Bolton Council

Greater Manchester West Mental Health NHS Foundation Trust

Bolton NHS Foundation Trust

Bolton Clinical Commissioning Group

Bolton Health & Social Care Integration

Monthly Report

November 2014

Index

Section 1 - Bolton Health & Social Care Integration Programme

Bolton, like the rest of the UK is seeing people live longer but this means that more people are living with multiple and complex health conditions. This is placing increasing financial strain on local health and social care services making them unsustainable for the future. Demand for services is increasing while budgets are remaining the same or falling. If nothing is done to address this, services in the near future will begin to buckle under the strain of this increasing demand.

Nationally, **50%** of all GP appointments and **70%** of inpatient bed days are taken up with caring for people with long-term conditions and locally a high proportion of the total health and social care budget is spent on looking after a small proportion of Bolton people – often older people with the most complex needs.

Many of the hospital stays currently taken up with caring for older people with long-term conditions could be avoided altogether if these people were better able to manage their health with the appropriate support. A review of UK hospitals found that generally 50-60% of hospital beds are occupied with patients that could be better cared for at home or community settings.

If even a small percentage of GP visits and hospital stays were avoided by supporting people at home or in the community, this would release funding so that more community and home-based care services could be developed that keep people independent, well and out of hospital. This will allow our hospitals to focus on providing high quality intensive support for those who really need it.

NHS Bolton CCG together with Bolton Council, Bolton NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust are making a number of changes to local health and social care services to make them more joined up and better coordinated for the benefit of Bolton people. We're also introducing new services to make health and care more personalised and to help keep people well, independent and in their own homes.

In Bolton, NHS organisations together with Bolton Council are committed to making changes that put Bolton people at the centre of our health and social care services to deliver a system that:

- Involves people in discussions and decisions about their care
- Helps people to make informed choices
- Supports people to remain healthy and independent
- Listens to peoples' wishes and hopes and puts these at the heart of decision making when planning support
- Communicates well among all professional involved in providing health and care services

Section 2 – Progress headlines Reconfiguration Workstreams

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. Four of the five operational work streams are in implementation phase (Intermediate Tier, Complex Lifestyles, Integrated Neighbourhood teams & Staying Well) and one is in planning phase (Care Coordination Centre) Project plans and progress monitoring are in place.

The development of phase 2 of Integration commenced 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.

Integrated Neighbourhood Teams

The Integrated Neighbourhood team have moved in to offices at Great Lever but work on telephony and IT is still in progress. 2% register lists have been received from 4 practices and a list of patients from a 5th practice is to be sent for the INT to prioritise. Work has progressed on analysis of the lists to understand which patients are existing users of health and social care services or may be known to secondary care mental health. An induction for the team took place on the 7th November and individual team members have been assigned to practices and will introduce themselves to practices and begin working with the practice on the lists. The team will begin to visit practices the week beginning 10th November. Members of the programme team have been visiting practices and have received a very supportive response to the Integration work A draft specification has been sent to providers for comment.

Complex Lifestyles

Urban Outreach are continuing their work with four of the six practices participating in the initial phase. Bolton Community Practice has contacted all 18 patients on their list. 10 declined and 7 agreed to take part in the service. Urban Outreach has met 6 patients so far and currently has 7 open clients on their list. Meetings took place at Beehive Surgery on 5th November and Garnett Fold on 6th November. The risk stratification tool has been used to identify the complex lifestyle patients but three of the four practices have disagreed with the list and feel GPs would be better able to identify the patients based on face to face contact and understanding the patient history. UO have planned to use a combined approach going forward and will request 10 patients from each practice as well as use the risk stratification list.

Intermediate Tier Services

Workforce plans and Health consultation documents for the Home, Bed Based and Admission Avoidance services have been completed. A staff consultation relating to the integration of health and social care staff has been planned and due for launch on the 19.11.2014. Estates planned moves have been proposed to enhance integration and co-locate teams, this will also require joint IT solutions and requirements have been submitted to the programme team. Recruitment to enhance the current Admission Avoidance Service is taking place and includes additional Registered General Nurses, Occupational Therapists, Physiotherapists and Social Care Navigators. A number of roles have been appointed to and staff are awaiting to commence in post. Temporary staffing are supporting the current service with community admission avoidance referrals increasing by 15% from September to October 2014.

The Integrated discharge function and progression of the medical model is being led by Bolton NHS Foundation Trust in collaboration with the Local Authority and CCG. Regular patient satisfaction/experience is being undertaken and reported in the performance dashboards now

available monthly. A patient story has been submitted to the programme team for use in reports and communications updates.

Collaborative working with Tailor Train is taking place with regards to enabling a single point of access to be made available for services via the Care Co-ordination Centre. Process mapping of referrals into and from Intermediate Tier Services has been completed.

Care Coordination Centre

TailorTrain has met with Intermediate Tier service leads to map the referral and access routes into and from Intermediate Tier Services with regards to facilitating a single point of access for services within the care co-ordination centre. Feedback from the session highlighted the complexity of the current referral processes particularly with regards to Reablement within the Home Based pathway.
Tailor Train has also undertaken site visit to existing Single Point of Access (SPA). Mapping has been sent back to Clinical and managerial leads for validation.

TailorTrain provided a technical review of the existing SPA at water's meeting health centre and it was noted the current service was already well advanced in comparison to other areas. Included in the TailorTrain brief is a review of resources (hardware, telephony and staff) that will be required to manage referrals is required.

TailorTrain have requested an update meeting and CCG commissioners will attend to provide input and commissioning perspective. No decisions have been made about bringing in other services as yet. A high level scoping exercise of all the services has been carried out but no decision has been reached. TailorTrain have confirmed that Intermediate Tier services would be operational by end of 2014.

Funding for Care Co-ordination Centre identified as a Scheme in the Better Care Fund-while this will address redesign work in the short term consideration needs to be given to recurrent running costs. The redesign of Social Care in accordance with the requirements of the Care Act will have an impact on the original timescales proposed in the Programme Plan. The development of the Early Intervention and Prevention Service Staying Well will inform the decisions as to which elements of Social Care are accessed via the Care Co-ordination Centre.

Staying Well

Staying Well Team Leader interviews have been completed and two individuals were suitable but require a second interview before final appointment is made. Further GP engagement visits are to be completed in collaboration with the Integrated Neighbourhood Team project lead where there is an overlap. The Project support officer post is being evaluated and Staying Well Training Programme is being developed

A review of the Staying Well Tool is planned and meetings will be held with preventative services to review the trigger questions. The community capacity building lead has been appointed and will start on 15th December

Better Care Fund

Bolton has received its letter from Dame Barbara Hakin on the 29th October 2014. The submission underwent a Nationally Consistent Assurance Review (NCAR) process and provided there are no material changes in circumstance and the 15/16 Mandate is published as expected, the plan has been classified as 'Approved with Support' once the 15/16 Mandate has been published.

The review recognised that whilst the plan is strong a number of areas for improvement identified which once addressed will enable us to move to a fully approved status.

This category means that the plan will be approved and the BCF funding will be made available to Bolton subject to the following standard conditions which apply to all BCF plans:

That the agreed actions from the NCAR are complete in the timescales agreed with NHS England
The Fund is used in accordance with the final approved plan and through a section 75 agreement;
The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year.

The programme team will coordinate a next phase of input into the BCF. The final submission is due 28th November 2015. A support meeting will be held with the GM LAT and the Integration leads to discuss items that require further support.

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

Section 3 - 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 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

- 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
- People living longer with multiple health conditions is placing financial strain on existing services

Section 4 Patient Story – Intermediate Tier Services

Jim is a 61 year old patient who was admitted to intermediate care bed based services from Royal Bolton CCU in September 2014. Jim's reason for admission was to increase mobility so as to make him independent and confident to return to his own home. On admission to intermediate care he was bed-bound.

Jim has had several previous hospital admissions with heart problems and a poor history of taking medication. Jim can usually get about on crutches but immediately before admission he had been bed bound and had not been out of bed since his hospital admission.

