

Bolton's 5 Year Plan for Reform (Locality Plan)

Moving from Planning to Delivery

Final Draft Version 1.2

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1.0 Executive Summary

On the 1 April 2016, the Greater Manchester Health and Social Care Partnership took charge of the £6bn health and social care budget from central government. The shared vision across Greater Manchester is to see the **greatest and fastest improvement to the health and wellbeing of the 2.8 million people who live in Greater Manchester**. 'Taking Charge' is a 5 year strategic plan for Greater Manchester built up from individual locality plans developed by the 10 local authorities and NHS organisations across the city region.

The Borough of Bolton has a resident population of approximately 280,000. The health and social care system comprises a number of statutory organisations along with a GP Federation and vibrant community and voluntary sector:

- Bolton Foundation Trust
- Bolton Council
- Bolton Clinical Commissioning Group
- Greater Manchester West Mental Health Trust
- Bolton Federation
- Bolton CVS
- HealthWatch Bolton

These organisations and wider stakeholders have worked jointly to develop Bolton's Health and Care Locality Plan to deliver real improvements in health and wellbeing for Bolton people and make services more sustainable for the future, in terms of money and patient care.

This implementation plan provides more detail on how we intend to improve the health outcomes for the people of Bolton within the context of rising demand for services and challenging workforce and financial constraints. Projections show that if the current systems do not change and respond to the challenges, there will be a financial gap of £82.8m by 2021.

The Bolton system is requesting a total of **£49.8m** from the GM transformation fund to supplement local funding already identified and in order to fully implement the transformation programmes required. This will enable recurrent savings of **£72.4m** by 2020/21. A further sum of business as usual savings of **£23.1m** will be delivered, bringing the system into a position of financial resilience by 2020/21.

By 2021/22, we want to:

- Improve health outcomes, increase healthy life expectancy and reduce inequalities through targeted interventions, including, for example:
 - reducing the number of people who have heart disease, a stroke, or diabetes
 - reducing the number of people, especially older residents, who are injured due to falls
- Support behavioural change with more people successfully managing their own health and wellbeing, supported by a knowledgeable and skilled teams of integrated health and social care professionals

- Reduce pressure on GPs, freeing up their time to support the management of people who have a higher level of clinical need
- Reduce hospital based care
 - by improving access to specialist health services locally (at neighbourhood/community level)
 - by reducing ambulance call outs and emergency admissions to hospital, including from care homes

Our vision is all about changing health and care so we spend less on hospital and long term care and more on care in the community

- ✓ We want to help people to live healthy lives and empower communities to support themselves,
- ✓ We need to get in early, offering screening and support to prevent illness
- ✓ We will focus extra help and support to stay healthy and independent for those who have the greatest need
- ✓ We will provide joined up care for those most at risk of hospital or care home admission, with more complex needs supported in the home or community setting
- ✓ For those people who need hospital care, our aim is to ensure the right people, and right capacity are in place to ensure high quality acute care.

To change things, we need to work differently. This means making services work in a more joined up way in Bolton to develop a broad and effective approach to population health. It means training staff to work in new ways. It means supporting behavioural change to ensure people become more independent and in control of their own health and wellbeing. The financial challenge facing us means we will have to look carefully at what the 'Bolton pound' can and should pay for.

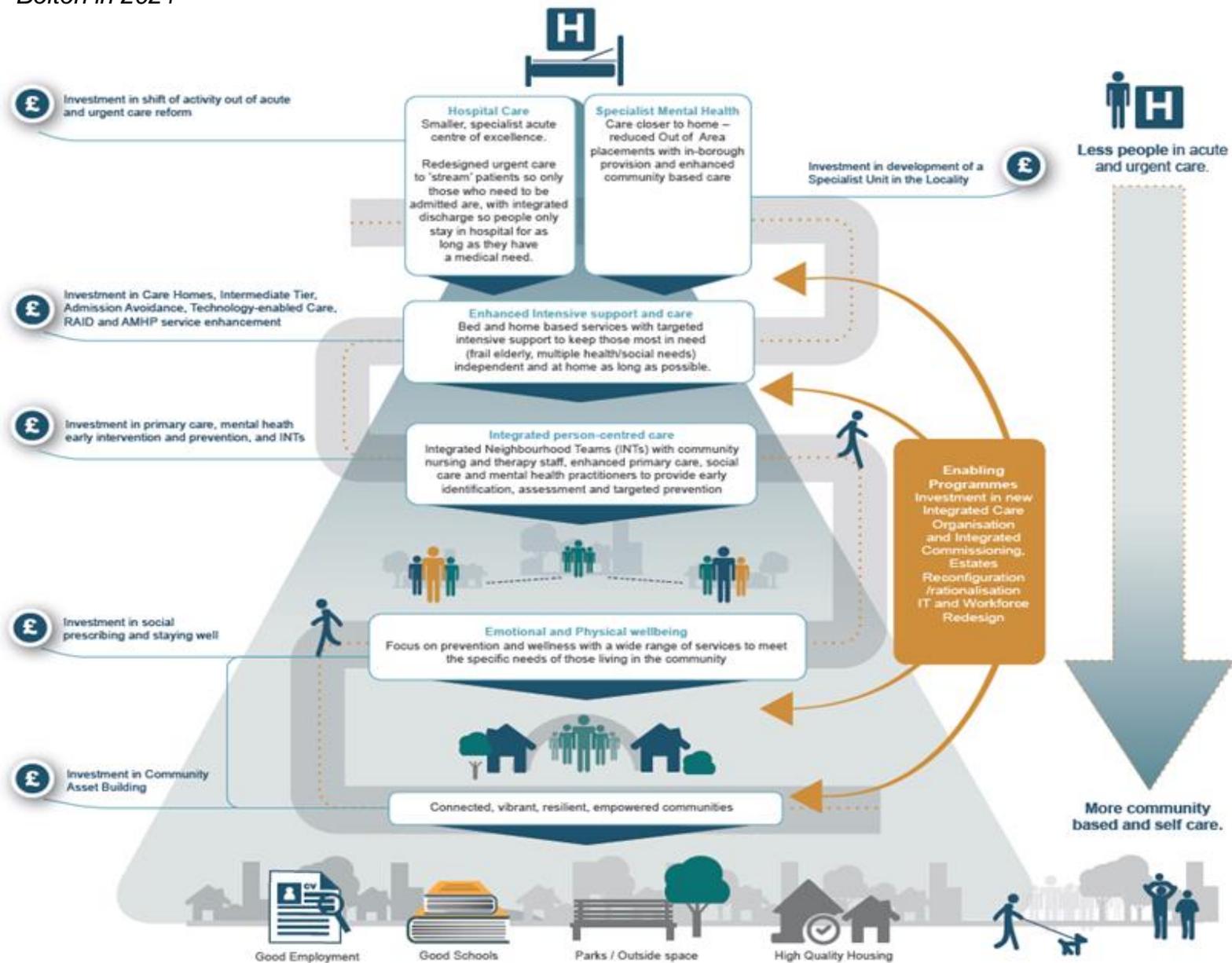
This plan describes how we will all work together to make the best use of the collective skills and knowledge within the system. In this way we will develop a population focused health and social care system that spans organisational boundaries, integrates care, builds on community assets working with neighbourhoods and focus relentlessly on improving health and wellbeing outcomes for that population.

Bolton in 2021

Bolton will be a vibrant place built on strong cohesive communities, successful businesses and healthy, engaged residents. It will be a welcoming place where people choose to study, work, invest and put down roots. We want our people and our place to prosper and we will make this happen by driving inclusive growth and reforming our services, in partnership, to promote wellbeing for all.

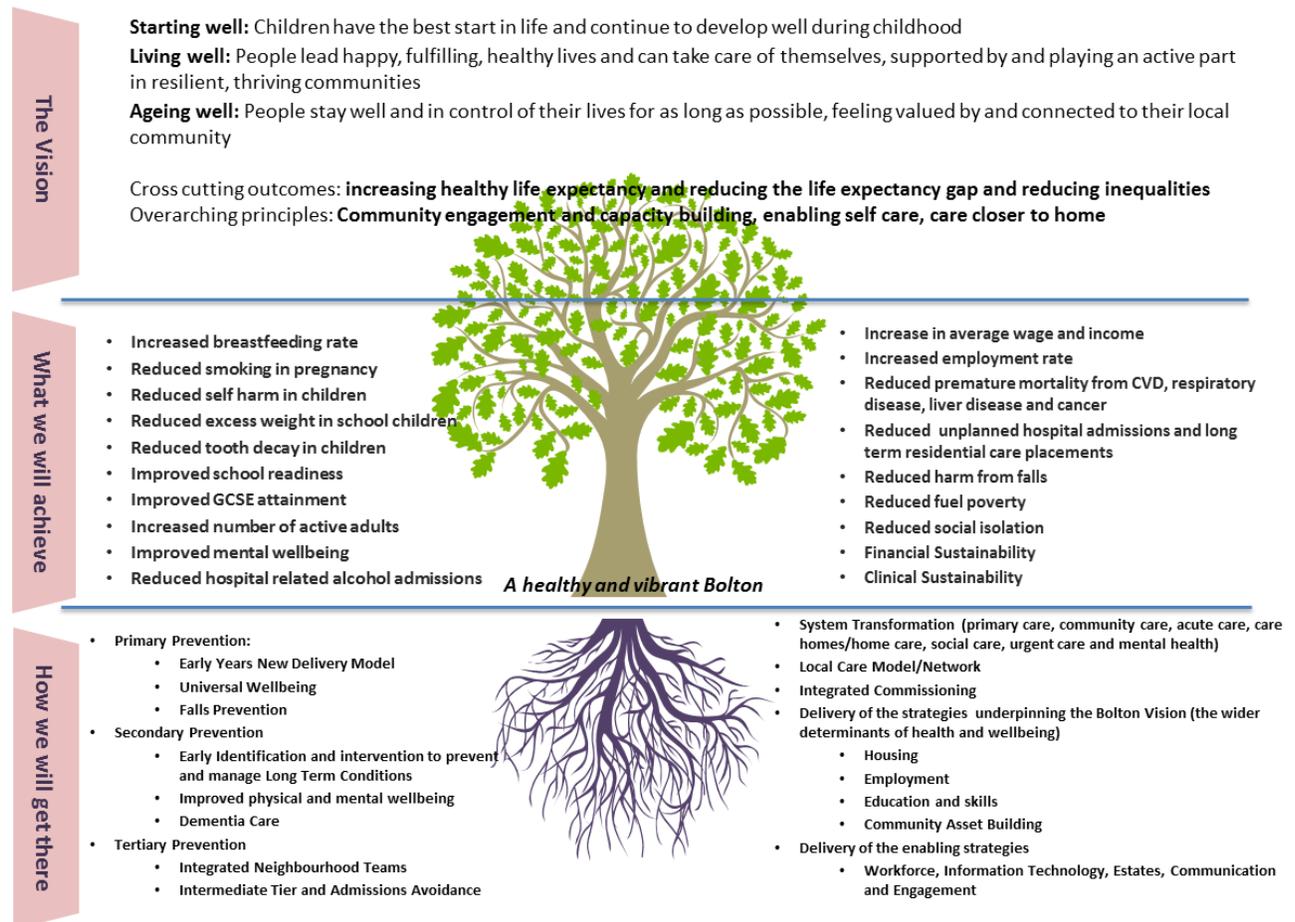
Diagram 1 below shows how the transformation outlined in the Locality Plan will reform the system by 2021.

Diagram 1 - Bolton in 2021



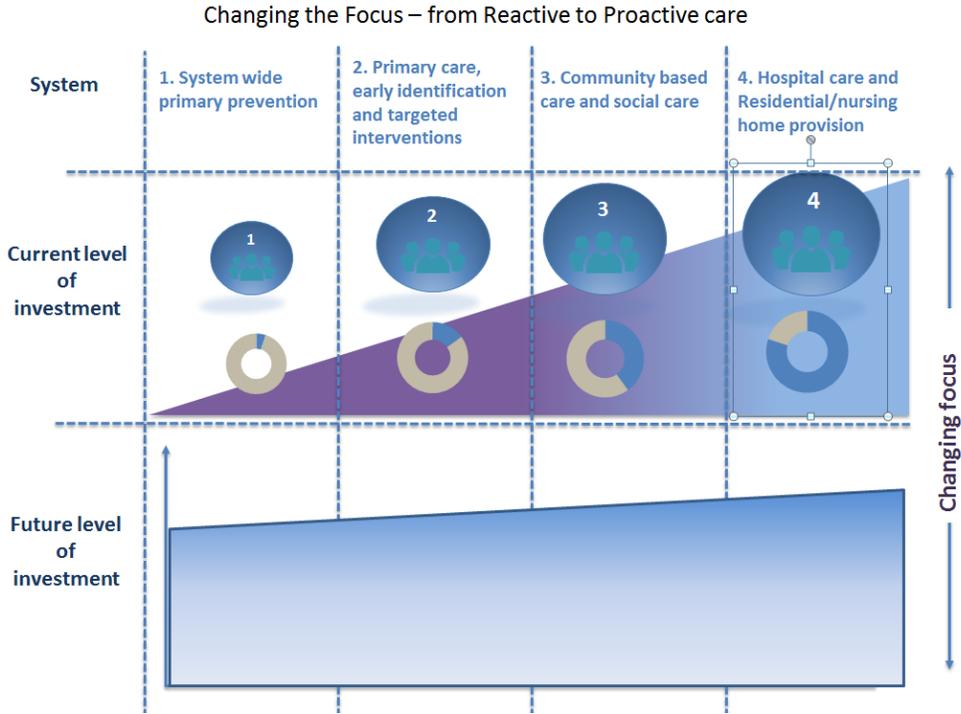
In order to deliver this vision we have identified the key themes where we will work together to deliver the Bolton which we aspire to. We will support our residents in starting well, living well and ageing well in an environment that is prosperous, clean, green, strong and distinctive. This is set out in Diagram 2 below.

Diagram 2: Delivery of the Bolton Outcomes



The Locality Plan describes the system-wide redesign which is planned for early intervention and prevention (at primary, secondary and tertiary level) and the transitional funding required to build a system-wide, strategic partnership to lead population level prevention and health improvement. This means developing proactive care approaches which will allow us, over the next 5 years, to reduce the amount of resource we are spending on tertiary prevention through double running the primary and secondary prevention programmes alongside until these have started to deliver the necessary reductions in the usage of high cost care. Diagram 3 below shows the planned shift of activity from acute spend over the next 5 years through the whole system transformation.

Diagram 3: Shifting from Reactive to Proactive Care



This Plan details the system reform planned across Bolton for Primary Care, Community and Hospital-based Care, Care Homes and Home Care, Technology Enabled Care, Mental Health, Community Asset Building and the Urgent Care System which are all required to ensure that Bolton is clinically and financially sustainable by 2021 and is able to deliver the population health and wider outcomes which have been agreed by all partners across the Borough.

The wider determinants of health and wellbeing: Housing, Employment, Education and Green Spaces are all critical to the delivery of the outcomes in the Locality Plan and all have clear and agreed strategies which are being implemented locally.

The wider whole system enablers of IT, Estates, Workforce and Engagement underpin all the strategies of system and service reform and are outlined in this plan – including the cost benefits of investment required.

There are two key high level outcomes for the Bolton Locality Plan to be delivered by 2021

- increase in healthy life expectancy and reduction of the internal life expectancy gap across Bolton
- achievement of financial and clinical sustainability across Bolton

Delivery of national quality and performance standards and statutory responsibilities: including the A&E 4 hour measure, CQC assessment and social care duties are also a significant element to this plan. The system reform programmes are all designed to deliver short and longer term improvements in quality and performance required to assure the Health and Wellbeing Board.

The areas of investment (through pump-priming) which Bolton requires in order to deliver a clinically and financially sustainable system which has significant reductions in health inequalities are the following. The alignment to the GM workstreams is detailed:

Early Intervention and Targeted Prevention *(GM Theme 1: Population Health)*

- Early Years Model (this is a GM wide programme)
- Building a system-wide, strategic partnership to lead the population level prevention and health improvement, with a focus on emotional and physical wellbeing and reducing falls and social isolation

System Reform

(GM Theme 2: Transforming Community Based Care and GM Theme 3: Standardising Acute Specialist Care)

- Primary Care
- Urgent Care
- Acute Reconfiguration and shift of activity into community
- Mental Health
- Care Homes
- Technology Enabled Care

System Enablers

(GM Theme 5: Enabling Workstreams)

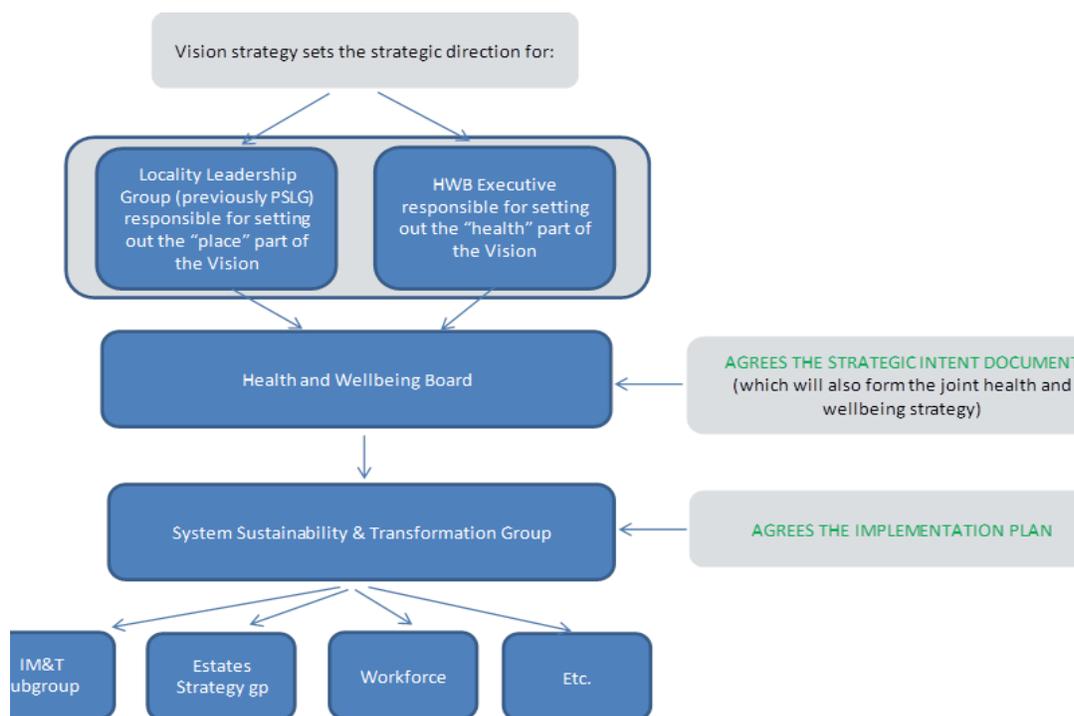
- Estates Reconfiguration/Rationalisation
- Workforce Redesign
- IT
- Engagement and Communication
- Development of the new Model of Care and Integrated Commissioning

We have already successfully delivered system enablers which are the “building blocks” to transformation: namely a new aligned incentivised contract between Bolton CCG and Bolton FT, commencement of joint commissioning planning for the key work programmes, well developed Workforce, Estates and IT strategies (which require non recurrent investment to implement), a fully aligned financial position and agreement to the stepped approach to the Local Care Model.

2.0 Bolton 2030 – the Vision for People and Place

The Bolton Vision Partnership (the governance for which is set out in Diagram 4 below) has successfully brought together a wide range of partners across Bolton over the past 15 years to deliver the community strategy. Through a focus on economic prosperity and narrowing the gap between our most and least well-off communities, we have successfully attracted almost £1bn of additional investment into Bolton, and made good progress against key inequalities, including health outcomes.

Diagram 4: Bolton Vision Governance



Bolton’s Local Strategic Partnership has recently approved a new long term plan for Bolton – “Bolton Vision 2030: Active, Connected & Prosperous” – which is a clear picture of the Vision Partnership’s ambitions for the Borough, setting out what we need to do to deliver a Bolton which future generations are proud to be part of. In 2030, we want Bolton to be a vibrant place built on strong cohesive communities, successful businesses and healthy, engaged residents.

The strategy builds on the framework for economic growth and service reform which underpins the GM devolution deal; but it is rooted in the partnership’s deep understanding of Bolton as a place, and the people and communities which make it a vibrant and enjoyable place to live, study, work, invest and put down roots.

Our ambition for Bolton is summarised in a clear statement of what we want to achieve:

IN 2030, WE WANT BOLTON TO BE A VIBRANT PLACE BUILT ON STRONG, COHESIVE COMMUNITIES, SUCCESSFUL BUSINESSES AND HEALTHY, ENGAGED RESIDENTS. IT WILL BE A WELCOMING PLACE WHERE PEOPLE CHOOSE TO STUDY, WORK, INVEST AND PUT DOWN ROOTS.

In order to deliver this vision, we have aligned around 6 key themes where the partnership will work together to deliver the Bolton which we aspire to:

- Giving our children the best possible start in life, so that they have every chance to succeed and be happy (“STARTING WELL”)
- Improving the health and wellbeing of our residents, so that they can live healthy, fulfilling lives for longer. (“LIVING WELL”)
- Supporting older people in Bolton to stay healthier for longer, and to feel more connected with their communities. (“AGEING WELL”)
- Attracting businesses and investment to the Borough, matching our workforce’s skills with modern opportunities and employment. (“PROSPEROUS”)
- Protecting and improving our environment, so that more people enjoy it, care for it and are active in it. (“CLEANER AND GREENER”)
- Developing stronger, cohesive, more confident communities in which people feel safe, welcome and connected. (“STRONG AND DISTINCTIVE”)

The partnership recognises that there are serious challenges ahead, including far-reaching changes in society and our communities, ongoing reductions in funding for many of our partners, and the impact of an ageing population; and that the best possible answer to these challenges is to reshape ourselves so that we are resilient and can take the opportunities which present themselves. To succeed, some radical changes in the way we think and act will be needed.

We will need to work beyond traditional boundaries of organisations and places. We have to join up our workforces, our assets and our funding to get the best outcome for people, and to find more efficient ways of procuring and delivering goods and services, so that we get better outcomes for less cost.

We are absolutely clear about our priorities – the critical issue is what we can afford to do. We will need to stop providing some services, or find ways of others providing them. In part this will depend on building skills and changing behaviours so that people rely less on public agencies and are more self-reliant.

We will need to engage our residents and local communities in a totally different way, to understand local priorities in real detail. This will require involving, engaging and consulting with people and communities, so that we really know what people value, and how much they are able and willing to do for themselves.

Finally, we will need to build capacity, skills and connections in our communities, so that they are not only capable of playing a much greater role in their areas, but eager to do so. The strapline of the Bolton 2030 Vision is “Active, Connected, Prosperous” – this

reflects the emphasis which the partnership agrees needs to be placed on increased levels of activity, both in terms of physical activity (because of the impact which it will have on health outcomes) and in terms of people being active members of communities.

Our Approach to Place

Bolton's Community Strategy, Vision 2030, focuses on enabling residents to manage their wellbeing and to be active, connected and able to access the opportunities that growth brings.

Bolton's approach to place based integration is shaped by this vision, ensuring a whole system integrated approach to managing need and demand. Growth and reform, therefore, remains a key priority alongside integrating place based approaches with health and social care reform. With this in mind, Bolton partners from the public and voluntary sector have been informing the local approach to place-based integration.

Key to this is building on established multi-agency neighbourhood working and early help processes to ensure that place based integrated teams interact efficiently within existing delivery components across the continuum of need from complex need to safeguarding supported by the Public Service Hub.

Bolton is reviewing its segmentation of the borough to better understand its 'natural neighbourhoods'. The Natural Neighbourhoods strand of Place Based Integration recognises that, for place based approaches to be successful, Bolton's definition of neighbourhoods needs to synchronise with communities' and practitioners' notions and experience of place and space. Qualitative and quantitative intelligence from multiple agencies has been gathered and is being overlaid with assets, including buildings and community groups and projects, to better understand this and has informed the selection of 2 neighbourhood adopter sites which will be used to pilot and further develop our approach. An important aspect of this is understanding need and demand, so that we are able to make informed choices about how to prioritise and allocate resources so as to have the greatest possible impact on our shared outcomes.

Strategic oversight and responsibility for place based integration will be undertaken by the Locality Leadership Group, comprising of leaders from the public and voluntary sector in Bolton. They are being supported by a multi-agency working group who are meeting via a series of workshops to shape the local approach and agree resources, processes etc for implementation. The 2 neighbourhoods of Halliwell and Johnson Fold are our early adopter sites for Public Service Reform. This work is being undertaken in parallel with, and aligned to, work to expand the scope of the existing Public Service Hub. Shared intelligence and learning from the hub will be used to support work and roll out of the neighbourhood adopter sites.

