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ISLINGTON

Resources Department
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND WELLBEING BOARD

Members of Health and Wellbeing Board are summoned to a meeting, which will be held in Council Chamber, Town Hall, Upper Street, N1 2UD on, **14 December 2021 at 1.00 pm.**

Enquiries to : Thomas French
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Despatched : 6 December 2021

Membership

Councillors:
Councillor Kaya Comer-Schwartz (Chair)
Councillor Nurullah Turan
Councillor Michelline Safi Ngongo

Islington Healthwatch:
Emma Whitby, Chief Executive

Officers:
Jonathan O'Sullivan, Acting Director of Public Health
Cate Duffy, Interim Director Children's Services
Stephen Taylor, Interim Director of Adult Social Care Transformation

Voluntary Sector Representative:
Katy Porter, Chief Executive, Manor Gardens Welfare Trust

Clinical Commissioning Group Representatives
Dr Jo Sauvage, NCL CCG, Governing Body Member for Islington
Sarah McDonnell-Davies, Executive Director of Borough Partnerships

NHS England
Dr Helene Brown, Medical Director, NHS England **(nv)**
Siobhan Harrington, Chief Executive, The Whittington Hospital Trust **(nv)**
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust **(nv)**

Islington GP Federation:
Michael Clowes, Chief Executive Officer **(nv)**

Quorum is 4 voting members including one CCG representative and one councillor. **(nv)** indicated nonvoting members of the Board.

A.	**Formal Matters**	**Page**
1.	Welcome and Introductions	
2.	Apologies for Absence	
3.	Declarations of Interest	

If you have a Disclosable Pecuniary Interest* in an item of business:

- if it is not yet on the council's register, you must declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may choose to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you must leave the room without participating in discussion of the item.

If you have a personal interest in an item of business and you intend to speak or vote on the item you must declare both the existence and details of it at the start of the meeting or when it becomes apparent but you may participate in the discussion and vote on the item.

*(a)Employment, etc - Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to all voting members present at the meeting.

4.	Order of Business	
5.	Minutes of the previous meetings	1 - 12
B.	**Discussion/Strategy items**	**Page**
1.	The formal ratification of in-principle decisions made at the inquorate meeting on 20 July 2021	

2.	Health and Wellbeing Board Terms of Reference Update *To Follow*	
3.	Update from NHS North Central London Community and Mental Health Service	13 - 22
4.	Better Care Fund Plan Approval *To Follow*	
5.	North Central London Integrated Care System Overview	23 - 54
6.	Strategy development update	

C. Questions from Members of the Public

To receive any questions from members of the public.
(Note: Advance notice is required for public questions).

D. Urgent Non-Exempt Matters

Any non-exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

E. Exclusion of Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, any of them are likely to involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972 and, if so, whether to exclude the press and public during discussion thereof.

F. Urgent Exempt Matters

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

G. Confidential/Exempt Items for Information **Page**

The next meeting of the Health and Wellbeing Board will be on **16 March 2022**

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London Borough of Islington

Health and Wellbeing Board - Wednesday, 10 March 2021

Minutes of the virtual meeting of the Health and Wellbeing Board held on Wednesday, 10 March 2021 at 1.00 pm.

Present: Cllr Richard Watts, Leader of the Council (Chair)
Cllr Nurullah Turan, Executive Member for Health and Social Care
Cllr Michelline Safi Ngongo, Executive Member for Children, Young People & Families
Jonathan O'Sullivan, Acting Director of Public Health for Islington
Siobhan Harrington, Chief Executive, The Whittington Hospital NHS Trust
Dr John McGrath, NCL CCG Governing Body
Emma Whitby, Chief Executive, Healthwatch Islington
Katy Porter, Chief Executive, Manor Gardens Welfare Trust
Sarah McDonnell-Davies, Executive Director of Borough Partnerships
Mike Clowes, Chief Executive Officer, Islington GP Federation

Also Present: Alan Caton, Independent Chair and Scrutineer, Islington Safeguarding Children Board
Clare Henderson, Director of Integration, Islington Directorate, North Central London CCG.

Councillor Richard Watts in the Chair

40 WELCOME AND INTRODUCTIONS (ITEM NO. A1)

Councillor Watts welcomed everyone to the meeting and introductions were given.

41 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies for absence were received from Dr Jo Sauvage, Carmel Littleton, Paul Sinden and Darren Summers, Deputy CEO Camden and Islington NHS Foundation Trust.

42 DECLARATIONS OF INTEREST (ITEM NO. A3)

None.

43 ORDER OF BUSINESS (ITEM NO. A4)

The order of business would be as per the agenda.

44 MINUTES OF THE PREVIOUS MEETING (ITEM NO. A5)

RESOLVED:

That the minutes of the meeting held on 4 November 2020 be confirmed as an accurate record of proceedings and the Chair be authorised to sign them.

45 **COVID-19 UPDATE (ITEM NO. B1)**

Jonathan O'Sullivan, Acting Director of Public Health for Islington presented the COVID-19 update which outlined the current position in terms of infections, testing and deaths relating to COVID-19 in Islington.

In the discussion the following main points were made:

- The case rate continued to fall in Islington and levels were close to the September 2020 levels.
- The latest rate was 25 cases per 100,000.
- COVID-19 rates were declining amongst all age groups and the number of cases by ethnicity was now so small that rates were subject to fluctuations.
- Rates of PCR testing were slightly increasing but positivity rates were also declining. Islington's positivity rate from PCR testing was now 2.0% (compared to over 25% over Christmas 2020). This was lower than the London rate of 2.9%.
- PCR testing rates were highest amongst the most deprived areas of Islington (where people were more likely to be working outside of the home) and in the older population and were lowest in the school age population.
- Lateral Flow Device (LFD) tests had started to rise again after a short period of slowing down. LFD was highest in the least deprived areas of Islington, highest in the Black population (more likely to be working outside of the home) and lowest amongst school children.
- The current epidemic curve peaked in January and had been falling since then. The number of cases had been reducing by approximately 40% week on week.
- In total in Islington, there were 346 deaths with COVID-19 mentioned on the death certificate up until 19 February. The latest week of data showed 9 deaths which was fewer than the previous week.
- COVID-19 admissions to Whittington Health had reduced from eight to six in the last week.
- The Chair stated that the pandemic had resulted in a very difficult winter and thanked those involved who had worked incredibly hard.
- Although the number of cases was falling, infection control measures were still vital. It was important that people were vaccinated when invited and followed the rules in order to protect staff and the community. Infections were still higher than in the summer of 2020 and it was important to remain vigilant and reinforce the infection control measure messages to avoid another surge in cases. Lessons learnt this winter could help plan for next winter.

RESOLVED:

That the report be noted.

46 **HEALTHWATCH ISLINGTON WORK PLAN 2021-22 (ITEM NO. B2)**

Emma Whitby, Chief Executive, Healthwatch Islington presented the Work Plan 2021-22 which set out the Healthwatch priorities for 2021-22.

In the presentation and discussion the following main points were made:

- Space had been left in the workplan to enable themes to be added during the year if any new issues arose.
- Work on sharing understanding in relation to COVID vaccination would continue. A factsheet had been produced to provide advice to the community and address the myths surrounding vaccination. This would be sent to Board members. Virtual meetings were being held and work was taking place with partners and community groups. An event in British Sign Language had taken place.
- Health workshops would continue and would be held virtually until further notice. Information was shared in relation to staying healthy, preventing ill health and managing conditions.
- Work would be done to look at access to services and also online GP consultations from a patient perspective. This would include waiting times, how patients were referred and how people viewed e-consult. Equity was championed.
- Within the Fairer Together partnership consideration was given to who the recipients of a service were, who was not accessing the service and how this could be addressed. The goal was to reduce health inequalities.
- Due to the pandemic service visits were not currently being undertaken. This would be reviewed in May 2021.
- Advocacy support would be provided.
- Work would be undertaken to investigate the barriers residents faced accessing digital support. Digital inclusion work had been taking place and this would continue. Access and patient experience would be vital as services recovered from the pandemic. The CCG was keen to work with Healthwatch Islington on this. It was important that the move to digital services did not exclude those who most required the services.
- Officers from Healthwatch Islington were often at meetings, inputting user perspectives into discussions e.g. at the All Age Mental Health Partnership.
- A mental health needs assessment had taken place.
- Members of the Board commented that the vaccine work undertaken by Healthwatch Islington was valuable.
- Cross borough working would continue.
- At the moment people were more focussed on mental health and wellbeing and this created opportunities as did people being more focussed on health.
- Emma Whitby was thanked for her report.

RESOLVED:

That the workplan be noted.

47 ISLINGTON SAFEGUARDING CHILDREN BOARD (ISCB) ANNUAL REPORT 2019/20 (ITEM NO. B3)

Alan Caton, Independent Chair and Scrutineer of the Islington Safeguarding Children Board, presented the report which set out the work of the Islington Safeguarding Children Board (ISCB).

