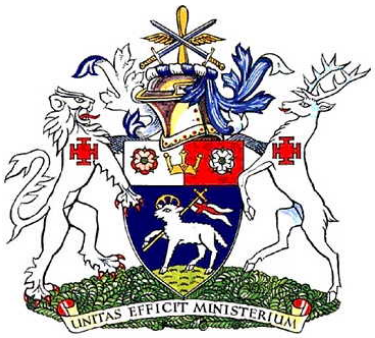	**Adults and Safeguarding Committee** **Date 5th June 2019**
Title	An update on the NHS Long Term Plan and Integrated Care Systems
Report of	Cllr Sachin Rajput – Committee Chairman
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
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Summary

The NHS Long Term Plan (LTP) envisages a shift of resources to community services from hospital settings and the integration of services around the needs of populations, with a greater focus on prevention. The LTP sets out organisational change for the NHS through the development of "integrated care systems" (ICS) which are to be based on the same geographical areas as Sustainability and Transformation Partnerships (STP). This report updates the committee on the way in which health services in the North Central London (NCL) STP are responding to the Long Term Plan; how Councils have inputted into these developments so far; and some of the key considerations from this for Barnet Council.

Officers Recommendations

1. **The Adults and Safeguarding Committee is asked to note and comment on the content of the report.**

1. WHY THIS REPORT IS NEEDED

1.1 The NHS Long Term Plan (LTP) sets out new requirements for the NHS, which will impact on how services are designed and delivered across England. The North Central London Sustainability and Transformation Partnership (the STP) has been developing proposals for greater integration of services through across the sub-region and in each borough. This report sets out some of the key requirements within the LTP, how these are being developed within NCL and some key considerations for the Council.

1.2 Barnet Council has a history of collaborative working with local health services and a range of integrated services and programmes of work in place. These were previously reported to this committee in September 2018. In addition, the five north London Councils in the STP footprint (Barnet, Camden, Enfield, Haringey and Islington) have developed a collective programme of work to enable a strong local authority voice within the STP. The Council is therefore well placed to explore new partnership arrangements that could deliver better health and wellbeing outcomes for residents.

2. THE NHS LONG TERM PLAN

NHS England (NHSE) published the LTP for the future of the health system in January 2019. It sets out plans intended to improve health outcomes for the population by moving away from reactive treatment of disease or individual conditions towards a greater focus on meeting the needs of the whole person and communities, through more preventative and joined up care.

2.1 The main resident benefits envisaged in the LTP include:

- Improving health outcomes in areas such as heart disease, stroke and cancer;
- Significant targets to improve access and quality of mental health services for adults and children (supported by a commitment to increase the rate of funding for the mental health system at a greater level than the overall increase in funding to the NHS);
- Helping more people to live independently at home for longer and preventing unnecessary hospital admissions (supported by an increase in primary and community care funding and the creation of primary care networks and expanded multi-disciplinary primary and community teams)

Changes will be supported by different services working together in more integrated ways to support holistic care and improved experience of care. A more detailed briefing on the LTP is available from the LGA[1]

2.2 To deliver these resident benefits, the LTP set out a 5 year NHS funding settlement with an average 3.4% increase in funding per annum. The NCL STP increase in funding in 2019/20 equates to around £114m. However, the NCL STP is one of the most financially challenged in England with a structural deficit of around £150m. In addition, the LTP only refers to NHS funding and does not address funding for social care or public health, which is critical to deliver the resident benefits set out above. This financial context will

[1] See https://www.local.gov.uk/sites/default/files/documents/20190117%20LGA%20briefing%20-%20NHS%20Long%20Term%20Plan%20FINAL.pdf

make it challenging for local systems to make the investments in prevention, primary and community health and care envisaged in the LTP.

2.3 The LTP also set out some significant changes to commissioning, with a requirement that all STPs will become Integrated Care Systems (ICS) by April 2021. Integrated care systems are defined by NHSE as systems where "NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve."[2] In a pure model, they involve an entity, often a partnership vehicle, which holds the entire budget for population health, including primary and community health services; mental health services and acute care. It could also include relevant council budgets such as public health or adult social care. There are various early examples of new ICS arrangements that are summarised in appendix 1.

2.4 The expectation is that ICS will enable and promote increased integration of different services, such as primary and community care and mental and physical health as well as health and social care. The benefits of this are expected to be that with "organisations and frontline professionals working together more closely", "patients [will see] services work in a more joined up way, [will only have] to tell their story once and [will receive] care better tailored to their individual needs".[3] This will be underpinned by better data and information sharing between services to enable targeting of more proactive, preventative support. NHS Regulators (NHSE and NHS Improvement) will focus more on how providers work collaboratively to improve resident outcomes.

