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

January 2015

Index

Section	Title
1	Bolton Health & Social Care Integration
2	Introduction and progress headlines
3	Communications and engagement
4	Patient Stories/Case studies
5	Staff Stories
6	Work-stream update
7	Performance headlines
8	Performance report
9	Glossary of Terms

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 Work-streams

High Level Summary

Bolton is firmly in to the second phase of delivery and testing with some positive outcomes and results emerging from the practices, staff and patients involved. This is an opportunity for Bolton's integrated services to test out the model of working and understand the success or challenges the new way of working reveal. Involving practices can be challenging due mainly to capacity within the practices but every effort is being made to support and engage with teams and to provide clarity and consistent messages about the future of integrated working. The programme team are working closely with IT and Estates to drive the planning required for the full roll out of integrated services in 2015. It is commonly understood that communication between all work-streams is essential to ensure requirements are aligned with the accommodation and technology staff will need to deliver the new models of care.

Integrated Neighbourhood Teams

The team caseload is growing. This has been achieved by proactively contacting patients on the 2% risk registers from the practices, referrals directly from GP's and referrals into other services that are passed through to the Integrated neighbourhood team. As contacting patients by telephone has proved ineffective in securing their participation - a patient information leaflet has been developed that is sent out to patients with an explanatory letter. The results of this approach will be reviewed in due course. A generic assessment tool is being tested by the team which will form part of the team tool kit.

Complex Lifestyles

To date 6 patients from Waters Meeting are engaged with the key worker – of these 1 is not responding to telephone calls and contact, and the key worker is unable to visit their home due to risk issues.

3 patients from Dalefield have been identified – no contact could be made with 1, 1 closed (no further help required – services are place in place to support the patient) and 1 not responding following initial visit at surgery.

There has been no further progress with Beehive though contact is being maintained and every encouragement to engage with the service being Garnett Fold – have identified patients for their "own" list and contacted three of them. They are due to be visited 02/12/14. The practice manager is discussing more patients to put on their list with the GPs on 03/12/14.

Intermediate Tier Services

Significant progress is being made within intermediate tier services. The number of hospital admissions avoided continues to increase month on month with a greater number of GP referrals being received by the Admission Avoidance Team as well as the number of patients being identified within A & E and with appropriate community services identified to support a return home without admission. Similarly the number of service users being managed within the home pathway by reablement and therapy is increasing.

Recruitment is continuing and posts being filled with a number of staff in post from 5th the January.

The Winifred Kettle beds have now closed with the support of the home pathway and the 24 hour reablement service.

The performance and quality dashboard continues to be available monthly

Work force development plans are continuing with support from organisational learning and development departments to ensure that staff have the skills and competencies to work in the new integrated teams

The medical model support to our intermediate care beds still needs agreement.

Draft plans are in place for the integrated discharge team and an agreed model will be defined by early January. The draft paper describing the model is due to be presented to the integration board in January.

Work is progressing at pace regarding the co-location of the intermediate care at home and reablement services-the new location has been agreed as Pikes Lane and estates are working towards early implementation.

Care Coordination Centre

Process mapping of access routes for all elements of Intermediate Tier (Referral & Assessment, Reablement, Intermediate Care at Home and Bed-Based) completed by external contractor. The original intention was to relocate the Admission Avoidance Team to Waters Meeting Health Centre with the Single Point of Access to simplify the referral process for the winter period. However, following more detailed analysis of the working practices it became apparent that this would be far more involved than originally anticipated and would not provide any significant benefits at this stage.

Staying Well

Good progress with the team now in place, commencing with their induction and training programme. A comprehensive training programme has been developed and will be delivered to the team over the next few months. This includes building relationships with low level preventative services where most of the Staying Well contacts will be. The review of the Staying Well tool kit is nearly finalised and a 3 days training session for the toolkit has been developed and ready to be delivered in the first week of January. The training for the tool kit aims to support staff to deliver a person centred holistic conversation based on the individuals quality of life. The training includes a skills based session, maximising the opportunity to empower individuals and focus the conversation using an asset based approach. Patient lists from the practices have not yet been received therefore the risk stratification work has not commenced as of yet. However conversations with practices have commenced and meetings arranged to discuss any potential barriers. Having had a couple of conversation with practices the barriers are mainly time and dedicated support to extract data. We aim to start the service in February.

Better Care Fund

Confirmation of the final **approved** status from the GMAT has now been received.

Section 3 - Communications and engagement

Our approach to communications and engagement has been revised and will be guided by three principles – informing, dialoguing and engaging in decision making.

Informing

We are committed to ensuring that patients and the public are informed about our plans. We have produced a suite of communications materials including a summary booklet which details the case for change, our strategy and more details of how we plan to deliver integration. This will be imminently available on partner organisations' websites and in print at various community locations. Updates will also be regularly communicated via partner organisational channels, websites, social media and via mass media.

Dialoguing

A range of stakeholder engagement activity focusing on integration has taken place across the Bolton health and care system. For example in December 2013, the Bolton Vision Conference took place involving over 100 participants from across the public, private and third sectors and sought views and feedback on our vision to integrate health and social care in Bolton. Additionally, in April 2014, a dedicated public event themed 'Changing our NHS' took place with over 150 people attending. Integration has been covered at a range of other patient/carer/voluntary groups including the Bolton Health, Care and Wellbeing Forum, Bolton Community Homes Board, Stronger Communities Partnership and most recently the Equality Target Action Group.

We are committed to ensuring that our engagement activities amount to more than simply informing and that we continue to truly dialogue with stakeholders and members of the public moving forward. To this end, we will continue to attend and engage on an ongoing basis with existing patient/carer/voluntary groups. We will explore new opportunities of engaging with hard to reach groups, having recently engaged directly with BME and LGBT representatives and members of the Deaf community via the Equality Target Action Group (ETAG). We are working closely with the wider CCG engagement team to develop opportunities to engage with representatives from other hard to reach groups for example new European migrants.

Engaging in decision making

Where specific feedback is received via patient/carer/voluntary groups or other channels, we are committed to accurately recording and where appropriate acting on such feedback. For example, recent feedback around accessibility of services for Deaf people has been fed into operational plans for intermediate tier services. To ensure that we are engaging in a reciprocal cycle, we will publish regular 'you said, we did' updates via our website and appropriate other channels as well as reporting back to the relevant forums.

Section 4 Patient Stories

The Integrated Neighbourhood Team has been working to capture and document a range of patient interventions and stories. Some stories are simple testimonial quotes while others include clinical background information and details of team interventions.

Daughter of elderly Asian patient

> *"I am so grateful to you and your team for showing such interest in my mother. She was prescribed antibiotics by the GP over the phone and wasn't told about stopping her weekly methotrexate whilst suffering with infection. You have shown such care in taking the incontinence problems seriously."*

Elderly patient living alone

Though prescribed a morphine patch for chronic pain, the patient was not applying the patch because she didn't know how to and didn't understand how the treatment worked. Instead the patient was taking excessive doses of paracetamol along with doses of co-codamol which also contains paracetamol. The pharmacist worked closely with the patient to aid her understanding of the danger of excessive paracetamol use and to demonstrate properly the use of the morphine patches.

> *"It's a good job you came to take these tablets away because I thought it was alright to have extra paracetamol when the ones in my blister pack hadn't done the job at taking away my pain".*

Bedbound patient living with partner

This patient is living with myopic muscular dystrophy, has chronic heart and lung problems and is on the end of life register. The patient's partner is finding it difficult to cope owing to the patient's deteriorating condition. The key worker has referred the patient to the hospice day centre to offer her partner some respite.

A medication review has been undertaken and joint working between the key worker and GP is underway to reduce admission and GP visits. The key worker organised an oxygen review at home, following which oxygen therapy was initiated. This offered enormous relief to both the patient's and partner's anxiety having the oxygen in place. Problems with the patient's hearing and sight were also addressed by arranging an audiology and optometry home visit with hearing aids now organised.

All additional support has been arranged with minimal disruption to the patient and partner and coordinated by a single member of the Integrated Neighbourhood Team.

Patient living in supported housing

This patient has a history of resisting engagement with health and care services and was reported as being a challenge to deal with. The patient has had multiple falls and regular worsening of chronic conditions. The patient initially declined the offer of support for fear of being admitted to a care home. A mental health staff member was nominated as key worker and has been visiting the patient every couple of days to build trust and a positive therapeutic relationship.

Care staff from supported housing commented that they have never seen the patient bond with anyone like he has with his key worker. The patient has now begun to accept assistance and support from other members of the INT. The LTC nurse visited to monitor his lungs and to prescribe medication. Therapists

have been involved to support the patient's mobility and reduce the risk of falls. Over the Christmas period, the patient has a severe chest infection which without support of the INT would almost certainly have resulted in hospital admission. Following the support and assistance, the patient has reported a significant improvement in relationships with carers in supported living.

Section 5 - Staff Story Intermediate Tier Services

Previously having worked in primary care and community pharmacy, the Integrated Neighbourhood Team (INT) pharmacist reports very much enjoying the new role. "I'm finding my work with the INT is much more rewarding than my previous job roles. When I was working in medicines management, I missed not having direct involvement with patients and when I was working in community pharmacy, I did not have ready access to patient data which I sometimes needed to deliver effective input from a pharmacy point of view."

A highlight of the new role for the INT pharmacist is getting to work with patients in their own homes. "What is different about my current work is being able to see patients in their own environment. I find patients are often more relaxed and therefore more open and honest about their medicines making it easier to pick up potential and sometimes serious problems. Building trust with the patient also facilitates working much more preventatively."

"I feel empowered to work more effectively with patients because of the holistic view I get by having daily contact with other professionals involved in caring for the patient. I am also able to ensure that any issues regarding medicines are picked up routinely in team MDT discussions, assessment and in care planning."

"Preventative action is a big focus of my work. I have identified many issues that are simple to solve but if not picked up can lead to serious problems."

Examples

Diabetic foot-care

"Many older people with diabetes are not looking after their feet very well which can leave feet very dry and sore. This has a big potential for impacting on mobility, falls and general wellbeing. Simply ensuring moisturising cream is added to a prescription and that support is given with this need if the person is not able to self-apply prevents potentially serious problems for patients with diabetes."

Medicine dosage

"I have encountered patients taking aspirin above the recommended dose for their condition and I have been able to put this right. There has also been a need to ask for things to be added to a prescription such as calcium tablets."

Pain management

"I worked with an elderly patient who lives alone and was not applying a morphine patch to treat her chronic pain because she didn't know how to use it nor did she understand how it worked. Instead she was taking the maximum daily dose of paracetamol from a blister pack and had additional paracetamol tables in an eggcup which she took like sweets. She was also taking co-codamol which contain paracetamol. I worked very closely with this lady to enable her to understand the risk around what she was doing with her medication and taught her to apply her morphine patch."

The patient's comment to me was:

"It's a good job you came to take these tablets away because I thought it was alright to have extra paracetamol when the ones in my blister pack hadn't done the job at taking away my pain."

Section 6 – Work-stream Milestone updates 06/12/14 to 05/01/15

Service Transformation work-stream updates

Complex lifestyles	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key Activities

The existing clients have been contacted regularly to provide support.

Key Activities and Risks

Overall to date the engagement with the GP's has not been as good as we would have hoped, to get GP's to provide contact the list of identified patients in the first instance has been a challenge and taken a lot of time and resource in regards to chasing up. The concern going forward was if this model is kept the same and scaled up to include all GP practices following the pilot phase, the time and resource required to encourage the GP's to contact the identified patients would be significant. As such a preliminary evaluation is planned for the last week in January to discuss the possible approaches moving forward. These options will then be brought back to the Integration Board for discussion.

