Integration Executive report to the Health and Wellbeing Board May 2024

JHWS – Living and Supported Well / Dying Well

Overview – about the Integration Executive

The Integration Executive is made up of partner representatives including Health, Social Care, Public Health, Housing, Healthwatch

For 23-24 the governance for the Integration Executive was made up of two sub-groups; the Integration Delivery Group and the Joint Commissioning and Finance and Performance Group

Each sub-group has a workplan with activity mapped against each of the JHWS priorities and commitments – a snapshot of each is on the next two slides

Development session to align priorities for the IE was held in Oct 23

IDG workplan – snapshot showing alignment from workplan to priorities

HWBB Outcome	HWBB Priority	HWBB Commitment	IDG Work Scheme	Target Date	Lead	RAG	Key Activity	Current Position
Living and Supported Well								
Living and Supported Well - upscaling prevention, self care. Effective management of frailty and complex care	I know how to manage my condition(s) and reduce the likelihood of getting more	I am able to look after myself and my ongoing health condition. I have advice, services and technology that helps me do this and have control to do it in the way that works for me.	BCF Planning	Ongoing	Lisa Carter		To comply with all governance HWBB, IE, JCG, IDG Service and chairing of meetings Attend wider meetings to provide updates Reporting Finance monitoring of spend Mid term submission Target setting Invoicing "	Year End Submission completed, signed and submitted May 23. Bcf have a new 2 year planning requirement this has been completed and is due for submission 27th June 23
			BCF Scheme Review	Ongoing	Lucy Hulls		Review each scheme that the BCF funds KLOE completed by each scheme Deeper dive into high volume contracts Performance monitor	Reviews of each of the schemes now complete, seeking confirmation of a deep dive into high cost schemes this will provide an ongoing support to enable timely submissions for Quarterly and Year end submissions alongside the 2 year planning for 23-24 Look at a deeper dive into high ticket schemes and report to IDG.
			BCF Discharge Funding Scheme	Ongoing	Naina Karadia/David Stanton		This funding is being allocated via: - a grant to local government - (40% of the fund) - an allocation to ICBs - (60% of the fund) Both elements of funding should be pooled into local BCF section 75 agreements.	£500 million has been shared across authoritiees, LCC has been given £5 million to spend by March 2023. Monies are to be used for staff retention, support with housing reablement scheme, nightime care/domcilary care, COVID designated beds, training, continence training, high dependency 121 nursing & assisted tech. Current spend is reported ASC Fortnightly and ICB Schemes Monthly - this will remain as an ongoing ask.
	I know how to manage my conditions and reduce the likley hood of getting more	People that support and care for me are able to share some information about me	LLR Integrated Data Sharing	Nov-22	Steve Pugh		1. ensure data sharing across systems for LLR 2. Technical issues for LCC to be addressed 3. Mental Health Teams to be able to benefit from shared data	LCC is in the final stages of testing to provide its social care information to be included in the Shared Care Record by early November. There is still a technical problem to resolve to enable LCC staff to view the LLR Care Record internally. Two further options to resolve this are being worked through. Our Home First team is fully engaged with the programme to baseline benefits. Non GP SystmOne units are being planned to be brought into the record, so this will help Mental health professional across LLR to view patient data Direct Care staff will get a winter bonus Steve to be invited to Feb IDG for update on activity and current position
