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Adults and Safeguarding Committee

17 September 2020

Title	**Integrated Care**
Report of	Councillor Sachin Rajput – Committee Chairman
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Summary

This report has been prepared to provide information on the progress made in the Barnet Integrated Care Partnership.

Officers Recommendations

1. **The Adults and Safeguarding Committee is asked to note the contents of the report and provide comments to inform the continuing development of the Barnet Integrated Care Partnership.**

1. WHY THIS REPORT IS NEEDED

1.1 Alongside the health and social care system response to the Covid-19 pandemic, the governance and organisation of the health system significantly changed on 1 April 2020. The five CCGs across North Central London merged together and the Integrated Care System (ICS - previously the Sustainability and Transformation Partnership or STP, across all NCL) and Integrated Care Partnerships (ICP - for each borough) have become the primary vehicle for joined up working between partners.

1.2 Partners across health and social care in Barnet have regularly come together to jointly plan for the local system. There has also been additional work across the whole of North Central London to support learning and resilience. This has resulted in, amongst other things, capacity planning, the mobilisation of additional rehabilitation beds, the block purchasing of care home beds, the development of new pathways – all focused on ensuring the right support for residents.

1.3 This report sets out some of the areas of focus over the last few months, the new governance arrangements and the next steps and objectives of the key workstreams within the Integrated Care Partnership.

2. REASONS FOR RECOMMENDATIONS

Barnet ICP work programme

Enhanced Health in Care Homes

2.1 Prior to the pandemic, there was already a significant focus within the NHS on work to ensure that primary care and community health services provided an enhanced level of care to people who live in care homes.

2.2 In March 2020, NHSE/I published the Enhanced Health in Care Homes (EHCH) Network Contract Directed Enhanced Service (DES) and accompanying EHCH Framework (EHCHF) with the intention that this would be delivered from 1st October. During COVID-19, on 1st May, NHSE/I published a letter asking primary care and community health services to provide a minimum level enhanced support to care homes from 15th May.

2.3 37% of North Central London's care homes are located within Barnet, making up 44% of the NCL care home bed base, but despite this, Barnet has historically been the only NCL borough without an in-reach model of clinical support, to provide enhanced healthcare support to some of the borough's most clinically vulnerable residents. The need to provide the right clinical offer to care homes became even more acute during the early weeks of the pandemic.

2.4 In response to this, and the requirements set out in the NHSE/I letter, a task and finish group including health and social care representatives and a range of clinicians, developed and mobilised a Covid19 focused in-reach offer for Barnet's care homes which went live in May 2020.

2.5 This was a nurse led intervention working in partnership with GPs to provide a specialist and multidisciplinary approach to registered nursing and residential homes that had the highest number of non-elective hospital admissions, alongside homes which were identified as needing additional support during the Covid-19 response.

This service, the Barnet One Care Home Team, has three primary functions:

a) To support the review of patients identified as a clinical priority for multi-disciplinary assessment and care, identified through the General Practice weekly 'check in' with care homes.
b) To support the delivery of personalised care and support plans for care home residents.
c) To provide medication support to care homes.

2.6 The One Care Home Team worked alongside the council's Care Quality and Public Health teams to provide wrap-around support to homes throughout the pandemic period.

2.7 Building on the learning gained throughout the period, the Integrated Care Partnership is now overseeing the development of a long term clinical model for Barnet's care homes, in line with the requirements of the primary care DES and informed by the Enhanced Health in Care Homes Framework.

2.8 A task and finish group, reporting to the ICP Delivery Board, including leads from the CCG, council, Primary Care Network Clinical Directors, the local acute hospital and the community services provider, is working to design the future in reach offer.

2.9 Consensus recommends that a community based clinical in-reach team comprising of matrons and other allied professionals, along with access to specialist input from geriatricians and other specialists when required, provides the highest level of quality care. The model is based on best practice and evidenced through similar schemes currently available in other NCL boroughs where such provision has demonstrated improved outcomes for people and for reduced activity in secondary care.

Same day access to health services and supporting discharge from hospital

2.10 There has been a huge amount of joint working on hospital discharge with the council's NHS partners during this period. The emergency Covid-19 arrangements brought in a new approach focused on extremely rapid discharge once patients were medically optimised to maximise hospital capacity to cope with Covid positive patients.

2.11 One of the first major changes was the creation of an integrated discharge team bringing together staff from the council, Central London Community Health (CLCH), North Central London Clinical Commissioning Group (the CCG) and the Royal Free Group (Barnet Hospital). This team has worked seven days a week from 8am to 8pm to ensure residents do not stay in an acute hospital when they are ready to leave, but with some additional support. Hundreds of residents have now been discharged with social care and / or health support, either straight home, to a rehabilitation bed in a community hospital or to a care home.

