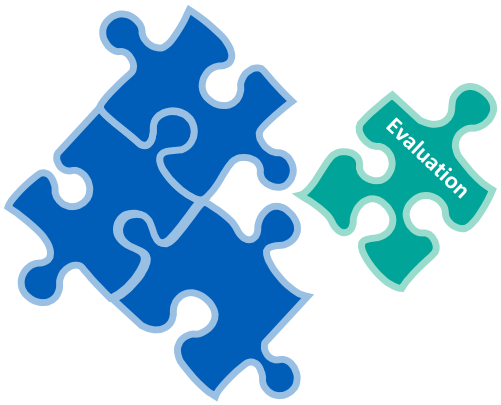
NHS
Leeds
Clinical Commissioning Group

Leeds CITY COUNCIL

SWIFT Interim Evaluation- Autumn 2018

Health and Care Evaluation Service

Will Ridge



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SWIFT Evaluation: Autumn 2018

Version Control

Version	Date	Author	Comments
1.1	21/08/2018	Will Ridge	Initial Draft
1.2	25/09/2018	Will Ridge	Redraft following comment from Ali Phiri and Lucy Jackson
1.3	01/10/2018	Will Ridge	Redraft following feedback from Frank Wood.

1.0.0 Headline Findings

This evaluation has used a control match cohort technique to evaluate the impact of the SWIFt service on demand for health and care resources. The business case for the SWIFT service sets seven broad outcomes for the project to achieve and this evaluation is against a subset of four of them:

- Reduction in all age all-cause mortality;
- Reduction in emergency admissions to hospital;
- Reduced length of stay;
- Reduction of care home admissions.

A full evaluation of the impact of this service and decisions about on the next steps to be taken should draw on this and other evaluation work including the national evaluation of the Time to Shine Programme and the findings from the recent stakeholder consultation exercise.

This evaluation has compared a sample of the people who went through the service against a similar cohort selected by a matching programme. Overall this evaluation has been limited by the small cohorts who have received support from the service for significant amounts of time, however, there is some emerging evidence which suggests:

- The typical person supported by the SWIFt service lives in an area with relatively high deprivation, have more multiple long term conditions and a greater level of frailty than average for the city;
- There is a lower mortality rate for people supported by the SWIFT service than the match cohort;
- Broadly stable A&E attendances for the intervention and match cohorts across the 2015/16-2017/18 financial years, however, some evidence of a greater proportion of attendances from the intervention cohort resulting in a hospital admission in comparison to the control group suggesting more appropriate A&E attendances;
- Large proportions of the population supported by the service neither attended accident and emergency, nor were admitted to hospital during each year with only around a third of the supported population admitted to hospital in the 2017/18 financial year;
- Those who were admitted saw increased lengths of stay for the patients support by the SWIFt service when comparing a baseline from 2015/16 with 2017/18;
- There are early signs of increases in some planned health care activity such as attendances from community health for the intervention group, but reductions in other types of planned activity such as outpatient and community based adult social care packages of care;
- This evaluation suggests increasing health care costs to the commissioner for the intervention cohort in comparison to the match cohort.

Sample sizes in the study were small with great variation in some areas of activity. As a result none of these findings were found to be statistically significant, this is broadly in line with other, similar interventions.

2.0.0 Introduction

This is a quantitative evaluation of the SWIFT (Supporting Well-being for Independence and Frailty) service. The evaluation will assess the success of the SWIFT service in the delivery of the benefits stated in its business case. The findings of the evaluation should not be viewed in isolation but should instead be used alongside the national evaluation of the Time to Shine Programme and the recent stakeholder consultation.

This document follows an initial evaluation in the autumn of 2017, which identified that the service had not been established for long enough to be able to identify cost savings associated with the cohort of patients supported by the service against a control matched cohort. This evaluation will return to this line of enquiry and with the benefit of a larger sample of service users and a greater amount of time for evaluation, and will use a more comprehensive set of criteria for cohort matching and test the service against the benefits in the business case.

