Report to:	Health and Wellbeing Board	
Date:	22 October 2014	
Report of:	Integration Board	**Report No:**
Contact Officer:	Helen Clarke, Integrated Care Lead, Bolton NHS Foundation Trust	**Tel No:** 01204 390390 ext. 5479

Report Title: **Health and Social Care Integration Update**

Non Confidential:	This report does **not** contain information which warrants its consideration in the absence of the press or members of the public
Purpose:	The purpose of this report is to update the Board on the latest progress in relation to each of the sections within.
Recommendations:	That the Health and Wellbeing Board: **1** note and make comments on the updates within **2** make suggestions on any other items for inclusion within the report
Decision:	
Background Doc(s):	

Bolton Health & Social Care Integration
Monthly Report

October 2014

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Section 1 – Introduction & progress headlines

The Complex Lifestyles programme has recently started in the Borough. Urban Outreach was successful in a tender to support the development of the service and work has commenced with one of the early adopter practices who are participating in the phased implementation of integrated care.

The aim of the **Complex Lifestyles** programme is to facilitate behaviour change so that clients with complex lifestyles reduce their presentations to inappropriate services. Additionally the programme seeks to provide intensive support to assist clients in navigating health and social care systems with the aim of enabling access to appropriate services. The Complex Lifestyles model will take a holistic approach to understanding and responding to individual client need whilst fostering increased self-care and reduced dependence on services that are currently unable to respond effectively.

Currently there is no single agency or service with responsibility for co-ordinating care and facilitating access to services for people with complex lifestyles. A new team of Engagement and Support workers is envisaged across the borough to link with the Integrated Neighbourhood Teams.

The proposed model will focus on those clients defined, within the overall **complex needs cohort**, as having **complex lifestyles.** These clients are expected to have a combination of issues/conditions, particularly in relation to:

- Active misuse of drugs and/or alcohol
- At risk of self-harm or further self-harm
- At risk of harming others
- Depression and/or anxiety
- Social deprivation (e.g. financial problems, worklessness)
- Housing/homelessness

The key features of the approach are:

- A person-centred, home based, visit and conversation to **listen to and thoroughly understand needs, challenges and barriers.**
- Individual action planning specific to expressed and perceived need.
- **Brief interventions to support, motivate and sustain behaviour change.**
- Facilitation to help individuals navigate appropriate services, information sources and resources.
- **Advocacy t**o ensure the delivery of active support, information or advice to encourage self-care and self-management plus reduced dependency.
- Direct liaison with other services, organisations and teams known to individuals with complex lifestyles.
- **Intensive support** to facilitate individuals in navigating systems of appropriate provision.
- Negotiation of systems for rapid referral and access across agreed agencies if appropriate.
- Establishment of appropriate data sharing arrangements.
- Development of joint approaches to care planning around each individual as required.
- Joint development of responses to clients in crisis.

Analysis carried out by the Public Health Department on Frequent A&E attenders indicates that:

- 75% of the complex lifestyles cohort (337/450 risk stratified clients) are likely to have drug and alcohol issues with/without concomitant mental health issues.
- Frequent attenders at A&E with drug and alcohol problems on average present to Bolton FT A&E approximately 10 times p.a.

- If 337/450 complex lifestyles clients presented to A&E at least 10 times each per year this would be a cost of £377,440 p.a. (i.e. 3,370 attendances @ £112 per presentation).
- A similar model of intervention, in Bolton, to the one proposed succeeded in reducing frequent attendances to A&E with this cohort by 65%.
- Assuming a 50% reduction on A&E attendances in this cohort was achieved, this would realise an annual saving of £188,720.

- **Additionally 35% of the cohort (118)** would be expected to be admitted to hospital, with an average LOS of 2 bed nights per presentation, up to 10 times p.a. (at a minimal tariff of £200 per bed night). Even if each of these clients reduced their hospital admissions by only one 2 night LOS episode p.a. this would be a cost saving of £47,200.

- **The complex lifestyles client group are more likely than their peers to be admitted to hospital by ambulance.** Previous analysis has indicated that 65% of this cohort (219 clients) calls an ambulance each time they attend Bolton A&E. Based on 2,190 ambulance calls per annum this would be a cost of £514,650 (@ £235 per call). A 50% reduction in ambulance call outs would equate to a saving of £257,325.

The Urban Outreach Support Worker has met with several patients who agreed to be contacted. Consultations took place at the surgery where an initial Health and Wellbeing Survey was carried out with them. One of the patients reported that they didn't need a great deal of support as they had other agencies helping already. Another of the patients was very grateful for the help and excited about working with the Support Worker. Although it is early days, in these recent cases the risk stratification model seems to have identified patients with the type of issues that the Complex Lifestyles programme has been designed to address.

Sections 8 and 9 of this report contain information on some of the key performance measures to date.
Updated 02/10/14 SMc

Section 2
Bolton Health & Social Care Integration Programme

As the population of Bolton grows older, the health and social care system in the Borough is under increasing pressure from a combination of reduced resources and increasing demand for services. It is becoming increasingly clear that current models of service provision are rapidly becoming unsustainable.

Within Bolton there is a strong track record of partnership working between NHS Bolton Clinical Commissioning Group, Bolton NHS Foundation Trust, Greater Manchester West Mental Health Trust and Bolton Council. Community services in Bolton are an asset and have the potential to form the building blocks from which a truly integrated system can be developed. General Practitioners and their teams are both providers and commissioners of health care in Bolton. General Practices have a track record in implementing population in health programmes delivered at pace and scale built upon year on year since the Big Bolton Health Check. Outcomes include increases in the diagnosis and evidence-based care of the people with long term conditions such as heart disease and diabetes in primary care. Resulting reductions in admissions to hospital and reductions in mortality have been achieved.

Closer integration of health and social care has been a pervasive and recurrent theme of public policy. The national framework document, *Integrated Care and Support* clearly signals the Government's commitment to integrated care and the willingness of national organisations to work together to ensure that policy and regulatory levers support this approach.

UK and international evidence suggests that integrating care can deliver better outcomes, improve individual experience and support cost containment, and that significant improvements can be made through a dual focus on redesigning services and supporting people to self-care (building on the assets around them). System level integrated care addresses the fragmentation of care, shifts the focus away from individual organisations and can provide powerful incentives to focus on prevention, self-care and cost reduction at a neighbourhood level.

There is strong support from Bolton people for the direction of integration with a survey in summer 2013 receiving 92% support for integrated services

Bolton Clinical Commissioning Group (BCCG), Bolton Council (BMBC), Bolton NHS Foundation Trust (BFT) and Greater Manchester West Mental Health Foundation Trust (GMW) are working together to develop and Integrated Care model across the borough to help to keep people well and out of hospital and care homes wherever possible.

Section 3 - Better Care Fund

Bolton has received initial feedback from the Greater Manchester local area team relating to sections of the BCF which require further comment or evidence from partner organisations.

Programme team have coordinated a first phase response to the feedback with support from key colleagues to provide evidence and further information where required.

Amendments are being made to the next draft of parts one and two in readiness for any future submissions.

A copy of the feedback can be provided on request. Please contact s.mccairn@nhs.net

Updated 01/10/14

Section 4 - Communications and engagement

As a complex transformational programme working across organisational boundaries, the integration of health and social care necessitates a coordinated and multi-layered approach to communications and engagement dialoguing with a highly diverse range of stakeholders with varying levels of awareness, interest and influence. The communications and engagement enabling workstream will support and facilitate the timely and accurate communication of key messages aligned to the following key objectives:

- Increase awareness and visibility of the integrating health and social care programme across key audiences
- Inform and reassure partners, stakeholders and the public by giving them a picture of what services will look like for Bolton residents in the future
- Engage and communicate across partners to achieve better outcomes and a more coordinated programme
- Minimise controversy and confusion and build confidence in the changes
- Clearly articulate the rationale and evidence informing the change
- Highlight the benefits of the changes for the public/staff/other partners

The newly appointed interim communications and engagement lead is undertaking a detailed mapping exercise to clearly articulate the programme's key messages aligned to key deliverables mapped against the range of relevant stakeholders.

High level key messages

- People living longer with multiple health conditions is placing financial strain on existing services
- Too many people go to hospital who could be treated in the community or at home (where most patients and service users would rather remain)
- Joining up health and social care services will improve patients' and service users' experience of services while helping to avoid expensive hospital stays
- An extra £2.5m is being invested in services based in the community
- Patients most at risk of being admitted to hospital will be offered support to manage their condition and keep them at home

Key stakeholders

- GPs
- Practice Managers
- Practice Nurses
- Existing community teams
- Elected members
- MPs
- Health OSC
- NHS England
- CCG/FT board
- Health and Wellbeing Board
- CCG/Council/FT staff
- GM Partners
- Patients
- Social care service users
- Healthwatch
- Media

Updated 02/10/14 JHill

Section 5 Patient Story

Background

The patient has multiple comorbidities: Unstable diabetes, brain injury, reduced mobility, ex-alcohol user, poor eyesight. They were highlighted via the risk stratification tool. The patient is a high user of primary and secondary services due to their uncontrolled/ unstable diabetes.

MDT discussion

The patient had social services involved to prompt medication, meal prep and assistance with personal hygiene needs, he also has District Nursing service 4 times daily to administer insulin and monitor BM's.

The patient has regular OPA at the diabetic centre to manage the condition. The patient also had the district nursing service visiting 4 x daily to monitor BMs and administer insulin, however on several occasions the patient informed the DN service not to return for 1-2 visits as they were going out and would ask their mum to administer the insulin – unsure whether this happens as the patient states they go to the pub when the mother is not present. The patient also had a care agency visiting 4x daily to prompt oral medication; they had on several occasions turned up with no access to the patient's home.

Health & Social care integrated response

GP assessed patient's medication and reviewed the need to take at certain times or if the medication regime could be changed to reduce the need for social input and missed visits. There was a discussion between the social worker and telecare services to possibly implement a medication prompt to further reduce the need for the care agency's input. The DN liaised with the diabetic centre to obtain aids/adaptations to enable the patient to administer insulin and monitor BMs to increase independence in their condition. The district nurse continued to visit for a short period of time to enable the patient to have sufficient information/education to manage his diabetes effectively. District Nurse spoke with the patient's mother to ascertain if she had been administering his insulin when they stated she had and coordinated services as appropriate. An effective dialogue between the patient and a nursing/medical person was required to discuss the patient taking ownership of their condition and actions regarding their own health and what could be provided.

Outcomes

Reduction in DN visits, the patient now has twice daily (BD) insulin. The diabetic centre has adjusted the insulin; and patient is managing with their new insulin regime. GP has adjusted the medication regime and the patient now only has a care worker once daily to prompt medication. Diabetic centre are reviewing the patient more frequently. The patient has taken on the ownership of his condition. DN team are utilising their time and resources more efficiently.

Patient feedback

"I feel much happier about taking my medicine. It's easier for me to remember and take and I don't need my mum's help as much. I can now go out in the day as I don't have to be at home and wait for someone to visit me and help me with my medicines.'

Collection of patient stories is being developed by the INT Clinical Facilitator and Comms workstream to inform impact of direct patient care. Updated 22/08/14 (SMc)

Section 6 - Staff Stories

This staff story is from a member of the Long term Conditions Team:

"I have worked with this MDT to help improve the health of these patients and been part of preventing these patients from being re-admitted.

One patient was a great worry to us due to a life threatening illness which with each emergency visit meant they were transferred to ICU. The MDT meant we could look at the patients care and make changes to support them taking better care of themselves at home, managing their condition so that they didn't go in to crisis and end up in hospital.

I have had the opportunity to attend one of the MDT meetings and felt part of the team. Everyone present all had the same vision, which was to put these patients' wellbeing first and work together to stop the patient going in to hospital. I can honestly say that I frequently drive home from my work feeling that I have helped my patients and there is no other feeling like it!"

This staff story is from the perspective of the Mental Health Practitioner who has recently joined the MDT:

"I have only just joined the team but I just wanted to say how excited I am at the prospect of the work the team hopes to achieve.