The second risk is that following the pilot period (finishing in March) if we decide to scale up the approach and commission out a larger service this will need to follow the councils tendering process and would take in the region of 6 months to commission, while we may be able to extend the current pilot for 3 months this potentially could leave a gap of up to 3 months without a service. In addition if another provider (not Urban Outreach) wins the tender this will mean going through another development phase. The operational group is working fortnightly to discuss and address these issues and this will be regularly fed back through the Integration Delivery Group.

Finally, the issue of information sharing is still present. There has been no final signed agreement between organisations, therefore the formal contract with Urban Outreach has yet to be produced and signed. There have been difficulties bringing together the key individuals from the different organisations e.g. Council, CCG and the CSU. We have been advised by the Council legal team we can continue the pilot using patient consent however, without the data sharing agreement formally in place it would be unlikely we could go out to tender for the roll out the programme.

Key Activities to Complete

Continue to work with practices to identify and work with the identified patients.

Key Milestones	Date	RAG Rating	Mitigating Actions
Sign off of provider contract and service spec.	In progress		Provider contract awaiting agreement for data sharing. Monitored by Jon H and legal team to resolve issue. UO to invoice Bolton Council for payment of service delivery to date. No impact anticipated on delivery of service.
Ensure Information sharing agreement is in place between provider and GP practice	Awaiting signoff		Templates have been completed and are subject to agreement by exec and boards. Awaiting sign off of AGMA IG documents by partner chief execs before content can be transferred to the new template. Being monitored by programme team.

Care Coordination Centre (CCC)	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key Activities

Tailor Train have continued to undertake capacity and demand analysis and are preparing documents for consideration by the CCG Exec.

Key Activities and Risks

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 Social Care Bill will have an impact on the original timescales proposed in the Programme Plan. The pilot of the Early Intervention and Prevention Service will inform the decisions as to which elements of Social Care are accessed via the Care Co-ordination Centre. The CCC requires a clinical triage element to be incorporated-a proposal is for this to be provided by co-location of the Referral & Assessment Team, with a member of the team covering the triage element on a rota basis. The estates work-stream will need to identify a suitable location for the CCC-to provide adequate space for staff and to accommodate all technical infrastructure requirements. An options paper needs to be developed for this.

Key Activities to Complete

Definitive list of services to be agreed as part of joint work to agree service delivery models between Providers and CCG. Phil Howe (FT IM&T Technical Infrastructure expert) to be consulted regarding technical infrastructure requirements for the CCC. Tailor Train have commenced design work with existing SPA service managers

Key Milestones	Date	RAG Rating	Mitigating Actions
Presentation to CCG executive and workforce group on vision for CCC	**21st Jan 15**		
Draft options paper re delivery model and possible commissioning arrangements.	**11th Feb 15**		
None to report			

Integrated Neighbourhood Teams	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key activities

The team are actively visiting patients, attending the MDT's of the practices where this has been requested by the practice and hold regular team MDT's to discuss patients. Detail is being collected on the numbers of patients seen and the outcomes which will be included in the monthly report to Integration Board. The Team Leader post has gone out to advert, closing date the 9th January 2015. Work has been completed with finance to ensure the recruitment planned is fully aligned with the budget available and the recruitment trackers comply. Estates have been provided with proposed numbers of staff for roll out and proposals for co-location within the estate that is available. Representatives from the INT steering group will join an estates work stream. IT access requirements have been reviewed now the team is operational and the document will be updated for IM & T work stream.

Risks and Issues

Although the number of patients known to the team is growing there is still a need to increase these numbers much more. Pathways into the team by other means than via the GP Practices are currently being developed. The team are to also focus attention on patients known to the GP's in this phase who have been discharged from hospital. Patients who are not currently in receipt of existing services are often declining the offer of support from the team despite continued attempts to engage them. The team do not have access yet to the primary care records in all the GP Practices involved in this phase.

Key Activities to Complete
Recruitment is in progress for 15/16. Planning for roll out to inform estates so that accommodation for the next phase can be agreed with the council and the FT to be continued. The recruitment of a team manager is in progress the advert has gone out closing date 9th January. To agree the collection of patient experience processes. To clarify the pathways between the nursing resource and the team.

Key Milestones	Date	RAG Rating	Mitigating Actions
Community Assessment Officers in post aligned to GP practices	01/10/14		This recruitment is in process with one new recruit in place and 2 appointed awaiting start dates.
Business Support Officer	01/11/14		This post has now been appointed to and the post holder is due to commence on the 5th January.
Reports outlining workforce alignment proposals to Integration Board for agreement	12/09/14 Deadline to be extended to align with estates work stream. 1st meeting 13th Jan 15		This report was to confirm the workforce to be aligned to the Integrated neighbourhood Teams across the council and Bolton FT based on work that was completed around new demand and existing activity in services across the borough.
Access to GP Practice records for some members of the INT	01/12/14		Arranging access to primary care records for those practices willing to engage and allow access for selected members of the team is overdue. All GP practices are agreeable to sharing clinical records on site though training is required. Remote access requires more technical work being lead by CCG.

Intermediate Tier	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key activities
A combined Local Authority and NHS monthly performance report continues to be available.

Risks and Issues
There is a risk that data reports may be flawed due to Business Intelligence teams not having access and visibility to systems raw data in both the NHS and LA systems and reports are reliant on spread-sheets being completed in both organisations and then collated. Information sharing agreements are still required. The length of time taken to recruit staff into posts has delayed service development but many more posts will be filled early in January 2015.

Key Activities to Complete
Draft model for an integrated discharge team. Progress on the medical model.

Key Milestones	Date	RAG Rating	Mitigating Actions
GP and medical model to be taken to CCG Executive.	Date to be confirmed.		Collaborative meetings taking place to progress the medical model.
Integrated discharge function	TBC		Draft plans being developed for model to be agreed January 2015

Removal of remaining beds at Winifred Kettle.	02/01/14		Completed
Progression of medical model.	31/12/14		Collaborative meetings being planned to progress the medical model.
IT & Estate work packages to be agreed at Integration Board for co-location and in place to support winter pressures.	TBC		IT & Estate to agree, meeting on 10th December. All requirements to be agreed then process and protocol going forward to be agreed.
Staffing recruitment.	On-going		Site for co-location of the home based team identified via estates. Existing home based services in place and activity is increasing. Skills and competencies being developed to support the new team via learning and development Existing admission avoidance function in place and recruitment taking place to establish enhanced service.
New home pathway in place	On-going		Site for co-location of the home based team identified via estates. Existing home based services in place and activity is increasing. Skills and competencies being developed to support the new team via learning and development Existing admission avoidance function in place and recruitment taking place to establish enhanced service.
New admission avoidance service in place	On-going		Existing admission avoidance function in place and recruitment taking place to establish new service.

Staying well	**Overall Rating**	**Nov 2014**	**Dec 2014**	**Jan 2015**

Key issues and Risks
Dependencies update:-
Availability of practices for meetings is limited the earliest dates for practices meeting is the month of January.
Index of Potential Care Needs risk stratification not complete due to all practices lists not received
Awaiting confirmation from IDG regards confirmation of Hubs and location for INT's so Staying Well Co-ordinators can be aligned and contracts drawn up with GP Practices.

Activities for next period
Continuation of Induction and Training Programme for staff
Completion of GP service level agreements and honorary contracts by the end of January, meetings with GP Practices booked in the month of January
Completion of Impact assessments by the February
Staying Well Team to design client offer letter and marketing materials
Staying Well Co-ordinators to meet and greet preventative services, share learning, build relationships for when the service commences to ensure seamless effective targeting of resources
To deliver Staying Well Toolkit training

Support required
Allocated one off Data Facilitator Support for practices to extract data so risk stratification and

Still awaiting confirmation if information sharing agreements for GP Practices are drawn up collective for Integration or are individual work-streams required to develop their own

Milestones
Staying Well Team now in post and have started their Induction and Training Programme
Staying Well Tool Kit Training Product developed by Public Health and will be delivered as a pilot to the new team in the first week of January

Key Milestones	**Date**	**RAG Rating**	**Mitigating Actions**
Staying Well Team now in post and have started their Induction and Training Programme.			
Staying Well Tool Kit Training Product developed by Public Health and will be delivered as a pilot to the new team in the first week of January.			

Enabling work-streams

Performance Monitoring	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key activities

The monthly performance report has been revised following feedback from the analysis workshop on 10th November, the Integration Board and the Joint Transformation Group. Where possible, all indicators are now benchmarked across Greater Manchester as well as showing the Bolton position. Local Authority measures are still outstanding as we work through the specific definitions. They will follow in future reports when agreement has been reached.
Practice profile reports have been produced for the practices engaging with the Integrated Neighbourhood Team in Great Lever, which include a demographic profile, long term conditions profile and secondary care activity.
Integrated Neighbourhood Team patches have been revised to reflect the Council's area working boundaries. Revised analysis of baseline activity to inform the apportionment of staff across the revised patches has been carried out.
A meeting has been held to discuss proposed KPIs for the Integrated Neighbourhood Teams. Further work required.

Key Activities to Complete
Further work on KPIs for the INTs.

Key Milestones	Date	RAG Rating	Mitigating Actions
Further work on KPIs for the INTs.	TBC		KPI's to be confirmed when service specifications finalised

Communications and engagement	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key activities
Key products completed and available including Bolton View, FAQs and PowerPoint slide-deck
Branding options paper is being drafted
Patient information leaflet and letter developed and in use by INT

Risks and Issues
None to report

Key Activities to Complete
Bring branding options paper to January IDG/ Feb Integration Board
Draft GP comms
Integration presentation at CCG staff briefing
Develop supporting patient information for Intermediate Tier

Key Milestones	Date	RAG Rating	Mitigating Actions
Agree key messages and produce control document	05/12/14		On track - complete and shared with comms and engagement leads via work-stream group
Prepare PowerPoint presentation for use by senior managers with staff	05/12/14		On track - final draft awaiting sign off
Prepare set of FAQs to help get consistent messages	05/12/15		On track - final draft awaiting sign off
Develop Bolton branding and strapline	TBC		Individual services requesting visual identity for uniforms etc. - branding options paper in draft shortly to be presented to key decision

			making groups

Workforce	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key activities

Fortnightly team development sessions have continued for the Integrated Neighbourhood Team-generic assessment documentation being piloted with regular review and re-design involving the team. Next development session on 7th January to focus on management of heart failure patients within the Integrated Neighbourhood Teams and development of an end-to-end care pathway with the Specialist (Acute) Heart Failure Nurse. Key Worker Development session held on 23rd December for Intermediate Tier staff, to clarify expectations of the key worker role and provide patient experience feedback to staff-specifically relating to the patient perception of care co-ordination and personalised goal setting.

Risks and Issues

Recruitment of local staff to Intermediate Tier, INTs, and Care Homes could destabilise other clinical teams in the health economy, both in the acute and community sectors. The risk is to be mitigated by ensuring backfill in place before leaving dates are agreed.

Key Activities to Complete

Integrated Care Workforce Demonstrator site-proposal to be submitted by 16th January-to be taken forward by members of the Workforce Steering Group.

Key Milestones	Date	RAG Rating	Mitigating Actions
Commence roll out of Culture Club	1st February 2015		Awaiting confirmation of start date of Culture Club course designer / facilitator

Finance and Contracting	Overall Rating	Nov 2014	Dec 2014	Jan 2015

Key activities

Work is being undertaken to determine the value of the budgets to be pooled, using a phased approach. Consideration has been given to the benefits of increasing the pool beyond the BCF schemes, by incorporating the whole of a service where that service receives a significant element of its funding from the BCF from 2015/16 onwards. The proposed integration pot of £39.5m is an indicative figure that may change as the Pooled Budget elements are finalised.