		I am able to look after myself and my ongoing health condition. I have advice, services and technology that helps me do this and have control to do it in the way that works for me.	Assisted Technology Offer		Steve Pugh		1. Scope the demand and activity associated with Pathway 1 2. Model a range of options for AT to feature in all Pathway 1 people 3. Scope funding as part of Pathway 1 rightsizing	Expression of Interested to be submitted to Adult Social Care Technology fund for £600k to improve assessment and provision of care tech solutions for unpaid carers. Aim to reduce delays in discharge and to avoid carer breakdown and avoidable hospital admissions. If accepted full business case will be put together with intention to launch early 2024. Steve to be invited to Feb IDG for update on activity and current position
			Virtual wards	Ongoing	Naina Karadia/David Stanton		1. Enhance the virtual ward offer to residents by commissioning appropriate AT and other tech solutions	Currently working on the SOP's for all virtual wards which will determine required activity by partner organisations. This will be particularly focussed around support to the frailty VW's and linked to the AT offer above. - LC Frailty ward pilot in City ongoing currently, we are not involved in deliery, more of a watching brief KK ro be considered for updates. This is being rescoped and deliverables to be shared then dscussed if this is to remain on plan. 22/04- Discovery work being undertaken to understand volumes and service level provided by LC to inform potential ask of LCC in support of County offer. Options paper to follow.
	I am supported to manage my complex	I get help from people that work together to keep me living at home for as long as possible. I can see the right person at a time that suits me. There is extra help to stop	Falls	Ongoing	Julia Wiggins		• Agree governance • Establishment of a Project Board (with identified SRO and LLR representatives). • Agree and design a new training delivery model • Key performance Indicators • Service Specification • Procurement "ng	DHU pilot due to continue until March 2024. From 4th September direct referrals to CRS will be possible to improve follow up and prevention aspect of service. Response to city care homes has also been added to service. Work to improve consistency of incoming referrals and data gathering is ongoing. Julia to be invited to Feb IDG to provide an updat eon activity and current position
			Intermediate Care Transformation	TBC	Tasneem Lakdawala/Tracy Ward		1. Develop a transformation plan for Intermediate Care 2. Form subgroups that report to strategic group for different workstreams 3. Develop individual workstream plans P1,P2,DM 4. Steering group to monitor performance with subgroups reporting by exception	Aims/Objectives/Metrics set for transformation and its subgroups. Currently looking at high level activity with timescales across 3 workstreams. P1, P2 and Decision Making. Groups meet fortnighly and report into steering group. Metrics will form an overall dashboard which we are currently working on gathering the data. All subgroups on track. Concerns over 33 bed defficate for P2 Res 24hr + looking at a plan to bridge gap. FOP has impacted some activity and highlighted a greater demand to capacity for RRR. Tasneem invited to update in Jan IDG

