North Central London
Health and Care
Integrated Care System

NHS

Delivering Population Health and Integrated Care Ambitions in Islington

Islington Health and Wellbeing Board

12th November 2024

NCL Population Health & Integrated Care Strategy and Delivery Plan overview

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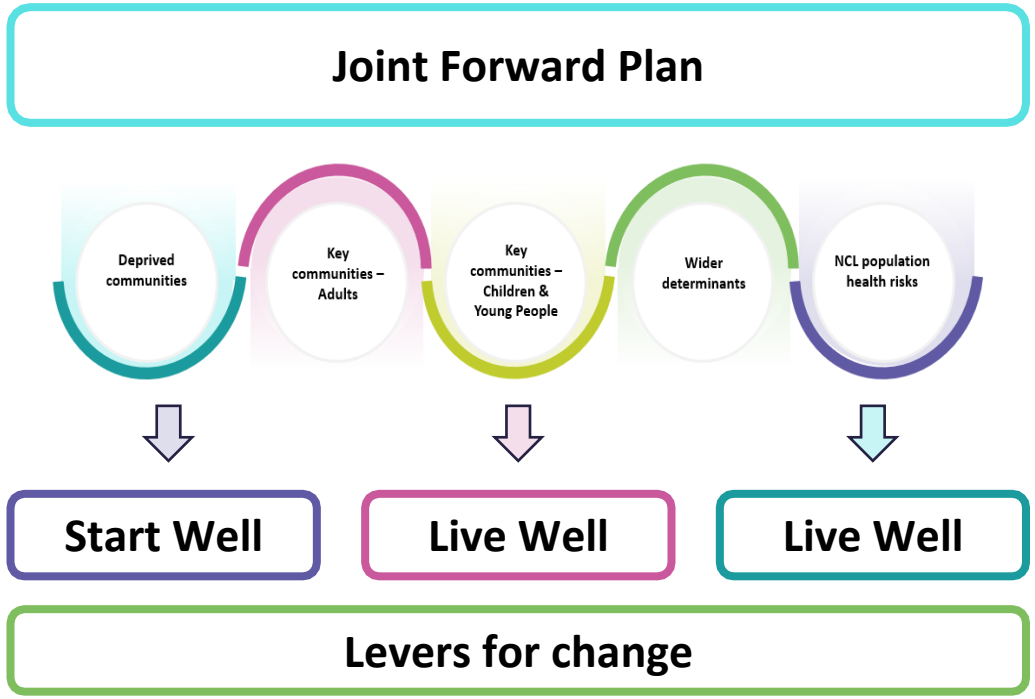
Our NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. The Strategy can be found here. It outlines our ambition to **tackle health inequalities** by a **shared emphasis** on **early intervention, prevention and proactive care**.

Since April 2023, significant socialising and planning work across the ICP has culminated in the development of our **NCL Delivery Plan** (which also serves as our Joint Forward Plan (JFP)), which outlines our critical path to **deliver against our PH & IC Strategy**. The NCL Delivery Plan can be found online here.

The Delivery Plan describes progress in implementing the strategy over the last 12 months, our plans for the coming 18 months and how we will monitor delivery using the NCL Outcomes Framework. The plans are aligned to a life course approach and incorporate:

- NCL communities experiencing the poorest outcomes, wider determinants of poor health and 5 key health risk areas
- NCL system transformation programmes, which are aligned to delivering our population health ambitions
- System levers which will create the conditions for population health improvement
- A number of areas within the plan have been identified by the ICP to **"super-charge"** - making the **best use of the collective weight** of the ICP to **accelerate and deepen impact**.



Work to develop Population Health approach since April 2023

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- **Engaging and socialising** the Delivery Plan with Health & Wellbeing Boards, Trust Boards, Borough Partnerships, forums involving the VCSE and patient representatives. This has culminated in the publishing of resident-focussed content which can be found online here.

- **Developing the NCL Outcomes Framework and launching the online dashboard to support monitoring –** *the dashboard can be found here.* Data in the dashboard are at Borough and NCL level, compared to London and England. There is also an Outcomes Framework annual insights report at NCL and borough level *(Islington content appearing later in the pack).*

- **Understanding and starting to align plans across borough and system** to maximise the impact of our joint working.

