Bolton Health & Social Care Integration

Monthly Report

October 2015

Section 1 – Executive Summary

Overall Programme Update

Substantial work continues to be undertaken on the Integration programme, with September being another productive month in terms of output, both across the core and enabling work streams. This has meant that the programme is continuing to progress well towards delivering the key outcomes.

Performance Summary

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

- There was a significant under performance against the non-elective target in the month of August, as emergency admissions were 294 = +12% above plan. The brings the year to date admissions to 497 = 3.6% above plan.

- The A&E target remains on track to deliver, although in the month of August A&E attendances were 455 = +6.3% above plan. Performance against the year to date target remains positive as attendances were 371 (-0.9%) below plan. However there is a real danger that significant over performance will result if Augusts activity is repeated in future months.

Progress Summary

The key highlights of the work undertaken across the core and enabling work streams include:

- INT full roll out is progressing well – with 48 GPs now engaged with the team.
- Agreement reached regarding the process of reporting Clinical Incidents and Complaints. Quarterly meetings will also be held with each of the organisations to review incidents and to share information
- Recruitment is progressing for the positions that are vacant within the teams. Inductions sessions also were organised for this month so that all of the staff within INTs have received the 2 day induction programme.
- Integrated Workforce workstream have completed the report for the Workforce Demonstrator Site and members of the workstream group will be attending a Showcase event in November 2015 to present this work.

Issues

There are no pressing issues on the programme that are causing undue concern. However, as we are now in full roll out phase for INTs, it is imperative that we remain wholly focused on successfully delivering the set objectives.

- Information Governance – Risk Stratification data is an issue for the Council as they do not have the Risk Stratified data
- The sharing of GP information with the Integrated Neighbourhood team remains a gap and being able to effectively deliver the service.

Section 2 – Performance Headlines

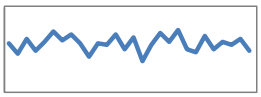
National Indicators

Emergency admissions (Bolton CCG patients, all providers)

The Better Care Fund target is to reduce the number of emergency spells by 3.5% in 2015/16 compared to 2014/15. In the month of August, the number of emergency admissions was 294 (+12.0%) above target. Year to date (Apr-Jul) the number of emergency admissions was 497 (+3.6%) above target.

In Month (Aug)		YTD (Apr-Aug)	
Target	Actual	Target	Actual
2,448	2,742	13,656	14,153

Trend from Apr13-Aug15

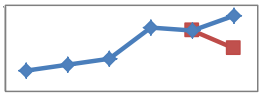


Permanent admissions of older people to nursing and residential care homes

There was an increase in the number of permanent admissions of older people to nursing and residential care homes when comparing Q1 2015/16 with 2014/15 (rolling 12 month totals). The Better Care Fund target for this measure was to decrease the number of permanent admissions to residential and nursing care homes to 361 in 2015/16.

2012/13	2013/14	2014/15	2015/16 Q1
350	380	377	392

Trend (annual) - target in red



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 Q1 2015/16 compared with 2014/15. The Better Care Fund target for this measure was 82.1% in 2014/15 and is 86.0% in 2015/16.

2012/13	2013/14	2014/15	2015/16 Q1
85.9%	78.5%	79.9%	79.1%

Trend (annual) - target in red

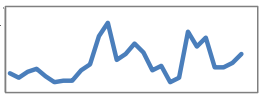
Delayed transfers of care (total delayed days)

A Better Care Fund target has been set for this measure, which accounts for an anticipated increase in the number of delayed transfers of care due to more accurate recording. For the current year to date, the number of delayed days is significantly above plan. DTOCs this YTD are lower than the figure for 2014/15 (2,420).

In Month (Jul)		YTD (Apr-Jul)	
Plan	Actual	Plan	Actual
308	513	1,270	1,647

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

Trend from Apr13-Jul15

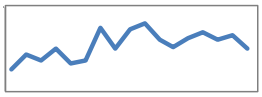


Referrals to home based intermediate care

The number of referrals to home based intermediate care is 617 for the current year to date (Apr-Aug). This is 42% higher than the number of referrals in the same period last year (434 referrals).

In Month (Aug)		YTD (Apr-Aug)	
Last year	This year	Last year	This year
80	106	434	617

Trend from Apr14-Aug15



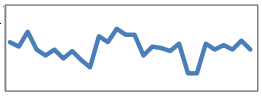
Local Indicators

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

The CCG's 5 year plan target is to reduce the number of A&E attendances by 3.2% from 2014/15 to 2015/16. In the month of August, the number of A&E attendances was 455 (+6.3%) above plan. Year to date (Apr-Aug) the number of A&E attendances was 371 (-0.9%) below plan.

In Month (Aug)		YTD (Apr-Aug)	
Plan	Actual	Plan	Actual
7,250	7,705	39,453	39,082

Trend from Apr13-Aug15

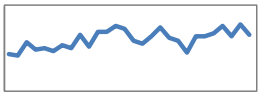


30 day readmissions (Bolton CCG patients, all providers)

The number of 30 day readmissions is higher when comparing Apr15-Aug15 with the same period in 2014. The readmission rate for this year to date (Apr-Aug) is 9.5%, which is slightly lower than the same period last year (9.6%).

In Month (Aug)		YTD (Apr-Aug)	
Last year	This year	Last year	This year
472	514	2,590	2,669

Trend from Apr13-Aug15

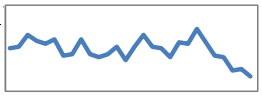


Non-elective average length of stay (Bolton CCG patients, all providers)

The CCG's 2015/16 plan target for average non-elective length of stay is 4.65 days. For the current year to date (Apr-Aug) the average non-elective length of stay is 4.41 days. The average length of stay for the same period in 2014/15 was 4.9 days.

In Month (Aug)		YTD (Apr-Aug)	
Plan	Actual	Plan	Actual
4.65	4.04	4.65	4.41

Trend from Apr13-Aug15

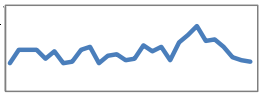


Non-elective average length of stay (Bolton CCG patients, medical specialties at Bolton FT)

The average non-elective length of stay (for Bolton CCG patients) in medical specialties at Bolton FT is 4.13 days for the current year to date (Apr-Jul). This is higher than the average length of stay in the same period last year (4.07 days).

In Month (Aug)		YTD (Apr-Aug)	
Last year	This year	Last year	This year
4.37	3.86	4.07	4.13

Trend from Apr13-Aug15



Section 3 – Workstream Performance and Update

Intermediate Tier Services

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

	target	August actual	Year to Date target	Year to date actual
NEL reduction	**60**	**38**	**298**	**231**
A&E reduction	**81**	**70**	**403**	**372**

In order to further support admission avoidance and attendance to Royal Bolton Hospital a new falls pathway has been agreed and is in place with NWAS. As a result patients that do not need to be conveyed to hospital following a fall are able to have a response by the Admission Avoidance Team within an hour and a range of support provided to maintain the patient at home. The case study this month is an example of patient who has received treatment following a fall via the NWAS pathway.

The recruitment for the vacant posts within the service is ongoing. A workshop was arranged to discuss the plans for co locating the Home Based services. Through the Co-location of the services the teams will be able to deliver a more effective and efficient services. The workshop was very productive and further meetings are being arranged to progress the work.

Next steps

- The colocation of the Home based teams is being progressed
- Progress is continuing with regards to the service specification for the Medical Model. There are Project meetings taking place which are ongoing

Intermediate Tier Services are continuing to see significant numbers of referrals to the Admisison Avoidance Team and the Home Based Pathway. The Admission Avoidance team have a presence every day in A/E deflecting patients into home based services wherever possible to avoid hospital admission, more than 50% of referrals are currently from A/E, as a result emphasis is being placed on advertising the team toGP practices.

Home Based Pathway- The reablement and intermediate care at home teams are working closely together supporting large numbers on the caseload-the number of joint reablement and therapy packages are slowly increasing and future co-location of the intermediate care at home and reablement teams will further facilitate this.

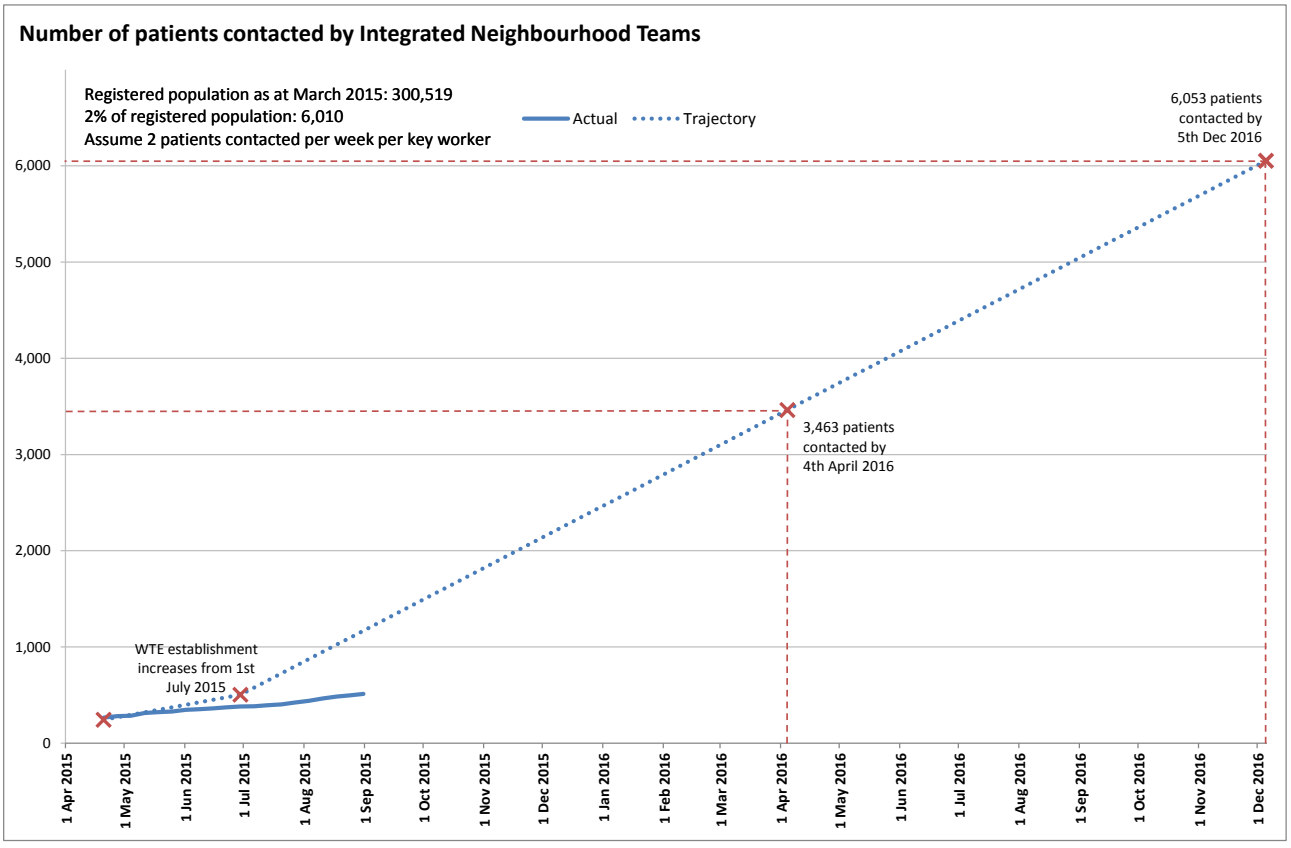
Bed Based Pathway- The majority of referrals to intermediate care beds are from the frailty unit at Royal Bolton Hospital, there is a disproportion of referrals from the hospital compared with community referrals.

Quality within all the teams remains high with excellent patient feedback and low numbers of complaint

Integrated Neighbourhood Teams

The project is not profiled to deliver reduction in non-elective and A&E activity until August as the service is only being fully rolled out from July onwards.

The diagram below shows the trajectory for the number of people who will receive care from the INTs over the next 18 months.



At the end of August the team had received 513 referrals (73 in August). 380 patients have accepted intervention (68 in August), while 108 patients have declined intervention. 25 patients had been referred, and had yet to accept, decline the service or be allocated a key worker

A number of activities were undertaken throughout August to fully implement the integrated neighbourhood teams across the borough, these include:

- Introductory meetings held with GPs and 48 are now engaged with the INTs.
- District Nurses are now aligned with the INT's as the consultation is complete.

- The Health and Well-being plan agreed at Integration Board in July is now in use by the team.
- All current staff who is co-located in the INT's has received an induction but more sessions will be needed for new staff.
- Team's 1 2 & 3 are now co –located in Breightmet HC
- The INT project plan was refreshed to identify remaining tasks up to the 31st March 2016 and endorsed at IDG.
- A meeting was held to agree a single process for managing incidents and complaints within the INT's.

