

BOARD OF DIRECTORS

PUBLIC MEETING

26 JUNE 2017

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 26 June 2017

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June 2017

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Monday 26 June 2017 at 1.15pm in Board Room, Stockport CCG, Regent House, Stockport.**

An agenda for the meeting is detailed below.

Yours sincerely

ADRIAN BELTON
CHAIR

AGENDA ITEM	TIME
1. Apologies for Absence.	1.15pm – 1.20pm
2. Opening Remarks by the Chair.	"
3. Declaration of Amendments to the Register of Interests.	"
4. OPENING MATTERS:	
4.1 To approve the minutes of the previous meeting of the Board of Directors held on 25 May 2017 (attached).	1.20pm – 1.25pm
4.2 Patient Story (Report of Director of Nursing & Midwifery attached).	1.25pm – 1.35pm
4.3 Report of the Chairman.	1.35pm – 1.45pm
4.4 Report of the Chief Executive.	1.45pm – 2.00pm
5. STRATEGY AND DEVELOPMENT:	
5.1 Stockport Together – Outline Business Cases (Report of Chief Executive attached).	2.00pm – 2.45pm
6 ASSURANCE AND GOVERNANCE:	
6.1 Performance Report (Report Chief Operating Officer attached).	2.45pm – 3.05pm
6.2 Maintaining Safe Staffing Levels (Report of Director of Nursing & Midwifery attached).	3.05pm – 3.15pm
6.3 Strategic Risk Register (Report of Director of Nursing and Midwifery attached).	3.15pm – 3.25pm

AGENDA ITEM	TIME
6.4 Board Assurance Framework (Report of Chief Executive attached).	3.25pm – 3.40pm
6.5 Key Issues Reports from Assurance Committees: 6.5.1 Finance & Performance Committee (to follow and Malcolm Sugden to report)	3.40pm – 3.45pm
6.6 Governance Self-Certifications (Report of Director of Corporate Affairs attached).	3.45pm – 4.00pm
7 CLOSING MATTERS:	
7.1 Date of next meeting: • Thursday 27 July 2017, 1.15pm, in Lecture Theatre B, Pinewood House, Stepping Hill Hospital.	4.00pm

STOCKPORT NHS FOUNDATION TRUST

**Minutes of a meeting of the Board of Directors held in public
on Thursday 25 May 2017
1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital**

Present:

Mrs G Easson	Chairman
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr J Sandford	Non-Executive Director
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Mrs A Barnes	Chief Executive
Mr P Buckingham	Director of Corporate Affairs
Mrs J Morris	Director of Nursing & Midwifery
Mr F Patel	Director of Finance
Mrs J Shaw	Director of Workforce & OD
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director

In attendance:

Mr A Belton	Designate Chair
Mrs S Curtis	Membership Services Manager
Dr D Waterman	Consultant in Palliative Medicine
Mr A Webb	Corporate Director – Services for People

134/17 Apologies for Absence

Apologies for absence had been received from Mr H Mullen and Mr K Spencer. It was also noted that Dr C Wasson would arrive late as he was conducting a number of media interviews.

135/17 Opening Remarks by the Chairman

The Chairman welcomed members of the Board to the meeting. She made reference to the terrorist attack at the Manchester Arena on 22 May 2017 and noted that Stepping Hill Hospital had been among the eight hospitals dealing with a number of casualties. She expressed thanks on behalf of the Board to staff across the organisation for their remarkable response in managing casualties from the incident and to members of the public and local businesses for their tremendous support. The Chairman advised that the Health Secretary had visited the Trust on 23 May 2017 to personally thank frontline staff. She noted that the Board had observed a minutes silence earlier that morning to remember those who lost their lives or were injured as a result of the attack and advised that the Trust had a staff counselling service in place for anyone affected by the atrocity.

The Chairman also referred to the major cyber-attack which had affected a number of NHS organisations on 12 May 2017. She noted that the Trust's IT systems had not been affected which was thanks to the IT team who had been keeping the Trust's systems safe by upgrading the anti-virus software on a regular basis. She advised, however, that Buxton Hospital and GP practices in Stockport had been affected and she wished to thank the Trust's health records staff who had supported those organisations. The Chairman concluded her opening remarks by showing a video clip of interviews from a number of Trust staff in relation to the terror attack which had been aired at the BBC Breakfast News earlier that morning.

136/17 Declaration of Amendments to the Register of Interests

There were no interests declared.

137/17 Minutes of the previous meeting

The minutes of the previous meeting held on 27 April 2017 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

138/17 Palliative Care & Last Days of Life

Dr D Waterman, Consultant in Palliative Medicine, provided a presentation to the Board of Directors on Palliative Care & Last Days of Life. The presentation covered the following subject areas:

- Context
- Care in Last Days of Life
- Priorities
- National Audit Site Results
- Community Audit
- Bereavement Survey 2014 & 2016
- What are the Bereaved Saying?
- CQC and End of Life Care – 2016
- Action Plan
- Death in Usual Place of Residence and Other Outcomes
- Questions.

The Chief Executive noted that Dr D Waterman was a Palliative Care Consultant for a Specialist Clinical Network and whilst he worked part time at the Trust, he regularly worked over and above his contracted hours. In response to a question from the Chief Executive who queried the Trust's ability to learn from other organisations, Dr D Waterman commented on the Trust's collaboration with Greater Manchester colleagues and noted that the Trust had made considerable progress with regard to essentials training. In response to a question from Ms A Smith, Dr D Waterman advised that the business case referred to in the presentation related to specialist resource in the areas of nursing, medical staffing and social care. With regard to a further question from Ms A Smith with regard to the requirement of side rooms, the Chairman advised that an Estates Strategy would be considered by the Board of Directors in the near future.

The Director of Corporate Affairs queried the low number of advance care plans in place for patients. Dr D Waterman advised that a number of patients would welcome the opportunity to discuss their wishes with regard to their care but noted that an audit would not recognise a conversation as an advance care plan and commented that there was further work to be done in this area. The Board of Directors thanked Dr D Waterman for the informative presentation.

Dr D Waterman left the meeting.

139/17 Patient Story

The Director of Nursing & Midwifery presented a patient story about a lady who had been admitted to Stepping Hill Hospital for planned surgery in March 2017. She noted that the lady who had never been in hospital before and had been extremely anxious prior to her admission had unfortunately suffered post-operative complications which had resulted in further surgery. The Director of Nursing & Midwifery advised that despite the traumatic experience, the lady had been very complimentary of the care she had received on ward D6 and the in the High Dependency Unit.

The Board of Directors:

- Received and noted the Patient Story Report.

140/17 Report of the Chairman

The Chairman reported that the Trust's Dementia Café had been officially opened on 27 April 2017. She also advised that the Trust, along with the Stockport Metropolitan Borough Council and the Metropolitan University, had won a Partnership of the Year award for training students in public health. The Chairman also noted that the Trust had received a top rating in the National Stroke Audit and advised that Greater Manchester as a whole had been rated as the best scoring Stroke partnership in the country. The Board wished to congratulate the Trust and its partner organisations for these fantastic achievements.

141/17 Trust Performance Report – Month 1

The Chief Operating Officer presented the Performance Report which summarised the Trust's performance against the NHSI Single Oversight Framework for the month of April 2017, including the key issues and risks to delivery. She advised that the report also provided a summary of the key risk areas within the Integrated Performance Report which was attached in full in Annex A. The Chief Operating Officer briefed the Board on the content of the report and whilst noting one area of non-compliance in month 1 which was the non-achievement of the Accident & Emergency (A&E) 4-hour target, she was pleased to report compliance of all other metrics. It was noted that the Referral to Treatment (RTT) and Cancer 62-day standard performance were compliant with the national standard for the sixth consecutive month.

With regard to the Emergency Department (ED) performance, the Chief Operating Officer noted an improved performance in April of 85.3% and advised that the Trust had therefore achieved the NHSI improvement trajectory of 85% for the first month of the quarter. It was noted that the improvement trajectory was 90% for Quarters 2 and

3 and 95% for Quarter 4. The Chief Operating Officer briefed the Board of the processes which had contributed to the improved position and noted that the step changes required for compliance in Quarters 2 and 3 related mainly to workforce and internal flow. She noted, however, that achievement of the 95% trajectory by Quarter 4 would be a challenge as it was more dependent of improvements in Delayed Transfers of Care (DTOC) and actions around admission avoidance.

Mr M Sugden referred to the deteriorating DTOC position and queried what assurances the Board could take regarding the achievement of the NHSI improvement trajectory. The Chief Operating Officer noted that the DTOC position had deteriorated further in May 2017 and briefed the Board of mitigating actions, including intermediate tier work in the area of transfer to assess. She referred to new ways of working as a consequence of Stockport Together and noted that the Local Authority was sourcing capacity out of the acute setting. The Chief Operating Officer reiterated, however, that Quarter 4 would be a challenge as successful compliance of the 4-hour A&E target would largely be outside of the Trust's remit.

The Corporate Director – Services for People advised the Board that the Local Authority's priority was to strengthen the domiciliary workforce of its providers but noted that this would take time as staff would require training. He also advised the Board of actions to improve flow through the system which included supporting patients in their own homes and working closely with the residential and nursing home sector to ensure an adequate capacity of community beds. Mr J Sandford referred to Chart C of the Performance Report and queried whether the increased number of admissions was as a result of patient acuity or change of practice in the Emergency Department. The Chief Operating Officer advised that Chart C should be read in conjunction with Chart E ('Emergency admissions via A&E >1 day length of stay') and noted that variance in the reported figure could be as much as 10%.

The Director of Finance briefed the Board on the Finance section of the report and noted that in April 2017, the Cost Improvement Programme (CIP) was £0.20m behind the profiled plan. With regard to financial sustainability, the Director of Finance reported that the Trust's overall Finance Use of Resources was 3 which was in line with the Trust's 2016/17 Operational Plan. He noted that the cash in the bank position on 31 March 2017 was £23.7m which was £5.4m ahead of plan and advised that the Trust was forecasting a requirement to borrow funds from the Independent Trust Financing Facility (ITFF) to pay for day-to-day services in 2017/18. The Director of Finance advised that the Trust's agency expenditure in April was £1.2m which exceeded the profiled NHSI agency ceiling to date.

In response to a question from the Chairman, the Director of Finance advised that the Trust's requirement for the working capital facility loan was very much dependent on CIP delivery. He noted, however, that even if the Trust delivered the CIP target, it was expected that the Trust would still need to draw the loan at Quarter 2. The Director of Finance advised that the Board would be kept informed of progress via fortnightly 'flash' reports. Mr M Sugden noted that the Finance & Performance Committee had highlighted CIP delivery as a particular concern and commented that he would welcome a debate on the subject at the forthcoming deep dive session. Mr M Sugden advised that the level of CIP delivery had been very small in April which adversely affected the position and increased the risk for the rest of the year. He added that a further report on the subject would be considered at the next meeting of the Finance

& Performance Committee. The Director of Finance advised that he had presented revised CIP governance arrangements to the Finance & Performance Committee which included appointing Accountable Officers for each Cost Improvement Programme. He noted that the Finance & Performance Committee would receive an assurance report from each Accounting Officer with regard to their themes. The Chairman commented that the Board would welcome the enhanced reporting.

The Director of Workforce & OD briefed the Board on the Workforce section of the report and provided an update on metrics relating to essentials training, appraisals, turnover, efficiency and sickness absence. With regard to essentials training, the Director of Workforce & OD noted issues with regard to e-learning and access to the system and noted that a report on this subject would be considered by the People Performance Committee. She noted that appraisals compliance had decreased slightly and advised that each business group whose performance was below 95% was asked to produce a recovery plan. The Director of Workforce & OD noted an improved position with regard to staff in post and noted a decrease of bank & agency costs in month. She advised that the Medicine business group continued to be the main area of concern with regard to bank & agency spend and noted that substantive recruitment was the sustainable solution to the issue. The Director of Workforce & OD concluded her report by advising the Board that the in-month unadjusted sickness absence figure for April 2017 was 3.80% which was a decrease of 0.04% compared to the March adjusted figure of 3.84%. She commended the Corporate Services and Diagnostic & Clinical Services business groups for achieving compliance below the 3.5% target in April 2017.

In response to a question from Ms A Smith, the Director of Workforce & OD advised that stress continued to be one of the main reasons for sickness absence but noted that in majority of the cases stress was not solely work-related. In response to a question from Mrs C Barber-Brown, the Director of Workforce & OD advised that the People Performance Committee would be considering a report with regard to long and short term sickness absences at its next meeting. In response to a question from Mr J Sandford who made reference to a number of 'red' rated workforce indicators, the Director of Workforce & OD advised that the People Performance Committee would be reviewing the targets, which she noted were very challenging. In response to a further comment from Mr J Sandford, the Director of Workforce & OD agreed to include benchmarking information against other Trusts in future reports to provide further context.

The Chief Executive noted the Trust's adverse in-month position against the agency cap and sought assurance with regard to improved performance going forward. The Director of Workforce & OD briefed the Board of work around medical workforce in the light of IR35 changes and consequent rate increases. In response to a question from the Chief Executive who noted the inconsistency between the current position and the reported improvement in substantive recruitment, the Director of Workforce & OD commented on the in-month increased costs as a result of IR35 changes. In response to a further question from the Chief Executive, the Director of Workforce & OD advised that the People Performance Committee and the Finance & Performance Committee tracked performance delivery on a monthly basis and agreed to provide more granular detail in future Board reports.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the position for Month 1 compliance standards
- Noted the future risks to compliance and corresponding actions to mitigate
- Noted the key risk areas from the Integrated Performance Report.

142/17 Maintaining Safe Staffing Levels

The Director of Nursing & Midwifery presented a report which provided an overview, by exception, of actual versus planned staffing levels for the month of April 2017. She briefed the Board on the content of the report and noted that average fill rates for Registered Nurses (RN) had increased to 91.9% in month. She further noted that average care staff rates remained above 100% to support RN rates. The Director of Nursing & Midwifery highlighted eight areas in Medicine with sub-optimal RN staffing levels, one area in Surgery & Critical Care and one in Child & Family. In response to a question from the Chairman, the Director of Nursing & Midwifery advised that the Trust ensured safety on wards by close monitoring of staffing levels and implementation of the Minimum Staffing Escalation Policy which included mobilisation of non-ward based nurses to front line areas to ensure patient safety.

The Director of Nursing & Midwifery briefed the Board on recruitment and retention issues and noted an improved position in Emergency Department staffing following the availability of greater support and development opportunities for Registered Nurses. In response to a question from Dr M Cheshire, the Director of Nursing & Midwifery advised that the table on page 6 of the report was not 'RAG' rated and noted that the colours had been mandated by a national template. The Director of Workforce & OD noted her disappointment that local NHS Trusts were increasing offers to student nurses above agreed rates. The Director of Nursing & Midwifery agreed to ensure that the Director of Workforce & OD was being included in discussions in this area. In response to a question from the Director of Finance, the Director of Nursing & Midwifery explained the Registered Nurses versus care staff fill rates detailed in Appendix A.

In response to a question from the Chief Executive, the Director of Nursing & Midwifery advised the Board of ways in which the Trust attempted to support its staff who were asked to assist in under-staffed areas. In response to a question from Mrs C Barber-Brown, the Director of Nursing & Midwifery provided further clarity with regard to the fill rate data in Appendix A and the way in which it was calculated. In response to a question from Mr M Sugden, the Director of Nursing & Midwifery explained the rules and various parameters with regard to minimum Registered Nursing staffing levels. In response to a question from Mrs C Barber-Brown, the Director of Nursing & Midwifery advised that it was not common practice for the Trust to close beds due to short staffing. She further commented that shortage of Registered Nurses was a national problem and was not an easy issue to resolve.

In response to a comment from Mr M Sugden, the Director of Corporate Affairs suggested that rather than request further numbers and data, a better way for the Board to gain assurance of safe staffing would be to review performance against the minimum staffing policy. Mr J Sandford agreed with this suggestion and noted that the Board would welcome more meaningful assurance with regard to safe staffing. Mrs C Barber-Brown noted that some of the data included in the current report was difficult

to understand. The Director of Nursing & Midwifery advised that the Board also received a six-monthly safe staffing report, the next of which would be considered in September 2017. The Designate Chair commented that the current reports focused on historical information rather than being forward looking. In response to comments from Mrs C Anderson and Dr M Cheshire, the Director of Nursing & Midwifery advised that a number of audits were undertaken with regard to safe staffing and noted that the table in s2 of the report provided the Board with overall assurance that safe staffing had been achieved. The Chairman summarised the discussion and noted that the Board could take assurance that safe staffing had been achieved for the month of April 2017 but that further consideration would be given to the way in which assurance was provided to the Board with regard to safe staffing.

The Board of Directors:

- Received and noted the Safe Staffing Report and the measures in place to ensure patient safety.

143/17 Strategic Risk Register

The Director of Nursing & Midwifery presented the Strategic Risk Register and noted with regret that the launch of the new Datix system had been further delayed due to an issue with the system provider. She advised, however, that training was now underway and noted that the Head of Risk & Customer Services would provide a presentation with regard to changes to the Risk Register at the June Board meeting. In response to a question from the Chairman, the Director of Finance provided background to the new strategic risk 3104. The Chairman noted that there were currently two entries with a risk score of 20 and two with a risk score of 25. In a response to a comment from Mr J Sandford, the Director of Corporate Affairs and Dr M Cheshire advised that 7-day working was regularly considered by the Quality Assurance Committee. The Chief Executive advised that a Clinical Engagement Session, which had been attended by the Executive Team and the business group triumvirate, had been held on 23 May 2017 and had focused on the Cost Improvement Programme and 7-day working. She noted that an update report following the session would be presented to the Quality Assurance Committee.

Mr M Sugden commented on a need to include risks relating to Stockport Together and South East Sector of Healthier Together on the Strategic Risk Register. The Chairman agreed that there were errors and omissions on the register and noted, for example, the absence of any risk relating to Referral to Treatment. The Director of Nursing & Midwifery advised that the new Datix system would improve the facility to manage and update risks but also noted the requirement for risk owners to update the register content on a timely basis.

The Board of Directors:

- Received the Strategic Risk Register and noted the content.

144/17 Cyber Risk Report

The Chief Executive presented a report which provided the Board with assurance on the Trust's IT systems following a cyber-attack on 12 May 2017. She briefed the Board on the content of the report and was pleased to report that the Trust's IT systems had not been affected by the cyber-attack as a result of ongoing arrangements to protect the integrity of systems security. The Chief Executive noted, however, that the more IT systems became networked between Greater Manchester organisations, the greater the risk would be with regard to systems security. She consequently noted the importance of ensuring that all organisations complied with consistently high levels of systems security to mitigate future risks.

The Board of Directors:

- Received and noted the Cyber Risk Report.

145/17 Key Issues Reports

Finance & Performance Committee

Mr M Sugden briefed the Board on matters considered at a meeting of the Finance & Performance Committee held on 17 May 2017. He advised that the Committee had considered a Month 1 Finance Report and had noted a concern with regard to the agency costs and a shortfall against planned Cost Improvement Programme (CIP) savings for the month. He noted that the Committee had consequently requested a high level view of the forecast position at the next meeting.

Mr M Sugden advised that the Committee had also raised a concern with regard to funding for the Community Unit which was currently only in place until 30 June 2017. The Chief Executive briefed the Board on developments in this area and advised that a piece of work would be undertaken by the Trust and Social Care to identify intermediate care requirements going forward, including domiciliary care. She advised that the initial assumption had been that substantive recruitment would be in place by June 2017 but it was now expected that recruitment would not be optimised until August 2017. The Chief Executive advised that until the future intermediate care requirements had been established, it was not the intention to close the Community Unit. In response to a question from Mr M Sugden who queried additional costs associated with the Community Unit, the Chief Executive noted a number of potential funding streams.

The Medical Director joined the meeting and the Corporate Director – Services for People left the meeting.

Mr M Sugden advised the Board that the Committee had also considered a report regarding the Trust's agency utilisation and expenditure and had suggested a focus on the identification of potential actions to address implications caused by changes to IR35 arrangements in specific service areas. He noted that the Committee had also considered a positive report with regard to Operational Performance and had reviewed an Outline Business Case (OBC) for the procurement of a Collaborative Image Sharing system being undertaken jointly by Providers across Greater Manchester. Mr

M Sugden advised that the Committee had noted the high level of clinical engagement on this project and had recommended the OBC for the Board of Directors for approval to proceed to Full Business Case (FBC). In response to a question from Mr J Sandford, the Director of Finance briefed the Board of actions in place to regain financial balance, including the development of a Financial Recovery Plan.

People Performance Committee

Ms A Smith briefed the Board on matters considered at a meeting of the People Performance Committee held on 18 May 2017. She advised that the Committee had considered a positive report following the introduction of New Starter Workshops with the Chief Executive and Director of Workforce & OD. She advised that the Committee had also reviewed a Quarterly Workforce & OD Performance Report and had consequently requested detailed information regarding sickness absence and essentials training 'hot spot' areas. Ms A Smith noted that the Committee had also proposed that the Trust's workforce targets required review to ensure they remained realistic and fit for purpose. She informed the Board that the Committee had considered a report on Performance Appraisal compliance and noted that a further report would be presented at the July meeting which would include an update on the Trust's position regarding the distribution of appraisal scores. Ms A Smith advised that the Committee had also received an update on the Workforce Streamlining Programme and had received positive assurance with regard to medical revalidation.

Ms A Smith then advised the Board that the Committee had considered a report on the Trust's agency utilisation and had noted a specific requirement relating to delivery of a 10% reduction in medical agency usage as well as noting the significant challenges relating to the changes to IR35 legislation. She advised that the Committee had received a Quarter 4 report from the Guardian of Safe Working and had considered an update report on the CQUIN Programme. On a less positive note, Ms A Smith advised that the Committee had reviewed the Corporate Risk Register and had raised concerns with regard to a number of risks which were out of date. She concluded her report by advising the Board that the Committee had considered a monthly progress report of actions following a Post-Graduate Education Monitoring Visit by Health Education England North West (HEENW) in September 2016 and had noted a concern with regard to associated communication and interface issues.

Quality Assurance Committee

Dr M Cheshire briefed the Board on matters considered at a meeting of the Quality Assurance Committee held on 23 May 2017. He advised that the Committee had received presentations on the subjects of Pressure Ulcers and Falls and that the Committee had consequently noted the assurance provided on progress being made in both areas. Dr M Cheshire advised the Board of an issue relating to the proportion of electric beds at the Trust which was currently circa 30% of the total bed stock. He advised that electric beds had benefits in relation to both pressure sores and staff lifting and noted that the Trust's proportion of such beds was significantly lower than other trusts in the Greater Manchester area. Dr M Cheshire noted that the Committee had requested that the Estates & Facilities team provide an assurance report on the plan and replacement programme to increase the proportion of electric beds.

Dr M Cheshire advised that the Committee had also considered a report which detailed progress with the CQC Action Plan and had noted that there were currently just six entries where the actions had yet to be completed, each of which were longer term in nature. He noted that the Committee had considered a report detailing the year-end position against the 2016/17 objectives in the Quality Strategy Delivery Plan and had recommended a need for additional focus relating to actions to improve attendance at resuscitation training. Dr M Cheshire then advised the Board that the Medical Director had presented a report on the subject of Pneumonia Coding and Mortality Indicators. He advised that the report had proposed a change in the approach to coding which would result in cases currently coded as 'Bronchopneumonia' being coded as 'Unspecified pneumonia'. He noted that the proposed change was in line with current national practice and the Committee had consequently endorsed the proposal. Dr M Cheshire advised the Board, however, that the change in practice was likely to result in a negative movement of the Summary Hospital Mortality Indicator (SHMI). Dr M Cheshire concluded his report by advising the Board that the Committee had reviewed the Corporate Risk Register and had noted the benefits expected to accrue from implementation of the Datix system.

146/17 Non-Executive Director – Declarations of Independence

The Director of Corporate Affairs presented a report relating to the independence of Non-Executive Directors. He advised that provision B1.1 of the NHS Foundation Trust Code of Governance required the Board to identify in the Annual Report each Non-Executive Director that it considered to be independent. The Director of Corporate Affairs advised the Board that all Non-Executive Directors had certified a 'clean' declaration with the exception of the Chairman who declared that she had served on the Board for more than six years. He noted that the conclusion of the Board of Directors would support an appropriate statement in the Annual Report 2016/17.

The Board of Directors:

- Received and noted the report and confirmed that it considered the Chairman and Non-Executive Directors to be independent.

147/17 Compliance with NHS Foundation Trust Code of Governance

The Director of Corporate Affairs presented a report which sought approval from the Board of Directors for compliance statements relating to the NHS Foundation Trust Code of Governance. He noted that NHS Foundation Trusts were required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report. The Director of Corporate Affairs advised that during 2016/17, the Audit Committee had completed six-monthly reviews of the Trust's compliance position against Code of Governance requirements and noted that no issues had been identified as a result of these reviews. He noted that a review of the draft Compliance statements had also been completed by the Audit Committee on 17 May 2017.

The Board of Directors:

- Received and noted the report and approved the Code of Governance disclosures as presented at Appendix 1.

148/17 Annual Governance Statement 2016/17

The Director of Corporate Affairs presented a report which sought approval from the Board of Directors for the draft Annual Governance Statement 2016/17. He advised that the NHS Foundation Trust Annual Reporting Manual (ARM) 2016/17 required that all entities covered by the requirements of the manual prepared an Annual Governance Statement. He advised that the ARM included a model Annual Governance Statement which could be adapted and expanded to reflect the particular circumstances of individual NHS Foundation Trusts.

The Director of Corporate Affairs advised that the draft Annual Governance Statement had been formally considered by the Audit Committee on 17 May 2017. He noted that the Committee had recommended the Annual Governance Statement to the Board of Directors for approval subject to an amendment of the Annual Quality Report section to incorporate outcomes of the external review of mandated indicators completed by Deloitte LLP. The Director of Corporate Affairs advised that following approval, a signed copy of the Annual Governance Statement would be submitted to NHS Improvement and the approved version would also be incorporated in the Trust's Annual Report & Accounts 2016/17.

The Board of Directors:

- Received and noted the report and approved the draft Annual Governance Statement 2016/17 at Annex A of the report.

149/17 Year-End Governance Declaration

The Director of Corporate Affairs presented a report, the purpose of which was to allow the Board of Directors to determine a positive declaration against General Condition 6 (G6) and Continuity of Services Condition 7 (Cos7) of the NHS Provider Licence or identify why such a declaration could not be made. He noted that the requirements of both Conditions were reproduced for reference at Appendix 1 of the report and a copy of the required declarations was included at Appendix 2. The Director of Corporate Affairs advised that guidance issued by NHS Improvement in April 2017 advised that, while Boards were still required to complete relevant self-declarations, there was no longer a requirement to automatically submit the declarations to NHS Improvement. He noted that instead, an audit process had been introduced whereby NHS Improvement would contact a select number of trusts to ask for evidence that they had self-certified. The Director of Corporate Affairs advised that Boards were required to sign off on self-certification of the G6 and Cos7 Conditions by 31 May 2017.

In response to questions from Mr J Sandford and Mrs C Barber-Brown, the Director of Corporate Affairs advised that the Board was asked to certify whether appropriate systems were in place to achieve compliance against General Condition 6 and noted that the Board had agreed a positive declaration against this Condition in previous years. The Board of Directors consequently agreed a positive declaration against General Condition 6.

The Board then considered the declaration against Continuity of Services Condition 7. Mr J Sandford and the Director of Finance proposed that the Board declared recommendation 3b given that the Trust did not have any legal guarantees for financial support. There followed a lengthy discussion during which differing views were expressed whether the Board should declare recommendation 3a or 3b. In conclusion, the Board of Directors agreed to declare recommendation 3a provided that the associated risks were clearly documented in the narrative box. The Board agreed to delegate authority for completion of the associated narrative to the Chairman, the Chief Executive and the Director of Finance.

The Board of Directors:

- Received and noted the report and agreed a positive declaration against General Condition 6. The Board of Directors agreed Recommendation 3a against Continuity of Services Condition 7, subject to the inclusion of relevant commentary with regard to the associated risks.

150/17 Report of the Chief Executive

The Chief Executive made reference to the Manchester terror attack and the continued support that would need to be provided to the victims, their families and anyone else affected by the incident. She also briefed the Board following a meeting which had been held between representatives from the Trust, Health & Social Care partners and Sir Simon Stevens, Chief Executive of NHS England and Mr Jim Mackey, Chief Executive of NHS Improvement, with regard to challenges with the 4-hour Accident & Emergency performance. She provided an overview of the meeting and noted that it had resulted in positive outcomes and agreement of next steps.

151/17 Any Other Urgent Business

There was no other urgent business.

152/17 Date, time and venue of next meeting

There being no further business, the Chairman closed the meeting and advised that the next meeting of the Board of Directors was scheduled to be held on Thursday 29 June 2017 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital. It was noted, however, that this date was subject to change and that the Board of Directors would be informed accordingly.

Signed: _____ Date: _____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
9/16	24 Nov 16	340/16	Strategic Risk Register	<p>Mrs J Morris advised that all risks would be transferred to the new Datix system by the end of December 2016 and suggested that once implemented, Ms C Marsland would provide a presentation to the Board with regard to the new system.</p> <p>Update on 27 Jan 2017 – A presentation would be provided to the Board in April 2017.</p> <p>Update 27 Apr 17 – The Board noted a delay to implementation of the Datix system and agreed that the presentation would be provided on 29 June 2017.</p>	J Morris
08/17	30 Mar 17	75/17	Trust Performance Report – Month 11	<p>With regard to the Trust's Cost Improvement Programme, the Chairman requested that a 'deep dive' session be held in the next two to three months to provide assurance to the Board.</p> <p>Update 27 Apr 17 – The Board endorsed a suggestion from the Director of Finance that scheduling of a 'deep dive' should follow consideration of the outcomes of a CIP Review by the Finance & Performance Committee on 17 May 2017.</p> <p>Update 25 May 17 – Mr F Patel advised that the session was likely to be held in June 2017.</p>	F Patel
09/17	27 Apr 17	108/17	Trust Performance Report – Month 12	<p>Further to a comment made by Dr C Wasson, it was agreed to invite ED representatives to deliver a presentation on the department's strategy and vision at the June Board meeting.</p> <p>Update 25 May 17 – It was noted that the presentation would be delivered at the July Board meeting.</p>	C Wasson
10/17	27 Apr 17	108/17	Trust Performance Report – Month 12	The Chief Executive suggested that Prof P Turner and Mr D Johnson, Orthopaedic Consultants, be invited to a future Board meeting to present on a piece of work they were leading on in Greater Manchester. She noted that the work related to Orthopaedics and the use of data to reduce variability to standardise care and maximise outcomes.	C Wasson

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Report to:	Board of Directors	Date:	26 th June 2017
Subject:	Patient Experience: Story of Care		
Report of:	Judith Morris Director of Nursing and Midwifery	Prepared by:	Emma Rogers Matron for Patient Experience

REPORT FOR APPROVAL

Corporate objective ref:	Patient Experience	Summary of Report	
Board Assurance Framework ref:		The purpose of a patient story at the Board of Directors meetings is to bring the patient's voice to the Board providing a real and personal example of the issues within the Trust's quality and safety agendas. It may also help to share the experiences of front-line staff and enhance understanding of the human factors involved in episodes of harm.	
CQC Registration Standards ref:		It is not intended to revisit the specific details of the story but rather to acknowledge that lessons have been learned where necessary and improvements to practice have been made.	
Equality Impact Assessment:	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Not required		
This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> FSI Committee		<input type="checkbox"/> Workforce & OD Committee <input type="checkbox"/> BaSF Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input checked="" type="checkbox"/> Other

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The following story relates to a 66 year old lady who was admitted to ward M4, Stepping Hill Hospital in April 2017 after emergency surgery for a fractured neck of femur following a fall.

The same night the lady was unable to sleep as there was a patient in the next bed with dementia who was shouting and screaming throughout the whole night. The lady felt that her recovery was being affected by the lack of sleep.

The lady referred to another night on M4 where she felt the ward was understaffed. On this particular evening the ward had 27 patients, many of whom were high dependency suffering from a dementia with 2 registered nurses instead of the 3 that were planned, together with their quota of support staff. The third nurse had been moved to assist another ward that was short-staffed.

Consequently medications were administered late and the lady was approached at 23:45 for observations to be carried out at which point she refused.

All that evening the noise and disturbance from 2 patients meant that the lady found it impossible to sleep. She could not praise the staff highly enough as she felt they were doing their very best in the situation, but unfortunately caring for the patients with dementia was consuming their time.

In the early hours when the noise had not settled the lady rang her buzzer to ask for pain relief but had to wait to receive it. She explained that she did not have pain but felt that it might help her to sleep. Following a discussion with the doctor the following morning, sleeping tablets were prescribed. Unfortunately these did not help and made the lady feel nauseous and due to this she lost her appetite.

Overall although the lady has since gone home and was full of praise for the nursing staff, she felt that her recovery was compromised by a lack of sleep.

Actions:

1. Comments shared with ward staff
2. Matron for Surgery investigated formal complaint and responded to the patient.
3. Ongoing Noise at Night audits being undertaken to monitor compliance with the specific standards.
4. Pilot of a new 'Enhanced Care team' – Healthcare Assistants specifically trained in caring for patients who have a dementia on a 1:1 basis.
5. Continuing nursing recruitment to ward M4.
6. Matrons for Surgery review staffing on a daily basis, re-allocate staff and use bank and agency staff if required.

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Report to:	Board of Directors	Date:	26 June 2017
Subject:	Chair's Report		
Report of:	Chair	Prepared by:	Mr P Buckingham

REPORT FOR NOTING

Corporate objective ref:	Summary of Report The purpose of this report is to advise the Board of Directors of the Chair's recent and planned activities
Board Assurance Framework ref:	
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	<input type="checkbox"/> Completed <input type="checkbox"/> Not required

Attachments:	Nil
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This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> F&P Committee	<input type="checkbox"/> PP Committee <input type="checkbox"/> SD Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input type="checkbox"/> Other
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1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to advise the Board of Directors of the Chair's recent and planned activities. In preparing this, my first report to Board, I would welcome feedback from colleagues on its content and use. My intention is to provide brief information since the previous Board meeting in relation to:

- Notable events, success and achievements for the Trust. I am keen that the appreciation of the Board is extended to Trust colleagues and Partner organisations where appropriate.
- Matters concerning the development of the Board itself, including its composition, focus, and ways of working
- My own engagements and visits on behalf of the Trust
- Any significant regulatory developments that as Chair I have been involved in
- A forward look to significant events or possible developments.

2. NOTABLE EVENTS

2.1 The Board was briefed at its previous meeting on the Trust's response to the major incident which occurred in Manchester on 22 May 2017. However, I feel that it is important to re-state the sterling efforts made by all of our staff involved, from across the organisation in responding to both the incident and subsequent aftermath. All of the patients treated by the Trust were successfully discharged and the efforts of staff have, quite rightly, resulted in a high degree of positive media coverage. Nonetheless, it is important that we remain vigilant and ensure that any lessons learned from the incident are incorporated in our Major Incident Plan.

