Report to:	Health and Wellbeing Board	
Date:	16 July 2014	
Report of:	Su Long, Chief Officer, Bolton CCG	**Report No:**
Contact Officer:		**Tel No:** 01204 462030
Report Title:	**NHS Bolton CCG 5 year Strategic Plan**	
Non Confidential:	This report does **not** contain information which warrants its consideration in the absence of the press or members of the public	
Purpose:	To present to the Board the 5 Year Strategy 2014/15 – 2018/19 and Plan on a Page 2014/15 – 2018/19. The documents pull into one place the plans the CCG, working in collaboration with their partners, intend to deliver over the next 5 years to deliver our objectives. The documents are prepared in response to the Strategic and Operational Planning 2014 to 2019 guidance Everyone Counts: Planning for Patients 2014/15 to 2018/19	
Recommendations:	That the Health and Wellbeing Board note the strategy and plan on a page	
Decision:		
Background Doc(s):		

BOLTON CLINICAL COMMISSIONING GROUP

5 YEAR STRATEGIC PLAN 2014-19

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FOREWORD – DR WIRIN BHATIANI

This 5 Year Strategic Plan 2014/15 to 2018/19 is built from local understanding of health needs for the population of Bolton now and in the coming years and reflects the partner role NHS Bolton CCG has in the overall health and wellbeing economy within Bolton.

Our mission is to commission services that improve the health of the population, ensures best care for patients; delivers services that demonstrate value for money and high levels of positive patient experience. We will commission for outcomes and focus on whole patient pathways from prevention to end of life care.

Bolton CCG will commission with meaningful engagement with the public and patients, our member Practices, our Health and Wellbeing Board, the Local Authority, the voluntary sector and our providers. We will collaborate with CCGs across a wider footprint to ensure that specialist services provided on a Greater Manchester basis are fit for purpose and reflect the needs of the Bolton population. Together we will tackle the issues that matter and make the sustainable improvements that are necessary to integrate services for the benefit of Bolton people.

We have significant challenges to deliver high quality services in a tight financial environment. This 5 year plan outlines our approach to this but does not supply the operational detail for how this will be delivered. We have a clear operational plan for year 1 and are now working as a priority on the detail for how we will deliver greater capacity and quality in general practice as a co-commissioner with NHS England.

Investing in and meeting high standards in Primary Care is a priority to meet our objective of supporting more people to remain independent at home. This document outlines that our overall strategy for the shift to more proactive care in the community will be delivered by Primary care as well as through transformation of our currently commissioned services of Community and Hospital-based care.

Dr Wirin Bhatiani
Chair – NHS Bolton CCG

1. INTRODUCTION TO BOLTON CCG & LOCAL HEALTH NEEDS

Bolton CCG is a membership organisation. We bring together the combined expertise of 50 local GP practices, the support of in-house and commissioning support staff, and the statutory accountability of a Governing Body. We commission services on behalf of Bolton people to deliver the best outcomes their health and wellbeing.

1.1. BOLTON HEALTH & SOCIAL CARE ECONOMY

Bolton has a resident population of 279,000 (ONS 2012) and a registered population (with Bolton GPs) of 298,000.

The CCG commissions the majority of its acute and community services from Bolton NHS Foundation Trust and mental health services from Greater Manchester West NHS Foundation Trust. Contracts are held with other NHS providers, private providers and voluntary sector organisations. We contract with GPs within Bolton for certain aspects of primary care.

The boundary of the CCG is co-terminous with Bolton Council and the two organisations work very closely together to ensure that commissioned services meet the current and future health needs of the local population and also focus specifically on pro-active and preventative care, rather than solely on treatment.

The CCG is a partner in the development of the Health & Wellbeing strategy, with five CCG members on the Health & Wellbeing Board alongside Bolton Council, Health Watch Bolton, NHS England, local NHS providers & third sector. The joint Health & Wellbeing Strategy is built from an understanding of the needs of our population.

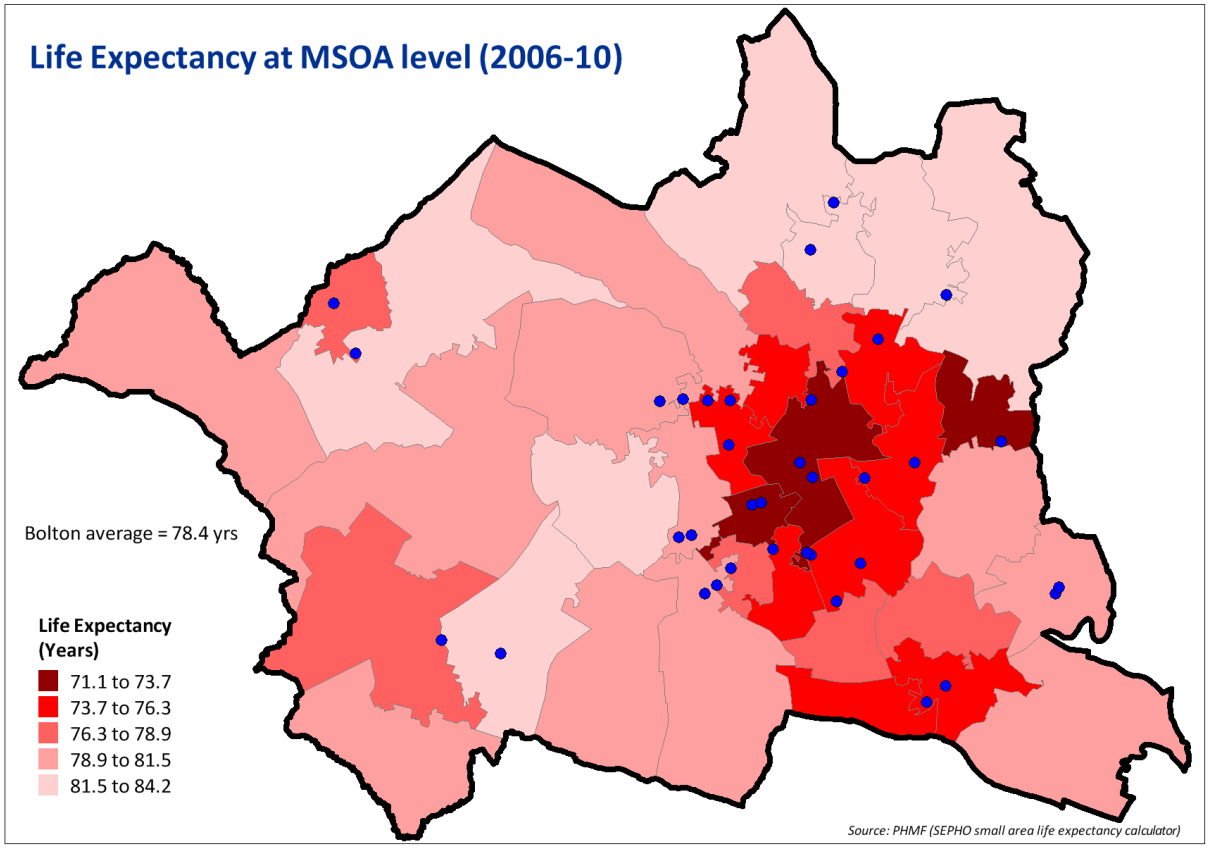
1.2. THE POPULATION OF BOLTON AND SUMMARY OF HEALTH NEEDS

Bolton's total population is set to increase by around 20% or around 54,000 people by 2035. This will be through a combination of people living longer, higher birth rate and immigration. The over 65 population will grow from 44,700 at present to 61,400 by 2030 (an increase of 37%). Bolton has a growing population of Black and Minority Ethnic (BME) residents, from 12.8% in 2001 to 20.6% in 2011.

Life expectancy in Bolton is improving at 77.4 years for Bolton men (1.8 years less than England) and 81.4 years for Bolton women (1.6 years less than England). The gap from the England average has improved from 2.5 years.

There are geographic inequalities in health in Bolton, with a 12.9 year difference in life expectancy between different parts of the town, less than 5 miles apart. Reducing inequalities in health and quality of care are important to the CCG.

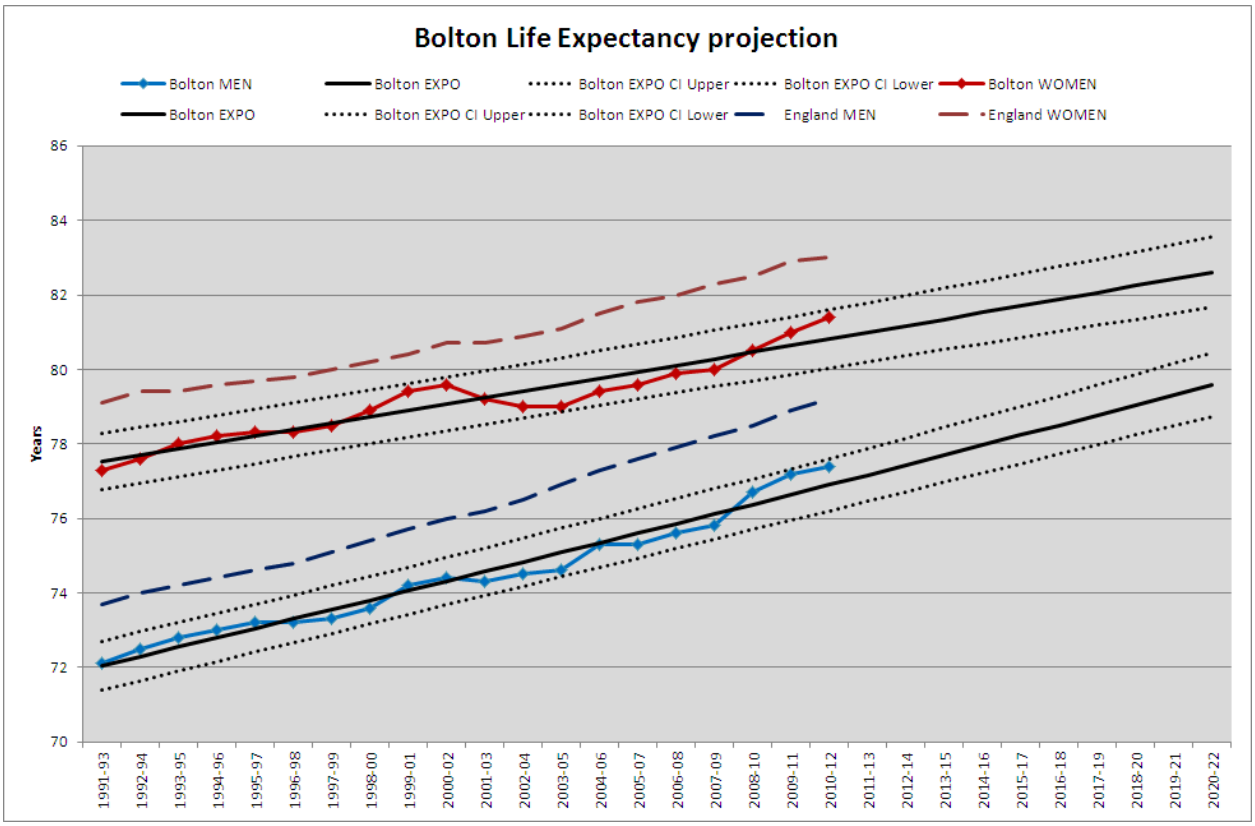
Figure 1: Life Expectancy inequalities across Bolton (with the 50 Practices indicated)



Our Joint Strategic Needs Assessment (JSNA) tells us the conditions that make the biggest contribution to the life expectancy gap are cardiovascular disease, respiratory disease, diabetes, alcohol related conditions and infant mortality. These all need improving.

The chart below shows Bolton's life expectancy trend along with its future expected projection. Our inequality gap to England rose steadily from 2000 to reach a peak of over 2 years lower life expectancy to the England average in 2007/09, but we have since seen three small but consistent reductions in this gap to 1.7 years.

Figure 2: Male and Female Life Expectancy in Bolton with comparison to England average & future projection



However, our internal gap in life expectancy, that is the difference between the most and least deprived in our town, has shown a consistent increase for both genders and we currently have the widest such inequality of all our statistical neighbours.
As the projections below demonstrate, if this trend is not acted upon this inequality can be expected to widen even further.

Further, detailed information on the population statistics and health needs of Bolton people from our JSNA can be found at Appendix 1.

Additional evidence about the health of Bolton's population can also be accessed at the innovative evidence site developed by Bolton Council's Public Health Department at: www.**boltonshealthmatters**.org

Figure 3a: Slope of Index of Inequality (indicating gap between most and least deprived areas of Bolton) - Males

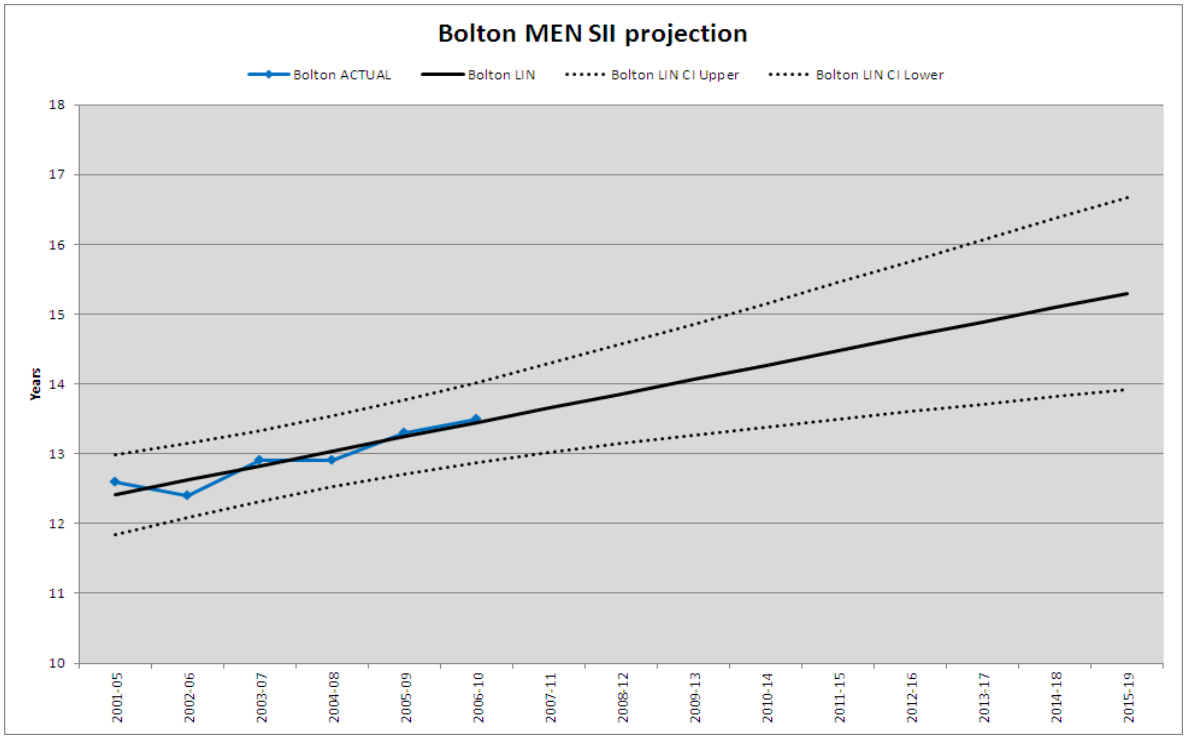
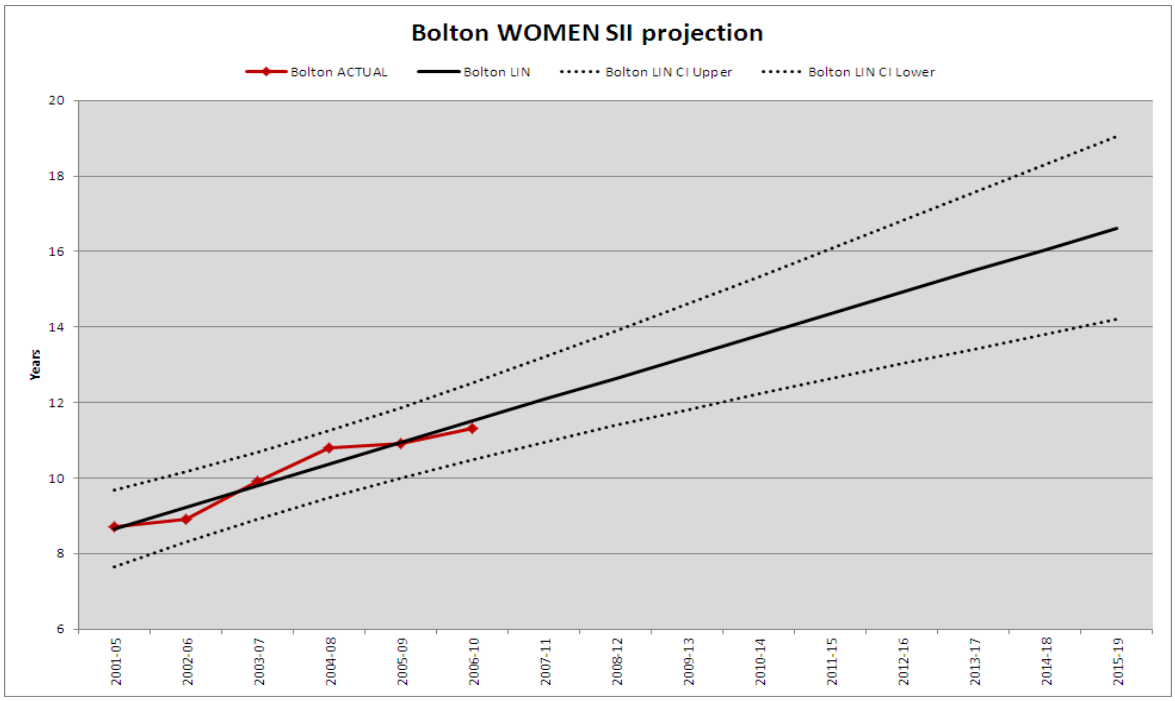


Figure 3a: Slope of Index of Inequality (indicating gap between most and least deprived areas of Bolton) - Females

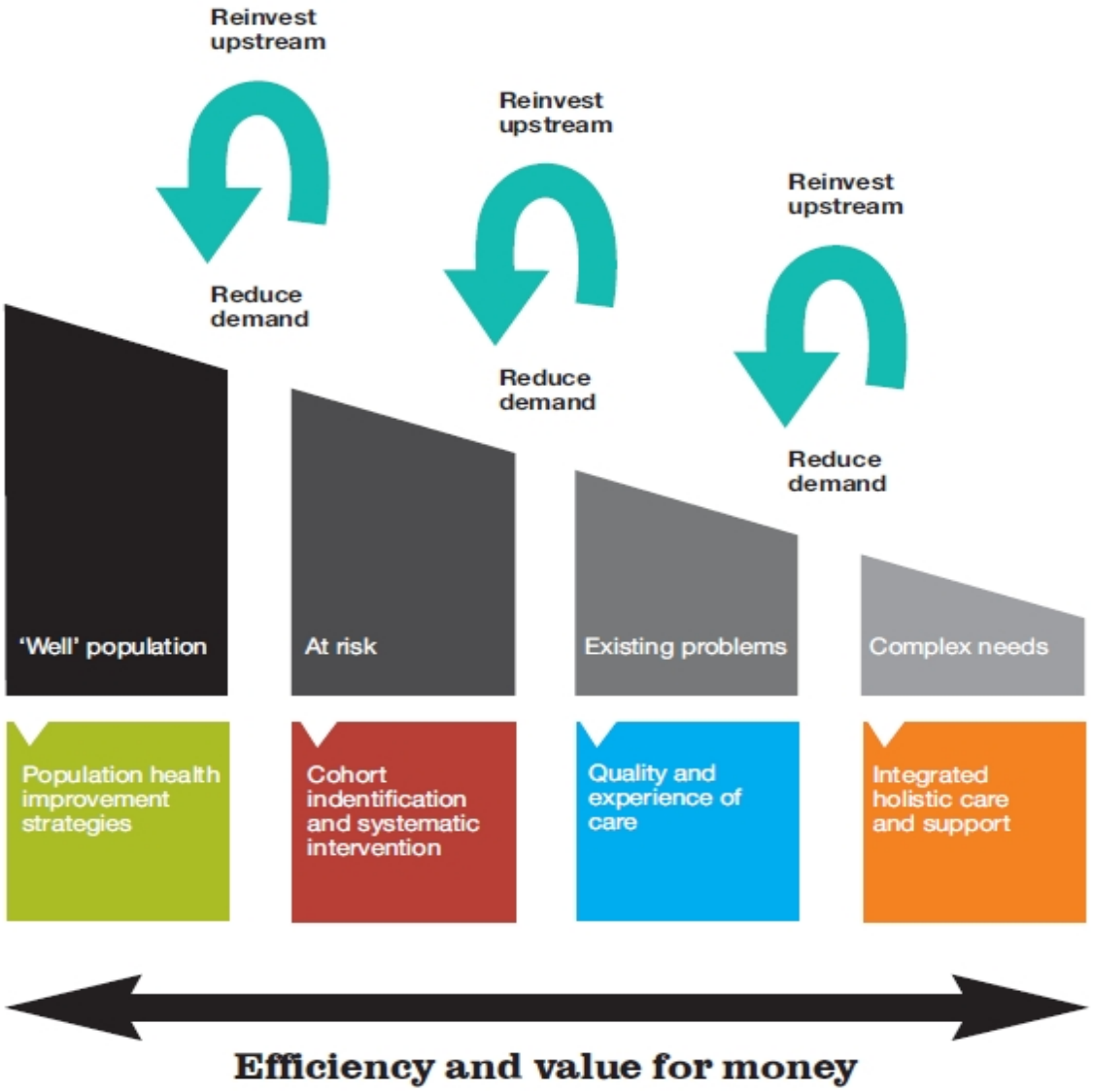


1.3. BOLTON'S HEALTH & WELLBEING STRATEGY 2013-2016.

Bolton's Health & Wellbeing Strategy 2013-2016, is a three year plan setting out the key priorities to support Bolton people to live longer, healthier lives and address the health inequalities which exist within the Borough.

The approach of the Bolton Health & Wellbeing Strategy is to invest in prevention and earlier intervention, reducing demand for hospitalisation and more complex care, further enabling reinvestment. This is demonstrated in the figure below:

Figure 4: Summary of Bolton's Health & Wellbeing Strategy



The Health & Wellbeing Strategy highlights six health arenas which are key to addressing premature mortality and associated health inequalities.

Alcohol
Cancer
Mental Wellbeing
Obesity

Cardio Vascular Disease Respiratory

The strategy strongly recommends that opportunities to do things differently should be exploited in order to have greater, systematic impact at both a population and individual level.

A copy of the Health & Wellbeing Strategy can be found on our website in the section about the CCG/ Our plans, policies and reports or here

1.4. CHALLENGES FACING THE CCG IN BOLTON

Over the coming years, the NHS nationally will receive less money than is needed. The impact of the ageing population, increasing availability of new drugs, treatments and technologies, and increasing demands on services alongside the state of the economy have led to a national estimate of savings needed of £30 billion over 5 years.

This means that in order to invest in new services that meet the health needs of Bolton people, the CCG needs to save money elsewhere.

1.5. STRATEGIC FINANCIAL CONTEXT

The NHS is facing an unprecedented financial challenge and this means that:-

- Bolton CCG has to identify savings of £24m over the next 5 years to ensure that the commissioning plans can be delivered.

- Bolton FT has to find efficiency savings of £73m over the next 5 years. In addition to this challenge the CCG is planning to reduce the annual amount spent on hospital based care by £11.4m and make reinvestments in community and primary care. This means that the FT needs to downsize its activities on the hospital site.

- Greater Manchester West FT has to find efficiency savings of £27.6m over the next 5 years. The CCG is planning to make further investments in mental health services over the next 5 years which may have an impact on GMW.

In addition to the NHS challenge, local authorities are also facing budget reductions. This means that Bolton council has to make savings of £59m over the next 3 years.

When we are developing our commission plans we need to understand the impacts on the healthcare system in Bolton and our neighbouring CCGs in Salford and Wigan. We do this by sharing our commissioning plans with our providers and neighbouring CCGs to ensure that they have time to respond and implement the required changes. We also review the strategic plans our local providers, neighbouring CCGs, local authority and NHS England to understand how these will impact health services in Bolton.

1.6. BOLTON CCG BUDGET ALLOCATION – FOR COMMISSIONING

CCG budget allocations are based on a funding formula. The formula takes account of the size and characteristics of the population, deprivation and unmet need.

