Report to:	Health and Wellbeing Board	
Date:	16 July 2014	
Report of:	Adrian Crook, Assistant Director Integration and Provider Services	**Report No:**
Contact Officer:	Sally McCairn, Project Manager (Health & Social Care Integration) Bolton CCG	**Tel No:** 01204 462076

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

Non Confidential: This report does **not** contain information which warrants its consideration in the absence of the press or members of the public

Purpose:

The purpose of this report is to:

1 Propose a template to be updated and presented to the Health and Wellbeing Board on a regular basis, and to

2 Update the Board on the latest available progress in relation to each of the sections within.

Recommendations:

That the Health and Wellbeing Board:

1 Acknowledge that this is a proposed template and that some sections of the report are yet to be populated with information

2 Consider and approve this reporting mechanism for further Board meetings

3 Note and make comments on the updates within

Decision:

Background Doc(s):

Bolton Council

Greater Manchester West Mental Health NHS Foundation Trust

Bolton NHS Foundation Trust

NHS Bolton Clinical Commissioning Group

Bolton Health & Social Care Integration Monthly Report

July 2014

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Section 1
Bolton Health & Social Care Integration Programme

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

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

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

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

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

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

Section 2
Better Care Fund

A range of media statements have been sent out recently from the Local Government Association. However, we are still waiting on guidance.

Bolton has yet to receive further feedback from NHS England; there is likely to be further request for information and we will keep the Health and Wellbeing Board updated at each meeting.

Section 3
Communications and engagement

Highlights will be added on a monthly basis

Section 4
Patient Stories

A is a 66 year old lady who lives alone and has been visiting her GP more recently lately. She suffers from schizophrenia but, despite this, generally functions well on a day to day basis. The GP selected her for an MDT discussion due to his concerns that she was expressing anxiety about her ongoing ability to remain at home and continue to look after herself, but also because the GP was anticipating a recent test result would identify A had a significant endometrial cancer.

Current response

Previously, the GP would have made separate referrals to Adult Social Care, District Nursing and possibly other professionals. Each service would have responded individually by trying to make contact with A and undertaking separate assessments.

Contact with A would have been made by professionals going to her home to knock on her door, as A does not have a telephone. Information sharing between the services would be poor and there would be no coordination of her care plan.

All this disruption would potentially have had a significant impact on her mental health.

MDT Discussion

A's circumstances were discussed in the MDT. The mental health representative advised that A was well known to secondary mental health services and noted that her new circumstances could have a significant impact on her functioning, if her care was not coordinated properly. Different professionals contacting her would increase her anxiety and would ultimately result in her withdrawing and not engaging with services.

The plan agreed was that the community psychiatric nurse (CPN) who A knows well would be the key worker. When the results of the tests were clear, communication with A and care planning would be undertaken through the CPN, to ensure A was not bombarded with new people and joint visits would be undertaken when required.

Challenges and learning

With regard to patient selection, this lady was already known to secondary mental health services that would commission any social care services she needed and also ask the GP to refer to district nurses if required.

It was difficult to determine what would be done differently for this lady, given she is already known to an integrated service. However, it is highly unlikely that mental health services would have learned about the concern regarding her physical health so early in her diagnostic pathway.

A review was planned for 6 weeks' time, for the MDT to review progress with regard to A's physical health and the outcome of any interventions.

Section 5
Organisational Objectives

Bolton CCG	
Bolton Council	
Bolton FT	
GMW	

Information to be added

Section 6
Programme Summary & workstream updates 01/06/14 – 08/07/14

The Health and Care integration programme in Bolton has reached a new phase - progressing from the planning stage to the implementation stage. Two of the five operational work streams are in implementation phase (Intermediate tier and Integrated Neighbourhood teams) and two are in planning phase (complex lifestyles and care coordination centre) Project monitoring plans are in place. The staying well project has been agreed and finalised by council committee and recruitment can now begin to support service delivery A letter has been sent to GPs to request Expressions of Interest to participate in the next phase of implementation. Practices will have the opportunity to choose working with an Integrated Neighbourhood Team or the Complex Lifestyles service which will be running in parallel to the avoidable admissions DES and the over 75 scheme. Selection criteria have been outlined in the letter and a panel will meet to select practices by the end of July and will commence in August 2014.

The support function work streams i.e. finance, performance, IT, workforce, communications/engagement and estates are established and will develop further as the requirements emerge from the design and refinement of the operational work streams. They also provide an overarching monitoring and planning tool for the programme as a whole.

