Bolton Health & Social Care Integration

Monthly Report

January 2016

Section 1 – Executive Summary

Overall Programme Update

Performance Summary

The following provides an overview of some of the key performance metrics:

- The data continues to show an under performance against the non-elective target in the month of November, as emergency admissions were 277 (9.9%) above the BCF Target. This brings the year to date admissions to 849 (3.8%) above the BCF annual target. Written confirmation of the remedial action plan requested from providers has not yet been submitted to the CCG through the Integration Delivery Group.

  GM benchmarking indicates that the rise in non-elective admissions is not unique to Bolton. Only 3 CCGs across Greater Manchester are achieving their BCF target. The BCF survey report for November 2015 identified that 80% of the CCGs who participated in the survey were not expecting to meet their BCF targets.

- The trajectory for achievement of the A&E target overall indicates that this target will not be delivered by year end following a further increase during November in A&E attendances; 462 (+6.2%) above plan. Performance against the year to date target is now negative as attendances are 536 (+0.9%) above plan.

Scheme Summary

The key highlights this month across the core and enabling work streams are:

- The Complex Lifestyles contract was awarded to Lifeline on 4th January 2016. Initial implementation meetings are taking place this month to agree an initial implementation plan, including engagement with key stakeholders.

- The pharmacy element of the Care Home project commenced on 1st October 2015 and is reportedly improving the quality of medicines optimisation in care homes. So far this has generated cost savings of approximately £21,000 (per annum) mainly due to a reduction in leg bags and catheters prescribing in one of the care homes. The provider is due to present their plans for roll out of the service, the service model and confirmation of their current activity across the care homes to CCG Executive on the 27th January 2016.

- Communications are planning a full launch of Integrated Services across Bolton. This will be followed by the establishment of a website, social media channels with video content, infographics and branded materials.

- The estates work stream is making good progress with the accommodation for all integrated neighbourhood teams across the 5 hubs. The provider has confirmed that the INT covering Hub 2 will move into their location at Waters Meeting within the next 4 weeks. The team will be fully co-located with District Nursing.

- Work has progressed to implement the Integrated Hospital Discharge Team which will operate across three of the complex care wards and provide discharge coordination 7 days per week. The service was due to commence on Monday 14th December but the update from the provider to Integration Delivery Group states that problems with recruitment has delayed the full implementation of this scheme.

- Work is in progress with NWAS to develop a deflection scheme for those patients proactively managed through the integration schemes who have an ABC Care Plan in place. This is due to commence later this month. The Admissions Avoidance Team is integral to this pathway, providing a rapid response to patients within 2 hours following a call from NWAS. The Care Home Service and the Integrated Neighbourhood Teams will contribute to this deflection scheme utilising the ABC Care Plans and through proactive follow-up of these patients.

  Crucial to the success of these schemes is the ability to share care plans across providers. Therefore work is also in progress to implement short term and longer term IT solutions which will enable the sharing of care plans across providers.

- The Intermediate Tier Home based pathway continues to see an increase in referrals and has again operated above their monthly target for referrals. Admissions to the bed based units also continue to rise and the bed based service has seen a reduction in their length of stay.

- For Staying Well the proactive visiting of clients continues to show an increase. However. despite the increase this month, the service remains below plan. The service has been asked by the CCG to produce a remedial action plan to increase the number of practices the service is working with and to increase the number of patients assessed.

- The range of Primary care initiatives recently approved by Executive will start to be rolled out from this month.

Issues

As noted there are significant concerns about current performance against BCF targets. There are a number of outstanding issues that need to be resolved by providers to include:

- The INTs continue to be significantly below the agreed trajectory despite some increase in the referrals received. The providers have been requested through Integration Delivery Group to provide a written Remedial Action Plans to outline what steps are going to be taken to improve engagement with GP practices to increase appropriate referrals and what measures will be put in place to support the required increase in activity.

- The Staying Well service is 12% below plan for November with regard to the number of patients to be contacted as per the agreed plan. The service is also below the year to date target for clients visited (19%). According to their plan, the Staying Well

service should now be engaging with at least 25 GP Practices. Last month's report noted they are only involved with the original 11 that were included in the pilot. No further information has been submitted by the providers about how many GPs the service is now engaging with.

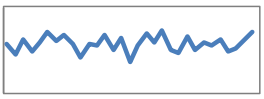
- The Care Home service has to date not submitted any information with regard to the number of patients they have developed a care plan for nor the number of GPs they are currently engaging with. The provider has been requested to submit this information to CCG Executive on the 27th January along with their agreed service model and pathways. The service has failed their targets for this month and is significantly below the year to date target.
- Recruitment and retention continues to be an issue which is monitored fortnightly through the Integration Delivery Group.

Section 2 – Performance Headlines

National Indicators

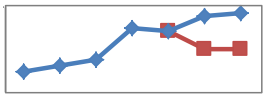
Emergency admissions (Bolton CCG patients, all providers)

The Better Care Fund target is to reduce the number of emergency spells by 3.5% in 2015/16 compared to 2014/15. In the month of November, the number of emergency admissions was 277 (+9.9%) above target. Year to date (Apr-Nov) the number of emergency admissions was 849 (+3.8%) above target.

In Month (Nov)		YTD (Apr-Nov)		Trend from Apr13-Nov15
Target	Actual	Target	Actual	
2,791	3,068	22,110	22,959	

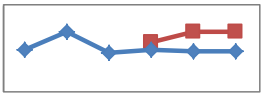
Permanent admissions of older people to nursing and residential care homes

There was an increase in the number of permanent admissions of older people to nursing and residential care homes when comparing Q2 2015/16 with Q1 2015/16 (rolling 12 month totals). The Better Care Fund target for this measure was to decrease the number of permanent admissions to residential and nursing care homes to 361 in 2015/16.

2013/14	2014/15	2015/16 Q1	2015/16 Q2	Trend (annual) - target in red
380	377	392	394	

Proportion of patients still at home 91 days after discharge from hospital in to reablement services

There was a decrease in the proportion of patients still at home 91 days after discharge from hospital in to reablement services in Q2 2015/16 compared with 2014/15. The Better Care Fund target for this measure was 82.1% in 2014/15 and is 86.0% in 2015/16.

2013/14	2014/15	2015/16 Q1	2015/16 Q2	Trend (annual) - target in red
78.5%	79.9%	79.1%	79.1%	

Delayed transfers of care (total delayed days)

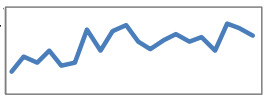
A Better Care Fund target has been set for this measure, which accounts for an anticipated increase in the number of delayed transfers of care due to more accurate recording. For the current year to date, the number of delayed days is significantly above plan. DTOCs this YTD are however lower than the figure for 2014/15 (by 514).

In Month (Oct)		YTD (Apr-Oct)		Trend from Apr13-Oct15
Plan	Actual	Plan	Actual	
308	863	2,193	3,138	

Note: due to a change in national reporting, this measure is one month behind others

Referrals to home based intermediate care

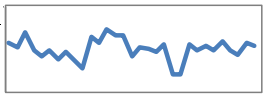
The number of referrals to home based intermediate care is 1,048 for the current year to date (Apr-Nov). This is 36.6% higher than the number of referrals in the same period last year (767 referrals).

In Month (Nov)		YTD (Apr-Nov)		Trend from Apr14-Nov15
Last year	This year	Last year	This year	
105	132	767	1,048	

Local Indicators

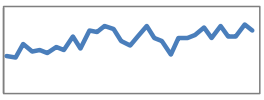
A&E attendances (Bolton CCG patients, all providers)

The CCG's 5 year plan target is to reduce the number of A&E attendances by 3.2% from 2014/15 to 2015/16. In the month of November, the number of A&E attendances was 462 (+6.2%) above plan. Year to date (Apr-Nov) the number of A&E attendances was 536 (+0.9%) above plan.

In Month (Nov)		YTD (Apr-Nov)		Trend from Apr13-Nov15
Plan	Actual	Plan	Actual	
7,408	7,870	61,958	62,494	

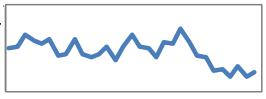
30 day readmissions (Bolton CCG patients, all providers)

The number of 30 day readmissions is higher when comparing Apr15-Nov15 with the same period in 2014. The readmission rate for this year to date (Apr-Oct) is 10.0%, which is slightly higher than the same period last year (9.8%).

In Month (Nov)		YTD (Apr-Nov)		Trend from Apr13-Nov15
Last year	This year	Last year	This year	
507	546	4,210	4,305	

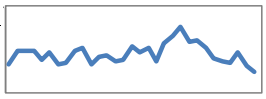
Non-elective average length of stay (Bolton CCG patients, all providers)

The CCG's 2015/16 plan target for average non-elective length of stay is 4.65 days. For the current year to date (Apr-Nov) the average non-elective length of stay is 4.33 days. The average length of stay for the same period in 2014/15 was 4.90 days.

In Month (Nov)		YTD (Apr-Nov)		Trend from Apr13-Nov15
Plan	Actual	Plan	Actual	
4.65	4.15	4.65	4.33	

Non-elective average length of stay (Bolton CCG patients, medical specialties at Bolton FT)

The average non-elective length of stay (for Bolton CCG patients) in medical specialties at Bolton FT is 4.02 days for the current year to date (Apr-Nov). This is slightly lower than the average length of stay in the same period last year (4.10 days).

In Month (Nov)		YTD (Apr-Nov)		Trend from Apr13-Nov15
Last year	This year	Last year	This year	
3.92	3.62	4.10	4.02	

Section 3 – Work stream Performance and Update

Intermediate Tier Services

Project Contribution to High level Outcomes (using agreed proxy metrics)

	Nov target	Nov actual	Year to Date target	Year to date actual
NEL reduction	**60**	**64**	**477**	**417**
A&E reduction	**81**	**98**	**644**	**659**

Intermediate Tier Services has continued to successfully develop with the additional Better Care Funding available since April 2015.

The majority of posts have been recruited to across Intermediate Tier Services and start dates are awaited for the final few which will provide maximum capacity to deliver the activity and outcomes that were originally benchmarked.

Admission Avoidance

Referrals to the Admission Avoidance Team remained high in November 2015 with 141, this correlates favourably with the national benchmarked monthly average in 2014 of 125 referrals. The numbers of referrals to the Admission Avoidance Team in Bolton have risen sharply from the baseline position of approximately 48 per month in 2014 to the current position as a result of transformational changes in the way the service operates and the funding that has been made available. Outcomes remain good from this service with low numbers admitted to long term care or indeed admitted to hospital following referral. There are a significant number, 33 in November 2015, referred each month to the Admission Avoidance Team in crisis following hospital discharge within the previous 30 days. Numbers have been rising of patients being stepped up into community intermediate care beds following referral to the Admission Avoidance Team due to increased availability of beds- there were 20 in November 2015, this has supported a reduction in the numbers being admitted to the hospital following referral to the Admission Avoidance Team of which there were only 4 in November. The average length of stay on the caseload remains constant at between 3 and 4 days. The team work closely with the home based pathway and patients are transferred as appropriate for ongoing support to maximise their potential for independence.

The rating of the service and patient satisfaction remains high with 100% rating the service as excellent in November 2015. The numbers of complaints are extremely low with none being reported for several months.

Robust pathways are in place with NWAS and Careline and referrals following falls are increasing from those two areas.

Home Based Pathway

The reablement and intermediate care at home teams work closely together and there has been an increase in the numbers of joint packages of care being provided. The numbers of patients benefitting from the home based services has increased throughout the year and in November this was a total of 246. The number of patients stepped down from the hospital to the home based pathway is still significantly more than those stepped up from the community as a result of the reduction in numbers of intermediate care beds, although GP referrals are increasing particularly into the reablement service. The average length of stay on the caseload remains constant at approximately 26 days and the outcomes remain good with low numbers admitted to long term care. Compliments remain high to the home based services with 46 being received in November 2015. Additional and final recruitment in January 2016 will support additional available capacity to support more patients at home.

The challenge remains regarding co-location of the intermediate care at home and reablement teams which would further support the development of the key worker role. A move to shared accommodation will enhance the joint provision of services with a single contact number for the home based and admission avoidance teams, estates and facilities are supporting the progression of this with scheduled fortnightly meetings.

Bed Based Services

The bed based services remain under constant pressure from both the hospital and community. Admissions to bed based services have remained higher than the national average throughout the year despite the additional capacity in home based services being made available. There were 95 referrals made in November to the bed based Units with 75 being admitted across both Units, the repeat referral rate was 32%. A review of the medical model may provide the opportunity for additional support to the home based services and the prevention of admissions to the Intermediate Care beds, this work is being progressed.

Since Laburnum Lodge successfully relaunched the criteria for the Unit and the Unit has in-reached into the hospital to identify the most appropriate patients likely to benefit from the facility this has enhanced the outcomes with far fewer patients being admitted to long term care. The service was rated as excellent by 100% of responding patients in November 2015. The average length of stay was 21 days in November which is slightly lower than the optimum but supports flow through the system.

Darley Court saw almost 50% step up and 50% step down split in referrals to the Unit for the first time, with the majority of step up referrals coming from the Admission Avoidance Team with a history falls and multiple long term conditions. The average length of stay in November was 24 days which is less than the optimum and was a result of the pressures and demand for Intermediate Care beds, there was also a rise in the number of patients

being admitted to long term nursing/residential care in November which may be related to the reduced average length of stay.