Bolton CCG had a recurrent budget allocation for programme costs of £335.8m in 2013/14 and this has been uplifted to take account of inflation and other pressures by 2.17% in 2014/15. A summary of the uplifts and projected budget allocations for programme costs is shown in the table below:

Figure 5: Bolton CCG projected budget allocations for commissioning (programme costs)

Year	2014/15	2015/16	2016/17	2017/18	2018/19
Uplift	2.17%	2.13%	2.25%	2.24%	2.22%
Budget Allocation – Programme Costs	£343m	£357m*	£365m	£373m	£381m

*Includes Better Care Fund additional recurrent allocation

Despite these budget increases being above inflation, the CCG has already seen this growth reduced through actions by NHS England such as:

- top-slicing resources for legacy issues already funded by Bolton CCG (Continuing Healthcare Restitution)
- delegating responsibility for functions without the resource it costs to support this (GP Information Technology Support)

We need to financially plan with these risks in mind. Section 8 details the financial plan. In summary, we have two challenges to meet:

a. We need to manage the NHS budget to ensure the NHS in Bolton doesn't go bust. We have to meet our statutory financial requirements despite increasing demands on the NHS but with no more money. This is our **financial challenge**

b. We need to free up money to elsewhere to deliver our vision of investing in community and primary care based services while reducing hospital activity. This is our **transformational challenge**

2. WHAT THE CCG WANT TO DELIVER

NHS Bolton CCG will commission services for Bolton people that deliver improved population health, best quality care, value for money and high levels of positive patient experience.

2.1. CCG VISION

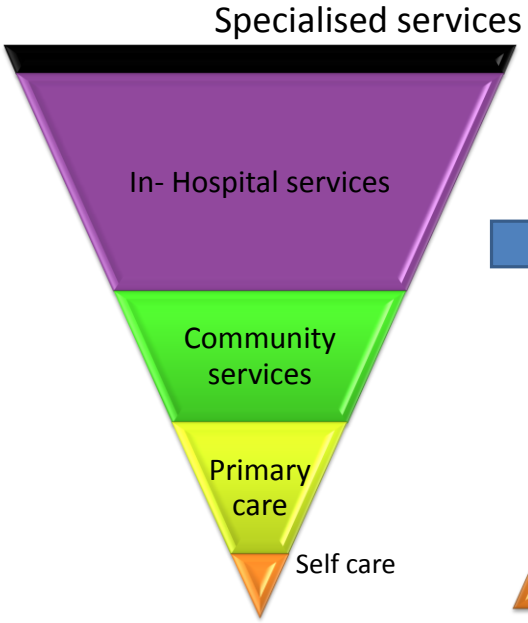
Bolton CCG has an ambitious vision to deliver fully integrated care across health and social care services, with primary care based firmly at the centre of this model. One where the patient is treated by the right professional at the right time in the right setting, to achieve the best possible outcome for that individual.

Currently, the majority of NHS resources in Bolton are spent on hospital services (acute and mental health). However, most Bolton people are well and the vast majority of daily healthcare contacts are in primary care.

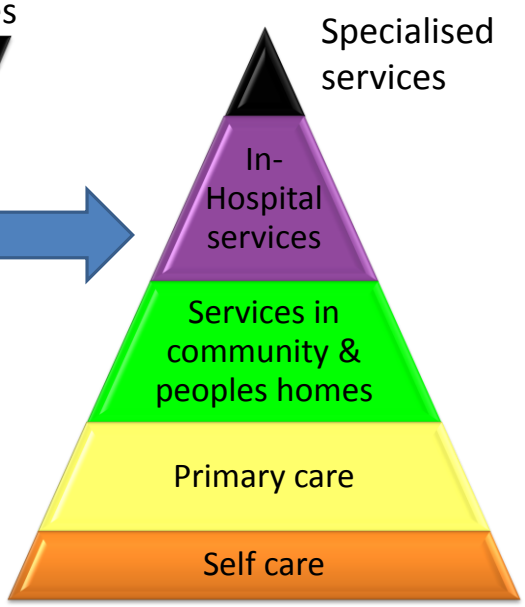
As outlined in Bolton's Health and Wellbeing Strategy, if we are to improve health outcomes in Bolton and reduce the inequalities in health, we must be more proactive with our health care and intervening earlier. The CCG commissioning vision is to more proactive with our health care and intervening earlier, shift the balance as shown in figure 6 below:

Figure 6: Bolton CCG Vision for Shifting Care

Our Legacy:



Our Vision:



What this should mean for Bolton people:

“I get the support I need to manage my own health conditions”

“I get to see a GP when I need to”

“I don’t have to go into hospital to have help with most of my health problems”

“If I need once in a lifetime surgery, it is done by the best Consultant & team with best chances of success”

Our approach to achieving this vision is built on what we have learnt works well in Bolton:

- Clinically led
- Delivered systematically at scale
- Uses comparative benchmarking data and addresses areas of variation
- Underpinned by strong clinician to clinician relationships and debate
- Focuses on achieving high quality outcomes for patients
- More support will be given to areas with most need/highest deprivation (applying Marmot review lessons).

2.2. PUBLIC PRIORITIES

Following extensive engagement with the public, the CCG agreed to check against the public's priorities in every commissioning decision made.

The public priorities are:

- ✓ More people should be supported to remain independent in their own homes
- ✓ Assurance of high quality of care in the home
- ✓ Services should be designed to fit around the individual
- ✓ Improved access to a GP
- ✓ Embrace technology (to support people to self-care, or to improve access)
- ✓ Spending more money on community services, mental health and prevention, and less on hospital services was supported

Further detail on the public engagement carried out by Bolton CCG, "Changing our NHS", can be found on our website.

2.3. OBJECTIVES

Bolton CCG has set organisational objectives to monitor the delivery of its vision. Our objectives are:

Improve health outcomes

- by focusing on the major causes of early mortality in Bolton

Improve the quality and experience of care

- by working with our providers to improve performance on NHS constitution promises
- by ensuring safe, effective and personal care

Ensure best value use of our budget

- by shifting resources from hospital to community & primary care services
- there will be more people supported in their own homes, rather than in hospital

During our first full year as a statutory body, good progress was made on delivery against the measures for improving health outcomes and the quality and experience of care despite the population pressures in Bolton. The transformation that will deliver improvement in shifting care and providing best value is now the priority for the CCG.

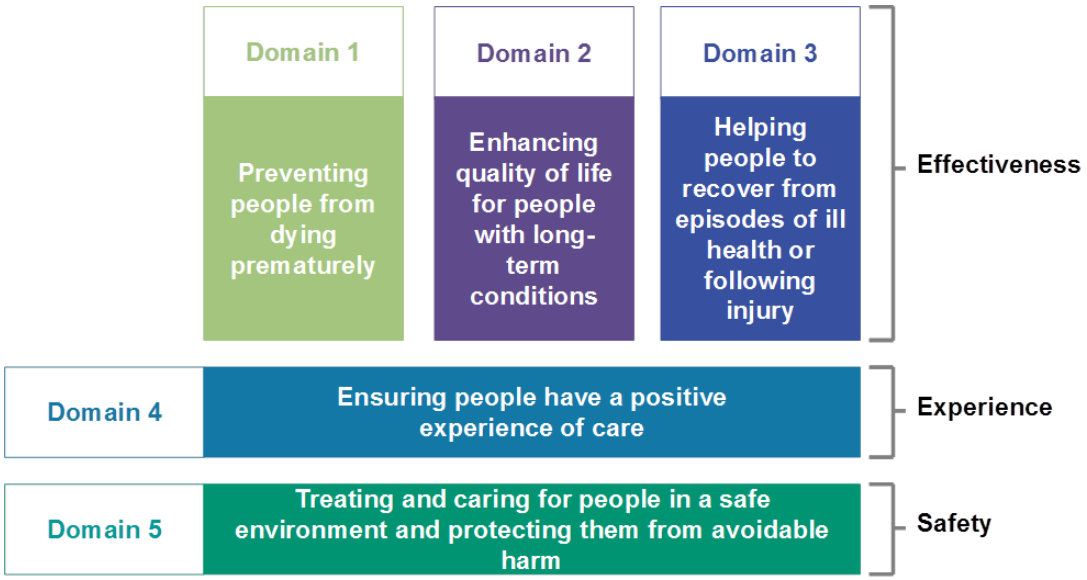
Figure 5: how we will measure achievement of our objectives over 5 years

Objective	Key Measures of Success (Goals)	From (2013/14)	To 2018/19

Improve Health Outcomes	Reduce the gap in life expectancy between Bolton and England	1.7 years (2012)	1.5 years (2018)
	Reduce the gap in life expectancy between the most and least deprived areas in Bolton (appears to be static but target includes impact of demographic growth)	m 12.1 f 9.2	m 12.1 f 9.2
Improve quality of care and patient experience of care	Achievement of all key targets / NHS Constitution	Several failing	All achieved
	Bolton patients and carers would recommend health services - to replace with Friends & Family test aggregate	Net agree +41%	Net agree 50%
Best Value: Shift care closer to home	Reduce emergency admissions	30,541	27,914
	Reduce elective & non elective length of stay	El 4.0,	El 3.7
		NE 5.4	NE 5.0
	Reduce readmissions as % of discharges(appears to be an increase but target includes impact of demographic growth)	5438	5459

2.4. MEETING THE NHS OUTCOMES FRAMEWORK

The NHS Outcomes Framework is a national set of indicators monitored to demonstrate how well the NHS is performing – by driving up quality throughout the NHS by encouraging a change in culture and behaviour focused on outcomes and not process. The framework is separated into 5 domains/areas:



2.5. HOW BOLTON CCG WILL MEASURE THESE OUTCOMES

Outcome Ambition	Key Measures of Success	Bolton CCG outcome ambition

			Current 2013/14	Ambition 2018/19
1	Securing additional years of life	PYLL from causes considered amenable to healthcare - persons (all ages) (OF 1a) (directly standardised)	2,690 years lost per 100,000 population	2,501 years lost per 100,000 population
2	Improving the health related quality of life of people with one or more long-term condition	Average EQ-5D score for people reporting having one or more long-term condition.	70.7%	73.7%
3	Reducing the amount of time people spend in hospital through better and more integrated care in the community	Delivery of fully integrated multi-disciplinary team working across health and social care	2178 per 100,000 population	1965 per 100,000 population
4	Increasing the proportion of older people living independently at home following discharge from hospital.	Increased percentage of older people living independently following a hospital stay	no baseline available at CCG level	
5	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Bolton patients and carers would recommend health services (Friends and Family Test)	132 negative responses per 100 patients	127 negative responses per 100 patients
6	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Bolton patients and carers would recommend health services (Friends and Family Test)	6 negative responses per 100 patients	5 negative responses per 100 patients
7	Making significant progress towards eliminating deaths in our hospital caused by problems in care *(no baseline for CCG: Bolton FT data used)*	Reduced harms in hospital (Harm Free Care measures)	95.53%	
		Reduced SHMI	104.88	
		Reduced adjusted mortality rate	105.10	

To achieve the outcomes measures, the CCG has put in place a number of strategies which are being delivered through a programme management approach and are detailed throughout this document.

The CCG uses benchmarking information to inform its high level strategy to improve outcomes, quality of care and efficiency and effectiveness of services. The 2013 "Commissioning for Value" indicative data has been used to inform where the CCG needs to look to change commissioned services. These include Mental Health, Trauma, CVD, Respiratory and cancer services.

The CCG also uses other indicative data such as the "Atlas of Variation", Better Value metrics and Programme Budgeting data to highlight areas for improvement.

The CCG regularly compares performance and outcomes for Bolton to peer organisations across the country. This allows the CCG to understand if the services being commissioned are delivery positive outcomes in relation to other areas and to set stretch targets where local performance is below the median, 75th and 90th centile of peers.

2.6. REDUCING HEALTH INEQUALITIES AS THE BEDROCK TO TRANSFORMATION

Health inequalities exist in Bolton related to socio-economic factors. These impact the determinants of health, lifestyle behaviours, access and uptake of healthcare services, and can be seen in patterns of disease and death. Inequalities are also experienced by specific groups within the population such as BME groups, LGBT groups, and those with learning disabilities, physical disabilities, and mental illness. In Bolton we know

that these inequalities are not inevitable and believe strongly we can make a difference.

The overarching measure of health inequalities is the Slope Index of Inequality. Local work to address health inequalities can be found in section 2 and appendix 1. Much more is going on, often specific to disease areas and/or key inequality group, more detail of which is provided in the JSNA on the Bolton's Health Matters website. The Bolton Health and Wellbeing Strategy aims to address the key priorities pertaining to local inequalities in health and is due to be reviewed in 2017.

2.6.1. EQUALITY DELIVERY SYSTEM (EDS) 2

The EDS is intended to improve equality performance and embed equality into mainstream NHS business. During summer 2013 NHS Bolton CCG engaged widely with patients from protected characteristic groups concerning the equality of its services, and in December 2013, it held a public grading of the way it puts equality into practice using the NHS Equality Delivery System (EDS), where it was graded as a "developing" organisation. It will use the actions identified in this process to improve the equality of its services and will use the refreshed EDS2 to ensure continued improvement.

EDS2 was developed from the findings of the evaluation of EDS with involvement of staff, patients and diverse communities. Therefore, NHS Bolton CCG will engage with local protected characteristic groups and health inclusion groups, such as carers, its Equality Target Action Group (ETAG), and its staff, to identify equality and diversity issues and concerns and tackle any discrimination wherever it occurs.

We will use EDS2 to answer the key question: *'How well do people from protected characteristic groups fare compared with people overall?'*

This will help us commission services that address Bolton's Health inequalities and improve health outcomes for some of Bolton's most vulnerable communities.

2.6.2. PARITY OF ESTEEM FOR MENTAL HEALTH

In essence, 'parity of esteem' is valuing mental health equally with physical health. Currently people with severe mental health problems have a life expectancy 10 to 15 years shorter than those without. Bolton CCG has prioritised improving outcomes for people with mental health issues.

Bolton has a very high suicide rate (11.7 per 100,000) but this is now reducing from a recent peak of 13.1; however, excluding the major cities of Manchester and Liverpool, we remain one of the worst areas in the country for suicide. While Bolton performs well on dementia emergency admissions, Bolton has higher than average mental health emergency admissions (287 per 100,000 compared to a national average of 243, marking us as significantly worse on national indicators). Such admissions should be avoided by improving community based services

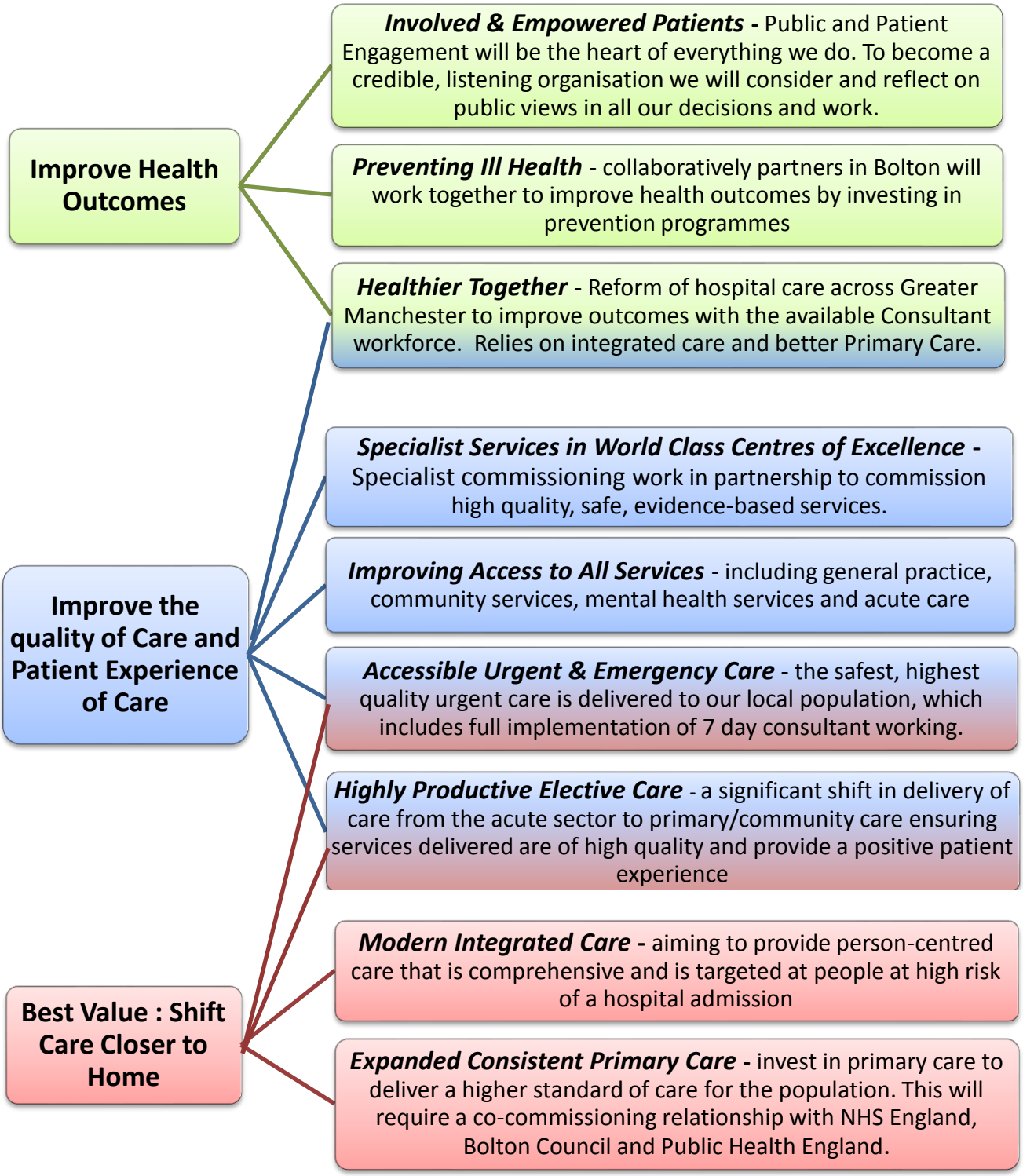
Bolton CCG has identified that mental health services across the Borough require significant input and redesign. In 2011/12 National Programme Budgeting data showed that mental health expenditure in Bolton was £13m per 100,000 population.

This was the lowest expenditure on mental health services nationally and less than 1/3 of the highest funded area. The outcomes for Bolton CCG residents are poorer compared to peer organisations.

Since 2011/12, Bolton CCG has already invested an additional £3.2m in mental health services.

3. TRANSFORMING HEALTHCARE

This section provides the plan for the future for transforming services to Bolton people to meet the needs and objectives outlined in sections 2 and 3.



3.1. INVOLVED & EMPOWERED CITIZENS

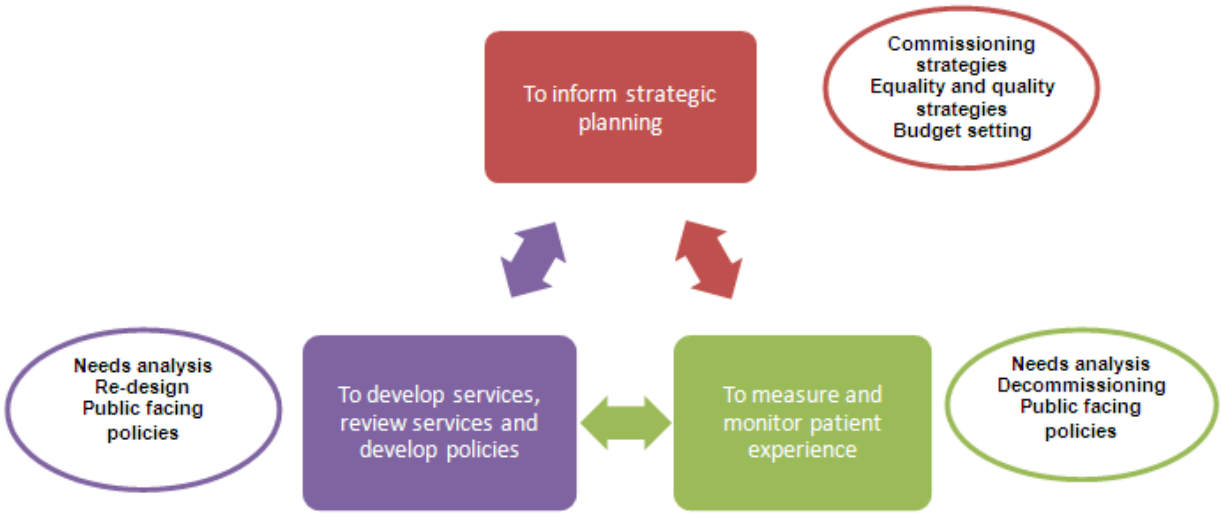
Bolton CCG is committed to engaging with our diverse population and has a strong history of engagement. Bolton CCG had a two-year communications and engagement strategy (2011-13) while in transition to become a formal NHS organisation. The strategy set out to establish a profile for the CCG and engage our stakeholders and public on key work. During this time, we developed our own in-house team and tested different communication channels and engagement methods. We have now enhanced our communications & engagement to ensure it becomes central to everything we do.

We published a new communications and engagement strategy 2013-15 called 'From Good to Great' in December 2013. The strategy can be found on our website.

The aim of the strategy is that through effective communications and engagement, the services commissioned by the CCG will reflect the needs of Bolton people, and ultimately people trust and support the decisions we make.

Public and Patient Engagement will be the heart of everything we do. To become a credible, listening organisation we will consider and reflect on public views in all our decisions and work. Our engagement will be carried out for three purposes shown in figure 7 below.

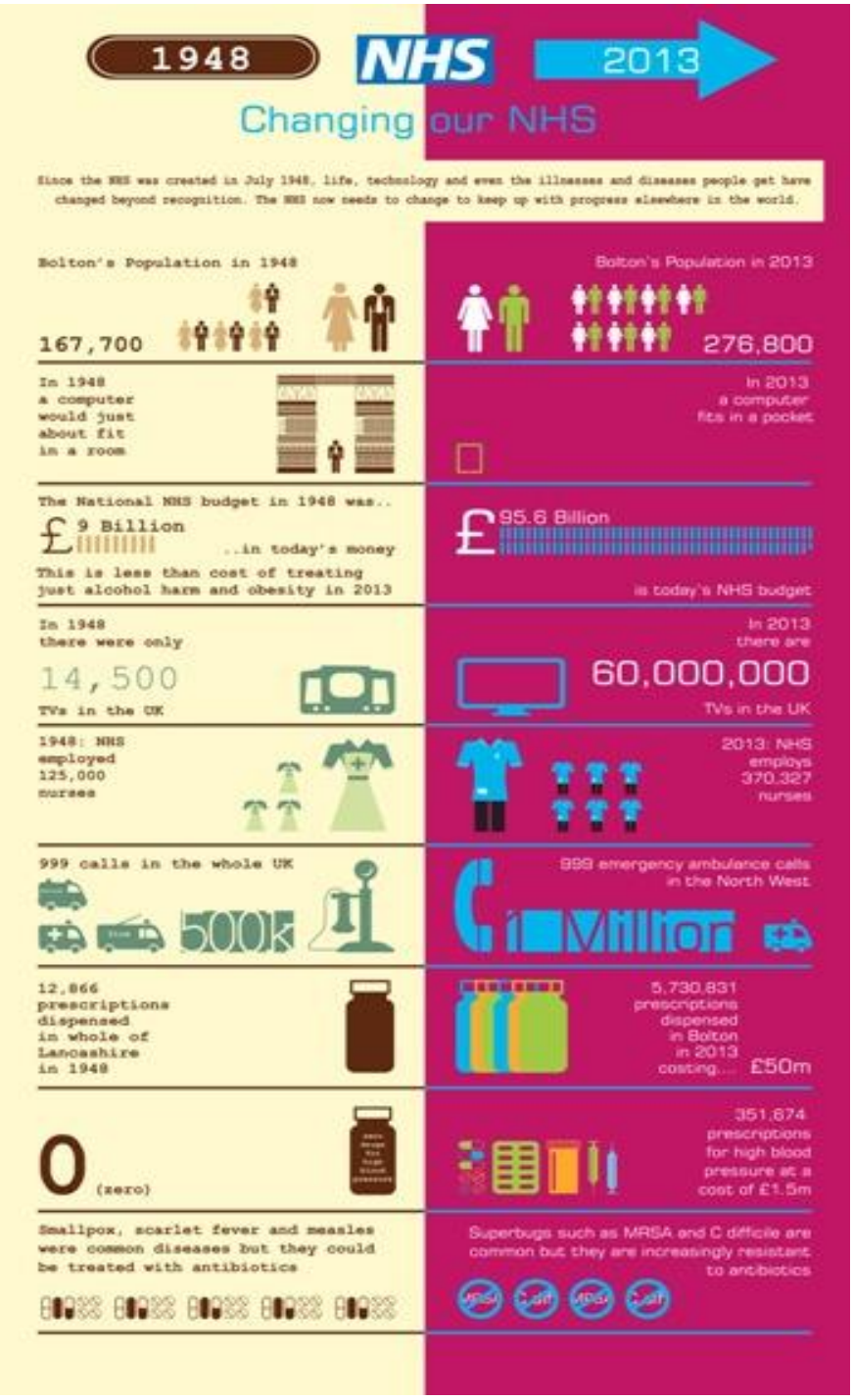
Figure 7: Purposes of our Engagement with Public and Patients



In 2013, Bolton CCG actively engaged its public on our draft commissioning strategy. We wanted public views on the future shape of health and social care services. Our engagement dovetailed NHS England's Call to Action, primary care, integration, reducing waste and self-care.