Service Transformation workstream updates

Complex lifestyles		**Overall Rating**	
The provider has been selected from Expressions of interest which is yet to be agreed by the appropriate director at the council Expressions of interest from GP practices interested in participating in the scheme are being collated and the closing date is the 14th July. Practices will be selected based on evaluation criteria that will determine their readiness to participate in the programme.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Select Provider	03/07/14		
Select GP practices for first phase	18/07/14		
Implement key worker/teams	30/07/14		

Care Coordination Centre		**Overall Rating**	
A paper was presented to the JTG to agree the release of funds to support the implementation of a care coordination centre for health and social care. Funding was agreed in principle but an outline paper was requested to determine the support required with the intention of identifying three quotes and providers to deliver the support required. Work is on-going to plan the migration of health services across to the existing SPoC including district nursing and emergency dental services. Similar planning is taking place at the council for social care services with the intention of bringing health and social care services under one access point at a later date. A list of forthcoming work taking place in social care as part of the care bill has been identified and the potential risks and impact the integration of Health and Social Care SPoC could have. This has been raised at the IDG and Integration Board.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Present options paper to CCG Exec for approval	30/07/14		
Select support provider	15/08/14		

Integrated Neighbourhood Teams	**Overall Rating**		
Locality boundaries for Integrated neighbourhood teams have been agreed by the Integration Board. The integrated neighbourhood team steering group meet fortnightly. Multi-disciplinary team meetings are also held fortnightly. The programme plan has been agreed by the steering group. Work is in progress to develop a virtual team for Westhoughton and a standard operating procedure is in place - content and selection criteria are reviewed regularly. Information and results will be collected at a practice level to monitor patient outcomes. Expressions of interest to participate in the next phase are being collated and assessment and selection of practices will take place on 18th July 2014			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Staff commence roles virtually within INT	30/07/14		Review dates with project lead. Recruitment to be closely monitored by Integration Delivery Group with support from workforce workstream

Intermediate Tier	**Overall Rating**		
The implementation Plan has been presented to CCG Execs. Expectations are that evidence is provided to indicate the home pathway is established well enough before the reduction of beds is commenced. Four service development design days have taken place to cover; the rapid assessment team, integrated discharge team, bed based intermediate care and domiciliary intermediate care which has informed the further design of these pathways. The new joint intermediate tier manager, Anne Greenwood, is now in post which will make a significant difference to the pace of change			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Report to Integration Board on workforce plans	11/07/14		
Estates group agree team location proposals	24/07/14		
IM & T group agree proposals and confirm timescales for implementation of IT requirements in the new locations	20/07/14		

More structure is being applied to the reporting mechanisms for each operational work stream. Each work stream now has a project plan with key milestones and target dates that can be monitored against actual progress and issues or blocks identified and addressed or escalated.

A programme issues log is now in existence that is discussed and dealt with or escalated by the programme team.

The IDG has become more delivery focussed and a change in the agenda and focus is expected to facilitate more effective and productive discussions.

Recruitment monitoring and funding approval requests are now being signed off and monitored weekly at the IDG.

Enabler workstreams

Performance Monitoring		Overall Rating	
'- High level indicators received from Bolton Council, Bolton FT and GMW to be included in the performance report, which will be presented to the IDG on Monday 7th July, for approval. - Bolton Council and GMW have agreed to provide a summary by postcode area/ GP practice to map activity across the borough - this work is on-going and is still on track. - Colleagues from all organisations have been contacted for their input to the NHS Benchmarking submission.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Performance report to be completed	30/07/14		

Communications and engagement		Overall Rating	
A communications officer will be appointed to the programme team two days a week to support the immediate comms and engagement work required for then initial implementation phase. Press release issued by the council (with CCG and Trust sign off) about progress with Integrated Neighbourhood Teams and Staying Well Communication to council staff involved in intermediate tier drafted to give an update following preference exercise. Considering which other stakeholders need this message before issuing to staff or at the same time INT and Staying Well press release has formed the basis of an article for Bolton Scene – now gone to print. Distribution to every household in Bolton from 21 July. Forward plan of proactive PR for each workstream in progress. Opportunities currently identified for INT and Intermediate Tier. Complex lifestyles to be considered once provider is appointed.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**

Finance and Contracting		Overall Rating	
The budget for the programme has been established and the first financial report / budget including spend against budget was presented to the integration board on 13th June 2014. Further work is required to complete the section 75 agreement.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**

Estates		Overall Rating	
The estates group are meeting monthly to discuss the wider estates agenda for Bolton. Two workshops have been scheduled for provider estates leads to meet and review forthcoming estates plans. Integration programme team will provide an outline of requirements based on the activity analysis of the Borough and proposed plans to divide the clusters in to two regions which will inform the number of hubs required for the Integrated Neighbourhood Teams.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**

IM&T and IG		**Overall Rating**	
The group will be participating in the estates scoping workshop over the next two to four weeks to provide input in to the preliminary plans and support any decisions relating to coverage, hardware and software.			
Key Milestones July 2014	**Date**	**RAG Rating**	**Mitigating Actions**
Sign off of GM IG agreement	June 2014		Discussions with LA to agree sign off in progress. To be raised at Integration Board Friday 11th July.

