North Central London
Health and Care
Integrated Care System

NHS

Improving Population Health in North Central London

Our mission to improve the health and wellbeing of residents in Barnet, Camden, Enfield, Haringey, and Islington.

nclhealthandcare.org.uk

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Who we are

North Central London Health and Care
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North Central London Integrated Care System (NCL ICS)

The North Central London Integrated Care System is a partnership of organisations that delivers health and care services across our five boroughs: Barnet, Camden, Enfield, Haringey and Islington.

It is made up of the NHS, local councils, and voluntary sector organisations, working together to improve the lives of residents in North Central London.

One of the 42 ICSs covering all of England, the NCL ICS was legally established on 1 July 2022 to:

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

As well as five local councils and 10 NHS Trusts, North Central London includes approximately 180 GP surgeries, 300 pharmacies, 200 care homes and many voluntary, community and social enterprise services providing essential care.

We are also home to internationally recognised centres of medical excellence and expertise, specialist NHS providers, and a number of renowned academic and research institutions.

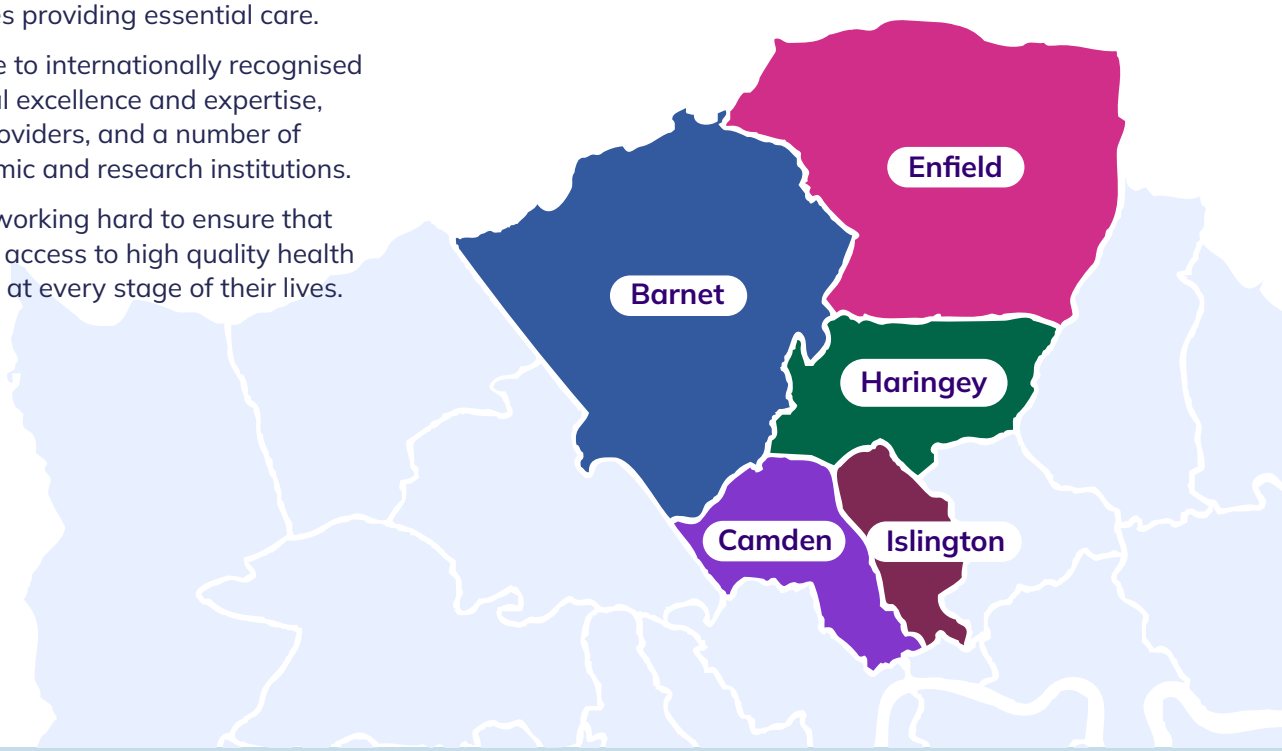
Together we are working hard to ensure that everyone has fair access to high quality health and care services at every stage of their lives.

North Central London Integrated Care Board (NCL ICB)

We are the NHS statutory organisation that plans, coordinates and commissions activity across the North Central London ICS. This means we decide how the NHS budget in our area is spent.

We join up health and care services and work in partnership with local councils, the voluntary and community sector and local NHS providers to achieve value for money.

Our mission is to improve the health, care and wellbeing of residents across our five boroughs and to tackle inequalities in access, experience and outcomes.