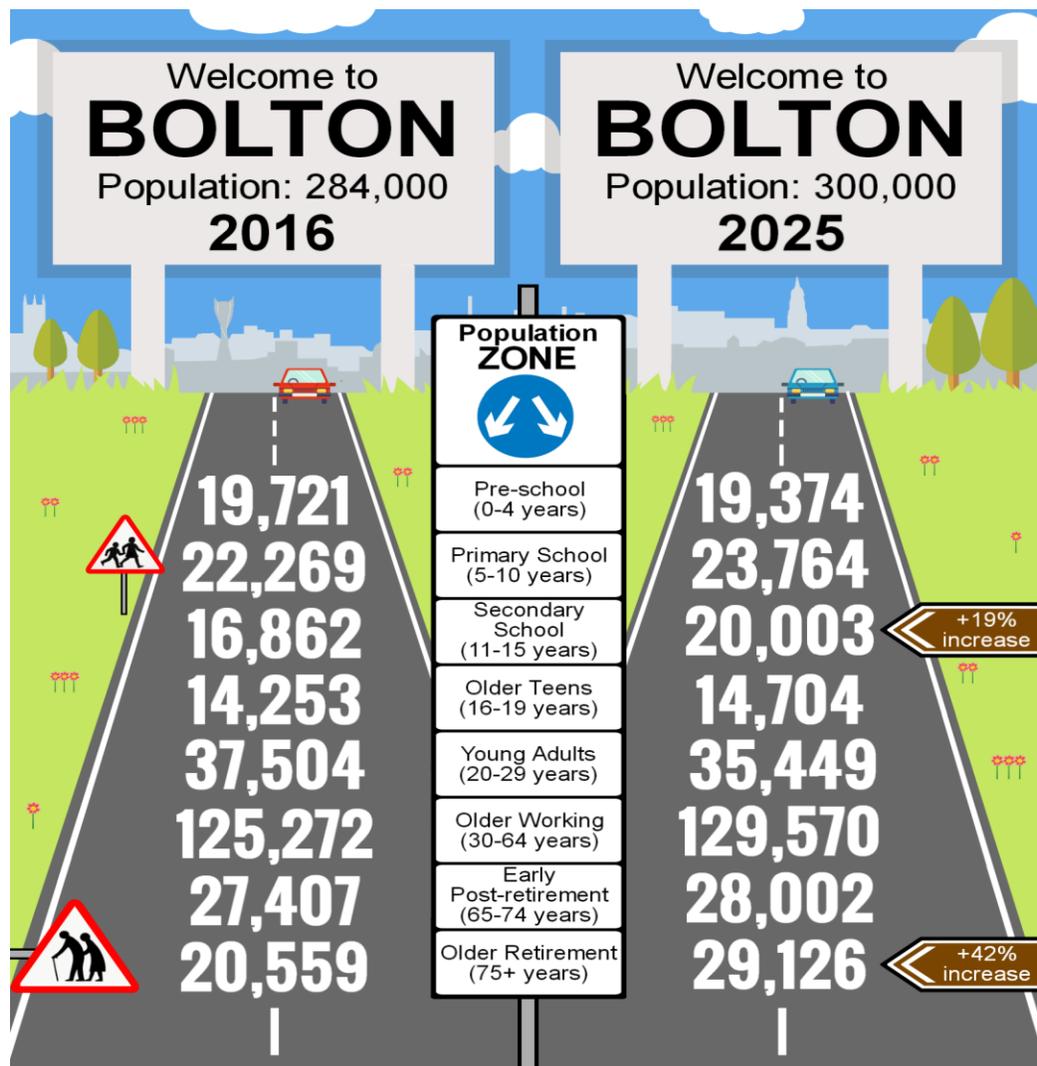
3.0 Population Health and Wellbeing

3.1 Bolton's Challenge

The demographic change in Bolton (as set out in Diagram 5 below) clearly highlights the increasing challenges ahead. Notably:

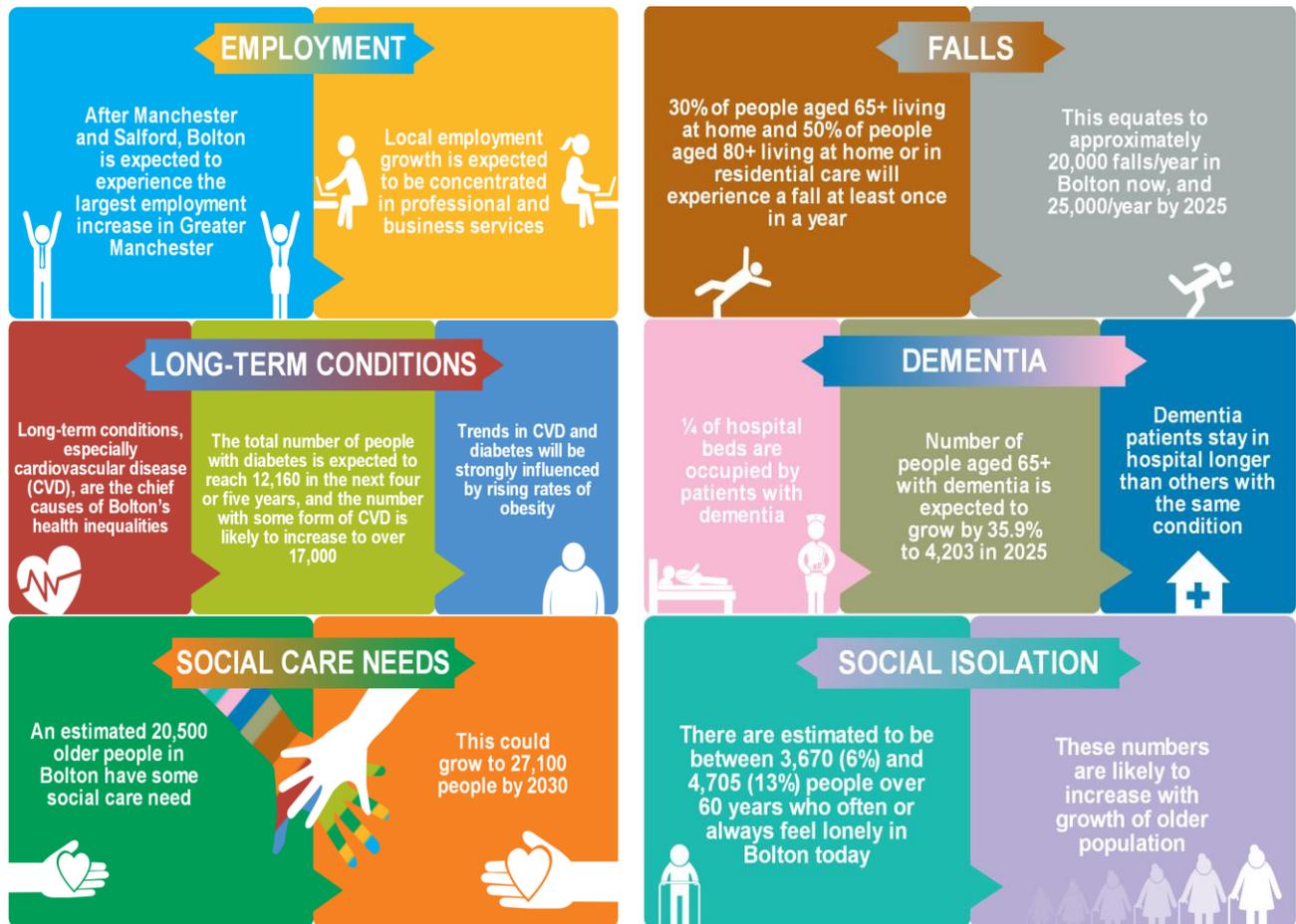
- By 2020 Bolton's population is expected to reach 289,000 (a 3.0% increase from today)
- Over the next 5-10 years pre-school, older teenager (16-19 years), and younger adult (20-24 years) populations will reduce, whilst primary, secondary school ages, and older age groups, increase.
- The population aged 65+ is expected to grow by almost 20% to around 57,300 people in 2025. This includes substantial growth in the population aged 80+ which will increase by over 40% to approximately 16,500 in 2025.

Diagram 5: Bolton's Changing Demographics



The specific challenge which will be posed to the Health and Care economy, with specific focus of the impact as a result of an increasing elderly population is set out in Diagram 6 below.

Diagram 6: The Challenges Facing Us



3.2 Where we need to get to: Local Health and Wellbeing Outcomes

The Health and Wellbeing Board has identified the following topic areas as priorities for Bolton:

- Giving children the best start in life
- Childhood obesity
- Self harm in children and young people
- Physical activity
- Alcohol harm
- Mental wellbeing
- Falls
- Social isolation

- Fuel poverty
- Housing condition and quality
- Employment and skills
- Health inequalities

Board discussions highlighted the importance of selecting a range of indicators that included end point measures (e.g. cardiovascular disease mortality), as well as those that focused on demonstrating improvements in prevention and population behaviours in order to reduce demand and keep people well in the longer term (e.g. physical activity).

Anticipated trajectories for Bolton, England, Greater Manchester (GM) average and the best performing are in GM have been modelled where possible for each indicator.

There are a small number of indicators where it has not been possible to set a trajectory due to the indicator being based on modelling from national survey data, or too few data points being available. For these indicators a target has been set that is about the direction of travel and narrowing the gap with England, rather than setting a specific level of ambition.

There are three indicators where a target has been proposed which suggests that performance will worsen over the next five years:

- Excess weight in Year 6 children
- Alcohol admissions
- Injuries due to falls

Bolton's recent performance against these indicators shows a steep upward trajectory, therefore the proposed targets aim to soften the trajectory rather than move it in the opposite direction. These will still be challenging targets to achieve.

Appendix A details the outcomes which show Bolton's current performance against the indicator and the level of ambition for improvement for each by 2021. A key principle in our approach to achieving these ambitions is that we will narrow the gap within Bolton, and we will directly monitor our progress in achieving this.

In order to achieve the required shift in performance against these outcomes, action will need to be taken across the system to achieve a radical upgrade in prevention and reform the health and social care system, including both policy change and service transformation.

3.3 How We Will Get There

Improving population health and reducing future demand will require radical changes in the way our health and social care system works. We need to work in partnerships with communities to build on their strengths and capabilities. Our focus needs to be on

enabling individuals and communities to be in control of their own lives and able to make decisions that will help them to stay well and live independently.

Our health is influenced by a wide range of social, economic and environmental factors. As individuals we cannot always control them and they influence and often constrain the 'choices' we make and the lifestyle we lead. Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. Similarly, good education, public planning and support for healthy living can all contribute to healthier communities.

The importance of addressing these wider determinants in order to improve the health and wellbeing of individuals and communities is reflected in our priority outcomes for improving health and wellbeing, and in our Vision Strategy. We want our children and young people to have the skills, aptitudes, drive and resilience which will allow them to find their place in the world and build fulfilling, happy lives. We will reduce poverty by removing barriers to work, increasing job opportunities for Bolton residents, improving skill levels so that people can earn more, and increasing productivity so that businesses can afford to reward their staff appropriately. We want Bolton to be an attractive place to live with good quality homes that meet the needs and aspirations of its residents. We'll drive up the quality of housing in Bolton through reinvestment in the existing housing stock and by collaborative working in neighbourhoods where interventions are needed. We will support people to find and remain in a home of their choice, providing a range of housing options that can assist people to live independently for longer at home and in their communities. Ensuring that Bolton has a strong and vibrant identity, with a talented, skilled and productive population, will help to create connected, engaged and resilient individuals and communities that enjoy the best possible health and wellbeing and are able to make informed choices about how to stay well.

We recognise that there are significant inequalities within Bolton. To ensure that we reduce these inequalities we need to combine our efforts to improve the health and wellbeing of the whole population, with targeted work to support greater improvements in the lives of people facing the greatest level of disadvantage and the poorest health outcomes. This includes targeted work to improve the health of those most at risk of developing long term conditions or needing additional health and social care support in the future, as well as work to address the wider determinants of health such as education, employment, housing and poverty.

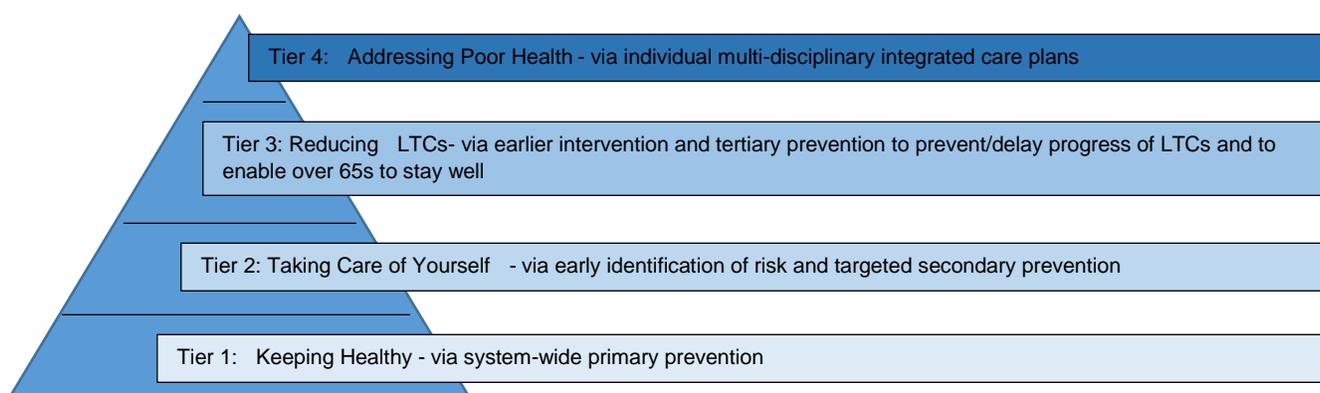
Asset based community development will be at the heart of our efforts to improve population health and wellbeing, building on the strengths of individuals, families and communities, and supporting individuals and communities to make informed decisions about their health and wellbeing and how they live their lives. This approach is designed to establish healthy communities in charge of, and making positive decisions about their own health and wellbeing, which will reduce demand for health and social care services in the longer term. Critical to delivery of the locality aims is fostering and implementation of a

genuine 'whole system' approach which includes the community and voluntary sectors as key partners.

We will implement new delivery models which will enable the shift in funding from unplanned hospital admissions and long term care placements to proactive and preventative care delivered through place-based, integrated approach, to neighbourhood working. To commission services to effectively meet the needs of the population of Bolton, we are segmenting the locality population into four 'tiers'.

Detailed segmentation work has been undertaken to quantify the size, characteristics and needs of the population in each tier. The 4 tiers are shown in Diagram 7 below.

Diagram 7: The 4 Population Segmentation Tiers



Tier 1: (Acorn Group 4 - Healthy)

Keeping Healthy

26% of Bolton's population are estimated to be currently healthy. These residents generally live in more affluent neighbourhoods with very low levels of illness and good lifestyle behaviours. Smoking rates are relatively low, whilst 5 a day consumption is high. Nevertheless alcohol intake exceeds recommended levels, especially in women.

However, in order to maintain good health throughout the life course and, more importantly to focus on less healthy neighbourhoods, **system wide primary prevention is required**. This will have the benefit of promoting good health and wellbeing across the entire population in. Additionally, the Marmot concept of proportional universalism will continue to be adopted in order to better focus on reducing inequalities and the closing the internal (healthy) life expectancy gap.

Critical to the successful delivery of the new neighbourhood models of care is **community development, capacity building and engagement**. These are essential to improving the health of the population and reducing health inequalities. We will work with communities, focusing on the communities which face the poorest health outcomes, using **asset based** approaches to build resilience and empower communities to play an

active role in improving their own health and wellbeing. This will **build on the strengths of the voluntary, community and social enterprise sector in engaging local communities**, including hard-to-reach groups, and improving health and wellbeing.

Giving every child the best start in life is crucial to closing the gap in health, education and social inequalities. The foundations for virtually every aspect of development – physical, intellectual and emotional – are laid in early childhood. The Healthy Child Programme for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Universal health services have a crucial role in setting the foundations for healthy development and wellbeing for children and families.

Fully implementing the **Early Years Delivery Model** is a core part of our population-wide approach early intervention and prevention, this strategy aims to establish a framework for the delivery of appropriate services at the right time, supporting children and families to become healthier, resilient and empowered. The Early Years Delivery Model is a key call on the GM Transformation fund across all localities (a GM-wide bid).

Good population health and wellbeing also needs to be supported by **healthy public policies**. Our public sector organisations will lead the way in promoting health and wellbeing through their policies and actions.

Tier 2: (Acorn Group 3 - Caution)

Taking Care of Yourself

24% of Bolton's population are estimated to need to exercise caution if they are to remain healthy in later life. They will need to look after themselves throughout adulthood to improve healthy life expectancy. These residents tend to be owner occupiers with modest to good incomes and are generally well educated. Their overall health is relatively good but some lifestyle behaviours are predictors of future illness, especially overweight, high blood pressure and high cholesterol. Again smoking levels are low but alcohol consumption exceeds recommended limits.

By promoting **early identification of risk and targeted secondary prevention** it will be possible to develop and tailor effective interventions (including self care) **for individuals and communities at risk**

This second tier comprises **people at risk of poor health and wellbeing, particularly in middle to older age**. However, the tier also includes residents who will benefit from targeted earlier intervention at a younger age. These residents may have characteristics that identify them as vulnerable or at risk. Intervening early with this group will to stop or limit specific behaviours/circumstances that may further compromise future good health; for example, the provision of targeted support for young parents through the Family Nurse Partnership.

This tier also includes a large proportion of the population who are at risk of long term conditions, for example due to smoking or being physically inactive, or who may already have long term conditions, such as hypertension, but do not yet have social care needs, and may not be accessing health services beyond primary care. Future demand on health and social care services could be prevented or delayed through **targeted prevention and early intervention** with this population.

A key focus for Bolton is on increased physical activity: from early childhood through to the over 65s. The evidence base for activity in helping to maintain a healthy weight, promote group activity to reduce isolation, improve mental wellbeing and reduce the prevalence of all major long term conditions is undisputable. The social prescribing programme has increased exercise as a key component. Bolton is also engaged in the Sport England programme.

Tier 3: (Acorn Group 2 - At Risk)

Reducing Long Term Conditions (LTCs)

32% of Bolton's population is estimated to be currently at risk of substantial ill health especially in middle to older age. These residents currently do not have high levels of illness but multiple unhealthy behaviours mean that their future health is at risk. Typically these residents are living on low incomes and in relatively deprived circumstances. They have extremely high rates of smoking, with some alcohol concerns. Most pertinently, however, their social circumstances such as unemployment, debt and dissatisfaction with life in general all contribute to these individuals experiencing very poor mental wellbeing.

Tertiary prevention and proactive management is required to prevent/delay the progress of existing conditions and support the older population to stay well.

The third tier is the population that has started to become ill or frail, but is currently not requiring significant health treatment and/or hospital admission (and therefore will not necessarily have a risk stratification score) but may be eligible for social care services. These individuals need preventative interventions to enable them to proactively manage their health and wellbeing to stop them moving into the top tier within the next few years requiring higher levels of health and social care resources.

Tiers 2 and 3 are where transformation of existing services together with additional funding is required to commission new and enhanced interventions to be delivered at individual or on a wider scale. At high level these include secondary and tertiary prevention, focusing on the specific long term conditions (and their risk factors) which are most prevalent across the locality: heart disease, respiratory disease and diabetes - delivered through **Integrated Teams wrapped around general practice** (on a neighbourhood basis) – including **an enhanced role for Health Improvement Practitioners**, working alongside the existing ANPs, district nurses, pharmacists, mental

health practitioners and MSK practitioners. This will include signposting people to the right provision of support, including **social prescribing with a focus on emotional wellbeing and physical activity**, to enable individuals to develop their health skills and knowledge to build their capacity to manage their own health and wellbeing including stopping smoking, reducing alcohol harm, eating healthily and becoming physically active. This will include increasing **dementia diagnosis and improving care, preventing falls, providing GP care to the frail elderly** and ensuring people aged over 65 retain their independence for as long as possible and reducing social isolation through participation in their community (to be supported through expansion of the **Staying Well programme** based around GP Practices and full roll out of the Safe, Warm and Dry initiative).

Tier 4: (Acorn Group 1 - Health Challenges)

Addressing Poor Health

18% of Bolton's residents are living with ongoing health challenges. These residents generally (but not exclusively) live in the most deprived areas of the borough and have the greatest levels of illness and frailty. Consequently these individuals may continue to exhibit risky behaviours by not quitting smoking and eating a diet that is low in fruit and vegetable consumption. Issues relating to isolation and mental wellbeing are most prevalent in this group with many individuals lacking support networks. Whilst the majority of these residents are older, younger adults are also represented in this group. These younger adults tend to be long term unemployed, drink to excess, experience anxiety and depression and make high demands on services, especially health services.

This top tier comprises of populations who have two or more long term conditions (including mental health), are the high risk frail elderly or those at the end of their life. There has been significant investment already made into services to support the individuals within this Tier, including:

- Admissions Avoidance
- Redesigned Intermediate care services (home and bed based)
- Services to support the most vulnerable and those with complex dependency, specifically the Integrated Neighbourhood Teams which also provide specialist in-reach support to Care Homes
- Complex (or chaotic) Lifestyles pilot programme

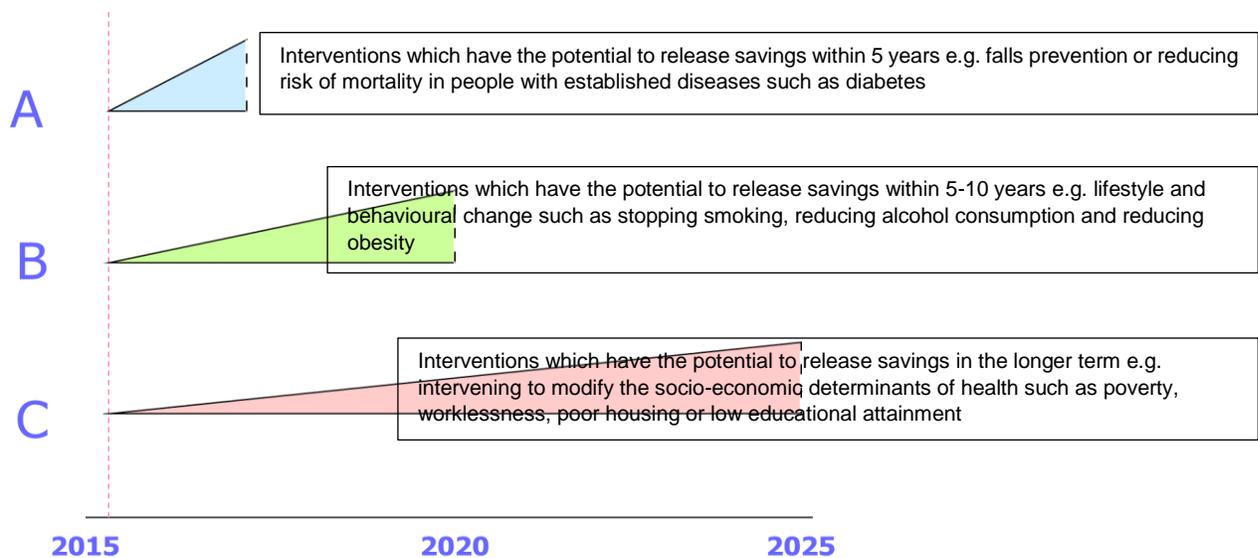
These schemes are proving to be successful in preventing unplanned hospital admissions and readmissions, A&E attendances, long term residential care placements, helping people to remain at home independently and improving the experience of care for people and their families/carers.

Further pump-priming investment is required (to expand the INTs [including in-reach to Care Homes]) to go “further, faster” to increase the proportion of people who are

successfully kept out of hospital and long term residential care through pro-active care management.

To secure a financially sustainable health and social care system, the impact of interventions in the short, medium and long term need to be considered. As the system starts to reduce the amount which is being spent on reactive care, more resource will be released back to invest in the schemes (targeted at the population at tiers 1 and 2) which will pay back in the medium to longer term (including the Early Years Delivery Model which is likely to start to pay back within 10 years but will deliver significant whole system cost reduction and improvement in whole population outcomes from year 20). This is set out in Diagram 8 below.