Section 7
Performance Headlines

Information to be added

Section 8
Bolton Integrated Health and Social Care Performance Report

Key Performance Indicators – Bolton wide

Key Performance Indicators – Westhoughton

KPI definitions

Data sources

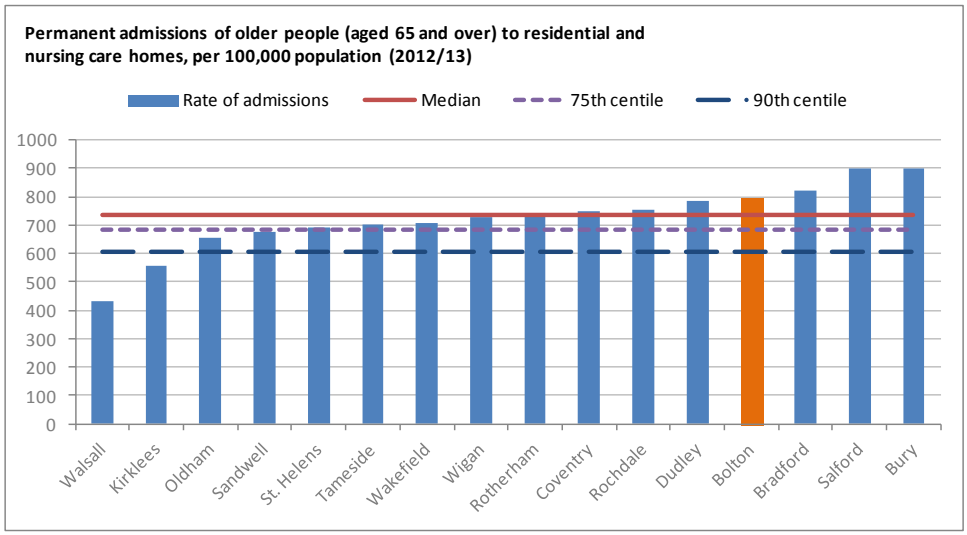
Key performance Indicators – Bolton wide

N1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes

Objective: To decrease

During the baseline year 2012/13, there were 350 permanent admissions to residential and nursing care homes in Bolton for people aged 65 and over. This equated to 793.1 admissions per 100,000 population aged 65 and over.
Chart 1 illustrates how Bolton compared with its statistical peers; in 2012/13 Bolton had the 4th highest rate of admissions to care homes within the group of 16 statistical peers.

Chart 1

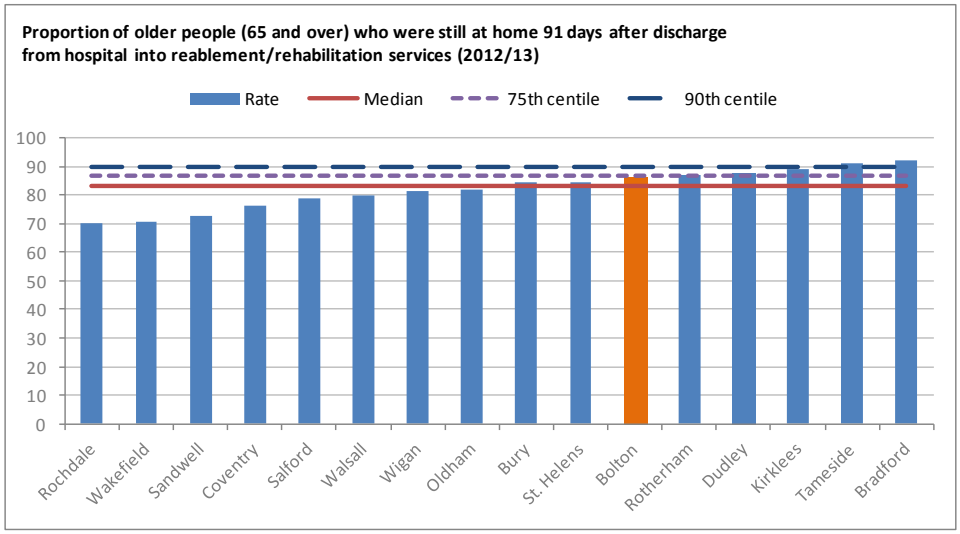


N2. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital in to reablement/ rehabilitation services

Objective: To increase

In the baseline year 2012/13, 85.9% of patients discharged from hospital to reablement/ rehabilitation services were still at home 91 days after discharge. Chart 2 illustrates how Bolton compared with its statistical peers in 2012/13; Bolton ranked 6th within the group of 16 statistical peers.

