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HILLINGDON
LONDON

Health and Wellbeing Board

Date: **TUESDAY, 30 JULY 2024**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE**

Meeting Details: The public and press are welcome to attend and observe the meeting.

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To Members of the Board:

- Cabinet Member for Health and Social Care (Co-Chair)
- Hillingdon Health and Care Partners Managing Director (Co-Chair)
- Cabinet Member for Families, Education and Wellbeing (Vice Chair)
- LBH Chief Executive
- LBH Executive Director, Adult Services and Health
- LBH Executive Director, Children and Young People's Services
- LBH Director, Public Health
- NWL ICS - Hillingdon Board representative
- NWL ICS - nominated lead
- Central and North West London NHS Foundation Trust - nominated lead
- The Hillingdon Hospitals NHS Foundation Trust Chief Executive
- Healthwatch Hillingdon - nominated lead
- Royal Brompton and Harefield Hospitals - nominated lead
- Hillingdon GP Confederation - nominated lead

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Lloyd White
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Agenda

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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as amended), in that they contain exempt information and that the public interest in withholding the information outweighs the public interest in disclosing it.

11 BCF Review Update 135 - 144

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JOINT FORWARD PLAN FOR 2024/25 TO 2028/29

Relevant Board Member(s)	Richard Ellis
Organisation	North West London Integrated Care Board (NWL ICB)
Report author	Toby Lambert, Executive Director of Strategy and Population Health
Papers with report	Appendix 1

1. HEADLINE INFORMATION

Summary	To consider the NWL ICB Joint Forward Plan.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Select Committee	Health and Social Care Select Committee
Ward(s) affected	N/A

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **comments on the suggestions for improving the process for the next Joint Forward Plan;**
2. **notes that, while the draft Joint Forward Plan was provided to Health and Wellbeing Boards for comment, successive pre-election sensitivity periods made formal feedback from all HWBs impossible within the set deadline; and**
3. **notes that the JFP was submitted to NHS England on 5 July (the deadline set).**

3. INFORMATION

Report history Committees/ meetings where this item has been considered	**Name of Committee/ Board**	**Date of Meeting**	**Outcome**
	ICS Leadership	15 March 2024	Endorsed
	Strategic Commissioning Committee	21 March 2024	Endorsed Agreed to publish draft Joint Forward Plan
	Integrated Care Board	17 April 2024	Noted (pending comments from HWBs)

<table>
<tr><td></td><td><table><tr><td>Integrated Care Board</td><td>16 July 2024</td><td>Approved</td></tr><tr><td>Integrated Care Partnership</td><td>18 July 2024</td><td>Noted</td></tr></table></td></tr>
<tr><td>Key messages</td><td>North West London ICB, in common with all ICBs, is required to produce a five-year Joint Forward Plan (JFP) that shows how the ICB and its NHS partners intend to deliver services to the population of North West London in line with the strategy set by the Integrated Care Partnership. The ICB is required to produce and publish this plan on an annual basis, before 31 March each year. The deadline for submission to NHS England has been changed to 5 July 2024 in recognition of the delays to the planning guidance for 2024/25 and the calling of the general election.

The ICB is also required to share the plan with each relevant Health and Wellbeing Board, who in turn are required to respond with their opinions as to whether the plan takes proper account of their joint health and wellbeing strategies.

NHS England guidance on the pre-election sensitivity period limited the ICB’s ability to discuss the JFP before the London mayoral and assembly elections, and NHS England has specifically instructed ICBs not to discuss at any meeting in public until after the general election. This has made it impossible for all HWBs to respond with their opinions, although Hillingdon’s HWB did send written feedback.

A summary of the JFP is provided at the end of this cover note and the full document is attached. The plan contains:
plans and outcomes across nine different priorities, decided through a prioritisation process
plans for the enabling work streams to support the priorities
borough plans setting out alignment with NWL priorities to achieve scale and separate, local priorities</td></tr>
<tr><td>Key risks and mitigations</td><td>Risks include:
HWBs not providing the statutory opinion on whether the JFP meets the needs of their local population. Mitigation: given the deadline of 5 July and restrictions on discussion during the pre-election sensitivity period, there was no mitigation available.
Feedback from HWBs that local needs and priorities are not adequately reflected. Mitigation: demonstrating that benefits of scale can be used to deliver more effectively when priorities are shared across NWL, and that this creates more space, rather than less, for local (i.e., not shared) priorities</td></tr>
</table>

	• Scepticism, particularly from ICB staff, that the organisation will adhere to the priorities and work set out in the plan. Mitigation: Living up the ways of working are intended to mitigate that. We also acknowledge that this is the first time NW London has attempted to prepare an NWL wide joint forward plan. We will integrate feedback on the process into next year's JFP process.

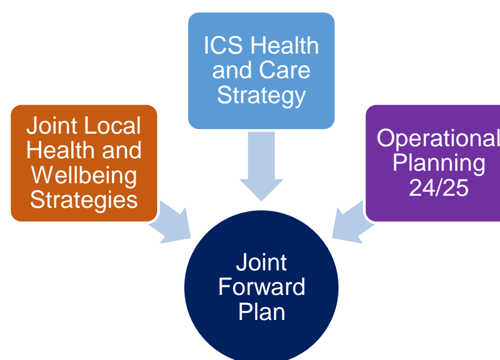
Describe how this work supports delivery of the NW London Integrated Care System's objectives (in particular describe the impact on inequality with reference to **equality impact assessment**)
• The JFP is the NHS plan to deliver on each of the ICS' objectives and therefore each of the objectives were considered explicitly. • The JFP will have a direct impact on each ICS objective, including the objective related to reducing inequalities – for example, priority 1 describes our plan for reducing inequalities and improving health outcomes through population health management.

What involvement and insights from residents and communities in NW London have informed this work?
• The JFP Plan builds on the North West London Health and Care Strategy that was developed last year. This strategy was subject to public consultation and the final iteration included feedback from residents and communities • Continuing input from the ICB's 'What matters to you' engagement programme has been fed into the development of the JFP. • The draft of the JFP was on the website, giving residents and communities the opportunity to comment before the JFP is finalised.

All Integrated Care Board papers are published, unless requested otherwise. If the paper is not suitable for publication, please confirm the reason for this below (Y= suitable, N = not suitable)		
Commercial Confidentiality	Y	
Patient Confidentiality	Y	
Staff Confidentiality	Y	
Other Exceptional Circumstances (please describe)		

Joint Forward Plan
Summary

The Joint Forward Plan is a statutory document that sets out how Integrated Care Boards (ICBs) and their partner NHS trusts propose to exercise their functions in the next five years. These should be reviewed before the start of each financial year.



In November 2023 North West London's Integrated Care Partnership published our Health and Care Strategy for North West London. The ICP brings together our eight local authorities, the NHS and

wider partners. The strategy sets out how we will improve outcomes in population health and wellbeing, prevent ill health and tackle inequalities, enhance productivity and value for money and support broader economic and social development.

The Joint Forward Plan takes the strategy (including the borough joint health and wellbeing strategies), the nationally set NHS operating plan[1] and agreed national and local targets and translates these into meaningful milestones and activities. It clarifies where the NHS will prioritise resources and objectives now and where we should invest in the future. It hence reflects and complements the Joint Health Wellbeing Strategies developed by each of our boroughs.

Our borough based partnerships and provider collaboratives will continue to have their own specific plans to improve health and wellbeing and to deliver the operating plan. However, aligning these with the Joint Forward Plan will mean that we can concentrate resources across the system in the most effective way possible.

Delivery will require cross-system collaboration from our providers through provider collaboratives, ICS programme teams, clinical networks, voluntary and community sector organisations (VCSEs) and borough teams. The board will receive assurance on delivery of the JFP through reports supplied to Performance Committee.

Context

North West London ICB, in common with all ICBs, is required to produce a five-year plan that shows how the ICB and its NHS partners intend to deliver the ICS strategy. The ICB is required to produce this plan each year.

The process of producing the Joint Forward Plan, as well as being a statutory requirement, is part of the organisational effectiveness work stream within the organisational design programme. It aims to:

- Show how the six priorities identified in the strategy translate into a work programme;
- Deliver consistent plans and priorities and improve coordination across the ICB (and thereby reduce bottlenecks resulting from conflicting priorities between different parts of the ICB and the wider ICS);
- Identify areas where working at scale across North West London to develop a shared offer and models of care that can tailored locally will enable us to go further and faster in delivering for our population;
- Be consistent with the ICB’s medium term financial strategy;
- Ensure that local priorities that are not shared between North West London’s borough Health and Wellbeing Strategies can continue to be progressed locally; and
- Be deliverable within the reduced capacity of the ICB.

Planning is taking place against a challenging backdrop – in common with the NHS across the country, our services have been under immense pressure in the last couple of years. Although NW London is one of the best performing healthcare systems, we have:

- A **financial challenge**, with a spend per head lower than average, insufficient capital to meet our estates need and a commitment to reallocate funding within NW London to services that need it most, rather than where it has been spent historically
- A **productivity challenge**, requiring a challenging 3.7% efficiency gain in addition to

[1] The 2024/25 priorities and operational planning guidance was published on 27 March. The JFP was developed using our best intelligence as to the likely content of the guidance.

normal expectation of productivity improvement, so we can free up the funds to invest in better, more equitable services; and

- An **organisational challenge**, with new statutory duties and a requirement to restructure our workforce, but also new opportunities through changes to the way we work across our partnerships and our providers coming together as collaboratives to capture the benefits of scale, reduce unnecessary variation and create greater resilience.

This means that our focus in the initial period of the plan has to be on reducing waiting times and maximising productivity so we can provide equal access to a common set of high quality services regardless of where our residents live. During this time, we will also be testing proactive approaches that prevent, reduce or delay the onset of need, support our residents to stay well and identify and support people at risk of or diagnosed with illness through providing best practice interventions.

Our aim is to be ready to roll out these programmes over time work together with our local authorities and voluntary sector partners, within the context of a resilient and productive NHS.

Process

We acknowledge that this is the first time that the ICB has attempted to prioritise and plan across its entire portfolio of work and has taken place within a very short timeframe. This first iteration of the JFP is capable of considerable improvement and subsequent JFPs will take on board lessons learnt and feedback from the first iteration to improve the process and the quality of the output each year.

In developing the plan, we took the following approach:

- Each programme, clinical network, borough team and collaborative submitted their **proposed work streams and plans** for the next five years, and in more detail for the earlier years.
- A **prioritisation framework** to support the leadership in selecting 5-10 shared initiatives was drawn up and taken through a working group. This covered the following domains:
    a. Alignment with the Health and Care Strategy;
    b. Contribution to health outcomes and inequalities;
    c. Alignment with national requirements, including the NHS E operating framework and the medium term financial strategy; and
    d. Delivery feasibility.
- We took **views from system leaders** on their priorities;
- A **town hall meeting** bringing together representatives across the ICS leadership was held in mid-February to discuss their plans, the initial prioritisation outcomes and what needed to be true to ensure the new priorities could be delivered well without additional asks;
- Based on feedback from the Town Hall the programmes, clinical networks, borough teams and collaboratives **resubmitted their plans, including enabling programmes assessing feasibility of delivering requirements** and we refined the priorities.

Summary of the Joint Forward Plan

The JFP contains nine priorities with corresponding activities, supported by four enabling work streams. It also includes a summary of each borough's plans.

Priorities

Priority	Intended outcomes	Focus in early years	Focus in later years
PRIORITY 1: Reduce inequalities and improve health outcomes through population health management (PHM)	• PHM based service design and investment decisions embedded in all settings including integrated neighbourhood teams. • Improved value for money and better able to meet population need and tackle health inequalities.	• Deliver PHM & Health Equity Academy – upskilling staff, starting with primary care; map financial position to need. • Deliver core common offer, address hesitancy.	• Intelligence Function with PHM underpinning our approach across the system for all conditions. • Complementary services where common offer does not deliver for specific groups.
PRIORITY 2: Improve children and young people's mental health and community care	• Consistent core healthcare offers for children resulting in equitable outcomes for health conditions in chil dhood, and for reducing risks in later adulthood • Local and national qualitative and quantitative evidence u nderstood and shared across partners • Integrated multi-professional partnership to provide seamless integrated healthcare to children	• Reduce waiting list for child and adult mental health services (CAMHS) • Close gap in school nursing provision for looked after children and children with special educational needs • Implement child health and family hubs • Deliver children and young people speech and language therapy priority quick wins	• Transformational improvements for specific conditions with known health inequity • Equity of experience of care
PRIORITY 3: Establish Integrated Neighbourhoo d Teams (INTs) with general practice at their heart	• Clarity for residents on how to get the care they need. • Avoidance in hospital and care home admissions Earlier detection of people at risk of ill health, earlier diagnosis of ill health and improved quality of care for people with long term conditions	• Establish and roll out standard operating procedures for the three Fuller areas, plus elective care • Extend same day access across all INTs • Establish core common offer for frail / elderly	• Focus on all residents and families to have care plans who need them with high adherence and making best use of local authority and community resources • Early and accurate diagnosis of disease
PRIORITY 4: Improve mental health services in the community and for people	• A reduction in unwarranted variation and equality in health outcomes, access to services and experience	• Focus on productivity to reduce waiting lists waiting lists.	• Increase capacity to where needed to reduce inequalities

Priority	Intended outcomes	Focus in early years	Focus in later years
in crisis	• An increased use of analysis and insights to help inform productivity and local decision making		
PRIORITY 5: Embed access to a consistent, high quality set of community services by maximizing productivity	• Reduction in waiting times for community services • Increase in urgent community response for first care contacts • Reduction in length of stay in community beds • More clinical time with patients	• Implement consistent offer in community nursing, community beds and specialist palliative care • Conduct demand and capacity modelling across system • Drive increased productivity across these services.	• Implement consistent offer in neuro rehab • Services in line with right demand and capacity • Launch additional virtual ward pathways • Identify and reduce patients experiencing inequality of access, experience and outcome in urgent and emergency care services
PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place	• Reduced delay for patients in hospital who are medically well enough to be discharged • More patients are discharged back to their place of residence than in previous years • Patients put at a reduced risk of harm by being discharged from hospital sooner	• Remove delay for medically optimised patients in hospital - implement discharge to assess or equivalent model and embed system escalations and operational support • Enhance support to care homes to improve intermediate care • Direct referrals to same day emergency care (SDEC) services	• Launch additional virtual ward pathways • Identify and reduce patients experiencing inequality of access, experience and outcome in urgent and emergency care services
PRIORITY 7: Transform maternity care	• Reduce the inequity of pregnancy care and outcome • Improved safety of services, with more support from maternity services to higher risk cases • Low numbers of still births and intrapartum brain injuries	• Develop maternity strategy • Achieve NHS England safe staffing standards • Inreach offer for ethnic communities adversely affected by poor outcomes in maternity services	• Implement wider maternity transformation
PRIORITY 8: Increase cancer detection rates and deliver faster access	• Improved early diagnosis by tackling variation in screening • Faster and more efficient access to	• Increase HPV vaccination uptake in school age children • Reduce population differences in seeking	• Roll out lessons on early diagnosis from Brent to wider NW London • Roll out and embed

Priority	Intended outcomes	Focus in early years	Focus in later years
to treatment	diagnosis and treatment	help for symptoms of concern, focussing on Brent • Deliver and maintain national performance requirements for faster diagnosis and treatment • Target lung health checks (TLHCs) in high risk wards	approaches to early diagnosis and treatment, ensuring spread and adoption of useful technology
PRIORITY 9: Transform the way planned care works	• Elimination of waits over 52 weeks for elective care • Reduction in avoidable outpatient referrals and activity • More meaningful and effective communications with patients, leading to fewer missed appointments and a better patient experience • Increase staff satisfaction, reduction in staff burnout	• Drive productivity in outpatients and elective care • Drive efficient use of diagnostic centres • Innovation of new workforce models to deliver clinics • Activities to improve patient communications (NHS App, better use of language)	• Focus on care in most appropriate setting through transformation of clinical pathways, moving closer to home • Embed continued wellbeing through recovery and proactive care models

We know that the Joint Forward Plan is currently underpowered in a couple of areas:

- We are committed to developing an urgent and emergency care strategy - completion due in the summer). Once complete, this will enable us to strengthen priority six on flow;
- The Acute Provider Collaborative is currently working up its strategy – completion again due in the summer. A particular theme in the strategy will be elective recovery and swifter access to specialist opinion (which underpins outpatient transformation). Once complete, this plan will allow us to strengthen priority nine (planned care).

Enabling programmes

The priorities confirm the estates, digital and data, workforce and communication and engagement requirements to deliver the priorities, in addition to the enabling activities to deliver the wider strategy.

Enabler	Intended outcomes	Focus in early years	Focus in later years
Estates	• Estate facilitates services which respond to the needs of the local population • Effective and appropriate utilisation	• Immediate prioritised investments • Fit for purpose estates for early INT sites	• Completion of major projects identified for integrated working • Infrastructure planning and delivery

	• Best design for integrated working		
Workforce	• A safe and manageable workload • Increased satisfaction from staff surveys • Clear workforce model included new and fulfilling roles with productivity gain	• Expand and diversify routes into recruitment • Workforce productivity and new ways of working for community nursing and mental health roles	• Workforce elements of the system wide programmes to enable new ways of working in support of new models of care
Digital and data	• Stable and secure ICT infrastructure • Shared records across health and care settings and with access to citizens to help them manage their own health and care • Data used intelligently to improve population health and reduce inequalities • Take advantage of digital healthcare innovation.	• Migration of the Whole Systems Integrated Care dashboard to a modern cloud platform and integration into workflows • Link 111, 999, VCS data to WSIC • Create population health dashboards for whole sector • Ongoing programme of digital enhancements	• Plan and implement the transformation required to make use of shared records
Communications and engagement	• The JFP includes an assessment of the communications and involvement work to deliver the priorities in addition to strategic activities not directly related to the priorities, such as the programme to combine resident insights with other data to improve decision-making and the campaign to simplify use of language across ICB and then wider ICS.		

