organisation Response - Final Submission

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

North Central London Integrated Care Board sees the 10-Year Plan as an opportunity to build on integrated system planning and support the transformation of care. The Plan must be bold, reduce fragmentation and tackle issues system wide. Small pilot schemes with short-term funding solutions are not sustainable.

System working is helping us progress integration, reduce inequity and address the three shifts. We use radical thinking, foster understanding and build consensus to overcome disagreement. However, several factors prevent our innovations from being scaled up. The plan needs to support ICBs in our role as strategic commissioners, improving health and sustainability in the medium term whilst simultaneously addressing more immediate system issues.

To move to a more preventative healthcare model and support greater care and support outside of hospital, the 10-Year Plan must:

- Focus on financial modelling that follows a predictive, actuarial approach, enables long-term, timely investment and enables tailoring according to local needs for high quality, holistic, early intervention.
- Allow for more flexible and robust capital investment and IT infrastructure to enable joined up working and fit for purpose estates across neighbourhoods, and a range of provision, not just hospitals.
- Outline a clear vision for resolving issues with digital progress and variation including interoperability, user-friendliness and governance that enable information to flow and staff to focus on care.
- Support staff to work at the top of their licence, ensure working conditions are flexible enough to retain staff, and that the curriculum for healthcare professions is broad enough to reflect the three shifts.
- Place accountability for neighbourhood working population health and equality, with all parts of the ICS and recognise that managing performance is a partnership endeavour. All partners must be required to analyse variation in population access and outcomes and take action to reduce this.
- Create greater alignment of targets, planning and delivery across sectors.
- Have a strong public health focus, with robust public health education on how to stay well and manage our health. Facilitate a whole life course, proactive approach that particularly supports people across transition periods during the life course.

- Be more explicit about how our systems can best support all children and young people through prevention and proactive support and address the rising demand for SEN and mental health support amongst children and young people.
- Ensure that resident voices are at the heart of decision-making and monitoring processes, to ensure our plans have the intended outcomes for the people we serve.

Fixing a broken NHS will rely on changes beyond healthcare services and it will be important for the 10-Year Plan and wider government policy to reflect this.

About North Central London

NCL's providers are at the forefront of delivering world-class services and research, from work on genome testing to regenerative hearing loss research and identifying the link between a COVID-19 vaccine and rare cases of blood clots.

Our population, around 1.8m, includes people experiencing high levels of deprivation, with over 10% of households in fuel poverty, people experiencing homelessness, refugees and asylum seekers and sex workers. Socioeconomic factors are pushing residents further into poverty. Mental health conditions are rising amongst all population groups, exacerbated by; cost of living, lack of decent, affordable homes, lack of opportunities and activities for young people, social media and the wider social context**.**

Disjointed systems and a lack of community-based staff and buildings create barriers. We know some residents are worried about the future; whether services will continue, and privatisation. The plan must reassure and build trust.

Long-term planning

We need significant investment in capital and digital infrastructure to deliver these shifts. The current limited capital allocation system results in below optimal allocation of scarce investment. Many buildings across primary and secondary care are not fit for delivering modern healthcare. Maintenance and refurbishment costs of the current physical estate is significant. We suggest a new, realistic assessment of the investment and timeframe needed to deliver improvement. We suggest a new minimum of 5-year capital planning allocations as the standard.

Our people

Recruitment and retention of staff continue to be a barrier, with lack of flexibility and reasonable adjustments cited as reasons for people leaving. We need to reduce the 12-month wait for Access to Work support.

National programmes must create clear, affordable routes into the whole range of health and care professions that are accessible to a wide range of people. We need to see developments to the curriculum for healthcare professionals that includes digital, leadership and humanities. We need new professional pathways in areas such as care for people with autism and other life-long conditions. Where things can be done once, nationally, there is potential for a huge increase in efficiency. We need to support staff to work at the top of their licence, and to work with Royal Colleges and regulators to support recognition of associated professions from pharmacy to nuclear medicine.