In the presentation and discussion the following main points were made:

- The report was a new style of report based on the first year working under the new safeguarding arrangements whereby the Metropolitan Police Service, the NHS Clinical Commissioning Group (CCG) and Local Authority were jointly responsible for safeguarding. They worked collaboratively and challenged one another.
- Much good work was undertaken in Islington and information was shared between agencies.
- The Board monitored emerging threats such as mental health, youth violence and home educating.
- The role of Chair of the Board had been replaced by Independent Scrutineer. Alan Caton had continued in this new role.
- Work would be undertaken to engage better with schools. An education sub-group had been set up to ensure that all schools, colleges and other educational settings could be fully involved in the new safeguarding arrangements.
- Serious case reviews were now called Child Safeguarding Practice Reviews. A number of these had taken place. It was important to learn from them and improve systems to improve outcomes. Actions were embedded into front line practice.
- If service users made suggestions about improvements that could be made, the ICSB would consider these.
- Work would continue to address neglect, harm suffered to children who lived where domestic violence took place, or where there was mental ill-health or substance misuse.
- Work would continue with young people at risk of being involved in serious violence, gangs and/or criminal exploitations.
- There were disproportionate funding contributions between some organisations, and this would need to be reviewed.
- At the start of the COVID-19 pandemic core members of the ICSB started meeting on a weekly basis and this proved successful. The group was now meeting on a monthly basis and this was working well.
- In response to a question about disproportionality work, the Independent Scrutineer advised that it was important that the Board liaised with individual agencies who might be referring disproportionately to assess whether they were referring appropriately, and to make changes where and when indicated.
- A dashboard was being developed as a way to monitor data and key issues. This was in development but had been delayed due to COVID.
- Alan Caton was thanked for his report.

RESOLVED:

That the report and key messages on pages 71 and 72 of the report be noted.

48 **COVID-19 RECOVERY REPORT (ITEM NO. B4)**

Jonathan O'Sullivan, Acting Director of Public Health for Islington presented the COVID-19 Recovery report which supported a discussion regarding the approach to recovery in the context of the direct and indirect impacts of COVID-19 upon the health and wellbeing of residents and patients in Islington and the impact on inequalities.

In the presentation and discussion the following main points were made:

- Recovery was not about going back to how services were before COVID but for services to be the best they could be going forward.
- There were direct and ongoing impacts arising from infection, the impacts upon services and access and the indirect impacts on health and wellbeing.
- There were a number of major national studies set up to investigate the long term impacts.
- There were many complex impacts and the report could not capture every impact or issue but was intended to be illustrative of the nature and extent of the impacts and challenges.
- Direct impacts arising from COVID-19 infection included the measures put in place to reduce and prevent infection, rehabilitation for those with serious acute illness, mortality, long COVID, the impacts of bereavement upon family and others affected and the disproportionate impacts upon the community, including ethnicity, age, areas of deprivation and disability.
- Services had faced and still faced challenges. During the first wave services were rapidly reconfigured and prioritised to deliver services safely. Access was being offered via telephone and digital methods as well as face-to-face. Services were impacted by the surges in hospital admissions and there was an impact of lost, non-COVID activity and potential impacts on waiting times and lists and non-COVID aspects of health.
- In North Central London it was estimated that there were approximately 650 fewer cancer referrals than would have been expected through the first wave and following months.
- Children's development had been negatively impacted.
- Some changes were beneficial e.g. a reduction in travel had temporarily reduced pollution. Measures such as Healthy Streets would mitigate some of the impacts of the return to increased travel.
- Inequalities had widened as a result of the pandemic.
- There was a high level of mental health disorders. Some of this would reduce with the easing of restrictions but for some the impact would be long lasting.
- The economic environment coming out of COVID-19 was likely to be of greatest importance to long term impacts and outcomes for residents, patients and community, however there were other policy choices and actions which were available and which could also address the impacts.
- Alan Caton, Independent Scrutineer on the Islington Safeguarding Children Board advised that one impact of COVID was that babies not

being seen by professionals had meant there had been a nationwide increase in babies suffering significant harm. A national report on this would be published in June 2021.

- There was a need for some services to take place face-to-face, even if some service contacts continued using telephone and other digital or remote means.
- School leavers faced uncertainty in the economic environment and more work could be done to provide opportunities. Many people had been undertaking either voluntary or short term paid work in the NHS or care system in the last year. Consideration could be given to providing longer term opportunities to the young people who might have been working in the system in the last year.
- Challenges had resulted in partners working together in new ways including through Fairer Together. There had been an acceleration in partnership working and it was vital that this continued during the COVID-19 recovery process.
- It was important to consider the implications of services operating more digitally. Services should be designed to be able to respond to and meet all needs, including for those most in need.
- Consideration should be given to how the workforce could be engaged to move services forward.
- It was important to ensure that everyone that should be included in the discussions was included.
- It would be a challenge to encourage more people to re-engage with services e.g. cancer screening.
- The Chair stated that priorities included mental health, supporting people back into work and supporting the local economy. COVID-19 had impacted on finances which would present a further challenge but partnership working would help achieve priorities.
- The All Age Mental Health Partnership was a step forward in working across services.
- The Health and Wellbeing Strategy would need to be renewed in the near future.
- In light of new ways of working introduced during the pandemic, a light touch review into meeting and governance arrangements should be conducted in the near future.

RESOLVED:

1) That the report be noted.
2) That a light touch review into meeting and governance arrangements be conducted in the near future.

MEETING CLOSED AT 2.25 pm

Chair

London Borough of Islington

Health and Wellbeing Board - Tuesday, 20 July 2021

Minutes of the inquorate meeting of the Health and Wellbeing Board held at Council Chamber, Town Hall, Upper Street, N1 2UD - Islington Town Hall on Tuesday, 20 July 2021 at 1.00 pm.

Present: Cllr Kaya Comer-Schwartz, Leader of the Council (Chair)
Cllr Nurullah Turan, Executive Member for Health and Social Care
Cllr Michelline Safi Ngongo, Executive Member for Children, Young People & Families
Jonathan O'Sullivan, Acting Director of Public Health for Islington
Jonathan Gardner, Strategy Director, The Whittington Hospital Trust (substituting for Angela Mc Nab)
Katy Porter, Chief Executive, Manor Gardens Welfare Trust
Stephen Taylor, Interim Director of Adult Social Care Transformation

Also Present: Clare Henderson, Director of Integration, Islington Directorate, North Central London CCG
Darren Summers, Deputy CEO Camden and Islington NHS Foundation Trust

Councillor Kaya Comer-Schwartz in the Chair

49 WELCOME AND INTRODUCTIONS (ITEM NO. A1)

Councillor Comer-Schwartz welcomed everyone to the meeting and introductions were given.

50 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies for absence were received from Dr Jo Sauvage, Cate Duffy, Angela McNab, Sarah McDonnell-Davies, Mike Clowes, Siobhan Harrington and Emma Whitby.

51 DECLARATIONS OF INTEREST (ITEM NO. A3)

None.

52 ORDER OF BUSINESS (ITEM NO. A4)

Agenda Item B2 was deferred to a future meeting. The order of business would be B1 and then B3.

53 MINUTES OF THE PREVIOUS MEETING (ITEM NO. A5)

RESOLVED:

As the meeting was inquorate, the minutes of the last meeting would be deferred to the next meeting.

54 PROPOSED CHANGE TO HEALTH AND WELLBEING BOARD AGENDAS (ITEM NO. B1)

Jonathan O' Sullivan, Acting Director of Public Health for Islington presented the report which set out proposals which sought to redevelop the workings of the board, with a greater thematic focus on collective problem-solving and action on health inequalities.

In the discussion the following main points were made:

- Routine reports being circulated in advance would mean questions could be submitted prior to the meetings.
- The Chair suggested that one of the thematic items should be related to children and young people as this was a key priority.
- Addressing the health inequalities angle through all thematic items would be helpful.
- Looking at themes through a geographical or community lens was suggested and the Chair suggested there could be guiding principles alongside the themes.
- It was suggested that the health and wellbeing and mental health of children and young people aged 17-18 who were transitioning to adulthood be included to identify any gaps.

RESOLVED:

That the decisions below be agreed in principle (as the meeting was inquorate) subject to ratification at the next meeting:-

1) That the proposed rebalancing of the Board's time towards thematic or deep dive looks into key health inequalities affecting people in the borough be agreed.

2) That there be three health inequalities themes identified each year with the Annual Public Health Report normally one of these three themes and one of the items related to Children and Young People.

3) That there be shorter time slots for routine reports received by the Board.

4) That future consideration be given to whether the proposed change in emphasis of the Board's time indicated a change in the core membership.

55 NORTH CENTRAL LONDON CLINICAL COMMISSIONING GROUP STRATEGIC REVIEW OF COMMUNITY AND MENTAL HEALTH SERVICES (ITEM NO. B2)

RESOLVED:

That this item be deferred to a future meeting.

56 REFRESH OF ISLINGTON'S JOINT HEALTH AND WELLBEING STRATEGY (ITEM NO. B3)

Jonathan O'Sullivan, Acting Director of Public Health for Islington presented the refresh of Islington's Joint Health and Wellbeing Strategy.