3.0.0 Service Description

The SWIFt service is provided by a consortium of third sector providers lead by Leeds Older Peoples Forum supported by five delivery partners- Age UK Leeds, Bramley Elderly Action, OPAL, Crossgates Good Neighbours and Health For All. The service is currently funded by the Time to Shine Initiative, and the Leeds Clinical Commissioning Groups, and supports older people with poor health and complex health needs typically including frailty.

The service supports frail, socially isolated older people and creates referral pathways from health and care services into third sector provision. The services they access through SWIFT improve their quality of life, reduce social isolation and loneliness through the provision of one to one, personalised support, to reduce demand for services from the health and care sectors- especially secondary health care. The majority of service users are supported through long term relationships with a support worker. A small minority are signposted to other relevant services, but not taken onto a workers caseload.

The business case for the service includes seven outcomes:

- Improve the health and wellbeing of older people reducing their risk factors for increasing frailty;
- Reduce social isolation and improve support networks for older people to increase resilience;
- Support a greater number of older people to live independently and safely in their own homes increasing time spent at home and reducing hospital and care home admissions;
- Enable independence by providing older people with choice and control over the services they use and their health and social care decisions;
- Provide person centred support for older people working across the health and social care system complementing existing services;
- Improve the wider determinants of health, including economic disadvantage and discrimination;
- Reduce premature winter deaths.

This evaluation will test the service against four indicators taken from these outcomes:

- Reduction in all age all-cause mortality;
- Reduction in emergency admissions to hospital;
- Reductions in length of stay in hospital;
- Reduction of care home admissions.

4.0.0 Methodology

This evaluation has assessed the system impact of the SWIFT service. It used the Leeds Data Model to assess the health and care resources that the cohort of people supported by SWIFT consume and used this to evaluate the impact of the service.

Records were provided by Leeds Older People forum that had collected the data from delivery partners. This dataset is a sample of the totality of activity through the SWIFt service, covering 210 people referred into the service between November 2016 and June 2018 who had their NHS reference number. As of the end of June 2018 the project had come into contact with the following:

- 625 clients in total across all projects have received 'full support'. A further 34 have been engaged as 'light-touch';
- 85 volunteers have been involved in the project- 30 volunteers aged 49 and under and 55 volunteers aged 50 and above;
- Volunteers have given approximately 2,074 hours of their time to support the SW projects since the start of the projects.

The data that this evaluation has drawn from includes:

- 198 people with a full support intervention- 31.7% of the total of 625, and nine, 25.7%, receiving a light touch intervention;
- 3 volunteers, 3.5% of the total, all aged 50 and above.

The delivery partners have reported that it is difficult for them to find the NHS reference numbers for the people they support, and this has resulted in a relatively small proportions included in this samples of the supported populations. The demographic data sets in this report are drawn from the whole sample of 210 people. . Service users who have died have been retained for the section on mortality, but removed from the system impact section. The system impact section includes only the cohort of people who started to access 'full support' between November 2016 and March 2017- 35 people

The system impact of SWIFt was evaluated against:

- Number and cost of accident and emergency attendances;
- Number and cost of non-elective inpatient bed days;
- Number and cost of elective inpatient bed days;
- Number and cost of community health attendances;
- Number of community mental health attendances;
- Number and cost of outpatient attendances;
- Number in receipt of adult social care funded community based services;
- Number in an adult social care funded residential or nursing permanent placement.

All cost activity was evaluated using final tariff costs taken form the Leeds data model.

The impact of the service is evaluated against a match cohort selected by a matching programme from the patient population aged over 50 in Leeds. The variables used for this match include:

- Basic Demographics: including age, gender, and deprivation at their residential address;
- Health Care Datasets: including ACG risk score, number of deficits on the e-frailty index, or if they were on the palliative care register;
- Health and Social Care Resource Consumption: based on routine datasets including A&E Attendances in the last year and last 30 days, non-elective inpatient beds days in the last year and last 30 days, placement in a residential or nursing home in the last year.

