	Adults and Safeguarding Committee **3rd June 2021**
Title	An update on the Barnet Integrated Care Partnership, the White Paper and Integrated Care Systems
Report of	Cllr Sachin Rajput – committee chairman
Wards	All
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Summary

The NHS Long Term Plan (LTP), published in 2019 proposed organisational change for the NHS through the development of 'integrated care systems' (ICS), based on the same geographical areas as Sustainability and Transformation Partnerships (STP). The White Paper, 'Integration and Innovation: working together to improve health and social care for all', published in February 2021, sets out the legislative proposals for a Health and Care Bill which will put ICSs on a statutory footing, as well as including proposals covering social care.

Since the last report on integrated care to this committee, officers have been working with Barnet and north central London NHS colleagues to develop the Barnet Integrated Care Partnership (ICP), with associated programmes of work.

This report updates the committee on the White Paper, and the progress of the Barnet Integrated Care Partnership.

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 Since the last report to this committee on integrated care, a significant amount of work has taken place to develop the Barnet Integrated Care Partnership. This report outlines the achievements to date and future priorities. The white paper sets out significant changes for health and social care, which are relevant to the remit of this committee.

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) are continuing their collective programme of work to enable a strong local authority voice within the developing ICS. The Council is therefore well placed to explore new partnership arrangements that could deliver better health and wellbeing outcomes for residents.

2. THE WHITE PAPER AND INTEGRATED CARE SYSTEMS

2.1 The main proposals in the White Paper relevant to the Adults and Safeguarding Committee's remit are summarised in this section of the report.

2.2 In England, Integrated Care Systems (ICSs) will be established as statutory bodies. Clinical Commissioning Groups will be abolished and their functions transferred to ICSs. 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."[1]

2.3 Integrated Care Systems will have two governing entities. The first, the 'ICS NHS Body' will be responsible for the day to day running of the ICS and consist of NHS organisations. It will have specific requirements to develop a plan to meet the health needs of the population within their area, to set the strategic direction of the ICS and develop a capital plan for NHS providers within the ICS. The ICSs will be required to meet financial objectives set by NHS England, which require financial balance to be delivered across the ICS area. The requirement for NHS commissioners to procure NHS care and treatment services competitively, will be removed. The ICS will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. The White Paper says that a clearly defined role for social care within the structure of the integrated care system board will be created, to give adult social care a greater voice in NHS planning and allocation.

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

2.4 The second governing entity, the 'ICS Health and Care Partnership' will include local government and other stakeholders, and have the responsibility to develop a plan to address the system's health, public health and social care needs. The ICS and relevant local authorities will be required to have regard to this plan. The White Paper indicates that local areas will be able to develop their ICS partnership body based on local need and building on pre-existing local partnerships.

2.5 The NHS and local government will be given a duty to co-operate with each other and the ICS will have a duty to have regard to the local Joint Strategic Needs Assessment and the Health and Wellbeing strategy.

2.6 The White Paper emphasises the importance of working at 'place' level to deliver effective integration: "A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary" (White Paper, para 1.14, p.10).

2.7 The White Paper also sets out a number of proposals for social care. Firstly, the DHSC will make changes to the data they collect on adult social care and the frequency with which they collect it. This will include increased data collection from social care providers, and on services provided to those who fund their own care.

2.8 The Health and Care Bill will place a new duty on the CQC to assess local authorities' delivery of their adult social care duties, with a power of intervention for the secretary of state where it is considered that a local authority is failing to meet their duties. The White Paper indicates that this will be phased in over time.

2.9 There will be a new power for the secretary of state to make payments directly to all social care providers. At present this power extends only to not-for-profit entities.

2.10 The Delayed Discharge regime, as set out in the Care Act 2014, will be abolished and the Discharge to Assess model (as used by the Barnet Integrated Discharge Team currently) will be enshrined in law.

2.11 The Better Care Fund will be separated from the NHS Mandate and have a standalone legislative power.

2.12 Subject to parliamentary business, the intention is that the proposals in the White Paper will begin to be implemented in 2022.

2.13 The link to the full White Paper is below:
https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

The Health and Social Care Select Committee recently published its response to the White Paper. The link can be found below:

https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/20/2002.htm

2.14 There are significant implications for councils in the White Paper. It is welcome that there is a commitment to local authority boundaries being the meaningful level for the commissioning and delivery of services. However, ICSs often cover several local authorities and the level of autonomy at the borough level and the relationship with the ICS, as set out in the White Paper, is not yet clear. It will be important that the Council is 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. Locally, the north central London ICS is beginning to prepare for the transition to the new model. They have appointed a director of transition and will be preparing detailed plan in line with new guidance and national timescales.