Full implementation will be completed in October when all GP's across Bolton will be engaged with the INT'. The teams now need time to establish themselves and monitoring of the engagement with GP Practices will be completed to identify any potential gaps

Planned activities in October include:

- Complete the introductory meetings with remaining GP practices
- Refresh the Equality Impact Assessment and the CQIA.
- Implement the patient experience collation methodology.

Care Homes

	target	July actual	Year to Date target	Year to date actual
NEL reduction	**5**	**7**	**19**	**21**
A&E reduction	**8**	**13**	**26**	**16**

The team is now fully resourced enabling the full roll out to be implemented without any impediment. Further work has been undertaken in the last month to ensure that the service is in a fit state to deliver the agreed outcomes, these include:

- A joint implementation steering group has been established that will meet fortnightly
- Work is in progress to develop a performance dashboard for the service in line with agreed metrics
- The roll out plan submitted was not endorsed by IDG so needs to be refreshed.

The service has completed the first phase (pilot) of the initial roll out plan so have currently been targeting 7 care homes who were identified as high user's of A & E and non- elective hospital admissions. The targets currently relate to these 7 care homes only.

The intention is to roll the service out to all the care and residential homes in Bolton.

Next steps

- Refreshed roll out plan to be endorsed at Integration Board and JTG
- Communication plan to be developed to all stakeholders

- Performance dashboard to be finalised in line with agreed metrics and signed off at Integration Board and JTG

Staying Well

Period	Forecast Clients Contacted	Actual Clients Contacted	% Increase/Decrease	Forecast Clients Visited	Actual Clients Visited	% Increase/Decrease
Apr-15	180	65	-64%	108	35	-68%
May-15	180	122	-32%	108	77	-29%
June-15	180	103	-43%	108	65	-40%
July-15	180	147	-18%	108	51	-53%
Aug-15	180	202	12%	108	86	-20%
Sept-15	180	226	26%	108	144	33%

The team, currently based in Horwich Town Hall will be integrated into the five INT hubs, as and when they become available. There are plans to roll out the staying well service borough wide in line with INT. The team attended and exhibited at the recent Better Future Event and received positive feedback from the public and other services.

It has been agreed by the Staying Well steering group that the programme is due to be rolled out to the rest of the GPs within the borough over a number of phases in the next 12 months.

Complex Lifestyles

The complex lifestyles new model of delivery was signed off by JTG – there was consensus that this model should be commissioned.

Formal permission to go out to tender for the complex lifestyles service was granted on 24/8/15. The timescales are still agreed for the service to be in place for January 2016 and the tender process is progressing. The advert is due to placed on the chest on 23rd October 2015.

Section 4 – Enabling Workstream Summary

Performance Monitoring

Progress Update
Work on the development of the 'local' performance dashboard for INTs and Intermediate Tier is ongoing. It has been agreed that a vast majority of the metrics identified for the work streams will be provided by the LA via the CareFirst system when this is possible.

Key Risks and Issues
If a number of performance metrics require additional data manipulation to source then this will cause delay in the production of the performance metrics.

Key Activities to be completed next period

Finalise details with the LA to ensure that the new dashboard becomes operational within the next month or so – once agreed this will feed into a monthly workstream performance dashboard.

Communications and Engagement

Progress Update
Discussed and agreed on targeted GP communications with other work streams

Detailed updates circulated to GPs and practice managers

Update given to CCG staff at monthly briefing

Update delivered to Bolton Housing & Health Steering Group

Patient consent for photography/video stories - protocol agreed with work streams

Key Risks and Issues

All stakeholders need to continue to be communicated with regularly about integration services and progression

Key Activities to be completed next period

Targeted comms for GPs to be circulated to practices, including Q&A leaflets and posters

Integration branding to be agreed and design process to begin

Comms to work with professional photographer to establish integration photo library for website and publications

Filming and publishing of video patient stories

E-newsletter to public & stakeholders

Item for stakeholder publications (ie Bolton Scene etc)
Contact cards to be created for health professionals to issue to patients/carers

Workforce

Progress Update

Recruitment is ongoing – there is a requirement to now fill two MDT administrator roles within the Hubs.

Key Risks and Issues

Staff on fixed term contracts up to 31st March 2016 will seek other opportunities if assurance of an extension to their contract is not provided - potentially destabilising the service. Providers are required to assure their respective staff.

Key Activities to be completed next period
Alignment of Therapy staff to Integrated Neighbourhood Teams

Plan for additional induction sessions

Finance and Contracting

Progress Update

Bolton's Q1 BCF performance was reported to NHS England on 28th August 2015 as required. The release of £1.79m of the BCF into Integration Pool is linked to the non-elective admissions reduction target, i.e., Pay for Performance (P4P) funding. That is, this P4P funding will only be released into the Pool on a proportionate basis based on achievement this target as set out in the BCF plan and in accordance with BCF Guidance. In Q4 and Q1, Bolton delivered a reduction of 75 NEL admissions against a target reduction of 613 spells for these quarters. This equates to savings of £112k compared to the target of £913k for the period. As a result, £112k will be released into the Pool in Q2, to give forecast Pool income of £29.994m at Q1. This is on the assumption that target reduction in NEL admissions will be delivered in Q2 and Q3. With forecast expenditure estimated at £29.729m at Q1, this would give an overall forecast underspend of £264k for the pooled activity at that date. As BCF funding is committed, the unreleased P4P element creates financial pressures to the pooled funds.

The agreed Pooled Budget for Integration is £30.8m for 2015/16. The forecast expenditure was estimated at £28.993m for Month 5. The forecast underspend of £1.591m is mostly attributable to slippages in recruitment into new schemes, i.e. INTs and Intermediate Tier; and delays in project start date for Complex Needs. However, with £802k of the P4P element of the BCF not released into the Pool, this gives an overall forecast underspend of £1m against the revised pooled funds of £29.994m at Month 5. In order to deliver the BCF target and manage potential cost pressures arising from non-delivery, target NEL reductions will be re-profiled and risk of delivery managed over the remaining BCF monitoring period (Q2-Q3).

Key Risks and Issues

Increase in NEL target based on previous year's outturn – this will require close monitoring and management.

Key Activities to be completed next period

The target for reduction in NEL admissions for the year will be re-profiled and delivery monitoring over

NB: Updated Month 6 Finance reports is only available from Friday 9th October which is why previous month information has been included. Updated information will be circulated once this available

Estates

Progress Update

Work has been on-going to establish the interim estates solution:

- On-going planning is being undertaken to ensure the sites for the INTs become available
- There has been a workshop led by Steve Tyldsley to review the feasibility of the admission avoidance team, IV therapy team and home based pathway teams of Reablement and intermediate care at home all co-locating at Hulton Lane. Meeting dates have been set to progress this work

Key Risks and Issues

Source of monies for both the capital works and on-going revenue costs are yet to be confirmed – a potential solution has been sourced (via legacy monies) this, however, may take a number of months before it is made available to us (requires submission of a comprehensive PID).

Key Activities to be completed next period

Planning to take place to ensure the additional sites become available for the INTs.

Meetings are taking place to discuss the work needed to collated the Home Based Pathway teams

IM&T and IG

Progress Update

Interim IT solution business case continues to await prior approval by Bolton CCG Executive

Key Risks and Issues

Practical operational issues are being fixed using interim, short term solutions. Poor fit for full scale service, reduced benefits and increased costs as a result.

Key Activities to be completed next period

Present revised interim IT solution business case at CCG Executive, Integration Board and JTG for sign off. Once agreed undertake appropriate next steps.

Provide support to enable the preferred telephony solution for the INTs to be successfully implemented.

Section 5: Case Study

A Bolton falls patient study

Mr P is 76 years old and lives with his wife, in Bolton. Mr P has recently completed a course of treatment as he was suffering from cancer. Although not told he was terminal, his treatment had finished and he had started to deteriorate and this had an effect on his ability to do the everyday things, i.e. struggling to walk small distances or exert himself, and was feeling fatigued very easily. Mr and Mrs P had always lived independently without any support, and were very proud of the fact so had not asked for any assistance previously.

Mrs P was concerned one morning when her husband became unable to get up from the settee, and she was unable to assist him, he had also fallen twice that weekend. As Mrs P did not who else to ask for help she called for an ambulance.

The crew identified when arriving on scene that Mr P did not have a care plan or any community care support. The crew took Mr P's baseline observations and once assisted to his feet found that he could mobilise, with his Zimmer, although taking a little longer than normally. He hadn't suffered any injury as a result of his falls, and wasn't acutely unwell that weekend.

Whilst talking to the crew, Mrs P admitted that she was struggling to cope, and didn't know who to ask for help and that was why she had called 999.

The crew identified Mr P as appropriate for referral to the local rapid response falls team in Bolton. The team were called and arrived at Mr and Mrs P's home within an hour.

After their assessment they were able to put grab rails in the house, involved social services, who arranged intermediate care at home and carers in the mornings. The District Nurses also were asked to assess the patient, and arranged for a bed for him downstairs and support from Macmillan Nurses. The Hospice team are also assessing him for support from themselves.

Unfortunately, Mr P was unable to get up off the settee again, unaided, within five days but on this occasion, Mrs P called the rapid response team direct. Again, the rapid response team attended within the hour and where able to assist Mr P. Now there are several cross functional agencies involved in providing care and support to Mr and Mrs P. Mr P has accepted that he needs that little bit extra help with his complex needs.

Mrs P thanked the ambulance trust and also the rapid response falls team, as she really appreciated that her husband was able to stay at home and avoided a trip and stay in hospital.

She added: "I didn't know who else to turn to, and was grateful they were able to keep my husband at home with me. I didn't expect such a rapid visit from the local team."

Appendix A – Detailed Performance Report

Better Care Fund metrics

BCF1. Total emergency admissions
Objective: to decrease

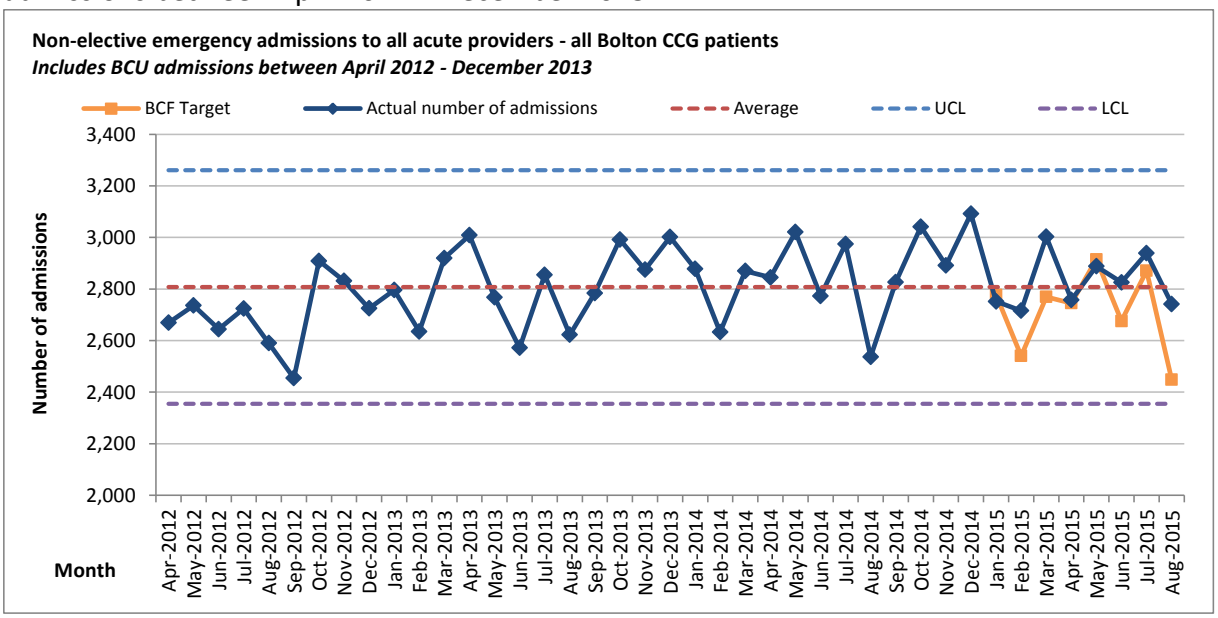
The key measure which will be used for Better Care Fund (BCF) performance payments is emergency admissions. This is now the sole measure on which the pay for performance element of the BCF will be assessed.

A target reduction of 3.5% has been set, which will be assessed by comparing the period January to December 2014 with January to December 2015 (shown in Chart 1 below). In the year January to December 2014, there were 34,385 emergency admissions. A **3.5%** decrease would therefore equate to **1,203** admissions in a year.