In the presentation the following points were made:

- The strategy set out the strategic priorities for improving health and wellbeing and reducing health inequalities. The strategy had been

developed in partnership using intelligence, insight, evidence and engagement with local communities, residents and patients to find out what would make the biggest difference and help Islington become a more equal borough.

- The strategy was not simply about adding 'years to life', but also 'life to years' and improving quality of life as well as life expectancy.
- The strategy recognised and gave synergy to, but did not seek to replicate other strategies and action plans on the wider determinants of health, e.g. better air quality and the environment, improving educational attainment, employment and wealth building in the borough.
- The Health and Wellbeing Board priorities (2017-2020) were: 1) ensuring every child had the best start in life; 2) preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities; and 3) improve mental health and wellbeing.
- Since 2011-13, life expectancy had increased in Islington for both men and women. Life expectancy at birth for men in Islington was now 79.7 years, an increase of 1.8 years since 2011. However, life expectancy for men in Islington remained lower than the London average (80.9) and was the sixth lowest amongst all London boroughs. For women in Islington, life expectancy was 83.4 years, which was lower than the London average (84.7), and was the second lowest amongst all London boroughs. Both male and female life expectancies in Islington were similar to national averages.
- In Islington, men and women spent on average the last 17.1 and 21.7 years of life in poor health respectively. For both men and women, there had been a much larger improvement in healthy life expectancy since 2011-13 compared to London and England. Although healthy life expectancy (HLE) for men and women remained lower in Islington, the borough was now statistically similar to London and England. For men there had been an 8.6% improvement in healthy life expectancy compared to 1.3% improvement in London and 0.3% improvement in England and for women there had been a 6.4% improvement in healthy life expectancy compared to improvement in 1% London and 0.1% improvement in England. These figures showed the work being done to improve quality of life was making a real difference.
- Whilst some of the impacts of Covid were short term, others were long term. Impacts included: the economic and social wellbeing of residents; longer waiting lists in the NHS; later diagnosis of many conditions e.g. cancer, diabetes, risk of stroke; mental health and wellbeing impacts; the impacts on children and young people; and the particular impacts on Black, Asian and other minority ethnic groups who had had a differential health, social and economic experience.
- The changing national strategic and organisational context for health and wellbeing included: 1) the Long term NHS Plan (2019) which was looking at secondary prevention and reductions in inequalities and variations in outcomes in relation to maternity, child health, long term

conditions and mental health; 2) Integration and innovation: working together to improve health and social care for all (2021) which included major changes to achieve local place and person-based integration to meet the needs of residents and communities; 3) Population health management which involved using data and evidence to identify, monitor and address inequalities and improve outcomes; 4) Beyond the Data (the 'Fenton report') PHE (2020) / ONS (2020) was looking at the long term structural inequalities that had driven the disproportionate impacts of Covid on Black, Asian and other minority ethnic groups. There would be the systematic use of ethnicity data, design and actions to improve access, preventive and treatment programmes, experience and outcomes of people from these communities and to address the wider determinants of their inequalities and poorer outcomes.

- The changing local strategic and organisational context for health and wellbeing included: 1) the Corporate Plan was being refreshed. The overarching objectives were: Decent and genuinely affordable homes for all; Jobs and opportunity: A safer borough for all; A greener and cleaner Islington. All of these impacted on health and wellbeing. 2) As part of Fairer Together strengths-based approaches were being organised and integrated to meet the needs of residents, patients and communities, and make the borough a fairer place to live – across the life course 'Start Well, Live Well, Age Well'. 3) The Challenging Inequalities Strategy - utilised the council's position as a strategic leader, as an employer and as a service provider and commissioner to create positive change to make meaningful and tangible change for staff and residents. The initial focus was on race equality, and would be expanded – next to include disability.
- Unknown future funding and the impacts on resources were significant challenges.
- It was proposed that an officer task and finish group be established, with representatives from across the Health and Wellbeing Board member organisations, that would be responsible for delivering the refreshed strategy to the Board. The review process would cover: 1) the impact of the current Joint Health and Wellbeing Strategy, and what more there was to do; 2) the needs and assets of the local population including intelligence from the Joint Strategic Needs Assessment (JSNA), which gave an overview of local needs and priorities, and this, together with other insight and engagement work, would help to develop priority areas of focus for future years; 3) the current and future heath landscape within the context of local financial and other challenges, the Fairer Together partnership and wider system transformation and integration with a focus on structural inequalities; 4) Engagement with local residents and stakeholders.
- The timetable would be between now and March 2022 with a proposal development session in the autumn to look at task and finish work and identify the approach and priorities to new strategy.

In the discussion the following main points were made:

- Members were supportive of the plans.

- Members were pleased to see the progress made over last period.
- The strategy was being produced at a time of significant change in the NHS.
- The local partnership had to have real focus on place.
- Having a clear set of priorities was helpful in leveraging the support of partners.
- In areas which were receiving higher levels of funding, there was a need to ensure community based models were being developed to respond to local challenges.
- A locality profile had shown that in Islington health inequalities were not focused in certain locations in particular but were more focused around social housing.
- High levels of social housing in Islington, the rise in preventable cancer deaths, respiratory deaths and diabetes being a contributory factor of higher premature deaths were significant challenges. The over 60s population in Islington was the most deprived in whole country and 48% children and families in the borough were deprived and this presented further significant challenges.
- In relation to improvements in healthy life expectancy it was difficult to calculate causality. It could be useful to trial pieces of work where changes in the data could be identified to prove interventions. There was a need to identify if causality could be due to shifts in population. Some interventions had shown clear results e.g. work on reducing smoking.
- It would be useful to get an understanding from colleagues in education on the educational and social development impacts of Covid on children and young people who had been unable to attend school and college.
- It was suggested that stakeholder and resident engagement be undertaken concurrently to aid in the co-production of the strategy. Jonathan O'Sullivan stated that the timing of engagement work was a balancing act and much engagement had already been undertaken. It was important that this informed future engagement. As many people were on summer breaks, consultation in the autumn and winter could be most beneficial.
- A Covid survey of 1,000 people had been undertaken last autumn/winter. This would be repeated in autumn/winter this year and could feed into the consultation.
- Part of the strategy was defining what mattered to people in the borough and why investment and resources were required.
- Focusing on the broad determinants of health and building this into local services would keep more people well in the community and reduce the impact on acute care.
- It was important to look at work already done across the council and other forums and also consider work being done across London and in particularly neighbouring boroughs. The Children's Services Scrutiny Committee had undertaken a review on impacts of Covid and a group of councillors would be undertaking work on poverty and health inequalities over the next few years. Fairer Together work should also be considered.

- Jonathan O'Sullivan asked for any volunteers for the task and finish group to contact him.

RESOLVED:
That the approach to refreshing the Joint Health and Wellbeing Strategy as set out in the report be agreed in principle subject to being ratified at the next meeting.

MEETING CLOSED AT 1.45 pm

Chair

ISLINGTON

Report of: Sarah Mansuralli, Executive Director Strategic Commissioning, NCL Clinical Commissioning Group

Health and Wellbeing Board	Date: 14 December 2021	Ward(s):

Delete as appropriate	Exempt	Non-exempt

SUBJECT: Update on the North Central London Clinical Commissioning Group' Review of Community and Mental Health Services

1. Synopsis

1.1 This report provides a brief update on the progress of the NCL CCG service reviews of community & mental health Services. It sets out some of the work to date to agree core service offers and then describes the current phase of work which will see the completion of a financial and non-financial impact assessment as part of developing a funding plan.

1.2 Once the current phase of work is complete the implications for all Boroughs will be clearer and will form the basis for more detailed local discussion.

Although the actual costs of fully implementing the core service offer is still being calculated the CCG is expecting to use a menu of opportunities to fund the plans. It has been clear with all Boroughs that funding will not be found from destabilising Boroughs, but rather from a mix of using transformational opportunities to deliver services differently and more efficiently, looking at opportunities to deliver services at scale and additional investment. Implementation of the core service offers will not start before April 2022.

2. Recommendations

2.1 To receive the report on the NCL CCG' s review of community and mental health services and receive a more detailed update at the next meeting of the board.

3. Background

3.1 NCL CCG has undertaken a review of community and mental health services because of its concerns at the current level of differences in the services its residents receive. Investment in community and mental health services varies as a result of the historic funding of the 5 legacy CCGs (Barnet, Camden, Enfield, Haringey and Islington). This variation results in different levels of access or service availability or the types of services e.g. provision of Intravenous antibiotics at home etc.

3.2 The CCG has started to address some of these historic differences by using specific national programmes to fund a differential level of investment e.g. for the Mental Health Investment Standard and the Ageing Well Programme. Despite this new funding discrepancies still exist and the CCG in carrying out these reviews expects to develop a funding and delivery plan that will set out how it will fund and commission the core services offer.

3.3 This report provides an update on the reviews and details of the current phase of work. At a high level it starts to set out some findings for Islington and suggestions on how investment across NCL will be funded. The report describes a combination of approaches all of which will need discussion and careful consideration.