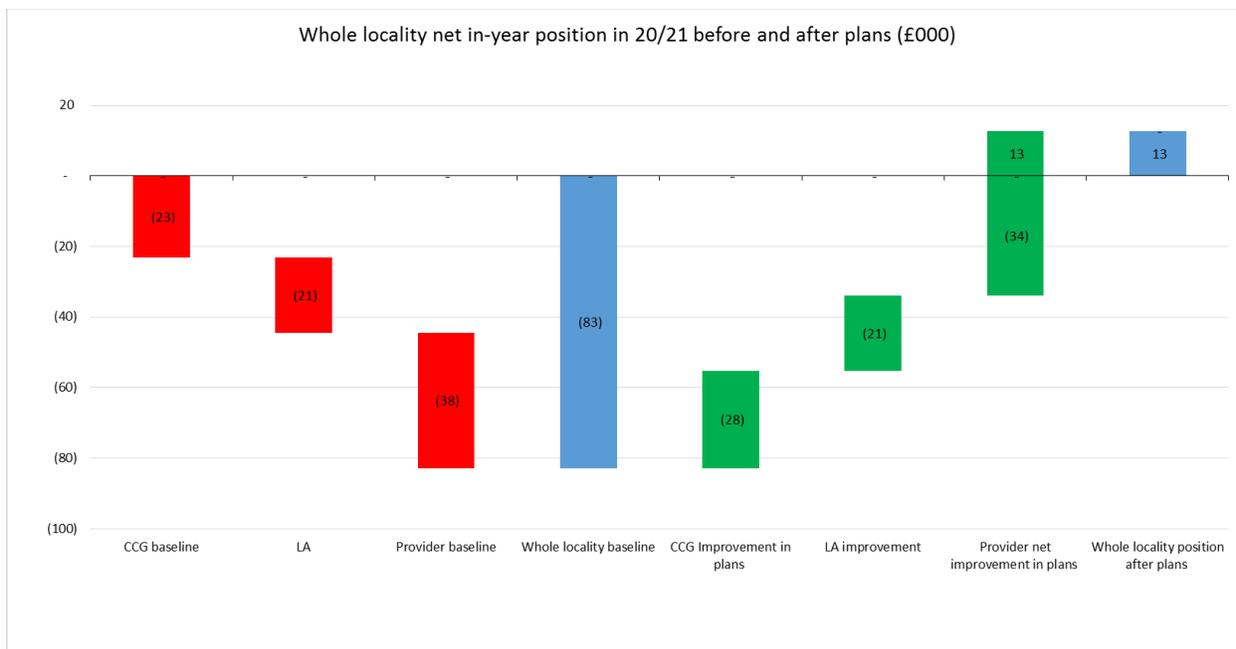
Diagram 8: "Pay Back" of Interventions



4.0 Financial Sustainability

One of the key drivers for change is the need to ensure that Bolton is financially and clinically sustainable as a “place”. The financial position for Bolton in 2020/21 is shown in Diagram 9 below. The overall position would be a deficit of £83m if we did nothing. Once the estimated impact of individual organisational and system efficiency plans are taken into account, the net position is a surplus of £13m.

Diagram 9: Financial Picture across Bolton in 2020/21



In order to deliver a financially sustainable Bolton, we therefore need to deliver the combined £96m organisational and system efficiency programmes.

Critical to the delivery of the efficiency programmes is the reduction of cost (not simply activity). Bolton CCG and FT have calculated the volume of activity reduction required year on year and what this means in terms of staffing and supporting infrastructure reduction.

However, this in itself is not enough. In a time of increasing demand, which will eventually destabilise the whole system, we need to radically reform our health and care system to enable us to continue to reduce the amount we spend on reactive care so that we can invest further in proactive, population health and wellbeing preventative services. This Locality Plan makes the local case for investment in system reform and pump-priming to deliver a truly financially and clinically sustainable Bolton. Investment of £49.8m over 4 years in the schemes detailed in this Plan will enable Bolton to deliver efficiencies by 2021. The required investment by scheme is detailed in Table 1 below.

Table 1 Investment Requirement

Programme	Investment (£000)
Acute reconfiguration and shift of activity into community	2,543
Technology Enabled Care	2,166
Care Homes and Home Care	5,078
Development of the new Model of Care (including integrated commissioning)	4,133
Emotional and Physical Wellbeing	2,791
Estates Reconfiguration/Rationalisation	3,850
IT	6,260
Mental Health	2,532
Primary Care	8,247
Urgent Care	8,666
Workforce Redesign	3,560
Total	49.8

The reduction in hospital activity which will be the major source of cost reduction is detailed in Table 2 below

Table 2: Reduction in Hospital activity by 2021

Point of Delivery	Activity 2015/16	Activity 2020/21	Reduction (actual)	Reduction (%)
Elective Activity	33,571	29,386	4,185	13%
Non Elective Admissions	41,399	32,230	9,169	22%
A&E attendances	96,151	78,979	17,172	18%
Emergency Readmissions	7,380	5,166	2,214	30%
Outpatient First Attendances	98,981	84,257	14,724	15%
Outpatient Follow Up Attendances	177,508	151,817	25,691	14%

The linkages between the Programme investment and delivery of outcomes and benefits is detailed in Appendix E.

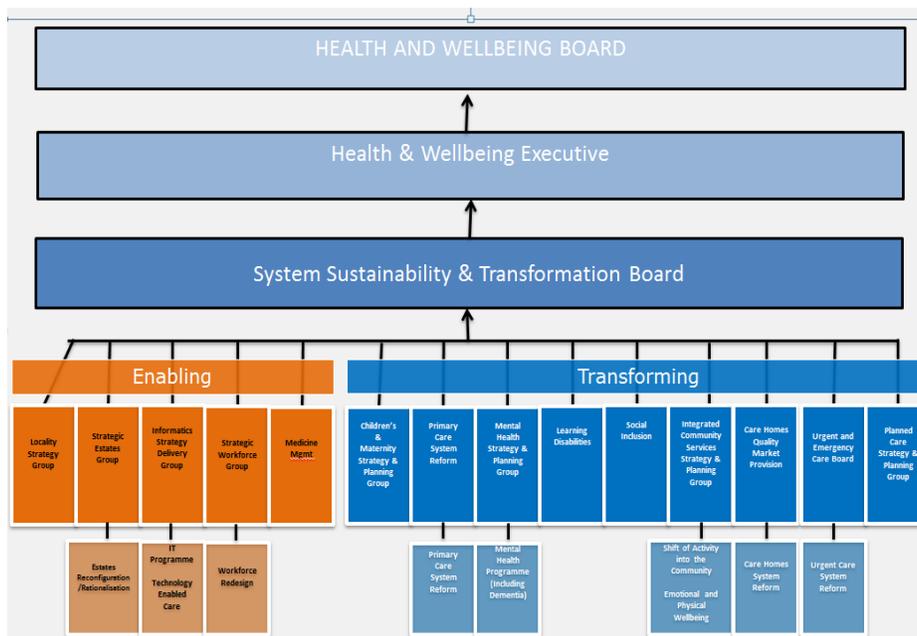
5.0 Governance

As the locality plan is embedded, delivery of the plan will become “business as usual”. To support the transition from planning to implementation a dedicated Programme Management Office will oversee the ongoing assurance and delivery of the programmes of work outlined in the plan along with the delivery of national and local performance standards.

Delivery of the plan is through the existing governance structure as set out on Diagram 10 below. Individual work streams and programmes are overseen by the relevant multi-partner strategy and planning groups, each of which has an accountable lead. Progress is reported to the System Sustainability and Transformation Board which comprises of senior leaders from across the system. This Board oversees strategic delivery and also scrutinises whole system performance, with all partners holding each other to account for the delivery of agreed outcomes.

The System Sustainability and Transformation Board reports through the Health and Wellbeing Executive and up to the Health and Wellbeing Board.

Diagram 10: Locality Plan Delivery Governance Structure



We have in place transformational enabling work streams for estates, workforce development and IT with representatives from all partner organisations. A high level programme delivery plan (with quarterly milestones) is detailed in Appendix B. A risk log for the programme has been developed and is attached at Appendix C.

6.0 Delivery Programmes

6.1 Population Health and Wellbeing Delivery Programmes

6.1.1 Start Well: Early Years Delivery Model

Greater Manchester Start Well Early Years Strategy - local implementation

The vision is for every child in Greater Manchester (GM) to have the best start in life. This means that every child grows up in an environment that nurtures their development, derives safety and security from their parents/care givers, accesses high quality early years services and has a belief in their goals and their ability to achieve them. Our ambition is that every child in GM acquires the skills necessary to negotiate early childhood, primary and secondary school and education and employment. In 2015 61% of children achieved a good level of development at the end of the Early Years Foundation Stage in Bolton, compared to 66% nationally.

The Start Well Early Years strategy sets out the GM vision for transformational system change and a long-term and sustainable shift from expensive and reactive public services to prevention and early intervention. This means building capacity within children, families, and communities through the provision of high-quality accessible universal services. This will start to break the intergenerational cycles of poverty and dependency. Reform of Early Years services is essential to increase the productivity and wellbeing of parents and their children and therefore ultimately economic prosperity in GM.

This transformational change aims to reduce duplication and make more efficient use of resources to achieve better outcomes wherever possible within existing budgets, including a vision for integrated leadership, commissioning and delivery. To be successful we need to commission services at the most appropriate spatial level and standardise best practice via the use of a GM outcomes framework.

This strategy acknowledges the unique challenge of the Early Years system with the diverse range of stakeholders across NHS services, Local Authority children's services, schools, private early years settings and wider stakeholders. Stakeholder engagement has progressed at different rates across the Early Years system and there remains a requirement to develop a mandate for co-production particularly with schools, early education providers, maternity services and CCGs.

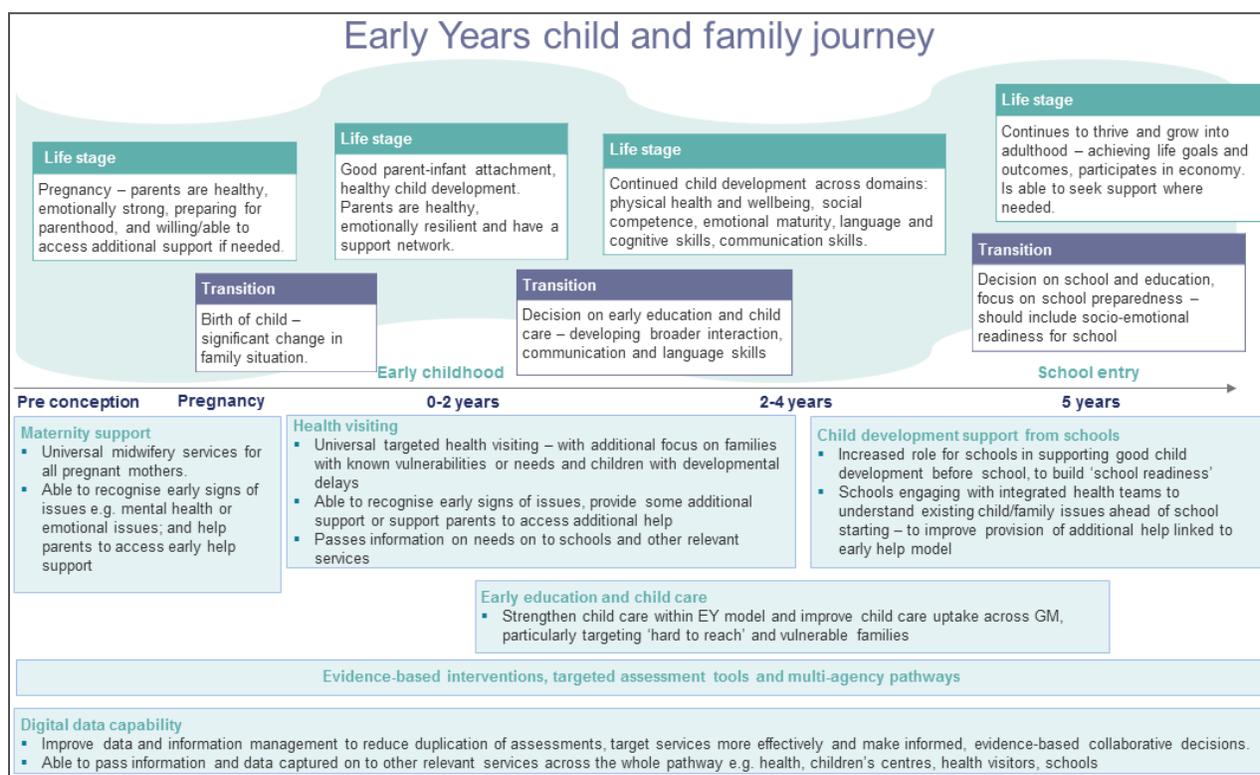
To achieve the ambitions of the strategy there is a requirement to significantly expand current engagement to include the following key stakeholders who are essential in co-producing the models of delivery:

- Early Education Providers (including private, voluntary, independent and Local Authority maintained settings and childminders)
- Schools and academies
- 0-5 health services (including Maternity, Health Visiting and Allied Health professionals)

- Community and voluntary sector partners
- Adult Mental Health services
- Clinical Commissioning Groups
- Primary Care (General Practice, Dental Practice)
- Local Authorities (Public Health, Children’s Services)

The child and family journey (Diagram 11) below outlines the life-stages and key transition points within the early years; importantly this recognises that interventions, especially where complex issues are embedded, need to happen as early as possible including pre-conception.

Diagram 11: The Early Years Journey



Giving every child the best start in life is crucial to closing the gap in health, education and social inequalities. Children’s life chances are most heavily predicated on their development in the first five years of life. Key components of this are a healthy pregnancy; good maternal mental health; secure attachment; love and responsiveness of parents along with high quality educational opportunities.

The overall objective of this strategy is to increase the number of GM children who are school ready. The GM devolution agreement, the transfer of Health Visiting commissioning to local Authorities, free early education places for disadvantaged 2 year olds, the Early Years Pupil Premium and the development of integrated services for 0-19

years present a golden window of opportunity to ensure a concerted approach to improving school readiness.

We will ensure that children are ready to start school by prioritising prevention and early intervention to address health, education and social inequalities. This will be achieved by the commitment to:

- **Using the strength of universal and targeted services to deliver prevention and early intervention:** Every child pre-birth to five years and their families will have an entitlement to the universal EYDM. This will include early identification of risks and developmental delays supported by evidence based assessments and interventions
- **A Coherent Approach:** We will strengthen Early Years partnerships and reduce duplication and develop a consistent approach.
- **Co-production of a 'place-based' and integrated approach to commissioning and service delivery:** Implementing integrating commissioning and provision of Early Years which minimises variation within localities and improves quality whilst recognising local differences.
- **Helping children, families and communities to secure outcomes themselves:** Build the capacity of families and communities to take charge of, and responsibility for, managing their own health and wellbeing.
- **Breaking cycles of poverty, inequality and poor outcomes in the early years:** We will help parents who are out of work to access education and training to help them towards work. We will address health, education and social inequalities by improving the physical and emotional health and wellbeing of the 0-5 population by addressing behaviours which inhibit their capacity to parent effectively.
- **Improve the quality of and access to early education:** This will include making best use of the Early Years Pupil Premium, improving the effectiveness of assessment information, early identification of children with SEND and supporting effective transition to primary school.
- **Putting quality at the heart of service delivery:** Self-evaluation and peer challenge will focus on quality and outcomes and will inform future planning. We will implement a GM outcomes framework and an information and data strategy. There will be continued evaluation of the evidence base and emerging best practice.

The EYDM comprises of three key components:

1. 8-stage New Delivery Model assessment pathway
2. A range of multi-agency pathways
3. A suite of evidence based assessment tools and targeted interventions.

The full EYDM is being tested in a single locality (Oxford Grove), however the ASQ assessments and a number of evidence based interventions have already been implemented Borough wide by the Health Visiting service and Local Authority.

Priorities for this delivery programme are to integrate and jointly commission early years provision and roll out the model Borough-wide. This is a GM priority which is fully supported by the Bolton locality.

6.1.2 Living Well: Wellbeing, Prevention and Health Improvement Partnership

Increasing the focus on prevention in our communities will help improve Bolton's health and wellbeing, quality of life and prosperity. This section proposes a system-wide partnership for prevention and health improvement, aiming for a step change in emotional and physical wellbeing in Bolton.

Better health positively impacts local communities and the economy and positively impacts people at all stages of their life.

Healthy children are in school more days and are better able to learn. For example, there is clear evidence linking student fitness and regular physical activity with academic achievement. Bolton's reception class of 2021 will have been born in 2017. A successful prevention system will directly impact those children's readiness to learn at school entry and their future life chances.

Healthy adults live longer, are happier, are more productive and at work more days. They have less need for health and social care services. Healthy older people keep their independence for longer. Older adults who are able to remain safely in their homes and linked in to their communities maintain positive mental and emotional health.

Investments in prevention across the life span complement and support treatment and care. We have good evidence of the prevention policies and programs that can be cost-effective, reduce health care costs, and improve productivity. There is strong evidence that the promotion of health and wellbeing and the prevention and early detection of ill-health at population level is highly effective when a systematic "place-based" model is led by a strong partnership and takes an asset based approach.

A place-based system of prevention takes responsibility for all people living within a given geographical area. The rationale of place-based systems of care is to bring organisations together around the population they serve.

Our partnership will tackle primary prevention on a continuum from the earliest opportunities within communities to the systematic identification and support in primary care of individuals at high risk of developing disease.

Taking the earliest opportunity for prevention, we will focus on preventing disease and illness before it happens, working together to create healthier homes, workplaces,

schools and communities and a healthier population. Our partnership approach will be asset based, which means really understanding the local associations and networks in areas, promoting and supporting active participation of local people and discovering their motivation to act and improve health and wellbeing. Our new prevention system will work with and through local institutions, communities of interest and faith groups to develop community fitness and confidence. To deliver this, we will develop a workforce of Bolton Community Asset Navigators recruited from local communities, helping to really understand and navigate local neighbourhoods; identifying assets, making links between them and building capacity for improvement.

We know that for many people in Bolton the levels of unhealthy behaviours and risk factors for chronic disease are extremely high, with a cohort of adults who require individual assessment and support to make rapid and sustained improvements in health in order to avoid significant ill health and medical care. Deploying additional resources within primary care, we will scale up existing innovations that have proven to deliver improved outcomes in the prevention of a wide range of chronic diseases. We will systematically identify those people at highest risk of disease and support them to improve their health so that they can live longer, healthier and productive lives, improve their resilience and reduce their healthcare costs. To deliver this ambitious programme we will develop a workforce of Bolton Health Improvement Practitioners with a focus on local recruitment and a programme of development in terms of health improvement and clinical skills.

The Bolton Strategic Partnership for Prevention and Health Improvement will develop and bring together voluntary sector and commissioned services and wider stakeholders who can assist with reducing health and care pressures, improving people's lives and wellbeing and ultimately preventing conditions starting in the first place by engaging with our community around lifestyle behaviour. Bolton has a wide range of statutory and voluntary sector partners who are ideally positioned to access parts of the community which may have had little contact with health and social care services and would benefit from links into community assets and/or referral to appropriate services.

Key outcomes for the partnership will include universal upscaling of healthy eating, increased physical activity, improved emotional and mental wellbeing, reduced prevalence of smoking and substance misuse, reduced falls, reduced social isolation, a reduction in population level risk factors for disease and ultimately a reduction in demand for health and care services.

6.1.3 Ageing Well: Staying Well including Falls Prevention

The Staying Well service for over 65s uses the Staying Well tool to assess both assets and needs of an individual and when possible makes use of the strengths/assets to help others and to reduce the needs of the individual rather than just targeting the need with a service. This service works with GPs to profile people over 65 with a long term health condition who are not known to Health and Social Care services. Staying well coordinators then visit these people and have conversations to build a relationship and to

listen to the person's story. This leads to a self-assessment using the Staying Well tool kit which asks the person to score themselves against a range of holistic topics covering all areas of life. These scores can be high so an asset/strength or low so a need. The Staying Well coordinators then focus on the assets and encourage the individual to make use of these assets to help themselves and others and in doing so often can address the low scores/need. So an isolated lonely person has good mobility and communication then becomes a volunteer befriender which not only supports someone else but reduces their own need. This approach is being implemented Borough-wide.

The "Wellbeing in Later Life" service offers a combination of befriending visits, afternoon teas, lunch and leisure clubs and physical and creative activity classes all delivered in a social setting with a strong focus on fun.

Keeping mentally, physically and socially active is the best way to improve mental and physical health and well-being. For older people it is also key to retaining independence and preventing, reducing or delaying dependence on statutory health and social care services. Everyone shares the ambition for older people to remain at home as long as possible, including older people themselves. However for far too many people their homes can become a lonely place that is no longer fit for purpose as they struggle with daily living tasks and errands. The lack of appropriate low level practical and emotional support leads to crisis scenarios and avoidable and premature admission to hospital and/or residential care. The VCSE sector in Bolton offers a menu of person centred services, delivered with a team of over 300 dedicated volunteers that provide low level practical and emotional support.

Through the delivery of Ambition for Ageing, a partnership project between Bolton CVS, Age UK Bolton, Bolton at Home and supported by Bolton Council, a range of asset mapping methodologies are being utilised to identify gaps and priorities. These will be tailored to consider different ages, disability, gender, faith, sexualities and ethnicity. A series of events are being co-ordinated across Bolton bringing together older people, community groups voluntary and private sector providers, commissioners and local businesses.

Bringing together older people and local existing decision makers to plan for the future is a new approach leading to greater inclusion, openness and honesty and a greater understanding of social value leading to sustainable outcomes. The project is delivering 'Branching Out' workshops to existing and emerging 50+ groups and the sessions have been adapted to take place in less conventional settings such as a café or with a group of friends. This approach has been successfully piloted by Bolton CVS and uses an interactive engagement tool to identify assets and develop a plan to make positive improvements in the areas. As part of the current Bolton CVS 'Why volunteer workshops' and 1-1 interviews we are encouraging over 50s to identify the assets that they bring to volunteering and be given the opportunity to undertake the Certificate in Volunteer Management accredited training course.

The whole programme is focussed around asset based approaches, social value, involving businesses, collaborative working and co-production to achieve age friendly

communities in Bolton, the learning will present valuable insight into how we can further develop this model to better meet the needs of other groups across the borough.

Our Falls Prevention Delivery Model

The number of people living into older age (≥ 65 years) is rising rapidly. Older people are more likely to fall and this has adverse consequences for their quality of life and that of their families. Falls also pose a substantial financial burden on health and social care systems.

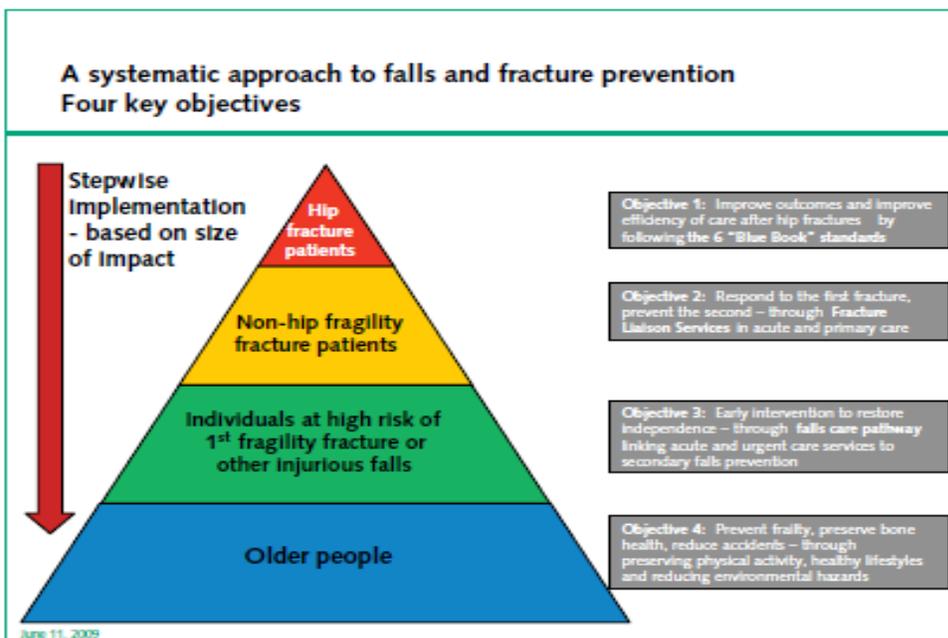
Preventing falls requires a multi-agency approach from all sectors and falls prevention needs to be part of everyone's business. The approach to falls prevention spans multiple tiers aiming to meet the needs of the general population of older adults including;

- those who have not fallen but are at risk
- those who have fallen with no injury or minor injury
- those who have fallen with a major injury

In recognition of the fact that targeted holistic interventions are more effective than interventions aiming to change one risk alone, the focus of the new Falls Prevention Model will be on building falls prevention into existing workforce structures and service delivery, including falls risk assessments being embedded in hospital discharge planning.

The "Prevention package for older people" (PPOP, 2009 as set out in Diagram 12 below) proposes the need for a systematic approach to falls and fracture prevention with four key objectives.