Borough place partnership priorities

The Joint Forward Plan also includes a summary of each borough based partnership's plans. The plan sets out where these align with the nine NW London priorities and can therefore be delivered at scale and where there are additional activities which may be phased differently or implemented now for specific, local reasons in agreement with their Health and Wellbeing Boards. The priorities within the Joint Forward Plan for Hillingdon are included below:

Hillingdon

Priorities for Hillingdon Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hillingdon resourced through partners

Year 1

Defining place governance and accountability within the wider NW London Integrated Care system

- Agreement to, and implementation of a Common Framework for Place Leadership and Accountabilities ((by July 2024) **

Developing and progressing the required new clinical models

Fast Track development of Integrated Neighbourhood Teams using PHM approach and mobilising local communities to tackle health inequalities with 3 core functions:

1. Same Day Urgent Primary Care for people with non complex needs*
2. Proactive Care for at risk population cohorts with a emphasis on Frailty in the first instance*
3. Preventative Care for a range of population health JSNA priorities with an emphasis on Hypertension, Anxiety/Depression and Obesity in the first instance.*

Years 1-5

Delivering the main priorities in our Place based Transformation Programmes

- New model of reactive care through:
  - Development of a new 24/7 Place Based Out of Hospital Reactive Care delivery model for those with complex needs and multi morbidity. *
  - Move from 'Good to Great ' in hospital discharge*
- Improve the health and wellbeing of CYP & families in Hillingdon - Experts by experience; THRIVE; Access and school based MH support; community based crisis; CYP neurodevelopmental pathway, Care experienced children; Health and Justice*
- Improve quality of care & health and wellbeing of people with a Mental Health or emotional wellbeing issue*
- Improve the health and wellbeing of people with a Learning Disability and/or autism**

Workforce estates and digital enablers to underpin integrated teams

- Building three integrated neighbourhood teams supporting 2 PCN's each, led by neighbourhood director, to include adult mental health in the team*

Embedding integrated neighbourhood teams and linking in community assets

- Deliver the priority programmes as agreed in the business case - hypertension, obesity, falls prevention, Childrens oral health, proactive care and MH with a particular focus on the health needs in the south of the borough. Recruit to PHM roles to support PHM infrastructure and support recruitment of neighbourhood directors for INT's to support PHM into BAU*

Integrated end of life

- Implement integrated end of life hub*
- Hub developed in 23/24 - continued development of integrated team in 24/25*

Ensuring best use of resources to address financial deficit

- Developing a 3-5 Year Place Based Financial Recovery Plan**
- Commission Reviews of those Services non recurrently funded by the ICB to ensure that they represent value for money and do not duplicate other services**
- Ensure Benefits realisation of the 3 HHCP Transformation Scheme**

Change management programme

Years 2-5

PHM priorities and programmes to underpin integrated neighbourhood teams and embedding PHM into BAU

- Development of HHCP estates strategy and 10 year plan; HHCP workforce passport, supporting new ways of working and building workforce skills within neighbourhood teams**

Integrated therapy reablement and rehabilitation

- Development of an integrated therapy team across THH, CNWL and ARRS First Contact Practitioners to support discharge and prevention of admission*

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Ways of Working

As we have progressed the organisational restructure, staff in the ICB have expressed considerable scepticism that that the organisation will indeed adhere to a defined list of priorities when there are considerable pressures to react to further demands. To build confidence, we have used feedback from the Town Hall event to develop a set of principles:

1. **Priorities are collectively agreed upon and endorsed** - ensuring alignment across all program teams, boroughs, networks, and collaboratives, fostering understanding and endorsement of the priorities and their sequencing;
2. **Programme priorities are aligned with Borough requirements** - ensuring consistent delivery of priorities to the same standard and at the same time. This may necessitate some programs and boroughs to adjust their focus and adopt a more collaborative approach;
3. **Clear establishment and monitoring of deliverables and metrics for each priority** - with a single empowered lead overseeing each aspect;
4. **We are empowered to discontinue deprioritised work and to challenge additional tasks** - thorough scrutiny and review should be applied to any work that does not support a priority;
5. **Resource allocation is accurately aligned with priorities** - with some activities being halted and increased focus directed towards certain areas;
6. **Leadership is committed to upholding these commitments** - being prepared to push back against national and regional requests, while carefully considering the implications of any additional tasks.

Overseeing implementation of the JFP

We will use the Joint Forward Plan to track our delivery against the milestones and actions in the priority areas and report these through the ICB performance processes. The performance report already contains a section on each of the ICS' programmes. Progress against the

milestones and actions in the JFP should be reported through this route. Local delivery is reported through local structures.

The ICB's Strategic Commissioning Committee is also establishing a cycle of strategic reviews. The committee has representation from a DASS (being agreed) and a DPH (currently H&F). The reviews should follow a clear structure – starting with the relevant goals laid out in the JFP and progress towards them.

Feedback from Health and Wellbeing Boards

Health and Wellbeing Boards HWBs were sent the draft plan on 9th April and asked to provide their commentary, and specifically respond with their opinion as to whether the plan takes proper account of each relevant joint local health and wellbeing strategy. The pre-election sensitivity period for the London elections made it impossible for the ICB to attend HWBs between late March and the 2 May 2024; the pre-election sensitivity period for the general election made it impossible for the ICB to attend HWBs from 25 May to the 4 July. NHS England revised the deadline for the Joint Forward Plan to 5 July 2024, which was of no help in securing the view of HWBs. Written and/ or executive feedback from our boroughs was sought in lieu of consideration from HWBs; Hillingdon HWB sent written feedback, much of which has been incorporated into this draft.

Potential improvements

Statute requires the ICB to prepare a joint forward plan every year. The team working on the joint Forward Plan has collated the following suggestions to improve the process for next year:

- Make the link to the health and care needs of residents clearer (i.e., update North West London's shared needs assessment, drawing on JSNAs, each September);
- Start the JFP process earlier in year (September) so that:
    - The outputs can inform commissioning intentions in December;
    - Those outputs and commissioning intentions can inform NHS operational planning (rather than be developed in parallel to the operating plan);
    - Programmes and boroughs can prepare a more detailed one year plan drawing on the JFP; and
    - Engagement with health and wellbeing boards can take place from January to March, enabling a final JFP by the end of March.
- Strengthen clinical and professional contribution into the JFP process (e.g., holding a clinical advisory group summit to inform the prioritisation of the plan);
- Strengthen input from partners (e.g., local authorities, voluntary sector, etc.). While partners were invited to the town hall meeting, and many partners sit on the ICS programmes who contributed to the JFP, this may not be the most effective way of inviting input;
- Strengthen the consideration of financial, workforce and other constraints in the JFP process, for example by supporting programme, borough and corporate teams with tools that will enable them to prioritise more effectively within the available resource.

Next steps

The NHS is required to produce a five-year Joint Forward Plan before the beginning of each financial year. This provides us with the opportunity to update the plan as local and national priorities evolve. Our aim is to produce a draft by December of each year, giving Health and Wellbeing Boards to comment in January and February to allow publication by the end of March.

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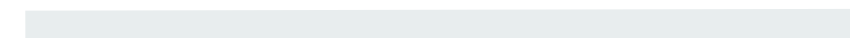
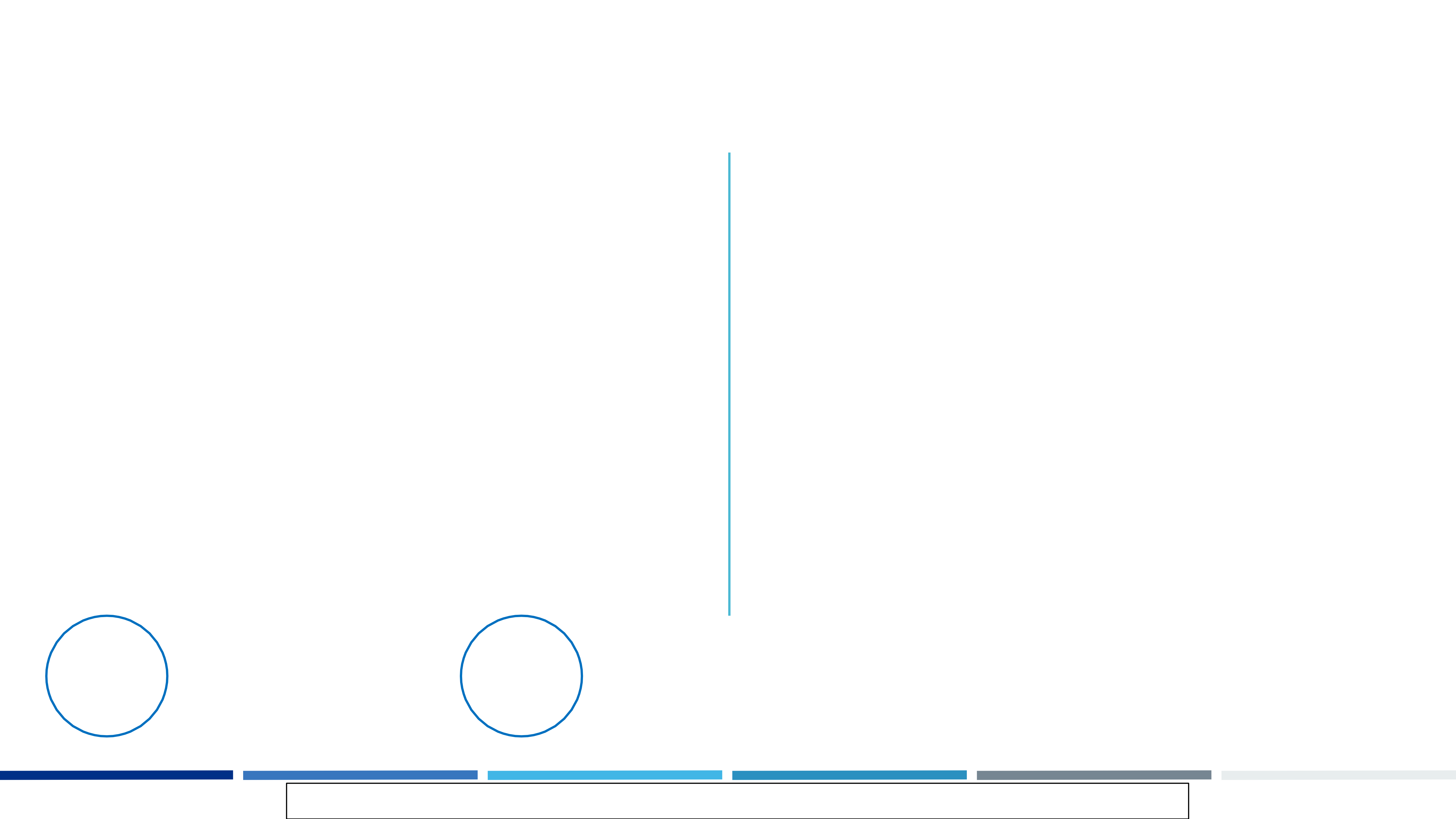
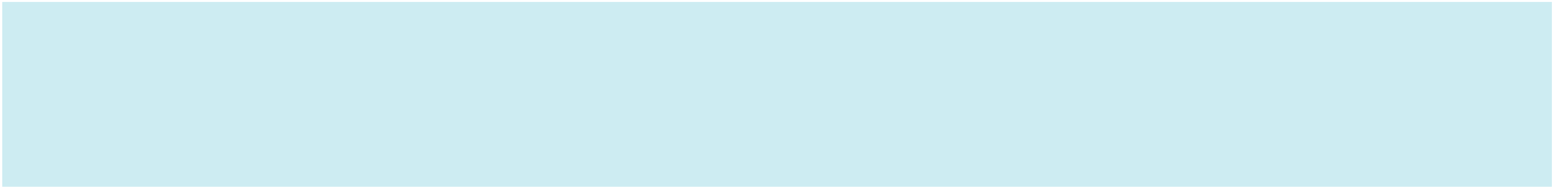
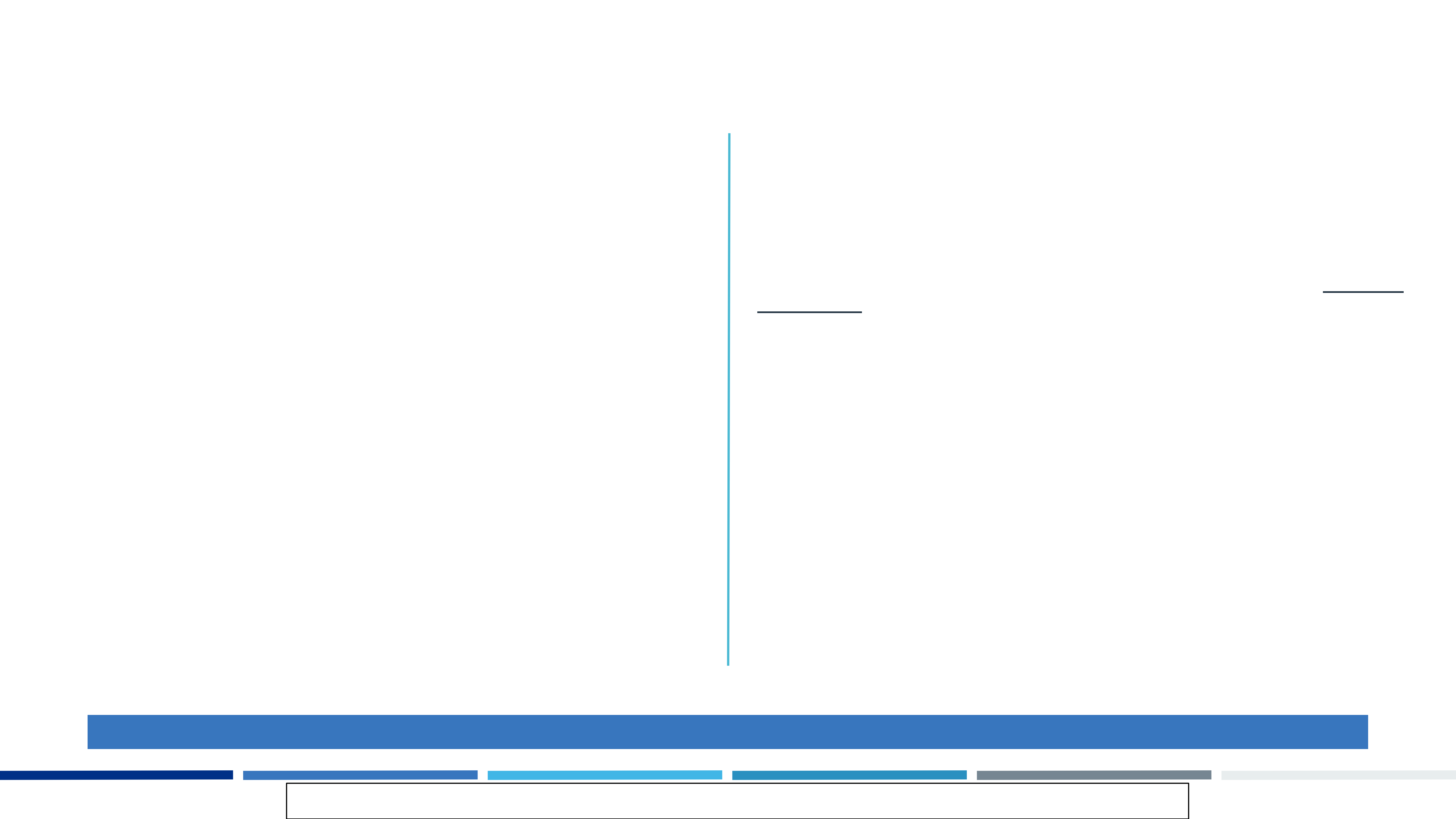
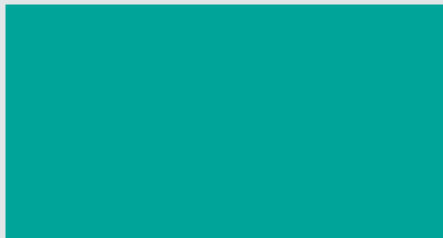
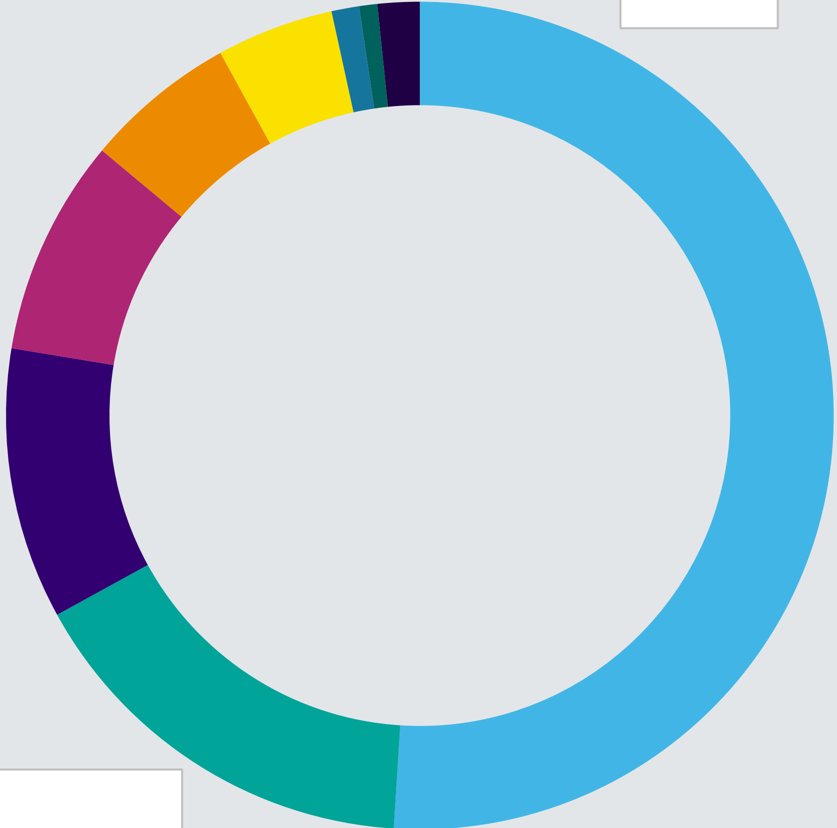


