Appendix A

Task and Finish Groups Update

1. Primary Care (GP) Access Task and Finish Group

Membership: Cllr Caroline Stock (Chair), Cllr Elliott Simberg, Cllr Matthew Perlberg, Cllr Richard Barnes, Cllr Gill Sargeant, Cllr Nick Mearing-Smith

Cllr Stock was appointed Chair of the Task and Finish Group.

The Task and Finish Group held its first meeting on 26 July 2023 and its second meeting will be held on 19th October, 7pm at Hendon Town Hall. Meetings are scheduled on 20 November, 7pm (HTH) and Monday 11th December.. The Group will discuss future meetings and timelines for completion of its work at the meeting on 19th October but this is anticipated to be January 2024.

At the first meeting Members discussed the draft scope, which would be further refined following the meeting. Primary Care representatives (GPs) and a Patient Participation Group representative attended the meeting to advise on the current situation and to present ideas for improving communication with residents. The LBB Director for Public Health attended as an expert to guide the discussion.

A number of issues were discussed as areas for potential review including:

- Digital exclusion and impact of GPs' remote working on Barnet demographic; improving communication with residents, including production of a signposting leaflet in Barnet First for all residents – further guidance on this would be received from the North Central London Integrated Care Board (NCL ICB).
- NHS sustainability, including other sources of care such as community pharmacists, and focus on single or multiple GP practice models, and review of what is happening where new developments arise in the Borough and in areas where patients have fed back that they cannot get registered with a local GP.
- Examination of 'what good looks like' to ensure the best models are in place for Barnet. To include an examination of the funding across NCL given Barnet's older population relative to other Boroughs, and its large number of care homes.

The agenda for the second meeting is outlined below and a background report that has been provided by the council, Barnet Healthwatch and NHS colleagues for the Group to consider on 19th October is attached.

Agenda, 19th October, Primary Care Access Task and Finish Group

1. Hear from Colette Wood on the Integrated Care Board's plans for Barnet, followed by questions from Members.
2. Dr Nick Dattani on best practice examples and models of care – followed by questions from Members
3. Hear from the Barnet Patient Participation Network followed by questions from Members
4. Hear from Barnet Healthwatch followed by questions from Members.

2. Discharge to Assess

Membership: Cllr Philip Cohen, Cllr Gill Sargeant, Cllr Tony Vourou, Cllr Lucy Wakeley

A briefing was held with James Mass, Director of Adult Social Care, on 25th July 2023. The Group would convene as soon as the Primary Care Access Task and Finish Group has completed its recommendations – Members would be notified following the next meeting of this group (19th October, see above).

The information below was presented at the briefing session with the Director Adults Social Care:

The theme is managing discharge of Barnet patients from acute hospitals and community beds. This will predominantly be from either Barnet Hospital and the Royal Free Hospital (Hampstead) sites; step-down hospitals such as Finchley Memorial Hospital and Edgware Hospital; but will also include other sites.

The four nationally recognised pathways for patients re discharge are:

- Pathway 0 - for people who return home on their own.
- Pathway 1 - for people who return home with care and support from the NHS and / or the council.
- Pathway 2 - for people discharged to a community hospital bed.
- Pathway 3 - for people who go to residential or nursing care.

Among the issues involved are:

- How does the discharge process work?
- What are the possible obstacles and delays?
- Is the discharge system financially sustainable given over-spending by council and NHS?

Barnet Council is part of the Barnet Integrated Discharge Team (IDT) along with Central London Community Healthcare Trust (CLCH), the North Central London Integrated Care Board (ICB), and Barnet Hospital. The voluntary sector, such as the Red Cross, also have an important role to play.

The process is that any hospital with a Barnet resident will look at the discharge procedures using the pathways described. Normally it would a nurse or therapist on the ward who propose a referral to the integrated team (IDT). There is a shared inbox between the agencies to look at referrals. There is a twice-daily discharge call in which the teams go through action needed, and work through possible disagreements. Much of the work is done remotely but social care practitioners will visit all residents on pathway 3 and the more complex pathway 1 cases on the wards.

In arranging discharge, the IDT liaises with another team called the Intermediate Bed Escalation (ICE) hub which co-ordinates pathway 2 bed referrals within the North Central London (NCL) and North West London (NWL) health systems.

There is weekly discharge reporting and the Group received the most recent data. The table below shows the position as at 19 July:

Discharge System	Total MO	MO P1	MO P2	MO P3	System MO Target	Distance from target	P1 Discharges (last week)	P2 Discharges (last week)	P3 Discharges (last week)	Total Discharges (P1-P3)	MO as % of total weekly discharges*	Hospital OPEL	Discharge OPEL (proposed)
Barnet	**36**	20	8	8	31	5	56	17	4	77	47%	1.0	3
Camden	**8**	2	3	3	14	-6	40	8	7	55	15%	1.0	2
Enfield	**27**	15	7	5	28	-1	45	13	4	62	44%	4.0	2
Haringey	**40**	15	11	14	22	18	28	5	5	38	105%	3.0	4
Islington	**28**	10	7	11	15	13	36	6	1	43	65%	1.5	4
Non NCL	**46**	15	21	10	23	23	63	11	3	77	60%	n/a	4
Total	**185**	**77**	**57**	**51**	**133**	**52**	**268**	**60**	**24**	**352**	-	**1.8**	**3**

For residents on pathway 1, a period of up to six weeks reablement is normally offered to support people to regain their independence as they recover in their own home.

Possible issues

- People have increasingly complex needs. This means those going home on P1 require more care on average; some P2 units within hospitals cannot support the level of need; and it can be difficult to find a care home that can support high needs on P3.
- Partners across North Central London, including Barnet Council, commissioned external support to identify improvements that can be made to help make the discharge system better for residents and more financially sustainable. Among the recommendations are the way different partners organise themselves, better data reporting, cultural change in hospitals around discharge decisions and the need to progress with decisions on financial responsibility between councils and the NHS.