Diagram 12: Key Falls and Fracture Prevention Objectives



Based on NICE recommendations and following a review undertaken by the Bolton Falls Strategy Group it is recognised that whilst there are examples of good practice and proactive falls prevention across the organisations and providers working within Bolton, a more comprehensive falls programme is required in order to achieve the reduction targets set out in the Locality Plan. The following key actions have been identified;

- Development of a single holistic falls risk check, which is embedded into existing services across all sectors
- System to collate intelligence to gather further evidence
- Using the housing stock condition database and applying this to GP or other registers/population lists to target those most at risk of fall. This will enable robust targeting taking the person and property information into consideration.
- Community based strength & balance programme.
- Physical Activity sessions including a holistic approach to reducing risk of falls delivered onsite (care settings), with the view to building capacity in house.
- Proactive removal of falls hazards from private sector housing
- Home Safety Check – Care and Repair caseworkers delivering a property check alongside falls questionnaire to assess risk of falls and need for home improvements / adaptations
- Pharmacy-led medication review for older people in a community setting
- Train the trainer model so a core group can go back to host organisations and train others to become Champions. Training to include understanding of any recent changes to fall prevention guidance, Identification of individuals at high risk of a fall and how to carry out a holistic falls risk assessment, engaging elderly patients in fall prevention methods and encouraging staff participation to raise awareness.
- Asset based community /peer support educational sessions (not necessarily badged as falls)
- Falls Prevention/Healthy Living Public Campaigns
- Development of digital holistic falls self-assessment
- Inspections of all supported living environments for older people (sheltered, extra care, residential, nursing) to identify falls risks understand current position and develop improvement plans. This would encompass factors relating to the environment alongside resident information and the role of staff. The approach would be to target hotspots and high incident areas via a face to face visit. Others areas can be targeted using an asset based model, empowering organisations to carry out their own inspection or tapping into voluntary sector resources

7.0 System Redesign

In order to deliver the radical change in population outcomes, requiring a significant shift in the way we use of resources (moving from reactive to proactive care models), we need to redesign the current systems of care - from how services are commissioned and delivered, to how they interface and react with each other. These system reform programmes (including the high level outcomes to be achieved) are set out below.

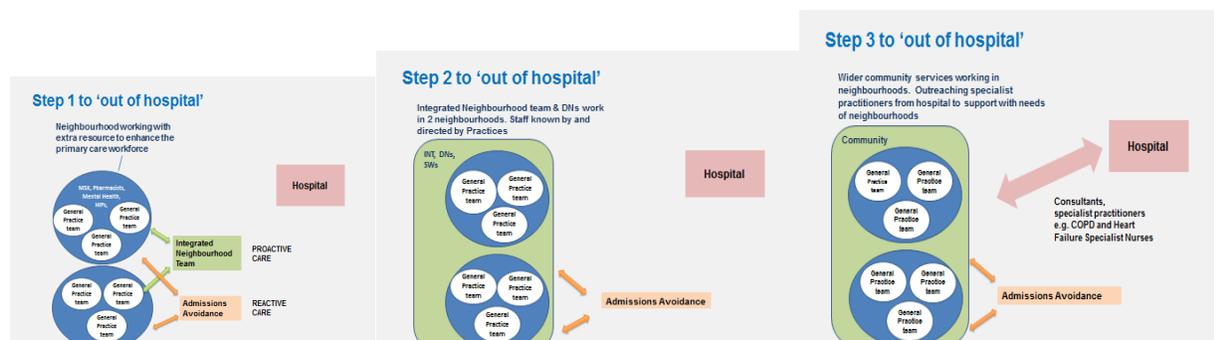
7.1 Transforming Primary Care in Bolton

Central to the new system for Bolton is the redesign of a primary care system which has integrated working at the heart, around neighbourhoods of 30,000-50,000 registered populations.

The new system will see GP practices working in clusters, with a redesigned primary care workforce fit for 2020. This will include first line assessment and intervention for mental health, musculo-skeletal and medication review issues. A newly designed Health Improvement Practitioner workforce will provide health and wellbeing support to those identified as benefitting from this service. Early identification and finding the missing 1,000s for secondary and tertiary prevention are key to driving the significant improvements in health and wellbeing for everyone in Bolton. Primary care will have access to a wide range of social prescribing and other interventions to support people to start, live and age well.

The 3 staged approach to delivery of the primary care system reform is set out in Diagram 13 below. Transformational funds are requested for the delivery of this.

Diagram 13: Phased Approach to the New Models of Care



The focus is on longer term prevention and early identification with targeted interventions for those most at risk of poor health and wellbeing (tier 3) with increased screening and vaccination uptake and reducing smoking, substance misuse and obesity, as well in tier 4 to ensure all children get the best start in life and the wellbeing of the whole population is improved.

To achieve this we need to invest more in primary and preventative care, including the development of a new workforce and expansion of the Health Improvement Practitioner role to support the significant shift required from reactive to proactive care.

The plan considers primary, secondary and tertiary prevention, whilst focusing on the specific long term conditions which are most prevalent across the locality: heart disease, respiratory disease and diabetes - delivered through Integrated Teams wrapped around general practice (on a neighbourhood basis) – including Health Improvement Practitioners, ANPs, district nurses, pharmacists, practitioners and therapists. This will include signposting people to the right provision of intensive support, to enable individuals develop their health skills and knowledge to build their capacity to manage their own health and wellbeing including stopping smoking, reducing alcohol harm, eating healthily and becoming physically active.

A neighbourhood model of integrated primary and community care will support the delivery of the outcomes of the locality plan and central to this is the need for Primary Care System Reform which has integrated working at the heart, around neighbourhoods of natural communities and practices are ready to embrace new models of primary care.

A new workforce will be involved predominantly with face to face patient care. This workforce will help to relieve GPs of a proportion of their patient contacts, allowing longer consultations for complex care, the over 75s, the 'at risk of hospital admission' patients, and patients with a list of multiple problems not suitable to be addressed by the new workforce.

GPs will thus be available for more intensive support to their integration teams, and will be able to deliver a proactive approach to bringing patients out of hospital for ongoing community care.

7.2 *Transforming the Urgent Care System*

The Bolton health and care economy has developed a strategic plan for the redesign of urgent care – to ensure delivery of responsive, emergency and urgent care when this is required, with the ethos of primary and community based care being the first point of contact for non- life threatening illness and injury. For patients who do enter the urgent care system, the focus is on ensuring that they get to the right service as rapidly as possible to enable them to return to their home in a timely fashion, with to maximum amount of independence retained.

The key elements of the redesign of the urgent care system locally are

- Improving flow, including full use of the SAFER metrics, full use of Estimated Date of Discharge and timely senior clinician decision making
- Efficient and effective discharge of patients (including the implementation of a fully Integrated Discharge Team, implementation of a “Discharge to Assess” model and expansion of Intermediate Tier services
- Improving ambulance response through implementation of robust “hear and treat” and “see and treat” models
- Looking to develop a clinical hub to support senior clinical decision making as a single point of contact.
- Improved access to mental health assessment and advice - to achieve this we will work with mental health services to ensure rapid access to mental health assessment, treatment, education and training in bed based and home based services intermediate tier services.

To achieve this vision, stakeholders are coming together to work in a more collaborative and innovative manner as more often treatment pathways require input from multiple health and care professional. There also need to closer co-operation with our neighbouring localities of Wigan, Salford and Bury.

It is essential over the coming years to optimise existing pathways to ensure that delays are minimised and quality and outcomes are improved. It is with this in mind that we are going to improve our access to diagnostics by guaranteeing that there are more rapid access slots for patients on the same day. In addition, this will be complemented by more rapid access outpatient clinics where these diagnostics can be followed up and patients do not have to wait to progress treatment. Not only will this improvement enhance patient care, it will also reduce the numbers presenting to Accident and Emergency for diagnostic treatments such as x-rays.

Furthermore, work will continue to improve the current Ambulatory Care Unit. Work will continue to increase the hours of this service (to at least 12 hours per day) and expand the service (for medical and surgical assessments) to 7 days a week. This will work in unison with the front end clinical decision maker model within the A&E Department, which will stream patients to the most appropriate service to meet their needs (including self care advice, referral to their GP, referral to the Out of Hours service, direct referral to the

Admission Avoidance Tea, direct referral to the Ambulatory Care Unit or Rapid Access Clinic).

Underpinning the improved delivery of urgent care performance is the need to improve the health literacy of the public. This increased level of clinical self-awareness will lead to better decision making by the public and there is a direct correlation between improved health literacy and improved health outcomes. However, this will not happen overnight and will have to be a strategy developed and implemented in conjunction with the offering already described. To this end, the CCG is developing a robust communications strategy that will re-frame how we talk about urgent care and when the public should access it.

Whole system metrics have been developed and are used by the newly established Urgent Care Board, with all partners holding each other to account for delivery.

7.2.1 Fracture Liaison

Osteoporosis is the most common chronic bone disease affecting both men and women, characterised by low bone density. The clinical manifestation of this disease is fragility fractures, most common in older people as a result of minimal trauma such as a fall from standing height.

Fractures most commonly occur in the spine, hip and wrist but can also occur in the arm, pelvis, ribs and other bones. The majority of direct medical costs to the NHS are from fragility fractures related to hip fracture care and hip or vertebral fractures are most closely associated with decreased life expectancy. Hip fractures in particular nearly always require hospitalisation, permanently disable half of those affected and can be fatal in approximately 20% of cases. Over half of those patients who experience a hip fracture have previously broken a bone.

The National Osteoporosis Society estimates that the implementation of an effective fracture liaison service for Bolton should deliver savings of circa £2 million over 5 years. Investment is required to deliver these savings as there is currently no fracture liaison provision in the Borough.

Secondary fracture prevention is a long-term multidisciplinary task requiring an integrated approach from secondary, primary and community services. A well organised Fracture Liaison Service has been demonstrated to be an effective way to prevent further fragility fractures and requires an integrated approach between various health care providers in hospitals, primary and community care settings. A Fracture Liaison Service ensures that patients are assessed after a fragility fracture and are offered secondary prevention. There is a strong evidence base that demonstrates investment in fracture liaison results in improved quality of care for patients alongside system wide savings in future years for health and social care.

The role of a fracture liaison specialist would include investigations such as bone scans, starting drug and other treatments, linking with the above mentioned services and monitoring compliance with medication, with support from a fracture liaison practitioner.

The maintenance of medication compliance could be undertaken within primary care once established.

The Fracture Liaison Service will;

- Identify patients over 50 years who have suffered a fragility fracture (through A&E and via Primary Care)
- Assess bone health and falls risk
- Provide information and support to patients to reduce the risk of a future fracture
- Provide interventions to improve bone health including referral to the specialist falls clinic
- Ensure patients receive long-term management/monitoring and treatment (within 4 months of fracture)

Bolton already has a well-established Rheumatology service with clinic appointments for osteoporosis, and an IV therapy service delivering IV bisphosphonates. In addition falls prevention and management is also a key component of the care delivered through a multidisciplinary proactive approach within the Integrated Neighbourhood Team. In addition to the generic professional interventions provided to patients to prevent falls; the Integrated Neighbourhood team also provide a specialist falls assessment and specific intervention for those patients who have fallen (on one or more occasions) with the aim to discover why the fall(s) has happened and to treat any underlying problems that may increase chances of repeat falls. It will also consider the health of patient's bones, as they may be at particular risk of having a fracture if falling regularly. Those patients who are considered particularly complex are supported to attend a consultant led multidisciplinary falls clinic following which further intervention may be required and/ or diagnostics recommended with significant results subsequently acted on.

Through additional investment, the introduction of a Fracture Liaison Service will enable all aspects of future fracture risk for patients to be proactively delivered and patient outcomes improved across Bolton, thus maximising outcomes for patients and reducing the associated costs to the Health and Social Care System.

7.3 Acute Care Reform

7.3.1 Standardisation of Care

Bolton NHS Foundation Trust is an integrated care organisation providing care and support in Bolton Hospital, health centres and clinics as well as intermediate care, domiciliary and ill-health prevention services.

The vision for Bolton is to provide fully integrated health services which work in collaboration with social care, mental health and voluntary service to meet the needs of the local population (this is set out later in the Local Care Model section of the plan).

The reduction of variation in health care services is a key component to delivering the Locality Plan, and a sustainable health economy in the longer term. In terms of acute service delivery, this means focusing on areas of variation in activity, spend and outcomes. The Effective Use of Resources programme has been a key driver for reviewing variation in acute services, and to date has resulted in a reduction of procedures covered by EUR policies (i.e. those which should only be undertaken when certain patient criteria are met) of 28%. NHS Bolton CCG is now working in partnership with providers to understand variation in wider acute services, informed by national recognised datasets – such as those provided by the NHS Right Care programme – to identify areas for further work and standardisation where required. It is recognised that this work also needs to incorporate primary and community care services.

Demand management is a key element of the collaborative working arrangements between NHS Bolton CCG and Bolton NHS Foundation Trust. The two organisations have a track record of working together to develop previous demand management schemes and primary care pathways, to support diagnosis and management within primary care wherever possible. A shared approach to demand management is being further embedded as part of the Locality Plan delivery, with a focus on:

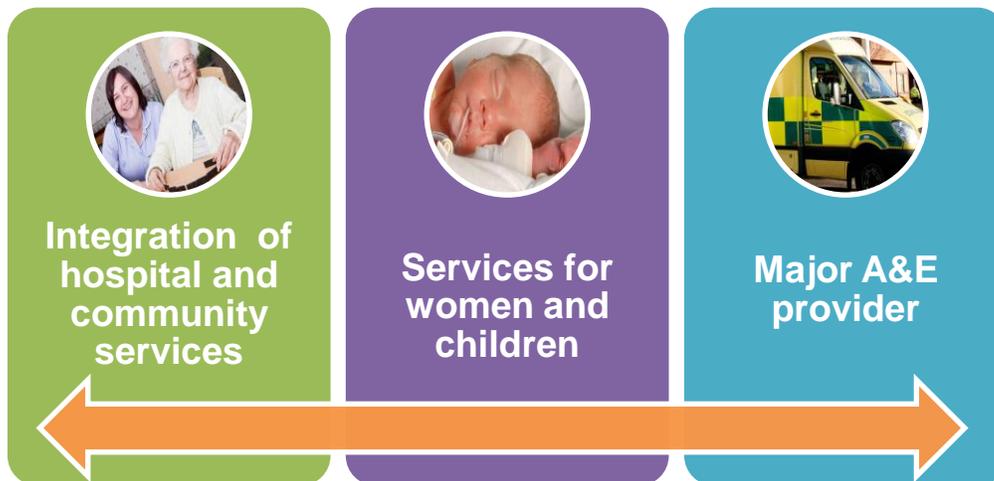
- Robust triage and assessment at the secondary care interface, to ensure only patients requiring secondary care input are seen within acute services
- Robust discharge pathways back to primary care
- Supported by standardisation of the primary and community care offer, as per Clinical Standards Board agreements
- Implementation of the agreed outpatient demand management schemes
- Cancer – standardisation of pathways ‘Find out Faster’ for Lung, Upper GI and Lower GI to improve outcomes through reduced delays

7.3.2 North West Sector Partnership

Working with Wigan, Wrightington and Leigh Foundation Trust (WWL) and Salford Royal Foundation Trust (SRFT) under the North West Sector Partnership, the aim is to ensure the provision of a full range of sustainable specialist and non-specialist acute-based services, with Bolton being well placed to be the centre of excellence for children’s and

maternity services, as well as having a full Emergency Department. This is set out in Diagram 14 below.

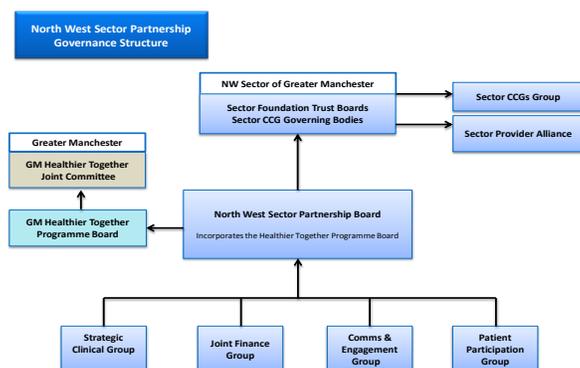
Diagram 14: High Level Vision for Bolton FT Provision of Care



There is a Partnership Board for the North West Sector (comprising of the 6 organisations Chief Executives and Chairs) which is underpinned by a CCG Collaborative Commissioning Group. The North West Sector Governance is set out in Diagram 15 below. Discussions are underway regarding the formation of a shared services board comprising of Executives from the three Foundation Trusts, The remit of this Board would be to oversee the operational delivery of single shared services alongside future transformational plans.

A transformational work plan has been agreed by the Partnership Board including the sector provider lead for each transformational programme. This named organisational lead will also report into Greater Manchester theme 3 on behalf of the sector to ensure alignment. Governance arrangements are set out in Diagram 15 below.

Diagram 15: North West Sector Governance



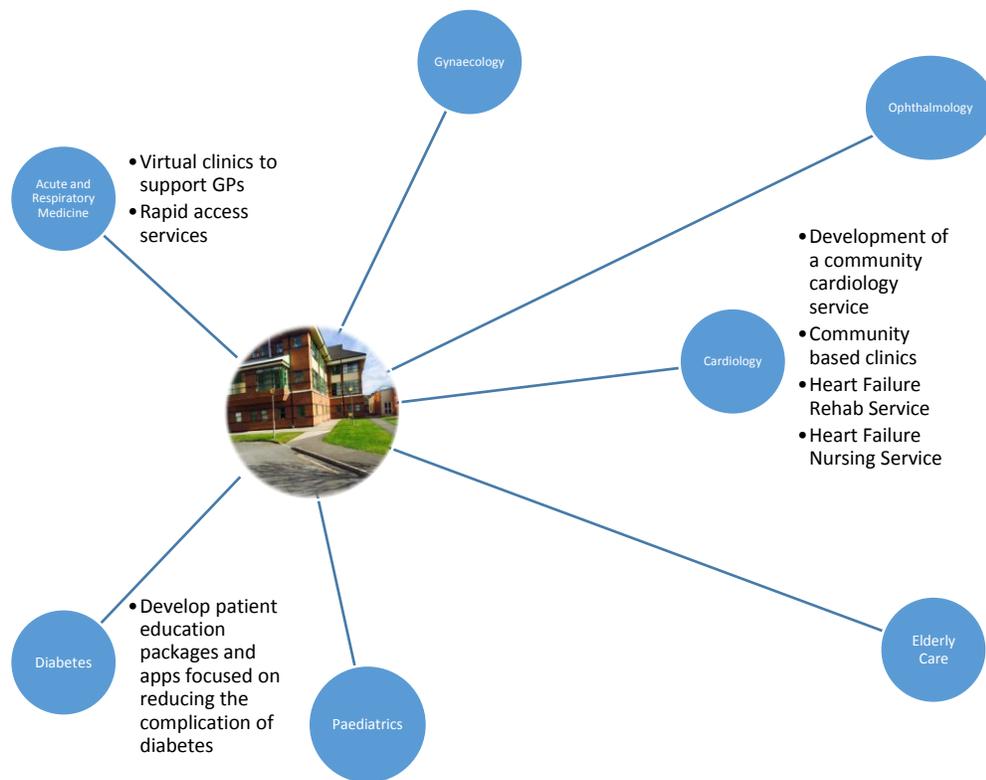
Plans for Acute Care Collaboration are more advanced within the North West Sector of Manchester than other sectors. Collaboration work streams are being led by the three sector Directors of Commissioning and three Trust Planning Leads to ensure that the schemes compliment all sector Locality Plans.

7.3.3 Moving Acute Care into the Community

Bolton has been developing community-based services for many years and is now planning to take this forward at scale and pace.

The high level plans for the specialties which will be community-based (respiratory, cardiology, gynaecology, paediatrics, ophthalmology, elderly care and diabetes) are set out in Diagram 16 below. The principle is that services will work with the Integrated Neighbourhood Teams (primary and community based) where this is an efficient model, with services which are lower volume and/or more specialist in nature being delivered on a more centralised basis.

Diagram 16: Acute and Community System Reform



Specialist medical care will not be confined to inside the hospital walls; specialist teams will work closely with GPs and those working in social care to make sure that patients have swift access to specialist care when they need it, wherever they need it. Much specialised care will be delivered in or close to the patient's home. Physicians and specialist teams will expect to spend part of their time working in the community, with a particular focus on caring for patients with long-term conditions and preventing crises. To support this way of working, the performance of specialist teams will be assessed according to how well they meet the needs of patients with specified conditions across the hospital and health economy, not just those located

The focus in phase 1 will be on the development of community based services with Respiratory and Cardiology Teams providing support to people with Long Term Conditions in the community.

Our Integrated Neighbourhood Teams

Developing our INT workforce

As the INTs have been developed there has been an identification of patients with complex need who require continual support across multiple disciplines. Looking after this cohort of patients requires support from multiple teams including Nursing, Social Work and Therapies. The most efficient way to care for patients who have had a care plan identified and require continual care and support and limit the number of different skilled professionals attend peoples home is to provide a workforce fit for the future.

This will entail developing practitioners who possess skills which could cross multiple care spectrums providing holistic care from a Social, Health and economical perspective. To provide this workforce we will work with professional bodies and Universities to develop a training programme which covers modules most appropriate to the skills needed for this workforce.

7.4 *Mental Health System Reform*

7.4.1 *Targeted Interventions*

Bolton's Locality Plan segments the local population into four 'tiers'. This is to ensure that new delivery models are targeted to the needs of the local population within each tier. The tiers also map to the Greater Manchester themes.

Some key local priorities specific to mental health in Bolton are set out below mapped to the population need in each tier.

Tier 1: System wide primary prevention to promote improved health and wellbeing across the population

- Promotion of mental wellbeing within communities by empowering individuals and communities to make mental health everybody's business
- Development and implementation of the suicide prevention strategy
- Support voluntary sector and mainstream community services to promote mental health awareness.
- Development of social prescribing that supports improved emotional wellbeing.

Tier 2: Secondary prevention and early identification for people at risk of poor health and wellbeing

- Ensure mental health expertise embedded within the Public Service Hub to support Complex Lifestyles and Troubled Families.
- Improve mental health support for older people placed in local nursing homes and residential homes
- Delivery of Working Well IAPT
- Support the primary care reform agenda with GPs developing the role of mental health practitioners at GP practice level

Tier 3: Tertiary prevention and proactive management to prevent or delay progress of conditions and support the older population to stay well

- Further develop mental health expertise within the Integrated Care teams and local neighbourhoods
- Extension of the Asperger's post diagnosis support locally
- Delivery of Dementia United pledges
- Improve dementia diagnosis rates
- Further develop innovative joint working with service users and voluntary sector to support people in communities and prevent need for admission

Tier 4: Multiple Long Term Conditions, individual multi-disciplinary care plans

- Continue to develop the range of crisis care in Bolton available 24 hrs a day 7 days a week further embedding the principles of the Crisis Care Concordat. This promotes joint working with the Police and other agencies to ensure appropriate care in a therapeutic environment when in a crisis. Further development of the RAID and Sanctuary services will be considered
- Further develop the range of specialist placements in the local area to increase choice and capacity, reduce the need to be placed outside of Bolton and support effective bed management that promotes discharge. These out of area placements are often high cost and divert resources out of the local area. They include more capacity in residential and nursing homes alongside further development of placements for those with complex or specialist needs
- Strengthen the local rehabilitation pathway in health and social care to enable individuals to access the right care at the right time that reflects and promotes their recovery and ensure care is delivered in the least restrictive setting possible.
- Improve the recognition and treatment of physical health care problems for those with serious mental illness
- Deliver Single Point of Access with senior clinical assessment and advice to ensure seamless, timely access to the right service at the right time
- Continue to embed the local community mental health team model to ensure continued access to extended out of hours support, increase provision of outpatient clinics in the community and further development of structured care pathways focussed on recovery
- Further develop local, timely access to Eating Disorder services across the age range
- Further develop NICE compliant Personality Disorder services at all tiers of need
- Strengthen transition arrangements based on need across CAMHS and adult mental health services
- Review local CAMHS services compared to national best practice and implement recommendations across all tiers of need as appropriate to improve access to mental health services for young people
- Deliver CAMHS transformation plans strengthening community and urgent care provision to reduce need for admission
- Support development of perinatal services to meet the needs in Bolton
- Promote joint working and training with Learning Disability and Substance Misuse services to improve early identification and treatment for those with a dual diagnosis

Further enhancement of IAPT services, development of ‘all-age’ crisis care as well as the development of a specialist unit in Bolton to repatriate out of area placements.

7.4.2 Moving Mental Health Services into the Community

Greater Manchester West undertook a significant service review in 2014 to redesign the acute care pathway for mental health services. This strengthened community and urgent care services to reduce the need for inpatient admission and promote effective discharge. Extended out of hours access was provided and new helpline introduced. The acute care

pathway model will continue to be embedded to support effective management of the reduced inpatient bed base. This includes the strengthened Home Based Treatment team providing a real alternative to hospital admission, continued provision of high quality safe care on inpatient wards, staffing levels that reflect patient need and strengthened bed management to promote discharge. This also includes close working with local providers to support identification of appropriate housing for example and development of local specialist resources to help to prevent the need for Out of Area admissions. There will continue to be increased provision of outpatient clinics in the local community, a strengthened multi-disciplinary response with community consultants based in the community with the community team and further development of structured care pathways focussed on recovery during 16/17.