Patient satisfaction with Darley Court remains high with 100% of responding patients rating the service as excellent.

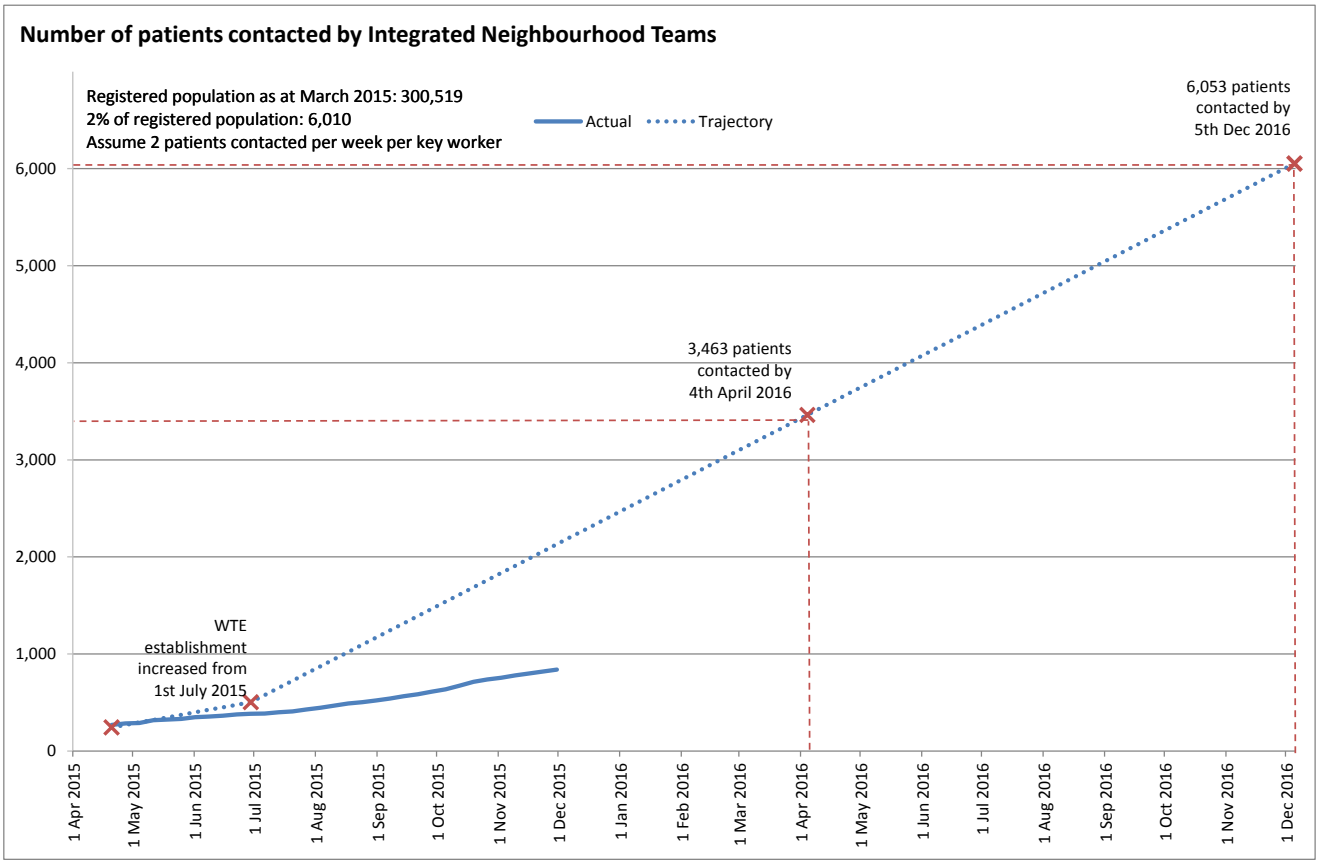
Integrated Neighbourhood Teams

Regular Provider Task Force meetings have continued, with the aim of overseeing an increase in referrals to the teams which have continued to be below the trajectory.

Work has commenced to identify alternative sources of referrals such as from the Acute setting and from Intermediate Care. Both of these settings see patients who would meet the criteria for ongoing intervention from the INT following their episode of acute care or rehabilitation.

All 10 practices who have confirmed their willingness to use the ABC Care Plan have been contacted in order to ensure these care plans are completed for their patients in receipt of the INT service.

The diagram below demonstrates the team's performance against the agreed trajectory up to the end of November 2015.



The integrated neighbourhood teams continue to be significantly off plan with regard to their agreed trajectory.

Care Homes

	Nov target	Nov actual	Year to Date target	Year to date actual
NEL reduction	**7**	**0**	**37**	**14**
A&E reduction	**11**	**0**	**55**	**20**

The Borough-Wide roll-out of the service has taken place in line with the implementation plan phasing. It is now anticipated that full roll-out will be complete by the end of March, four months earlier than originally planned.

The Team has been endeavouring to complete ABC Care Plans for all the residents that are seen by the team but the nurses have found that some GP practices have little or no awareness of the ABC Care Plans, so further communication and engagement with regard to the plans is required.

Capacity Planning is being undertaken to ensure that the balance between proactive and reactive work can be maintained throughout the year.

The Pharmacy element of the Care Home project commenced on 1st October 2015 with 1 x Whole Time Equivalent (WTE) Pharmacist and 0.5 WTE Pharmacy Technician working in the team.

The Pharmacist is currently undertaking medicines reviews on patients in Mill View, Shannon Court, The Withins and Four Seasons on patients referred by the Advanced Nurse Practitioners (ANPs).

The Care Home Pharmacy Technician is providing input on their re-ordering process and 'quick wins' at the Withins, Greenlands, the Old Vicarage and The Bungalow.

The team is improving the quality of medicines optimisation in care homes whilst so far generating cost savings of approximately £21,000 per annum mainly due to a reduction in leg bags and catheters prescribing in one of the care homes. They are working on draft Medicines Reconciliation Guidelines for new admissions.

Staying Well

Month	Target clients contacted	Actual clients contacted	Performance vs. target	Target clients visited	Actual clients visited	Performance vs. target
Apr-15	180	65	-64%	108	35	-68%
May-15	180	122	-32%	108	77	-29%
June-15	180	103	-43%	108	65	-40%
July-15	180	147	-18%	108	51	-53%
Aug-15	180	202	+12%	108	86	-20%
Sept-15	180	226	+26%	108	144	+33%
Oct-15	180	210	+17%	108	124	+15%
Nov-15	180	158	-12%	108	134	+24%

As we approach our first birthday of the Staying Well service, we demonstrate positive outcomes.

We have a dashboard capturing service data, and November saw an increase in service offer take-up to 85%.

New Practices from phases 3 & 4 are coming on-board and we plan for this to be a natural progression in line with the agreed roll out option.

Recruitment is underway for a Staying Well Coordinator and Supervisor.

Complex Lifestyles

The Complex Lifestyles contract was awarded to Lifeline on 4th January 2016. Public Health and Commissioning team have an initial implementation meeting planned for Friday 15th January 2016 where an initial implementation plan, including engagement with key stakeholders, will be agreed.

Section 4 – Enabling Work stream Summary

Performance Monitoring

Progress Update

Work on the development of the 'local' performance report for INTs, Intermediate Tier, Staying Well and Care Homes is almost complete. Some operational data is being received from the Local Authority and is being compiled into the report. A schedule for provision of future operational data for the board report has been agreed. Further work is needed to ensure this meets the requirements for the dashboard. A data group has been set up to discuss performance data on a regular basis. An investigation is taking place into setting up a patient level data set to be used for intelligence purposes.

Key Risks and Issues

If performance metrics require additional data manipulation to source then this will cause delay in the production of the performance metrics.

Key Activities to be completed next period

A meeting will take place between the CCG and LA to clarify provider level data being provided by the LA to ensure that the new dashboard becomes operational within the next month or two – once formalised this will feed into a monthly workstream performance dashboard.

Communications and Engagement

The communications plan has been updated to reflect communications activity around the new integration brand/identity, which will be launched to the public and our stakeholders in the coming weeks at an open event. A new website, social media channels, video content, infographics and branded materials will follow this launch, enabling us to boost the profile of integrated services with the residents of Bolton and the wider public.

A refreshed engagement plan is also being created to accompany the new branding, which will outline plans to increase the awareness of integrated services amongst our stakeholders – notably GP practices and patient forums.

The coming months will also see an annual report for integrated services being published, and the wider promotion of patient stories in the local press and online.

Workforce

A number of staff working within the Integrated Care schemes have now commenced educational programmes to prepare them for their new roles. This includes two members of the Care Home Team, who have commenced the Advanced Practitioner Masters level programme. These staffs have been backfilled so that service delivery is not compromised while they are at university.

Culture Club sessions for staff working within the Integrated Care schemes have continued and are booked in until the end of March. Further cultural transformation work will be undertaken in Darley Court at the request of the staff working there.

A meeting has been arranged with Health Education North West in February to take forward the wider roll-out of the Integrated Care workforce products that were showcased at the Workforce Demonstrator site event in November.

A demonstration of the WRaPT Workforce Repository and Planning Tool is to be rescheduled in February also.

Finance and Contracting

Progress Update

The agreed Pooled Budget for Integration is £30.8m for 2015/16. The release of £1.79m of the BCF into the Integration Pool is linked to the non-elective admissions reduction target, i.e., Pay for Performance (P4P) funding. This P4P funding will only be released into the Pool on a proportionate basis based on achievement of this target as set out in the BCF plan and in accordance with BCF Guidance.

At Q2 15/16 NEL activity was above plan and as a result no P4P income has been released into the fund during the quarter. Activity is unlikely to reduce to the anticipated levels during Q3 and therefore we are forecasting that there will be no additional P4P income released in the next quarter. Total unreleased P4P income is £1.7m reducing the Integration Pool from £30.8m to £29.1m.

The forecast expenditure was estimated at £28.4m for Month 8. The forecast underspend of £2.4m is mostly attributable to slippages in recruitment into new schemes, i.e. INTs and Intermediate Tier; and slippage within the budget for Primary Care Support.

However, due to the P4P element of the BCF not being released into the Pool, this underspend is reduced and we are forecasting an overall underspend of £767k.

Key Risks and Issues

Bolton continues to see an increase in NEL admissions. Integration schemes were not fully implemented due to slippages in recruitment and fragmented delivery on integrated services. In spite of various mitigating actions being taken, it is highly unlikely that the BCF NEL target will be achieved this year. This increase in NEL activity based on previous year's outturn will require close monitoring and management.

Key Activities to be completed next period

Analyse month 9 performance and expenditure.

Estates

The Integrated Community Services Division is working collaboratively with both the FT and LA Estates Teams and the Family Care Division within the FT, to make best use of the Community Estate.

Health Visitors have now moved out of Waters Meeting Health Centre, making space for the INT and the aligned DN Teams for Hub 2 to be co-located-this will be a big step forward.

It is anticipated that a similar piece of work can be undertaken for Hub 3, based on Crompton Health Centre.

Work has continued to redesign Winifred Kettle as the base for Hub 4.

The fortnightly meetings have continued to progress the work to facilitate the co-location of IMC at Home and Reablement at King St as an interim base.

These meetings will also oversee the co-location of the IV Therapy Team with the Admission Avoidance Team and the long-term co-location of all the Intermediate Care home-based services.

IM&T and IG

Progress Update

Detailed requirements for a short term and medium term solution have been articulated at a high level only.

Graphnet & MIG is used by the 3 Manchester CCGs for ePaCCS and shared care plans as well as for information sharing. A meeting was held with Graphnet and a demonstration of the product was arranged for Monday 7th to the IDG and on the 23rd December to the CCG Exec Team.

A business case is to be prepared for Exec consideration and a reference site visit in Manchester is currently being arranged for:

- 4 Clinical Directors
- 1 LMC lead
- GP IT Lead
- 1 lead from LA
- 1 lead from FT

Key Risks and Issues

There is currently no practical quick to implement solution for sharing of care plans. It has been recommended that the care plans are held within the existing GP systems and INT staff attend the practice to update, which supports the ethos of greater integrated working.

NHS Mail has been suggested as a means of sharing the plans across the wider H&S care economy. It should be noted that council staff should have secure email addresses: http://systems.hscic.gov.uk/nhsmail/secure

Key Activities to be completed next period

- Create & submit business cases for MIG & Graphnet

Section 5: Case Study

MH, 78, was referred to the Integrated Neighbourhood Teams with a multitude of conditions including Chronic Obstructive Pulmonary Disease, heart failure, diabetes, gastritis, restless legs, hypertension and angina. Her quality of life was very low, she was dependent on her husband, and she required numerous interventions.

After discussion with the patient, her key worker arranged for various members of the team to intervene. They worked to improve her breathing through exercise and the use of an inhaler, change her medications, prevent falls through the installation of equipment in her home, and remove fluid from her lungs. As a result of these changes, her health, mood and independence have all dramatically improved.

“I think this service is very beneficial,” said the patient. “I have every faith in my key worker as she has pushed very hard to get me to where I am now, and I respect and admire her very much. The rest of the team has been very helpful too, so thank you to you all.”