Jim is known to the district nursing teams as he requires regular compression bandaging for his leg ulcers. He does not receive community physiotherapy or any other regular health support. He had contact numbers for health services should he need them.

Jim has lived in a hostel for the past twenty years and has a private carer who attends to his personal care, shopping, medication and meals. Jim also has a social worker. He has had previous admissions to intermediate care prior to this admission and was familiar with the services and the staff at the care home.

On initial arrival Jim was welcomed by 3 staff, and shown to his room. Staff offered him a drink and he was given a tour so he knew where the bathroom and lounge were.

Jim saw a Doctor on his first day and a physiotherapist the following day. He was supported to stand and took 2 steps with support. He continued with his physiotherapy and progressed to walking with crutches from his room to the lounge and bathroom with support of someone behind for confidence.

Jim attended the MDT meeting with his carer and was included in decisions about his future care and his own goals were considered. Jim wanted to get better and be able to get a taxi to stay over with his friend every week from Friday to Monday.

Here are some of Jim's thoughts about his stay in Intermediate Care

It's been perfect here and I mean it from the bottom of my heart

The staff are very good especially Mandy

I get a cup of tea when I want – even at night

The food is nice here and the cooks are good

Not a bad thing to say

Section 5 - Staff Story Intermediate Tier Services

I would just like to take this opportunity to share mine and my staffs' view of the changes made to intermediate tier services. From my point of view as a Registered Manager of a residential intermediate care unit I was previously isolated and had little support or guidance from my previous management team. Within the Unit we did work as a team but didn't understand the pressures of requirement each provider had.

The last year has been busy and a lot of hard work has been required. However I have never known my team to be as enthused as they are today. I believe the support, guidance and expertise of our current senior managers has assisted me in re-focussing and understanding the requirements we need to evidence the fantastic work that's carried out.

We have new team boards which display our achievements. It showcases our success and staff are proud to be part of this. Our first friends and family test evidenced 100% of service users and their families would recommend our services. We have a clear understanding of both NHS and council requirements and are working together to ensure we as a team achieve out joint goals. We still have a way to go but it's an exciting journey that my team and I are all proud to be a part of this new and improved intermediate tier service.

Thank you

Section 6 - Workstream Milestone updates 01/11/14 – 07/11/14

Service Transformation workstream updates

Complex lifestyles	Overall Rating	Sept 2014	Oct 2014	Nov 2014

Activities to complete

Monitor patient consultation by UO key worker, i.e. patient profile, number of patients, outcomes and where possible evaluation.
Complete consent process with patients identified as part of complex lifestyles cohort
Continue IG completion in line with new documentation to be issued by Bolton Council

Lessons learnt

A significant proportion of Bolton Community Practices risk stratified patients declined taking up the complex lifestyle service - when compared to other practices. Further investigation is required to understand the reasons for this, perhaps evaluating the conversation with patients and how the service is offered. In addition to this further evaluation of the patients identified by the risk stratification tool would also be beneficial. It was agreed at an operational meeting on the 6th November that UO would take a combined approach to identifying patients going forward to ensure the correct service users are in receipt of the service.

Key Milestones October - November 2014	Date	RAG Rating	Mitigating Actions
Sign off of provider contract and service spec	In progress		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.
Completion of first phase evaluation	15/12/14		

Care Coordination Centre (CCC)	Overall Rating	Sept 2014	Oct 2014	Nov 2014

Key Milestones November – December 2014	Date	RAG Rating	Mitigating Actions
Finalise list of services from health & social care to be accessed via the care coordination centre	28/11/14		
Agree & ratify timetable to incorporate services into the CCC	12/12/14		
Present capacity report for Care Coordination Centre to IM&T and Estates workstreams	19/12/14		

Integrated Neighbourhood Teams		Overall Rating	Sept 2014	Oct 2014	Nov 2014
Key Milestones November 2014	**Date**	**RAG Rating**	**Mitigating Actions**		
Community Assessment Officers in post aligned to GP practices	01/10/14		Minimal impact on service delivery. BMBC are continuing to advertise posts. Programme team are monitoring progress.		
Full Access to organisation systems to record patient information	01/11/14		Access to a system for GMW staff is still in agreement and will be picked up at IMT workstream 07/11/14. GMW have produced an example of an ISA which has been signed for social care access to GMW's system. Agreement needed for GMW staff to access care first.		

Intermediate Tier		Overall Rating	Sept 2014	Oct 2014	Nov 2014
Key Milestones October – November 2014	**Date**	**RAG Rating**	**Mitigating Actions**		
GP and medical model to be taken to CCG Executive	Date to be confirmed.		**Assurance from FT DDO has been received that a service is in place for GP cover of residential intermediate care and Darley Court. Work is on-going at the FT to establish a new medical model going forward. This is being picked up at the FT with the CCG and BMBC. The medical model will also include access to consultants for the home based pathway.**		
Estates group to discuss draft options for team location proposals	15/10/14		Estates workstream are considering all options and plans being formulated to link in with INT hub locations, other service moves and the wider estates strategy for Bolton. A date to move teams to a new location has been requested from the Estates workstream Lead.		
Remaining beds removed from Winifred Kettle	31/10/14. Revised date 03/12/14		Closure delayed due to the requirement to increase the number of home based care packages by 18. Currently these have increased to 15 and are being monitored by the Head of Intermediate Tier who is liaising with the programme team. A plan and regular meetings are in place to oversee the closure of beds.		

Staying well	Overall Rating	Sept 2014	Oct 2014	Nov 2014

GP SLA and honorary contracts are being drawn up.
Team to begin review of information sharing agreements

There has been agreement with in the staying well programme to separate the proactive and reactive services. Individual plans will be drafted and the proactive element monitored by the programme team

Clarification is required on what the Over 75 checks patient offer includes. This will determine whether Staying Well include over 75 patients.

Need confirmation whether Staying Well need to develop their own information sharing agreements or will this be covered by an overarching Integration agreement.

Key Milestones November 2014	Date	RAG Rating	Mitigating Actions
Review of patient lists	17/11/14		Coordination needs to take place at the CCG to make all list requests with GPs. Project lead for INTs has been drafted as an information document for GPs to understand the reasons for information requests and how information will be used.
Agree Impact assessments	24/11/14		
Sign off of information sharing agreements	01/12/14		
Practice briefing meeting complete	01/12/14		
Launch new integrated tool	08/12/14		

Enabling workstreams

Performance Monitoring	Overall Rating	Sept 2014	Oct 2014	Nov 2014

Analysis workshop has been arranged for 10th November, to discuss KPIs and outcome measures for integration. The outputs from this workshop will inform the content of the monthly performance report. High level objectives agreed for CCG, Council and GMW. Bolton FTs high level objectives for the monthly performance report are still to be confirmed.

2% high risk population lists have been requested from 7 practices which are participating in the next phase of the rollout of INTs. Lists have been received from 4 practices. Further work is required to address IG concerns from the remaining practices.

The lists have been shared with Bolton Council in order to flag the patients on CareFirst so that they can be directed to the right services. Meeting held with Bolton Council performance/ information colleagues to discuss KPIs. Further discussions will take place at the analysis workshop on 10th November.

Intermediate tier dashboard to be developed to include key assurance measures for the CCG exec team. Amendments to the performance report following feedback from the Integration Board.

Key Milestones November – December 2014	Date	RAG Rating	Mitigating Actions

Communications and engagement	Overall Rating	Sept 2014	Oct 2014	Nov 2014

Toolbox suite of communications products under development to include graphically designed:

- public summary intended to sit across all four partner websites (for approval)
- summary PowerPoint presentation
- summary on a page
- frequently asked questions
- web content
- Update and engagement with ETAG patient/public group on 13 November
- Communications and Engagement workstream now meeting fortnightly
- Draft communications plan in place with accompanying programme of communications activity, action plan and products

Key Milestones October & November 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	05/12/14		In progress
Prepare PowerPoint presentation for use by senior managers with staff	05/12/14		In progress
Prepare set of FAQs to help get consistent messages	05/12/15		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	Sept 2014	Oct 2014	Nov 2014

Workforce recruited for INT and in progress for Intermediate Tier and Staying Well. New workforce needs to be recruited for the Care Home service which is in progress. Providers to commence recruitment to April 2015 BCF-funded schemes subject to receipt of letters of comfort from the CCG.