We launched the public engagement on 5th July 2013 – the 65th anniversary of the NHS, to celebrate the NHS but also acknowledge and explain why it needs to change. A diverse range of people took the time to share their ideas and views in a number of different ways, including telephone and online surveys, focus groups, twitter conversations using #mynhsidea, discussions at patient meetings, and online forums.

Many also joined the CCG at our town centre event in a marquee where people completed surveys, wrote on 'graffiti walls', and spoke face to face with CCG Board members. We used an [infographic] to help illustrate the case for change by showing how NHS, society and demography has changed since the NHS was created in 1948. This proved a great draw and talking point with people.



After this borough-wide engagement, we focused on the views of service users and those identified at risk of future hospital admissions using in-depth face-to-face interviews to feed into our integration planning. The CCG, Council and Healthwatch Bolton carried out interviews with patients.

Overall, we heard the views of over 1,500 people to inform our commissioning decisions over the next 5 years. We now have robust and rich intelligence on what matters to Bolton people and their priorities for the CCG when commissioning services on their behalf.

Following the extensive engagement with the public, NHS Bolton CCG has formally agreed a framework to check against the public's priorities in every commissioning decision we make – see section 3.4

Over the last 12 months we developed our own channels and networks, and we are now building on these to ensure public voice is at the heart of everything we do. We have recruited a health panel to work with us to share their views, ideas and attitudes about health services and their health and wellbeing. Over time we will build relationships with our panel members engaging them remotely and face to face, and co-design services together. We will engage our health panel and ETAG and will also target other groups depending on the target audience and issue.

We are developing our own social media presence including Facebook, Twitter, and You Tube. Digital media will underpin our stakeholder engagement through Twitter, videos, apps and our website. Digital communications will not replace our other channels for the public – only complement traditional methods – but where appropriate social media will be our primary channel for engaging with key partners and many community groups. Globally, there is definitely a channel shift and we need to embrace this shift. However, the majority of our public tell us still prefer traditional media and our target audiences are often elderly and people in lower socio-economic groups. We will continue to monitor trends in usage and preferences and develop digital channels in line with the needs of Bolton people.

We engage with Bolton's diverse community – not just those easiest to talk to. NHS Bolton CCG has an active equality and diversity public network which call our ETAG (equality target action group). Members represent community groups from 9 protected characteristics. ETAG meets every 2 months to discuss our plans and get views on service change. More details on how to get involved with ETAG can be found on our website here.

In all our engagement, Bolton's diverse, hard to reach, communities will have opportunities to become involved with the CCG and we'll work hard to ensure their voice is heard in shaping high quality services.

To deliver quality, we need to improve how we capture patient experiences – we won't rely on others to tell us what Bolton patients are saying about the services that we commission. We will develop our own methods including a Bolton survey for all our providers capturing real-time and retrospective information.

Ideally, surveys should be carried out in real-time at the point of service or interaction. This is shown to measure experience over perception of experience. However a downside is the most recent interaction with a person would cloud how they respond, and could be disproportionately important to them at the time. Moreover, only surveying patients in real-time would exclude collecting data on patient outcomes and satisfaction with the results rather than the process.

Our Bolton survey will sample a number of patients in real-time (continuous tracking) on events driven survey, and at least twice a year carry out a relationship and outcome based survey. The real-time surveys will allow providers to tackle any operational issues quickly, and the periodic surveys will enable us both together to identify systematic or bigger issues to improve.

We will measure experience of patients in primary, secondary and community services to look at whole pathway.

We will promote the use of valid external tools such as NHS Choices and the Friends and Family Test to increase the number of responses and therefore their value to us as a performance management tool.

3.2. PRIMARY AND SECONDARY PREVENTION OF ILL HEALTH

Bolton CCG, in collaboration with Bolton Council and the Council's Public Health department, and most recently Public Health England, has a strong record of partnership working to improve health outcomes by investing in prevention programmes. Upstream interventions, jointly commissioned in the context of whole systems delivery, have resulted in key successes which continue to be realised and which can be used to further inform preventative approaches.

All 50 Practices in Bolton take part in the primary care work programme which has a strong component of primary and secondary prevention, focused on the diseases most likely to kill Bolton people early. The high coverage of the NHS health check continues in Bolton with actions in primary care to ensure registers for Cardiovascular disease, Atrial Fibrillation, Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Chronic Kidney Disease, etc are as accurate as possible, with care bundle interventions applied to patients on these registers.

Examples of Bolton's success towards improved outcomes wholly or partly attributed to primary and secondary prevention are:

- Reduced teenage conceptions
- Reduced number of repeat terminations
- Above average immunisation and vaccination rates in both children and adults
- Unparalleled uptake of health checks
- Reduced diabetes prevalence
- Lower than expected cancer prevalence

There are huge challenges associated with investing in prevention programmes. Outcomes are often difficult to evidence and sustained behaviour modification is frequently hard to achieve especially in communities that are less amenable to change and/or hard to reach and engage. Nevertheless Bolton CCG is committed to continuing to work collaboratively to ensure that the continuum of that seamless service delivery is enhanced from prevention, early intervention, timely diagnosis and appropriate treatment/management. As a result of the Health & Social Care Act 2012, stronger joint commissioning is the key to ensuring that services do not become fragmented and continue to develop to meet evolving need.

With partners, the CCG has specific joint commissioning ambitions that it wishes to achieve over the coming five years. These include:

- Recommissioning of health and wellbeing services for children aged 5-19 years
- Review of child and adolescent mental health services (CAMHS)
- Recommissioning IAPT services
- Recommissoning of integrated wellness services
- Further linking primary and secondary care to positively impact on rising levels of liver disease
- Rolling out the learning from the Staying Well programme
- Investing in integrated neighbourhood MDTs (with an additional focus on “Making Every Contact Count”)
- Testing out new approaches to addressing the needs of people with complex lifestyles involving drug/ alcohol/ mental health issues
- Reviewing Enhanced Service Provision in Primary Care
- Developing and ensuring the delivery of Bolton wide multiagency Flu Campaigns
- Further improving termination services to increase uptake of post abortion contraception
- Further improving the management of infectious diseases to include a stronger emphasis on secondary prevention
- Improving breast feeding rates
- Ensuring the acute care providers also “Make Every Contact Count”
- Redesigning falls prevention services and interventions
- Improving the third sector offer to communities
- Maximising the local impact of the Greater Manchester Starting Well and Ageing Better programmes

3.3. PREVENTION AND EFFECTIVE TREATMENT IN OUR PRIORITY DISEASE AREAS

3.3.1. Alcohol

Bolton is ranked in the top quarter nationally for all measures of alcohol-related harm and deaths from liver disease are making an increasing contribution to our internal life expectancy gap. We are in a situation where the more affluent parts of our population drink more, but the most deprived communities experience 2-3 times

greater loss of life attributable to alcohol because of associated risk factors such as smoking, CVD, and mental health problems.

We currently perform around average on alcohol indicators compared to our statistical neighbours, but this should be improved as premature death from liver disease is one of our few increasing mortality trends; current mortality rate is 22.3 per 100,000 and Bolton is ranked 7th of our 15 similar local authorities in Longer Lives. This scores Bolton as 'better than average' for our group, but only slightly so – therefore, we should aim to improve to at least the top of the 'better than average' group with a target rate of 19.0.

The greatest preventative gains will come from central policies focused on the monetary cost and control of alcohol. This should be combined with local programmes of work; in Bolton this currently includes:

- A local joint-agency alcohol strategy prioritised by the Bolton Vision partnership of public sector partners, faith leaders and business leaders.

- At scale AUDIT C stratification of drinking population in primary care and onward referral to appropriate support

- Recent increase in nurses on the Gastroenterology Ward with a focus on reducing length of stay and preventing further presentation/readmission.

- A recent large-scale redesign of specialist alcohol treatment system with a single point of access to improve triage time;

3.3.2. Cardio Vascular Disease (CVD)

CVD is the most significant contributor to our gap in life expectancy, both the gap to England and our internal inequality. Around 700 people die in Bolton each year of CVD; within this total the most are from CHD (300) and stroke (180). The mortality rate reduces year on year but our reduction is not as fast as that seen nationally which is causing the relative gap to widen.

'Longer Lives' ranks Bolton as the 135th worst area for CVD mortality (from 150 areas in England) and of more concern 14th worst compared to the 15 areas of similar deprivation. Our position here has worsened from the 2013 release last year. We want to halt this declining picture and in particular, improve our ranking relative to our comparators. Our ranking here is currently 'worst' and so we should aim to increase our ranking to 'average' by improving our premature CVD mortality rate from 107.8 per 100,000 towards our group average of 99.2.

Bolton has refined its CVD risk assessment programme into 'Triple Aim', designed to increase identification of people recorded on local disease registers, improve disease management, and support the delivery of Public Health targets. As a result Bolton has seen significant increases in the recording of people with CVD on registers and has been able to track a reduction in referrals to secondary care.

Over the past several years new services related to CVD have been established or enhanced. These include:

- Best care of patients on CVD, Heart Failure and AF registers. This involves GPs recording outcomes being met and measured against a care bundle. All 50 Practices take part, with comparative information shared on the scores achieved and outcomes

- A Rapid Access Chest Pain Clinic to ensure early diagnosis and quick referral to appropriate services;

- Cardiac Rehabilitation services for patients referred by the Chest Pain Clinic and those who have had a heart attack, to prevent further hospital admissions;

- The Community Stroke Team help stroke patients with rehabilitation after discharge from hospital.

3.3.3. Cancer

After CVD, cancer accounts for the largest numbers of deaths each year in Bolton, around 650. Bowel and lung cancer are the most significant in both numbers and contribution to inequalities. Many cancers are not as strongly associated with deprivation as CVD and this helps our comparative performance nationally, but the lung cancer gap, especially in women, continues to widen. Recently, for the first time in Bolton's history more women died of lung cancer than men.

Overall, cancer mortality in Bolton in similar to the national average with the notable exception of lung cancer which remains a major cause of inequality in our town. We want to reduce the lung cancer gap to England, especially in women.

Key to reach our goals for cancer is early diagnosis, screening, and public awareness. Key in Bolton are smoking cessation, equitable access and uptake of screening programmes, and work to reduce emergency admissions through better management in primary care and supported self-care/management following primary treatment.

3.3.4. Obesity

Obesity increases the risk of many diseases including CVD and cancer – the two biggest killers in Bolton. Locally, over our three most recent health surveys obesity has increased significantly, reflecting national trends. The increases have been greater in Bolton men, who are more likely to be overweight but women are more likely to be obese. Currently 20% of Bolton women and 18% of Bolton men are obese. Obesity in Bolton's reception children appears stable but is increasing in Year 6 children.

We want to halt the increase in adult obesity locally by maintaining the current prevalence, and address the increase in excess weight between Reception and Year 6 children – excess weight increases from 20.0% to 35.6% between these age

groups locally, and we should seek to maintain the Year 6 figure at 35% (our most recent statistical neighbour average).

Few interventions have been successful at reducing population obesity levels so far. We know this means that new ways need to be developed and introduced, requiring multidisciplinary approaches, effective behaviour change interventions, and the establishment of new social norms. Current services tackling obesity locally include:

- The adult clinical dietetics service accepts referrals for patients with a BMI greater than 30 or who are overweight with comorbidities; patients are offered a place on the 'Fresh Start' programme and/or one-to-one sessions with a dietician;

- The specialist weight management service treats patients with a BMI of 40 and above with or without comorbidities and is a multidisciplinary team comprising a lead clinician, specialist dietician, psychologist, and a physical activity coordinator. It also provides a gateway to bariatric surgery;

- Get Active deliver a wide range of physical activity opportunities to those aged 45 and above across Bolton.

3.3.5. Respiratory

There are serious health inequality issues in Bolton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Bolton as a whole, and historically, COPD detection rates have been lower in these more deprived areas - local evidence suggesting that these groups are not engaging with primary care prevention initiatives. Bolton's asthma admission rate is 2.9 per 100 people on the disease register; this is higher than nationally (2.2 per 100 patients), suggesting poorer management of asthma locally.

The COPD mortality rate in Bolton is relatively static at around 36.6 deaths per 100,000 and we should seek to make reductions similar to those we've seen in cardiovascular conditions over recent years. We should aim to reduce the COPD prevalence inequality gap between the most (5.1%) and least (0.6%) deprived in Bolton, largely a result of the difference in smoking levels between the two.

Best care interventions in primary care are showing improved scores. The Chronic Disease Management Team supports general practice to improve the management of COPD. Other local services are in place to specifically meet the needs of those with respiratory disease locally:

- The Rapid Access Breathlessness Clinic is commissioned to provide assessment, diagnostic tests, and treatment to new onset of symptoms and breathless patients;

- The Domiciliary Oxygen Assessment Service assesses patients with demonstrated or suspected hypoxia and assesses patients who have not been assessed but are receiving oxygen;

- The Pulmonary Rehabilitation Service provides services for those with a diagnosis of COPD meeting the access criteria;

- BART - Bolton Adult Respiratory Service - provides support for acute episodes of respiratory illness.

3.4. EXPANDED, CONSISTENT PRIMARY CARE

NHS Bolton CCG is committed to the successful delivery of high quality general practice, recognising that this is essential to a sustainable health care system for the future.

NHS England wants general practice to play a stronger role in the co-ordination of care, particularly for people with long term conditions and complex health and care problems and respond to the challenge of reducing premature mortality.

3.4.1. HISTORY OF SUCCESS IN BOLTON

In Bolton, General Practices have successfully driven improvements in health and reduction in admissions through our primary care work programme over many years, starting with the Big Bolton Health Check and expanding into effective management of patients on disease registers beyond QOF requirements in all priority disease areas.

NHS Bolton has developed a set of general practice peer clusters to enable comparison of performance that takes into account the different populations that practices work with (see appendix 2). This allows practice performance on specific service outcomes to be benchmarked appropriately and has encouraged open sharing and comparison in Bolton, with customised input, support and advice to practices to enable to improve performance based on their practice demography.

Safety considerations in Primary Care are paramount to the Clinical Commissioning Group (CCG), and therefore a Local Enhanced Scheme (LES) was implemented in 2013/14 to promote a culture of safety within practices making sure clinical incidents and their key themes are shared more widely with both the GP community and the commissioning governing body. We should understand how our systems work and how they can fail, reward and encourage people to report problems, learn from our near misses and errors, and share good practice. Analysing and sharing clinical incidents has been found to be very helpful in primary care and can not only change cultural perspectives but improve service quality.

3.4.2. OUR STRATEGY FOR GENERAL PRACTICE IN BOLTON

The Health and Wellbeing Board have agreed that future service transformation to integrated care will be centred on General Practices in Bolton. This will use the many strengths of general practice such as its system of registered patient lists, its generalist skills and its central role in the management of long term conditions.

Improvement in General Practice quality and responsiveness is a priority of Bolton people and is central to the CCG strategy for the shift in care out of hospital.

We know Bolton GPs are central to:

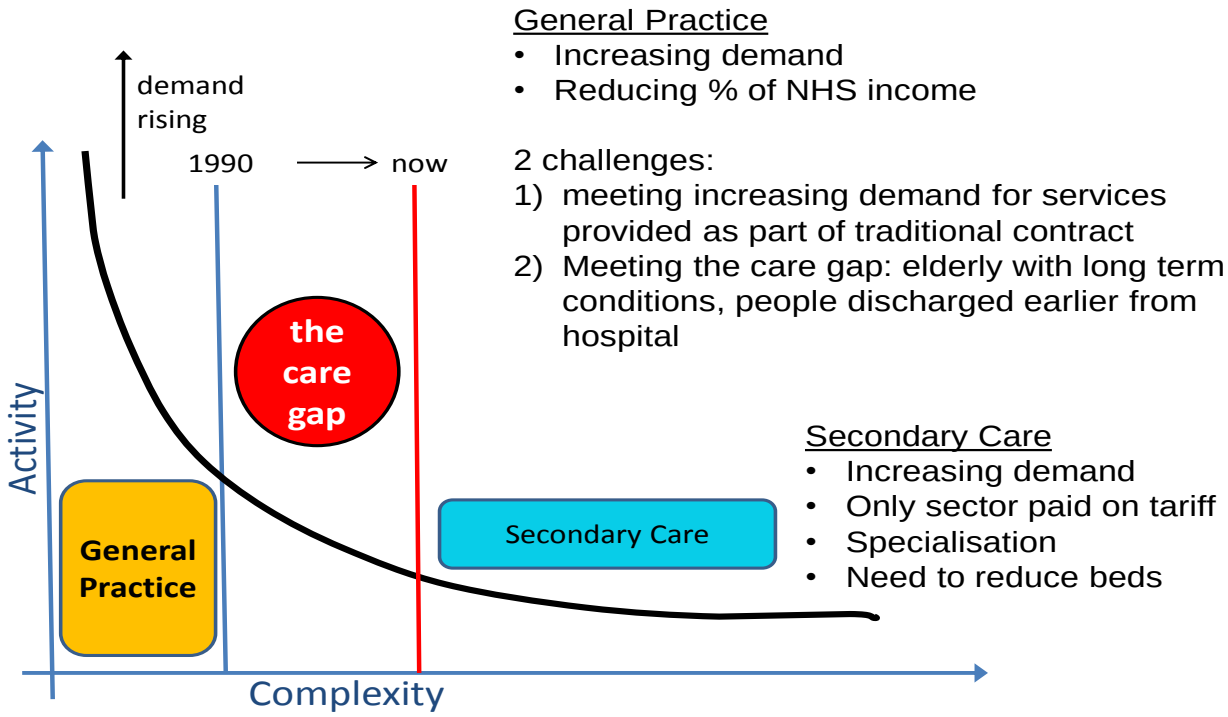
- the management and support of patients with long term conditions
- addressing peoples physical, mental and social care needs
- providing fast, responsive access to care to prevent avoidable attendances / admissions to hospital
- preventing ill health and ensuring timely diagnosis

GP-led integrated out-of-hospital services can reduce avoidable emergency admissions and A&E attendances, prevent ill-health and lead to more timely diagnosis. A stronger role for general practice will enable us to make the changes necessary to deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

However, General Practice can only support the CCGs objective to shift care from hospital to primary and community based care if the capacity exists to do so. It is nationally acknowledged there are growing pressures on general practice services, whilst income to General Practice is under threat.

The proportion of NHS resource provided to General Practice has reduced over the past 8 years. With demand is increasing, General Practice is finding it ever harder to respond to new workload. This leads to two related issues, explained in figure 8, below, which the CCG is committed to ensuring appropriate resource and improvement are directed to.

Figure 8: The challenges in General Practice



The 2 General Practice Challenges:

1. The pressure being felt to meet the rising demand for General Practice with a shrinking proportion of the total NHS resource and reducing GP numbers.

2. The need to more proactively care for patients at highest risk of unplanned hospital admission: those with long term conditions, the frail elderly and those with complex needs. These are commonly the people affected by the 'care gap' shown in the chart and need longer appointments in general practice with multi-disciplinary care planning and support.

The CCG intends to respond to these issues by:

- Firstly, creating capacity to support more proactive care for the highest risk and elderly patients. This will be achieved through CCG coordination of the Enhanced Scheme for reducing unplanned admissions and through using the £5 per head set aside in the CCG financial plan, building towards the Better Care Fund plans with local partners

- Secondly, creating and resourcing a new specification for a consistent high quality General Practice in Bolton, working with NHS England Primary Care commissioners.

3.4.3. A NEW SPECIFICATION FOR GENERAL PRACTICE IN BOLTON

In order to invest in high quality general practice NHS Bolton are proposing to develop a new local specification for General Practice that not only supports the CCG in its delivery of its objectives but invests in primary care to deliver a higher standard of care for its population. This will require a co-commissioning relationship with NHS England Primary Care commissioners and with other relevant partners such as Public Health England and the local Public Health team at Bolton Council.

They key aim of the new specification will be to improve the quality and consistency of general practice across Bolton in order to:

- improve health
- reduce inequalities
- ensure cost effective use of resources

The standards within this new contract will focus on improving access to general practice, improving quality of care and patient experience of care, improved prescribing (medicines optimisation) and reducing waste, early identification and better management of long term conditions and the use of evidence based care pathways.

Engagement has commenced with member Practices and Health and Wellbeing Board partners. The decision on this investment in General Practice capacity and quality will be made in 2014.

3.5. MODERN INTEGRATED CARE

The development of an integrated model for the delivery of health & social care is a joint programme led by the Health and Wellbeing Board and involving NHS Bolton CCG, Bolton Council, Bolton NHS FT, Greater Manchester West Mental Health FT, Healthwatch Bolton and our community voluntary sector.

The programme is being developed in line with national guidance and aims to provide care that is comprehensive, targeted at people of high risk of a hospital admission.

The high level aims of the Bolton Integrated Care Model are to deliver integrated health and social care services for the people of Bolton which:

- Aim to keep patients well, independent and in their own homes (recognising the importance of family and community in promoting wellbeing)
- Provide a good experience of care for patients and their families and result in better outcomes
- Meet the challenges of rising need for health and social care services within dwindling resources
- Are centred around the needs of the individual

3.5.1. PRINCIPLES FOR HEALTH AND SOCIAL CARE INTEGRATION

The following principles have been agreed between partners involved in Bolton's Health and Well-being Board:

- Patients should receive high quality care which is centred on their needs rather than the needs of professionals and organisations.
- The clients/patient should be empowered to manage their own care and self-care.
- Services should be local wherever possible.
- Services should be centralised where necessary (to ensure clinical safety).
- Care should be integrated across health and social care in all settings.
- Services should be accessible, convenient and responsive.
- Information and communications should be centred around the client/patient not the organisation/professional.
- High quality care should be accessible quickly regardless of the time or day of the week.

3.5.2. THE VOICE OF BOLTON PEOPLE IN INTEGRATION

Patients, service users and the public have been actively engaged by all partners.

Through CCG engagement on our commissioning strategy throughout summer 2013, 92% of people seen supported the idea of health and social care tailored to the needs of the individual as it would enhance independence and quality of life.

The important requirements which emerged from the interviews carried out were:

- Better co-ordination of care i.e. have a single person or co-ordinator to contact with questions or request for help.

- Knowing where to get help is key for patients and carers. Patients and service users felt they only received help once it was requested as opposed to a proactive response to need.

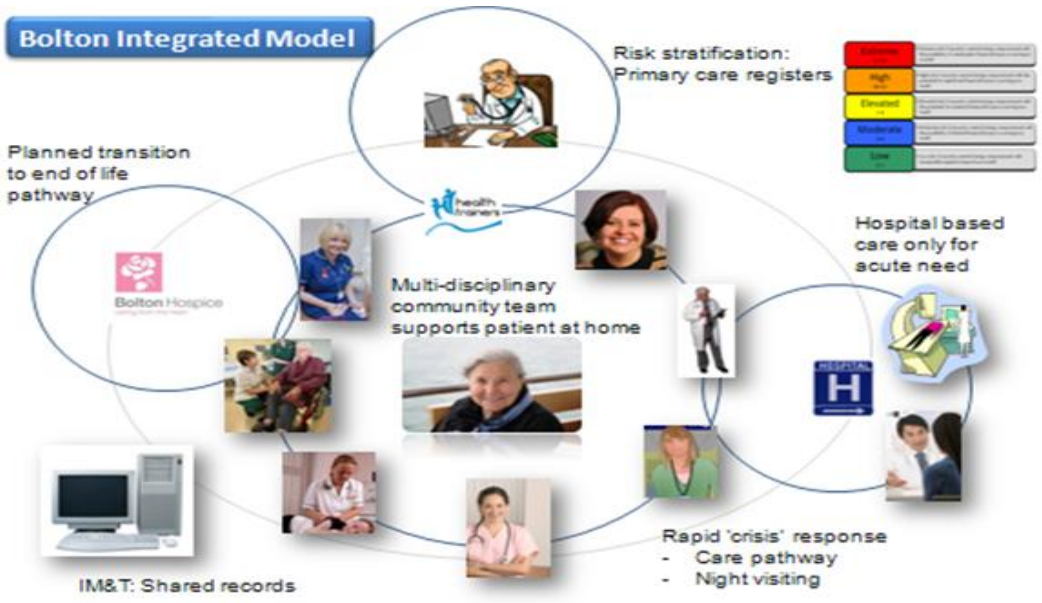
- Improved communication between health and social care agencies to improve service and patient experience

3.5.3. DESIGN AND IMPLEMENTATION OF INTEGRATED CARE IN BOLTON

The full implementation of the new Integrated Care model will see a major shift in care delivered to individuals within their own homes (or usual place of residence).