In the year to date (January to August 2015), there have been 22,624 admissions, an increase of 92 from the same period in 2014.

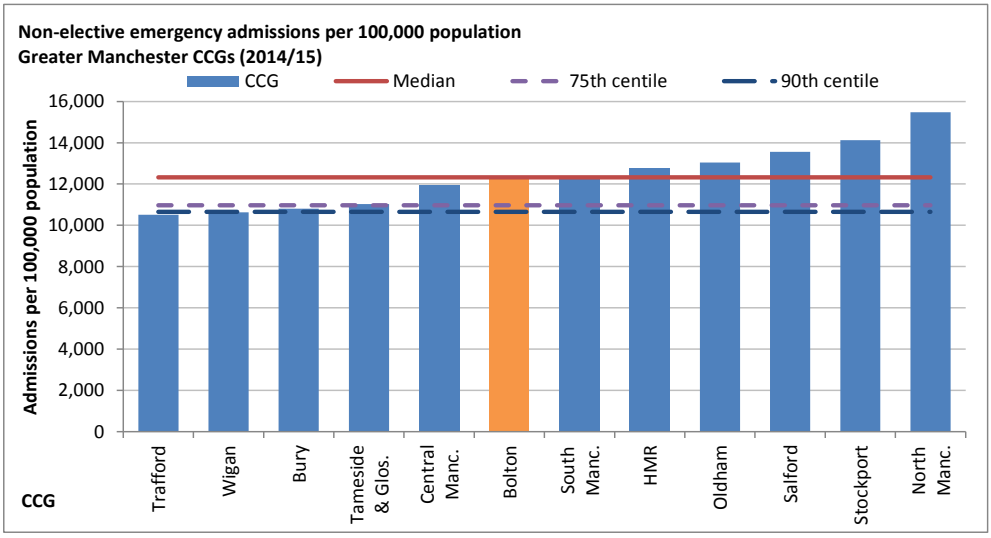
Bolton CCG's 5 year plan target for 2015/16 is a decrease of 2.8% from 2014/15. There was a 1.8% increase from 2013/14 to 2014/15.

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



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

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



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

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

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

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

Objective: To decrease

In the 12 months to June 2015 there were 392 permanent admissions to residential and nursing care homes in Bolton, this equated to 858.5 admissions per 100,000 population aged over 65. In the Better Care Fund submission, Bolton was set an ambition to decrease the number of permanent admissions to nursing and residential care homes (per 100,000 population) to 805.7 in 2014/15 and to reduce further to 752.6 in 2015/16. At the same time, the number of people aged over 65 in Bolton is projected to grow by 5.7% from 2013/14 to 2014/15 and by a further 2.2% in 2015/16.

Chart 3 shows the number of permanent admissions to nursing and residential care homes, per 100,000 population from 2010/11 to date, along with the BCF ambition for 2015/16.

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

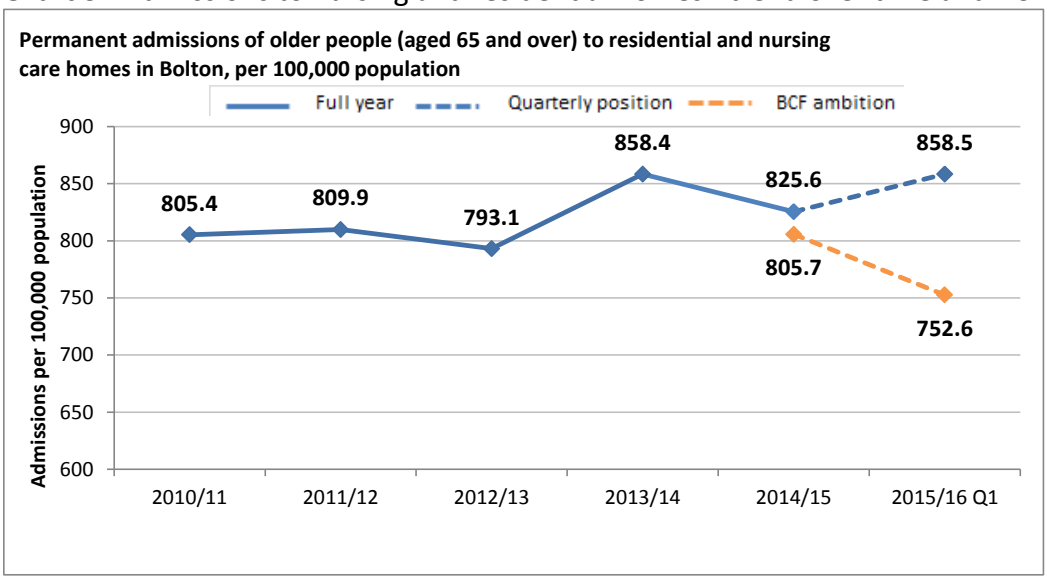
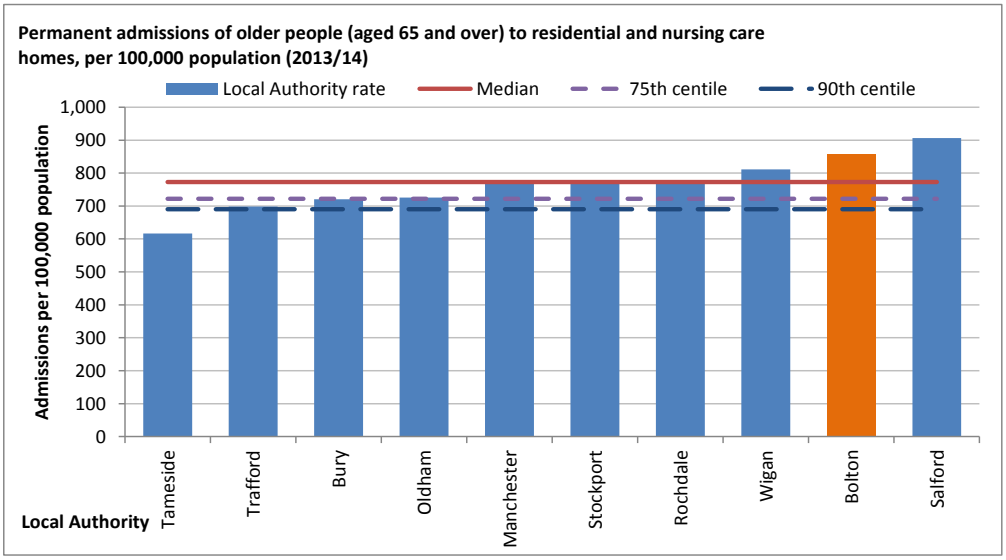


Chart 4 shows that Bolton had the second highest rate of admissions to residential and nursing care homes in 2013/14 when benchmarked across Greater Manchester.

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

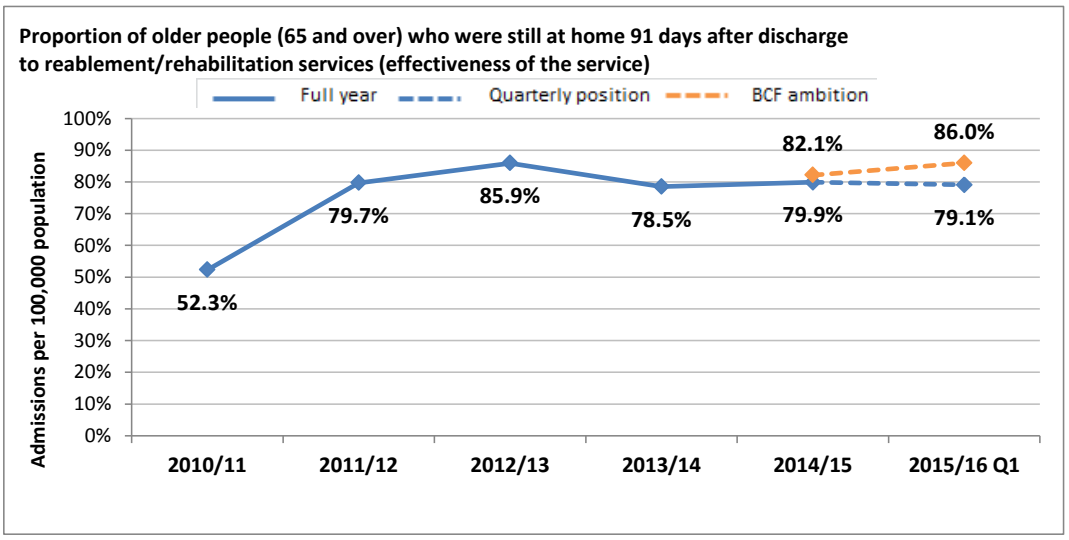


BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge to reablement/ rehabilitation services (effectiveness of the service)
Objective: To increase

In the first quarter of 2015/16, 79.1% of patients were still at home 91 days after discharge to reablement/rehabilitation services.

Chart 5 illustrates this measure over time from 2010/11 to 2015/16, along with the levels of ambition that were included in the BCF submission. The aim is to increase the proportion of people still at home 91 days after discharge to reablement to the level seen in 2012/13 (86%).

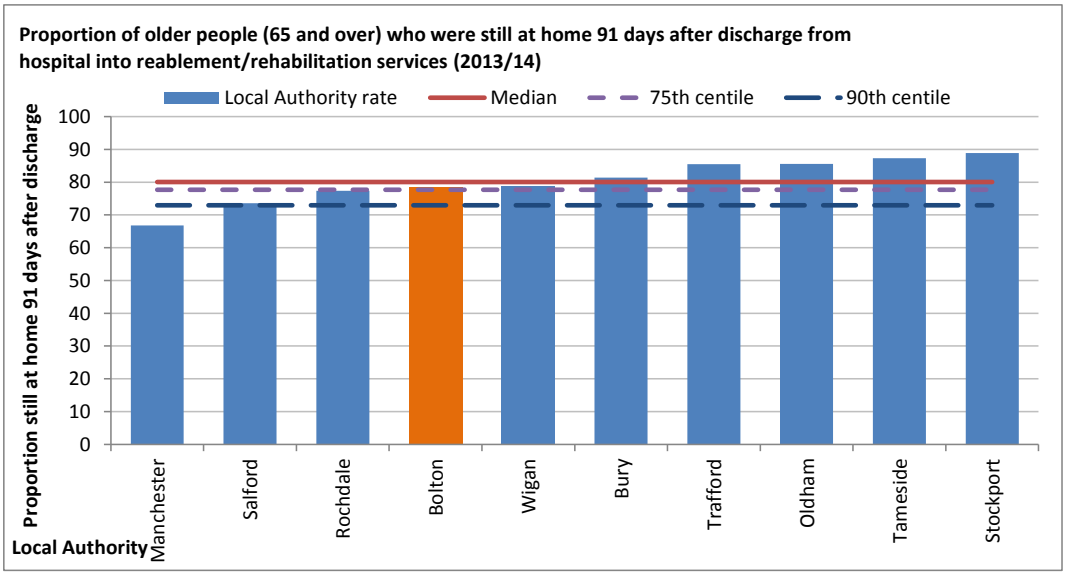
Chart 5 – Proportion of people still at home 91 days after discharge – trend over time and BCF ambitions



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

Chart 6 shows that in 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 for Bolton patients. A marked increase can be seen from March 2014, which is due to a change in recording at Bolton FT. The reported number of delayed days decreased between September and December 2014, the data shows an increase in January, February and March 2015, with a fall back below the average in April, May and June 2015.

In the Better Care Fund submission, Bolton's levels of ambition for 2014/15 allowed for the anticipated growth in the number of delayed transfers of care due to improved recording. The target for January to June 2015 was 321 (as shown in the chart below). The target for the remainder of 2015/16 is 308 delayed days per month.