For a number of the integration schemes, business case outlines have been completed but others require further work before the related expenditure is approved. Work is also on-going to develop service specifications.

Risks and Issues

Funding gaps in relation to the services that have been identified for pool have been identified, currently estimated at £400k. As work is still currently underway to confirm additional funding requests and the value of the Pooled Budget for Phase 1, discussions are still underway to assess how the gap will be addressed.

There are expectations for integration schemes to start deliver ing benefits in 2014/15 - i.e., £432k savings expected from Intermediate Tier and INT. However, there is a risk that these savings may not be realised due to slippages in scheme start dated

Key Activities to Complete

Recurrent funding for all staff for 2014/15 and 2015/16 has been confirmed (comfort letters were issued to BFT and GMW to provide the relevant assurances). There are some funding gaps that have been identified for 2015/16-discussions are currently underway as part of the development of Integrated care contractual arrangements (i.e., Section 75 agreement and Risk Share arrangements) to agree how these will be addressed.

Additional non-recurrent funding requests have been received in relation to INT team leader post and the workforce demonstrator. These are currently estimated at £120k (to be confirmed) for 12 months. Discussions are currently underway regarding how the elements falling into 2015/16 will be funded. To be confirmed by end of January 2015.

Work is currently underway to develop the Section 75 agreement and the risk share framework. A paper setting the approach and to nominate the pool host being taken is being presented to CCG execs and Council Deputy Leader on 7th January 2015 for approval.

Key Milestones	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 (original letter sent on 03/11/14 and revised one on 13/11/2014). Following discussion on BCF funding and payment arrangements between FT and CCG finance teams, an additional letter was sent to the FT on 10/11/2014.
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	Nov 2014	Dec 2014	Jan 2015

A workshop has been held in December in which the work-streams tabled requirements for future hubs. Locations have been suggested for some work-streams as an option but no formal sign off have been given to initiate any moves. It was previously agreed at the Integration Board that formal sign off for any planned moves will be given by Bolton Strategic Estates Group, chaired by Annette Walker from the CCG.

A new Estates work-stream begins in January and will work to define, implement and deliver estate requirements for integration.

Key Milestones	Date	RAG Rating	Mitigating Actions
Deliver Estates request protocol to be shared with all work-stream leads	On-going		Coordination of estates and IM&T teams is in progress and they will work collaboratively to implement an agreed process to deliver estate and IM&T requirements.
Prepare plan and timetable for move to support colocation of Intermediate Tier home based reablement service	05/12/14		Estates lead working directly with work-stream lead for Intermediate tier to progress.

IM&T and IG	Overall Rating	Nov 2014	Dec 2014	Jan 2015
The work-stream plan for IT and Information Governance is now operational and an IT manager is now in place. The work-stream meetings are now every two weeks. Progress is being made to tighten up the technical requirements that have been emerging. There is an agreed timeframe of the end of January for the scoping of IT requirements and quotes from three different providers are currently being collated.				

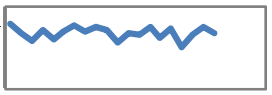
Key Milestones	Date	RAG Rating	Mitigating Actions

Updated 04/12/14

Section 7 - Performance Headlines

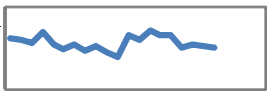
Emergency admissions (Bolton CCG patients, all providers)

The CCG's 5 year plan target is to reduce the number of emergency admissions by 2.7% from 2013/14 to 2014/15. For the purposes of this measure, BCU activity in 2013 has been added in to the baseline year. In the month of November, the number of emergency admissions was 44 (1.5%) above plan. Year to date (April to November) the number of emergency admissions was 325 (1.4%) above plan.

In Month (November)		YTD (April - November)		Trend from Apr 2013 to Nov 2014
Plan	Actual	Plan	Actual	
2,848	2,892	22,587	22,912	

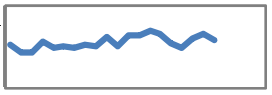
A&E attendances (Bolton CCG patients, all providers)

The CCG's 5 year plan target is to reduce the number of A&E attendances by 1.1% from 2013/14 to 2014/15. In the month of November, the number of A&E attendances was 240 (3.3%) above plan, perhaps due to a relatively low number of attendances in November last year. Year to date (April to November) the number of A&E attendances was 1,668 (2.7%) above plan, partly due to a high number of attendances earlier in the year.

In Month (November)		YTD (April - November)		Trend from Apr 2013 to Nov 2014
Plan	Actual	Plan	Actual	
7,300	7,540	62,163	63,831	

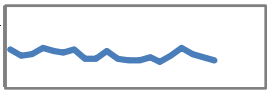
30 day readmissions (Bolton CCG patients, all providers)

The number of 30 day readmissions has increased by 466 (13%) when comparing April - November 2014 with April - November 2013. The readmission rate for this year to date (April - November) is 9.5% which is an increase from 8.6% in the same period last year.

In Month (November)		YTD (April - November)		Trend from Apr 2013 to Nov 2014
Last year	This year	Last year	This year	
470	493	3,594	4,060	

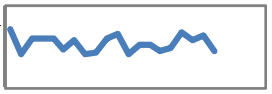
Non-elective average length of stay (Bolton CCG patients, all providers)

The CCG's 2014/15 plan for average non-elective length of stay is 4.8 days. For the current year to date (April - November) the average non-elective length of stay was 4.9 days. This is a decrease from 5.1 days in 2013/14.

In Month (November)		YTD (April - November)		Trend from Apr 2013 to Nov 2014
Plan	Actual	Plan	Actual	
4.8	4.7	4.8	4.9	

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 4.1 days for the current year to date (April - November). This is equal to the average length of stay in the same period last year.

In Month (November)		YTD (April - November)		Trend from Apr 2013 to Nov 2014
Last year	This year	Last year	This year	
3.8	3.9	4.1	4.1	

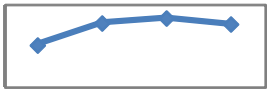
Permanent admissions of older people to nursing and residential care homes

There was an increase in the number of permanent admissions of older people to nursing and residential care homes in 2013/14 compared with 2012/13.
The Better Care Fund target for this measure is to decrease the number of permanent admissions to residntial and nursing care homes to 378 in 2014/15.

2010/11	2011/12	2012/13	2013/14	Trend (annual figures)
340	345	350	380	

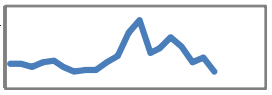
Proportion of patients still at home 91 days after discharge from hospital in to reablement services

There was a decrease in the proportion of patients still at home 91 days after discharge from hospital in to reablement services in 2013/14 compared with 2012/13.
The Better Care Fund target for this measure is 82.1% in 2014/15.

2010/11	2011/12	2012/13	2013/14	Trend (annual figures)
52.3%	79.7%	85.9%	78.5%	

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, due to a considerably high number of delayed days at the start of the financial year. However the trend line illustrates that the number of delayed days appears to be decreasing in recent months and in November the number of delayed days was below plan.

In Month (November)		YTD (April - November)		Trend from Apr 2013 to Nov 2014
Plan	Actual	Plan	Actual	
367	203	2,936	3,855	

Updated 04/12/14 LT – Section 8 contains a series of charts to illustrate the key points above, as well a more comprehensive range of indicators.

Section 8 - Performance Report

Bolton Integrated Health and Social Care

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

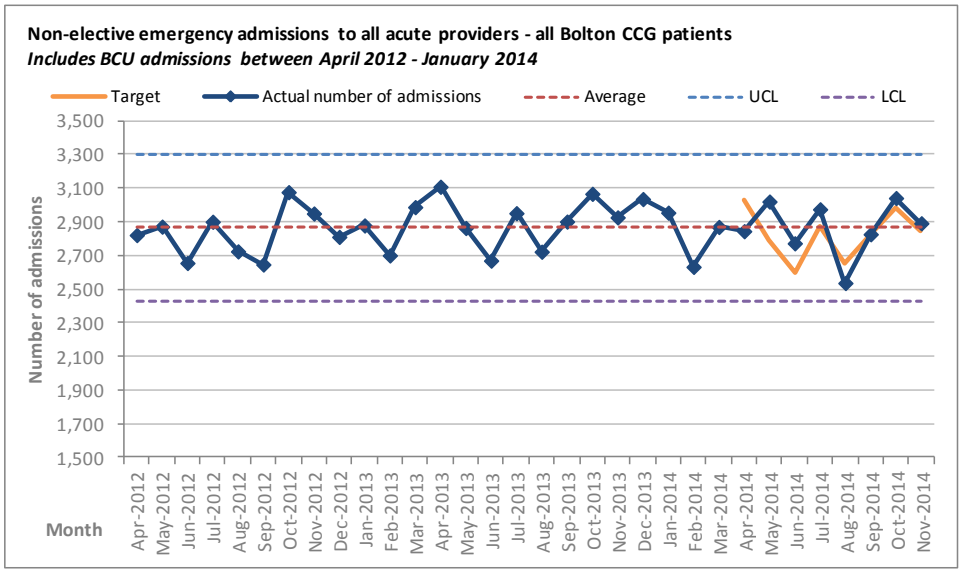
BCF1. Total emergency admissions
Objective: to decrease

The key measure which will be used for Better Care Fund (BCF) performance payments 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.

Bolton CCG's 5 year plan target for 2014/15 is a decrease of 2.7% from 2013/14.

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 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

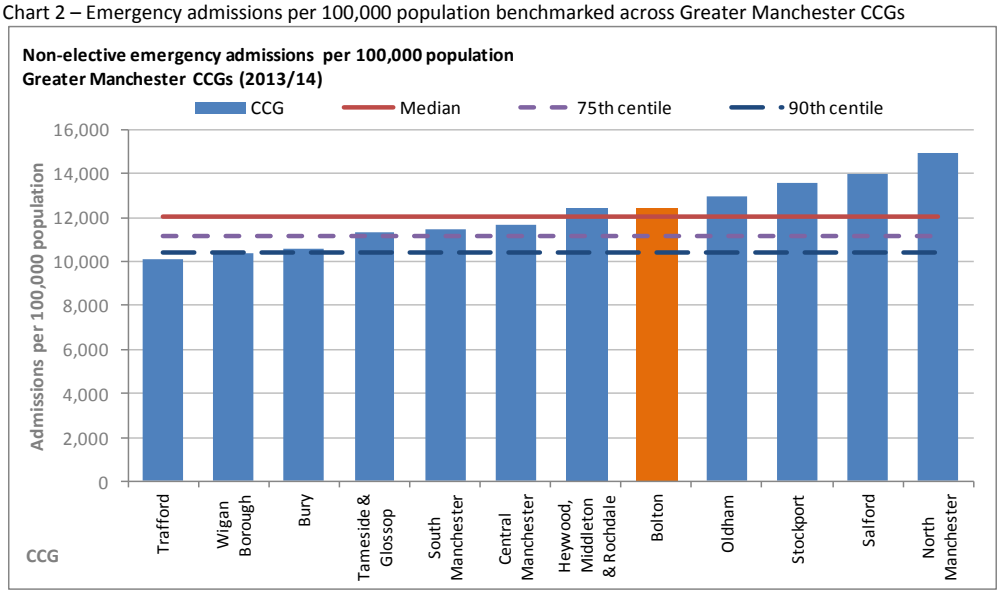


Chart 2 illustrates that, when compared with Greater Manchester CCGs, Bolton CCG benchmarked just above the median rate in 2013/14.

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, this equated to 856.2 admissions per 100,000 population aged over 65. In the Better Care Fund submission, Bolton has 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 targets.