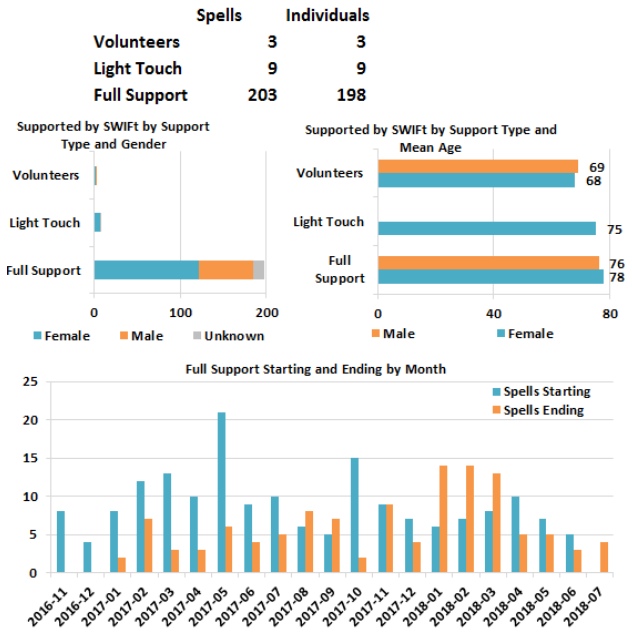
A more complete list of the variables used in the match is in appendix one. The matching process only delivers results for those that it can achieve an acceptable match for. This evaluation uses 184 records from the intervention cohort and 184 records matched to this group, of whom 35 service users in this group have been supported by the SWIFt service for a full year or more at evaluation and had their records used in the system impact section.

5.0.0 Detailed Findings

5.1.0 Descriptive Population Analysis

5.1.1 Demographics and Deprivation

Fig 1: SWIFt Support Spells



As is shown in figure one the sample of the population submitted for the evaluation was around two thirds female- 65% of the population receiving full support. Average ages for both male and female populations were in the late 70s- 76 and 78 respectively. Both these are roughly consistent with the last, interim evaluation of SWIFt.

The average length of support has increased since the last evaluation. The last data set showed patients were supported for 90 days on average. In this data set the most common length of support is 92 days (18 instances) with a median of 122, the mean average has increased to 151 days as the project has run for a greater period of time.

The cohort receiving 'full support' is relatively deprived with 45 patients (26%) resident in the most deprived decile, with 10 (5.8%) resident in an LSOA in the most deprived 1% nationally, and 23 (13.3%) in the most deprived 3% nationally. 19 of the population (11%) live in the two least deprived deciles.

5.1.2 Health and Care Needs

In September 2016, two months before the SWIFt service accepted its first referrals, a population health management exercise was undertaken covering the patient population registered with Leeds GPs. This categorised the GP registered population in Leeds into one of four groups- healthy, those

Fig 2: Population Health Management Groups for the SWIFt Supported Sample against Age Sex Standardised Leeds Population

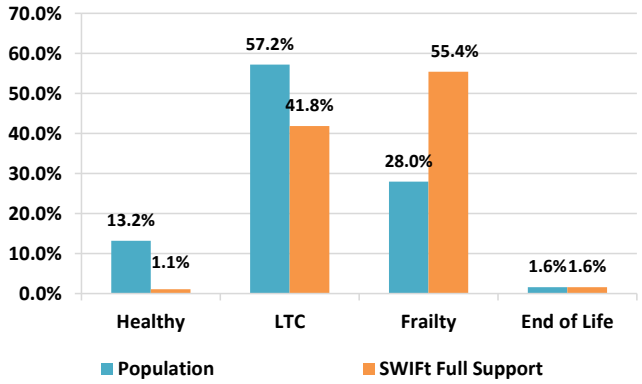


Fig 3: Number of Long Term Conditions for the SWIFt Supported Sample against Age Sex Standardised Leeds Population

