Cover

Q4 2016/17	
Health and Well Being Board	**Leeds**
completed by:	Lesley Newlove
E-Mail:	lesley.newlove@nhs.net
Contact Number:	0113 8431627
Who has signed off the report on behalf of the Health and Well Being Board:	Gordon Sinclair

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

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Budget Arrangements

Selected Health and Well Being Board:	Leeds

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

Appendix 3 - Leeds BCF 2016/17 Q4 Reporting Template

National Conditions

Selected Health and Well Being Board: Leeds

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	Yes	
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - In Progress	No - In Progress	No - In Progress	Yes	
health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	No - In Progress	No - In Progress	Yes	
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes	Yes	
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

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National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

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Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Leeds

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000	£13,990,000			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	In line with plan

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Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514	£14,600,500			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514	£14,600,500	£14,351,478	£55,958,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	Catch up of payments of Disabilities facilities grant from Q1 & Q2

Commentary on progress against financial plan:	All completed by 31st March 2017

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.

Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

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National and locally defined metrics

Selected Health and Well Being Board:	Leeds

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Non elective admissions have slightly reduced when compared to Q3. This is a relative improvement on previous quarter but does not improve as against the BCF trajectory. Plans for addressing growth in NEAs are currently being developed as part of the West Yorkshire STP and our local element 'The Leeds Plan'.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	As with NEAs we have seen a slight improvement as against the previous quarter but do not meet the BCF ambition. We have succesfully implemented the Integrated Discharge Service which has reduced delays with assessments to patients however we are still experiencing issues with delays in placement of into community health services, home care and residential care. The implementation of new reablement

Local performance metric as described in your approved BCF plan	Dementia Diagnosis Rate
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	There has been a slight downward turn during the end of Q4 for over 65 dementia diagnosis resulting in 76.1% against a target of 76.9%. It is worthy of note however that the result for all ages is 76.5% against the expected prevalence. This is up from March 2016 when it was 74.2%

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Local defined patient experience metric as described in your approved BCF plan	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionaire post discharge. These questionaires will be used to generate a patient satisfaction score based on a wieghted average for all questions completed. There is a target in place to reach 50 completed questionaires per quarter for the service as a minimum.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	There have been 259 completed questionnaires returned in Q4

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The figures are 622.5 per 100,000 over 65 population

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Quarter 4 figures show there to be 88% of people over 65 receiving short term support from hospital are still at home 91 days later.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board: Leeds

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	There was already a well established, strong relationship between health and social care in Leeds. The BCF has added a bit more focus to this relationship but has also brought with it additional bureaucracy.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Disagree	There was already a well established health and wellbeing structure in place before BCF and more confusion has now been created with a multiplicity of plans including BCF, A&E plan, WY and Harrogate STP and our own Leeds Plan.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Strongly disagree	Despite our best efforts, our BCF plan has not contributed positively to managing NEAs. Further analysis on this is still to be conducted once the final year end figures are known but changes in coding practice in the Acute sector are a known factor.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	The levels of DToCS have been managed positively in conjuction with the A&E delivery plan.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	

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Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Development of the Leeds Care Record	7. Digital interoperability and sharing data
Success 2	The Community Intermediate Care bed strategy	6. Delivering services across interfaces
Success 3		Please select response category

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Reducing NEAs	6. Delivering services across interfaces
Challenge 2	Managing the impact of NEAs on the wider system flow	6. Delivering services across interfaces
Challenge 3		Please select response category

Footnotes:
Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):
1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change
Other

Additional Measures

Selected Health and Well Being Board: Leeds

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Community	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Mental Health	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	Unavailable	Unavailable	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)	31/08/2018	31/08/2018	31/08/2018	31/08/2018	31/08/2018	31/08/2018

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	115
Rate per 100,000 population	15

Number of new PHBs put in place during the quarter	23
Number of existing PHBs stopped during the quarter	2
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	95%

Population (Mid 2017)	784,459

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

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Narrative

Selected Health and Well Being Board:	Leeds

Remaining Characters	30,401

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Further to returns made up to Q3, our most significant area of success during 2016-17 is the development of the Leeds Care Record. There are now over 4000 active users including GPs, Adult Social Care, Hospices, NHS 111 and Leeds Community Healthcare. Our Informatics Director has confirmed that a lot of good feedback has been received from users showing how patients are benefitting from this integrated information. It is a good example of where money has been invested and savings are being made recurrently.

Another significant area of success is our strategy around Community Beds. Longer term commissioning investment has been secured to improve and enhance community bed-based capacity, in readiness for next winter. Plans will increase capacity from 179 beds to 231 beds (factoring in demographic growth up to 2019/20). Approximately 75% of the beds will be retained for Intermediate Care and 25% for a new transfer to assess model. The capacity will meet existing demand as well as meeting the needs of:-

• additional patients from the community who can't access a Community Bed due to lack of capacity (equivalent to 158 admissions avoided per year)

• at least 50 patients currently waiting in hospital for residential or nursing beds based on Medically Fit For Discharge Data; excludes patients waiting to go home or for complex care - equivalent to 12,500 hospital bed days per year and 4500 excess bed day payments

A 'hospital to home' service has been maintained but has been integrated further into an Integrated Discharge Service within LTHT working with Discharge Nurses, Therapists and hospital Social Workers. The service continues to evolve and ongoing development reports into the System Resilience Governance.

The biggest challenge we have faced is reducing non-elective admissions and managing the impact of NEAs not reducing. Whilst a change in coding practice in the Acute Sector has impacted on this, we also know that underlying growth is a contributing factor. Once the end of year figures are known, we intend undertaking further analysis in order to fully understand this.

We would also like to mention that on tab 7 row 32 in respect of the Digital Integrated Care Record pilot, we have had to answer 'no pilot underway' even though the Digital Integrated Care Record system is live but there was no option to put this.