3. BOARD DEVELOPMENT

3.1 The recruitment process for the Chief Executive and Director of Nursing positions is proceeding to plan and I am pleased to report that the process has attracted a good quality field of prospective candidates for both positions. A long-listing process was completed on 14 June 2017 and a shortlisting process is scheduled to take place on 28 June 2017. The interviews for shortlisted candidates will be held on 13 July 2017 (Chief Executive position) and 20 July 2017 (Director of Nursing position) and I aim to ensure that a range of stakeholders have the opportunity to participate as members of Focus Groups as part of the interview process.

3.2 Board members have had informal discussions in recent weeks around 'Ways of Working' which has included consideration of key priorities which help to facilitate an appropriate focus for future agenda planning and discussion at Board and Committee meetings. It is imperative that we ensure that sufficient time and attention is devoted to strategic developments such as Stockport Together, Healthier Together, while maintaining an appropriate oversight of key business as usual activities such as cost improvement delivery and achievement of corporate objectives. I will also be looking to undertake a similar approach for Council of Governors activities through engagement with our Governors.

4. CHAIR ENGAGEMENTS

- 4.1 Since the last Board meeting on 25 May 2017 I have held introductory meetings with Mr A Webb and Mr T McGee from Stockport Metropolitan Borough Council and with Mrs J Cromblehome, Chair of Stockport CCG. I have also undertaken a number of 'drop in' visits as summarised at Appendix 1.
- 4.2 I have been keen to establish contact with the Chairs of neighbouring NHS organisations and, particular, with my counterparts from the Stockport Together partners. In terms of the latter, my aim is to underscore the Trust's commitment to maintaining progress with integration through the Stockport Together programme.

5. FORWARD LOOK

- 5.1 A key subject for consideration at the meeting on 26 June 2017 will be the Stockport Together Outline Business Cases and I anticipate that there will be a degree of follow-up work for consideration at the next Board of Directors meeting on 27 July 2017. I also expect to be in a position to confirm appointments to the Chief Executive and Director of Nursing positions at the July meeting.

6. RECOMMENDATIONS

- 6.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

SUMMARY OF CHAIR VISITS - JUNE 2017

- Surgical and Critical Care
- Outpatients
- Electronic Patient Records Project Team
- Integrated Transfer Unit
- Human Resources Department
- Head of Volunteers
- Library and Knowledge Transfer Team
- NHS Providers: Chairs & Chief Executives Network - 20 June 2017

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Report to:	Board of Directors	Date:	26 June 2017
Subject:	Chief Executive's Report		
Report of:	Chief Executive	Prepared by:	Mr P Buckingham

REPORT FOR NOTING

Corporate objective ref:	Summary of Report The purpose of this report is to advise the Board of Directors of national and local strategic and operational developments which include: <ul style="list-style-type: none">• Care Quality Commission
Board Assurance Framework ref:	
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	<input type="checkbox"/> Completed <input type="checkbox"/> Not required

Attachments:	Nil
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This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> F&P Committee	<input type="checkbox"/> PP Committee <input type="checkbox"/> SD Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input type="checkbox"/> Other
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1. INTRODUCTION

1.1 The purpose of this report is to advise the Board of Directors of national and local strategic and operational developments.

2. CARE QUALITY COMMISSION (CQC)

2.1 Following the CQC's unannounced inspection of urgent and emergency care and medical care services at the end of March 2017, the Trust received a draft report from the CQC on 28 April 2017. A challenge on factual accuracy of the report was submitted by the Trust on 18 May 2017 and we are currently awaiting the final version of the report.

2.2 In the meantime we have taken action on the quality issues raised as part of the immediate feedback from the inspection, which include improving staff understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards, some medicines management and infection prevention issues in the Emergency Department and nursing staffing.

2.3 Trust representatives attended a Risk Summit with all regulators on 10 May 2017 which resulted in a number of actions:

1. The Trust is designated as 'challenged for quality in urgent and emergency care'.
2. There will be a monthly Improvement Board chaired by NHS Improvement, which will monitor the progress being made by the Trust against the Stockport urgent care delivery plan, and which will replace the weekly ED Safety meetings. The first of these meetings was held on 14th June.
3. The Trust will develop an overall quality improvement plan to incorporate the required actions for the CQC, the Northwest Deanery and the Stockport urgent care delivery plan.
4. The Trust is able to access NHSI improvement support monies and a bid for £200,000 has been submitted to enable us to strengthen clinical leadership development, quality improvement capacity and capability and Board oversight and scrutiny.

3. RECOMMENDATIONS

3.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Report to:	Board of Directors	Date:	26 June 2017
Subject:	Stockport Together – Outline Business Cases		
Report of:	Chief Executive	Prepared by:	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	Summary of Report <i>Identify key facts, risks and implications associated with the report content.</i> The purpose of this report is to seek Board of Directors endorsement of the Stockport Together Outline Business Cases.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Not required	

Attachments:	Annex A – Summary Economic Case Annex B – Neighbourhood Outline Business Case Annex C – Intermediate Tier Outline Business Case Annex D – Ambulatory Care Outline Business Case Annex E – Outpatients Outline Business Case Annex F – Enabler Outline Case
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This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> F&P Committee <input type="checkbox"/> PP Committee <input type="checkbox"/> SD Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input type="checkbox"/> Other
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1. INTRODUCTION

- 1.1 We have been working together with partners and with the public and patients to test and trial new ways of working that improve people's experience of treatment and care and their outcomes. The results of this initial work are encouraging. These Outline Business Cases describe how we can by working together more closely deliver these new models of care and associated benefits to many more people on a permanent basis.
- 1.2 It is important that, before we propose making these changes permanent, we hear from a wider group of patients and the public to ensure that our thinking is right and is shaped by their experiences and expectations. It is equally important that as the work on the design of the new service models continues to progress, the Boards of all the Partners remain sighted and able to comment on and influence the content ahead of final approval being sought.
- 1.3 The final approval of these Outline Business Cases is subject to our learning from a period of wider patient and public involvement. We anticipate the Boards of each Partner organisation receiving Final Business Cases for discussion and proposed approval in late 2017. In the meantime funding from the Greater Manchester Health & Social Care Partnership will enable us to continue to develop and test our thinking. Changes will not happen overnight and there will be continual adjustment of ideas as we implement them. This is just one of many stages at which we will need patients and the public to be involved if the people of Stockport are to have the best health and care services available so they can live healthier and happier lives.

2. BACKGROUND

- 2.1 The Stockport Together programme is complementary to and consistent with Simon Stevens "Five Year Forward View" and the new devolution bid in 2014 was ahead of the game in the concept of regional Sustainability and Transformation Partnerships (STP). This ensured that, when STPs were first formally required as planning footprints in 2015, the Greater Manchester proposition for integrated health and social care provision was already well developed. Within Greater Manchester there are ten Local Care Organisations (LCO) based on each of the ten 'place' based boroughs.
- 2.2 Stockport Together was also a development in advance of the Vanguard programme and this enabled a successful bid to become a Multi-specialty Community Provider (MCP) Vanguard programme when the national innovation commenced. In Greater Manchester there were two successful national vanguards; Stockport and a Salford Primary and Acute Care System (PACS) programme. The essential difference being that a MCP is based on the primary care registered list population: a bottom up approach while PAC'S is a more hospital centre model of hospital and primary care, or a top down approach. In both models health and social care integrate.
- 2.3 In developing the MCP, the partners in Stockport were clear from the start that the traditional MCP of primary, community and social care services was not sufficient to make the level of changes which were required. Mental health services and emergency medicine, acute medicine and frail elderly care were also considered to be essential. The national Vanguard team viewed Stockport programme as an "MCP Plus".

- 2.4 National monies were made available in 2014/15 to support development of the Vanguard programme. However, in 2015/16 with the development of Greater Manchester Health & Social Care devolution it became evident that Greater Manchester would be expected to fund the on-going transformational programme. Greater Manchester is gaining £6 billion of treasury monies for the period 2016-2021 and allocated £450 million as a Transformation Fund. Stockport Together bid against this fund and were successful in a £19.3 million allocation over a three year period 2016/17-2020. This is to facilitate pump priming and programme costs but the financial benefits, alongside population and patient benefits, must be delivered as early as possible to avoid the additional, non-recurrent funding, becoming a cost pressure on top of the existing funding gap. The delivery of these benefits is therefore crucial.
- 2.5 The Stockport Together partners have worked collaboratively to produce a number of Outline Business Cases which are included for reference at Annex A-E of this report. These Business Cases set out the approach to the service re-design and development of new models of care to deliver benefits to patients in providing care closer to home and the efficient deployment of resources across the local health economy. There is a clear emphasis on service development based on eight Stockport Neighbourhoods with local services shaped by Neighbourhood teams and tailored to meet patient needs within the relevant localities. A preventative approach to local service provision will have a consequent impact on the number of referrals for hospital-based services.
- 2.6 The nature of service change will be informed by outcomes of a listening exercise which is currently being undertaken in order to seek views from stakeholders across the local health economy. The Outline Business Cases will be further developed to incorporate feedback prior to the consideration and approval of Full Business Cases by the governing bodies of the Stockport Together partners. However, the proposals have a number of implications which are specific to the Trust, such as the financial and risk implications, and the Board of Directors will need to take these factors into account prior to endorsing the Outline Business Cases. The following sections summarise the key factors for consideration by the Board prior to an approval decision.

3. STRATEGIC CONTEXT

- 3.1 The planning and implementation of new models of care will not be undertaken in a vacuum and, from a Trust perspective, there are a number of known and potential developments in the wider strategic environment which could have implications for delivery of the Stockport Together programme. One known development is the phased implementation of the Healthier Together programme with Phase 1 scheduled to commence in October 2017 and Phase 2 in April 2018. The Healthier Together programme therefore has the potential to impact on both management and staff capacity to deliver service changes and the realisation of benefits associated with the new models of care. With regard to the latter, reductions in activity through the Stockport Together programme will be offset, to a degree, by increased activity and higher bed numbers under the Healthier Together programme with consequent implications for effective resource planning.
- 3.2 Less certain are service developments and re-alignment which will result from work currently being undertaken by the Greater Manchester Health & Social Care Partnership under working titles of Theme 3 and Theme 4 developments. The principle underpinning these developments is the consolidation of relevant services, such as Breast Services, to achieve specialist service

provision across a Greater Manchester footprint. At the present time, work is not sufficiently advanced to assess the impact of these developments on Trust's services and the only certainty is that there will be some form of impact. The impact could of course be positive as well as negative. What is certain is that, on top of Healthier Together (which is actually one of the Theme 3 programmes), the strategic change programme across Greater Manchester adds another layer of complexity to an already complex environment with a further impact on management capacity.

4. QUALITY OUTCOMES

4.1 The overarching aim of the developments set out in the Outline Business Cases is the implementation of a new, fully integrated, 24/7 neighbourhood based model of health and social care. The model will be built around General Practice and is based on the **best available evidence with an emphasis on prevention** that will create the **capacity and capability**, in both primary and community care alternatives, to deliver the right care and support in or close to peoples' homes rather than in hospital.

4.2 Implementation of the model will enable delivery of the following high level quality outcomes:

- Keeping people independent at home for longer
- Ensuring safe and sustainable General Practice and out of hospital services
- Reducing avoidable hospital admissions for the 15% of the population most at risk by 27%
- Substantially reducing avoidable visits to the accident and emergency department by 32%
- Reducing avoidable admissions to care and residential homes
- Reducing the average length of time people stay in hospital by up to 50%
- Transforming the traditional approach to outpatient and elective activity

4.3 The key benefits for patients through implementation will be:

- People will only have to tell their story once
- Reduced hand-offs between services by creating neighbourhood teams who work together with primary care and the third-sector to deliver care and support to meet patients' and carers needs.
- Patients will have a named case manager who will organise and co-ordinate their care.
- Breaking-down demarcation lines between professionals and multi-skilling of staff to improve care.
- Services will be available over extended hours
- More care will provided closer to home
- There will be fewer confusing transfers between organisations and services
- Increased breadth of provision in local GP practices

4.4 The key system benefits will be:

- Practitioners working to shared population groups and priorities
- Efficiencies through shared assessment, care plan and reduction in formal referral processes
- Parity of esteem given to mental and physical health
- Reduced hand-offs and costly repetition of activities

- More appropriate use of resources
 - Increased ability to rapidly move resource to where it is most needed
 - Greater value achieved for each health and care pound
 - Reduced ‘gaps’ in service provision where vulnerable people could be lost
- 4.5 The key benefits summarised above represent the ‘prize’ to be achieved from delivery of new models of care in the Stockport health and care economy. Benefits will also be achieved in relation to social care, primary care, mental health services, community services and care homes. However, winning the ‘prize’ will not be a simple exercise and comes with a degree of associated risk.
- 5. FINANCIAL IMPLICATIONS**
- 5.1 The Stockport Together programme cost and benefit analysis summary:
- **£19.8m** of GM transformation funding will be invested to pump prime the implementation of the Integrated Service Solution over the period 2016/17 to 2018/19.
 - This will deliver a forecast recurrent financial saving to the local health and care system by 2020/21 of **£38.8m**.
 - **£16.4m** of these savings will be reinvested recurrently to fund the re-provision costs of the Stockport Together programme.
 - This will result in a net system benefit of **£22.4m** by 2020/21. It should be noted that the cost reduction benefit will rise to £25.4m by 2021/22.
- 5.2 The majority of the savings will be derived from Stockport NHS FT representing broadly 70% of Stockport CCG Acute provision. These savings will be generated from avoided future growth and cost reductions deliverable as a result of providing out of hospital care. The benefit analysis represents a significant investment shift from acute hospital to out of hospital health and care in Stockport principally in General Practice and Community Services.
- 5.3 The cumulative annual impact for the Trust by point of delivery is set out in the Table below which states that of the £38.8m the proportion attributable to SFT will be £22.6m split £12.75m growth and £9.8m activity deflections.

Table 1: Impact on Stockport NHS FT based on cost reduction

Savings by Point Of Delivery for SFT: avoided growth vs activity reduction				
POD	£'m			
	17/18	18/19	19/20	20/21
Savings through Avoided Growth				
A&E	(£0.144)	(£0.307)	(£0.458)	(£0.630)
Non Elective Spells	(£0.997)	(£1.883)	(£2.668)	(£3.441)
Outpatient	(£0.588)	(£1.709)	(£2.578)	(£3.450)
Elective	(£1.349)	(£2.646)	(£3.964)	(£5.227)
Total Avoided Growth	(£3.078)	(£6.546)	(£9.668)	(£12.749)
Deflections enabling cost reduction				

A&E	(£0.376)	(£1.131)	(£1.313)	(£1.676)
Non Elective Spells	(£0.821)	(£3.714)	(£4.381)	(£6.554)
Outpatient	£0.034	(£0.984)	(£2.882)	(£3.498)
Elective	£0.082	£0.508	£1.210	£1.907
Total Activity Reduction	(£1.082)	(£5.320)	(£7.366)	(£9.822)
Total	(£4.160)	(£11.866)	(£17.034)	(£22.570)

5.4 Plan for Cost Reductions

The Directors of Finance from the Trust, the CCG and SMBC have formed a close working group to oversee the development of the economic case for Stockport Together, management of the transition funding and development of a risk and gain share. They have also commissioned and worked with PriceWaterHouseCooper (PWC) on a financial model to cover the whole health economy. This model has derived the figures in Table x above and analyses the impact on all 3 organisations over a 5 year period. The Trust has used the intelligence from the patient level costing system to inform variable, semi-fixed and fixed costs at point of delivery level within the model and this is how cost reductions have been calculated.

- 5.5 The business case development has been on a top down approach and based on the evidence collated in the original Stockport Together work undertaken and the next stage is to reconcile this to a bottom up approach at specialty level. This is at different stages for each of the business cases and will need to be completed in order to translate the activity deflections into currencies which inform a workforce plan.
- 5.6 The cost reduction is taking place at the same time as the work streams in the Trust deliver our own CIP and processes via the existing governance process for CIP will ensure that “double counting” does not take place and both objectives are delivered. For example the outpatient business case at specialty level is being developed by the outpatient working group within the optimising capacity work stream.
- 5.7 The Chief Operating Officer is the executive responsible for the operationalisation of the business cases within the Trust and for enacting a plan to deliver the savings, workforce reform and service reconfiguration associated with the reduction in activity. The plan for this is currently in development and the Trust Board need to agree timelines and expectations for this.
- 5.8 Agreement has been reached between the Directors of Finance that the PWC model will be used for the basis of changes to activity within the Trust’s contract with the CCG. The current position within the model will be used as a basis for the 6 month contract review with the CCG in September 2017; however at this point in time the cost reductions expected in 2017/18 are reduced from the level expected when the plan was agreed in November 2016. The real impact of cost reductions will take effect from 2018/19 and therefore it is important that the internal operationalization is done at an appropriate pace.

5.9 Sensitivities of the financial model

In assessing the range of the financial risks facing the Trust in the implementation of the Stockport Together Business Cases, a number of scenarios were reviewed and the financial

impact calculated. Each of these scenarios fall within the gain and risk share principle that have been agreed between Stockport NHSFT, Stockport CCG and Stockport MBC and assess the values at 2020/21.

5.10 The major variables that impact upon the sensitivity analysis are as follows:

1. The Health and Social Economy is investing an additional £16.4m in Stockport Together, which if nothing else changes i.e. the economy continues to experience growth and no deflections in activity then under the gain and risk share the Trust would be liable for a third of the additional recurrent cost which is £5.5m;
2. The Commissioner continues to experience growth in activity across all its providers. Under the summary economic case, the providers will continue to be paid at tariff for the growth that is occurring which is included in the CCG plans however it costs the Trust significant more to deliver the activity than the income that we receive. On a cost reduction basis the value assigned to averted growth for all Business Cases is £18.5m of which £12.7m is attributable to SFT. Based on the underlying deficit, the Trust loses 15.7% on tariff income and therefore the cost to the Trust would be £2m more if growth continues;
3. The Commissioner continues to experience the same level of activity across all its providers. Under the summary economic case, the providers continue to be paid at tariff for the on-going levels of activity which is included in the CCG plans however it costs the Trust significant more to deliver the activity than the tariff that we receive. The value assigned to on-going levels of activity at Stockport FT is £9.8m, and therefore the continued additional cost but not a new risk (lost opportunity) is £1.5m;
4. If Stockport Together Business cases deliver the planned levels of activity diversions and therefore delivers £38.8m of benefits for the Commissioner, the Trust would benefit £7.5m being from the gain share of £22.4m as shown in Table 2 above on the cost reduction basis (£38.8m benefit less £16.4m recurrent investment).
5. To build on the factors described in point 3 and point 4 above, the Trust could benefit or lose on its ability to reduce the cost burden following activity diversions. For example, the Trust could save a further £1.5m due to higher than tariff costs or could lose £2.3m being the net of £7.5m benefit of the gain and risk share and the cost of £9.8m not saved.

- 5.11 The assessment of financial risk described is summarised in the following tables:

	Business Case Assumption	Stockport FT Impact	Financial Risk	Notes
Recurrent Investment	£16.4m	£5.5m	£5.5m	Represent one third share of additional cost
Continued level of growth	£18.5m	£12.7m	£2.0m	Represents 15.7% additional cost of delivering tariff activity
On-Going levels of activity	£24.0m	£9.8m	£0.0m	Lost opportunity for savings but not a financial risk
Total			£7.5m	

Scenario A	Scenario B	Scenario C	Scenario D	Scenario E
£7.5m Loss	£2.3m Loss	Balanced	£7.5m Benefit	£9m Benefit
No Benefit of the Business Cases realised and the Trust is liable for a third share of the recurrent investment and incurs above tariff costs in delivering activity	Full benefit of the Business Cases realised however the Trust is not able to reduce costs in line with activity Diversion	Partial benefit of the Business Cases realised to meet the additional recurrent cost of investment	Full benefit of the Business Cases Realised plus the Trust able to reduce costs in line with summary economic case	Full benefit of the Business Cases Realised plus the Trust able to reduce costs in line with current costs

- 5.12 The Directors of Finance will continue to work together to look at the financial model across Stockport as a whole and have agreed an early warning system as part of the risk and gain share, to ensure that divergences from plan are identified as early as possible and corrective action taken. Governance processes are already in place for the transition fund and these will be further strengthened by the early warning system.
- 5.13 At this stage in the process it is impossible to predict where the Trust expects to be on the range identified in the table above and therefore there is no decision to be taken by the Board, it is for noting purposes only. This range will also have been presented to the other boards as part of the business case approval process and it is expected that each organisation will have comments to make with regards to this section and the level of risk it presents and how the financial impact of this is managed within the financial governance structure of that organisation.

6. KEY ENABLERS

- 6.1 The Key Enablers for implementation of the Outline Business Cases are:

- Workforce
- IM&T Infrastructure & Support
- Estates Support
- Information Services / Business Support

6.2 Workforce

Successful delivery of the business cases is inherently dependent upon realignment of the workforce. At present, whilst much work has been done in the development of new roles and the movement of staff within the intermediate tier and neighbourhoods in support of the implementation of the necessary changes for delivery of the new models of care, there are a number of ongoing challenges. The current position is a move from 170.25 FTE to 250.17 FTE. The increase in the workforce is attributable to the change in skill mix and increased utilisation of the unregistered workforce across both health and social care services and extended working hours.

6.3 There are significant and ongoing recruitment challenges, which are reflective of the challenges being experienced nationally, particularly for Consultants, GPs, Nursing, Allied Health Professionals and social workers. Whilst the definitive workforce numbers and skill mix is a work in progress the indicative position suggests that there will not be the available workforce to run an enlarged version of the existing system. There is insufficient professionally registered clinical staff available and for the non-registered workforce there is considerable competition in the market for non-skilled and semi-skilled workers with very high employment rates locally.

6.4 The enabler support plan specifically describes the approach for enabling the change required across the overarching system to deliver Stockport Together implementation. The strategic enabler aim for the workforce is to ensure a cohesive workforce with the right skills which is engaged and well informed, working in the right place and working to an integrated and person centred ethos. This in itself is a challenge due to the complexity of contractual arrangements, differing job descriptions with similar skill sets, and differing pay scales. The emphasis of the work undertaken to date has been in improving the service skill mix, developing extended and generic roles and supporting staff to work differently to overcome challenges. As referenced earlier, the process for business case development is at differing stages and as such the workforce implications and requirements continue to emerge as the business cases are further developed and refined.

6.5 The 'Supporting People Through Change' programme has had a positive impact with initial teams and the further implementation of this approach will be explored to support teams at key periods of transition. The Workforce Team has also been working with strategic leads to support high level workforce planning activity to inform the development of the new models of care. In addition, a Workforce Engagement Forum has been established which promotes effective communications between partners and a collective approach to supporting and developing staff affected by service changes and ensures that trade union perspectives to the development and implementation of policy and practice, including ideas on the workforce implications of service change are considered.

6.6 IM&T Infrastructure and Support

Good progress has been made in terms of the IM&T platform that staff will work on. However, as the 3 teams coming together have 3 different networks historically there is still work to be

undertaken to provide a system which allows all relevant staff to access all of our systems systematically. There is a Capital allocation in the Programme to provide Mobile working capability to the Neighbourhood teams and this will be a key factor in ensuring that Neighbourhood Teams work effectively.

6.7 Estates Support

Progress in this area has been impaired pending completion of building alterations to provide appropriate accommodation and facilities for the 8 Neighbourhood Teams. The delay is not considered to be critical as the teams are yet to be fully established in some locations. As the programme progresses, the Trust will be able to critically review the Estate on the Stepping Hill site. The Operational plan will result in a fundamental change of the Estate on the site and the need for maximising any savings as well as agreeing a Site Utilisation Plan will be significant and will link to the update of the Trust's Estates Strategy.

- 6.8 In addition to the above, the Stockport Together team commissioned 3 Utilisation Surveys. The surveys have reviewed the space we use in both the hospital and our Community settings. The operational teams have been tasked with critically reviewing the report and we can then link with our partner organisations regarding how we take this forward. This analysis will result in an Estates Strategy that critically reviews space used across Stockport and uses the principles of Agile Working to make best use of the Estate.

6.9 Information Services/Business Intelligence

Now that the Community EPR system first phase has been implemented, the question of how we provide access to the information on all our systems to our staff within the economy becomes a bigger issue, as without a data sharing agreement in place this is difficult. There are on-going meetings to resolve this issue with the expectation that there will be an agreement reached by 31 August 2017. The Data Sharing agreement will be across Primary, Secondary, Social and Community Care. I would suggest that as with IT above the Board would be best served with a presentation which brings Board members up to speed with the opportunities, the challenges and the current position regarding Business Intelligence.

6.10 Summary

While progress is being made with development of each of the Enabler work streams, endorsement of the Outline Business Cases will necessitate additional pace and closer work with operational teams on a day by day basis will be key factor. The Board will need to be provided with both a greater understanding of the content of the Enabler work streams and assurance on progress and/or risks. It is suggested that time be identified for Board presentations on the Workforce, IM&T and Information Governance work streams in September 2017.

7. STOCKPORT TOGETHER PARTNERS

- 7.1 In summary, there is a real recognition that there has been considerable progress and much greater ownership across the health and care system of the business cases. The main themes emerging from the early socialisation of the Stockport Together Business cases can be clustered into 3 key domains:

- the models of care
- Clarity of the cases
- Deliverability

7.2 Models of Care

- a) At a high level the model of care and anticipated outcomes are broadly agreed and there is an increasing consensus about the proposed approach.
- b) There are concerns on some of the detail – specifically differing views from General Practice regarding the proposals in relation to GP at scale, the impact of ambulatory care on A&E capacity reduction, progress with the enabler work stream and how the proposed new outpatients model will deliver the expected numbers in terms of deflections.

7.3 Clarity

- c) The cases are long and as such clarity is often sacrificed
- d) Stronger (ironically slightly longer) executive summaries are needed and they must include the finances more clearly
- e) Intermediate Tier – the Summary Economic case has clear benefits associated but these are not stated in the individual intermediate tier case

7.4 Deliverability

- f) The CCG and SFT need to have a much clearer articulation of how the benefits will be realised particularly in relation to bed reduction.
- g) Concerns that implementation, governance, risk identification and management need to be clearer

All these points have been taken into account in the final iteration of the cases.

7.5 In terms of the incentives for the transformation of Primary Care, the algorithm is actually very simple. General Practice is under enormous pressure itself. The Stockport Together business cases would invest £8.1m into Primary Care to address both these pressures and to deliver the required programme outcomes in terms of hospital diversion. This investment is entirely contingent of being able to re-profile some of the current levels of acute spend towards primary and community care.

8. GOVERNANCE

8.1 Implementation of the New Models of Care will be directed and managed through an Alliance Provider Agreement (APA) agreed by the Stockport Together Providers (Stockport NHS Foundation Trust, Stockport Metropolitan Borough Council, Pennine Care NHS Foundation Trust and Viaduct Health). The APA formalises the governance arrangements for implementation of the Business Cases and the roles of the Neighbourhood Teams and Integrated Transitional Management Team within these arrangements. The Stockport Together Providers have procured appropriate legal advice to inform preparation of the APA document. The APA approach is recognised as being a necessary transitional arrangement to facilitate progress with New Models of Care in advance of establishment of an Accountable Care Trust. Consequently, the agreement is scheduled to terminate on 31 March 2019.

8.2 A key element of the APA is establishment of an Alliance Provider Board which will have overall responsibility for overseeing implementation of the Business Cases. The Alliance Provider Board will comprise an Executive-level representative from each of the four Providers together with an independent non-voting Chairman. Each representative will have delegated authority to make

decisions on behalf of the party that they represent and will be responsible for reporting to their respective host organisations. The Alliance Provider Board will meet with the Integrated Transitional Management Team on a monthly basis to seek assurance on clinical, governance, finance and performance matters related to Business Case implementation. Key matters for consideration by the Board in relation to the APA arrangements are set out in the following paragraphs.

8.3 Alliance Provider Board Member

Nomination of the Trust's representative for membership of the Alliance Provider Board will necessitate careful consideration. The selected individual should have the appropriate expertise and experience to effectively discharge functions on behalf of the Board of Directors and, most importantly, should have the capacity to assimilate APB member commitments within their current portfolio. An Executive Team assessment of the situation resulted in the nomination of the Director of Support Services as the Trust's APB representative.

8.4 Scheme of Delegation

The financial model for implementation of the Business Cases under the Alliance arrangements will be based on creation and management of a Virtual Pooled Fund. The Alliance Provider Board will have responsibility for decisions on Virtual Pooled Fund expenditure. Consequently, the Trust's representative will require delegated financial authority in order to take decisions as an APB member in relation to levels of expenditure which, in normal circumstances, may necessitate approval by either the Executive Team and/or the Board of Directors. Factors such as consistency, or not, with the Trust's Scheme of Delegation and consistency with the levels delegated to other APB members will need to be taken into account when agreeing an appropriate level of delegated authority.

8.5 Host Arrangements

The APA provides the Trust with a range of responsibilities as 'Host' and, as such, the Trust will enter into contracts and make payments on behalf of the Alliance Provider Board, the Integrated Transitional Management Team and the Integrated Neighbourhood Leadership Teams. While the APA provides the Trust with protection, in that the parties to the APA will keep the Host fully indemnified for any losses incurred in discharging these responsibilities, there is a degree of complexity associated with these transactional processes. The Board of Directors will require assurance that robust and effective standard operating procedures are in place, and are being consistently applied, in order to mitigate the risk or error and/or financial loss.

8.6 Reporting Arrangements

The Board of Directors must be assured that appropriate reporting arrangements are in place to ensure that there is effective and timely communication between the Board and the Alliance Provider Board via the Trust's nominated representative. The frequency and nature of such reporting will need to be determined together with consideration of whether reporting should be direct to the Board, via one of the Assurance Committees or through a combination of the two.

8.7 Nature of the Agreement

Board members will be aware that an Alliance Model was considered during the Options Appraisal completed in November 2016 and that one of the reasons that this Option was

discounted related to the complexity and level of risk associated with arrangements based on a collaborative approach compared with that of a single organisational form. While transition to a single organisational form model continues to be the stated aim of all Stockport Together partners, there is a risk that the programme will result in an Alliance Model by default rather than design. The Board will need to identify means to regularly seek assurance that progress towards a single organisational form continues in parallel with implementation of the Alliance model and that such progress is made at an appropriate level of pace.

9. RISK

9.1 This section provides a high level summary of the key risks, and associated mitigating actions, relating to the Stockport Together Outline Business Cases. This report will recommend that, subject to Board agreement, all identified risks should be subject to a formal risk assessment and incorporation in the Trust's Risk Register.

9.2 Risk 1

Risk: Implementation of New Models of Care is impaired as a result of delay in concluding the Alliance Provider Agreement with a consequent impact on service delivery and benefits realisation.

Mitigation: Provider commitment to ensure that Alliance Provider Agreement is formally completed by all parties to facilitate an initial Alliance Provider Board meeting by 31 July 2017.

9.3 Risk 2

Risk: Inconsistency of workforce requirements by business case and lack of oversight of workforce interdependencies means that available workforce plans are high level.

Mitigation: Workforce baseline is available and engagement with strategic leads in the identification of the workforce implications of the service changes has commenced. Further development of detailed workforce numbers to understand the overall impact across Stockport Together and hospital services is underway.

9.3 Risk 3

Risk: Recruitment challenges in a number of staff groups may impact on service delivery/implementation of new models of care.

Mitigation: Development of 'new' and extended roles, supporting improved skill mix within the teams together with targeted learning and development programmes to support new ways of working.

9.4 Risk 4

Risk: An integrated workforce from differing employers with varying terms and conditions presents a risk that staff may migrate to the employer with the enhanced terms and conditions; therefore creating recruitment difficulties; or present equal pay claims and risks.

Mitigation: Development of terms and conditions oversight matrix which details the differing terms and conditions and supports the monitoring of potential consequences at the workforce engagement forum.

9.5 Risk 5 - Financial Risk

Whilst there is a risk share agreement in place in the event of the non-diversion of activity, the implementation of the business cases and the removal of the costs are the Trust responsibility. The income will be removed from the contract and therefore if the Trust does not reduce capacity and workforce accordingly the Trust deficit will increase further. This risk can be mitigated by the early operationalisation of the business cases led by the Chief Operating Officer and by robust monitoring of the key indicators.

- 9.6 There are a number of complex business changes that will affect the Trust as well as the Stockport Together business cases e.g. Healthier Together and the Trust needs to ensure that all financial implications are modelled over a rolling 5-year planning period. If this is not undertaken alongside a robust activity, workforce and capacity plan taking into consideration all the external factors, then there is a risk that business decisions will be taken that are not in the best interests of the Trust. This can be mitigated by a revised business case approval process via the senior management group and a change to the business case requirement.
- 9.7 The culture of contracting within the Trust is evolving and the process of working within the Stockport economy is different than the business model previously encouraged in the early years of being a Foundation Trust, where additional activity was driven through without necessary agreement from the CCG. The Trust now operates within a block contract for non-elective and outpatient activity and with the implementation of the business cases the Trust needs to share business case developments with the CCG so that they understand the quality and safety challenges the Trust faces, or there is a further risk that the Trust's deficit will increase. This can be mitigated by a changed relationship with the CCG and a mechanism for discussing how minimum staffing levels need to be maintained for services such as medical rotas and finding a way to ensure that the contract income meets this need.

10. RECOMMENDATIONS

- 10.1 The Board of Directors is recommended to:

- Endorse the Outline Business Cases as the current description of the approach of the Stockport Together partners to design and delivery of new models of care.
- Note that the cases will remain in outline and be finalised for approval, anticipated late 2017 as a result of learning from a period of wider patient and public involvement and continued input from clinicians and professionals working across health and care.
- Support the continuation of the Greater Manchester Transformation Funding being invested in testing the thinking locally and in refining and developing the services
- Consider and agree the proposed further actions set out at Appendix 1.

SUMMARY OF FURTHER ACTIONS FOR THE BOARD

1. Review and challenge the sensitivity analysis and agree an acceptable level of financial risk for the developments (see section 5.11 of the report)
2. Request an operational delivery plan detailing the programme of capacity and cost reduction in line with the Summary Economic Case, and how the Healthier Together programme impacts upon this reduction by 27 July 2017
3. Request Board presentations on the Workforce, IM&T and Information Governance work streams in September 2017.
4. Provisionally approve nomination of the Director of Support Services as the Trust's representative for the Alliance Provider Board.
5. Request that a draft Scheme of Delegation for the Alliance Provider Board representative be prepared for consideration by the Board of Directors on 27 July 2017.
6. Request an assurance report detailing how the Trust's responsibilities under Host Arrangements will be effectively discharged for consideration by the Board of Directors on 27 July 2017.

SUMMARY ECONOMIC CASE: STOCKPORT TOGETHER

Abstract

This document describes the summary economic case for the implementation of the new models of care developed as part of the Stockport Together covering the period to 2020/21

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1. Executive Summary

The health and social care system in Stockport is unsustainable in its current form. If working practices do not change, the financial position is set to deteriorate so that by 2020/21, if no action is taken, there will be a c£156.8m deficit in the Stockport Locality as set out in table 1 below.