In the meetings I have attended so far it has been really good to see different agencies working together as partners and developing effective relationships for patients needing a multi agency approach. The links created should streamline pathways of care and reduce confusion between agencies.

The idea of proactively managing people who are at high risk of unplanned admission to hospital due to the possible breakdown of existing care arrangements will hopefully help more patients to continue to live at home safely for longer and potentially more independently in the long term.

This should improve the patient experience and lead to better care outcomes including the added benefit of slowing disease progression for individuals. The ethos of encouraging self care regardless of how minimal any self care action may seem, is a worthwhile goal. As is supporting patients to understand and manage their conditions better.

I look forward to working together with yourself and the other team members in achieving the above and would like to say how glad I am to have this wonderful opportunity. "

Updated 22/08/14 (SMc)

Section 7 - Programme Summary & workstream updates 22/09/14 – 30/09/14

High Level Summary

The Health and Care integration programme in Bolton has reached a new phase - progressing from the planning stage to the implementation stage. Three of the five operational work streams are in implementation phase (Intermediate Tier, Complex Lifestyles and Integrated Neighbourhood teams) and one is in planning phase (Care Coordination Centre) Project monitoring plans are in place. The Staying Well project is currently finalising their project plan to support implementation and are recruiting to posts.

GPs have been selected to participate in the next phase of implementation - either working with an Integrated Neighbourhood Team or participating in the Complex Lifestyles service. The selection process has been undertaken and practices have received notification in writing. The development of phase 2 of Integration will commence in August with the second phase expected to run from September 2014 – January 2015

The enabling work streams (finance, performance, IT, workforce, communications/engagement and estates) are all established and will develop further as the requirements emerge from the design and refinement of the operational work streams.

Service Transformation workstream updates

Complex lifestyles	**Overall Rating**	

The first pilot practice has identified 10 patients to start contacting, patients have started to agree to participate and the details of these patients have been passed on to Urban Outreach who have made initial contact and arranged some introductory sessions. The equality impact assessment, data sharing agreement and privacy impact assessment have all been provisionally agreed (subject to minor amendments) and will be forwarded to the appropriate boards/ individuals for sign off. The other practices have been contacted by the CCG to highlight that we will be getting in touch shortly to start the complex lifestyles project with their patients.

<u>To complete</u>
Terms of reference to be agreed by steering group on 3rd October.
Organise initial meeting with next participating practice.
Risk stratification list analysis with practice manager to be arranged with integration performance lead
Begin patient consent process with patients identified as part of complex lifestyles support.
Continue IG completion in line with new documentation to be issued by Bolton Council
Honorary contract between UO and next participating practice to be put in place and signed

Key Milestones August, September & October 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Sign off of provider contract and service spec	TBC		Monitored by Public health and programme team. Providing support where required. Slight delay with contract sign off. This is being closely managed by the workstream lead and they have confirmed this will be completed in the next two weeks. We have been assured that this delay will have no impact on the provider's delivery of service or invoicing.
Agree patient consent and information sharing protocols	12/09/14		A suite of documents developed as part of phase one INT are being adapted for use with the complex lifestyles project. Honorary contract to be drawn up between provider and practice until ISA is in place
Agree CQIA/EIA/HIA	10/10/14		To be agreed at October board. No impact on delivery of service.

Care Coordination Centre (CCC)	Overall Rating	

External Contractor now commenced in post and initial meeting held on 16.9.2014 to scope out work and provide contacts. Contractor has set aside time on 1st October to map the referral and access routes into Intermediate Tier Services with the Service Leads. Contractor to undertake site visit to existing Single Point of Access.

Activities to complete
Task and finish group set up to expedite the incorporation of Intermediate Tier Services into the Care Co-ordination Centre as a priority for this winter.
Definitive list of services that are planned to be incorporated into the CCC has been circulated to service managers for comments with a view to finalising the list at the next Steering Group meeting on 8th October.

To complete
External Contractor to undertake mapping of existing access routes, call volumes and system capacity.
Definitive list of services to be agreed at Steering Group on 8th October.

Key Milestones September – October 2014	Date	RAG Rating	Mitigating Actions
Provider to commence work up of Business Case	24/09/14		In progress
Ratify timetable for incorporation of services to CCC	10/10/14		In progress
Phased - Commence incorporation of services to CCC	Start 31/10/14		

Integrated Neighbourhood Teams	Overall Rating	

A draft programme of team-specific staff Induction is being developed for further discussion and approval at the INT Steering group on 2nd October. A team Induction is being proposed for 3rd November subject to agreement by steering group. Optional appraisal paper written to inform Estates workstream re suitable sites for a co-located team and Estates Space Request form completed and submitted for consideration at Estates Operations Board.

Social workers for INTs now recruited. Clinical Supervision arrangements for the staff in the co-located team confirmed.

To complete
Identify suitable estate and agree date for staff to move in.
Confirm management arrangements
IT requirements to be agreed with IM&T workstream

Key Milestones September – October 2014	Date	RAG Rating	Mitigating Actions
IT solution in place for sharing Care Plans with OOH, NWAS	12/09/14		Work packages in development with support from IM&T workstream. Next meeting to be held on 26/09/14
CQIAs- to Quality and safety committee.	18/10/14		On track
Staff from health and social care in post to form first phase INTINT	10/10/14		On track. Recruitment being monitored by programme team at IDG
Workforce alignment proposals agreed by Integration Board	10/10/14		
Estates group confirm estate for integrated team hubs through agreement with providers	31/10/14		
Agree Service specification for Integrated Neighbourhood Teams at Integration Board	10/10/14		

Intermediate Tier	Overall Rating	

Workforce plans and Health consultation documents for the Home, Bed Based and Admission Avoidance services completed - all 3 plans are with FT HR/finance and DDO for agreement to progress. A meeting planned for 2.10.2014 to agree and sign off plans which include estate options for team co-location.

Unions and HR have been consulted with in preparation for staff moves/relocation. NHS IT links requested via IT work plan for one site to co-locate IMC@Home Team and Reablement to enhance integration.
Recruitment for Admission Avoidance Service taking place-RGNs, OTs, PTs and SNCs.

To complete
Baseline quantative standardised data being collected across home based, bed based and admission avoidance teams for assurance framework - first draft report anticipated 10th October via BI team.
Patient satisfaction being collected by all teams -.
IT work package completed and submitted to IM&T work stream
Qualitative data to be included in November report.
Appointments made to home based pathway posts
Workforce plans have been submitted to programme team

Key Milestones September – October 2014	**Date**	**RAG Rating**	**Mitigating Actions**
GP and medical model to be taken to CCG Executive	TBC		**Medical cover is in place at all units so there is no risk to patients. Meeting to be arranged with clinical leads to seek consensus to agree improvements to the new medical model going forward.**
Estates group to discuss draft options for team location proposals	15/10/14		Workshop to be held on 15th October to agree staff locations
Report to Integration Board on workforce plans	12/09/14		To be reviewed at next Integration Board 10/10/14

Staying well	**Overall Rating**	

Staying Well Transformation Meeting undertaken
Project Plan agreed and actions delegated for next meeting
Transformation meeting group members agreed
Shortlisting commenced for Staying Well Co-ordinator and Team leader Post
Shortlisting for the Community Capacity Post complete

To complete
Complete job evaluation questionnaires and process for all posts

Key Milestones September & October 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Agree record keeping processes/systems	30/09/14		complete
Performance indicators and metrics agreed	30/09/14		complete
Marketing & promotional strategy in place	31/10/14		In progress

Enabling workstreams

Performance Monitoring	Overall Rating	

Significant progress has been made on the performance section of the monthly update report. All indicators for which data is readily available will be included in the October report. However, the high level objectives for each organisation are still outstanding.
Supporting evidence has been supplied for the Better Care Fund submission, although further work is required over the coming weeks.

To complete
Obtain high level objectives for each organisation, to include in the monthly update report
Work with finance workstream to model the benefits from BCF and integration schemes
Produce key slides to illustrate BCF schemes/ risk stratification data/ anticipated benefits in a visual, user friendly format.

Key Milestones August & September 2014	Date	RAG Rating	Mitigating Actions
Individual patient tracking to be put in place at local level	31/08/14		Further discussion will be required with IM&T and IG to develop a more comprehensive tracking tool that can be used on a larger scale. To raise at IM&T on 12th September. On-going discussion is taking place at the IM&T workstream regarding this milestone and will depend on longer term IT solutions and technology.
October report (July data) - to include Intermediate Tier section	25/09/14		On track
Complete Benchmarking submission	25/09/14		On track
Performance indicators and metrics agreed for Staying Well	30/09/14		On track

Communications and engagement	Overall Rating	

Communications officer is now in post
High level key messages and communications strategy is being developed for a first phase round of communications and engagement. Meetings to be scheduled with workstream leads to ensure key messages are drawn out and gain an understanding of key stakeholders who will be impacted by service reconfiguration.in the borough.

Key Milestones September & October 2014	Date	RAG Rating	Mitigating Actions
Website – go live	TBC		Escalate to Comms team and IM&T re: updating CCG website. Current restrictions in place to add new pages to website. Revise date for website. Consider other sites as an option. In progress
Agree key messages and produce control document	TBC		In progress
Prepare PowerPoint presentation for use by senior managers with staff	TBC		In progress
Prepare set of FAQs to help get consistent messages	TBC		In progress
Prepare set of short film case studies to show what changes mean to real people in Bolton	TBC		In progress
Develop Bolton branding and strapline	TBC		In progress

Workforce	Overall Rating	

Service specifications and service delivery models have been developed for Integrated Neighbourhood Teams, Intermediate Tier Services, Staying Well, Complex Lives. New service specification for Care Homes developed by Commissioner and FT Provider has been requested and is expected within 2 weeks. The Care Co-ordination Service for the over-75s is to be commissioned by the CCG on behalf of 26 GP practices in Bolton and delivered by Bolton FT.

Intermediate Tier Workforce:
A training needs analysis has been undertaken to identify gaps in skills and knowledge. Key priority service training and mandatory training gaps will be addressed, dates have been identified and staff will be released from their current roles in 'waves' to attend.

Where required bespoke training is being arranged. All existing training records are available from the central IT system and these are being cross referenced for accuracy and monthly updates are provided.
Staff are being allocated a month's shadowing within the home based service through phased release from their current roles.

Fortnightly meetings with Health staff in Intermediate care have been positively received and fruitful in terms of engaging the staff in the redesign process.

Culture club training is being developed. Team are developing a delivery plan which will commence with Integrated Neighbourhood Teams.