National training records will create efficiency, as would national guidance around arrangements for staff who move and a position on secondments. Recruitment is impacted by the cost of living and lack of affordable housing. More key worker housing schemes, affordable rent and subsidised travel would help. We need terms and conditions that help us retain staff.

Guidance should recognise inflation across our system, requiring ICBs to give the same uplift to primary care as to Trusts without additional negotiations, increasing efficiency. National guidance around indemnity and insurance would support rapid progress. National Insurance increases will impact provider costs. Contracts for additional roles need to cover appropriate management and supervision of physician's associates and social prescribing link workers. Providers subsidising these roles hinders sustainability.

IT systems that support our ambitions

Our IT platforms must be staff and patient friendly and support the flow of information so that patients don't need to keep retelling their stories. Analytics need to support continuous improvement of processes and policies drawing on both data and patient perspectives. This needs to be supported nationally to reduce the current postcode lottery exacerbating health inequalities.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Developing the neighbourhood model

We need to support general practice and ensure it remains attractive. Pro-active, multi-disciplinary working should be the default approach, particularly for 'high risk and complex' population cohorts. Physical and mental health and well-being must be assessed and addressed together. Resources should be pooled, integrated and increased. Staff must be enabled to spend a greater proportion of time on proactive care and operational integration and have access to multi-disciplinary support at neighbourhood level as they would in a hospital setting. Job descriptions, terms and conditions need to reflect these new ways of working.

NCL examples:

- Multi-disciplinary virtual wards in NCL have helped 20,000 people receive care at home, thanks to robust assessments, improving hospital bed capacity.
- Our Silver Triage initiative helps avoid unnecessary admissions for residents experiencing frailty. 16% of those assessed were conveyed in the last reporting period, compared to 71% before the project started and 100% of paramedics would use the system again.
- The NCL Interface Group has enabled us to support more people with prostate cancer earlier and at home.

Community mental health centres must look and feel like positive, open, and supportive spaces that are inviting to the public.

NCL aspires to support more people to live more years in good health and to experience a dignified death. We want to ensure that residents can talk about death in a supportive caring way to support dying at home, including care homes and hospices. We need strong palliative

care with support for families, informal carers and neighbourhood-based colleagues to offer appropriate support at home. This must include access to appropriate pain management and funding for respite. Currently too many NCL residents have to make frequent A&E visits in their final months of life.

Financial mechanisms that develop primary care estate

Within NCL we gathered evidence which demonstrated higher levels of emergency attendance from practices with lower quality estate, lower numbers of salaried GPs and lower levels of GP training. In the last two financial years, we have invested five percent of our capital allocation directly to addressing the quality of the primary care estate. These improvements, designed with residents, have enhanced space, access, and patient and staff experience. The new, purpose-built Welbourne Centre, was opened by Rt Hon David Lammy MP this month.

We've placed key NCL Community Diagnostic Centres in locations such as shopping centres, increasing access and reducing waiting times. However, additional investment and innovative financing models are needed, beyond what we can achieve through prioritisation.

We would like to see greater long-term planning and financial stability provided by NHSE and the DHSC, and a new approach to planning capital requirements of large schemes for service reconfiguration. We want to avoid sticking with the current system of Capital Development Expenditure Limit (CDEL). Financial frameworks for estates must incentivise Trusts to hold leases for shared and flexible spaces.

Ensuring high quality provision as we move care out of hospitals will require increased funding to primary care, before secondary care spending can be reduced, as benefits will take time to realise. Local care estate must be a priority, and we recommend ICSs are required to rapidly increase the share of capital going to general practice and wider community-based estate. We need IT infrastructure that supports this transition, and we must ensure support is available to staff in those settings.

Clarity and accountability are needed

The 10-Year Plan must provide a clear vision for the neighbourhood model to be adopted and require ICS partners to collectively consider the wider estate. Partners could be required to collaborate on producing a system infrastructure strategy, system-owned plans around capital investment and system estates plans with national level accountability.

Trust Boards are developing their understanding of place and neighbourhood, this needs to be consistent. It's important for larger providers crossing ICS borders to understand the local service landscape, national guidance is needed. Trust Boards could be required to develop strategic estates plans, clarifying opportunities and gaps around integrating delivery, data and digital capabilities. This could form part of the application for Foundation Trust status.