4. Implications

4.1 **Financial Implications:**
There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. Any recommendations from this report, if adopted, will need to be expanded upon and reviewed with the financial implications assessed.

4.2 **Legal Implications:**
No legal implications.

4.3 **Environmental Implications and contribution to achieving a net zero carbon Islington by 2030:**
As this report is an update on progress of the service review, there are no environmental implications at this stage.

4.4 **Resident Impact Assessment:**

This paper details the work of the CCG across North Central London and therefore an Islington Resident Impact Assessment isn't required in this instance. However, the impacts on residents are set out in the report

5. Conclusion and reasons for recommendations

5.1 The collaborative work over the summer has been essential in helping the CCG move into the next phase of these reviews. The development and agreement of detailed core service offers has provided a strong base from which to start to develop a clear funding and transition implementation plan. The programme will need to continue to work closely with provider colleagues to understand costs and opportunities to fund the plans and to test these with partners to ensure there is an ICS wide agreement on how the core service offers will be delivered.

Once the amount of funding required is known, along with funding opportunities, the CCG expects to then be able to work closely with Borough partners to discuss and agree local implementation of the core service offer. The process for supporting local discussion and delivery is still to be agreed and will require further thought over the next period to ensure a consistent approach to delivering the core service offer, but within the context of local place and through local relationships.

Delivery will require a large amount of transformational change to be able to deliver the benefits of the core service offers. Delivery of these will not only have a benefit for local people, but will also help and support the wider aspirations of the CCG/ICS in other areas such as elective recovery, a move away from crisis or emergency care and the delivery of its population health improvement plans.

It is expected that very detailed discussions will start from mid-December into February to give partners the opportunity to understand the requirements to deliver the core service offer and agree how this will be funded and achieved over an agreed timescale.

5.2 The Health & Well Being Board are asked to agree to receive a more detailed update on the progress of the reviews.

Appendices

- Full report on the NCL Community and Mental Health Services Strategic Review

Background papers:

None

Signed by:

Sarah Mansuralli
Executive Director of Strategic Commissioning
North Central London CCG

Date: 24 November 2021

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Islington Health & Well Being Board – 14.12.21

1. Introduction

This report is designed to provide members with an update on the progress of the North London Clinical Commissioning Group's (NCL CCG) work on its service reviews of community and mental health services. Both reviews have been run in parallel and are considering all NHS funded community & mental health services for adults and children.

The two service reviews were prompted because of concerns about the impact of differential spending and therefore service provision across the five NCL Boroughs. This was the result of the historic legacies of the five former CCGs where there were very differential levels of investment. Based on figures for community services this ranges from £117 (unweighted spend per head of population in 20/21) in Haringey to £232 in Islington. For mental health services spend per unweighted head of population is between Barnet at £161 to Camden at £264. The Islington spend per unweighted head of population for mental health in 20/21 is £242. The different levels of spending have contributed to a number of differences in the availability, waiting times and criteria for accessing services.

As part of this work core service offers have been developed and a gap analysis undertaken to better understand the current position against the service set out in the core offer, e.g. does it match in terms of accessibility, opening hours, expected level of staff skills and competencies needed to deliver the service etc.

This report provides a brief update to members on the current phase of the reviews and briefly updates on emerging but high level implications for Islington residents. Work is currently being concluded on the development of a financial and non-financial benefits analysis and this paper will describe the emerging narrative on opportunities arising from this work, as well as the current timelines on decision making. It will not at this stage provide any definitive actions or implications for Islington, as we do not yet have the level of detail to formulate more detailed plans. This more detailed stage of work will start from January and we expect to be having detailed discussions with partners, local people etc. about our proposals. Any implementation of the core offer would start to take place only after April 2022 and once detailed plans have been agreed.

Underpinning the review has been work to co-design and co-produce the core offer, utilising the skills and contributions of residents, services users, Healthwatch, voluntary groups etc. along with CCG and Local Authority staff. Residents and service users have already played an important role in terms of helping shape some of the requirements set out in the core offer, e.g. reflecting local frustrations with the challenge of accessing services as an example. As this work develops we are looking at ways for not only deeper involvement of borough partners, but also thinking how we can ensure that the ICS developing strategy on public and patient engagement continues to support and help shape this work.

2. Background and Context; Recap on Development of Core Service Offers

The coming together of the five CCGs into one pan NCL organisation has provided an opportunity for NCL CCG to take a detailed look at the community and mental health services its residents' receive. Populations and services have obviously been impacted by Covid and part of the work of the reviews has been to consider the impact of the pandemic

on service delivery, on population health and especially for those very deprived populations where the impact of Covid has hit the hardest. It was also an opportunity to think about some of the accelerated changes that Covid drove, for example the use of digital technology or remote monitoring to help manage patients' diseases. Part of the review has also been to consider both national best practice and clinical requirements alongside local innovation, so that the development of core service offers reflected the CCG's aspiration for its services in terms of reducing health inequalities and driving quality improvement.

To underpin the service reviews two Baseline Report documents have been developed and are available on the CCG's website. These provide some details on needs/deprivation spend and set out some of the current challenges in terms of service provision. For example, they describe workforce profiles in different boroughs, or waiting times or give examples of the challenges from a workforce perspective of staffing a number of small services such as Community paediatrics or Tissue Viability services across all five Boroughs. They also set out some of the implications for the different range of services and admission criteria, for example for colleagues in the Acute Sector trying to discharge a patient to a non-local Borough in NCL or the London Ambulance Service who have to be able to understand the different community options that might be available to help support a patient to stay in their home rather than be taken to hospital.

To develop a core service offer there were a series of iterative workshops across the summer which involved the considerable input of many colleagues in clinical roles, operational, and commissioning, from Local Authorities, and from service users and voluntary groups. At the end of the workshop discussions the CCG received two reports that set out the core service offers for community and mental health services. The core service offer reports contain a description of each of the functions that should be available across NCL for different population segments, i.e. children and young people, young adults 18-25 (mental health only) working age and older people, and how the different functions integrate within the wider heath and care system. Specifically the core service offers were set out as a brief description for each function. The brief description includes; what the function is e.g. district nursing and what it aims to deliver; it covers opening hours and out of hours provision, response times for initial contact and then responses times in line with national specifications etc. The descriptions also cover who the service is for, how it might integrate or link with other services, where its delivered e.g. home based and the workforce capabilities needed to deliver the function e.g. that could be rapid response team nurses being able to deliver intravenous antibiotic therapy.

3. Stage Two; Financial and Non-Financial Impact Assessments

Since the core service offers and gap analysis development was completed in September, the CCG has continued to work with its partners Carnall Farrar on two further pieces of more detailed analysis. One strand of this analysis is a detailed review of service costings to allow an inter trust comparison of efficiency and productivity as well as understanding the costs of estate and overheads, the implications of paying staff inner versus outer London supplements etc. This work is due to be completed by early December and will provide the CCG with much more information to use in discussion with community and mental health Trust colleagues on the opportunities for efficiencies and transformation to support the delivery of the core service offer.

The second piece of analysis is a non-financial impact assessment. This has considered the impact of consistently implementing the whole of the core offer against the following domains; quality, access, inequality and inequity and workforce. This work sets out the benefits that the delivery of the core service offer could bring e.g. in terms of reducing non-elective admissions or supporting earlier discharge or other wider system benefits such as reducing the waiting time for children' speech and language therapy and the impact that has in the longer term on mental health services. Although this is more difficult to quantify it is important to try and recognise the impact on a wide range of indicators that delivering a core service offer consistently across NCL could have both financially, but more importantly in the longer term on improved population outcomes.

Both the work on the financial and non-financial impact assessment will be able to contribute to helping the CCG and then the Integrated Care System understand and agree how NCL CCG and then the North London Integrated Care System will fund the implementation of the core service offers consistency across NCL.

The work to develop the financial and non-financial impact assessment should be completed by mid-December and it should provide sufficient information to support the start of much more detailed discussions with Borough partnerships, Community and Mental Health Trust colleagues on how we will implement the core service offers for community and mental health services.

4. Emerging Implications For London Borough of Islington

As noted above work is not yet completed on the financial and non-financial implications and impact of consistently delivering the core service offers, so it is difficult currently to pull out specific implications for Islington residents. This section of this report starts to indicate some areas that may have implications and which would then need further discussion. However a starting point is to note that NCL CCG has confirmed that its intention is not to destabilize any Borough in NCL and nor is it looking at levelling down what services local people have access to locally. However, neither can the CCG continue to leave the current inequity of provision across NCL, not least because residents of NCL move across Boroughs e.g. for schools or for health services such as inpatient care. So, the CCG will be looking at what opportunities exist to fund the level of investment that may well be required and over what timescale it is reasonable to expect to move to full delivery of a consistent NCL core service offer.