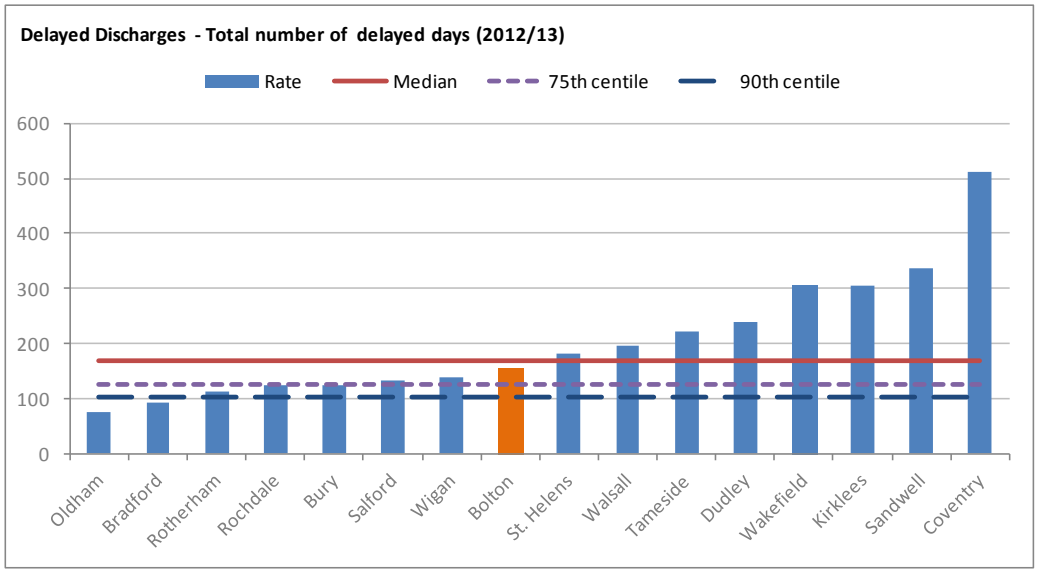
Chart 2



N3. Delayed discharges (total number of delayed days)
Objective: To decrease

In the baseline year 2012/13 Bolton had, on average, 336 delayed days per month. This equates to a rate of 156 days per 100,000 population aged over 18. Chart 3 illustrates how Bolton compared with its statistical peers in 2012/13.
In 2013/14 the average number of delayed days per month was 323.

Chart 3



N4. 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.**

In 2012/13, Bolton had the lowest rate of avoidable emergency admissions when compared to its statistical peers and across Greater Manchester CCGs. There were 511 avoidable emergency admissions on average per month in 2012/13.

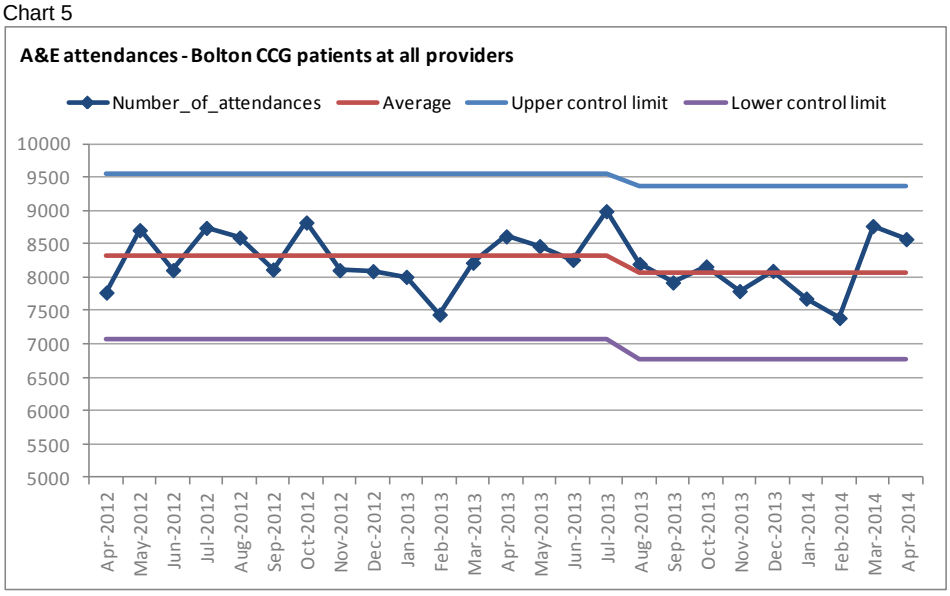
2013/14 will be published later in the year.