2.5 There is also the expectation that health commissioning will become more long term, strategic and that the cost of commissioning will be vastly reduced. The key requirement is that in time there will be one CCG for each STP area, which would mean Barnet CCG merging with the other 4 NCL CCGs. Whilst there is no published timeline, it is understood that NHSE are expecting local systems to move at pace on this requirement. In addition, each CCG is expected to make 20% management savings in 19/20.

2.6 The LTP argues for a greater level of integration between the health and social care systems; and sees ICSs as the key mechanism through which the NHS will work with councils at the local level. The LTP does not set out detail about the wider role of local authorities in promoting wellbeing, tackling health inequalities and as a leader of place. The plan does not set out details about how local democratic accountability may play a part in ICSs.

3. DEVELOPMENTS IN NCL

3.1 Before the Long Term Plan was published, the STP convenor, Helen Pettersen (who is also the accountable officer of the 5 north London CCGs), hosted an NCL workshop on the future of integrated health and care in north London. The purpose of this was to test out some ideas and proposals about Integrated Care Systems.

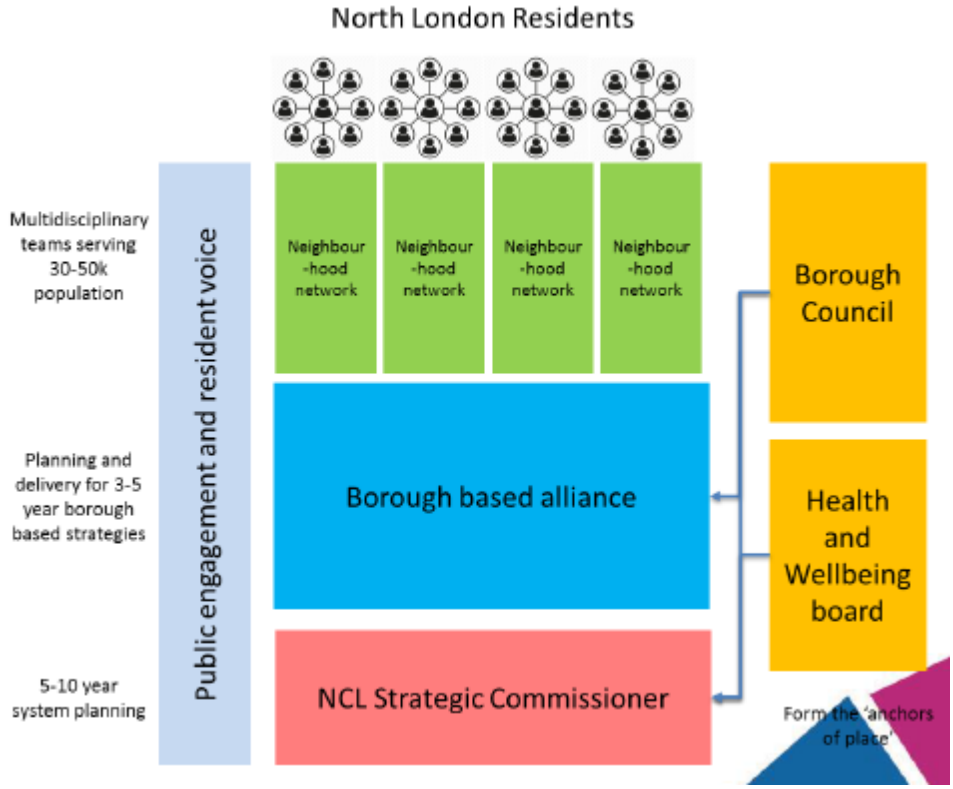
3.2 Following the initial event, 5 further workshops were held (1 in each borough) between January and March, which included Members and senior officers from each council. At

[2] http]s://www.england.nhs.uk/integratedcare/integrated-care-systems/ accessed 22.05.19.

[3] As above

the Barnet event, Cllr Caroline Stock as chair of the Health and Wellbeing Board attended, along with senior officers. HealthWatch and patient representatives also attended. The event demonstrated shared aspirations to improve resident outcomes and the various organisations committed to ongoing meetings to further develop the Barnet response to the LTP requirement.