Appendix A – Detailed Performance Report

Better Care Fund metrics

BCF1. Total emergency admissions
Objective: to decrease

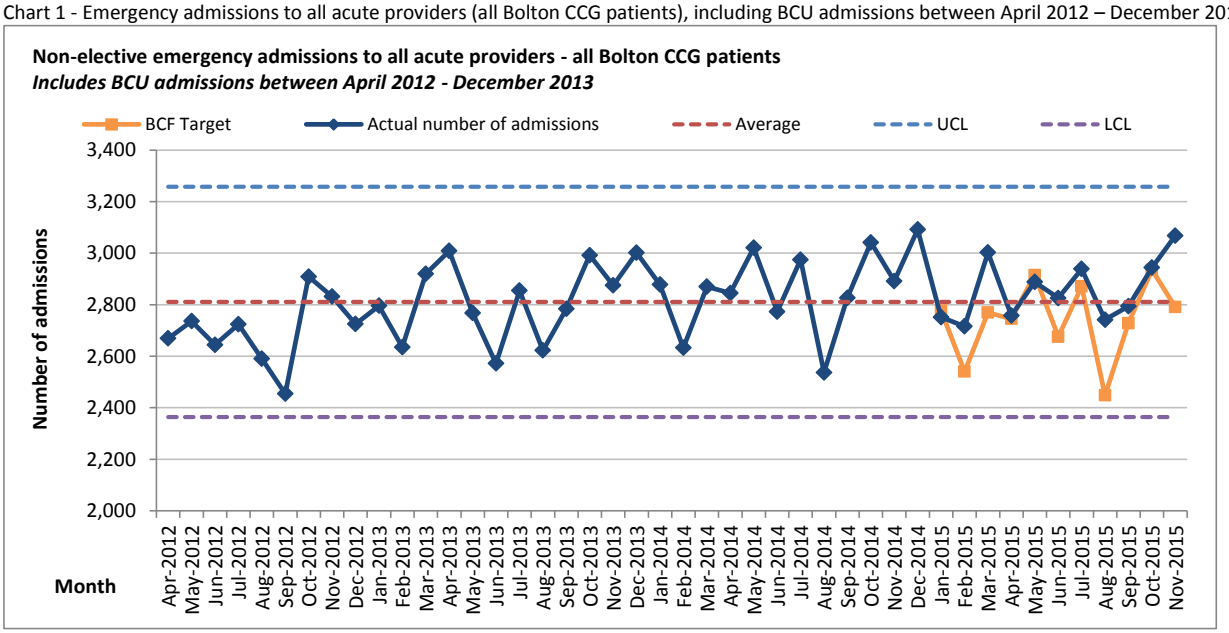
The key measure which will be used for Better Care Fund (BCF) performance payments is emergency admissions. This is now the sole measure on which the pay for performance element of the BCF will be assessed.

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 (shown in Chart 1 below). In the year January to December 2014, there were 34,385 emergency admissions. A **3.5%** decrease would therefore equate to **1,203** admissions in a year.

In the year to date (January to November 2015), there have been 31,430 admissions, an increase of 137 from the same period in 2014. The figure is 1,232 above target (YTD target is 30,198).

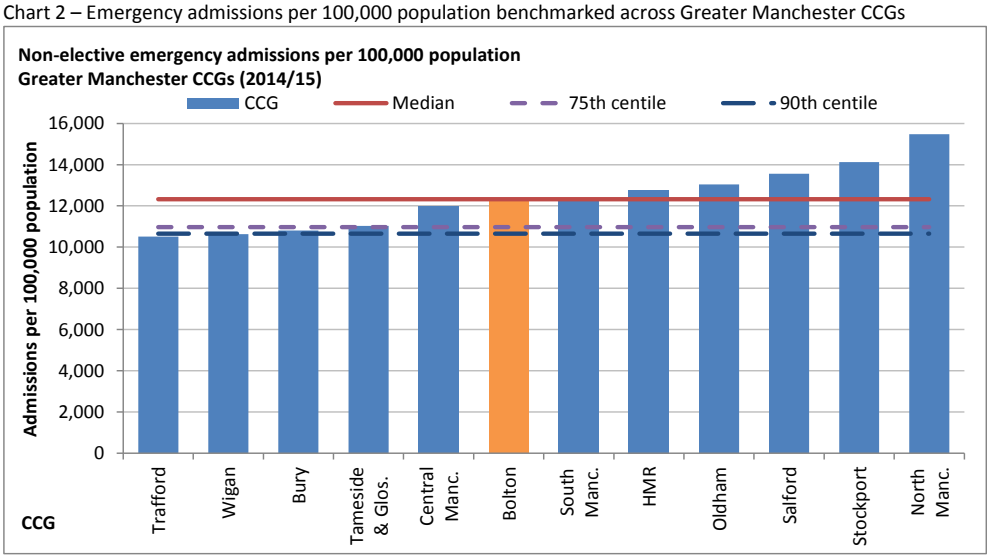
Bolton CCG's 5 year plan target for 2015/16 is a decrease of 2.8% from 2014/15. There was a 1.8% increase from 2013/14 to 2014/15.

Chart 1 - Emergency admissions to all acute providers (all Bolton CCG patients), including BCU admissions between April 2012 – December 2013



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

Chart 2 – Emergency admissions per 100,000 population benchmarked across Greater Manchester CCGs



When compared with Greater Manchester CCGs, Bolton CCG benchmarked slightly above (+0.3%) the median rate in 2014/15.

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:

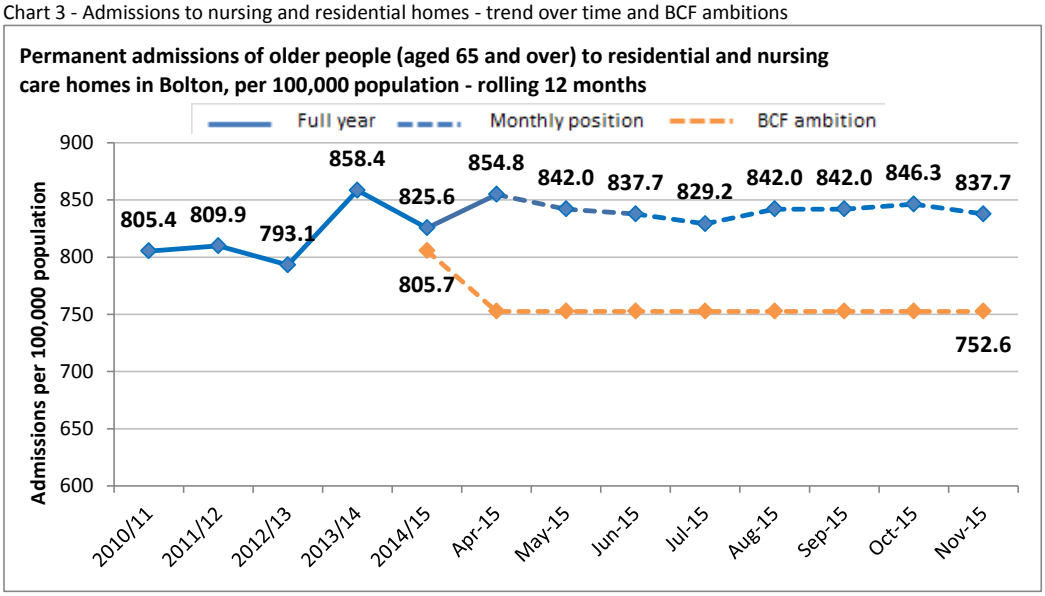
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital in to reablement/rehabilitation services (effectiveness of the service)
- Delayed discharges (total 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 the 12 months to November 2015 there were 392 permanent admissions to residential and nursing care homes in Bolton, this equated to 842.0 admissions per 100,000 population aged over 65. In the Better Care Fund submission, Bolton was set an ambition to decrease the number of permanent admissions to nursing and residential care homes (per 100,000 population) to 805.7 in 2014/15 and to reduce further to 752.6 in 2015/16. At the same time, 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 3 shows the number of permanent admissions to nursing and residential care homes, per 100,000 population from 2010/11 to date, along with the BCF ambition for 2015/16.

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

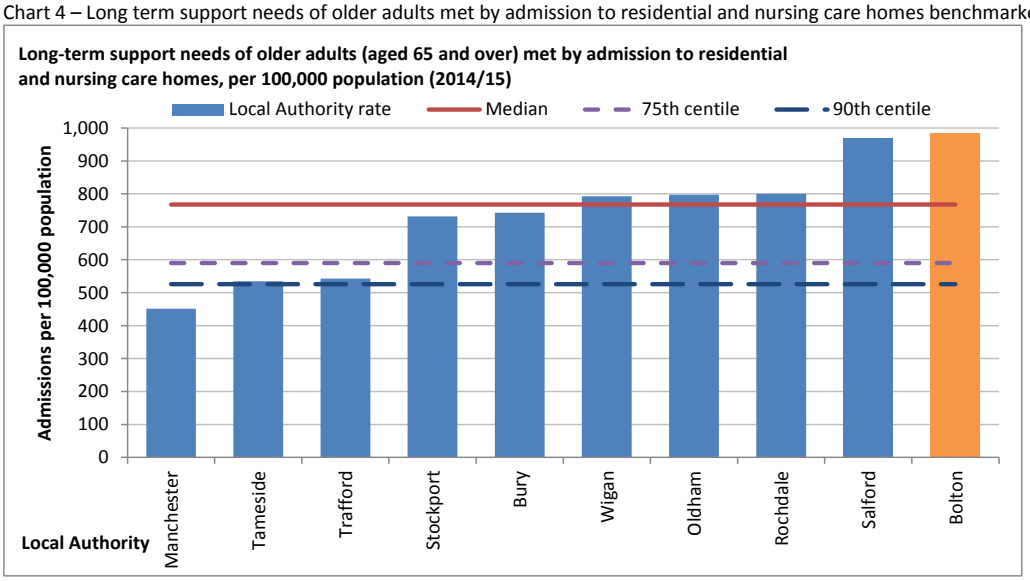


The transition from ASC-CAR to SALT this year resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population".

With the introduction of SALT, the measure was re-defined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population." This change is reflected in the benchmarking data in Chart 4.

Chart 4 shows that Bolton had the highest rate of long term support needs met by admission to residential and nursing care homes in 2014/15 when benchmarked across Greater Manchester. In 2013/14, Bolton had the second highest rate.

Chart 4 – Long term support needs of older adults met by admission to residential and nursing care homes benchmarked across Greater Manchester



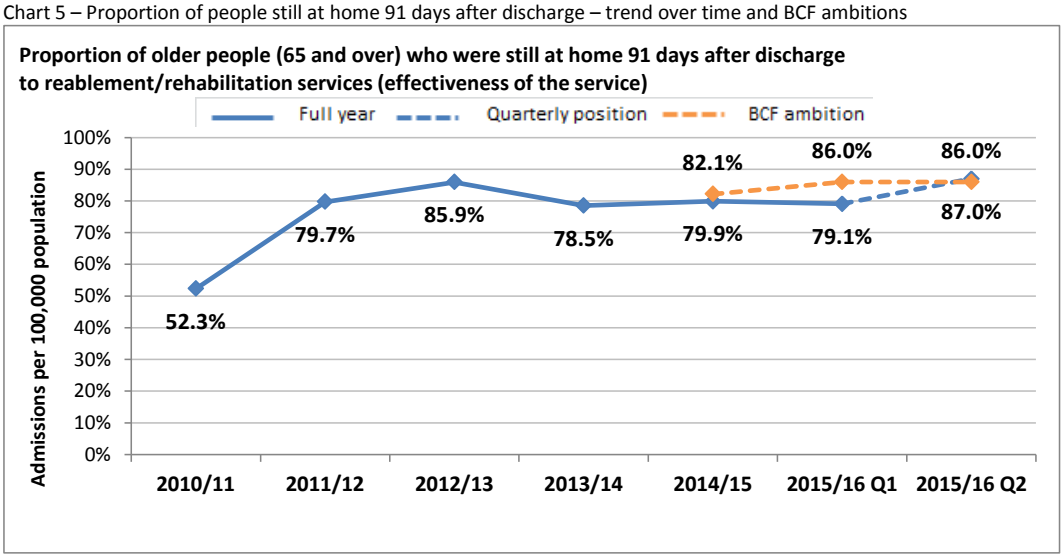
BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge to reablement/ rehabilitation services (effectiveness of the service)

Objective: To increase

In the second quarter of 2015/16, 87.0% of patients were still at home 91 days after discharge to reablement/rehabilitation services.

Chart 5 illustrates this measure over time from 2010/11 to 2015/16, 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 to the level seen in 2012/13 (86%).

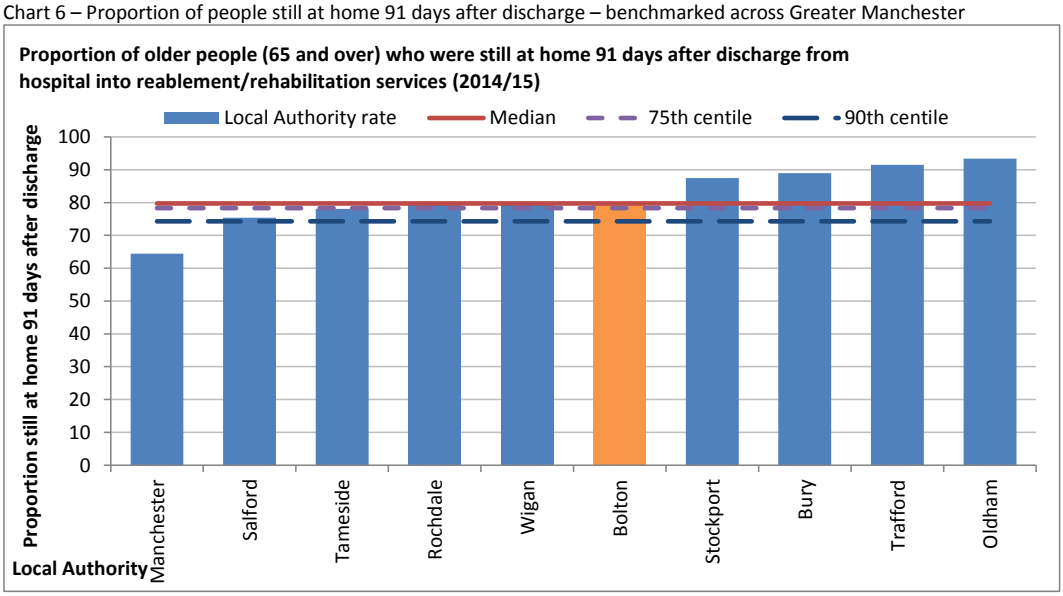
Chart 5 – Proportion of people still at home 91 days after discharge – trend over time and BCF ambitions



Please note the data in chart 5 includes social care reablement services only.