GM1. A&E attendances at all providers

Objective: To decrease

Chart 5 shows the number of A&E attendances at all providers over the last two years for all Bolton CCG patients.
The number of attendances decreased significantly from August 2013 to February 2014, however there was a particularly high number of attendances in March and April 2014.

Chart 5

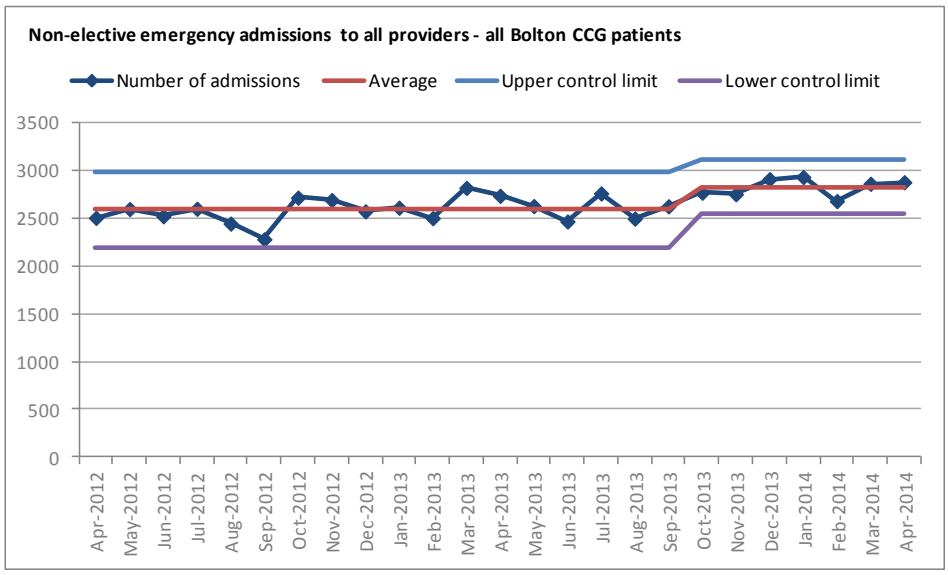


GM2. Non-elective emergency admissions to all providers

Objective: To decrease

Chart 6 shows the number of emergency admissions to all providers for all Bolton CCG patients. There was an increasing trend from August 2013 to January 2014, which has become more stable in recent months. There was a 5.7% increase in non-elective admissions from 2012/13 to 2013/14 for Bolton patients across all providers.