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

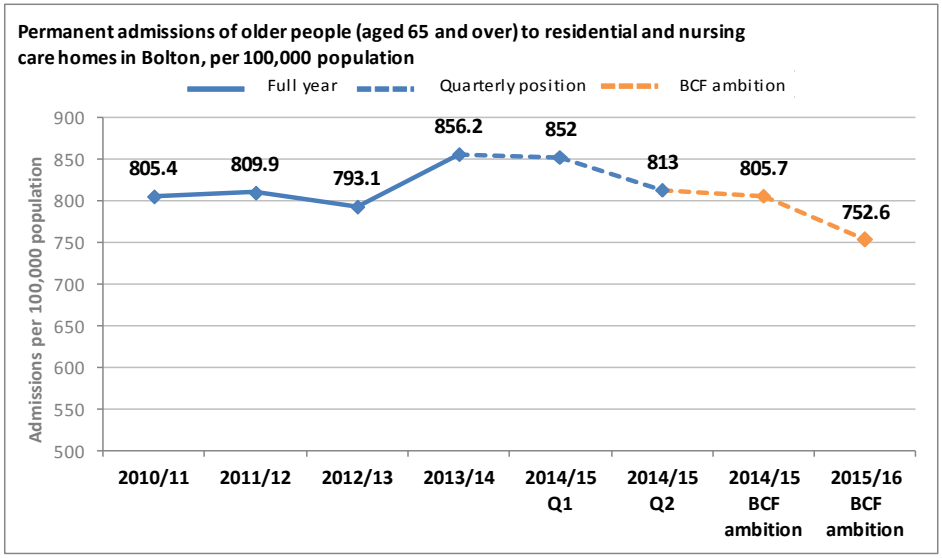
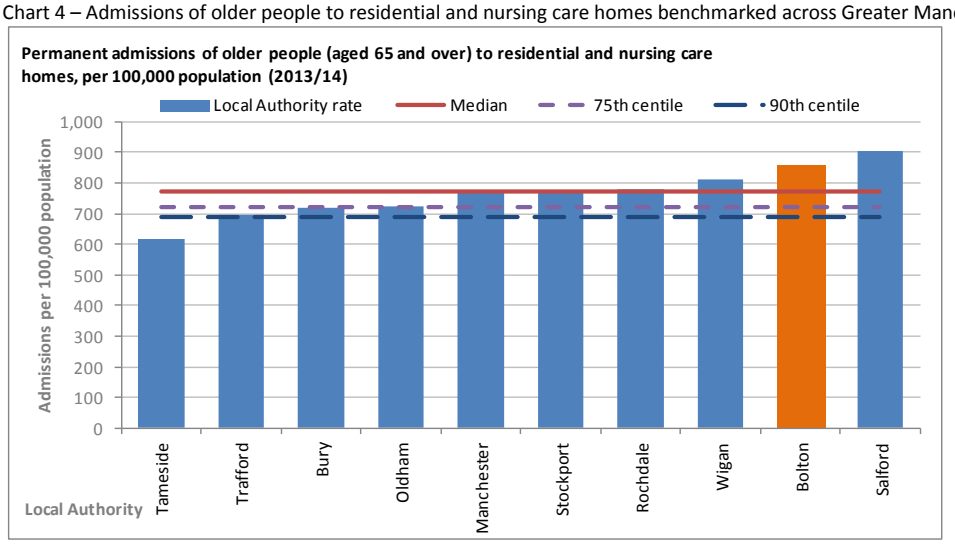


Chart 4 shows that Bolton had the second highest rate of admissions to residential and nursing care homes in 2013/14 when benchmarked across Greater Manchester.

Chart 4 – Admissions of older people to residential and nursing care homes benchmarked across Greater Manchester

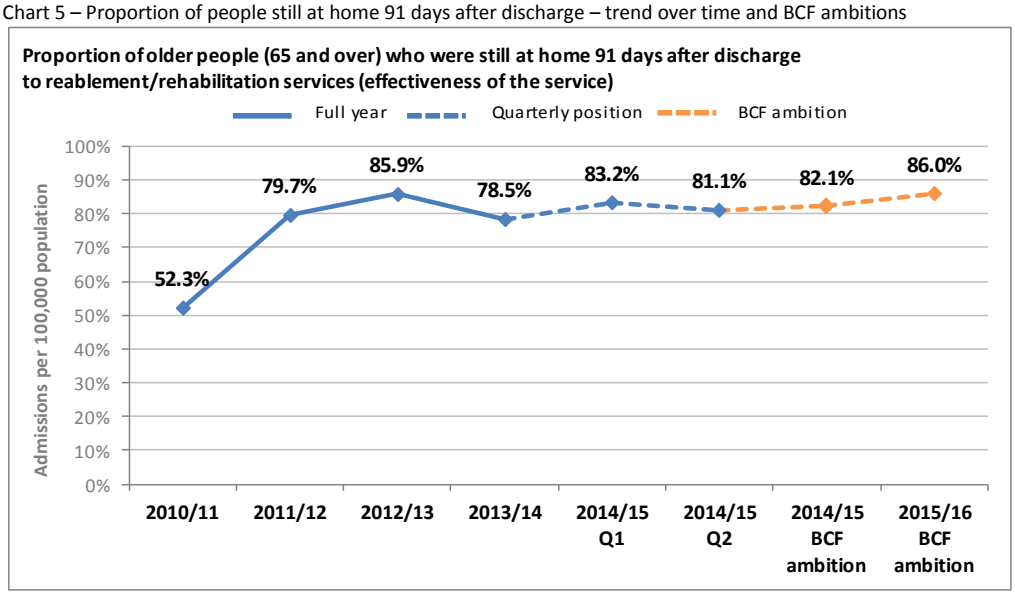


BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge to reablement/ rehabilitation services (effectiveness of the service)

Objective: To increase

In 2013/14, 78.5% 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 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%).

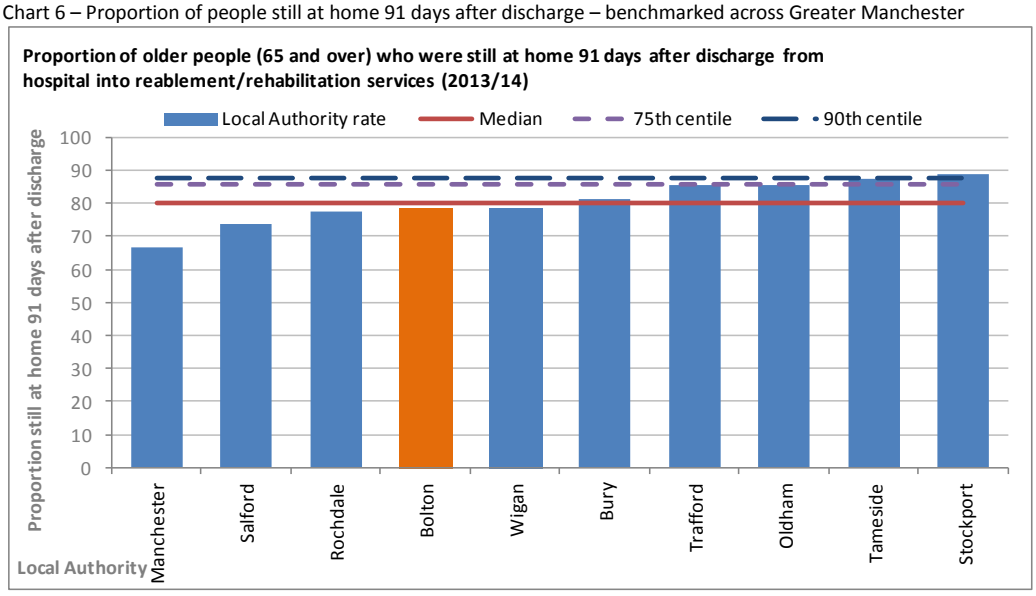
Chart 5 – Proportion of people still at home 91 days after discharge – trend over time and BCF ambitions



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

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

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 from April 2012 to November 2014 for Bolton patients. A marked increase can be seen from March 2014, which is due to a change in recording at Bolton FT, however the number of delayed days has decreased in recent months.

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 the period April 2014 – December 2014 is an average of 367 delayed days per month (as shown in the chart below). The target for 2015/16 is an average of 311 delayed days per month.

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

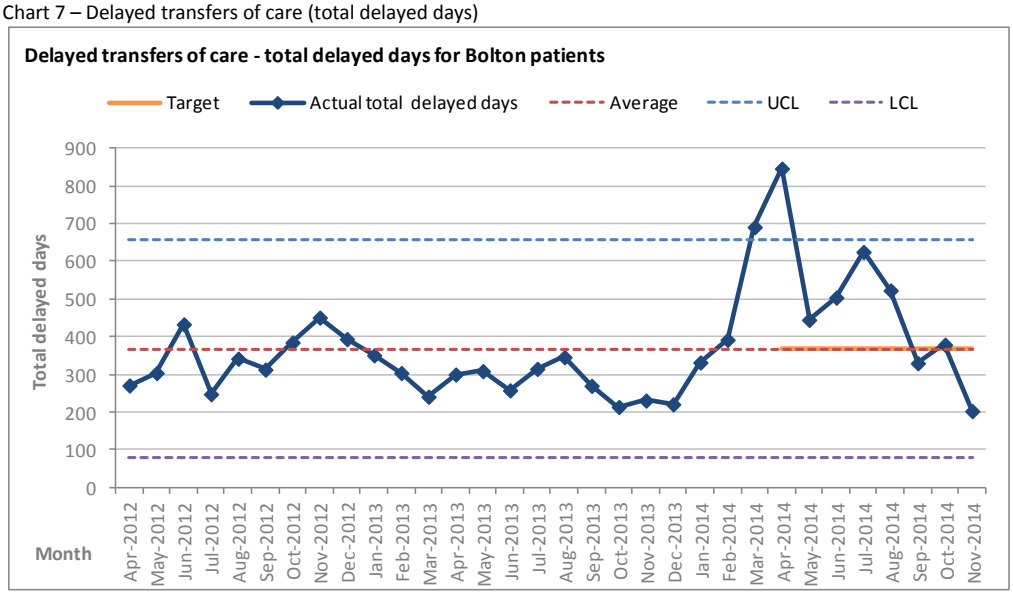


Chart 8 shows the number of delayed days over the last 12 months, broken down by attributable organisation. Over the 12 month period December 2013 – November 2014 two thirds of delayed days were attributable to NHS, 30% were attributable to social care and 3% were attributable to both NHS and social care. In the most recent month (November) all delayed days were attributable to NHS.