Table 1: Financial Forecast: Do nothing financial gap

April 2017		£'000			
Do Nothing Gap	2016/17	2017/18	2018/19	2019/20	2020/21
Stockport MBC	£10,500	£18,193	£27,316	£34,031	£40,464
Stockport CCG	£5,121	£13,377	£29,162	£37,083	£37,080
Stockport FT	£34,398	£42,400	£54,400	£63,622	£75,764
Pennine Care	0	£1,661	£2,266	£2,871	£3,476
Total Deficit	£50,019	£75,631	£113,144	£137,607	£156,784

In response, the statutory partners working across Health and Social Care have developed a system sustainability plan to address this significant financial challenge. The main contributory elements to the Stockport sustainability plan are set out in Table 2 below. As can be seen, the Stockport Together Programme represents c30% of this overarching financial plan. The other contributory elements to the plan (Greater Manchester themes and individual Partner Cost improvement Programmes) are detailed elsewhere and are out of scope to this summary case. It should nevertheless be noted that when required investments are taken into account, full delivery of the overall sustainability plan will still require a net financial gap of c£20.5m to be bridged by 2020/21. This is set out in Table 3.

Table 2: Planned Savings Programmes and non-recurrent resources to address 2020/21 Forecast deficit

April 2017		£'000			
	2016/17	2017/18	2018/19	2019/20	2020/21
Stockport MBC	(£10,500)	(£18,193)	(£20,590)	(£23,669)	(£23,946)
Stockport CCG	(£7,871)	(£17,444)	(£24,778)	(£33,282)	(£33,882)
Stockport FT	(£28,836)	(£15,000)	(£30,000)	(£30,000)	(£30,000)
Pennine Care	£0	£0	£0	£0	£0
Stockport Together Saving	£0	£0	(£23,974)	(£34,080)	(£45,470)
GM Themes	£0	(£3,000)	(£7,000)	(£12,000)	(£22,000)

Stockport Together Investment	£0	£0	£20,121	£19,739	£18,986
Total	(£47,207)	(£53,637)	(£86,221)	(£113,292)	(£136,312)

Table 3: Stockport system deficit under the planned “do something” scenario

April 2017		£'000			
		2016/17	2017/18	2018/19	2019/20
Stockport MBC		£0	£0	£6,726	£10,362
Stockport CCG		(£2,750)	(£4,067)	£4,384	£3,801
Stockport FT		£5,562	£27,400	£24,400	£33,622
Pennine Care		0	£1,661	£2,266	£2,871
Stockport Together Saving		0	0	(£3,853)	(£14,341)
GM Themes		0	(£3,000)	(£7,000)	(£12,000)
Total		£2,812	£21,994	£26,923	£24,315
					£20,472

It should be noted that the planned £48.5m net benefits in 2020/21 from the Stockport Together and Greater Manchester themes set out in table 3 above are yet to be allocated to individual organisation position.

The finalisation of the Stockport together business cases that are referenced in this Summary Economic case (Acute Interface, Intermediate Care, Neighbourhoods and Outpatients) has now enabled this original sustainability plan to be refreshed.

The planned Stockport Together investment referred to in Table 2 was originally £18.9m with a recurrent benefit of £45.5m providing for a net benefit of £26.5m. This has now been updated as work on the business cases for Stockport Together has been completed. Table 4 indicates that the final Stockport Together business cases will require recurrent investment of £16.4m and will deliver a recurrent benefit of £43m giving a net system benefit of £26.7m.

The table below illustrates the changes between the original sustainability plan and the position following the Stockport Together final business cases:

Table 4: Changes between Sustainability Plan and Final Business Cases

	£'000					
	Sustainability Plan			Stockport Together Business cases		
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21
Stockport Together Investment	£20,121	£19,739	£18,986	£19,344	£18,223	£16,375

Recurrent Saving	(£23,974))	(£34,080))	(£45,470))	(£26,150))	(£34,149))	(£43,049))
Net Saving	(£3,853))	(£14,341))	(£26,484))	(£6,806))	(£15,926))	(£26,674))

The final business cases investment and benefit can be further illustrated in Table 5 which represents a summary by individual Stockport Together business case.

Table 5: Summary of Recurrent Investment and Savings Statement per business case

Investment & Savings by business case	£'000						
	Investment			Benefit			Net Benefit
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2020/21
Acute Interface	£2,500	£2,334	£2,168	(£4,871)	(£6,089)	(£6,089)	(£3,921)
Intermediate Care	£2,457	£1,532	£1,103	(£3,275)	(£4,003)	(£4,730)	(£3,628)
Neighbourhood	£12,106	£11,445	£10,987	(£11,170)	(£14,907)	(£20,465)	(£9,478)
Outpatients	£2,280	£2,128	£2,117	(£6,833)	(£9,150)	(£11,765)	(£9,647)
TOTAL	£19,344	£17,439	£16,375	(£26,150)	(£34,149)	(£43,049)	(£26,674)

In summary, upon full implementation in 2020/21, the combined business cases within the Stockport Together programme will deliver savings of £46.3m in activity priced at the **national tariff** (composed of £43m from business case savings and an additional £3.3m CCG investment into Primary Care). This will result in a net system benefit of £26.67m after allowing for a recurrent investment in services of £19.7m (composed of £16.4m Stockport Together investment and the £3.3m CCG investment into Primary Care referred to above). This is detailed in the summary investment and savings statement set out in Table 6 below.

Table 6: Summary Investment and Funding (inc Savings) Statement as per June's business cases

June 2017	£'000				
Investment:	2016/17	2017/18	2018/19	2019/20	2020/21
Non Recurrent investment inc. transformational fund	£5,294	£17,127	£1,487	£0	£0
Stockport Together Investment			£19,344	£18,223	£16,375
CCG Recurrent investment		£3,390	£3,390	£3,390	£3,390
Total Investment	£5,294	£20,517	£24,221	£21,613	£19,765
Source of Investment Funding:					
Investment agreement allocation	(£5,294)	(£13,663)	(£793)		
SRG		(£696)	(£696)		
CCG transformation fund		(£1,825)			
CCG funding - Primary Care		(£1,890)	(£1,890)	(£1,890)	(£1,890)
GM Standards - Primary Care		(£1,500)	(£1,500)	(£1,500)	(£1,500)
External - NHSE Pharmacy bid		(£705)	(£480)	(£263)	
Savings based on business cases			(£26,150)	(£34,149)	(£43,049)
Total Funding	(£5,294)	(£20,279)	(£31,509)	(£37,802)	(£46,439)
Total Net Saving	£0	£238	(£7,288)	(£16,188)	(£26,674)

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

It is important to note that the savings contained within all the Stockport Together business cases have been calculated using **national tariff¹**. The Finance Directors within the local system recognise, however, that whilst savings based on tariff can be removed on day one, the costs within the system will take longer to remove. They have therefore agreed a set of principles to govern the removal of costs and the timing of the realisation of savings. These principles are that:

- **Variable costs** can be removed immediately,
- **Semi-fixed costs** can be removed after 1 year and
- **Fixed costs** can be removed after 3 years.

This means that the savings of £43m contained within the business cases and referenced above will be removed over the time period **2017/18 to 2024/25** (rather than by 2021) with the vast majority (£41.8m) removed in the period 2017/18 to 2021/22 as set out in Table 7 below.

The remainder of this summary economic case is therefore based on this agreed approach of realising savings through a cost rather than tariff removal approach.

As a result, Table 8 restates the Summary Investment and Funding (including Savings) Statement as per June's business cases for the period 2016/7 to 2020/21 based on this cost reduction approach. The impact is overall savings of £38.7m by 2020/21 (compared to £43m based on tariff) and net savings of £22.4m by 2020/21 (compared to £26.6m based on tariff). This is still predicated on recurrent investment of £16.4m. It is important to note that the variance between the two approaches (cost and tariff removal) is purely a function of time and is reconciled by 2024/25.

¹ The national tariff is a set of prices and rules used by NHS providers and commissioners for certain types of NHS (largely hospital based) care

Table 7: Savings per the business case activity based on cost reduction (PWC model)

Savings by POD stating growth vs deflections with a time delay for cost reduction							
Point of delivery (POD)	17/18	18/19	19/20	20/21	21/22	2022 to 25	Total
Growth							
A&E	(£184)	(£209)	(£194)	(£220)	-	-	(£808)
NEL	(£1,263)	(£1,121)	(£993)	(£979)	-	-	(£4,356)
Outpatient	(£919)	(£1,752)	(£1,357)	(£1,363)	-	-	(£5,391)
Elective	(£2,045)	(£1,965)	(£1,997)	(£1,914)	-	-	(£7,920)
Total Growth	(£4,410)	(£5,048)	(£4,541)	(£4,476)	-	-	(£18,475)
Deflections							
A&E	(£483)	(£967)	(£234)	(£465)	(£12)	(£53)	(£2,214)
Elective	125	646	1,063	1,056	967	597	4,453
NEL	(£1,039)	(£3,661)	(£845)	(£2,751)	(£1,311)	(£863)	(£10,470)
Outpatient	53	(£1,590)	(£2,965)	(£964)	(£2,632)	(£944)	(£9,042)
Prescribing	(£700)	(£800)	(£1,500)	(£2,000)	-	-	(£5,000)
Residential & Nursing	0	(£2,300)	0	0	-	-	(£2,300)
Total Deflections	(£2,045)	(£8,673)	(£4,481)	(£5,124)	(£2,989)	(£1,263)	(£24,574)
Total Growth & Deflections	(£6,455)	(£13,721)	(£9,022)	(£9,600)	(£2,989)	(£1,263)	(£43,049)
Cumulative	(£6,455)	(£20,175)	(£29,197)	(£38,797)	(£41,786)	(£43,049)	-

Table 8: Summary Investment and Funding (inc Savings) Statement as per June's business cases restated based on cost reduction

June 2017		£'000			
Investment:	2016/17	2017/18	2018/19	2019/20	2020/21
Non Recurrent investment inc. transformational fund	£5,294	£17,127	£1,487	£0	£0
Stockport Together Investment			£19,344	£18,223	£16,375
CCG Recurrent investment		£3,390	£3,390	£3,390	£3,390
Total Investment	£5,294	£20,517	£24,221	£21,613	£19,765
Source of Investment Funding:					
Investment agreement allocation	(£5,294)	(£13,663)	(£793)		
SRG		(£696)	(£696)		
CCG transformation fund		(£1,825)			
CCG funding - Primary Care		(£1,890)	(£1,890)	(£1,890)	(£1,890)
GM Standards - Primary Care		(£1,500)	(£1,500)	(£1,500)	(£1,500)
External - NHSE Pharmacy bid		(£705)	(£480)	(£263)	
Cost reduction based on business cases			(£20,175)	(£29,197)	(£38,797)
Total Funding	(£5,294)	(£20,279)	(£25,534)	(£32,850)	(£42,187)
Total Net Saving	£0	£238	(£1,313)	(£11,237)	(£22,422)

Through these business cases there will be significant investment in;

- GP practices
- GP Practices working together 'collegiately' at scale
- Integrated community services for both physical and mental health, social care and Third Sector provision
- Community based Crisis Response, Intermediate Care and Reablement

The fundamental building block of this new health and care system will be eight neighbourhood teams which will bring together primary care, physical and mental health and social care services. Neighbourhood leadership will be provided by a general practitioner, supported by senior nursing, therapeutic and social work colleagues, who will together ensure that services meet the needs of local people. Services will offer seven-day access and support people to remain healthy, build independence and personal resilience and address risk factors associated with developing a long-term condition. They will be

supported to do this by a reformed and enhanced 24/7 Intermediate Tier which will provide essential community crisis response, intermediate care, reablement and home care services which together act as the critical bridge between acute hospital, neighbourhood and home avoiding unnecessary admission to hospital and supporting sustainable early discharge.

Changes to the operation of the Emergency Department will also be introduced to include provision of a co-located primary care Ambulatory Illness Team and extension to the operating hours of the Ambulatory Care Unit to optimise the utilisation of people being managed on ambulatory care sensitive conditions pathways rather than as a hospital admission. We will also implement alternative approaches to traditional outpatient models that deliver more effective solutions outside of the hospital setting particularly using technology to enable communications, advice and treatment between patients, GPs and specialists. Our overarching goal is to ensure that people will be supported to achieve positive personal health, care and wellbeing outcomes, whilst maintaining their independence.,

The success of the Stockport Together business cases and the basis of this economic business case is almost entirely contingent on the system's ability to ensure that the 15% of people most at risk of hospitalisation (either as an Emergency Department attendee, emergency admission or as an outpatient appointment) are able to manage their care better and that there are sufficient evidence based community alternatives to avoid unnecessary hospital based interventions.

Taken together, the business cases deliver the evidence based community alternatives and enhanced capacity which, properly implemented, will avoid unnecessary hospital based interventions. By deploying the full range of interventions set out in these business cases, we will be able to work intensively with this cohort to appropriately deflect activity away from hospital in the following proportions:

Table 9: Impact on Activity of Stockport Together Business Cases

Point Of Delivery CCG activity plan 2016/17	Stockport CCG activity with agreed growth assumptions					Deflection percentages of business case deflections to 16/17 CCG plan			
	16/17	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21
A&E	100,133	102,136	104,383	106,470	108,706	- 20.1%	- 24.8%	- 30.7%	- 32.0%
Non Elective	41,286	42,153	42,996	43,770	44,645	- 12.3%	- 16.6%	- 21.4%	- 27.7%
Outpatient	341,168	353,791	366,528	379,356	392,634	-2.9% - 24.1%	- 16.6% - 31.6%	- 21.4% - 40.4%	- 27.7% - 40.4%
Elective	42,705	43,474	44,213	44,964	45,684	-1.2% -1.6%	-1.2% -1.6%	-2.3% -2.3%	-3.1% -3.1%
Total	525,292	541,554	558,120	574,560	591,669	-6.8% -21.8%	-6.8% -21.8%	- -28.3%	- -34.8%

2. Introduction

The Stockport Together partners are undertaking a fundamental change in the way health and social care services are delivered, organised and commissioned. The full strategic case for change was set out in the **Stockport Together Overview Business Case** published in July 2016 in which we described a series of more detailed business cases to follow. These business cases have now been developed and collectively build a **system level change** in the way services are delivered. We refer to this new service model in its totality as the **Integrated Service Solution**. This document summarises the key features and attributes of this integrated service solution and describes the summary benefits of its deployment in terms of better patient outcomes and as a significant contribution to the overall long term financial sustainability of the Stockport Health and Care system.

This document is structured into 5 key sections

Section 3 - The Case for Change (Pages 10 – 19)

Section 4 - Proposed new Model of Care and its underpinning evidence base (Pages 20 – 34)

Section 5 - Investment Plan and Benefits Realisation Plan (Pages 35 – 42)

Section 6 - Approach to Managing Risk including Risk and Gain Share (Pages 43 – 51)

Section 7 - Proposed Service Development Implementation Plan and Governance (Pages 52 – 54)

Appendix 1 – Evidence base (Pages 55-60)

3. Case for Change

3.1 Local drivers

The health and social care system in Stockport is unsustainable in its current form. If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be a c£156.8m deficit. This will be driven by inflation (wages, fuel, technology, medical advances) and demographic pressure from an ageing population driving activity growth (+12.6%) which will outstrip any growth in resources.

These financial and activity forecasts based on a ‘Do Nothing’ scenario are set out in tables 10 and 11 below:

Table 10: Activity Forecast for Stockport CCG: Do Nothing scenario using the agreed growth assumptions underpinning the GM Investment Agreement

Point of Delivery	CCG Activity Plan	CCG Activity Plan Based on agreed Growth Assumptions			
		2016/17	2017/18	2018/19	2019/20
Do Nothing Gap	2016/17	2017/18	2018/19	2019/20	2020/21
A&E	100,133	102,136	104,383	106,470	108,706
Non Elective	41,286	42,153	42,996	43,770	44,645
Elective	42,705	43,474	44,213	44,964	45,684
Out Patients	341,168	353,791	366,528	379,356	392,634
Total	525,292	541,554	558,120	574,560	591,669

Table 11: Financial Forecast: Do Nothing Gap

April 2017		£'000			
Do Nothing Gap	2016/17	2017/18	2018/19	2019/20	2020/21
Stockport MBC	£10,500	£18,193	£27,316	£34,031	£40,464
Stockport CCG	£5,121	£13,377	£29,162	£37,083	£37,080
Stockport FT	£34,398	£42,400	£54,400	£63,622	£75,764
Pennine Care	-	£1,661	£2,266	£2,871	£3,476
Total Deficit	£50,019	£75,631	£113,144	£137,607	£156,784

The consequence will be a reduction in both the range and quality of services we provide unless we undertake significant transformation in the way in which those services are configured. We are already seeing the impact of the deficit compounding the pre-existing challenges in the urgent care system. So for example, we have been consistently one of the poorest performers in England against the national A&E standard waiting time and delays to discharge from hospital. Currently A&E performance at the end of 2016 was around 80% against a target of 95% and delayed transfers of care were at c9% rather than 3.5%.

The pressures that we are already facing will, if we do not change the way services are configured, be compounded by seven further factors.

a) Growth in people living with long-term conditions

Table 12: The table below details the eight most prevalent long-term conditions in Stockport².

Long-term condition	Number
Hypertension	44,745
Anxiety	30,085
Depression	29,100
Asthma	20,545

² Stockport JSNA [click here](#)

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Obesity	20,050 ³
Diabetes	15,700
Coronary heart disease	12,230
History of falls	12,150

27% of the population (84,700) have at least one of these eight conditions and this will increase with age, from 2% in the 0-4 age band, to 88% in those aged 85 and over. By age 60, half of the people have one or more of these conditions and 15% of the population have two or more of eight key long-term conditions. Many more may also have a condition which is currently undiagnosed. It is estimated that the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport, this will equate to an additional 47,700 people living with a condition.

This population is also getting older and in Stockport the number of people aged over 65 will increase from 55,700 in 2014 to 61,000 by 2020. As people age the likelihood of them developing long-term conditions and requiring hospital intervention increases. Currently 124,000 people or 51% of the total adult population of Stockport are known to have one or more long-term conditions. 26,500 people (59%) have two or more conditions. By the age of 65, 58% have at least one and 20% have two or more. By the age of 85 this has risen to 87% and 53% respectively.

We know that currently 70% of all health & social care spend is driven by people with one or more long-term conditions and 50% of GP appointments and 7 out of 10 hospital beds are utilised by these individuals. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are overdue for an appointment for a long-term condition.

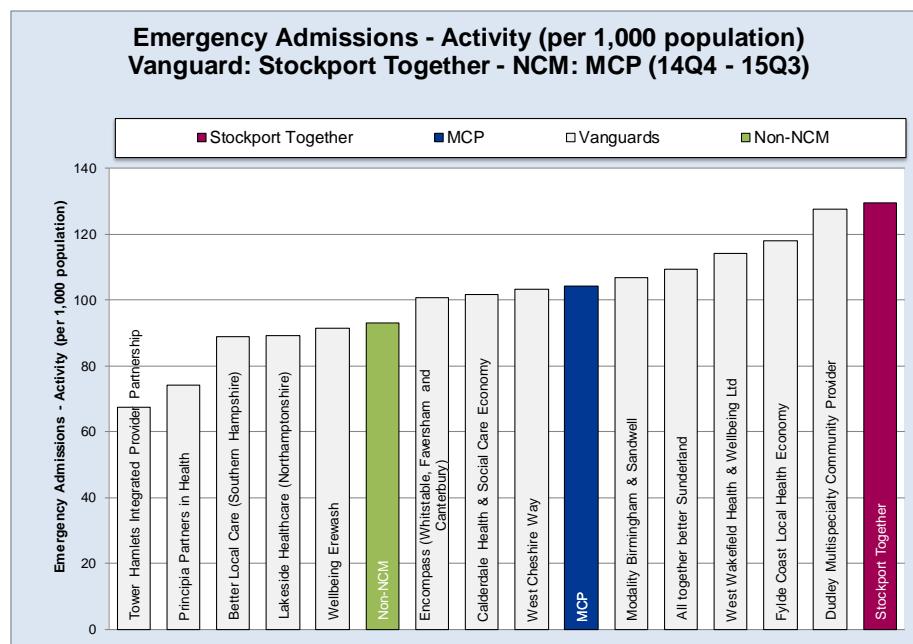
b) High Non-Elective Bed Utilisation

Stockport has for many years had much higher non-elective admission rates per head of population than the England and peer group average. Stockport admits 37% more people to hospital as an emergency admission than the England average; our emergency admission rate for this cohort is also double the average for the North-West. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living difficult.

³ Undercount of actual prevalence

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Table 10: One of many peer comparisons is shown below.



Unless we restore parity with peers and indeed go further, the financial pressures and thus quality of services will further deteriorate given the growth in the numbers of older people with long-term conditions.

If we look to understand what is driving this locally we know that:

- 15% of the population as at June 2016 accounted for 50% of all A&E attendances and 79% of all emergency admissions during the period July 2015 to June 2016.
- Within this cohort at least 36% of these admissions (14,885 admissions) were in some way sensitive to ambulatory care and therefore potentially avoidable
- 13% of all emergency admissions among those over 65 were from care homes
- There is considerable variation in admission by neighbourhood even when the population is weighted for need (876 per 10,000 to 612 per 10,000)
- However, access to general practice is better than many areas as reported by the population in national surveys.

c) Underfunding of and lack of capacity in out-of-hospital based services

General Practice and Community Health Services (both physical and mental health) have been underfunded for many years compared to others in Greater Manchester. This is both a consequence of the over use of expensive hospital beds which consume a disproportionate amount of the Stockport budget; and at the same-time, it in part contributes to high admissions. Breaking this cycle is fundamental to the Stockport Together business cases.

The underfunding of community based health services has been compounded in recent years by the reduction in funding available for social care nationally and played out locally. This shows up in the ability of social care providers to stay in the market as prices have to be

driven down.

More specifically, Stockport General Practices are the lowest funded per head of population in Greater Manchester. Much of this reflects ***national weighting of population need***, but as we have seen there is national recognition of under-funding in general practices across the board. The table below shows that compared to Greater Manchester as a whole, Stockport Practices are funded £5.43 less per weighted head of population. It should be noted that £4.02 of this relates specifically to premises.

Table 13: Relative spend per weighted head of population Stockport to Greater Manchester

GP Services			GP Premises			Other	Total
Contract	QOF	Enhanced	Reimbursement	Other	Void & subsidy		
(£3.95)	£1.94	£0.91	(£0.97)	(£0.01)	(£3.04)	(£0.31)	
(£1.10)			(£4.02)			(£0.31)	(£5.43)

The GP Forward View is clear that safe, sustainable and appropriately resourced General Practice is a fundamental keystone of an effective National Health System. We believe that one result of current funding levels is a lack of out of hospital capacity. To illustrate this, a demand and capacity mapping exercise was undertaken by the Stockport Urgent Care Delivery Board⁴ (see appendix 1) in February 2017. Its purpose was to bring together a cohesive picture of demand, capacity and flow in the urgent care system for Stockport CCG registered patients across 3 financial years (2014/15, 2015/16 and 2016/17). It also looked at the impact on the Stockport urgent care system by 2020/21 of a ‘Do nothing’ scenario. A further scenario was developed in which the impact on ‘flow’ of the assumptions built into the Stockport together business cases was modelled.

This analysis showed that over the last three years out of hospital ‘flow’ has been significantly eroded. This is one of the root causes of the over hospitalisation of older people and poor urgent care performance in Stockport. Specifically:

- the number of new referrals seen by community health services has fallen by 22%
- 12% less patients accessed short term residential care placements mainly due to a 36% increase in the length of stay
- 41% less patients accessed short term nursing care placements mainly due to a 29% increase in the length of stay.
- There is a current deficit of 1047 home care hours unmet.

Moreover, in a ‘Do nothing’ scenario, the modelling demonstrated that by 2020/21 this situation is likely to significantly worsen. There will be:

- A further increase in demand into the urgent care system by an additional 10%;
- A further shrinking of capacity outside of Stepping Hill hospital
- As a result, lengths of stay will increase further with a resultant deterioration of patients ability to live independently

⁴ SFT Stocks and Flow , Stockport Together, February 2017, A Atkinson and K Spencer

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- An Adult Social Care market that is only able to deal with patients discharged from hospital.

Increasing out of hospital capacity particularly creating the community and primary care based alternatives to hospital intervention is essential to restoring ‘flow’ to the Stockport health and care system and is at the heart of the Integrated Service Solution.

d) Fragmentation and inefficiency in existing services

Currently when we talk about community based health and social care services we are describing a plethora of individual services each with their own line management structures, numerous referral and assessment processes, multiple electronic and paper records, different operating hours and competing expectations. This leads to frustration for professionals working in this environment and delays in and fragmentation of service delivery for individuals and carers. There is little evidence of joined up working for the benefit of an individual across team and organisation and care being owned collectively at a local level.

e) Recruitment

In most areas there are significant recruitment challenges; Consultants, GPs, nursing and social workers. Even if we had the resources to fund them it is very unlikely in the next few years that we would have the available professional workforce to run an enlarged version of the existing system. At the non-registered end of the workforce there is considerable competition in the market for non-skilled and semi-skilled workers with very high employment rates locally.

f) Adult Social Care Capacity

Currently most resources are targeted at crisis response (such as responding to significant deterioration, carer breakdown, care package breakdown, safeguarding etc.). This limits the amount of proactive support adult social care can undertake in terms of care planning, making use of community assets, better tailoring of packages and regular review. It also limits capacity to work more intensively with individuals with the most complex needs.

Addressing this shortfall in social care capacity through the Stockport Together business cases will allow resources to be more effectively targeted to focus on preventing, reducing and delaying need as set out under the Care Act. Specifically:

- Proactive support will enable Adult Social Care to improve planning, make better use of community assets, tailor packages to the person (thus reducing package breakdown), and regularly review so that packages can be reduced over time where this is appropriate.
- Reduced caseloads for social workers will enable them to offer a more intensive response to people with complex needs
- Greater capacity will be provided to work with ‘new’ cases emerging as a result of the Care Act (vulnerable adults)

g) Growth in Outpatient Attendances

Stockport’s most recent Joint Strategic Needs Assessment (JSNA) states that around

51,000 (51%) out of the 100,000 first outpatient appointments and 175,500 (70%) out of 250,000 follow up outpatient appointments for its registered population are attributable to the 15% of the registered adult population most at risk of emergency admission. This is set against a national background where first outpatient appointments have risen by 26% since 2008/09. These upward trends are likely to be exacerbated in future by local demographic and epidemiological pressures. At the same time, we know that circa 40-50% of all outpatient appointments in Stockport result only in advice and/or pharmaceutical treatment. In line with the overarching Stockport Together approach, there is potential to develop alternative approaches to traditional models of outpatient care that will deliver more effective solutions (in terms of both cost and quality) outside of the hospital setting particularly using technology to enable communications, advice and treatment between patients, GPs and specialists.

A recent report by the Nuffield Trust (March 2017) entitled 'Shifting the Balance of Care' provides analysis of the effectiveness of new and emerging alternative approaches to models of care. The report provides helpful evidence that many of the approaches proposed within the outpatient business case are effective. These include:

- Support for self-care
- GP continuity of care for patients
- Improved GP access to specialist expertise
- Rapid access clinics for urgent specialist assessment

The net result of the factors set out above is that the resources available for health and social care in Stockport are distributed in such a way that perpetuate a cycle of low alternatives to admission, higher than average admission rates, extended lengths of stay and low access to reablement. This is compounded by a focus on physical health needs at the expense of those of mental health. National benchmarking of the Stockport system reflects this as detailed in Table 14 (programme budgeting spend adjusted for known significant investments.). The impact of the proposed Stockport Together investment and activity reduction programme on the same benchmarks is set out in table 15.

Table 14: Programme Budget Analysis for NHS Stockport CCG – Expenditure variance to national average (scale is £000).

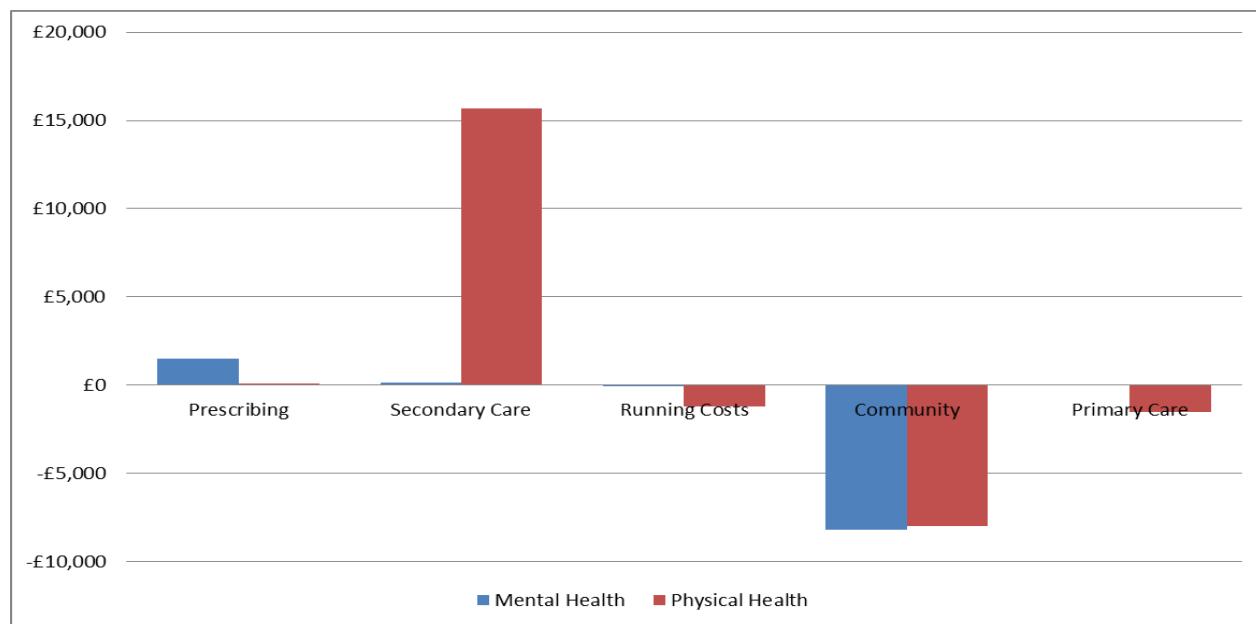
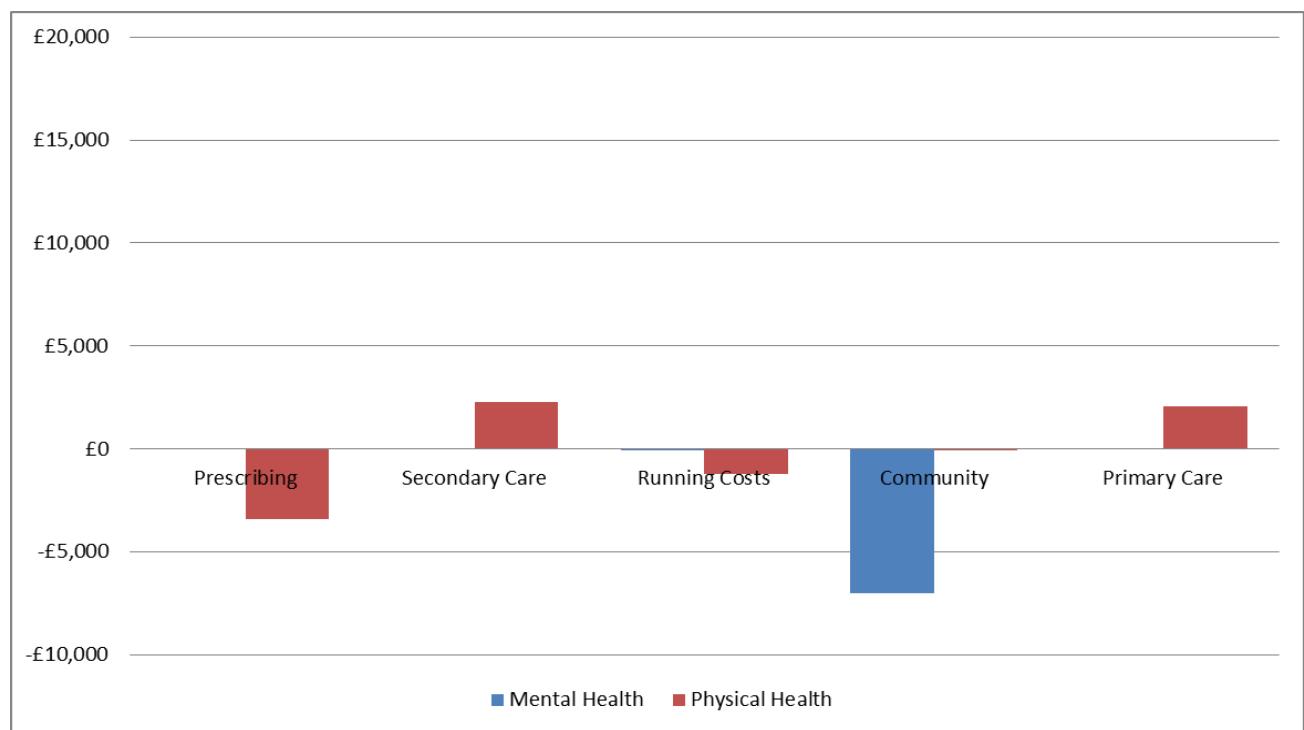


Table 15: Programme Budget Analysis for NHS Stockport CCG – Expected expenditure variance to national average after Investment and Activity Reductions (scale is £000).



* note this is the commissioner benchmark and excludes above tariff costs in acute providers estimated to be a further £12m.

The proposed business cases aim to break this current cycle by re-deploying resources out of acute urgent capacity and providing a transformed, properly resourced, model of care across primary care and community services which is able to identify and respond to mental health and physical health needs on an equal basis.

So, locally we face a significant challenge. We will need to spend the Stockport £ in a more efficient way addressing the underlying demographic and inflationary challenges, and the longstanding over hospitalisation and fragmentation of the existing system. The implementation of an integrated service solution based on strong neighbourhood teams is the most fundamental part of our wider response to this challenge.

3.2 National and regional drivers

Whilst Stockport has a particularly pressing position and its own specific factors that influence this, these challenges also confront the NHS and social care nationally, and both the NHS and the Greater Manchester Health & Social Care Partnership (GM) have responded with a set of expectations which the Stockport Together business cases are designed to address.

a) NHS Five Year Forward View

The five year forward view sets out an expectation that decisive steps will be taken to break down the barriers between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

There is an acknowledgement that England is too diverse to have a “one size fits all” model of care and that local health communities will be expected to choose from among a range of new radically different care delivery options. The option chosen locally because of the need to rebalance the community-hospital relationship is the Multispecialty Community Provider (MCP). This encourages groups of GPs to combine with nurses, other community health services, hospital specialists and mental health, social care and voluntary sector to create integrated out-of-hospital care taking delegated control of the local NHS budget.

The five year forward view requires the NHS to take action on prevention, invest in new models of care, help sustain social care and address inefficiency in the system. In doing so it expects the NHS to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade.

b) GP Forward View

The five year forward view stated that *the foundation of NHS care will remain list-based primary care*, and that there would be a new deal for GPs given the pressures they are under.

The Forward View for General Practice described that over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention, but this will take time to address existing workforce issues. Part of the solution will be the need to make general practice more attractive.