Induction Programme for INT prepared for delivery on 7th November. First draft of Competency Framework for INTs developed for discussion at workforce sub-group on 7th November. This will inform the development of a comprehensive workforce development plan for INTs. Fortnightly team development workshops have been scheduled for the Great Lever co-located team.

Intermediate Care at Home workforce consultation scheduled to commence on 19th November. Delivery of relevant content of INT Induction to be cascaded to DNs borough-wide to facilitate their engagement with the team at Great Lever.

Key Milestones November 2014	Date	RAG Rating	Mitigating Actions
Agree workforce training requirements in accordance with workforce plans - EOL Care, Frailty, Dementia, LTC management	12/12/14		
Deliver core training package in process of assessment and personalised care planning for phase two INT	19/12/14		

Finance and Contracting	Overall Rating	Sept 2014	Oct 2014	Nov 2014

Key Milestones September 2014	Date	RAG Rating	Mitigating Actions
Confirm funding for all staff for 2015/16	11/11/14		A letter of comfort has been sent to GMW from CCG. An additional letter for the FT is being drafted following discussion between FT and CCG finance teams.
Develop a S75 agreement, including risk sharing arrangements with all providers	28/02/15		
Develop and agree a contract model for integrated services	28/02/15		

Estates	Overall Rating	Sept 2014	Oct 2014	Nov 2014

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 and other service estate requirement. With support from NHSPS the estates group will begin development of a Borough wide estates strategy.

A second workshop is to be held in December 2014 with the INT from Great Lever to determine staff requirements

for future IM&T hubs.

Key Milestones September 2014	Date	RAG Rating	Mitigating Actions
Preparation of Great Lever health centre for INT	01/11/14		Space prepared.
Deliver Estates request protocol to be shared with all workstream leads	14/11/14		Estates team to provide protocol and defined process for all estates requests going forward to ensure
Prepare plan and timetable for move to support colocation of Intermediate Tier home based reablement service	05/12/14		Request is being reviewed at estates operational group w/c 10/11/14. Estates group will oversee all requirements to ensure move is delivered. Estates have advised that all teams follow due process with any estates requests due to engagement and other issues with services or teams displaced due to these moves.

IM&T and IG	Overall Rating	Sept 2014	Oct 2014	Nov 2014

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 November 2014	Date	RAG Rating	Mitigating Actions
Appointment of Interim IT manager	30/10/14		An informal meeting is taking place 11/11/14. GB to provide update. IT manager now in post 17/11/14
Support to Integrated Neighbourhood teams to ensure connection to appropriate network and systems and equipment is in place for Great Lever	01/11/14		Delay due to tight deadlines. IM&T workstream meeting to identify solution for GMW members of the INT and access to appropriate system. Interim solutions in place to support team.
Support to Intermediate Tier home based reablement service to ensure connection to appropriate network and systems and equipment is in place for Pikes lane	TBC		Awaiting approval of estates request. Key tasks to be discussed and any issued raised at regular IM&T workstream meetings

Updated 10/11/14

Section 7 - 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.

No real increase in emergency admissions

Between April and September 2014 there were 16,978 emergency admissions for Bolton patients. In the same period last year there were 15,879 emergency admissions. However, when the number of admissions to the Bolton Community Unit (BCU) is added back in to the 2013 baseline year the number of admissions is 17,220, which equates to a 1.4% decrease year on year.

10% expected increase in over 65s

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.

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 – September 2014 the number of attendances has increase by 2.1% (1,009 attendances) when compared with the same period last year.

Increase in 30 day readmissions

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-September) the crude 30 day readmission rate was 9.5%. This is an increase from 8.7% in the same period last year.

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-September 2014) the average length of stay was 4.9 days.

Patients feel supported to manage their condition

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.

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.

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

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.

Updated 07/11/14 LT – Section 9 contains a series of charts to illustrate the key points above, as well a more comprehensive range of indicators.

Section 8 - Performance Report

Key Performance Indicators, including Better Care Fund metrics

KPI definitions

Data sources

Please contact Elizabeth Taylor (Integration Performance Lead) with any queries

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Better Care Fund metrics

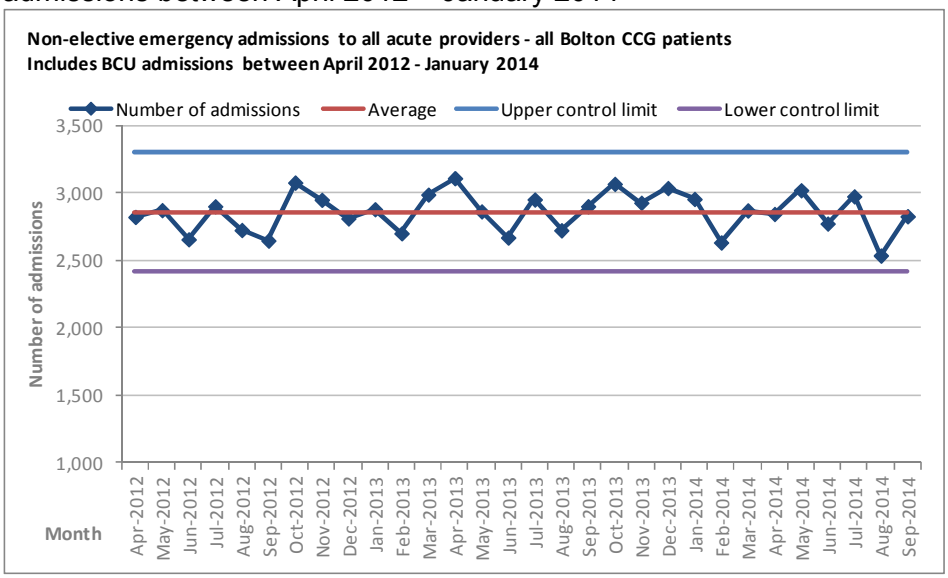
BCF1. Total emergency admissions

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 - Emergency admissions to all acute providers (all Bolton CCG patients), including BCU admissions between April 2012 – January 2014



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

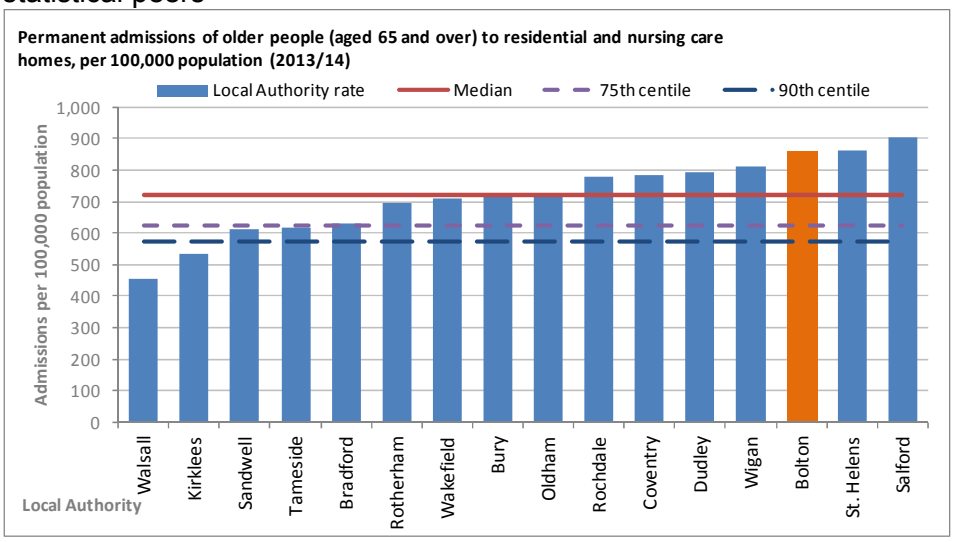


Chart 3 - Admissions to nursing and residential homes - trend over time and BCF ambitions