- **System Progress on Population Health outcomes** is set out in detail in the Delivery Plan. Improvements include:
  - Mental Health – Longer Lives: The proportion of adults with SMI having a physical health check increased by 44%
  - Improved the uptake of Targeted **Lung Health** Checks from 30% to 55%. Over 20,000 people have now had a lung health check.
  - **Inclusion Health** needs assessment completed which has been identified as an example of good practice in national guidance and over £1m invested in integrated homelessness discharge support post hospital

NCL Outcomes Framework Insights Report 23/24 Summary

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The NCL Outcomes Framework (OF) annual insights report summarised key insights at NCL and borough level from the NCL OF dashboard. The report demonstrates that while we have made **some progress, the five population health risks identified in the PH&IC remain relevant and require ongoing system and borough focus**, and there are also broader areas requiring focus across the life course (Start Well, Live Well and Age Well).

Childhood immunisations
Although there has been notable, steady improvement in the proportion of children who have been fully vaccinated by age five, 31% of children in NCL were not fully vaccinated by the end of 2022/23

Cancer
Despite steady improvement in bowel cancer screening over recent years, overall cancer screening coverage is poor, with all boroughs except Enfield having lower coverage than London in at least one programme in 2023

Mental health and wellbeing
The proportion of adults with SMI having a physical health check increased by 44% from 2020/21 to 2022/23, but we are not achieving our target of 0–18 year olds receiving at least one contact from an NHS-funded mental health service.

Heart health
With 73% of NCL patients with high blood pressure treated to within age-specific target range within the last 12 months, we are falling short of the national target (77% for 2023/24; now 80% for 2024/25)

Lung health
Only 53% of NCL patients with chronic respiratory disease are vaccinated against flu, and only 69% of people aged 65+

Start Well

Poverty - 17% children live in poverty (2021/22 data which is likely to have increased since)
Maternal smoking - More than one in 20 women giving birth in NCL smoke
Newborn hearing screening - NCL boroughs are within the 6 worst performing boroughs in London
Oral health - More than one in four 5-year-olds in NCL have experience of tooth decay
Healthy weight - 38% 11-year-olds are overweight or obese
Communication skills - One in five reception children do not achieve expected communication and language skills
Mental Health - An estimated 1 in 5 11-16 year olds have a mental health disorder. Prevalence estimates for Camden are 33% higher compared to the national average

Live Well

Smoking - More NCL patients aged 15+ years smoke compared to London
Healthy weight - 55% of adults are overweight or obese
Alcohol - Admissions for alcohol-related conditions are higher in three of our boroughs (Islington, Haringey and Enfield) compared to London
Employment - 35% people with a long term physical or mental health condition of working age are not in employment
Diabetes - Only 31% patients with Type 1 diabetes and 43% of patients with Type 2 diabetes in NCL achieved all three treatment targets

Age Well

Loneliness – Only 36% older adult social care users have as much social contact as they would like
Dementia diagnosis - Although rates across NCL were similar to London, Camden, Haringey and Barnet did not meet the national benchmark for dementia diagnoses
Avoidable admissions – Unplanned admissions for older adults with certain long-term conditions have increased across all our boroughs since 2020/21
Intermediate care – On average more than one in ten of NCL's hospital beds per week are occupied by patients who did not meet Criteria to Reside but were not discharged
Carers - The average quality of life score for carers in NCL was 7 out of 12 which, although low, was comparable to London

Key Next Steps

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The priorities and indicators in the Population Health Delivery Plan and NCL Outcomes Framework are wide ranging, multiple and complex. We will be tracking progress against all the actions outlined in the Delivery Plan, but it is important that we are able to demonstrate the tangible improvements that we hope to make in population health in the next 18 months.

How could we address this?

- We need to identify a smaller sub-set of **key (sentinel) population health metrics** to allow us to demonstrate our impact with which to effectively track and showcase the progress we are making and the benefits of coming together on a multi-geographical footprint across ICS. This will include the key population cohort to be targeted for each metric in order to **improve equity.**
- These metrics should be aligned to existing measures and be supported by a **wider benefits realisation programme**
- This will also clarify roles and responsibilities so that all partners are aware of the contribution they can make – including identifying areas for collaboration. For example, boroughs are best placed to utilise local insights to deliver change.
- The benefits realisation programme will consider how we work differently across partners to make progress on the agreed sentinel measures – this will include a deep dive process that will bring together the worlds of academic research, intelligence and insights and NHS/LA delivery to ensure we are harnessing strengths of all partners to reduce inequalities and improve outcomes.