The General Practice Forward View recognises that most observers concur that solutions to the challenges facing general practice “*lie in a combination of investment and reform*” and require action from CCGs and practices themselves. It continues to recognise that GPs’ core role will be to provide first contact care to patients with undifferentiated problems and provide continuity of care where this is needed, but also to act as leaders within larger multi-disciplinary teams working at different organisational levels, for example, their own practice, a neighbourhood of practices and across the local health economy. It emphasises that local systems should encourage and support general practices to work together at scale in a variety of new forms enabling greater opportunities for them to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary sector organisations.

c) Care Act 2014

The Care Act 2014 consolidated good practice in statute as well as bringing in new reforms. It required councils to extend personalisation in social care as well as increasing the focus on wellbeing and prevention. It also expected local authorities and partners to have **a wider focus on the whole population** in need of care, rather than just those with eligible needs and/or who are state-funded. In particular:

- There is a new statutory principle of individual **wellbeing** which underpins the Act, and is the driving force behind care and support.
- Local authorities (and their partners in health, housing, welfare and employment services) must now take steps to **prevent, reduce or delay** the need for care and support for all local people.
- There is a statutory requirement for local authorities to **collaborate, cooperate and integrate** with other public authorities e.g. health and housing.

d) Greater Manchester Health & Social Care Partnership

In December 2015 all the GM partners agreed the 5 year plan for the conurbation. This focussed on four big areas of change. Two of which the Stockport Together business cases make a significant contribution towards.

• Radical upgrade in population health & prevention

It is expected that in each locality there will be a fundamental change in the way people and

communities take charge of – and responsibility for – managing their own health and wellbeing, whether they are well or ill. It is expected that this will include exploring the development of new relationships between NHS and social care staff and the public who use services; finding the thousands of people who are currently living with life changing health issues and do not even know about them and investing far more in preventing ill health. There is a desire that more people start well, live well and age well.

- **Transforming care in localities**

There should be the development of local care organisations where GPs, hospital doctors, nurses and other health professionals come together with social care, the voluntary sector and others looking after people's physical and mental health, as well as managers, to plan and deliver care – so when people do need support from public services it's largely in their community, with hospitals only needed for specialist care.

The local challenges therefore are reflections of those identified nationally and within Greater Manchester, and the national and regional bodies have prescribed how we are expected to respond. Local circumstances and national directives require a radical change in service delivery and organisational approaches.

4. The Integrated Service Solution

4.1 Overview

Given the case for change set out above, there are four key underpinning concepts within the Stockport Together Business Cases:

1. Invest £19.7m recurrently over the next 4 years largely in those 'out of hospital' areas that benchmark as either low or very low; Primary Care, Community, Social and Mental Health Care
2. Implement a new fully integrated 24/7 neighbourhood based model of health and social care built from and led by General Practice which is based on the **best available evidence** and **with an emphasis on prevention** that will create the **capacity** and **capability** (in both primary and community care alternatives) to deliver the right care/ support in or close to people's homes rather than in hospital
3. Train and develop a well-resourced, motivated, empowered and flexible workforce integrated across health and social care with the right skills, experience and attitude to deliver this new joined up model of care
4. As a by-product of delivering the right care and support to people, we plan to realise financial savings based on cost reduction of £22.4m by 2020/21.

The four main Stockport Together business cases (Neighbourhood incorporating healthy communities, Intermediate Tier, Acute Interface and Outpatients) cannot be viewed as separate, standalone entities. They are rather a series of interdependent and interlocking proposals which collectively build a mutually reinforcing **system level change** in the way services are delivered. We refer to this new service model in its totality as the **Integrated Service Solution**. The proposed integrated service solution focuses on the way most local adult health & social care out of hospital services will be delivered and their critical relationship with the urgent care/planned care system particularly local acute hospital services at Stepping Hill. This includes general practice, community health services, mental health services, adult social care, the intermediate tier, ambulatory emergency care, access to specialist consultant advice and third sector provision.

The new model of care addresses the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport. It will create a new integrated health and social care system in which:

- High quality care and support is delivered that is personalised, joined up and coordinated around the person
- People will be more in control of their own health and wellbeing
- Safer and stronger communities are built which are more able to meet their own needs
- Primary care is sustainable and is the fundamental building block upon which integrated health and social care is delivered
- Progressive and impactful integration overcomes fragmentation, and resources are deployed to where they are most needed

- The focus of service delivery changes from the current emphasis on the management of illness to an approach based on early intervention, prevention, self-management and choice
- Care is delivered in the right place at the right time by the right person, every day of the week, enabling care and support to be delivered wherever possible close to people's homes rather than in hospital
- Staff will be given the autonomy and time to care in a system which places a greater emphasis on helping people devise solutions that fit their needs rather than the needs of organisations.

To this end, there will be a range of approaches to support the health and wellbeing of the 85% of the local population without chronic health needs, and intensive, highly integrated approaches for the 15% of the population with chronic health needs who are most at risk of a hospital intervention or long term care

The key features of the integrated service solution are:

The development of Healthy Communities where people have the knowledge, skills and confidence to better manage their own health experience through:

- **An emphasis on prevention, self-management and proactive engagement with people who are at high risk of developing Long Term Conditions and therefore of future hospital intervention.** We plan to achieve this by mobilising existing and new community resources to strengthen local networks and to promote the resilience of individuals, families and their communities. Interventions will include recruiting volunteers as community health champions, working with primary care and Integrated Neighbourhood Teams to provide an additional level of support to people at high risk of hospital admission and other vulnerable individuals in the community. There will be a renewed focus on self-care and self-management for people with LTCs alongside health coaches to support lifestyle change. A small Community Investment Fund will facilitate community-led activity around health, wellbeing and resilience, with a focus on developing peer support groups, activities for people with LTCs, tackling loneliness and increasing social connections
- **A focus on a place based approach.** Aligned to the work to transform services we also want to change the way we think about public services to improve outcomes in communities. Our place based integration approach, which will be trialled in the Heaton's neighbourhood, will change the assumption that public services alone can solve problems; recast them as part of a local system (including people, families, communities, local organisations and institutions, the third sector and local businesses) that can influence outcomes, particularly around isolation and vulnerability.

The implementation of a Neighbourhood Model of Care which will see integrated multi-disciplinary services, with Primary Care at its centre, working with people and communities to collaboratively achieve improved health and social care outcomes and in which:

- **Most services will be delivered through 8 GP led integrated neighbourhood teams** comprising a multi-disciplinary team of health and care professionals including a core team of GP's, community nurses, social care staff and integrated health and social care support-workers together with a wider team of mental health professionals, allied health professionals, pharmacists, acute consultants, independent and third sector staff. Services will be expanded and extended to operate 24/7 and staff will be co-located as far as practicable with primary care. This will enable GPs to build effective working relationships with named, identifiable teams of staff.
- Each Neighbourhood team will work holistically with GP's to meet the needs of the entire practice population but specifically **to identify and intensively case manage the 15% of their patients at greatest risk of future admission** in order to avoid crisis and reduce the risk of a hospital episode through:
 - Use of formal risk stratification including use of frailty scores and social factors
 - Intelligence gathered from GP's, Advanced Nurse Practitioner's and social care
 - Frequent user information from the ambulance service and acute hospital

Teams will then coordinate evidence based case management for these patients through a multi-disciplinary team approach which will:

- Ensure patients' wishes are fully considered.
 - Encompass physical health, mental health, social care and housing provision.
 - Develop a shared care plan with a range of personalised services wrapped around the patient to meet their needs
 - Identify a named case manager and monitor progress against the agreed care plan.
- **There will be a neighbourhood leadership team** which will consist of a neighbourhood appointed GP (as lead), social work, community nurse and practice manager. This team will be responsible under a Neighbourhood Integration agreement for;
 - Deployment of resources within the neighbourhood
 - Shaping resources to meet the local need
 - Owning the local delivery of health and social care outcomes
 - Representing the neighbourhood in the wider system

As part of the implementation of the core neighbourhood business case and the implementation of the transitional management structure for the MCP, Neighbourhood Leads

will be appropriately resourced to take up their leadership responsibilities and engage fully with their respective Neighbourhood Teams

- **GP capacity will be transformed and increased by up to 37% through efficiency gains, a significant financial uplift and a reshaped primary care workforce.** The emphasis will be placed on creating safe and sustainable General Practice where the necessary capacity is created that will enable GPs to focus on delivering **more intensive, proactive and personalised care for people with long-term conditions at individual practice level.** This will be achieved by:

- Increasing funding into individual general practice at a rate greater than the rest of the NHS,
- Investing into general practice to meet the Greater Manchester standards and standards for safeguarding
- Investing into general practice to improve workflow and navigation. The Navigation service development in particular will ensure that patients are able to see the right person first time. This will be one of the main mechanisms through which patients will be able to access the widened range of collaborative general practice services proposed below such as physiotherapy, pharmacy, mental health services, local voluntary sector services, lifestyle change services, health coach and practice health champion activity.

These initiatives at Practice level will be complemented by further investment into a range of new and expanded capacity releasing initiatives for **General Practices to work collaboratively together at scale** across Stockport or a Neighbourhood to provide a specified range of new and expanded services including:

- **Acute Visiting and Clinical Triage:** This new service will establish a safe and resilient system that can receive all acute calls for GP practices across Stockport between the hours of 8am and 8pm. Clinical triage will be provided within 2 hours of the call. Following clinical triage, all calls deemed to need a visit or a face to face appointment will receive the relevant intervention within 2 hours of the triage decision being made. In this way, the response will be equivalent to that offered at ED but will be more convenient to the patient.
- **Medicines optimisation:** using a dedicated team of pharmacists rather than GP's to manage the end to end prescribing processes across a neighbourhood including undertaking Medicines reviews. The service will include:
 - Management of repeat prescriptions (including high cost drugs)
 - Lifestyle advice and coaching
 - Signposting to other support services as part of medication reviews (smoking cessation, self-care courses, community assets etc.)
 - Membership of the Neighbourhood Multi-Disciplinary Team providing support and guidance around prescribing multiple medications for patients with complex needs
 - Training and support for care home staff, GP's, AHPs, community nurses etc.
- **Direct Access Physiotherapy:** Musculoskeletal Physiotherapists will operate a direct access service led by a 'First Contact Practitioner'. The aim will be to free GP Capacity

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by reducing the number of patients with MSK conditions requiring GP consultations

- **Enhanced Mental wellbeing service** accessed through social prescribing to support patients with low level mental health conditions by providing additional time to listen and identify the underlying issues that underpin their conditions
- **Find and prevent:** a service development which will focus on longer-term prevention and detection of those who have yet to develop complex care needs. The initial focus will be on 5 main conditions: Diabetes and pre-diabetes (type 2), Hypertension, Atrial fibrillation, COPD and Dementia
- **Better use of treatment rooms:** This will involve the redevelopment of existing Practice treatment rooms to be able to support a wider variety of patients who currently need to attend outpatients / A&E services in acute trusts. The new 'neighbourhood hubs' will offer a range of enhanced services including Intra Venous (IV) therapy, catheter care, try without catheter (TWOC), phlebotomy, Deep Vein Thrombosis (DVT) diagnosis and treatment
- **7-day working:** additional appointments within neighbourhoods at evenings and weekends will be introduced. Weekday provision will increase by 1.5 per day, providing pre-bookable and same day appointments to general practice services.. There will be access to pre-bookable and same day appointments on both Saturdays and Sundays to meet the needs of the neighbourhood population.
- **There will be significantly increased, transformed community based Health, Social care and Third Sector support (+59%) for those with one or more long-term conditions, those who are at risk of developing a long-term condition and those with complex social care needs.** Teams will be resourced and trained to address the demand and capacity consequences of working intensively with the 15% of the population most at risk of admission. The workforce will be transformed to place a greater emphasis on blended health and social care roles at the pre-registered, integrated support worker level. Extended 24/7 operating hours will be introduced across all core services and a new 'Steady in Stockport' falls prevention service will commence to address one of the major causes of hospital admission in older people – an area in which Stockport currently performs poorly compared to the England average.
- **Investment into Mental Health for the provision of neighbourhood based integrated psychological and physical health support will be increased.** This new 'all age' service is designed to address gaps in existing service provision particularly the needs of people with long term conditions with unmet psychological needs, people demonstrating complex behaviours and/or complex health issues, people who may have substance misuse and other issues impacting on physical and mental health, people with Medically Unexplained Symptoms (MUS) and people who are high users of services (e.g. emergency department, primary care, community services, hospital out-patient or diagnostic services)
- **There will be a greater range of support for care homes and home based long term packages of care with an investment of £1.2m.** This will address the shortfalls identified in the Demand and Capacity Mapping and will ensure that more people are supported to live safely and independently in their own homes on a long term basis. The commissioned and contracted home support providers, all of whom will be on the Council's framework of

registered and accredited provision, will offer a seven day service and will be linked to specific neighbourhood teams.

The transformation of the Intermediate Tier - those range of integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. The key features of the new service are:

- **There will be significant additional capacity (+40%) invested into a transformed and enhanced 24/7 Intermediate Tier** which will provide the essential community crisis response, intermediate care, Reablement and short term home care packages which together act as the critical bridge between hospital, neighbourhood and home avoiding unnecessary emergency admission to hospital and supporting sustainable early discharge.
- **The 20 existing health and social care services currently providing various forms of intermediate Care will be reformed into 3 core services:**
 - **A single point of co-ordination and triage** staffed by skilled call handlers and navigators to transfer and triage all Intermediate Care referrals received to ensure that the appropriate response is provided to the patient.
 - **A community health and social care crisis response service** staffed by a team of health and social care professionals providing what is known as 'step up' care: an urgent response to a sudden deterioration in a person currently living at home giving them the maximum opportunity to recover and avoid a hospital admission.
 - **A new Active Recovery Service** delivering significantly increased short term home and bed based packages of care covering intermediate care and Reablement. This is often referred to as 'step-down' care; early discharge support for people recovering from an illness, fall or post-operation who do not require inpatient treatment and can be cared for in the community.
- **The systematic implementation of 'Transfer to Assess' alongside the SAFER bundle in all wards to reduce average hospital length of stay by up to 50% and prevent the de-conditioning of older people that is associated with their over hospitalisation.** An Integrated Transfer Team (ITT) will facilitate discharge and carry out an assessment to ensure that frail older people who are medically well enough to leave hospital are assessed, where appropriate, in their home environment or a community setting, rather than on a hospital ward. They will link with the Intermediate Tier and Neighbourhood services to ensure there is seamless, joined up care.

Strengthening Ambulatory Emergency Care at Stepping Hill hospital to ensure, where appropriate, that emergency patients presenting to hospital for admission are rapidly assessed and streamed to ambulatory emergency care units, to be diagnosed and treated on the same day with ongoing clinical care and without the need for full admission to hospital. This will be achieved by

- **Strengthening Ambulatory Emergency Care within the Emergency Department at Stepping Hill by:**
 - **Provision of a co-located primary care streaming service (Ambulatory Illness Team) operating from 8am to midnight 7 days per week.** In this new model, the workforce will have both acute and primary care clinicians at the front-door of the Emergency Department. This combination of primary & acute experience and expertise will enable patients presenting with lower risk needs to be treated outside of the A&E department.
 - **Extending the operating hours of the Ambulatory Care Unit from 8am to midnight 7 days per week to optimise the utilisation of people being managed on ambulatory care sensitive conditions pathways.** An ambulatory care unit is a patient focused service which enables some conditions to be assessed, diagnosed and treated without the need for an overnight stay in hospital.

Implementing alternative approaches to traditional Outpatient Models that deliver more effective solutions outside of the hospital setting particularly using technology to enable communications, advice and treatment between patients, GPs and specialists. This includes:

- **A 40% reduction in the amount of outpatient activity commissioned in Stockport by 2021 (107,500 outpatient first and follow up appointments).** This will be achieved by transforming the outpatient pathway to focus on:
 - Active support for patients through technology and community support channels to enable them to take more control of their condition. This includes better decision support, improved self-care and provision of advice
 - Enhanced specialist support for GPs in clinical decision making
 - Introducing appropriate clinical triage for referrals and diagnostic interventions so that patients are seen in the right setting by the most appropriate health professional thereby avoiding wasted appointments
 - Providing alternative mechanisms and support to traditional appointments to enable

earlier discharge from outpatient clinic. This includes virtual clinics for patients that do not require a face-to-face appointment and by investing in enhanced community specialist nurse capacity to enable and support outpatient pathways

- Identifying outpatient activity that provides no benefit to the patient, does not need to take place and which can therefore be stopped
- Better more coordinated support for patients with complex conditions

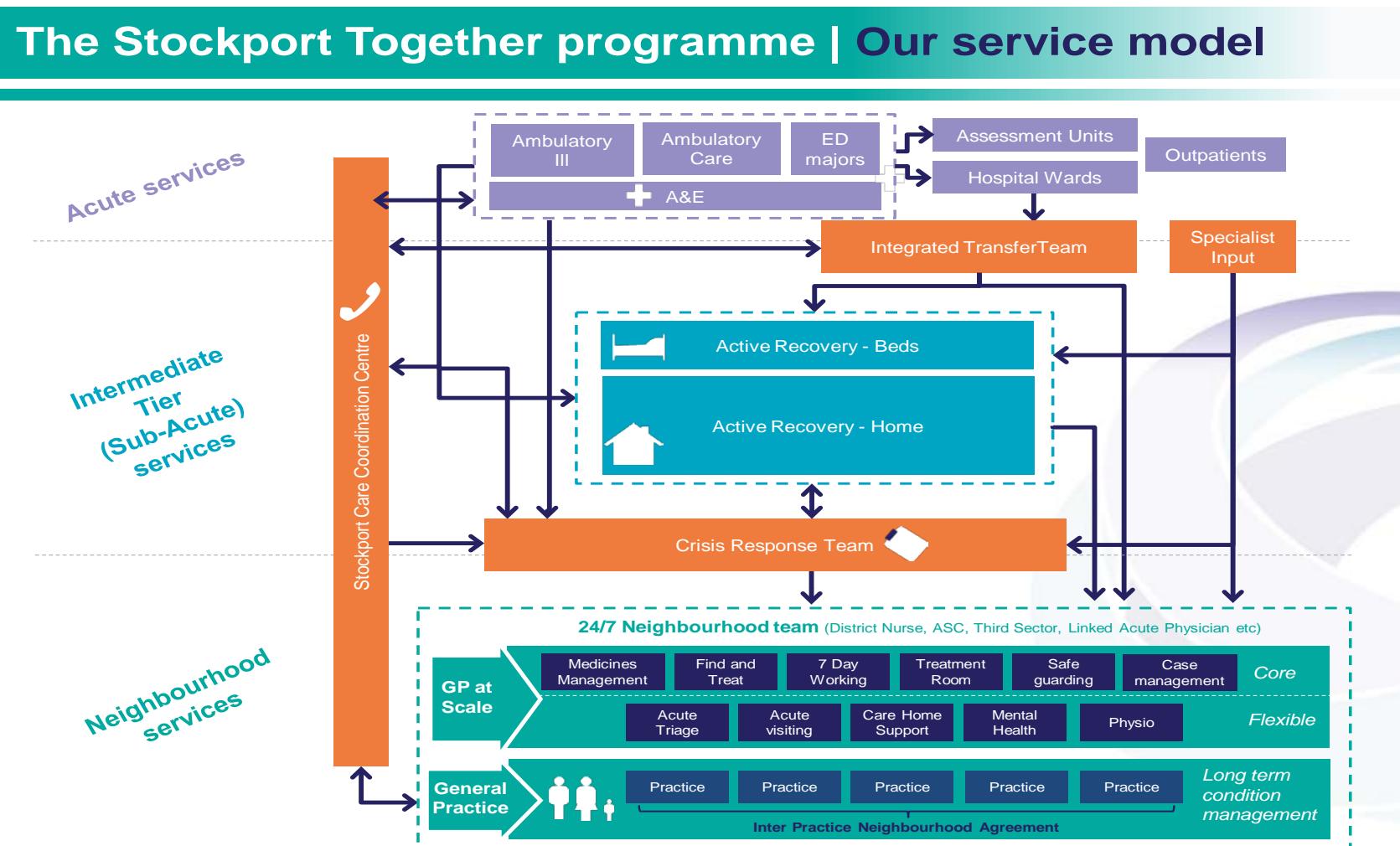
The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with a commissioned programme of support from a range of organisations including AQuA, ECIP and Skills for Health.

The expected outcomes from this commissioned programme of support will include:

1. The further development of a collective responsibility for person centred care and support amongst staff
2. The strengthening of existing integration to ensure people who need care and support (including families and carers) experience a seamless health and social care service
3. A development and appreciation of the shared knowledge and expertise of staff across traditional occupational boundaries
4. Support for staff during the change journey including building individual's understanding of their preferred learning styles and the impact this can have on that journey
5. The engagement and involvement of the workforce to inform organisational and service design including workforce structures, practices, values and culture
6. Development of leaders and managers to enable them to carry out effective organisational design and implementation
7. Creation of a management development programme to grow cross-cutting managerial skills to operate beyond occupational boundaries and give them the ability to manage across a number of professional disciplines and support the implementation and sustainability of the new models of care

The integrated service solution and how the various components interrelate are described overleaf:

Figure 1: The Stockport Together Integrated Service Solution



4.2 The benefits and evidence base underpinning the Integrated Service Solution

Benefits

Our goal is Implement a new fully integrated 24/7 neighbourhood based model of health and social care built around General Practice which is based on the **best available evidence** and with **an emphasis on prevention** that will create the **capacity** and **capability** (in both primary and community care alternatives) to deliver the right care and support in or close to people's homes rather than in hospital

It will enable delivery of the following high level outcomes;

- Keeping people independent at home for longer
- Ensuring safe and sustainable General Practice and out of hospital services
- Reducing avoidable hospital admissions for those most at risk
- Substantially reducing avoidable visits to accident and emergency departments
- Reducing avoidable admissions to care and residential homes
- Reducing the average length of time people stay in hospital by up to 50%
- Transforming the traditional approach to outpatient and elective activity

Quantified benefits can be found in appendix 1 on page 55 of this document.

The key patient benefits will be;

- People will only have to tell their story once
- Reduced hand-offs between services by creating neighbourhood teams who work together with primary care and the third-sector to deliver care and support to meet patients' and carers needs.
- Patients will have a named case manager who will organise and co-ordinate their care.
- Breaking-down demarcation lines between professionals and multi-skilling of staff to improve care.
- Services will be available over extended hours
- More care will be provided closer to home
- There will be fewer confusing transfers between organisations and services
- Increased breadth of provision in local GP practices

The key system benefits will be;

- Practitioners working to shared population groups and priorities
- Efficiencies through shared assessment, care plan and reduction in formal referral processes
- Parity of esteem given to mental and physical health
- Reduced handoffs and costly repetition of activities
- More appropriate use of resources
- Increased ability to rapidly move resource to where it is most needed
- Greater value achieved for each health and care pound
- Reduced 'gaps' in service provision where vulnerable people could be lost

The key benefits for social care will be;

- More people are enabled to remain independent for longer
- Health teams fully aligned to care approaches
- More opportunities to support early intervention and prevention
- Enhanced opportunity for whole family approach
- Simplified access to mental health services
- Greater support for care homes
- Greater ability to meet care package requirements at a neighbourhood level
- Increased support from primary and community care on a seven-day basis

The key benefits for primary care will be;

- Safe and sustainable model for primary care
- Increased expertise within practice
- Great ability to offer a wider range of services at a local level
- Reduced administrative burden
- Increased range of mental health support in the neighbourhoods
- Reduced complexity of referral
- Greater ability to shape local provision for the local population
- Greater strength from scale
- Improved access to community health and social care services

The key benefits for community health will be;

- Greater access to medical expertise and social care support
- Improved range of resources
- Ability to support people more holistically
- Increased range of mental health support in the neighbourhoods
- Quicker access to support when patients are in exacerbation
- Reduced numbers of crisis situations in care and nursing homes
- Simplified access to community resources

The key benefits to care and nursing homes;

- More formal support from health and care practitioners
- Increased training and support opportunities
- Closer working with local teams
- Increased ability to influence the health and care provision setting
- Increased career development opportunities
- Alternative options than 999

The key benefits for mental health;

- Increased opportunity for physical health training for mental health staff (peer to peer)
- Increased opportunity for mental health training for physical health staff (peer to peer)

- Increased multidisciplinary support for those with mental health support needs
- Informal support more aligned with formal support
- More opportunities for raising public awareness and informal guidance
- Parity of esteem for mental and physical health

Evidence

The success of the Stockport Together business cases and the basis of this economic business case is almost entirely contingent on the system's ability to ensure that the 15% of people most at risk of hospitalisation (either as an Emergency Department attendance, emergency admission or as an outpatient appointment) are able to manage their care better and that there are sufficient evidence based community alternatives to avoid unnecessary hospital based interventions.

Our analysis shows that there are a relatively small number of people in Stockport who are the heaviest users of health and care services. These are the 36,000 residents (15% of the overall population) who, at any one point in time, have the highest risk of being admitted to hospital in the next 12 months (i.e. with a risk score of ≥ 18.03 based on the Combined Predictive Model). This top 15% of those people most at risk, as at June 2016 accounted for 50% of all A&E attendances and 79% of all emergency admissions during the period July 2015 to June 2016. This also applies to hospital outpatient utilisation. Stockport's most recent Joint Strategic Needs Assessment (JSNA) states that around 51,000 of the 100,000 first appointments and 175,500 of the 250,000 follow up appointments are attributable to this cohort of the population.

Within this cohort at least 36% of these admissions (14,885 admissions) were in some way sensitive to ambulatory care and therefore potentially avoidable with the right community alternatives to hospital in place

To further exemplify this, Table 14 below sets out the top 10 reasons for emergency admission to hospital in Stockport between July 2015 and June 2016. 28% of all emergency admissions in this period had a primary diagnosis in this top ten list. Of these 6,011 admissions; 52% (3,126) had a diagnosis related to conditions with some level of sensitivity to ambulatory care and therefore potentially avoidable.

Table 16: The top 10 reasons for emergency admission (Jul 15 to Jun 16):

Primary diagnosis	Number of admissions
1. Pain in throat and chest	982
2. Pneumonia, organism unspecified	944
3. Other disorders of urinary system	810
4. Abdominal and pelvic pain	715
5. Other chronic obstructive pulmonary disease	579
6. Other soft tissue disorders, not elsewhere classified	500
7. Unspecified acute lower respiratory infection	386

Primary diagnosis	Number of admissions
8. Cellulitis	382
9. Atrial fibrillation and flutter	381
10. Acute myocardial infarction	332

Consequently, we believe that by deploying the full range of interventions set out in this business case, we will be able to work intensively with this cohort to appropriately deflect activity away from hospital and create 'flow' across the system in the following proportions:

Table 17: Impact on Activity of Stockport Together Business Cases

Point Of Delivery	CCG activity plan 2016/17	Stockport CCG activity with agreed growth assumptions					Deflection percentages of business case deflections to 16/17 CCG plan			
		16/17	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21
A&E	100,133	102,136	104,383	106,470	108,706	20.1%	-	24.8%	30.7%	32.0%
Non Elective	41,286	42,153	42,996	43,770	44,645	12.3%	-	16.6%	21.4%	27.7%
Outpatient	341,168	353,791	366,528	379,356	392,634	-2.9%	-	24.1%	31.6%	40.4%
Elective	42,705	43,474	44,213	44,964	45,684	-1.2%	-1.6%	-2.3%	-3.1%	-
Total	525,292	541,554	558,120	574,560	591,669	-6.8%	21.8%	28.3%	34.8%	-

We are confident that these levels are deliverable because the local, national and international evidence supports both our service model and the underpinning assumptions that we have made about their impact on activity reduction particularly when set in the context that Stockport is an outlier in these areas both locally and nationally.

The evidence base used to underpin the development of the integrated service solution and the associated activity deflection assumptions are set out below:

- 'The evidence for integrated care', McKinsey March 2015
- 'Transforming urgent and emergency care services in England', August 2015, NHS England
- 'GP 5 year forward view', NHS England 2015
- 'Case management: what it is and how it can best be implemented' Kings Fund 2011:
- 'Extensive Care Approach', Fylde Coast
- 'The evidence for integrated care' Local Government Association, 2013

- Wigan MBC unregistered social care workforce,
- Clinical Standards for Fracture Liaison Services, NICE, 2017; Quality Standard QS 86: Falls in Older People, NICE, 2013, Clinical Guideline CG 161: Falls in Older People: assessing risk and prevention
- ‘Releasing time in General Practice’ Robert Varnam, 2014
- ‘Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing’ Nesta, 2016
- ‘Admission Avoidance Audit: Tame Valley and the Heatons’ February 2017, Dr James Higgins

A summary of the international evidence on the impact of integrated care by McKinsey 2015 ('The evidence for integrated care', March 2015) and subsequently NHS England 2015 ('Transforming urgent and emergency care services in England', August 2015), concluded that it is the impact of a number of key components operating together that can deliver the sort of step change that systems are seeking.

These are:

- **Implement Case Management within better, more joined up Neighbourhood Teams with greater capacity:** Assertively managing acutely at risk populations through individual care planning and multi-disciplinary teams delivered primarily in primary and community care
- **Improve and increase Intermediate Care capacity:** Early review by a suitably qualified clinical decision maker supported by responsive intermediate care (with the right balance between step up/step down) can reduce admissions by up to a quarter
- **Implement Ambulatory Emergency Care:** consider all potential acute admissions for ambulatory emergency care unless care needs can only be met by an inpatient stay:

They further concluded that reductions in emergency admission and ED attendances as a result of the implementation of integrated care of between 20-30% could be expected. These components are all at the heart of the implementation of our integrated service solution.

This national and international evidence is further supported by more local studies. A recent admission avoidance audit of a cohort of 3,082 patients (the top 6%) most at risk of admission was conducted in Tame Valley and the Heatons by local Stockport GP and Neighbourhood Lead, Dr James Higgins⁵. This concluded that of those patients who had experienced a non-elective admission to hospital in the audit period, a little under 24% of these admissions were potentially avoidable largely through better joined up use of existing out of hospital services, the implementation of a range of new community based services and through the intensive case management of those at the highest risk of admission (the top 2%).

The Stockport Together business cases rely heavily for their impact on non-elective activity on what is called the Extensivist Care and Case Management approach. In particular, the

⁵ Admission Avoidance Audit: Tame Valley and the Heatons' February 2017, Dr James Higgins
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cases have used the findings from the Fylde Coast Extensive Care Approach due to its similarity to the Stockport Integrated Service Solution. This is a community based service providing co-ordinated and integrated care for people with at least 2 complex conditions. Eligible patients are referred by their GP against set criteria. The findings from the implementation of this approach in Fylde Coast demonstrate the following deflection rates:

- A&E attendances: 19%,
- Non-elective admissions: 25%,
- Outpatient first attendances: 10%,
- Outpatient follow up appointments: 17%
- Elective admissions: 37%.

It is recognised that the overall target for reduction in Outpatient activity (40%) is ambitious. The national evidence base is currently limited in scope and emergent. There are, however, an increasing number of positive findings across a range of national and local specialty specific studies upon which our proposals have been constructed. These include:

- Results from Stockport 100 day Rapid Testing initiatives across Trauma & Orthopaedics, Gastroenterology (IBD and Fatty Liver Disease), Cardiology & Respiratory (Breathlessness clinic) and Diabetes.
- Hibbard et al, 'Supporting People to Manage Their Health' Kings Fund 2014
- Derek Wanless – 'Our Future Health Secured – A review of NHS Funding and Performance' (2008)
- Lewisham Care Study by Dr B Fisher – Lewisham GP 2012 patient survey
- NHS Greenwich GP improvement and education programme
- Super 6 model of diabetes care
- Dr Partha Kar, Clinical Director Endocrinology/Diabetes, Consultant Physician, Portsmouth Hospitals NHS Trust, UK
- UCL GI diagnostic review initiative
- Chronic Kidney Disease in Tower Hamlets EMIS patient record review initiative
- Ashford CCG MSK clinical triage initiative

In addition, in developing our proposals and validating their underpinning assumptions, we have worked closely with senior clinical and operational staff in both acute and primary care.

Appendix 1 is a detailed analysis of the evidence bases that have been used to support each of the key interventions within the business case and the tariff benefits.

5.1 Investment Plan and Benefits Realisation Plan

Context

The Stockport Together Business cases represent a significant component of the overall sustainability plan for the local system. As set out in section 3 above, the health and social care system in Stockport is unsustainable in its current form. If working practices do not change, the financial position will deteriorate so that by 2020/21 there will be a c£156.8m deficit. This is detailed in Table 18 below:

Table 18: Financial Forecast: Do Nothing Gap

April 2017		£'000			
Do Nothing Gap	2016/17	2017/18	2018/19	2019/20	2020/21
Stockport MBC	£10,500	£18,193	£27,316	£34,031	£40,464
Stockport CCG	£5,121	£13,377	£29,162	£37,083	£37,080
Stockport FT	£34,398	£42,400	£54,400	£63,622	£75,764
Pennine Care	0	£1,661	£2,266	£2,871	£3,476
Total Deficit	£50,019	£75,631	£113,144	£137,607	£156,784

In response, the statutory partners working across Health and Social Care have developed a system sustainability plan to address this significant financial challenge. The main contributory elements to the Stockport sustainability plan are set out in Table 19 below. As can be seen, the Stockport Together Programme represents c30% of this overarching financial plan. The other contributory elements to the plan (Greater Manchester themes and individual Partner Cost improvement Programmes) are detailed elsewhere and are out of scope to this summary case. It should nevertheless be noted that when required investments are taken into account, full delivery of the overall sustainability plan will still require a net financial gap of c£20.5m to be bridged by 2020/21.

Table 19: Planned Savings Programmes and non-recurrent resources to address 2020/21 Forecast deficit

April 2017		£'000			
	2016/17	2017/18	2018/19	2019/20	2020/21
Stockport MBC	(£10,500)	(£18,193)	(£20,590)	(£23,669)	(£23,946)
Stockport CCG	(£7,871)	(£17,444)	(£24,778)	(£33,282)	(£33,882)
Stockport FT	(£28,836)	(£15,000)	(£30,000)	(£30,000)	(£30,000)
Pennine Care	£0	£0	£0	£0	£0
Stockport Together	£0	(£700)	(£23,974)	(£34,080)	(£45,470)
GM Themes	£0	(£3,000)	(£7,000)	(£12,000)	(£22,000)

Stockport Together Re-provision Costs	£0	£0	£20,121	£19,739	£18,986
Total	(£47,207)	(£54,337)	(£86,221)	(£113,292)	(£136,312)

Stockport Together Investment and Benefits Realisation Plan

It is important to note that the savings contained within all the Stockport Together business cases have been calculated using **national tariff⁶**. The Finance Directors within the local system recognise, however, that whilst savings based on tariff can be removed on day one, the costs within the system will take longer to remove. They have therefore agreed a set of principles to govern the removal of costs and the timing of the realisation of savings. These principles are that:

- **Variable costs** can be removed immediately,
- **Semi-fixed costs** can be removed after 1 year and
- **Fixed costs** can be removed after 3 years.

This means that the savings of £43m contained within the business cases will be removed over the time period **2017/18 to 2024/25** (rather than by 2021) with the vast majority (£41.8m) removed in the period 2017/18 to 2021/22.