Chart 6 shows that in 2014/15, Bolton had the fifth highest value for this measure when compared across Greater Manchester, in 2013/14 Bolton had the 4th lowest value.

Chart 6 – Proportion of people still at home 91 days after discharge – benchmarked across Greater Manchester



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

Chart 7 shows the trend in the number of delayed days for Bolton patients. A marked increase can be seen from March 2014, which is due to a change in recording at Bolton FT. The reported number of delayed days decreased between September and December 2014, the data shows an increase in January, February and March 2015, with a fall back below the average in five of the last seven months. The figure for October 2015 was 863 days, much greater than the average.

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 for January to June 2015 was 321 (as shown in the chart below). The target for the remainder of 2015/16 is 308 delayed days per month.

Chart 7 – Delayed transfers of care (total delayed days)

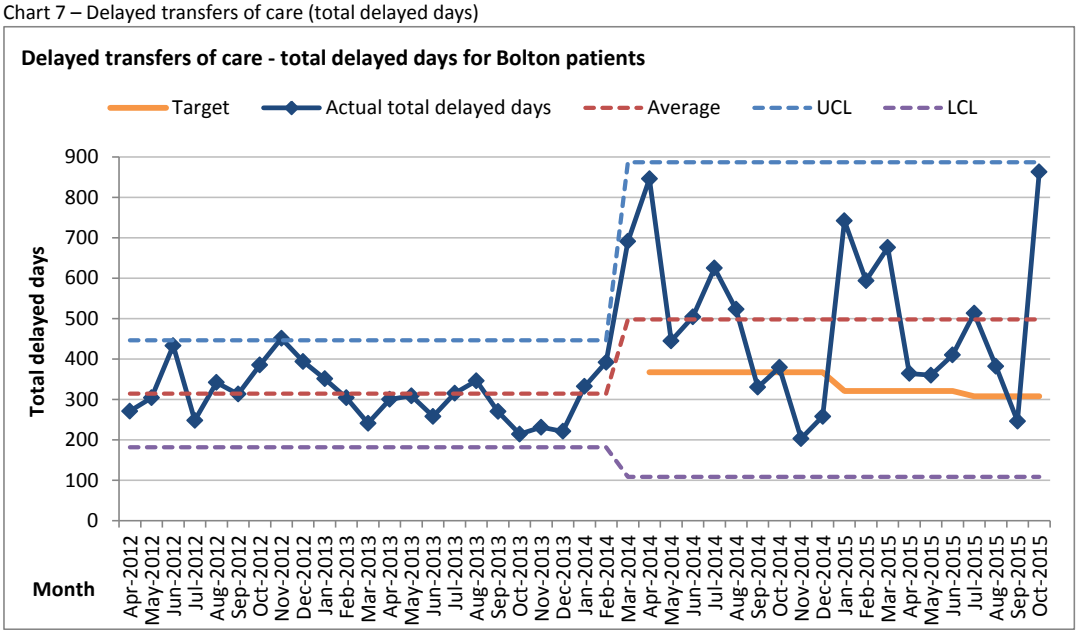


Chart 8 shows the number of delayed days over the last 12 months, broken down by attributable organisation. Over the 12 month period September 2014 to August 2015, 80% of delayed days were attributable to NHS, 14% were attributable to social care and 6% were attributable to both NHS and social care organisations.

Chart 8 – Delayed transfers of care for Bolton patients, by attributable organisation

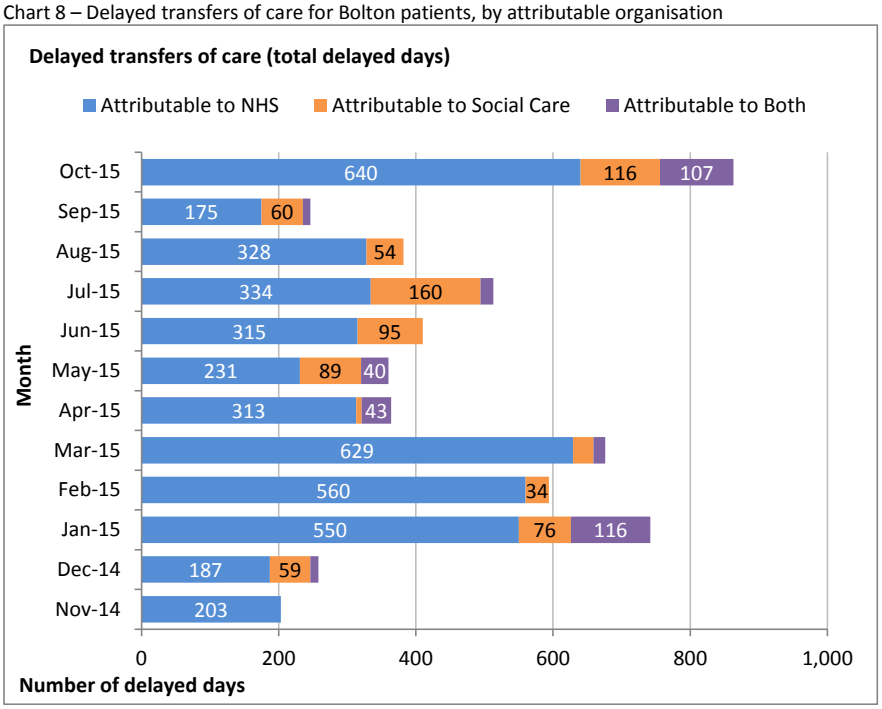
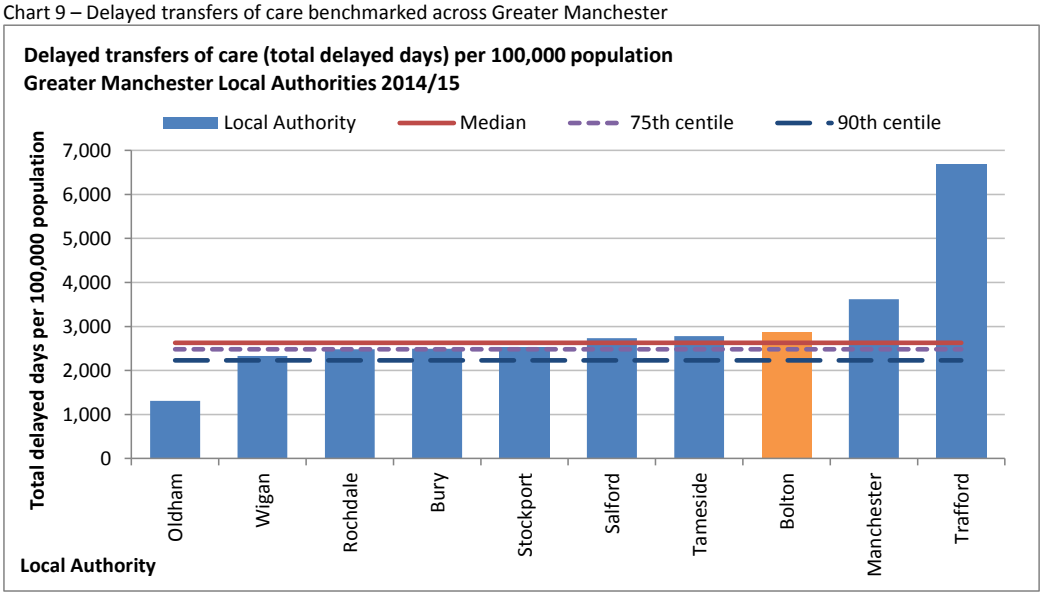


Chart 9 shows how the number of delayed transfers of care in Bolton compared across Greater Manchester in 2014/15. Bolton benchmarked above the Greater Manchester median rate.

Chart 9 – Delayed transfers of care benchmarked across Greater Manchester



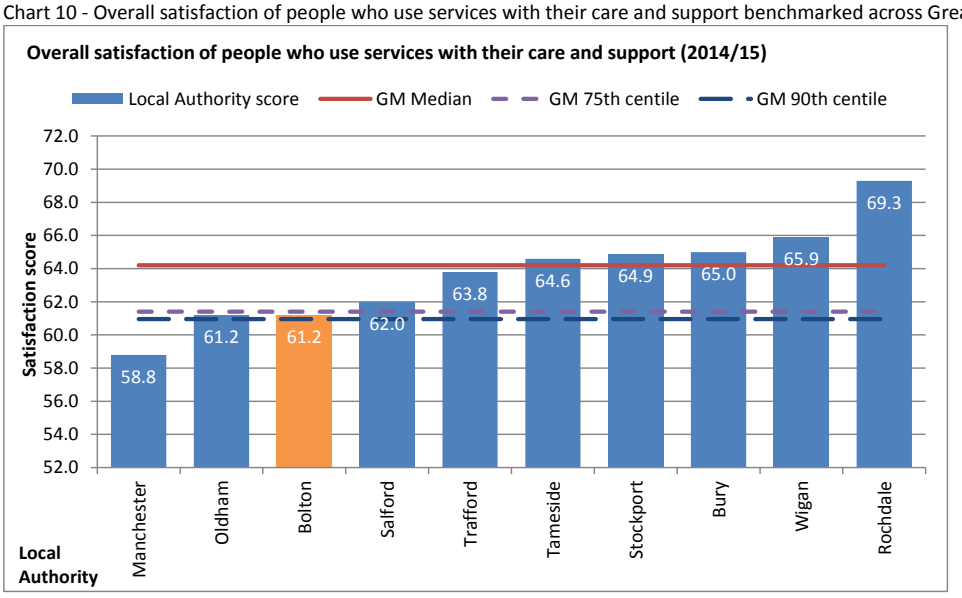
BCF5. Overall satisfaction of people who use services with their care and support
Objective: to increase

As part of the 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 2014/15 Bolton scored 61.2%, below the median score for Greater Manchester. In 2013/14 Bolton scored 65.6%, just above the median. In the BCF submission, an ambition was set to reach 66.6% in 2014/15 and 67.6% in 2015/16.

Chart 10 - Overall satisfaction of people who use services with their care and support benchmarked across Greater Manchester

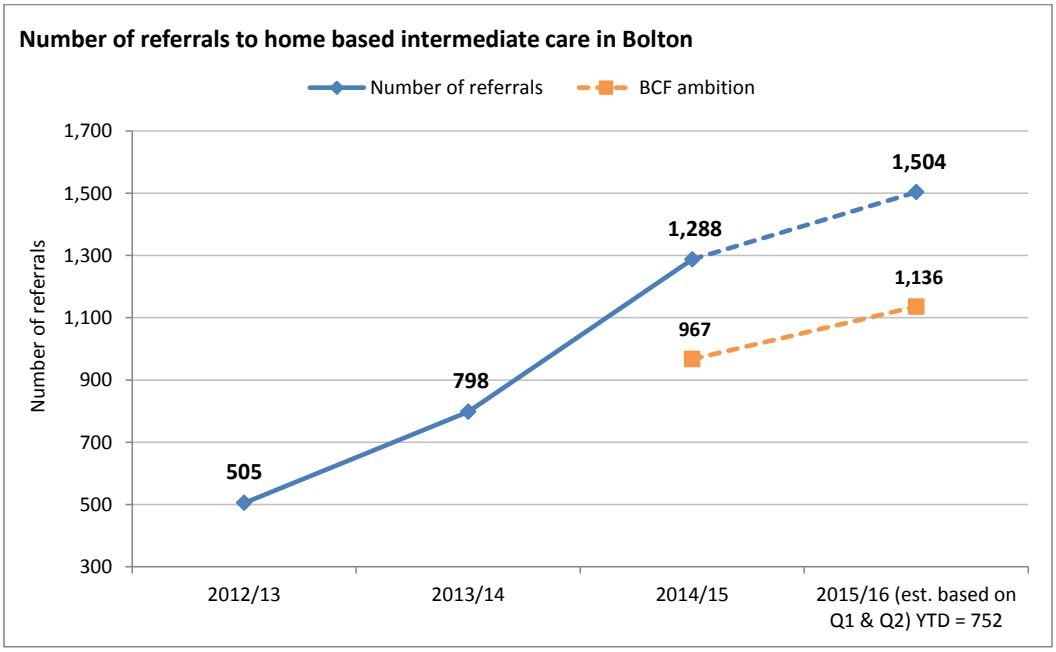


BCF6. Referrals to home based intermediate care
Objective: to increase

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 11 shows that Bolton exceeded this target in 2014/15.