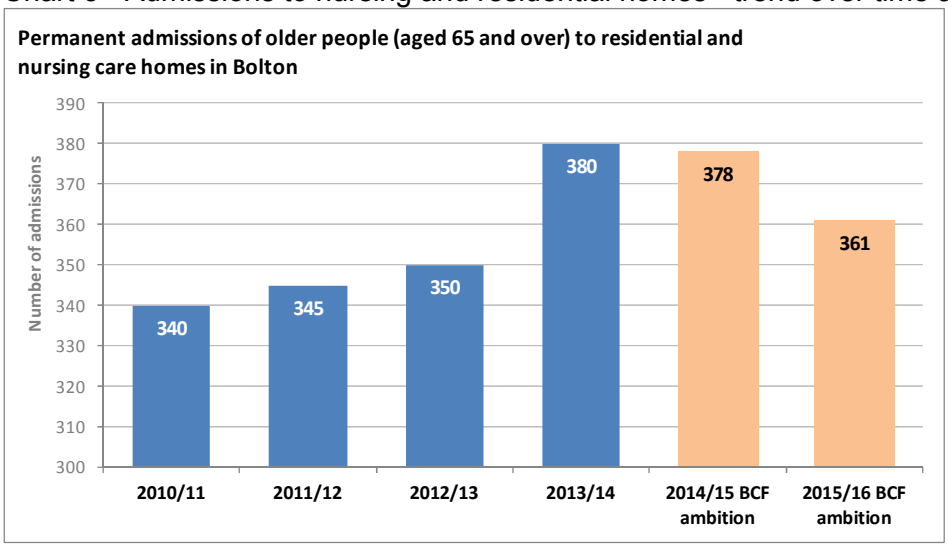


Chart 3 shows the number of permanent admissions to nursing and residential care homes over time from 2010/11 to 2013/14, along with the BCF plans for 2014/15 and 2015/16.

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

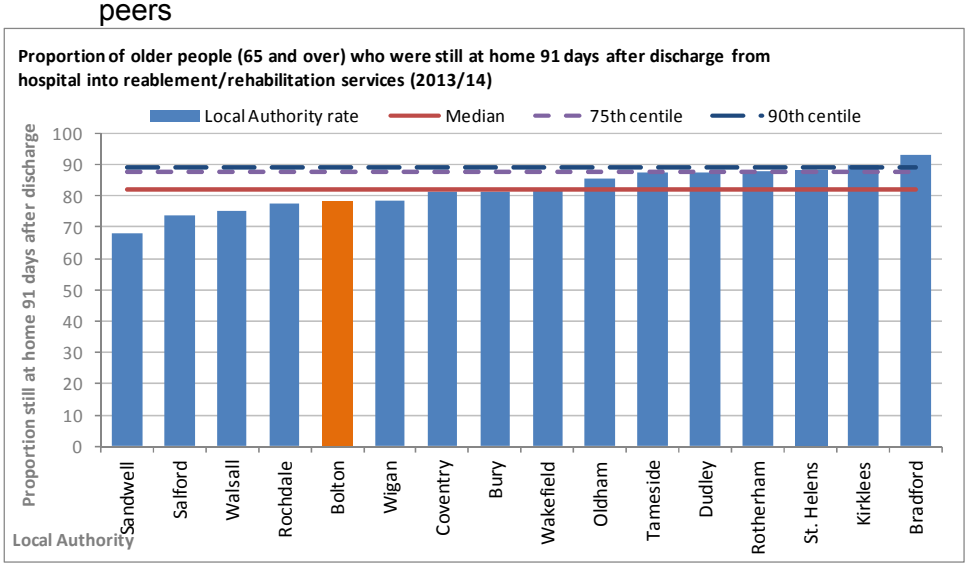
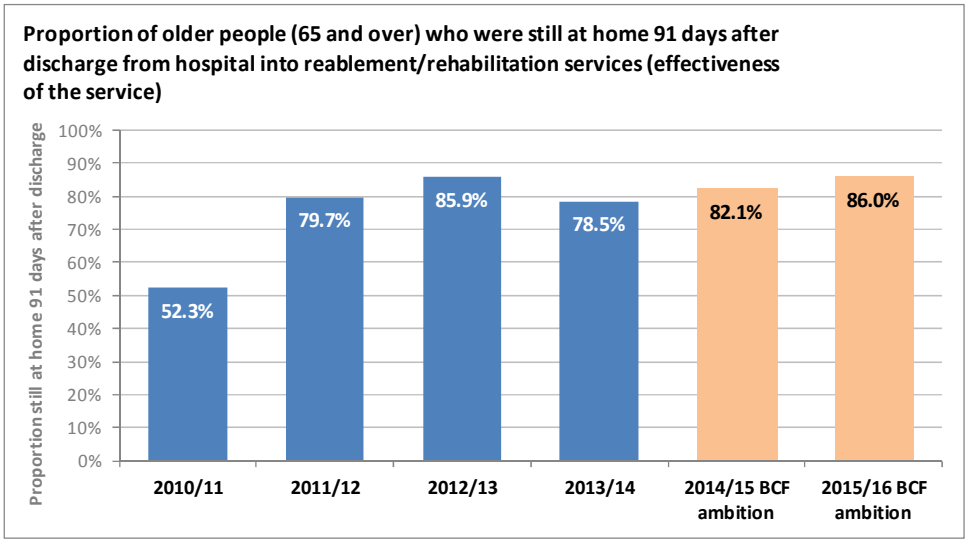


Chart 5 – Proportion of people still at home 91 days after discharge – trend over time and BCF ambitions

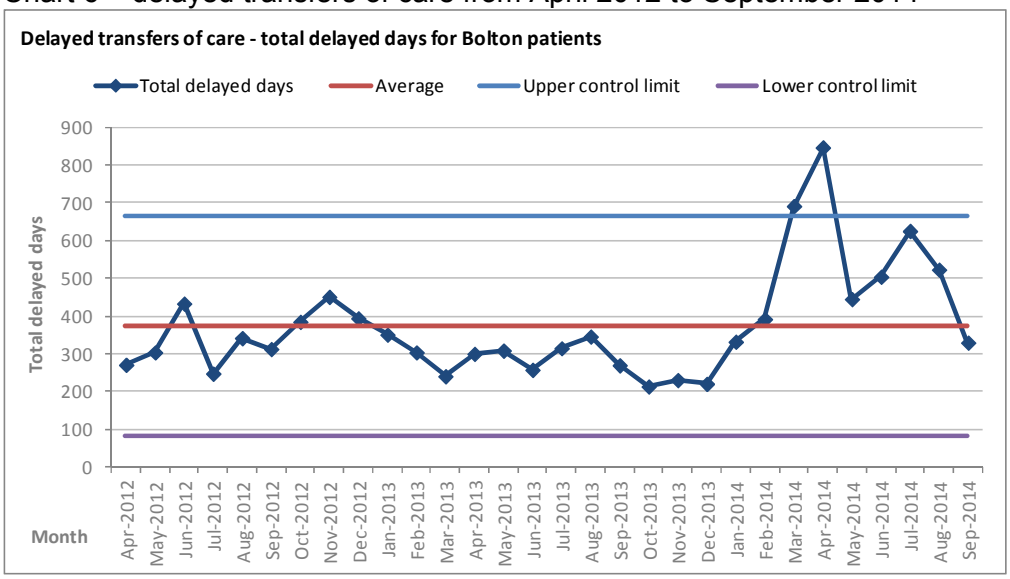


BCF4. Delayed transfers of care (total number of delayed days)
Objective: To decrease

Chart 6 shows the trend in the number of delayed days from April 2012 to September 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 6 – delayed transfers of care from April 2012 to September 2014