Many people with long term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. Care for people with long term conditions could be improved by better integrating specialist mental health support with primary care and chronic disease management. In Bolton there are specialist mental health practitioners within Integrated Neighbourhood Teams and Admission Avoidance Teams. This will promote the improved awareness and knowledge of mental health conditions within mainstream services, enabling early identification and improved outcomes for individuals whilst protecting vertical integration of primary to tertiary mental health services.

All levels of support from prevention and early intervention through to specialist support should be responsive with clear access arrangements. In Bolton there is a Single Point of Access to mental health services. It provides senior clinical decision making at the front door to mental health services and ensures early assessment and early provision of care and treatment that reflects need.

For those older people that do require inpatient admission work will continue to develop the mental health inpatient unit as a centre of excellence for inpatient care of Older People with both functional and organic mental health problems and will require transformation fund investment for this . This is supported by provision of an Intensive Support pathway to reduce need for admission. The further development of integrated care and improved specialist support to local intermediate care, nursing and residential care providers is also key to this.

7.4.3 Dementia Prevention and Care

To make a real difference to the lives of people living with dementia, organisations, groups and businesses need to be engaged, involved and take action. Dementia Friendly Communities is an approach that aims to influence infrastructure and provision within defined communities or geographical areas to ensure that people with dementia are not excluded and receive appropriate support to remain engaged in community life.

Bolton is testing an approach to develop a dementia friendly community in Horwich, with a view to a borough wide roll out. A sub group of Bolton Dementia Partnership Group has

been developed to deliver this work. In February 2016 a launch took place at which many local businesses and organisations signed up to become a dementia friendly business/organisation.

By working collaboratively with a range of partners to develop dementia friendly communities, our aim is to ensure people living with dementia and their carers can continue to engage in day to day life and enjoy the things they do.

Bolton is now officially registered as a Dementia Action Alliance. The aim of a Dementia Action Alliance is to bring local organisations, groups, and businesses together to improve the lives of people living with Dementia. This can include any organisation that is committed to improving their services for people living with dementia. Typical organisations include businesses, shops, bus companies, taxi firms, police forces, fire and rescue services, local authorities, tourist destinations, charities, care providers and health trusts. The Dementia Action Alliance will:

- Help co-ordinate and support Bolton to become a dementia friendly community
- Help build capacity and connect the community ensuring partnership working across all sectors
- Raise the profile of Bolton Dementia Action Alliance and its work to create a dementia friendly community
- Enable local people and organisations to help people to live well with dementia in Bolton
- Share learning, make decisions about, and prioritise the action of the Alliance
- Recruit members to join the Alliance through local networks
- Develop a monitoring and evaluation framework to evidence impact
- Receive and act upon feedback obtained from people with dementia and their carers
- Work positively with all organisations from all sectors for the benefit of people affected by dementia and their carers

For older people with memory problems it is also essential to offer early access to high quality memory assessment and post diagnostic support services. The Bolton memory assessment service has received national MSNAP accreditation and locally dementia diagnosis has significantly improved. **It is a local priority to further strengthen the service to ensure it can continue to deliver waiting time targets and further develop comprehensive post diagnostic support that reflect national evidence based best practice. Investment is required to achieve this (from the Transformation Fund).**

For older people placed in local nursing and residential homes early identification and prevention means improving the training, education and support with special mental health assessment when required to ensure early identification and effective treatment of mental health problems. Reform of the care home system (with targeted investment) is included within this Plan.

7.5 Care Homes and Home Care

7.5.1 Care Homes

There are currently approximately 1,600 care home beds in Bolton. This represents a market worth approximately £40m per year which employs over 1,500 people. 730 of these beds are occupied by people funded by the public sector at a net cost of £17m per annum with the remaining being occupied by people who fund their own care. Due to large demographic pressure in the 85 years plus age bracket, the average age at which Bolton admits someone to a care home is 86, current forecasts predict an extra 246 people over the age of 65 requiring care home admission by 2024 which is 55% more than in 2016.

Significant challenges currently exist in this sector. Like the different boroughs in Greater Manchester quality, price and availability vary widely, this leads to boroughs competing with each other for the best value care homes and care homes able to pick and choose residents.

Nursing homes are finding it increasingly difficult to find nursing staff to work in their units resulting in a restriction in the supply of good quality nursing beds which is the segment of the market needed the most.

There is a need to invest in new models of care in care homes, closer aligned with the NHS, with better skilled staff and with economic models that benefit both commissioners, the local economy and residents that fund their own care.

Bolton is currently an outlier for residential care admissions, in part because of a lack of clear and planned alternatives but work is needed to ensure that care home placements are not used to support people who could otherwise be supported at home.

Similarly, too many residents from nursing and care homes attend A & E and/or are admitted to hospital, with circa 19 beds in the hospital at any one time being taken up by patients who also have a care home bed. In 2015/16 806 non-elective admissions resulting in 7,152 bed days were made by residents who live Bolton's care homes.

Through a new Care Home Excellence Group, we will seek to improve the outcomes for Adults who need 24 hour care and support through the design and delivery of new local models of care.

The work will have a focus on residential and nursing care and will rely on working across organisations, alignment with NHS and forging new and productive relationships with providers and customers.

Through sub-streams and specific projects, the group will develop new models of care which will enable care homes to become high-quality 'centres of excellence' that maximise independence and reduce the call on urgent care and hospital admission.

Complementary work within the acute hospital will strive for improved communication between hospitals and care homes in an endeavour to deliver dramatic reductions in length of stay.

The key objectives are set out below.

Commission a New Care Home Model

Design, develop and commission a new care home model with new joint contracts, standards, fees, contract monitoring and assurance process with an onus on incentivising quality and excellence.

Improve the Management of Transfers

Improve the processes for transferring people to and from care homes including how information is shared, reducing necessary 'up-grades' and changes in place of residence, develop effective pathways for care homes.

Improve Customer Safety

Focus on increasing harm free care (including falls, pressure ulcers, UTIs); improving infection control with enhanced guidance and support, improving the administration and use of medication through significant investment in pharmacy support to care homes, improving workforce competency by the NHS and Council supporting the care homes with a package of training, increase the use of equipment, telecare/health and environmental upgrades to reduce falls and pressure ulcers by enabling care homes engaged with Bolton's driving up care home excellence program to draw down grants from a capital fund.

Remodel the Workforce

- Developing the structure, roles and supply needed to build care home excellence. People who work in care homes will be highly motivated, skilled and caring individuals
- Establish a customer/patient experience model
- Ensuring experience is central to the design of care home excellence. Focus on involving customers and their families in designing models of care, developing new and innovative approaches to testing customer experience, developing as a further barometer of customer safety and ensure customer experience is at the heart of driving up excellence.

As a result the following outcomes will be achieved.

- Care Homes are safer
- Care homes send fewer people to hospital and when they are there their stay is much shorter

- The people who live in care homes and their families are happier and their experience improved
- The people who work in care homes are happier, more highly trained and report higher levels of staff engagement
- The Bolton care home market is full of high quality, resilient providers

7.5.2 Home Care

There are currently 19 domiciliary care providers in Bolton that employ over 700 staff. Currently the local authority commissions over 1.2 million visits a year at a cost of over £7m per annum. This however does not represent the whole of the market as more care is purchased by self-funders, people in receipt of direct payments or personal health budget and people in receipt of continuing health care. This means that the size of the home care market will be significantly greater than this and it is estimated at least £73m is spent each year in Greater Manchester on home care.

The current model is broken with unsupportable costs and a weak and fragmented market. There is a difficulty retaining and recruiting staff with some agencies in GM seeing a turnover of staff of 30% in their first year. Greater Manchester provides us with an opportunity to adopt a radical co-design approach with service users and providers to develop a sustainable model that meets wider range of needs.

At a Greater Manchester level Adult Social Care will join forces to design and commission a new model of care at home in partnership with service users, providers and investors. Care at home that that reduces urgent care and builds community health and care capacity.

Better home support is the key to earlier more effective intervention and should be part of the core health and care offer linked to primary and community health and available to all ages and all people with complex needs.

7.6 Technology Enabled Care

Bolton has started the initial reform of adult social care based on the model of “prevent, delay, reduce” the interventions with the aspiration to keep people happy, healthy and independent in their own home.

The adult social care reform is comprised of the following key elements:

- Developing place-based community capacity and supporting individuals within their own communities, this includes the improvement of daytime activities
- Early identification and targeted prevention
- Implementation of a single front door and comprehensive sign posting service. Including expanding information and improving access to information and advice to

allow people to make informed choices about the care and support they want (on a formal and informal basis)

- Redesigning Care Home and Home Care Services (as set out in Section 7.5 above)
- Development and implementation of a strategy to improve carers support
- Improving services for people with learning disabilities by ensuring that they are person-centred, with the right level of support delivered in the right setting
- Further enhancing and upscaling intermediate care and reablement services
- Improving and streamlining hospital discharge (including implementation of a new “discharge to assess” model)

These improvements will only be achieved through embedding the changes, ensuring culture change through ongoing workforce development across health and social care and improving the IT resources to enable effective joint working and management of resources through the virtual capital budget for each neighbourhood.

Further resources will be required to ensure housing is fit for purpose for those with complex needs and aids, adaptations and care and repair budgets to ensure that individuals can stay at home for as long as possible and to meet the current waiting backlog. Assistive technology and response will help prevent admissions and readmissions.

7.6.1 Technology Enabled Care

This Programme is based on a very strong evidence base which demonstrates that through the use of technology, we can more efficiently and effectively meet an individual's needs.

Technology enabled care allows people to remain independent and mitigate and reduce risks (rather than relying on traditional care packages such as home care delivered by a health or care assistant). This is achieved by aids and equipment to allow people, their carers and families and in care homes to monitor their own health and wellbeing through the use of falls alarms, medication dispensers, remote health monitoring and other similar devices.

Use of Telehealth within the Intermediate Neighbourhood Teams

Telehealth enables individuals to manage their own long-term condition effectively at home and can result in early diagnosis of unforeseeable health related problems as well as empowering patients to take a more active role in their care. Investment in telehealth units would enable this enhancement to our INT service.

8.0 Development of a Local Care Model

To enable the collaborative design and delivery of the programmes within the Locality Plan, we need to put in place new models of care focussed on the outcomes for people supported by integrated commissioning and new contractual models to support placed based integration. Our plans for the development of these are set out below.

8.1 Integrated Care Organisation

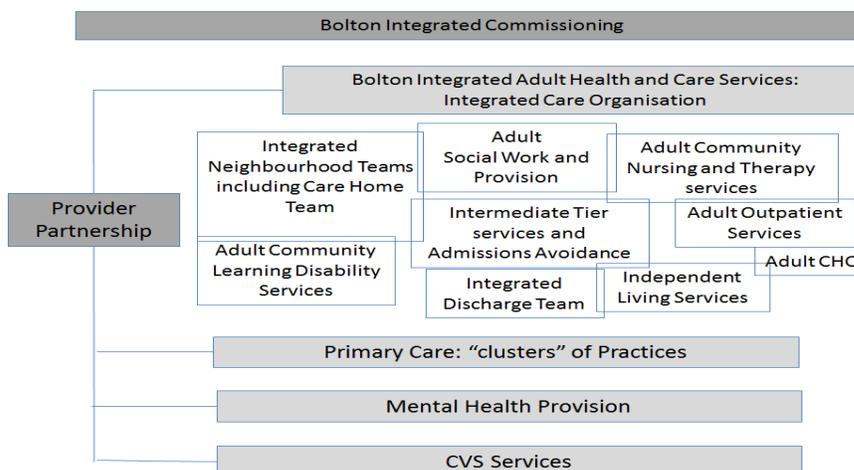
Bolton’s strategic direction for the design and delivery of a Local Care Model is focussing on the population of Adults and Older people in the first phase to bring together the system wide partners for community health and social care. The developments will be taken forward through strengthened partnerships building on existing integrated services working towards the design and establishment of an Integrated Provider Care Organisation (ICO), these developments will be overseen by the Health and Wellbeing Executive and the establishment of a provider Partnership Board that will include wider partners to connect Primary care, CVS and integrated Mental Health services.

The emerging Local Care Model, will focus on integrating pathways and services from across community health and adult social care including; Intermediate Tier services, Integrated Neighbourhood Teams and Community Learning Disability services, and case management functions from both the Council and CCG. These services will work in partnership with primary care and the existing integrated Mental Health services.

The model of delivery of the integrated commissioning and integrated provider organisation/s will be developed through detailed analysis and appraisal of the best outcomes for people and place to move to full implementation by 2021.

The provider partnership relationship is set out in Diagram 17 below.

Diagram 17: ICN model



The steps to delivery of the Local Care Model are set out in Diagram 18 below.

Diagram 18: Steps to Delivery of the Local Care Model

Bolton's steps to Local Care Organisation



8.2 Integrated Commissioning

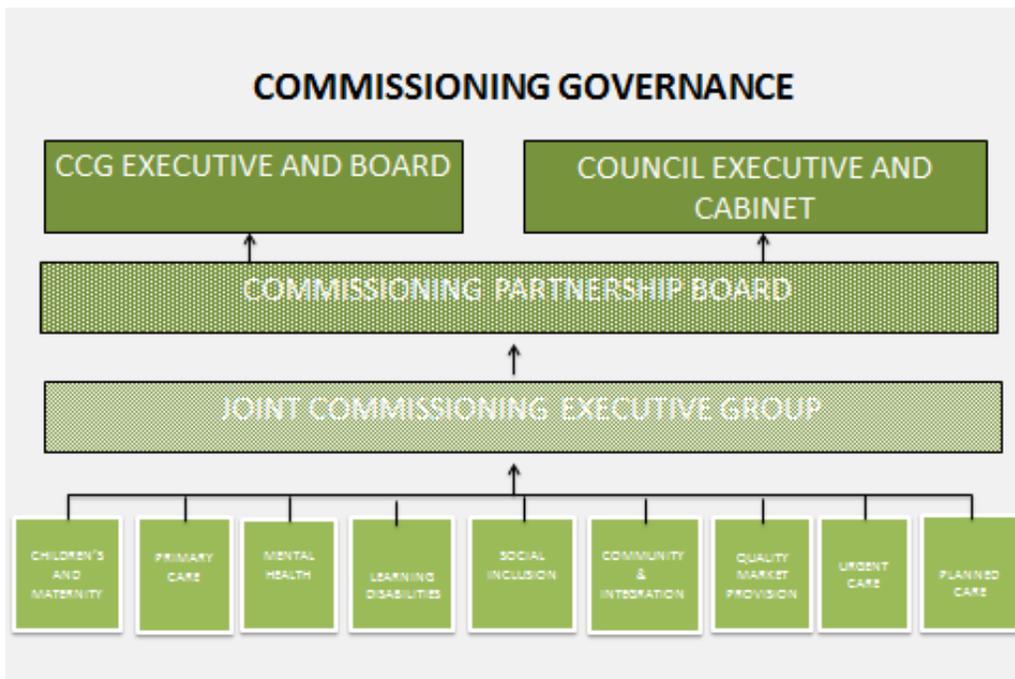
Bolton CCG and Council have a long history of working in partnership to improve the service provided to the residents of our borough. We have been fortunate that our boundaries are co-terminous and as such both organisations have been able to deliver high quality services at a place based level. This is especially important in this new environment of integration as we move beyond organisational boundaries and are more focused on place based care.

Bolton commissioners recognise over the years that each organisation has built up very strong skills in different areas of commissioning. Building on these strong skill sets the first phase to move towards integrated commissioning is to build commissioning teams around themes within our commissioning responsibilities, pooling skills and identifying lead organisations, maximising the potential of the skills and experience that exist within our two organisations. Some themes will be led by the council and some by the CCG whilst others where we are developing new and innovative care delivery models will be led jointly. Each commissioning team will develop a work programme of intelligence gathering, data reporting and evaluation that will be delivered by our integrated data, analysis and intelligence functions using seamless and integrated data flows and information sharing. The high level commissioning structure is set out in Diagram 19 below.

The two key commissioning teams which will progress to fully integrated commissioning

teams in the first instance would be Integrated Community Services and Adult LD services to reflect the strategic priority to focus on Adults and Older people and the developments of the Integrated provider organisation and provider partnership. This will ensure a full place based approach can be taken to whole system for this population, including governance and financial sustainability to enable the system to be accountable for delivering the agreed outcomes as a whole for Adults and older people. This will also consider which commissioning activities will continue to be carried out by the commissioners, those to be shared and those best transferred to the provider.

Diagram 19: High Level Commissioning Governance



9.0 Enabling Workstreams

There are a four whole system strategic workstreams which underpin the delivery of the locality plan vision and outcomes: Estates Reconfiguration, IT, Workforce Transformation and Engagement. Each of these has a strategy in development with an underpinning governance structure and action plan. The high level deliverables of each of the workstreams is set out below.

9.1 Estates

The Bolton locality has established a Strategic Estates Group which has been meeting since 2014 and is chaired by the Director of Estates of Bolton FT and vice chaired by the CFO of Bolton CCG. The SEG has membership from all relevant partner organisations and has been working to support the transformation required to deliver the locality plan and respond to the requirements of 'Taking Charge'.

A strategic estates framework was developed in December 2015 along with an implementation plan. The overall estates vision for the Bolton locality is to provide a first class estate which enables patients to receive the highest quality public services.

A number of key principles have been established:-

1. Estate must be utilised as fully as possible
2. Estate must be developed in line with the 'One Public Estate' agenda
3. The overall estate foot-print must be reduced wherever possible to release investment in services
4. Disposal of poor quality estates
5. Promoting the use of flagship buildings, Bolton One and Brightmet
6. Development of alternatives to traditional estate approaches through the innovative use of technology
7. Co-location of health and social care services to promote integration
8. A smaller acute hospital footprint

Estates Reconfiguration/Rationalisation

Bolton has developed a strategic estate plan that identifies the key estate infrastructure necessary to develop and support the proposed future pattern of health and care delivery across the borough.

The strategy reviews in detail the current state and condition of both community and GP premises identifying also issues re utilisation, accessibility and demand. An accurate baseline position has been produced which confirms current financial position and identifies deliverable rationalisation and efficiency gains. It reviews partner organisations infrastructure and assess and highlights opportunities for joint working. It also reviews the locality and commissioning plan and identifies demand for additional community spaces. Utilising best practice and performance measures it translates this requirement

into physical infrastructure needs. Our agreed Estates implementation plan 16/17 highlights the key tasks and objectives to be undertaken this year as the organisations mobilise to deliver transformed models of care.

The estates response has been to plan to:

- provide buildings designed to promote joint working, communication and coordination
- provide sufficient community/GP capacity to integrate services using co-location of acute, community, specialist and GP services where this is deemed appropriate
- ensure buildings are utilised to maximum effect across the health economy ensuring value for money by cross organisational multi agency asset use
- develop sufficient community based capacity in each locality to support self-care, disease management
- develop buildings and facilities in each locality that match the core objectives of quality, accessibility close to home and exceeding patient expectations
- maximise the use of new technologies in all buildings
- reduce overall footprint and achieve appropriate utilisation benchmarks
- ensure suitable facilities to support the concept of neighbourhood teams in each locality

Underpinning the above are four key elements which drive our estates strategy:

- The imperative to respond to the transformation in care being proposed via developing estate flexibility to respond to evolving strategic service whilst addressing the demand gaps and capacity changes needed to ensure transformed care delivery.
- our transformed model of care based on neighbourhoods cannot function without place based additional capacity
- the seamless service delivery envisaged in our new model requires colocation and space in which to prosper
- the need to reduce our overall footprint, deliver rationalisation and savings, deliver our targeted disposal strategy and ensure performance targets of 80% in community facilities is maintained.

9.2 IT

GM Digital Transformation Bid – Bolton - Delivering an Integrated Care Record across a Connected Single Place of Care Introduction

The development of an integrated care record is a key part of our locality plan and if we are to meet the Government's objective of a digitally enabled NHS as set out in 'Safer Hospitals, Safer Wards: Achieving an Integrated Care Record (NHS England, July 2013). It is also a key strand of the GM agenda for supporting more integrated services. The implementation of an EPR and its enablers is now considered an essential component of safe and effective care and as part of the Digital Maturity Road Map.

In the recently approved Bolton Partners IM&T Strategy, a revised approach to the integrated care record delivery was set out which proposed the adoption of a preferred EPR solution and all its necessary enabling work, which is consistent with the wider GM vision and also on an obvious basis for supporting changing clinical pathways on a North West Sector footprint.

The implementation of an integrated care record is wholly dependent upon having a robust and reliable IT infrastructure. This Paper sets out the on-going financial requirements needed to support the implementation of a single place of care integrated care record, through an EPR and enabling works to improve the digital maturity of our Care System.

The world outside the NHS is changing rapidly and the NHS has acknowledged it is struggling to keep up. In the outside world access to information and services is easier, social interactions no longer require face to face environments, consumers are no longer passive and transparency is increasing. While the NHS productivity and efficiency challenge remains, there is increasing consensus that our Health Care System needs to transform in line with the outside world and GM partners to improve quality, experience, outcomes and efficiency.

Over the last year the Health Economy has made considerable progress to improve our working relationships for the benefit of our population. We have entered into a Health Economy Contract designed to incentivise the right behaviours across our system by maximising the Bolton pound and creating a one team approach to solve our growing financial challenges. The current do nothing scenario is a financial gap of £83m by 2020/21.

The six key priorities for Bolton over the next 5 years are employment, falls, long-term conditions, dementia, social care needs and social isolation. One irrefutable fact about these priorities is that they can only be addressed by a single place single team culture across Bolton. A key cornerstone of this to have a single integrated care record. The need for digital maturity is not a luxury, it is essential, but the time frame for delivery has been severely hampered by the amount of investment funding available and could leave us

years behind our wider GM partners. We are currently below the GM average of digital maturity and significant below one of our North West Sector partners.

The Bolton Care System is now entering a period of unprecedented change. Nationally, focus on efficiency, productivity and quality is increasing whilst locally, the ‘Healthier Together’ reconfiguration and the Greater Manchester Devolution Agreement echo the national aims. While the challenges are vast and the transformational change needed is bigger than any before, the Bolton Care System is dedicated to moving forward and providing high quality healthcare for its local community.

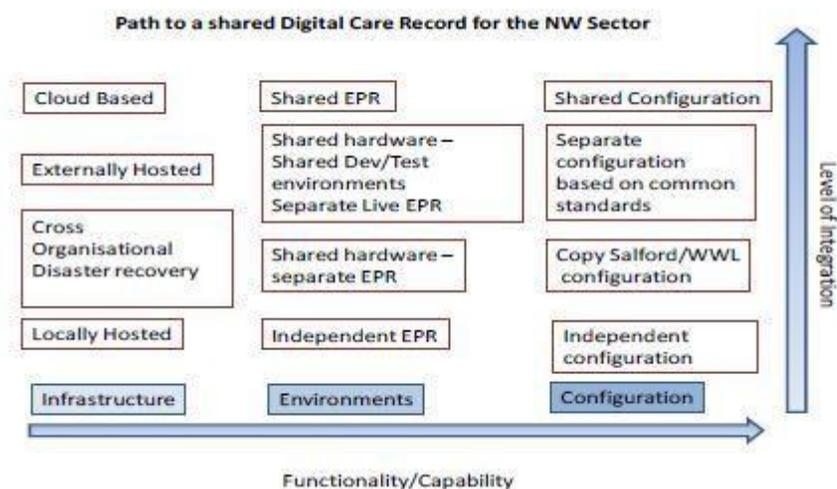
There are a number of key areas that will enable this transformation but nationally and locally it is recognised that creating a digital future through information and technology will be critical. As a result, the Bolton Partners IM&T Strategy set out the key Information management and technology focus over the next five years.

The high level aims of the Bolton Partners IM&T Strategy are:

- Integrated IM&T across the locality
- Timely and effective technology solutions
- Consistent user experience across locality regardless of base or location

It is proposed that there is a single place hosted integrated care record. This approach does not prevent a future linking of applications across the North West Sector to provide a shared digital care record. The locally hosted option still embraces the notion of shared resources through the transfer of knowledge and skills and some high level sharing of resources. Diagram 20 below highlights the opportunity to progression to a shared digital care record for the North West Sector of Manchester, based on an implementation of the our integrated care record.