Key Milestones October 2014	Date	RAG Rating	Mitigating Actions
Agree interim workforce business case for intermediate tier at Integration Board	10/10/14		Work is on-going with the workforce plan. There has been a request for change from the Intermediate tier workstream to submit plans at the October Integration Board.
Agree interim workforce business case for Integrated Neighbourhood Teams at Integration Board	10/10/14		

Finance and Contracting	Overall Rating	

Tracking of savings will be reported from October 14.
Meetings scheduled to discuss contract models & Section 75 agreement
BCF Part 2 is in progress

Tasks to complete
1. On-going work on contract models and section 75 agreement
2. Invoices for all additional hours worked up to and including July and August 2014 to be sent to the CCG.
3. The funding for all staff for 2014/15 has now been confirmed but is subject to issue of 'comfort' letters to the BRFT and GMW.
4. Expenditure forecast profiles to be sent from the FT and to be signed off by Chief finance officer of CCG and BMBC

Key Milestones September 2014	Date	RAG Rating	Mitigating Actions
BCF Submission draft	10/09/14		complete
BCF Submission final draft	17/09/14		Complete
Confirmation of funding for all staff 2015/16	30/09/14		Letter has been sent to Bolton FT. Letter to GMW is in draft. Further discussions required to agree assurance for council from a provider perspective.
Sign off of funding for all additional hours worked in July and August at FT	25/09/14		Invoices not received. Requires escalation to finance team

Estates	Overall Rating		
Estate leads presented outputs from workshops held in July and August. A list of potential buildings aligned with the 5 hubs has been drafted. Further work is to be carried out on proposed buildings to understand services currently delivered and a utilisation study. This will be added to the workforce alignment work being drafted by the Integration programme team and will form the basis of an options appraisal. Workshop booked for 15/10/14 and will be attended by service reconfiguration leads to specify needs and requirements for staff that will be colocated. Further meetings are required to determine the service model for each INT/hub and align any plans with primary care development plans and other service estate requirement. With support from NHSPS the estates group will begin development of a Borough wide estates strategy.			
Key Milestones September 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Further development of Bolton Estates strategy	30/09/14		In progress. Next workstream meeting to be held on 23/10/14

IM&T and IG	Overall Rating		
The workstream plan for IT and Information Governance is still under development. As this is an enabling workstream the plan can only be fully detailed once the INT and Intermediate Tier schemes were fully worked up and can describe their IT requirements. AGMA have agreed the GM information sharing framework and supporting documents which have been signed by chief execs. An interim IT manager will be brought in to lead IM&T delivery for the service reconfiguration workstreams and resolve any capacity issues causing delays to completion of work. Workstream meetings now every two weeks. Progress is being made to tighten up the technical requirements that have been emerging. New gatekeeper process being put in place which will ensure that IT requirements are managed in an appropriate way. Further work is required to fully understand the long term vision of what is required of an IT solution. This work has commenced but is dependent on other workstreams and their milestone timescales.			
Key Milestones June - September 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Sign off of GM IG agreement	30/06/14		In progress and being monitored by Programme team. Sign off expected by end of Oct 2014
Development of IT and IG project plan for MDT roll out	30/09/14		In progress and will be dependent on work package sign off for each workstream. Next IM&T meeting to take place on 26/09/14
Agree IG and Information sharing process and protocol for new starters in INTs and complex lifestyles	15/09/14		In progress. Being addressed in fortnightly workstream meetings Expected to be agreed end of October 2014.
Appoint interim IT manager	08/10/14		

Updated 02/10/14 (SMc)

Section 8 - Performance Headlines

The Better Care Fund payment for performance fund will now be linked to total emergency admissions only. There is an expectation that all Health and Wellbeing Board areas should set a minimum target reduction of 3.5% from the calendar year 2014 to the calendar year 2015.

Increase in emergency admissions

In 2012/13, there were 30,953 emergency admissions for Bolton patients. In 2013/14, there were 32,763 admissions, which is an increase of 6% year on year. Between April – July 2014 there were 11,614 emergency admissions for Bolton patients, which is an 8.4% increase compared with the same period last year.

Over the next five years, the number of people aged over 65 in Bolton is projected to grow by 10%. This will have a significant impact on healthcare resources as 34% of emergency admissions in Bolton in 2013/14 were patients aged 65 and over.

10% expected increase in over 65s

Increase in A&E attendances

The number of A&E attendances for Bolton patients across all providers decreased by 1.4% from 2012/13 to 2013/14. However, in April – July 2014 the number of attendances has increase by 2.5% when compared with the same period last year.

As well as an increase in A&E attendances and emergency admissions there has been an increase in recent months in the rate of readmissions for Bolton patients. For the current year to date (April-July) the crude 30 day readmission rate was 9.6%. This is an increase from 8.7% in the same period last year.

Increase in 30 day readmissions

Reduced average length of stay

Although the number of emergency admissions has increased, the average length of stay for non-elective admissions is decreasing steadily for Bolton patients, from 5.3 days in 2012/13 to 5.1 days in 2013/14. In the current year to date (April-July 2014) the average length of stay was 4.8 days.

66.8% of Bolton patients responded positively in the latest GP Patient Survey when asked the question “In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?” This is the second highest proportion of patients responding positively when compared across Greater Manchester CCGs.

Patients feel supported to manage their condition

Although the payment for performance element of the BCF is linked solely to emergency admissions, there are a number of other metrics which will be included in BCF plans. CCGs and councils are expected to identify their ambitions for improvement in the following areas: Admissions to residential and care homes, effectiveness of reablement, delayed transfers of care, patient/ service user experience, bed based intermediate care (Bolton’s locally selected metric).

Increase in admissions to residential and care homes

The number of permanent admissions of older people (aged 65 and over) to residential and nursing care homes increased in 2013/14 to 380, compared with 350 in 2012/13.

The proportion of people aged 65 and over who were still at home 91 days after discharge from hospital in to reablement/ rehabilitation services decreased from 85.9% in 2012/13 to 78.5% in 2013/14.

Decrease in patients still at home 91 days after discharge from hospital to reablement service

Updated 02/10/14 LT – Section 9 contains a series of charts to illustrate the key points above, as well a more comprehensive range of indicators.

Section 9
Bolton Integrated Health and Social Care Performance Report

Key Performance Indicators – Bolton wide, including Better Care Fund metrics

Key Performance Indicators – Westhoughton GP practices

KPI definitions

Data sources

Please contact Elizabeth Taylor (Integration Performance Lead) with any queries
elizabethtaylor5@nhs.net
01204 46 2183

Better Care Fund metrics

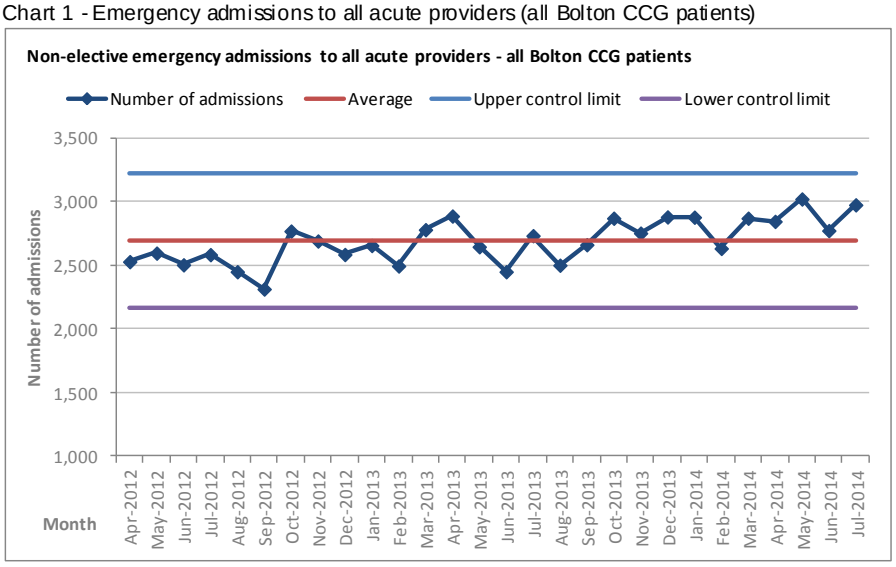
BCF1. Total emergency admissions
Objective: to decrease

The key measure which will be used for Better Care Fund (BCF) performance payments has changed from "avoidable" to total emergency admissions. This is now the sole measure on which the pay for performance element of the BCF will be assessed.

A target reduction of 3.5% has been set, which will be assessed by comparing the period January to December 2014 with January to December 2015.

Chart 1 shows the trend in emergency admissions from April 2012 to July 2014. This year to date (April-July 2014) there has been an 8.4% increase compared with the same period in 2013.

Chart 1 - Emergency admissions to all acute providers (all Bolton CCG patients)



The CCG is undertaking further analysis into the cause of the increase in non-elective admissions, which is due to a combination of increased A&E attendances and ambulance conveyances.

There has also been an increase in short stay admissions, believed to be linked to the closure of the Bolton Community Unit in January 2014 and related opening of the new Frailty Unit. This could mean that the increase seen at the start of 2014 is not entirely "new" activity. It could be activity that has been displaced following the closure of the BCU in January 2014.

Analysis by primary diagnosis has revealed increases in admissions with **cellulitis** (44% increase from 108 in April-July 2013 to 156 admissions in April-July 2014) and **UTIs** (12.9% increase from 317 in April-July 2013 to 358 in April-July 2014). These conditions would potentially have been managed in the BCU in the past.

An increase in admissions with respiratory disease and mental health related conditions has also been observed and further analysis by age group shows that the largest increase in non-elective admissions was for patients aged 65 years and over. Admissions for this age group have increased by 11.5% from 3652 in April-July 2013 to 4073 in April-July 2014.

To address the over-performance the CCG and FT are working on the development of new ambulatory care pathways aimed at avoiding admissions for specific cohorts of patients who can be managed within primary/community care, early redesign of the Rapid Assessment Team and Intermediate Tier services and analysis of the RAID pathway.

Please note chart 1 does not include admissions to Greater Manchester West; the data source (Monthly Activity Return) contains admissions to general and acute specialties only.

As part of the Better Care Fund submission, Health and Wellbeing Boards were also asked to identify their ambitions for improvement against wider performance metrics:

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital in to reablement/ rehabilitation services (effectiveness of the service)
- Delayed discharges (total number of delayed days)
- Overall satisfaction of people who use services with their care and support
- Referrals to home based intermediate care

BCF2. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
Objective: To decrease

In 2013/14 there were 380 permanent admissions to residential and nursing care homes in Bolton, which equates to 858.4 admissions per 100,000 population aged 65 and over. Chart 2 shows that Bolton had the third highest rate of admissions to residential and nursing care homes when benchmarked against statistical peers.

In the Better Care Fund submission, Bolton has set an ambition to decrease the number of permanent admissions to nursing and residential care homes to **378 in 2014/15** and to reduce further to **361 in 2015/16**. Although these targets do not appear to be overly ambitious, the number of people aged over 65 in Bolton is projected to grow by 5.7% from 2013/14 to 2014/15 and by a further 2.2% in 2015/16.

Chart 2 – Admissions of older people to residential and nursing care homes benchmarked against statistical peers

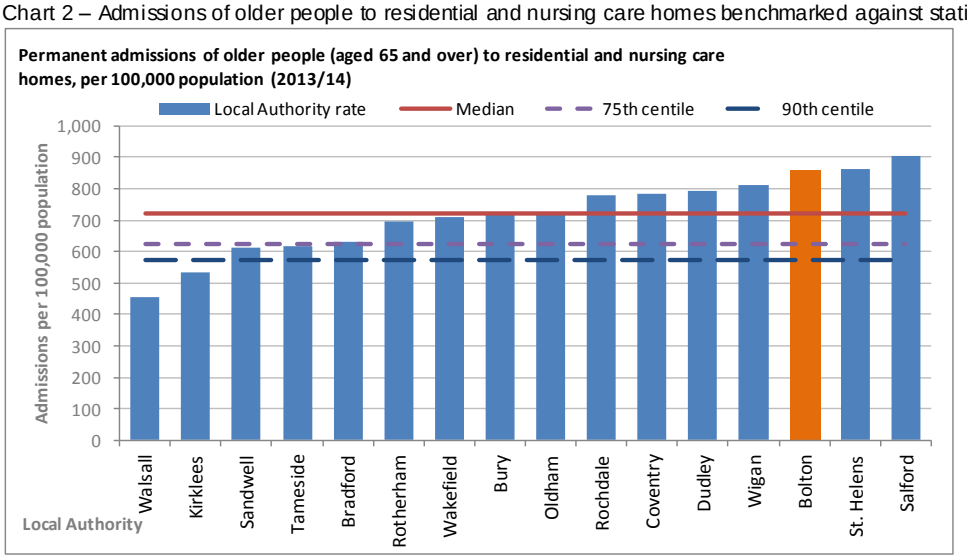


Chart 3 - Admissions to nursing and residential homes - trend over time and BCF ambitions

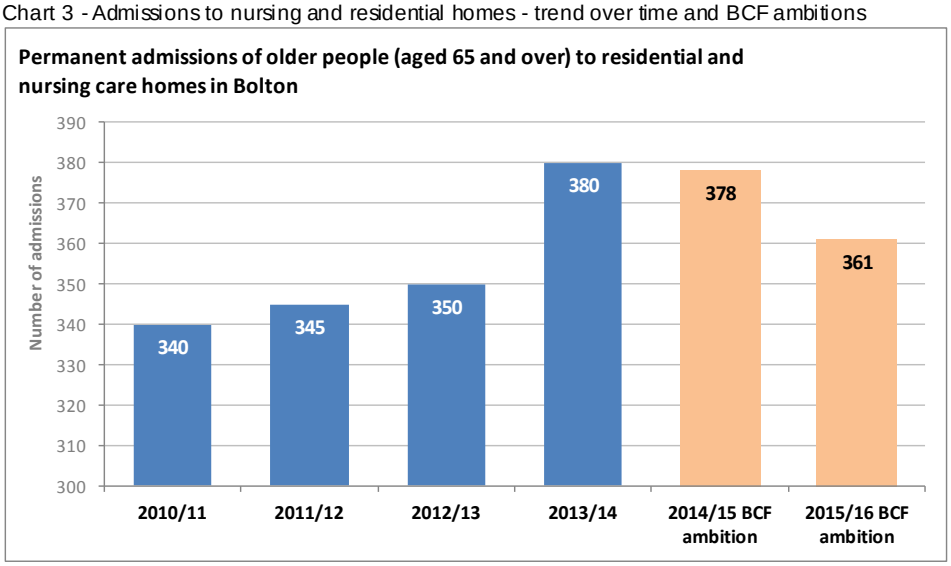


Chart 3 shows the number of permanent admissions to nursing and residential care homes over time from 2010/11 to 2013/14, along with the BCF plans for 2014/15 and 2015/16.

BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital in to reablement/ rehabilitation services (effectiveness of the service)
Objective: To increase

In 2013/14, 78.5% of patients were still at home 91 days after discharge in to reablement/ rehabilitation services. Chart 4 shows that Bolton had the 5th lowest value compares across statistical peer organisations.

Chart 5 illustrates this measure over time from 2010/11 to 2013/14, along with the levels of ambition that were included in the BCF submission. The aim is to increase the proportion of people still at home 91 days after discharge to reablement over the next two years to the level seen in 2012/13 (86%).

Chart 4 – Proportion of people still at home 91 days after discharge – benchmarked against statistical peers

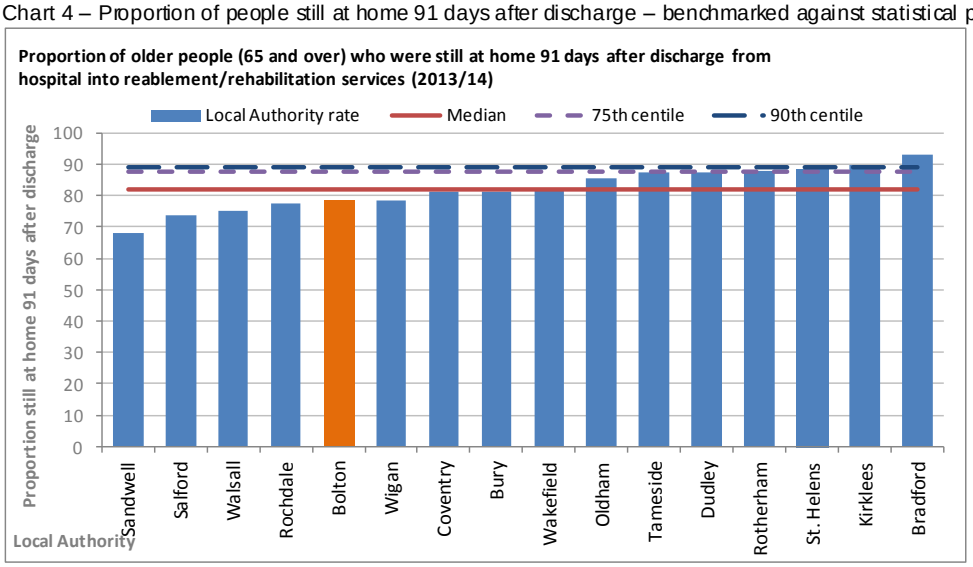
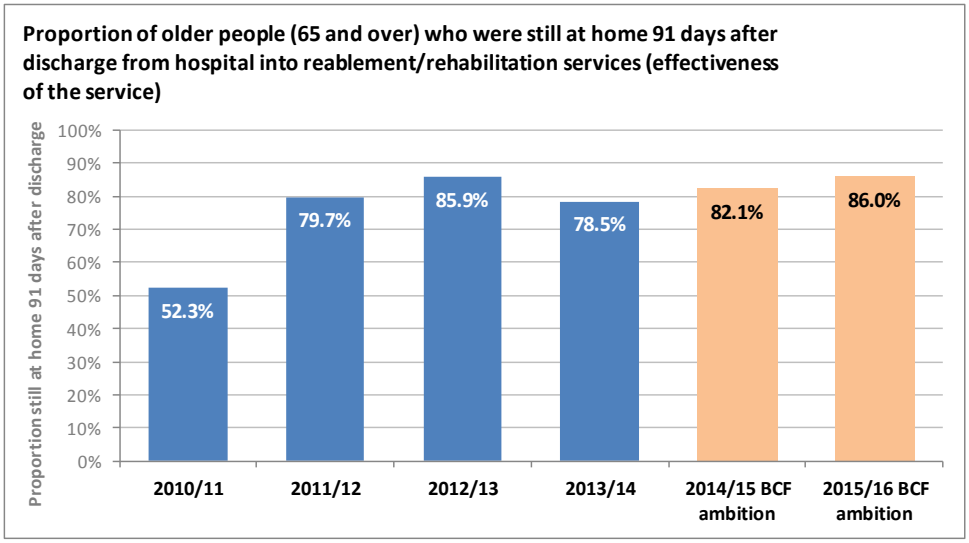


Chart 5 – Proportion of people still at home 91 days after discharge – trend over time and BCF ambitions



BCF4. Delayed transfers of care (total number of delayed days)
Objective: To decrease

In 2013/14 there were 3,879 delayed days for Bolton patients. This includes delays attributable to NHS and social care. Chart 6 illustrates how Bolton benchmarked against its statistical peers in 2013/14; Bolton's rate of delayed days per 100,000 population was just below the statistical peer median.

Chart 6 – delayed transfers of care benchmarked across statistical peers

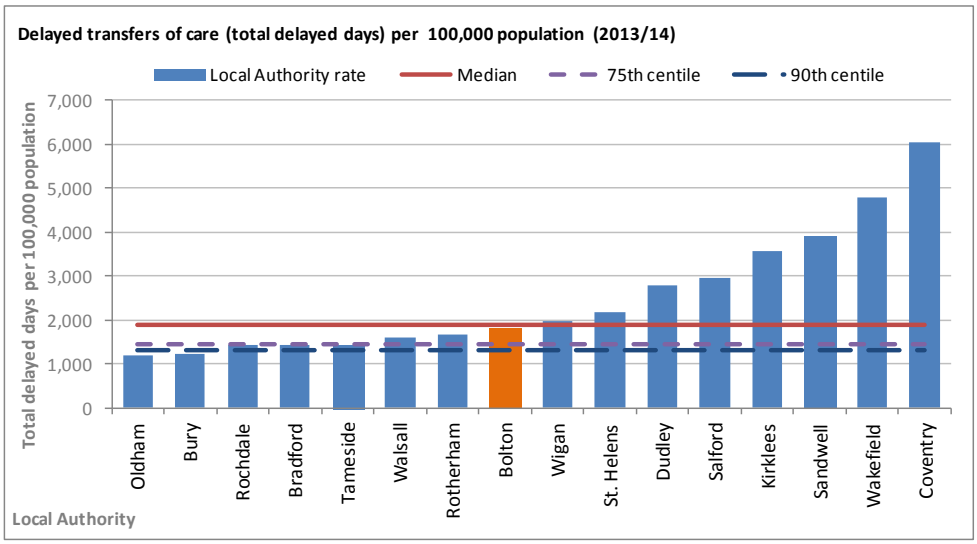
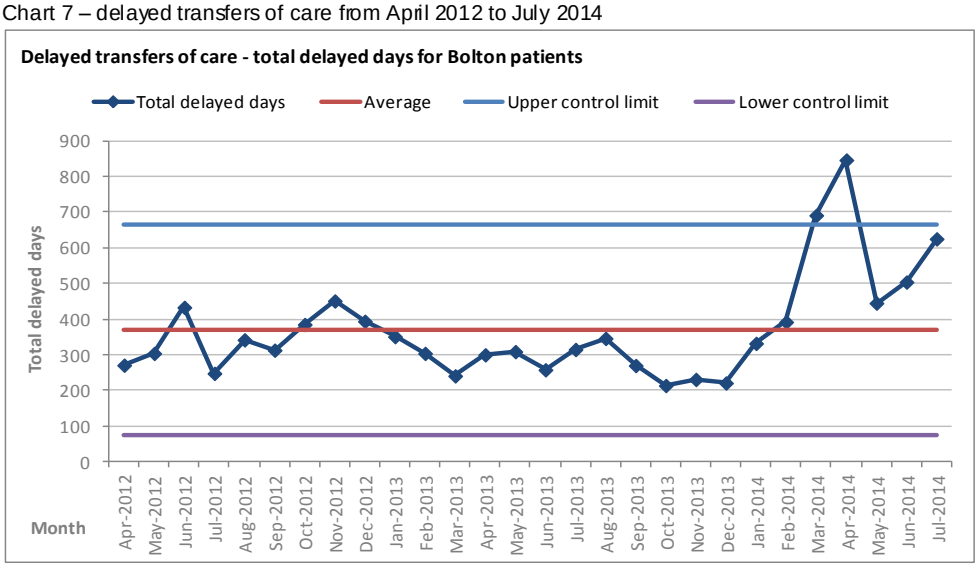


Chart 7 shows the trend in the number of delayed days from April 2012 to July 2014 for Bolton patients. A marked increase can be seen from March 2014, which is due to a change in recording at Bolton FT.

In the Better Care Fund submission, Bolton's levels of ambition for 2014/15 allowed for the anticipated growth in the number of delayed transfers of care due to improved recording. The target set for 2015/16 is an average of 311 delayed days per month.

Chart 7 – delayed transfers of care from April 2012 to July 2014

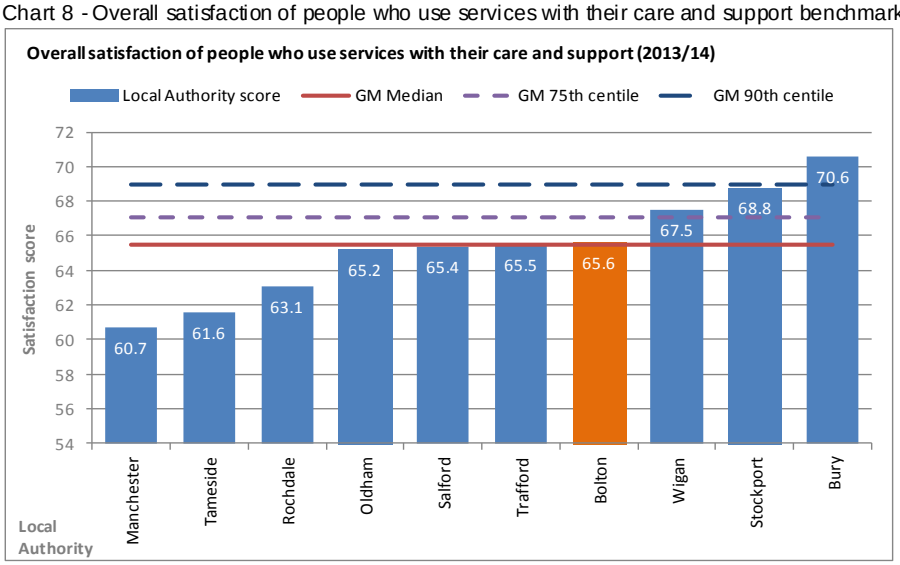


BCF5. Overall satisfaction of people who use services with their care and support
Objective: to increase

As part of the latest BCF submission, Health and Wellbeing Boards were required to select a patient experience metric.
Bolton chose "overall satisfaction of people who use services with their care and support".
This metric was chosen because it is the nearest equivalent measure to a new metric which is under development for both the NHS Outcomes Framework and the Adult Social Care Outcomes Framework, "Improving people's experience of integrated care".