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

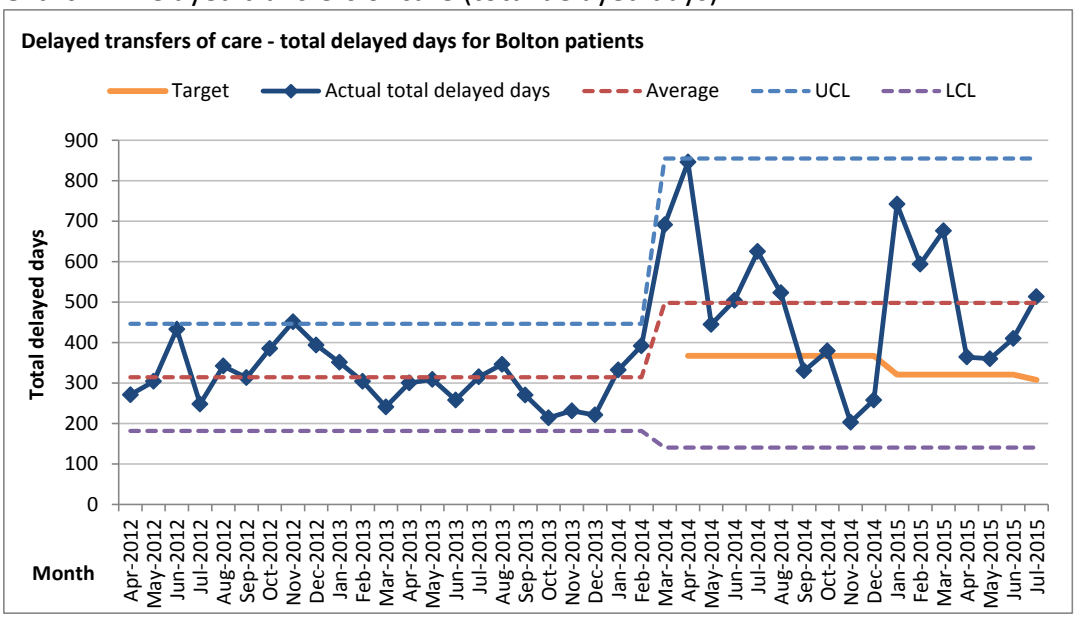


Chart 8 shows the number of delayed days over the last 12 months, broken down by attributable organisation. Over the 12 month period August 2014 to July 2015, 79% of delayed days were attributable to NHS, 16% were attributable to social care and 5% were attributable to both NHS and social care organisations.

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

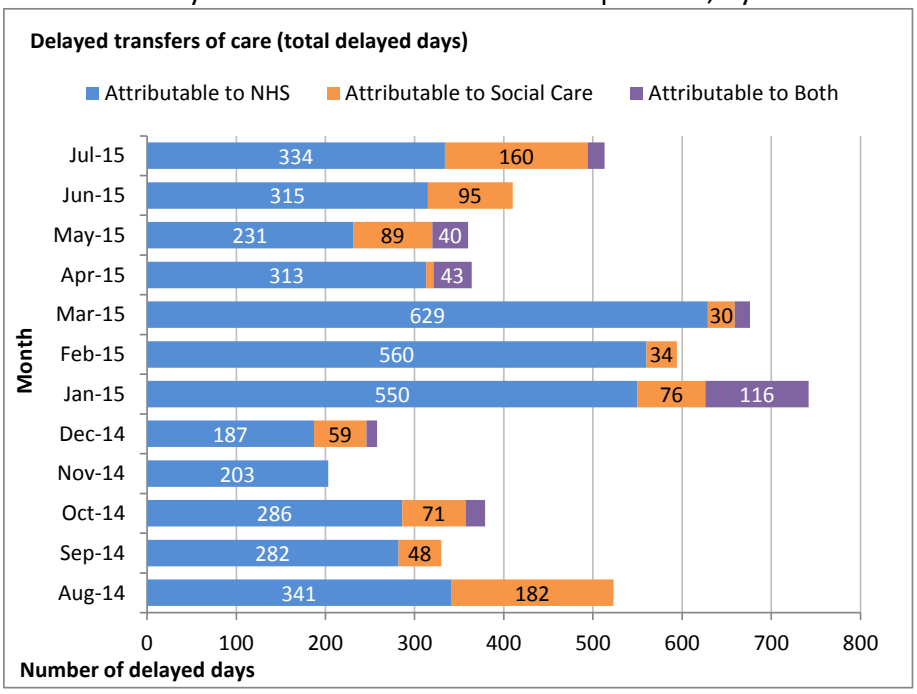
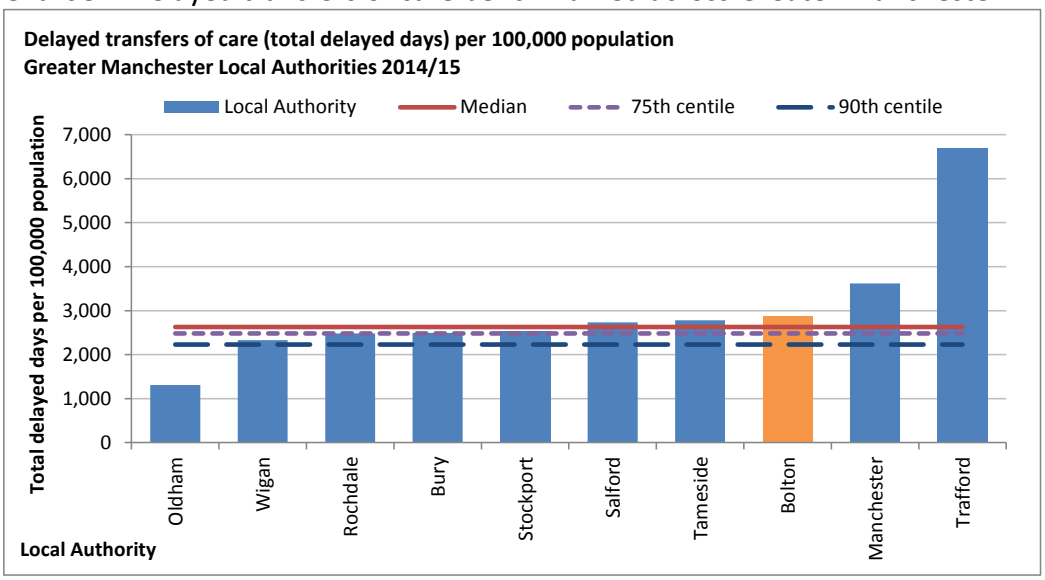


Chart 9 shows how the number of delayed transfers of care in Bolton compared across Greater Manchester in 2013/14. Bolton benchmarked above the Greater Manchester median rate.

Chart 9 – Delayed transfers of care benchmarked across Greater Manchester



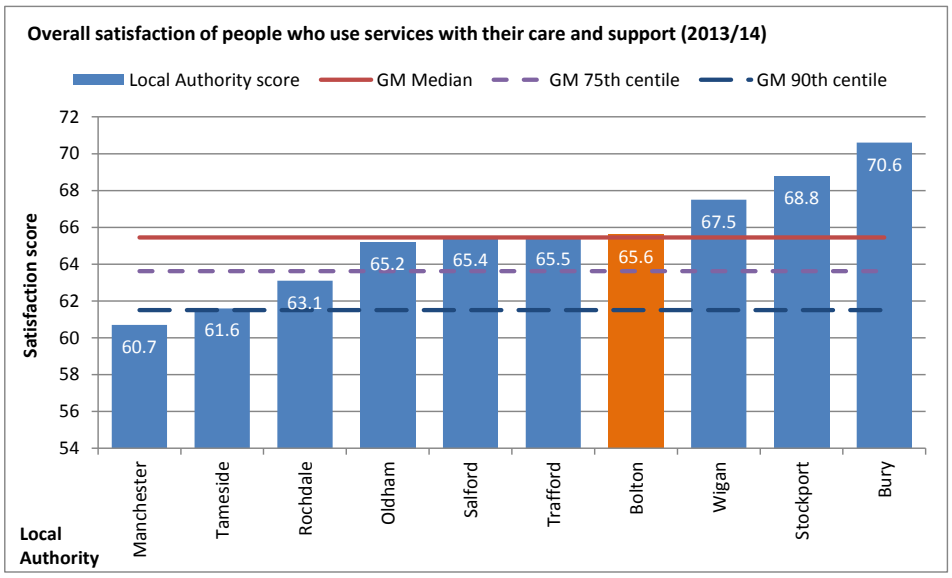
BCF5. Overall satisfaction of people who use services with their care and support
Objective: to increase

As part of the BCF submission, Health and Wellbeing Boards were required to select a patient experience metric.
Bolton chose “overall satisfaction of people who use services with their care and support”.

This metric was chosen because it is the nearest equivalent measure to a new metric which is under development for both the NHS Outcomes Framework and the Adult Social Care Outcomes Framework, “Improving people’s experience of integrated care”.

The metric is the proportion of respondents who say they are "extremely satisfied" or "very satisfied" in response to the question "Overall, how satisfied or dissatisfied are you with the care and support services you receive?”. In 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



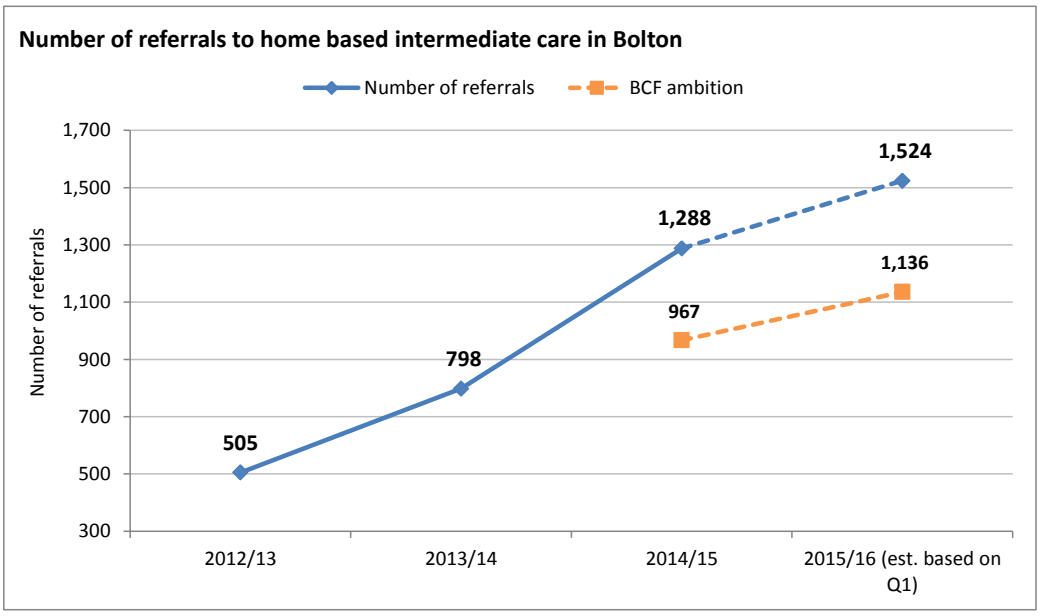
BCF6. Referrals to home based intermediate care

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 Bolton exceeded this target in 2014/15.

Chart 11 – Referrals to home based intermediate care



Greater Manchester and locally selected metrics

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

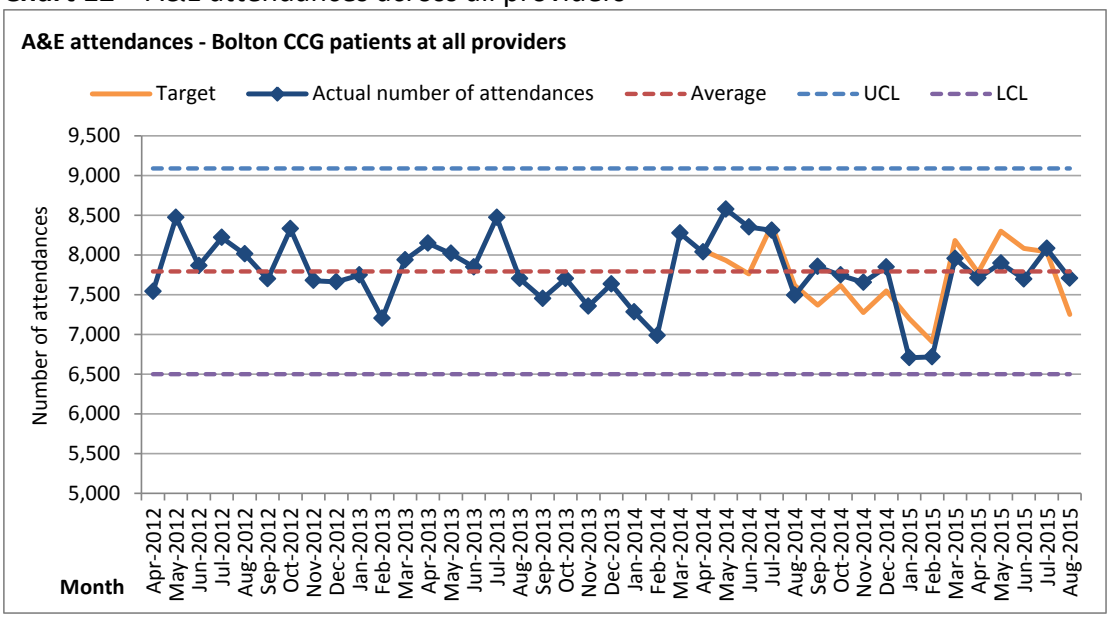
GM1. A&E attendances

Objective: To decrease

Chart 12 shows the number of A&E attendances at all acute providers from April 2012, for Bolton CCG patients.
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. January and February 2015 had fewer attendances than the average.