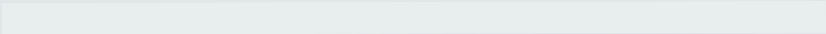


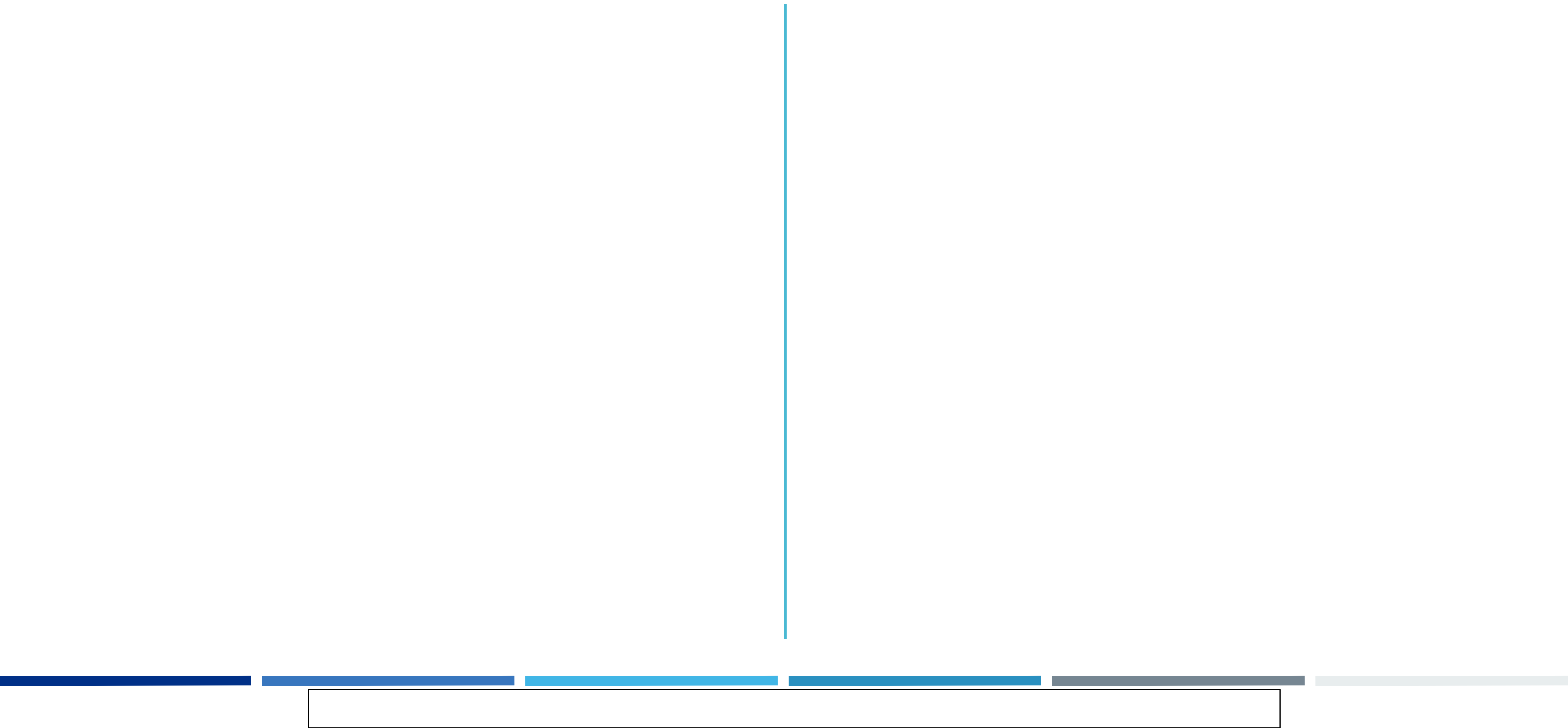


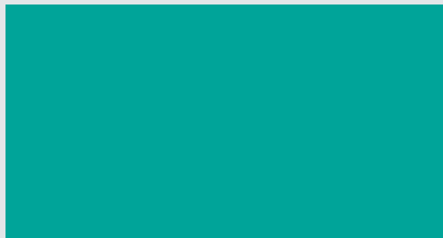
THIRD SECTOR
TOGETHER

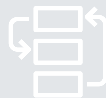


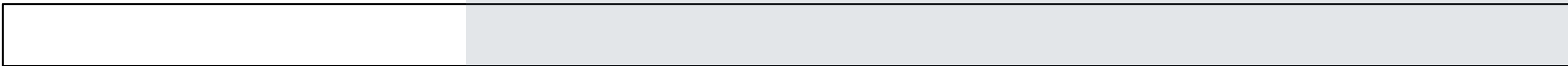



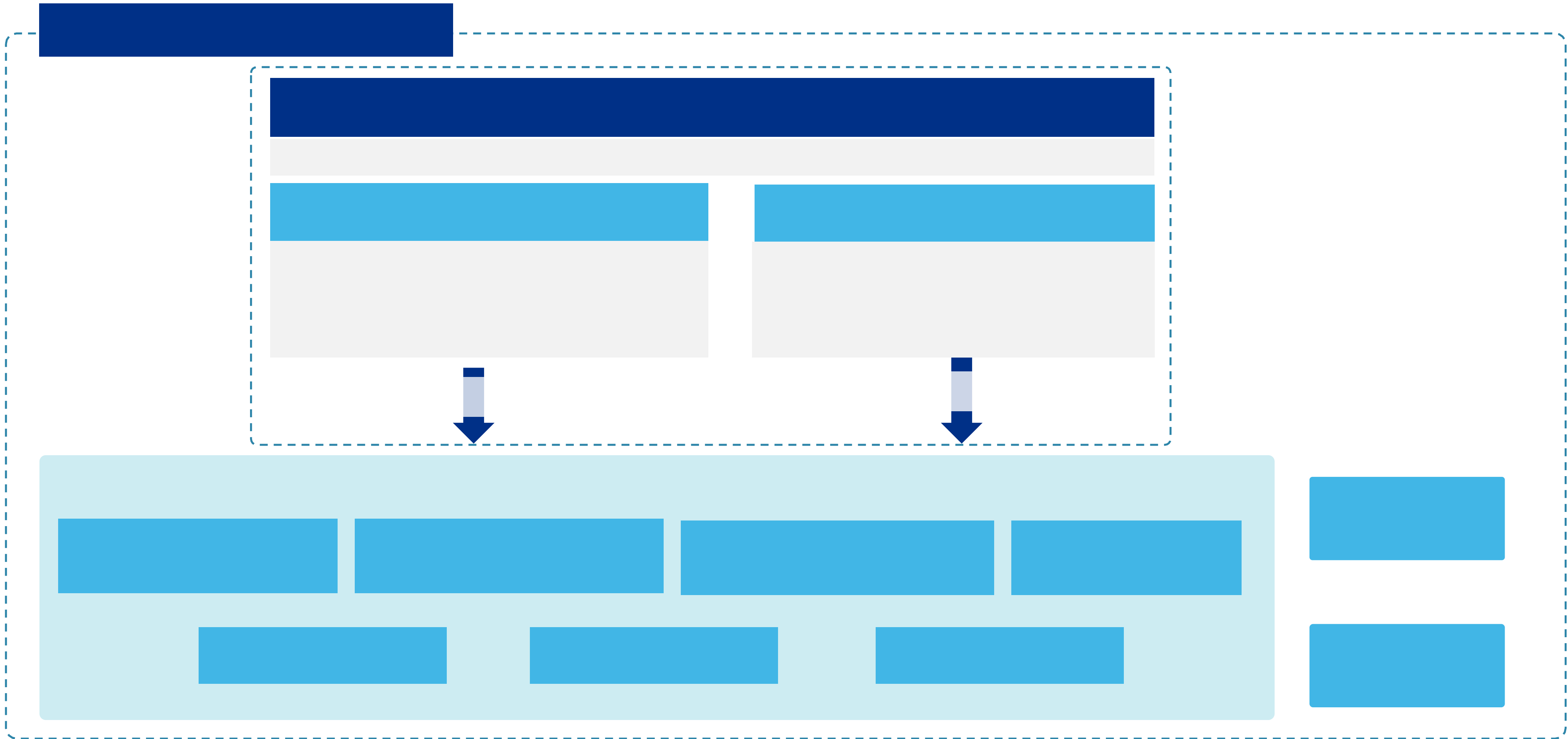


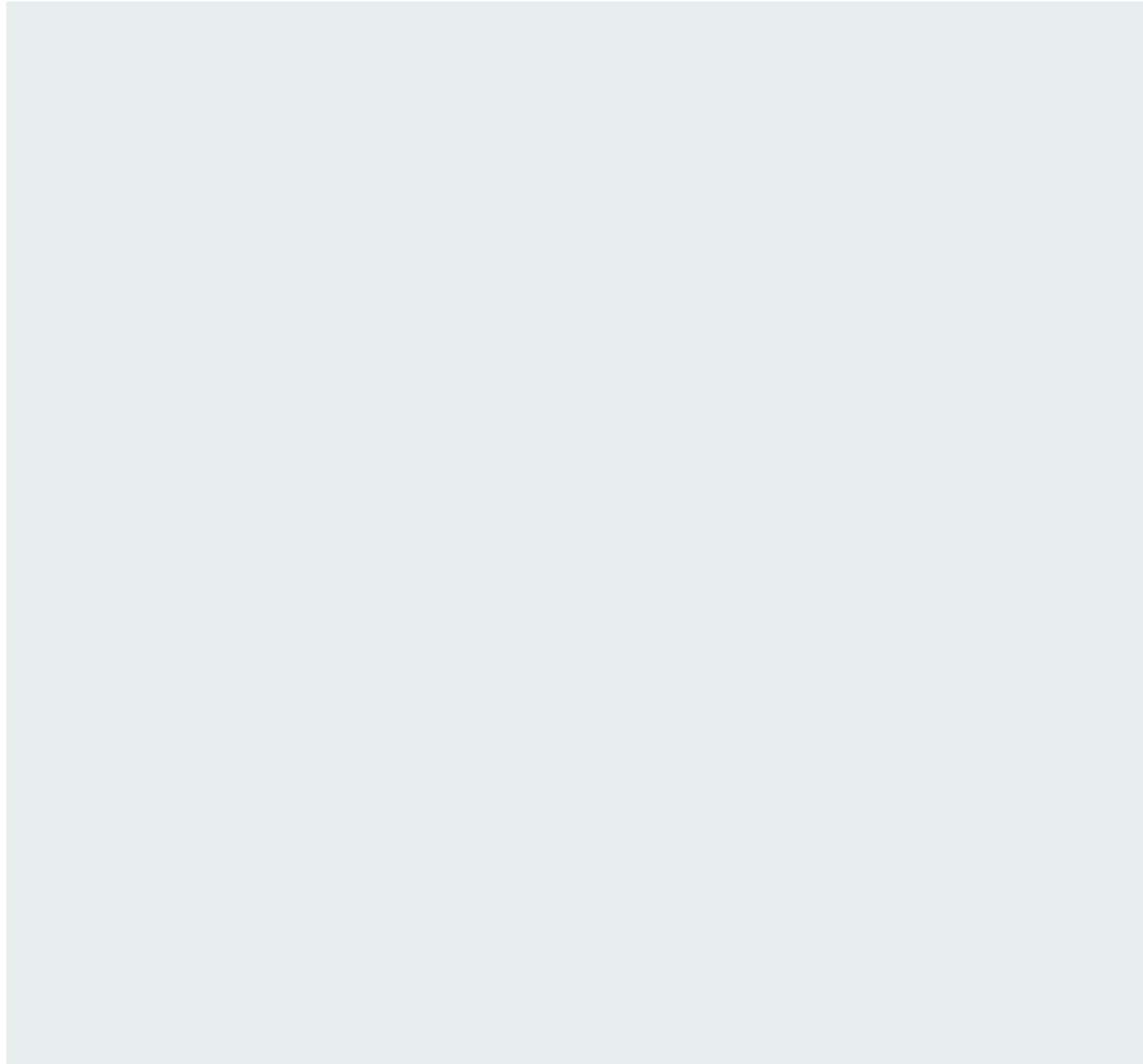


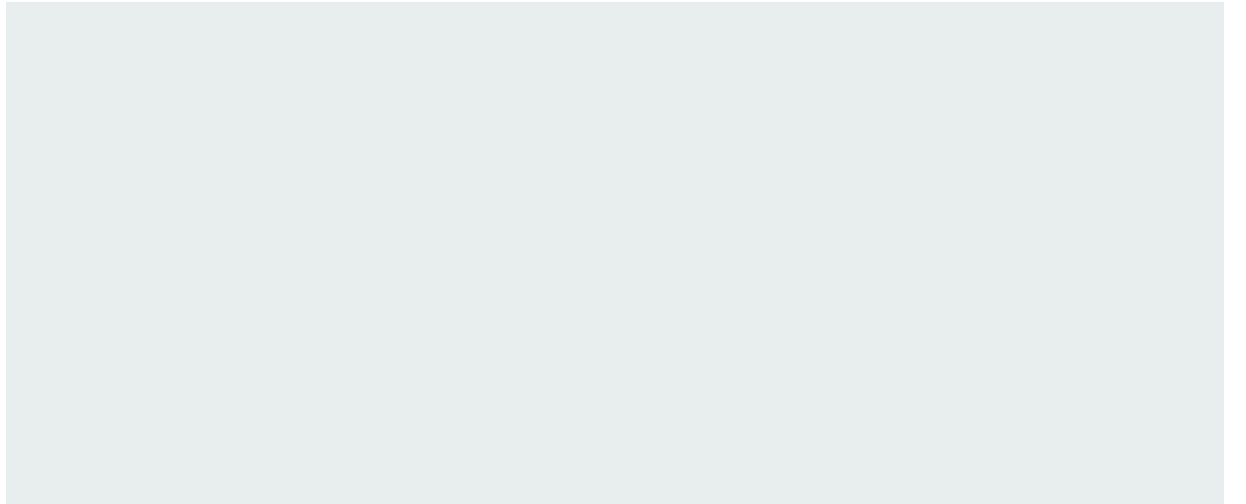


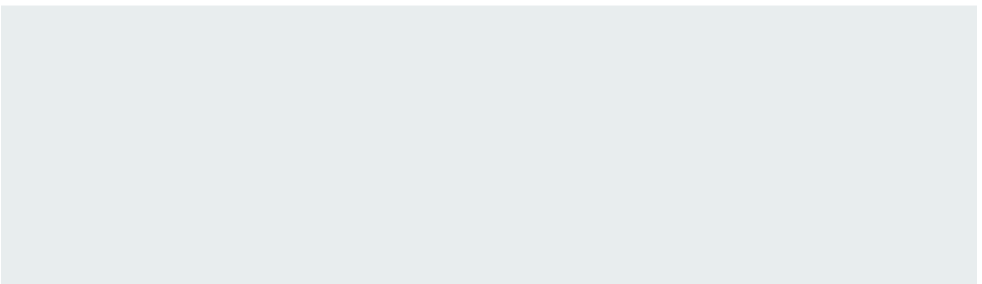


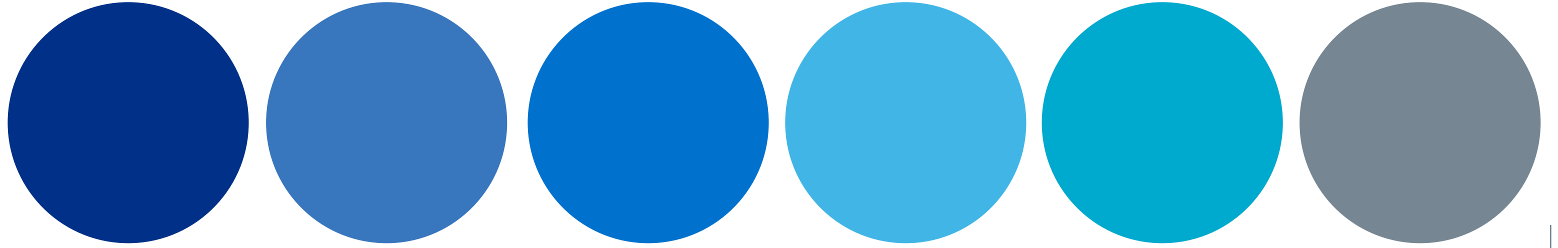
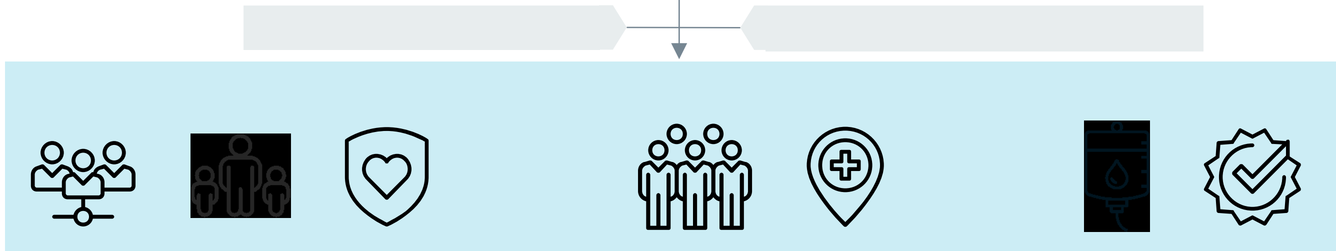
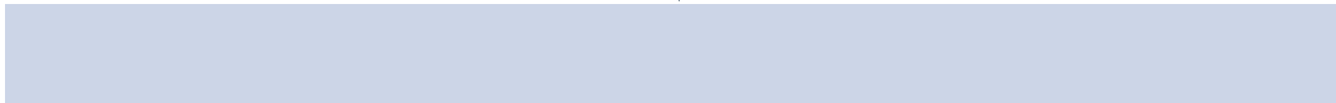