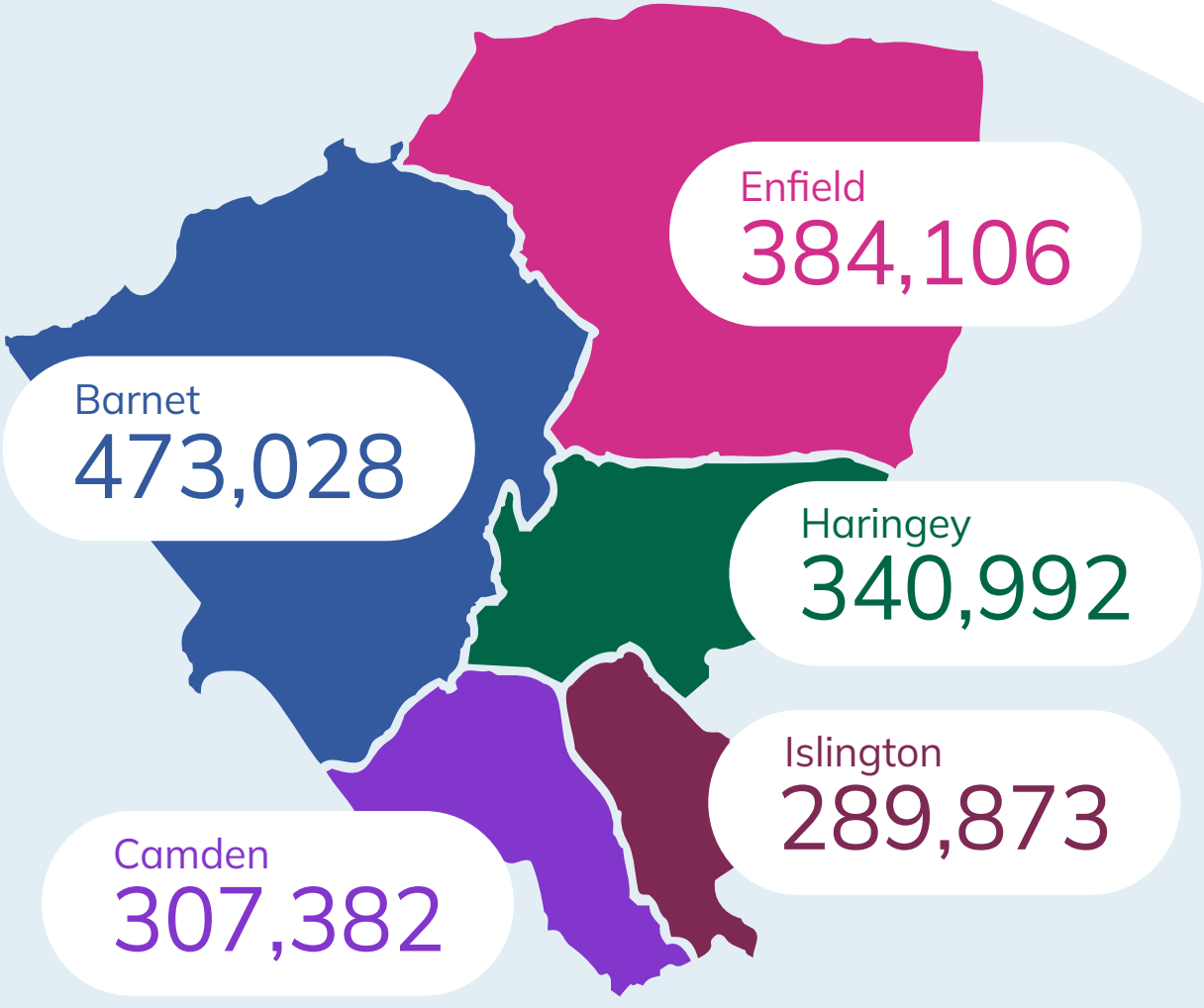


Our population

Population at a glance

North Central London (NCL) has a relatively young population of around 1.8m people and a similar number registered with our GPs.

There is constant turnover of residents in North Central London as people move in and out of boroughs. Some of the people that we provide services for work, study, or visit NCL but do not live in our boroughs. A significant portion of our residents remain unregistered, including those from 'inclusion health groups' (for example, people experiencing homelessness, refugees and asylum seekers and sex workers).