Diagram 20 – Implementation Approach



The implementation of an integrated care record is fundamentally about the promotion of best practice health care through the minimisation of errors leading to improved safety, quality and efficiency to improve outcomes and the effectiveness of healthcare across the single place. The key deliverables arising from the implementation of an integrated care record are:

- A single integrated patient record with a common look and feel that supports a more seamless provision of clinical and operational information across the health economy.
- Improved data quality and reporting that enables better care planning, operational planning, clinical coding and day to day decision making.
- Better safety and quality of care through more holistic patient and clinical information and access for the right people at the right time.
- Support for new models of care delivery including integrated care by providing more accurate information, data and interoperability options.
- A rationalisation of the current suite of clinical IT systems and reduce the risks associated with multiple, disparate systems creating far greater efficiencies and freeing up Informatics time to concentrate on providing exceptional INFORMATICS and future strategic requirements.
- Replacement of aged, often slow and clunky IT systems with a modern, integrated and flexible approach that does not constrict or constrain how care should be delivered;
- The ability to customise IT solutions to best suit the needs of the constituent local organisations , staff and patients rather than being stuck with a range of off the shelf solutions that cannot be enhanced or integrated.

Once the integrated care record is established there will be opportunities for reducing the costs associated with the delivery of healthcare. Not implementing an integrated health record across a connected Bolton will put the delivery of our required £96m savings at significant risk, within the region of £30m non-delivery. If we don't improve our digital maturity it puts our locality plan and the benefits that can be delivered for patients and clinicians at significant risk of non-delivery.

With such a large degree of change possible for the Care System as a result of the implementation of an integrated care record and the enabling works it is important to fully understand the importance of robust change leadership and delivery. Technology can never be optimised and fully support clinical and operational work without the appropriate change resource and funding being identified for each and every IT project. A key part of successful change will be the relationships created between the clinical IT advocates and Informatics but additional resource will always be needed, over and above people's day jobs, to truly realise the benefits of future Informatics projects. Our locality plan clearly demonstrates we have that commitment across our Care System.

It is also vital that the delivery of the strategy is led by the required locality plan and GM plan rather than Informatics dictating what the processes need to be based on the technology or its functionality.

For the delivery of this transformation change skills will be required across areas such as; behavioural and mind set change, stakeholder engagement, creating energy for change, process creation and optimisation, benefits creation and change delivery. Bolton is not a named Vanguard with all the support that comes with it, we are a single place, with a single vision and leading by example with our Health Economy Contract. There is a need for change and as a Care System we are embracing that need and forging ahead to make our Care System both viable and sustainable.

Work has been done to establish the likely level of funding required to support this bid to help advance our digital maturity across the single place. This section set outs the level of funding required to support this bid for the enabling works (both infrastructure and Connected Bolton) and the EPR foundations of our integrated care record.

- Enabling Works for Integrated Patient Record – Initial infrastructure £1.5m
- EPR Foundations for Integrated Patient Record £1.5m
- Enabling Works for Integrated Patient Record – Connected Bolton £2.0m
- Clinical change enabling activities, training, public engagement and leadership – Bolton Integrated Patient Record - £1.2m

Regarding procurement and ability to spend this funding within 16/17, all of the preferred options of suppliers are on framework agreements which means we can get out to market relatively quickly and have contractual agreements in place very quickly. We would be able to spend all of the above within the last two quarters of 2016/17.

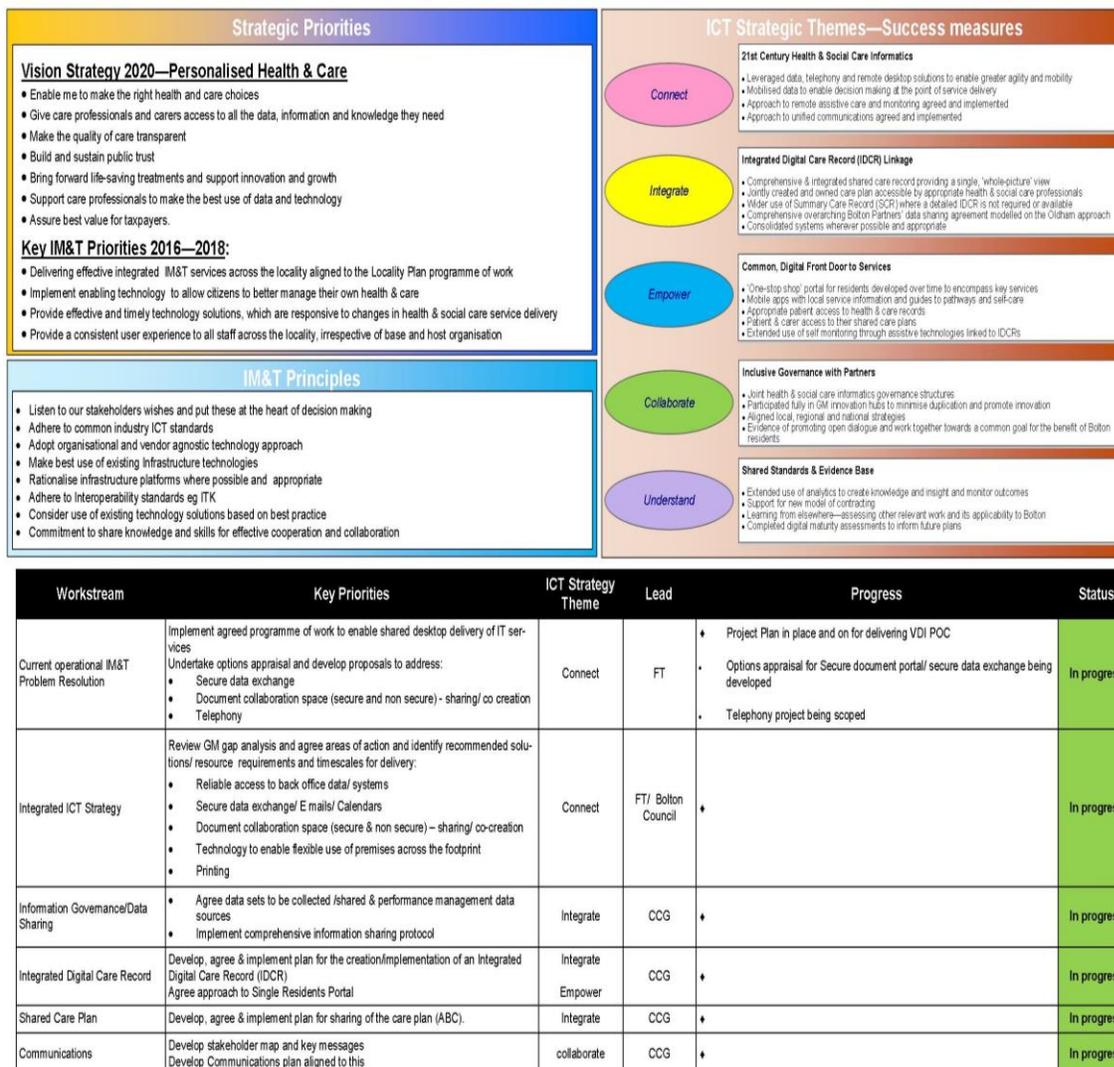
Principles for Locality Partnership IM&T Approach

Close partnership working and adherence to the principles and behaviours outlined in the Memorandum of Understanding that has been agreed by the Bolton Locality IM&T Strategy Delivery Group will ensure that:

- Total Cost of Ownership can be reduced by reusing existing systems across the whole locality
- Where organisational requirements necessitate local systems to be implemented eg telephony that these systems adhere to IM&T principle six (interoperability) which ensures that systems can be joined together to give the appearance of a single joined up system at the lowest possible costs to each organisation. An example of this being telephony. Telephony systems would therefore be connected together to provide no-cost/low cost calls
- The Integrated Care Record acts as the central shared care record across the locality and all current and future systems interoperate with it.

Bolton's high level integrated Informatics Strategy for the period 2016 to 2018 is shown in Diagram 21:

Diagram 21: Informatics Strategy



9.3 Workforce

The workforce contribution is key to delivering the service transformation, quality and financial challenges ahead. The key elements of the vision are:

- Person centred care; focus on person, not on organisation. Change the conversation to personal strengths and assets
- Staff of all disciplines working well together
- Services working in partnership
- 'Think Home First': building on strengths in the community with the 'unseen' workforce as well as existing formal organisations and structures
- Sustainable, efficient, productive workforce sufficient to meet demand
- Having a workforce that is representative of the population by 2021

Diagram 22: - Bolton's Workforce Vision



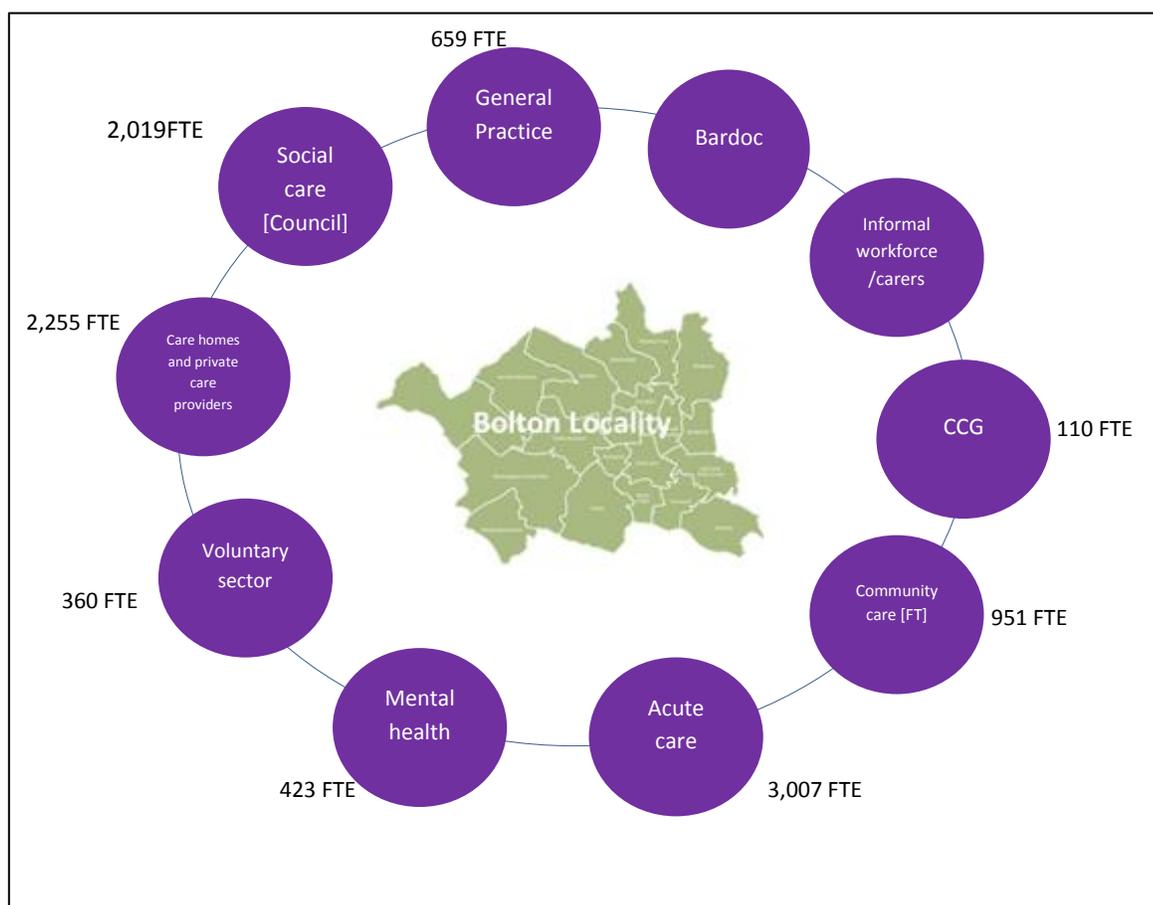
Bolton is starting from a position of strength in delivering this vision.

'Staff across all disciplines worked well together for the benefit of patients. Services worked in partnership with the local authority and voluntary organisations in the local community. ... good examples of multi-disciplinary working supporting new mums, where local businesses, charities and the Trust worked together to ensure parents had the equipment and furniture they needed.' (CQC Quality report Bolton Foundation Trust March 2016).

Bolton Workforce Overview in numbers

An initial exercise has been carried out to scope the size and location of the Health and Social Care workforce supporting the Bolton population. This has included private and voluntary sector providers and paid and volunteer staff as well as the workforce of the key public sector health and care organisations in Bolton.

Diagram 23 shows the current view of FTE (Full Time Equivalent) numbers in each of the organisations/ groupings. The table below shows the 16-17 forecast pay cost for each group.



Forecast 2016-17	FTE	Cost £m
Bolton FT	3,958	£161.1
GMW	423	£17.9
GP Practices	659	£27.4
Council	2,019	£69.6
Care homes/dom care	2,255	£39.7
Voluntary Sector	360	£24.1
CCG	110	£6.4
Total	9,785	£346.1

The Workforce Strategy Group and workstreams

Bolton has established a workforce strategy group chaired by the CCG Chief Officer. This group reports into the system sustainability and transformation board and is tasked with developing a workforce strategy that is aligned with the needs of the local population in accordance with the overarching GM workforce framework. Specific roles of the group are to:

- Consider and plan for the implications of the transformation of health and social care outlined within the overarching Strategic Plan and Locality plan and its impact on the workforce
- Produce a Bolton Strategic Workforce Plan, and accompanying workforce development plan, which clarifies the numbers and types of roles, as well as the development and training needs of the health and social care workforce
- Act as the link between Bolton and the Greater Manchester Strategic Workforce Board on sub-regional public service workforce reform programmes
- Call upon, as required, the workforce planning capacity in the Greater Manchester Strategic Workforce Board Delivery Unit to support the delivery of the local Workforce Plan
- Support delivery of the workforce requirements of the locality plans
- Lead on the development of the strategy to deliver the required changes in the workforce

The following four workstreams have been identified:

- Workforce models and new role development
- Education, Leadership and Development
- Recruiting and retaining talent
- Engagement and Communication

Each workstream will use the GM OD framework to carry out a diagnostic exercise before developing detailed action plans.

9.4 *Communication and Engagement*

The Bolton locality has started a full engagement process (led by Bolton CCG, Healthwatch and the CVS) for the population of Bolton in a conversation that will encourage them to actively respond to the challenges the health and social care system faces, whilst providing opportunities for meaningful and robust engagement. As a health economy in Bolton, reach into communities is vast. The plan is to strengthen this potential and, in collaboration ensure that activity is not duplicated, with focus on a single conversation about health and social care.

As a result, all partners are working together to deliver an engagement infrastructure across Bolton that will support all elements of the Locality Plan. This will provide opportunities for a multi-channel approach, and will build upon existing conversations with the general public about health and social care in Bolton, whilst also emphasising the role that individuals can play in their own health and wellbeing. For this plan to be successful, effective demonstration of the impact of people's contributions is critical, ensuring openness and transparency in all decision making processes, and in proposals for potential change.

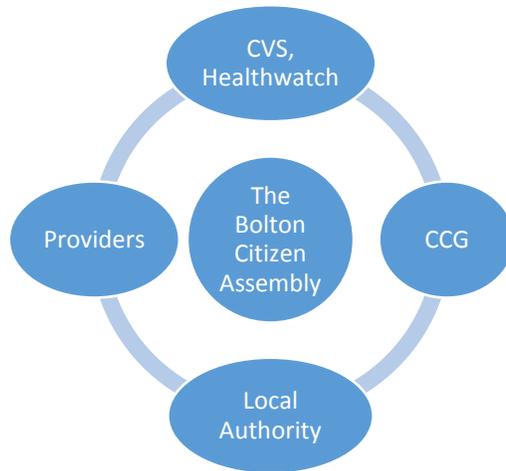
The engagement infrastructure connects existing and well established groups/forums across the town to ensure it is all encompassing, whilst finding innovative ways to reach out to the general public and seldom heard communities. The engagement approach will building on co-production principles and better understanding the diverse needs of communities, using intelligence from existing individuals, groups and networks and also those not actively engaged in the current system in order to influence change.

As part of this engagement, a comprehensive, easily navigable and publically accessible evidence base of patient opinion and experience (that will help to inform decision makers) will be developed.

A key outcome of this activity will be a more inclusive approach to developing and designing services, testing concepts and involving the wider community in decisions that impact directly on them. Using existing assets and networks to effectively harness opportunities for engagement, we will be 'taking the questions to where the people are'.

An Assembly for Bolton people will sit at the heart of the infrastructure (as set out in Diagram 24 below) linking to existing panels/forums or interest groups as well as key partners.

Diagram 24: Engagement Infrastructure



The initial priorities for delivery are

- ➔ Healthy Lifestyles and exercise (with specific groups)
- ➔ Falls
- ➔ Data and records

A collaborative, 'test and learn' programme will be adopted that aims to influence change in the way that we engage individuals across Bolton.

10.0 GM Workstreams

Key to delivery of the Bolton Locality Plan is implementation of the workstreams which are being developed at a GM level. Specifically Children's Services redesign, Cancer Services, Mental Health and Learning Disabilities.

The high level programmes, together with the benefits to be derived for the Bolton population are set out below:

10.1 Children's Services Redesign

Integrated Early Help and Health

- Systematic early intervention and prevention system focused on improving children's life outcomes: education, health, work. This is a standard core offer across GM
- Place and asset based, embedded in local 'anchor' organisations i.e. schools and primary care centres; and focused on whole family support
- Redesigned acute and community paediatric and maternity services (including CAMHS, CWD provision)

Education and Early Years

- An integrated early years model, with schools taking responsibility earlier
- Schools forming physical community 'anchors' through which early help can be delivered
- Formation of a GM education and employability board to work in partnership with the regional schools commissioner (RSC) on; pupil place planning; school improvement capacity and QA / analytics to ensure coherence and alignment to the devolved priority
- GM employability challenge to drive work readiness, workforce reform and innovation in the 'skills pipeline' through schools

Youth Offending

- Redesigned local YOS as part of the early help offer, with targeted support for CYP who are at-risk of offending or re-offending
- Dis-establishment of some aspects of local provision (appropriate adults, PACE, sex offending interventions etc.) and commissioning at a GM level through one framework
- Implementation of a GM wide specialist Court team

Looked After Children

- Agreement to one-GM Looked After Children strategy, and developing a more balanced and self-sufficient market for placements within GM
- Provision of a consistent edge of care offer across GM building on best practice approaches including potential, additional ASUs
- Increased focus on permanency for children entering the care system

Complex Safeguarding

- Development of a new, GM approach for complex safeguarding through a centralised, lead hub and operational spokes model

Quality Assurance

- Development of a bespoke QA framework for GM which takes an integrated approach to case oversight and management, and places QA as close to the point of delivery as possible
- Creation of a GM Quality Assurance role to oversee and assure the process; and use as a vehicle to facilitate sector-led improvement, intelligence-led QA and workforce development and a better understanding of population drivers, analytics and evidence-based interventions
- Development of a GM approach to multi-agency improvement planning and self-assessment

Children and Young People's Mental Health

- Mental health providers in Bolton will work across agencies to promote early identification, prevention and care and treatment of mental health problems. A particular area for development is strengthening the interface between those in transition from child and adolescent services to adult mental health services. New national guidance around the further development of specialist mental health Early Intervention services for those with first onset psychosis and those with suspected psychosis were released in 2014. Delivery of NICE guidance for EI services should improve outcomes for young people with psychosis and significantly reduce their likelihood of adult chronic conditions. This includes requirements to deliver new referral to treatment targets within 2 weeks and the need to provide access to more psychological therapies and recovery focused support. This supports reduction in self harm and suicide. Early Intervention and prevention should will also include perinatal care and early years development.

10.2 Mental Health Services

The Health and Social Care Partnership in Greater Manchester have developed a Mental Health Strategy to cover the next five years. This clearly sets out the vision for improving mental health care to narrow the gap in life expectancy and ensure parity of esteem with physical health care. It plans to deliver this with a shift of focus of care to prevention and early intervention. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector is also key to transforming the mental health and wellbeing of GM residents.

Five pillars of strategic initiatives are set out. The five pillars are:

- **Prevention** – Place based and person centered life course approach. Improving outcomes, population health and health inequalities
- **Access** – Responsive and clear access arrangements connecting people to the support they need at the right time

- **Integration** – Parity of mental health and physical illness through collaborative cross sector working – public and voluntary sector
- **Sustainability** – ensuring effective use of GM funding by improving clinical and financial sustainability by reviewing contracts and incentives, integration, improving IT and investing in new workforce roles
- **Golden Threads** – cross cutting themes including improving parity of esteem, using research effectively, preparing an adaptable workforce, using technology and targeting existing programmes (e.g. Troubled Families and Working Well to ensure access to the right mental health treatment)

As highlighted earlier in this Locality Plan, much work is already ongoing in Bolton that drives forward the implementation of the GM Mental Health Strategy and Wellbeing Strategy for Bolton residents across the life course – Starting Well, Living Well and Ageing Well.

10.3 Learning Disability Services

The Greater Manchester Strategic Plan had identified learning disability/autism as a cross cutting theme, where there is real opportunity for collaboration and integration across health and social care to make significant progress at scale and pace. Work is currently taking place at a GM level to align programmes across all ten Local Authorities and bringing together the work of both the GM fast stream and GM Adult Social Care (ADASS) LD groups.

The key drivers for an integrated approach are the need to:

- Ensure a robust understanding of the population within GM, levels of need and services in order to shape new integrated models of assessment and care
- Reduce the level of inpatients (GM has the second highest nationally) in secure and out of area settings
- Improve quality of life, life expectancy and diagnosis of health conditions for those with LD and autism.
- Improve the quality, flexibility and sustainability/resilience of provision and identifying gaps in provision
- Support carers and those living at home with their families
- Manage the cost of LD services, particularly for the most complex 3% of the population, ensuring consistency of the costs, and the funding available through CHC, dowries and social care.

The combined work programme across GM will:

- Set up a GM wide intelligence data unit which identifies need and projected needs
- Develop a GM strategy based on intelligence
- Integrate health and social care commissioning functions to reduce the price of 'high cost' placements and support a dynamic purchasing system.
- Work in partnership with housing and the VCS in order to manage/develop the market.

- Identify ways to provide early intervention and prevention, and for screening and prevention services so individuals can stay healthy
- Ensure personalisation and personal budgets are integral to all provision
- Develop best practice across Community Learning Disability Teams
- Develop GM wide housing with care options and pathways
- Ensure co-production when designing new services

Bolton Specific Focus

The focus for Bolton will be to ensure: that people with learning disabilities, their families and allies in Bolton are: supported as individuals; are able to use the same services as everyone else; will have choice and control over their lives; feel safe; and be part of their community, including accessing training and employment opportunities. This involves the co-ordination and integration of community services to support the delivery of effective, efficient high quality accessible services across the different life stages.

Change will be effected through:

- Development of an 'All Age' care pathway which supports transition (Starting Well)
- A redesign of the Community Learning Disability Team offer for adults to promote healthy lifestyles and quality of life (Living Well)
- Development of a Housing with Care pathway to meet the accommodation needs and aspirations of those with Learning Disability/Autism, creating local housing options which provide a high quality LD/autism friendly environment. (Living Well)
- Supporting health needs of individuals and their carers as people get older, through effective health screening e.g. for dementia (Ageing Well)

10.4 Cancer Services

NHS Bolton CCG and Bolton NHS FT are engaged in the Greater Manchester Cancer Vanguard programme, which aims to radically transform cancer services in Greater Manchester and parts of Cheshire.

This partnership consists of The Christie NHS Foundation Trust, NHS Trafford Clinical Commissioning Group (CCG), which acts on behalf of all Greater Manchester CCGs in planning services, and Manchester Cancer, a network of cancer specialists. The aim of the Vanguard is to test and fast-track innovations in cancer care, addressing many of the recommendations within *Achieving world-class cancer outcomes*, the report of the Independent Cancer Taskforce.

The Cancer Vanguard is a two-year programme which will initially focus on rapidly testing out new ideas in its priority areas over the next year (2016/17). These will then be evaluated to reshape its focus in the second year (2017/18). The projects have been established to align with a number of workstreams, including:

- Cancer prevention, screening and early detection
- Cancer education

- New diagnostic models
- Developing standards of care
- Living with and beyond cancer and supportive care
- Radiology and cellular pathology
- Streamlining the cancer commissioning process

As such, the Bolton health economy will be seeking to input into these projects from both a commissioning and provider perspective, with a view to learning from and implementing new delivery models following the 2017/18 evaluations.

With the full support of the GM Cancer Vanguard, Bolton is piloting a “faster diagnosis” programme. This aims to speed up time to diagnosis for three cancer pathways – upper GI, lower GI and lung – to provide patients with a confirmed diagnosis or exclusion of cancer within 28 days of referral from a GP. The Faster Diagnosis pilot is expected to enhance patient experience, further strengthen partnership approaches to delivering cancer diagnostics across primary and secondary care and improve outcomes by capturing and treating more patients at cancer stages 1 and 2.