Chart 6

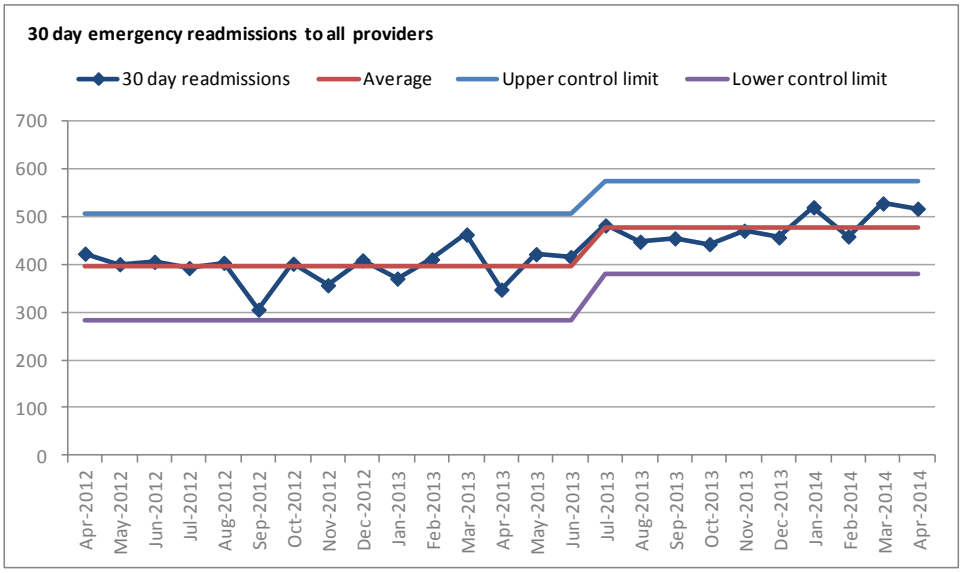


GM3. 30 day emergency readmissions to all providers
Objective: To decrease

Chart 7 shows the number of emergency readmissions within 30 days of previous discharge (following an elective, day case or non-elective admission). There was a significant increase from July 2013. The readmissions rate for the year 2012/13 was 7.8%, for 2013/14 the readmission rate was 8.8% (readmissions as a percentage of all discharges).

There are some exclusions for this measure, full details of which can be found in Appendix 1.

Chart 7



GM5. Increasing the percentage of people who die in their usual place of residence
Objective: To increase

In the period October 2012 – September 2013, 42.4% of deaths in Bolton occurred in the person's usual place of residence. Bolton ranked 6th across their statistical peer group, as illustrated in Chart 8.

Chart 8

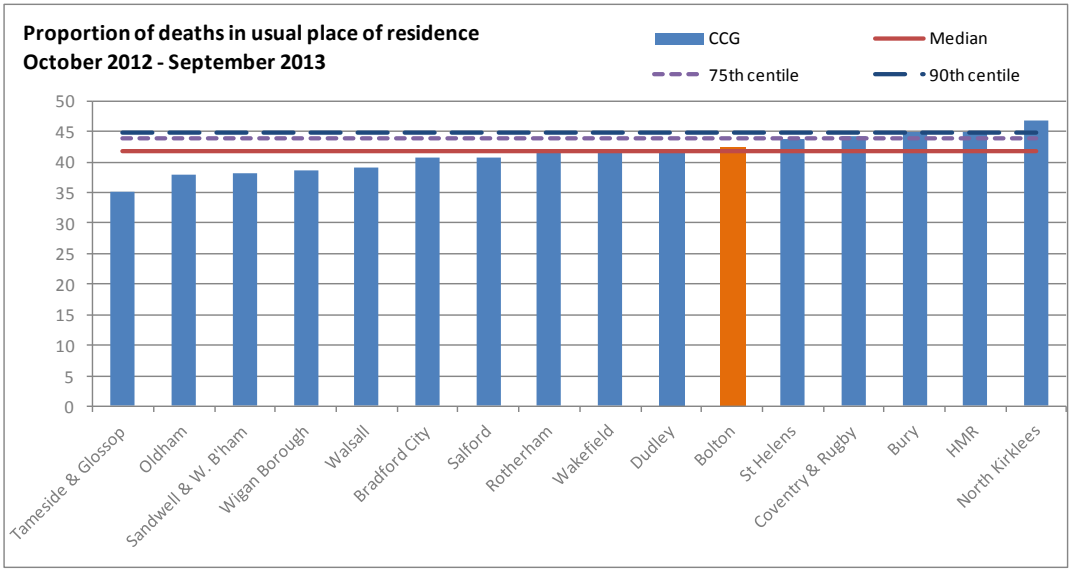
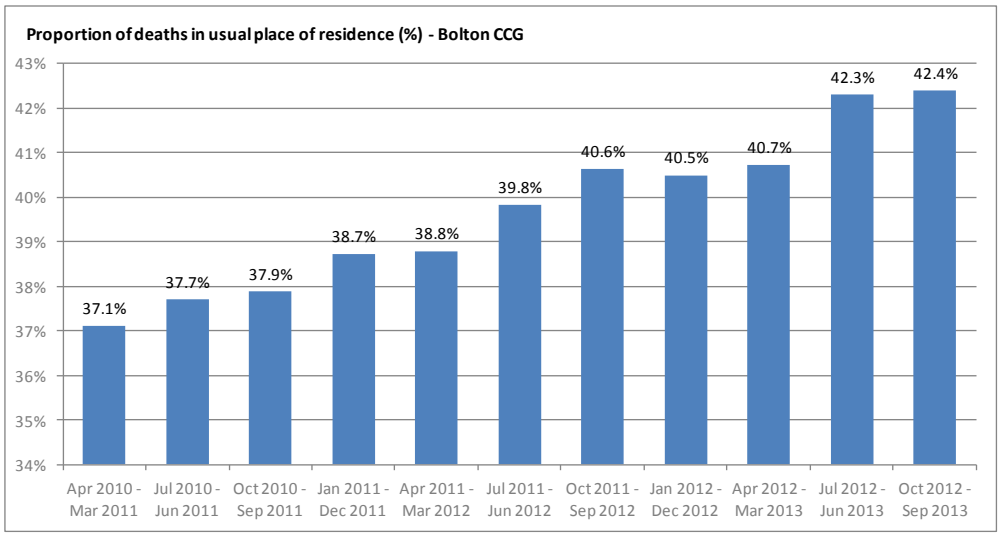


Chart 9 shows a rolling 12 month position for the proportion of deaths occurring in the person's usual place of residence in Bolton. There has been a steady increase from 37.1% in the year 2010/11.