Figure 9: Vision for Integrated Care in Bolton

Modern integrated care



General Practice is at the core of the Bolton model for integrated health and social care, which will be designed around the needs of populations of 20,000 to 30,000 people built from clusters of practices. This will result in 10 clusters. Each practice population has been “risk stratified” using the national tool for stratification. A multi-disciplinary health and social care team will serve each population cluster.

Patients/clients with multiple long term conditions and/or at high risk of hospital admission and the frail elderly will be allocated a care coordinator who will be responsible for developing and coordinating the patient’s/client’s care plan. The multi-disciplinary team will include adult community nurses, GPs, social workers, physiotherapists, occupational therapists and community psychiatric nurses and generic workers.

District Nursing teams have already been aligned to the 10 clusters and currently work from 10 health centre bases. Therapists currently work from 3 ‘zones’ across the borough of Bolton, whilst the Social Care Teams work from 2 bases covering the North and South of Bolton.

A phased implementation of the service model commenced in early 2014. As the model is rolled out across clusters, it will be continually evaluated and any necessary changes made so that the most effective model can be in place across the entire borough from April 2015.

The multi-disciplinary team will also systematically identify individuals at high risk of future health and social care need and provide advice, support and assistance to

enable people to remain healthy, happy, and independent for longer. The Staying Well approach is being piloted in 6 practices and early evaluation is very positive.

Key individuals within the multi-disciplinary team will operate outside "normal working hours" with services available 7 days a week, 365 days a year. Although routine assessment and care planning will be undertaken during the Monday to Friday working week, District Nursing is a 24/7 service as will be the step-up Intermediate Tier Services that will need to be able to respond if a patient's Crisis Management Plan being in need of activation in the out of hours period.

The multi-disciplinary team will be able to pull in specialist expertise from the following – tissue viability; palliative care; IV therapies, microbiology, diabetology; cardiology, gastroenterology, dermatology, rheumatology, gynaecology, respiratory medicine, orthopaedics, speech and language therapy, dietetics and podiatry. Rehabilitation (Cardiac, Pulmonary and Heart Failure). Falls and reablement services will also support the multi-disciplinary teams. Geriatric medicine and Psychiatry will be particularly important. Consultant job plans will reflect these new ways of working.

£650,000 of the Better Care Fund will be focussed upon the provision of support to Carers. Support provided will incorporate the provision of short term breaks to provide respite for Carers and other support, such as funding for Carers Support Groups aimed at those supporting those with dementia and other mental health conditions. In addition, funding has been set aside to reflect the requirements of the Care Bill, where carers' needs will be separately assessed and support packages put in place.

The outcome of this support for carers will be to reduce barriers to early discharge from hospitals and to reduce the risk of hospital admissions through a lack of adequate support to carers within Bolton.

We have developed a detailed engagement and communications plan to give us qualitative feedback about the service changes and enhancements we are implementing.

3.5.4. EXPECTED OUTCOMES OF INTEGRATED CARE IN BOLTON

This new model of care will significantly change the split between funding for acute care and community care.

Royal Bolton Hospital will have reduced its acute bed base by 253 (from 861) by 2018/19 (29% reduction) and its estate on the acute hospital site will significantly reduce. The community assets will be fully utilised to provide one stop assessments, diagnosis and treatments for the majority of patients. Care will be delivered to patients at a time when they need it, over 7 days per week. Patients and service users (together with carers) will be the heart of individual care planning, with one shared record for all health and social care professionals to work with. The care plan will provide a holistic package of care for the patient, with a comprehensive escalation plan for the patient and their providers of care to implement should the patient's condition deteriorate.

Intermediate Tier services will be predominantly home-based, with a reduction in intermediate tier beds and a reduction in residential care placements over the next five years. Funding will have increased to home-based and reablement services by 37% to provide support for 600 more people at home.

There will be pooled budgets and a risk share arrangement in place between the providers and commissioners of services. A far greater proportion of direct care will be provided by the third sector who will be fully integrated within the care models. The borough of Bolton will have the appropriate workforce in place to deliver holistic care to all its population at risk of current or future hospital or residential care, with fully integrated health and social care teams based around the 10 clusters of GP Practices. Individuals being care for in the multi-disciplinary teams will have joined up care with a key worker to ensure no duplication occurs across or between agencies and individual health and social care workers.

There will start to be a shift in resource allocation between reactive and pro-active care, with additional resources being allocated to preventative care across the Borough.

This will deliver the outcomes jointly agreed and monitored by the Bolton Health and Wellbeing Board, which will be clearly built into the refresh of the Health and Wellbeing Strategy during 2016 and in 2018/19 will be firmly aligned to those actions agreed for the Health and Social Care Integration Programme.

The outcome metrics are as follows;

- Reduce permanent admissions of older people to residential and nursing care homes, per 100,000 population
- Increase the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce delayed transfers of care from hospital per 100,000 population
- Reduce avoidable emergency admissions (national composite measure)
- Increase the proportion of people who receive home based intermediate care (per 100,000 population)

3.6. PRIORITISING MENTAL HEALTH

Locally, the numbers of people accessing support for common mental health problems (anxiety and depression) fall below the level of need measured in the population,

indicating a significant number of people living unsupported with common mental health problems and the associated physical health and lifestyle risks this brings.

3.6.1. WE WANT TO ACHIEVE:

- significantly reduced suicide rate (to our statistical neighbour average of 8.9),
- a reduction in emergency admissions for mental health conditions to our regional average (256)
- increase in the recorded prevalence of depression (from a current diagnosed prevalence of 11% to an estimated prevalence of 26% (self-reported))
- further increases in dementia primary care registers (current diagnosis ratio of 0.48, national best is 0.69)

3.6.2. WHAT WE HAVE DONE SO FAR:

Bolton has recently redesigned its acute mental and dementia services and pathways. Key recent changes include:

- ✓ The establishment of a Mental Health Liaison Service at the acute hospital site of Bolton FT (RAID). This is a key priority for Bolton CCG as it provides better services for mental health service users while also improving all patient experience in A&E and reducing length of stay at Bolton FT

- ✓ Changes to maximise access to screening and assessment. As part of this, primary care psychological therapies have been transferred to GMW from the Royal Bolton to ensure closer working ties and improve the care pathway by minimising gaps;

- ✓ The establishment of a Memory Assessment Service for dementia in Bolton and increased integration of older people's mental health services.

- ✓ There are now two services for common mental health problems in Bolton with activity contributing to the IAPT programme. At 'step 3' is the primary care psychological therapy service delivered by GMW which is now an established service. The 'step 2' services are provided by Think Positive and 1Point and the CCG is confident that with the additional capacity commissioned from December 2013, the 15% access target will be achieved by March 2015.

- ✓ A fully redesigned home based care approach to more acute mental health conditions, with investment in 24/7 community services to provide a viable alternative to admission to a mental health bed has been extensively consulted on and will be implemented in 2014.

3.6.3. OUR PLAN FOR MENTAL HEALTH

The CCG is working with all key partner agencies (Bolton Metropolitan Borough Council, Greater Manchester West NHS Foundation Trust, Bolton NHS Foundation Trust and the local voluntary sector) to develop a revised strategy for the commissioning and provision of mental health services for the population of Bolton.

This includes a detailed needs assessment, together with a review of all current service provision to enable a joint understanding of where additional investment is required and where service redesign should be undertaken.

Key areas of work to improve outcomes and patient experience for those with mental health problems include:

- Reprocurement of Improving Access to Psychological Therapy (IAPT) services for patients with moderate mental health issues requiring counselling or psychological therapy to ensure that sufficient capacity is commissioned to meet demand and to keep waiting times low
- Redesign of Child and Adolescent Mental Health Services (CAMHS) to ensure sufficient capacity is commissioned to meet demand and to reduce waiting times and keep them low
- Ensuring appropriate care for people with Learning Disabilities – with enhanced step down placements being secured for service users who do not require to be in Calderstones (and other secure facilities)
- Full implementation of the RAID service to prevent people with moderate mental health issues (including drug and alcohol abuse) who attend A&E from being admitted to hospital where not clinically required
- Working with Bolton Council to ensure delivery of high quality, effective drug and alcohol services
- Improving diagnosis of mental health problems
- Ensuring that services provide seamless transition from children's to adult services
- Implementation of a single point of access for mental health services to ensure that patients access the right service at the right time
- Full implementation of the home based mental health care pathway with associated reduction in beds and centralisation of elderly mental health beds at a new-build specialist unit.

Once redesigned, the mental health services will ensure timely access for those in need of support, with evidence-based pathways and good outcomes, including reduced deliberate self-harm and suicide, improved mental health and wellbeing and will contribute towards the CCG and Bolton Council's strategic aims of improved school achievements, reduction in offending and increased number of people in work and living independently.

3.7. ACCESSIBLE URGENT & EMERGENCY CARE

Bolton CCG has made significant improvements in the delivery of high quality, patient centred urgent and emergency care. Key successes in Bolton include:

- The achievement of the 4 hour A&E target for the full year and every Quarter of 2013/14

- 0 over 12 hour trolley waits in A&E in 2013/14
- Low emergency readmission rates
- Reduced non elective length of stay during the year
- Development of plans for an Integrated Discharge Planning Team
- Redesign of Intermediate Care services – with a planned shift of care from bed placements to care for individuals within their own home
- Development of phased implementation plan for Integrated health and social care teams to focus on those at highest risk of hospital and long term residential care admission to enable them to live independently in their own home.

However, there is still much more to do to ensure that the safest, highest quality urgent care is delivered to our local population, which includes full implementation of 7 day consultant working by 2016/17 so that all patients have improved outcomes from care delivered by the highest qualified clinicians in hospital at weekends.

The new Integration agenda places a focus on the provision of care towards the most vulnerable in our population, however Bolton CCG is keen target service provision and development to ensure that all age groups within Bolton receive quality access to urgent care. A revision of the current Urgent Care Strategy will be undertaken in 14/15 to identify key new areas of work in a targeted approach to improve urgent care taking a whole system approach.

3.7.1. DESIGN OF URGENT CARE BUILT ON PUBLIC ENGAGEMENT

We have engaged with the public, patients and with other stakeholders including our member practices urgent care services over an 18 month period. This included market research to inform social marketing campaign, on the future of the walk in centre and options for out of hours redesign. This included borough-wide engagement and engagement with hard to reach communities.

In spring in 2013, we carried out online and postal surveys, and face to face to engagement with users of the GP out of hours service.

The key findings were:

- The majority of people had positive experiences of using GP out of hours services and high levels of confidence in staff.

- The current location and service model were popular, and the proximity to Water's Meeting was a factor in use.

- Half of people surveyed would contact their practice or GP OH service if needed a GP in out of hours but a tenth said they would go to A&E.

- Poor GP access or perceived poor access did influence use, and a small majority preferred the service at OOH to their own GP.

- Over a third didn't feel informed about health services in Bolton. this was highlighted in reported low usage of pharmacists and NHS Direct.

- There was no agreement on introducing technology to innovate service such as Skype appointments. We have found people tend to support this innovation but for other people, not for themselves.

This built upon extensive, multi-method engagement the previous year on knowledge, behaviours and use of urgent care services by Bolton people. The findings have given us a real insight into people's views, attitudes, awareness of services and behaviour. There was:

- Confusion / lack of understanding of urgent care services, particularly alternatives to A&E, low awareness of out of hours service, and pharmacy services.

- Difficulty in making a GP appointment, especially if urgent.

- The attitude/unfriendliness of receptionists was an issue in accessing GP services.

- People often use A&E as an alternative to other primary care services.

3.7.2. AGREED AIMS FOR URGENT CARE

Bolton CCG's key strategic intent to is prevent the need for urgent and emergency care wherever possible – this is being driven through the provision of planned interventions and care (with a focus on self care and prevention) for people who are at risk of current or future admission to hospital. The CCG is focussing specifically on those nearing the end of their life, the frail elderly, people with multiple long term conditions and those with complex lifestyles (which may involved alcohol and drug abuse) as referenced in section 4.5 on Integration.

The CCG and Bolton FT are also developing further ambulatory care pathways to prevent people with conditions which can be managed in the community (such as low risk cellulitis) from being admitted to hospital. These patients will instead be assessed and managed in the community or their own home.

The CCG has recently worked with key partner agencies on the update of the shared urgent care strategy. This strategy focuses on the role of primary care in supporting the population to take responsibility for their own health, health promotion and early awareness of treatable conditions and driving systematic identification in Primary Care of patients at risk of long term health conditions and hospital admission – then putting in place active intervention across primary and community care. Specific focus is on CVD and respiratory as these were highlighted as value opportunities in the 2013 "Commissioning for Value" indicative data.

Bolton CCG has benchmarked its performance against peer organisations for quality and outcomes relating to urgent care. These are detailed below:

	Bolton CCG	Peer Group Median	Peer Group 75th centile	Peer Group 90th centile
Non elective admissions per 100,000	11,095	11,495	11,033	10,626

population				
Emergency Readmissions (indirect standardised rate)	11.7	12.4	11.9	11.7
A&E attendances per 100,000 population	32,702	35,301	32,437	31,474
Non-elective Length of Stay	4.9	4.65	4.45	4.10
A&E Net promoter friends and family score	Note this relates to Bolton FT as a provider and is benchmarked across Greater Manchester providers for the period Apr-Dec 2013.			
	64.3	57.7	65.7	71.9

In order to reduce variation and improve outcomes challenging outcome metrics have been agreed which will see:

- 9.7% reduction in emergency admissions 2013/14 to 2018/19 (30,924 to 27,914)
- 5.8% reduction in A&E attendances from 2013/14 to 2018/19 (95,039 to 89,518)
- A net promoter score of +71.9 in A&E by 2018/19 (from +64.3 baseline in 2013)
- 16.3% reduction in non elective length of stay by 2018/19 (4.9 to 4.1 days)
- Sustaining performance at or above the 90th centile of peer organisations for emergency readmissions (at 11.0 standardised rate per 100,000 population from a baseline of 11.7)

The joint Urgent Care Board (Bolton CCG, Bolton FT, BMBC and NWAS) have agreed a range of qualitative and quantitative measures which ensure the monitoring of the delivery of a high quality, timely urgent care system. These include measurement of A&E re-attendances and patient experience of care. A daily real-time monitoring system (with set thresholds to trigger alerts) has been established which can be accessed by all organisations to enable rapid escalation of any issues which occur. Daily conference calls take place during times of increased pressure across the urgent care system.

3.7.1. CCG URGENT CARE COMMISSIONING PRIORITIES

Our commissioning priorities for urgent care moving forwards include:

- Re-procurement of the GP Out of Hours service
- Full implementation of the Integrated Neighbourhood Teams (Integrated Care) to prevent avoidable unplanned admissions to hospital or long term residential care
- Providing comprehensive intermediate tier services in the community with a single point of access

- Designing and implementing a range of ambulatory care pathways (for COPD and cellulitis) to prevent unplanned short term admission to hospital for conditions where patients can be managed in the community
- Redesigning community services which support the shift of unplanned care to the community
- Further pathway development to encourage a seamless journey for patients through the system.
- Continued patient and public engagement on when to use A&E and when to access other urgent care (including GP Out of Hours or a local pharmacist) to reduce inappropriate reliance on the Emergency Department
- Reducing length of stay of people who are admitted to hospital as an emergency
- Reducing the proportion of people who are readmitted to hospital soon after their original unplanned admission
- Focussing on pro-active care, case management and use of technology to reduce the dependence on urgent care services

3.7.2. COMMISSIONING PRIORITIES - PARAMEDIC EMERGENCY SERVICE

Commissioning Intentions for the Paramedic Emergency Service (PES) have been produced by the lead commissioner (NHS Blackpool CCG) on behalf of the 33 CCGs in the North West (NW).

The PES commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee 'Urgent and Emergency Services' report (July 2013), and the Keogh 'Urgent and Emergency Care Review' (November 2013). Both reports describe PES as having a changed role within an enhanced system of urgent care.

One of these key required changes is to achieve a reduction in conveyance to hospital and the PES contract for 2014/15 has been designed to encourage this by incentivising this through CQUIN. This will allow the provider, North West Ambulance Service (NWAS), to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by 'See and Treat' and 'Hear and Treat'. All of these schemes support the achievement of 'Safe Care Closer to Home', which is a strategic goal of NWAS, as well as supporting Bolton CCG plans for integration.

Over the 5 year period of the strategy the review and redesign of transport will be a key cornerstone to the successful implementation of the shift of activity from hospital to community settings. The traditional transport model which exists currently will not efficiently deliver the significant activity shifts required to release the benefits outlined in the Better Care Fund plans.

Bolton CCG will engage with the Bolton population in 2014/15 to inform the redesign of Health and Social Care transport to meet the future needs of our integrated services. This will also require consultation with key stakeholders, as the change potential will impact across the whole system with key deliverables aligned to decreases in conveyance, referral to other services and transportation to non-traditional hospital settings.

This redesign will be an opportunity to enable the integration plans to be delivered effectively and efficiently and not in isolation.

3.7.3. COMMISSIONING PRIORITIES - PATIENT TRANSPORT SERVICES

Five PTS contracts are in place across the North West, which were awarded following a procurement exercise. Each are three year contracts, which began on 1 April 2013. There is one provider for each of the county areas; the provider for Bolton is Arriva.

The current service specification contains increased operating hours, and higher quality standards than the previous one. Planning for the next tender will begin during 2014/15, which will include reviewing the current service specification against new and emerging policy and guidance, such as 24/7 working. Bolton CCG will engage in this process via the GM Urgent Care Commissioning Leads Ambulance Commissioning Group, and the wider governance in place.

3.8. HIGHLY PRODUCTIVE ELECTIVE CARE

As with urgent and emergency care, Bolton CCG's strategy and vision for the delivery of elective (planned) care is to see a significant shift in delivery of care from the acute sector to primary/community care.

Historically there has been an annual increase of 3% in hospital activity year on year. The CCG has started a programme of pathway redesign which is resulting in a reduction of non specialist referral to secondary care (a reduction of 3.4% of GP referrals to hospital was seen in 2013/14 compared to the previous 12 months) – with patients with specific clinical conditions being managed in primary care by their GP or within a community service. This benefits patients, who are getting the right care at the right time and do not need to travel to hospital for an appointment, frees up the specialists in the hospital to see the urgent or more complex conditions and results in patients across all sectors being seen in a timely manner, in the most cost effective way.

The CCG is working with the local acute provider, Bolton Hospital, on the shift of activity for high volume specialties which are clinically appropriate to be delivered in primary/community settings. These include: gynaecology, urology, ENT, Dermatology and Musculoskeletal services.

This strategy of shifting some of our budget away from hospital service to community services is supported by Bolton people in our engagement. When we worked on priorities with Bolton people, investing in community and primary care services, better assessment and treatment of dementia, investing in prevention and disinvesting in some elective services such as tonsillectomies and IVF are commonly suggested.

3.8.1. AGREED AIMS FOR ELECTIVE CARE

The CCG is working proactively with local providers of elective care (predominantly Bolton FT and the MBI Beaumont) to ensure that services delivered are of high quality and provide a positive patient experience. The CCG will continue to ensure that, for the local population, all waiting time targets are met and that the care delivered is harm free and provides the best outcomes (measured through PROMs and PEMs).

The CCG is also ensuring that all services which are commissioned for the local population are in line with best practice and evidenced-based medicine. Only procedures which are proven to add value to an individual will be commissioned. This is to ensure that benefits to patients are proportional to risk and also to ensure the most efficient use of the limited commissioning resources available.

Bolton CCG has benchmarked its performance against peer organisations for quality and outcomes relating to planned care. These are detailed below:

	Bolton CCG	Peer Group Median	Peer Group 75th centile	Peer Group 90th centile
Elective (inc daycase) admissions per 100,000 population	13,662	14,833	14,034	13,315
Daycase rates	77.2%	80.7%	82.4%	83.2%
Outpatient first attendances (per 100,000 population)	33,337	32,518	30,049	28,361
Outpatient follow up attendances (per 100,000 population)	73,423	81,215	70,550	63,127
New to follow up ratios	2.20	2.54	2.25	2.10

Elective Length of Stay	3.3	3.1	2.98	2.85
Inpatient net promoter friends and family score	Note this relates to Bolton FT as a provider and is benchmarked across Greater Manchester providers for the period Apr-Dec 2013.			
	76.9	74.5	77.1	79.5
Procedures of limited clinical value (per 100,000 population)	Apr-Sep 2013 baseline, benchmarked across Greater Manchester CCGs			
	18.55	17.39	15.56	14.26

In order to reduce variation and improve outcomes challenging outcome metrics have been agreed which will see:

- 7.5% reduction in outpatient first attendances from 2013/14 to 2018/19 (90,374 to 83,609)

- 18.5% reduction in outpatient follow up attendances from 2013/14 to 2018/19 (188,819 to 153,976)

- An increase in daycase rates to 82.4% in 2018/19 (from 77.2% in 2013)

- A net promoter score of +79.5 in inpatients by 2018/19 (from +76.9 in 2013)

- 13.6% decrease in length of stay by 2018/19 (3.3 to 2.85 days)

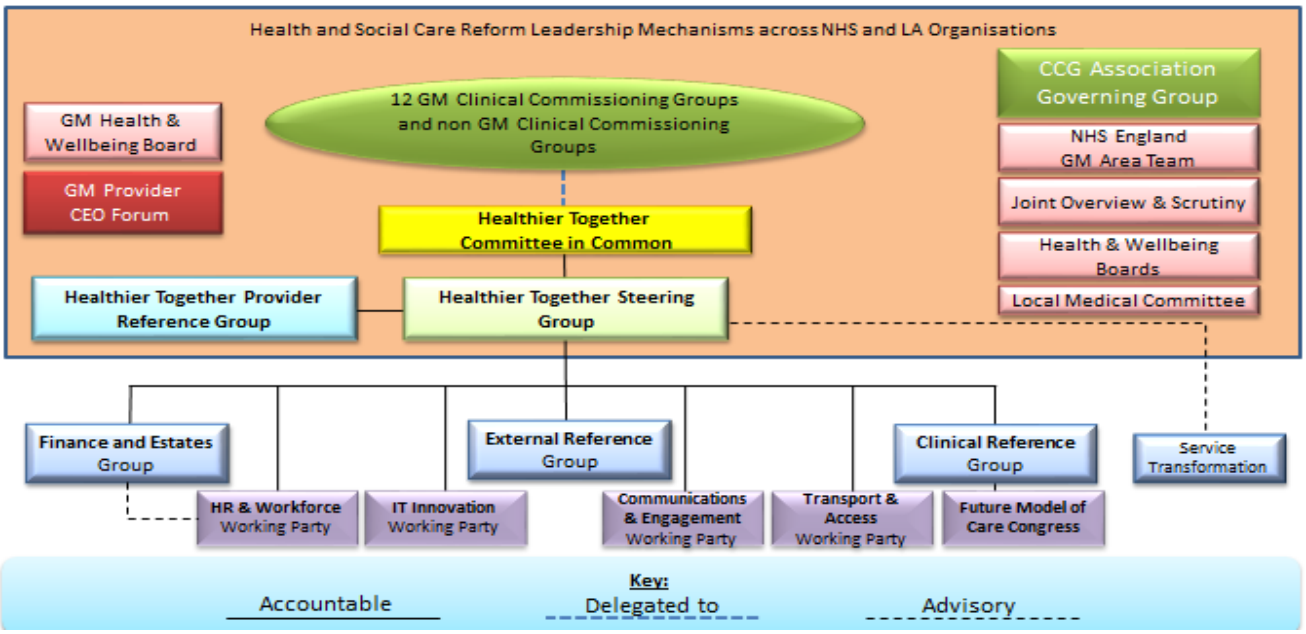
- 23.1% decrease in Procedures of Limited Clinical Value (18.55 per 1,000 population in 2013 to 14.26 by 2018/19)

3.9. HEALTHIER TOGETHER

The Healthier Together programme is part of the Greater Manchester (GM) Programme for Health and Social Care (H&SC) Reform, which aims to provide the best health and care for Greater Manchester. It is the largest and most ambitious health and care reconfiguration programme in the country.