3.3 Following these workshops, the NCL STP developed a set of draft high-level proposals for how health and care services might be arranged, summarised in the diagram below:



3.4 In this model it is envisaged that providers will work together at a borough level to shape services around the needs of local residents (rather than an STP level). The model links councils and Health and Wellbeing Boards to both borough and strategic level activity. There is also a commitment from the STP that the borough is the dominant level for the planning and delivery of health and care services. Whilst the proposals are currently limited in detail, Helen Pettersen has committed to working with all partners to explore proposals and develop the detail with an intention of developing “shadow arrangements” later this year.

3.5 The STP recently appointed Mike Cooke, former Chief Executive of Camden Council, as the Independent Chair of the STP. This new role has been established to “provide independent leadership of the STP, establish a Partnership Board for North Central London by April 2020, support the implementation of the STP and the development of an Integrated Care System (ICS).”[4]

4. COUNCIL RESPONSE AND IMPLICATIONS

[4] Job advert from https://www.jobs.nhs.uk/showvac/1/2/915511158 accessed on 22.05.19.

4.1 Barnet Council have sought to engage meaningfully with the STP programme and local NHS partners to date. Progress reports on the STP have been presented to the HWB on a regular basis. Specific items have also been scrutinised at the Health Overview and Scrutiny committee in Barnet and at the north London level.

4.2 There is no national requirement for councils to be part of ICSs. Different councils have approached local developments differently (see appendix 1). The rest of this report sets out some considerations for councils in relation to the proposed north London model for the committee to comment on.

4.3 **Borough based partnership:** It is welcome that there is a commitment to the borough being the meaningful level for the planning and delivery of the majority of services. At this point however neither the level of autonomy this will entail nor the relationship with the "STP strategic commissioner" is clear. A key test for the Council is that we should be able to meaningfully influence the development of local primary and community health services to ensure that they respond to the needs of Barnet's population. Councils are well placed, with health partners, to agree local priorities for investment and how to integrate services in a way that makes the greatest improvement in health and wellbeing for our residents.

4.4 **Enhanced democratic accountability:** A key requirement for councils should be that new ICS arrangements strengthen local democratic accountability, which should be more easily achieved within a strong autonomous borough partnership that responds to priorities set by the Health and Wellbeing Board. At the NCL level, councils are making the case that democratic leadership should sit alongside clinical leadership to guide health and care priorities.

4.5 **Strengthened public accountability:** In this model, the STP has committed to increase public engagement. There should be strong engagement at the borough level, building on existing infrastructure and approaches where this works well. Councils are experienced in shaping services with our residents and understanding their priorities and we think health colleagues can learn from our approach.

4.6 **Shared commitment to change:** Developing more integrated arrangements will require a significant culture change from all partners. It will necessitate thinking about the total resources for health and care and making bold proposals to deliver more preventative and pro-active services. This will require a high level of trust and an enduring commitment from all key partners to change how services are delivered and to shift the balance of resources.

4.7 **Breadth of the partnership:** The model above focuses on health care services. It is important that any new arrangements, if they are to deliver a meaningful change, consider the whole population and are committed to addressing the wider determinants of health, such as employment, housing, community safety and lifestyle factors. It will also be important to ensure that there is a strong voice and role for the voluntary sector and social care providers in shaping service delivery.

5. REASONS FOR RECOMMENDATIONS

5.1 The NCL response to the LTP is currently being developed with partners and is evolving. Each CCG has been tasked by the STP convenor to engage with local partners, including councils, to explore how the proposed model could work in the local borough. There is an appetite from NHS partners to explore different arrangements and there are opportunities for improved outcomes for our residents from increasing investment in proactive and preventative health and care services. Continuing to actively engage and shape proposals presents the best opportunity to realise improved outcomes.

6. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

6.1 The Council could choose not to engage with this process concerning the arrangements the NHS aims to put in place in the future. This is not recommended as engaging with the process creates an opportunity to articulate the needs of residents and the potential to improve health and wellbeing outcomes.

7. POST DECISION IMPLEMENTATION

7.1 Officers, the committee chairman and the chairman of the health and wellbeing board will continue to engage in the process. Officers will bring back a further report when more detailed proposals are developed.

8. IMPLICATIONS OF DECISION

8.1 Corporate Priorities and Performance

8.1.1 This area of work is clearly aligned to our corporate aim that “our residents live happy, healthy, independent lives with the most vulnerable protected”. The priorities will also support the delivery of the Health and Wellbeing Strategy.

8.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

8.2.1 Engaging with this process will be delivered within our existing resources. The aim of developing a strong borough based partnership would be to invest in more pro-active and preventative models of care that would support efficient use of social care and health resources.

8.3 Social Value

8.3.1 We are seeking to strengthen our partnership arrangements with health providers in such a way that addresses wider determinants of health, such as employment and housing challenges, and has a strong voice for Barnet voluntary sector and social care providers.

