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

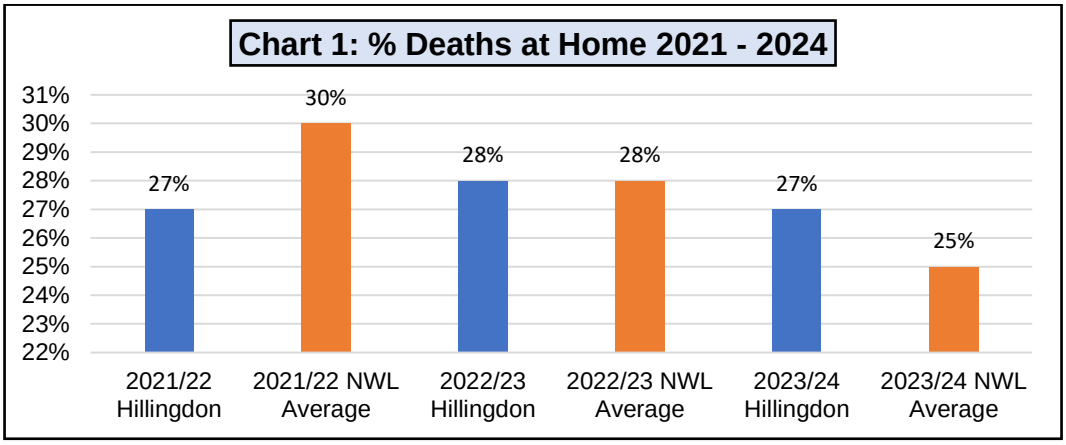
24. **Palliative Integrated Care Service (PICS):** The PICS hub is the new end of life model. It provides 24/7 end of life support across all areas of the system, i.e., acute, community and care homes. The service brings together staff from CNWL, Harlington Hospice and Hillingdon Hospital's Palliative 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.