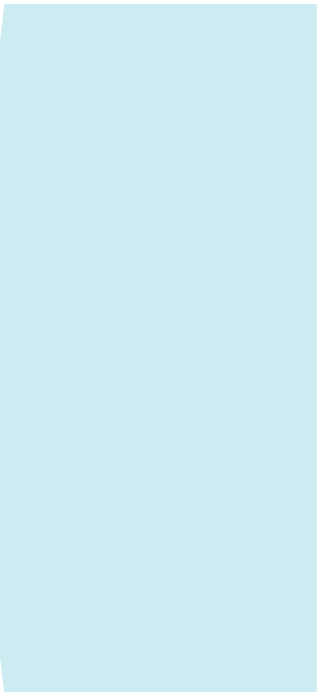


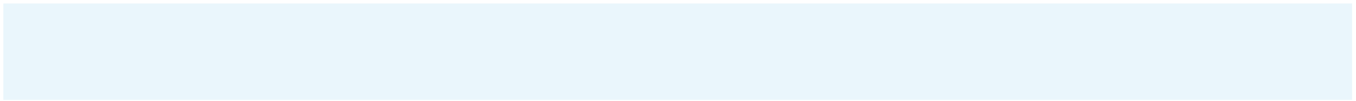


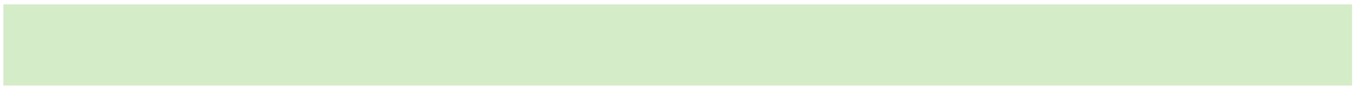


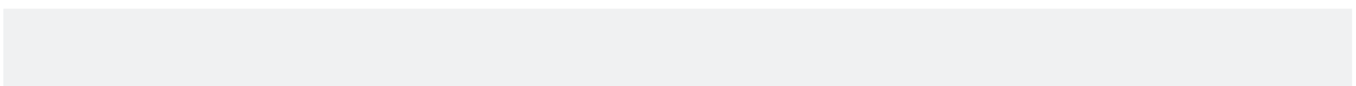


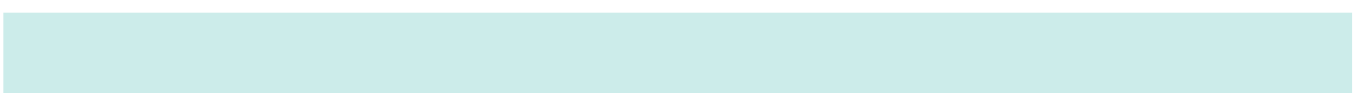




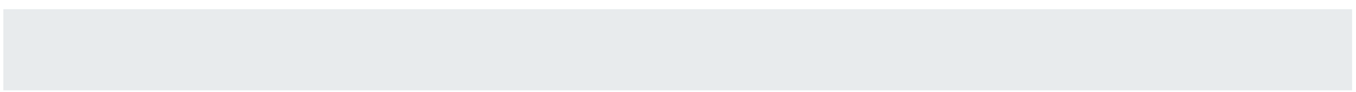


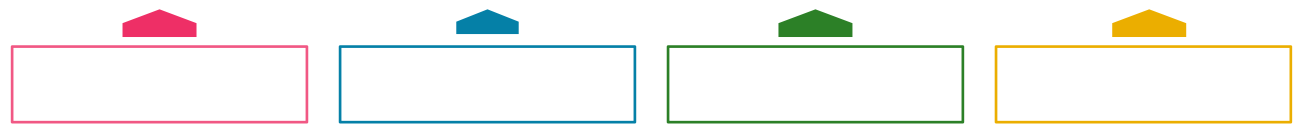


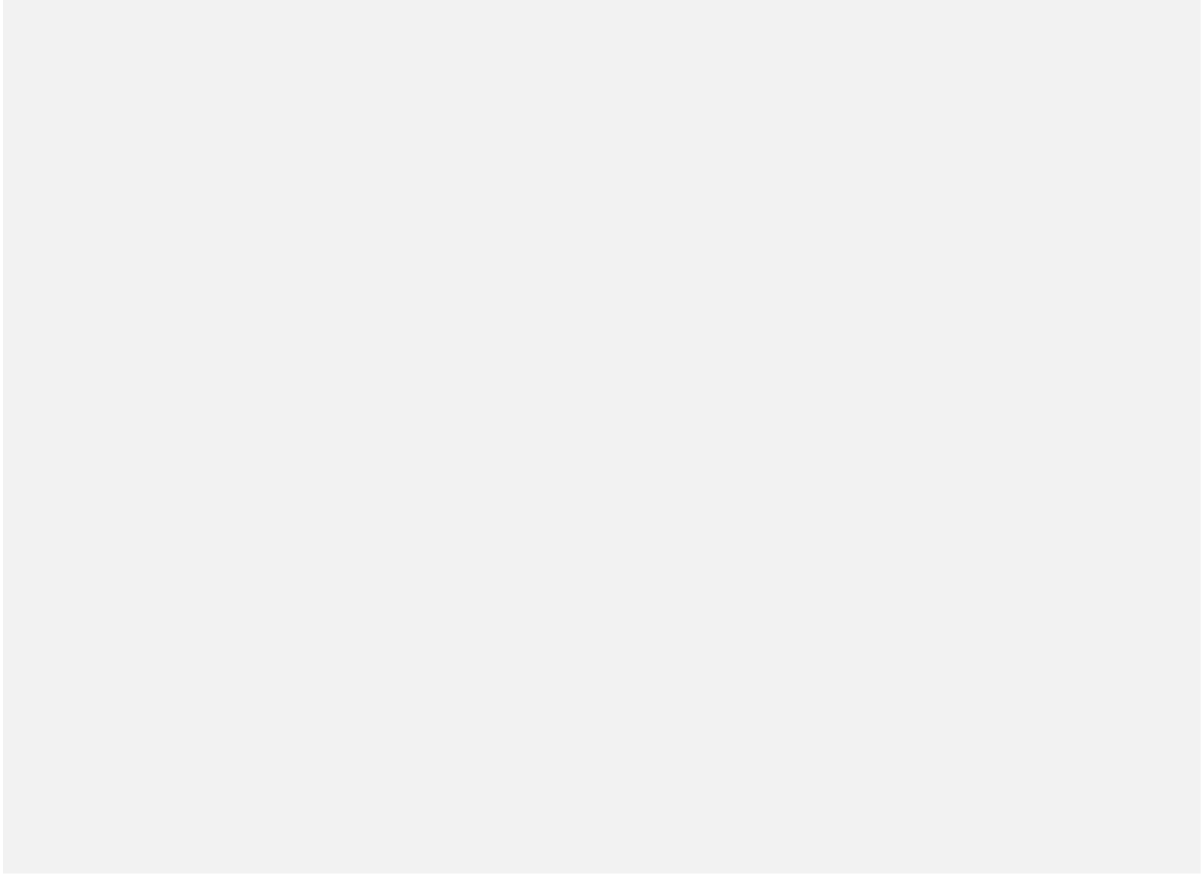


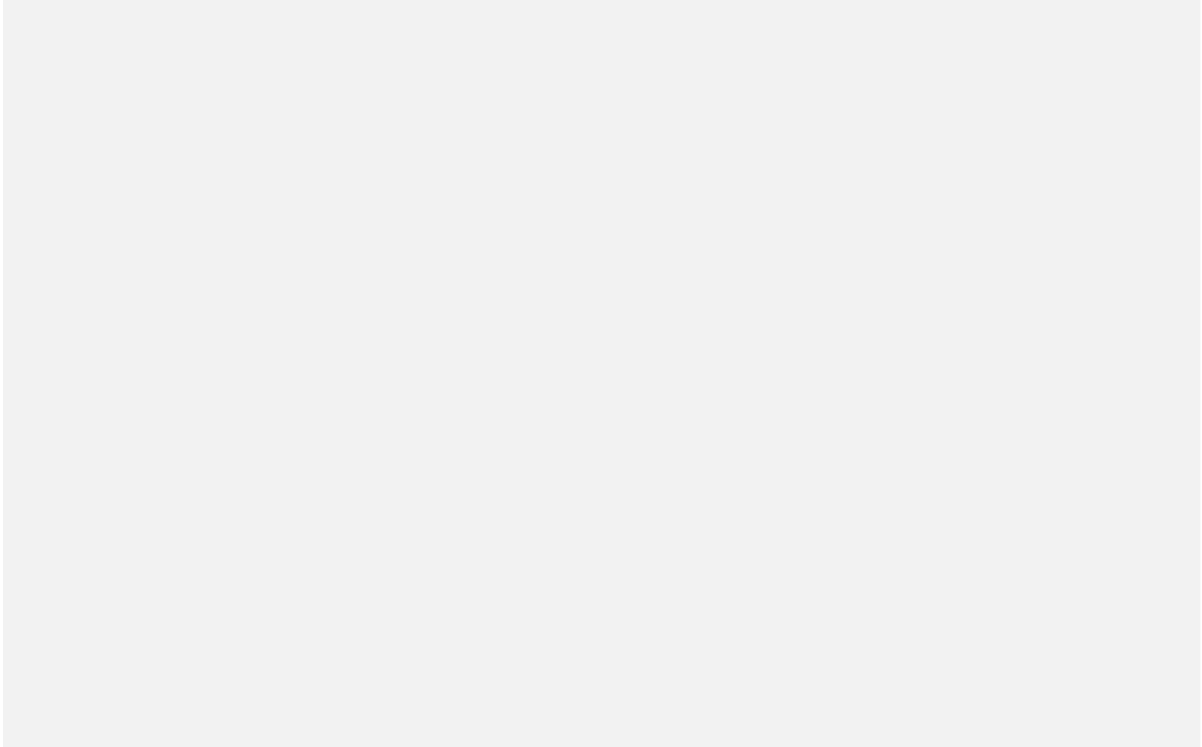


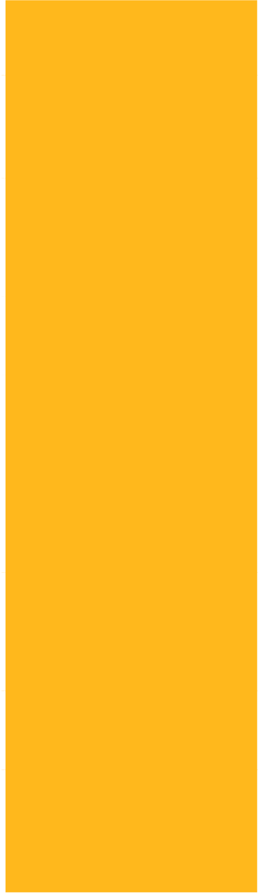


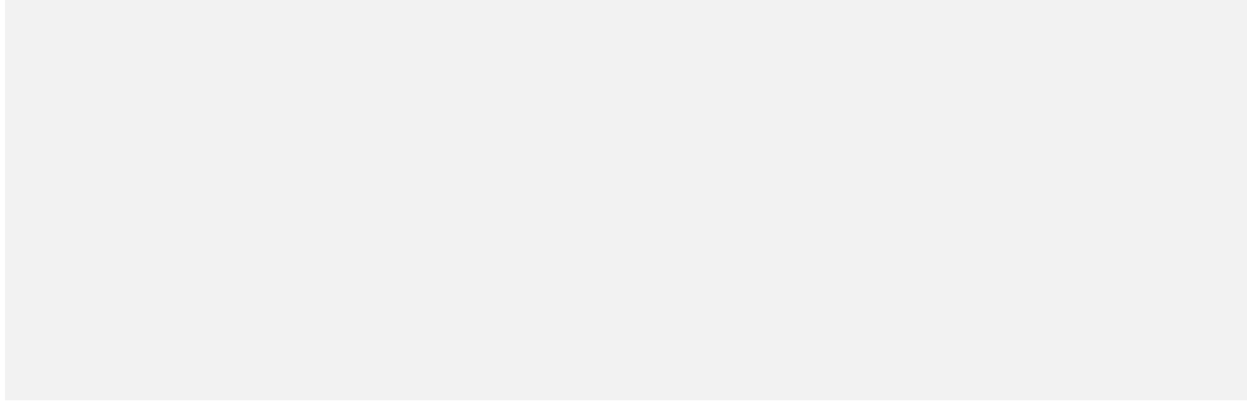


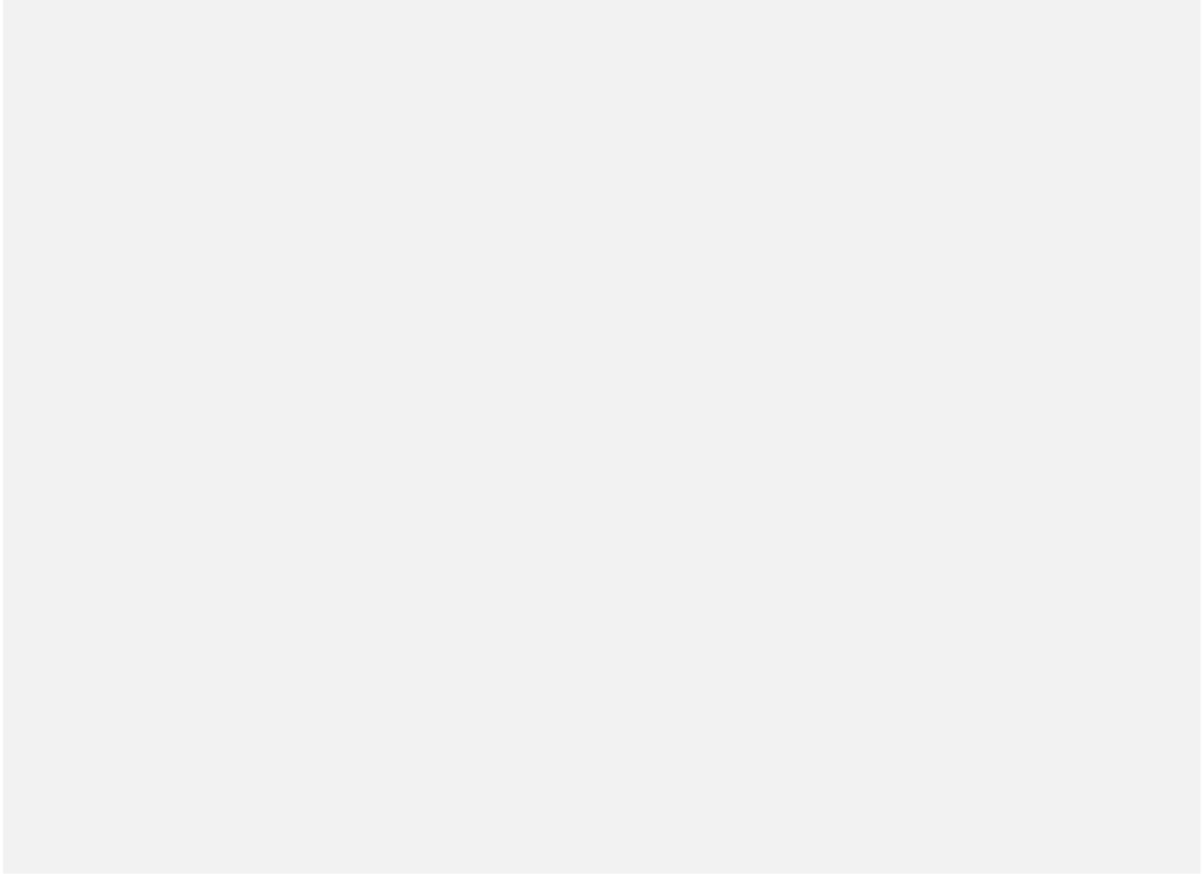


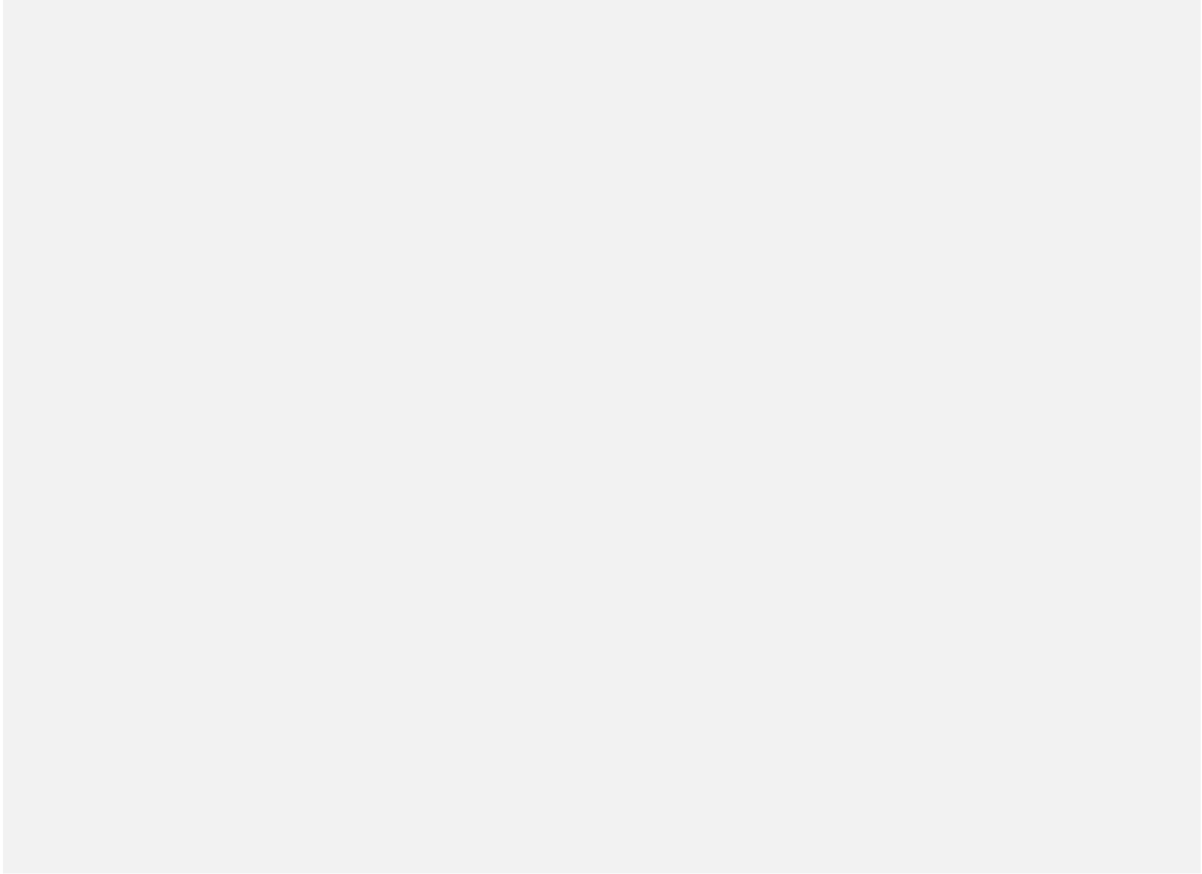


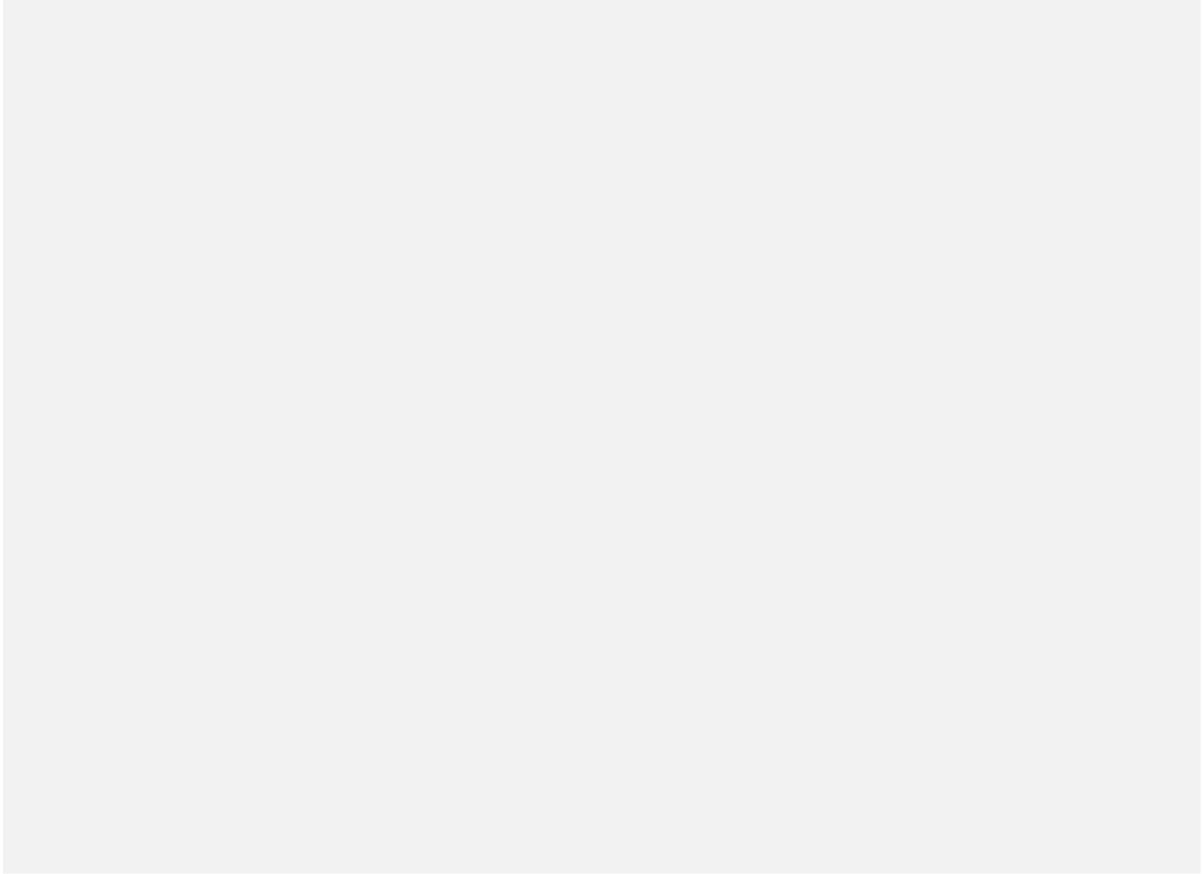


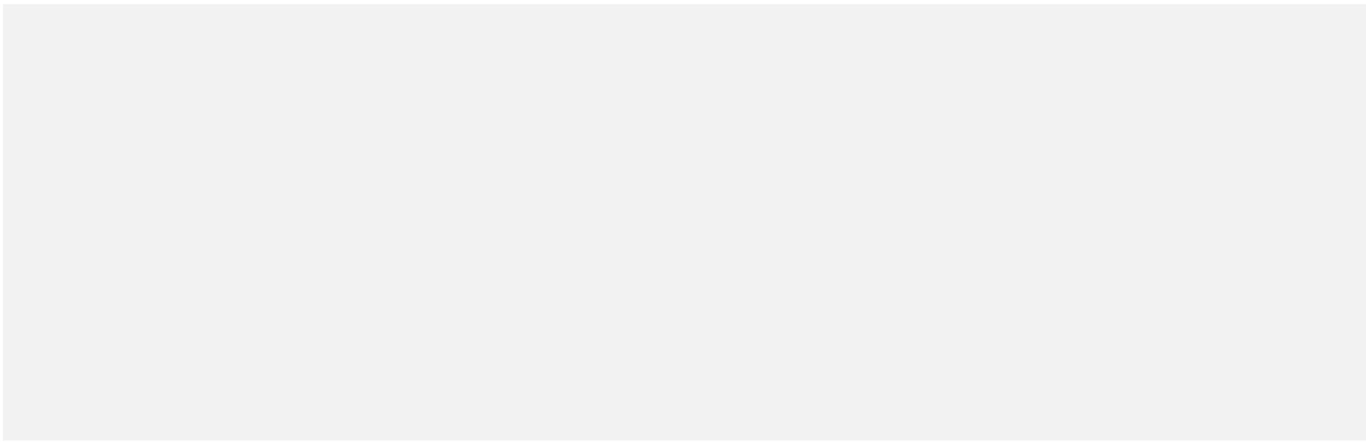


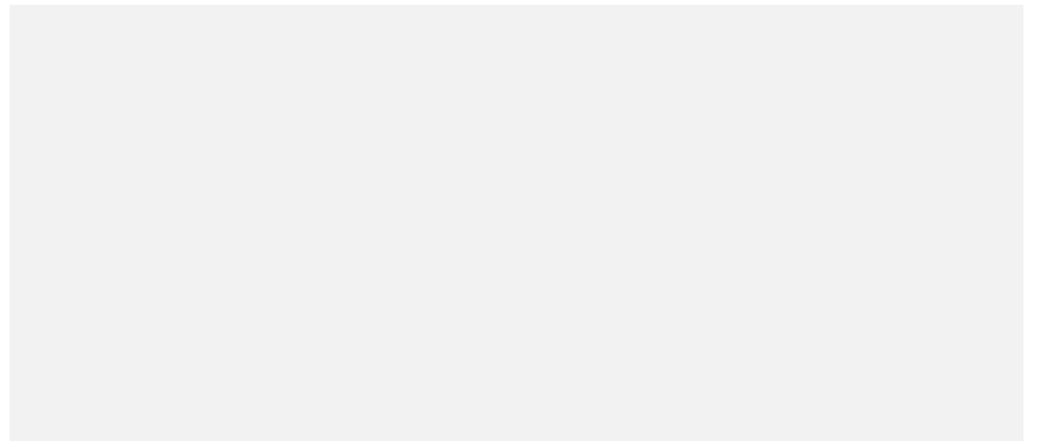


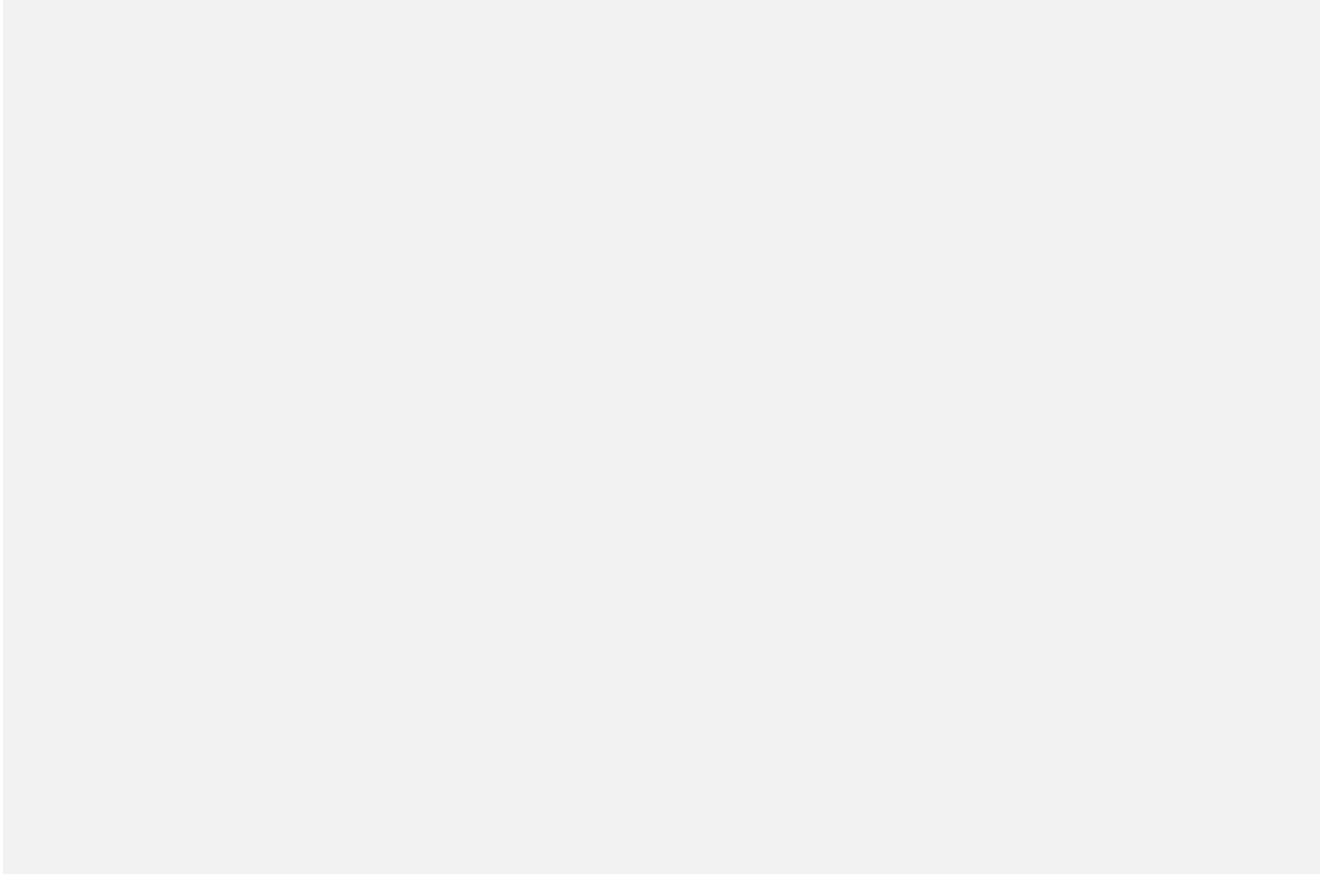