Islington already has many elements of the core service offers already in place. For example, Islington is the only Borough in NCL that has a full range of children's services and some innovative examples of care e.g. the Children's Hospital at Home Team. This is one example of how Islington's existing good practice has been incorporated into the core service offer, so children and families across NCL have access to this service. However, Islington does not have all of the new elements included as part of the core service offer e.g. new coordinating functions i.e. a central point of access, trusted assessor function and care coordination. Parts of these services are in place, but not to the full extent set out in the core service offer. These would need to be developed as part of the plans on implementation, and thought given to how these services/functions sit within local pathways of care and link into services provided by the Local Authority and or voluntary sector, which would support these functions such as social prescribing or access to local physical activity etc.

Whittington Health, the provider of community services in Islington and Haringey, like other providers faces challenges in the provision of some small and/or fragile services where there are concerns with clinical resilience and the availability of the workforce. Part of the next phase of work, along with the financial and non-financial impact assessment are discussions being planned for December- January to identify services that might be clinically better suited to be provided on a different footprint than currently, e.g. for children services such as community paediatrics, the children continuing care team or for adults the tissue viability service. The decision on footprint is related to how the service would be organised, rather than where it will be delivered. The core service offer sets out where services should be provided e.g. at home, in local community clinics. However, there are opportunities to consider changes to geographical footprints to secure larger more resilient services that can still work locally, but can also benefit from opportunities for skill mix and staff development as part of a larger clinical team. These discussions will be for both community and Mental Health services, as both areas have small and clinically fragile services.

5. Next Steps

The CCG is developing a much more detailed understanding of service costs and the opportunity for greater productivity and service efficiencies. This understanding forms one part of the next phase of work which will contribute to the development of a menu of opportunities to fund the core service offer. As already noted this is likely to consist of a mix of looking for transformational change opportunities, and in doing this learning from Local Authority partners to realise productivity and efficiently benefits in doing things differently. There will need to be some investment in boroughs, and the work on at scale provision should also help realise efficiencies and support workforce resilience.

Work will also be completed on the non-financial impact assessment. This will help us to demonstrate to partners, especially acute sector colleagues, the importance of agreeing a small percentage of their funding moving to support community services. The intention is to be able to demonstrate that investment in community and mental health services is beneficial in terms of supporting their focus on elective activity and reducing waiting times by freeing up capacity and management capacity from managing the current levels of non-elective care. This shift of funding would need to be agreed over several years which would also support the work of NCL to continue to implement a local workforce plan designed to support delivery of the core service offers.

As the level of opportunity emerges then there will need to be detailed discussions with local Borough partners to develop local plans to implement the core service offer in a way that fits with local need etc. The move to deliver the core service offers could act as a prompt for further and more detailed discussions on integrated working across primary, community, mental health, acute, Local Authority and voluntary and charitable sector partners. Thee CCG/ICs will expect to have these more detailed discussions once further information is available to support the level of detail necessary to facilitate practical discussions.

6. Conclusions

This report provides a brief update on the work the CCG has been undertaking towards the delivery of a core and consistent service offer across NCL. The outputs from the review remain very high level at this stage whilst further more detailed analysis take place. This work is

nearing completion and will provide the basis for more detailed discussions that the CCG is aware that partners are keen to start.

The CCG will shortly be updating its communications and engagement plans and starting the more detailed discussions it knows will be necessary to move the review along from their current stage to that of making a tangible difference to people living in all Boroughs of North Central London.

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ISLINGTON

Islington Borough Partnership
The Laycock Centre

Report of: Islington Director of Integration, NCL CCG, Clare Henderson

Health and Wellbeing Board	**Date:** 14th December 2021	**Ward(s): Islington**

Delete as appropriate	Exempt	Non-exempt

SUBJECT: North Central London Integrated Care System Overview

1. Synopsis

1.1 This report provides an overview of the ongoing development of the North Central London Integrated Care System (NCL ICS). System partners are working together to design how the ICS will operate at a neighbourhood, place (borough) and system-level, ahead of operational roll out as a statutory body from April 2022.

2. Recommendations

2.1 To note the progress made on the development of the North Central London Integrated Care System.

3. Background

3.1 Integrated Care Systems (ICSs) are a new form of partnership between organisations that support the health and wellbeing of local communities, including the NHS and local councils alongside voluntary, community and social enterprise sector organisations. From 1st April 2022, the North Central London (NCL) ICS will be fully operational as a statutory organisation, responsible for strategic commissioning and with a financial allocation set by NHS England.

The ICS aims to improve outcomes in population health, tackle inequalities, enhance productivity and value for money, and help the NHS to support broader social and economic development. For our local residents this mean faster progress can made to improve services in response to feedback and an increasing system focus on the wider-determinants of health.

Integrated Care will not just be at the NCL system-level but also within our boroughs or at 'Place'. Partners are currently working together to design what the ICS will look like at the

system, borough and neighbourhood (locality) levels. The ICS level will focus on activities better undertaken on the larger NCL footprint, as well as system planning. The five place-based borough partnerships will be a critical point of integration and coordination of services, supporting the development of neighbourhoods and primary care networks (PCN) to enable greater provision of proactive and personalised care.

Core components of the ICS governance include the Integrated Care Board (ICB) which will act as a single board to lead integration within the NHS. The board will become operational in April 2022, with Francis O'Callaghan as the ICB Designate Chief Executive.

Place-based partnerships will oversee functions and decisions at a borough level, with the ICB will remaining responsible for NHS resources deployed at place. The NCL provider alliance has been formed with all providers and primary care members; the alliance will work to agree specific objectives with the ICB and support delivery of strategic priorities.

Effective communication and engagement across partnerships will be key to the ICS development and implementation. An ICS community partnership forum has been established to oversee patient resident engagement and involvement, bringing together Healthwatch, local authority, VCSE and community representatives for strategic discussions. Place-based partnerships will deliver local resident engagement and also ensure voluntary sector organisations play a key role in delivery of partnership plans.

4. Implications

4.1 **Financial Implications:**

There are no financial implications arising from this report. The measures and recommendations proposed in this report are not currently quantifiable. Any recommendations from this report, if adopted, will need to be expanded upon and reviewed with the financial implications assessed.

4.2 **Legal Implications:**

Health and Wellbeing (HWBs) were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system work together to improve the health and wellbeing of their local population. There is emphasis on collaboration, population health and integration, including new models of care and sustainability and transformation partnerships (STPs) which have evolved into integrated care systems (ICSs).

The Care Act 2014 section 6 (1) states that a local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of—(a)their respective functions relating to adults with needs for care and support.

Relevant Partners include each NHS body in the authority's area (Care Act 2014 section 7 (c)) The reference to an NHS body in a local authority's area is a reference to—(a)the National Health Service Commissioning Board, so far as its functions are exercisable in relation to the authority's area,(b)a clinical commissioning group the whole or part of whose area is in the authority's area, or(c) an NHS trust or NHS foundation trust which provides services in the authority's area. (Care Act 2014 Section 8).

4.3 **Environmental Implications and contribution to achieving a net zero carbon Islington by 2030:**

N/A

4.4 **Resident Impact Assessment:**

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

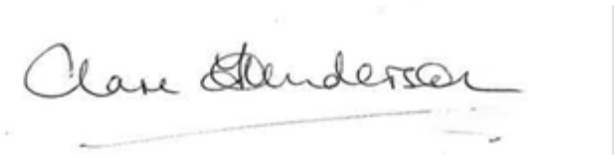
5. Conclusion and reasons for recommendations

5.1 NCL ICS will continue to develop and function in shadow form in 21/22 and focus on working with system partners to ensure delivery of an operational system ahead of 1st April 2022.

Appendices

- North Central London ICS Overview - Slides

Signed by:



Clare Henderson, Director of Integration, NCL CCG Date: 17th November 2021

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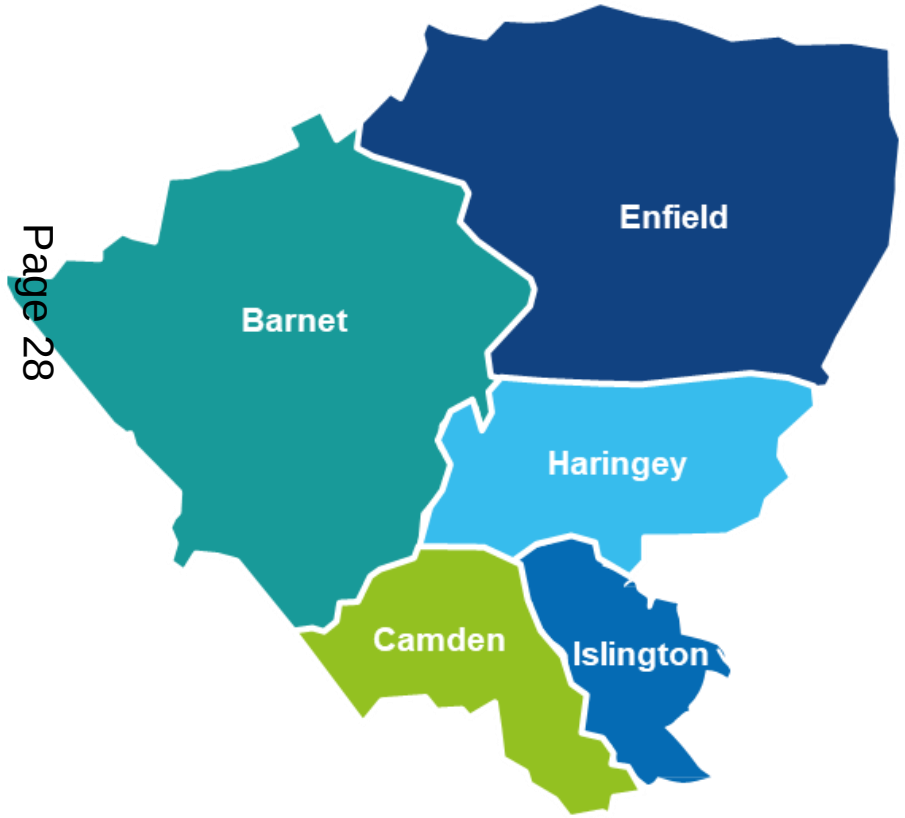
Developing the North Central London Integrated Care System