JCG workplan - snapshot showing alignment from workplan to priorities

HWBB Outcome	HWBB Priority	HWBB Commitment	Scheme	Lead	RAG	Key Activity	Current position
1. Intermediate Care							
Living and Supported Well - upscaling prevention, self care. Effective management of frailty and complex care	**I know how to manage my conditions and reduce the likley hood of getting more**	People that support and care for me are able to share some information about me	**Falls**	Julia Wiggins/Ali Brookes	Amber	1. Scope Crisis Falls Service for Leicestershire (mirror Leics City) 2. Ascertain business case including process for access and funding	DHU pilot due to continue until March 2024. From 4th September direct referrals to CRS will be possible to improve follow up and prevention aspect of service. Response to city care homes has also been added to service. Work to improve consistency of incoming referrals and data gathering is ongoing. 23/02/24 LC KK WIll provide a mandate for JW to look at joint commissioning. (commitments from organisations for funding - part of the scoping work) JW - to bring what is being funded in Leicestershire
		I am able to look after myself and my ongoing health condition. I have advice, services and technology that helps me do this and have control to do it in the way that works for me.	**Bed Based/Intermediate Care** **- NE D2A** **- Sovereign Unit** **- D2A beds**	Lucy Hulls/Tracy Ward	Green	1. case reviews and analysis 2. voice of the person analysis 3. data analysis 4. Present findings to senior groups for mandate on any project work	Analysis of data complete with a project plan and timeline being developed to cover 18 months for implementation. 3 subgroups report monthly to an Intermediate Care Transfomation Steering group. Monitoring high level activy and will report by exception. All on track with some set backs in delays with County Panel introduction however activity in place to mitiagte this.
2. Personalisation							
Enabler - A strong, skilled and supported workforce	**I am supported to manage my complex health and care needs**	I get help from people that work together to keep me living at home for as long as possible. I can see the right person at a time that suits me. There is extra help to stop me needing hospital or residential care if I'm unwell or fall. If I do go into hospital, there is help to get me back home as quickly as possible.	**Integrated personalised care framework training**	Naina Karadia/David Stanton	Green	1. To ensure that training needs for health and social care sectors are met to enable appropriate delivery of shared tasks detailed in the framework. 2. Options appraisal for jointly commissioned training for care providers. 3. Consultations with current staff	Delegated training task list now completed and agreed across LLR by all partners this is to be utilised and embedded within the redesign of our current offer, which will enable us to move further within the design phase to establish a innovative training design for each training task e.g. frequency, method, KPI'S and Service Specification • Continuous development with the Design T&F LLR members and to align a procurement project board to support with actions, responsibilities and sufficiency • Consider how those training needs would be achieved in a procured model which has sufficient adaptability to take on additional requests, variations of training methods and timelines • Support with mapping out a clear service specification for procurement April 2024 • Financial Transfer to ICB has now completed to enable ICB to procure and take on the Lead commissioning responsibility from 1st October 2023 UPDATED 1/9/23
Overaching Principle - Providing person centred care and support			**Personal Budgets**	TBC	Green	1. Develop options to jointly deliver and / or manage personal budgets / personal health budgets on behalf of health and social care	We have a number of people who have both a personal health budget and a personal budget. We did a piece of work to look at integrating the payment card, however we hit a red line which was that in the LA payments are made every 4 weeks and in the ICB this is every month. Time spent with finance partners in both areas trying to rationalise this but it was not possible to have a single payment method without there being a lot of manual payments. Other areas who have been able to do this have introduced another means of payment, which come at a cost. As a system we have joint funded cases and reviews which are done between the LA and our colleagues in MLCSU. The element which is not integrated is payment and we still have joint reviews, in the main, rather than looking to have a trusted assessor model. Numbers of cases to follow
3. People with complex needs							
Living and Supported Well - upscaling prevention, self care. Effective management of frailty and complex care	**I am supported to manage my complex health and care needs**	I get help from people that work together to keep me living at home for as long as possible. I can see the right person at a time that suits me. There is extra help to stop me needing hospital or residential care if I'm unwell or fall. If I do go into hospital, there is help to get me back home as quickly as possible.	**Complex nursing care**	Dave Pruden	Green	1. Ascertain current demand for both general nursing and complex nursing in the County 2. Options appraisal for jointly commissioning new provision for both long term placements and elements of P3	Fair cost of Care exercise (FCOC) and Market Sustainability Plan (MSP) near completion - Key findings and messaging specific around Nursing Market capacity and the need to grow provision 23/02/24 IL to speak with DP for current position and next steps
			Adults with disabilities	Inderjit Lahel/ICB rep	Green	1. Scope activity for adults with complex disabilities 2. LCC programme for supported living	Scoping development taking place for adults with complex disabilities. Engagement with ICB to take place. LCC programme for Supported living currently in place
			Mental Health		Green	1. Reduce length of stay 2. Quicker and safer discharges 3. Ability for A&C to track patients through the system 4. Reduce reliance on ward staff for information 5. Develop a system discharge hub like UHL for effective communication	We are currently looking at developing a discharge hub for mental health within systmone. Fornightly project meetings taking place with LPT leading on the project. Timeline to be confirmed. Funding through discharge grant
Dying Well - understanding the need, effective transitions, normalising end of life planning	**I know how to plan for end of life**	I receive co ordinated care and support at end of life and have the opportunity to tell services about my experience	**End of Life**	Lucy Hulls/kerryjit Kaur	Green	1. Look at recommendations for EOL JSNA 2. Acsertain business case for key recommendations	EOL JSNA Delivery plan now available and approved. To be added to the next next Joint Commissioning group for discussion for next steps and actions in May 23 Bring update from EOL development session. Whats the position, what work has been dine and next steps. May 24