Benefits Realisation – a worked example for Heart Health

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Making the shift upstream with more preventative practice and care

Primary prevention: acting across the population to reduce risk	**Early diagnosis:** so we can identify health conditions early, to make treatment quicker and easier	**Secondary prevention:** halting progression of conditions or individual risk factors	**Prompt and urgent care:** treating conditions before they become crises	**Long-term care and treatment:** In both NHS and social care settings
NHS	Making Every Contact Count – tackling health behaviours and lifestyle risks	Optimising management of hypertension and CVD e.g. via the LTC LCS	Case-finding in high-risk patients on GP patient lists and opportunistically in secondary care	
Local Authority	Commission primary prevention lifestyle services and NHS Health Checks	Commission population-based lifestyle services to manage risk factors	Commission NHS Health Checks; population-based community health screening	
VCSE & Healthwatch	Deliver targeted primary prevention lifestyle initiatives with local communities; leveraging reach into underserved communities	Deliver targeted population-based lifestyle services/ initiatives to manage risk factors; leveraging reach into underserved communities	Run community awareness campaigns and blood pressure checks	
Academic Partners	Research across these areas and putting these into practice through engagement with services and commissioners			

Working with communities to engage in prevention

What else does evidence suggest would work?

Are there gaps when we focus on key communities?

Example of aligning plans and strategies across partners to deliver population health outcomes in Islington

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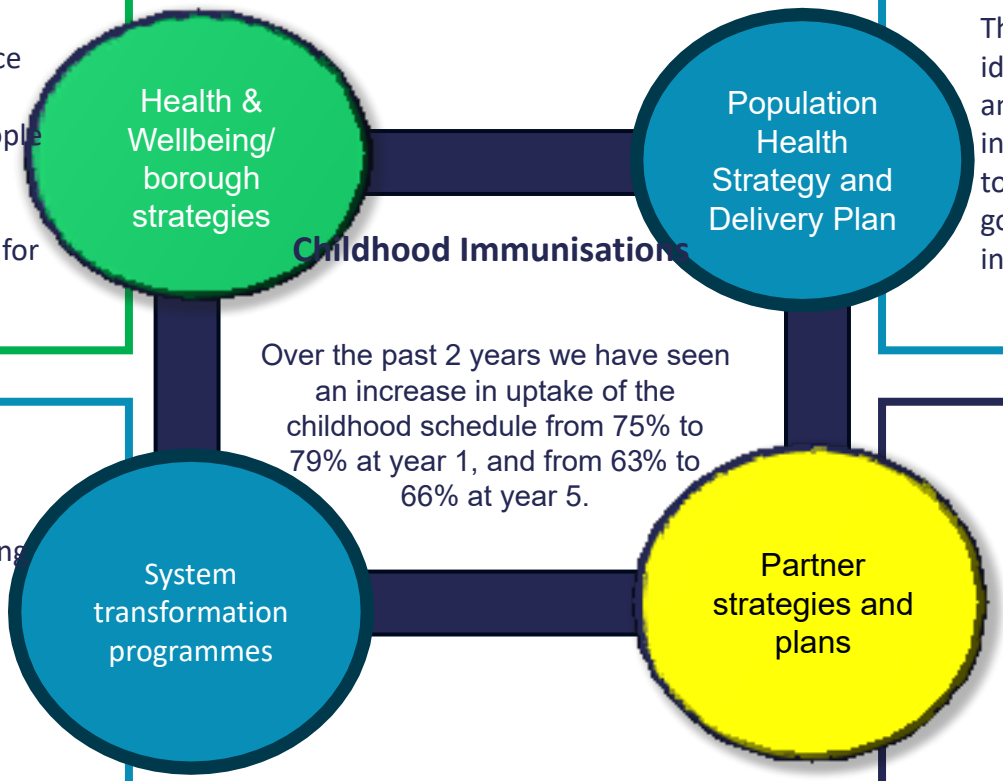
Draft Joint Health & Wellbeing Strategy (2024 -)
Every child is healthy and has good development through the early years period - immediate and long-term impacts of health issues such as low vaccination rates remain significant challenges with stark inequalities.

Children and Families Board
Remit is to steer and achieve collective impact and place leadership for children and families as the vehicle for making Islington a place where children and young people feel safe, belong, and thrive, leading to fulfilling lives.

Islington Immunisation Strategy
Refreshed Imms strategy to reflect the NICE guidelines for Vaccine uptake in the general population.



Our **NCL Delivery Plan** outlines our ambition to increase routine childhood immunisation vaccine uptake with a focus on most deprived communities and communities with lowest uptake.