A summary of the proposed investment plan and associated benefits for the Stockport Together Programme covering the years 2017/18 to 2020/21 based on this cost reduction approach (rather than tariff) are set out in Table 20 below. For comparison purposes, table 22 sets out the equivalent summary based on tariff. As discussed in section 1 , the variance between the two approaches (cost and tariff removal) is purely a function of time and is reconciled by 2024/25.

In summary:

- £19.8m of GM transformation funding will be invested to pump prime the implementation of the Integrated Service Solution over the 4 year period. This will deliver a forecast recurrent financial saving to the system by 2020/21 of £38.8m (based on cost reduction). For ease of reference, this figure of £38.8m excludes the £3.3m CCG investment into Primary Care GM standards set out in Table 20 and reproduced below.
- £16.4m of these savings will be reinvested recurrently to fund the re-provision costs of the Stockport Together programme providing for a net system benefit of £22.4m by 2020/21 rising to £25.4 by 2021/22 (Cost benefit £41.8m less Stockport Together investment of £16.4m) and £43m by 2024/25.

⁶ The national tariff is a set of prices and rules used by NHS providers and commissioners for certain types of NHS (largely hospital based) care

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Table 20: Summary Investment and Funding (inc Savings) Statement as per June's business cases restated based on cost reduction

June 2017		£'000			
Investment:		2016/17	2017/18	2018/19	2019/20
Non Recurrent investment inc. transformational fund		£5,294	£17,127	£1,487	£0
Stockport Together Investment				£19,344	£18,223
CCG Recurrent investment			£3,390	£3,390	£3,390
Total Investment		£5,294	£20,517	£24,221	£21,613
Source of Investment Funding:					
Investment agreement allocation		(5,294)	(13,663)	(793)	
SRG			(696)	(696)	
CCG transformation fund			(1,825)		
CCG funding - Primary Care			(1,890)	(1,890)	(1,890)
GM Standards - Primary Care			(1,500)	(1,500)	(1,500)
External - NHSE Pharmacy bid			(705)	(480)	(263)
Cost reduction based on business cases				(20,175)	(29,197)
Total Funding		(5,294)	(20,279)	(25,534)	(32,850)
Total Net Saving		0	238	(1,313)	(11,237)
					(22,422)

- This will represent a significant investment shift from acute hospital to out of hospital health and care in Stockport principally General Practice and Community Services.
- The £38.8m savings will be realised from two main sources: avoided future growth (£18.5m) and cost reductions (£20.3m) achieved from deflecting existing activity principally in non-elective care and the transformation of outpatient services.
- The majority of the savings (£22.6m) will be derived from Stockport NHS FT representing broadly 70% of Stockport CCG Acute provision. These savings will be generated from avoided future growth (£12.7m) and cost reductions deliverable as a result of providing better out of hospital care (£9.8m). Whilst 70% represents an average for SFT across all activity, this varies according to point of delivery. This is set out in Table 21 below:

Table 21: Stockport CCG percentage of Activity by Provider

Stockport CCG % of Activity by Provider	Stockport NHS FT	Other Provider
Accident and Emergency	78%	22%
Non Elective Admissions	79%	21%
Outpatient First Appointment	68%	32%
Outpatient Follow Up	60%	40%
Elective	66%	34%

- From 2018/19, investment is funded almost entirely from realized benefits accruing from the implementation of the Integrated Service Solution as Transformation funding will largely have ceased.
- Robust programme management of the Implementation and Mobilisation plan and an agreed Risk and Gain Share will be critical as £16.4m more cost (the Stockport Together re-provision costs) will be put into the system over the next 4 years as a result of these business cases: this would pose a significant system risk if the proposed benefits are not subsequently delivered.
- The financial benefits are driven entirely by the impact of the Integrated Service Solution in delivering the evidence based community alternatives and enhanced capacity which by 20/21 will avoid unnecessary hospital based interventions (based on 2016/17 baseline) in the following proportions:
 - -32% reduction in ED Attendances
 - -27.7% reduction in Non-elective Admissions
 - -40.4% reduction in Outpatient Attendances
 - -3.1% reduction in Elective Hospital spells

This is set out in detail in table 23 below.

Table 22: Summary of Recurrent Investment and Tariff Savings Statement per business case

Investment & Savings by business case	£'000						
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2020/21
Acute Interface	£2,500	£2,334	£2,168	(£4,871)	(£6,089)	(£6,089)	(£3,921)
Intermediate Care	£2,457	£1,532	£1,103	(£3,275)	(£4,003)	(£4,730)	(£3,628)
Neighbourhood	£12,106	£11,445	£10,987	(£11,170)	(£14,907)	(£20,465)	(£9,478)
Outpatients	£2,280	£2,128	£2,117	(£6,833)	(£9,150)	(£11,765)	(£9,647)
TOTAL	£19,344	£17,439	£16,375	(£26,150)	(£34,149)	(£43,049)	(£26,674)

Table 23: Impact on Activity of Stockport Together Business Cases

Point Of Delivery	CCG activity plan 2016/17	Stockport CCG activity with agreed growth assumptions					Deflection percentages of business case deflections to 16/17 CCG plan			
		16/17	17/18	18/19	19/20	20/21	17/18	18/19	19/20	20/21
A&E	100,133	102,136	104,383	106,470	108,706	-20.1%	-24.8%	-30.7%	-32.0%	
Non Elective	41,286	42,153	42,996	43,770	44,645	-12.3%	-16.6%	-21.4%	-27.7%	
Outpatient	341,168	353,791	366,528	379,356	392,634	-2.9%	-24.1%	-31.6%	-40.4%	
Elective	42,705	43,474	44,213	44,964	45,684	-1.2%	-1.6%	-2.3%	-3.1%	
Total	525,292	541,554	558,120	574,560	591,669	-6.8%	-21.8%	-28.3%	-34.8%	

In summary, we expect the Integrated Service Solution to drive a substantial reduction in non-elective acute activity for ED attendances, acute non-elective spells, hospital based outpatient appointments and excess bed days. The Stockport system can have confidence that their proposed new care models will deliver this step change in performance because the models:

- Build on the evidence of good practice across Stockport, the UK and abroad as set out in section 4.
- Address the fundamental and interconnected root causes of poor flow across the local health and social care system by investing in a substantial increase in out of hospital capacity enabling better care to be provided closer to home
- Address first and foremost the needs of the most intensive users of services to achieve greater leverage and impact from the new care models
- Integrate all aspects of health with social care provision reducing duplication and multiple hands-offs for patients.
- Will be supported by the commissioning and implementation of an Organisation, Team and Individual development programme to develop the vision, values and behaviours that will be required to enable joined up, integrated care.
- Will be backed by a comprehensive, well-resourced implementation plan that has been aligned to the required benefits realization and which will be robustly managed through agreed Provider/Commissioner governance arrangements.

The benefits realisation plan is clearly contingent on delivering financial savings of £38.8m by 2020/21. The £38.8m savings will be realised from two main sources: avoided future growth (£18.5m) and cost reductions (£20.3m) achieved from deflecting existing activity principally in non-elective care and the transformation of outpatient services.

The detailed year on year profile of the expected activity deflections and savings split by Point of Delivery (POD) are set out in Table 24 below. It should be noted that the savings depicted represent the cumulative annual benefit by point of delivery. An under delivery in any one year will impact the required savings in subsequent years.

Table 24: expected benefits from avoided growth & activity reductions split by Point of Delivery

Activity deflections by POD stating avoided growth vs activity reductions				
Growth	17/18	18/19	19/20	20/21
A&E	-2,003	-4,250	-6,337	-8,573
Non Elective Spells	-867	-1,710	-2,484	-3,359
Outpatient	-12,623	-25,360	-38,188	-51,466
Elective	-769	-1,508	-2,259	-2,979
Total: Avoided Growth	-16,262	-32,828	-49,268	-66,377
Deflections				
A&E	-18,103	-20,539	-24,440	-23,492
Non Elective Spells	-4,198	-5,130	-6,358	-8,074
Outpatient	2,684	-56,945	-69,645	-86,327
Elective	246	811	1,281	1,675
Total: Activity Reductions	-19,370	-81,802	-99,161	-116,218
Grand Total	-35,632	-114,630	-148,429	-182,595

Savings by Point Of Delivery: avoided growth vs activity reductions				
	£'000			
POD	17/18	18/19	19/20	20/21
Savings through Avoided Growth				
A&E	(£184)	(£393)	(£588)	(£808)
Non Elective Spells	(£1,263)	(£2,384)	(£3,377)	(£4,356)
Outpatient	(£919)	(£2,671)	(£4,028)	(£5,391)
Elective	(£2,045)	(£4,009)	(£6,006)	(£7,920)
Total Avoided Growth	(£4,410)	(£9,458)	(£13,999)	(£18,475)
Deflections enabling cost reduction				
A&E	(£483)	(£1,450)	(£1,684)	(£2,149)
Elective	125	770	1,833	2,889
Non Elective Spells	(£1,039)	(£4,701)	(£5,546)	(£8,296)
Outpatient	53	(£1,537)	(£4,502)	(£5,466)
Prescribing	(£700)	(£1,500)	(£3,000)	(£5,000)
Residential & Nursing	0	(£2,300)	(£2,300)	(£2,300)
Total Activity Reductions	(£2,045)	(£10,718)	(£15,198)	(£20,322)
Total	(£6,455)	(£20,175)	(£29,197)	(£38,797)

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**STOCKPORT
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The Stockport Together business cases anticipate a saving for 2017/18 based on cost reduction of £6.4m composed of £4.4m savings due to avoided growth and £2m savings achieved through cost reductions from deflected acute activity (see table 24 above). The contracts that have been agreed between the Stockport CCG and its providers for 2017/18 anticipates a benefit to the system of a reduction in growth of £3.6m and a deflection of activity of £5.7m meaning a total system benefit of £9.3m. This is subject to any required in year investment or over performance to CCG contracts. The contract allows for a review prior to Month 6 and a subsequent reassessment of the mobilisation pace of Stockport Together and, if required, an adjustment to the profile of benefits delivery.

It should also be noted that consistent with the Stockport Together strategy and GM Investment Agreement, the 2017/18 and 2018/19 contract agreement between the CCG and SFT in particular has been set so as to anticipate:-

- A reduction in acute activity resulting from implementation of business cases.
- No growth.
- A compensating payment to SFT in acknowledgement that costs will reduce at a slower rate than tariff activity.

The majority of the savings benefits (£22.6m) will be derived from Stockport NHS FT representing on average 70% of Stockport CCG Acute provision. These savings will be generated from avoided future growth (£12.7m) and cost reductions deliverable as a result of providing better out of hospital care (£9.8m). The cumulative annual benefit for SFT by point of delivery is set out in Table 25 below.

Table 25: Benefits realization for Stockport NHS FT based on cost reduction

Savings by Point Of Delivery for SFT: avoided growth vs activity reduction

POD	£'000			
	17/18	18/19	19/20	20/21
Savings through Avoided Growth				
A&E	(£144)	(£307)	(£458)	(£630)
Non Elective Spells	(£997)	(£1,883)	(£2,668)	(£3,441)
Outpatient	(£588)	(£1,709)	(£2,578)	(£3,450)
Elective	(£1,349)	(£2,646)	(£3,964)	(£5,227)
Total Avoided Growth	(£3,078)	(£6,546)	(£9,668)	(£12,749)
Deflections enabling cost reduction				
A&E	(£376)	(£1,131)	(£1,313)	(£1,676)
Elective	82	508	1,210	1,907
Non Elective Spells	(£821)	(£3,714)	(£4,381)	(£6,554)
Outpatient	34	(£984)	(£2,882)	(£3,498)

Total Activity Reduction	(£1,082)	(£5,320)	(£7,366)	(£9,822)
Total	(£4,160)	(£11,866)	(£17,034)	(£22,570)

This will represent a significant investment shift from acute hospital to out of hospital health and care in Stockport. This should be regarded as a natural and welcome consequence of delivering the right care and an important step in the rebalancing of the local health and care system. All Providers will, over the coming weeks, develop detailed plans to validate and operationalize the benefits set out in this summary system economic plan. This will then form part of the providers own Strategic and Operational Plans.

6. Approach to Managing Risk

Notwithstanding the confidence that the local system has in the efficacy of the proposed Integrated Service Solution, there are clearly significant risks to the delivery of the expected financial, service and patient benefits

To be successful, the Stockport system has to:

1. Curb the level of demand for acute hospital interventions
2. Effectively implement a new service model at pace, leverage a change in system and workforce behaviours, implement new ways of working across a disparate workforce and work effectively across organisation boundaries.
3. Significantly increase out of hospital capacity to deliver quality care for people in the community by successfully recruiting a new type of workforce whilst retaining, developing and retraining existing teams
4. All the while, successfully capping the system-wide cost of delivering health and social care services to our population cohort against a background of a system with performance issues in Urgent Care and current regulatory intervention.

There are clearly mitigations for all these individual risks (see below) but given the scale of required savings set out in Section 5, the Directors of Finance of both Providers and Commissioners have now agreed a proposed approach to the specific management of financial risk including a mechanism for Risk and Gain share to underpin the implementation of the Stockport Together business cases which, subject to the relevant approval from Boards and Governing Bodies, will be subsequently turned into formal contractual terms.

This proposed approach to managing financial risk is based on the following set of key principles:

- Promotes one integrated system with a shared vision, a single co-produced plan and one

budget: 'If one fails, we all fail'

- Is transparent and easy to understand
- Is built upon an 'open book' approach
- Incentivises the right behaviours: bringing organisations and people together and promoting co-operation rather than facilitating conflict.
- Enables the new models of care
- Moves the Stockport health and care system over time towards a focus on outcomes

A set of design principles have also been developed to underpin the Risk and Gain share. These are:

- A single contract should be put in place from 2018/19 between commissioners and either providers 'acting as an alliance' or with a single provider entity dependent on the outcome of the commissioners procurement process
- Underpinning the contract must be a risk and gain share agreement between Commissioners (the CCG and SMBC) and the alliance of Providers/ future single provider entity based on an agreed formula
- In the case of a Provider Alliance, providers will have their own 'backing risk and gain share' agreement to the main agreement with commissioners again based on a formula to be agreed
- SMBC will only 'lose or gain' once thus avoiding the potential for double jeopardy/benefit
- The scope of the risk and gain share will initially be limited to the £43m associated with the Stockport Together Business Case Programme but should subsequently be extended through an agreed process to All STOCKPORT health and social care provision delivered by Stockport providers
- The implementation of the payment component of the outcomes framework will be phased in over time to avoid adding further risk into the system in the early years of the implementation of the new models of care
- An agreed Stop loss mechanism will be developed and implemented for any forecast loss which breaches an agreed threshold in any one year

The overriding priority of Commissioners and Providers should be to ensure that the new models of care are implemented rigorously and effectively and in accordance with the agreed mobilisation, implementation and benefits realisation plans. This is to ensure that the significant patient care and financial benefits of Stockport Together are delivered. It is important to recognise that any triggering of the proposed Risk Share component of the contract will ultimately constitute a collective failure with significant financial and service consequences for the system going forward.

However, in the spirit of the agreed principles set out above, it is proposed that risk and benefit in relation to the in scope services to Stockport Together is held and shared collectively by commissioners and providers based on the following 3 step process for the

proposed risk share approach and a simpler methodology for Gain Share:

Proposed Risk Share

Step 1: Financial Early Warning System

A collective Financial Early Warning System (FEWS) will be implemented which will trigger intervention in the event of any forecast loss which would breach an agreed threshold. The FEWS would be based on a weekly analysis by Directors of Finance of three key indicator sets:

- Compliance with the agreed Mobilisation and Implementation Plan of the Integrated Service Solution
- Movements in the trajectory of a set of key Activity 'Deflection' indicators
- Progress against the agreed Benefits realisation Plan

Step 2: Benefits Maximisation Process

Following the triggering of an intervention through the FEWS, a 'Benefits Maximisation' Process' would be implemented. This would be an agreed contractual time limited process which identifies, agrees and deploys the necessary mitigations to seek to preserve the benefits of the programme and minimise/eradicate residual financial loss. These mitigations could include, but would not necessarily be limited to any combination of:

- Management action by the most appropriate organisation
- Deferring further investment/deployment of cost
- Changing the scope of service specification
- Amending access criteria and/or clinical thresholds
- Increasing contract/non recurrent funding

Step 3: Liquidation of Residual Loss

In the event of a financial loss crystallising in any one financial year, an agreed risk share for the residual loss would be deployed between commissioners and providers on the following proposed basis:

- Stockport CCG: 33.3%
- Stockport MBC: 33.3%
- Stockport Providers: 33.3%

Proposed Gain share

It is proposed that the first call on any gain share would be the £19m required recurrent investment. Thereafter, benefits would be shared on the following basis:

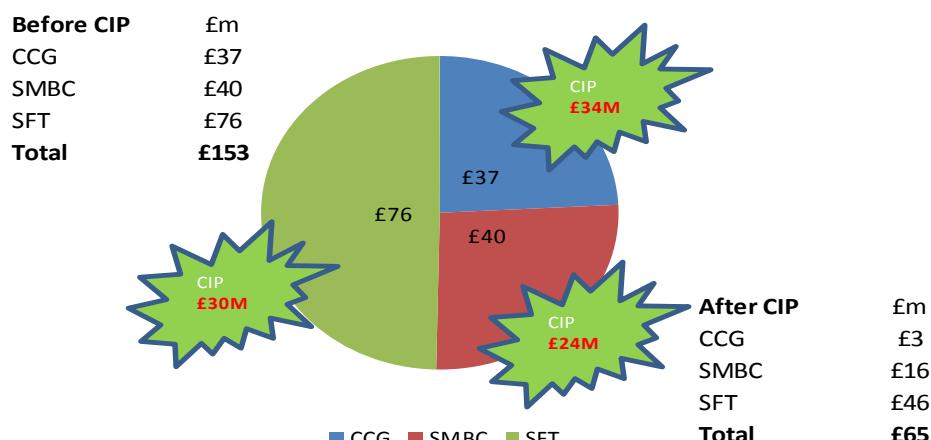
- Stockport CCG: 33.3%
- Stockport MBC: 33.3%
- Stockport Providers: 33.3%

The Risk/ Gain share Process

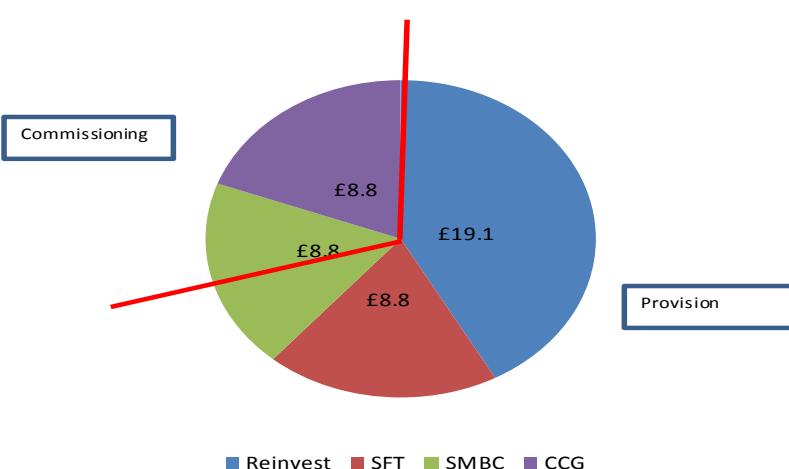
The practical operation of the proposed risk and gain share process is set out visually below:

Stockport - Risk / Gain Share Agreement

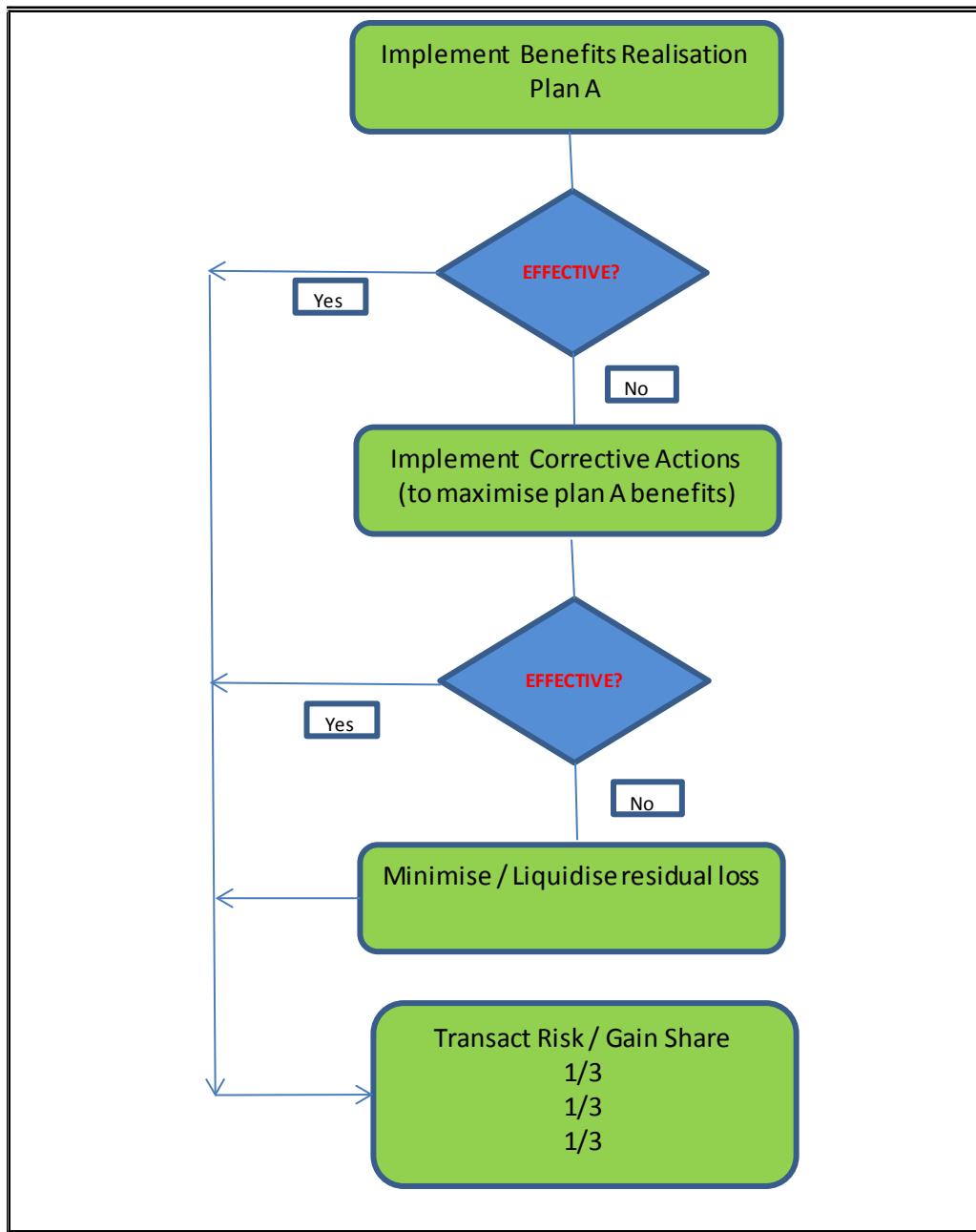
(1) Each Organisation owns its own risk on the key elements of both "Do Nothing" and impact of individual CIP



(2) The £45m Stockport Together Benefits will be firstly reinvested and then shared equally.



(3) There is a process that sets out how gains will be maximised and losses minimised



Top 4 Risks

The major overarching risk facing the Stockport together programme is quite simply that the expected financial, service and patient benefits do not materialize. Set out in Figure 2 below are the top 4 risks to the delivery of programme benefits and their proposed mitigations:

Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
1	Failure to curb the demand for acute hospital urgent and planned care interventions as set out in the benefits realisation plan	4	5	20	<ul style="list-style-type: none"> The Integrated Service solution is based on a sound international evidence based General Practice, the Neighbourhood Teams and Intermediate Tier will be resourced to address the demand and capacity consequences of working intensively with the 15% of the population most at risk of admission A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme The implementation of the Financial Early Warning system will provide the system with ability to react quickly to variations from plan Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health 	3	4	12

Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
2	Failure to effectively implement the new service model, leverage the required change in system and workforce behaviours and implement new ways of working across a disparate workforce	4	5	20	<ul style="list-style-type: none"> A well-resourced single programme management office will oversee the implementation and change programme Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health Internal Change teams will be created and staffed by people from across organisations with appropriate external support and facilitation Providers will implement a formal alliance supported by integration agreements setting out delegated authority powers 	3	4	12



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					<ul style="list-style-type: none"> • Leadership will drive system thinking and breaking down of silos • Barriers to joint working will be addressed (whether IT, IG, cultural) 			
Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
3	Failure to increase out of hospital capability and capacity to that required in the business cases to deliver the quality care for people in the community by successfully recruiting a new type of workforce whilst retaining, developing and retraining existing teams	4	4	16	<ul style="list-style-type: none"> • Development of a clear and comprehensive Workforce Strategy integrated across Providers • Implementation of Integrated Recruitment and Retention strategies which make a compelling offer to the unqualified workforce not currently engaged in care • A new offer to the External Homecare market • A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme • Development of HR shared services across Stockport Providers • Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services • The new models of care will be supported by access to a 	3	3	9



					comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health			
Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
4	Failure to successfully reduce the system-wide cost of delivering health and social care services to our population cohort against a background of a system with performance issues in Urgent Care and current regulatory intervention	4	5	20	<ul style="list-style-type: none"> A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme Providers will implement a formal alliance supported by integration agreements setting out delegated authority powers. The Provider Board will have delegated authority for in scope Stockport Together services and will performance manage the benefits realisation plan Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services to shorten governance 	3	4	12



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				lines <ul style="list-style-type: none">• The implementation of the Financial Early Warning system will provide the system with the ability to react quickly to variations from plan and a mechanism for liquidating loss in the event of failure of the programme• The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits			
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7. Proposed Service Development Implementation Plan and Governance

It is clear that the effectiveness and robustness of the Service Development Implementation Plan and the supporting governance framework is critical to the success of the business case and to de-risking the benefits realization.

The Stockport Together business cases will collectively require the mobilisation and implementation of 30 discrete packages of work or service developments. These work packages are set out in summary form below. Prince2 will be deployed as the programme project management methodology. Implementation will be delivered through Operational Structures with clear operational accountability for each work package supported by access to a single integrated Stockport Health and Care Programme Office and Transformation Team augmented with commissioned support from external agencies including AQuA, ECIP and Skills for Health. This will comprise a core team of 25 wte including Programme Managers, Change managers, Workforce Advisers, Communications experts and OD specialists.

External capacity and capability to support a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change is currently being procured under local framework agreements.

Implementation Work Packages at a glance

| Service developments in summary



To support the effective implementation of the Integrated Service Solution, Providers will implement a formal alliance arrangement in which a newly constituted Provider Alliance Board will have delegated authority for all in scope Stockport Together health and social care provider services (to be known as Stockport Neighbourhood Care). A Transitional Management Structure with single line management responsibility will also be implemented to ensure that the new models of care are effectively implemented and the benefits maximised. This will be supported by the implementation of formal integration agreements enabling the Transitional Management Team and Core Neighbourhood leadership to exercise appropriate decision making authority. The Provider Board will create a time limited Implementation Board including commissioner representation to ensure that the Integrated Service Solution is implemented according to the agreed design and implementation plan. A draft Service Development implementation timeline fully aligned to benefits realisation is included as appendix 2.

The Stockport Together programme has also reviewed its governance structure and arrangements in the light of the transition from the business case development to the implementation and benefits realisation phase. The proposed new arrangements which will oversee the implementation of the Integrated Service Solution have been based on the following key principles:

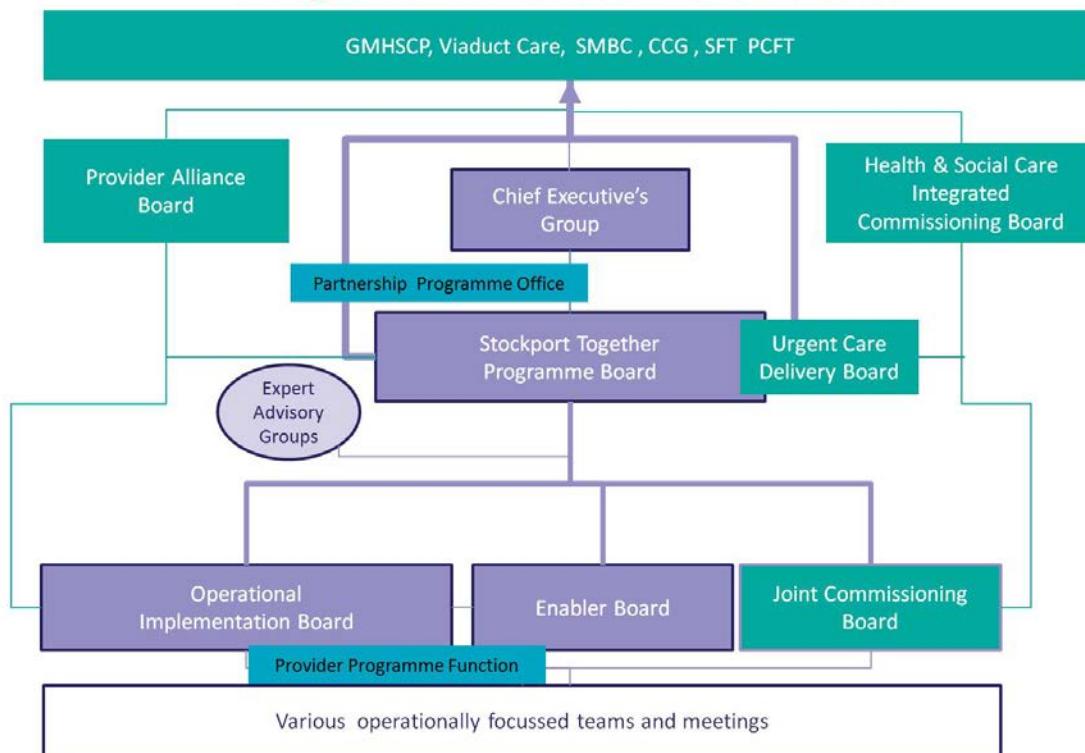


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- Proportionate governance is in place to maintain the programme aspiration and ensure the requisite pace of delivery with a degree but not absolute managed control
- The public, employees and other stakeholders are key partners in the change programme
- All partners dependent upon benefits realisation should be fully sighted on all relevant information
- Clear lines of accountability based on streamlined governance frameworks which avoid duplication and / or acknowledge and understand where overlapping remits require it
- Partners should recognise and support each other in delivery of their varying responsibilities for health & social care in the existing system
- The Chief Executives' group should maintain collective ownership of all issues, challenges and successes
- Leaders at all levels should hold each other to account for delivery and expect to be held to account in a mutually supportive environment
- The programme operates within the existing statutory and formally delegated decision making responsibilities
- There is a relentless focus on timely benefits (financial and outcomes) delivery

These arrangements are set out in detail overleaf:

Programme Governance Structure



4

The **Chief Executives Group** is composed of the Chief Executives of all five statutory health

and care organisations in Stockport. It provides and communicates the vision and strategic direction for Stockport Together and the Integrated service solution. The group also manages the external messages and relationships and resolves any unresolved issues at Executive Programme Board

The **Stockport Together Programme Board** is made up of senior representatives from both commissioning and provider organisations in Stockport and has responsibility for the governance of the delivery, quality, safety and sustainability of the integrated service solution. This includes seeking and receiving assurance from Providers that the implementation of the care models is proceeding according to the agreed design and implementation plan. It is also responsible for ensuring formal change control is in place.