The metric is the proportion of respondents who say they are "extremely satisfied" or "very satisfied" in response to the question "Overall, how satisfied or dissatisfied are you with the care and support services you receive?".
In 2013/14 Bolton scored 65.6%, which was just above the Greater Manchester median, as illustrated in chart 8.
In the BCF submission, an ambition was set to reach 66.6% in 2014/15 and 67.6% in 2015/16.

Chart 8 - Overall satisfaction of people who use services with their care and support benchmarked across Greater Manchester



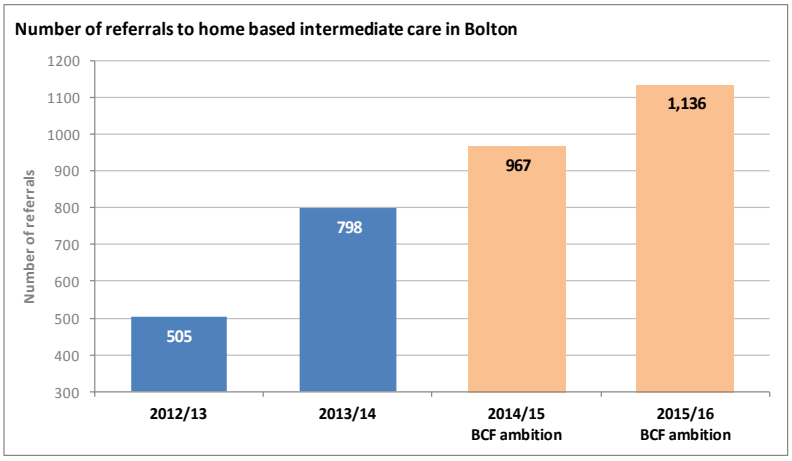
BCF6. Referrals to home based intermediate care
Objective: to increase

For the Better Care Fund submission, Health and Wellbeing Board areas were required to select a local metric. Bolton chose to monitor referrals to home based intermediate care.

The National Audit for Intermediate Care in 2012/13 identified that Bolton was an outlier with regard to the number of intermediate care beds commissioned and intermediate tier services are now being refocused on home based services.

In 2012/13 the Greater Manchester average was 522 referrals per 100,000 population. This has been set as a target for Bolton to reach by 2015/16, which equates to 1,136 actual referrals. Chart 9 shows that significant progress was made in 2013/14 towards meeting this target.

Chart 9 – referrals to home based intermediate care



Greater Manchester and locally selected metrics

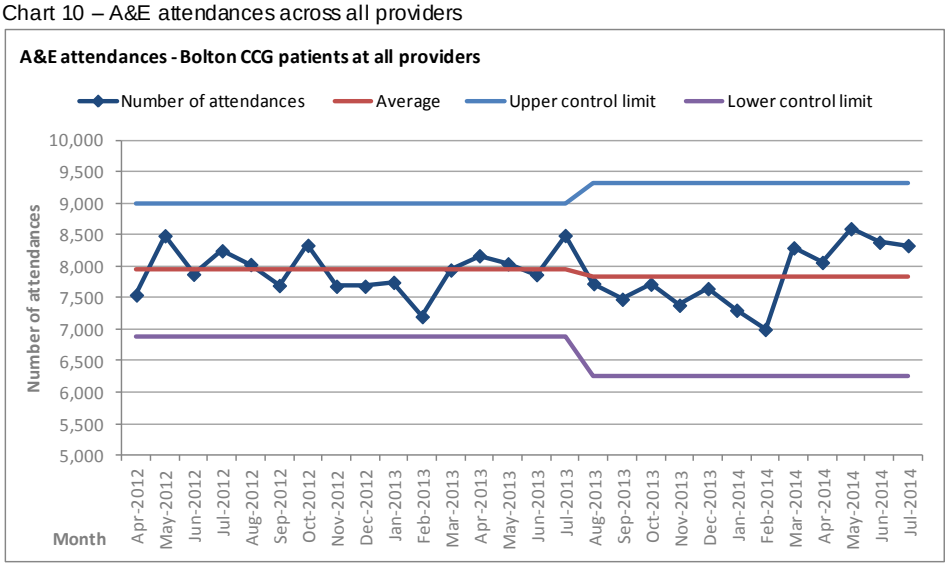
A number of further metrics have been identified across Greater Manchester and locally within Bolton.

GM1. A&E attendances

Objective: To decrease

Chart 10 shows the number of A&E attendances at all acute providers over the last two years for Bolton CCG patients.
The number of attendances decreased significantly from August 2013 to February 2014, however there was a particularly high number of attendances between March and July 2014.
When comparing April-July 2014 with the same period last year, there has been a 2.5% increase (804 attendances).

Chart 10 – A&E attendances across all providers



Further analysis of A&E attendances at Bolton FT, which accounts for 90% of all A&E attendances for Bolton patients, has identified some conditions where particular increases have been seen.

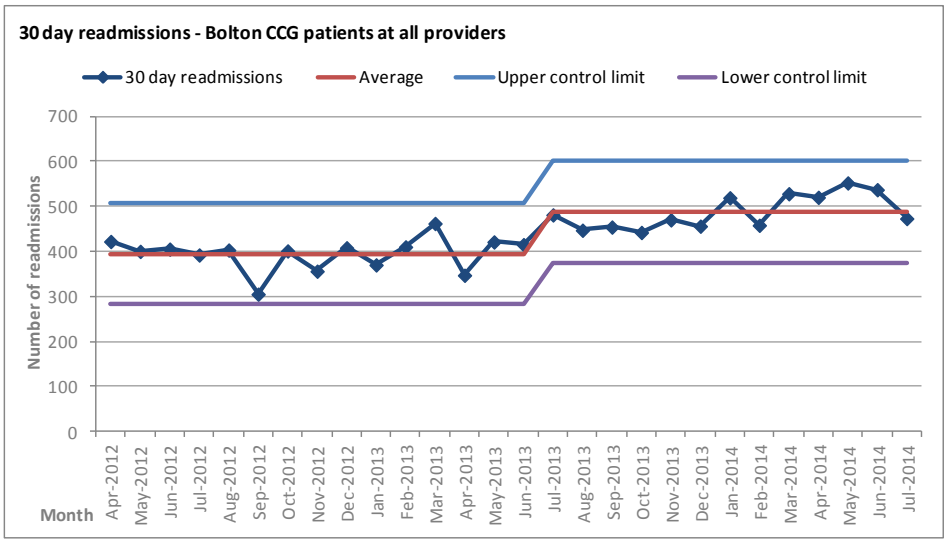
There has been a 15% increase in attendances for ophthalmological conditions from 579 in April-July 2013 to 666 in April-July 2014. There has also been a steady increasing trend from April 2012 in attendances for poisoning (including overdose); attendances in this category have increased from 445 in April-July 2012 to 503 in April-July 2013 and 580 in April-July 2014.

GM2. 30 day emergency readmissions

Objective: To decrease

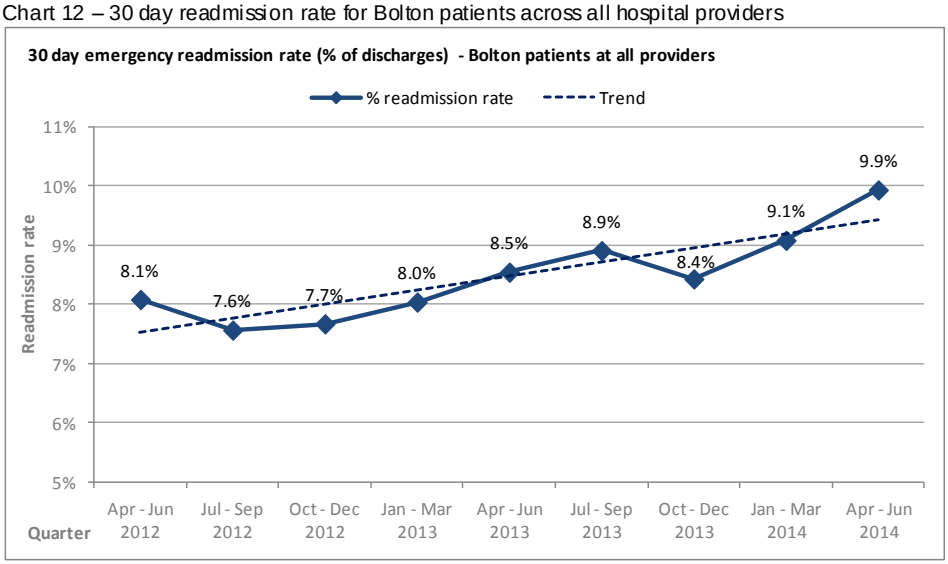
Chart 11 shows the number of emergency readmissions within 30 days of previous discharge (following an elective, day case or non-elective admission). There was a significant increase in the actual number of readmissions from July 2013.

Chart 11 – 30 day emergency readmissions for Bolton patients across all hospital providers



To provide some context to the number of readmissions, chart 12 illustrates the crude readmissions rate (readmissions as a percentage of all discharges) by quarter, from Quarter 1 2012/13 to Quarter 1 2014/15. This has increased steadily, particularly from January 2014.The readmissions rate for the year 2012/13 was 7.8%, for 2013/14 the readmission rate was 8.8%.

Chart 12 – 30 day readmission rate for Bolton patients across all hospital providers



It should be noted that the number of readmissions shown in charts 11 and 12 includes patients who were discharged from one provider and readmitted in an emergency to a different provider, as well as patients admitted to the same provider twice.

However, this measure does not include emergency admissions to Greater Manchester West Mental Health Foundation Trust, as admissions with no national tariff are excluded. There are also some further exclusions for this measure, full details of which can be found in Appendix 1.

GM4. Percentage of people who die in their usual place of residence
Objective: To increase

In the year April 2013 to March 2014, 44% of deaths in Bolton occurred in the person's usual place of residence. Bolton CCG ranked 6th across their statistical peer group, as illustrated in Chart 13.

Chart 13 – Proportion of deaths in usual place of residence – benchmarked against statistical peers

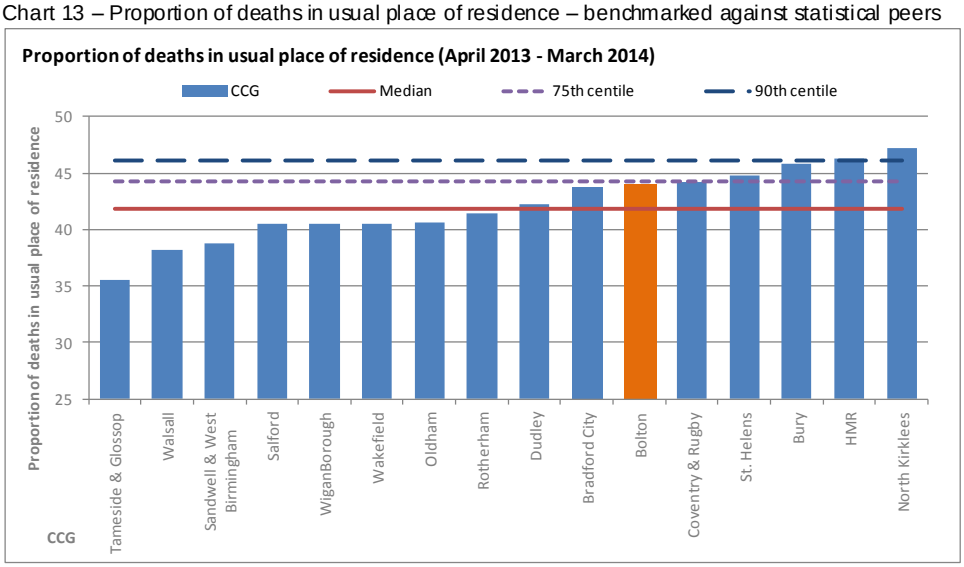
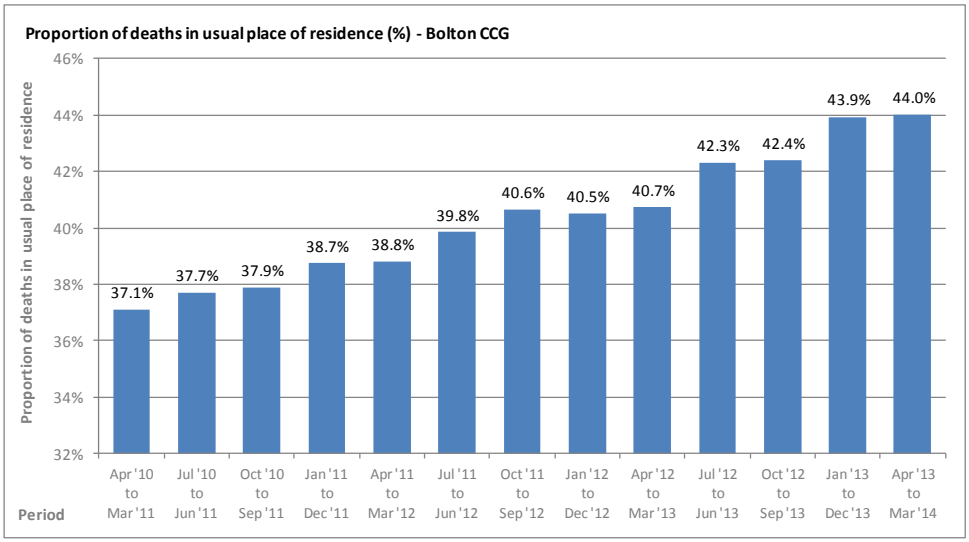


Chart 14 shows a rolling 12 month position for the proportion of deaths occurring in the person's usual place of residence in Bolton. There has been a steady increase from 37.1% in the year 2010/11.