The Strategy outlines an aim to conduct a gap analysis to identify outcomes across different population sub-groups and geographies to develop focus areas for tackling health inequalities. We also want to develop a common framework to accelerate work across childhood imms, reflecting governance, a focus on prevention, working across partners, including the VCSE and success measures

NCL Childhood Immunisation and Vaccination Programme
An ICP-sponsored system-wide programme is overseeing a programme to improve:

- Vaccine conversation competency
- Communications and engagement via new information sources
- Operational processes & quality call/recall
- Workforce training and development
- Data quality

ICB **Asylum Seeker and Refugee Locally Commissioned Service** MMR vaccination

ICB **Commissioned Childhood Immunisations Inequalities Project**

Islington's Childhood Immunisation Inequalities Project focuses on:

- Childhood Immunisation Catch Up Call/Recall call centre being set up by the Islington GP Federation & North 2 PCN
- Healthwatch recruiting an Immunisation Community Outreach worker to engage with local community groups.
- Delivering comms & patient information in relevant languages, plus training for parents about the importance of immunisations for children, to underserved communities with low vaccine uptake.

Islington Borough

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- **Deprivation:** 44% (6,089) of primary school pupils in Islington's schools are eligible for the deprivation Pupil Premium - a grant aimed at raising the attainment of disadvantaged pupils. The proportion is even higher for secondary school pupils where 64% (4,935) are eligible for the deprivation Pupil Premium.
- **Physical health and LTCs**: In Islington, one-in-six adults aged between 18 and 74 years has a diagnosed long-term condition (about 28,000 adults in total). One-third of these have more than one condition. There are also large numbers of people living with undiagnosed long-term conditions.
- **Mental health**: In England, Islington has the third highest prevalence (about 3,886 people) of serious mental illness and the 5th highest prevalence (about 45,000 people) of common mental disorders.
- **Employment among those with a physical or mental long term health condition:** Islington has had the highest proportion of people employed for the last two reporting periods and at 80% in 22/23 this was significantly higher than London.
- **Immunisations and screening:** Islington, like other London boroughs, has lower levels of uptake of childhood immunisations (2 dose MMR coverage by the age of 5 is 66.3%) (NCL Outcomes Framework, 2022/23) and cancer screening (breast – 45.9%, bowel – 61.1%, cervical 25 - 49 years – 51.3%, cervical 50-64 years – 69.7%) (OHID, 2023) with challenges in uptake amongst particular population groups.
- **Respiratory conditions:** as an inner London borough, Islington residents breathe polluted air. Islington has the highest admission rate in NCL for children with Asthma (170.1 per 100,000) which is double the England average and the highest emergency admission rate in NCL for COPD (531 per 100,000).
- **Homelessness** - The rates of statutory homelessness (21.9 per 1,000) and hospital admissions for violent crime (47.4 per 1,000) are worse than the London and England average.

How are partners already delivering (an integrated approach to population health) in Islington?

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Start Well Highlights

"All children and young people have the fair chance to succeed, and no one gets left behind" *(HWB strategy)*

Increasing CYP vaccination coverage – through collaboration across the system and innovation, over the past 2 years we have seen an increase in uptake of the childhood schedule from 75% to 79% at year 1, and from 63% to 66% at year 5.

Improving MMR uptake – in addition to the above, we have seen rates of MMR1 (at 2 years) increase from 75% to 79%, and for MMR2 (at 5 years) from 64% to 68% through effective partnership working. This suggests alterations and new approaches implemented are beginning to build a sustainable model.

Children and Families Partnership Board to oversee and assure our borough ambitions for children, young people and families

Integrated Paediatric Service (PINCs) **multi-disciplinary integration of acute and primary care plus wider partners** has been expanded across the borough in 23-24. Involvement of all GP practices, CAMHS, social care and family support services.

Integrated approach to low acuity presentations- Integrated work between GPs, A&E and HV and children's centres to embed use of healthier together materials to enhance parental confidence in managing minor illnesses at home (7% reduction in A&E attendance in Islington vs Camden winter 23-24).

CYP **Asthma** - our interventions have been: Embedding the LTC LCS, GP in-reach clinics to support this, school transitions project enhancing asthma education for highest risk adolescent group.

Improving support for neurodiverse children and young people including addressing waiting times and addressing wait times for therapy services to ensure a core offer across all NCL boroughs.

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Live Well Highlights

"People live in connected, prosperous and sustainable communities"
(HWB strategy)

Innovative approach to **LTC management -** PCNs are exploring new ways to work with local partners, including their local Voluntary, Community and Social Enterprise (VCSE) sector with a focus on people living with Long Term Conditions who are in the key groups that is Non-White-British and 20% most deprived.

Learning Disabilities – 78.7% of Islington's eligible population living with LD had an annual health check in 2023/24.

Severe Mental Illness (SMI) – In 2023/24 the target for physical health checks was 2,553, the actual number carried out was 2,637. Development of the Islington collaborative partner plan to deliver the Longer lives programme is underway.