2.12 This new way of working has led to a change in social work practice. The required speed of discharge, and the inability to access the wards and see people face to face, means that the integrated team will work together with the individual and their family or advocates to identify the immediate support required to return home with more focused and person-centred support planning taking place post-discharge. Those discharged into nursing care have been case-managed by the CCG's nurse-led continuing healthcare team.

2.13 The funding regime also changed, with free care and support provided to all those discharged from hospital or for those where additional care and support was preventing a hospital admission. The continuing health care (CHC) regime was therefore suspended. This changed on 1 September 2020 when there was a switch to provide free care and support for up to 6 weeks following discharge to allow for assessments and eligibility determination to take place outside of the acute hospital. The CHC regime has now been re-introduced and there is a significant backlog of people requiring an assessment to clear. The 6 weeks of funding will ensure that any disputes over eligibility for CHC and which organisation should fund care will not delay discharge from hospital as this can be resolved within the period of temporary funding.

2.14 Between the period of September to March the five councils in North Central London will be working with the CCG to review those funded under the emergency Covid arrangements, determine the support these adults require going forward and their eligibility for continuing health care. The council has already started to financially assess these individuals so they are aware of their maximum contribution towards the cost of their care and support if they are assessed as not eligible for CHC. Both the council and the CCG will be recruiting additional staff to undertake this exercise.

Integrated Pathways

2.15 Integrated care pathways are a vital part of maximising good outcomes for individuals in health and social care, as they create a comprehensive journey for the person utilising a multi-disciplinary approach to treatment, support and management, particularly of specific conditions or diagnoses.

2.16 A central plank of developing new and improved pathways for integrated care are through Primary Care Networks (PCNs). These are also a key part of the NHS Long Term Plan, with general practices being a part of a network, which provide the structure and funding for services to be developed locally, in response to the needs of the patients they serve.

2.17 Primary Care Networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care.

2.18 Primary Care Networks are based on GP registered lists, typically serving communities of around 30,000 to 50,000. They are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system.

2.19 Throughout the pandemic, there have been a range of initiatives to support local primary care services to effectively manage patient flow, ensure pathways are joined up and that local residents have access to the right healthcare and associated services when they needed it.

2.20 Examples include:

a) the commissioning of hot and cold clinics via the GP federation, which could be scaled up and scaled back as necessary.
b) Support to care homes as set out above
c) Roll out of iPads for all care homes to enable video consultations to be completed.
d) Additional IT equipment for all 52 local practices to enable staff to work remotely
e) SATs probe delivery service, manned by volunteers and coordinated through the council's Covid community response programme, to monitor patients safely from their own home
f) Review of shielded patients to ensure all vulnerable patients on the lists to be followed up

2.21 Moving forward, the focus is on working to developed integrated pathways for specific cohorts and conditions. This will initially involve the development of community hubs for older people and scaling up of the frailty model already in place in parts of the borough, for wider roll out across Barnet

2.22 The workstream will also further develop integrated models supporting individuals to self-manage and consideration of improved support for older people with long term conditions such as diabetes, chronic obstructive pulmonary disease or arthritis.

2.23 The Barnet Integrated Care Partnership (ICP) are committed to reducing the future impact of COVID on the different ethnic minorities who were particularly adversely affected by COVID-19 during the first wave of the pandemic. The recent Public Health England reports demonstrated the unequal impact on different ethnic groups of the first wave of the pandemic [1]. More than a third of residents of Barnet are from Black, Asian or other ethnic groups. Four wards within Barnet (Colindale, Burnt Oak, West Hendon and Hale) have a higher proportion of residents from these groups than the London average of 40%. One quarter of all Barnet adults do not speak English at home. HealthWatch have been commissioned to engage with local residents to understand the impact of COVID on different local communities. NHS guidance on Phase 3 of addressing the COVID pandemic [2] stresses the importance of addressing health inequalities in the Integrated Care System, which is developing plans in response to the national guidance.

2.24 The ICP has committed to develop a new work programme to address COVID health inequalities which will include risk factor reduction, culturally competent communications in appropriate languages, and supporting community organisations which support the Barnet diverse communities. In addition, Public Health are in the process of setting up a COVID community champions programme to support individuals to share evidence based messages with their communities but also get feedback from individuals about the challenges they face in dealing with any COVID restrictions.

ICP and ICS governance

2.25 As referred to in 1.1 above, NHS Sustainability and Transformation Partnerships (STP) have been retitled integrated care systems (ICS) by NHSE/I. NHS guidance indicates that in future ICSs may become formally constituted. The north central London STP is now therefore known as the NCL ICS. Each borough in NCL has established an integrated care partnership (ICP), which forms part of the ICS. The ICS is developing a refreshed programme governance structure, and has appointed Rob Hurd, accountable officer of the RNOH, as its first System Lead. This role provides day to day leadership across the partner organisations for ICS priorities.