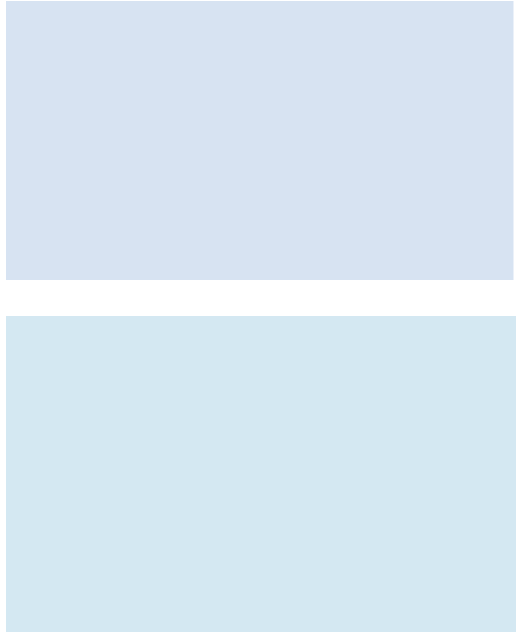


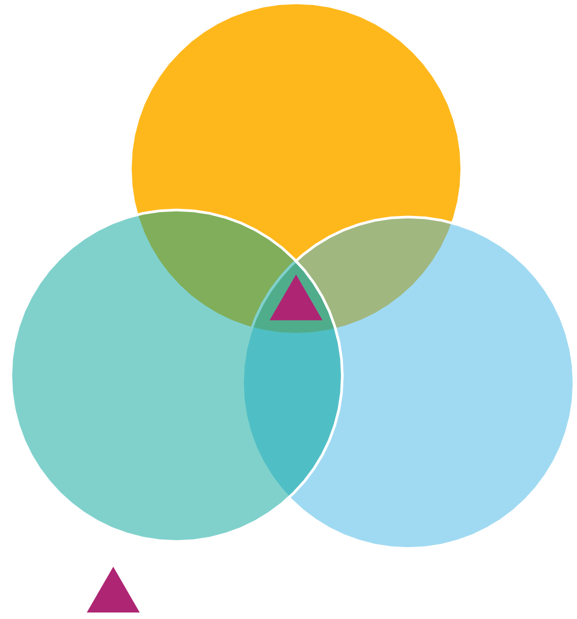


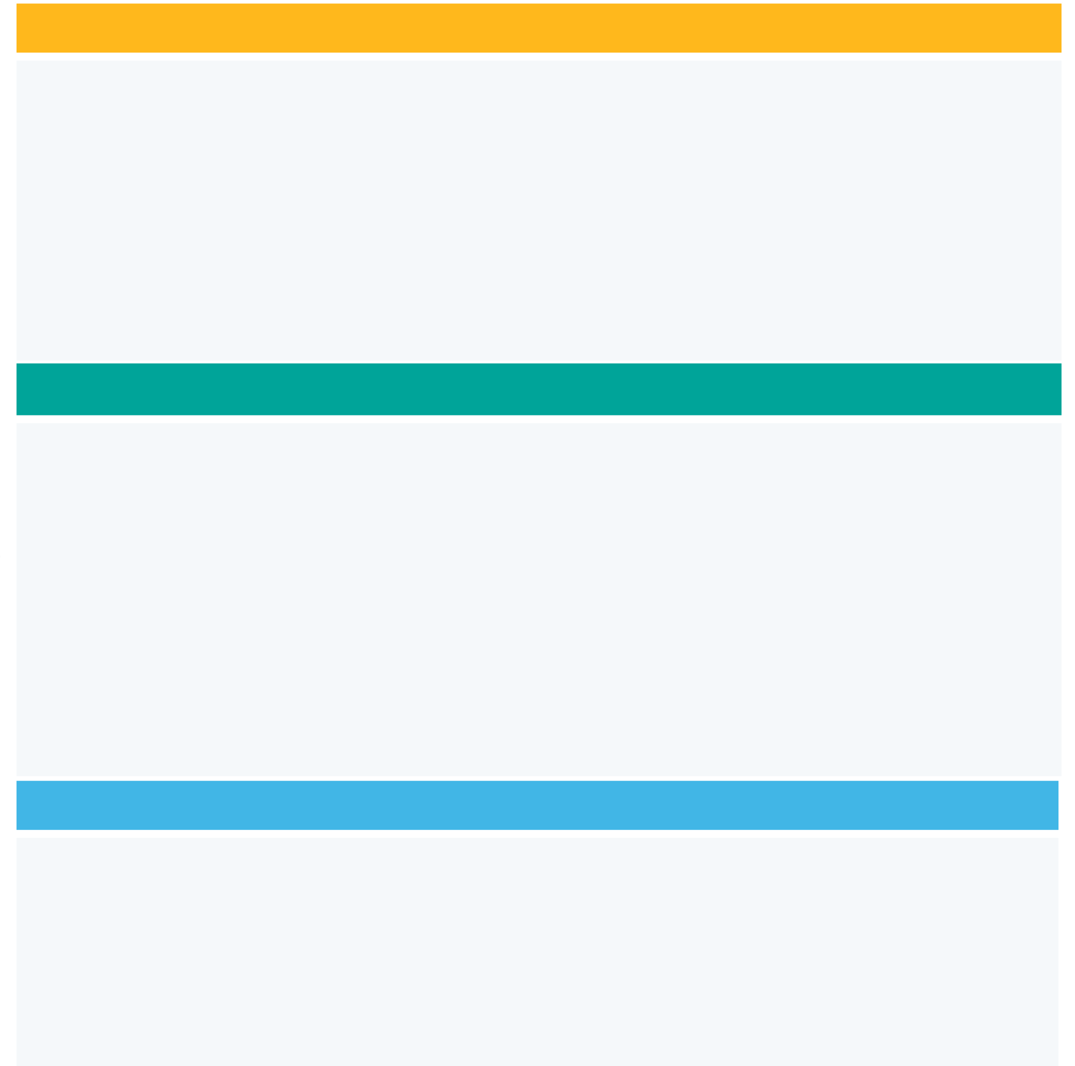




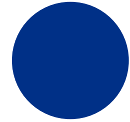


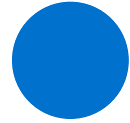


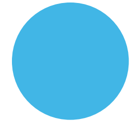


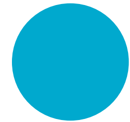


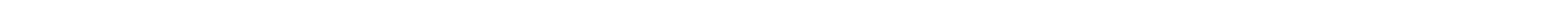
Hospital Entrance
Emergency Department

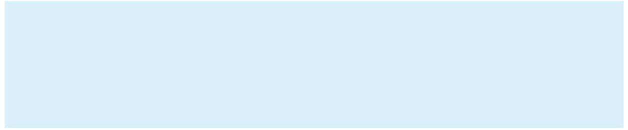


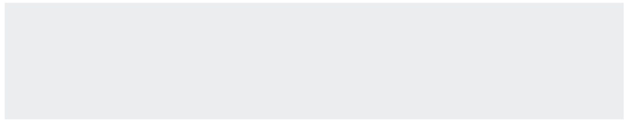


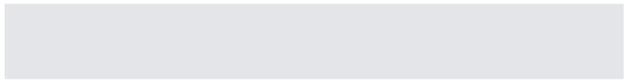


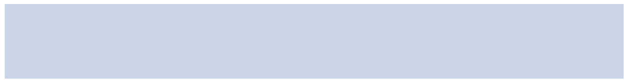




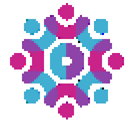




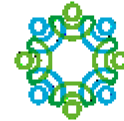




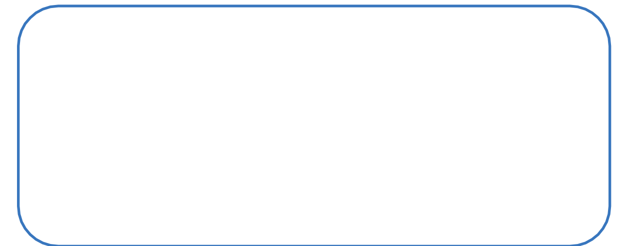
North West London
Acute Provider Collaborative