Chart 14 – Proportion of deaths in usual place of residence – Bolton CCG patients



L1. Avoidable emergency admissions
Objective: To decrease

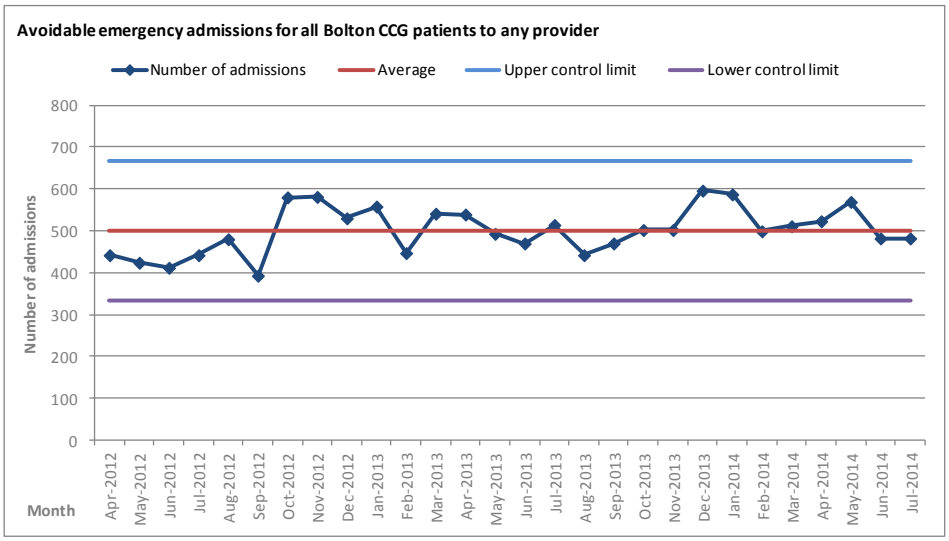
This is a composite measure of:

- chronic ambulatory care sensitive conditions
- acute conditions that should not usually require hospital admission
- asthma, diabetes and epilepsy in children
- children with lower respiratory tract infection.

A full list of the conditions included can be found in Appendix 1.

Chart 15 shows the trend in avoidable emergency admissions for Bolton patients across all hospital providers. There is a slight seasonal trend, with relatively more admissions in winter months (October 2012 to January 2013 and December 2013 to January 2014). Overall the trend is increasing; there was a 5.1% increase from 2012/13 to 2013/14 and a 2% increase in April-July 2014 compared with the previous year.

Chart 15 – avoidable emergency admissions to all providers



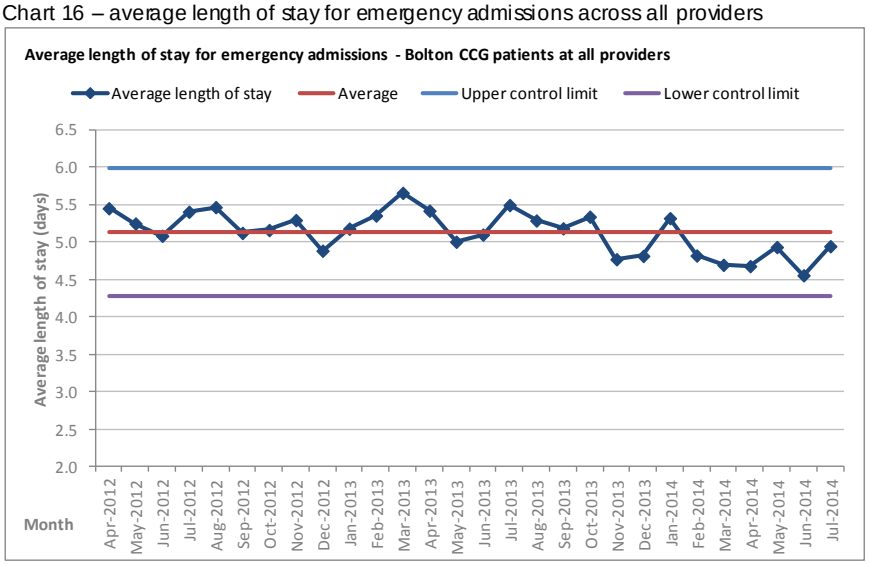
Although an increasing trend is observed in chart 15 above, it should be noted that Bolton benchmarked well for this measure according to the latest available data. In the period October 2012 to September 2013, Bolton had the lowest rate of avoidable emergency admission across it statistical peers.

L2. Average length of stay (non-elective)

Objective: To sustain

In the year 2012/13, the average length of stay for an emergency admission across all hospital providers was 5.3 days for Bolton CCG patients. This decreased to 5.1 days in the year 2013/14. The average length of stay for emergency admissions has shown a decreasing trend since November 2013, as illustrated in Chart 16. For the 2014/15 year to date (April to July) the average length of stay for a non-elective admission was 4.8 days.

Chart 16 – average length of stay for emergency admissions across all providers



L3. Emergency admissions due to falls and fall related injuries (over 65s)

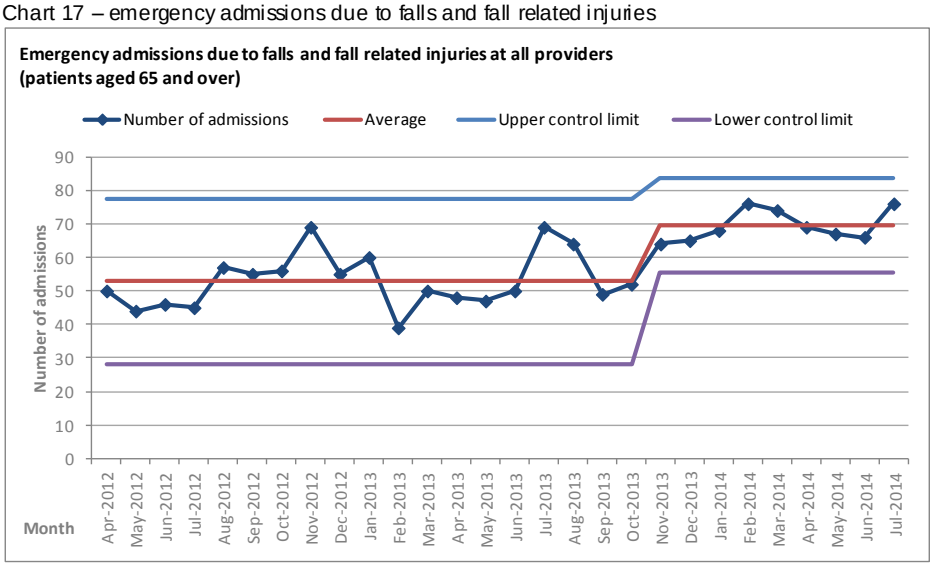
Objective: To decrease

Chart 17 illustrates the number of emergency admissions for patients aged 65 years and over, to any hospital provider, with a fall related injury.

Overall there is an increasing trend in the number of falls admissions. The number of admissions increased in November 2013 and has remained relatively stable since then, unlike previous years where greater seasonal variation was observed.

Comparing the latest available 12 months' data with the same period the previous year, the number of admissions has increased by 20.6%, from 655 (August 2012 – July 2013) to 790 (August 2013 – July 2014).

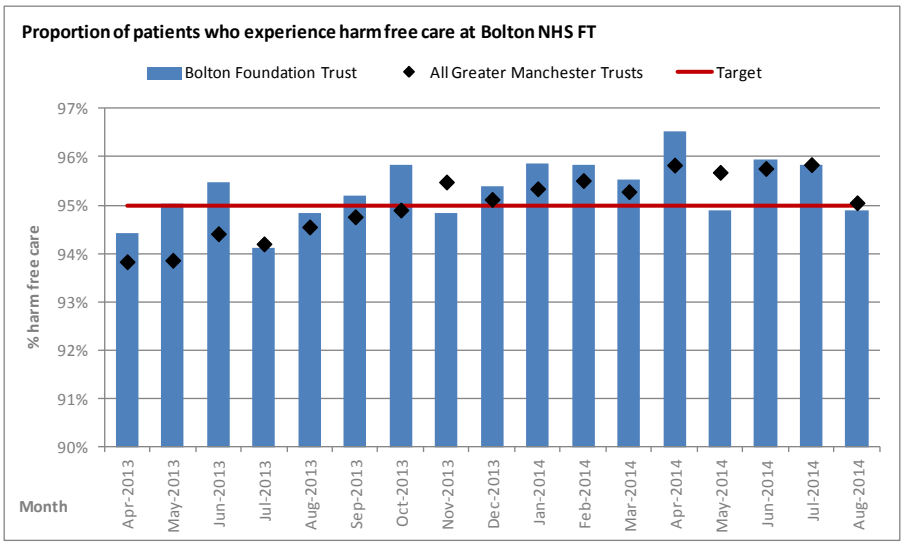
Chart 17 – emergency admissions due to falls and fall related injuries



L4. Proportion of patients who experience harm-free care
Objective: to increase

Chart 18 shows the proportion of patients who experienced harm-free care at Bolton NHS FT between April 2013 and August 2014. This measure is taken from the NHS Safety Thermometer, which records the presence or absence of four harms: pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter, new venous thromboembolisms (VTEs). The target, set nationally, is to achieve 95% harm-free care. Chart 18 also shows the monthly harm-free care achievement for all Greater Manchester Trusts combined.