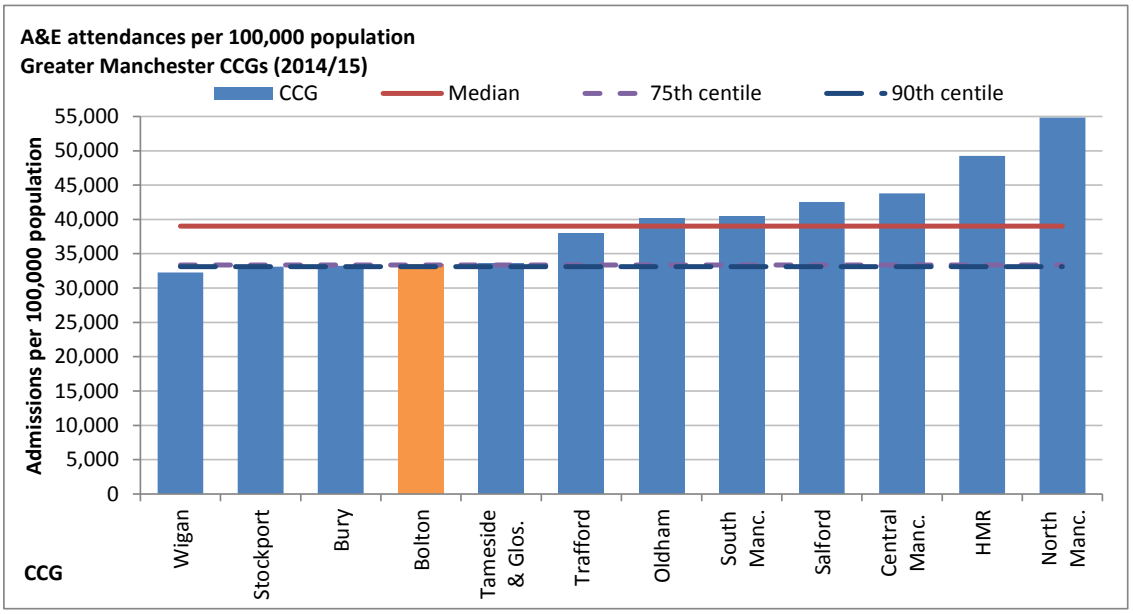
Bolton CCG's target for 2015/16 was to decrease the number of A&E attendances by -3.2% from 2014/15. For the year to date 2015/16, attendances have reduced by -4.1% when compared to 2014/15 (1,675 attendances).

Chart 12 – A&E attendances across all providers



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

Chart 13 – A&E attendances benchmarked across Greater Manchester

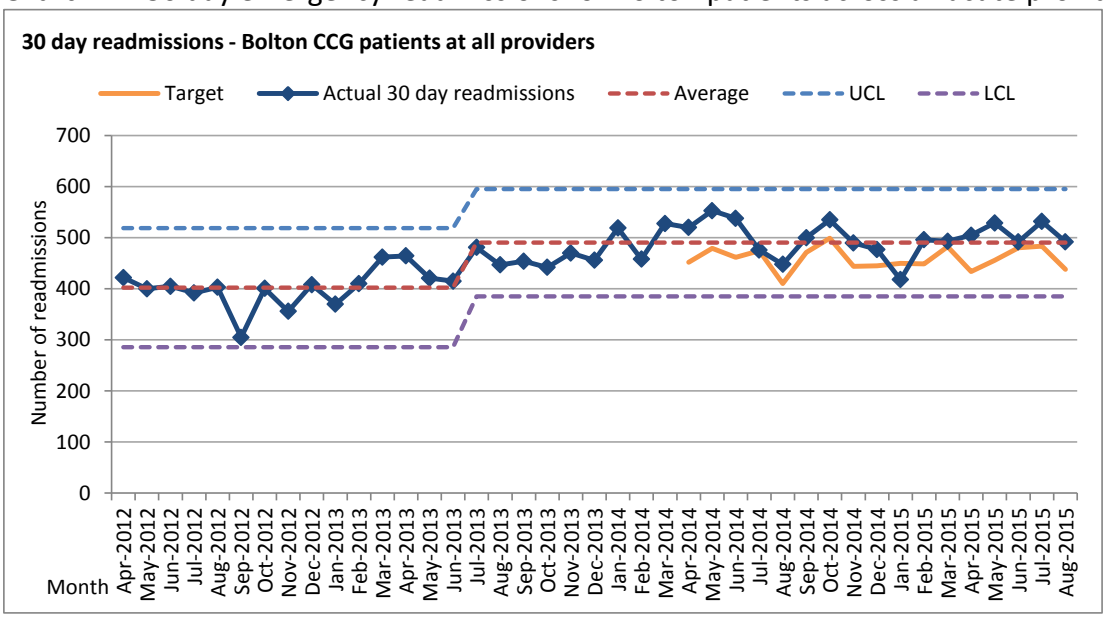


GM2. 30 day emergency readmissions

Objective: To decrease

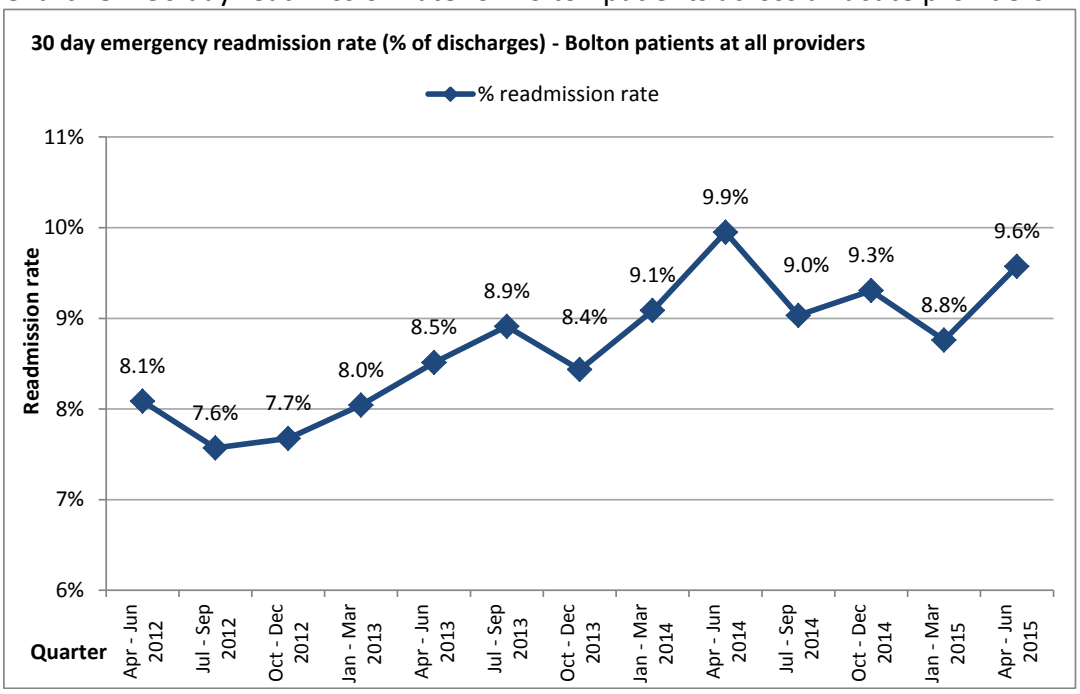
Chart 14 shows the number of emergency readmissions within 30 days of previous discharge (following an elective, day case or non-elective admission). When comparing 2015/16 YTD with the same period in 2014/15, there has been a +0.6% increase in the number of 30 day readmissions.

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



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

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

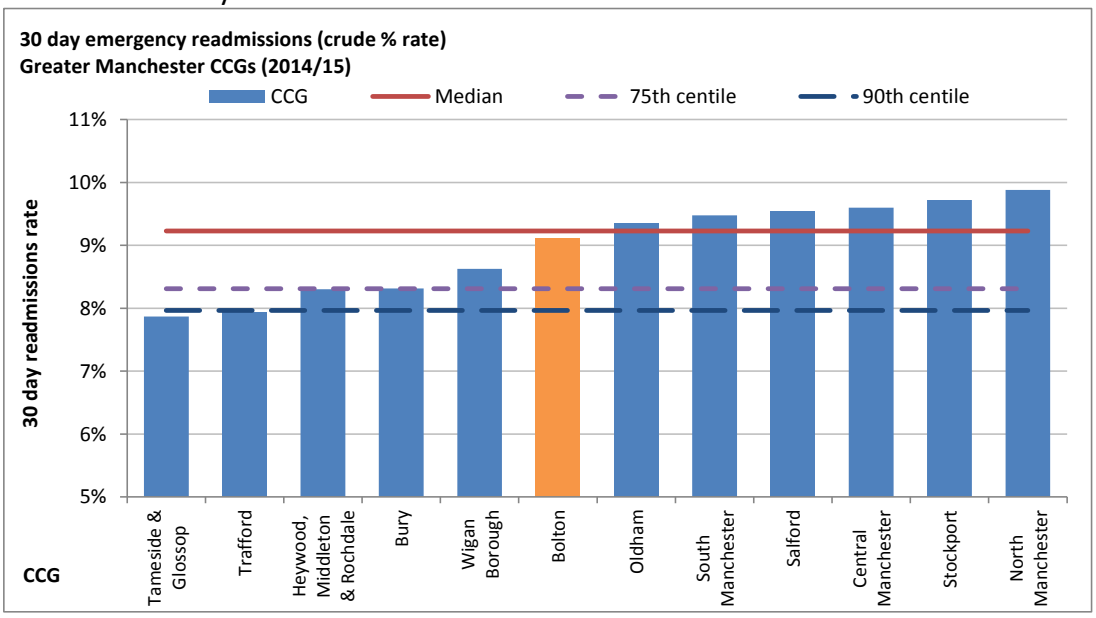


It should be noted that the number of readmissions shown in charts 14 and 15 includes patients who were discharged from one provider and readmitted in an emergency to a different provider, as well as patients admitted to the same provider twice.