- **Individual and Placement Support (IPS)** Access - evidence-based mental health employment service. Offers free, specialist advice and is integrated into all of Islington's mental health team in Primary and Secondary Care.
- **Islington Core mental health team's** link workers are partnered with different community organisations to help offer an integrated, holistic approach e.g. Age UK, Healthwatch, Hillside clubhouse and Islington People's rights (IPR). This can help increase the outreach function of core teams and overcome barriers in access and treatment.

Heart Health – NCL Heart Health 'programme' that is initially focussed on improving detection and treatment of high blood pressure/hypertension. Identifying and engaging with the range of partners in the system who are involved across the high blood pressure pathway from prevention to detection and treatment

Cancer screening - The North Central London Cancer Alliance, which coordinates cancer care improvements with partners in Barnet, Camden, Enfield, Haringey, and Islington, has been working with homelessness services, healthcare workers and people experiencing homelessness to understand the reasons for the low uptake.

How are partners already delivering (an integrated approach to population health) in Islington?

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Age Well Highlights

"People live healthier and more independent lives, for longer"
(HWB strategy)

A multi-disciplinary **whole system integrated approach to Ageing Well** in Islington , Proactive Frailty and Complex Care Team (FACCT) , this includes Integrated Community Ageing Team (ICAT), ICAT for Care Homes, Integrated Care Coordination (INC) Proactive Ageing Well Service (PAWS) and Community Matrons including:

ICAT - a consultant-led multidisciplinary (MDT) team specialise in the assessment and management of older people, particularly those with severe or increasing frailty. Carried out in people's usual place of residence.

INC – MDT led by general practice, identifies people at rising risk and with the most complex needs. Health and social care issues are discussed systematically, a coordinated plan is created that makes the best use of local services.

PAWS - GPwSI led MDT, supporting identification, assessment and management of people living with moderate frailty. Aims to keep people as well as possible, reduce risk of admission to hospitals or care homes for preventable causes, and maximises quality of life.

Virtual Wards (also known as 'hospital at home') – the NCL Virtual Ward programme has expanded access to circa 23 virtual beds through the Whittington Virtual Ward and UCLH@Home and the number of available beds is expected to increase during 2024/25.

The launch of Islington's Adult **Carers Strategy** in June 2024 demonstrates our partnership commitment across many organisations and teams, to Islington's carers. The LBI is working with all the partners to implement the action plan and work in partnership to make Islington a carer friendly borough.

Integration and Localities - The new integrated front door was launched on 1st October 2024 which was developed jointly by Whittington Health and Islington's Adult Social Care Services. The service provides a single point of access for all adult social care, urgent community health and hospital discharge referrals, delivering a coordinated, timelier, and holistic response.

How are partners already delivering (an integrated approach to population health) in Islington?

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Wider determinants- Working with our Communities and embedding the VCSE.

The Islington **Health and Care Academy** is a multi-agency strategic partnership whose ambition is to support unemployed Islington residents, school and college leavers to identify suitable career paths in the health and social care sector and equip them with the skills and knowledge to secure "good work" in these fields.

Continuing to **tackle entrenched inequalities through a wide range of NCL-funded partnership schemes**, with demonstrated impact e.g. Tackling 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.

Homelessness - NCL Borough Integrated Homelessness models development – ensuring there is no "wrong door" to support and treat people who are homeless with co-occurring substance use issues, mental health challenges and/or neuro-diversity

Parks for Health - Our public parks and green spaces are used, enjoyed, and maintained as health assets for the whole community.

Islington has a strong history of working with **HW, VCSE and local communities**

- Good Neighbours Scheme – a successful community asset building, and empowerment programme delivered by Help on Your Doorstep. Based at the Walter Sickert Community Centre, the project is sat in the heart of Islington's New River Green estate, a deprived community that experiences significant health inequalities. Taking an early intervention and prevention approach, we work with the community, we look at the skills, assets and needs in the community.
- Development of Islington Adults Early Intervention and Prevention 'Wellbeing' Service, delivered by Age UK Islington following a successful bid, awarded on the 1st October 2024.

Asylum Seeker Locally Commissioned Service (LCS) - South Islington PCN has established a GP Liaison role to facilitate

Considerations for the Health and Wellbeing Board

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- Is the HWB assured that coherence is being developed between local priorities and system priorities? What further work would strengthen this?

- The Outcomes Framework Insights Report is part of a data driven approach to improving outcomes – how do we ensure this is reviewed in context with wider data?

- How can we work together most effectively to assure delivery of our joint population aims and ambitions?