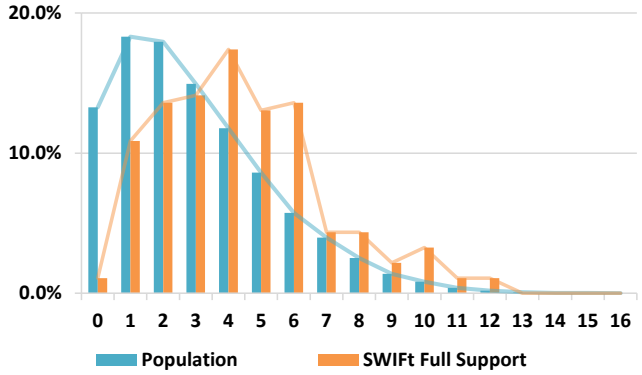
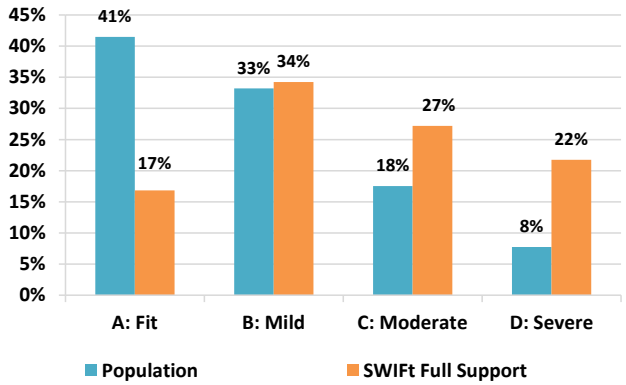


Fig 4: eFI Groups for the SWIFt Supported Sample against Age Sex Standardised Leeds Population



living with long term conditions, those with frailty and those receiving end of life care. The different proportions of people in these groups have been compared to an age sex standardised figure for the population of Leeds and the results of this are in figure two.

The majority (55.4%) of the population in the sample who had received the 'full support' offer from the SWIFt service are in the frailty cohort- greater than the age sex standardised population- 28.0%.

The next largest group was those with long term conditions- 41.8% of the SWIFt group and 57.2% of the general population.

Just two of the population that were in the SWIFT sample were in the healthy group (1.1%) smaller than the standardised broader population (13.2%).

Three of those supported by SWIFt were in the end of life group- on a palliative care register, proportionally in line with the age sex standardised group.

As shown in figures three and four the supported population had a greater number of long term conditions and frailty in comparison to the broader population.

Two (1.1%) of the sample population supported by SWIFt had no long term conditions, while 88% had two or more LTCs. The standardised comparator group had 24 (13.3%) with no long term conditions and 68.4% with two or more.

The most common Long Term Conditions in the cohort supported by SWIFt were hypertension (112 or 56.6%), Arthritis (86, 43.4%), Diabetes (61, 30.8%), and Depression (61, 30.8%).

The population health management exercise included data on the number of electronic Frailty Index (eFI) scores on their primary care records. The results of this are presented in figure 4. Overall this suggests that the population supported by SWIFt had greater frailty in comparison with an age sex standardised cut of the population of Leeds.

Only one of the service users in the SWIFt cohort had no flags for frailty. While the largest group for the age sex standardised population was 'Fit' (41%), only 17% of those supported by SWIFt were in this group.

The most common frailty group in the supported sample that received 'full support' was 'Mild' (34%), broadly in line with the proportion for the standardised group (33%).

27% of the cohort had moderate frailty, higher than the standardised population at 18%.

A greater proportion of the population had severe frailty- 22% in the SWIFT sample against 8% in the population dataset.

The most common flags were for polypharmacy (71.7%), Anaemia and haematinic deficiency (61.7%), visual impairment (36.7) and urinary system disease (35.6%).