The programme is responsible to the 12 Clinical Commissioning Groups across Greater Manchester, with the CCGs exercising our statutory responsibility for commissioning through a shared decision-making body, the Healthier Together Committees in Common (formally a sub-committee of each CCG Governing Body).

Figure 10: Leadership, Governance and Engagement in Healthier Together



3.9.1. THE HEALTHIER TOGETHER CASE FOR CHANGE

The way hospital services in Greater Manchester have evolved and are currently organised, with a hospital in each borough providing a similar broad range of services, was designed to meet the needs of the last century.

This has led to variations in the range and quality of services available in different areas, resulting in inequality of access to services in different areas. For example, the mortality of patients who undergo Emergency General Surgery varies from **23.1** to **51.7** per 1,000 spells across Greater Manchester, depending on where people are treated. This needs to change, with everyone entitled to the best outcome wherever they live, and yet we have a limited number of specialist clinicians, rising demand and serious financial pressures.

An analysis by Mott McDonald has forecast the financial gap between expected activity in acute trusts and available funding across Greater Manchester over the next 5 years at £742 million, with a further £333 million gap in social care funding – a total system-wide pressure of over £1 billion. Doing nothing is not an option.

As more people receive appropriate treatment at home or in the community, those patients that do need to be admitted into hospital, especially in an emergency, are likely to have more complex needs. They are most in need of very specialist care and being assessed by a senior doctor will improve their chances of the best outcome. Senior doctors are not available in all specialities on site 24 hours a day, 7 days a week due to the large spread of services across Greater Manchester. This means that Greater Manchester has an inequity of provision out of hours and at weekends often leading to poorer outcomes for patients.

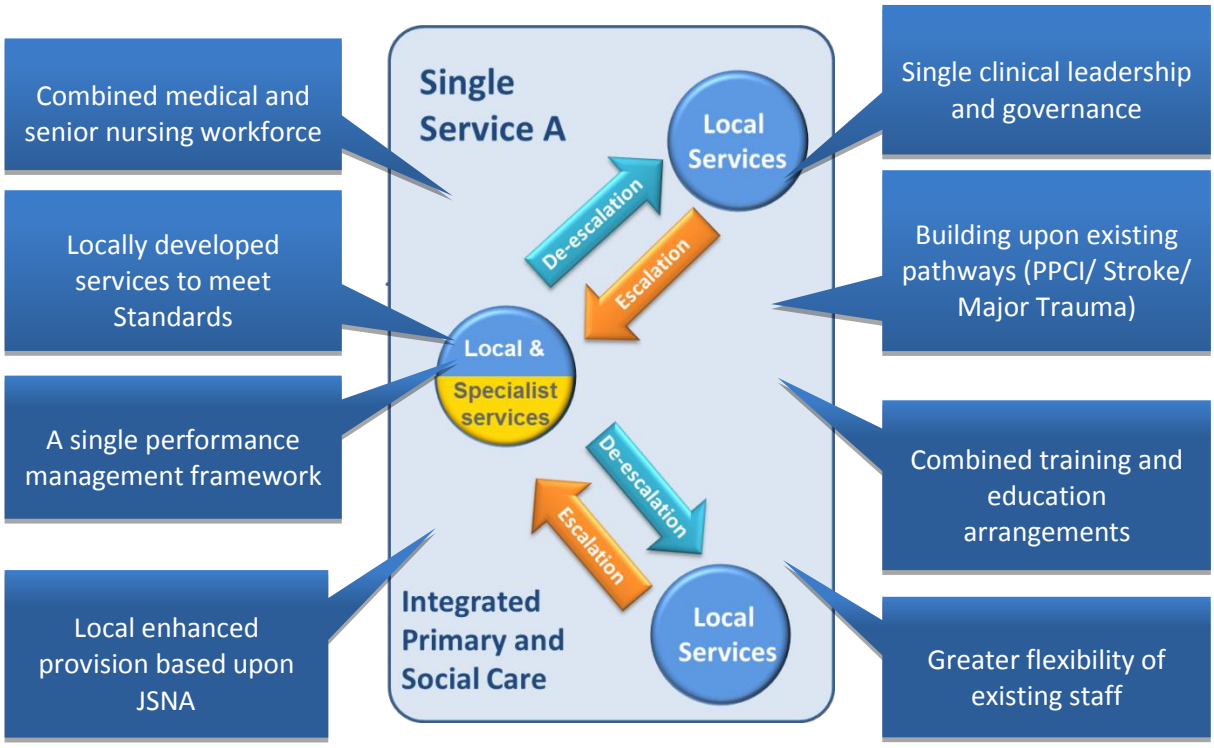
3.9.2. THE PROPOSED MODEL OF CARE

Over the last 24 months, over twenty clinical congresses involving hundreds of clinicians have considered the issues facing our health system. They have explored the potential solutions to ensure services remain high quality, safe and cost effective for future generations. They have agreed the commissioning standards for the in-scope services “in-scope” services: Urgent, Acute and Emergency Medicine; General Surgery; and Women and Children’s services.

The proposals arising from these congresses are for services to be shared across a number of defined hospital sites, with clinicians working across those sites to provide seamless care, with the teams delivering the “once-in-a-lifetime” specialist care on a designated site. These “single services” are shared across the geographical footprint, and the clinical teams benefit from being part of a wider, sustainable and better supervised team, raising standards in the routine work in the District General Hospital as well as meeting the clinical standards at the specialist site, raising standards for the whole population.

This should also significantly improve efficiency at all the sites (as routine activity would no longer be interrupted by emergencies), and it is expected that that the Trusts would share the financial risk to avoid the perception of “winners and losers”.

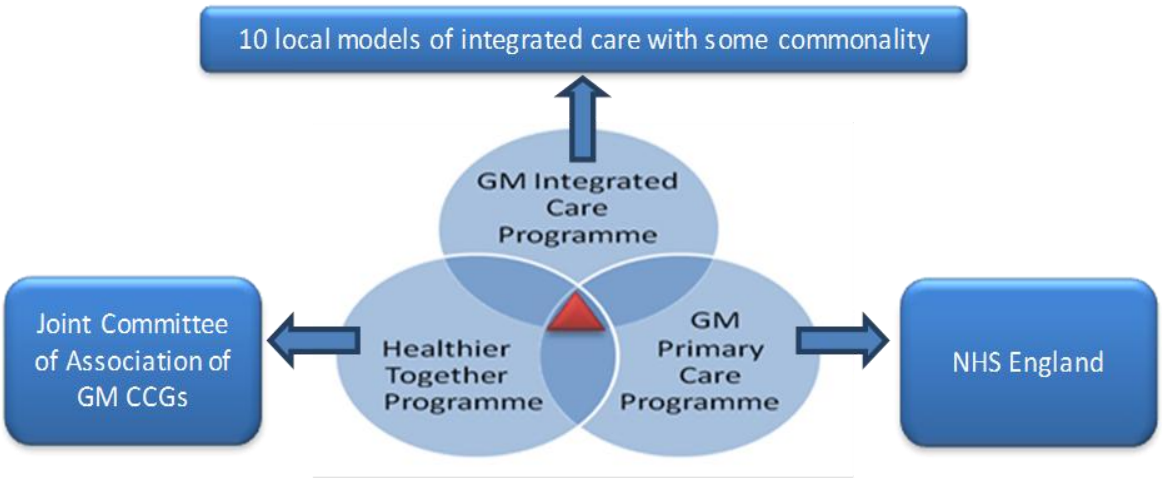
Figure 11: The Healthier Together Model of a Single Service



3.9.1. CONTEXT LOCALLY

As the different parts of the health and social care system are inter-dependent, major changes to services in the community are required before significant hospital changes can take place. The wider Healthier Together programme brings together the locality programmes developing Community-based Care (Integrated Care and Primary care) with the reform of "In Hospital" care across Greater Manchester:

Figure 12: The linked strategies for Health and Social Care reform



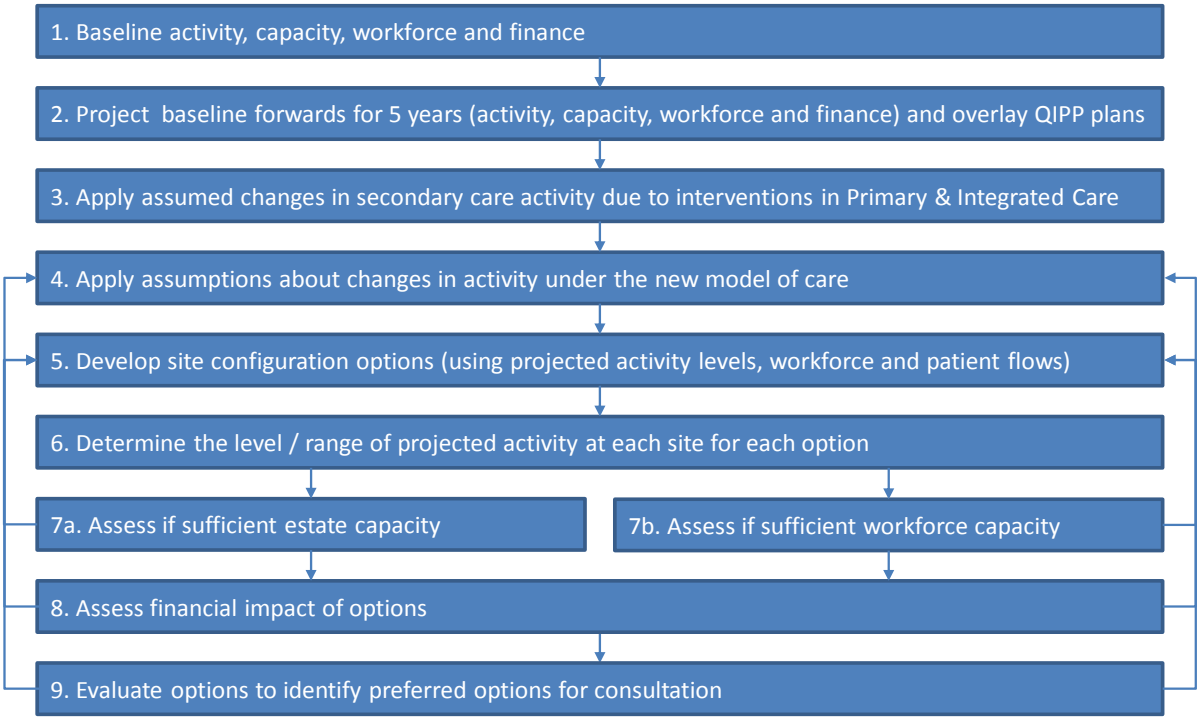
Clinicians across Bolton FT, Salford FT and Wigan FT are working together to identify how clinical rotas and governance could be designed to support the Healthier Together single service model. This will provide an insight during the consultation that CCGs can use in their eventual decision making.

3.9.2. THE NEXT STEPS

The proposals to change hospital services will be subject to statutory public consultation, and must pass the requirements of the NHS Assurance process. Clinical assurance has already been secured for the model via the National Clinical Advisory Team (NCAT) – *"We unanimously support the Programme to proceed to Consultation. This is the most ambitious and well thought out work we have come across. We are highly impressed".*

The determination of the viable options for consultation have been subject to a rigorous 9 stage process:

Figure 13: Steps for Healthier Together Options appraisal



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Following extensive pre-consultation engagement, including with key partners such as the Association of Greater Manchester Authorities (AGMA) the Committees in Common of the CCGs will decide to proceed to consultation in June 2014. Subject to NHS Assurance, it is planned that formal consultation will take place in the summer of 2014, with a final decision at the end of 2014. There are considerable risks in a programme of this size and complexity, and given the proximity of a general election there is a possibility that the formal consultation and decision will need to be postponed until 2015 – this would clearly delay the programme and the delivery of the benefits expected to be realised.

3.10. SPECIALIST SERVICES IN WORLD CLASS CENTRES OF EXCELLENCE

The 5 year strategic plan for North West Specialised services is set within the context of a whole system transformation which addresses the 6 attributes for high performing systems.

Commissioning of specialised services will form an integral part of an overall health and care system planning approach. Specialist commissioners will work with partners including Health & Wellbeing Boards and Academic Health Sciences Networks & Centre to ensure transparency and openness of evidence-based commissioning decisions and best practice and innovations are adopted and implemented at scale.

Specialist Commissioners will work in partnership and align plans to commission specialised and non-specialised high quality, safe, integrated, evidence-based services to prevent premature death, ensure people have the best quality of life possible, ensure successful and quick recovery and positive experience of care in key priority areas:

- Mental Health - NW development of CAMHS tier 4 system, Review Secure Mental Health Services

- Cancer and Blood - Cancer IOG compliance, HIV commissioning arrangements

- Trauma and Head - Adult neuro-rehabilitation services, Major trauma

- Internal Medicine - Cystic fibrosis capacity, Cardiac services, Vascular services, Respiratory services, Acute kidney injury , Inherited metabolic disorders

- Women and Children - Neonatal services, Paediatric neurorehabilitation

Bolton CCG works with the other 11 CCGs in Greater Manchester to ensure that commissioning for services that require a wider geographical focus is undertaken together. We do this through the agreed governance of the Association of Greater Manchester CCGs and these meetings provide a link to Specialist Commissioners.

The 5 year Plan for Specialised Service Commissioning will:

- Improve access, reduce variation in clinical outcomes and improve patient experience
- Consolidate and develop sustainable services based within networks of excellence and aligned to research and innovation
- Engage patients and the public in planning, commissioning and service development
- Ensure services are value for money and meet national service specifications and quality standards

4. FOCUS ON: IMPROVING ACCESS

4.1. ACCESS TO GENERAL PRACTICE

The most recent GP Patient Survey shows reductions in satisfaction with access, both for in-hours and out-of-hours services. Nationally 76% of patients rate overall experience of making an appointment as good; persistent inequalities in access and quality of primary care, including twofold variation in GPs and nurses per head of population between more and less deprived areas.

The CCG's commissioning strategy engagement asked the public the most important aspects of GP services and what most needed improving. We carried out online and telephone surveys and face to face to engagements with the public. The key findings were:

- The most important thing for the public is getting to see a GP urgently, and this was also the biggest priority for improvement. The public told us "urgent" was seen as the same day, and they were prepared to see any GP at the practice if urgent.

- Getting through on the phone was the second biggest area for improvement.
- Often receptionists were seen as hindering access to GPs.
- People supported the idea of telephone appointments, instead of face to face appointments where appropriate.
- Patients wanted to see a GP for a serious issue but were happy to see a nurse for long-term conditions or minor complaints, and saw this as a good way to free up GPs time.
- Convenience was also important to the public and stressed the need for the NHS to recognise people's busy lives.

At a full day deliberative event in April 2014 with 140 Bolton people, representative of the total population, the majority told us:

- They were happy to see a nurse rather than a GP for urgent but routine needs

- Extending opening hours were important to them but not if it means the CCG spending less money on keeping people well.

- They supported GPs having longer than 10 minute appointments for those in greatest need

4.1.1. AGREED AIMS ACROSS GREATER MANCHESTER

The Primary Care commissioning team of Greater Manchester Area Team have engaged widely on the development of their Primary Care Strategy and the standards included within it. To provide the consistency required to support the Healthier Together Programme outlined in section 3.9, Greater Manchester CCGs agreed the following community based care standards:

- people will have access to professional health and social care advice and triage (assessment) provided 24 hours a day, seven days a week and be directed to the most appropriate service to meet their needs.
- access to GP services and community care will be provided within 2 hours for the most urgent and same day if needed
- Children between 0-5 should also be able to access same day GP services if needed

It is the aim that people will be able to use primary care as their first port of call when accessing health services, and that people should be satisfied with access to services and this will result in reduced inappropriate ambulance call outs, attendances at A&E and emergency admission to hospital.

4.1.2. BOLTON PLANS FOR IMPROVED GENERAL PRACTICE ACCESS

Our aim is to enable general practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

The CCG plan for transformation of General Practice is outlined in section 4.4. and the improved local specification for general practice will include measures of patient access and experience. This is being supported through:

- Working with the Primary Care Foundation - practices have been addressing access to their patients and looking at appointment systems.

- Sharing events amongst Practices, to encourage best Practice to be spread

- The CCG innovation fund, where £2 million is supporting projects in General Practice, several of which are testing extended access through working with neighbouring practices to offer more appointments (within a geographical area) in the evenings and at weekends

- In other innovation projects, practices are redesigning their working day to free up time for GPs to work with the more complex patients to offer proactive comprehensive assessments. They will also be able to target the housebound / patients requiring home visits earlier in the working day (rather than at the end of surgery).

- In other innovation projects, practices are testing the use of technology to book appointments and even carry out appointments online.

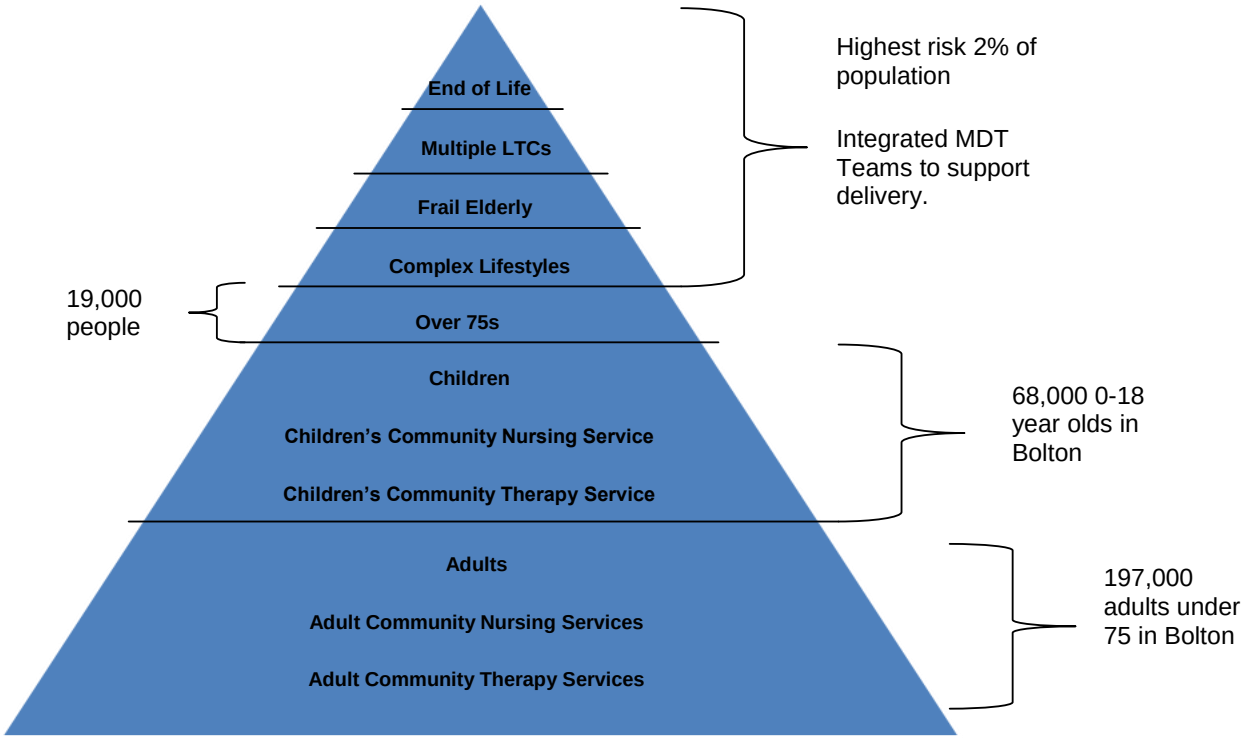
4.2. ACCESS TO COMMUNITY SERVICES

Bolton CCG commissions its community services from Bolton Foundation Trust. These include very large services such as district nursing and physiotherapy as well as a range of smaller services including children's dietetics and palliative care. The CCG and the FT recognise that some of the community services are not sufficiently responsive, efficient or effective. This has been borne out from patient, public and GP feedback and on service delivery across Bolton. Therefore, during 2014/15, the organisations are working together to redesign and re-specify the range of community services based on groupings of the population.

A number of the services, including district nursing, falls services and stroke services will be redesigned as part of the Integrated Care model. Services will be provided based on the needs of local populations across the Borough and will be fully integrated with social care and mental health services. Other services such as physiotherapy and speech and language therapy will be reviewed and redesigned as appropriate.

The CCG aims to ensure that, by the end of 2015/16 all community services have low waiting times (24 hours for an urgent appointment and 4 weeks for a routine appointment), are fully integrated with other health and social care services and provide high quality, value for money services which have excellent patient outcomes and are highly rated by service users.

Figure 14: community services focused on population 'tiers'



4.3. ACCESS TO MENTAL HEALTH SERVICES

Improving access to mental health services is a key priority for the CCG. The programme of work in mental health and learning disability services includes:

- Commissioning additional IAPT services to meet the local need
- Review of CAMHS services to ensure capacity meets local need
- Reducing waiting times for all mental health services – from referral to start of treatment
- Full implementation of the RAID service
- Improving the pathway for patients out of hospital services
- Improving community services to reduce the number of patients admitted to hospital who can be appropriately managed in the community
- Ensuring drug and alcohol services meet the needs of the local population to prevent avoidable A&E attendances
- Ensuring good Enhanced Support Services are in place for learning disability service users who do not need to be in a secure setting
- Continuing the strong progress made to date in the early diagnosis of dementia and ensuring improvements in the care of people with dementia and their family/carers

The key metrics for mental health are outlined below:

- All urgent (not emergency) referrals seen within 24 hours

- Maximum wait of 6 weeks for a routine appointment
- Achievement of the IAPT target for good access for the local population (minimum 15%)
- Achievement of the recovery rate (50% minimum) following treatment in IAPT
- Achievement of the CAMHS outcome metrics
- Strong delivery against the 25 outcome based metrics set out in “Closing the Gap”
- A significant reduction in suicide and deliberate self harm
- Year on year improvement in the dementia diagnosis rate (from 60.9%)

4.4. ACCESS TAILORED TO MINORITY GROUPS

The CCG has ensured there are targets locally within each of the health outcome areas that highlight key equality issues evidenced nationally and locally:

Priority Area	Objective
Cancer	To increase the percentage of women with a learning disability who take up cervical cancer screening
Cancer	To increase the percentage of women with a learning disability who take up breast cancer screening
Cancer	To increase the percentage of lesbian women who take up cervical cancer screening
CVD	To reduce the percentage of people of South Asian origin that are dying of cardiovascular disease
Mental health	To reduce the percentage of people of South Asian origin who are at increased risk of mental health problems
Mental health	To reduce the percentage of lesbian, gay or bisexual people who are at increased risk of mental health problems

The CCG's equality strategy highlights the structures in place to engage with equality target groups, to meet our requirements for Equality Impact Assessments and to deliver all other aspects of our equality duties.

There are 2 key approaches the CCG is using to reduce inequalities, to ensure a positive equality impact of this commissioning plan:

- Improving equality strand information on GP patient registers
- Applying Marmot Principles: universal action proportionately applied according to disadvantage.

Through improving the equality strand information held on GP patient registers, the CCG intends to be able to provide evidence of improvement in our equality outcome targets any inequalities in health, intervention or outcome in order to manage this. Currently, public health equity audits and health surveys are relied upon to give a snapshot picture of inequalities.

An example of this is the collection of ethnicity data on disease registers, which enabled the CCG to analyse primary care 'best care' scores in COPD, coronary heart disease, diabetes and chronic kidney disease. This analysis has shown that people from different ethnic groups score the same and are therefore getting the same quality of care and level of outcomes in primary care.

The Marmot review "Fair Society, Healthy Lives" (2010) highlights that more support is needed for the most disadvantaged and support given should be proportionate to the scale of disadvantage. The CCG recognises this and ensures that primary care improvement projects are given greater incentive and prioritised support from health trainers according to the level of deprivation and need of the Practice population.

Equality Impact Gaps/ Concerns:

Gap/ Concern	Action
1. Do we know if we are equitable on who gets on Practice disease registers?	- audit of who has not responded to invitation for health check, by target group - reinforce importance of practices completing ethnicity data on whole practice list, not just disease registers
2. Unregistered patients are disadvantaged by the primary care intervention part of this strategy. It is likely that more disadvantaged groups are not registered.	- Work to encourage patients to register with a GP through public engagement, voluntary sector engagement
3. Bolton internal gap in Life	

expectancy is not reducing fast enough, CVD mortality gap has grown	- Do more to specify services we commission to provide more intervention to the areas of highest need and deprivation - Influence action on wider determinants of health through membership of Health & Wellbeing Board

5. FOCUS ON: NHS CONSTITUTION

5.1. REFERRAL TO TREATMENT WAITING TIMES

Bolton CCG is fully committed to ensuring achievement of all three national 18 week referral to treatment targets (admitted, non admitted and incomplete treatments) at individual specialty level as well as ensuring no patient waits for longer than appropriate from referral to treatment completion for all providers. Performance to date against the national targets has been good at an aggregate level throughout 2013/14, with the target achieved every month, but there have been some specialties, notably Orthopaedics where the target was failed for several months.