10.5 Population Health Outcomes

Impacts on Premature Preventable Death

Across Greater Manchester the key diseases that relate to preventable premature death have remained largely unchanged for the past 20 years or so. For example locally there has been an increase in deaths from alcohol related/fatty liver leading to cancer whilst breast cancer survival rates have improved. Increased public awareness, early diagnosis and increasingly effective therapeutic drug regimens have all contributed to improved survival rates. Nevertheless, primary prevention remains the most cost effective method of avoiding the likelihood of preventing premature deaths that are amenable to intervention. The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense. The main diseases that are amenable to prevention but which continue to impact negatively on life expectancy, healthy life expectancy and health inequalities are:

- Cardiovascular disease i.e. CVD (including heart disease and stroke)
- Cancer
- Respiratory illness (e.g. Chronic Obstructive Pulmonary Disease)

The above diseases have been highlighted across Greater Manchester because of their cumulative impacts on health and social care services and because co-ordinated public health action can continue to positively influence outcomes. Primary prevention (stopping people starting smoking) coupled with secondary prevention (supporting people to stop smoking) will reduce the incidence of all of the main causes of preventable premature death. Likewise there is a large body of evidence that a balanced diet, healthy

weight, responsible drinking and moderate physical activity can not only prevent these diseases but ameliorate associated long term morbidity.

10.5.1 Bolton population health outcomes

CVD is the chief cause of Bolton's internal life expectancy gap and also when compared to the England average. Whilst preventable CVD mortality has reduced locally year on year, the pace has declined in recent years, which is in line with the national picture. Bolton's performance for preventable mortality from CVD at <75 years remains significantly higher than England's and the North West region, but the existing rate (below) is typical of a Greater Manchester Authority.

Cancer deaths that are preventable peaked towards the end of the last decade. However, in general, Bolton does not stand out in this respect as Bolton currently has a lower preventable cancer mortality rate (<75 years) than both the North West and Greater Manchester.

Preventable respiratory mortality (<75years) has reduced in Bolton since 2001 but this indicator is currently demonstrating a period of stasis similar to the national picture. Respiratory disease locally is also a major contributor to the significant inequality gap between Bolton and England and this has persisted over the past decade. Again, Bolton performance for preventable mortality from respiratory disease at <75 years is similar to the Greater Manchester average but it is notably higher than the England average. To a lesser extent Bolton's performance is poorer than that of the North West region.

Impacts on Longer Term Morbidity, Mobility and Independence

Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care.

Injuries due to falls has been adopted by Greater Manchester as an important target area given the negative effects falls can have on individuals, families and support services. Slowing down the current upward trend in falls locally and bringing it back into line with Greater Manchester averages is one of the main objectives of Bolton's Locality Plan.

10.5.2 Impacts on Wider Determinants of Health and Inequality

School readiness

Greater Manchester has agreed to also have a focus on the wider determinants of health and inequality. To this end School Readiness has been adopted as an overarching indicator of children's future life chances. The indicator compares children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children and is a key measure of early years development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life. This is currently the case in Greater Manchester as a whole and Bolton. Therefore the ambition is to reduce the gap, year on year, between those children who are deemed school ready and those who are not.

Children in poverty

The percentage of children living in poverty again is an indicator of inequality and the wider determinants of health. The indicator is defined as the percentage of dependent children aged <20 years living in relative poverty (i.e. living in households where income is less than 60 per cent of median household income before housing costs). The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. In terms of performance, the level of poverty in Bolton is higher than England, the North West, and Greater Manchester with 21.9% of Bolton's children currently living in poverty. The proportion has reduced slowly but consistently for several years but the latest data release shows a minor increase and therefore it is too early to determine whether this trend will persist.

Appendix A – Level of Ambition for Improvement in Key Outcome Measures

	Indicator	Current performance	2021 ambition	Quantifiable benefit	How
Starting well	Smoking in pregnancy	15.1%	8.8%	237 fewer Bolton women smoking in pregnancy	Smoking cessation service provides specialist support to pregnant women
	Breastfeeding 6-8 weeks	39.9%	44.5%	175 more Bolton women breastfeeding at 6-8 weeks	Breastfeeding support provided through the Infant Feeding Support Service. Baby friendly status achieved
	Low birth weight	3.4%	2.8%	19 fewer low birthweight births	Smoking cessation and breastfeeding support as above Targeted support for teenage parents through Family Nurse Partnership Food and Health service. Service provides advice on food and nutrition, including a focus on support in early years Young people's sex education and contraceptive services commission by Bolton Council as part of 5-19 service provided by Bridgewater includes support to schools in respect of policies, curriculum and training, school and adolescent health nurse drop ins, provision of easily accessible contraceptive services etc. Young parent support via high performing FNP
	Tooth decay in children aged 5	40.5%	35.7%	182 fewer children with tooth decay	Some of the programmes delivered include: the Brush Bus (supervised brushing , Brushing for life

					<p>Baby clinics – staff from the oral health improvement team attend to give advice</p> <p>Swap it programme – sessions at Children 's Centre to swap bottles and dummies for tooth brushing packs</p> <p>Dental voucher scheme – vouchers for vulnerable children to access a dentist</p> <p>BHEYS award – Bolton healthy early years scheme, an award scheme for nurseries to support an improvement in children's health behaviours</p> <p>Oral health messages are also reinforced and delivered by the Children and Young People's 5-19 Health and Wellbeing Service</p>
	Excess weight: Reception age	19.4%	18.0%	53 fewer Reception age children of excess weight in Bolton	<p>Healthy vending in place at Bolton Hospital and in development with Bolton Community Leisure Trust</p> <p>Bolton Hospital display nutritional information and healthy choices</p>
	Excess weight: Year 6	33.6%	34.7%	37 more children of excess weight at Year 6 in Bolton [this is 86 fewer than trajectory]	<p>Workplace health group in place at Bolton Hospital</p> <p>Weight management support for children and their families is commissioned by Bolton Council and provided by Bridgewater as part of the 5-19 service</p> <p>Children identified as overweight or obese via the National Child Measurement Programme are provided</p>

					with information about local programmes and invited to access this support
	Children admissions for self-harm	541.5 (per 100,000)	460.1 (per 100,000)	43 fewer child admissions	<p>Support for schools is commissioned by Bolton Council and provided by Bridgewater as part of the 5-19 service</p> <p>Behaviour change programmes, early intervention, staff training, suicide awareness and prevention, links to Tier 2&3 services and clearer pathways are included in the service specification and are key areas for development</p> <p>Work with the voluntary sector to develop support for young people at risk of self harm and suicide has been undertaken as part of the Building Health Partnerships programme</p> <p>Specialist support is provided through CAMHS</p>
Living well	Active adults	3.0% gap	>3.0%	N/A	<p>Get Active programmes</p> <p>Support available through Health Practitioners/Community Asset Navigators</p> <p>Structured exercise programmes for cardiac rehabilitation, cancer and specialist weight management</p>
	Alcohol admissions	693.0 (per 100,000)	656.1 (per 100,000)	98 more admissions [this is 164 fewer than trajectory]	<p>Alcohol screening and brief interventions provided in primary care</p> <p>Referral pathways in place to specialist services, commissioned by Bolton Council and provided by Arch and Lifeline</p> <p>Environmental services undertake test</p>

					purchasing
	Self-reported wellbeing: people with a low satisfaction score	1.3% gap	<1.3%	N/A	<p>Support for schools and families is commissioned by Bolton Council and provided by Bridgewater as part of the 5-19 service</p> <p>Some programme delivery eg 5 ways to wellbeing to be systematically delivered</p> <p>LA anti-bullying strategy developed</p> <p>SEAL programme in schools (social and emotional aspects of learning)</p> <p>Support for parents is available through Health Visiting and Family Nurse Partnership services, commissioned by Bolton Council and provided by Bolton FT</p> <p>Provision of training to promote wellbeing, mindfulness and emotional resilience available to front line services and voluntary and community groups</p>
	Preventable mortality <75 years: CVD*	65.1 (per 100,000)	34.2 (per 100,000)	209 fewer preventable deaths	<p>NHS Health Checks delivered with high invitations and uptake rates</p> <p>Investment in Health Improvement Practitioners and Community Asset Navigators to provide lifestyle support in primary care</p> <p>Structured exercise referral available for cardiac rehab</p> <p>Social prescribing and further development of asset based approaches.</p>
	Preventable	91.2 (per	77.8 (per	91 fewer	National screening

	mortality <75 years: cancer*	100,000)	100,000)	preventable deaths	<p>programmes delivered, targets to be met for all programmes</p> <p>NHS Health Checks delivered with high invitations and uptake rates</p> <p>Investment in Health Improvement Practitioners to provide lifestyle support in primary care</p> <p>Structured exercise referral available for breast cancer</p> <p>Plans for social prescribing and further development of asset based approaches.</p>
	Preventable mortality <75 years: respiratory*	26.6 (per 100,000)	16.9 (per 100,000)	65 fewer preventable deaths	<p>Smoking cessation, commissioned by Bolton Council and provided by Bolton FT and pharmacies</p> <p>NHS Health Checks delivered with high invitations and uptake rates</p> <p>Investment in Health Improvement Practitioners and Community Asset Navigators to provide lifestyle support in primary care</p>
	Preventable mortality <75 years: liver	21.2 (per 100,000)	19.5 (per 100,000)	12 fewer preventable deaths	<p>NHS Health Checks delivered with high invitations and uptake rates</p> <p>Investment in Health Improvement Practitioners to provide lifestyle support in primary care</p> <p>Hepatitis B & C screening included in relevant contracts</p>

					<p>Primary care liver disease pathway in place</p> <p>Liver disease action plan in place</p>
Ageing well	Injuries due to falls*	1975.0 (per 100,000)	2213.5 (per 100,000)	107 more admissions [this is 205 fewer than trajectory]	<p>Falls screening and falls management plans are completed for at risk patients admitted to hospital</p> <p>Falls service in place providing support in the community including multi-disciplinary falls clinics</p> <p>Development of a comprehensive falls prevention strategy</p> <p>Proactive inspections of all supported living environments for older people (sheltered, extra care, residential, nursing) to identify falls risks understand current position and develop improvement plans (asset based model)</p> <p>Home Safety Check – Care and Repair caseworkers delivering a property check alongside falls questionnaire to assess risk of falls and need for home improvements / adaptations</p> <p>Exercise, strength and balance programmes</p> <p>Information and participation in falls prevention programmes and falls prevention is a key priority in everyday business. Investment in Exercise Programmes etc as part of social prescribing</p>
	Dementia:	2187	3253	1,066 more	Dementia risk

	recorded prevalence	dementia diagnoses recorded	dementia diagnoses recorded	people with dementia diagnosed in Bolton	<p>assessment included in NHS Health Check</p> <p>Investment in Health Improvement Practitioners/Community Asset Navigators to provide lifestyle support in primary care</p> <p>Dementia friendly communities pilot in place with plans to roll out to other areas of the Borough</p> <p>Programme of dementia friendly training currently being rolled out</p> <p>Bolton Dementia Partnership Board and its diverse membership ensures a joined up approach in delivering care and support for people living with dementia and their carers</p> <p>Development of Bolton Dementia Action Alliance will bring local organisations, groups, and businesses together to improve the lives of people living with Dementia</p> <p>Training in Dementia Care at Bolton FT/Bolton Council is ongoing and adaptable with various accessible sessions embedded in Trust/Council training programmes</p> <p>Bolton FT Dementia Steering Group debates and escalates these areas to ensure further integration and improvement</p> <p>Investment in the Memory Assessment Service to</p>
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					increase capacity and reduce waiting times
	Permanent admissions to residential and nursing homes (65+)	832.0 (per 100,000)	645.5 (per 100,000)	85 fewer permanent admissions	<p>Strategies and services which focus on:</p> <p>early intervention to avoid the risk of an admission secondary interventions in place to avoid unnecessary admissions, for example during a crisis</p> <p>Staying well aims to help people to live well in the community for as long as possible.</p> <p>Support for carers</p> <p>Early diagnosis and support to people with dementia</p> <p>Treatment for older people with incontinence</p>
	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	908.1 (per 100,000)	782.7 (per 100,000)	342 fewer admissions	Effective management of long-term (LTCs) or chronic conditions (such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure) in the community
	Social isolation: social care users who have as much social contact as they would like	3.5% percentage gap	<3.5%	>1,930	Range of voluntary and community sector support available, including targeted support/activities e.g. men only groups
All ages	Healthy life expectancy: Male	61.5 years	65.0 years	N/A	<p>Action on health inequalities requires action across all the social determinants of health</p> <p>To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.</p>
	Healthy life expectancy: Female	61.8 years	66.7 years		
	Internal life expectancy gap: Male	11.3 years	10.3 years		
	Internal life expectancy	10.9 years	8.8 years		

	gap: Female				<p>Reducing health inequalities will require action on six policy objectives:</p> <ol style="list-style-type: none"> 1. Give every child the best start in life 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives 3. Create fair employment and good work for all 4. Ensure healthy standard of living for all 5. Create and develop healthy and sustainable places and communities 6. Strengthen the role and impact of ill-health prevention
	Emergency admissions: all conditions	10441.0 (per 100,000)	9319.6 (per 100,000)	3,107 fewer admissions	<p>Education and support for self-management for those with long term conditions, in particular COPD, asthma and heart failure</p> <p>Rehabilitation for those who have recently suffered an exacerbation of COPD, exercise based rehabilitation for coronary heart disease</p> <p>Early review by a senior clinicians in emergency departments</p> <p>Structured discharge planning</p> <p>Patient experience of GPs at practice level including being able to speak to the surgery by phone easily, and being able to see their preferred GP</p>
Wider determinants					
Housing	Quality housing	12.0% homes with category 1 hazards	<12%	N/A	<p>Mapping of private rented stock in the area</p> <p>Clear policies and processes for dealing with and triaging complaints</p>

					<p>from residents and tenants</p> <p>Identify and tackle bad landlord and letting agent practice</p> <p>Raise awareness and encourage tenants to raise complaints and concerns about their landlords, letting agents or neighbouring tenants</p> <p>Use local authority powers to tackle criminal landlord behaviour</p> <p>Educate landlords and agents about their obligations</p>
	Prevention of homelessness	8.4 (per 1,000 households)	10.5 (per 1,000 households)	An additional 252 households would be prevented from becoming homeless above 2016 numbers	<p>Welfare Rights and consumer advice (includes housing advice): Advice within primary care settings such as GP surgeries; Targeted welfare advice for patients leaving secondary care; Holistic advice services (including debt, mental health) to young people in a non-health setting (eg youth advice services)</p> <p>Holistic in-tenancy support: Support and services available to people living in their own home/tenancy to help them live independently and successfully maintain accommodation. Usually targeted at those who are at risk of losing their homes</p> <p>Targeted support and advocacy to people leaving institutions: Targeted support to plan and respond to known 'transition' points from institutions. Could include housing and income</p>

				<p>support for psychiatric patients pre discharge; residential programme for young people leaving care</p> <p>Critical time intervention (CTI) targeted at groups in the community: CTI is targeted at groups in the community who have already experienced homelessness and their characteristics and circumstances mean that once they are back living in their own accommodation are more likely to become homeless again</p> <p><u>Stronger Leadership & joint Strategic Working</u></p> <p>Clear priorities in HWB Strategy & clear data in JSNA re: homelessness prevention</p> <p>Clear & co-ordinated guidance to all agencies to ensure 'every contact counts'</p> <p>Embed 'prevention first' approach to identify intervention opportunities within at risk communities</p> <p><u>Access to Advice & Early Intervention</u></p> <p>Primary homelessness prevention into primary and secondary care settings</p> <p>Improve engagement with schools/education settings & early years services to improve identification of children/young people at risk</p> <p>Support frontline health professionals to identify</p>
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					<p>appropriate local resources/services to refer people at risk of homelessness</p> <p><u>Improve Data Collection & Evaluation</u></p> <p>Improve data recording and sharing to enable services to better target interventions at those at risk</p>
	Fuel poverty	0.6% gap	<0.6%	<13,111 households in fuel poverty	<p>Warm Homes Healthy People group, a sub group of the health and housing group, has been established to offer a strategic steer for all fuel poverty/energy efficiency work across the borough (using NICE quality standard)</p> <p>Single point of access for all fuel poverty/energy efficiency related queries established</p> <p>Behaviour change task and finish group ensures that a consistent message relating to advice, education, switching, promotion, etc. is available to all Bolton residents regardless of tenure</p> <p>Private tenure housing adaptations are available through Bolton care and repair</p> <p>Social landlord activity collected via Bolton Community Homes</p> <p>Data task group uses latest evidence and research to inform Warm Home Healthy People and behaviour change groups</p> <p>Green Loans scheme</p>

					available through local credit union Currently developing a Bolton wise brand for all energy related activity and materials
Economy	School readiness: children achieving a good level of development at end of Reception*	5.2% gap	<5.2%	>2,397 children achieving a good level of development at end of Reception	Early Years Delivery Model implemented in one area, with aspects of the model rolled out borough wide Good maternal mental health Learning activities, including speaking to your baby and reading with your child Enhancing physical activity Parenting support programmes High-quality early education
	Children in poverty*	21.9%	16.4%	3,745 fewer children living in poverty	Support job creation Supporting families in work through work schemes such as help to work/work programme etc. and supporting families through Troubled Families programme Making work pay – increasing childcare subsidy & providing free school meal Tackling low pay by paying living wage Improving qualifications to ensure opportunities for better jobs Free school meals are available for all KS1 (infants) children. School meals subsidised in KS2 across Bolton's primary schools

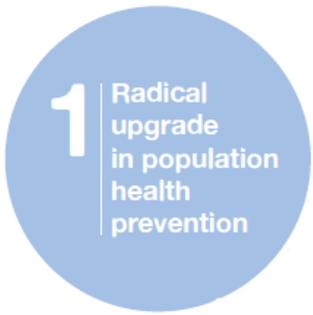
					<p>Plans being developed for free breakfast clubs Urban Outreach provide packed lunches for pupils eligible for free school meals during the long summer holidays</p> <p>Targeted support available through targeted families, complex dependencies and complex lifestyles programmes. To be further developed as part of GM place-based work and multi-agency hub</p> <p>Locality plan linked to economic strategy</p>
	GCSE attainment	1.4% gap	<1.4%	>1,790 pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent	<p>Rigorous monitoring and use of data</p> <p>Raising pupil aspirations using engagement/ aspiration programmes</p> <p>Engaging parents (particularly hard-to-reach parents) and raising parental aspirations</p> <p>Developing social and emotional competencies</p> <p>Supporting school transitions providing strong and visionary leadership</p>
	Employment rate of people with long term health conditions	48.8%	61.7%	7,851 more people with long-term conditions in employment	<p>For those unemployed looking to get back into employment:</p> <p>integrated programme to help claimants enter or return to work including a combination of interventions such as: return to work interview with adviser; a condition management component to help manage health condition; vocational training, financial measures as motivation,</p>

					<p>support before and after return to work such as mentoring or OH support</p> <p>For those with a poor prognosis of returning to work:</p> <p>an intensive programme of interventions such as: CBT/education and training on physical and mental coping strategies for work and everyday activities (this may be combined with exercise programmes); counselling about a return to work; workplace modifications; referral to physiotherapy services or vocational rehabilitation (including training)</p>
	Employment rate	3.9% gap	<3.9%	>135,200 people in employment	<p>Workplace interventions to improve health and wellbeing</p> <p>Working with local employers to encourage, incentivise and enforce good quality work</p> <p>Interventions to increase employment opportunities and retention for those with a long-term illness or disability</p> <p>interventions to increase employment opportunities and retention for older people</p>
	Average wage	£63 gap	<£63	N/A	<p>Local economic strategies can adopt various approaches to poverty reduction to achieve wider economic and fiscal benefits, including developing effective relationships with local businesses and employers, through:</p> <p>attracting more higher-paid jobs in</p>

					<p>relevant sectors/occupations;</p> <p>improving pay rates by encouraging employers to adopt the Living Wage; improving affordable childcare/other care so people can increase their working hours;</p> <p>ensuring sufficient part-time jobs for those who want/need them;</p> <p>employment/training programmes to increase the local workforce's employability; delivering a training system for people to achieve qualifications needed by employers;</p> <p>promoting progression in work by encouraging employers to train people, to invest in their skills;</p> <p>a housing strategy ensuring sufficient affordable housing;</p> <p>a strategy for affordable, convenient public transport so residents can access employment without losing their gains from working;</p> <p>a procurement strategy which maximises impact locally and is geared towards reducing poverty;</p> <p>focused actions for people in entrenched poverty; a local support services framework for the welfare system which helps people to escape poverty and insecure employment.</p>
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Note: The agreed Greater Manchester outcome measures are denoted with (*). Ambitions for these measures will need to be updated once GM levels of ambition for each locality have been agreed.

Appendix B - Bolton Locality Plan – Milestone Plan 2016-18

Early Intervention and Targeted Prevention	
GM Theme	Bolton Strategic Theme
	<ul style="list-style-type: none"> • Early Years Model • Living Well: Wellbeing, Prevention and Health Improvement Partnership • Ageing Well: Staying Well and Falls Prevention

Strategic Scheme	Programme	Responsible Group	Milestone	Q3	Q4	Q1	Q2	2017> 2018
Early Years Model	Early Years Delivery Model	Children's and Maternity Strategy and Planning Group	Full implementation and evaluation of full EYDM in Oxford Grove					
			Jointly commission early year provision					
			Roll of EYDM model borough wide					
Living Well: Emotional and Physical Wellbeing	Social Prescribing	Social Inclusion	Implement and note the social prescribing pilot model for Bolton					
			Define framework and VCS offer					
			Form a network of community and VCS providers and develop robust referral and access systems					
			Establish workforce to deliver social prescribing model for Bolton					
			Connect VCS to framework offer					
			Bolton's public					

			sector organisations to promote health and well-being through their policies and actions					
			Roll out of social prescribing borough wide					
	Community Asset Development	Social Inclusion	Analysis of VCS development and training needs					
			Implement workforce development and training programme					
			Undertake 'State of the VCS Bolton' survey					
Community Asset Mapping	Social Inclusion	Map all community and provider services						
Aging Well	Falls Prevention	Integrated Community Services Strategy and Planning Group	Embed falls risk assessment into hospital discharge planning					
			Produce falls prevention health needs assessment and action plan					
			Build falls prevention into existing workforce structures and service delivery					

System Re-design	
GM Theme	Bolton Strategic Theme
 	<ul style="list-style-type: none"> • Primary Care • Urgent Care • Acute Reconfiguration and shift of activity into the community • Mental Health: Early Intervention IAPT and Dementia Care • Care Homes and Home Care • Adult social care (Technology Enabled Care)

Strategic Scheme	Programme	Responsible Group	Milestone	Q3	Q4	Q1	Q2	2017> 2018
Primary Care	Health Promotion and Early Intervention	Primary Care System Reform	Organise practices into neighbourhoods to develop a modernised workforce. Delivery of the Bolton Quality Contract					
			Supporting services such as INTs and District Nurses to further integrate within clusters					
			Build outreach support from hospital based specialists and agree a implement model of provision					
			Workforce Redesign					
Urgent Care	Efficient and effective discharge of patients	Urgent and Emergency Care Board	Expansion of intermediate tier services					
			Implementation of a fully integrated discharge team					
			Implement discharge to assess model					
			Improve					

			ambulance response times through implementation of a robust 'hear and treat' and 'see and treat' model					
	Streaming at the front door of ED	Urgent and Emergency Care Board	Expansion of ED					
			Senior decision maker at the front door of ED					
			Co-location of GP OOH to ED					
			Further establish ambulatory care for medical and surgical patients					
Major Fracture Prevention	Urgent and Emergency Care Board	Implement a Fracture Liaison Service						
Acute reconfiguration and shift of activity into the community	Standardisation of care	Integrated Community Services Strategy and Planning Group	Review of primary, community and acute care benchmarking data to understand variation					
			Standardisation of the primary and community care offer					
	North West Sector	Planned Care Strategy and Planning Group	Review of 25 acute services with option appraisal and recommendations for the sector					
			Development of Heathier Together Business Case with plans to more high risk elective activity by April 2017					
			Agrees option for priority services plans to progress required change					
	Paediatrics	Children's and Maternity Strategy and Planning Group	Completion of full sector review of paediatric services with clear recommendations					
Mental Health: early intervention and on and	Prevention and Early Intervention	Mental Health Strategy and Planning	Development and Implementation of the suicide prevention strategy					

		Group	Embed mental health support within services such as the Public Service Hub, Nursing and care homes and within GP practices						
			Delivery of the working well IAPT						
	Bolton Learning Disability and Autism Programme	Bolton Learning and Disability Strategy and Planning Group	Section 75 pooled budget implementation						
			Redesign the community learning disability offer						
			Devise an 'all age' care pathway						
	Dementia Care	Mental Health Strategy and Planning Group	Pilot a dementia friendly community within Horwich						
			Develop a network of dementia friendly businesses and organisations						
			Establish Bolton as an active Dementia Action Alliance						
			Further strengthen the Bolton memory assessment service						
			Development of integrated care and specialist support to local intermediate care, nursing and residential care providers						
Care Homes and Home Care			Co-design a new fee model to support more complex patients and align to reduction in NHS						

	Strategy Development and Implementation	Care Homes Quality Market Provision	activity and improvement in quality					
			Co-design a robust offer of training support to care home staff					
			Design and implement improved pathways in and out of the acute setting					
			Implement enhanced care home service including increased pharmacy					
			Co-design new primary/acute care service for care homes					
			Scope out new care home roles and test feasibility and affordability					
			Develop and implement harm free care package of support					
			Bring on line equipment and environment capital fund					
Adult Social Care	Adult Social Care (Technology enabled care)	Housing and Health Steering Group	Invest in housing that is fit for purpose for those with complex needs and assist people to live independently at home through Bolton Care and Repair					
		Tele-health	Implement telehealth unit into homes home patients with LTCs to enhance the work of the INTs.					