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

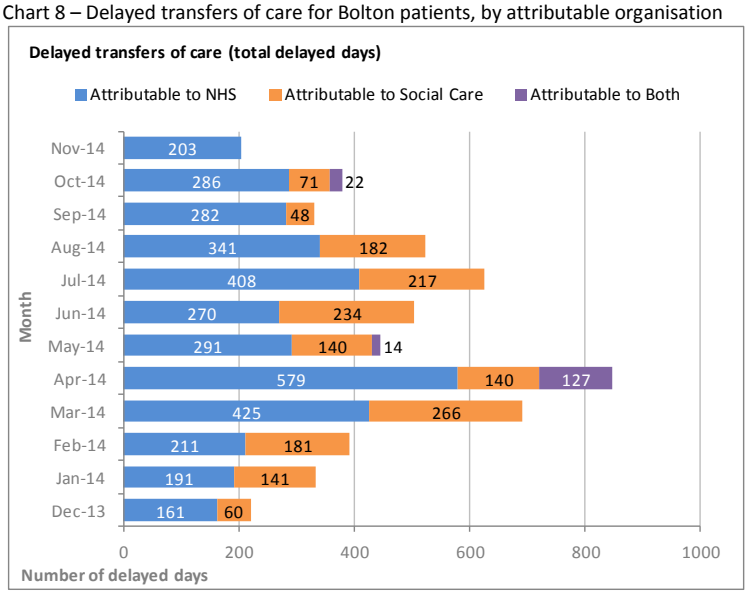
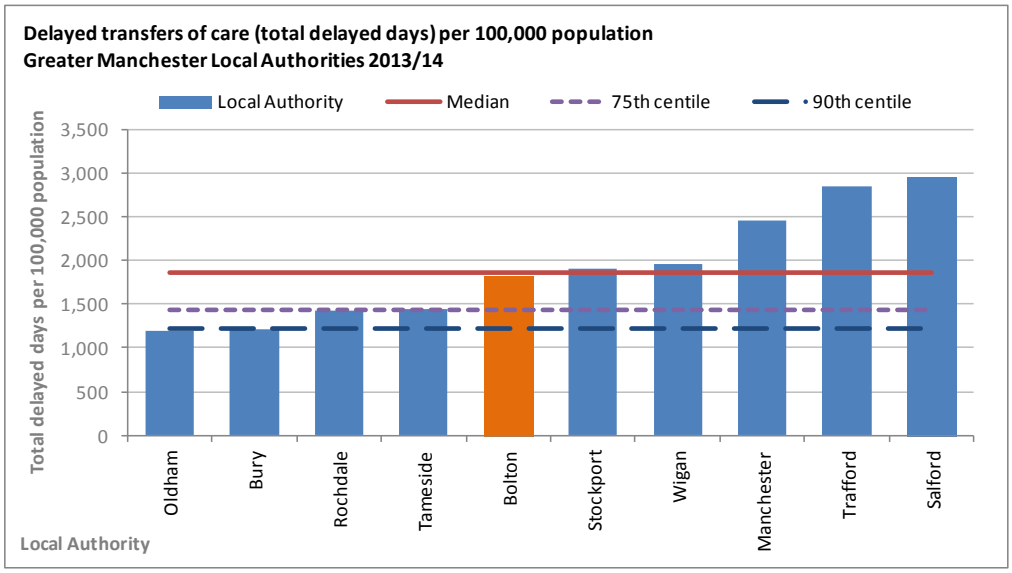


Chart 9 shows how the number of delayed transfers of care in Bolton compared across Greater Manchester in 2013/14. Bolton benchmarked at the Greater Manchester median rate.

Chart 9 – Delayed transfers of care benchmarked across Greater Manchester

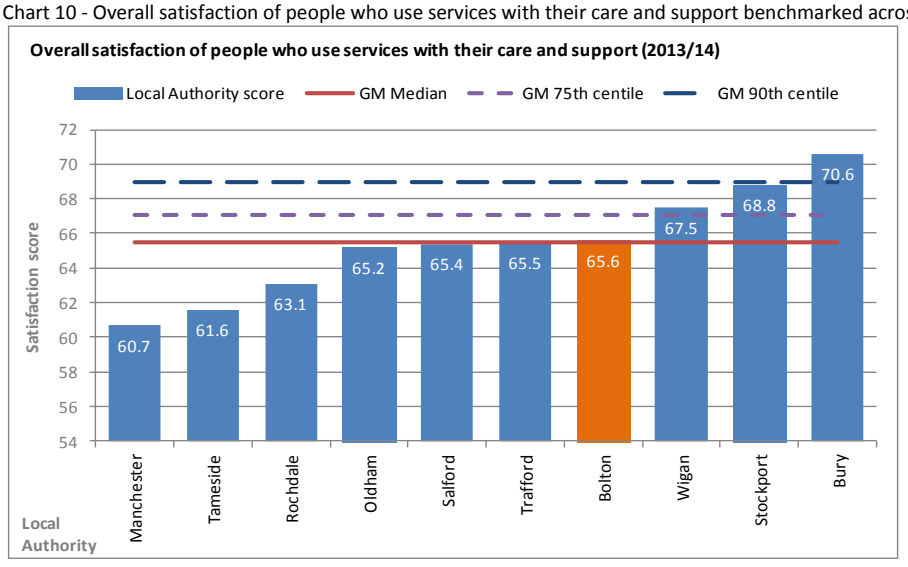


BCF5. Overall satisfaction of people who use services with their care and support
Objective: to increase

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 2013/14 Bolton scored 65.6%, which was just above the Greater Manchester median, as illustrated in chart 10. 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



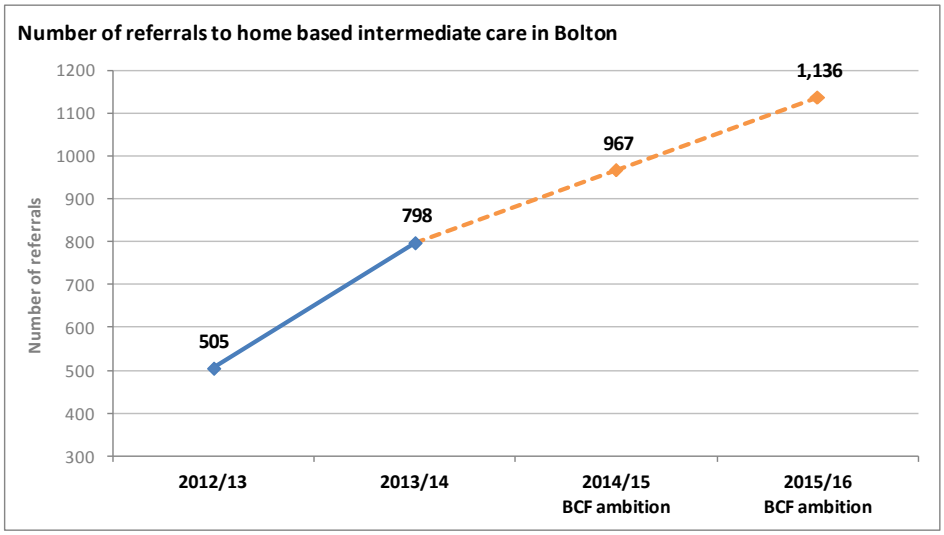
BCF6. Referrals to home based intermediate care
Objective: to increase

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

Chart 11 – Referrals to home based intermediate care



Greater Manchester and locally selected metrics

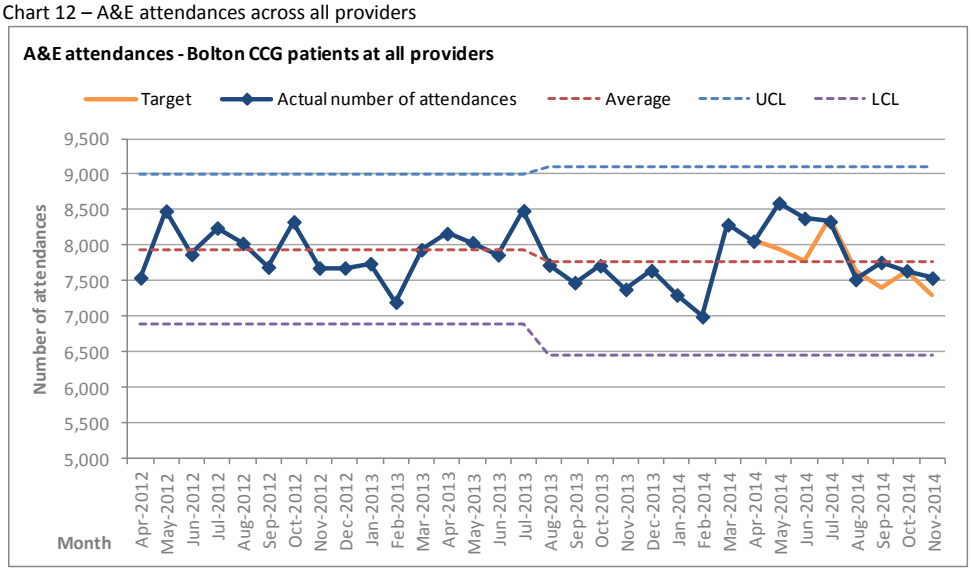
A number of further metrics have been identified across Greater Manchester and locally within Bolton.

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.
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-November 2014 with the same period last year, there has been a 1.6% increase (977 attendances). Bolton CCG's target for 2014/15 is to decrease the number of A&E attendances by 1.1% from 2013/14.

Chart 12 – A&E attendances across all providers

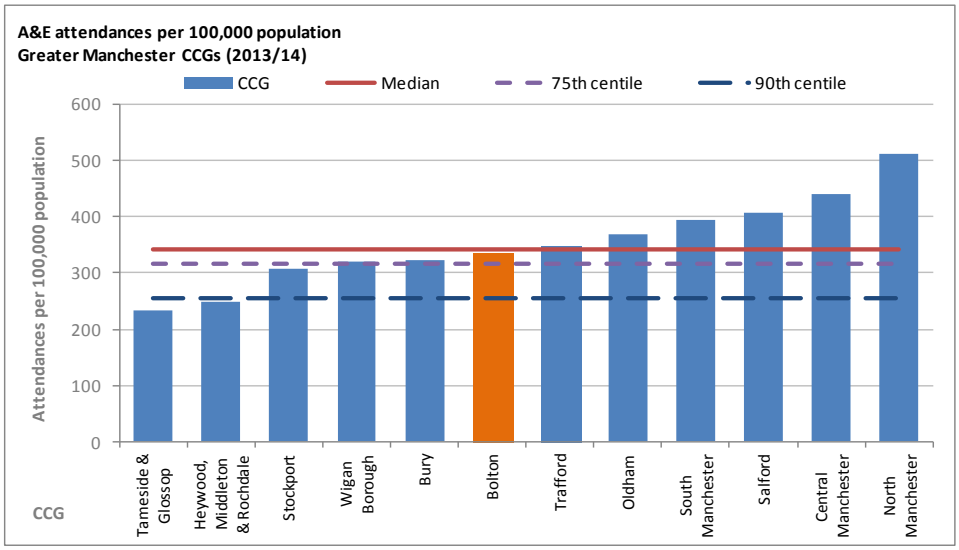


Further analysis of A&E attendances at Bolton FT, which accounts for 90% of all A&E attendances for Bolton patients, has identified some conditions where particular increases have been seen.

When comparing April-November 2014 with the same period in the previous year, the number of attendances with gastrointestinal conditions has increased by 375 (+8.1%), attendances with poisoning (including overdose) have increased by 194 (+19.5%) and attendances with respiratory conditions have increased by 317 (+8.9%).

Chart 13 shows how Bolton CCG's A&E attendances compare across Greater Manchester. In 2013/14, Bolton had an average number of attendances per 100,000 population.