2.26 The Barnet ICP is led by a board consisting of officers from Barnet council, NCL CCG, the Royal Free, Central London Community Health, Barnet, Enfield and Haringey mental health trust, Barnet GP Federation and clinical director representatives of Barnet primary care networks. Chairing of the board is shared on a rotational basis by board members. The work programme is delivered by an operational delivery board, again comprising all partner organisations. This board is chaired by the executive director - adults and health, from the council.

2.27 Following the appointment of a new Accountable Officer in February 2020, and the impact of the Covid19 on changes in working practices, approaches to partnership and service delivery, the CCG has now commenced a second consultation on the future structure of NCL CCG. Staff will be consulted though the Autumn with a new structure due to be in place by April 2021.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Integrated health and care is priority in the council's corporate plan and a national requirement for the NHS.

4. POST DECISION IMPLEMENTATION

4.1 Officers will continue to report progress on the Barnet ICP to the committee. Any items arising from the ICP work programme that require a committee decision will be brought to committee at the appropriate time.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

a) Barnet Council's corporate plan 2019-2024 sets out a commitment to supporting residents to live 'happy, healthy, independent lives with the most vulnerable protected'. It also sets out as an objective "supporting our residents who are older, vulnerable or who have disabilities, to remain independent and have a good quality of life".

b) The approach taken to working with health partners is in support of this objective.

5.2 Resources (Finance and Value for Money, Procurement, Staffing, IT, Property, Sustainability)

There are no additional resource implications for the council arising from the recommendations of this report. The activities listed will be managed within the appropriate organisation's budgets.

5.3 Social Value

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

The Covid-19 Hospital Discharge Service Requirements published on 19 March 2020 required acute and community hospitals to discharge all patients as soon as they are clinically safe to do so. It suspended the duty of the responsible body to carry out Continuing Health Care

Assessments and the Coronavirus Act 2020 made provision for this extension to continue during the emergency period.

The suspension ended on 1st September 2020, and a new operating model (Guidance Hospital discharge service: policy and operating model) replaces the emergency discharge provisions. Guidance on the Reintroduction of NHS Continuing Health Care (NHS CHC) was published on 21st August 2020.

The Terms of Reference for the Adults and Safeguarding Committee are set out in the Council's Constitution (Article 7) as follows:

(1) Responsibility for all matters relating to vulnerable adults, adult social care and leisure services.
(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 Well Being Strategy and its associated sub strategies.
(3) To submit to the Policy and Resources Committee proposals relating to the Committee's budget for the following year in accordance with the budget timetable.
(4) To make recommendations to Policy and Resources Committee on issues relating to the budget for the Committee, including virements or underspends and overspends on the budget. No decisions which result in amendments to the agreed budget may be made by the Committee unless and until the amendment has been agreed by Policy and Resources Committee.
(5) To receive reports on relevant performance information and risk on the services under the remit of the Committee.
(6) To recommend for approval fees and charges for those areas under the remit of the Committee.

5.5 **Risk Management**

The council has an established approach to risk management, which is set out in the Risk Management Framework. The work programme of the ICP includes risk management within its programme structure.

5.6 **Equalities and Diversity**

a) Equality and diversity issues are a mandatory consideration in the decision-making of the council. The Equality Act 2010 and the Public-Sector Equality Duty require elected Members to satisfy themselves that equality considerations are integrated into day-to-day business and that all proposals emerging from the business planning process have taken into consideration the impact, if any, on any protected group and what mitigating factors can be put in place.

b) The public-sector equality duty is set out in s149 of the Equality Act 2010. A public authority must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

c) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it; and
c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

d) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include steps to take account of disabled persons' disabilities.

e) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, the need to:
a) Tackle prejudice; and
b) Promote understanding.

f) The relevant protected characteristics are:
- Age;
- Disability;
- Gender reassignment;
- Pregnancy and maternity;
- Race;
- Religion or belief;
- Sex; and
- Sexual orientation.

5.7 **Corporate Parenting**

In line with Children and Social Work Act 2017, the council has a duty to consider Corporate Parenting Principles in carrying out any functions that relate to children and young people. The services set out in this report relating to health service access are relevant to young people and care leavers.

5.8 **Consultation and Engagement**

Integrated care is a priority within the council's corporate plan. Consultation on the Corporate

Plan (Barnet 2024) was carried out in summer 2018.

5.8 **Insight**

5.8.1 N/A

6. BACKGROUND PAPERS

N/A