The **Provider Alliance Board** is composed of four Executive Directors, one from each of the constituent Providers within the Provider Alliance plus an independent chair. The Alliance Provider Board will:

- provide assurance to the 4 Provider Boards on the delivery of integrated service solution;
- provide assurance to the 4 Provider Boards on benefits realisation;
- hold the Transitional Leadership Team of Stockport Neighbourhood Care to account for implementation of the integrated service solution and benefits realisation;

The **Operational Implementation Board** will be led by Senior Provider Operational and Clinical Staff with support from Senior Programme Managers. Its role will be:

- To oversee operational implementation of the agreed model of care in line with the plan
- To ensure effective issues and risk management is in place
- To address issues rapidly as they arise
- Escalate issues unresolvable at implementation level
- To make recommendations to the Executive Board for changes to the plan

SUMMARY ECONOMIC CASE: APPENDICES

Abstract

This document describes the summary economic case for the implementation of the new models of care developed as part of the Stockport Together covering the period to 2020/21

Appendix 1 – Benefits Realisation

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
GP Practice						
Navigate and Signposting	5.5%		£376,450	£0	0	<ul style="list-style-type: none"> NHS Alliance 'Making Time in General Practice' suggests that 4% of GP time could be saved through enhanced navigation and signposting in General Practice.¹¹ Local assessment suggests this could be up to 8% of GP time. We have used the NHS alliance data which constitutes the lower of the two figures
Total			£376,450	£0		

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Collaborative general practice						
Find & Treat			£286,000	(£1,426,581)	3,860 non-elective admission deflected for Diabetes, COPD, Hypertension, AF & Dementia	National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies for each disease group
Enhanced Pharmacy & Repeat Prescribing offer	5.5%		£2,000,000	(£5,000,000)	Not applicable	<ul style="list-style-type: none"> • GP 5 year forward view • The Journal of MedEconomics⁸ estimated that employing Pharmacists in Primary Care can save 7% of GP time just in dealing with patient medication queries generated by patient requests for prescriptions. This excludes other areas of GP workload that Pharmacy could impact • GP Magazine reported a reduction in GP workload of 30-40% through the employment of primary care Pharmacists across East London.
Enhanced physio offer	6.5%		£620,000	£0	Not applicable	<ul style="list-style-type: none"> • GP 5 year forward view • The Chartered Society of Physiotherapists suggests that up to 30% of GP appointments are for MSK and could be impacted by Direct Access Physiotherapy⁹ • Physio First, West Wakefield found that 20% of GP appointments were for MSK complaints. They were able to impact 70% of these appointments.¹⁰ <p>For consistency, we have used the lower Wakefield findings which gives a net impact of 14% on GP workload</p>
Mental wellbeing support			£450,556	£0	Not applicable	GP 5 year forward view
Neighbourhood treatment room & minor injury			£250,000	£0	Not applicable	GP 5 year forward view
Back office (EMIS)			£100,000	(£846,385)	5632 in Out Patient First appointments	GP 5 year forward view
Healthy Communities	3.5%		£571,514	£0	Not applicable	<ul style="list-style-type: none"> • NHS Five Year Forward View: Empowering People & Communities, • Realising the Value economic modelling & five year key impact: peer support, self-management education & health coaching, group activities to support health & wellbeing, asset based approaches in a health and wellbeing context, JSNA data. • We have assumed that this service supports the deflections already set out in the Extensivist model set out above
Neighbourhood clinical triage	5.0%		£100,000	(£27,175)	618 A&E (minors)	
Neighbourhood acute visiting	5.0%		£100,000	£0		
Total			£4,478,070	(£7,300,141)		



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DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Integrated multidisciplinary teams						
Remodelled Neighbourhood Teams	2.5%	20%	£2,115,902	(£10,864,874)	5,805 A&E Attendances 4,373 Non-elective admissions 3,058 Outpatient first appointments 21,591 Outpatient follow up appoint 569 Elective	<ul style="list-style-type: none"> The evidence for the impact on non-elective activity of what is called the Extensivist Care and Case Management approach ranges from 25-30% reduction for the high user cohort. This business case has used the findings from the Fylde Coast Extensive Care Approach due to its similarity to the Stockport Neighbourhood Model We have profiled the impact of the model on the top 6% of users in 2017-2019 and the top 15% of users in 2019-2021 The evidence for Falls Prevention is well documented and subject to NICE Guidance²
Home support worker night service			£428,558			
Neighbourhood Teams Extended Hours			£677,485			
Mental Health	3.5%		£704,648			
Integrated Fall Service			£428,200			
Home care support / Care home support		Additional 65 long term care packages (net 4% increase)	£1,190,579	(£2,300,000)	97 care home respite admissions 624 care home admissions 624 non elective admissions per week.	The Local Government Association undertook a review of the evidence regarding the impact of integrated care in general and case management specifically and found that there is evidence that it has resulted in a reduction in use of residential and nursing homes and an associated increase in use of home care services ³
Enhanced Allied Health Professionals (Borough wide)			£587,343		Not applicable	
Total			£6,132,715	(£13,164,874)		
Grand TOTAL			£10,987,235	(20,465,015)		



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Crisis Response						
Active Recovery						
Transfer to Assess						
Step Up/Step Down Beds						
Total			£1,102,521	(£4,730,373)		

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Ambulatory Care Unit			£1,290,300	(£3,778,164)	<ul style="list-style-type: none"> -2,028 Non Elective admissions 	<ul style="list-style-type: none"> The evidence base for both these areas is set out in the NHS England publication 'Transforming urgent & emergency care services in England, August 15'. AI is now a mandatory element within ED. <i>Ambulatory Emergency Care, The Middlesbrough Experience</i>, NHS Institute for Innovation and Improvement <i>Directory of Ambulatory Emergency Care for Adults</i>, NHS Institute for Innovation and Improvement, November 2012 <i>Kettering General Hospital NHS Foundation Trust Case Study</i>, June 2016 <i>Directory of Ambulatory Emergency Care for Adults</i>, version 3 was published in 2012 The Royal College of Physicians – Acute Medicine Task Force & endorsed by the College of Emergency Medicine, 2012 Implementing AEC
Ambulatory Illness (Primary Care Streaming)			£877,781	(£2,310,880)	<ul style="list-style-type: none"> -26,260 ED attendances 	
Total			£2,168,081	(£6,089,044)		

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Outpatients						
1. Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice			£41,000	(£816,662)	First Attendance -5,959 Follow Up -9,844	<ul style="list-style-type: none"> Results from Stockport 100 day Rapid Testing initiatives across Trauma & Orthopaedics, Gastroenterology (IBD and Fatty Liver Disease), Cardiology & Respiratory (Breathlessness clinic) and Diabetes. Hibbard et al, 'Supporting People to Manage Their Health' Kings Fund 2014 Derek Wanless – 'Our Future Health Secured – A review of NHS Funding and Performance' (2008) Lewisham Care Study by Dr B Fisher – Lewisham GP 2012 patient survey NHS Greenwich GP improvement and education programme Super 6 model of diabetes care Dr Partha Kar, Clinical Director Endocrinology/Diabetes, Consultant Physician, Portsmouth Hospitals NHS Trust, UK UCL GI diagnostic review initiative Chronic Kidney Disease in Tower Hamlets EMIS patient record review initiative Ashford CCG MSK clinical triage initiative
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5. Identifying outpatient activity that can be stopped			£9,555	(£59,718)	First Attendance -98 Follow Up -483	
6. Coordinated support for complex patients			£0	£0		
7. Stopping OP activity			£365,089	(£3,479,722)	First Attendance -7,407 Follow Up -25,301	
			£2,117,295	(£11,764,523)		

SUMMARY ECONOMIC CASE: APPENDICES

Abstract

This document describes the summary economic case for the implementation of the new models of care developed as part of the Stockport Together covering the period to 2020/21

Appendix 1 – Benefits Realisation

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
GP Practice						
Navigate and Signposting	5.5%		£376,450	£0	0	<ul style="list-style-type: none"> NHS Alliance 'Making Time in General Practice' suggests that 4% of GP time could be saved through enhanced navigation and signposting in General Practice.¹¹ Local assessment suggests this could be up to 8% of GP time. We have used the NHS alliance data which constitutes the lower of the two figures
Total			£376,450	£0		

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Collaborative general practice						
Find & Treat			£286,000	(£1,426,581)	3,860 non-elective admission deflected for Diabetes, COPD, Hypertension, AF & Dementia	National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies for each disease group
Enhanced Pharmacy & Repeat Prescribing offer	5.5%		£2,000,000	(£5,000,000)	Not applicable	<ul style="list-style-type: none"> • GP 5 year forward view • The Journal of MedEconomics⁸ estimated that employing Pharmacists in Primary Care can save 7% of GP time just in dealing with patient medication queries generated by patient requests for prescriptions. This excludes other areas of GP workload that Pharmacy could impact • GP Magazine reported a reduction in GP workload of 30-40% through the employment of primary care Pharmacists across East London.
Enhanced physio offer	6.5%		£620,000	£0	Not applicable	<ul style="list-style-type: none"> • GP 5 year forward view • The Chartered Society of Physiotherapists suggests that up to 30% of GP appointments are for MSK and could be impacted by Direct Access Physiotherapy⁹ • Physio First, West Wakefield found that 20% of GP appointments were for MSK complaints. They were able to impact 70% of these appointments.¹⁰ <p>For consistency, we have used the lower Wakefield findings which gives a net impact of 14% on GP workload</p>
Mental wellbeing support			£450,556	£0	Not applicable	GP 5 year forward view
Neighbourhood treatment room & minor injury			£250,000	£0	Not applicable	GP 5 year forward view
Back office (EMIS)			£100,000	(£846,385)	5632 in Out Patient First appointments	GP 5 year forward view
Healthy Communities	3.5%		£571,514	£0	Not applicable	<ul style="list-style-type: none"> • NHS Five Year Forward View: Empowering People & Communities, • Realising the Value economic modelling & five year key impact: peer support, self-management education & health coaching, group activities to support health & wellbeing, asset based approaches in a health and wellbeing context, JSNA data. • We have assumed that this service supports the deflections already set out in the Extensivist model set out above
Neighbourhood clinical triage	5.0%		£100,000	(£27,175)	618 A&E (minors)	
Neighbourhood acute visiting	5.0%		£100,000	£0		
Total			£4,478,070	(£7,300,141)		



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NEIGHBOURHOOD OUTLINE BUSINESS CASE EXECUTIVE SUMMARY

Abstract

This business case describes the integrated neighbourhood-based health and social care services, with primary care at the centre, which will be delivered in Stockport from 2017/18 to 2020/21.

Senior Responsible Officers:

Tim Ryley, Director of Strategy, Stockport CCG

Keith Spencer, Provider Director, Stockport Together

Executive Summary

Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to ensure the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

Business Case Overview

This paper sets out the case for integrated neighbourhood teams, which will be the main delivery model for out-of-hospital health and social care services.

The business case describes in detail the new model and the anticipated impact on the local system. It demonstrates the benefits of an integrated out-of-hospital model in terms of health outcomes, service user experience, workforce capacity and financial sustainability.

It sets out investment requirements and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business case identifies anticipated risks and the mitigations in place to maximise benefits.

The Case for Change

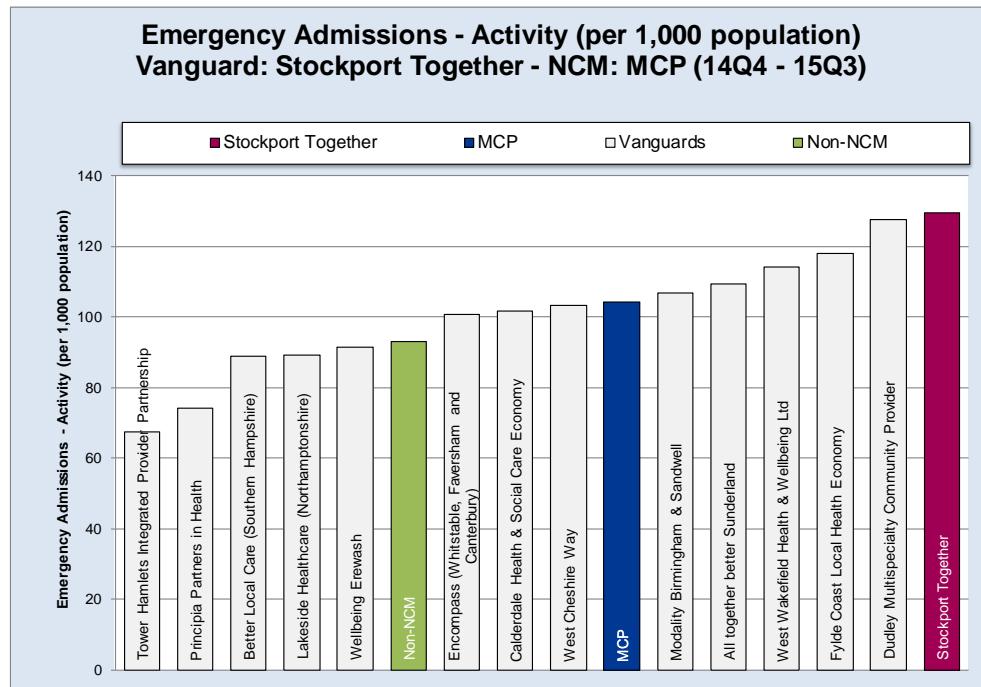
Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current form, Stockport's health and social care system is unsustainable. If working practices do not change, by 2020/21 there will be a funding gap of around **£156m**.

27% of the population (84,700) have at least one long-term condition. By age 60 this rises to 50% and by age 85, 88% of the population have at least one long-term condition. The number of Stockport residents aged 65 and over is set to rise from 55,700 to 61,000 by 2020. It is therefore estimated that the number of people living with a long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease.

Rising prevalence of dementia has also contributed to increasing complexity in social care. We know that there are 2,850 people in Stockport who have dementia, with a further 1,000 people undiagnosed – this is higher than the national average and increasing. By 2030 dementia prevalence will be 50% higher than it is currently. Emergency admissions for dementia have doubled in the last 8 years with 2,200 emergency admissions for dementia per year.

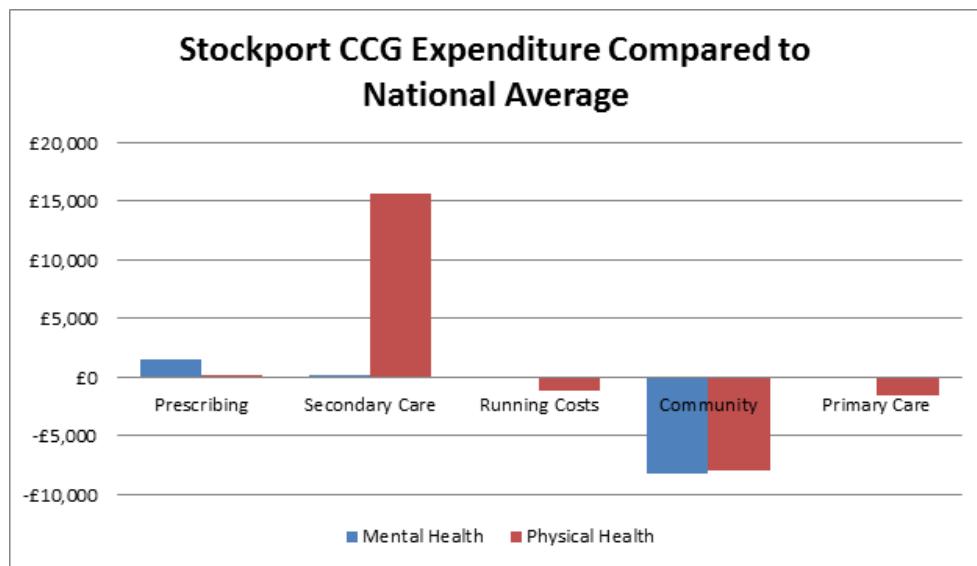
For many years, Stockport has had a much higher rate of emergency hospital admissions than peers or the England average. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living difficult.

Figure 1: Emergency Admissions Rates



High rates of expensive non-elective admissions have resulted in a chronic underfunding of primary and community services. Stockport spends £5.43 a head less on primary care than Greater Manchester colleagues. Compared to the national average, Stockport over-funds hospital care and underfunds both physical and mental health out of hospital.

Figure 2: Stockport CCG Spending Compared to the National Average



If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be an economy deficit of around **£156 million**. The current system is also unsustainable in terms of workforce capacity, with significant recruitment challenges for: Consultants; GPs; nurses; and social workers. Even if we had the resources to fund growing demand, it is unlikely that we would have the professional workforce to run an enlarged version of the existing system.

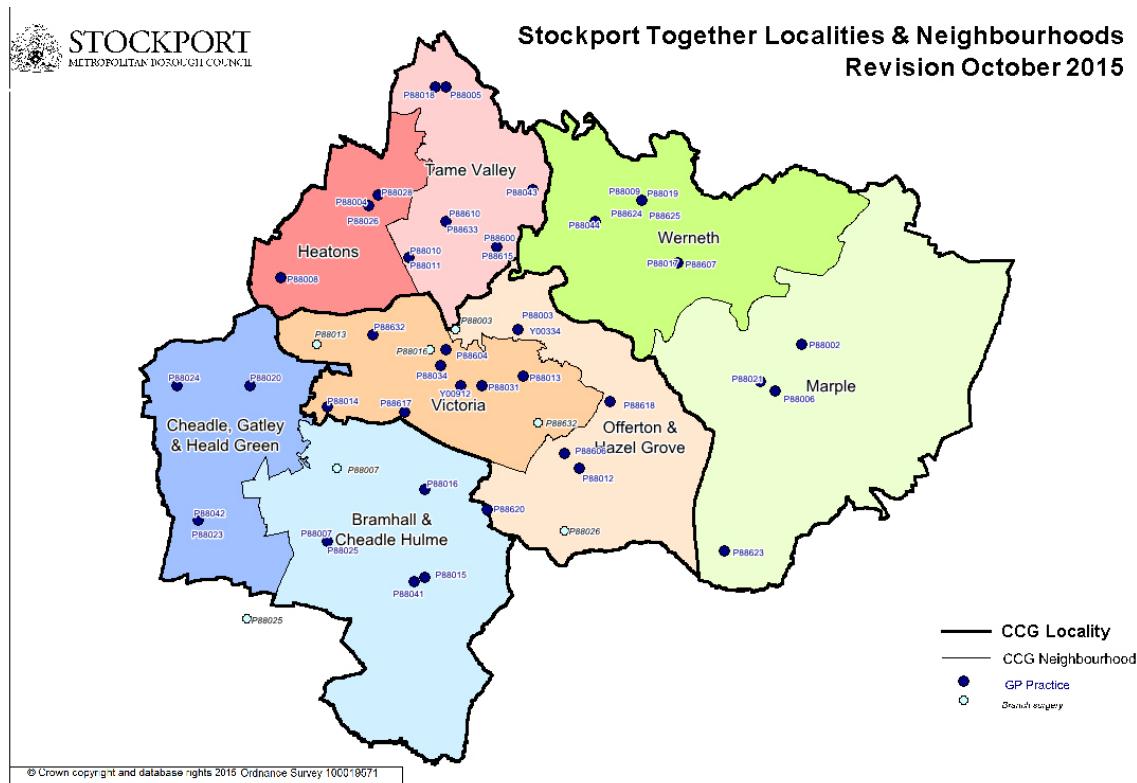
The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets.

Stockport Together's vision is an integrated health and social care service supporting people to improve their health, care and wellbeing outcomes. Through education, early intervention and prevention people will remain healthier for longer. Where people do develop a complex condition, services will be delivered close to home through neighbourhood teams, reducing the need to access hospital based services. We will deliver high quality care and support that is personalised and coordinated around the needs of people, their family and carers.

The fundamental building block of our new health and care system will be 8 integrated neighbourhood teams which will bring together primary care, community healthcare, mental health and adult social care services, as well as some aspects of third sector provision.

Figure 3: Neighbourhoods Map



Neighbourhood leadership will be provided by a general practitioner, supported by senior nursing, therapeutic and social work colleagues, who will together ensure that services meet the needs of local people. Services will offer seven-day access and support people to remain healthy, build independence and manage long-term conditions.

Figure 4: Neighbourhoods Structure



The model is one of early intervention, prevention and self-care. It promotes parity of esteem between physical and mental health and will provide greater support to care homes. The Neighbourhood operating model will deliver services 24/7 365 days a year and will be built around the following key components:

1. **Safe and Sustainable General Practice** where the capacity is created to enable GPs to focus on delivering more intensive, proactive and personalised care for people with long-term conditions at practice level
2. **Collaborative General Practice Operating at Scale** working collectively across a Neighbourhood to provide defined services 'at scale' where it is more efficient and cost effective to do so, including medicines management, find and prevent, 7-day working, safeguarding, use of treatment rooms, and intensive case management
3. **Integrated 24/7 Community Health and Care Teams** serving GP registered populations in multidisciplinary teams to support those most at risk of admission through: Intensive Case Management and a co-ordinated Response to Deterioration; a new falls prevention service; new blended roles across Health and Social Care; a Stockport Care Co-ordination Centre; self-care and self-management through a comprehensive Third Sector offer; investment in Mental Health Services embedded in neighbourhood teams; a new enhanced home care offer and a step-change in the quality and capacity of the external social care workforce to support independence.

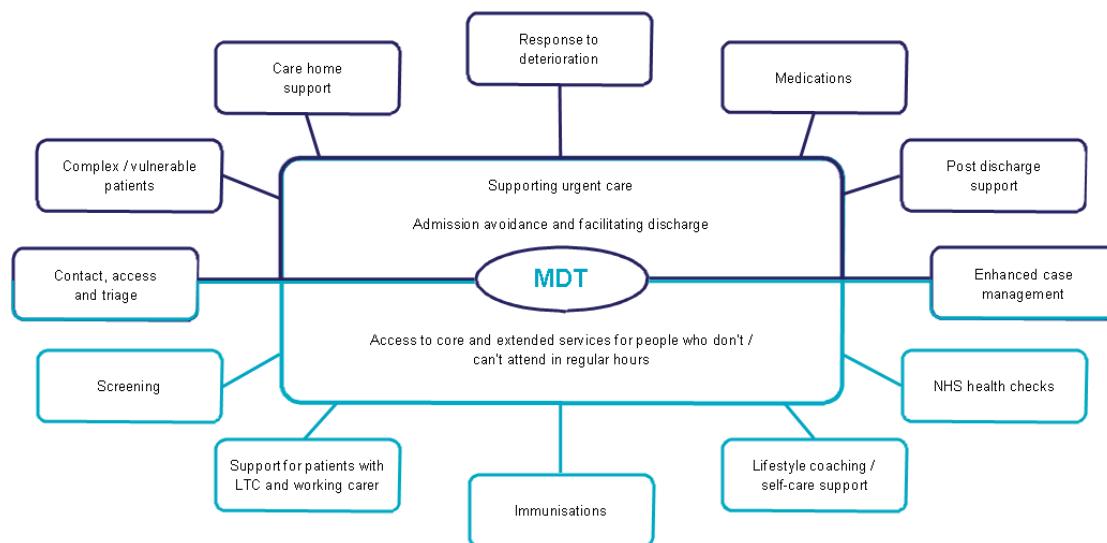
Table 1: Core Components of the Neighbourhood Model

Core Component	Service Developments
Safe and Sustainable General Practice	National financial uplift
	Greater Manchester standards
	Long-term Conditions Management
	Improved workflow
	Navigation
Collaborative General Practice at Scale	7-day access
	Acute visiting and clinical triage
	Direct Access Physiotherapy

	Mental Wellbeing Support
	Find & Prevent
	Self-Care
	Medicines reviews
	Specialist peer GPs and other clinicians
	Interventions to release capacity at the hospital
	Back office support
Integrated 24/7 Community Health and Care Teams	MDT approach including AHP and 7 day elements
	Enhanced Care Home Team
	Additional Mental Health (and IAPT realignment)
	Falls Prevention Service
	Home Care

Multi-Disciplinary Teams will support Stockport patients using a single shared record and care plan. Specialist resources will be drawn in to support individuals when needed. Extended Hours and weekend opening times will be used to support urgent care, to prevent admissions, to facilitate early discharge from hospital and to provide access to core services for people who cannot attend in regular hours.

Figure 5: Extended Hours and Weekend Service



Benefits of the Model

Stockport Together's proposed service solution will provide a comprehensive out-of-hospital service that meets the increasingly complex care needs of our ageing population.

The earlier identification and treatment of disease, as well as addressing low level social and mental health issues, will support people to better manage their health. Greater investment in care nearer home and in a proactive, preventative approach will enable us to keep people independent at home and address health inequalities. The community falls prevention service will reduce injuries among people over 65 by 330 and save around £518k on admissions relating to fractures.

Table 2: Anticipated Activity Deflections

Anticipated Deflections	Number	Percentage
ED attendances	6,400	-19%
Non-Elective admissions	5,100	-25%
Outpatient first attendances	30,200	-10%
Outpatient follow up appointments		-17%
Elective admissions	1,300	-37%
Care Home Beds	721	

Through this business case there will be significant investment in out of hospital services. In total, workforce capacity will be increased by 24%, delivering over 2,000 additional practitioner hours per day Monday to Friday. Community Pharmacists will continue to be an important part of the wider team, providing: advice and support for patients with minor ailments; advice and support around lifestyle change; and Health Check services.

Table 3: Increase in workforce capacity

Core Component	Current FTE	2020/21 FTE	Increase (%)
General Practice	857	905	6%
Collaborative General Practice	71	137	94%
Integrated Multi-Disciplinary Teams	249	395	59%

Investment Plan

This business case proposes making an initial investment of **£11.21m** in 2017/18 into neighbourhood teams. By 2020/21 a recurrent investment of £14.29m will deliver a benefit of **£20.47m** and a net benefit position of **£9.477m**.

Table 4: Cost benefit Analysis of fully implemented model (2020/21)

Cost-Benefit Analysis	Re-provision Cost 2020/21	Reduction in GP workload	Activity Reduction 2020/21	Benefit 2020/21
GP Practice				
Navigate & Signposting	£376,450	5.5%		£0
GM Standards	£1,500,000			£0
Total	£1,876,450			£0
Collaborative General Practice				
Find & Treat	£286,000		3,860 NELs	£1,426,581
Enhanced Pharmacy offer	£2,000,000	5.5%		£5,000,000
Enhanced Physio offer	£620,000	6.5%		£0
Mental Wellbeing support	£450,556			£0
Neighbourhood treatment room	£250,000		5,632 GP 1sts	£0
Back Office (EMIS)	£100,000			£846,385
Healthy Communities	£571,514	3.5%		£0
Neighbourhood clinical triage	£100,000	5.0%	618 ED attends	£27,175
Neighbourhood acute visiting	£100,000	5.0%		£0
Primary Care 7 Day Service	£1,800,000			£0
Total	£6,278,070			£7,300,141
Integrated Multi-Disciplinary Teams				
Remodelled Neighbourhood Teams	£2,115,902	2.5%	5,805 ED attends	£10,864,874

Home support worker night service	£428,558		4,373 Non-electives 3,058 1 st outpatients	
Neighbourhood Teams extended hours	£677,485		21,591 follow-ups	
Mental Health	£704,648	3.5%	569 electives	
Integrated Fall Service	£428,200			
Home care / Care Home support	£1,190,579		97 care home respite 624 home admissions 624 NELs a week	£2,300,000
Enhanced Allied Health Professionals	£587,343			£0
Total	£6,132,715			£13,164,874
GRAND TOTAL	£14,287,235			£20,465,015

For primary care, there is a total investment of **£10.04m** (£32.41 per head) which includes: £1.87m (£6.22 per head) to ensure a safe and sustainable general practice; £1.55m (£5 per head) to deliver the GM standards for primary care; and £6.28m (£20.47 per head) to deliver collaborative general practice.

Risk Management

The business case identifies the main risks to the success of this model as:

- Failure to curb the demand for acute hospital urgent and planned care
- Failure to effectively implement the new service model
- Failure to increase out-of-hospital capability and capacity by recruiting a new type of workforce whilst retaining, developing and retraining existing team
- Failure to successfully reduce the system-wide cost of delivering health and social care services to our population.

Mitigation plans are set out in the business case to ensure full realisation of benefits.

Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans.

Stockport Together will undertake a 'listening period' from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

If agreed, the plans would be fully implementation by April 2019.

NEIGHBOURHOOD OUTLINE BUSINESS CASE

Abstract

This business case describes the integrated neighbourhood based health and social care services, with primary care at the centre, which will be delivered in Stockport from 2017/18 to 2020/21

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Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

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1 Executive Summary

Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to ensure the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

Business Case Overview

This paper sets out the case for integrated neighbourhood teams, which will be the main delivery model for out-of-hospital health and social care services.

The business case describes in detail the new model and the anticipated impact on the local system. It demonstrates the benefits of an integrated out-of-hospital model in terms of health outcomes, service user experience, workforce capacity and financial sustainability.

It sets out investment requirements and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business case identifies anticipated risks and the mitigations in place to maximise benefits.

The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current form, Stockport's health and social care system is unsustainable. If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be a funding gap of around **£156m**.

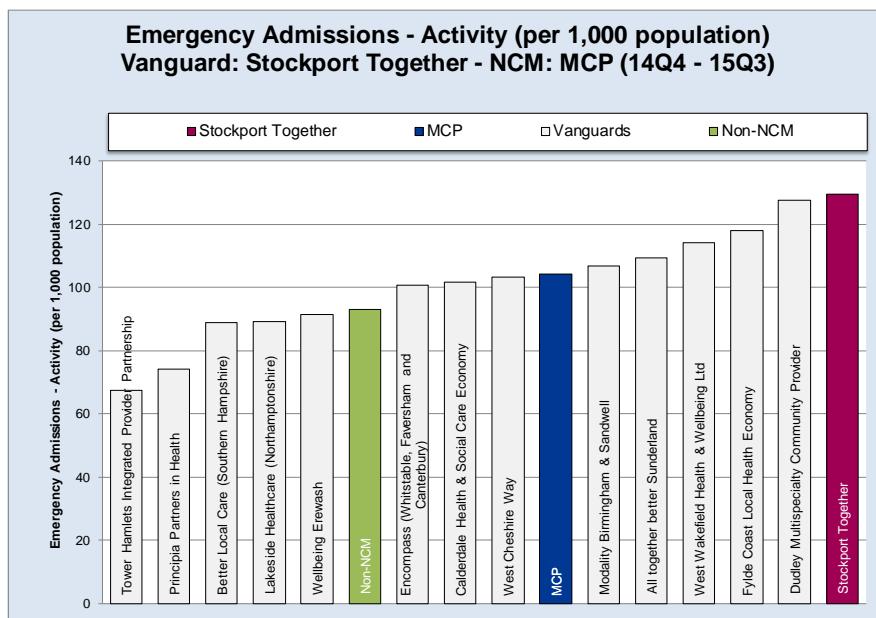
27% of the population (84,700) have at least one long-term condition. By age 60 this rises to 50% and by age 85, 88% of the population have at least one long-term condition. The number of Stockport residents aged 65 and over is set to rise from 55,700 to 61,000 by 2020. It is therefore estimated that the number of people living with a long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease.

Rising prevalence of dementia has also contributed to increasing complexity in social care. We know that there are 2,850 people in Stockport who have dementia, with a further 1,000

people undiagnosed – this is higher than the national average and increasing. By 2030 dementia prevalence will be 50% higher than it is currently. Emergency admissions for dementia have doubled in the last 8 years with 2,200 emergency admissions for dementia per year.

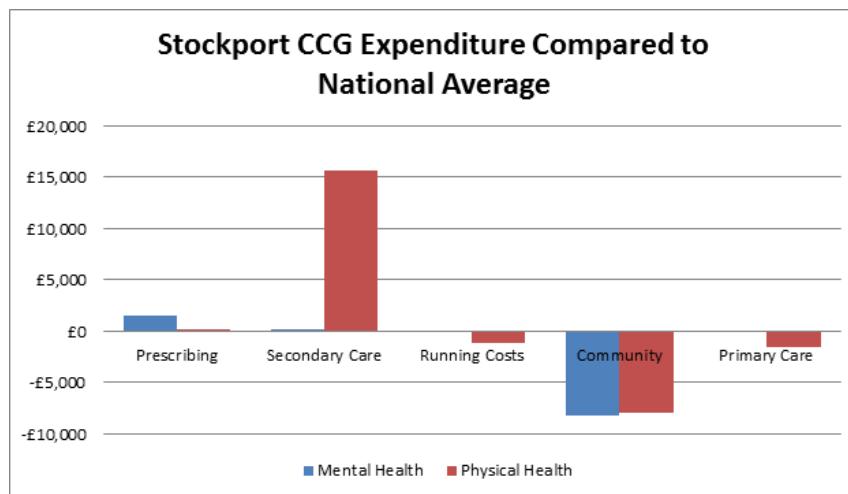
For many years, Stockport has had a much higher rate of emergency hospital admissions than peers or the England average. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living difficult.

Figure 1: Emergency Admissions Rates



High rates of expensive non-elective admissions have resulted in a chronic underfunding of primary and community services. Stockport spends £5.43 a head less on primary care than Greater Manchester colleagues. Compared to the national average, Stockport over-funds hospital care and underfunds both physical and mental health out of hospital.

Figure 2: Stockport CCG Spending Compared to the National Average



If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be an economy deficit of around **£156 million**. The current system is also unsustainable in terms of workforce capacity, with significant recruitment challenges for: Consultants; GPs; nurses; and social workers. Even if we had the resources to fund growing demand, it is unlikely that we would have the professional workforce to run an enlarged version of the existing system.

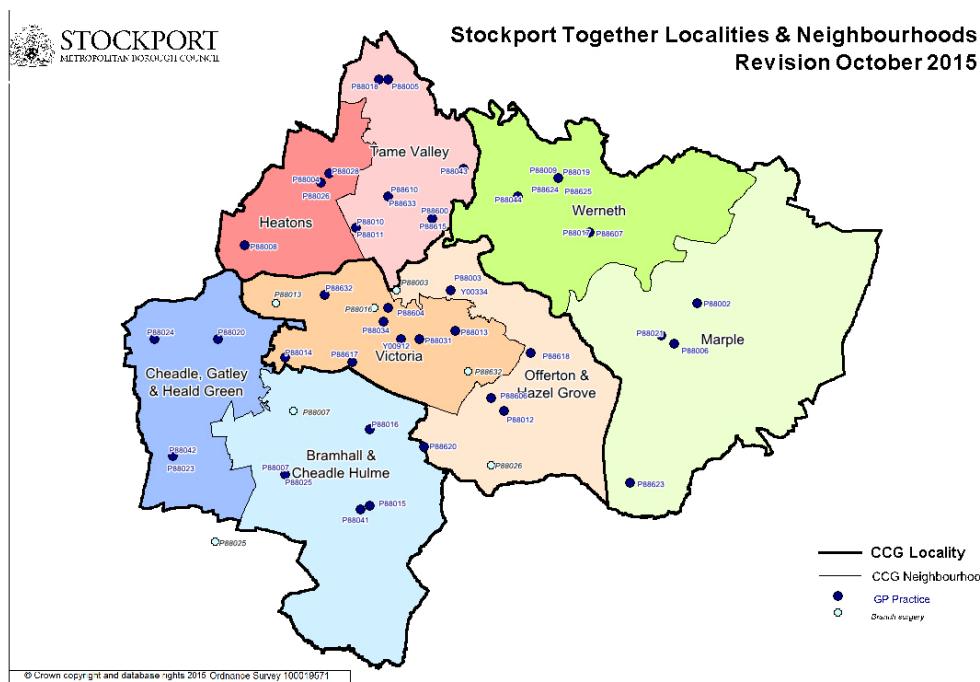
The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets.

Stockport Together's vision is an integrated health and social care service supporting people to improve their health, care and wellbeing outcomes. Through education, early intervention and prevention people will remain healthier for longer. Where people do develop a complex condition, services will be delivered close to home through neighbourhood teams, reducing the need to access hospital based services. We will deliver high quality care and support that is personalised and coordinated around the needs of people, their family and carers.

The fundamental building block of our new health and care system will be 8 integrated neighbourhood teams which will bring together primary care, community healthcare, mental health and adult social care services, as well as some aspects of third sector provision.

Figure 3: Neighbourhoods Map



Neighbourhood leadership will be provided by a general practitioner, supported by senior nursing, therapeutic and social work colleagues, who will together ensure that services meet the needs of local people. Services will offer seven-day access and support people to remain healthy, build independence and manage long-term conditions.

Figure 4: Neighbourhoods Structure



The model is one of early intervention, prevention and self-care. It promotes parity of esteem between physical and mental health and will provide greater support to care homes. The Neighbourhood operating model will deliver services 24/7 365 days a year and will be built around the following key components:

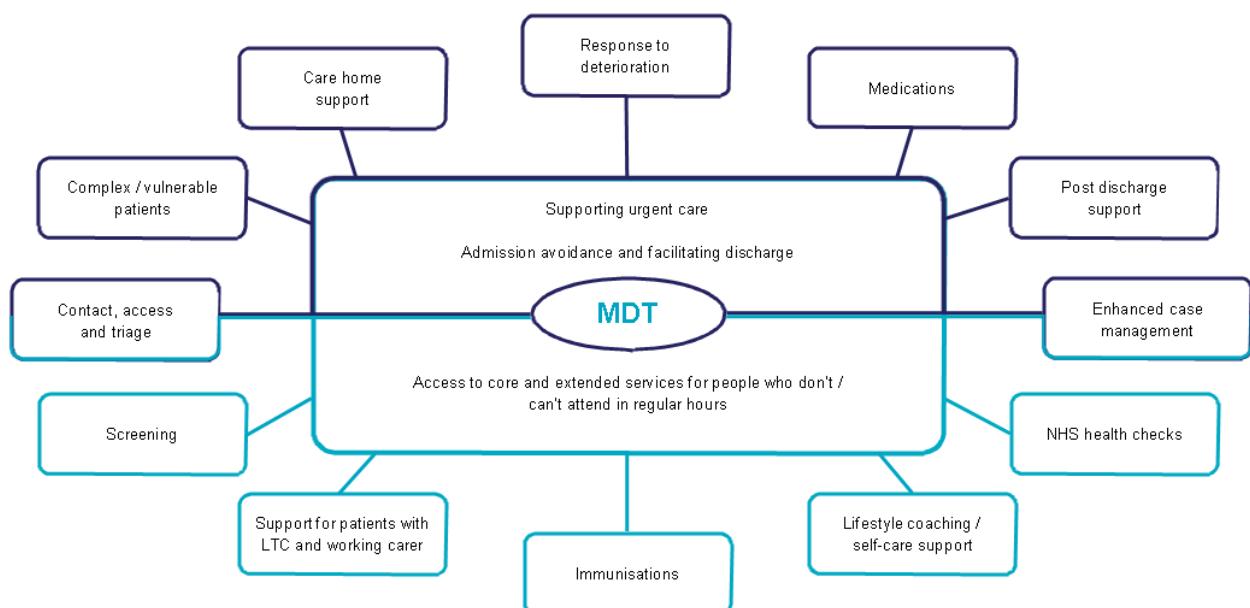
- 1. Safe and Sustainable General Practice** where the capacity is created to enable GPs to focus on delivering more intensive, proactive and personalised care for people with long-term conditions at practice level
- 2. Collaborative General Practice Operating at Scale** working collectively across a Neighbourhood to provide defined services 'at scale' where it is more efficient and cost effective to do so, including medicines management, find and prevent, 7-day working, safeguarding, use of treatment rooms, and intensive case management
- 3. Integrated 24/7 Community Health and Care Teams** serving GP registered populations in multidisciplinary teams to support those most at risk of admission through: Intensive Case Management and a co-ordinated Response to Deterioration; a new falls prevention service; new blended roles across Health and Social Care; a Stockport Care Co-ordination Centre; self-care and self-management through a comprehensive Third Sector offer; investment in Mental Health Services embedded in neighbourhood teams; a new enhanced home care offer and a step-change in the quality and capacity of the external social care workforce to support independence.