Chart 18 – Patients experiencing harm-free care at Bolton NHS FT



L5. Number of longer term care packages
Objective: to decrease

Data to follow

L6. Number of people in receipt of personal budgets or personal health budgets
Objective: to increase

Data to follow

L7. Percentage of people receiving reablement or intermediate care at the point of discharge
Objective: to increase

Data to follow

L8. Percentage of people finishing Intermediate care or reablement who have a reduced package of care
Objective: to increase

Data to follow

L9. Percentage of people finishing reablement or intermediate care who have no package of care
Objective: to increase

Data to follow

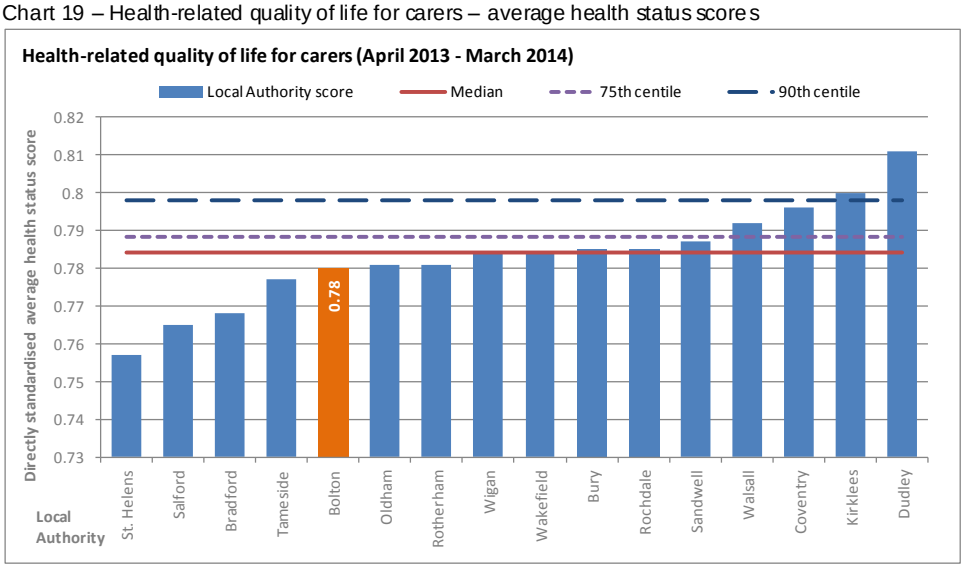
L10. Health-related quality of life for carers

Objective: to increase

Chart 19 shows the latest available health-related quality of life scores for Bolton CCG and its statistical peers, taken from the 2013/14 GP Patient Survey. Bolton had the fifth lowest score out of the 16 statistical peer organisations.

The score has been relatively consistent over the last three years: In 2011/12 Bolton scored 0.786, in 2012/13 the score was 0.792 and in 2013/14 Bolton's score was 0.78.

Chart 19 – Health-related quality of life for carers – average health status scores

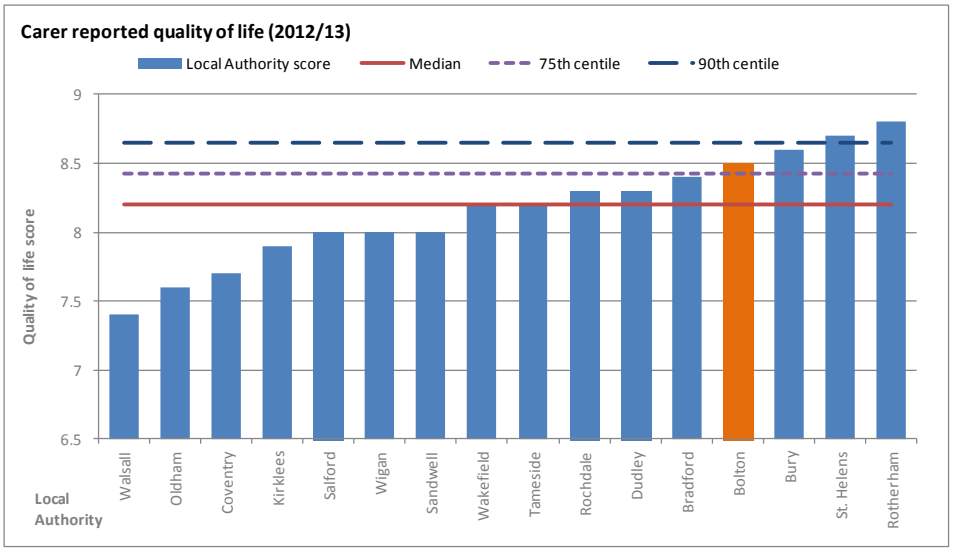


L11. Carer reported quality of life

Objective: to increase

Chart 20 shows quality of life scores for carers in Bolton, as reported in the biennial carers' survey. In 2012/13, when the survey was last carried out, Bolton had the 4th highest scores among it statistical peer organisations.

Chart 20 – Care reported quality of life

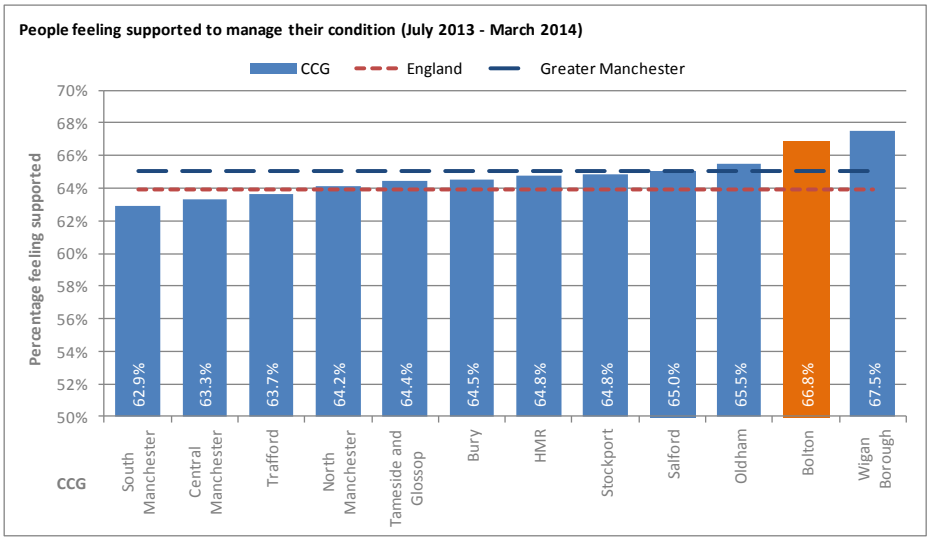


L12. People feeling supported to manage their condition

Objective: to increase

Chart 21 shows the percentage of people who answered "yes" to the following question in the GP Patient Survey:
"In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?"
Bolton CCG had the second highest proportion of patients responding positively (66.8%) when compared across Greater Manchester CCGs. This measure has been relatively consistent over the last three years.

Chart 21 – proportion of people feeling supported to manage their condition

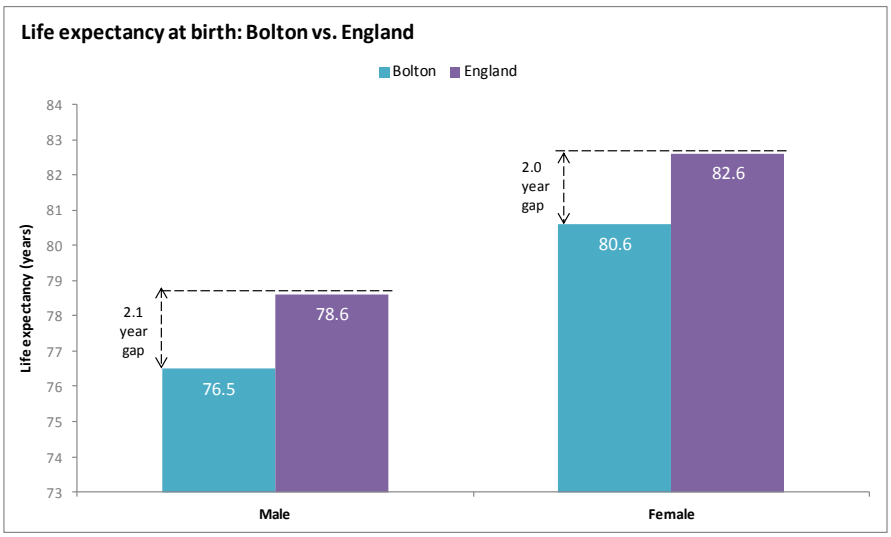


L14. Reducing the gap in life expectancy between Bolton and the England average

Objective: to decrease

Life expectancy in Bolton is currently 76.5 years for men and 80.6 years for women. The gap in life expectancy between Bolton and England now stands at 2.1 years for men and 2.0 years for women. Chart 22 illustrates this gap between Bolton and England.

Chart 22 – Life expectancy at birth – Bolton vs. England

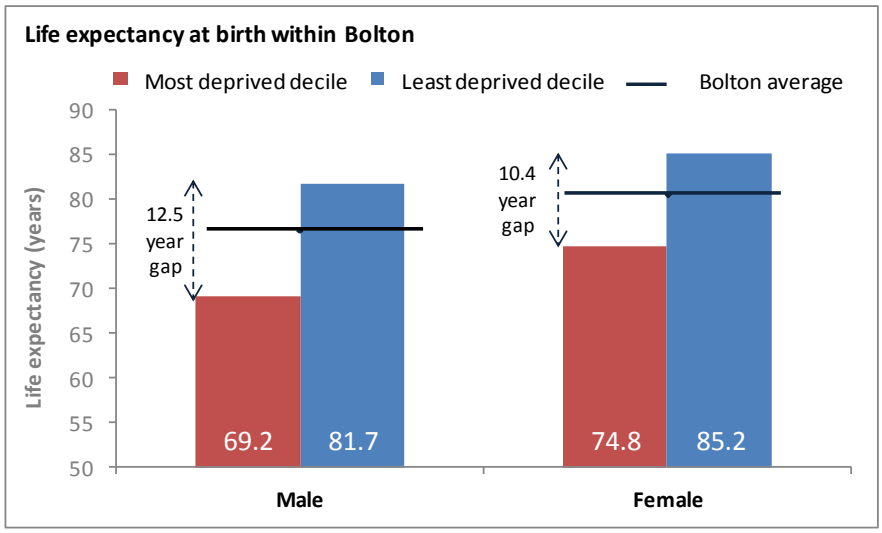


L15. Reducing the gap in life expectancy across Bolton

Objective: to decrease

Within Bolton there is a significant gap between the most deprived and least deprived areas. The most deprived decile in Bolton has a life expectancy of 69.2 years for men and 74.8 years for women. The least deprived decile in Bolton has a life expectancy of 81.7 years for men and 85.2 years for women. This is a gap of 12.5 years for men and 10.4 years for women, as illustrated in chart 23.

Chart 23 – Life expectancy at birth – gap within Bolton



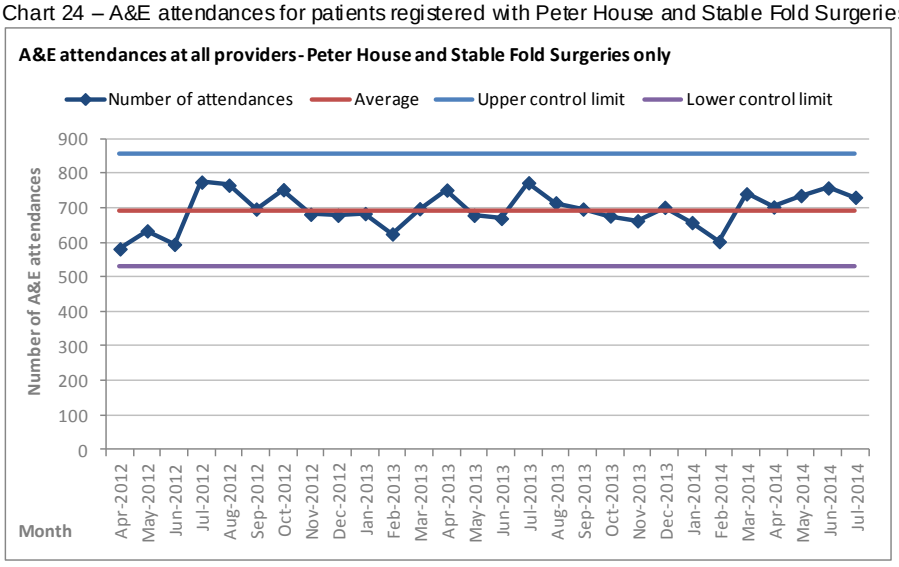
Key Performance Indicators – Westhoughton

This section looks at the GP practices in Westhoughton, where the first phase of the rollout of integrated neighbourhood teams has taken place.
These indicators are very high level and as such it may be some time before any impact is seen.

A&E attendances

Chart 24 shows the number of A&E attendances for patients registered with Peter House Surgery and Stable Fold Surgery in Westhoughton. In recent months there has been a relative increase in the number of A&E attendances, in line with the 2% increase year to date (April – July) compared with the same period last year which has been seen Bolton wide.