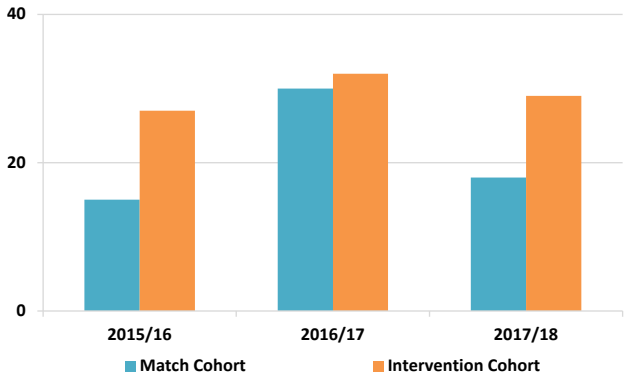
5.2.0 Evaluation of Impact on System Activity

5.2.1 Impact on Mortality

Comparison of 184 intervention and matched records shows that nine people died in the cohort receiving full support from SWIFT and fifteen in the matched group. This was tested with Coxs regression which found that the difference in mortality between the match and intervention groups was not statistically significant.

5.2.2 Impact on Accident and Emergency Attendance and Emergency Admissions to Hospital

Fig 5: A&E Attendances for the Match Cohort and SWIFt Cohort



Based on this sample of service users the intervention cohort did not attend accident and emergency regularly over the three years covered in this evaluation. More than 60% of both intervention and match cohorts did not attend A&E in the 2015/16 or 2017/18 years. Typically large proportions of the cohort were not admitted to hospital in any given year with around two thirds not admitted in 2015/16 or 2017/18. In both these cases the available evidence shows higher proportions attending both A&E and being admitted to hospital in 2016/17 with around half the two cohorts admitted for at least one bed day.

Total attendances at accident and emergency were higher for the intervention cohort in the 2017/18 year at 29 in comparison to 18 for the control group. These figures were not greatly different to these cohorts in 2015/16 when they were 27 and 15 respectively. However, the 2016/17 year shows

a consistently greater number across these two cohorts with 32 and 30 attendances, this is likely to be in part a product of attendances at accident and emergency and hospital stays generating referrals into the SWIFt service.

There is some emerging evidence that the SWIFt supported cohort were more likely to be admitted to hospital after an attendance at accident and emergency than the match cohort with 72% of attendances resulting in an admission in the intervention group in 2017/18 against 50% for the match cohort, this compares to 56% and 40% in 2015/16. Given the small cohort size- 35 service users in each group and less than 30 attendances in each year, a greater time period is required to more thoroughly follow up this line of enquiry. This trend suggests that the intervention group are more likely to attend accident and emergency appropriately then the control group

As demonstrated in the previous section the number of non-elective bed days has increased for the intervention cohort in comparison to the match group. However, this difference is not statistically significant.

5.2.3 Impact on Length of Hospital Stay

Figure six shows total length of stay during the 2015/16, 2016/17 and 2017/18 financial years, split by elective and non-elective hospital spells. This data set only includes those who had started the SWIFt service in March 2017 or earlier.

Fig 6: Bed Days for Match Cohort and SWIFt Cohort

	Elective Inpatient Bed Days			Non Elective Inpatient Bed Days			Total Bed Days		
Cohort	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Match Cohort	16	19	11	166	154	158	182	173	169
Intervention Cohort	10	19	5	74	164	259	84	183	264

Total length of stay has increased for the intervention group supported by the SWIFt service from a baseline of 84 nights in 2015/16 to 264 in 2017/18, while the total length of stay for the match cohort has fallen slightly from 182 to 169 though both groups saw variation across both the intervention and match. Total bed nights also showed an increase for the intervention group, though the difference between the two groups was not found to be statistically significant and was driven by a small number of patients.

Fig 7: Long Stays Admissions for Match Cohort and SWIFt Cohort

	Hospital Stays of 7+ days			Hospital Stays of 21+ days		
Cohort	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Match Cohort	4	7	6	2	1	2
Intervention Cohort	3	6	10	1	3	4

The match and intervention cohorts were evaluated for long stays in hospital. All long stays in these cohorts were for non-elective admissions. In 2017/18 the intervention cohort had a slightly higher number of both hospital stays greater than 7 days (10- 6) and 21 days (4-2) than the match cohort.