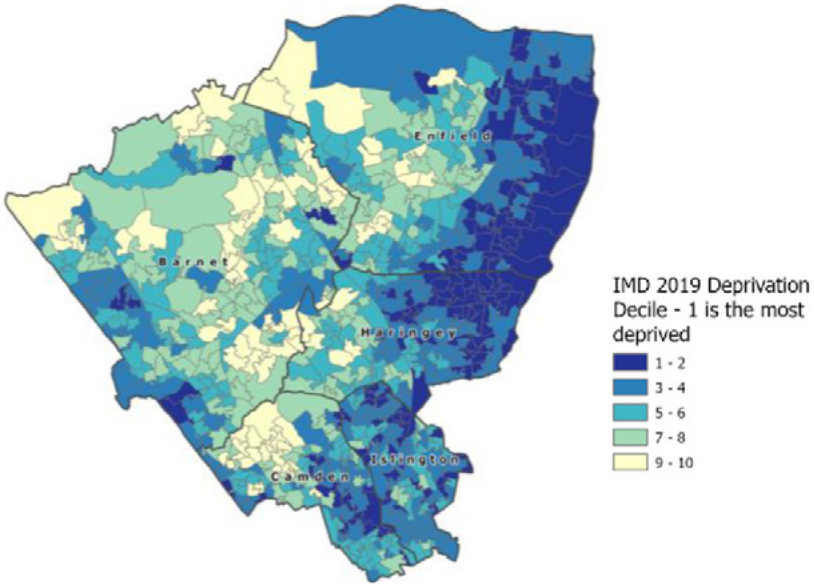
Deprivation

North Central London is the second most deprived ICS in London, with areas of deprivation across all five boroughs that are often in close proximity to areas of affluence.

More than half of the population lives in the 40% most deprived areas nationally, and more than one in 10 households across NCL are in fuel poverty, rising to over 15% in Haringey.

There are also distinct patterns of deprivation with particular concentrations towards the east of NCL, with Enfield, Haringey and Islington having on average higher levels of deprivation.

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



Source: Index of Multiple Deprivation (IMD 2019)

Diversity

Our population is ethnically diverse.

Barnet and Camden have larger Asian communities, making up nearly 20% of the population in those boroughs.

Haringey and Enfield have a similar proportion of black residents.

Across North Central London, one in five residents come from non-British white backgrounds.

Within each of these groups, there are health and demographic variations.

What is population health?

Working with our residents, patients, and partners, we have developed an ambitious Population Health and Integrated Care Strategy which reflects a significant change in our approach to the health and care system.

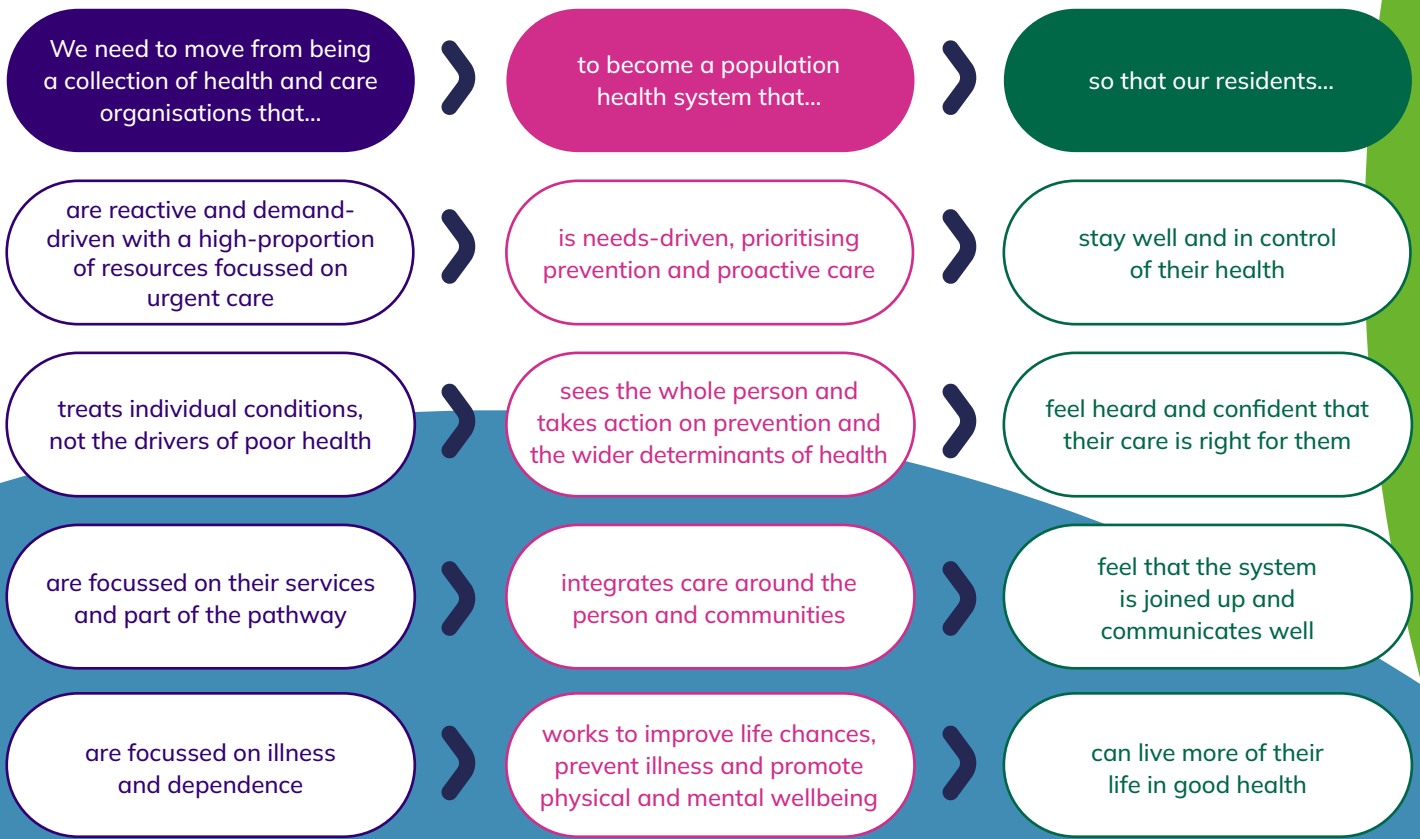
The strategy aims to:

Reduce health inequalities – working together to identify unmet needs across our different communities and address them with services and support that are accessible and inclusive.

Focus on prevention, early intervention, and proactive care – empowering people to stay healthy and acting early when people are at risk of becoming unwell.

Work together as a system – making sure that our services, people, data and wider resources are joined up and that actions are taken based on what our residents are telling us. We want to build on the great work that is already happening in pockets of North Central London and work together to tackle the wider causes of avoidable poor health (including inadequate housing or environmental issues).

The diagram below illustrates how we want the system in North Central London to change.



Each of our five boroughs have distinct populations and different challenges and inequalities that we must address, for instance:

Barnet

Barnet has the highest proportion of people over 65 of the NCL boroughs, making up more than 13% of its population. The borough has higher rates of emergency admissions of people aged 65 and over compared with the London average.

Camden

Camden has the lowest uptake of cancer screening across the NCL boroughs. Camden also has a higher rate of hospital admissions for alcohol-related reasons compared with the London average.

Enfield

More than four in 10 pupils in Year 6 are overweight or obese, much higher than the London average. There is also a high level of GP-diagnosed diabetes in the borough (8.8%) compared with the London average (7%).

Haringey

Haringey has the highest GP-recorded smoking prevalence in NCL at 18.7%. Just over two thirds (68.8%) of people with diagnosed high blood pressure had a blood pressure reading below the target threshold for their age, at their last reading. This is well below the national target of 80%.

Islington

Islington has a higher incidence of depression in those aged 18 or over compared with the London average and a higher rate of premature mortality in adults with severe mental illness.

Delivering our population health and integrated care strategy

Our residents are at the heart of what we do. We want to make sure they're able to play an active role in their own health and wellbeing, working together to manage health problems early on, or better still, prevent them from happening at all.

We also need to look at the bigger picture, focussing on the environments, habits and situations that can gradually affect people's health. By working with residents and other partners from across the system, we want to tackle some of the root causes of ill health, from air quality and employment, to financial hardship and social connections.

Together, we're determined to tackle the inequalities that we know affect so many of our residents, helping more people to live longer, healthier lives.

Transforming our approach

By putting people and improving population health outcomes at the centre of how we work, we hope to build the foundations to create better health outcomes for our local residents not just in the short term, but for generations to come.

To achieve the objectives set out in our Population Health and Integrated Care Strategy, we must have a clear plan that brings together the health, care, and voluntary sector in North Central London.

Some things will take time to progress, but there are many things we want change more quickly. Our Delivery Plan sets out some of our priorities and the changes we want to put in place in the next 18 months.

Setting Targets and Measuring our Progress

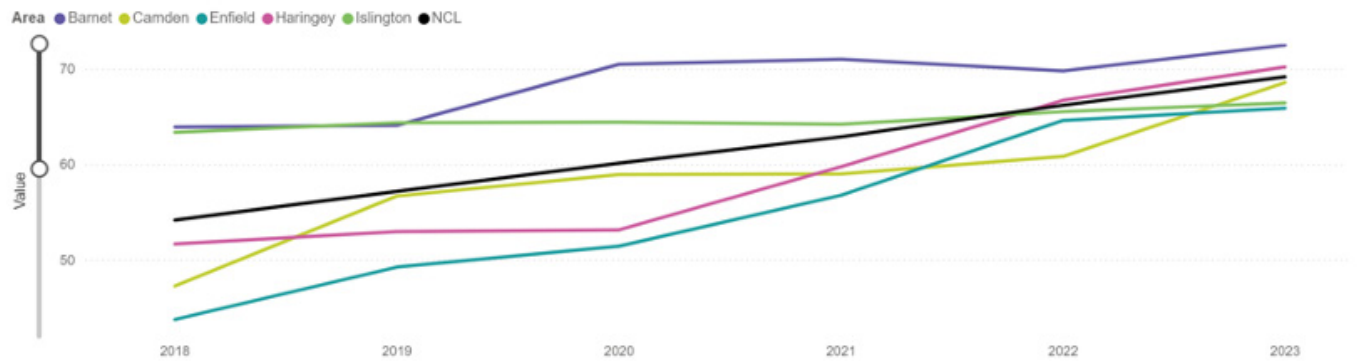
To make sure we stay on track, we have developed an NCL Outcomes Framework with indicators to monitor how we are doing at supporting our population to achieve key health outcomes and the delivery of our strategy over the long term.