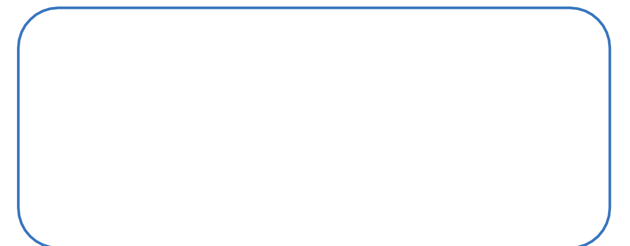


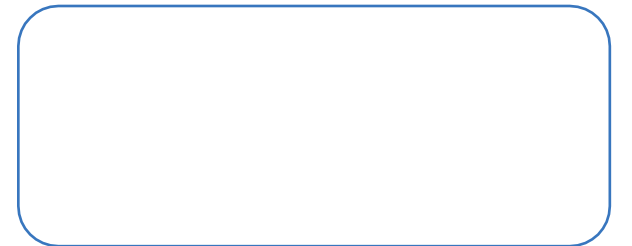
NWL Mental Health,
Learning Disabilities & Autism
Provider Collaborative

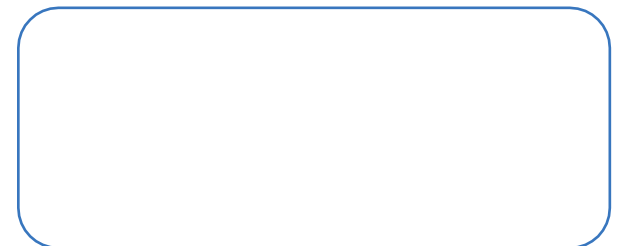


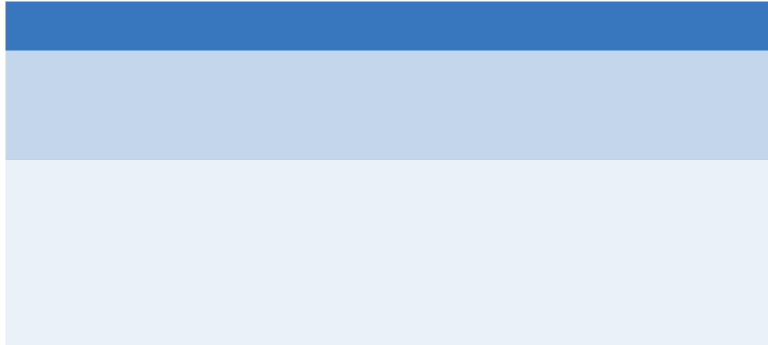
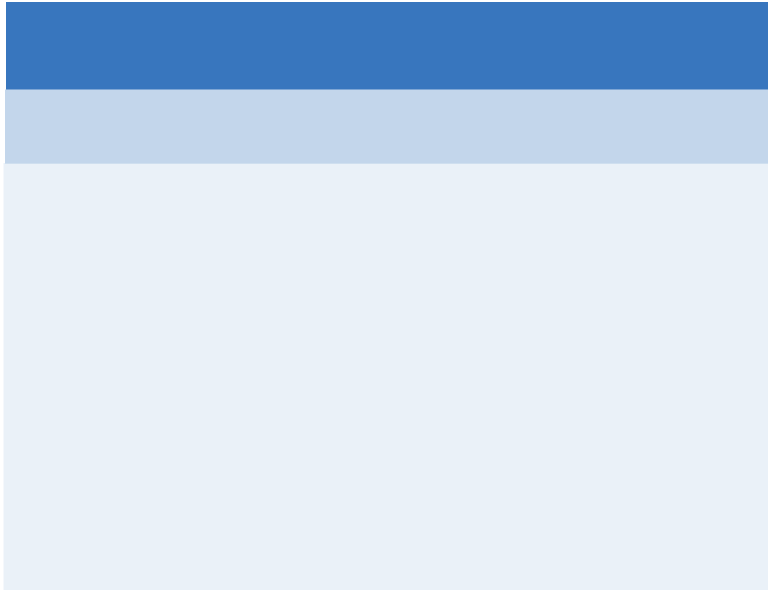
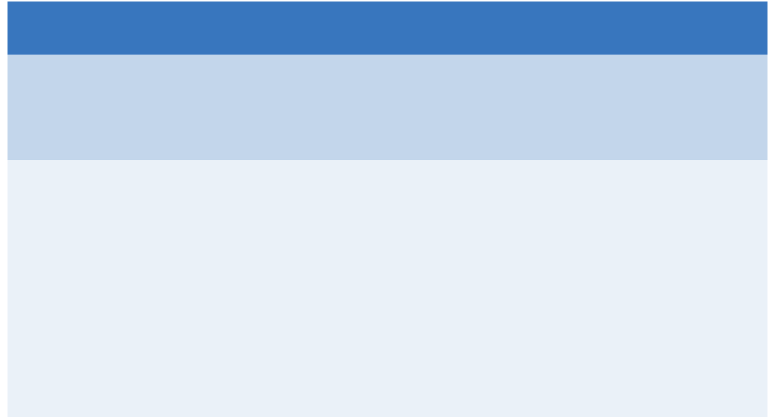
North West London
Community
Collaborative

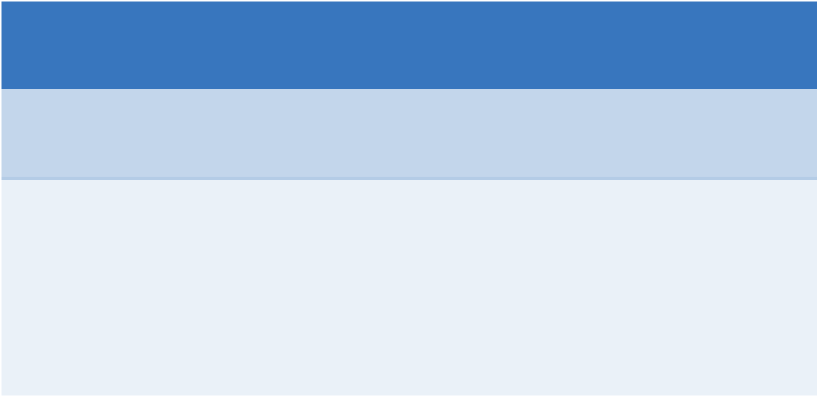
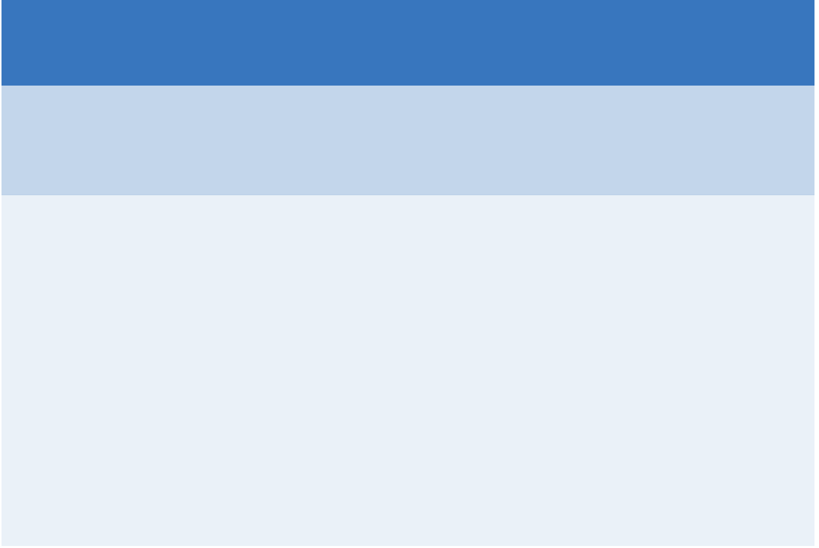


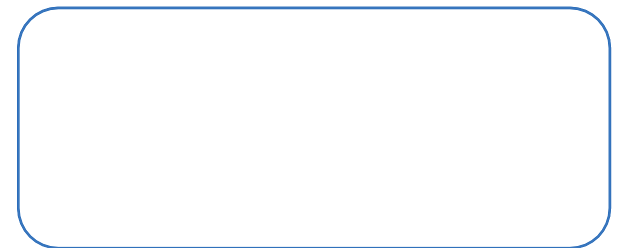


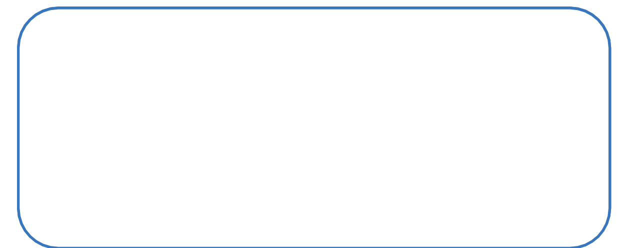


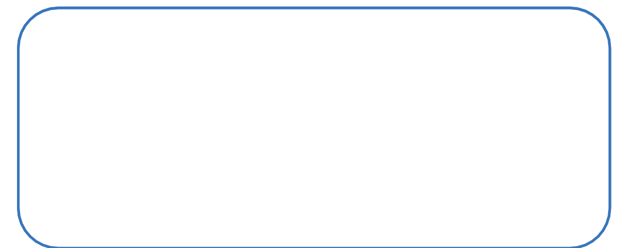


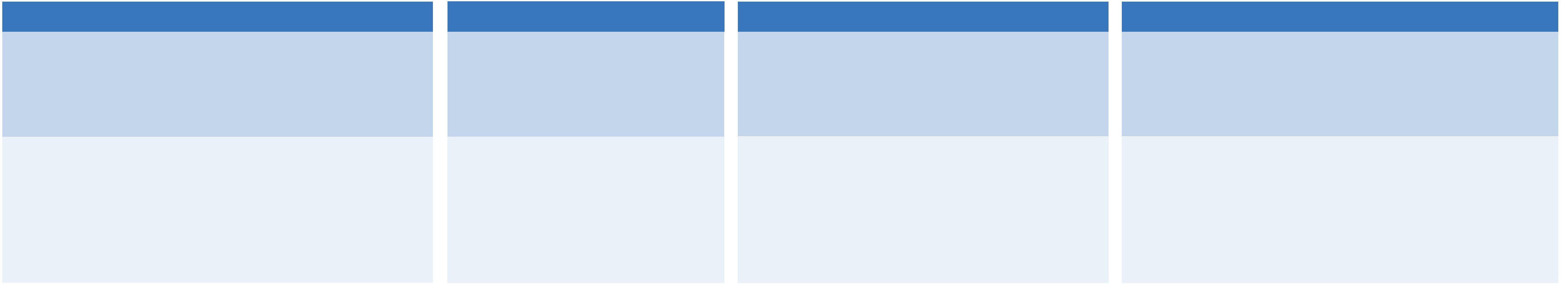




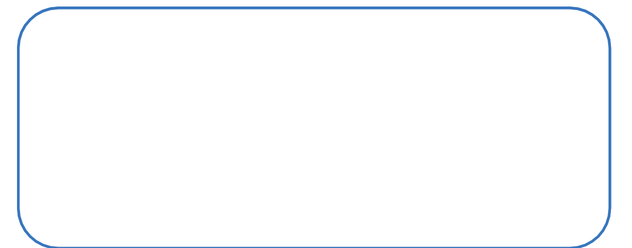



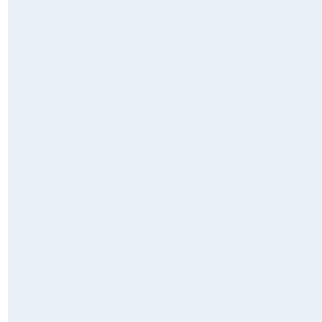


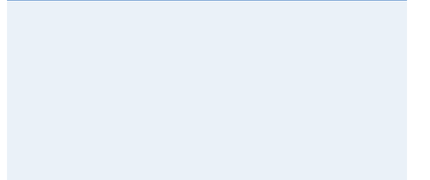
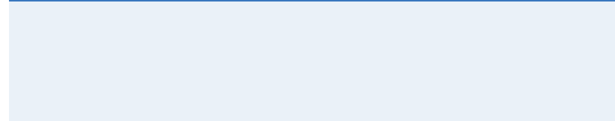


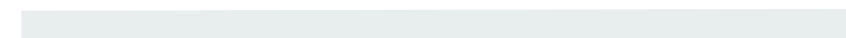


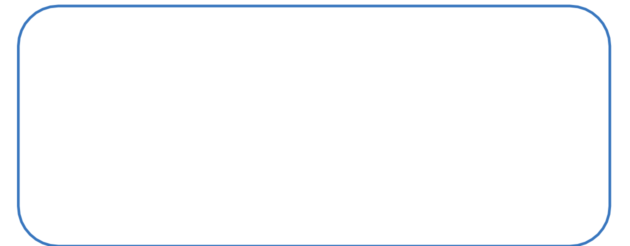


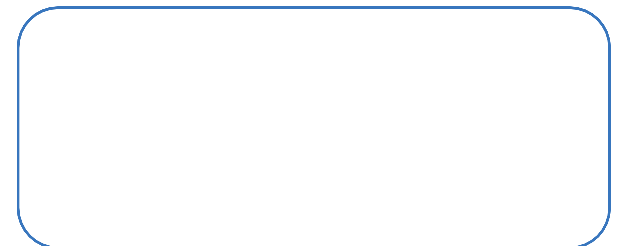
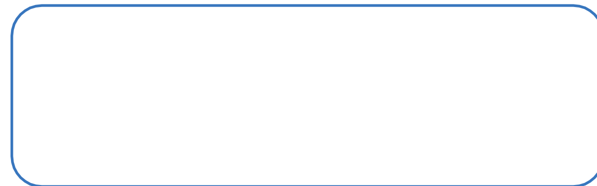


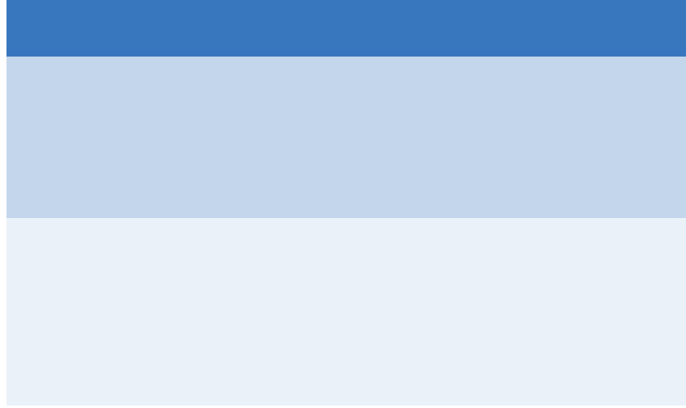
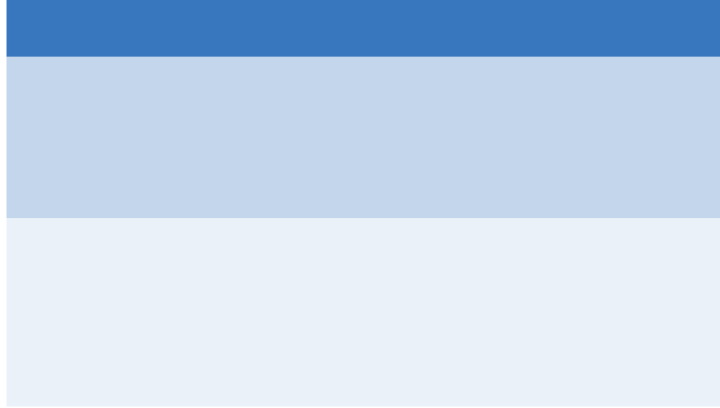
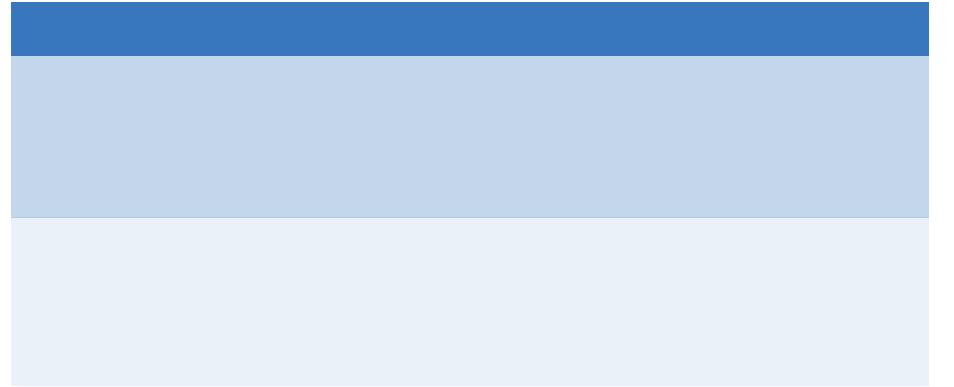
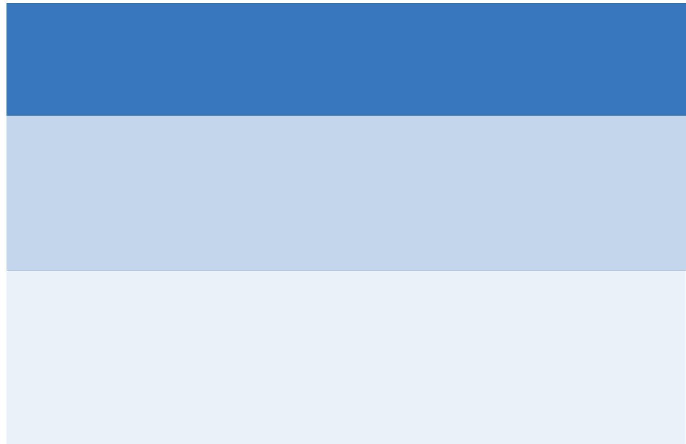
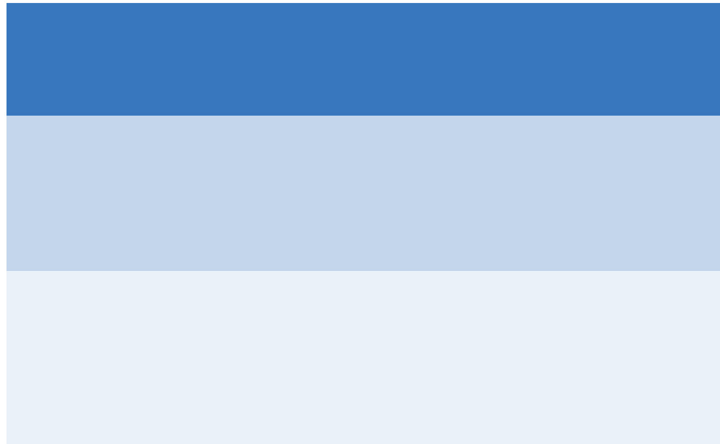
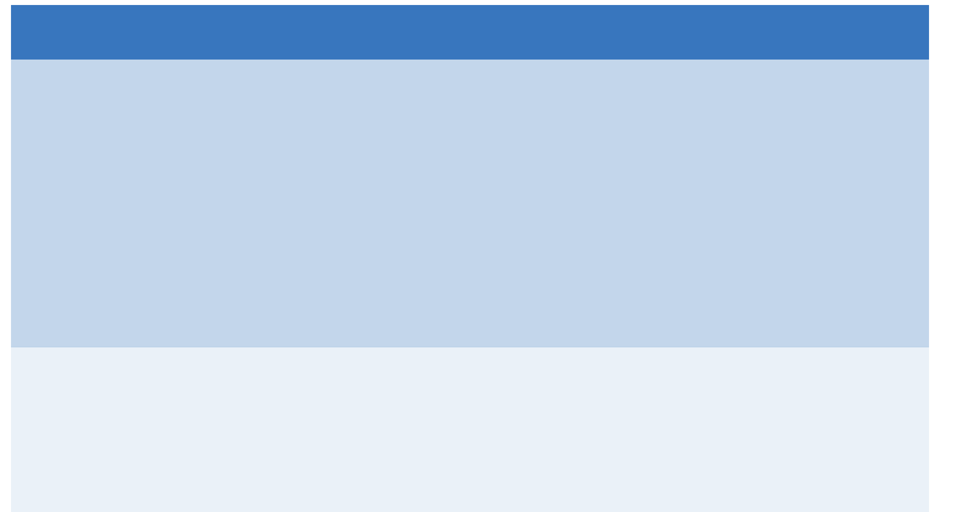