What influences our priorities

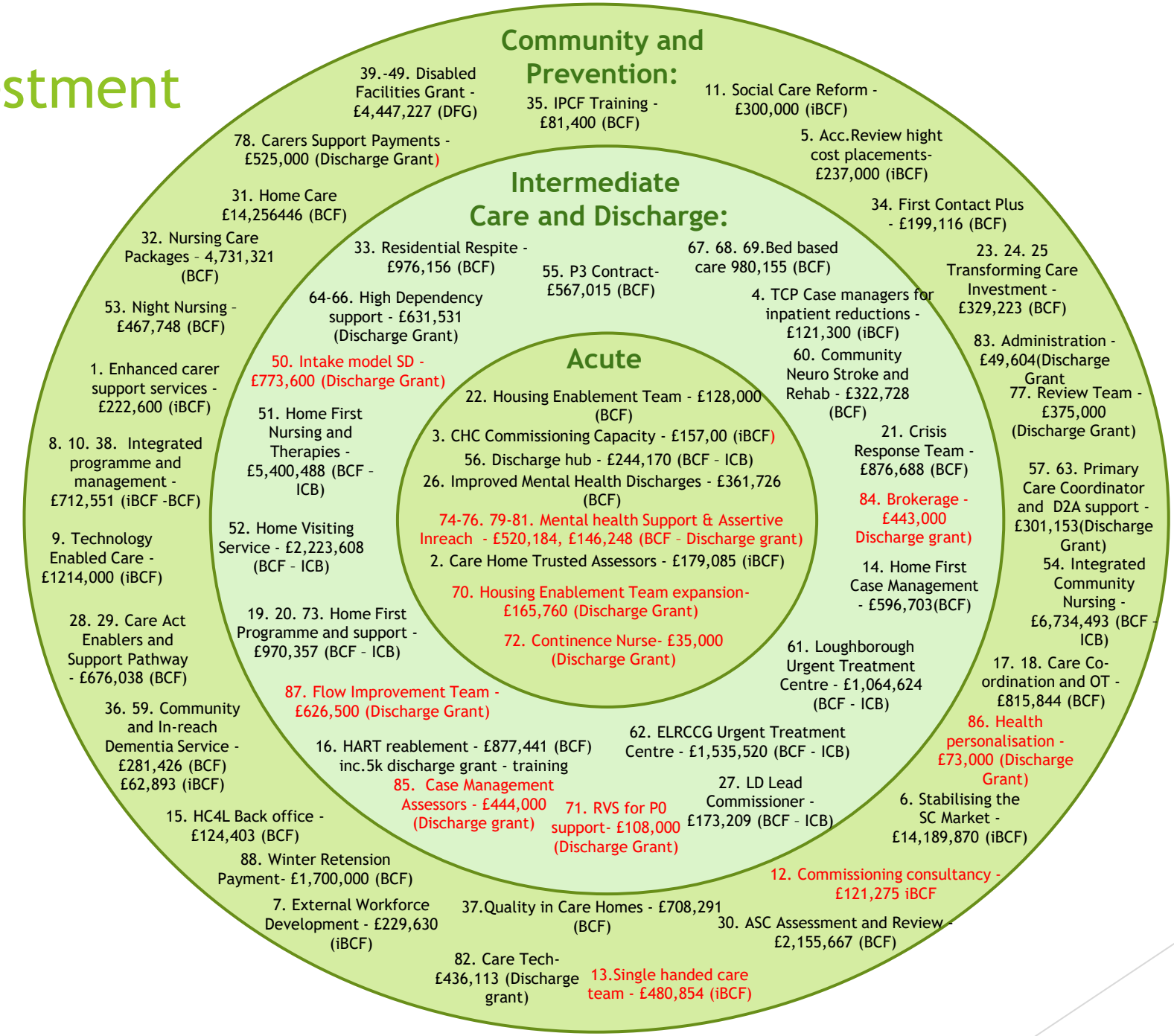
- JHWS – Living and supported well / Dying well
- Better Care Fund
- Urgent and Emergency Care recovery plan
- Winter plans
- Adults and Communities 10-year vision

Overview – about our investment

- BCF – Investment in integration activity is pooled by health and social care into the Better Care Fund – for 23-24 this totalled 74 million.

- The BCF is made up of several elements
  - ✓ BCF – adult social care / health contributions
  - ✓ iBCF – social care precept
  - ✓ Disabled facilities grant - passported directly to the districts with top-slicing agreed and reported separately.
  - ✓ Discharge grant

BCF investment



Acute	Intermediate Care and Discharge support	Community and Prevention
Total BCF: £2,045,173	Total BCF: £19,604,623	Total BCF: £56,423,342
New: £867,192	New: £2,395,100	New: £675,129
% of total 2.6%	% of total 25%	% of total 72.4%

KEY: Schemes highlighted in red denotes new investment 78,073,138

Living and supported well

‘Supporting people to live as independently as possible, for as long as possible while maximising their quality of life’

Priority areas

- Up-scaling prevention and self-care
- Effective management of frailty and complex care