This framework is publicly accessible and contains detailed population health data at system level (NCL) and borough level.

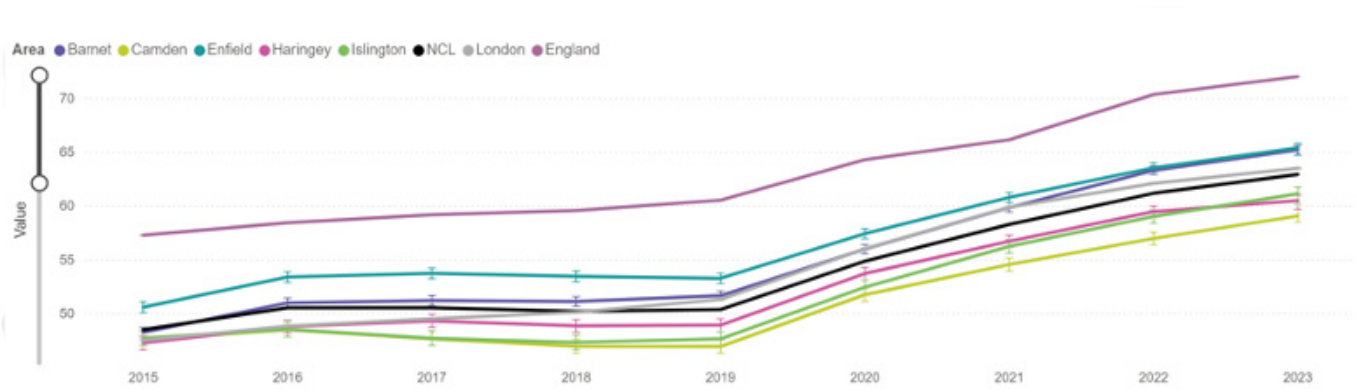
We will produce annual insight reports that set out the key data changes, successes, and emerging challenges that impact our residents in North Central London.

By working together, we want to support people at every stage of their lives. We've separated the outcomes we want for our population plans into three key themes: ***Start Well***, ***Live Well***, and ***Age Well***.

Percentage of children fully vaccinated by age 5



Percentage of target population screened for bowel cancer



Visit the interactive dashboard tool here

Start Well

Start Well covers the early years of life from pregnancy, birth, early childhood, and school years to young adulthood.

Our ambition	Through our work we will:
We want every child to have the best start in life with no child left behind	❯ Improve maternal health and reduce inequalities in perinatal health outcomes (from pregnancy until age 1) ❯ Reduce inequalities in infant mortality ❯ Increase immunisation and newborn screening coverage ❯ Ensure all children are supported to have good speech, language and communication skills ❯ Improve oral health for children
We want all children and young people to be supported to have good mental and physical health	❯ Ensure early identification and proactive support for mental health conditions ❯ Reduce the number of children and young people who are overweight or obese ❯ Deliver improved outcomes for children with long term conditions
We want young people and their families to be supported in their transition to adult services	❯ Ensure all young people and their families have a good experience of their transition to adult health and care services

Read more about our priorities for the next 18 months for Live Well in our Delivery Plan

Live Well

Live Well covers most of adulthood, from leaving school to approximately 65 years old.

Our ambition	Through our work we will:
We want to ensure early identification and improved care for people with mental health conditions	❯ Reduce racial and social inequalities in mental health ❯ Improve physical health in people with serious mental health conditions ❯ Reduce deaths by suicide
We want to see fewer early deaths from cancer, cardiovascular disease and respiratory disease	❯ Reduce prevalence of key risk factors, including smoking, alcohol, obesity and physical activity ❯ Improve air quality ❯ Ensure early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease
We want to reduce the impacts of wider social, economic and environmental factors on people's health and wellbeing	❯ Reduce unemployment and increase the number of people working in fulfilling employment ❯ Ensure people live in stable and healthy accommodation and are safer within the communities they live in

Read more about our priorities for the next 18 months for Live Well in our Delivery Plan

Age Well

Age Well covers later life, from approximately 65 years to end of life.