Chart 9

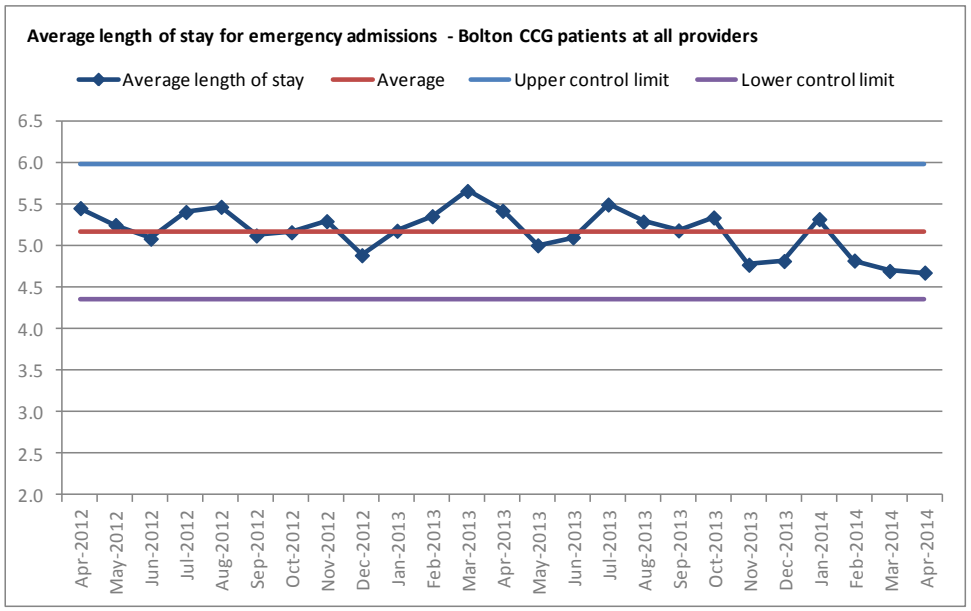


L5. Non-elective length of stay (all providers)

Objective: To sustain

In the year 2012/13, the average length of stay for an emergency admission 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 10.

Chart 10

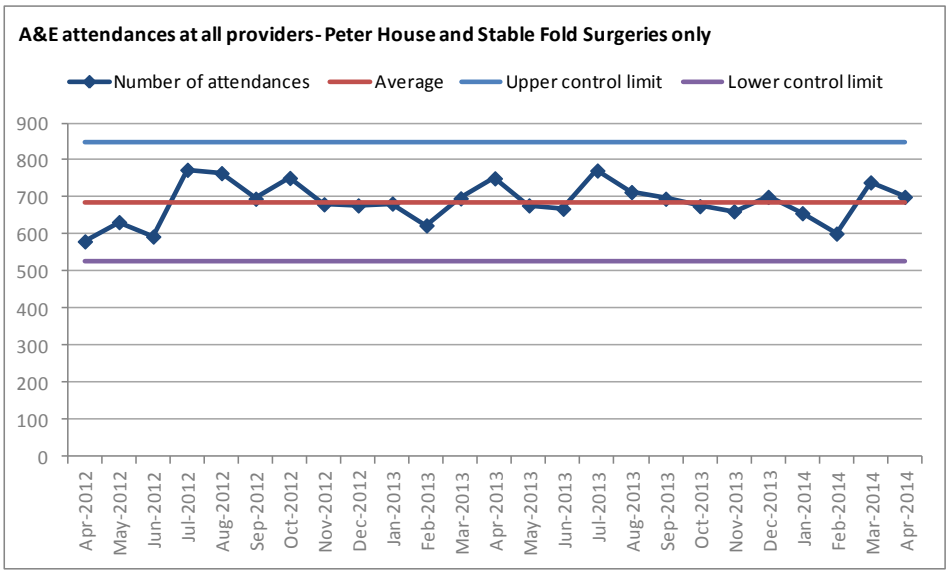


Key Performance Indicators – Westhoughton

A&E attendances at all providers

Chart 11 shows the number of A&E attendances for patients registered with Peter House Surgery and Stable Fold Surgery in Westhoughton. In 2012/13 the practice had 8,158 A&E attendances across all providers. In 2013/14 there were 8,318 attendances, which is an increase of 2%.