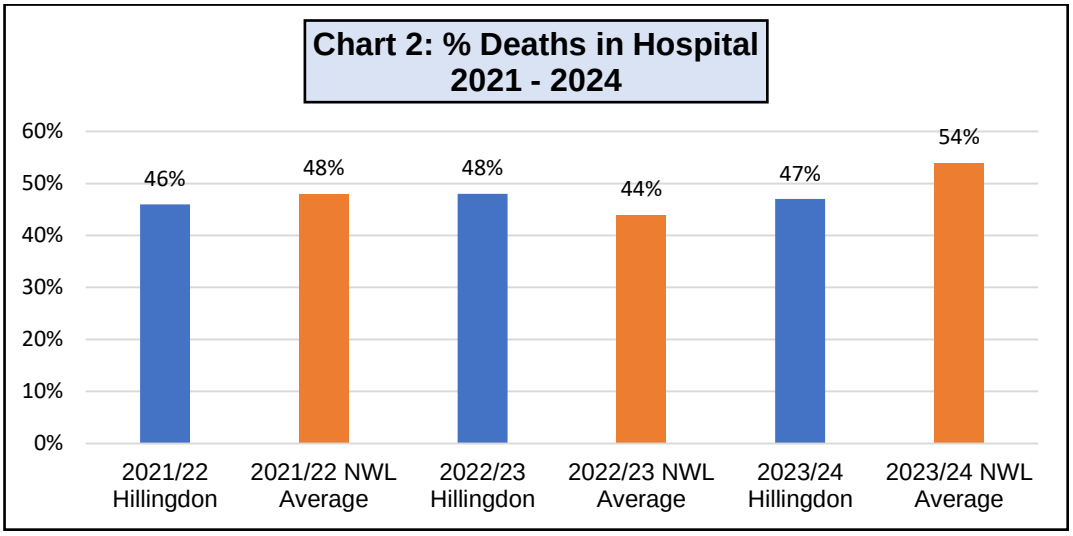
Key Performance Indicator Updates

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

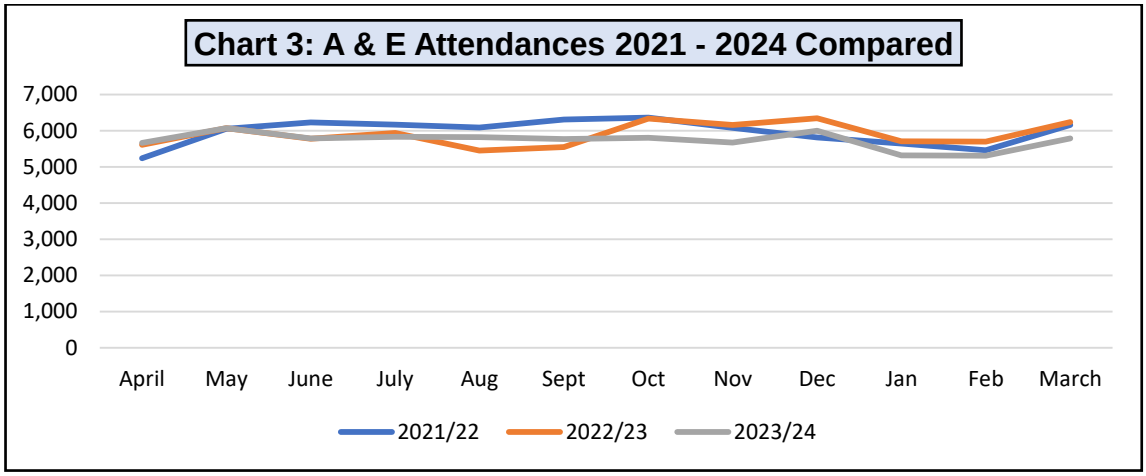
- **% of deaths of people that occurred at home in the last twelve months:** A higher proportion of deaths of people occurring at home is desirable and the data in chart 1 below shows that in 2023/24 Hillingdon's performance was just above the NWL average and performance over the last three years has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

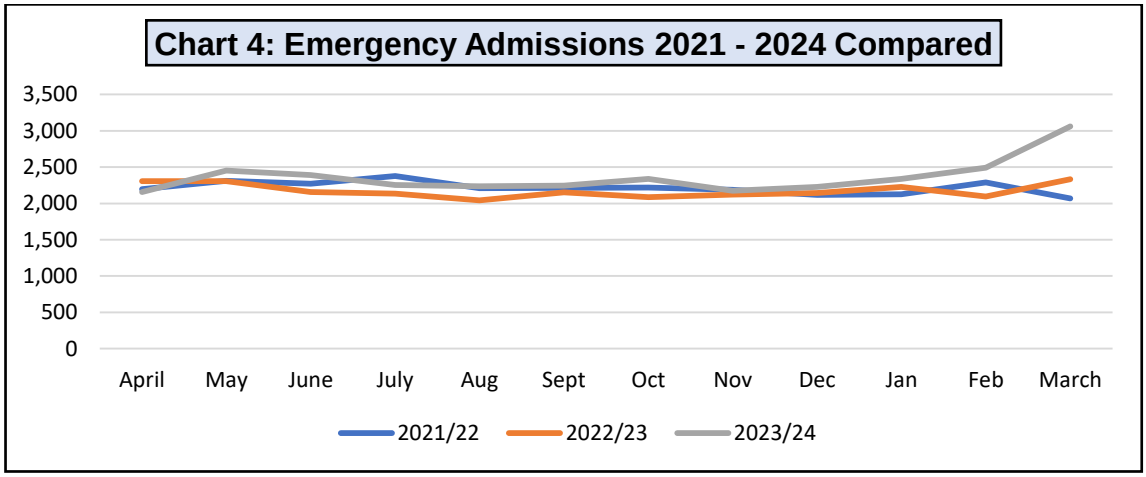


- **% of deaths of people that occurred in hospital in last twelve month period:** The objective is that the percentage of deaths that occurred in hospital should be at a minimum and reflect the last place of care choice of residents. Chart 2 below shows that for the January to December 2023 period Hillingdon's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