Enabling Better Care – System Enablers	
GM Theme	Bolton Strategic Theme
	<ul style="list-style-type: none"> • Estates reconfiguration/rationalisation • Workforce redesign • IT • Engagement and Communication • Development of the New Care Model (including integrated commissioning)
<p style="font-size: 2em; font-weight: bold; margin: 0;">5</p> <p style="font-weight: bold; margin: 0;">Enabling better public services</p> <p style="font-size: 0.8em; margin: 0;">The creation of innovative organisation forms, new ways of commissioning, contracting and payment design and standardised information management and technology to incentivise ways of working across GM, so that our ambitious aims can be realised.</p>	

Strategic Scheme	Programme	Responsible Group	Milestone	Q3	Q4	Q1	Q2	2017> 2018
Estates reconfiguration/rationalisation	Darley Court	Strategic Estates Group	Refurbishment					
	Rationalisation – Lever Chambers	Strategic Estates Group	Dilapidations					
			Decanting					
	Bolton One	Strategic Estates Group	Reimbursement					
	Halliwell Children’s Centre	Strategic Estates Group	Audiology Booth					
	Rationalisation – Hulton Lane	Strategic Estates Group	Investment in Castle Hill to enable staff to move out of Hulton Lane					

	Mobile Estate and Technology	Strategic Estates Group							
Workforce redesign	Integrated Team	Strategic Workforce Group	Development of an overall workforce strategy and policy						
			Development and agreement of locality terms and conditions of employment						
			Delivery of the Race Equality Scheme						
	Workforce Transformation and OD	Strategic Workforce Group	Development of a staff engagement strategy to ensure staff are able to contribute to and co-design, the new workforce structure/roles in the future						
			Identification of the implications for education commissioning encompassing both health and social care staff in its new state.						
Bolton Integrated Facilities Management Service (BIFMS)	Strategic Workforce Group								
IT	Delivering effective integrated IM&T services across the locality aligned to the locality plan programme of work	Informatics Strategic Delivery Group	Implement agreed programme of work to enable shared desktop delivery of IT services including secure data exchange, document collaboration space and telephony						

			Agree data sets to be shared and implement comprehensive protocol					
	Implement enabling technology to allow citizens to better manage their own health	Informatics Strategic Delivery Group	Develop, agree and implement plan for the creation/implement of an Integrated Digital Care Record					
			Develop a communication plan with key messages					
	Provide effective and time technology solutions, which are responsive to changes in health and social care delivery	Informatics Strategic Delivery Group	GM collaborative imaging procurement					
			Develop, agree and implement plan for sharing of the care plan					
	Provide a consistent user experience to all staff across the locality, irrespective of base and organisation	Informatics Strategic Delivery Group	Review GM gap analysis and agree areas for action and identify recommended solutions and timescales for delivery					
			Develop a stakeholder map with key messages					
	Engagement and Communication	Full engagement process for the population of Bolton	Health Partnership Executive	Develop a comprehensive, easily navigable and publically accessible evidence base of patients opinion and experience				

			Establish an Assembly for Bolton people linking to existing panels/forums or interest groups as well as key partners					
			Adoption of the collaborative 'test and learn' programme.					
			Wider stakeholder and public engagement to evaluation turns to actions					
Development of New Care Models	Implementation of the infrastructure for delivery	Health and Well-being Executive	Establishment of a PMO to support					
			Workforce Redesign					
			Development of GP Federation					
			Legals, consultancy and due diligence					
			Evaluation and replicability					
	Delivery of the Local Care Model	Health and Well-being Executive	Delivery of the Local Care Model as described on page 40. Complete steps 3 and 4					

			Delivery of the Local Care Model as described on page 40. Complete steps 5 to 7					
			Delivery of the Local Care Model as described on page 40. Complete steps 8 to 10					

Appendix C

Programme Risk log

Risk ID	Title	Risk Description	Existing controls	Owner	Impact	Likelihood	Current risk score	Current risk score	Impact on risks of Transformation Fund Interventions	Impact	Revised Likelihood	Revised risk score	Residual risk score
1	Financial Sustainability	Failure of the whole system to deliver a financially balanced system by 2021	New contract agreed between BFT and BCCG which incentivises cost and activity reduction and new models of delivery. Joint approach to financial risk management. New system board established to drive forward the locality plan aims of clinical and financial sustainability with both DOFs attending. Work to apply for the T-Fund is underway and partners working jointly in open book manner. Locality plan implementation is being driven by the new system board and under pinning groups which include finance and informatics	AW	4	3	12	12	Transformational Funding will enable investment in the areas identified has having the greatest financial benefit by 2021 through the Cost Benefit Analysis	4	2	8	8
2	Clinical Sustainability	Failure to maintain service delivery appropriate to the needs of the people of Bolton over the period 2016 to 2021	System Sustainability and Transformation Board North West Sector Programme Board Seven priority areas for immediate service review and change have been agreed from a resilience perspective across all NW Sector organisations	MW	4	3	12	12	Investment from the transformational funds will enable investment and training of alternative workforce models areas where resilience exists including development of a system workforce focused and educated on preventative care	4	2	8	8
3a	National Standards	Failure to deliver against key national targets which support the GM Transformation	Monthly Board Performance Reports supported by Remedial Action Plans for areas at risk of non delivery. Focus on urgent care at S&T Board and JLG. System reform key programme under the Locality Plan (whole system focus). GM Assurance Framework under development.	ML	4	4	16	16	Transformation funding for Urgent Care redesign will significantly support the achievement of national standards	4	2	8	8
3b	National Standards	In times of financial stress and transformation there is a risk that services may fail to meet the fundamental standards required by the regulators resulting in poor or	Robust quality assurance systems operate in the regulated activities of Bolton NHS Foundation Trust and Bolton Council that highlight potential breaches in regulation and prompt proactive action. An emerging quality assurance function is beginning to provide similar systems and assurance to the independent care sector.	AC	3	3	9	9	Transformational Fund investment will enable the reduction of NEL, in particular the frail and vulnerable. This will reduce demand on these pressures services	3	2	6	6
3c	National Standards	Risk that GPs will not meet the fundamental standards required by CQC during this time of financial stress and transformation	CCG Supporting Primary care system reform, specifically looking at workforce requirements CCG investment in primary care to sustain funding in general practice Infrastructure funds available to maintain CQC Compliant buildings CCG Support to practices failing CQC requirements National vulnerable practice scheme	LH	3	3	9	9	Investment in a new model for Primary Care will enable more people to be cared for within their community and avoid unnecessary referral to more expensive specialist/acute care.	3	2	6	6
4	Health Improvement	Failure to deliver the agreed improvements in population health	Health related outcome targets are in place and will be overseen by HWBB and locality plan group. GM plans are in development to upscale prevention activity. At a local level joint and collaborative commissioning intentions aim to address gaps in health improvement interventions. There is an increasing focus on social prescribing and community assets approaches to better foster self care. Interventions which form part of the Locality Plan will be tailored towards those communities most at risk of poorer health using Acorn	DM	4	5	20	20	Investment in what we offer in our neighbourhoods and communities, including clear support and signposting to assess will enable the People of Bolton to lead active and healthy lives.	4	3	12	12
5	Integrated Commissioning	Failure to fully integrate the commissioning functions and budgets across the Council and CCG	Commissioning Partnership Board in operation with clear ToR. Joint Commissioning structure agreed with lead AD identified for each programme. Strategy and Planning Groups established for majority of work programmes. Budgets	ML	3	3	9	9	Faster implementation of pooling of budgets and integration of commissioning functions	3	2	6	6
6	Locality Integrated Care Model	Failure to integrate local care delivery across primary, community, hospital, social care and third sector and realise benefits to patients and public.	Existing INT development programme. Expansion of Integrated Provider Board to include General Practice. Development and strengthening of GP Provider organisation. Clear strategy and implementation plan for addressing IT and clinical system challenges. Revisions to contracting arrangements to support	MS	4	4	16	16	Transformational Funding would enable the development of the agent and leadership required to truly integrate care	4	2	8	8
7	Workforce	Over the period of the plan, and as service needs change, there is a failure to recruit and retain a workforce that is sufficient (both in	Organisationally oriented workforce planning processes are variable. Locality Workforce Development Group is being established.	MW	5	4	20	20	Transformational funds would enable the investment of a new community and primary care workforce which will reduce to demand for secondary care in the future.	5	2	10	10
8	Estates	Failure to deliver an estate and supporting infrastructure to deliver the new care models by 2021	Economy wide Strategic Estates Group in operation with agreed ToR, strategy, implementation plan and risk strategy. Sub groups established to drive the agenda forward. Wide membership representing range of partners.	ST	4	3	12	12	Will enable estates to be reconfigured to support effective and efficient delivery of services.	4	2	8	8
9	IM&T	Failure to deliver an integrated digital shared care record across all partner organisations by 2020	Digital Care Record programme board now up and running, chaired by Su Long. This group will oversee the implementation of the shared care record. This is further supported by the Locality IM&T strategy group which has members from all partner organisations.	GB	4	3	12	12	IM&T is a key and critical enabler to integrated care and acute care collaboration within the sector.	4	2	8	8
10	Patient engagement	Failure to engage patient groups leading to poorly designed interventions which do not reflect patients aspirations for public services and fail to achieve patient buy in potentially	Alliance contract with Healthwatch Bolton and Bolton CVS in place. This helps to focus and coordinate engagement activity ensuring people from all walks of life are reached and listened to. Data from these activities is made available to LA and CCG. Themes for engagement decided 3 times per year by partnership of CCG/LA/ CVS/Healthwatch. This set up is funded only until 31st March 2017.	JF	4	4	16	16	Investment in required in order for the locality to establish the infrastructure to truly engage the people of Bolton in the development of the plans and consequently develop control of their own health and wellbeing.	4	2	8	8
11	Voluntary and Community Sector Engagement	Failure to engage the voluntary and community sector effectively leading to lack of transformational delivery	Clear continued communication with sector via regular presentations updates at voluntary and community sector forums. Representation from The Voluntary and Community Sector at key strategic and operational meetings. Engagement with voluntary and community sector groups to identify barriers and actions to improving health and well being. Development of Business case for social prescribing.	LM	4	3	12	12	Investment in required in order for the locality to establish the infrastructure to truly engage the people of Bolton in the development of the plans and consequently develop control of their own health and wellbeing.	4	2	8	8

Appendix D

Equality Impact Assessment/Equality Analysis

Our locality Plan sets out our priorities for health and Social Care in Bolton and outlines what we will do over the next five years to deliver improvements to health in the borough and reduce inequalities in health. Our Health and Social Care partners are committed to promoting equality, diversity and human rights in the delivery of all of its functions, in order to ensure that health and social services are accessible and appropriate and are developed and delivered based on the needs of local patients and stakeholders.

The locality plan is an opportunity to develop joint equality objectives that reflect not only the legal obligations described in the Public Sector Equality Duty, but also align with the aspirational goals and mandated standards listed below that are applicable to the whole of health and social care:

- NHS Equality Delivery System 2 (EDS2)
- NHS Workforce Race Equality Standards (WRES)
- NHS Accessible information Standard (AIS)

Under the General duty of the Public Sector Equality Duty (PSED), the CCG and the LA, as public authorities, must, in the exercise of their functions, have due regard to the need to:

- eliminate discrimination, harassment, victimisation;
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; .
- foster good relations between people who share a relevant protected characteristic and people who do not share it.

The 'Protected Characteristics' defined in the Equality Act are:

- Age;
- Disability;
- Gender;
- Pregnancy & Maternity;
- Race;
- Religion or Belief;
- Sexual Orientation;
- Trans-gender.
- Marriage/Civil Partnership

Commissioners must assess the impact of their work on protected groups to ensure that no section of the community is disproportionately or unfairly affected by decisions taken by the organisation.

In Bolton, we also want to take into account the effects of our decisions on people with caring responsibilities and on residents living in our priority areas, where access to healthcare services is lower and the effects of deprivation have led to increased levels of ill-health.

In order to have due regard to the aims of the general equality duty, we need to understand the impact of our activities on equality. Having 'due regard' to equality considerations can involve assessing the impact on equality of policy and commissioning decisions. This is known as Equality Analysis.

Equality Analysis ensures that:

- We place equality considerations at the centre of plans.
- We understand the effects their decision on the aims set out in the general equality duty.
- We can demonstrate compliance with the general equality duty with regard to all relevant functions.
- We have sufficient information to understand the cumulative (or combined) impact of a number of decisions that are made together.

The aim of this Equality Analysis is to explore in further detail local and national health inequalities, what is important to local people, and consider the potential impacts of this plan on different groups to ensure that no one suffers discrimination or unequal treatment.

Diversity in the Borough

Our Borough is very diverse, with a rich and exciting multicultural heritage. It has areas of high deprivation where health outcomes are relatively poor, and areas of affluence where health outcomes are generally relatively good. In addition, different vulnerable groups within the borough have poorer health outcomes than the general population, or experience particular barriers to accessing health care.

The socio-economic profile of our BME groups is often vastly different from that of our White British residents with consequent effects on their quality of life and health outcomes. BME groups generally have worse health than the overall population and language or cultural barriers may prevent these groups from accessing mainstream services.

Based on the governments estimates round 5-7% identify as lesbian, gay or bisexual in Bolton. (LGBT) people experience significant health inequalities, which impact both on their health outcomes and their experiences of the healthcare system.

The census does not measure how many residents within the borough identify as transgender, however, the Gender Identity Research and Education Society estimates that 1 in 4,000 of the UK population seeks support to change their gender. If we use this estimation for the borough's population the number equates to an estimated 70 people

who might identify themselves as transgender. Transgender people have reported that they consider themselves to be amongst the most marginalised and discriminated against groups in society Source: Census 2011 and Gender Identity Research and Education Society.

Carers in Bolton are a key resource and as the population ages there will be additional impact on carers. Carers are defined as people who provide unpaid care, helping family, friends or neighbours with long-term physical or mental ill-health or disability or problems relating to old age. The number, age profile and levels of care vary from electoral ward to ward.

Hidden Carers do not identify themselves as carers and therefore may not seek support and information that would benefit them. In particular, problems in identifying individuals in some specific groups can lead workers to believe, incorrectly, that these individuals do not need or want services or support. These include the following carers:

- Minority ethnic backgrounds as well as those from emerging communities.
- Lesbian, gay, bisexual and transsexual people.
- People with mental health problems.
- People who look after someone with a drug or alcohol problem.

Veterans are men and women who have served in the Royal Navy, Army and Royal Air Force (regular or Reserve) and who have now left to rejoin civilian life. Because of their military service, their healthcare needs can be different from those of other patients. There are no definite figures on the total number of veterans in the UK at the present time, although estimates were produced by the ONS in conjunction with the Royal British Legion 2007.

Locality Plan and EIA/EA

The locality plan for health and social care in Bolton summarises the ambition and aspirations for improving health and wellbeing outcomes for local people that have been agreed by all partners in the Borough.

The partners are committed to tackling inequalities in health and promoting equality in relation to age, caring responsibilities, disability, gender identity, marriage / civil partnerships, pregnancy / maternity, race, religion or belief, sex, sexual orientation and social class.

The Locality Plan identifies seven inter-related areas with supporting work programmes (underpinned by our Primary Care Strategy) that will be prioritised over the next few years. These areas are:

- Primary Care
- Community Care
- Social Care

- Hospital Care
- Mental Health and Wellbeing
- Community Pharmacy
- Working with the Voluntary, Community, Social Enterprise Sector

To achieve our aims in these areas, we will:

- strengthen and build on the partnerships between the community and voluntary sector, the Council and other statutory partners
- continue to engagement and involve local protected groups and the general community
- develop themed and locality-based alliances
- recognise and invest in the capacity of local communities to help improve health outcomes
- develop a social prescribing model for Bolton
- co-produce solutions with local communities
- recognise the contribution of the community and voluntary sector and support volunteers and volunteering

EIA/EA Recommendations

- Further detailed EIA/EAs will be required, with a breakdown of how protected groups will be affected by each programme area and what measures are in place to ensure positive outcomes.
- Attention will be paid to equality and diversity when managing changes.
- Integrated equality approach across the locality plan partnerships will be developed, including standardisation of EIA/EA processes and equality requirements to support commissioning arrangements.
- Joint equality objectives will be developed to reflect partnership aspirations and the PSED which will align with other mandatory requirements such as EDS2, WRES and AIS.
- Governance arrangements will be determined to ensure that progress against equality and diversity requirements is tracked, monitored and published on appropriate websites by the 31st January annually as part of Public Sector Equality Duty equality information requirements.

Appendix E – Scheme Outcomes Benefits Mapping

Locality plan scheme → Outcome → benefits map

V9. 24/10/2016

Themes

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- C1: Acute reconfiguration and shift of activity into community
- C2: Technology Enabled Care
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- C10: Mental Health including dementia
- C11: Primary Care
- C13: Urgent Care
- C14: Workforce

Outcomes

Population health and wellbeing outcomes

- Overall outcome: Supporting a clinically and financially sustainable health and social care system**
- STARTING WELL: Increased breastfeeding rate (175 more Bolton women breastfeeding at 6-8 weeks (up to 44.5%))
- STARTING WELL: Reduced smoking pregnancy (237 fewer Bolton women smoking pregnancy)
- STARTING WELL: Reduced self-harm in children (43 fewer child admissions 460.1 per 100,000)
- STARTING WELL: Reduced excess weight in school children (53 fewer reception age children of excess weight in Bolton and 37 more children of excess weight at Year 6 in Bolton (18%), 86 fewer than trajectory (34.7%))
- STARTING WELL: Reduced tooth decay in children (182 fewer children with tooth decay, down to 35.7%)
- STARTING WELL: Low birth weight (19 fewer low birth weight births 2.8%)
- LIVING WELL: Increased number of active adults (>3%)
- LIVING WELL: Reduced hospital related alcohol admissions (98 more admissions which is fewer than trajectory, 656.1 per 100,000)
- LIVING WELL: Reduced premature mortality from CVD, respiratory disease, liver disease and cancer (34.2 for CVD, 77.8 for cancer, 16.9 for respiratory, 19.5 for liver (all per 100,000))
- AGEING WELL: Reduced harm from falls (to 2,213.5 per 100,000)
- AGEING WELL: Dementia: recorded prevalence (to 3,252 dementia diagnosis recorded which is 1,066 more people with dementia diagnosed in Bolton)
- AGEING WELL: Reduced social isolation (reduce to <3.5% which is > 1,930 individuals)
- AGEING WELL: long term residential care placements (645.5 per 100,000 which is 85 fewer permanent admissions)
- AGEING WELL: Unplanned hospitalisation for ACS conditions (Adults) (782.7 per 100,000 which is 342 fewer admissions)
- ALL AGES: Reduced unplanned hospital admissions (reduced to 9,319.6 per 100,000 which is 3,107 fewer admissions)**
- ALL AGES: Healthy life expectancy MALE (increase to 65 years)**
- ALL AGES: Healthy life expectancy FEMALE (increase to 66.7 years)**
- ALL AGES: internal life expectancy gap MALE (reduce to 10.3 years)
- ALL AGES: internal life expectancy gap FEMALE (reduce to 8.8 years)
- HOUSING: Quality housing (<12% of homes with cat 1 hazards)
- HOUSING: Prevention of homelessness (10.05 per 1,000 household, an additional 252 households would be prevented from becoming homeless)
- HOUSING: Fuel poverty (<0.6% gap which is <13,111 households in fuel poverty)
- ECONOMY: Improved school readiness (<5.2% which is <2,397 children achieving a good level of development at the end of Reception)
- ECONOMY: GCSE attainment (<1.4% gap, 1,790 pupils achieving 5 or more GCSEs A* - C)
- ECONOMY: Increased employment rate (<3.9% gap, >135,200 people in employment)**
- ECONOMY: Employment rate of people with long term health conditions (<61.7%, 7,851 more people with long-term conditions in employment)**
- ECONOMY: Average wage (reduce £63 gap)
- ECONOMY: Self reported well being: people with a low satisfaction score (<1.3%)**

Benefits

Referenced as per the CBA

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- B23: Reduced readmissions (30% by 2020/21)**
- B24: Nursing care admissions (Weeks)
- B25: Outpatient first attendances (15% by 2020/21)**
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- B32: Reduced ambulance call outs (A&E minors not from a care home)
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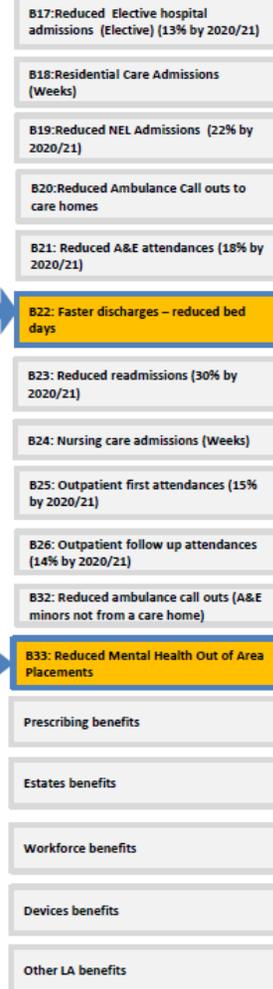
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Locality plan scheme → Outcome → benefits map
V9. 24/10/2016

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Population health and wellbeing outcomes

Overall outcome: Supporting a clinically and financially sustainable health and social care system

STARTING WELL: Increased breastfeeding rate (175 more Bolton women breastfeeding at 6-8 weeks (up to 44.5%))
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STARTING WELL: Reduced tooth decay in children (182 fewer children with tooth decay, down to 35.7%)
STARTING WELL: Low birth weight (19 fewer low birth weight births 2.8%)

LIVING WELL: Increased number of active adults (>3%)
LIVING WELL: Reduced hospital related alcohol admissions (98 more admissions which is fewer than trajectory, 656.1 per 100,00)
LIVING WELL: Reduced premature mortality from CVD, respiratory disease, liver disease and cancer (34.2 for CVD, 77.8 for cancer, 16.9 for respiratory, 19.5 for liver (all per 100,000))

AGEING WELL: Reduced harm from falls (to 2,213.5 per 100,000)
AGEING WELL: Dementia: recorded prevalence (to 3,252 dementia diagnosis recorded which is 1,066 more people with dementia diagnosed in Bolton)
AGEING WELL: Reduced social isolation (reduce to <3.5% which is > 1,930 individuals)
AGEING WELL: long term residential care placements (645.5 per 100,000 which is 85 fewer permanent admissions)
AGEING WELL: Unplanned hospitalisation for ACS conditions (Adults) (782.7 per 100,000 which is 342 fewer admissions)

ALL AGES: Reduced unplanned hospital admissions (reduced to 9,319.6 per 100,000 which is 3,107 fewer admissions)
ALL AGES: Healthy life expectancy MALE (increase to 65 years)
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ALL AGES: Internal life expectancy gap MALE (reduce to 10.3 years)
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HOUSING: Quality housing (<12% of homes with cat 1 hazards)
HOUSING: Prevention of homelessness (10.05 per 1,000 household, an additional 252 households would be prevented from becoming homeless)
HOUSING: Fuel poverty (<0.6% gap which is <13,111 households in fuel poverty)

ECONOMY: Improved school readiness (<5.2% which is <2,397 children achieving a good level of development at the end of Reception)
ECONOMY: GCSE attainment (<1.4% gap, 1,790 pupils achieving 5 or more GCSEs A* - C)
ECONOMY: Increased employment rate (<3.9% gap, >135,200 people in employment)
ECONOMY: Employment rate of people with long term health conditions (<61.7%, 7,851 more people with long-term conditions in employment)
ECONOMY: Average wage (reduce £63 gap)
ECONOMY: Self reported well being: people with a low satisfaction score (<1.3%)

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