Our ambition	Through our work we will:
We want people to live as healthy, independent and fulfilling lives as possible as they age	❯ Ensure people get timely, appropriate and integrated care when and where they need it ❯ Prevent development of frailty with as people age ❯ Intervene earlier and improve care for people with dementia
We want everyone to remain connected and thriving in their local communities as they age	❯ Ensure people have meaningful and fulfilling lives as they age ❯ Ensure people are well-informed and can easily access support for managing financial hardship (including fuel poverty) as they age

Read more about our priorities for the next 18 months for Age Well in our Delivery Plan

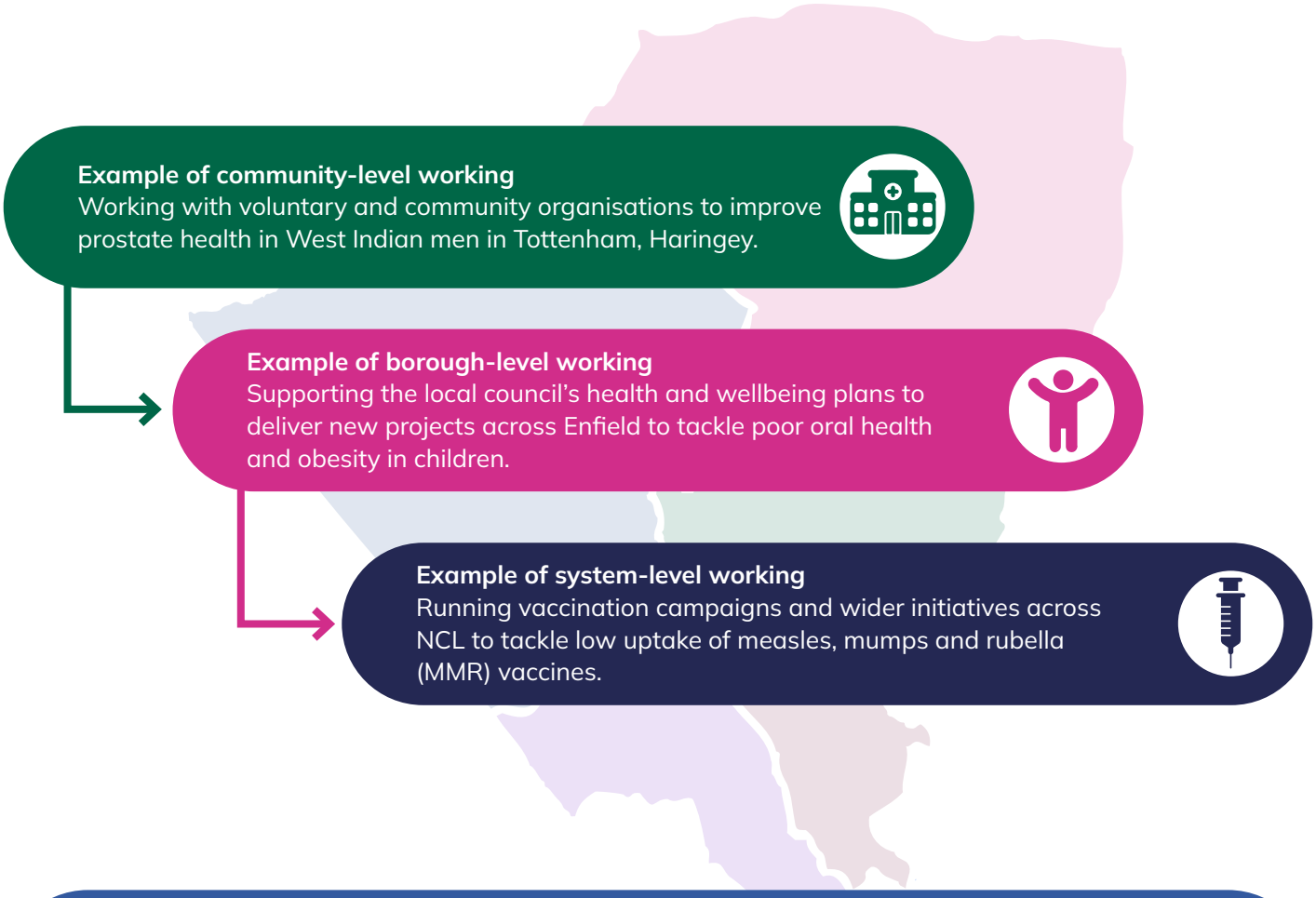
System partners working together at every level

We know the diverse nature of our population, and we understand that different boroughs have different needs.

Within each borough, there are also people, communities and groups who face particular challenges or barriers. It's vital that we engage with residents and stakeholders at all levels and adapt our services so that we can have the greatest impact for our communities.

By working together, we want to ensure that across North Central London we have put in place the right tools and systems to reach and support the greatest number of people, maximise efficiencies, and deliver value for money.

We will work at a system, borough, neighbourhood and community level, collaborating across the Integrated Care System to achieve our objectives.



There are five Borough Partnerships who deliver our strategy in each borough. The next steps for each of the Borough Partnerships include:

- Setting local programmes of work in each borough aligned with our Delivery Plan.
- Driving systematic cross-borough learning.
- Aligning resource to focus on priority areas.

Case study: driving sustainable changes for heart health in NCL

As a system focussed on improving population health, we must work together to tackle some of North Central London's biggest challenges – ones that no individual organisation or sector could resolve on its own.

One of the biggest health risks set out in our Population Health & Integrated Care Strategy is heart health, specifically high blood pressure (hypertension).