Table 1: Core Components of the Neighbourhood Model

Core Component	Service Developments
Safe and Sustainable General Practice	National financial uplift
	Greater Manchester standards
	Long-term Conditions Management
	Improved workflow
	Navigation
Collaborative General Practice at Scale	7-day access
	Acute visiting and clinical triage
	Direct Access Physiotherapy
	Mental Wellbeing Support
	Find & Prevent
	Self-Care
	Medicines reviews
	Specialist peer GPs and other clinicians
	Interventions to release capacity at the hospital
	Back office support
Integrated 24/7 Community Health and Care Teams	MDT approach including AHP and 7 day elements
	Enhanced Care Home Team
	Additional Mental Health (and IAPT realignment)
	Falls Prevention Service
	Home Care

Multi-Disciplinary Teams will support Stockport patients using a single shared record and care plan. Specialist resources will be drawn in to support individuals when needed. Extended Hours and weekend opening times will be used to support urgent care, to prevent admissions, to facilitate early discharge from hospital and to provide access to core services for people who cannot attend in regular hours.

Figure 5: Extended Hours and Weekend Service



Benefits of the Model

Stockport Together's proposed service solution will provide a comprehensive out-of-hospital service that meets the increasingly complex care needs of our ageing population.

The earlier identification and treatment of disease, as well as addressing low level social and mental health issues, will support people to better manage their health. Greater investment in care nearer home and in a proactive, preventative approach will enable us to keep people independent at home and address health inequalities. The community falls prevention service will reduce injuries among people over 65 by 330 and save around £518k on admissions relating to fractures.

Table 2: Anticipated Activity Deflections

Anticipated Deflections	Number	Percentage
ED attendances	6,400	-19%
Non-Elective admissions	5,100	-25%
Outpatient first attendances	30,200	-10%
Outpatient follow up appointments		-17%
Elective admissions	1,300	-37%
Care Home Beds	721	

Through this business case there will be significant investment in out of hospital services. In total, workforce capacity will be increased by 24%, delivering over 2,000 additional practitioner hours per day Monday to Friday. Community Pharmacists will continue to be an important part of the wider team, providing: advice and support for patients with minor ailments; advice and support around lifestyle change; and Health Check services.

Table 3: Increase in workforce capacity

Core Component	Current FTE	2020/21 FTE	Increase (%)
General Practice	857	905	6%
Collaborative General Practice	71	137	94%
Integrated Multi-Disciplinary Teams	249	395	59%

Investment Plan

This business case proposes making an initial investment of **£12.1m** in 2018/189 into neighbourhood teams. By 2020/21 a recurrent investment of **£10.98m** from savings elsewhere plus £3.4m additional investment into primary care will deliver a benefit of **£20.47m** and a net benefit position of **£9.477m**. As indicated in the table below this is one of the two major contributors to the overall financial benefit of the programme.

Table 4: Cost benefit Analysis of fully implemented model (2020/21)

Investment & Savings by business case	£'000						
	Investment			Benefit			Net Benefit
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2020/21
Acute Interface	£2,500	£2,334	£2,168	(£4,871)	(£6,089)	(£6,089)	(£3,921)
Intermediate Care	£2,457	£1,532	£1,103	(£3,275)	(£4,003)	(£4,730)	(£3,628)
Neighbourhood	£12,106	£11,445	£10,987	(£11,170)	(£14,907)	(£20,465)	(£9,478)
Outpatients	£2,280	£2,128	£2,117	(£6,833)	(£9,150)	(£11,765)	(£9,647)
TOTAL	£19,344	£17,439	£16,375	(£26,150)	(£34,149)	(£43,049)	(£26,674)

In total for primary care (Stockport Together and CCG additional investments), there is investment of **£10.04m** (£32.41 per head) which includes: £1.87m (£6.22 per head) to ensure a safe and sustainable general practice; £1.5m (£5 per head) to deliver the GM standards for primary care; and £6.28m (£20.47 per head) to deliver collaborative general practice.

Risk Management

The business case identifies the main risks to the success of this model as:

- Failure to curb the demand for acute hospital urgent and planned care
- Failure to effectively implement the new service model
- Failure to increase out-of-hospital capability and capacity by recruiting a new type of workforce whilst retaining, developing and retraining existing team
- Failure to successfully reduce the system-wide cost of delivering health and social care services to our population.

Mitigation plans are set out in the business case to ensure full realisation of benefits.

Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans – subject to appropriate public involvement.

Stockport Together will undertake a ‘listening period’ from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

If agreed, the plans would be fully implementation by April 2019.

2 Introduction

The Stockport Together partners are undertaking a fundamental change in the way health and social care services are delivered, organised and commissioned. The full strategic case for change was set out in the **Stockport Together Overview Business Case** published in July 2016 in which we described a series of more detailed business cases to follow. This business case is **one of that series of cases** that together will collectively build a **system level change** in the way services are delivered. We refer to this new service model in its totality as the **Integrated Service Solution**.

This business case focuses on the way most local adult health and social care out of hospital services will be delivered. This includes general practice, community health services, community mental health services, adult social care and some aspects of third sector provision. It describes the fundamental building block of the whole new Integrated Service Solution and the reformed health and social care system it sits within.

The key concepts contained within this business case are;

- Services will be delivered through fundamentally reshaped and integrated neighbourhood teams
- The model is one of early intervention, prevention and self-care
- GP capacity will be increased through efficiency gains, a significant financial uplift and a reshaped primary care workforce
- There will be significantly increased community based support for those with one or more long-term conditions and those who are at risk of developing a long-term condition/s
- The model ensures parity of esteem with physical and mental health (with appropriate funding distribution)
- There is greater support for care homes
- Neighbourhoods will use a wide range of technology to deliver enhanced efficiency, improve access and expand patient choice

3 Public consultation

These business cases seek approval on proposals for investments in health and social care. Collectively, they set out plans that we are developing for the future of health and social care in Stockport.

These proposals will eventually look to move resources from hospital services to more community based care to better manage future demand and growth in health and social care.

The Health and Social Care Act 2012 places a requirement on Clinical Commissioning Groups to ensure public involvement and consultation in commissioning processes and decisions. It includes involvement of the public, patients and carers in:

- Planning of commissioning arrangements, which might include consideration of allocation of resources, needs assessment and service specification.
- Proposed changes to services which may impact on patients

In July, following the completion of the business case presentation through formal governance processes the pre-consultation period will begin and will seek to:

- Build on the case for change and transformation of services
- Demonstrate -that all options, benefits and impact on service users have been considered.

- Demonstrate - that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals

Following this a formal public consultation period will take place which will facilitate genuine and meaningful involvement to ensure we can reach, inform, communicate and formally consult with local people from Stockport including staff who work in health and social care services.

4 Vision

The vision is for integrated health (physical, mental and primary care) and social care services to support local people to improve their health, care and wellbeing outcomes. Through education, early intervention and prevention people will remain healthier for longer and be less likely to develop a long-term condition. Where people do develop a complex condition, wherever possible, services will be delivered close to home through neighbourhood teams, reducing the need to access hospital based services.

We will deliver high quality care and support that is personalised, joined up and coordinated around the needs of people, their family and carers.

5 Case for Change

Local drivers

The health and social care system in Stockport is unsustainable in its current form. If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be a c£156m deficit. This will be driven by inflation (wages, fuel, technology, medical advances) and demographic pressure from an ageing population outstripping any growth in resources.

The consequence will be a reduction in both the range and quality of services we provide unless we undertake significant transformation in the way in which those services are configured. We are already seeing the impact of the deficit compounding the pre-existing challenges in the urgent care system. So, for example, we have been consistently one of the poorest performers in England against the national Accident and Emergency (A&E) standard waiting time and delays to discharge from hospital. Currently A&E performance at the end of 2016 was around 80% against a target of 95% and delayed transfers of care were at c9% rather than 3.5%.

The pressures we are already facing will, if we do not change the way services are configured, be compounded by six further factors.

5.1.1 **Growth in people living with long-term conditions and complexity of need**

Table 5, below details the eight most prevalent long-term conditions in Stockport¹.

Long-term condition	Number
Hypertension	44,745
Anxiety	30,085
Depression	29,100
Asthma	20,545
Obesity	20,050 ²
Diabetes	15,700
Coronary heart disease	12,230
History of falls	12,150

27% of the population (84,700) have at least one of these eight conditions and this increases with age, from 2% in the 0-4 age band, to 88% in those aged 85 and over. By age 60, half of the people have one or more of these conditions and 15% of the population have two or more of eight key long-term conditions. Many more may also have a condition which is currently undiagnosed. It is estimated that the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport this will equate to an additional 47,700 people living with a condition.

This population is getting older and in Stockport the number of people aged over 65 will increase from 55,700 in 2014 to 61,000 by 2020. As people age, the likelihood of them developing long-term conditions and complexity of social care needs increases. Currently 124,000 people or 51% of the total adult population of Stockport are known to have one or more long-term conditions. 26,500 people have two or more conditions. By the age of 65, 58% have at least one and 20% have two or more. By the age of 85 this has risen to 87% and 53% respectively.

Prevalence of dementia has contributed to increasing complexity in social care. We know that there are 2850 people in Stockport who have dementia, with a further 1000 people living with dementia who have not had a diagnosis. Dementia prevalence is higher than the national average and increasing. By 2030 dementia prevalence will be 50% higher than it is currently. Emergency admissions for dementia have doubled in the last 8 years with 2200 emergency admissions for dementia per year.

We know that currently 70% of all health and social care spend is driven by people with one or more long-term conditions and 50% of GP appointments and 7 out of 10 hospital beds are

¹ Stockport JSNA [click here](#)

² Undercount of actual prevalence

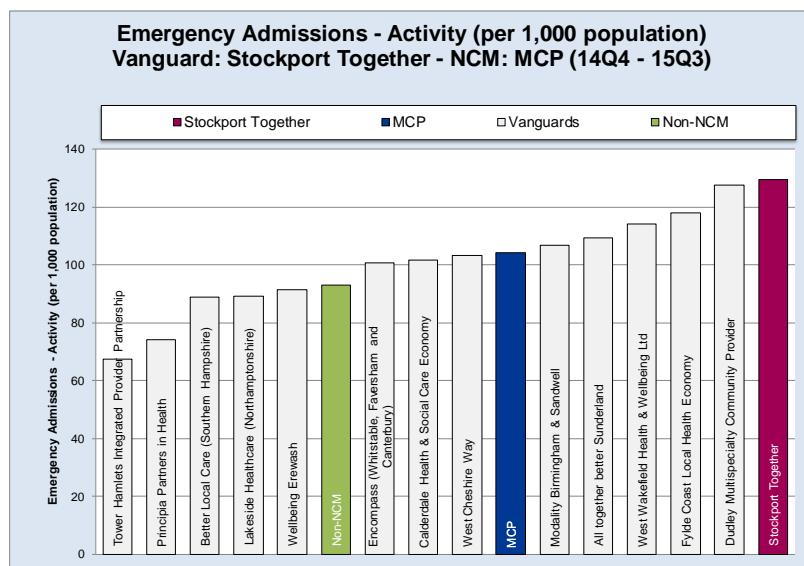
Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

utilised by these individuals. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are overdue for an appointment for a long-term condition.

5.1.2 High Non-Elective Bed Utilisation

Stockport has for many years had much higher than England and peer group non-elective admission rates per head of population. Stockport admits 37% more people to hospital as an emergency admission than the England average; our emergency admission rate for this cohort is also double the average for the North-West. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living difficult.

One of many peer comparisons is shown below (**Figure 1**).



If we look to understand what is driving this locally we know that:

- 15% of the population as at June 2016 accounted for 50% of all A&E attendances and 79% of all emergency admissions during the period July 2015 to June 2016.
- Within this cohort at least 36% of these admissions (14,885 admissions) were in some way sensitive to ambulatory care and therefore potentially avoidable.
- 13% of all emergency admissions among those over 65 were from Care Homes
- There is considerable variation in admission by neighbourhood even when the population is weighted for need (87.6 per 100,000 to 61.2 per 100,000.)
- However, access to general practice as reported by the population in national surveys is better than in many areas.

5.1.3

Underfunding of community and primary care services

General Practice and Community Health and Social Care Services (both physical and mental health) have been underfunded for many years compared to others. This is a consequence of the over use of expensive hospital beds which consume a disproportionate amount of the Stockport budget; and at the same-time, it in part contributes to high admissions. Breaking this cycle is fundamental to this business case.

The underfunding of community based health services has been compounded in recent years by the reduction in funding available for social care nationally which has impacted locally. This has had a significant impact on the capacity of frontline assessment staff and the sustainability and quality of the market locally.

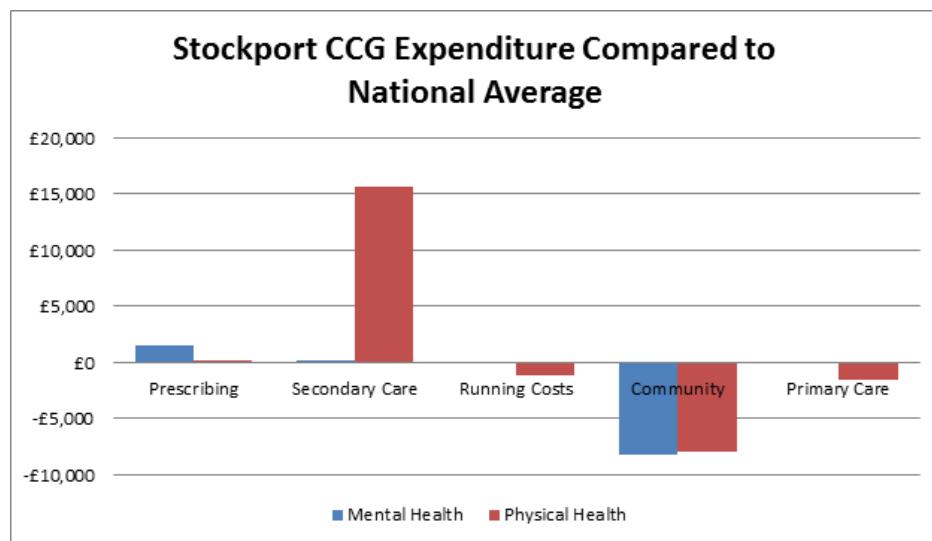
More specifically, Stockport General Practices are the lowest funded per head of population in Greater Manchester. Much of this reflects ***national weighting of population need***, but as we have seen there is national recognition of under-funding in general practices across the board.

Table 6 - Relative spend per weighted head of population Stockport to Greater Manchester

GP services			GP premises			Other	Total
Contract	QOF	Enhanced	Reimbursement	Other	Void & subsidy		
-£3.95	£1.94	£0.91	-£0.97	-£0.01	-£3.04	-£0.31	
	-£1.10			-£4.02		-£0.31	-£5.43

Similarly, the number of new referrals seen by community nursing has fallen by 22% in the last two and a half years. Social care has significant market pressures with 181 care homes beds lost since June 15, increased demand of 1274 home care hours between Jan 16 and Jan 17, and there is a current deficit of 1047 home care hours unmet. Whilst additional funding has been provided through the new government allocation, this only supports immediate pressures and does not address the long-term changes required. As the following Figure (**Figure 2**) shows, Stockport CCG currently over funds physical health in secondary care and underfunds both physical and mental health in the community when compared to national averages;

Figure 2 – Stockport CCG expenditure compared to national average



5.1.4 Resource allocation and redistribution

The resources available for health and social care are distributed in such a way that a cycle of low alternatives to admission, high admissions, extended lengths of stay, low access to reablement is perpetuated. This is alongside a focus on physical health needs over those of mental health. Benchmarking of the Stockport system reflects this. The data source is 2013/14 programme budgeting with adjustments for known significant investments.

Table 7 Spend benchmarking

Service	Spend benchmarks as	Benchmark Range
Primary Care	Low	£0m-£5m
Community Services	Low	£6m-£10m
Mental Health	Very Low	£10m-£15m
Urgent Care *	Very High	£10m-£15m

* note this is the commissioner benchmark and so excludes above tariff costs in acute providers estimated to be a further £12m.

The proposed business cases aim to break the current cycle by re-deploying resources out of acute urgent capacity and providing a transformed, properly resourced, model of care across primary care and community services which is able to identify and respond to mental health needs on an equal basis to physical health.

5.1.5 Fragmentation and inefficiency in existing services

Currently when we talk about community based health and social care services we are describing a plethora of individual services each with their own line management structures, numerous referral and assessment processes, multiple electronic and paper records, different operating hours and competing expectations. This leads delays in and fragmentation of service delivery for individuals and carers and to frustration for professionals working in this environment. There is little sense of working together for the benefit of an individual and owning their care collectively at a local level.

5.1.6 Recruitment

In most areas, there are significant recruitment challenges; Consultants, GPs, nursing and social workers. Even if we had the resources to fund them it is very unlikely in the next few years that we would have the available professional workforce to run an enlarged version of the existing system. At the non-registered end of the workforce there is considerable competition in the market for non-skilled and semi-skilled workers with very high employment rates locally.

5.1.7 Adult social care capacity

Currently most resources are targeted at crisis response (responding to significant deterioration, carer breakdown, care package breakdown, safeguarding etc.). This limits the amount of proactive support adult social care can undertake in terms of care planning, making use of community assets, better tailoring of packages and regular review. It also limits capacity to work more intensively with individuals with the most complex needs.

Additional social care capacity will allow resources to be more effectively targeted to focus on preventing, reducing and delaying need as set out under Care Act. Specifically:

- Proactive support will enable Adult Social Care to improve planning, make better use of community assets, tailor packages to the person (thus reducing package breakdown), and regularly review so that packages can be reduced over time where appropriate.
- Reduced caseload for social workers so that they can offer a more intensive response to people with complex needs
- Greater capacity to work with 'new' cases emerging as a result of the care act (vulnerable adults)

Locally we face a significant challenge. We will need to spend the Stockport £ in a more efficient way addressing the underlying demographic and inflationary challenges, and the longstanding over hospitalisation and fragmentation of the existing system. The

development of strong neighbourhood teams described in this business case is the most fundamental part of our wider response to this challenge.

National and regional drivers

Whilst Stockport has a particularly pressing position and its own specific factors influencing this, these challenges face the NHS and social care nationally, and both the NHS and the Greater Manchester Health and Social Care Partnership (GM) have responded with a set of expectations which this business case is designed to respond to.

5.2.1 NHS Five Year Forward View

The Five Year Forward View sets out an expectation that decisive steps will be taken to break down the barriers between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centers, organised to support people with multiple health conditions, not just single diseases.

There is an acknowledgement that England is too diverse to have a “one size fits all” model of care and that local health communities will be expected to choose from among a range of new radically different care delivery options. The option chosen locally because of the need to rebalance the community-hospital relationship is the Multispecialty Community Provider (MCP). This encourages groups of GPs to combine with nurses, other community health services, hospital specialists and mental health, social care and voluntary sector to create integrated out-of-hospital care taking delegated control of the local NHS budget.

The five year forward view requires the NHS to take action on prevention, invest in new models of care, help sustain social care and address inefficiency in the system. In doing so it expects the NHS to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade.

The recently released five year forward review, “Next Steps on the Five Year Forward View”, continues to reflect these themes and especially emphasises:

- Continued commitment to general practice,
- Urgent care system improvement including discharge,
- Additional support to Mental Health care,
- Helping frail and older people stay healthy and independent and
- The creation of accountable care systems

5.2.2 GP Forward View

The Five Year Forward View stated that the foundation of NHS care will remain list-based primary care, and that there would be a new deal for GPs given the pressures they are under.

The Forward View for General Practice described that over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention, but this will take time to address existing workforce issues. Part of the solution will be the need to make general practice more attractive.

The General Practice Forward View recognises that most observers concur that solutions to the challenges facing general practice “lie in a combination of investment and reform” and require action from CCGs and practices themselves. It continues to recognise that GPs’ core role will be to provide first contact care to patients with undifferentiated problems and provide continuity of care where this is needed, but also to act as leaders within larger multi-disciplinary teams working at different organisational levels, for example, their own practice, a neighbourhood of practices and across the local health economy.

It emphasises that local systems should encourage and support general practices to work together at scale in a variety of new forms enabling greater opportunities for them to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary sector organisations.

5.2.3 Care Act 2014 and Deprivation of Liberty Safeguards

The Care Act 2014 consolidated good practice in statute as well as bringing in new reforms. It required councils to extend personalisation in social care as well as increasing the focus on wellbeing and prevention. It also expected local authorities and partners to have a wider focus on the whole population in need of care, rather than just those with eligible needs and/or who are state-funded. In particular:

- There is a new statutory principle of individual wellbeing which underpins the Act, and is the driving force behind care and support.
- There is a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities e.g. health and housing.
- Information advice and guidance to the whole population, not just those with eligible social care needs
- Responsibilities to prevent, reduce and delay the need for social care support, including offering preventative services to people that do not meet the threshold for social care services
- Assessment and review of eligibility under new national eligibility criteria
- Duty to assess and plan with carers in their own right and to offer personal budgets where eligibility criteria is met
- Responsibilities to shape market and prevent and mitigate against market failure

- Responsibility to undertake Best Interest assessments and Court of Protection work for an increased cohort of individuals under Deprivation of Liberty Safeguards.

5.2.4 High Impact Changes

Stockport Together will be implementing high impact changes which will support the reduction in delayed transfers of care. As outlined in **table 8**, the neighbourhood business case drives a range of relevant interventions / service development;

Table 8 – high impact changes - DTOC

High Impact Change	Intervention / Service Development
1: Early discharge planning	<ul style="list-style-type: none"> • In reach approach via integrated teams and Multi-Disciplinary Team (MDT) planning (urgent care). • Additional community resources (integrated teams, reablement, voluntary and community sector) on hand to enable discharge plans across 7 days per week.
2: Monitoring patient flow	<ul style="list-style-type: none"> • Single integrated discharge team in place as part of Intermediate Tier arrangements able to track in-patient and care home bed capacity electronically across system.
3: Multi-Disciplinary Team approach	<ul style="list-style-type: none"> • MDT's with GP at the centre delivered by neighbourhood business case. • Top 15% of users supported via MDTs. • Voluntary sector and care navigators key MDT members.
4: Discharge to assess	<ul style="list-style-type: none"> • Intermediate Tier business case implementing transfer to assess and already operational in a number of areas. • Investment within neighbourhood case into packages of care is essential to enable this.
5: Seven-day services	<ul style="list-style-type: none"> • Neighbourhood business case delivers 7-day services. • Up to 2000 addition hours per day provided by neighbourhood business case. • Expanded GP and integrated models provide more services closer to home, 7 days per week.
6: Trusted assessor	<ul style="list-style-type: none"> • Integrated teams and intermediate tier

	<p>are moving to trusted assessor approach.</p> <ul style="list-style-type: none"> • Those returning to residential homes after an episode hospitalisation through assessment of other appropriately trained staff (no need for home staff to make in hospital assessment).
7: Focus on choice	<ul style="list-style-type: none"> • Personalised care planning to be introduced. • Care navigators to provide additional personalised planning to support access to third sector.
8: Enhancing health in care homes	<ul style="list-style-type: none"> • Increased support for care homes provided by neighbourhood business case. • Increased GP and pharmacist time for care homes. • New care home support team to support quality improvement.

5.2.5 Greater Manchester Health and Social Care Partnership

In December 2015, all the GM partners agreed the five-year plan for the conurbation. This focussed on four big areas of change. Two of which this business case makes a significant contribution towards.

Radical upgrade in population health & prevention

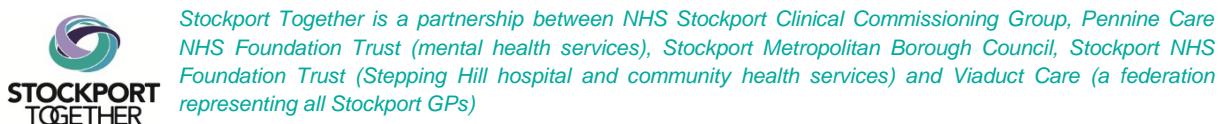
It is expected that in each locality there will be a fundamental change in the way people and communities take charge of – and responsibility for – managing their own health and wellbeing, whether they are well or ill. It is expected that this will include exploring the development of new relationships between NHS and social care staff and the public who use services; finding the thousands of people who are currently living with life changing health issues and do not even know about them and investing far more in preventing ill health. There is a desire that more people start well, live well and age well.

Transforming care in neighbourhoods

There should be the development of local care organisations where all sectors (GPs, hospital doctors, nurses, other health professionals, social care and the voluntary sector) come together to plan and deliver care. This will mean that when people need support from public services it's largely in their community, with hospitals only needed for specialist care.

Association of Directors of Adult Social Services (ADASS) Transformation Programme

The ADASS Transformation Programme identifies a range of priorities outlined in the **Figure 6** below:



Priorities for action and delivery in 2017/18

<p>Residential & Nursing Care</p> <ul style="list-style-type: none"> ➢ Convene a GM strategic provider forum to co-design the solutions required for residential and nursing care settings ➢ Co-produce an agreed model of care and specification for residential and nursing care with service users and providers ➢ Develop an assessment of estates investment needed to support solutions identified ➢ Strengthen links with primary care for those in residential and nursing homes to reduce urgent care impact ➢ Build a strategic partnership with CQC, developing a shared approach to performance and improvement ➢ Develop a proactive system response to service failure, to build on good practice and improve quality 	<p>Care at Home</p> <ul style="list-style-type: none"> ➢ Support definition of development contracts for localities with near-term contract expiry and/or market risks ➢ Co-produce an agreed model of care and specification for care at home with service users and providers ➢ Mobilise work in support of a sustainable workforce, with focus on skills development and career pathways ➢ Develop approach to deployment of the Apprenticeship Levy, to help build a pipeline for the social care workforce ➢ Work with LCOs to develop a GM market position statement on future services and expected outcomes ➢ Define and pilot different models of care at home focused on the needs of individuals
<p>Learning Disabilities</p> <ul style="list-style-type: none"> ➢ Create an LD service user/provider forum to support co-design with service users and their families and providers ➢ Implement a GM-wide ethical commissioning framework ➢ Scope a review of supported living and supported housing ➢ Build on existing good practice to increase the scale of family-based care (eg Shared Lives model) across GM ➢ Build on good practice to develop and implement a scalable approach to employment for those with LD ➢ Creating a single commissioning and procurement function for people with high-level complex needs 	<p>Support for Carers</p> <ul style="list-style-type: none"> ➢ Develop a memorandum of understanding to gain agreement across GM on the approach to carer support ➢ Scope approach to common information, advice and support ➢ Develop a rights based carers' charter setting out what carers in GM can expect ➢ Develop a carers' champion network across health and social care organisations ➢ Develop an approach to carers and employment and seek sign up from private and public sector organisations
<p>Process</p> <ul style="list-style-type: none"> ➢ Agree a single GM approach to discharge 	<p>2</p> <ul style="list-style-type: none"> ➢ Agree a single GM approach to assessment

Therefore, the local challenges are reflections of those identified nationally and within Greater Manchester, and the national and regional bodies have prescribed how we are expected to respond. Local circumstances and national directives require a radical change in service delivery and organisational approaches.

5.3 In-scope

The principle service areas directly **in scope** of this business case are:

- All adult services provided by Stockport NHS Foundation Trust through its community contract.
- All adult services provided in the community by Pennine Care NHS Foundation Trust, excluding Learning Disabilities and drug and alcohol services.
- All non-core services provided through general practices in Stockport and through their local GP Federation Viaduct Care.
- Several pertinent services provided by the Targeted Prevention Alliance (TPA).)

The model will be developed for the whole GP adult registered population.

6 The proposed Neighbourhood model

6.1 Model Introduction

Considering the challenges set out above, Stockport Together has ambitious plans for health and social care services in Stockport. The Neighbourhood model, as described in this document has been co-designed with service users, carers and staff and it responds directly to the wider strategic objectives of Stockport in the following ways:

- Clinically safe and sustainable.
- Supports the achievement of financial sustainability.
- Improves health and social care outcomes and reduces inequality.
- Addresses the need to further integrate health and social care services with primary care at the centre, particularly for those people with long-term conditions.
- Addresses the need for pathway redesign, enabling more patients to be supported in a community setting, closer to home.
- Promotes early intervention and self-care to help address the biggest causes of premature death in Stockport.
- Enables people to maintain their health, wellbeing and independence at home for as long as possible by promoting self-management, community resilience and choice.
- Enables long-term cost management and reduction through early intervention and prevention.
- Builds safer and stronger communities and enables communities to meet their own needs.
- Promotes health improvement.
- Gives staff the autonomy and time to care.
- Enables people to develop solutions that fit their needs rather than the needs of their organisation.
- Is based on the best available national and international evidence.

6.2 The high-level neighbourhood model

The Neighbourhood model addresses the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport. It meets Stockport's strategic objectives by creating a system in which:

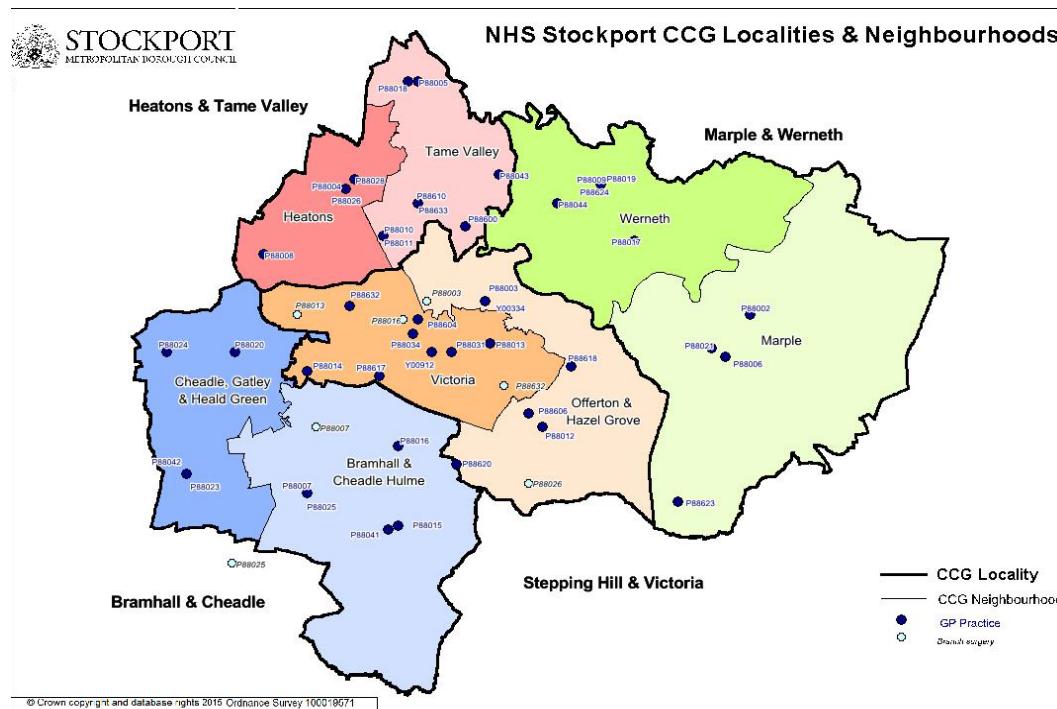
- High quality care and support is delivered that is personalised, joined up and coordinated around the person.
- People will be more in control of their own health and wellbeing.
- Primary care is sustainable and is the fundamental building block upon which integrated health and social care is delivered.

- Progressive and impactful integration overcomes fragmentation, and resources are deployed to where they are most needed.
- The focus of service delivery changes from the current illness management approach to early intervention and prevention.
- More focus is given to developing resources in the community that can support the required transformation.

There will be a range of approaches to support the health and wellbeing of the 85% of the population without chronic health needs, and intensive, highly integrated approaches for the 15% of the population with chronic health needs who are most at risk of admission to hospital

Future services will be delivered from eight neighbourhoods;

Figure 3 – Localities and neighbourhoods



As set out in the following Figure (Figure 5), the neighbourhood model will see integrated services, with Primary Care at its centre, working with people and communities to collaboratively achieve improved health and social care outcomes. There will be an increased focus on addressing wider determinants of poor health and building healthy lifestyles.

Figure 4 – Neighbourhood structure

Our plan is to implement a Neighbourhood operating model that will deliver services 24/7, 365 days per year and which will be built around the following key components;

Safe and Sustainable General Practice:

- Where General Practice has sufficient resource, of the right kind, to provide services which are fit to meet the needs of the practice population and ensure the positive wellbeing of staff.

Collaborative General Practice Operating at Scale:

- Where General Practice is able to work collectively across a Neighbourhood to provide defined services 'at scale' where it is more efficient and cost effective to so do including medicines management, find and prevent, 7-day working, safeguarding, use of treatment rooms and intensive case management.