The CCG has set plans for the 18 week target to be achieved in every speciality in 2014/15 and plans to reduce this every year from 2015/16. The CCG is working to ensure that no patient waits more than 40 weeks for completion of their treatment by the end of 2014/15 and this will be reduced to a maximum of 26 weeks in 2018/19.

5.2. DIAGNOSTIC WAITING TIMES

Bolton FT experienced significant pressures within MRI and Endoscopy during 2013/14. This was due to a combination of increased demand and reduced capacity across these modalities. The CCG closely monitored the Trust's delivery against the remedial action plan and trajectory to reduce the number of patients waiting over 6 weeks to less than 1% of total people on a diagnostic waiting list.Bolton CCG and the Hospital Trust are proactively monitoring demand and capacity for diagnostics so that

additional capacity can be put in place in a timely manner if demand increases in any month in future.

The CCG is also progressing a project from 2014/15 to understand the variation in demand for diagnostics (using the NHS Atlas of Variation in Diagnostic Services, November 2013). This project is aimed at reducing unwarranted variation in the request for and undertaking of specific diagnostic tests to increase value and improve quality.

5.3. A&E WAITS

The 4 hour A&E target was achieved every quarter in 2013/14 as Bolton FT put in place robust measures and improved systems and processes within the Emergency Department to ensure sustainability of the target, specifically during the winter period.

The CCG continues to monitor the delivery of this target on a daily basis and is proactively working to reduce the number of people who attend the A&E department who could have been seen by their GP, local pharmacist or self-cared.

The CCG funded a wide ranging awareness campaign from November 2013 which provided advice to the local population about which type of healthcare should be accessed for common conditions. This had a positive impact with a reduction of patients attending A&E in Quarter 4 (January to end March 2014) compared to the same period in 2013. The CCG will continue with this campaign in 2014/15 and beyond.

The CCG has also worked with Bolton Hospital to stream patients in A&E who did not need to attend an Emergency Department to an area where they can book an appointment with their own GP or be given advice about available pharmacists.

5.4. CANCER WAITS

Bolton CCG is committed to the delivery of high quality, timely cancer care for the local population. The rates of cancer are higher in the North West of England, with poorer outcomes than the national average. There is much evidence to show that that the earlier cancer is diagnosed, the greater the likelihood of successful treatment and survival.

Bolton CCG closely monitors the delivery or cancer services. In 2013/14 the majority of national cancer standards were met in every quarter of the year. Peer reviews are also undertaken across cancer services and the CCG works closely with the Trust to ensure that any issues which are highlighted are resolved in a timely manner. Bolton CCG is working with Bolton FT on redesigning cancer pathways which have the longest time from diagnosis to treatment, often involving two or more other providers, to ensure that as a minimum, the national cancer standards are met– working towards achieving the target for all patients and undertaking staging for all patients.

5.5. CATEGORY A AMBULANCE CALLS

Ambulance speed of response performance targets are statutory requirements incorporated in the NHS Constitution. These relate to Red 1 and 2, 8 minute response requirements and the availability of an ambulance vehicle and qualified crew able to transport a patient at the scene of the incident within 19 minute of receiving the emergency call.

The cumulative performance for Bolton CCG was:

- 77.3% for Red 1 (against a national target of 75%)
- 76.9% for Red 2 (against a national target of 75%)
- 96.2% for Red 19 minutes (against a target of 95%)

5.6. MIXED SEX ACCOMMODATION

Bolton CCG is committed to protecting the privacy and dignity of its population when they access healthcare. Bolton FT had 5 MSA breaches in 2013/14. All cases occurred on the High Dependency Unit which due to its design can only provide a certain amount of single sex accommodation. The FT has actions plans in place in relation to this estate and also in relation to responsibilities for escalation and step down when a breach is likely to occur. The FT also surveys all relevant patients and staff following a breach to ensure their concerns are captured.

The CCG will continue to work with the FT and monitor implementation of these actions and other initiatives via the Quality and Safety Committee. There are currently 2 further Trusts across GM with breaches and the CCG will be engaging in learning from these via the GM Quality Collaborative.

5.7. CANCELLED OPERATIONS

The CCG is fully committed to ensuring that patients do not have their planned operations cancelled by the provider unless there are exceptional circumstances. In the event that any patient's procedure is cancelled at short notice, the CCG will ensure that the provider offers the individual another binding date within 28 days of the original planned procedure. If the provider is not able to do this they will arrange and fund the procedure to be undertaken at another provider of the patient's choice.

5.8. MENTAL HEALTH

The majority of mental health services accessed by Bolton residents are delivered by Greater Manchester West NHS Foundation Trust (GMW). The NHS Constitution sets out the right for all people under adult mental illness specialties on Care Programme Approached (CPA) to have a follow up appointment within 7 days of being discharged from psychiatric inpatient care.

The national target for CPA follow up within a maximum of 7 days is 95%. GMW achieved the full year target for Bolton residents in 2013/14, with performance of 96.7%. However, there were some months in the year when the provider failed to achieve the target. Each failure to follow up within the period is investigated by GMW and a report provided to the CCG with actions being taken as appropriate.

5.9. A&E WAITS DECISION TO ADMIT

The maximum four-hour wait in A&E remains a key NHS commitment and is a standard contractual requirement for all NHS hospitals. In addition NHS England has a contractual requirement, covering NHS hospitals that no A&E patient should wait more than 12 hours on a trolley.

Bolton FT has historically performed well against this important national target and this performance has been sustained throughout 2013/14, where many Trusts failed the target for the year. The CCG will continue to work closely with the FT to ensure that a minimum of 95% of patients are seen within 4 hours and will look to improve performance against this target year on year.

5.10. AMBULANCE HANDOVERS

Acute Hospitals and CCGs are also measured against delays in the handover of patients from ambulance crews to A&E Department. In 2013/14, Bolton FT had 1848 delays over 30 minutes and 482 over 60 minutes. The CCG is working with NWAS and Bolton FT to eliminate these delays, such that, by 2018/19 there will be no delays over 20 minutes.

Throughout 2013/14, Blackpool and County Ambulance CCG Leads have worked collaboratively with NWAS, the NHS England (North) Handover and Turnaround Board and the Ambulance Strategic Partnership Board to discuss management of patient handover and how this can be improved.

To date, progress has been very encouraging with significant improvements seen in handover recording compliance and corresponding reductions in patient handover times.

6. FOCUS ON: QUALITY, SAFETY & EXPERIENCE

The CCG has a strong governance structure underpinned by key strategy documents such as:

- The CCG Constitution
- The CCG Quality Strategy
- The CCG Communications and Engagement Strategy
- The CCG Francis Action Plan

The CCG also has regular reports on Quality at committees and boards including: Quality & Safety Reports; Quality Matrix; Complaints and Incident reports and a Francis Action Plan to monitor implementation of the recommendations detailed in this section of the commissioning plan. Quality and Performance Groups and Quality Assurance Groups are mechanisms by which Providers can be held to account.

Following the release of the report: *Hard Truths – the journey to putting the patient first* (November 2013), the CCG will now review and refresh the CCG Quality Strategy and the Francis Action Plan through the CCG Executive and Quality and Safety Committee.

6.1. FRANCIS & BERWICK

Bolton CCG has fully considered the Governments final response to the Francis Inquiry *Hard Truths- the journey to putting the patient first* (DH November 2013):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259648/34658_Cm_8754_Vol_1_accessible.pdf

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013, called for a 'fundamental culture change' across the health and social care system to put patients first at all times. Robert Francis QC, the Inquiry Chair, called for action across six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour.

It also responds to six independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- *Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England*, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England

- *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, by Camilla Cavendish

- *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Professor Don Berwick

- *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart

- *Challenging Bureaucracy*, led by the NHS Confederation

- *The report by the Children and Young People's Health Outcomes Forum*, co-chaired by Professor Ian Lewis and Christine Lenehan

The CCG will ensure that where poor care is detected, there is clear action and clear accountability. The CCG has set out how it will work with the whole health and care system to prioritise developments , including major new actions on the following vital areas:

6.1.1. TRANSPARENCY

The CCG will plan to consider how it will ensure it stays well informed, with a lot more information being available in the public domain about the safety of the services we commission. The Quality & Safety report to Board and the website will be conduits for this. The CCG will also work with Providers around similar expectations of transparency, e.g. transparent monthly reporting of ward-by-ward staffing levels and other safety measures; or the publication of the Friends and Family Test.

6.1.2. SAFE STAFFING

The CCG will work with appropriate Providers to ensure they publish self - determined staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This will be based on specialty. This will be mandatory and will be done on a monthly basis.

From June 2014 this will be done using models and tools approved independently by the National Institute of Clinical Excellence (NICE)as they commence work on staffing guidelines in various health sectors. The CCG will ensure that reports to Trust Boards are in line with NQB guidance i.e. monthly publishing and reporting on the reasons why and the actions taken when staffing capability and capacity frequently falls short of what is planned.

6.1.3. COMPLAINTS

The CCG will work with Providers to ensure patients and their families can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.

The CCG will require Trusts to report quarterly on complaints data and lessons learned.

The CCG will also take note of lessons learned from the Ombudsman who will significantly increase the number of cases they consider

The CCG will liaise with GMAT re: primary care complaint themes or serious issues.

The CCG will collect protected characteristic data to ensure equal access to the complaints process and will look at developing mechanisms whereby patients can raise concerns, akin to incident reporting, with the CCG without formally complaining.

6.1.4. CANDOUR

A statutory duty of candour will exist on providers, and a professional duty of candour on individuals through changes to professional guidance and codes. The CCG will support Providers accordingly and encourage them to be open regarding safety incidents. This will be incentivised through schemes such as CQUINs where appropriate e.g. Lessons Learned Once, and learning from incidents will be shared through the Quality & Safety Committee. This relates to primary care too and will be supported by the CCGs Incident Reporting System.

The CCG will work with Providers to develop Quality Accounts that provide patients with appropriate information about the services they use, and that they add value to the quality assurance infrastructure used by Trusts and local and national organisations.

The CCG will work with Providers to ensure they adhere to their safeguarding and EDHR duties both as an employer and Provider. This will be monitored via the Quality & Performance Groups with Providers.

The CCG will also ensure, where possible, that information provided by services is accurate and complies with statutory or other legal obligations, but will be considerate to reduce the burden of information bureaucracy on Providers too.

6.2. KEY ISSUES FOR CONSIDERATION BY THE CCG

6.2.1. PREVENTING PROBLEMS: PATIENT PARTICIPATION IN PLANNING SERVICES

Statutory guidance for clinical commissioning groups on involving patients in planning services and in their own care has been published by NHS England along with a set of supportive tools.

Bolton CCG will commission support for patients' participation and decisions in relation to their own care or will have a plan to do so. This will include information and support for self-management, personalised care planning and shared decision-making which will be a key component regarding the integration agenda.

6.2.2. DETECTING PROBLEMS EARLY

'Whistleblowing': The CCG will ensure that people within all Providers have systems in place to whistle blow.

Standards: The CCG needs to ensure that it considers NICE and other best practice standards when commissioning and monitoring provider's performance and quality of care. The CCG has systems in place for GPs to incident report, not only to improve GPs effectiveness as commissioners but as providers too. The CCG will act on this information, work with Providers where appropriate, and share learning as widely as required e.g. practice bulletins, Learning & Development newsletter.

The CCG is working closely with the GM Quality Collaborative to look at how early warning systems can be represented in dashboards indicating real time and the CCG will work effectively with the Local Authority led Safeguarding Intelligence Forum to discuss low level concerns prior to potential escalation with appropriate stakeholders. This process will also encompass walkrounds in providers e.g. secondary, community, mental health and nursing and social care providers.

6.2.3. TAKING ACTION PROMPTLY

Working together: The CCG needs to work closely with regulators (CQC, Monitor) to ensure it takes a coordinated approach to overseeing quality issues within providers and that it shares information across the system. The CCG will also work with health and social care providers to share and triangulate information which will be governed by the Quality & Safety Committee internally.

6.2.4. ENSURING ROBUST ACCOUNTABILITY

The CCG is committed to making patient safety a reality and has initiated making this commitment, as detailed in the Quality Strategy, visible to staff, member practices, providers and to the public, in the months and in the years ahead.

The CCG note that NHS England will explore the development of a parallel set of arrangements (fit and proper person's test for Board level appointments) for clinical commissioning groups.

The CCG will ensure clinically-led commissioning will put doctors, nurses and other health professionals at the heart of its commissioning, with an explicit focus on improving health outcomes for the whole population and reducing inequalities in health.

The CCG note that NHS England will continue to hold clinical commissioning groups to account for quality and outcomes as well as for financial performance, through the clinical commissioning group's assurance framework. NHS England also has powers to intervene where there is evidence that clinical commissioning groups are failing or are likely to fail.

The basic tool available to commissioners is the contract. The CCG will use contracts to require Providers to meet appropriate Quality Standards and Guidelines, measuring these and holding to account accordingly, including specific focus on clinical outcomes of specialities that give cause for concern.- The CCG note that excellent commissioning can address pro-actively the risk of services becoming unsafe by spotting trends in the population and responding by changing the nature of the services. The primary care incident reporting system supports this rationale.

6.3. THE QUALITY STRATEGY AND PATIENT SAFETY

The ultimate aim of the Quality Strategy is to commission the highest quality health care services for the people of Bolton. The CCG also want the implementation of the Strategy to strengthen local pride in the NHS and want the people of Bolton to be confident that their health care services are amongst the very best, all of the time.

The CCG vision is to commission a quality of health care that we would all want for ourselves, our families and our friends. A vision where all clinical care commissioned is appropriately measured so it can increasingly demonstrate improved outcomes of care and where information on quality is acted on promptly and effectively to ensure continuous quality improvement. This care will be personalised, safe and effective.

The CCG has three quality ambitions which provide a focus for all its activity and supports its vision, as follows:

- *Productive partnerships between patients, families, carers and those delivering health care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.*
- *There will be no injury or harm to people from the health care they receive, and an appropriate, clean and safe environment will be commissioned for the delivery of health care services at all times.*
- *The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will not be tolerated.*

6.3.1. OPENING COMMITMENTS IN CCG QUALITY STRATEGY

- The CCG has robustly identified, and understood the handover of Quality & Safety issues from the PCT.
- The CCG will drive local health systems towards a sustained focus on quality, guided by the NHS Constitution and other drivers e.g. NHS Outcomes Framework, Quality Premium. The CCG will enable this by harnessing their insights from the daily reality of its membership i.e. General Practice, together with insights from the wider community, including, healthcare providers, local authority, patients, carers and the public.

- The CCG will gain significant engagement from constituent practices as a driving force to improve services and outcomes.
- The CCG recognises that improving quality will be most effective when it involves cooperation between clinicians in the wider multi-professional care community and valuing the ideas of other clinicians.
- The CCG has already identified local quality priority areas, aligned with QIPP, and will continue to provide examples of delivering quality, innovation and productivity.
- A governance structure has been established to monitor Quality and Safety,
- Patient and carer feedback to practices, along with complaints and concerns/incidents raised with the CCG (by health and social care), will be a significant way in which the CCG strengthens its ability to detect early warning signs of deterioration in quality, as well as evidence of excellence that should be adopted and spread.
- The CCG will work with 'HealthWatch' and other partners to understand the experience of service users
- Strategic and operational planning informs, and will be reflected in, the CCG's contracts with Providers, the delivery of which will be monitored rigorously by the CCG, including being assured of the quality of care Providers deliver. The CCG recognises that mature and trusting relationships with Providers, both drives and sustains improvement. Concerns will not be used in an adversarial sense but as an opportunity for Provider's to quality improve with contractual levers being used only if appropriate improvement isn't realised as agreed.
- The CCG will support Providers to innovate, where appropriate, in order to continuously improve and meet future challenges. This will include working collaboratively to develop appropriate CQUINs.

6.3.2. DELIVERING QUALITY & SAFETY WITH OUR PROVIDERS

The CCG has developed a Quality Framework to enable delivery of the aims and objectives outlined above. The CCG will continually define quality priorities which will link into its work plan. These will be areas where the CCG want to see quality improved in specific ways, be that in response to poor performance, patient experiences, or in order to implement best known evidence and practice locally, e.g. through pathways, procedures and other re-design and innovation work.

The CCG has a statutory duty to commission and ensure high quality care for the local population and will provide scrutiny of all providers and assure the Board and its membership that continuous improvement in quality of care is being achieved. The ambition is to create and maintain the necessary governance and delivery structures across the CCG so that interventions pursued are clearly and appropriately integrated, aligned and managed.

The CCG has established a Quality and Safety Committee, as a sub-committee of the CCG Board, to not only oversee the implementation of the Quality Strategy but

to also ensure whole system integration and alignment and ensure emerging actions are consistent with all areas of concern with Providers, such as contracting and performance concerns. The Committee has the role of assuring the CCG Board of the quality of all health interventions commissioned by the CCG and is the formal mechanism by which the CCG discharges its responsibilities for clinical quality and sets the strategic direction for quality governance

The CCG will also engage with providers via regular quality meetings or via presence at provider's clinical quality meetings. This will be inclusive of continuing health care and safeguarding in order that those most vulnerable receiving health and social care are monitored and there is a process for escalating concerns accordingly, initially via a low threshold intelligence forum and subsequently if concerns are not resolved, via Quality & Safety Committee and Contract groups, liaising with the Local Authority and CQC where appropriate.

6.3.3. CCG QUALITY STRATEGY – GOING FORWARD

Below are examples of key specific objectives to be undertaken to underpin the three domains of quality central to this Strategy:

Contracting – in line with the recommendations of the Francis Report the CCG will ensure the quality assurances commissioners need are embedded in every contract it holds. This will include fundamental quality standards with agreed methods for measuring compliance and redress for non-compliance.

Infection Prevention and Control – the CCG, in developing a health economy Infection Prevention and Control Committee will oversee compliance with the NHS Constitution and ensure Clostridium Difficile Infections (CDI) continually reduce in line with national trajectories. Sharing the learning from all HCAIs will take place via this multi-stakeholder committee with initiatives rolled out across the health economy to ensure a collective approach to tackling this issue.

Harm Free Care – the CCG will continue to support harm free care initiatives, aiming to, for example, eliminate grade 3 & 4 pressure ulcers and reduce the rate of falls related injuries in older people. The CCG will work collaboratively with Providers of health and social care to spread the culture of harm free care across the health economy, and continue to develop/implement measurement of harm. This will include the introduction of the safety thermometer in social care to measure harm and the development of nursing standards and escalation policies, in line with supporting Providers in the development and implementation of strategies e.g. falls, pressure ulcers, CAUTIs.

Prescribing – in understanding the significant role of medicines in the safety, effectiveness and personalised nature of care, the CCG will support initiatives within medicines optimisation to improve patient outcomes e.g. reduce the use of broad spectrum antibiotics, improve patient concordance, move from branded to generic medicines, and adherence to prescribing policies. The CCG will promote the use of prescribing care bundles within primary care and the use of the prescribing safety thermometer to measure any harm related to prescribing.

Primary care quality – the CCG understands that the quality of primary care provision is vital to its commissioning objectives. The CCG, via its Triple Aim Programme of work with practices and via close collaboration with the Area Team of NHS England, will enable continuous quality improvement in primary care e.g. reducing variation and supporting performance concerns.

Patient, carer and public involvement – the CCG's Communication and Engagement Strategy will enable innovative engagement with patients, carers and the public and ensure that the outcomes of these processes informs CCG decision making. The CCG also commits to actively promoting, and bringing to life, the NHS Constitution. Initiatives, such as CQUINs will support the implementation of the Friends and Family Test across the health economy enabling Providers to gain real time feedback from service users and staff.

Membership development – a Local Enhanced Service for Quality has been developed in order to enhance the GP membership's role as both a commissioner and provider. This will initially link to incident reporting but as culture changes take place, other innovative areas of quality improvement will be promoted and all practices will be visited to highlight the strategy and enable membership involvement in its continued development.

6.4. PATIENT EXPERIENCE

Listed below are a number of initiatives scheduled by the CCG to utilise the 'experiences' of patients to improve the quality of service provision:

- Patient surveys are to be rolled out 2014/15 to seek views on secondary care and GP services.
- Corridor Events to take place in collaboration with Healthwatch Bolton and Bolton FT - with a focus on community services (surveys to be carried out in health centres) CCG website seeks feedback from patients and members of the public
- Capture information and themes from complaints and PALS
- Review information on NHS Choices from service users
- Develop CCG incident reporting system to capture/monitor incidents reported by GPs, Care Homes, Bolton FT and other providers
- In collaboration with Bolton Council and NHS England, work with our Providers to improve feedback on patient experience (Complaints/PALS/Friends and Family Test). Improve Action Planning by Providers in response to FFT feedback - outcomes will be reported to governing body
- Improve care delivered by our providers by monitoring the level of care delivered against NICE quality standards and CCG indicators linking to NHS Outcomes Framework
- Assessing the quality of care in particular vulnerable groups
- Patient Engagement Officer to roll forward mechanisms in place for capturing feedback from hard to reach groups

6.5. COMPASSION IN PRACTICE

The CCG supports the 6Cs and the six areas of action as follows:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

We want the 6Cs to be universally adopted and embraced by our providers hence they need to be an explicit part of the CCG's commissioning plan. The CCG understands its role in creating the right provider culture. The CCG will set clear expectations for our providers to support staff in the delivery of the 6Cs, to manage performance, to champion change and create an environment where the courage to speak out is both welcomed and promoted.

The CCG will link the 6Cs to priority action areas:

- Helping people to stay independent, maximising well-being and improving health outcomes – this will require engagement with nurses in public health, social care and general practice
- Working with people to provide a positive experience of care
- Delivering high quality care and measuring the impact of care
- Building and strengthening leadership
- Ensuring the services we commission have the right staff, with the right skills, in the right place
- Supporting positive staff experiences

The CCG recognises that implementation of these priorities will be challenged by the financial pressures placed on Providers and the ability to recruit enough appropriately qualified staff to meet the staffing lever guidance as defined by NICE. The CCGs Chief Nurse will work with and support Providers to achieve appropriate, safe and effective staffing levels and to develop and implement nursing standards across primary and secondary care, to ensure that quality is measured in terms of outcomes and not just attainment of actual staffing quotas.

6.6. STAFF SATISFACTION

Bolton CCG values our staff, seeking regular feedback and input from staff through twice-yearly surveys, through the monthly Staff Forum, and through our intranet site.

Based on requests made by Staff Forum, we introduced a clocking in system for fire safety, purchased a defibrillator and changed car parking for people who make frequent off-site visits.

The latest staff survey showed 95% of staff were proud to work for the CCG, 90% of staff knew our strategic priorities, and 85% understood how their role contributed to them.