More data is required for further evaluation; however, the available sample suggests that the SWIFt service has not yet had a positive impact on either total bed nights, or long stays in hospital. There is great variation within the two cohorts over the 2017/18 year with a small number of patients staying in hospital for more than 70 days in the year.

5.2.4 Impact on Reduced of Care Home Admissions

None of the service users supported by the SWIFt or in the match cohort have been admitted to a local authority funded residential or nursing placement over the time period studied.

5.2.5 Impact on Planned Health and Care Activity and Elective Admissions

The impact of the SWIFT cohort has been tested against the match cohort using a number of different data sets and activity types to evaluate the impact of the service.

Figure 8: Community Health Attendances for the Match Cohort and SWIFt Cohort

Year	Match Cohort	Intervention Cohort	Difference Intervention-Match
2015/16	447	239	-208
2016/17	239	192	-47
Difference 2016/17- 2015/16	-208	-47	161
2017/18	730	878	148
Difference 2017/18- 2015/16	283	639	356

Figure seven shows the number of attendances from Leeds Community Health for the match and intervention cohorts. Both cohorts have seen increases in the number of attendances between 2015/16 and 2017/2018- with an increase of 63% for the match cohort, and 267% for the intervention group. The increase in the intervention group is largely accounted for by a small number of patients with increases of 355, 164 and 102 attendances, while the change in the match cohort can also be largely attributed to one member of the group with an additional 406 attendances. Statistical testing with both parametric and none parametric tests show these results did not have statistical significance.

Figure 9: Community Mental Health Attendances for the Match Cohort and SWIFt Cohort

Year	Match Cohort	Intervention Cohort	Difference Intervention-Match
2015/16	0	0	0
2016/17	0	2	2
Difference 2016/17- 2015/16	0	2	2
2017/18	1	0	-1
Difference 2017/18- 2015/16	1	0	-1

As shown in figure eight, based on this sample of patients there is not enough community mental health activity to draw any concrete conclusions about the impact of the service on demand for the service. This is drawn from community based mental health activity, and it is possible the cohorts supported are accessing services such as IAPT.

Figure 10: Outpatient Attendances for the Match Cohort and SWIFt Cohort

Year	Match Cohort	Intervention Cohort	Difference Intervention-Match
2015/16	137	124	-13
2016/17	129	128	-1
Difference 2016/17- 2015/16	-8	4	12
2017/18	98	95	-3
Difference 2017/18- 2015/16	-39	-29	10

Outpatient attendances have fallen for both the match and intervention cohort from 137 and 124 in 2015/16 to 98 and 95 in 2017/18. The decrease for the intervention group in this sample is smaller than that for the match cohort; however, this difference is not statistically significant.

Figure 11: Service Users in Receipt of Adult Social Care Funded Community Based Services for the Match Cohort and SWIFt Cohort

Year	Match Cohort	Intervention Cohort	Difference Intervention-Match
2015/16	2	3	1
2016/17	3	3	0
Difference 2016/17- 2015/16	1	0	-1
2017/18	5	2	-3
Difference 2017/18- 2015/16	3	-1	-4

This measure is for the cohort of people in receipt of local authority funded community based services such as day care, domiciliary care and a direct payment, on 31st Mach each year as a snap shot. Over the period covered only one service user, in the intervention group ceased to receive a community based package of care, while the match cohort grew from two to five. Neither of the changes was found to be statistically significant, but may be indicative of emerging evidence of a reduced demand for community based support from a cohort supported by the SWIFt service in comparison with the match group.