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

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

Chart 16 – 30 day readmission rate benchmarked across Greater Manchester

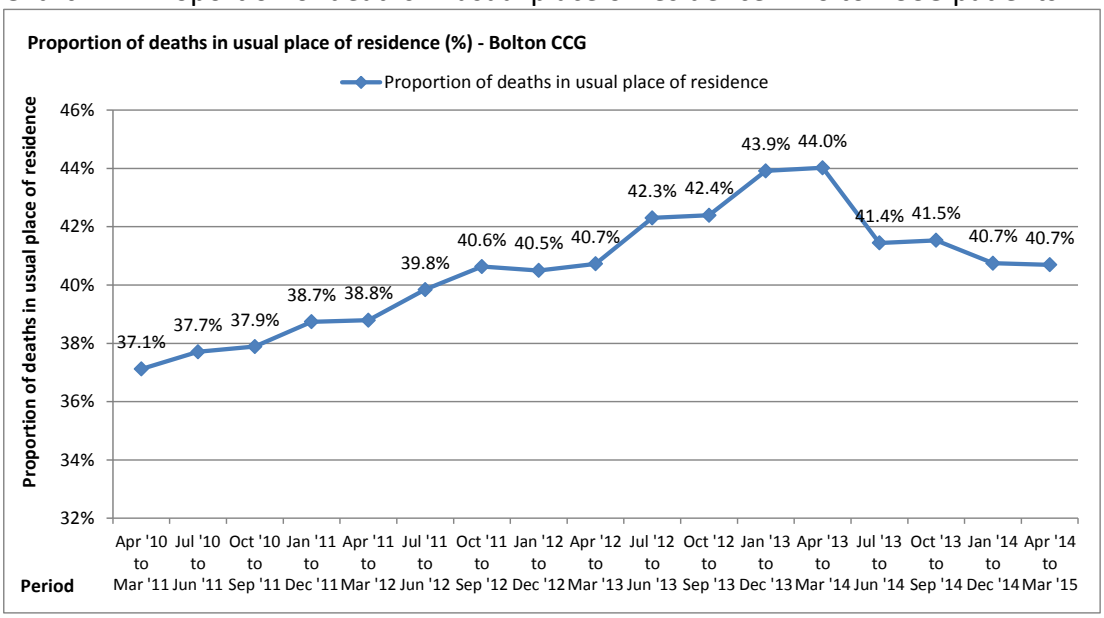


GM4. Percentage of people who die in their usual place of residence

Objective: To increase

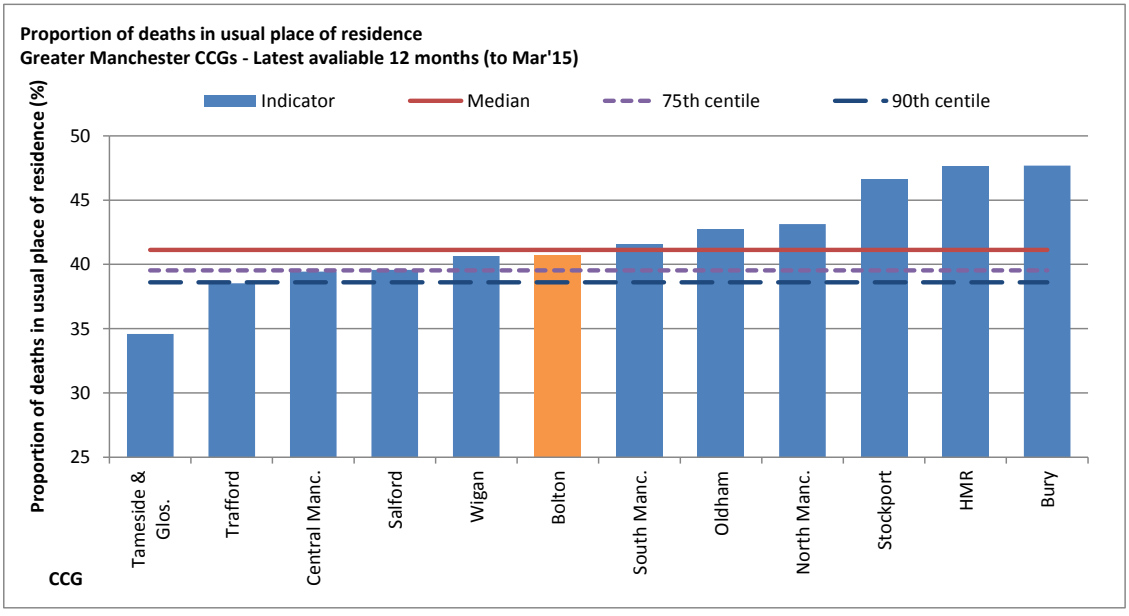
Chart 17 shows a rolling 12 month position for the proportion of deaths occurring in the person's usual place of residence in Bolton. There has been a steady increase from 37.1% in the year 2010/11, with a slight fall in the last three data points.

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



In the year January 2014 to December 2014, 40.8% of deaths in Bolton occurred in the person's usual place of residence. Bolton CCG ranked 6th 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:

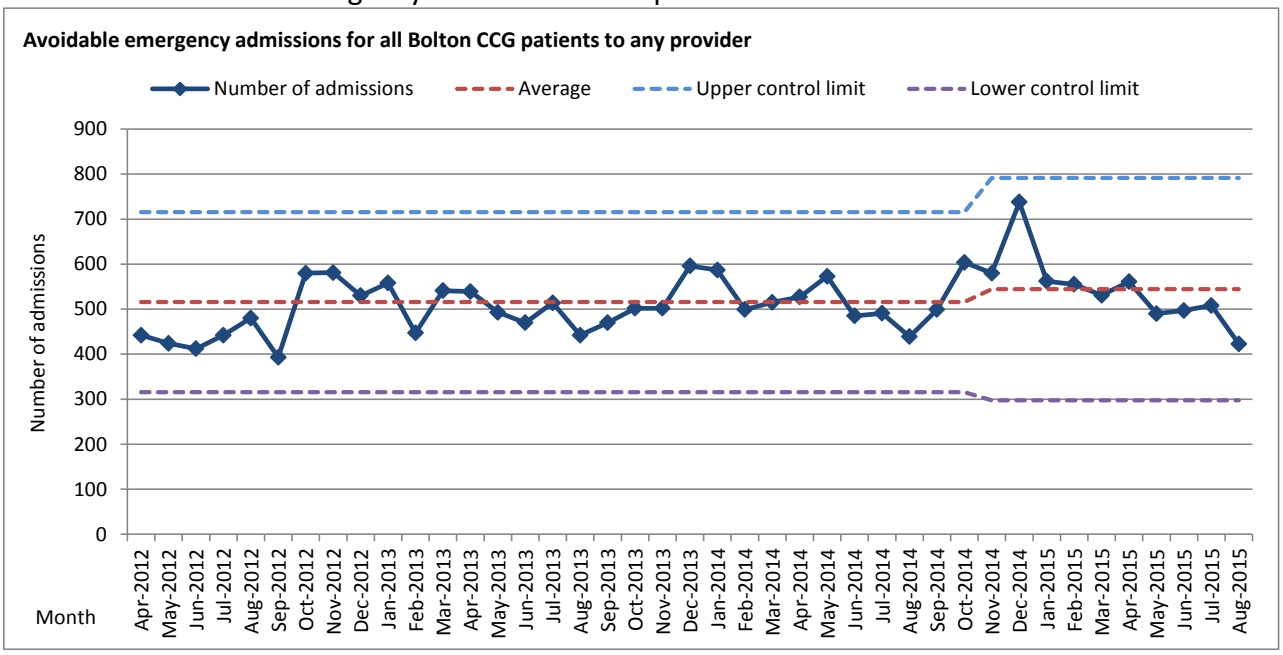
- chronic ambulatory care sensitive conditions
- acute conditions that should not usually require hospital admission
- asthma, diabetes and epilepsy in children
- children with lower respiratory tract infection.

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

Overall the trend is increasing; there was a 5.1% increase from 2012/13 to 2013/14 and a 7.4% increase when comparing 2013/14 to 2014/15. There has been a -1.4% reduction YTD in 2015/16 when compared to the same period in the previous year.

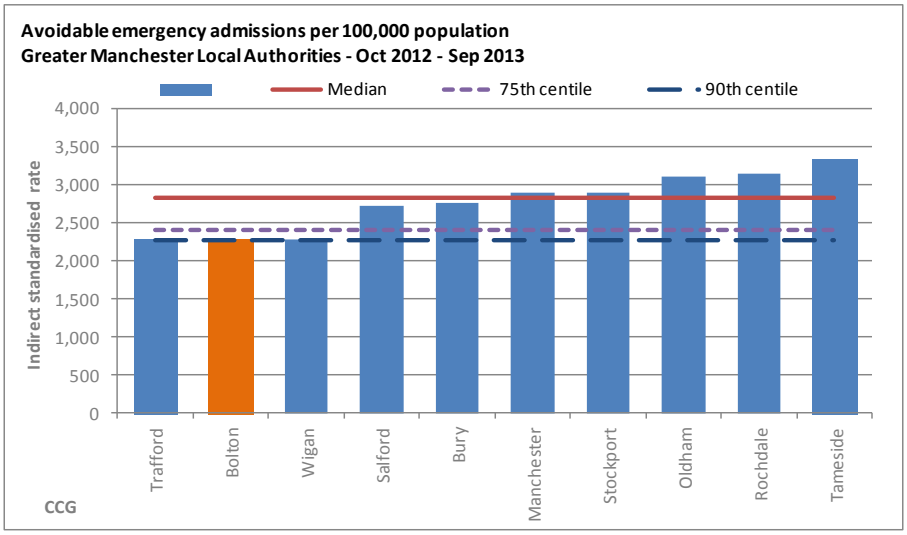
Chart 19 – avoidable emergency admissions to all providers



It should be noted that the types of conditions which are included in this measure could in the past have been admitted to the Bolton Community Unit, which closed in December 2013.

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

Chart 20 – Avoidable emergency admissions benchmarked across Greater Manchester



L2. Average length of stay (non-elective)

Objective: To decrease

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

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

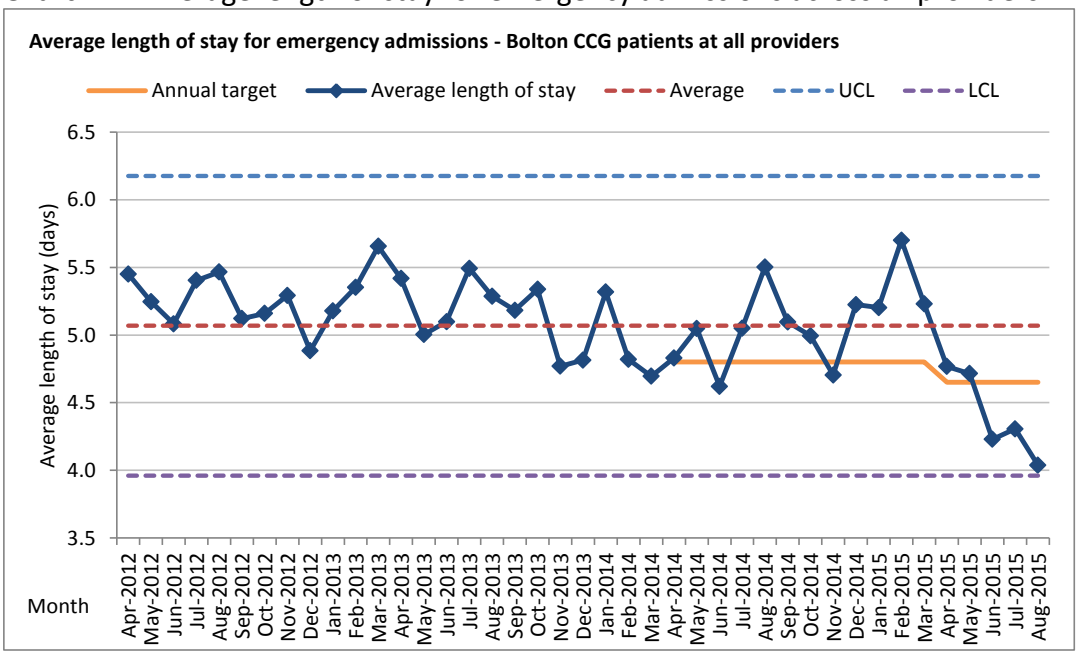
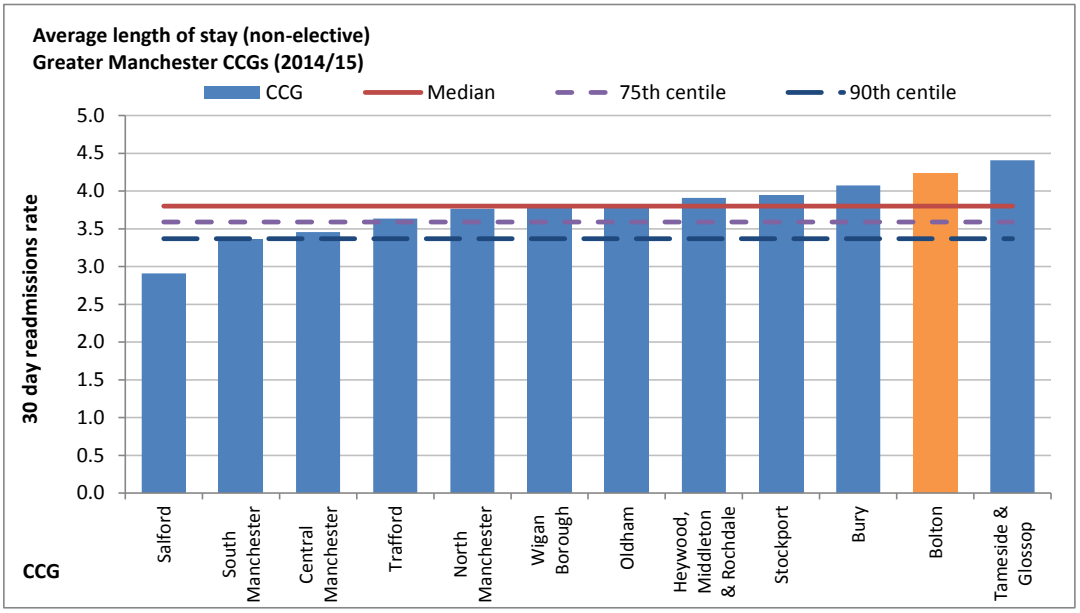


Chart 22 illustrates how Bolton CCG benchmarks against other Greater Manchester CCGs for average non-elective length of stay. In 2014/15, Bolton CCG was above the Greater Manchester median length of stay.

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



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

Objective: To decrease

Chart 23 illustrates the number of emergency admissions for Bolton patients aged 65 years and over, to any hospital provider, with a fall related injury. Overall there is an increasing trend in the number of falls admissions.

Comparing 2014/15 with 2013/14, the number of admissions increased by 23%, from 730 in 2013/14 to 900 in 2014/15. There have been 18 more admissions in the year to date 2015/16 when compared with 2014/15, an increase of 5.2%.

It should be noted however that the closure of the BCU in December 2013 may affect these figures, as this cohort of patients may have been treated in BCU in the past.