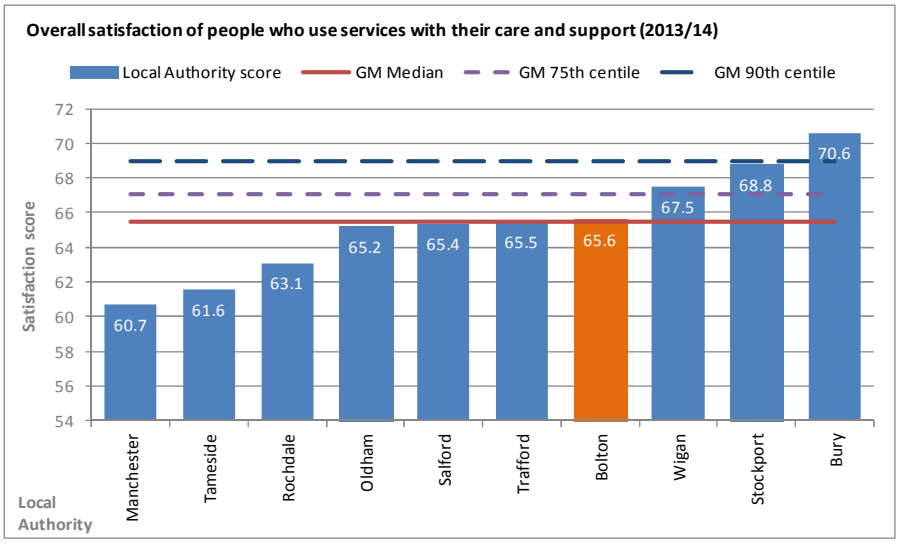


BCF5. Overall satisfaction of people who use services with their care and support
Objective: to increase

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 7. In the BCF submission, an ambition was set to reach 66.6% in 2014/15 and 67.6% in 2015/16.

Chart 7 - Overall satisfaction of people who use services with their care and support benchmarked across Greater Manchester



BCF6. Referrals to home based intermediate care

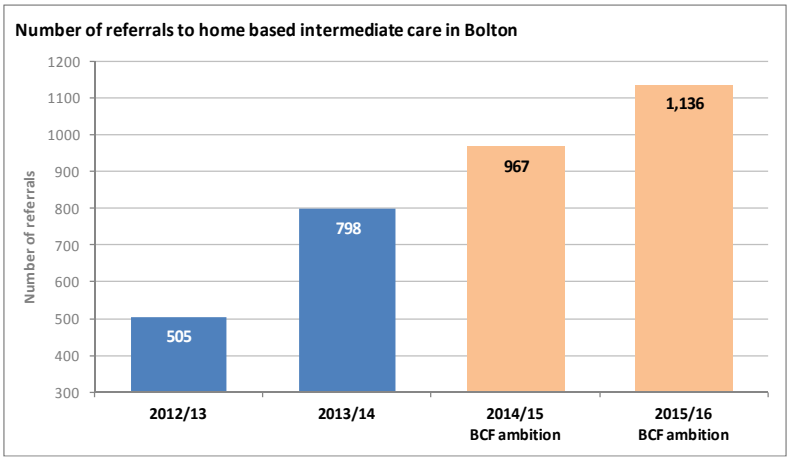
Objective: to increase

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 8 shows that significant progress was made in 2013/14 towards meeting this target.

Chart 8 – referrals to home based intermediate care



Greater Manchester and locally selected metrics

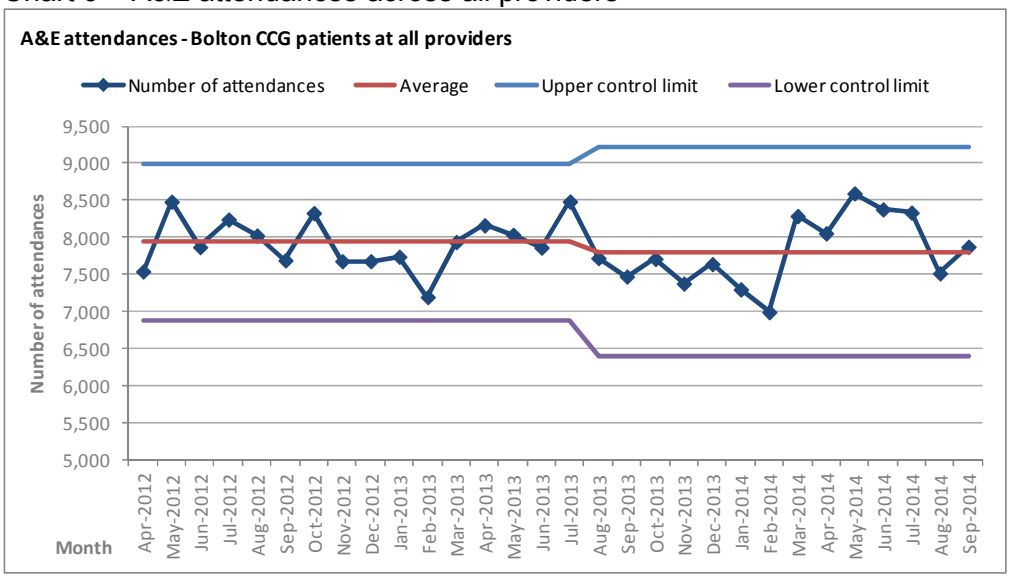
A number of further metrics have been identified across Greater Manchester and locally within Bolton.

GM1. A&E attendances
Objective: To decrease

Chart 9 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-September 2014 with the same period last year, there has been a 2.1% increase (1,009 attendances).

Chart 9 – A&E attendances across all providers



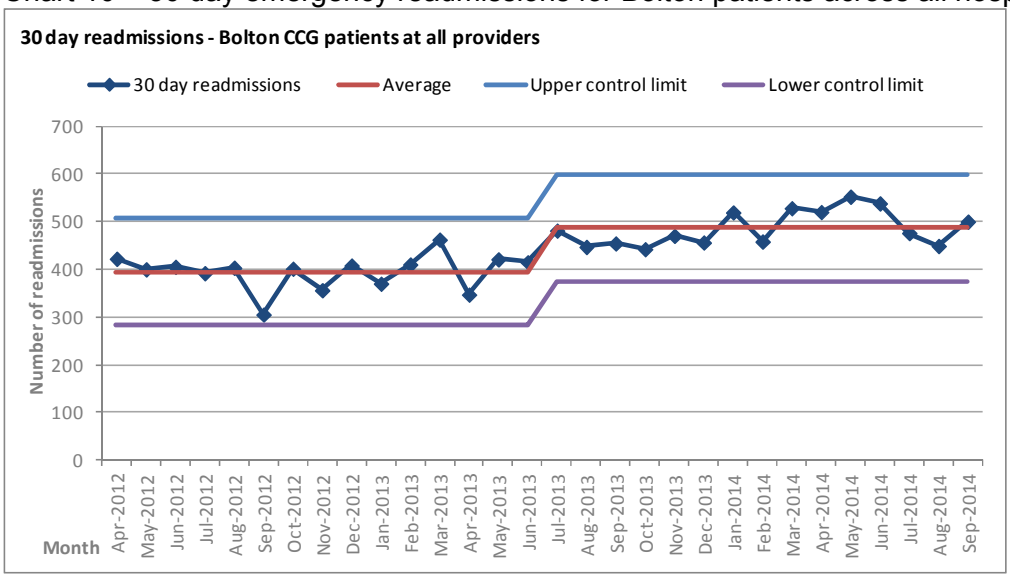
Further analysis of A&E attendances at Bolton FT, which accounts for 90% of all A&E attendances for Bolton patients, has identified some conditions where particular increases have been seen.

When comparing April-September 2014 with the same period last year, the number of attendances with gastrointestinal conditions has increased by 239 (+6.8%), attendances with poisoning (including overdose) have increased by 135 (+17.4%), attendances with muscle/ tendon injuries have increased by 111 (+10.5%) and attendances with ophthalmological conditions have increased by 94 (+10.8%).