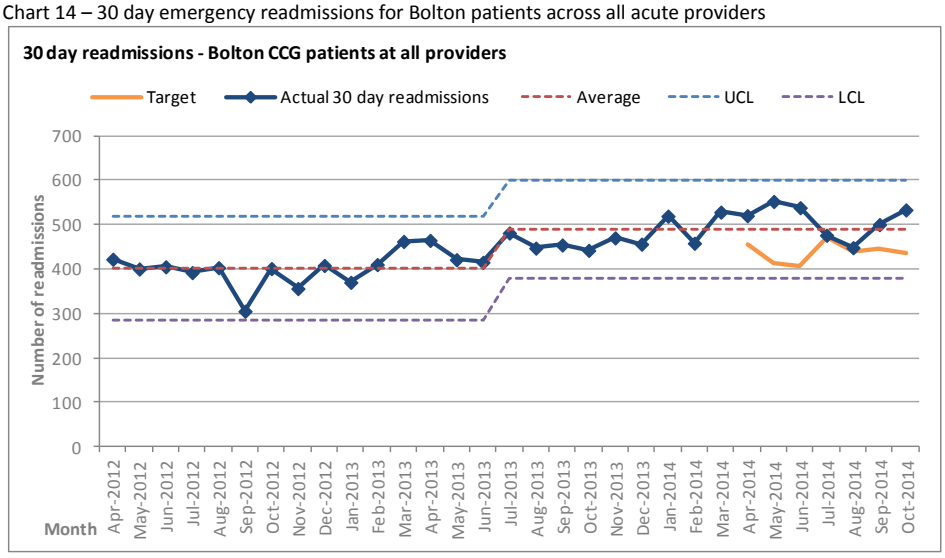
Chart 13 – A&E attendances benchmarked across Greater Manchester



GM2. 30 day emergency readmissions
Objective: To decrease

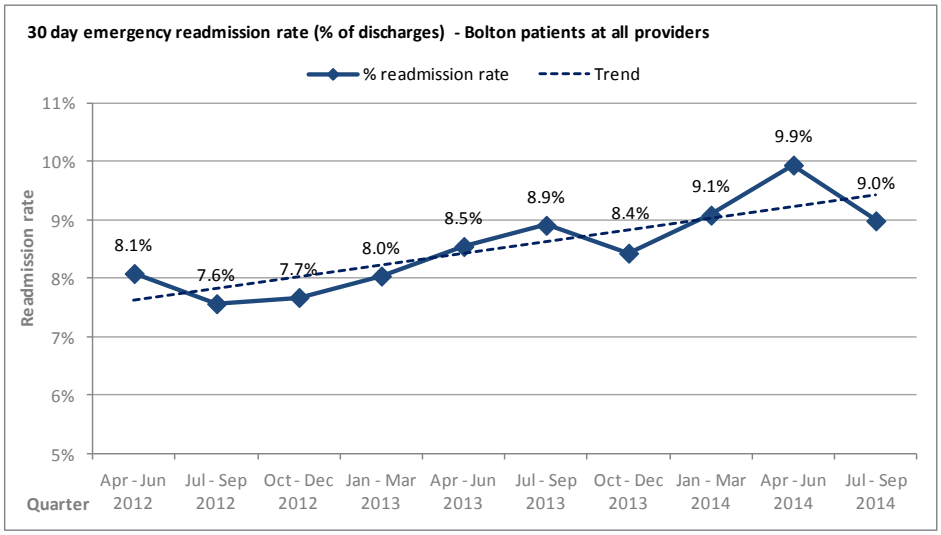
Chart 14 shows the number of emergency readmissions within 30 days of previous discharge (following an elective, day case or non-elective admission). There has been an increase in the number of 30 day readmissions, particularly in quarter 1 (April – June) of this financial year.

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 Quarter 1 2012/13 to Quarter 2 2014/15. This has increased steadily, particularly from January 2014.

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

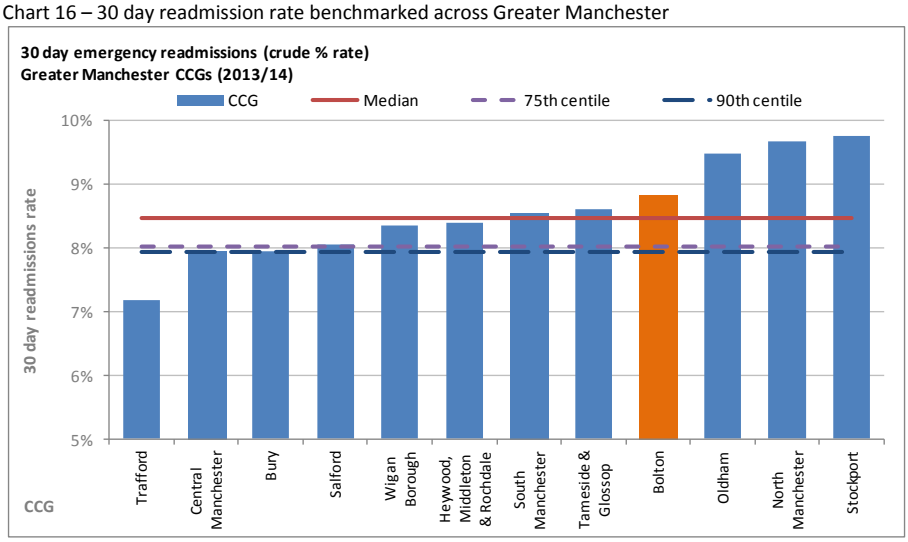


It should be noted that the number of readmissions shown in charts 14 and 15 includes patients who were discharged from one provider and readmitted in an emergency to a different provider, as well as patients admitted to the same provider twice.

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 2013/14. Bolton CCG had the 4th highest readmission rate (8.8%).

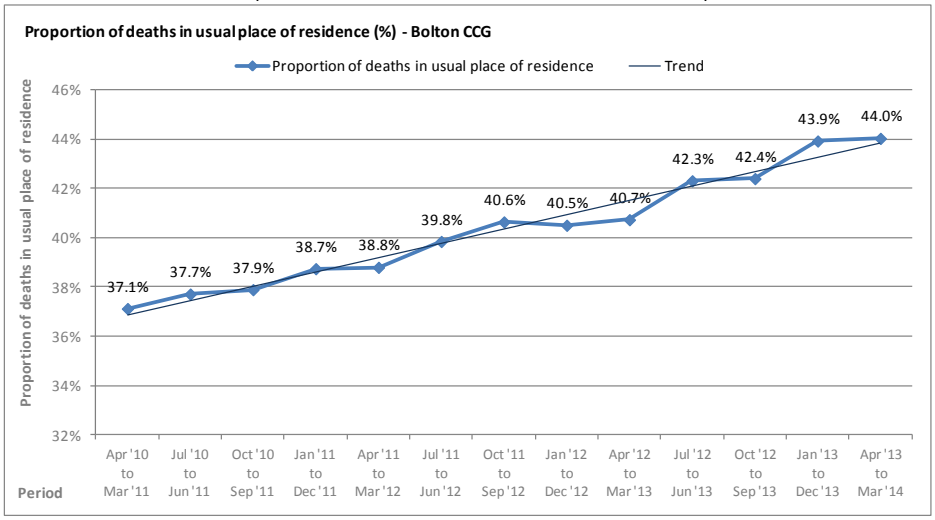
Chart 16 – 30 day readmission rate benchmarked across Greater Manchester



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

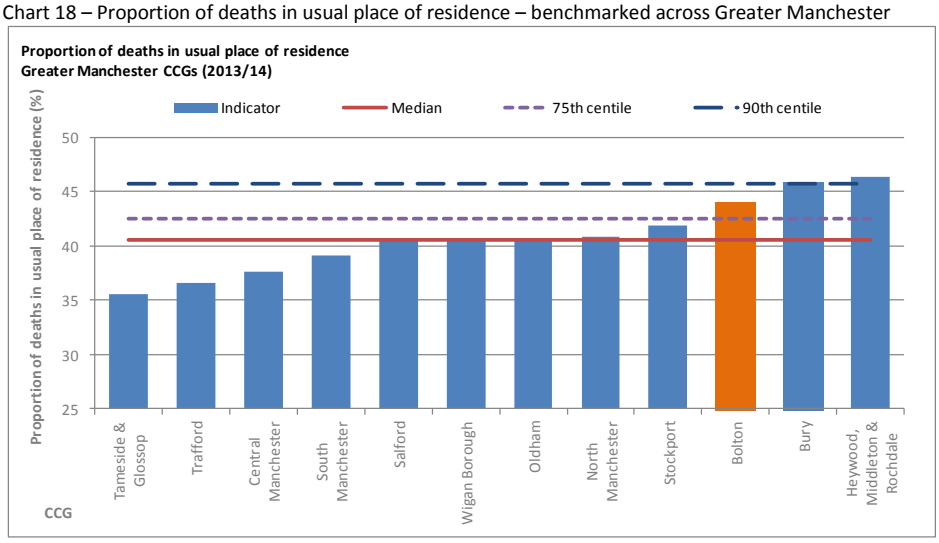
Chart 17 shows a rolling 12 month position for the proportion of deaths occurring in the person's usual place of residence in Bolton. There has been a steady increase from 37.1% in the year 2010/11.

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



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 3rd across Greater Manchester, 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

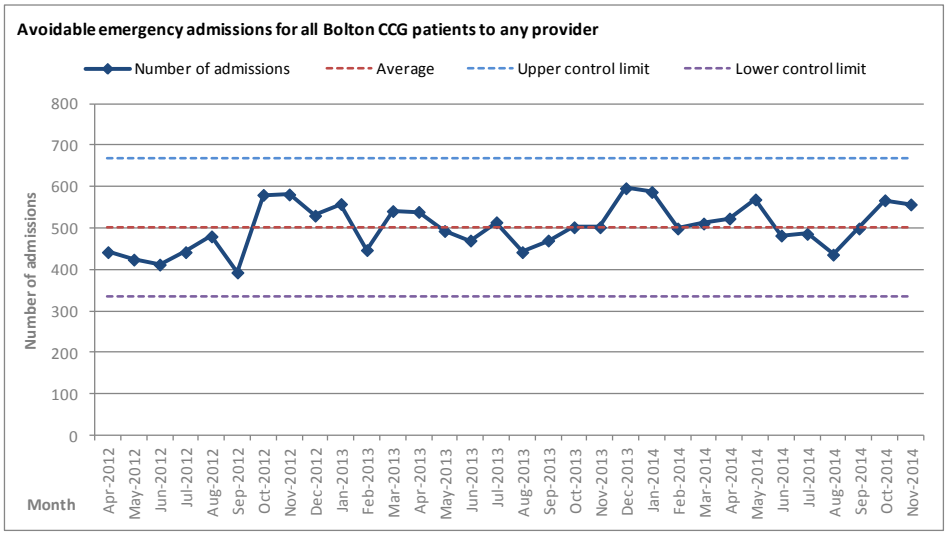
This is a composite measure of:

- 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 (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 4.8% increase in April - November 2014 compared with the previous year.

Chart 19 – avoidable emergency admissions to all providers

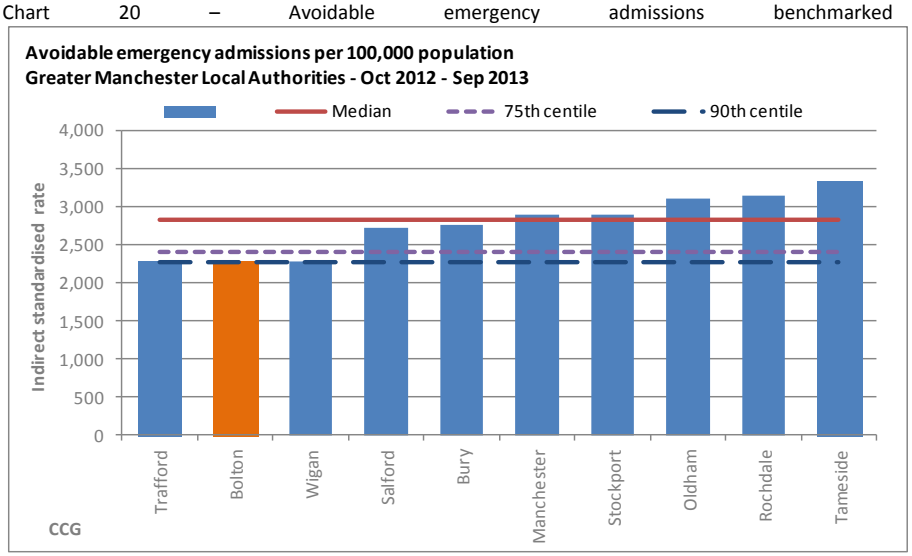


Although an increasing trend is observed in chart 19 above, it should be noted that Bolton benchmarked well for this measure according to the latest available data. In the period October 2012 to September 2013, Bolton had the second lowest rate of avoidable emergency admissions across Greater Manchester.