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

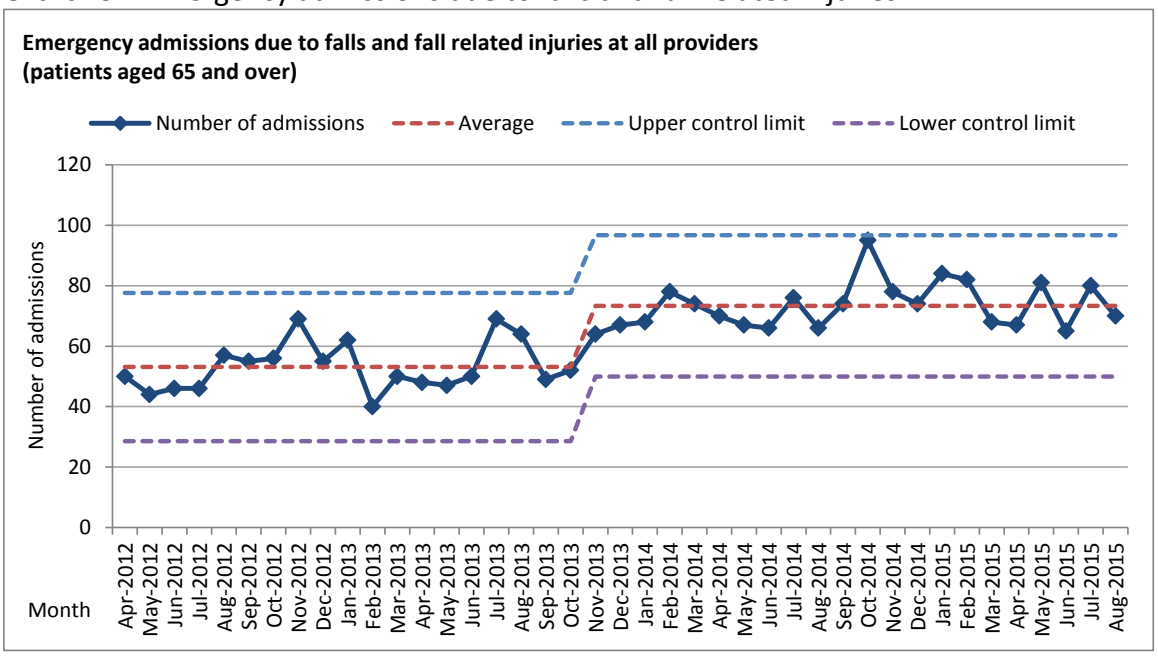
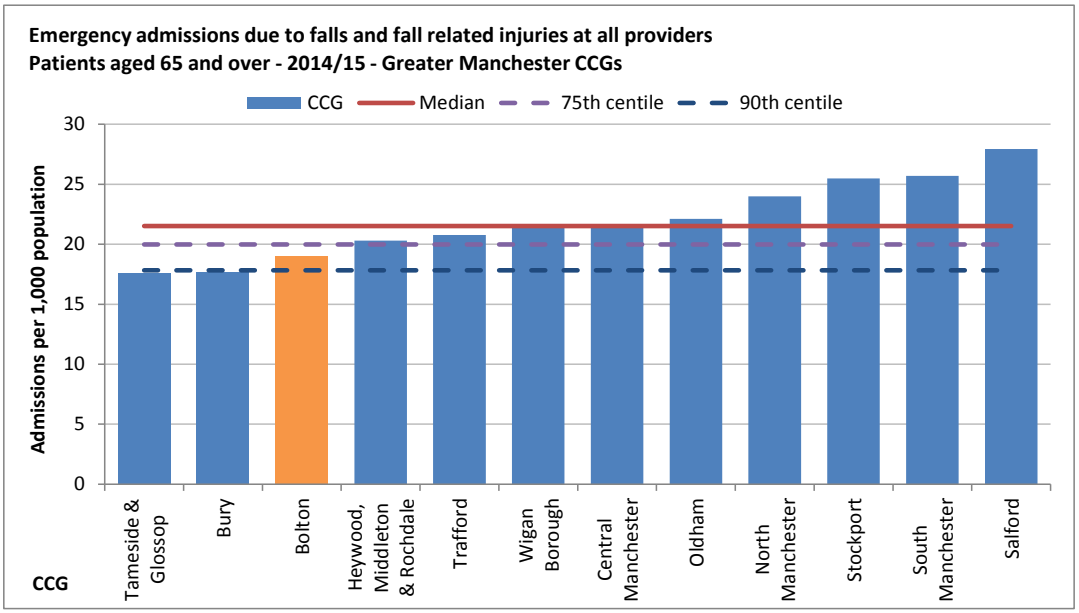


Chart 24 shows how Bolton CCG compares across Greater Manchester for the number of falls admissions per 1,000 population aged over 65. In the year 2014/15 Bolton had the third lowest rate of falls admissions across all Greater Manchester CCGs.

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



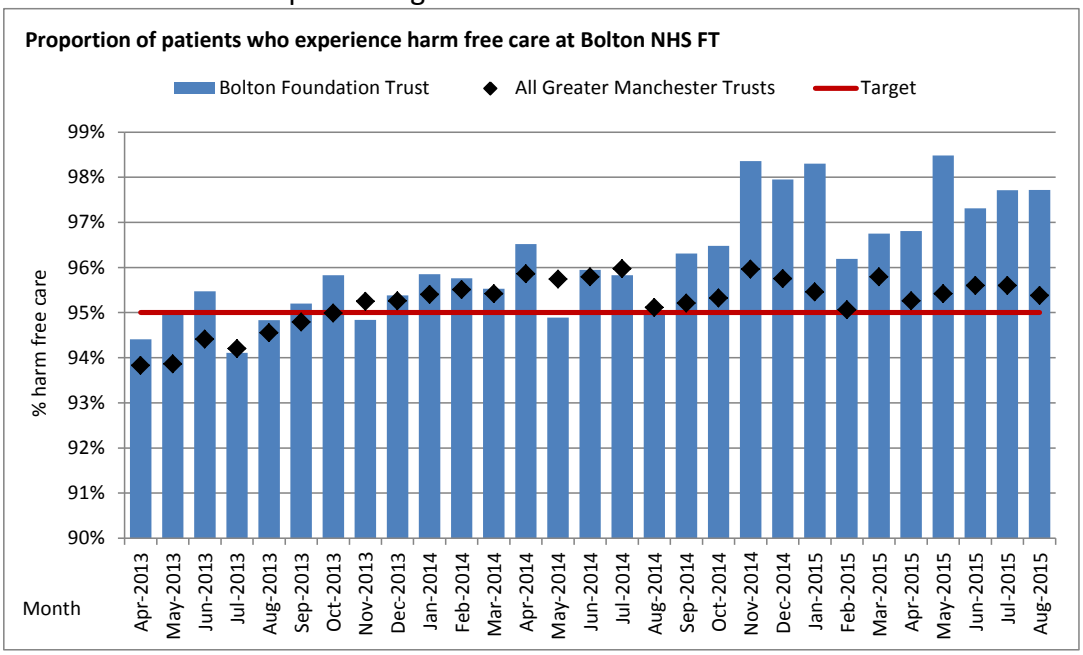
L4. Proportion of patients who experience harm-free care

Objective: to increase

Chart 25 shows the proportion of patients who experienced harm-free care at Bolton NHS FT between April 2013 and August 2015. This measure is taken from the NHS Safety Thermometer, which records the presence or absence of four harms: pressure ulcers, falls, urinary tract

infections (UTIs) in patients with a catheter, new venous thromboembolisms (VTEs). The target, set nationally, is to achieve 95% harm-free care. Chart 25 also shows the monthly harm-free care achievement for all Greater Manchester Trusts combined.

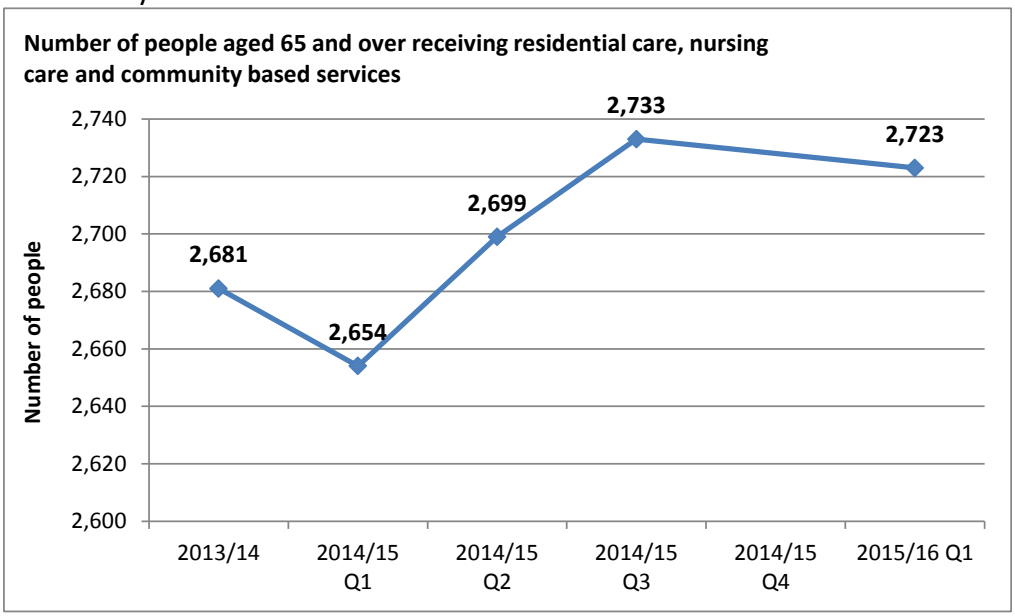
Chart 25 – Patients experiencing harm-free care at Bolton NHS FT



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

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

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

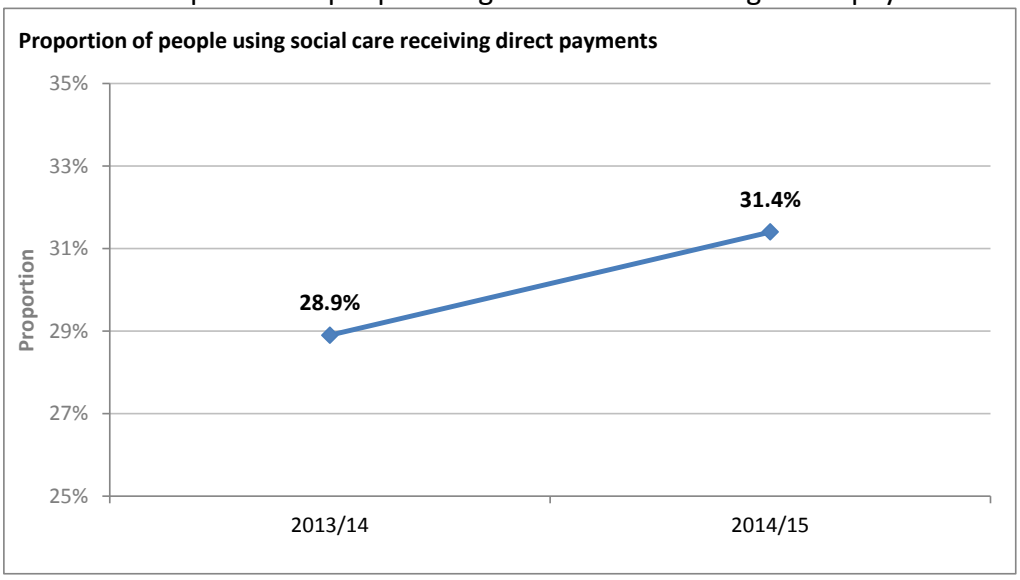


L6. Proportion of people using social care receiving direct payments

Objective: to increase

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

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

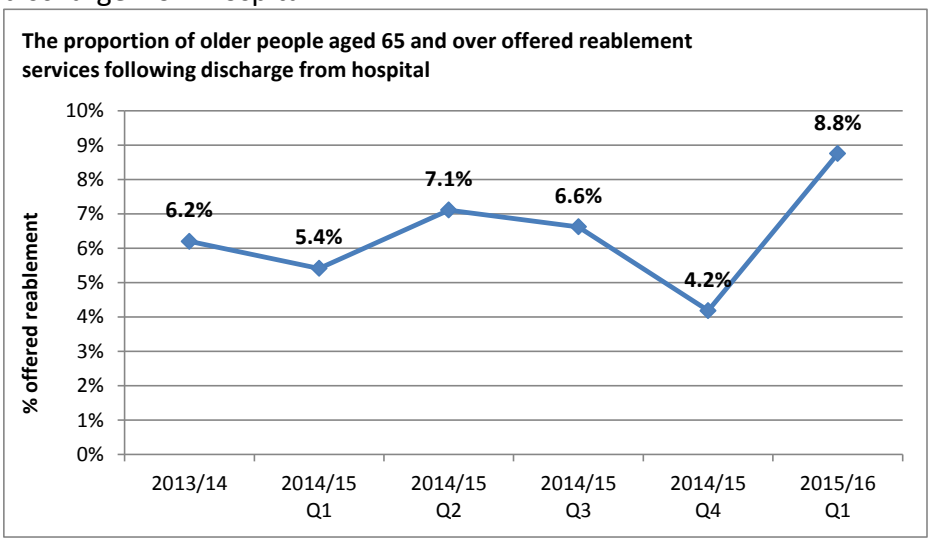


L7. The proportion of older people aged 65 and over offered reablement services following discharge from hospital

Objective: to increase

Chart 28 shows the number of older people offered reablement services following discharge from hospital as a proportion of all discharges (people aged 65 and over). The full year figure for 2014/15 was 5.0%.