Borough partnership's role in delivery should be clarified. Chairing the partnership should be a recognised role with a competency and behaviours framework that recognises system leadership skills.

The January 2024 change in scrutiny arrangements, moving the power to call in decisions to the Secretary of State, could stall large scale changes. A materiality test could help ensure that only specific decisions face a possible call in to minimise the risk of wasted resource.

Specific accountability for the interface between partners is needed

The gaps in care created by the poor interface between primary and secondary care is a patient safety issue impacting our ability to move care closer to home and intervene early. This is exacerbated by IT that impedes data sharing and consistent recording.

We would welcome more specific national requirements on system partners to ensure smooth inter-organisational interfaces. Financial levers that incentivise more effective collaborations and create clearer accountability would increase efficiency, reduce risk and provide better patient experience.

Patients with long term conditions experience fragmented and inefficient care. The NCL Health Alliance Complex Long Term Conditions Service is identifying patients who have the highest outpatient contacts to support them holistically. Our work shows clinicians and coordinators need better access to individual patient records. Carer support is critical but rarely sufficient.

Working with Social Care and VCSE

A key enabler of community-based care is a diverse range of accessible, community-based social care and voluntary sector services to support people outside of hospitals. Councils are under huge financial pressure. Rising costs of care, high rents, and limited and low-quality placements limit our system's ability to support people outside of hospital at all life stages including end of life.

We need affordable, high-quality, proactive care provision that matches levels of acuity. Councils need support to meet increasing demand for Special Educational Needs support (SEND) and SEND transport. We need better housing provision. Patients with mental health needs are most likely to be re-admitted because of issues with poor housing impacting their health.

There are not enough care home beds or good homes available. Nursing and care homes, often run by the private sector, may choose to only support people with less complex needs, leading to higher levels of need in council provided placements.

The 10-Year Plan must require greater alignment across systems. We need a national care service with national standards and pooled budgets for collaboration. It must require social care partners to respond more quickly to discharge those who are medically fit to minimise deconditioning. The plan must recognise the social care and VCSE workforce and unpaid carers as key to moving people out of hospital, maintaining people's independence and enabling prevention. The plan must enable improved provision of individualised care packages for those with complex needs, who are frail, and *particularly* for children. Maternity pathways must be multi-disciplinary to support physical and mental well-being and the impact of poverty and other barriers.

We need a greater commitment to building services around children and young people at home, in school and college. Children wait longer for elective care, have to miss school for appointments, thus falling behind peers post-recovery, and are more likely to experience loneliness with potential life-long impacts.

We need to clearly outline the roles VCSE organisations should be developing to support delivery of neighbourhood health. Centrally allocated budgets must provide greater

assurance and longevity of funding and must account for rising costs like elsewhere in the system. Short-term, delayed allocations create uncertainty. This increases staff and volunteer turnover, impacting delivery. The National Council for Voluntary Organisations 2024 report '*The True Cost of Delivering Public Services'* highlights many VCSE having to subsidise statutory contracts.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

We need a clear and consistent vision and delivery plan for digital. The vision must enable us to learn from NHS partners leading the way. Software and governance must enable information to flow across departments and systems and be user-friendly for staff and patients. We need connectivity that enables efficiency with minimal environmental impact.

Varied Digital Maturity

The national Digital Maturity Assessment highlights progress but significant variation, across NCL. World-class hospitals in NCL mean access to cutting-edge technology and opportunities to pilot artificial intelligence for use behind the scenes and with patients. A pilot scheme using WhatsApp AI to schedule cervical screening appointments is being rolled out across NCL to address low uptake. It allows patients to book, reschedule and cancel appointments via WhatsApp at any time, interacting as with a human receptionist. Early feedback is positive. Learning from this pilot could inform other services.

NCL's Demand Smoothing Programme is an algorithmic model developed to enable acute providers to direct patients to services with more capacity at the outset of their journey. It's resulting in better journeys and experience.

NCL Cancer Alliance's SUMMIT study (for lung cancer screening) began in 2019. Now governance issues are resolved from 2025 it will transition to a national screening programme.