8.4 Legal and Constitutional References

8.4.1 The Council’s Constitution (Article 7, Article 7 – Committees, Forums, Working Groups and Partnerships) sets out the responsibilities of all council Committees. The responsibilities of the Adults and Safeguarding Committee include:

(1) Responsibility for all matters relating to vulnerable adults and adult social care.

(2) Work with partners on the Health and Well Being Board to ensure that social

care interventions are effectively and seamlessly joined up with public health and healthcare and promote the Health and Wellbeing Strategy and its associated sub strategies.

8.5 Risk Management

8.5.1 Risks will be managed in relation to Barnet's corporate approach to risk management.

8.6 Equalities and Diversity

8.6.1 In developing proposals we will have regard to the council's Equalities Policy together with our strategic Equalities Objective - as set out in the Corporate Plan - that citizens will be treated equally with understanding and respect; have equal opportunities and receive quality services provided to best value principles.

8.6.2 Progress against the performance measures we use is published on our website at: www.barnet.gov.uk/info/200041/equality_and_diversity/224/equality_and_diversity

8.7 Corporate Parenting

8.7.1 In line with Children and Social Work Act 2017, the council has a duty to consider Corporate Parenting Principles in decision-making across the council. In engaging with this process, officers will ensure that the health and care needs of looked after children and young people; and care leavers, are considered by those developing the STP ICS model.

8.8 Consultation and Engagement

8.8.1 As proposals begin to emerge we will ensure these are shaped by resident engagement, through liaison with HealthWatch, the council's Involvement Board, and engagement mechanisms for children and young people.

8.9 Insight

8.9.1 The Council's position is informed by local, sub-regional and regional engagement; our understanding of the health and wellbeing of our communities articulated in the JSNA and our experience of developing effective integrated services with health partners.

9. BACKGROUND PAPERS

9.1 Integrated health and social care to the Adult and Safeguarding Committee on 20 September 2018.

Appendix 1

Some brief examples of areas that are reported as developing new integrated care system type arrangements:

Salford (pop 230,000):

Acute hospital, community health, mental health and social care incorporated within an integrated care organisation. Core primary care not included, but part of wider integrated system. Initially continuation of block and PBA for organisations, with a plan to move to capitated payments over time. Salford Royal NHS Foundation Trust likely to provide acute, community and social services, and sub-contract for others. Currently working with commissioners and Salford Primary Care Together (GP provider body) to develop accountable care organisation model. Plan for a 5 year contract with option to extend for a further 5 years.

Northumberland (322,000):

Very similar scope to Salford, but with a plan to transfer a whole population budget immediately. Led by Northumbria Foundation Trust and planned 10 year contract.

South Somerset (135,000-500,000)

Seeking to set up a joint venture vehicle between the acute Foundation Trust, General Practice and possibly wider partners with responsibility across acute, community, mental health and some primary care (not core primary care). Intending to explore including social care later. Plan to start with south Somerset and expand to county wide over time.

Dudley (318,000)

Scope is to include core and enhanced primary care, community and mental health, some outpatient and urgent care. Social care not included initially. Build around GP neighbourhoods. Seeking a single company to deliver and sub-contract services under a long-term contract.

Wakefield (363,000)

Scope of integrated budget is non-core primary care; community health, most mental health and some adult social care and public health. No acute services are included; however, the intention is to shift activity from acute to community with a focus on prevention and early intervention. Looking to transfer a whole population budget for 10 years to a new organisation with partners exploring a joint venture.

Cornwall

Cornwall Council is set to take over the functions of Kernow Clinical Commissioning Group as part of the development of an accountable care system.
Local Government Chronicle reports that the system, which is set to begin operating in shadow form from April, will see an “integrated, strategic commissioning function” based in the council, which will commission services from one or more “accountable care partnerships” based around the existing NHS providers. These are Royal Cornwall Hospitals Trust and community and mental health services provider Cornwall Partnership Foundation Trust.

Manchester

Manchester has won new delegated powers as a health system, which has seen each borough developing joint integrated commissioning arrangements in a variety of forms and new provider partnerships, this has included City of Manchester Council and 3 CCGs establishing a new commissioning organisation, and in some areas (such as Oldham, Rochdale, Thameside) the Council CEX becoming the accountable officer of the CCG. The emphasis has been on individual borough level plans being a key building block of the overarching system plan, whilst responding to system wide drivers where required. Integrated commissioning has also enabled a greater focus on wider determinants of health such as employment pathways and integrating wider public sector services with health and care, such as housing and community safety.