Chart 11 – Referrals to home based intermediate care



Greater Manchester and locally selected metrics

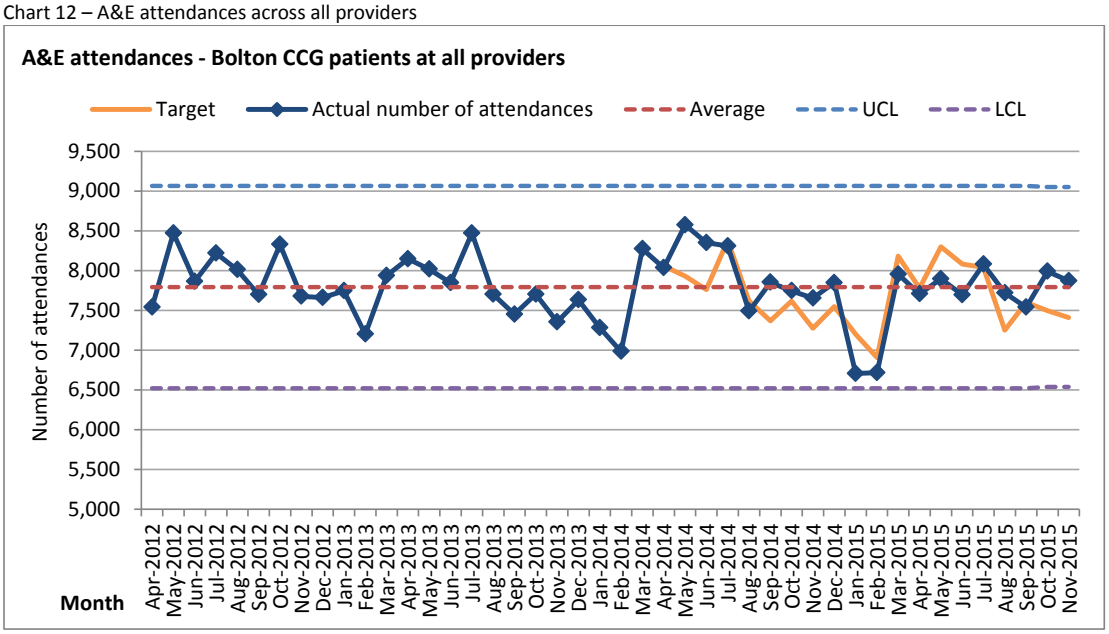
A number of further metrics have been identified across Greater Manchester and locally within Bolton.

GM1. A&E attendances
Objective: To decrease

Chart 12 shows the number of A&E attendances at all acute providers from April 2012, for Bolton CCG patients. There were a particularly high number of attendances between March and July 2014. January and February 2015 had fewer attendances than the average.

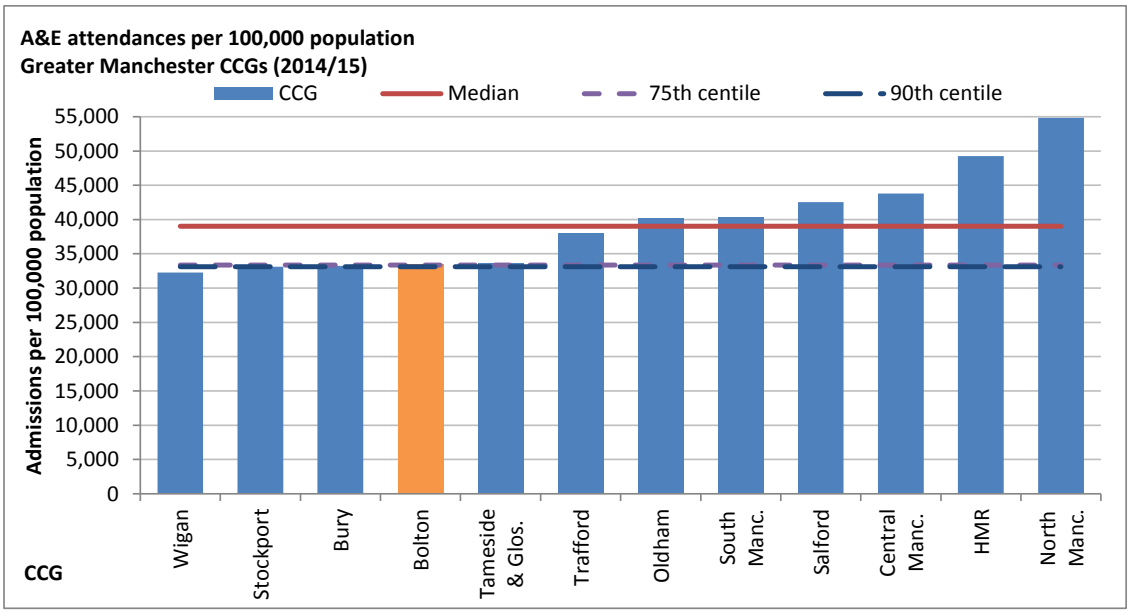
Bolton CCG's target for 2015/16 was to decrease the number of A&E attendances by -3.2% from 2014/15. For the year to date 2015/16, attendances have fallen by -2.4% when compared to 2014/15 (equal to 1,512 fewer attendances).

Chart 12 – A&E attendances across all providers



In 2014/15, Bolton had a lower than average number of attendances per 100,000 population, when compared across Greater Manchester.

Chart 13 – A&E attendances benchmarked across Greater Manchester

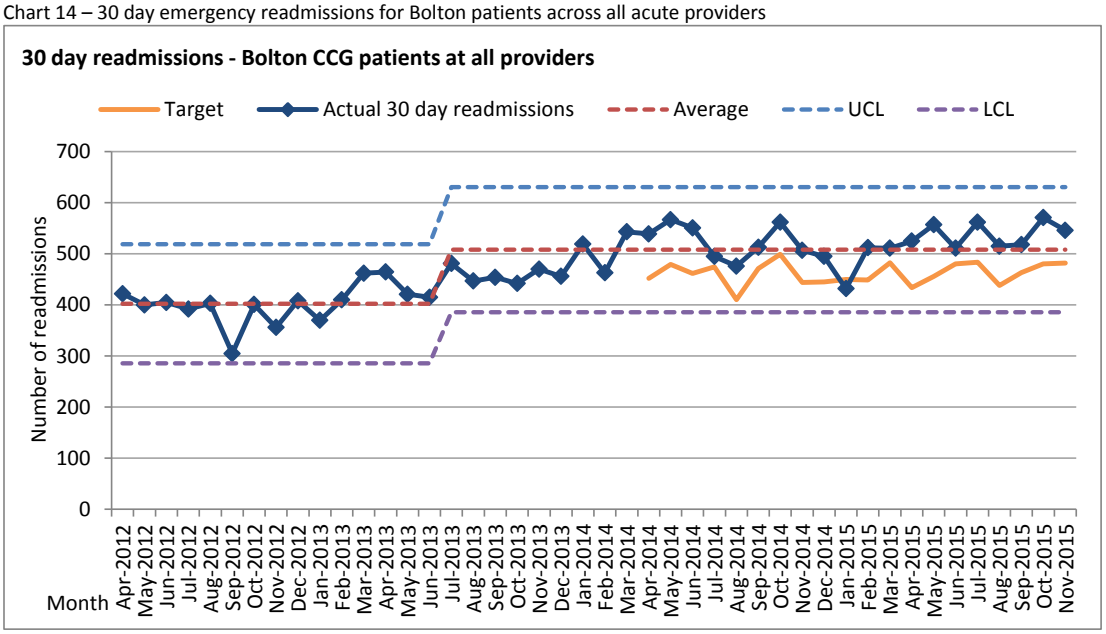


GM2. 30 day emergency readmissions

Objective: To decrease

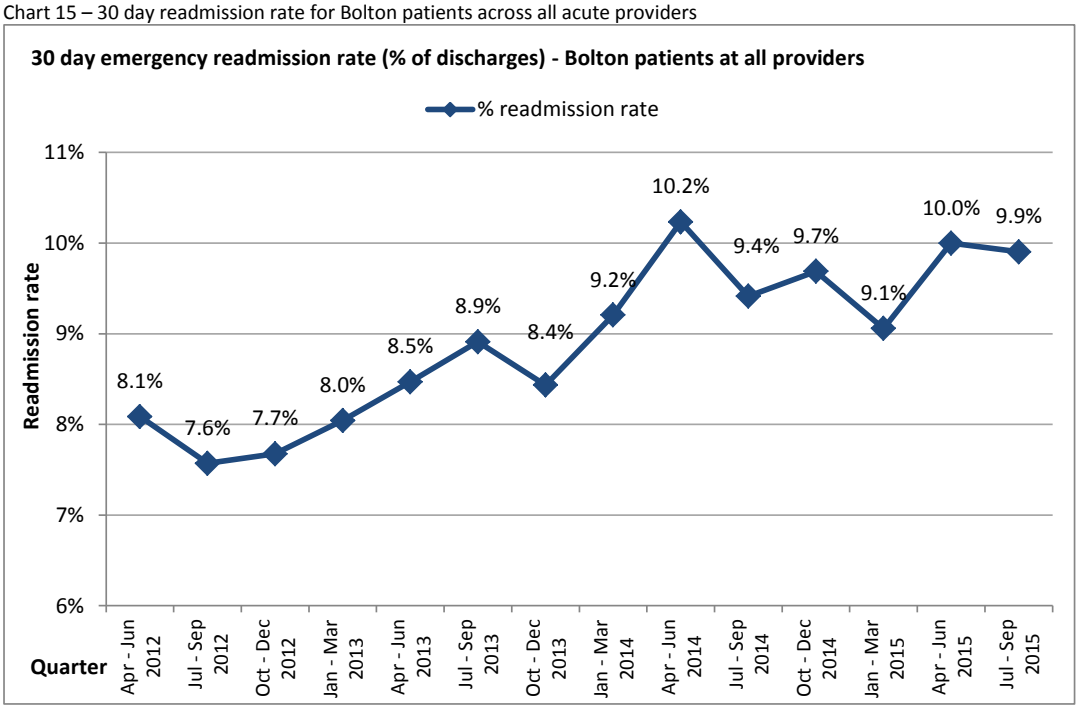
Chart 14 shows the number of emergency readmissions within 30 days of previous discharge (following an elective, day case or non-elective admission). When comparing 2015/16 YTD with the same period in 2014/15, there has been a +0.4% increase in the number of 30 day readmissions.

Chart 14 – 30 day emergency readmissions for Bolton patients across all acute providers



To provide some context to the number of readmissions, chart 15 illustrates the crude readmissions rate (readmissions as a percentage of all discharges) by quarter, from Q1 2012/13 to Q2 2015/16.

Chart 15 – 30 day readmission rate for Bolton patients across all acute providers

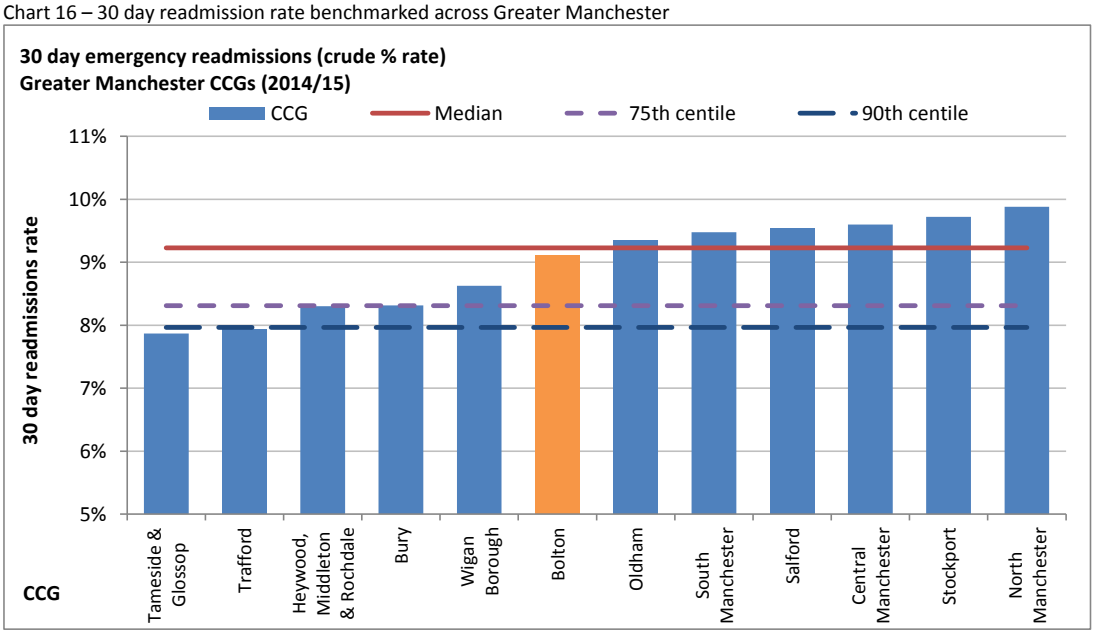


It should be noted that the number of readmissions shown in charts 14 and 15 includes patients who were discharged from one provider and readmitted in an emergency to a different provider, as well as patients admitted to the same provider twice.

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 at the end of this report.

Chart 16 shows the 30 day readmission rate across Greater Manchester CCGs in 2014/15. Bolton CCG was below the median readmission rate (9.2%).