Interoperability

Inefficiencies and poor patient-experience are created by platforms' interoperability through information not being shared and gaps in medical records.

Mental Health Core Teams use Rio software whilst GP and VCSE partners use EMIS. Interface issues mean not all patient data flows across systems. This undermines our ambition for residents to not have to repeat their stories and to be provided with reasonable adjustments where needed.

Platforms that are designed once, nationally, with local input, and that everyone adopts, would increase efficiency and benefit less digitally confident users.

Consistent governance and data sharing approaches

We need to create greater confidence and consistency around information governance and information sharing. Currently, different parts of our system take different stances. Facilitating consistent governance approaches nationally, and tools to support this such as risk management software, would increase efficiency.

IT strategies should be cross-organisational, using hardware and software that support integrated operating models and effective patient journeys. Analytic capacity should be weighted towards the triangulation of clinical data with socio-economic data, rather than sector-based activity, to support population health management. ICBs have less access to population health data than CCGs did, making targeting work harder.

London-wide deliberation events for the London Health Data Strategy highlight public support for some data sharing, and the need for a clear narrative and ongoing dialogue about the benefits to develop new treatments and help people stay well. Ongoing dialogue is building trust.

The current Data Protection and Digital Information Bill could have gone further by making GPs joint data controllers with NHSE thus making personal health records more useful.

Patient-facing information

Across the system, we need a stronger focus on getting the basics right. Delayed and unclear patient letters and texts can be contradictory, causing confusion, missed appointments and poor patient experience.

Providers need guidance to create consistent, user-friendly, accessible text messaging and patient letters. We need nationally developed patient and carer tested and accessible information standard (AIS) compliant templates with AI assistance to aid completion, to ensure consistent, user-friendly, accessible patient communication.

NHS IT systems across all areas of care need to be more user-friendly for staff and patients, with IT providers proactively supporting greater inter-operability with competitors' software and enabling us to meet the recording requirements of the AIS. IT must optimise the time staff can spend with patients.

While some patients find the NHS App a helpful timesaver for repeat prescriptions and accessing test results, others state that GP appointments are rarely available this way, or that online functions are 'closed' due to high demand. The app has the potential to offer primary care consultations with general practice and pharmacy. Only 56% of NCL residents have downloaded the app, despite several promotional campaigns. Providers use tools inconsistently and need better tools to enable practices to manage demand.

Our data doesn't tell us the number of people using the app, only the number of uses. Tools should be designed *with* less digitally literate residents and be easy to use from smartphones (for those without laptops), and for those without smartphones. Apps should have clear up-to-date instructions in a range of languages and for different operating systems.

The Long-Term Plan requires services to provide an online offer. To guarantee equitable access for digitally excluded residents, we must ensure access to an off-line offer. All materials, on and offline, need to be clearly written. Some residents distrust online tools and artificial intelligence in general. The VCSE could support education and inclusion, with funding.

Beyond the NHS

For patients living in areas with lower connectivity, an infrastructure solution is needed that's beyond the remit of healthcare. Parts of our wider system are so poorly connected, it's easier to rely on pen and paper.

Beyond the NHS we need greater legislation to protect residents from harms, whether scams for the less digitally literate or social media restrictions for young people or those vulnerable to misinformation, exploitation and abuse.

Increasing digital capability would bring real benefits for staff and patients, however, consideration must be given to the impact on our net zero ambitions. Digital and artificial intelligence already contribute significantly to global carbon emissions and this is set to rise dramatically.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

To tackle the wider determinants impacting local health outcomes we need clearer accountability and shared performance indicators that encourage joint working at local level. Plans must ensure that unregistered populations are not forgotten.

Playing to our strengths

The role of the NHS in the delivery of prevention and early intervention needs to be formally acknowledged. Local and national public health campaigns must be informed by experiences and insights from ICBs and primary care and use a disease prevention and behavioural sciences approach.

In October 2024, Camden launched its first Integrated Neighbourhood Team (INT), bringing together staff from Central North West London Trust and the council to support adults with health and care needs. Working from a shared office health, social care, mental health services, and voluntary sector professionals work as one team, simplifying access for residents.