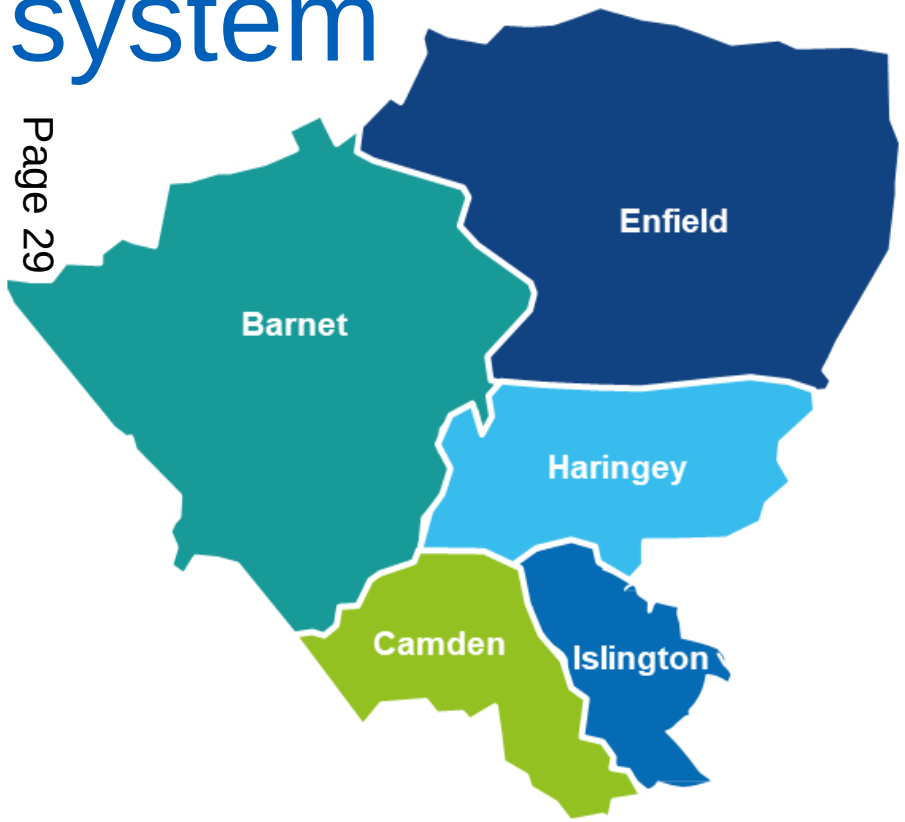
The North Central London population



- Around 1.6 million residents, with a relatively young population in some boroughs compared to London average
- Diverse population with historic high migration – from within UK and abroad; around 25% of people do not have English as their main language
- Higher rates of deprivation than some London areas, with pockets of deprivation across all boroughs
- Significant variation in life expectancy between most affluent and most deprived areas
- Approx. 200,000 people in NCL are living with a disability

[1] Index of Multiple Deprivation, 2019

The North Central London health and care system



- 12 hospital trusts
- 5 local authorities
- One clinical commissioning group
- 200+ general practices
- 300+ pharmacies
- 200+ care homes
- Countless voluntary sector organisations and community groups providing essential care

[1] Index of Multiple Deprivation, 2019

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Building on strong NCL partnership foundations to form our ICS

The formation of Integrated Care Systems (ICS)

- The NHS Long Term Plan committed to delivering Integrated Care Systems (ICSs) across England by April 2021, to build on the lessons learnt and good work carried out by Sustainability and Transformation Partnerships (STPs).

- Integrated Care Systems (ICS) are a new form of partnership between organisations that support the health and wellbeing of local communities. Partners include the NHS and local councils alongside voluntary, community and social enterprise sector organisations

- In April, the Department of Health and Social Care published a White Paper (February 2021): *'Integration and Innovation: working together to improve health and social care for all'*.

- Government and Parliament will establish ICSs in law and remove legal barriers to integrated care for patients and communities. Decisions on legislation will be for Government and Parliament to make.

- From 1 April 2022, Integrated Care Systems (ICSs) will become fully operational as statutory organisations responsible for strategic commissioning, with a financial allocation set by NHS England. In North Central London, our ICS will operate in shadow form this financial year.

The core purpose of an Integrated Care System

- The core purpose of an Integrated Care System is to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - help the NHS to support broader social and economic development.
- Each ICS will have a responsibility to coordinate services and plan health and care in a way that improves population health and reduces inequalities between different groups.
- This way of working closely reflects how the NHS and Councils in North Central London have already been working together in recent years, to improve our population's health and reduce inequalities through greater collaboration.

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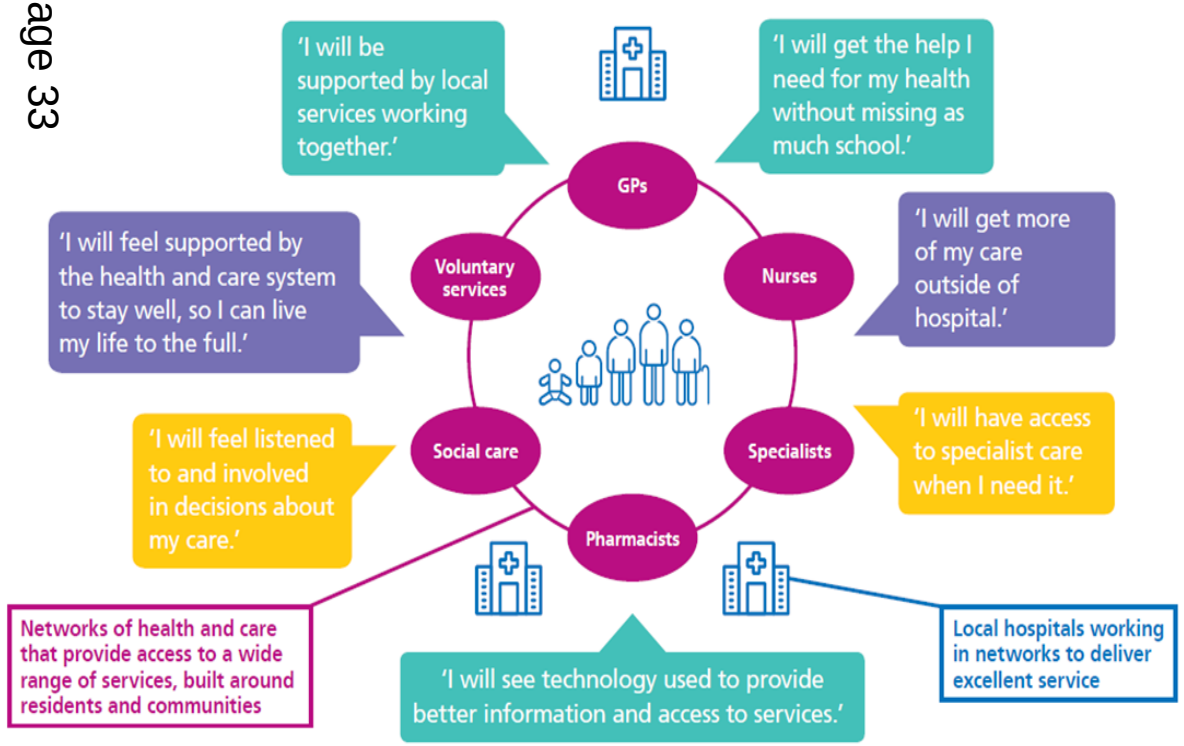
What will this mean for residents?

Faster progress towards what residents have told us they want from local services:



And an increased system-focus on the wider determinants of health and wellbeing:

- Fulfilling work
- Education and skills
- Our surroundings
- The food we eat
- Money and resources
- Transport
- Housing
- The support of family, friends and communities

Building on strong foundations in NCL

- Whilst ICSs are new statutory organisations, we have a track record of close working between partners, NHS and LA, through the STP and other collaborative programmes of work.
- In April 2020 the five Clinical Commissioning Groups in North Central London (NCL CCGs) – Barnet, Camden, Enfield, Haringey and Islington – merged to form one CCG.
- We have strong partnerships already formed in each borough to support working at a ‘place’ level
- Alongside this, we have 33 thriving primary care networks across the area.
- Over the last year system partners have worked closely together, with the CCG, Councils, NHS providers, general practices, voluntary and community organisations, working to respond to the pandemic.
- There has been continued progress towards a more strategic approach to health commissioning at NCL-level, and within our borough partnerships.