5.2.6 Impact on Cost

Figure 12: Difference in Tariff Costs for the Match Cohort and SWIFt Cohort

Year	Match Cohort	Intervention Cohort	Difference Intervention-Match
	Planned Cost		
2015/16	£ 46,786.68	£ 24,810.28	£ 21,976.40
2016/17	£ 45,434.46	£ 44,254.47	£ 1,179.99
Difference 2016/17- 2015/16	-£ 1,352.22	£ 19,444.19	-£ 20,796.41
2017/18	£ 39,648.61	£ 37,346.60	£ 2,302.01
Difference 2017/18- 2015/16	-£ 7,138.07	£ 12,536.32	-£ 19,674.39
	Unplanned Cost		
2015/16	£ 26,949.00	£ 43,015.00	-£ 16,066.00
2016/17	£ 58,532.00	£ 36,058.00	£ 22,474.00
Difference 2016/17- 2015/16	£ 31,583.00	-£ 6,957.00	£ 38,540.00
2017/18	£ 30,098.00	£ 57,582.00	-£ 27,484.00
Difference 2017/18- 2015/16	£ 3,149.00	£ 14,567.00	-£ 11,418.00
	Total Cost		
2015/16	£ 73,735.68	£ 67,825.28	£ 5,910.40
2016/17	£ 103,966.46	£ 80,312.47	£ 23,653.99
Difference 2016/17- 2015/16	£ 30,230.78	£ 12,487.19	£ 17,743.59
2017/18	£ 69,746.61	£ 94,928.60	-£ 25,181.99
Difference 2017/18- 2015/16	-£ 3,989.07	£ 27,103.32	-£ 31,092.39

Total costs for health care increased for the intervention cohort between 2015/16 and 2017/18 by more than £27,000- an average of around £775 per person, while the cost of the matched cohort fell by just under £4,000, about £114 per person, in the same time period. The difference between these two cohorts is not statistically significant but the indicative increase in the cost of care for the intervention cohort should still be noted and tested in future when larger cohorts are available.

Interestingly, and again indicatively, there is some evidence that the proportion of spend on planned costs- community health, elective inpatient and outpatient care, is growing in the intervention group (36%- 39%), and falling in the match cohort (63%- 56%). As with the total cost this is not by itself a finding with significance, but should be monitored with larger data sets and more time in a study.

6.0.0 Discussion

This evaluation has identified emerging evidence of impact of the service. This includes:

- The typical person supported by the SWIFt service lives in an area with relatively high deprivation, have more multiple long term conditions and a greater level of frailty than average for the city;
- There is a lower mortality rate for people supported by the SWIFT service than the match cohort;
- Broadly stable A&E attendances for the intervention and match cohorts across the 2015/16-2017/18 financial years, however, some evidence of a greater proportion of attendances from the intervention cohort resulting in a hospital admission in comparison to the control group suggesting more appropriate A&E attendances;

- Large proportions of the population supported by the service neither attended accident and emergency, nor were admitted to hospital during each year with only around a third of the supported population admitted to hospital in the 2017/18 financial year;
- Those who were admitted saw increased lengths of stay for the patients support by the SWIFt service when comparing a baseline from 2015/16 with 2017/18;
- There are early signs of increases in some planned health care activity such as attendances from community health for the intervention group, but reductions in other types of planned activity such as outpatient and community based adult social care packages of care;
- This evaluation suggests increasing health care costs to the commissioner for the intervention cohort in comparison to the match cohort.

This evaluation has not been able to identify any significant trends in the health and care activity for the cohort of people supported by the SWIFt service when it is compared to a similar match cohort of service users. This can be attributed to two factors, the first being the small cohort of people that could be included in the study- 35 who had received long term support for at least a year at the horizon of the data provided. The second factor is that the cohort of people supported by the service did not attend accident and emergency and were not admitted to hospital with a great regularity for an extended amount of time. In both the 2015/16 and 2017/18 year only around a third of the intervention cohort either attended A&E or were admitted to hospital.