GM2. 30 day emergency readmissions
Objective: To decrease

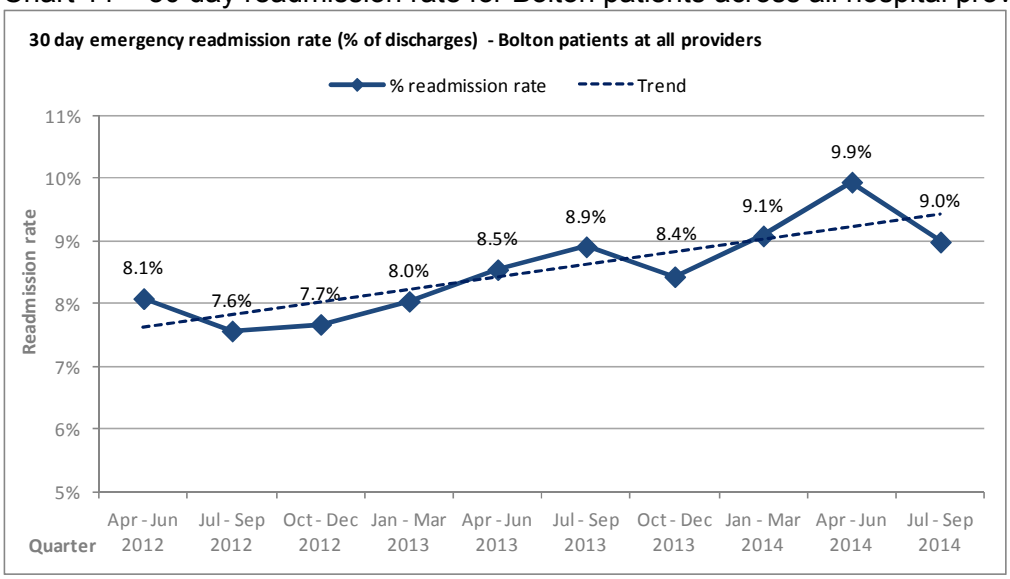
Chart 10 shows the number of emergency readmissions within 30 days of previous discharge (following an elective, day case or non-elective admission). There has been an increasing trend, which is also illustrated in chart 11.

Chart 10 – 30 day emergency readmissions for Bolton patients across all hospital providers



To provide some context to the number of readmissions, chart 11 illustrates the crude readmissions rate (readmissions as a percentage of all discharges) by quarter, from Quarter 1 2012/13 to Quarter 2 2014/15. This has increased steadily, particularly from January 2014.

Chart 11 – 30 day readmission rate for Bolton patients across all hospital providers



It should be noted that the number of readmissions shown in charts 10 and 11 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 12.

Chart 12 – Proportion of deaths in usual place of residence – benchmarked against statistical peers

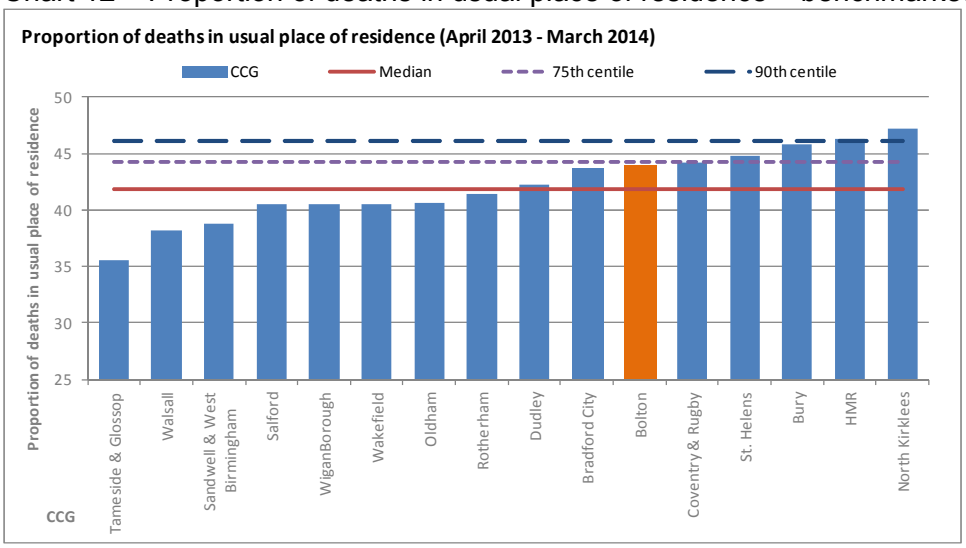
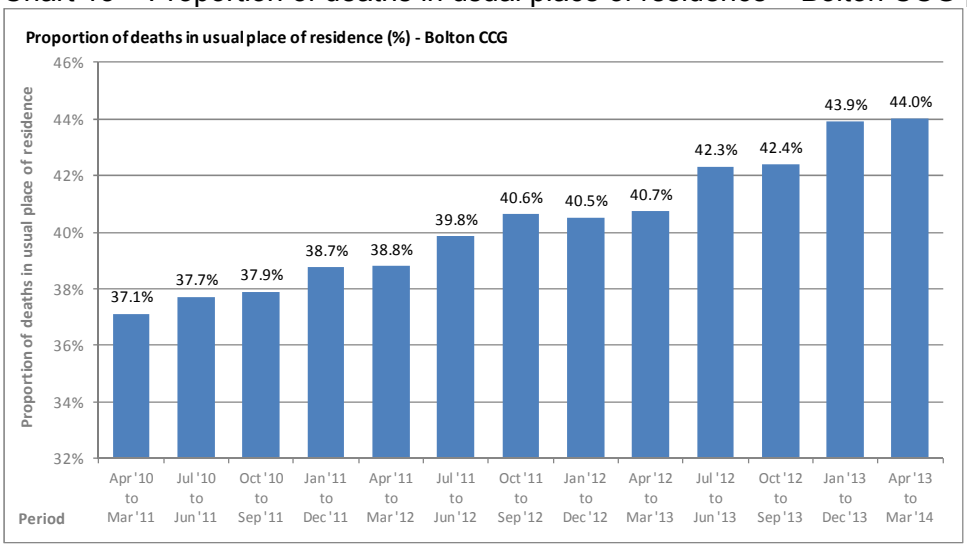


Chart 13 shows a rolling 12 month position for the proportion of deaths occurring in the person's usual place of residence in Bolton. There has been a steady increase from 37.1% in the year 2010/11.

Chart 13 – Proportion of deaths in usual place of residence – Bolton CCG patients



L1. Avoidable emergency admissions

Objective: To decrease

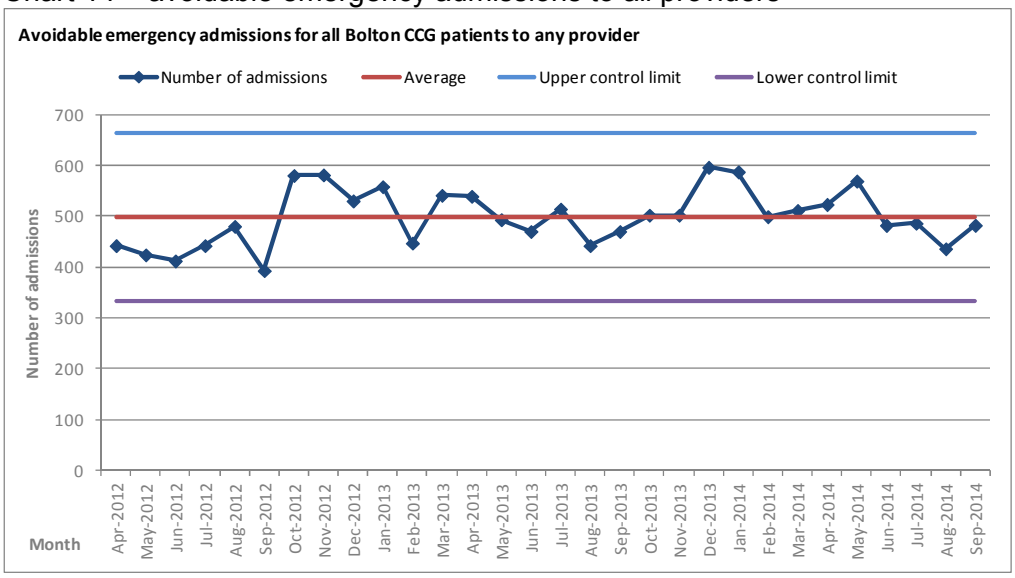
This is a composite measure of:

- 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 14 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 1.7% increase in April-September 2014 compared with the previous year.