NCL Cancer Alliance has supported the system to massively increase its survival rates and would welcome a longer-term commitment to Alliances and multi-year funding to enable more strategic investment.

Access to high quality primary care

High quality, easily accessible primary care is key to prevention, early treatment, improved quality of life, and reduced pressure on the NHS, yet only 9% of national spend is allocated to primary care despite the growth in list sizes and demand.

Despite increasing numbers of appointments being offered patients still report issues with access. Appointments and processes don't always give patients and staff sufficient time for holistic diagnosis.

NCL's 'Your Local Health Team' campaign is supporting residents to access appropriate care. Residents are positive about Pharmacy First. However, reduced spending has led to pharmacy closures and too few resources where most needed. The Plan must support a thriving pharmacy and opthalmology offer. Inconsistencies in offerings, and access routes make this unnecessarily difficult to communicate to patients. There is no centralised patient-

facing information on the pharmacy offer. Our VCSE partners are vital in ensuring messaging reach excluded residents.

Wider determinants

Tackling the wider determinants will require a shared commitment from system and national partners.

In NCL we are excited to be part of the WorkWell programme, supporting people with health needs or disabilities to start a new job, to stay in their current role or to return to work. It is too early to see results, but system partners have worked together at pace and are confident we can share learning soon.

For those with a disability-related communication need or English as a second language we need better systems for recording, flagging and addressing needs as patients move through our systems. We need a consistent approach to offering interpreting, and to recognise that for some, face-to-face appointments can make communication clearer.

NCL Inequalities Fund

Our NCL Inequalities Fund enables us to track outcomes of our early intervention work with excluded residents. Resident feedback shows people value social prescribing, peer support and information in community languages.

The fund allocates £5million annually through VCSE partners. Examples include:

- Barnet's Peer Support for cardio-vascular disease prevention and management targeted adults, particularly those from South Asian, African, or Caribbean heritage and led to a 13% reduction in hospital admissions.
- Islington's Family Health project reached 200 families in the most deprived wards to raise awareness of the importance of vaccinations, and how to access them.
- An NCL-wide Heart Health project recruited 19 Community Connectors, speaking 8 local languages to talk to residents about the impact of high blood pressure, and the influence of lifestyle factors, reaching over 2,000 residents to date.

Financial incentives

The Mental Health Investment Standard has enabled us to move resources to mental health provision. These levers, new levers, or changes to existing levers could help do this with prevention services.

Reduced public health budgets impact on prevention. A decade ago, Islington funded health checks from age 35 as many local people acquire conditions younger than the England average, but funding had to be reduced. Residents feel better signposting and support to manage their conditions would improve checks.

NCL's new Check and Test approach offers proactive, holistic, person-centred support to residents with long-term conditions using a year of care model. Communications have been tested with diverse local audiences with lived experience. Targeted risk-based approaches work for finding people with Long-Term Conditions and are being used for targeting communities in conversations about cancer.

Community-led approaches, supported and enabled through co-ordinated public sector action, can successfully mobilise individual and shared assets and deliver better outcomes than working separately. NCL's Good Neighbours Scheme reaches residents in Islington and Haringey experiencing poverty, isolation and housing issues. It reaches hundreds of residents, with 84% becoming more active, 81% feeling more connected and 56% taking up volunteering. Short-term funding cycles and limited funding impact our ability to scale up successful projects.

Our voluntary sector is experiencing increased demand, and complexity of need, greater competition for funding, a lack of funding to cover costs and for much-needed general advice services. This impacts our system's ability to intervene at the earliest opportunity.

National recognition of the financial constraints our residents are experiencing does help. The Care Leavers Prescription Scheme is a useful tool, though inconsistent IT systems make it hard to demonstrate impact so far and to share data, with data sometimes duplicated or missed. Reporting is sometimes time-consuming because manual searches need to be run where data requests from NHS England are more specific than our recording tools allow. It would be more cost effective if NHSE liaised nationally with IT providers and in a timely way.