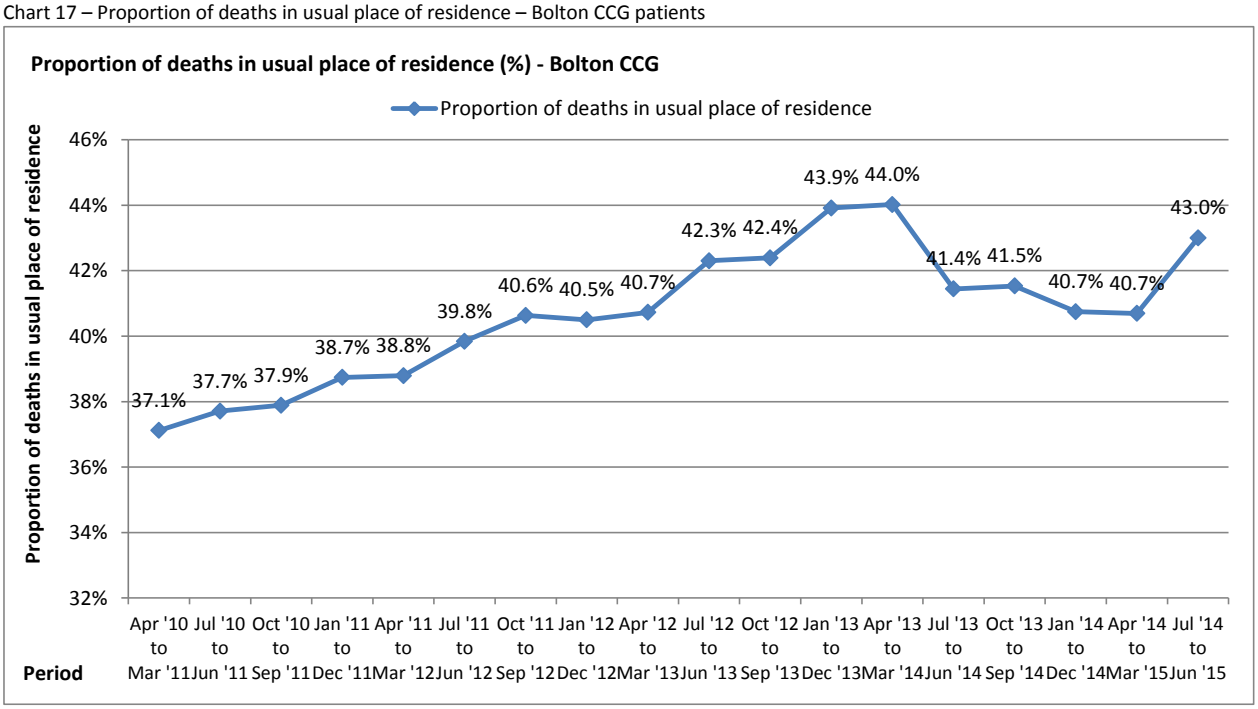
Chart 16 – 30 day readmission rate benchmarked across Greater Manchester



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

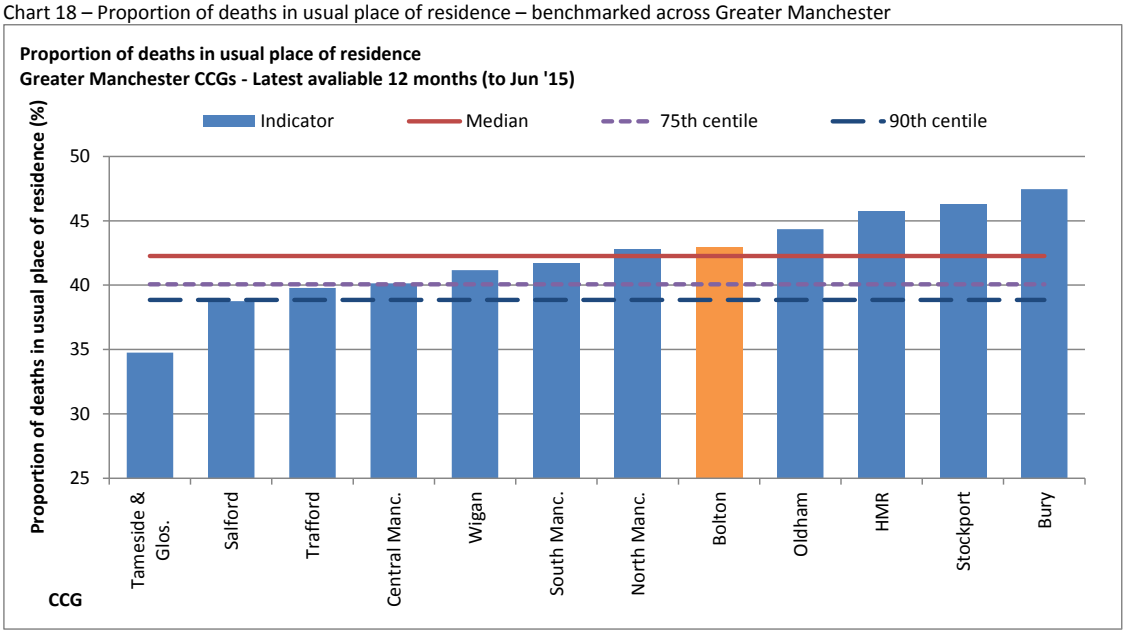
Chart 17 shows a rolling 12 month position for the proportion of deaths occurring in the person's usual place of residence in Bolton. There has been a steady increase from 37.1% in the year 2010/11, with a slight fall in the last four data points.

Chart 17 – Proportion of deaths in usual place of residence – Bolton CCG patients



In the year July 2014 to June 2015, 43.0% of deaths in Bolton occurred in the person's usual place of residence. Bolton CCG ranked 8th across Greater Manchester, above the median, as illustrated in Chart 18.

Chart 18 – Proportion of deaths in usual place of residence – benchmarked across Greater Manchester



L1. Avoidable emergency admissions
Objective: To decrease

This is a composite measure of:

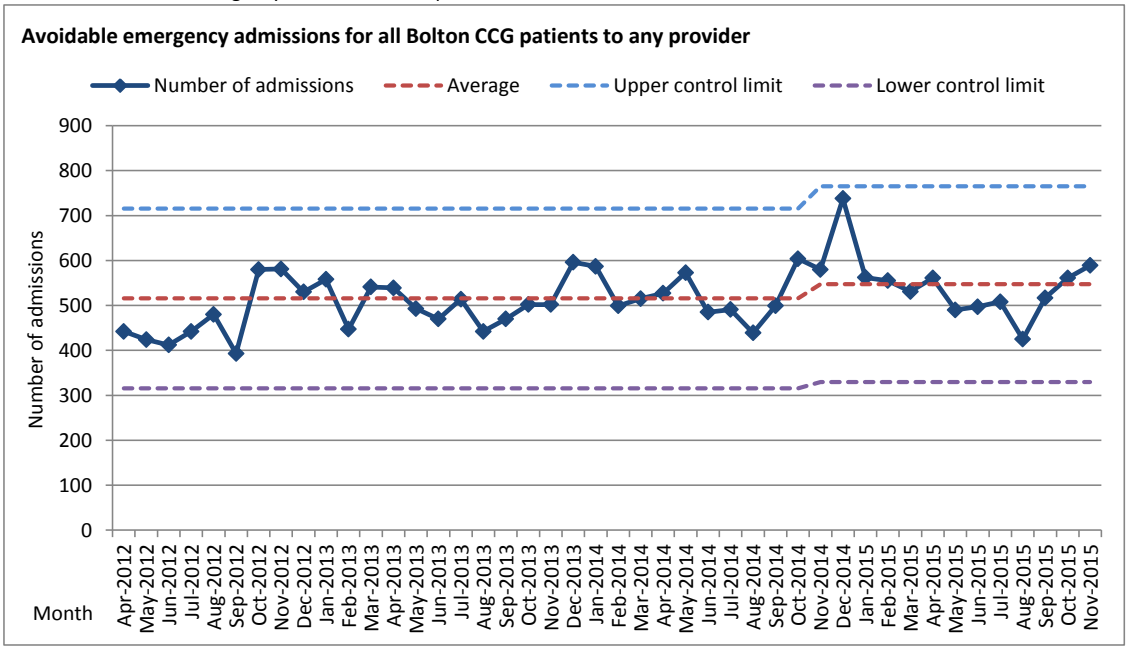
- chronic ambulatory care sensitive conditions
- acute conditions that should not usually require hospital admission
- asthma, diabetes and epilepsy in children
- children with lower respiratory tract infection.

A full list of the conditions included can be found in at the end of this report.

Chart 19 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 (December 2013 to January 2014 and October 2014 to December 2014).

Overall the trend is increasing; there was a 5.1% increase from 2012/13 to 2013/14 and a 7.4% increase when comparing 2013/14 to 2014/15. There has been a -1.2% reduction YTD in 2015/16 when compared to the same period in the previous year.

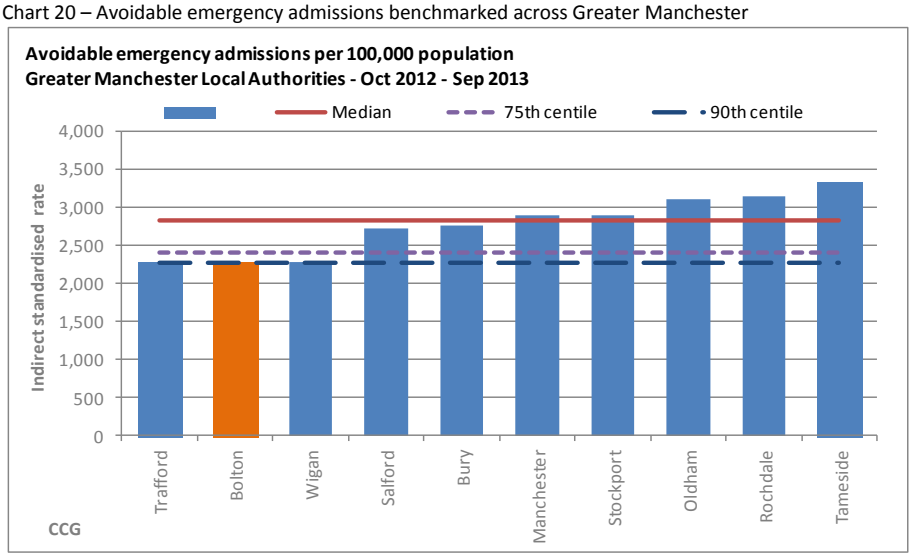
Chart 19 – avoidable emergency admissions to all providers



It should 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, which closed in December 2013.

Chart 20 illustrates how Bolton compares across Greater Manchester. Data for the latest available 12 month period (October 2012 – September 2013) shows that Bolton had the second lowest rate of avoidable admissions across Greater Manchester.

Chart 20 – Avoidable emergency admissions benchmarked across Greater Manchester



L2. Average length of stay (non-elective)
Objective: To decrease

In the year 2013/14, the average length of stay for an emergency admission across all hospital providers was 5.1 days for Bolton CCG patients. The target for 2014/15 was 4.8 days, however the average length of stay in 2014/15 was sustained at 5.1 days. Average length of stay has fallen below the average since May 2015, for the year to date 2015/16 the average length of stay is 4.33 days.

Chart 21 – Average length of stay for emergency admissions across all providers

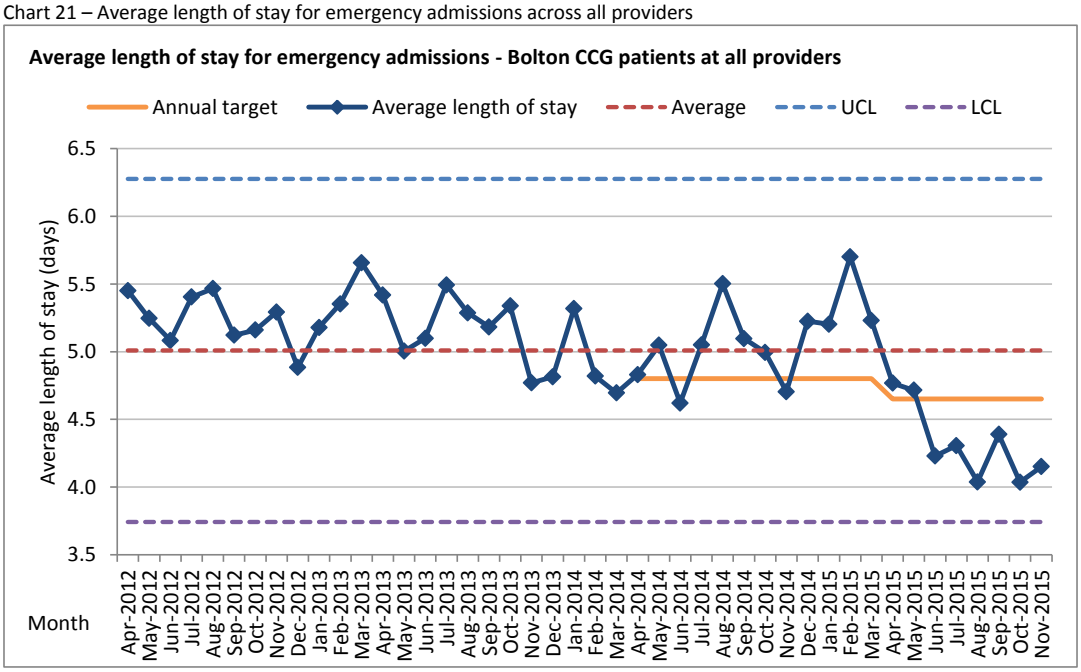
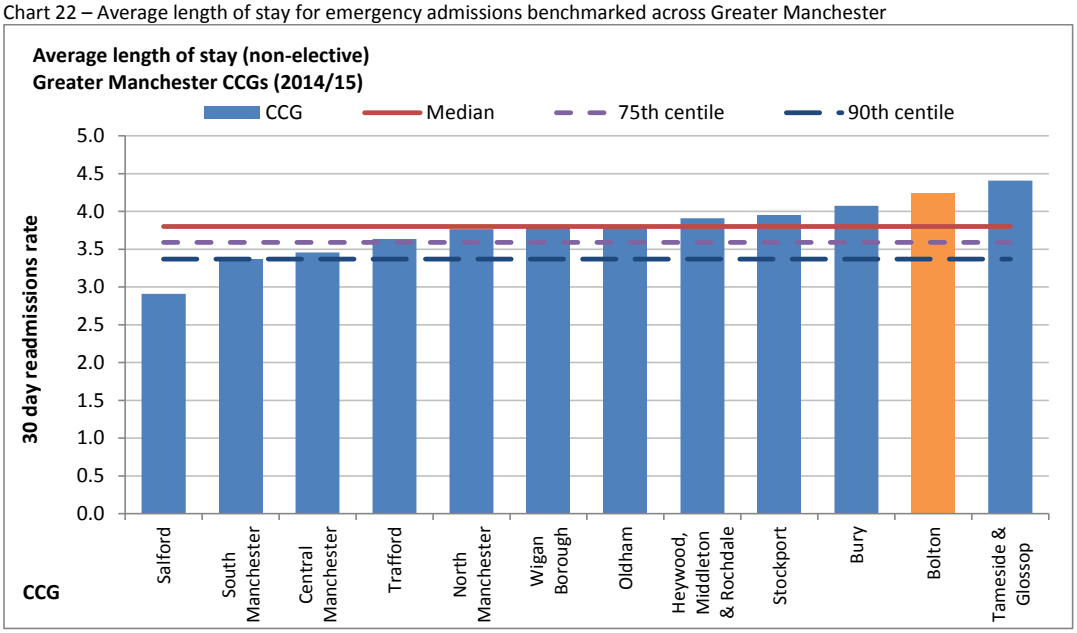