Chart 14 – avoidable emergency admissions to all providers



Although an increasing trend is observed in chart 14 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.

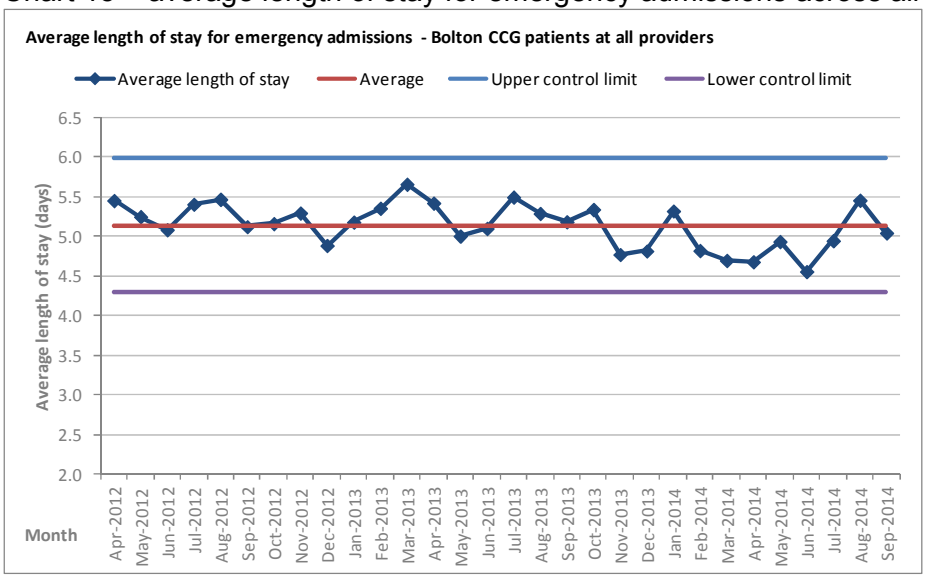
It should also be noted that the types of conditions which are included in this measure could in the past have been admitted to the Bolton Community Unit (see BCF1 Total Emergency Admissions).

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 15. For the 2014/15 year to date (April to September) the average length of stay for a non-elective admission was 4.9 days.

Chart 15 – 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

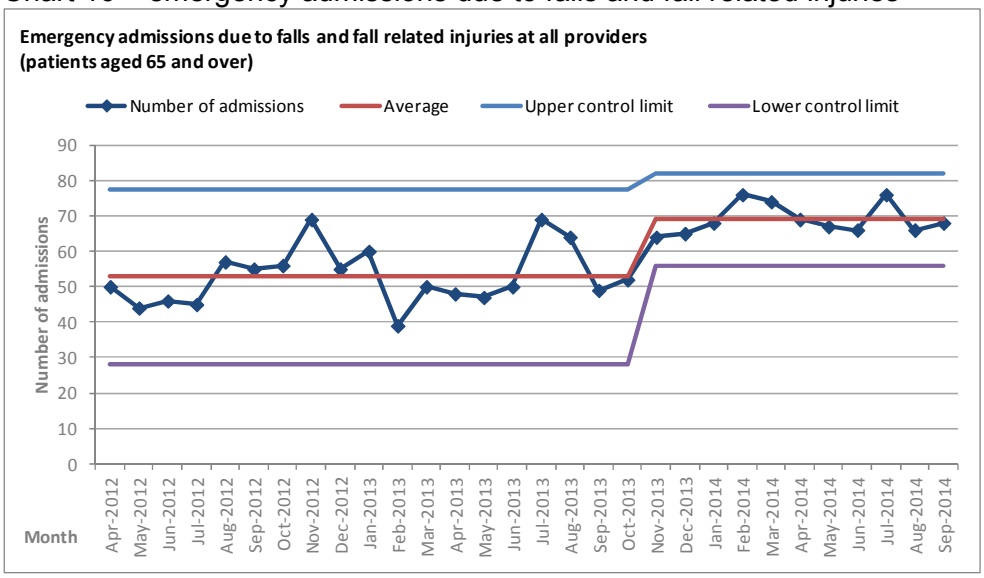
Chart 16 illustrates the number of emergency admissions for patients aged 65 years and over, to any hospital provider, with a fall related injury.

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 23.6%, from 656 (October 2012 – September 2013) to 811 (October 2013 – September 2014).

It should be noted however that the closure of the BCU (see BCF1 Total Emergency Admissions) may affect these figures.

Chart 16 – emergency admissions due to falls and fall related injuries

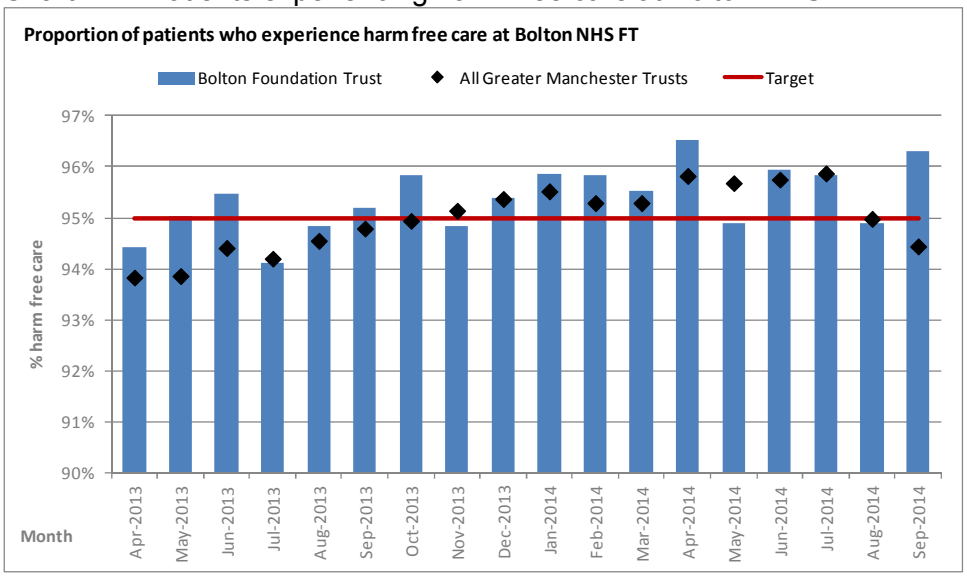


L4. Proportion of patients who experience harm-free care

Objective: to increase

Chart 17 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 17 also shows the monthly harm-free care achievement for all Greater Manchester Trusts combined.