6.7. SEVEN DAY SERVICES

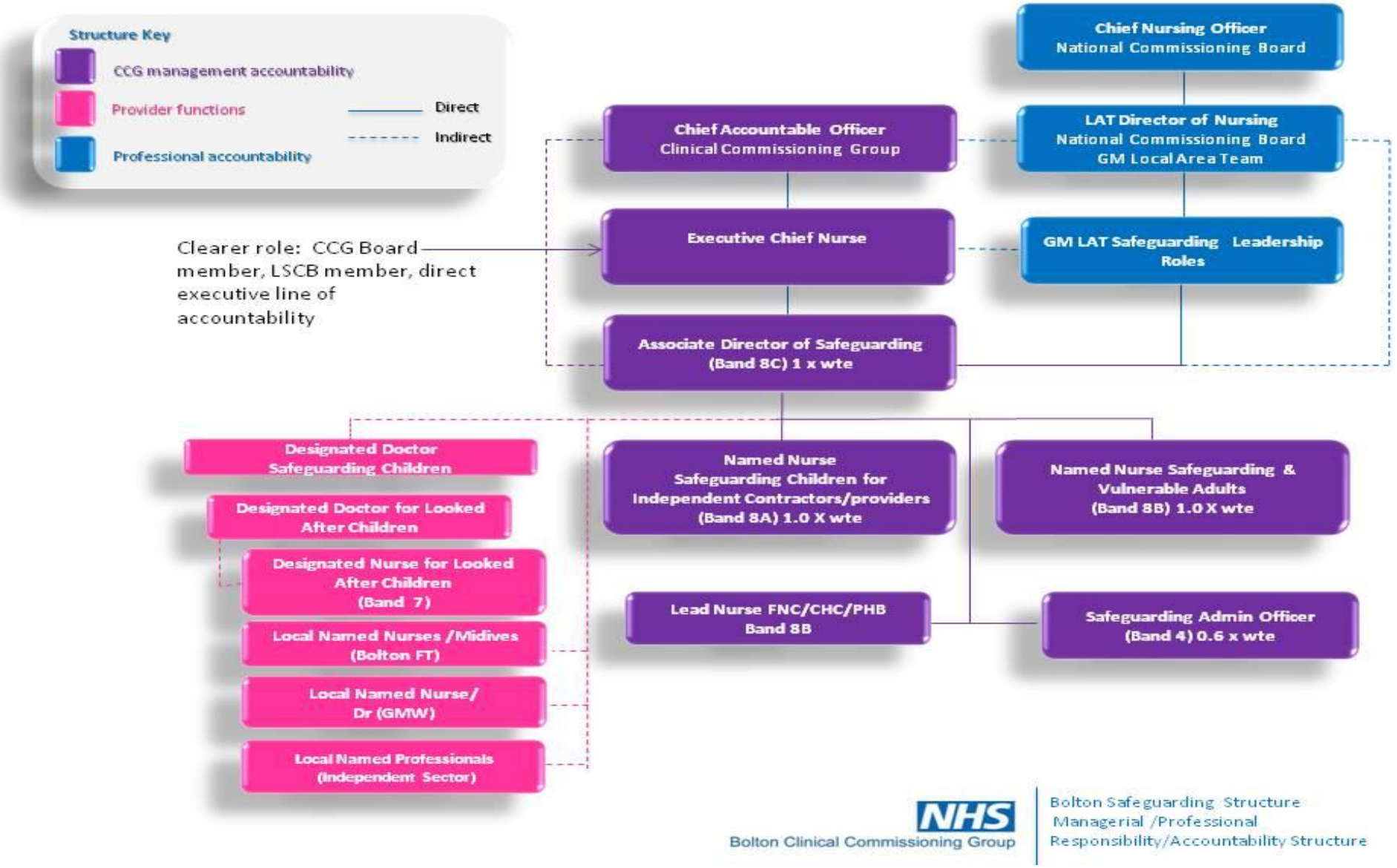
The CCG is fully committed to ensuring excellent outcomes for the population of Bolton. Recent national evidence has shown that having access to senior medical staff at weekends and in the evenings can significantly improve outcomes for patients who are admitted to hospital outside of normal working hours. The Greater Manchester "Healthier Together" programme is one step in addressing this with the new standards set for acute surgery.

Bolton CCG aims to ensure that all specialties with emergency admissions have access to senior medical support within 20 minutes.

6.8. SAFEGUARDING

6.8.1. ACCOUNTABILITY ARRANGEMENTS FOR SAFEGUARDING

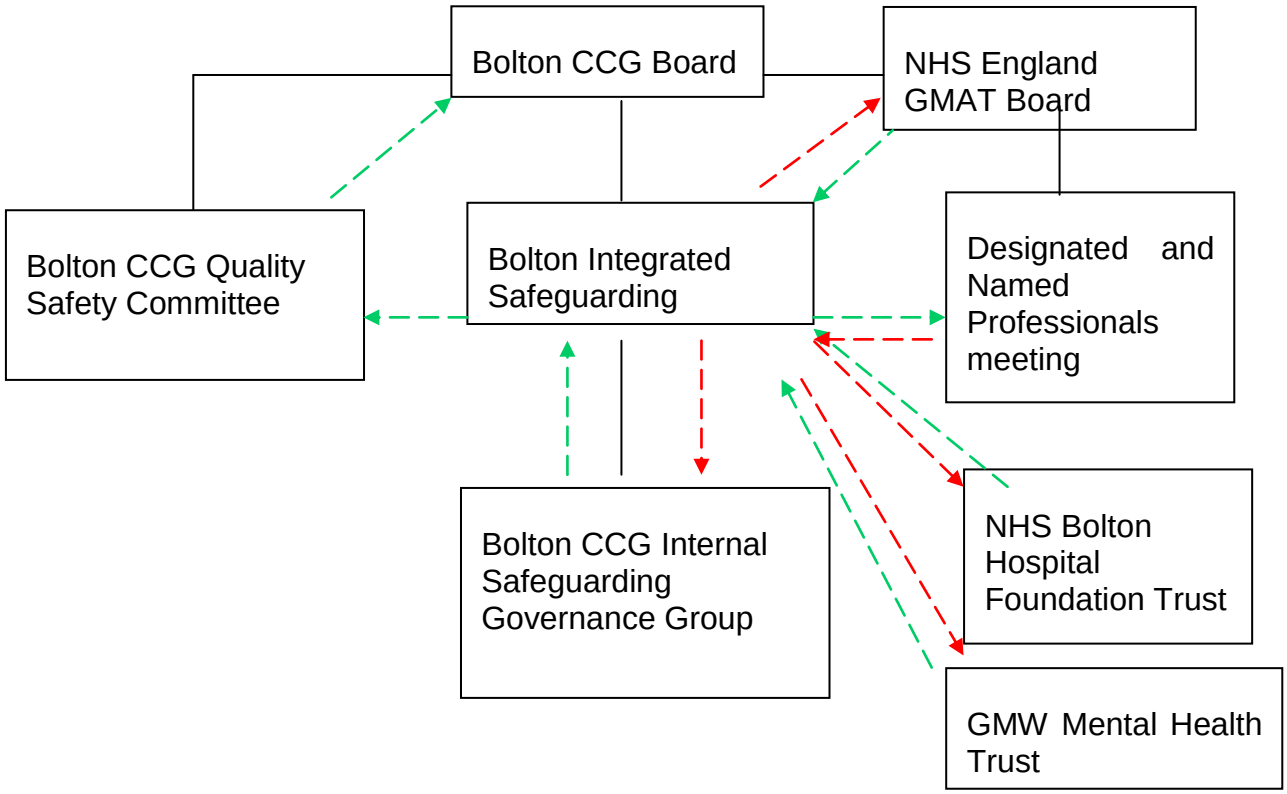
Safeguarding is a priority area for Bolton CCG and the CCG achieved authorisation status with full compliance regarding safeguarding arrangements. A service model with increased investment into the safeguarding team has been implemented. These arrangements ensure the CCG comply with statutory duties including the Mental Capacity Act and PREVENT agenda. This investment reflects the needs of the local population.


Structure Key
CCG management accountability
Provider functions
Professional accountability
Direct
Indirect
Chief Nursing Officer
National Commissioning Board
Chief Accountable Officer
Clinical Commissioning Group
LAT Director of Nursing
National Commissioning Board
GM Local Area Team
Clearer role: CCG Board member, LSCB member, direct executive line of accountability
Executive Chief Nurse
GM LAT Safeguarding Leadership Roles
Associate Director of Safeguarding
(Band 8C) 1 x wte
Designated Doctor
Safeguarding Children
Designated Doctor for Looked After Children
Designated Nurse for Looked After Children
(Band 7)
Local Named Nurses /Midives
(Bolton FT)
Local Named Nurse/
Dr (GMW)
Local Named Professionals
(Independent Sector)
Named Nurse
Safeguarding Children for Independent Contractors/providers
(Band 8A) 1.0 X wte
Named Nurse Safeguarding &
Vulnerable Adults
(Band 8B) 1.0 X wte
Lead Nurse FNC/CHC/PHB
Band 8B
Safeguarding Admin Officer
(Band 4) 0.6 x wte
NHS
Bolton Clinical Commissioning Group
Bolton Safeguarding Structure
Managerial /Professional
Responsibility/Accountability Structure

Bolton CCG has established good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities, as well as effectively commission services ensuring that all service users are protected from abuse and neglect. CCG Governance arrangements have been reviewed and re-established to reflect the needs of the CCG and the population of Bolton.

Fig 15: Bolton CCG Safeguarding Governance and Assurance Arrangements

(The lines indicate reporting/ minutes)



6.8.2. CONTINUING HEALTH CARE TEAM

The CHCT commission services for some of the most vulnerable people in our population. The transfer of CHC team to the CCG has improved clinical and commissioning support. A database has been created to ensure systems collect and analyse data to benchmark performance and monitor expenditure. This service being improved and resource has been increased to review restitution cases.

The CHC operational manager is working with the Greater Manchester Lead for the personal budgets agenda and additional resource will be considered to ensure full implementation with the statutory timescales.

The monitoring of safeguarding standards in care homes and nursing homes remains challenging. Arrangements are reviewed for all residents in receipt of Continuing Health Care Funded placements. Incidents are investigated by the Safeguarding Adult Lead and Adult Social Care in collaboration with the CQC team.

6.8.3. MONITORING SAFEGUARDING STANDARDS FOR MULTIPLE PROVIDERS

The new arrangements have resulted in a multiplicity of smaller providers of services and this presents a challenge to Bolton CCG as it is recognised that there should not be reliance on the regulatory body to ensure services are safe and effective. An approach of continuous improvement using triangulated data will improve patient safety and early identification and response to safeguarding concerns.

6.8.4. LOOKED AFTER CHILDREN

Bolton perform above the national target in relation to good health outcomes for Looked After Children. Bolton Performance Data at March 2013 shows that 98% of looked after children are up to date with immunisations, dental checks 84.4% with dental checks 92.8% completed statutory health assessments.

The CCG will continue to work with the local authority to ensure that commissioning arrangements for looked after children are safe and effective and meet the health needs of children using any future joint funding arrangements flexibly.

Bolton has tripartite arrangements with Wigan and Salford relating to the Child Death Overview Panel. Bolton CCG part fund the Greater Manchester Rapid Response Team who provide the rapid response to children who have died suddenly and unexpectedly. This is a team of paediatricians who have a rota which covers the Greater Manchester Area hosted by Manchester. These arrangements have been highlighted nationally as a gold standard service. This service specification is currently under review.

6.8.5. CCG SAFEGUARDING PRIORITIES

Safeguarding priorities are aligned to the CCG quality and patient safety strategy and to the Bolton Safeguarding Children and Adult Boards priority areas

Future commissioning of services will take into consideration key priority areas of:

Child sexual exploitation: A key priority area for agencies and Bolton CCG commission services that support an integrated approach to children at risk of sexual exploitation ensuring that health services recognise that sexual exploitation is child abuse and not a lifestyle choice.

Domestic abuse: Bolton CCG has contributed to 3 domestic homicide reviews in the last 2 years. Lessons learnt from reviews and the recommendations are embedded into practice and shape future commissioning of services.

Female Genital Mutilation: Bolton is a culturally diverse population and health agencies have developed clinical pathways to respond appropriately and sensitively to female genital mutilation

A priority is to improve the understanding and response of providers regarding domestic violence, child sexual exploitation and Female Genital Mutilation by learning local reviews, DHRS, SCRs and research.

Our supporting priority is to develop a comprehensive performance monitoring system to capture safeguarding data and monitor providers regarding statutory safeguarding requirements.

6.8.6. REVIEW OF SAFEGUARDING POLICIES

Bolton CCG safeguarding policy includes the requirements of the PREVENT agenda. The Bolton Safeguarding Childrens Board Management of Allegations is concordant with the CSU HR Policy

Further reviews planned:

- Safeguarding training policy for children and vulnerable adults review to reflect the requirements of the Intercollegiate Document 2014.
- Audit provider polices as part of compliance with safeguarding standards.

6.8.7. HOW WILL WE MEET THE STANDARDS IN THE PREVENT AGENDA?

The Chief Nurse is the strategic lead for the PREVENT requirements and will oversee the CCG Safeguarding Team to ensure the commissioning and provider functions of the PREVENT agenda are implemented.

Progress will be monitored against the delivery of the Prevent agenda within the CCG and providers to ensure compliance with requirements for Prevent as set out in the NHS Contract.

The CCG Safeguarding Adults Lead Nurse is the trained facilitator who will deliver the Health WRAP training programme The PREVENT requirements are identified in the CCG Safeguarding Policy.

As part of the commissioning process the CCG will expect to see from the services it commissions full compliance with all statutory and contractual standards of the PREVENT agenda

The CCG Prevent Lead will:

- Ensure Bolton CCG staff have an awareness of the Prevent agenda and that all members of staff that have access to members of the public receive Health WRAP training.
- Work closely with Prevent Leads from commissioned organisations to ensure that

appropriate processes are in place and that there is a robust and effective training plan in place for key staff.

- In the event of a referral, coordinate all the relevant healthcare providers to ensure that information is collated as soon as possible.

- Represent the CCG on the Channel Panel and will ensure that Governing Body representatives are fully informed of progress.

- Provide the CCG Board with an annual report detailing the work performed during the financial year in respect of the Prevent agenda.

- Report the required data and information to the Regional Prevent Lead.

A training programme will be developed and delivered within 2 years to meet the requirements of the accountability and assurance framework for protecting vulnerable people

6.8.8. IMPROVING QUALITY APPLICATION OF THE MENTAL CAPACITY ACT

- The CCG's MCA Lead has primary responsibility on behalf of the CCG for ensuring that it commissions appropriate health services in compliance with the MCA for adults normally resident within Bolton who may not have capacity to consent to treatment (including out of area treatments)

- CCG Mental Capacity Policy

- Monitoring of provider compliance including evidence of MCA compliant capacity assessments, best interest meetings, schedule of urgent authorisations, staff training, person-centred care, safe restrict and restraint policy, family involvement in decision making, statutory duty to report DOLS authorisation and outcomes to the CQC.

6.9. BOLTON RESPONSE TO WINTERBOURNE REVIEW

Events at Winterbourne View Hospital resulted in a Serious Case Review published on 7th August 2012. The Government issued the following targets as a means of achieving improved standards of care:

- NHS & Social Care Commissioners will review all current hospital placements by June 2013

- NHS & Social Care Commissioners will support everyone inappropriately placed in hospital to move to community based support as quickly as possible and no later than June 2014

- Every area will put in place a locally agreed joint plan for people of all ages with challenging behaviour, which accords with the model of care, by April 2014

A 63 point action plan was developed for completion by 2016, the aim of which is to transform health and care services for people with learning disabilities and/or autism who have mental health conditions or behaviour which challenges services.

6.9.1. BOLTON CONTEXT

Learning disability services are well established and enjoy a long history of positive joint working across health and care. Local teams benefit from their multi-disciplinary make-up which includes Social Workers, Learning Disability Nurses, Psychologists, Occupational Therapists, Physiotherapists and Speech & Language Therapists. This also incorporates a borough wide Intensive Support Team made up of practitioners who have particular expertise in working with offenders with learning disabilities and people who have autism and complex needs.

For specialist learning disability services, Bolton Council has a lead commissioning role and acts on behalf of the CCG under a Section 75 partnership agreement.

As an authority, Bolton has relatively few out-of-area placements and in recent years has been proactive in developing local services for this client group, in particular, the jointly funded 12 specialist supported tenancies for people with autism and complex needs. Since becoming operational in 2011, this service has enabled a number of individuals to return from out of area specialist services and has enabled other individuals to remain living in the borough who may otherwise have been placed elsewhere.

There are no NHS specialist learning disability hospitals or assessment and treatment units currently in operation in Bolton though there has been recent interest from both NHS and non NHS providers.

6.9.2. BOLTON RESPONSE TO WINTERBOURNE

A multi-agency Steering Group was established to ensure implementation and reports to the Safeguarding Adults Board. The key aspects of the action plan can be summarised as:

- Completion of reviews of all NHS funded placements
- Establishing robust monitoring arrangements
- Review of local policies on managing complex behaviours
- Commissioning alternative services locally which will enable all people inappropriately placed in hospitals to return to Bolton
- Reviewing the delivery of local multi-agency preventative work to minimise future admissions to out of area services
- To produce an all-age challenging behaviour policy
- To ensure robust liaison and co-ordination arrangements are in place with all relevant agencies

Reviews

The review schedule was completed within the target timescale of 1st June 2013. Bolton widened the review process to incorporate semi structured interviews with both service users and wherever possible, their family members, to better understand their experiences. As a result, the review outcomes are believed to be comprehensive and holistic and enable a rigorous framework for continued placement monitoring.

Service Developments

It is essential that local services are in place to meet the varying and complex needs of this client group and to ensure that the national target for resettlement by June 2014 is achieved. To promote service development in this area, Bolton is undertaking work at a local level and more widely is contributing to work being undertaken across the Greater Manchester CCGs by Commissioners of learning disability services.

Policy Review

The DH's final report on Winterbourne View raised serious concerns in relation to failures of safeguarding processes and made clear the need to review local policies and processes.

Work is underway to review policies which relate to the management of complex behaviours, and the development of a statement of principles has been sanctioned which will provide a benchmark against which the policies of agencies operating locally can be measured.

Inter-Agency Working

To promote inter agency collaboration, liaison has now taken place with Calderstones (who are the main regional provider of specialist learning disability in-patient services), CQC, the North of England Specialised Commissioning Team, Greater Manchester West and other Greater Manchester CCGs. The aim of this has been to promote a better understanding of the function, roles and responsibilities of these agencies and to identify areas for joint working and information sharing.

Review of Local Services

Thorough quality checks on all locally based 24 hour supported housing services for people with learning disabilities have been undertaken. These services provide 24-hour support for approximately 200 people with learning disabilities. Quality checks were undertaken using the Council's service specification as a basis, and with a particular emphasis on safeguarding. These are in the process of enhancing their quality assurance systems and the improvement plans developed from their findings.

6.9.3. NEXT STEPS

Bolton's response continues to evolve to fulfil the recommendations/directives contained within the DH's final Winterbourne Report. Whilst it is anticipated that other areas of work will be identified in the process, on an immediate basis the focus of future work can be summarised as follows

- To plan the development of an all age challenging behaviour strategy
- To ensure that learning achieved via liaison with other agencies is disseminated within the organisation
- To review local arrangements to minimise unnecessary hospital admissions,
- To review the local position within local learning disability services in respect of the use of the various forms of restraint and physical intervention
- To complete national and regional stock-take exercises and report on these to the national Winterbourne View Joint Improvement Programme or GM Quality Surveillance Group accordingly

7. INNOVATION

7.1. RESEARCH

We are promoting research and the use of evidence base in the implementation of our pathways and in our commissioning decisions.

We have a clinical standards board, which reports to the quality committee and produces evidence based policy. This process will be built upon to ensure joint working across health economy on NICE and CNST requirements.

The CCG is a member of AQuA (the advancing quality alliance);

- Using guidance shared by AQuA where national innovation is identified

- Bolton CCG took part in wave 1 of the Discovery Community for Integrated Care with AQuA and the Kings Fund: (Great Lever integration pilot)

The CCG is a member of the GM Academic Health Science Network to maintain our strong links with research. A specific deliverable will be the extension of NW e Health's clinical trials management system (FARSITE) to all NHS organisations, making it easier and quicker to identify people eligible for research trials.

We are receiving the 'strategic medicines management' product from our Commissioning Support Unit which will provide review of research evidence and proposal of cross GM medicines policy.

7.1.1. RESEARCH GOVERNANCE

Along with the other CCGs across GM, we have an inherited SLA with ReGroup http://www.gmregroup.nhs.uk. who undertake research governance on our behalf. This includes: ethical issues, compliance with national requirements on approval etc. Regroup are able to provide data on the number of applications, type of applications, decisions, time of decisions.

We will establish a process to review each proposal, led by Clin. Director for Primary Care & Health Improvement

7.2. INNOVATION

There are two key projects that NHS Bolton CCG is currently involved in to test new ways of working with primary care.

7.2.1. GREATER MANCHESTER DEMONSTRATOR PROJECT

The CCG received funding from NHS England to look at integrated working across Bolton.

Our successful project focuses on our important care homes population and the relationship between Practice and community professionals, aiming to test:

- Improved access to patient records
- Working across health and social care agencies
- Use of technology i.e. video consultations
- Integrated care planning

There are two key aspects to the project:

- Providing the technology to introduce remote video consultations between professionals and patients in care homes that support the delivery of clinical care outside of hospital.
- Implementing a single integrated patient record. Two ways of accessing patient records will be piloted: for professionals, the aim will be to improve communication and team working. For patients / carer, the aim will be to promote direct patient access to records in Bolton, empowering patients.

The learning from this pilot in primary care, supporting the elderly in a care home environment will be applicable to the home environment with the intention that rollout to the home could commence next year if successful.

The technology is key to supporting a major change in the way primary care is delivered, enabling care home and home visits in future to be minimised or with the option of carrying out support remotely. This will support the CCG vision of improved access to primary care for all by moving away from the current process of 'batching' practice appointments and making home visits at the end of these, instead focusing on those people that need the most time and making more appointments available with various members of the primary care team through the working day.

Expected outcomes:

- Timelier access to specialists who can apply the highest standards of care associated with their clinical discipline when evaluating nursing/ care home residents, improving clinical outcomes

- Reduced number of GP call outs and therefore increased GP access and ability to redesign appointments to offer more to urgent patients, reducing A&E demand
- Reduced A&E admissions or readmissions (through better care planning, remote monitoring or remote consultations with clinicians, better management of health situations while in the care home)
- Reduce hospital length of stay (minimise any risks of increased lengths of stay)
- Reduced ambulance activity
- Improved patient and their family's satisfaction experience (Allowing patients to remain closer to the support network of carer's / nurses and family, giving timelier access to the right clinician and / or information)
- Reduction in adverse events in care homes
- Improved staff satisfaction in care homes (Access to professional education and information to ensure all staff involved in caring for residents are up to date and able to work to the latest guidelines/best practice/benchmarking i.e. NICE, End of Life Care)
- Promote patient access to records to test the transformational potential for patients to take more power over their own care (e.g. checking blood test results), aiming to implement this in peoples homes following evaluation
- More timely diagnosis and intervention and potentially eliminating the need for unnecessary or repeat diagnostic procedures or tests
- Regular evaluation of integrated care pathways/complex care plans could be undertaken via video consultations from health and social care teams i.e. MDT review.

The project is currently running in 5 care homes in Bolton and evaluation expected later in the year.

7.2.1. BOLTON GENERAL PRACTICE INNOVATION FUND

NHS Bolton CCG identified £2 million to non-recurrently test out new ideas that would support the implementation of the CCG's objectives. Bids were invited from practices in the areas of:

- Improving Primary Care access
- Improving access to patient records
- Managing demand
- Care planning for the most complex patients
- Reducing demand on hospital services
- Better use of technology

Following evaluation of these projects, the CCG will use the learning to develop a fuller primary care strategy, based on the information in section 4.4

Overview of the successful bids:

Bid category	Overview	What this means for patients	Expected outcomes
Access	Improving access to primary care through extending the hours that GP' currently work	Patients will be able to access their own GP (or a federation of GP's in the evenings and at weekends. They will have access to records providing continuity of care	Reduced demand for A&E and GP Out of Hours (Emergency Doctor)
Shifting services	Shifting services from the hospital to the community	More clinics in the community providing care closer to home provided by a range of specialists (including GPs with a special interest)	Reduced activity at the hospital
Redesign of primary care	Practice are redesigning they organise their working patterns in GP surgeries	To provide more / longer appointments for those patients with greatest need. Working more closely with nurses / therapists and social care to ensure all needs are met	Reduced activity at the hospital Patients feels more supported to manage their condition
Prescribing	To look at prescribing patterns / ordering of repeat prescriptions	Patients tell us they don't always need all their repeat medication but quite often receive all this which leads to stockpiling	Reduced waste in prescribing
Technology	To test how technology can support GP's during home visits or consultations	GPs will have access to your notes to avoid duplication	Free up GP time
Other	Additional translation and education for non- English speaking people	To assist during consultation with health professionals To educate right services to access	Reduced DNAs in services Free up GP time

8. FINANCIAL STRATEGY AND RESILIENCE

The CCG is required to have a 5 year financial plan to support its overarching commissioning vision and strategy. The CCG's financial strategy is to be a long-tern financial sustainable organisation which delivers all its key financial targets and manages its financial risks. The CCG will do this by:

- The use of a dynamic financial model;
- Regular review of the CCG financial position, including deep dive analysis of variations against plan;
- Monthly modelling of financial scenarios, including upside and downside, which is taken through the Executive Team monthly;
- Holding a contingency and a risk reserve;
- Maintaining robust forecasting mechanisms, which will provide early indications of where spend is above plan and support in identifying levers to bring back in line with plans.

CCGs are funded on an annual basis through budget allocations for both commissioning of healthcare services (programme costs) which have been confirmed for 2014/15 and 2015/16 with indicative uplifts published for the further 3 years, and for running costs which have been confirmed for the next 5 years. CCGs cannot spend beyond their budget allocation and must demonstrate that their plans are affordable and value for money.

When we are developing our commission plans we need to understand the impacts on the healthcare system in Bolton and our neighbouring CCGs in Salford and Wigan. We do this by sharing our commissioning plans with our providers and neighbouring CCGs to ensure that they have time to respond and implement the required changes. We also review the strategic plans our local providers, neighbouring CCGs, local authority and NHS England to understand how these will impact health services in Bolton.