Living and Supported Well – key achievements

HWBB priority	Activity	Detail	Beneficiaries	Investment 23-24	Outcomes
Up-scaling prevention and self-care	Care Co-ordination	A Health and Social Care proactive care approach using risk stratification within the community enabling patients to receive the 'right care, at the right time, at the right place'. 19.5 FTE	7307	£764,454	Empower patients to self-manage their long-term condition(s)
	Falls – care homes	Reducing the amount of fallers in the care homes with the highest incidences	2736 falls a reduction of 15% from 3409	Core funding	Reducing the number of falls within care homes
	Falls – DHU car	Responding to falls in the community to support at home avoiding admission to hospital	834	Ageing Well	Reducing admissions due to falls
	DFG's	Disabled Facilities Grants help towards the costs of making changes to peoples' home so they can continue to live there.	1135 (approx. based on Q3 return)	£4,447,228	People living with disability and long-term conditions have access to the right housing, care and support.
	Primary care enhanced support	Supporting people in discharge to assess beds to enable access to primary care services away from their usual place of residence	540 (approx. based on Q3 return)	£262,053	Improve access to health and care services including primary care and appropriate funding support

Living and Supported Well – key achievements

HWBB priority	Activity	Detail	Beneficiaries	Investment 23-24	Outcomes
Up-scaling prevention and self-care	INT development	Integrated Neighbourhood Teams bring together multi-disciplinary professionals from different organisations across health and care services	Locality based	Core funding	Co-ordinating opportunities for integration in localities and building asset-based approaches and social prescribing to work with and for people and communities
	First contact plus	First Contact Plus is an online tool which helps adults in Leicestershire find information about a range of services all in one place.	5716	£187,845	Improving access to health and care services
	Assistive Technology	Offering a wide range of equipment to maintain independence at home	820	£690,575	Patients self-manage their long-term condition(s) through digital approaches, assistive technology, accessible diagnostics and support
	Housing Enablement Team	Integrated housing offer within clinical care settings, focused on delivering health and wellbeing outcomes for patients to maximise opportunities to contribute towards safe and timely discharges from hospitals	1583	£286,760	People living with disability and long-term conditions have access to the right housing, care and support

Living and Supported Well – key achievements

HWBB priority	Activity	Detail	Beneficiaries	Investment 23-24	Outcomes
Effective management of frailty and complex care	Carers support services	Support services to carers within adult social care including support payments for carers looking after those discharged from hospital	1053	£747,600	Supporting people and carers to live as independently as possible and implementing the LLR Carers strategy
	Integrated HART reablement and therapy teams	Reablement in a person's own home to maximise independence and reduce care needs including the integrated locality teams for therapy and HART	4793 HART 13,012 Therapy	£1,651,000 HART £5,400,488 Therapy	Provide joined up services that support people and carers to live independently for as long as possible aiming for a 2 day start for all requests
	Home first teams	Support for those in hospital to return home or to a discharge to assess bed and step-up support for those in the community needing support	3540	£1,892,374	Delivering an effective health and care integration programme that will deliver the Home First step-up and step-down approach for Leicestershire.
	Domiciliary care	Support from independent providers for care packages in the home	2626 people 632,215 hours	£14,256,446 BCF and iBCF contributions	Reducing the number of permanent admissions to residential and nursing homes.
	Royal Voluntary Service discharge support	Supports people leaving hospital on pathway 0. Ensuring safe and timely discharge, ongoing support in the community and reducing risk of readmissions	1067	£80,505	Effective health and care integration programme that will deliver the Home First step up and step-down approach for Leicestershire.

Living and Supported Well – key achievements

HWBB priority	Activity	Detail	Beneficiaries	Investment 23-24	Outcomes
Effective management of frailty and complex care	External workforce development	Team to work with communities to encourage people to work within care settings	N/A	£229,630	Supporting the creation of an integrated health and social care workforce
	Integrated Personalised Care Framework	Framework for delivering training on a range of joint health and social care tasks across the workforce	N/A	£81,400	Supporting the creation of an integrated health and social care workforce
	Residential respite	Providing a stay in a care home for a short time to give a carer a break from caring	146	£923,865	We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia
	Community response service	Interim support service that provides quick targeted interventions to those in the community that need it to remain at home and avoid admissions	1091	£906,909	Offer a two-hour crisis response for people that may otherwise need to attend hospital, reducing admissions and increasing community care capacity
	Urgent Care Centres	Provision of walk-in clinics focused on the delivery of urgent ambulatory care in a dedicated medical facility outside of a traditional emergency department	N/A	£2,600,145	Reducing the number of emergency bed days people with Long Term Conditions experience

Dying Well

‘Supporting people in Leicestershire to understand, normalise and plan for this stage of life to ensure everyone has choice about their care and treatment, and support for loved ones and carers.’