Chart 17 – 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

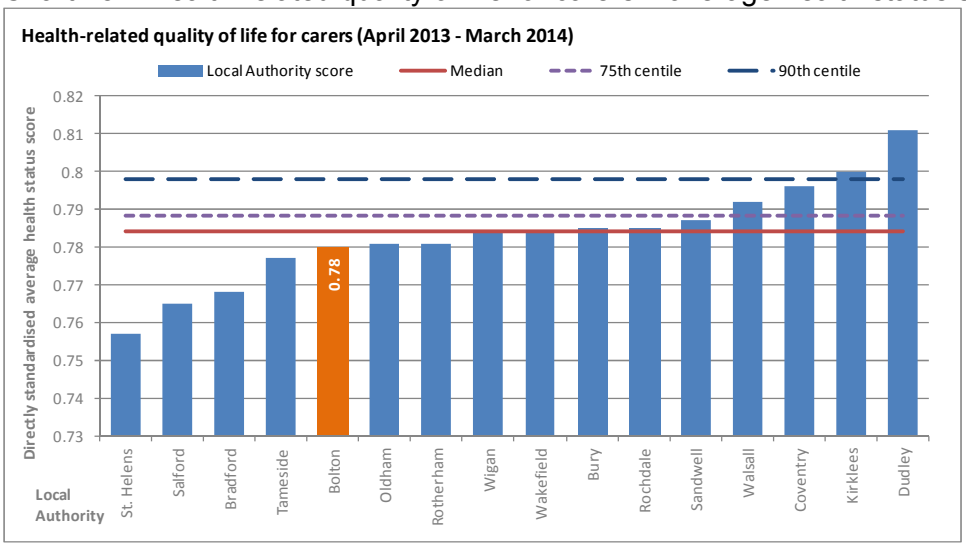
L10. Health-related quality of life for carers

Objective: to increase

Chart 18 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 18 – Health-related quality of life for carers – average health status scores

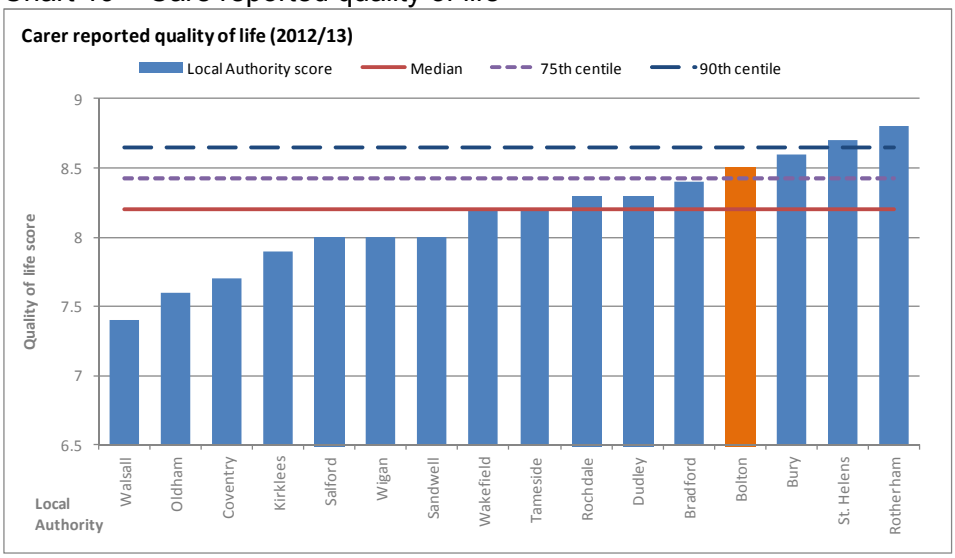


L11. Carer reported quality of life

Objective: to increase

Chart 19 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 19 – Care reported quality of life



L12. People feeling supported to manage their condition

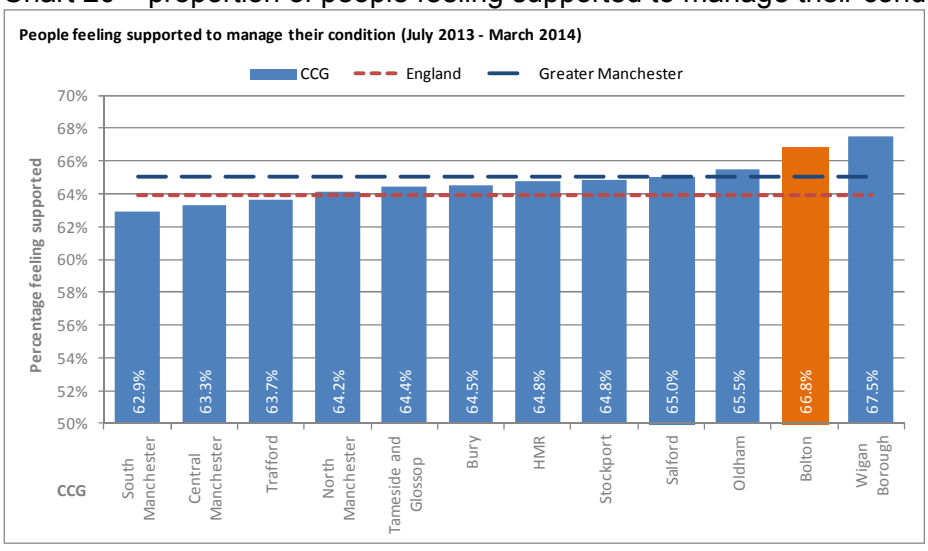
Objective: to increase

Chart 20 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 20 – proportion of people feeling supported to manage their condition

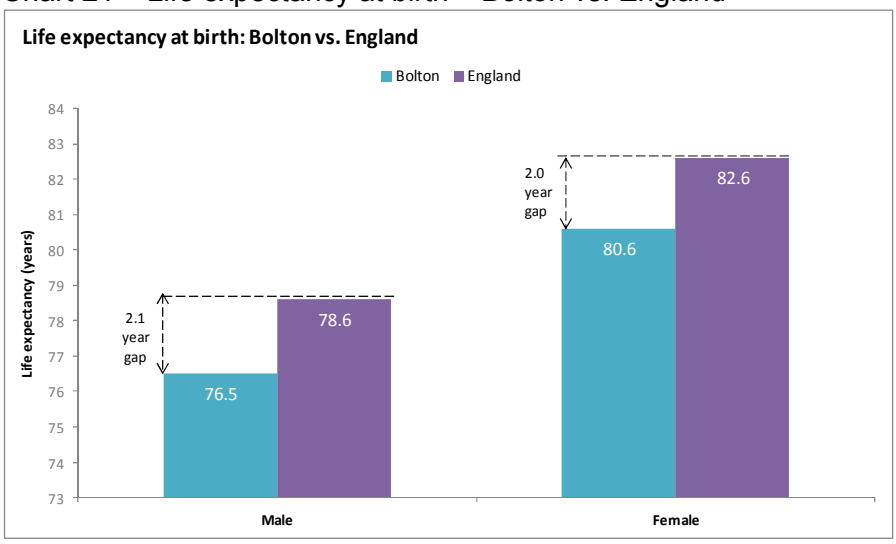


L14. Reducing the gap in life expectancy between Bolton and the England average

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 21 illustrates this gap between Bolton and England.

Chart 21 – Life expectancy at birth – Bolton vs. England

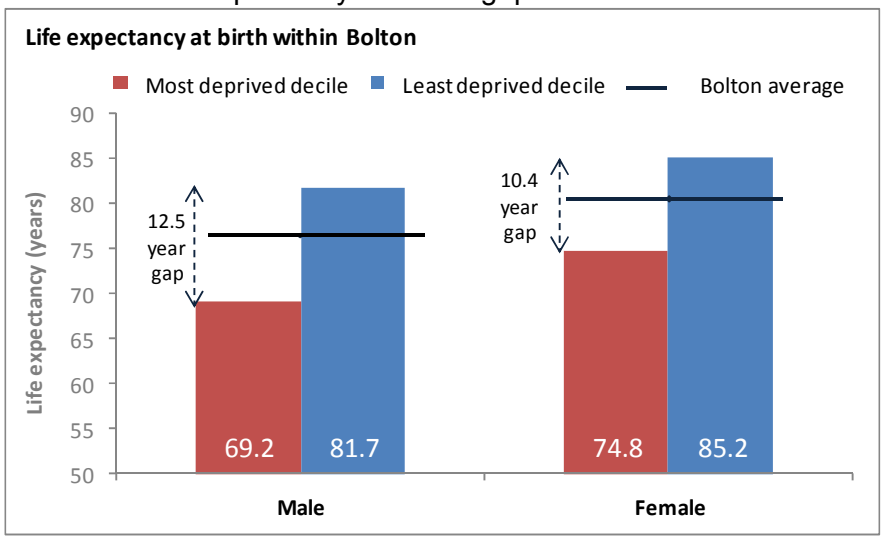


L15. Reducing the gap in life expectancy across Bolton

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 22.

Chart 22 – Life expectancy at birth – gap within Bolton



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 9 - 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