8.1. BUDGET ALLOCATIONS

8.1.1. PROGRAMME COSTS

CCG budget allocations are based on a funding formula. The formula takes account of the size and characteristics of the population, deprivation and unmet need.

Bolton CCG had a recurrent budget allocation for programme costs of £335.8m in 2013/14 and this has been uplifted to take account of inflation and other pressures by 2.17% in 2014/15 and 2.13% in 2015/16. These uplifts are slightly above the minimum growth level identified by NHS England (2.14% in 2014/15 and 1.70% in

2015/16). A summary of the uplifts and projected budget allocations for programme costs is shown in the table below:

Figure 16: Projected Annual Budget allocations – programme resource

Year	2014/15	2015/16	2016/17	2017/18	2018/19
Uplift Budget Allocation – Programme Costs	2.17% £343m	2.13% £357m*	2.25% £365m	2.24% £373m	2.22% £381m

*Includes Better Care Fund additional recurrent allocation

8.1.2. BUSINESS RULES

NHS England has devised a set of 'business rules' within which CCGs must operate. These are summarised and explained in the table below:

Figure 17: NHS CCG Business Rules

Business Rules	2014/15 % of allocation	15/16 – 18/19 % of allocation
Minimum contingency Budget set aside for unexpected pressures.	0.5%	0.5%
Cumulative surplus carry forward The level of prior year savings that the CCG must hold and not spend or increase without permission from NHS England.	1%	1%
Non-recurrent spend The level of one-off spending the CCG must spend in order to demonstrate good financial health.	1.5%	1.0%
Non recurrent transformation The level of spend that the CCG must invest to enable its vision of integrated services to be achieved.	1% Call to Action	4% Better Care Fund

8.1.3. RUNNING COSTS

CCGs must support and operate their commissioning activities within a running cost allowance to ensure value for money. In 2013/14, the CCG had a running cost allowance of £7.0m which will remain broadly the same for 2014/15 but then reduce by 10% the following year to £6.3m. This is in line with government requirements to keep administration costs in the NHS as low as possible. Running costs for Bolton CCG for the next 5 years have been notified as follows:

Figure 16: Bolton CCG Running Costs Allowance

Year	2014/15	2015/16	2016/17	2017/18	2018/19
Running Costs	£7,029k	£6,320k	£6,313k	£6,307k	£6,302k

The CCG regularly reviews its running costs for value for money and has developed a model to monitor costs and run financial projections. This is reviewed by the Governance and Risk Committee on a regular basis to provide assurance and benchmark costs against other CCGs. The Governance and Risk committee has reviewed the CCG plans to ensure that running costs in 2015/16 are contained within a reduced financial envelope whilst still continuing to deliver its commissioning activities.

The CCG buys a number of support services from the Greater Manchester Commissioning Support Unit where this is more cost effective than providing an in-house service. The CCG regularly reviews its support services arrangements to ensure value for money.

8.2. FINANCIAL PLANS

8.2.1. PLANNING ASSUMPTIONS

The CCG builds it financial projections using a set of assumptions. Each year planning assumptions are shared and agreed with the CCGs main providers. However, in order to manage the risk that future assumptions are incorrect it is common practice to model a number of different financial scenarios.

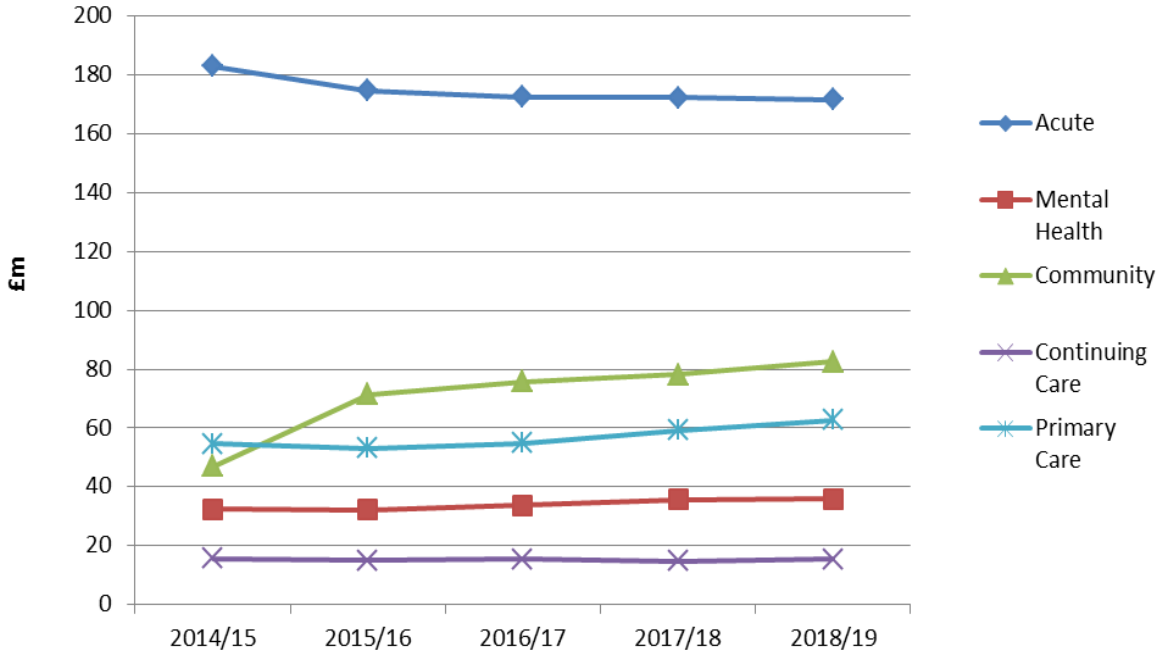
It is important to note that the planning assumptions in each scenario can change. NHS Bolton CCG has developed a dynamic financial model which is capable of re-forecasting each scenario based on changing assumptions. This provides an understanding of what the CCG could face in terms of financial challenges and helps to develop ‘what if’ style thinking. A common characteristic of high performing organisations is their ability to consider how to address the most challenging situations.

8.2.2. FINANCIAL PLAN 2014/15 – 2018/19

An overview of the CCGs financial plan is detailed in the table below, which identifies the high level forecast revenue position for the next five years. The CCG’s financial position is the difference between its expenditure and budget allocation in each year. The expenditure of the CCG is rising due to increased demands on services along with inflationary pressures. The challenge for the CCG is to ensure

that its allocation is spent wisely on achieving the best possible outcome from within its limited resources.

Figure 17: Financial plan by commissioning area



	2014/15 £ m	2015/16 £ m	2016/17 £ m	2017/18 £ m	2018/19 £ m
Acute	183.0	174.8	172.6	172.4	171.6
Mental Health	32.4	32.2	33.7	35.7	35.9
Community	46.9	71.5	75.8	78.2	82.5
Continuing Care	15.6	14.9	15.4	14.7	15.3
Primary Care	54.6	53.1	54.9	59.3	62.8
Other incl contingency	9.9	9.7	11.7	12.0	12.3
Total Programme Costs	**342.5**	**356.2**	**364.2**	**372.2**	**380.4**
Running Cost	**7.0**	**6.3**	**6.3**	**6.3**	**6.3**
Total Cost	**349.5**	**362.5**	**370.5**	**378.5**	**386.7**

The table shows that the rising demand for services will create a financial pressure for the CCG unless action is taken within its commissioning strategy to continually improve the efficiency and effectiveness of services. The CCG has developed a programme called QIPP (Quality Innovation Productivity Prevention) to enable this to happen.

8.2.3. FINANCIAL DETAIL FOR YEAR 1: 2014/15

The CCG has been notified of a total revenue allocation of £353m in 2014/15 as analysed in the table below.

Figure 18a: Year 1 Resources Available

	2014/15 £ m
Opening Recurrent Baseline	335.4
Growth at 2.17%	7.3
Running Cost Allowance	7.0
Return of 2013/14 Surplus	3.3
Total Resources available	**353.0**

The CCG had opening recurrent budgets of £333.8m and total reserves of £20.4m in 2014/15 as analysed in the following table. The table also shows the CCG needs to deliver cost improvements through its QIPP programme of £4.7m in 2014/15.

Figure 18b: Year 1 financial plan

	2014/15 £ m
Expenditure Budgets	333.8
Reserve for Investments and Pressures not incl above	3.6
NHS England mandated 2.5% non-recurrent Reserve	8.7
NHS E mandated 0.5% Contingency	1.7
Risk Reserves	6.4
Total Expenditure before QIPP & required surplus	**354.2**
Required 1% Surplus	3.5
Total before Impact of QIPP	**357.7**
Required QIPP Programme	**(4.7)**
Total Resources Available	**353.0**

8.2.4. INVESTMENTS

The CCG is planning to make significant investments to support the implementation of health and social care integration and enhanced primary care. These will be funded from the CCG allocation uplift and QIPP savings.

8.2.5. STATEMENT OF FINANCIAL POSITION

The CCG's Statement of Financial Position reports on the organisation's assets, liabilities and taxpayers equity at any point in time. The Statement of Financial Position included in the detailed financial plan assumes capital plans are approved by NHS England.

8.2.6. CASH

The CCG draws down cash from the Department of Health based on requirements set out within detailed cash-flow forecasts. The CCG must remain within cash planning targets set within its financial plans submitted to NHS England.

8.2.7. CAPITAL

Bolton CCG is progressing strategic estates developments within the health economy to support its commissioning plans. In December 2013 the CCG submitted estimated capital plans for 2014-15 and 2015-16 to NHS England in accordance with the CCG's strategic plans and these are included in the detailed financial plan submitted to NHS England.

8.2.8. CONTRACT VALUES

The CCG agrees contracts with its providers of commissioned services on an annual basis. This involves agreeing the activity levels, quality, performance and financial terms. Contracts are routinely adjusted to reflect the changes relating to commissioning decisions and the impact of any QIPP schemes. Table 8.4 reflects the CCG Commissioning Strategy to reduce expenditure on hospital based services and re-invest in services in community and primary care based settings.

8.3. QIPP STRATEGY 2014/15 – 2018/19

The table below shows the financial challenge based upon the current modelling assumptions and the QIPP plans required in order to maintain compliance with the business rules.

Figure 19: Required QIPP (efficiency savings)

Year	2014/15	2015/16	2016/17	2017/18	2018/19
QIPP Challenge	£4.7m	£4.4m	£6.0m	£4.5m	£4.5m

Our QIPP plans are initiated and developed by using benchmarking techniques, research into best practice and feedback from a range of sources including patients and GPs. QIPP plans are progressed through systematic stages of concept through to implementation using a rigorous project management approach. Progress, risks and issues are reported to the CCG board on a regular basis.

8.4. RISKS

Risks to the delivery of our financial plans have been identified in the table below. We regularly review our risks for the following years and these relate primarily to the contracts in place with Acute, Community and Mental Health providers. Further risks will continue to be assessed and included in financial plans if necessary.

Figure 20: Risks to Financial Plans

Risk Area	Risk Impact	Mitigation
Allocations	Allocations beyond 2015/16 have not been confirmed and could have a material impact.	Scenario planning, development of ambitious QIPP plan to cope with all scenarios. Establishment of contingencies within scenarios.
Mental health PBR	National policy direction is to implement PBR in mental health. This could have an adverse impact on the CCG based on current analysis.	Inclusion of cost pressures in financial planning assumptions. QIPP and commissioning strategy. Develop risk sharing arrangements.
Demand/PBR	The PBR system of paying based on levels of activity means that commissioner costs increase with demand.	Demand management QIPP work stream. Develop risk sharing arrangements.

		Establishment of contingencies within scenarios. Apply contract controls.
Prescribing	Prescribing costs increase due to a range of factors some of which are beyond the CCG control. Exchange rate volatility National pricing agreements Licensing arrangements	Medicines management QIPP workstream. Joint working in health economy. Strong clinical leadership and engagement. Establishment of contingencies within scenarios.
Provider Cost Improvement Programmes	Provider organisations have significant cost improvements to deliver which may impact on the ability to deliver services. .	Joint working with Provider colleagues. Establishment of strong governance arrangements for delivery of QIPP. Joint clinical groups, clinically led changes. Strategic alignment. 3-5 year planning rather than annualised cycles. Development of strategies with LA, providers, NHS England etc
Continuing Healthcare	High cost packages continue to rise. Thresholds change. Reductions to social service budgets impact on the demand for continuing healthcare packages.	Commissioning review of continuing healthcare. Enhancement to commissioning arrangements with additional funding and expertise. Establishment of better links with LA and providers. Establishment of contingencies within scenarios.
High cost drugs and new technologies	High cost drug prescribing continue to rise. Supply induced demand.	Discussions in joint clinical group to develop cost control approaches to include prior approval schemes. Development of incentives for providers to reduce cost in this area.
LA budget reductions	Significant reductions in social care budgets impact on healthcare.	Development of strategic plans with LA and Providers under oversight of the HWB board.

8.5. PROCUREMENT

The CCG is required to use procurement processes where commissioned services are not demonstrating value for money and where providers have been unable to meet expectations. The CCG will follow the NHS rules and legal requirements in carrying out this process.

Over the next five years the CCG will re-procure a number of services including:-

- GP Out of Hours
- Improving Access to Psychological Therapies
- Any Qualified Provider (AQP) services
- Independent Sector Clinical Assessment and Treatment Services (ISCATs)

APPENDIX 1: Population statistics and evidence of health need from Joint Strategic Needs Assessment

Starting Well

Bolton's total population is set to increase by around 20% or around 54,000 people by 2035. Although the borough is set to gain approximately 30,000 migrants from other countries, it is projected that Bolton will lose around 14,000 residents who will move elsewhere in the UK. The borough is projected to experience a marginally higher birth rate than the national average.

The proportion of children in Bolton is slightly higher than the average for Greater Manchester or for England and Wales. In 2011, 25.8% of the population were aged 0-19, with 6.8% of these being 0-4. The population of dependent children is unevenly distributed across the borough, ranging from 26% in Rumworth to 18.6% in Little Lever & Darcy Lever. Although overall the total number of dependent children has remained relatively stable since 2001, there has been a significant increase in the number of under-fives, with 2,000 extra children in this age group now living in Bolton, reflecting a general trend across the UK. Population projections for Bolton suggest that the number of dependent children will increase by 17% between 2010 and 2035.

Bolton has also seen a changing ethnic composition of these births and the highest birth rates are seen in the most deprived areas of the town, where we also see the highest density of Black and Minority Ethnic (BME) residents.

Developing Well

The proportion of children in poverty in Bolton was 22.7% in 2011, down from a peak of 25.2% in 2001. This is higher than the England average of 20.1%, but in line with similar areas. There are wide variations in levels of child poverty across the borough indicating a need for a targeted approach to tackling and mitigating child poverty in the borough, rather than a 'one-size-fits-all' response.

Bolton has a growing BME population from 12.8% in 2001 to 20.6% in 2011. The proportion of BME children aged 5-19 has increased at a slightly higher rate from 16.9% in 2001 to 27.5% in 2011.

As at the 2011 Census, 2,170 (3.8%) of all 0-15 year olds (56,970 total population) were limited in their day to day activities through ill health or a disability.

Living Well

In the Census 2011 219,300 Bolton residents (79.3%) reported their health as being very good or good. However, of the 116,370 households in Bolton there are 33,300 (28.7%) in which resides at least one person with a long-term health problem or disability. The proportion of people with a long-term health problem or disability has remained the same over the decade between the last two Censuses, but the actual number of people has increased significantly and this is primarily due to increasing

population aged 55-64 years. This cohort will continue to grow into the future.

Key vulnerable groups in Bolton include disabled people (29,700), carers (30,650), LGBT groups (4,300-10,600), homeless and the vulnerably housed (630 homelessness applications per year), offenders and recent offenders (1,800 supervised by NPS at any one time), gypsies and travellers (250 families), refugees and asylum seekers (750), substance misusers (2,800 problem drug users (PDUs)) and street sex workers.

Working Well

In Bolton 134,930 people are economically active, which represents 67.2% of the population aged 16-74 years. Of these economically active people, 118,780 are in employment (full-time, part-time, or self-employed). However, 9,910 of the economically active group are currently unemployed; in addition, there are 3,930 individuals who are long-term unemployed and 1,770 who have never had a job. Over recent years Bolton's unemployment rate peaked in 2009/10 following the recession of 2008 at 10.4% and has gradually reduced since then.

Our main employment sectors are 'Wholesale and retail trade/repair of motor vehicles' with 23,310 employees, 'Human health and social work activities' with 16,140 employees, 'Manufacturing' with 13,180 employees, 'Education' with 11,580 employees, and 'Construction' with 10,400 employees. These sectors account for 60% of the total numbers of employees aged 16-74 years. The town centre provides the hub of employment by providing around a third of the jobs in the borough.

Ageing Well

Bolton's population is ageing as a result of increased life expectancy and demographic trends. The over 65 population will grow from 44,700 at present to 61,400 by 2030 (an increase of 16,700 (37%)). Of most concern is the increase of people aged over 85 from 5,700 at present to 10,100 by 2030 as these people are more likely to have complex health and care needs.

It is a key priority for all services to plan effectively for this demographic change in order to take advantage of the opportunities this presents as well as to ensure the needs of older people can be met in the future.

Although currently the majority of older people in Bolton are White (95%), there will be an increasing proportion of older people from minority ethnic groups over the next 5-10 years. In particular, the proportion of older people with an Asian/Asian British ethnicity will increase significantly.

Significant increases are also expected locally in the number of older people with a long–term illness or disability as a result of the ageing population. In less than ten years, the number of older people in Bolton living with a limiting long-term illness or disability will increase by 17% (from 23,500 to 27,500), with obvious implications for

local services.

End of Life

In Bolton, 60.6% of all deaths occur after the age of 75, which is notably fewer than the England average (66.7%). In addition, 31.3% of Bolton residents die over the age of 85, which is again lower than we see nationally (36.2%). The percentage increase in Bolton's 85+ population by 2033 will be 126.3%, or an extra 11,800 people.

As would be expected the majority of people who die in a hospice in Bolton have cancer recorded as their underlying cause of death (131 people from a total of 136 dying in a hospice over a typical three year period). Of the Bolton residents dying in a hospital, the greatest number die from CVD or respiratory disease, followed by cancer and renal disease. End of life care for those dying of CVD and respiratory disease can be complicated due to the increased likelihood of comorbidities associated with CVD and the acute exacerbations for COPD patients (accounting for the majority of respiratory deaths). In Bolton, Alzheimer's, dementia, or senility is listed as either an underlying or contributory cause in 13.4% of deaths. The majority of Bolton residents dying where Alzheimer's/dementia/senility is mentioned on their death certificate die either in a care home or at hospital.

The number of people dying from liver disease is increasing in Bolton, as it is across England. Over 70% of people with liver disease die in hospital, and end of life care for people with liver disease can be particularly challenging as patients tend to be younger, often come from isolated or ethnically diverse subcultures, and are more likely to have come to healthcare attention by circuitous routes of access. They may feel great stigma associated with their disease, the progress of which is punctuated by acute exacerbations.

In Bolton, 0.71% of the population will have a palliative care need.

Appendix 2: The Practice peer group clusters in Bolton – e.g. of their use in benchmarking

Practice	Practice List Size	Number of patients > 45 years (no disease)	>45yrs no disease patients as percent of list size	PEER AV: >45yrs no disease patients as percent of list size	Numbers of risk assessments undertaken	Percent Risk Assessed	Peer Average of ASSESSED	Number of patients on primary prevention register	Percent on risk register	Average of RISK REGISTER
Derby Practice	1,966	301	15.3%		258	85.7%		63	24.4%	
Sidda	1,655	210	12.7%		189	90.0%		35	18.5%	
Falouji	2,427	422	17.4%		232	55.0%		61	26.3%	
Naqvi SMH	2,593	318	12.3%		275	86.5%		24	8.7%	
SSP Health		98	N/A	**16.5%**	94	95.9%	**83.6%**	27	28.7%	**23.3%**
Astley Brook Practice	1,779	417	23.4%		327	78.4%		101	30.9%	
Naqvi UK	1,601	239	14.9%		151	63.2%		21	13.9%	
Prasad	5,163	831	16.1%		808	97.2%		194	24.0%	
Kumar A	1,970	328	16.6%		312	95.1%		90	28.8%	
Great Lever Practice	2,640	627	23.8%		412	65.7%		146	35.4%	
Newgrosh	2,098	602	28.7%		316	52.5%		63	19.9%	
Dakshina-Murthi	2,221	534	24.0%		495	92.7%		139	28.1%	
Loomba & Partner	5,632	1,404	24.9%		1,022	72.8%		261	25.5%	
Caldwell & Partners	7,514	1,766	23.5%	**24.4%**	1,682	95.2%	**80.7%**	316	18.8%	**28.5%**
Hunt & Partner	4,015	1,043	26.0%		929	89.1%		346	37.2%	
Caswell	2,613	502	19.2%		442	88.0%		152	34.4%	
McLardy & Partners	3,625	1,011	27.9%		756	74.8%		313	41.4%	
Selverajan	2,318	470	20.3%		372	79.1%		95	25.5%	
Littlewood & Partners	8,937	2,638	29.5%		2,014	76.3%		503	25.0%	
Zarrouk	2,376	741	31.2%		524	70.7%		175	33.4%	
Avondale Practice	2,019	569	28.2%		428	75.2%		125	29.2%	
Woods & Partners	4,124	1,180	28.6%		1,031	87.4%		399	38.7%	
Rout	2,376	712	30.0%	**29.8%**	682	95.8%	**83.9%**	198	29.0%	**25.9%**
Singh & Partners	4,459	1,337	4,459		1,020	76.3%		199	19.5%	
Parikh & Partners	4,206	1,066	25.3%		1,025	96.2%		284	27.7%	
Ormiston & Partners	5,240	1,671	31.9%		1,488	89.0%		359	24.1%	
Shri-Kant & Partner	4,834	1,598	33.1%		1,441	90.2%		255	17.7%	
Agarwal & Partners	5,598	1,537	27.5%		1,027	66.8%		364	35.4%	
Silvert & Partners	13,317	3,750	28.2%		2,751	73.4%		558	20.3%	
Barua	3,399	1,020	30.0%		916	89.8%		326	35.6%	
Wakefield & Partners	6,738	1,998	29.7%	**30.3%**	1,561	78.1%	**77.6%**	435	27.9%	**29.6%**
Kent	1,837	739	40.2%		669	90.5%		226	33.8%	
Ariff & Partners	6,786	1,851	27.3%		1,370	74.0%		447	32.6%	
Patel & Partners	5,953	2,072	34.8%		1,756	84.7%		613	34.9%	
Lowe & Partners	5,986	2,082	34.8%		1,625	78.0%		484	29.8%	
Phillips	4,768	1,670	35.0%		1,372	82.2%		491	35.8%	
Lynch & Partners	9,886	3,156	31.9%		2,528	80.1%		542	21.4%	
Wall & Partners	10,103	3,196	31.6%		2,200	68.8%		624	28.4%	
Walker & Partner	4,169	1,271	30.5%		1,212	95.4%		420	34.7%	
Walmsley & Partners	5,369	1,683	31.3%	**33.5%**	1,301	77.3%	**82.1%**	455	35.0%	**27.5%**
Jain	3,409	1,127	33.1%		914	81.1%		248	27.1%	
Little Lever Practice	2,051	663	32.3%		565	85.2%		172	30.4%	
Korlipara & Partners	7,740	2,614	33.8%		2,157	82.5%		442	20.5%	
Lancashire & Partners	13,198	4,972	37.7%		4,468	89.9%		1,198	26.8%	
Saul & Partners	7,649	3,105	40.6%		2,711	87.3%		601	22.2%	
Market St Practice	2,576	971	37.7%		712	73.3%		187	26.3%	
Lamb & Partners	9,611	3,428	35.7%		2,479	72.3%		703	28.4%	
Nagle & Partners	19,711	6,876	34.9%		5,568	81.0%		1,022	18.4%	
Dryburgh & Partners	12,424	4,392	35.4%		3,645	83.0%		780	21.4%	
Symes & Partners	7,460	2,739	36.7%	**36.3%**	2,429	88.7%	**83.6%**	748	30.8%	**23.8%**
Ladybridge Practice	4,222	1,496	35.4%		1,218	81.4%		319	26.2%	
Kirby & Partners	4,663	1,618	34.7%		1,395	86.2%		358	25.7%	
Fletcher & Partners	9,696	3,728	38.4%		3,408	91.4%		938	27.5%	
Umebuani	2,714	1,108	40.8%		847	76.4%		267	31.5%	
Liversedge & Partners	4,805	1,595	33.2%		1,548	97.1%		266	17.2%	