Priority areas

- Understanding the need
- Normalising end of life planning

Dying Well development session

HWB Development session held in Mar 24.

Below highlights key areas for delivery activity agreed at the development session for the IE to take forward in the next 1-2 years in line with the EOL strategy timeframes:

- JSNA and JHWS Priorities aligned to LLR delivery – slides 16-17
- Investment is through Core Health budgets
- Delivery of priorities across LLR will be through series of 7 workstreams
- Opportunities for integrated working and services will be explored with all partners including VCS
- Link EOL priorities in Community Health and Wellbeing Plans through INT's
- Support mapping work to look at Leicestershire gaps in delivery of services
- Ensure Dementia services are linked to EOL support
- Undertake joint engagement activity

EOL LLR workstreams

Workstream 1:

- Health equity in Palliative and End of Life Care (Y1A1)

Workstream 2:

- Data review and standardisation
- Shared Care Record

Workstream 3:

- Training and workforce development

Workstream 4:

- Improving ReSPECT and Advance Care Planning

Workstream 5:

- Communication, information & engagement

Workstream 6:

- Service provision and care transfer

Workstream 7:

- Improving access to Anticipatory Medication in the community

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Understanding the need	We will carry out a Joint Strategic Needs Assessment chapter looking at end of life specifically	Undertake a health equity audit to examine how health determinants, access to services, and related outcomes are distributed across the population	1
	We will seek to gather views from people to understand what dying well means to them and how this could be achieved	Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5
Effective Transitions	We will seek your views on what planning and services for late and end of life should look like and how you should be informed about your choices	Undertake a health equity audit to examine how health determinants, access to services, and related outcomes are distributed across the population.	1
		Gain common understanding of current challenges relating to access of patient information and shared care records between settings / organisations, scoping interventions required from Year 2 onwards.	2
		Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5
	We will ensure there is a clear transition in care planning from living with long term conditions into the later and end of life	Pilot a new approach to AM in the community to include delivery to patient's home. Underpinning improvements are required around the authorisations process (underway), education and training (recognising dying / deterioration / symptom management), access to equipment (eg. Syringe drivers), formulary – routes and quantities.	7
		Map current service provision and identify gaps in service, taking into consideration how services work together, are referred into and how they refer onwards.	6
	We will ensure there is appropriate support for carers following the bereavement of a loved one so they can have a supportive transition into the next stage of their lives	Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5
		Pilot a new approach to AM in the community to include delivery to patient's home. Underpinning improvements are required around the authorisations process (underway), education and training (recognising dying / deterioration / symptom management), access to equipment (eg. Syringe drivers), formulary – routes and quantities.	7

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Normalising End of Life Planning	We will offer care plans and ReSPECT plans to all vulnerable people with a take up target of 95%	Review of the audit, current uptake and quality.	4
	We will use our better understanding of needs through the EoL JSNA chapter to consider other aspects of end-of-life planning	Map current service provision and identify gaps in service, taking into consideration how services work together, are referred into and how they refer onwards.	6
		Undertake a health equity audit to examine how health determinants, access to services, and related outcomes are distributed across the population.	1
		Gain common understanding of current challenges relating to access of patient information and shared care records between settings / organisations, scoping interventions required from Year 2 onwards.	2
	We will develop a social marketing campaign based on insight to normalise end of life planning	Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5
	We will educate our workforce so that everyone understands how to support people at end of life	Review the training matrix, developed in 2022/23, develop and launch a training programme that meets the needs of the LLR workforce.	3
		Develop metrics that measure the impact of training, as well as the numbers trained.	3
	We will improve co-ordination of care at end of life, as measured through patient feedback	Pilot a new approach to AM in the community to include delivery to patient's home. Underpinning improvements are required around the authorisations process (underway), education and training (recognising dying / deterioration / symptom management), access to equipment (eg. Syringe drivers), formulary – routes and quantities.	7
		Map current service provision and identify gaps in service, taking into consideration how services work together, are referred into and how they refer onwards.	6
		Develop a live service directory.	6
		Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5