Building on strong foundations in NCL

- The new legislation will mean the NHS moves away from the current way of planning and paying for healthcare.
- In the current system NHS hospitals were encouraged to compete with each other to provide the best care possible.
- This improved quality, but has meant it is harder to move money to prioritise prevention.
- The new way of working will support more collaboration and joint planning between NHS organisations with the aim of both improving quality and investing in preventative and proactive care.

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Building on strong foundations in NCL

Responding to the Covid-19 pandemic has accelerated, and consolidated, ways the system worked together to deliver for residents. Acting like an ICS already in many ways:

- **Innovative approaches to patient care -** pulse oximetry led by primary care and virtual wards led by secondary care to avoid Covid patients' admission to hospital and early discharge where appropriate
- **Accelerated collaboration -** single point of access for speedier and safe discharge from hospital to home or care homes; development of post-Covid Syndrome multi-disciplinary teams to support patients
- **Mutual planning and support -** system able to respond quickly to a significant increase in demand for intensive care beds
- **Smoothing the transition between primary and secondary care -** increased capacity for community step-down beds to ease pressure on hospitals
- **Sharing of good practice -** clinical networks to share best practice and provide learning opportunities
- **Clinical and operational collaboration -** Ensuring consistent prioritisation across NCL so most urgent patients are treated first

Benefits of forming an ICS in North Central London

Improved Outcomes

Enable greater opportunities for working together as 'one public sector system' – ultimately delivering improved patient outcomes for our population

Working at Place

Support the further development of local, borough-based Care Partnerships and Primary Care Networks

Reduce inequalities

Identify where inequality exists across in outcomes, experience and access and devising strategies to tackle these together with our communities

Efficient and Effective

Help us build a more efficient and effective operating model tackling waste and unwarranted variation.

New Ways of Working

Accelerate our work to build new ways of working across the system to deliver increased productivity and collaboration

Economies of Scale

Help us make better use of our resources for local residents and achieve economies of scale and value for money

System Resilience

Help us become an system with much greater resilience to face changes and challenges to meet the needs of our local population by supporting each other.

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NCL Integrated Care System: our vision and principles

Our ICS purpose: To improve outcomes and wellbeing, through delivering equality in health and care services for local people. **Supporting them to Start Well, Live Well and Age Well.** We also want to support the many local people who are employed by health and social care to **Work Well.**

Our Principles:

- We will work as one system to benefit the whole population of NCL and work together to drive health equality.
- We will retain the local patient, resident and clinical voice in the commissioning and delivery of health and care, by working effectively together at the three levels of our system.
- We will value our staff, our partners and their expertise to deliver the best health and care possible for the patients and residents of North Central London.
- We will work on a population health basis, planning for population needs as a system, and through local partnerships and neighbourhoods/networks.
- We will work to deliver joined-up care for our population planning around residents not organisations
- We will emphasise the value of subsidiarity, working as locally as is feasible whilst retaining strategic, effective commissioning for North Central London

We will be guided by a shared set of objectives (an 'Outcomes Framework'), setting out the difference we will make for the population in NCL and how we will be monitoring that we are achieving our strategic aims.

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NCL focus on tackling health inequalities

Restore NHS services inclusively	• Ensuring that all analysis undertaken in relation to the restoration of NHS services specifically considers equalities dimensions, including ethnicity and deprivation E.g. in our elective recovery and waiting lists, and community diagnostics hubs • Continuing to build up our population health management platform, HealtheIntent. In six months' time, we plan to have all acute and mental health trusts on HealtheIntent, alongside GPs and Royal Free that are there now. We will have also started onboarding community trust and adult social care data.
Mitigate against digital exclusion	• Commissioning an Equalities Impact Assessment report into the causes and contributing factors to digital exclusion, views from local stakeholders, the impact of Covid, and recommendations for action to address digital exclusion. • Establishing a pilot in Haringey, as a joint initiative with North Middlesex and the local Haringey ICP, that focuses on practical steps that can reduce digital exclusion for those already in the system, i.e. purchasing of hardware. • Prioritising digital exclusion in our most deprived wards through the utilisation of NHS Charities funding.
Ensure datasets are complete and timely	• Use of our population health management platform, HealtheIntent, to understand where care teams can make improvements in recording of equalities data. • System-wide audit on the use of "other" category in ethnicity data
Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes	• Ongoing work with NHSE/PHE to encourage commissioning and delivery of a more culturally and socially competent flu vaccination programme, with appropriate equity monitoring during the coming winter. • Using HealtheIntent for : Deploying a registry for physical health checks among people with serious mental illness, Developing a similar registry for learning disabilities, Deploying our registries for COPD, diabetes, childhood asthma and atrial fibrillation, and dashboards on population health needs, childhood immunisations, frailty and quality improvement for long term conditions. • Working closely with PHE as part of our ICPS, to identify key priorities and implement changes in line with national guidance and the recommendations of publications including Beyond the Data. For example, Enfield is focusing on their most deprived communities, and is jointly funding (with the local authority) community participatory research and community engagement to look childhood obesity.
Strengthen leadership and accountability	• A Population Health Management and Health Inequalities Committee has been established, led by our ICS Chair and with broad stakeholder engagement across local authorities, primary, community and acute services. The aim of this Committee is to embed a population health approach across the system, including a focus on reducing health inequalities.

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Priority NCL ICS Programmes for 2021/22

We have defined 9 clinical and care priorities plus four enabler programme priorities:

- Elective Recovery
- Mental Health
- Community/ Local Care
- Urgent & Emergency Care
- Children, Young People & Maternity
- Primary Care Recovery
- Cancer Alliance
- Diagnostics
- Social Care

+

- Estates
- Workforce
- Digital
- Corporate

Our **Clinical and Care priorities** focus on **tackling health inequalities** and improving the **overall quality of care for our residents through service improvement and transformation -** an integral component being **recovery of services to pre-pandemic levels** in an equitable manner .

Our **enabler programmes** help establish the foundation of a truly integrated care system, and contribute to **releasing system efficiencies** that strengthen our health and care system.

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Governance and structures of the NCL ICS

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Working towards an NCL ICS

Together, system partners are designing what our Integrated Care System (ICS) will look like at neighbourhood, place and system-level

Neighbourhoods build on the core of the primary care networks and **enable greater provision of proactive, personalised, coordinated and more integrated health and social care** through multidisciplinary teams taking a proactive population based approach to care at a community level.

Boroughs are the **critical point of integration and coordination of services**. All boroughs have a **strong sense of defined population being coterminous with local authorities**. The work at borough partnerships is focussed on bringing together partners **develop and coordinate services based on agreed outcomes.**

The NCL ICS will focus on activities that are better undertaken at an NCL level **where a larger planning footprint increase the impact or effectiveness** of these functions. It will also be responsible for **system planning,** towards our goals of reducing inequalities and improving health outcomes.

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Core components of NCL ICS Governance

- There are some elements of system wide governance we will need to set up and implement to support the formation of an ICS. This is subject to legislation and further work locally on how these will work. These are set out below.
- Integrated Care will not just be at system-level but also within our boroughs, or at 'Place'.
- System partners will work together to confirm the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.

Integrated Care Partnership

Guidance to be issued by DHSC in September.

Responsible for developing integrated care strategy for whole population across partners in NCL

Forerunner of this in NCL: **Quarterly Partnership Council**

Integrated Care Boards (ICB)

Unitary (single) Boards to lead integration within the NHS.

Board membership to be outlined in legislation.

Forerunner of this in NCL: **Steering Committee**

Community Partnership Forum

Will bring together NHS, Healthwatch, local authority, VCSE and community representatives for strategic discussions.

Builds on work of the Engagement Advisory Board, established for the North Central London STP

Place-based partnerships

Functions to be exercised and decisions to be made, by or with place-based partnerships at a borough level.

ICB will remain accountable for NHS resources deployed at place-level.

All boroughs have partnerships in place

Provider Collaborative

Will agree specific objectives with one or more ICB, to contribute to the delivery of that system's strategic priorities.