Chart 22 illustrates how Bolton CCG benchmarks against other Greater Manchester CCGs for average non-elective length of stay. In 2014/15, Bolton CCG was above the Greater Manchester median length of stay.

Chart 22 – Average length of stay for emergency admissions benchmarked across Greater Manchester



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

Chart 23 illustrates the number of emergency admissions for Bolton 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.

Comparing 2014/15 with 2013/14, the number of admissions increased by 23%, from 730 in 2013/14 to 900 in 2014/15. There have been 10 fewer admissions in the year to date 2015/16 when compared with 2014/15, a decrease of -1.7%.
It should be noted however that the closure of the BCU in December 2013 may affect these figures, as this cohort of patients may have been treated in BCU in the past.

Chart 23 – Emergency admissions due to falls and fall related injuries.

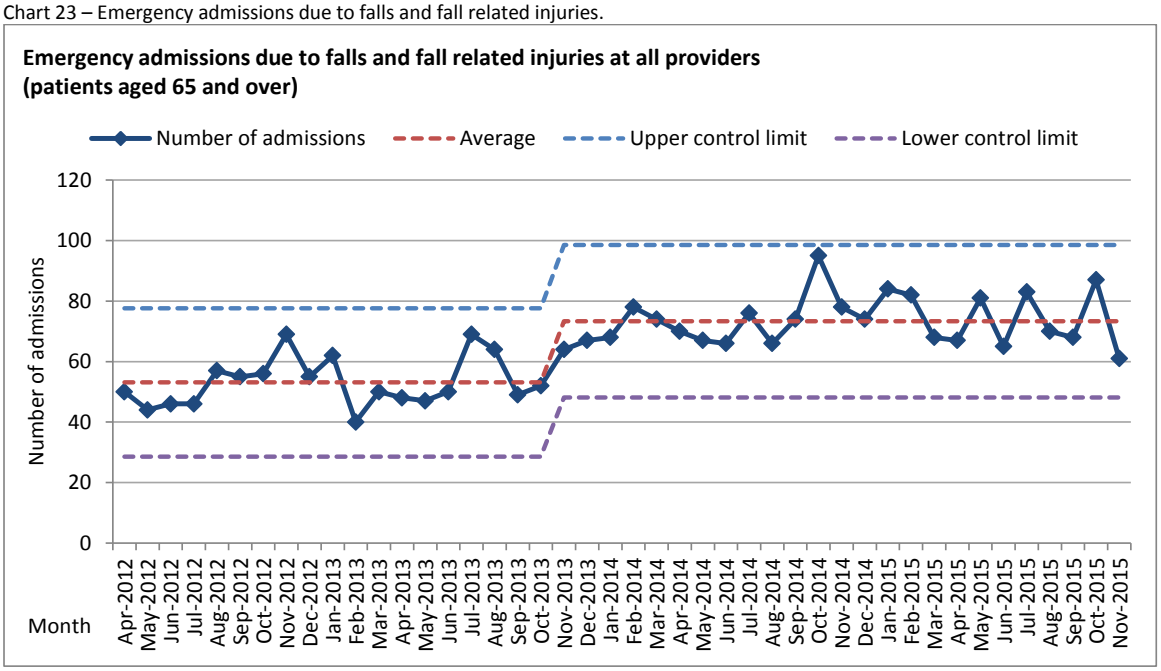
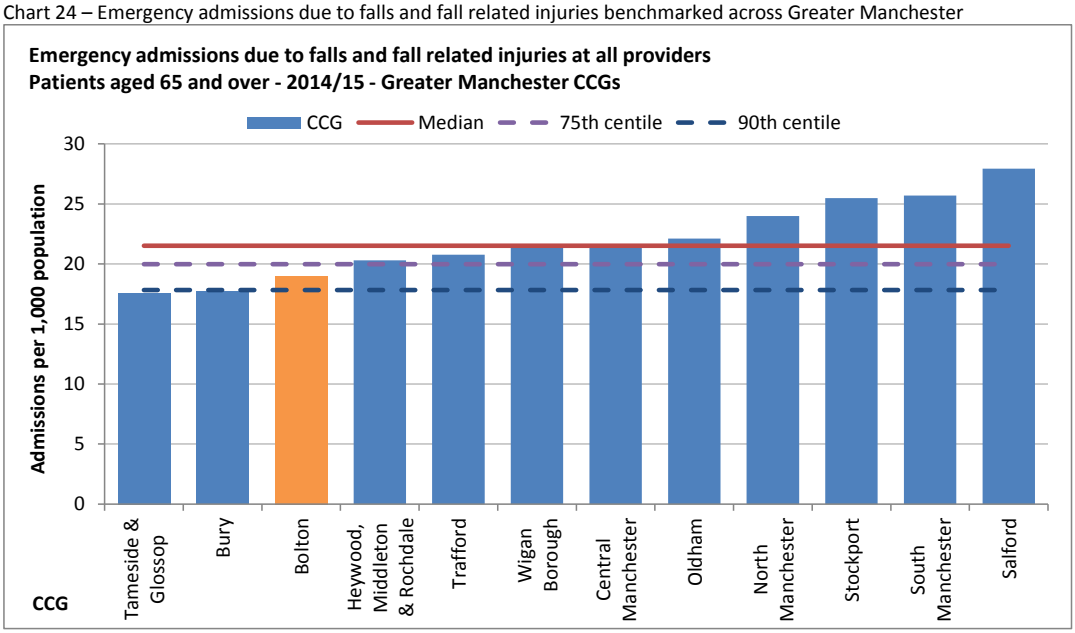


Chart 24 shows how Bolton CCG compares across Greater Manchester for the number of falls admissions per 1,000 population aged over 65. In the year 2014/15 Bolton had the third lowest rate of falls admissions across all Greater Manchester CCGs.

Chart 24 – Emergency admissions due to falls and fall related injuries benchmarked across Greater Manchester

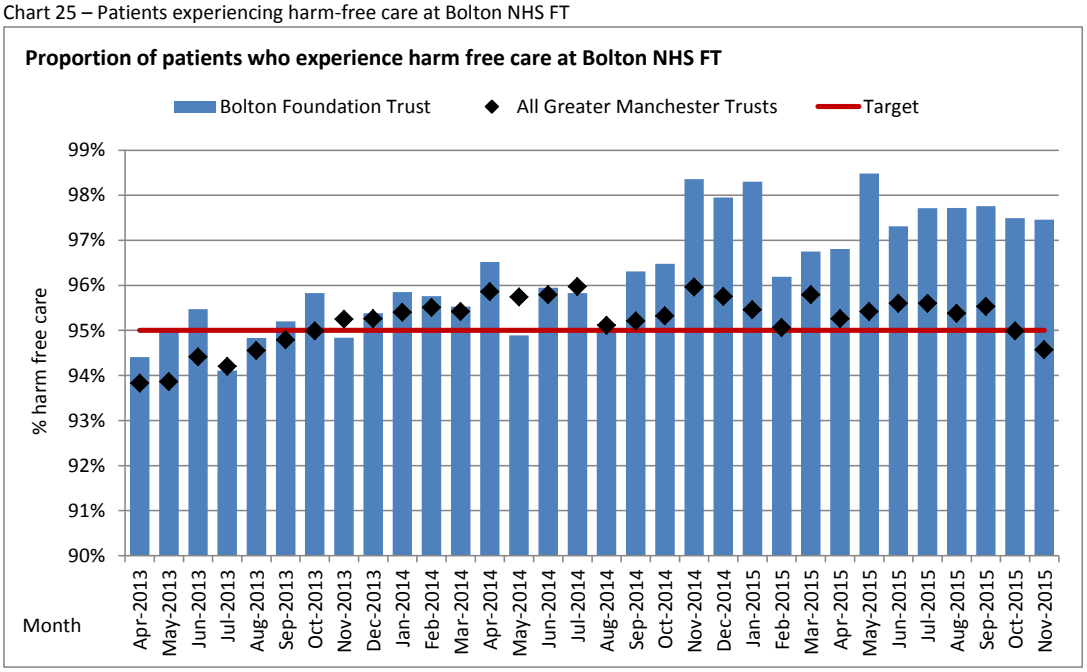


L4. Proportion of patients who experience harm-free care

Objective: to increase

Chart 25 shows the proportion of patients who experienced harm-free care at Bolton NHS FT between April 2013 and September 2015. 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 25 also shows the monthly harm-free care achievement for all Greater Manchester Trusts combined.

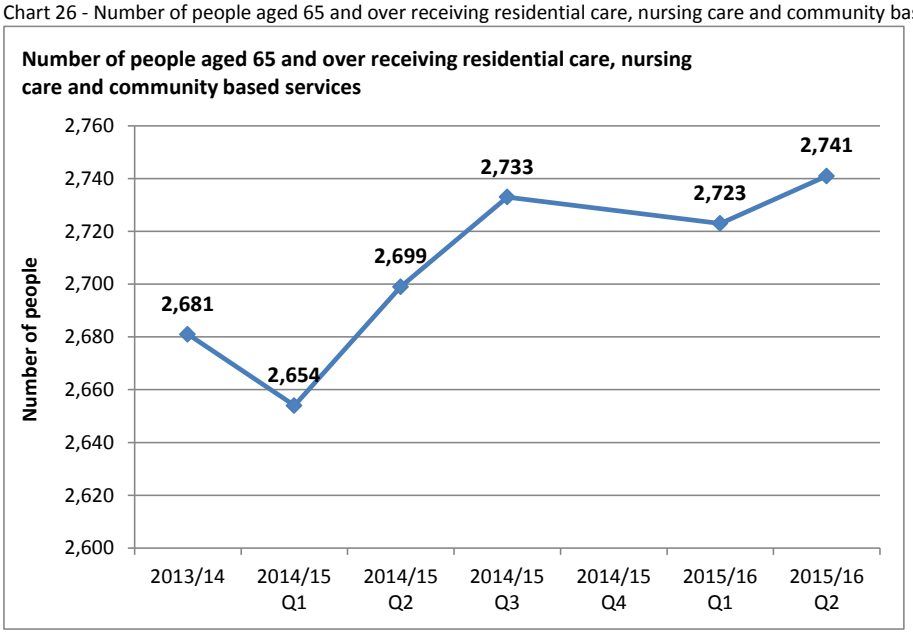
Chart 25 – Patients experiencing harm-free care at Bolton NHS FT



L5. Number of people aged 65 and over receiving residential care, nursing care and community based services

Chart 26 shows the number of people aged 65 and over receiving residential care, nursing care and community based services in Bolton. The numbers represent a snapshot at quarter end. The total number of people receiving the service at any point in 2014/15 was 3,402.

