	Health and Wellbeing Board **15th July 2021**
Title	An update on the Barnet Integrated Care Partnership and Integrated Care Systems
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Wards	All
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Summary

Since the last report on integrated care to the Health and Wellbeing Board, officers across the NHS and the council have been working to develop the Barnet Integrated Care Partnership (ICP), with associated programmes of work.

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.

This report updates the Board on the progress of the Barnet Integrated Care Partnership and sets out some key information on the White Paper.

Recommendations

1. **The Health and Wellbeing Board 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 the Board 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.

1.2 The Council, the Barnet directorate of NCL CCG and NHS provider organisations have a history of collaborative working and there are a range of integrated services and programmes of work in place.

2. THE WHITE PAPER AND INTEGRATED CARE SYSTEMS

2.1 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."

2.2 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.

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2.3 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.

2.4 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.

2.5 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).

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

2.7 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

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 provides an holistic, personalised, preventative model of care. The MDT consists of GP practices, Central London Community Health, 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, are used to create personalised care plans 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.

3.5 In addition, a further MDT focusing on dementia is 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 GP primary care support to care homes via the Nursing Homes Locally Commissioned Service (LCS), which provides a named GP for each care home & weekly GP-led ward rounds in care homes. The workstream has also created 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 ward round 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 infection prevention and control -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 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/ schemes	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 professionals, 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 assess 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.

3.14 The integrated discharge team was set up in rapid time, in response to national requirements and to ensure effective flow in hospital during the pandemic. The team operates across Barnet Hospital and the community hospitals and consists of community health, CCG and council staff. 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 across the ICS. 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
- Reducing health inequalities
- Neighbourhood models of integrated care
- Engagement and co-production

3.16 **Consultation and Engagement**

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.

4. REASONS FOR RECOMMENDATIONS

4.1 The White Paper sets out significant changes that are relevant to the remit of the Health and Wellbeing Board. It is important that the Board is informed of these proposals, along with local and NCL developments.

5. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

5.1 Not applicable in the context of this report.

6. POST DECISION IMPLEMENTATION

6.1 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 Corporate Plan's Healthy priority, which has integrated care at its core. The priorities will also support the delivery of the Joint 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 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.

7.3 Social Value

7.3.1 We are seeking to strengthen our partnership arrangements 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 Under the Council's Constitution, Article 7 Committees, Forums, Working Groups and Partnerships the terms of reference of the Health and Wellbeing Board includes the following responsibilities:

• To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.

• To promote partnership and, as appropriate, integration, across all necessary

areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate

• To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing.

• Specific responsibilities for overseeing public health and developing further health and social care integration

7.4.2 The timescale for the legislative proposals in the White Paper (Integration and Innovation: working together to improve health and social care for) to begin being implemented is from April 2022. Some of the key legislative proposals outlined in the new whitepaper include:

NHS and local authorities have a duty to collaborate

Building on its ambitions of integrating care to support better patient outcomes, the White Paper details two forms of integration which will be underpinned by the legislation. They are: integration within the NHS to remove some of the boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.

The NHS and local authorities will be given a duty to collaborate with each other. There will be measures for statutory integrated care systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body.

The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care

Discharge to Assess model

Introduced nationally in March 2020, the discharge to assess (D2A) model focuses on discharging patients from hospitals into the appropriate setting, considering what care they might need after being discharged from hospital, whether that is care at home or going into a care home, for instance.

Now, the government is looking to bring forward measures to update approaches to this process to help facilitate smooth discharge, by putting in place a legal framework for a D2A model, whereby NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care, replacing the existing legal requirement for all assessments to take place prior to discharge.

7.4 **Risk Management**

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

7.5 **Equalities and Diversity**

7.5.1 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.

7.6 **Corporate Parenting**

7.6.1 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.

7.7 **Consultation and Engagement**

7.7.1 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.

8. BACKGROUND PAPERS

None.