The cohort of people supported by the service is broadly in line with the intended cohort with above average levels of deprivation, long term conditions and frailty. However, they do not seem to place a great demand on either health or social care resources at present, making it more difficult to realise the potential savings in the business case. It may be worthwhile to consider if changes are made to the way cohorts are recruited to the service to ensure more regular hospital attendees are supported, or the deliverable outcomes of the service are reviewed and updated.

There is evidence that services such as SWIFt can deliver benefits to the broader health and care system, and some of this was used to support the business cases for the service. However, to be able to evidence this requires a relatively large number of people and a significant amount of time. The sample of service users who received 'full support' from the service was 198 individuals the last of whom started the service in June 2018. It should be able to provide some more robust findings than was possible for this cohort in time.

Evidence from the service suggests that those who engage with it do feel it provides a positive benefit to them. However, there may need to be some further discussion between the commissioners and delivery partners about how they identify and support individuals in the long term if they are to focus on achieving the stated outcome of reducing length of stay, and emergency attendances and admissions, which may result in them supporting slightly different cohorts.

Limitations

The following limitations have been identified for this evaluation:

The size of cohort and variation within it has limited the power of the analysis that has been carried out. Alternatives were explored- the variation within the cohort was too great to impute additional data, alternatively shortening the timeframe for the cohort to six months would increase the cohort to around 87 which is still like to be too small for valuable analysis, and would start to introduce issues around seasonality into the data.

The match cohort has been generated using a control matching packages in R. The variables used in the match have been detailed in appendix one. These delivered the best match possible, however, with more time and a more comprehensive dataset including reliable data such as if a person had a carer at a given time would enable the match to be a better quality.

The cohort of people supported by the project was a sample. Drawing the match cohort from the Leeds population and the set-up of the project City wide means it is possible that some patients supported by the service have been included in the match cohort. More comprehensive coverage of NHS reference numbers would help resolve this limitation.

Recommendations

The following recommendations have been made:

- Decisions should not be made based on the contents of this evaluation alone, but should also consider the findings of the national Time to Shine Evaluation and the stakeholder feedback session.
- The power of this evaluation has been limited by the size of the sample available for analysis. It is suggested that a further evaluation is carried out in the future to capture a more complete dataset of the impact the service has had.
- It is suggested that work is undertaken to either change the way the service identifies people for support to target more people who access more support from secondary health, or review and update the outcomes for the service.

Appendix 1- Control Cohort Match Criteria

The following criteria were used to select a control cohort from the Leeds population:

- Patient age at 01/09/2016;
- Patient Gender;
- Composite Number of deficits in the Frailty Index at 01/09/2016;
- Count of Long Term Conditions;
- Patient on the Palliative Care Register Y/N (Exact match) on 01/09/2016;
- Integrated Health and Social Care Team of the GP practice they are registered with;
- Public Health Management Cohort;
- Indices of multiple deprivation score for the patient's resident Lower Super Output Area on 01/09/2016;
- IMD Health Deprivation and Disability Score for the patient's resident LSOA on 01/09/2016;
- Income Deprivation Affecting Older People Score for the patient's resident LSOA on 01/09/2016;
- Adjusted Clinical Groups Risk of High Resource Usage at 01/09/2016;
- Number of A&E Attendances 01/11/2015- 31/10/2016;
- Number of A&E Attendances in October 2016;
- Number of Non-Elective Bed Days 01/11/2015- 31/10/2016;
- Number of Non-Elective Bed Days in October 2016;
- Number of Elective Bed Days 01/11/2015- 31/10/2016;
- Number of Elective Bed Days in October 2016;
- Number of Out Patient Attendances 01/11/2015- 31/10/2016;
- Number of Out Patient Attendances in October 2016;
- In receipt of community health services 01/11/2015- 31/10/2016;
- In receipt of community health services in October 2016;
- In a residential or nursing home placement on 01/11/2015;
- In a residential or nursing home placement on 01/11/2016;
- In receipt of an adult social care community service on 01/11/2015;
- In receipt of an adult social care community service on 01/11/2016.