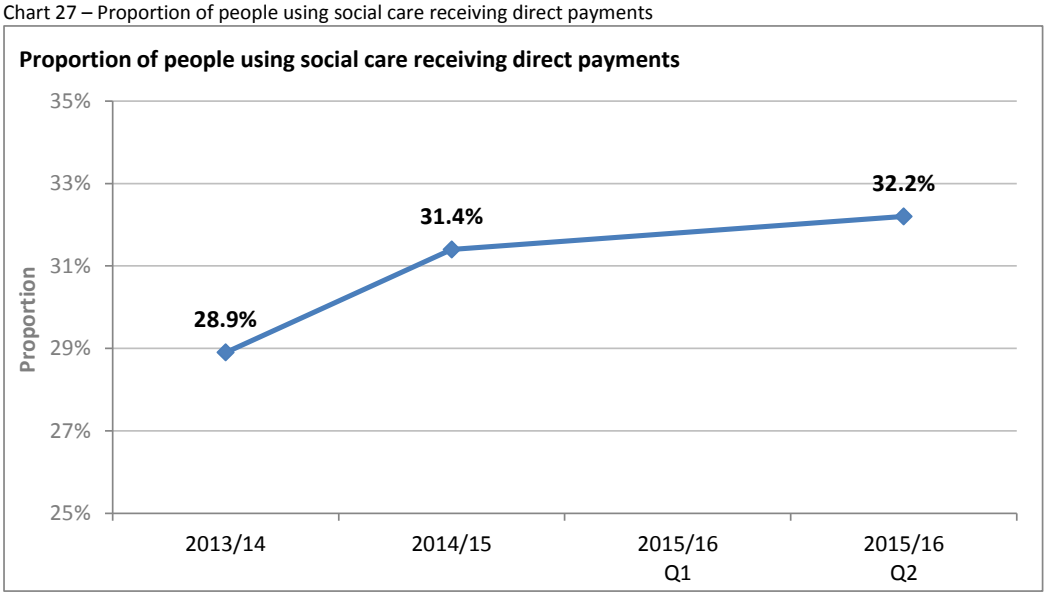
Chart 26 - Number of people aged 65 and over receiving residential care, nursing care and community based services



L6. Proportion of people using social care receiving direct payments
Objective: to increase

Chart 27 shows the proportion of people using social care receiving direct payments at year end.

Chart 27 – Proportion of people using social care receiving direct payments



L7. The proportion of older people aged 65 and over offered reablement services following discharge from hospital
Objective: to increase

The number of older people offered reablement services following discharge from hospital as a proportion of all discharges (people aged 65 and over). The full year figure for 2014/15 was 4.3%.

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

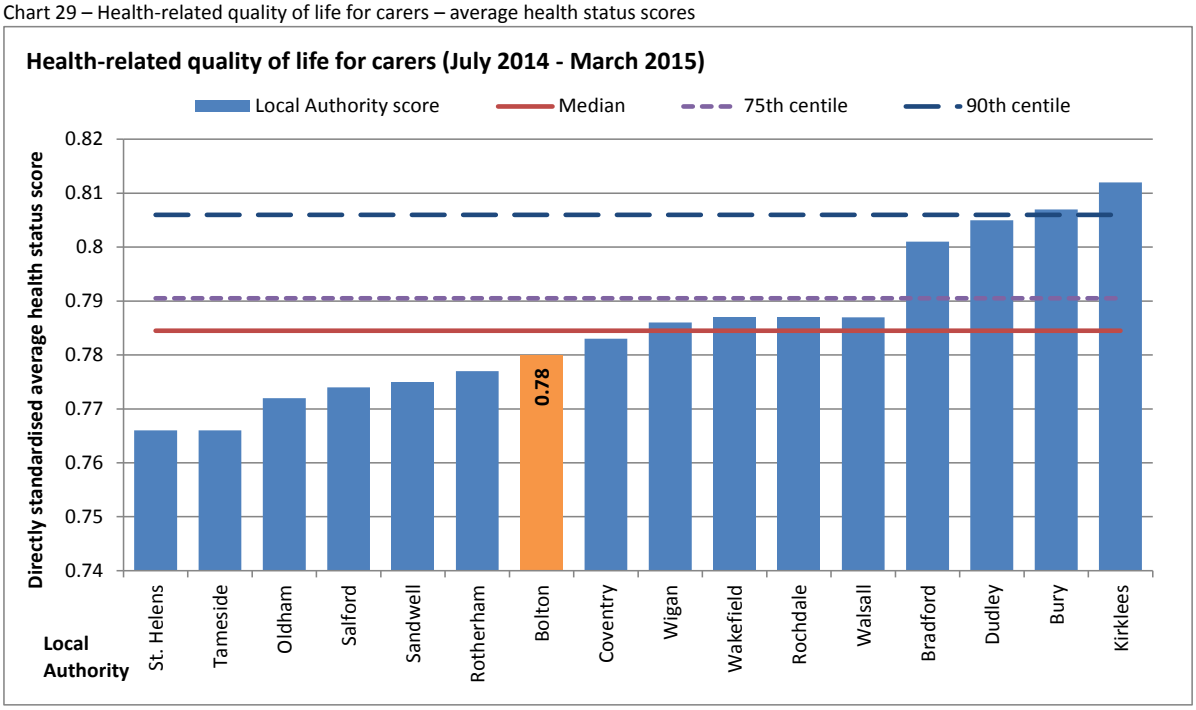
Data to follow

L10. Health-related quality of life for carers
Objective: to increase

Chart 29 shows the latest available health-related quality of life scores for Bolton CCG and its statistical peers, taken from the 2014/15 GP Patient Survey. Bolton had the seventh 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. The latest score for 2014/15 was 0.78 again.

Chart 29 – Health-related quality of life for carers – average health status scores

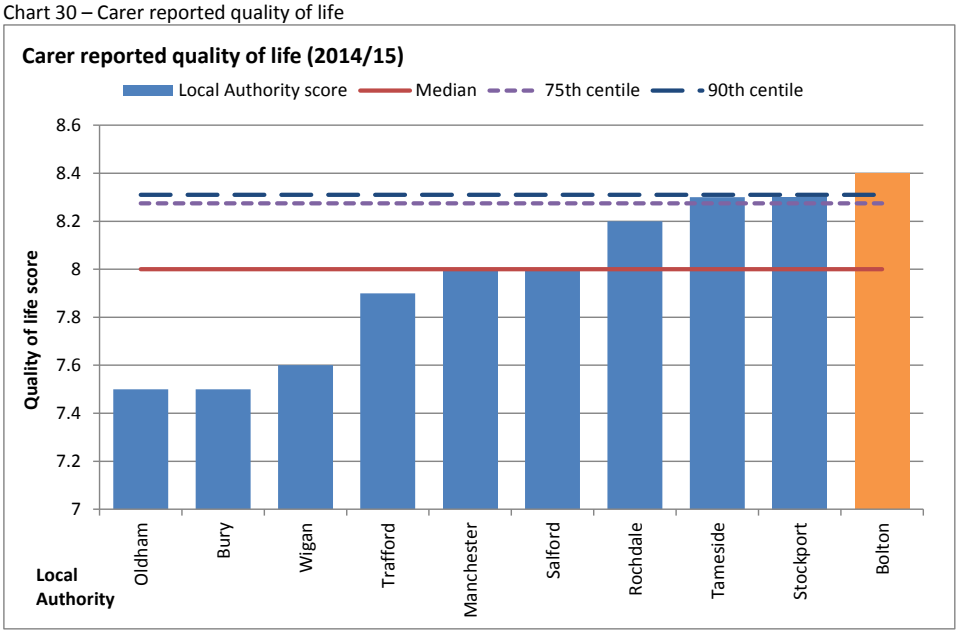


L11. Carer reported quality of life

Objective: to increase

Chart 30 shows quality of life scores for carers in Bolton, as reported in the biennial carers' survey. In 2014/15, Bolton had the highest score amongst its statistical peer organisations.

Chart 30 – Carer reported quality of life



L12. People feeling supported to manage their condition

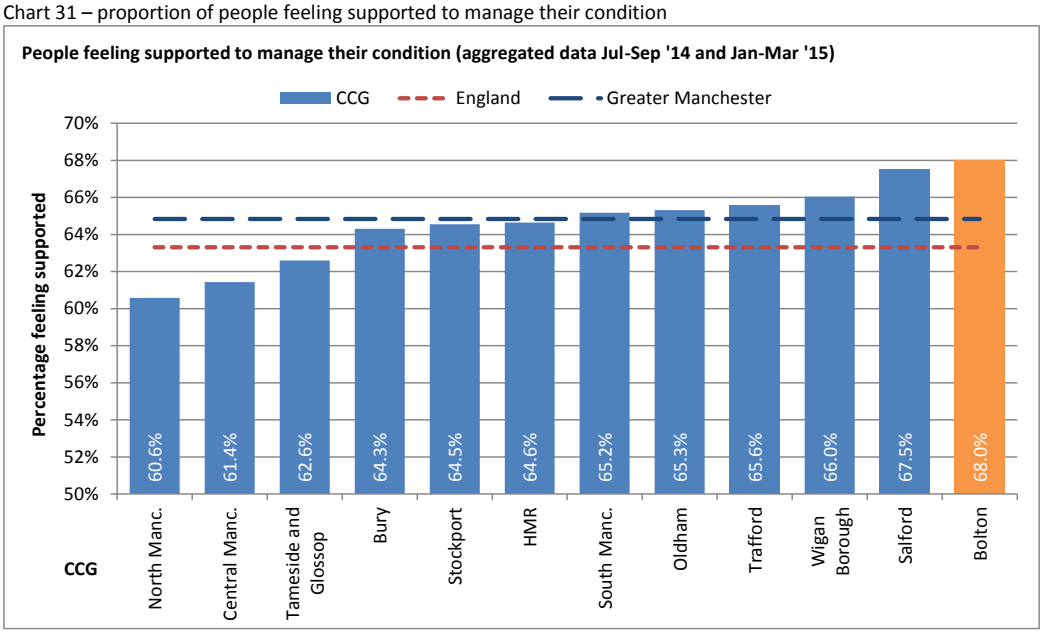
Objective: to increase

Chart 31 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 highest proportion of patients responding positively (68.0%) when compared across Greater Manchester CCGs. This measure has been relatively consistent over the last four years.

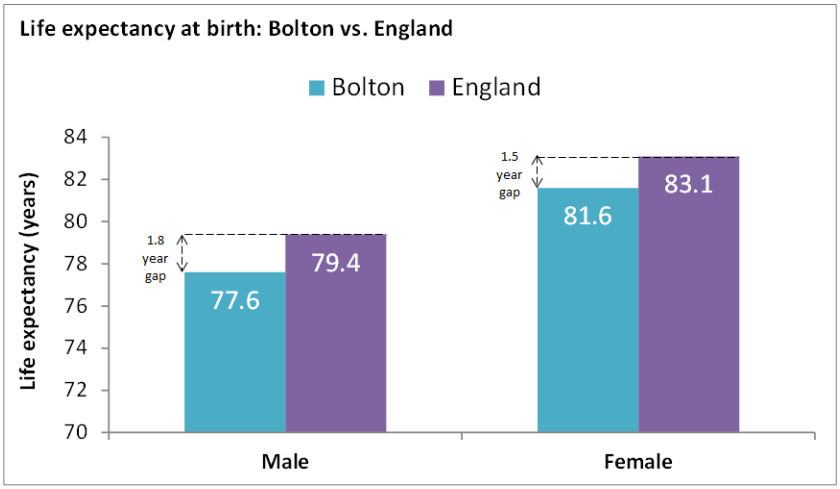
Chart 31 – proportion of people feeling supported to manage their condition



L14. Reducing the gap in life expectancy between Bolton and the England average
Objective: to decrease

Life expectancy in Bolton is currently 77.6 years for men and 81.6 years for women. This is based on the latest figures (2011-13). The gap in life expectancy between Bolton and England now stands at 1.8 years for men and 1.5 years for women. Chart 32 illustrates this gap between Bolton and England.

Chart 32 – Life expectancy at birth – Bolton vs. England

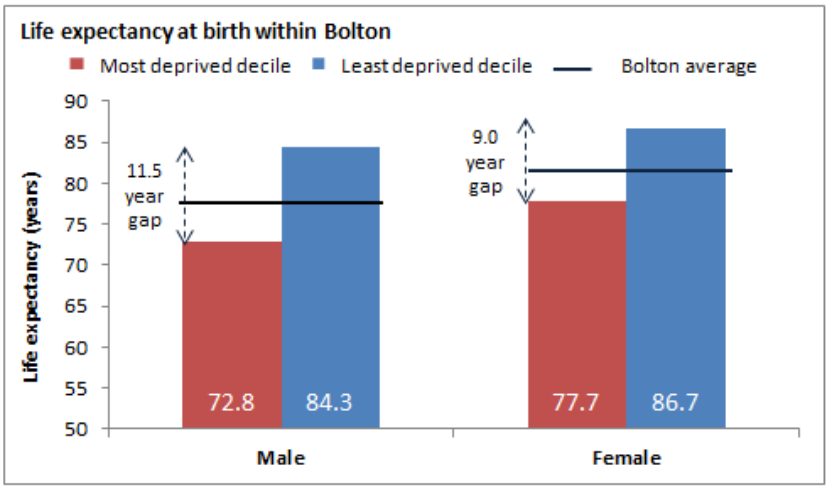


L15. Reducing the gap in life expectancy across Bolton

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 72.8 years for men and 77.7 years for women. The least deprived decile in Bolton has a life expectancy of 84.3 years for men and 86.7 years for women. This is a gap of 11.5 years for men and 9.0 years for women, as illustrated in chart 33.

Chart 33 – 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)/ CareFirst	
BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from to reablement/ rehabilitation services	Adult Social Care Outcomes Framework (ASCOF)/ CareFirst	
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. Number of people aged 65 and over receiving residential care, nursing care and community based services	CareFirst	
L6. Proportion of people using social care receiving direct payments	CareFirst	
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	
L9. Increasing the percentage of people finishing reablement or intermediate care who have no package of care	Bolton Council	
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	