Chart 24 – A&E attendances for patients registered with Peter House and Stable Fold Surgeries

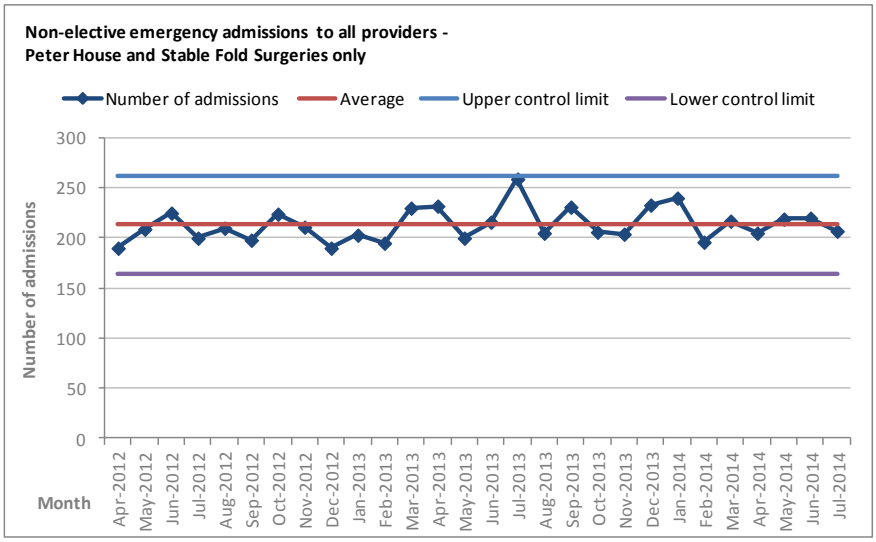


Emergency admissions

Chart 25 shows the number of emergency admissions for patients registered with Peter House Surgery and Stable Fold Surgery in Westhoughton. Although the trend appears to be relatively steady, there was an increase of 6% between 2012/13 and 2013/14, which is in line with the increase seen across Bolton as a whole.

In recent months the trend has been relatively steady and does not mirror the increase seen across Bolton as a whole. However it should be noted that these practices have historically had relatively low rates of admissions when compared across all GP practices in Bolton.

Chart 24 – Emergency admissions for patients registered with Peter House and Stable Fold Surgeries

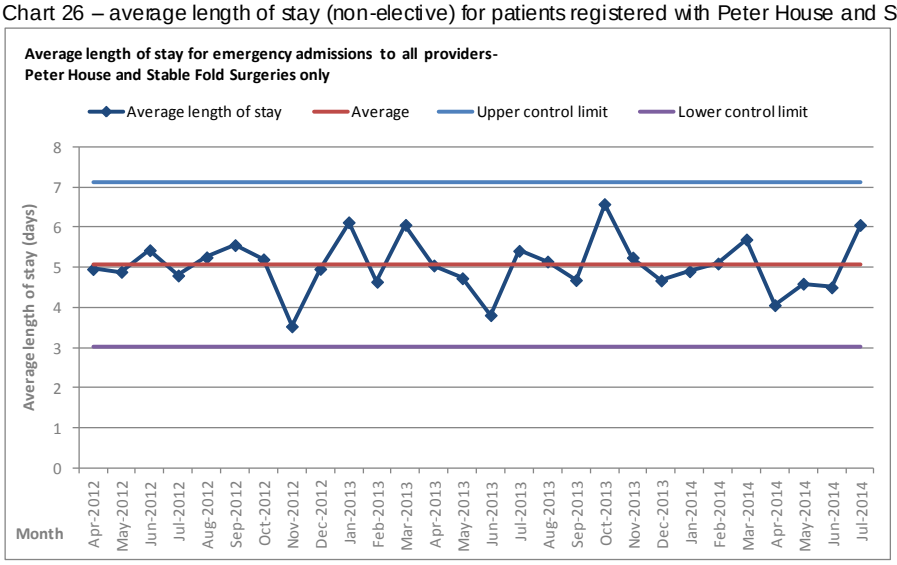


Non-elective length of stay

Chart 26 shows the average length of stay for non-elective emergency admissions for patients registered with Peter House Surgery and Stable Fold Surgery in Westhoughton. This decreased in April to June 2014, which is in line with the Bolton wide position, however it increased again in July.

Please note however that average length of stay for a population of this size will be much more sensitive than the average length of stay for Bolton as a whole; one patient with a long length of stay has the potential to skew the average length of stay considerably.

Chart 26 – average length of stay (non-elective) for patients registered with Peter House and Stable Fold Surgeries



KPI Definitions

L1. Avoidable emergency admissions

The avoidable emergency admissions measure is a composite measure of four categories:

- Chronic ACS conditions (adults), including:
  - COPD/ emphysema
  - Atrial fibrillation and flutter
  - Heart failure
  - Asthma
  - Angina
  - Epilepsy
  - Diabetes
  - Anaemia
  - Bronchiectasis
  - Hypertension
- Acute conditions not normally requiring admission (adults), including:
  - Urinary tract infections
  - Pneumonia
  - Gastroenteritis
  - Cellulitis
  - Convulsions
  - Gastro-oesophageal reflux disease (GORD)
  - Viral intestinal infection
  - Tubulo-interstitial nephritis not spec as acute or chronic
  - Tonsillitis
  - Volume depletion
  - Cutaneous abscess, furuncle and carbuncle
- Children with lower respiratory tract infections (LRTIs), including:
  - Bronchiolitis
  - Pneumonia
  - Influenza
- Asthma, diabetes and epilepsy in under 19s

GM2. 30 day emergency readmissions

The following exclusions apply to the 30 day readmissions KPI:

- Excludes spells with a primary diagnosis of cancer
- Excludes spells with an obstetrics HRG
- Excludes patients aged under 4
- Excludes patients who self-discharged from the initial admission
- Excludes spells which do not have a national tariff

Where a readmission rate is shown, the following exclusions apply to the denominator:

- Excludes spells which do not have a national tariff
- Excludes patients aged under 4
- Excludes spells where the patient died.

Data Sources

KPI	Data Source	Comments
Better Care Fund Indicators		
BCF1. Emergency admissions	Monthly Activity Return (MAR)	
BCF2/ GM4. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Adult Social Care Outcomes Framework (ASCOF)/ Bolton Council	
BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital in to reablement/ rehabilitation services	Adult Social Care Outcomes Framework (ASCOF)/ Bolton Council	
BCF4. Delayed transfers of care (total number of delayed days)	Unify	
BCF5. Overall satisfaction of people who use services with their care and support	Adult Social Care Outcomes Framework (ASCOF)	
BCF6. Referrals to home based intermediate care	National Audit for Intermediate Care (NAIC)	
Greater Manchester Indicators		
GM1. A&E attendances	Patient Level SLAM/ SUS	
GM2. 30 day emergency readmissions	Patient Level SLAM/ SUS	
GM3. See BCF2.	-	
GM4. Increasing the percentage of people that die in their usual place of residence.	ONS, via National End of Life Care Intelligence Network	
Local Indicators		
L1. Avoidable emergency admissions	Patient Level SLAM/ SUS	
L2. Average length of stay (non-elective)	SUS	
L3. Reducing the number of admissions due to falls and fall related injuries (over 65s)	Patient Level SLAM/ SUS	
L4. Increasing the proportion of patients who experience harm free care	NHS Safety Thermometer	
L5. Reducing the number of longer term care packages	Bolton Council	Definition tbc
L6. Increasing the number of people in receipt of personal budgets or personal health budgets	Bolton Council	Definition tbc
L7. Increasing the percentage of people receiving reablement or intermediate care at the point of discharge	TBC	
L8. Increasing the percentage of people finishing Intermediate care or reablement who have a reduced package of care	Bolton Council	Awaiting SALT return
L9. Increasing the percentage of people finishing reablement or intermediate care who have no package of care	Bolton Council	Awaiting SALT return
L10. Improved health-related quality of life for carers	HSCIC/ GP Patient Survey	
L11. Improved carer reported quality of life	HSCIC/ Carers' survey	
L12. People feeling supported to manage their condition	HSCIC/ GP Patient Survey	
L13. See BCF5.	-	
L14. Reducing the gap in life expectancy between Bolton and the England average	Public Health Intelligence Team	
L15. Reducing the gap in life expectancy across Bolton	Public Health Intelligence Team	

Section 10
Organisational Objectives

Bolton CCG			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Reduce A&E attendances for Bolton patients across all providers	Reduce by **2.7%** in 2014/15 compared with 2013/14	Target	8,078	7,951	7,782	8,395	7,641	7,395	7,632	7,301	7,563	7,223	6,922	8,202	32,207
		Actual	8,060	8,595	8,380	8,327									33,362
Reduce emergency admissions for Bolton patients across all providers *(BCF payment for performance target)*	BCF target to reduce by **3.5%** from 2014 to 2015	Target	2,746	2,517	2,331	2,600	2,379	2,532	2,730	2,619	2,740	2,738	2,505	2,730	10,194
		Actual	2,845	3,021	2,773	2,975									11,614
Reduce 30 day emergency readmissions for Bolton patients across all providers	Reduce by **0.02%** in 2014/15 compared with 2013/14	Target	347	420	414	480	446	453	441	469	455	518	457	527	1,661
		Actual	520	552	537	473									2,082
Sustain average non-elective length of stay for Bolton patients across all providers	Sustain average non-elective length of stay at **4.8** days	Target	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8
		Actual	4.68	4.93	4.56	4.94									4.78

Bolton Council		Quarter 1 (Apr - Jun)	Quarter 2 (Jul - Sep)	Quarter 3 (Oct - Dec)	Quarter 4 (Jan - Mar)	YTD
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (effectiveness of the service)	78.5% in 2013/14. This is a decrease compared to 85.9% in 2012/13.					
Delayed transfers of care from hospital per 100,000 population	6.6 in 2013/14. This is an improvement (decrease) from 6.9 in 2012/13.					
Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	1.9 in 2013/14. This is an increase from 0.9 in 2012/13.					
Improving people's experience of integrated care	This is a new measure for 2014/15, therefore no baseline data is available.					

Bolton NHS Foundation Trust		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Reduce average length of stay at the FT														
Reduce 30 day emergency readmissions to the FT														
Reduce A&E attendances at the FT														
Reduce emergency admissions to the FT														
Reduce the mortality rate														
Reduce hospital acquired infections at the FT														
Improve the Friends and Family scores for inpatients at the F														
Improve the Friends and Family scores for A&E at the FT														

Greater Manchester West Mental Health Foundation Trust		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
tbc														
tbc														
tbc														

Section 11

Glossary of Terms	
MDT	Multi Disciplinary Team
GP	General Practitioner
GSF	Gold Standard Framework
CPN	Community Psychiatric Nurse
MH	Mental Health
BCCG	Bolton Clinical Commissioning Group
BMBC	Bolton Metropolitan Borough Council
BFT	Bolton Foundation Trust
GMW	Great Manchester West
BCF	Better Care Fund
INT	Integrated Neighbourhood Team
BMs	Measurement of blood glucose
OPA	Out Patient Appointment
DN	District Nurse
BD	A type of Insulin
ICU	Intensive Care Unit
IT	Information Technology
CCG	Clinical Commissioning Group
ISA	Information Sharing Agreement
GMCSU	Greater Manchester Commissioning Support Unit
OOH	Out of Hours
NWAS	North West Ambulance Service
IM&T	Information Management and Technology
RGNs	Registered General Nurse
FT HR	Foundation Trust Human Recourses
DDO	Divisional Director of Operations
SRG	System Resilience Group
FAQs	Frequently asked questions
NHSPS	NHS Property Services
COPD	Chronic Obstructive Pulmonary Disease
ACS	Ambulatory Care Sensitive
SLAM	Service Level Agreement Monitoring – data source for hospital activity at Bolton NHS Foundation Trust
SUS	Secondary Users Service – data source for hospital activity at any provider other than Bolton NHS Foundation Trust
ONS	Office for National Statistics
HSCIC	Health and Social Care Information Centre