High blood pressure is the top 'modifiable' risk factor for premature death due to cardiovascular diseases, ahead of poor diet, obesity, high cholesterol, high blood sugar and smoking.

The following pages set out why heart health is a priority for the NCL ICS and details some of the ways we are working as a system to tackle this health risk.

Why heart health is a priority

27% all UK deaths are due to cardiovascular diseases. (e.g. coronary heart disease). It is also one of the most common causes of premature mortality – deaths under the age of 75.

Nearly one in four deaths under 75 years in NCL are avoidable, i.e. from causes that could have been prevented or treated.

21% of preventable deaths and 39% treatable deaths from 1 January 2016 to 31 December 2020 were due to cardiovascular diseases.

Heart disease and stroke account for just over 20% of the gap in life expectancy between those living in the most and least deprived areas.

Premature death from cardiovascular diseases is almost twice as high in the most deprived 10% of the population compared to the least deprived 10% (national data).

Working at system level

Managing long term conditions:
Around 430,000 people in NCL live with one or more long-term conditions (LTC). Those experiencing inequalities are more likely to develop LTCs earlier in life. We are taking a proactive approach with all GP practices across NCL implementing a new evidence-based model of care building on the Year of Care methodology and co-designed with patients and community groups.

This more personalised care will help people manage their conditions effectively, improve their quality of life, and prevent health issues escalating wherever possible. The model also seeks to proactively identify people at risk of developing LTCs, with earlier detection and diagnosis. Finally, it is enabling closer working between GPs and voluntary, community, and hospital services to reduce pressure on the system.

Pharmacies:
Most pharmacies in North Central London now offer free blood pressure checks and personalised advice for patients. Anyone over 40 without an existing diagnosis of high blood pressure can walk in for this service, and all adults regardless of age or diagnosis can be referred to the pharmacy by their practice. Depending on the blood pressure reading, pharmacists may give advice to support healthy living, offer a 24hr blood pressure monitor to wear and return the next day, or, if necessary, may advise to see a GP for a follow up appointment.

Using data to improve detection and care:
Data saves lives by improving clinical care, planning, service design, and research. We have been early adopters of better data integration, securely linking health data from different healthcare providers, giving a more complete picture of the needs of individuals and groups and enabling more proactive care. For instance, looking at blood pressure measurements alongside other data helps GP practices identify health and care needs as well as inequalities for groups of patients and refer them on to the right programmes. These insights enable more targeted service provision for those with, or at risk of, high blood pressure.

Heart Checks:
The national NHS Health Checks programme (five-yearly checks to assess risk of cardiovascular disease for people aged 40 to 74) is commissioned by local authorities in NCL. With different arrangements in place across each of our boroughs, we are working together as a system in our heart health programme to share learnings and best practice to optimise our reach, particularly from communities with the highest risk.

NCL health and wellbeing bus:
A bus that supports the health and wellbeing of care home workers. This bus travels to different care homes and provides health checks (including blood pressure checks) for the workforce who may not otherwise have time to visit the GP or prioritise their own health and wellbeing.

Working at borough level

Community research and support programme:
Led by Healthwatch Islington, this programme partnered with the Diverse Communities Health Voices Partnership (DCHVP) to focus on research on long-term conditions (LTCs) linked to early intervention and physical activity, including high blood pressure and diabetes.

This work aimed to gain greater understanding of how best to support residents with LTCs and the local perception of physical activity and cultural barriers to it.

Camden mobile health bus:
A community outreach programme designed to detect risk factors for Type 2 Diabetes (which can increase the risk of heart disease and stroke). Targeting those aged 30 to 70 years old in Camden, the bus provides education, signposting, and referrals to services to help prevent progression to diabetes. Since the start of the project, over 2,500 patients have used the service across over 50 locations.

Working at community level

Healthy heart peer support project:
This project in Barnet aims to empower residents in the borough with South Asian, African, and Caribbean heritage to better manage their cardiovascular health. The project is based on peer-to-peer support from trusted and reliable staff who understand, and are part of, these communities. The team carry out blood pressure checks, have effective conversations about ways to reduce risks, and signpost participants to local services.

This approach gives communities a voice to address barriers, supports them to reduce health inequalities, and connects them to decision-makers. The programme has so far reached over 1,800 people in Barnet, and Peer Engagement Officers have supported nearly 100 events in community settings.

Case study: Silver Triage

The Silver Triage system enables specialist doctors (geriatricians) to advise and guide ambulance paramedics in assessing older people living in care homes.

The ambulance service accesses the scheme through a single phone number. Paramedics can explain the situation, the patient's background, their initial assessment, and their recommended plan.

The specialist doctor can then add to this and support the ambulance teams with helping make sure the right plan is put into action.

By bringing together different parts of the ICS, the Silver Triage initiative ensures more older people living with frailty receive urgent care in their home rather than in hospitals (which can be particularly distressing to those with dementia).