2.15 The introduction of a new assurance framework for councils' delivery of social care duties is also significant. Such arrangements have not been in place for several years. The White Paper commits to designing the framework collaboratively, building on existing service improvement activities and phased implementation. However, this will be an area of significant focus for the council and more details will be shared with the committee as they become available.

2.16 Commentary on the White Paper's proposals from the Local Government Association and London Councils can be found below:

Link: London Councils Health and Social Care White Paper: Innovation and Integration Briefing

https://www.local.gov.uk/parliament/briefings-and-responses/lga-briefing-health-and-social-care-bill-white-paper

3. THE BARNET INTEGRATED CARE PARTNERSHIP

3.1 The Barnet ICP's current work programme has 3 workstreams: integrated pathways; same day access and discharge; & support to care homes.

3.2 **Integrated pathways**: The workstream has focused on the development of a community multi-disciplinary team (MDT) model to better support frail older residents in Primary Care Network 2, which covers East Barnet, Oakleigh, Brunswick Park and Coppetts, where 17% of its population of 60, 500 are aged 65 or over. The intention has been to develop a model that could be scaled across Barnet.

3.3 The MDT works with residents aged 65 or over who are moderately or severely frail; and dependant on the clinician's judgement, with people who are (if outside criteria) within the last 12 months of their life expectancy or on the palliative care register. The MDT working is a shift away from a reactive, disease orientated and disjointed model of care, towards a more holistic, personalised, preventative model of care. The MDT consists of GP practices, CLCH, Social Care, secondary care and the voluntary sector and is coordinated by a frailty specialist nurse. The nurse undertakes home visits and completes comprehensive geriatric assessments which, in discussion with patients and their families, is used to create a personalised care plan via the MDT.

3.4 The MDT has been evaluated and the findings are that the MDT has helped to improve outcomes for people and their carers, as well as improving end of life care. Since the launch of the frailty MDT, there has been a reduction in non-elective and A&E admissions in the PCN, whilst also facilitating closer working between system partners in the quest to provide a personalised holistic plan for patients and their carers.

3.5 In addition, a further MDT is in the process of being piloted in PCN 5, which covers Hendon, Brent Cross, Golders Green and Childs Hill. The aim is to develop a model which provides pre-diagnostic support, support at the point of diagnosis and post diagnosis, creating a blended approach for not just the adult with dementia, but also the carer of that person. The model has already placed a dementia nurse and a VCS co-ordinator within the PCN, as well as embedding cognitive stimulation therapy. The model went live in November 2020 but the MDT element was delayed due to the second wave of Covid-19. This work is now being re-started.

3.6 The next step is to develop a plan for MDTs for older people to be rolled out across all Barnet PCNs. The plan will take into account the continued pressures of the pandemic, recovery and the vaccination programme.

3.7 **Clinical support to care homes** This workstream has focused on the roll out of the primary care support to care homes (such as a named GP for each care home, weekly GP-led ward rounds in care homes and the creation of a dedicated clinical in-reach team for care homes. The 'One Care Home' in-reach team (OCHT) was set up in May 2020. The Team's role is:

a) To support the review of patients identified as a clinical priority for MDT assessment and care, identified through the General Practice weekly 'check in' with care homes.
b) To support with the delivery of personalised care and support plans for care home residents
c) To support the provision and medication support to care homes.
d) To provide training (including IPC), support and empowerment of staff.
e) To provide a dedicated clinical support line, 7 days a week, 8a.m-8p.m for patient referrals and/ or queries to improve support and access for care home residents to multi-disciplinary clinical support.
f) To ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing

3.8 The OCHT are supporting 91 care homes and supported living schemes in the borough to date:

Number of Homes	Type of Residence	Number of Beds
23	Older People's Nursing Homes	1099
16	Mental Health Care	172

25	Learning Disabilities Care	146
27	Older People's Residential Homes	1073

3.9 The Team has carried out approximately 350 community matron-led resident reviews and 259 physiotherapy reviews. In addition, the MDT has supported 129 residents to date. The MDT includes community matrons, allied health professional, Barnet and Enfield Mental Health Trust consultants and Barnet Hospital Consultant Geriatricians. Further work is underway to promote the offer and raise awareness of the MDT sessions with the PCNs, as well as looking at ways to strengthen the feedback process to GPs.

3.10 During the pandemic the team delivered a wide range of support including**:**

- Testing approximately 629 residents and 515 staff
- Working with public health and the care quality team to support bedded care settings experiencing outbreaks.
- Delivering Infection Prevention and Control (IPC) and Coordinate My Care training
- Care planning and support alongside GPs.