INTEGRATED HEALTH & CARE PERFORMANCE REPORT - 2023/24 Q4

Relevant Board Member(s)	Councillor Jane Palmer Keith Spencer
Organisation	London Borough of Hillingdon
Report author	Gary Collier – Adult Social Care and Health Directorate, LBH Sean Bidewell – Integration and Delivery, NHS NWL
Papers with report	None

HEADLINE INFORMATION

Summary.	This report provides an update on the delivery of the transformation workstreams established to deliver the priorities within the Joint Health and Wellbeing Strategy. This includes progress with the delivery of the 2023/25 Better Care Fund Plan.
Contribution to plans and strategies.	The Joint Health and Wellbeing Strategy and Better Care Fund reflect statutory obligations under the Health and Social Care Act, 2012.
Financial Cost.	The value for the BCF for 2023/24 was £96,534,618 made up of Council contribution of £66,875,873 and an ICB contribution of £29,658,745.
Ward(s) affected.	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a) **ratifies the Co-Chairs' decision to approve the draft NHS England Better Care Fund end of year template on behalf of the Board; and**
b) **notes and comments on the content of the report.**

INFORMATION

Strategic Context

1. This report provides the Board with an update on delivery of the priorities within the Joint Health and Wellbeing Strategy for the January to March 2024 period (referred to as the '*review period'*), unless otherwise stated. Reference to 2023/24 means April 2023 to March 2024.

2. This report is structured as follows:
   A. Key Issues for the Board's consideration.
   B. Workstream highlights and key performance indicator updates.

3. Reference in this report to HHCP means Hillingdon Health and Care Partners, this is an

alliance of local (mainly NHS) organisations that includes The Confederation of Hillingdon-based GP practices, the Central and North West London NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and H4All. HHCP's main objective is to improve the health and wellbeing of Hillingdon's residents and their experience of care through improved coordination and integration of services and earlier intervention to prevent crises. The Council will become a signatory to the alliance agreement in 2024/25.

4. Reference to the ICB (or NHS NWL) means the North West London Integrated Care Board. NWL means a reference to the local authorities areas within the North West London sector and this includes the London Boroughs of Brent, Hammersmith & Fulham, Harrow, Hillingdon and Hounslow, the Royal Borough of Kensington & Chelsea, and Westminster City Council.

A. Key Issues for the Board's Consideration

2023/24 BCF End of Year Template

5. All health and wellbeing board areas in England were required to submit their 2023/24 end of year performance template on 23rd May 2024. The template was submitted as a draft pending sign-off by the Health and Wellbeing Board, as required under national conditions. The Co-chairs were asked to sign-off the template on the Board's behalf due to the postponement of the scheduled meeting in compliance with partner purdah obligations following the declaration of the General Election.

6. The full template can be accessed via the following link Better Care Fund - Hillingdon Council However, the key aspects of the template are addressed in this section of this report. The template is an excel spreadsheet containing nine worksheets where input is required and these are:

- National conditions.
- Metrics.
- Income and expenditure actual
- Spend and activity.
- Intermediate care (IMC) activity hospital discharge
- IMC activity community
- Year-end feedback

7. **National conditions:** This asked if Hillingdon continued to meet the four national conditions for the 2023/24 BCF, which it did. It also asked whether the BCF plan was subject to an agreement under section 75 of the National Health Service Act, 2006, which was approved in November 2023.

8. **Metrics:** This required information about the outturn position against the five national BCF metrics. A key point for the Board's attention is that there has been a data issue during 2023/24 that has impacted on the avoidable admissions, and falls-related admissions metrics and has required a work around. Hillingdon's end of year position against these metrics, including the impact of, and response to, the data issue is summarised below:

- ***Avoidable admissions*** – ***Not on track to meet target (Amber)*****:** During Q3 there was a national data issue that affected half of the country and the effect was to grossly under-estimating activity for Q3. In London there was a particular issue in NWL and NHS England's Better Care Fund Team provided support to identify and address the data issue causes. To acquire an indication of Hillingdon's performance against this metric during 2023/24 the actual data for the April to October 2023 period has been used with a monthly average taken for the period November 2023 to March 2024. This meant that Hillingdon was below target.

- ***Discharge to usual place of residence*** – ***On track to meet target* (Green):** An average of 91.93% was achieved in line with the target.

- ***Falls*** – ***On track to meet target* (Green):** Data from the National BCF Team was significantly lower than was considered realistic. It has therefore been assumed that this is inaccurate and the 2023/24 plan taken as the outturn.

- ***Residential admissions to care homes*** – ***Not on track to meet target (Amber)***: This is an Adult Social Care Outcomes Framework (ASCOF) measure and is based on intended purpose of the placement, i.e., whether the social care professional considers it to be temporary or permanent, rather than the actual outcome. This means that the actual number of permanent admissions in 2023/24 was 231 as opposed to 325 using the ASCOF measure. However, 2023/24 did see a 31% (55) increase in permanent admissions compared to 2022/23, which is linked to increased acuity.

- ***Reablement still at home 91 days after discharge*** – ***Not on track to meet target (Amber)*****.** The Co-chairs are reminded that the denominator for this ASCOF measure is people discharged from hospital to reablement in Q3 and the numerator will be those still at home 91 days later, which is in Q4. At the time of the submission of the draft template the data for this metric was not available. The outturn was 89.9% against a target of 94.9%. The target was not achieved because 15 of the 17 people not still at home 91 days after discharge had passed away and the remaining 2 had been readmitted. The Board is reminded that 2023/24 is the final year of this metric.

9. **Spend and Activity:** This was seeking the year end position against planned spend and activity for areas identified by NHS England's Better Care Fund Team and **not** for all items of expenditure and activity within the plan.

10. The overall end of year financial position set out in the income and expenditure tab was that there was an underspend of £1,708,721 against the Disabled Facilities Grant (DFG) allocation included within the 2023/24 plan submission. The Council received an additional £445,992 DFG allocation too late to be reflected in the 2023/24 submission. Government has directed that the additional allocation should be reflected in the end of year template, which means that the total underspend attributed to DFG allocation in 2023/24 was £2,154,713. This funding has rolled forward into 2024/25 plan.

11. There was an underspend of £150k against reablement, which was used to offset pressures in ASC learning disabilities placements. The result is that apart from DFG, all other funding streams within the BCF were on plan.

12. **Intermediate Care Hospital Activity**: Intermediate care services are provided to people, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The aim of these services is to maximise independence and prevent escalation of need. This section of the report refers to intermediate care services to support hospital discharge pathways. The pathways are explained below. The key points for the Board's attention are:

- ***Discharge pathway 1***: This pathway is supported by the Comfort Care Bridging Care and Reablement Services and the CNWL Bridging Therapy (also known as D2A Rehab Service). There was sufficient capacity to meet demand during 2023/24 and it is important to note that the Hillingdon model has been emulated and applied across the NWL ICS.

- ***Discharge pathway 2:*** The main provision for this pathway is the Hawthorn Intermediate Care Unit (HICU) for general physical rehab needs and the Alderbourne Rehab Unit (ARU) for people with neuro rehab needs. The Integrated Care System Intermediate Care Escalation (ICE) Hub was introduced during 2023/24 to coordinate access to NHS provided rehab facilities across NWL. A block contract for ten beds at Michael Sobell House intended for people at end of life also provided additional capacity when not required.

Hospital Discharge Pathways Explained

- **Pathway 0 (P0):** Discharges home or to a usual place of residence with no new or additional health and/or social care needs.

- **Pathway 1 (P1):** Discharges home or to a usual place of residence with new or additional health and/or social care needs.

- **Pathway 2 (P2):** Discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support.

- **Pathway 3 (P3):** Discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances.

- ***Discharge pathway 3*:** This is the pathway that experienced the longest lengths of stay in 2023/24, which is linked to the consistently high occupancy rate within Hillingdon's care home market, i.e., average of 96%, the reluctance of providers to accept people with more complex needs and also a lack of supply for people with learning disabilities and/or mental health needs. A three-year block contract for ten step-down beds at Parkfield House has been established and another in respect of five beds at Drayton Village was approved by the Council's Cabinet in July 2024. A strategy for increasing local care home capacity is being implemented but is unlikely to deliver results during 2024/25 and therefore part of the plan includes diverting demand to other pathways.

13. **Intermediate Care Community Activity:** The Board is advised that with the approval of the Co-chairs an error with the demand figures for the Urgent Community Response Service and the Community Rehabilitation Service was corrected to reflect unique people rather than available slots or sessions.

14. **Year-end Feedback:** This was intended as an opportunity to give feedback on the impact of the BCF and asked five questions against a set of drop-down menus and the two key successes and challenges against the available menus are shown below.

Successes	
Response Category	**Response**
Success 1: Strong, system-wide governance and systems leadership	Streamlined integrated Place-based governance arrangements developed that includes local authority and borough-based partnership previously constituted under an alliance agreement.

Successes	
Response Category	**Response**
Success 2: Pooled or aligned resources	Joint work between the Council and the borough-based partnership has resulted in local authority premises being repurposed to provide accommodation for the three Same Day Urgent Care Hubs that are critical to diverting activity from Hillingdon Hospital's Emergency Department and Urgent Treatment Centre.
Challenges	
Response Category	**Response**
Challenge 1: Good quality and sustainable provider market that can meet demand.	Continuing issue with the capacity and willingness of the care market to meet the needs of Hillingdon's health and care system.
Challenge 2: Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors).	Continuing issue with the availability of timely and accurate data to provide a single version of the and ongoing system-wide cultural issue about those inputting data recognising the importance of its accuracy.

Hospital Activity

15. Table 1 below illustrates the Q1 position. The important point to highlight is that the number of people in a hospital bed not meeting the criteria to reside was significantly above the target. There is currently sufficient community capacity to meet demand across all discharge pathways and a project is in place that is focused on eight medical wards at Hillingdon Hospital with the intention of improving discharge flow. To support this a senior community clinical decision maker from CNWL has been embedded as part of the ward teams. Their role is to work with the ward team to identify and enable earlier discharges and to place greater emphasis on a 'pull' discharge model. In addition, each ward will have an allocated senior decision maker from Harlington Hospice to facilitate flow for end of life patients.

Table 1: Hospital Activity Dashboard			
Metric	**Target**	**Apr - June 2024 Average**	**Rating**
Emergency admissions (weekday) - Average daily adms	54	36	Green
Emergency admissions (weekend) - Average daily adms	23	31	Amber
Discharges (weekday) - Average daily discharges	59	48	Amber
Discharges (weekend) - Average daily discharges	25	25	Green
No criteria to reside	34	43	Amber

B. Workstream Highlights and Key Performance Indicator Updates

16. This section provides the Board with progress updates for the five workstreams, where there have been developments. The successful and sustainable delivery of the five workstreams is dependent on five enabling workstreams and this report provides updates where appropriate. The five enabling workstreams are:

1. Supporting Carers.
2. Care Market Management and Development.

3. Digital, including Business Intelligence
4. Workforce Development
5. Estates

Transformation Workstreams

Workstream 1: Integrated Neighbourhood Working.

Workstream Highlights

17. **Integrated Neighbourhood Team structure:** The March Board update identified the intention to recruit to three Neighbourhood Team director posts. All post have now been recruited to and postholders will be in place by the end of August 2024. A key function of the directors will be to improve the processes that enable effective neighbourhood working across multiple partner agencies. For example, aligning KPIs, establishing MDTs, aligning standard operating procedures, enabling joined up governance processes.

18. **Population Health Management (PHM) Infrastructure:** This is addressed in the update report on the Joint Health and Wellbeing Strategy, which is a separate item on the Board's agenda.

19. **Hypertension Diagnosis Programme:** The programme to diagnose high blood pressure, which is one of the major causes of death and disability in Hillingdon, has moved to business as usual and the outcomes from the project are currently being evaluated.

20. **Integrated Neighbourhood Frailty Pilot:** The Board is reminded that frailty is a condition mainly associated with old age and is a major contributor to falls in the 65 and over population. As part of a more proactive approach to preventative care, a pilot has been established between Neighbourhood Teams, the Council and up to 181 residents in four of the borough's sheltered housing schemes, i.e., St Catherine's Farm Court, James Court, Mandela Court and Roberts Close. 23 out of an initial group of 50 residents have been seen under the pilot. Living well into retirement workshops have been delivered and there has been positive feedback from attendees. The next steps include benefits realisation analysis to inform a larger scale programme and moving to business as usual.

21. **Community Champions Pilot Project:** Community champions are volunteers who work with existing networks in deprived communities to identify barriers to accessing accurate information and to provide tailored support, such as phone calls for people who are digitally excluded. The champions are linked to GP surgeries. The pilot is supported by funding from NHS England's Health Inequalities Fund. Phase 1 of the project is intended to operate from March to September 2024 in Harefield. Funding for phase 2 has been secured and this will operate from October 2024 to April 2025. The purpose of the pilot to ascertain if the model provides value for money and if it is scalable.

Key Performance Indicator Updates

22. Workstream 1 performance indicators include:

- **People with severe mental illness (SMI) receiving a full physical health check:** *Exceeded (Green)* – The 2023/24 ICB target is 60% and the Hillingdon position during the

review period was 77.2%

- **People over age of 14 on a doctor's learning disability register who have had an annual health check:** *Exceeded (Green)* - The 2023/24 ICB target is 50% and Hillingdon achieved 73% during the review period.

- **People with diabetes who have received nine care processes in the last 15 months:** *Exceeded (Green)* – The 2023/24 ICB target was 50% and Hillingdon achieved 67.8% during the review period.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49 (Core20Plus5 measure):** *Slippage (Amber)* **-** The 2023/24 ICB target was 80% but 64.5% was achieved during the review period. Hillingdon's performance in May 2024 was 65% which is 6.5% higher than the NWL average. Key actions to improve performance include RM Partners (one of the 21 Cancer Alliances established by NHS England to lead on the delivery of the cancer care recommendations in the NHS Long-term Plan) meeting with all six PCNs to share performance data and provide instruction on accessing data on screening dashboards. There has been targeted 1:1 support for the two practices with the lowest to discuss actions for improvement.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 5.5 years for aged 50 and over (Core20Plus5 measure):** *Slippage (Amber)* **-** The 2023/24 ICB target was 80% but 76.9% was achieved during the review period. The Board is reminded that action to improve performance against this measure and the equivalent above for the 25 to 49 age group includes 1:1 meetings between the cervical cancer clinical lead and lower performing practices to identify issues and offer support; through proactive signposting and text message reminders to patients across our neighbourhoods; and through the clinical lead attending upcoming PCN meetings to present on performance to date and discuss further ideas for overcoming barriers to attending for cancer screening.

- **Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less**: *Exceeded (Green)* – The 2023/24 outturn was 60.2% against a NWL target of 44.7%. However, the Board may wish to note that this is rated as amber in the Joint Health and Wellbeing Strategy update as Hillingdon has the second highest hypertension rates of NWL borough, and cardiovascular mortality is higher than London and England.

- **Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less**: *Exceeded (Green)* – The 2023/24 outturn was 76.8% against a NWL target of 59.7%

- **Admission rate for people aged 65 and older by severe frailty index per 1,000:** *Exceeded (Green)* – The ceiling rate for 2023/24 was 719 and the outturn was 643.

Workstream 2: Reactive Care

23. The Board is reminded that the priorities for this workstream are:
    - Implementation of a new end of life operating model.
    - Implementation of an integrated active recovery service.
    - Implementation of a '*Maximising Homefirst'* programme to reduce length of stay of residents in hospital.