Chart 28 – The proportion of older people aged 65 and over offered reablement services following discharge from hospital



L8. Percentage of people finishing Intermediate care or reablement who have a reduced package of care

Objective: to increase

Data to follow

L9. Percentage of people finishing reablement or intermediate care who have no package of care

Objective: to increase

Data to follow

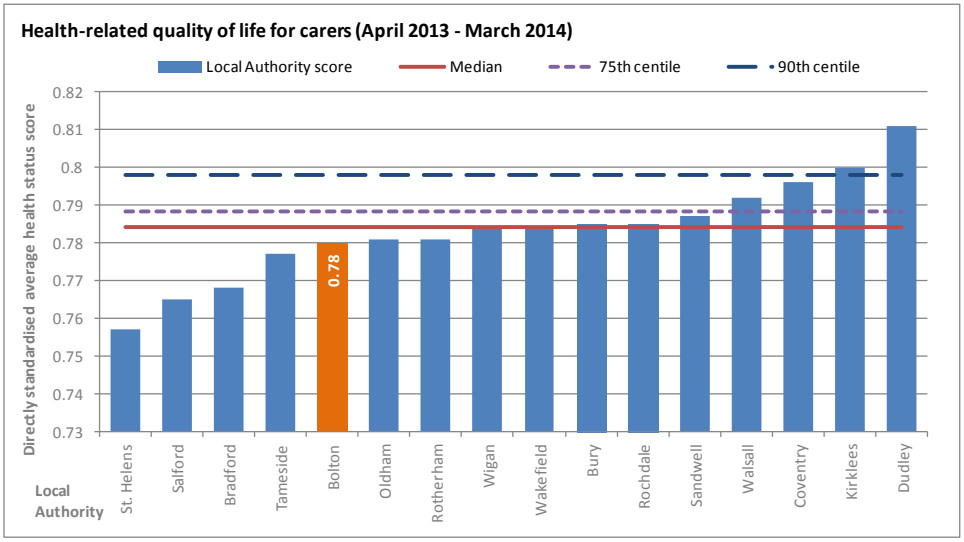
L10. Health-related quality of life for carers

Objective: to increase

Chart 29 shows the latest available health-related quality of life scores for Bolton CCG and its statistical peers, taken from the 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 29 – Health-related quality of life for carers – average health status scores

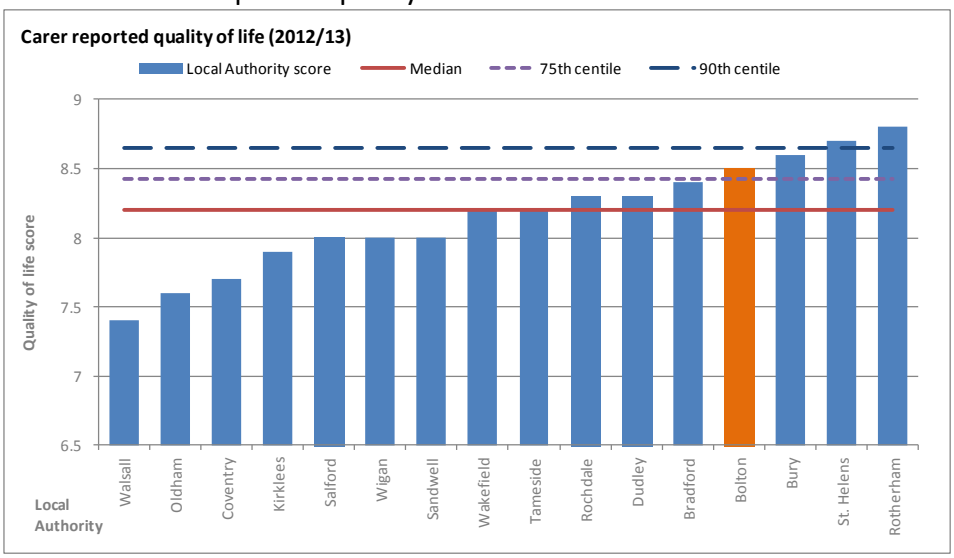


L11. Carer reported quality of life

Objective: to increase

Chart 30 shows quality of life scores for carers in Bolton, as reported in the biennial carers' survey. In 2012/13, when the survey was last carried out, Bolton had the 4th highest scores among it statistical peer organisations.

Chart 30 – Care reported quality of life



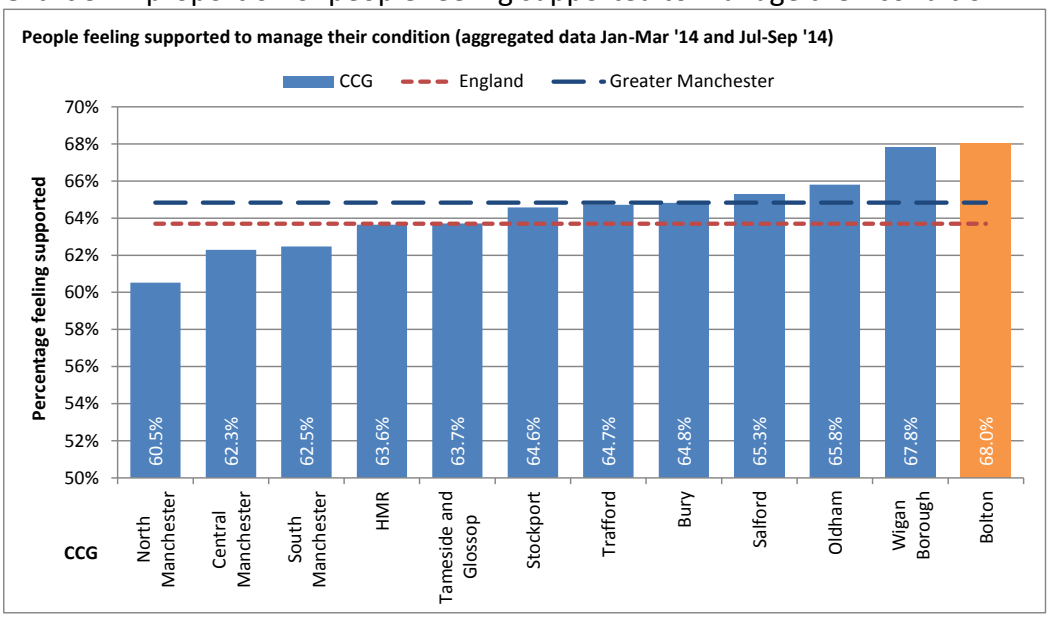
L12. People feeling supported to manage their condition

Objective: to increase

Chart 31 shows the percentage of people who answered "yes" to the following question in the GP Patient Survey:
"In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?"

Bolton CCG had the highest proportion of patients responding positively (68.0%) when compared across Greater Manchester CCGs. This measure has been relatively consistent over the last three years.

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

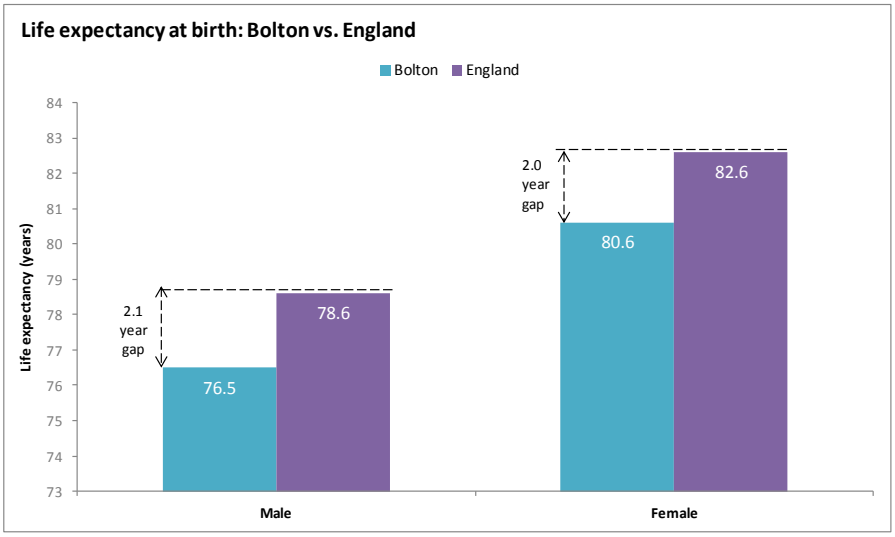


L14. Reducing the gap in life expectancy between Bolton and the England average

Objective: to decrease

Life expectancy in Bolton is currently 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 32 illustrates this gap between Bolton and England.

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



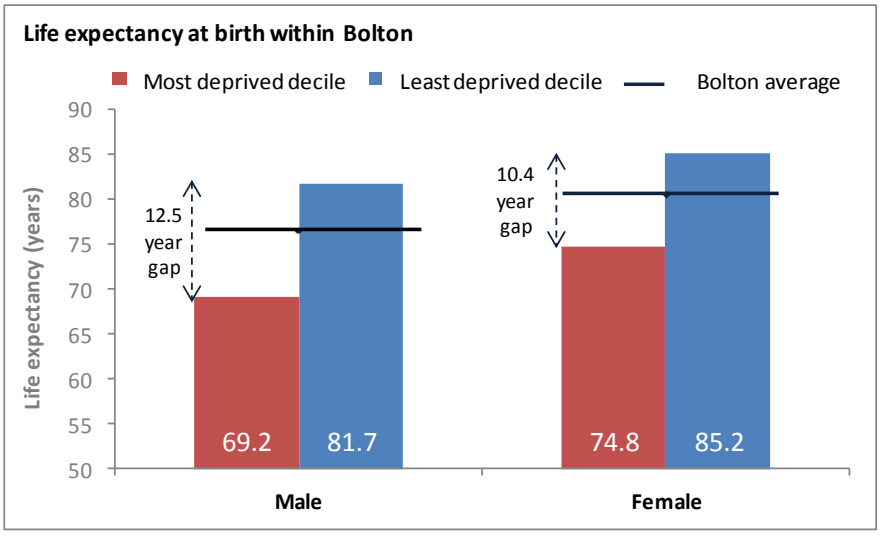
L15. Reducing the gap in life expectancy across Bolton

Objective: to decrease

Within Bolton there is a significant gap between the most deprived and least deprived areas. The most deprived decile in Bolton has a life expectancy of 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 33.

Chart 33 – Life expectancy at birth – gap within Bolton



KPI Definitions

L1. Avoidable emergency admissions

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

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

GM2. 30 day emergency readmissions

The following exclusions apply to the 30 day readmissions KPI:

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

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

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

Data Sources

KPI	Data Source	Comments
Better Care Fund Indicators		
BCF1. Emergency admissions	Monthly Activity Return (MAR)	
BCF2/ GM4. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Adult Social Care Outcomes Framework (ASCOF)/ CareFirst	
BCF3. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from to reablement/ rehabilitation services	Adult Social Care Outcomes Framework (ASCOF)/ CareFirst	
BCF4. Delayed transfers of care (total number of delayed days)	Unify	
BCF5. Overall satisfaction of people who use services with their care and support	Adult Social Care Outcomes Framework (ASCOF)	
BCF6. Referrals to home based intermediate care	National Audit for Intermediate Care (NAIC)	
Greater Manchester Indicators		
GM1. A&E attendances	Patient Level SLAM/ SUS	
GM2. 30 day emergency readmissions	Patient Level SLAM/ SUS	
GM3. See BCF2.	-	
GM4. Increasing the percentage of people that die in their usual place of residence.	ONS, via National End of Life Care Intelligence Network	
Local Indicators		
L1. Avoidable emergency admissions	Patient Level SLAM/ SUS	
L2. Average length of stay (non-elective)	SUS	
L3. Reducing the number of admissions due to falls and fall related injuries (over 65s)	Patient Level SLAM/ SUS	
L4. Increasing the proportion of patients who experience harm free care	NHS Safety Thermometer	
L5. Number of people aged 65 and over receiving residential care, nursing care and community based services	CareFirst	
L6. Proportion of people using social care receiving direct payments	CareFirst	
L7. Increasing the percentage of people receiving reablement or intermediate care at the point of discharge	TBC	
L8. Increasing the percentage of people	Bolton Council	

finishing Intermediate care or reablement who have a reduced package of care		
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	