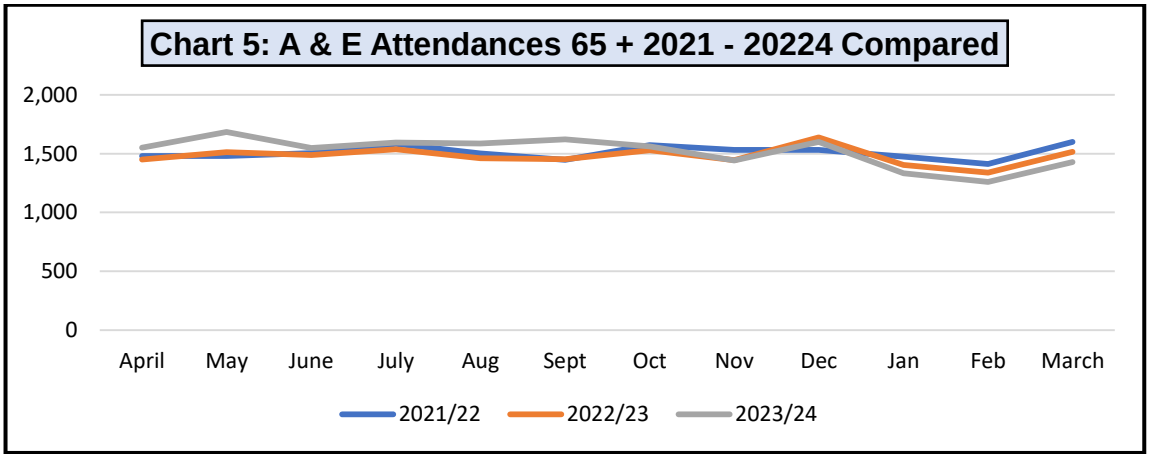
- **A & E Attendances and Emergency Admissions:** Between April 2023 and March 2024 there were 68,836 attendances, which is lower than in the two previous years. There were 28,367 emergency admissions during 2023/24, which exceeds the figures for each of the two preceding years and the conversion rate 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.

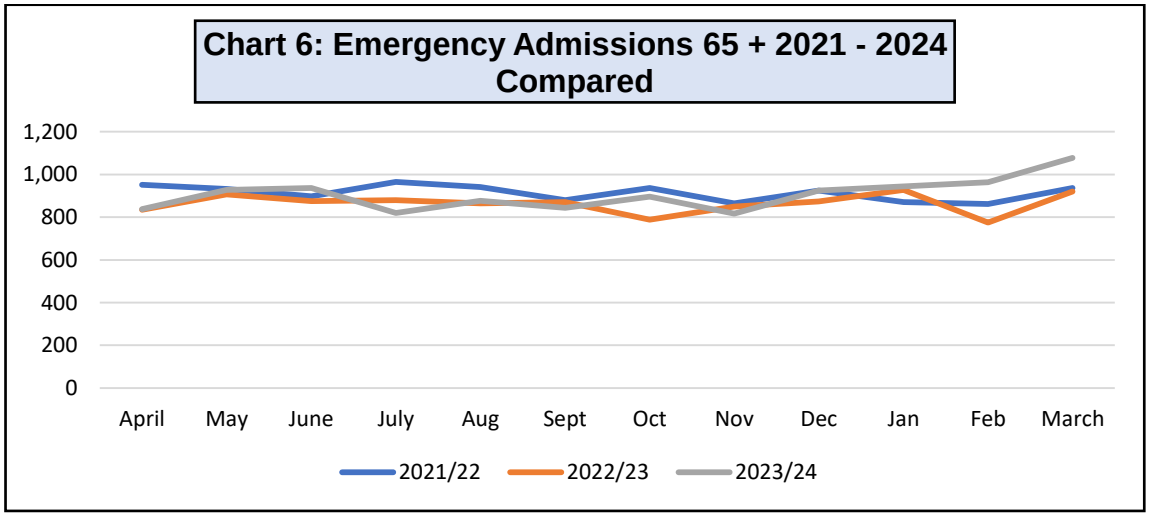




27. **A & E Attendances and Emergency Admissions 65 +:** There were 18,216 attendances of people aged 65 and over during 2023/24 review period, which is higher than 2022/23 but lower

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