Changing the way we work

We have identified six ICS "levers for change" which we believe will make our new way of working a long-term success. These levers will underpin our approach, helping us to ensure that as a system we can add real value and accelerate our work to improve health and care for our population.

1. **Making population health everyone's business**

   No single organisation can bring about the positive changes in population health we want to deliver on their own. It's only by working together, with every partner playing their own unique role that we will really start to make measurable progress. That's why we need to make population health everyone's business – ensuring everyone working across the system takes joint responsibility for improving the physical and mental health and wellbeing of our residents.

2. **Strengthening integrated delivery**

   We're all here to support our residents to live long and healthy lives and we need to do that in a joined up way. Through integrated delivery, we want to ensure that there are no barriers between different services, that people's needs are addressed holistically and that care is centred around the individual, with different services working together. There are already brilliant examples of this happening at every level of our system, from neighbourhood to system level. By strengthening our partnership approach, we will build on these positive examples, making sure all our services are people-focused and fit for purpose.

3. Collaborating to tackle the root causes of poor health

We know that for many of our residents, staying healthy and well is made more challenging by their everyday lives. We must also tackle the 'wider determinants of health' like housing, education, employment, social connections and their unequal distribution across the population if we're going to make a difference – these factors can often have a greater influence on health than healthcare, behaviours or genetics. By addressing these determinants and the root causes of poor health, we want to reduce the likelihood of health problems arising in the first place, improve our population's wellbeing, and decrease the demand for healthcare services. We can only achieve this by collaborating with our partners.

4. Aligning resources to need

Our system is facing significant pressures, and our services need to change to ensure they can meet the present and future needs of our population. This means moving more resource towards prevention and early intervention, setting goals and identifying where further changes are needed. Working collaboratively and involving residents is key to informing our decision-making and will allow us to ensure that our collective resources go even further to meet our population needs.

Case study: Homeless Health Inclusion Programme

People experiencing homelessness (PEH) have an average life expectancy 30 years lower than the general population, with a third of deaths identified as preventable. To tackle this issue in NCL, the Islington Health Outreach Team supports the identification and treatment of health needs of PEH in Islington using a combination of engagement, diagnostic tools, health navigation, outreach nursing, and the provision of flexible GP appointments.

NCL clinicians built up relationships and contacts with local teams (including hostels, key and support workers, Islington Council teams and local charities), and engaged or supported nearly 200 people experiencing homelessness.

5. Becoming a learning system

We will work with NCL's world-leading research experts to become a system that is evidence based and evidence-generating.

By ensuring that research, evidence and learning are central to how the Integrated Care System plans and delivers care, we will deliver greater impact and value.

6. Creating 'one workforce'

From nurses to GPs, volunteers to carers, there are approximately 100,000 people working across our system that will bring our ambitions to life. Our NCL ICS People Strategy, describes our plan to create 'One Workforce' across our health and care providers, building a sustainable workforce that truly enables us to focus on population health improvement. This will include reducing the workforce shortage through better planning and mapping of skills, developing meaningful careers and increasing retention rates. We are already embracing new ways of working through technological advancements and by creating new opportunities for residents to join our workforce. This includes working in partnership with local further and higher education providers to deliver our Nursing Associate Apprenticeship and a new T-Level qualification in Health, as well creating a new Care Leaver's programme.

Case study: Care Leavers Programme

The NCL ICS Care Leavers Programme aims to support care experienced young people into meaningful education, employment and training opportunities in health and care. Working with partners such as Islington Council, Drive Forward Foundation, UCLH, Royal Free London, NCL Imaging Network, Primary Care Anchor Network and Health and Social Care academies, we've hosted recruitment and careers events to support young people across North Central London. We have also begun to offer free prescription for care leavers, and will continue to support and work closely with this group going forward.

Oversight on delivery and progress

An important part of the development of the North Central London Integrated Care System (NCL ICS) is establishing appropriate governance.

The Integrated Care System is led by two boards:

1. North Central London ICB Board of Members

NHS North Central London Integrated Care Board (ICB) allocates NHS budget and commissions services.

2. North Central London Health and Care Partnership

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

The NCL ICS also has a Population Health and Inequalities Committee which bridges these two boards.

Find out more

Outcomes Framework:
You can find more data about our population's health by visiting the Outcomes Framework.

Population Health Strategy:
You can download the full North Central London Population Health and Integrated Care Strategy document here.

You can also watch our film on Population Health here.

Our Delivery Plan:
You can download our plan to deliver our Population Health Strategy here.

Borough Health and Wellbeing Strategies:

You can find the Health and Wellbeing Strategies for the five NCL boroughs in the links below:

- Barnet
- Camden
- Enfield
- Haringey
- Islington

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“There is so much need out there and none of us can do it on our own.”

Ruth Glover
Director – Open Door
Adolescent Psychotherapist

Barnet Camden Enfield Haringey Islington