Cross – cutting themes

HWBB priority	Activity	Detail	Beneficiaries	Investment 23-24	Outcomes
Improved mental health	Transforming Care Programme	A wide range of staffing and support services for those who have learning disabilities detained under the mental health act	N/A	£366,863	Prioritises Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.
	Improving mental health discharges	Teams working within mental health care settings enabling people to manage their conditions and maximise independence on discharge	N/A	£341,251	Teams working within mental health care settings enabling people to manage their conditions and maximise independence on discharge
	High dependency support	Providing case management, 1:1 care in a bedded setting for those with high level needs and behaviours (including dementia care)	72	£617,340	Supporting key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy
	Bariatric beds inc therapy and MH support	Specialist beds and equipment to support bariatric patients to recover from periods of ill health. Helping them to maximise independence with therapy and Mental Health support	18	£109,916	Prioritises Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.

Cross – cutting themes

HWBB priority	Activity	Detail	Beneficiaries	Investment 23-24	Outcomes
Reducing health inequalities	Shared care records	Shared care records assist staff to make the best decisions by having a more joined-up picture of information. This is important in providing safe, personalised, and connected care to all on an equitable basis	All		Equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire
	System one unit for Mental Health	Providing a discharge unit for Mental Health settings to enable joined up discharge planning across partners and equitable outcomes across all patient bed bases.	N/A		Equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire
	Hoarding project	To work with and support those that struggle to maintain a tidy and clean home environment. Includes targeted MH support and care planning to maintain the environment going forward	141	£204,527	Varying services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes

Indicators – what have we achieved so far?

- Increase in HART reablement service capacity by 30% (target to increase by 50% when fully mobilised)
- Increase in people receiving housing support from the Housing Enablement Team – up 25% in 23/24 from 22/23 (1239 in 22-23, 1583 in 23-24)
- Approximately 35% decrease in residential care bed usage compared to 2022
- 11% increase in the availability of packages of care to support discharges from hospital with an additional 15 plans per week for those being discharged home with reablement or care support
- Top quartile performance in amount of people still at home 90 days post reablement circa 89%
- Improved wait times for plans in hospital
- Reduction in the number of people admitted to hospital after a fall approx. 2716 in 23-24 from 2832 in 22-23 (4% reduction)
- Reduction in hip fractures due to a fall – in line with England average
- Fully integrated HART and therapy locality teams in the County, resulting in workforce time saved 0.5 days per team per locality helping to increase capacity and reduce waiting times
- The percentage of deaths that occurred at home in Leicestershire in 2022 (31.7%) was significantly above the percentage in England (28.7%).
- The percentage of deaths that occurred in hospital in Leicestershire in 2022 (39.3%) was significantly below the percentage in England (43.4%).
- Better collaboration between partners and services and improved outcomes for service users integrated training sessions across partners

Challenges

INCREASE IN DEMAND FOR ALL SERVICES

RECRUITMENT ACROSS ALL SECTORS TO SUPPORT INCREASE IN DEMAND

LACK OF STABLE INVESTMENT – NOT RECURRENT AND NOT REVENUE IN SOME CASES

SHORT-TERM DEMANDS DELAYING LONG-TERM PLANNING

MARKET AVAILABILITY TO MEET INCREASING CARE NEEDS

REDUCED TRAINING ON HEALTH CARE TASKS FOR CARE PROVIDERS

For 24-25

- Build on the delivery of Dying Well outcomes within the LLR workstreams
- Create an options appraisal for discharge to assess bedded requirements to improve equality of access to recovery, rehabilitation and reablement (3 R model) in bedded settings for all
- Pilot a housing initiative supporting those with respiratory illness in poor housing
- Further integrate adaptations services within Lightbulb
- Increase capacity in combined HART and Crisis response service by a further 20% to meet current unmet demand
- Further work on use of population health management data across integrated services
- Increase training in integrated locality teams to provide more joined up services
- Recommission training for the integrated personalised care framework
- Streamlining governance for the Integration executive – combining delivery and commissioning groups into one for ease of reporting and delivering outcomes
- Developing the role of Integrated Neighbourhood Teams
- Is there anything the Health and Wellbeing Board would like to see included in the plans for next year?

Summary

Overview of the Integration Executive

Current governance and workplans

How this aligns to the JHWS priorities and commitments

Work completed against these priorities for 23-24

Performance improvements

Challenges faced

Forward plans for 24-25

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