3.11 The team has received positive feedback, highlighting the benefits of inter-disciplinary working, the enhanced speed of escalation and resolution of patient's health care needs, the training benefits for Care Home staff and community matrons and enabling more proactive and supportive care of residents within their home setting.

3.12 **Same Day Access and Discharge** This workstream contains two elements: development of an urgent treatment centre model at Finchley Memorial Hospital, building on the walk-in centre there, and the implementation of the integrated discharge team and discharge to assessment model, as required by the national pandemic discharge guidance.

3.13 Urgent Treatment centres are GP-led, open at least 12 hours a day, offer appointments that can be booked through 111 or via GP referral and can diagnose and treat the most common ailments for which people attend A&E. It is anticipated that the work on the urgent treatment centre model at Finchley will be complete by summer 2021. In addition, as services are reinstated as the recovery from the pandemic continues, Finchley Memorial Hospital Walk-in Centre is preparing for a return to usual operating hours. There has also been the establishment of better links with NHS 111 to start the transition to a book ahead approach for same day access, enabling more effective triage. This will develop further in the next twelve months. The temporary closure of Edgware Community Hospital walk-in centre has been extended to 30 September 2021 to allow resources to be deployed to more urgent areas in-line with Covid recovery plans.

3.14 The integrated discharge team is continuing to operate across Barnet Hospital and the community hospitals. The discharge to assess model will become an on-going statutory requirement for councils and the NHS, as set out in the White Paper, and the council is working with the other north London councils and ICS partners to develop a permanent model for the team. National NHSE funding for discharge has also been extended until September 2021. The team has achieved a great deal in the time it has been in operation:

- There is a better experience for residents – less time spent waiting in an acute hospital bed when they don't need to be there. In the first year of operation, the team have enabled over four thousand residents to leave hospital to the right place for them.
- It has had a significant impact in helping save bed days by reducing length of stay and avoiding what would have been delayed transfers of care. Average length of stay in Barnet Hospital between February to April 2019 was 21 days, whilst in the same period in 2020 it was 8 days.
- There is staff capacity available at the right time to support timely discharge, 8a.m – 8p.m, seven days per week, from community health, continuing health care, social care brokerage and social work.
- The Home First principle has been applied across the whole process, with three quarters of patients going home.
- It is easier to find appropriate residential / nursing and extra care placements for individuals – communications between ward staff, consultants and those working on discharge have been improved to ensure needs are properly understood and there has been a change to focus on a quick initial move to further assess and understand ongoing needs.
- A more flexible approach to the use of NHS community rehabilitation beds has helped with improving flow across the system.
- The streamlining of arrangements has meant hospital staff can focus more on meeting the needs of patients.
- Feedback from patients and their families has been positive.

3.15 **Future priorities**

In addition to the workstreams above, the ICP is in the early stages of scoping programmes of work in the following areas:

- Mental health and dementia
- Children and Young People's health
- Health inequalities
- Engagement and co-production

4. REASONS FOR RECOMMENDATIONS

4.1 The White Paper sets out significant changes for councils that are relevant to the remit of the Adults and Safeguarding Committee. It is important that the committee is informed of these proposals, along with local and NCL developments.

5. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

5.1 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.

6. POST DECISION IMPLEMENTATION

6.1 Officers, the committee chairman and the chairman of the health and wellbeing board will continue to engage in the process. Officers will bring back further reports at the appropriate points in the development of the ICS and ICP, and as the social care proposals are fleshed out.

7. IMPLICATIONS OF DECISION

7.1 Corporate Priorities and Performance

7.1.1 This area of work is clearly aligned to the Barnet plans Healthy priority, which has integrated care at its core. The priorities will also support the delivery of the Health and Wellbeing Strategy.

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

7.2.1 Engaging with the ICP and ICS development 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. It is anticipated that any new responsibilities for councils resulting from the new Health and Care Bill would be funded through the new burdens funding regime.

7.3 Social Value

7.3.1 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.

7.4 Legal and Constitutional References

7.4.1 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.

7.4.2 The White Paper sets out the Government's legislative proposals for a Health and Care

Bill.

7.5 **Risk Management**

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

7.6 **Equalities and Diversity**

9.6.1 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.

7.7 **Corporate Parenting**

7.7.1 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 ICS and ICP.

7.8 **Consultation and Engagement**

7.8.1 Engagement in the ICP work programme will be achieved through the co-production workstream and through liaison with HealthWatch, the council's adult social care Involvement Board, and engagement mechanisms for children and young people.

5.8 **Insight**

5.8.1 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.

8. BACKGROUND PAPERS

8.1 Integrated health and social care to the Adult and Safeguarding Committee, 20 September 2018.

8.2 An update on the NHS Long Term Plan and Integrated Care Systems to the Adult and Safeguarding Committee, June 2019