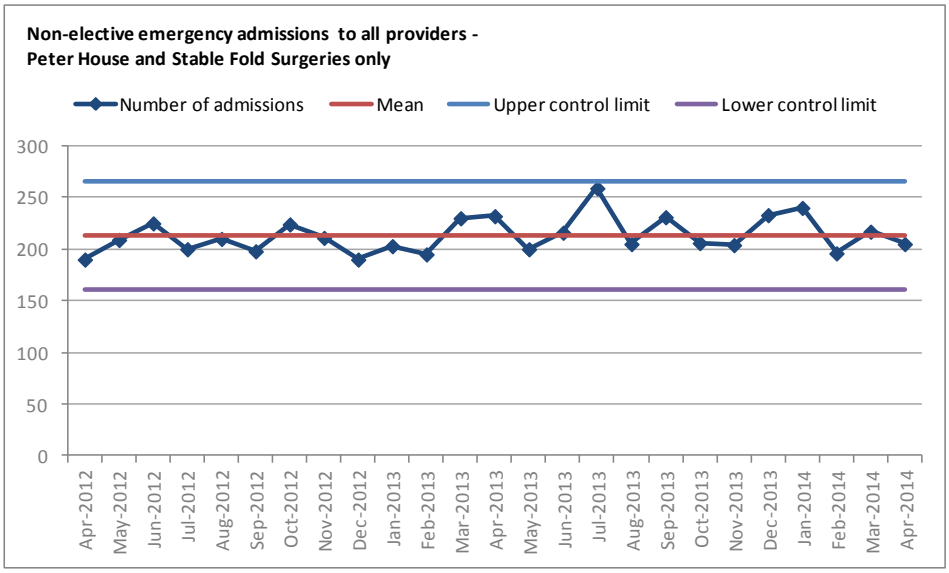
Chart 11



Emergency admissions to all providers

Chart 12 shows the number of emergency admissions for patients registered with Peter House Surgery and Stable Fold Surgery in Westhoughton. Although the trend appears to be relatively steady, there was an increase of 6% between 2012/13 and 2013/14, which is in line with the increase seen across Bolton as a whole (see chart 6 above).

Chart 12



KPI Definitions **APPENDIX 1**

N4. 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

GM3. 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
National Indicators		
N1/ GM4. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Adult Social Care Outcomes Framework (ASCOF)	
N2. 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)	
N3. Delayed discharges (total number of delayed days)	Unify	
N4. Avoidable emergency admissions	Patient Level SLAM/ SUS	
Greater Manchester Indicators		
GM1. A&E attendances at Bolton FT	Patient Level SLAM/ SUS	
GM2. Emergency admissions to Bolton FT	Patient Level SLAM/ SUS	
GM3. 30 day emergency readmissions	Patient Level SLAM/ SUS	
GM4. See N1.	-	
GM5. Increasing the Percentage of people that die in the usual place of residence.	ONS, via National End of Life Care Intelligence Network	
Local Indicators		
L1. Reducing the gap in life expectancy between Bolton and England Average	TBC	
L2. Improved health-related quality of life for carers	TBC	
L3. Improved carer reported quality of life	TBC	
L4. Reducing the gap in life expectancy across Bolton (measured by the sloping index of inequality)	TBC	
L5. Average length of stay (non-elective)	Patient Level SLAM/ SUS	
L6. Reducing the number of longer term care packages	TBC	
L7. Reducing the number of admissions due to falls	Patient Level SLAM/ SUS	
L8. Increasing the number of patients who experience harm free care	NHS Safety Thermometer	
L9. Increasing the proportion of people that are able to manage their own condition	TBC	
L10. Increasing satisfaction with the care and support provided to older people	TBC	
L11. Increasing the percentage of people receiving reablement or intermediate care at the point of discharge	TBC	
L12. Increasing the percentage of people finishing Intermediate care or reablement who have a reduced package of care	TBC	
L13. Increasing the percentage of people finishing reablement or intermediate care who have no package of care	TBC	
L14. Increasing the number of people in receipt of personal budgets or personal health budgets	TBC	

Bolton Council

Greater Manchester West Mental Health NHS Foundation Trust

Bolton NHS Foundation Trust

NHS Bolton Clinical Commissioning Group