NCL Provider Alliance forming with all providers and Primary Care as members

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North Central London's sustainability and transformation partnership

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Clinicians at the heart of our NCL ICS

Future clinical leadership

- Clinical leadership will remain at the centre of the NCL ICS - at system, place and neighbourhood level
- Must reflect the multidisciplinary nature of an ICS, and the diversity of our population
- Continued need for primary care clinical leadership
- Setting objectives for effective partnership working between clinical and professional leaders, officers and system partners to provide high quality health and care for NCL patients and residents

Our clinical workforce

- COVID has made us think and act in a more integrated way, aiming to deliver the best care for our population
- Development of the North Central London ICS will build on the good work done to support staff throughout the pandemic
- We are looking at the possibility of having some NHS staff based across multiple sites, to manage the demand on the system
- Working together offers the opportunity to reduce duplication, learn best practice and learn from / teach each other

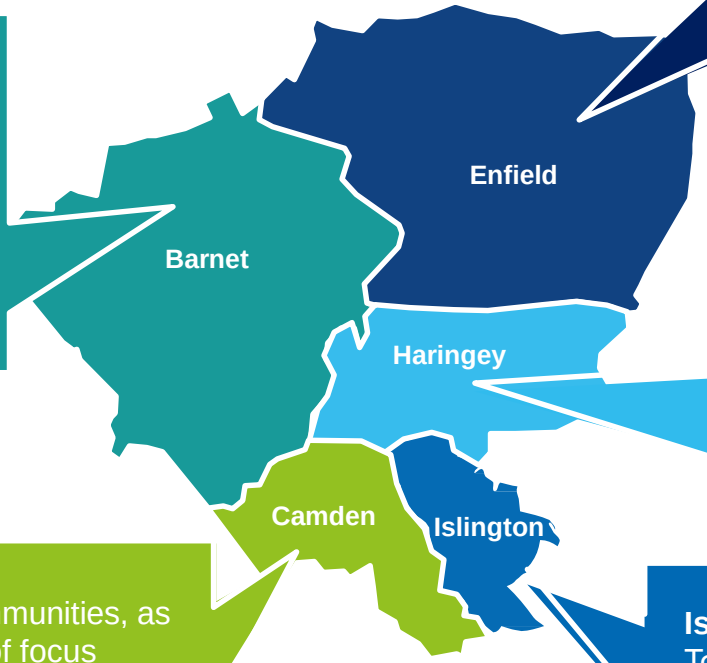
Our Place-Based Partnerships

Enfield - COVID has helped accelerate integrated working. Priorities have been expanded from an initial focus areas following success around flu and Covid vacs. Provider Integration Partnership oversees delivery

- 10 'organisations' represented (25+ members of delivery board)
- 4 PCNs (not geographical – neighbourhoods within @ 50k)

Barnet - Older population gives rise to focus on proactive care, same day urgent care and support to remain independent.

- 1[illegible] + 'organisations' represented (25+ members of delivery board)
- 7 PCNs



Haringey –Focused on expansion of community based care models, MH, wider determinants and inequalities and a local strengths based approach that also addresses risks driven by deprivation.

- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs

Camden – Strong focus on CYP, MH, citizen's engagement/coproduction & dialogue with families & communities, as well as a developing Neighbourhood model. New areas of focus include accelerating provider developments at PCN and borough level and connecting with local communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of ICP/8 PCNs)

Islington – active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (incl police, fire, housing). Senior leadership from Islington Council & CCG. Emphasises joint commissioning, operational joint working & expansion of neighbourhood level delivery. New Delivery Board estbalished to drive key workstreams:

- 15+ 'organisations' represented (25+ members of delivery board)
- 5 PCNs

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Place-Based Partnership priorities

- Covid-19 and flu vaccine programme
- Tackling Inequalities: in outcome, in access, in experience, for deprived communities, for BAME communities
- Mental health and mental wellbeing – for all but especially population groups historically less engaged
- Community joint working and the voluntary and community sector (VCS)
- Health inclusion groups – homeless, asylum and refugee
- Children, Young People and families – support to deliver key outcomes and address the impact of the pandemic 20/21
- Access – inclusive, appropriate, timely – focus on specific groups e.g. people with learning disabilities, serious mental illness, refugees
- Digital inclusion/exclusion
- Wider determinants including employment and housing
- Priority outcomes and populations, including those groups at risk of disadvantage/worse outcomes during the pandemic
- Proactive and Personalised care in the community – including use of technology, expansion of social prescribing models
- Urgent community response – in particular joint working across primary, community and social care supported by VCS

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Building resident and community voices at the heart of our ICS

Community involvement and representation

Health and Wellbeing Boards

Health and Wellbeing Boards are linked to all borough partnerships:

- Most boroughs have updated their Health and Wellbeing Board ToR to include a link to the Borough Partnerships.
- Cllrs are largely engaged through the HWBB although there is increasing interest in direct involvement.
- HASCs also regularly request reports on the development of integrated care locally.

Patient & resident involvement & engagement

Patient and resident engagement is being undertaken in different forms across borough partnerships:

- All partnerships have their local Healthwatch as members on their partnership groups.
- Some Healthwatch members leads on specific areas of focus/priorities within the partnership.
- Most ICPs have engagement groups (e.g. Haringey Citizen Health & Care Advisory Board, Camden Citizens Assembly, Islington conducts regular community engagement events).
- Some CCG borough teams also support a patient engagement forum, with resident and VCS representation.
- CCG Community Members sit on many of our committees and support wider engagement work.

Engaging the VCS

Voluntary & community sector organisations play a role in all partnerships:

- VCS is represented on all partnership groups across all boroughs. In some, VCS leads on priorities areas (for example MIND in Camden alongside CIFT).
- In all others they are “plugged into” the work and have played an increasingly significant role in delivery of partnership plans (social prescribing, mental health and wellbeing support, delivery of equipment, support to access services, support to comms campaigns such as flu).

Principles for communication and engagement

Effective communication and engagement across partnerships will be key to the ICS development and implementation. The key principles we will work to are included below.

Shape a programme of collaborative work between CCG, Council and Provider comms and engagement team – to build shared processes and ways of working for the future ICS, focused on:

- Building shared approaches to engagement, co-production etc.
- Models to bring together resource (staff and budgets) from across partner organisations
- Regular opportunities to share practice and make connections on engagement work across organisations
- Processes to centrally collect and report on insights to inform plans and decisions
- Shared evaluation models to demonstrate impact of engagement / community involvement
- Workforce training – develop skills to work with communities and VCSE, and build understanding that this is part of everyone's role in tackling health inequalities.

ICS Community Partnership Forum

- Established to oversee ICS resident engagement and involvement – to be aligned strategically with the ICS Quarterly Partnership Council and ICS Steering Committee.
- An expert reference group on community engagement as well as a forum for discussion and debate on emerging proposals and strategies.
- The Forum met for the first time in October 2021, and will meet quarterly.
- Current membership includes:
  - North Central London ICS Chair
  - North Central London Provider Alliance Chair
  - North Central London Executive Director of Strategic Commissioning
  - North Central London Executive Director of ICS Transition
  - Healthwatch representatives from the five boroughs
  - Council of Voluntary Services representatives from the five boroughs
  - Patient representatives from the five boroughs
  - Communication and Engagement reps from NCL Clinical Commissioning Group

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Community involvement and representation

Strong resident, patient and VCS involvement (at system, place and neighbourhood level) is critical. Over the next six months we will seek views, including the below areas of focus - from the ICS Community Partnership Forum, CCG Patient Public Engagement and Equalities Committee, Council Leaders, elected members, our Healthwatches and VCS, and wider audiences.

Ongoing Work to do at System-Level:

- Ensure transparent governance – public board meetings; resident, service user and carer representatives in governance etc.
- Developing shared principles and methods for involving people and communities, and co-production
- Capturing insights to build a picture of resident priorities and needs, and acting on this as a system
- Develop a shared approach to involvement / decision making with VCSE, supporting a resilient third sector

Ongoing Work to do at Place-Level

- Develop place-based partnership approaches on engagement and involvement, linked to ICS framework
- Ensure partnership links with HOSCs, HWBB, Healthwatch and VCSE sector are strong and effective
- Support Primary Care Networks and neighbourhood team links into communities
- Make every contact count to signpost residents to services and support

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Key stakeholders

Organisation	Stakeholder group
North Central London CCG	Governing Body, Executive Management team, Extended Executive Management team, Clinical Leads, union reps, all staff
Local authority (Barnet, Camden, Enfield, Haringey and Islington)	Council leaders, Chief executives, health and social care leads, Directors of adult social care / services, directors of public health, directors of children's social care / services, comms leads, council staff
NHS providers (incl mental health trusts, acute trusts and community trusts)	Chairs, Chief executives, Chief operating officers, Medical directors, nursing leads, comms leads, Trust staff
Primary care	LMC, Federation leads (chairs / chief execs / chief operating officers), PCN clinical directors, GPs, practice managers, practice staff
Cross-cutting groups	Health and Wellbeing Board representatives, Joint Health Overview and Scrutiny Committee members, borough Health Overview Scrutiny committees (HASC / HOSC)
Elected members	MPs (x 12); Councillors
VCSE	Healthwatch (x5) – Chief executives, Chairs, comms leads; NHS charities; VCSE organisations aligned to priorities (including but not limited to): mental health, children and young people, aged care and ageing, long term conditions; cancer; maternity and women's health
Patient / resident groups	Resident health panel, CCG patient groups (organised by borough), strategic review reference groups, Trust patient reference groups, Council patient reference groups, VCSE groups

Barnet, Camden, Enfield, Haringey and Islington residents and communities

If you have a question about our transition to an Integrated Care System in North Central London, please contact us at northcentrallondonics@nhs.net in the first instance.