There are moves across England to recognise the needs of care experienced people, but the lack of statutory duty means we can't identify them on our systems unless they allow us to. This makes it harder to give them the services they need and means we're only staffed to meet the needs until age 18. Evidence gathered from a local review shows we could protect these young adults better by supporting them to 25. Islington has employed a specialist nurse for care leavers who are 16+ to support them through this time of transition.

Research partnerships

Academic, clinical partnerships across life sciences are significant for NCL. We need greater permissions and flexibility regarding land use and work with SMEs and universities to enable roll out of inventions that benefit health. The National Health Research Institute is funding a NCL Research Engagement Network, and Islington-focussed Health Determinants Research Collaboration. These create opportunities to develop our evidence base for planning, commissioning and measuring progress against our Population Health Strategy. They are engaging residents from the start. Opportunities to use this learning to inform the national direction, will help maximise the benefits.

NCL performs well on flu and Covid vaccine uptake in care homes, and we're using our health inequalities fund to engage specific communities and residents in wards where uptake is lowest to help increase vaccines uptake for both children and adults.

Dentistry provision in NCL is at 90% capacity for NHS appointments. Short term we need funding for greater capacity. Longer term we need a review of the national dental contract. The current contract is treatment based and doesn't reward prevention. What we commission locally is not scalable. NCL's aim to move dental care for children out of hospital is compromised by hospital referrals from outside of London, where specialist provision is often limited.

The NHS needs to look more deeply at behavioural science and how it can help us address demand and complexity across physical and mental health and wider determinants. If we're

serious about preventing ill health, we need to see greater regulation of issues causing harm including; housing, cost of living, substance abuse, domestic violence and social media.

Q5. Please share specific policy ideas for change, including how you would prioritise these and what timeframe you would expect to see this delivered in.

We are working with local and regional partners to test, learn and share so that local developments are evidence-led.

We would like the 10-Year Plan support progress and innovation in the following ways:

Short term

1. Build on the multi-disciplinary neighbourhood model to support people closer to home across the life stages.
2. Ensure that planning guidance and financial allocation is timely and longer term, to reduce the risk of destabilising provision, from VCSE to transformational projects such as IT.
3. Create specific guidance for ICBs and providers to clarify roles and responsibilities in relation to complaints and public health remit, and to strengthen collective responsibilities for estates and interfaces within resident pathways.
4. Create a clear, national vision for digital with longer-term funding that maximises interoperability and provides national guidance on data sharing to reduce inefficiencies and inconsistencies.

Medium term

5. DHSC to consider developing and mandating a 'Local Care Investment Standard' focused on community-based care and prevention which replicates and sits alongside the 'Mental Health Investment Standard'. This must include pharmacy, ophthalmology and dentistry. It will help ensure resources are shifted to more proactive care models and incentivise acute trusts to integrate their resources upstream to prevent ill-health, keep people out of hospital and ensure a smooth transition of patients along pathways.
6. Increase resource to support dental activity in those areas already at capacity.
7. NHSE to require an approach to managing service interface that's based on the patient safety approach, with a duty upon organisations to review and audit patient/carer transitions across the interfaces between services as well as across departments within larger organisations. Audits would look at quality, safety, risks, efficiency and patient/ carer/ service user experience.
8. Explore opportunities to create more flexible working for our staff, and work with Royal Colleges to ensure the curriculum for our future workforce reflects the digital and non-medical skills needed.
9. Be more explicit about how the NHS will provide a service for all children and young people 0-25 with transition to adult service decisions based on need rather than age.
10. Develop a materiality test to determine the appropriate level of oversight for service change, to mitigate the risk of wasted resources if a decision is called in.
11. Align performance targets and timeframes across sectors.
12. Place greater responsibility on Trusts to demonstrate a contribution to collective estates planning and include this in the Foundation Trust application process.

Long term

13. Wider policy to focus on population health and well-being to reduce ill health and for the NHS to be supported to better understand and apply behavioural sciences. Enable ICBs to determine local and national research priorities.
14. Enable ICBs to maximise the benefits of working with academic and clinical research partners to accelerate the roll out of treatments, and approaches.