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

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

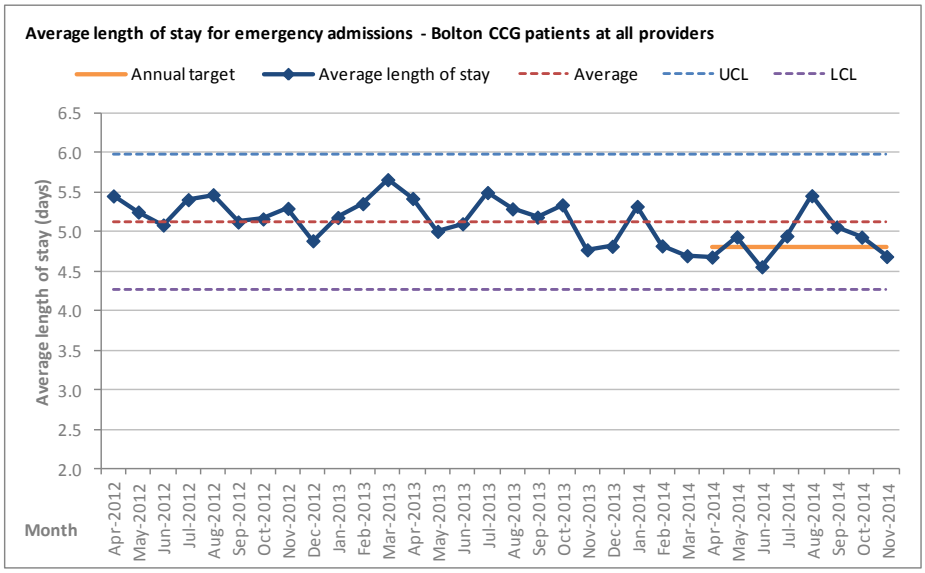
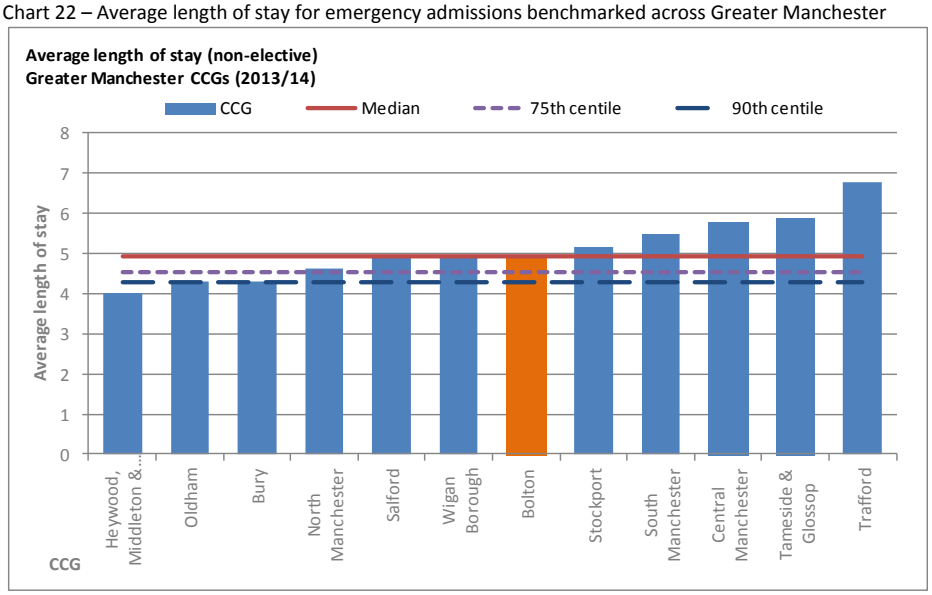


Chart 22 illustrates how Bolton CCG benchmarks against other Greater Manchester CCGs for average non-elective length of stay. In 2013/14, Bolton CCG achieved the Greater Manchester median length of stay.

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. 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 31.6%, from 652 (November 2012 – October 2013) to 858 (November 2013 – October 2014).

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

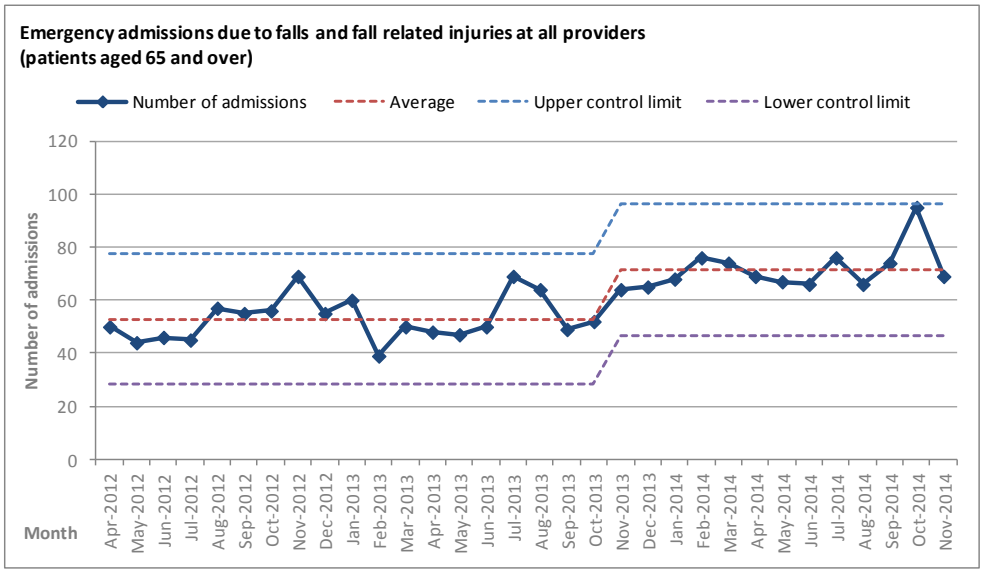
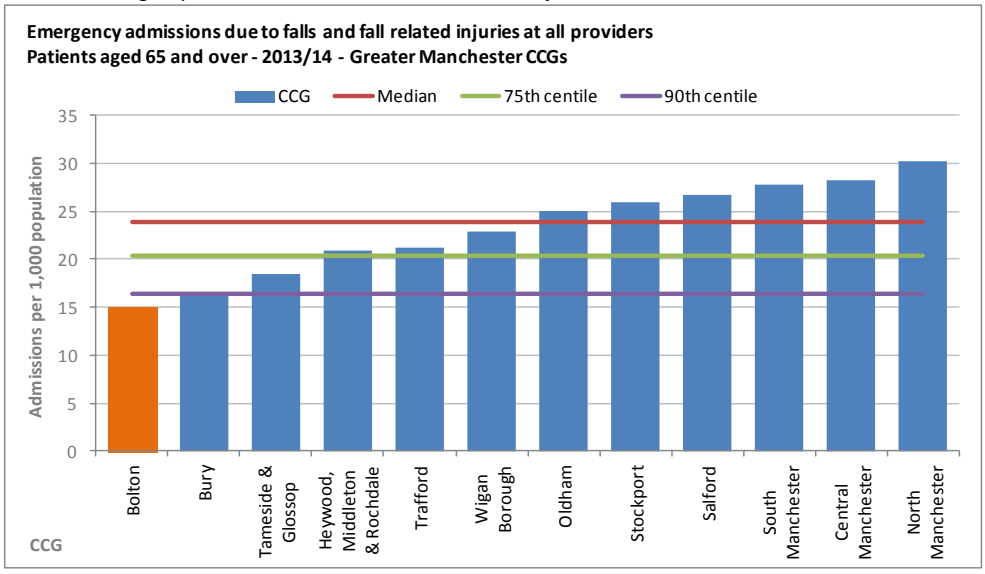


Chart 24 shows how Bolton CCG compares across Greater Manchester for the number of falls admissions per 1,000 population aged over 65. In the year 2013/14 Bolton had the lowest rate of falls admissions across all Greater Manchester CCGs.

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

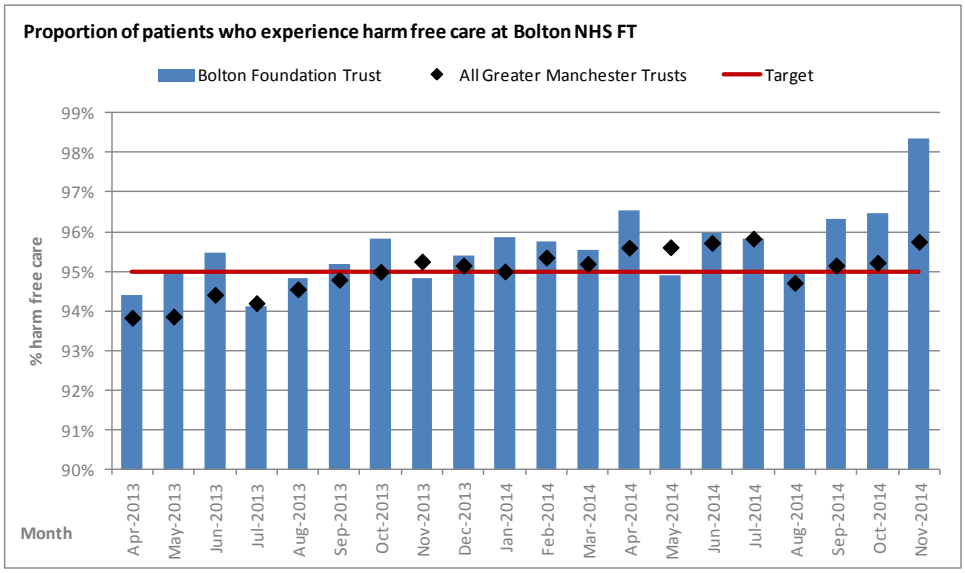


L4. Proportion of patients who experience harm-free care

Objective: to increase

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

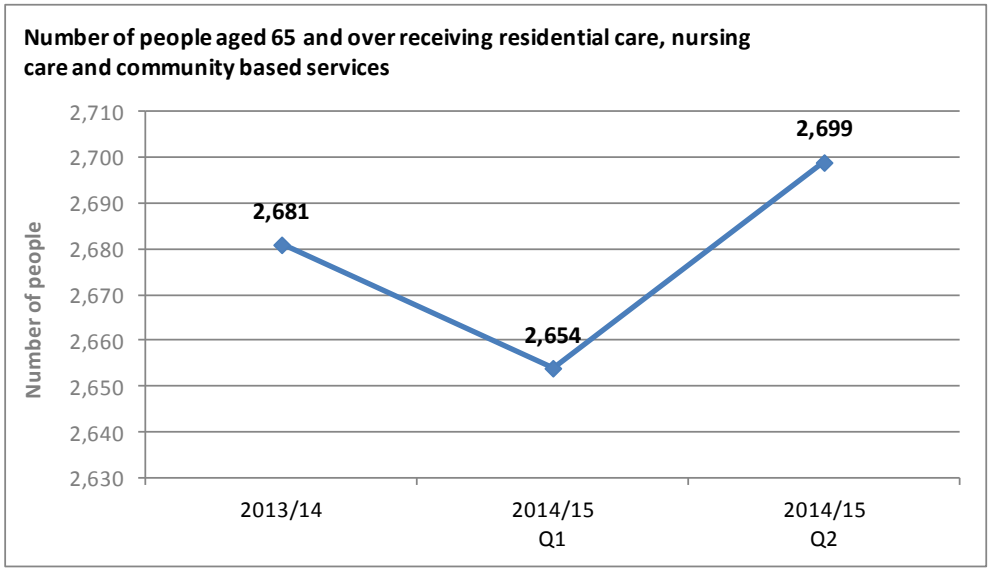
Chart 25 – Patients experiencing harm-free care at Bolton NHS FT



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.