Workstream Highlights

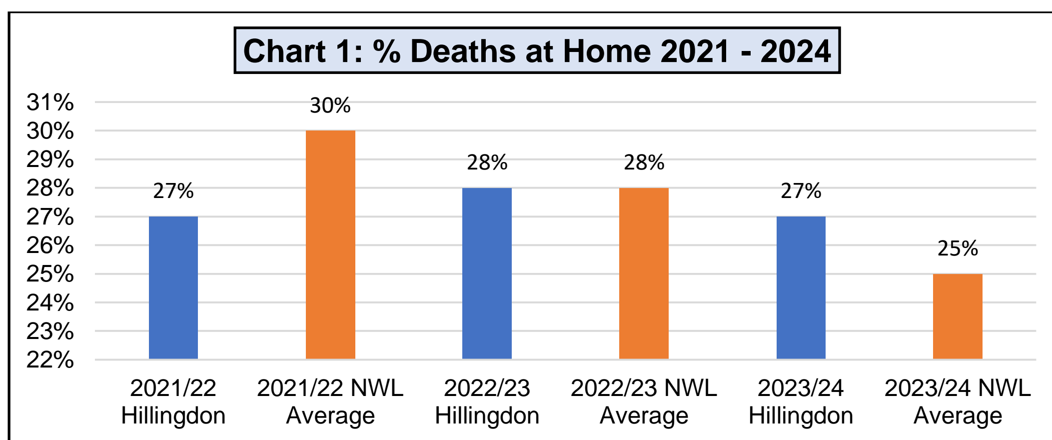
24. **Palliative Integrated Care Service (PICS):** The PICS hub is the new end of life model. It provides 24/7 end of life support across all areas of the system, i.e., acute, community and care homes. The service brings together staff from CNWL, Harlington Hospice and Hillingdon Hospital's Palliative Care Team. A key objective of the service is to enable more people at end of life to die at home where this is their preferred place of care. The hub became operational in January 2024 and is evolving in response to operational practice, e.g., trusted assessor protocols have been established between Hillingdon Hospital and Harlington Hospice to improve the efficiency of the referral process.

25. **Implementation of an Integrated Active Recovery Service:** The integration of services to create a single Active Recovery Service is complex. The intention is to integrate therapy services and wrap services around the Integrated Neighbourhoods, to align Community Rehabilitation Services and Reablement more closely and maximise the Homefirst/Discharge to Assess programme to reduce length of stay.

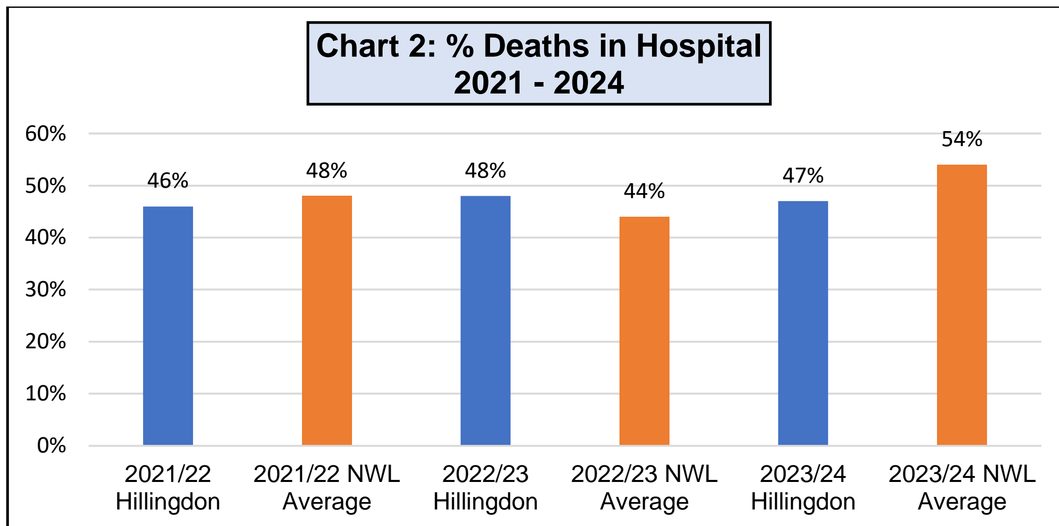
Key Performance Indicator Updates

26. The following is an update on workstream 2 indicators where data is available:

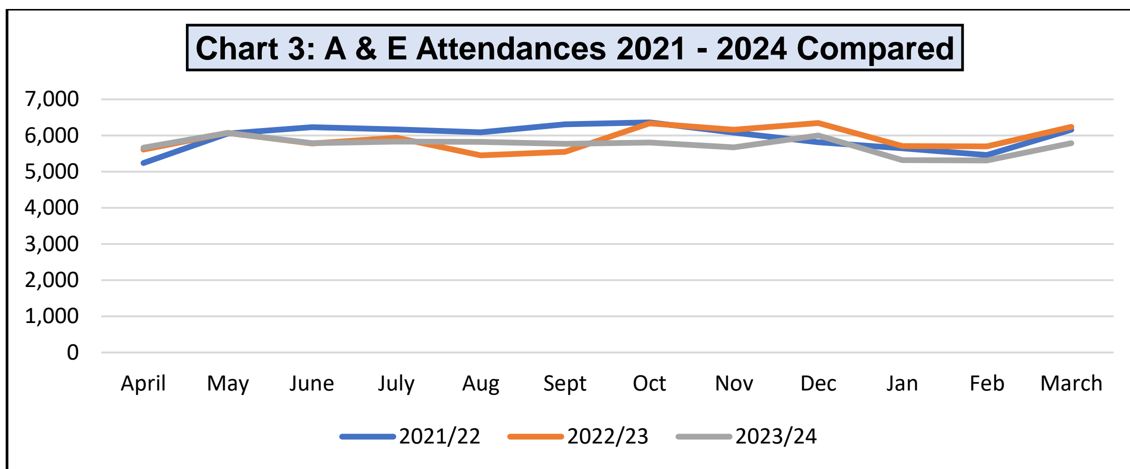
- **% of deaths of people that occurred at home in the last twelve months:** A higher proportion of deaths of people occurring at home is desirable and the data in chart 1 below shows that in 2023/24 Hillingdon's performance was just above the NWL average and performance over the last three years has been close to the NWL average.

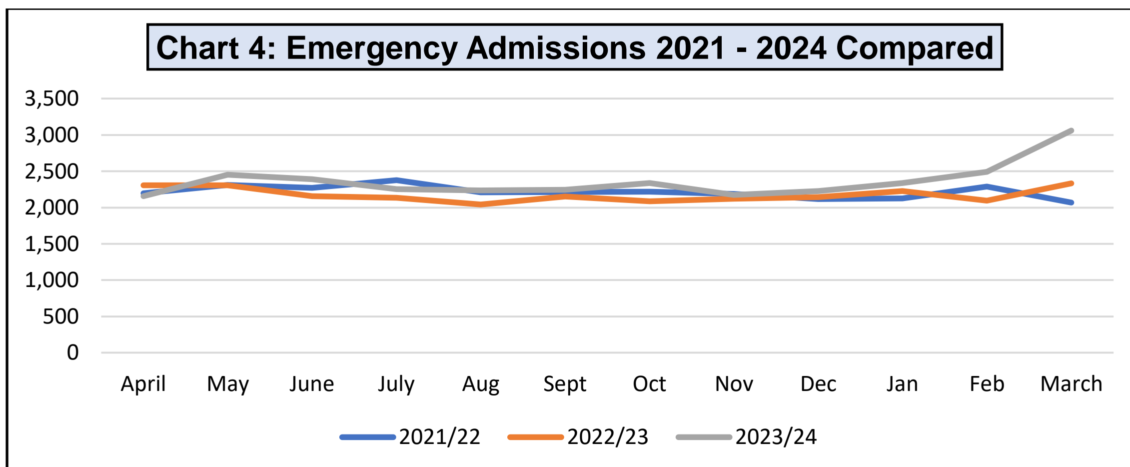


- **% of deaths of people that occurred in hospital in last twelve month period:** The objective is that the percentage of deaths that occurred in hospital should be at a minimum and reflect the last place of care choice of residents. Chart 2 below shows that for the January to December 2023 period Hillingdon's performance was better than our direct comparators within the NWL sector.



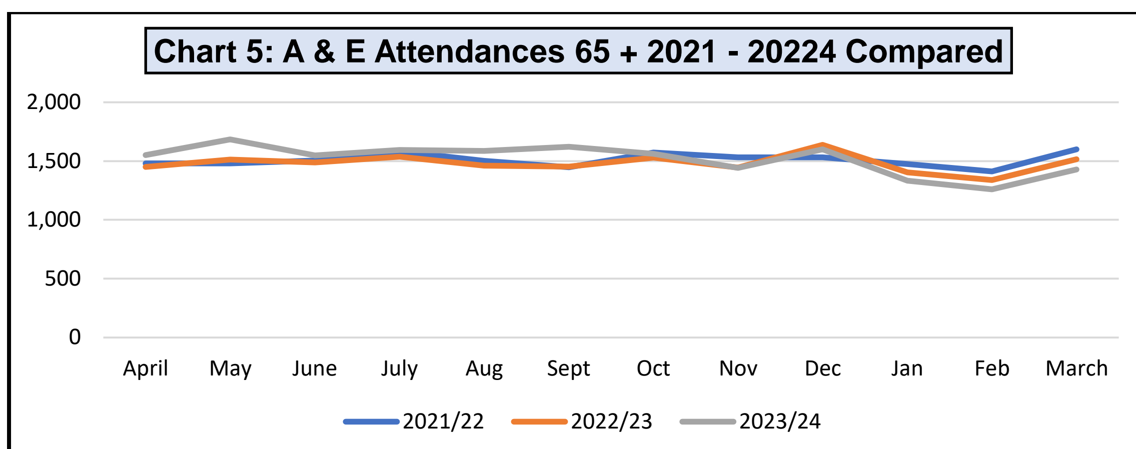
- **A & E Attendances and Emergency Admissions:** Between April 2023 and March 2024 there were 68,836 attendances, which is lower than in the two previous years. There were 28,367 emergency admissions during 2023/24, which exceeds the figures for each of the two preceding years and the conversion rate of attendances to admissions of 41% was slightly higher than the previous two years (37%). Charts 3 and 4 below show the attendances and admissions trends over the last three financial years.

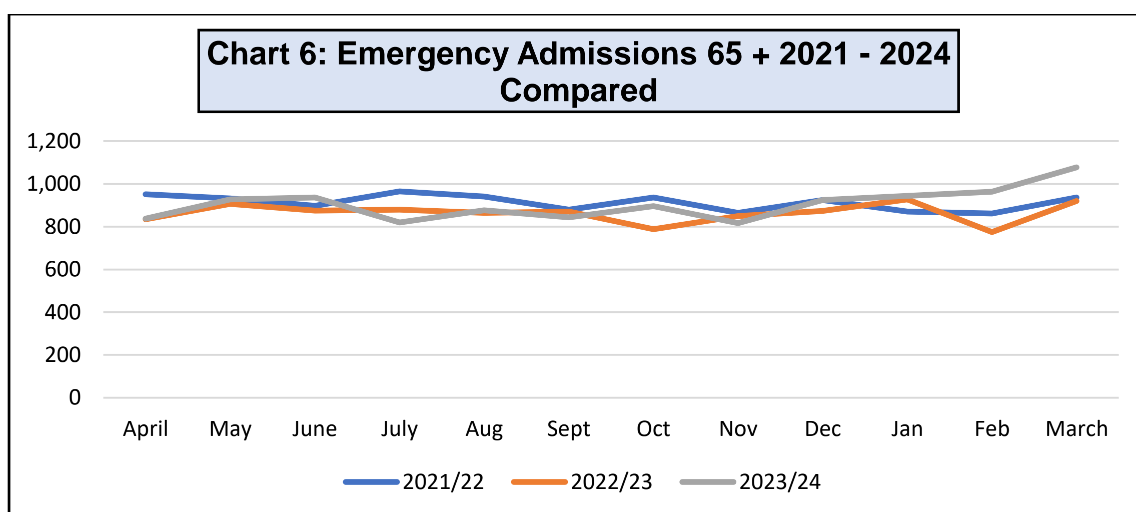




27. **A & E Attendances and Emergency Admissions 65 +:** There were 18,216 attendances of people aged 65 and over during 2023/24 review period, which is higher than 2022/23 but lower

than 2021/22. The conversion rate of attendances to admissions of 60% was higher than in 2022/23 but lower than 2021/22. Charts 5 and 6 below show the attendances and admissions trends over the last three financial years.





- **Hillingdon Hospital bed occupancy:** *Slippage (Amber)* – The target occupancy level over the winter period was 92% but the average for the period 1st September 2023 to 31st March 2024 was 99%.

Workstream 3: Planned Care

Key Performance Indicator Updates

28. The following is an update on workstream 3 indicators where data is available:
    - **Patients waiting 52 weeks or more for surgery:** In March 2024 there were 479 people waiting 52 weeks or longer for surgery, which is a reduction of 749 (61%) on the same period in 2023. This is attributed to contracts that the ICB has established with the private sector.
    - **% Patients receiving tests within 6 weeks of referral:** For the period April 2023 to March 2024 the average was 79.5%, which compares to 70% in 2022/23.
    - **% Urgent cancer referrals receiving diagnosis within 28 days:** For the period April 2023 to March 2024 the average was 71%, which is equal to the performance in 2022/23 and an improvement on 2021/22 (66%).
    - **Average waiting times in days for outpatients:** The average waiting time in days for

2023/24 was 140 days compared with 159 days in 2022/23 and 117 days in 2021/22, which indicates improvement but some distance to travel to get to

Workstream 4: Children and Young People

Workstream Highlights

29. **Holiday Activities and Food Programme (HAF)**: This is a national programme funded by the Department for Education (DfE) that provides eligible children and young people access to funded holiday provision during the Easter, Summer and Winter school holiday periods. Eligible children and young people include children from reception to school year 11, those aged up to the age of 18 who have with special educational needs (SEN), that are in receipt of benefits-related free school meals (FSM). It also provides healthy meals, enriching activities, and free childcare places to children from low-income families, benefiting their health, wellbeing and learning. The 2021 census data tells us we have 11,526 children whose parents claim free school meals. Of the children known to be in receipt of FSM in Hillingdon data tells us that over 1,800 have special education needs and require some additional support and a further 840 have an Educational Health Care Plan due to their more complex needs.

30. During 2023/24 the HAF programme has:

- Offered 32,296 sessional places to children across Hillingdon (with 68% take up).
- Engaged 3,693 unique children (35% of the eligible cohort).
- Of which 2948 were primary and 745 were of secondary age, including 497 children with SEN (13.5% of the attendees had SEN, nearly double the expected 7%, which is the percentage of the eligible cohort with SEN).
- Distributed 2,450 at home activity packs, cookery packs and '*Take and Make'* boxes.
- Dished up over 24,000 healthy meals.

31. **Adolescent Development Services:** These services included 1:1 structured support for children and young people in the areas of emotional health and wellbeing (Link Team), sexual health and relationships (KISS team) and substance use and misuse (Sorted Team).

2023/24 Adolescent Development Services Activity Summarised

Referrals Supported

- LINK – 420
- KISS – 114
- SORTED – 217

Children and Young People Engaged Across Primary & Scondary Schools & Uxbridge College

- KISS – 985
- SORTED – 5,963

Training and Information Sessions Delivered for Parents and Professionals

- Link – 48 professionals
- KISS – 42 professionals
- SORTED – 319 parents and professionals

32. **Stronger Families Hub:** The Council's Stronger Families Hub is the single point of contact for children, young people, and families in Hillingdon to access a wide range of support services 24/7. The model combines a social work led service, adult mental health service and the Hillingdon Multi-agency Safeguarding Hub (MASH). During the review period there were 26,527 enquiries with a wide range of reasons for the contact but the majority were vulnerability of the young person (19%), domestic incident (10%) and socially unacceptable behaviour (8%).

33. The main outcomes arising from the contact were information and advice (37%), statutory social care (24%), referrals to other agencies (10%) and referrals to MASH (9%).

Key Performance Indicator Updates

34. The following is an update on workstream 4 indicators where data is available:

- **Education, Health, and Care Plan (EHCP):** *Slippage (Amber)* - The national target for the completion of EHCPs is 20 weeks from referral. The local target is to achieve this in 80% of cases. The percentage of plans completed within 20 weeks for 2023/24 was 57%. This is a 4% increase on the same time period in 2022/23, which was 53%.
- **Children and Adolescent Mental Health Service 18 week wait from referral to first consultation:** *Exceeded (Green)* **–** The national target is 85% and performance for 2023/24 was 98.4%.

Workstream 5: Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.

35. **Changes to psychological therapies (also known as Talking Therapies) metrics:** Following the 2023 Autumn Statement there has been a national shift in the Talking Therapies model away from access and with more focus on recovery and improvement. This means that from April 2024 tracking and reporting against access targets will cease. The new national targets are:

- 66.6% of referrals finishing a course of treatment showed reliable improvement.
- 50.1% of eligible referrals moved to recovery.

Key Performance Indicator Updates

36. The following is an update on workstream 5 indicators where data is available:

- **% of adult population receiving access to psychological therapies:** *Slippage (Amber)* **–** The 2023/24 outturn was 5.7% against a NWL target of 6.3%.
- **% of adults receiving access to psychological therapies within 6 weeks of referral:** *Slight slippage (Amber)* **-** Hillingdon's performance for 2023/24 was 99.8% against a target of 100%.
- **% of adults receiving access to psychological therapies within 18 weeks of referral:** *Exceeded (Green)* **-** Hillingdon's performance for 2023/24 was 100% against a national target of 95%.
- **Estimated diagnosis rate for people aged 65 and over with dementia:** *Slippage (Amber)* – An outturn of 66.2% was achieved in 2023/24 against a target of 66.7%. The England average was 62.2%. The main reason for not meeting the target during this period, was due to temporary gaps in permanent staffing in the Memory Service. Locum support was in place but still impacted on diagnosis delivery at times. The learning from this is that some pathway changes are being developed to ensure there is sufficient workforce to cover during any staff absences.

Enabling Workstreams

Enabler 1: Supporting Carers

37. The Council is the lead for this enabling workstream, which seeks to support unpaid carers of all ages to continue in their caring role for as long as they are willing and able to do so. A detailed update on actions to support carers in Hillingdon was considered by the Council's Health and Social Care Select Committee at its meeting on the 24th July 2024 and the report can be accessed via this link London Borough of Hillingdon - Agenda for Health and Social Care Select Committee on Wednesday, 24th July, 2024, 6.30 pm

Enabler 2: Improved market management and development

38. The Board is reminded that the Council is also the lead organisation for this enabling workstream, the primary objectives of which are to support the sustainability of the market and also to integrate commissioning arrangements where this will produce better outcomes for residents and the local health and care system.

Workstream Highlights

39. **Short-term nursing block contract:** Two block contracts with two have been established for a total of 15 step-down beds that will secure provision until March 2027.

Finance

40. The 2023/24 financial outturn position is addressed in paragraphs 9 to 11 above. A separate report on the Board's agenda addresses the 2024/25 BCF financial arrangements.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025

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Exempt information by virtue of paragraph(s) 3 of Part 1 of Schedule 12A of the Local Government Act 1972 (as amended).

Agenda Item 11

Document is Restricted

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