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



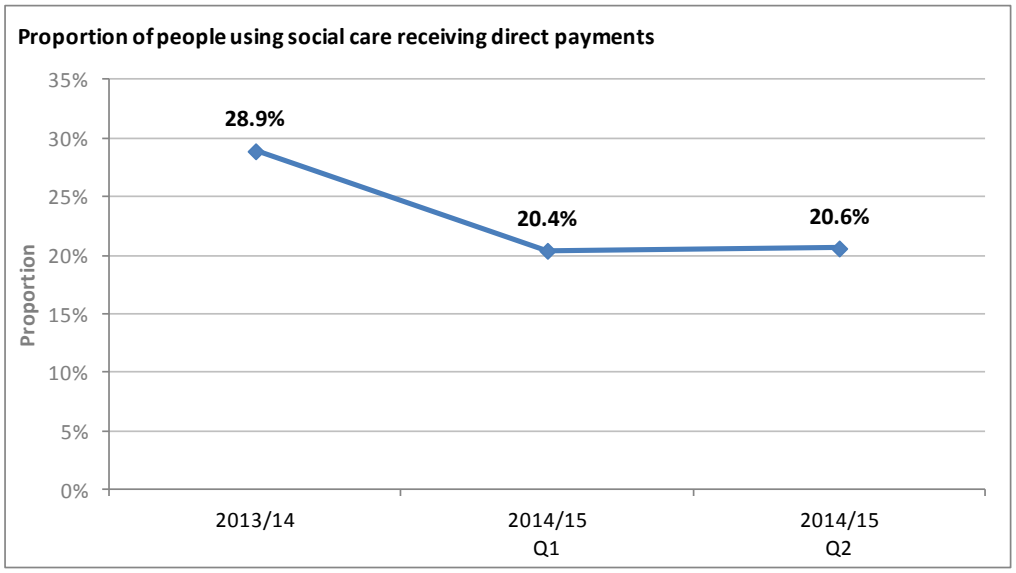
L6. Proportion of people using social care receiving direct payments

Objective: to increase

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

Please note the 2013/14 end of year figure is not directly comparable to the 2014/15 Q1 and Q2 figures as the definition has changed from those receiving direct payments through the year, to a snapshot at quarter end.

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



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

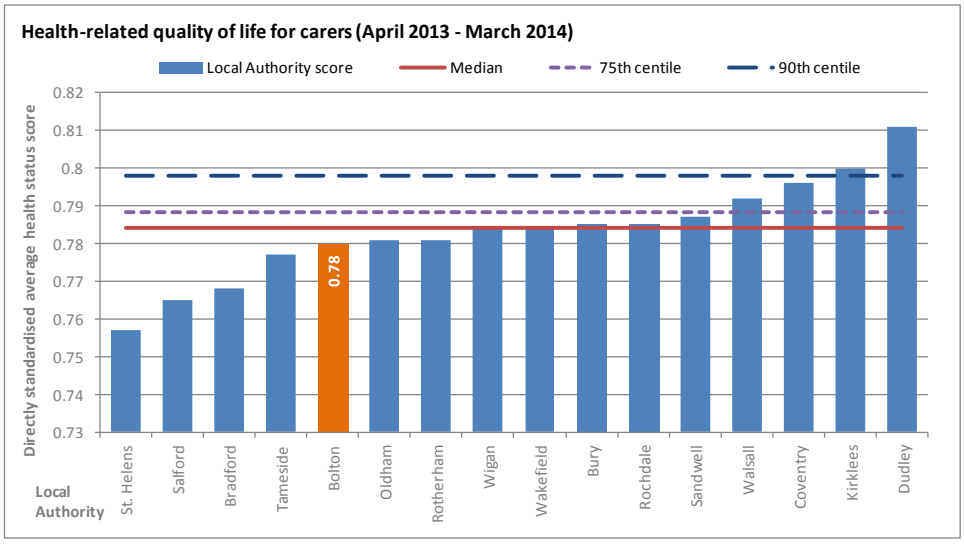
L9. Percentage of people finishing reablement or intermediate care who have no package of care
Objective: to increase
Data to follow

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

Chart 28 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 28 – Health-related quality of life for carers – average health status scores

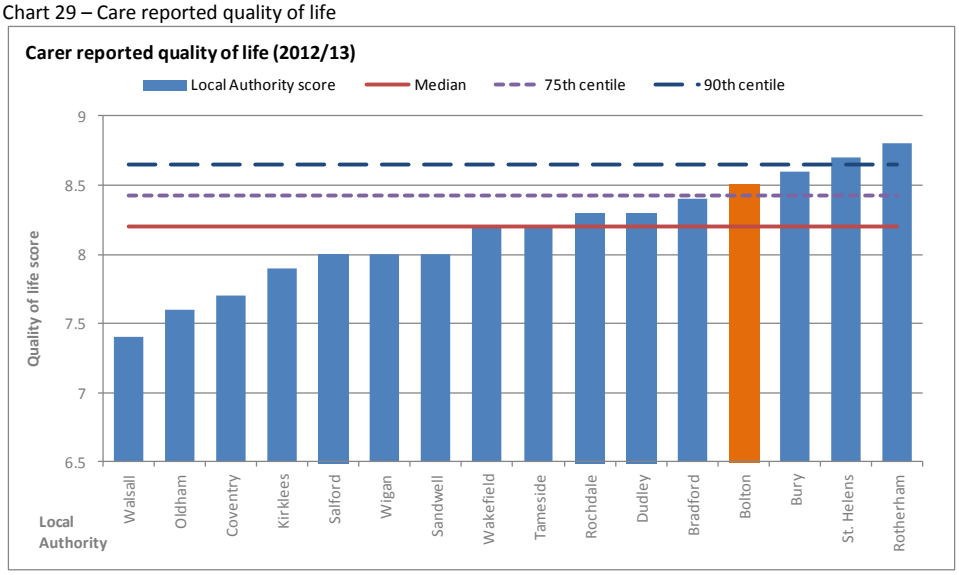


L11. Carer reported quality of life

Objective: to increase

Chart 29 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 29 – Care reported quality of life



L12. People feeling supported to manage their condition

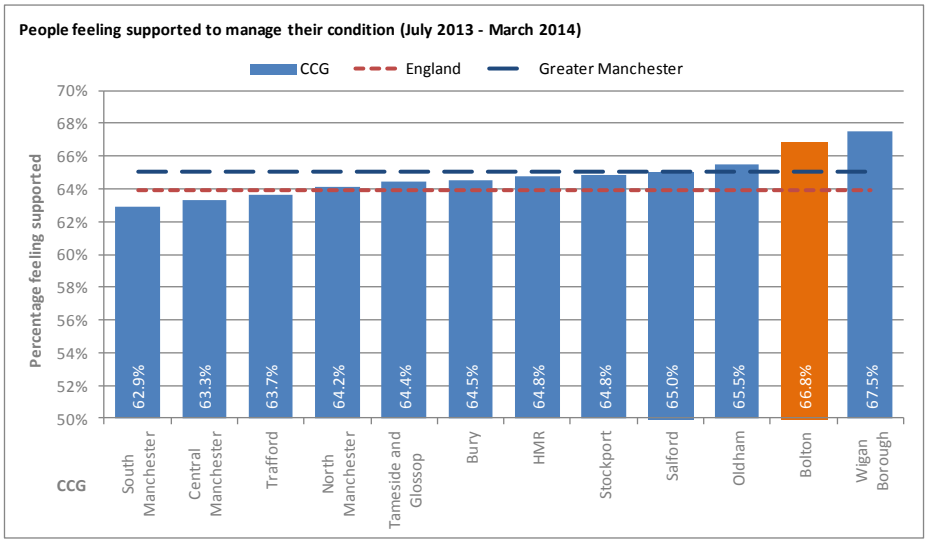
Objective: to increase

Chart 30 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.

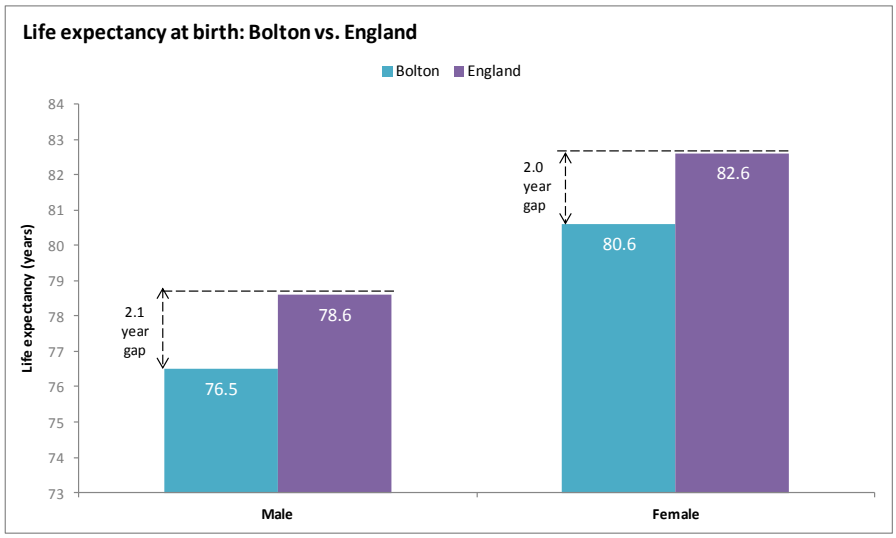
Chart 30 – proportion of people feeling supported to manage their condition



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 31 illustrates this gap between Bolton and England.

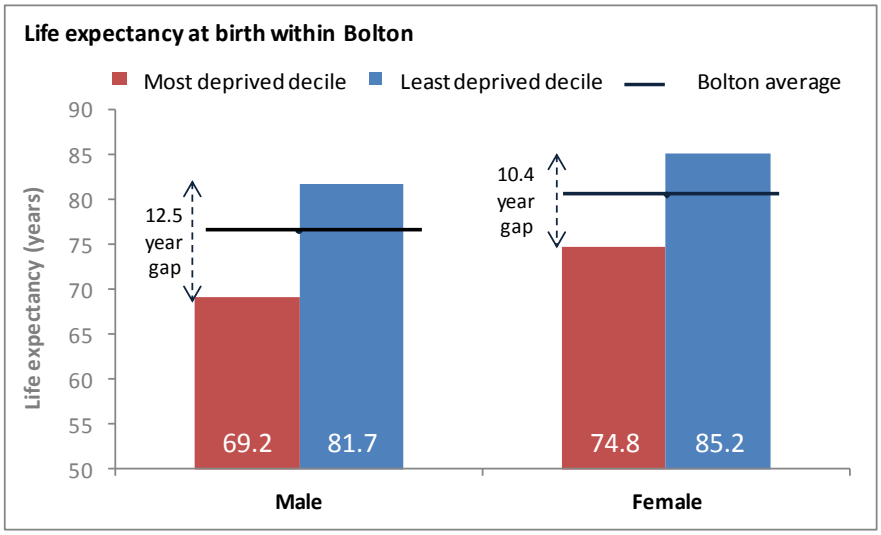
Chart 31 – Life expectancy at birth – Bolton vs. England



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 32.

Chart 32 – 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	

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