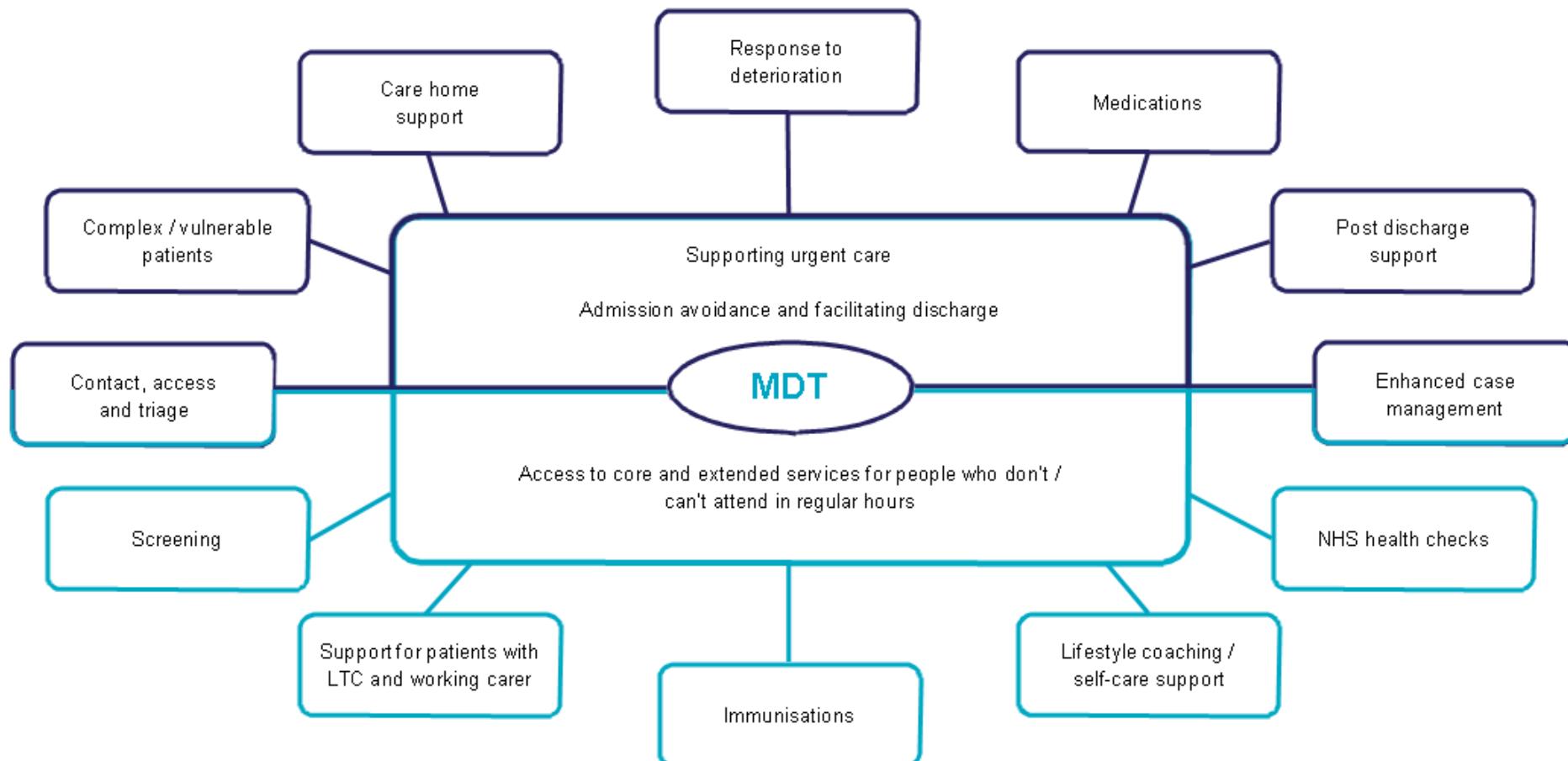
Integrated 24/7 Community Health and Care Teams

- The mobilisation of 8 teams serving GP registered populations and consisting of primary and community health, mental health, social care, and third sector practitioners working together in multidisciplinary teams.
- Teams that are resourced (with 24% more staff) and trained around a new service model to address the demand and capacity consequences of working intensively with the 15% of the population most at risk of admission including a new falls prevention service.
- Promulgation of a new 'can-do' culture amongst staff with a greater emphasis on the pre-registered workforce and new blended roles across Health and Social Care.
- A Single, fully integrated Contact, Access and Triage point integrated from Year 2 with Intermediate tier hub to create a new Stockport Care co-ordination Centre
- Implementation of Intensive Case Management and a co-ordinated Response to Deterioration for the 15% most at risk of admission.
- Where communities are empowered to enable self-care and self-management through a comprehensive Third Sector offer.
- Where Mental Health Services are invested in, refocused towards Neighbourhood working and embedded alongside neighbourhood teams.
- A new enhanced home care offer and a step-change in the quality and capacity of the external social care workforce in order to support more people to remain at home.

6.3 7 day / extended hours

Services will operate an extended ours model covering 7-days per week, with flexibility to meet the needs of local population. For example, some neighbourhoods may offer more early morning appointments and others later appointments depending on the local requirement. Specific details around the GP, social worker and community nursing offers can be found in **sections 6.8.1 and 6.9**. The Figure below lays out the seven day - extended hours / weekend component of MDT service delivery;

Figure 5 – Extended hours and weekend services



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

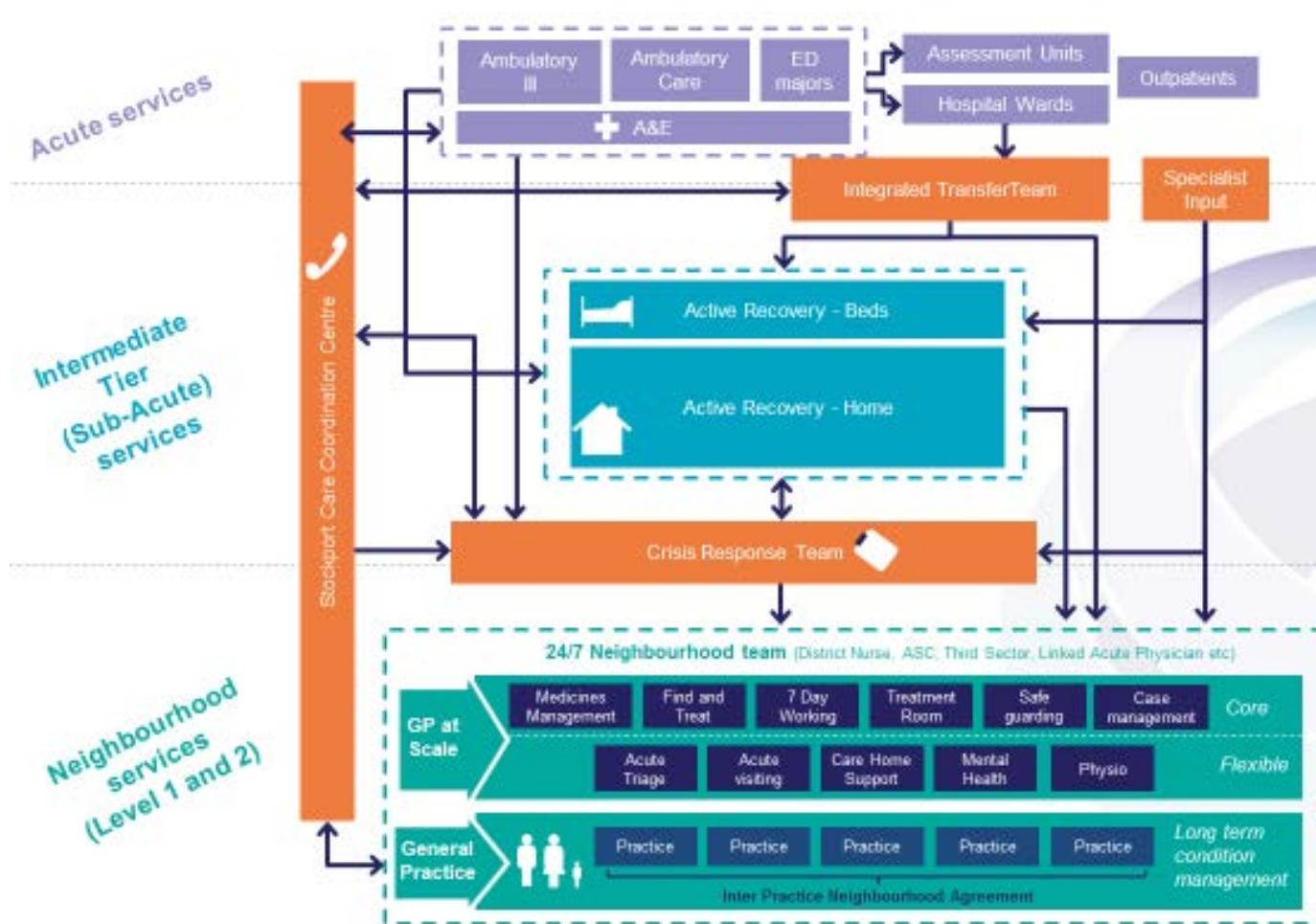
6.4 Structure and responsibilities within the neighbourhood model

6.4.1 Structure

The neighbourhood model is one of integrated health and social care, with primary care at its centre, embedded in local neighbourhoods. All components of the model are responsible for and focused on delivering improved, person centred health and social care outcomes.

Figure 7, below, shows where the neighbourhood teams sit in the overall Stockport Model;

Figure 7 – Neighbourhood model and relationship with the wider Stockport Together model



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Table 1, below sets out the detail of the specific service developments that are contained within each of the three core components of the Neighbourhood model;

Core Component	Service Developments
GP practice	National financial uplift
	Greater Manchester standards
	Long-term Conditions Management
	Improved workflow
	Navigation
Collaborative General Practice	7-day access
	Acute visiting and clinical triage
	Direct Access Physiotherapy
	Mental Wellbeing Support
	Find and Prevent
	Self-Care
	Medicines reviews
	Specialist peer GPs and other clinicians
	Interventions to release capacity at the hospital
	Back office support
Integrated Community Team	MDT approach including AHP and 7 day elements
	Enhanced Care Home Team
	Additional Mental Health (and IAPT realignment)
	Falls
	Home Care

The individual service developments are described in more detail in **sections 6.7, 6.8 and 6.9** of this document.

6.4.2 Neighbourhood leadership

The neighbourhood leadership team will consist of a neighbourhood appointed GP, social worker, community nurse and practice manager. This team will be responsible under a Neighbourhood Integration agreement for;

- Deployment of resources within the neighbourhood.
- Shaping resources to meet the local need.
- Owning the local delivery of health and social care outcomes.
- Representing the neighbourhood in the wider system.

As part of the implementation of the funding arrangements for the core neighbourhood business case and the implementation of the transitional management structure for the MCP, Neighbourhood Leads will be appropriately resourced to take up their leadership responsibilities and engage fully with their respective Neighbourhood Teams.

6.4.3 Neighbourhood management

It is recognised that each neighbourhood will need a management and back office infrastructure. This need is not considered or costed within the neighbourhood business case. A complete review of management need will be conducted by providers with view to redistributing existing resource and capability to meet the needs of neighbourhoods. The underpinning premise, as determined by the Stockport Together Leadership, is that no additional funding will be required.

6.4.4 Business intelligence

The new model of care requires a step change in provision of business intelligence (BI), particularly around identifying the key MDT cohort/s and those at high risk of developing a long-term condition (find and prevent service). Specific additional capacity of 1 FTE for BI support to the find and prevent services is allocated via this business case. The wider additional need for BI support is being considered outside of this business case and anticipated to be resourced through redistribution of existing system personnel with the underpinning premise of no additional funding requirement.

6.4.5 Multidisciplinary integrated teams with primary care at the centre

MDT's will support the 15% of patients who have a chronic health condition through;

- Integrating services around the individuals and their carers.
- Utilising single shared record and care plan.
- Drawing in specialist resources and support including mental health when required.
- Considering individual's physical, mental and social care needs.
- Enabling greater independence.
- Addressing wider determinants of good health, care and wellbeing outcomes by collaboration with the third sector.

6.4.6 Neighbourhood relationship with boroughwide services

Neighbourhoods will be supported by access to intermediate tier services including;

- Crisis response for patients in exacerbation (short term, 72-hour support).
- Step-up bed capacity.
- Coordinated discharge services.
- Specialist services (e.g. diabetes, COPD, falls etc.)
- End of life coordination.

6.4.7 Neighbourhood relationship with the Acute setting

Neighbourhoods will work closely with acute colleagues to;

- Gain advice, support and access to specialist colleagues.
- Provide enhanced post-acute care support closer to home.
- Ensure effective information sharing is in place to support patient care and timely discharge.
- Ensure correct referrals and reduced inappropriate referrals.

6.4.8 Indemnity

It is not anticipated that the new neighbourhood model will present many issues around indemnity. A specific concern raised was in relation to supporting patients registered with another practice. In support of writing this business case, checks were performed with a number of insurers including MPS, MDU and MDDUS. All the checked providers of relevant insurance are updating their policies to reflect the needs of Primary Care in England. Whilst specific wording varies the core theme is that 'hub activity' would be covered so long as;

- Work is undertaken during the scheduled opening hours of the practice (within 8am-8pm seven days a week) where registered patients are seen by appointment and where staff have access to the patient's full general practice records.
- Patients from other practices are included where there is an arrangement to provide care during scheduled opening hours and there is access to full patient records.

All independent practitioners should seek direction from their insurer, based upon their specific circumstances prior to commencement of the neighbourhood model.

6.5 Neighbourhood workforce

6.5.1 System level

The overall neighbourhood workforce has been constructed to meet the needs of the population of Stockport and to prevent, reduce and delay people needing to access health and social care support and resources. Specific considerations have been;

- Expected activity levels by professional group.
- Levels of activity deflection from the acute setting.
- Levels of activity diversion between professional groups (particularly supporting the release of GP time / capacity.)
- Opportunities to integrate across health and social care.
- The intention to support more people to self-care.

- The move towards early intervention and prevention.

The information presented in this section is underpinned by national evidence. It is however recognised that the population profile and need varies across each of the neighbourhoods. Neighbourhood leaders will therefore have the opportunity to alter the balance of the workforce to ensure it delivers maximum benefit to the local population.

The neighbourhood business case delivers an increase in total workforce. **Table 3** sets out the current workforce in each core component and the increase in workforce by 20/21;

Core Component	Current FTE	2020/21 FTE	Increase (%)
General practice	839	895	7%
Collaborative general practice	47	114	141%
Integrated multidisciplinary teams	249	395	59%
Total	1134	1403	24%

Not only does this business case provide additional resource across all core components of the neighbourhood model, it also supports the reshaping of both primary care and the wider neighbourhood workforce model. Specifically, additional resource is being provided to support the diversion of activity from GP's and the move to early intervention and prevention.

As detailed in **table 9** at neighbourhood level, the average number of staff available to support patients increases by 269 FTE, providing an additional 2000 hours of care per day (Monday to Friday). As stated above this increase in capacity is understated because it omits other sources of non-business case funding which will also increase GP practice capacity;

Model component / Staff group	Available resource		
	Number of staff (FTE)	Hours available per day	
System wide	1134	1403	8508 10524

The staff referred to in **tables 3 and 9** will be based in neighbourhoods.

6.5.2 Neighbourhood level

Each neighbourhood will deliver the whole service described in this document. There will however be variance between neighbourhoods in workforce configuration / staffing mix reflecting a weighted population based on;

- The size of each area's population;
- A weight, or adjustment, per head for need for health care services related to age (all else being equal, areas with older populations typically have a higher need per head);
- A weight, or adjustment, per head for need over and above that due to age (all else being equal, areas with poorer health have a higher need per head);

- A weight, or adjustment, per head for unmet need and health inequalities;

Table 10, below, gives detail of the weighted population;

Neighbourhood	% of weighted pop	Weighted pop
Bramhall	17.1%	57617
Victoria	15.7%	52778
Tame Valley	15.4%	51849
Heatons	12.6%	42403
Werneth	10.6%	35759
Cheadle	10.4%	34962
Stepping Hill	9.5%	31883
Marple	8.7%	29406
Grand Total	100.0%	336656

The ‘starting workforce’ for each neighbourhood has yet to be determined and will be addressed during the development of the operational plan.

Community pharmacists, whilst not direct members of the MDT, will continue to be an important part of the wider team, providing;

- Advice and support for patients with colds and minor ailments.
- Advice and support around lifestyle change.
- Health check services.

6.6 Safe and Sustainable General Practice and Collaborative general practice

6.6.1 Built from the GP forward view

Developing safe and sustainable General Practice is central to the neighbourhood model. The model will:

- Create the necessary capacity that will enable General Practice to focus on delivering more intensive, proactive and personalised care for people with Long-term conditions.
- Use standardised care pathways across Stockport to optimise care for people with long-term conditions reducing unnecessary variation, particularly in relation to falls prevention and diabetes.
- Maximise face to face appointments for those who need them with extended appointments for patients with the most complex conditions / situations.
- Create the capacity and legal framework that will allow practices to work together across a Neighbourhood to provide defined services ‘at scale’ where it is more efficient and cost effective to do so.
- Create a series of core offers which must be delivered at scale at neighbourhood level including medicines management, find and prevent, 7-day working, physiotherapy,

mental wellbeing, safeguarding, treatment rooms, case management, response to deterioration and re-provision of services.

The neighbourhood model is built from the GP Forward View and the ten high impact actions to release capacity in general practice. These are set out in **table 11**, below;

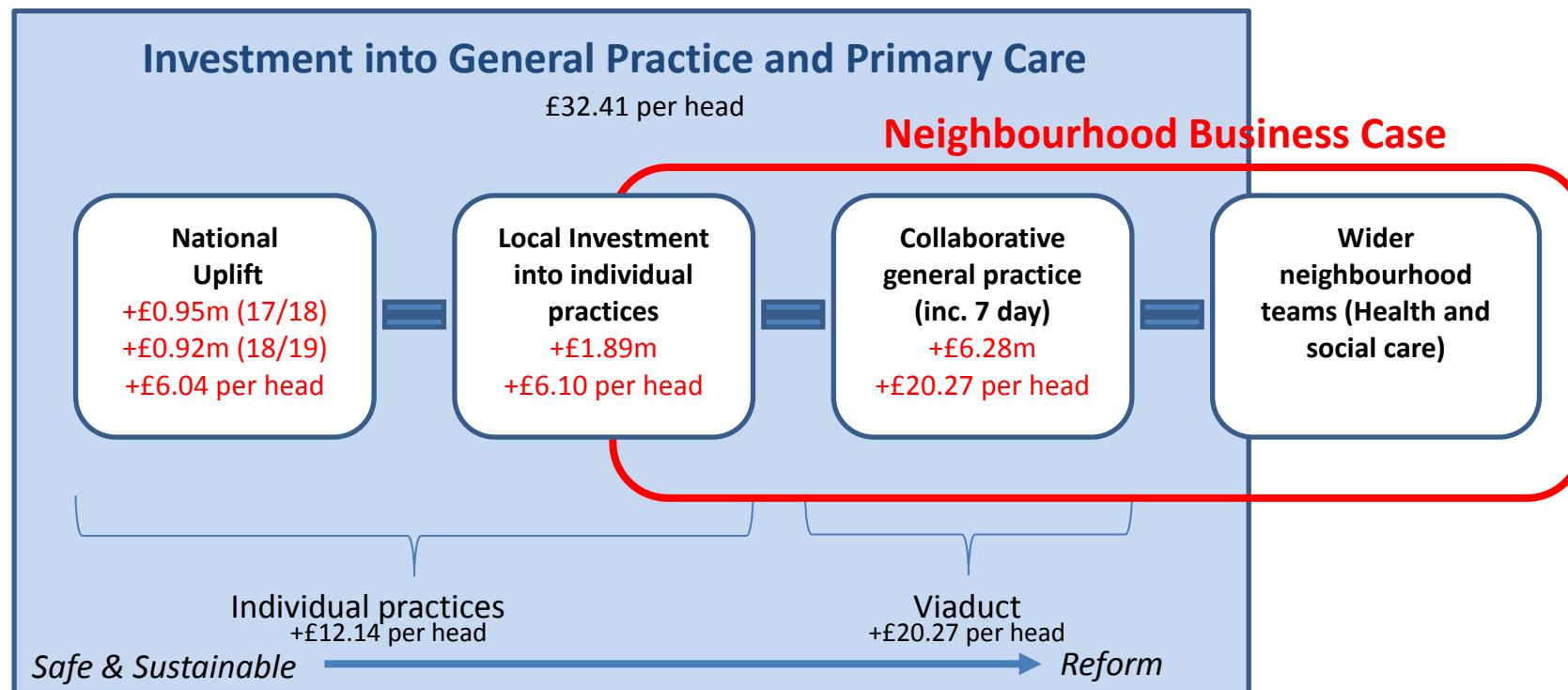
High Impact Action	Delivered through
Active signposting	<ul style="list-style-type: none"> Receptionists will be provided with additional training to enable them to direct patients to the most appropriate source of help. Self-help and self-management resources will be available in print and digital formats.
New consultation type	<ul style="list-style-type: none"> Expanded use of phone, remote and e-mail consultation will ensure convenience for all patients and improve capacity and efficiency.
Reduced DNAs (did not attend)	<ul style="list-style-type: none"> Increased number and variety of appointments will ensure relevance and convenience for patients. 7-day services will support patients to gain appointments at the most appropriate time for them so reducing the likelihood of DNA. Online booking and cancellation will support slots to be simply freed up. E-mail and text reminders will be used routinely.
Develop the team	<ul style="list-style-type: none"> Multidisciplinary teams will support the most complex patients. New primary care workforce models will bring together GP's, physiotherapists, community pharmacists and nursing staff to ensure patients can see the right person, first time.
Productive workflows	<ul style="list-style-type: none"> Reduced organisational boundaries will simplify workflow and the patient journey. Introduction of standardised processes across pathways will reduce variation and simplify working practices. Continued increase in the use of digital workflow management approaches will increase efficiency and productivity.
Personal productivity	<ul style="list-style-type: none"> Routine processes will be simplified. Standardisation of IT systems will occur. Enhanced skills training will be available to all staff.
Partnership working	<ul style="list-style-type: none"> General practice will be supported and encouraged to build new ways of working across neighbourhoods which build resilience and efficiency. Barriers to partnership working will be reduced through partnership agreements, blurring of organisational boundaries and a neighbourhood approach to governance (rather than organisational.)
Social prescribing	<ul style="list-style-type: none"> A full healthier communities programme will support patients to address wider determinants of good health, care and wellbeing outcomes. Community navigators will be embedded on primary care.

	<ul style="list-style-type: none"> • Online directories will support people to find the right support for them.
Support self-care	<ul style="list-style-type: none"> • Self-care coaches will support those at high risk of developing long-term conditions, recently diagnosed or not successfully managing their condition, including those making additional demands on primary care as a result of low mental wellbeing. • Specific support programmes will be introduced / expanded (e.g. diabetes.)
Develop QI expertise	<ul style="list-style-type: none"> • Multidisciplinary quality improvement will operate at neighbourhood level, supporting service redesign and continuous quality improvement. • Best practice will be shared between neighbourhoods. • Standardisation will support smarter and more efficient working.

6.6.2 Investment in Primary Care

As shown in **Figure 8**, there will be £10.08m (£32.41 per head) investment in General Practice and Primary Care, through a range of sources including the neighbourhood business case, other local initiatives and national uplift;

Figure 8 – investment in General Practice and Primary Care through the Neighbourhood Business Case and General Practice Five Year Forward View



This funding uplift will ensure that general practice is safe and sustainable, the GM standards are achieved by all practices and there is sufficient neighbourhood capacity to support the required activity deflection from the acute setting. The high-level funding breakdown is as follows;

Table 12 – breakdown of funding for primary care

Funding Category	Source of Funding	£m	£/head	Further Detail
National Uplift	CCG Allocation	£0.95m £0.92m	£3.07/head £2.97/head	Estimated net 2.6% uplift in 2017/18 on national contracts (GMS/PMS) Estimated net 2.5% uplift 2018/19
Local Investment into General Practices	CCG Allocation	£1.55m	£5/head	Payment is linked to delivery of GM standards for Primary Care.
	ST Benefits	£0.34m	£1.10/head	Navigate & Signpost
Extended Collaborative general practice	CCG Allocation (£1.8m) / ST Benefits (£4.48m)	£6.28m	£20.27/head	7-day access Find & Treat Pharmacy Physiotherapy (direct access) Mental Health Navigators EMIS Support Healthy Communities Acute Visiting and Clinical Triage
Total		£10.04m	£32.41/head	

6.7 Core Component - GP practice

The Five Year Forward view for general practice established that the *foundation of NHS care will remain list-based primary care* and that the solutions to the challenges facing general practice *lie in a combination of investment and reform*. By implementing the neighbourhood business case we will be adopting these principles and commitments.

Through this business case we will ensure general practice is safe and sustainable by:

- Increasing funding into individual general practice at a greater rate than the rest of the NHS,
- Investing into general practice to meet the Greater Manchester standards and standards for safeguarding recognising that many practices already deliver these,
- Investing into general practice to improve workflow and navigation, and
- Implementing the neighbourhood business case will deliver a range of new and expanded initiatives which will make a significant contribution.

The impact will be:

- Increased capacity that will enable General practice to focus on delivering more intensive, proactive and personalised care for people with complex needs.
- Standardised care pathways across Stockport reducing unnecessary variation.

6.7.1 National financial uplift

We will ensure that general practice is safe and sustainable, thus creating a firm base from which neighbourhood wide, multidisciplinary service focused on supporting early intervention and prevention can be created.

There will be an additional 2.5% per annum invested in core general practice across each of the next two years, from the national financial settlement. This will not have attached local expectations, reflecting the Five Year Forward view intention to address the recent shortfall in general practice investment.

6.7.2 Greater Manchester Standards

We will further ensure general practice is safe and sustainable by investing an additional £1.55m in supporting delivery of the Greater Manchester primary care standards. Given the already high standards of general practice in Stockport this will largely support practices to continue to deliver standards they have already implemented or gone a significant way towards implementing for their patients. This investment does not form part of the neighbourhood case but is essential to ensure general practice is able to play the pivotal role envisaged for it in this business case.

6.7.3 Long-term conditions management

As described in the case for change there are currently 124,000 people in Stockport (51% of the total adult population) who are known to have one or more long-term conditions. 26,500 people have two or more conditions. The 15% of the population who will receive the more focused support under the neighbourhood model, account for 70% of all health & social care spend and 50% of GP appointments.

The overall aim of the wider Stockport model is to safely release GP capacity, enabling increased support for people with long-term conditions closer to home. Investment is made via the neighbourhood business case in new approaches which release the required GP capacity. Key initiatives which will release GP capacity are;

- Improved workflow (**section 6.7.4** of this document.)
- Navigation (**section 6.7.5** of this document.)
- Acute visiting and clinical triage (**section 6.8.2** of this document.)
- Direct access physiotherapy (**section 6.8.3** of this document.)
- Mental wellbeing (**section 6.8.3** of this document.)

As detailed in **section 9**, the overall neighbourhood business case, driven by the above initiatives, will release approximately 37% GP capacity. Under the new neighbourhood model, it is anticipated that this release of GP time will contribute to increasing support to those with long-term conditions in the community setting. Specifically;

- Extended appointments for those with a long-term condition.
- Patients in exacerbation supported by GPs (and crisis response team) to remain in their own homes rather than being admitted to the acute setting.
- A greater focus on supporting patients with long-term conditions to self-care and maintain healthier lifestyles.
- A greater focus on supporting people at high risk of developing a long-term condition to make appropriate lifestyle adjustments.

Wider support available to GPs with the neighbourhood team to support patients with long-term conditions includes;

- Self-care coaches to support people with long-term conditions to make life style adjustments.
- Accessible voluntary and community sector services to support people to address wider determinant factors of good health, care and wellbeing outcomes.
- Other professionals within the multidisciplinary team (physical health, mental health, pharmacist and social care.)

Overall this approach is expected to enable more people with long-term conditions to be better supported in their local neighbourhood.

6.7.4 Improved workflow

Currently, in many practices, most incoming letters, reports and results are passed to GPs to check and action. The average GP spend 60-90 minutes per working day on these administrative tasks. Within the new neighbourhood model, practice administrative staff will be trained to read all incoming clinical correspondence. Staff are then able to code, action and file correspondence and re-route only those which require clinician review. Training involves a four-day programme which will be centrally funded and delivered through the GP forward view.

Evidence from the EPiC (extended primary integrated care) project in Brighton and Hove has shown that up to 80% of patient correspondence could be successfully completed without the involvement of a GP, saving 40 minutes of GP time per day. In the benefits table (**section 8** of this document) this service development will contribute a 5.5% reduction in GP workload under navigation and signposting.

Clinical correspondence can be processed at any time. There is no necessity for this function to be delivered over 7 days but this option exists if it releases time during busier periods of the week.

6.7.5 Navigation

The Navigation service development aims to ensure patients get to see the right person first time. This will be one of the main mechanisms through which patients will be able to access the widened range of collaborative general practice services such as physiotherapy, pharmacy, mental health services, local voluntary sector services, lifestyle change services, health coach and practice health champion activity.

Practice reception staff will be upskilled to conduct a basic triage process. When patients call the surgery requesting an appointment, the receptionist will follow an algorithm which helps identify the most appropriate member of the practice team with whom to book an appointment. For example, someone calling with lower back pain and no pre-existing conditions or complications, would be offered an appointment with the physiotherapist.

National monies allocated for staff training will be used to ensure practice receptionist staff are appropriately trained.

In the benefits table (**section 8** of this document) this service development is a contributor to the 5.5% reduction in GP workload under navigation and signposting.

6.8 Core component – Collaborative general practice

This core component of the neighbourhood model is designed to provide a range of specific services and additional capacity over extended hours through general practices formally collaborating at a neighbourhood and borough level. The aims are to;

- Provide a wider range of services in primary care.
- Improve access to primary care services (local delivery and extended hours of operation.)
- Reduce variation in the quality of services.
- Support more people to access services in the neighbourhood setting (reduced need for accessing services in the acute environment.)
- Support a greater focus on early intervention and prevention.
- Provide more intensive support for those with long-term conditions.

It is through the creation of efficiency in other parts of the health and social care system that recurrent funding will be created. Investments and interventions are intended to reduce the existing GP workload to enable;

- An improved work life balance and better retention.
- Safe and sustainable general practice.
- Greater support for those with long-term conditions and reductions in inappropriate acute activity.
- Opportunity to provide GP leadership.

The initiatives described in **section 6.8** will be commissioned over the next 18 months. Priorities are meeting the needs of the urgent care system and starting to create a more sustainable general practice. Whilst it is the intention to achieve these outcomes through commissioning evidence based initiatives such as those described below, the final delivery model, the specific capacity and staffing approach are anticipated to vary between neighbourhoods. This will reflect local need, existing expertise and patient feedback. Neighbourhood leaders will coordinate the development work with colleagues across the Stockport Together partnership.

6.8.1 7-day access

7-day access will be provided to meet the requirements of;

- Greater Manchester GP standards.
- National policy.
- Locally agreed priorities.

This service development will see the introduction of additional appointments within neighbourhoods at evenings and weekends. Weekday provision will increase by 1.5 hours per day, providing pre-bookable and same day appointments to general practice services.

This will be deployed flexibly to meet the needs of the neighbourhood population. There will be access to pre-bookable and same day appointments on both Saturdays and Sundays to meet the needs of the neighbourhood population.

The main aims are to;

- Ensure ease of access for patients including:
 - All practice receptionists will be able to direct patients to the service and offer appointments to the additional hours service on the same basis as appointments to non-additional hours services.
 - Patients will be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.
- Provide capacity for practices/the central booking team to book patients identified through the find and treat services, providing appointments to screen for risk factors and provide advice on their management, and to optimize treatment where possible.
- Provide capacity for practices/the central booking team to book patients who require vaccination & immunisation (excluding travel vaccinations except for those allowable through GMS.)
- Provide capacity for practices/the central booking office to book patients with a long-term condition for prevention and management of long term conditions. These appointments should be available for those people who are working and those people for whom there is an advantage if a working carer is able to accompany them or they themselves are a carer and able to get support at the weekend. It is anticipated that the additional appointments will enable the movement of work around the week and allow for longer appointments when required for some people with more complex needs.
- Deliver an ability for patients to book routine appointments at the weekends/evenings
- Provide multi-disciplinary services that offer a one stop approach are encouraged and the provider should consider how services can be organized to facilitate this
- Support long-term condition patients who are unable to attend reviews during the week, for example due to work commitments.

Additionally, there will be GP support for the wider neighbourhood teams provided from 8am to 8pm, seven days per week. During normal practice hours (8am to 6.30pm Monday to Friday) this will be from the local practice. Outside of these times medical cover will be provided by neighbourhoods to all local practices. For complex patients that the practice think they can keep at home but want a GP visit over the weekend they can ask the service to undertake this visit. Acute care will remain via 111 and seen by Mastercall.

Patients will access the extended hour support via their practice. It is envisaged that there will be a cohort of complex patients who will be given direct access to the weekend service to prevent them going directly to ED unless needed.

Key benefits of this service development include;

- New capacity at the time when working people can attend.
- Working carers can attend with patient at the weekend.
- Longer appointments during the week.
- Reduced ED attendance.
- Care homes will have a doctor to call instead of an admission.

In terms of benefit, this service development links closely with each of the areas under Collaborative general practice section of the benefits table (**section 8** of this document).

6.8.2 Acute visiting and clinical triage

This service will establish a safe and resilient system that can receive all acute calls for all practices across Stockport between the hours of 8am and 8pm and provide a clinical triage within 2 hours of the call. Following clinical triage, for all calls deemed to need a visit or a face to face appointment, this will be delivered within 2 hours of the triage decision being made. In this way, the response will be no less than that offered at ED and will be more convenient to the patient.

At the weekend, this service will provide two additional functions:

- The medical cover for the long-term condition appointments.
- To provide medical review for patients identified on a Friday who are at risk of admission, in order to safely keep them at home.

The specific delivery model is likely to vary between neighbourhoods based upon local need and existing practice. Neighbourhood leaders will work with colleagues to shape solutions. Funding will be from a collaborative general practice contract, with allocation to this initiative subject to negotiation of the distribution of the global sum.

Acute home visiting

Currently, most practices manage their own home visits on a daily basis. A typical home visit will take 3-4 times the length of a surgery appointment. Most practices will take paper summaries of the patient record and write up/action visits retrospectively, adding further administration time at the surgery if several visits are performed. Visits are often fitted around surgery time and typically GPs will visit 11am-2pm between morning and afternoon clinics. In some practices, this can mean all GPs can be out visiting around this time, meaning there is no GP available on site. Any late requests requiring visits on the same day are often done after afternoon surgeries, often after 6.30pm. Late visits are more likely to be acute issues and there may be difficulties if crisis response services or admission is required at this time.

Under the neighbourhood model there will be the potential for shared acute home visiting services. This would involve GP's within the neighbourhood being on a rota to complete all home visits, on behalf of all the practices in the neighbourhood. Where continuity of care is important, the home practices would continue to provide the service. As a backup service / where continuity of care is less important, this service development would replace the need

for each individual GP to conduct home visits as and when required. The solution would be tailored by each neighbourhood to meet demand but with common themes:

- Protected clinician time throughout the day for acute visiting, to allow more resilience and better timetabling of visits.
- ‘Shared’ visiting across several practices enabled by shared access to clinical systems.
- Alignment with neighbourhood teams to allow coordinated MDT visits.
- Mobile devices to allow real time access to clinical system from patient’s home.
- Time released through neighbourhood approach to acute, non-complex visits allows practices to dedicate more time to complex/high intensity patients requiring longer visits and continuity of care.

The acute home visiting service will support patients in their own home, care homes and support discharges from the hospital to reduce length of stay for admitted patients by ensuring a timely post discharge reviews.

The key benefits of this service development will be;

- Improved efficiency of visiting to release GP time, including reduced travel time, reduced admin and improved safety due to mobile records access.
- Less GPs going out on visits daily, so increased appointment availability and access for ambulant patients.
- Less 999 calls as patients do not have to wait as long for visits.
- More timely visiting reduces late referrals to crisis/hospital services, thus reducing the likelihood of an avoidable overnight hospital admission.

Clinical Triage

Within the neighbourhood model, clinical triage is one of the options open to practice navigators (**section 6.7.5**). Where the receptionist assesses there is a need for a clinical assessment on the same day, the patient will be offered a time slot to receive a call from the appropriately qualified professional. Depending on the situation of the patient this will follow one of two forms;

1. People with a current care plan will continue to be managed by their own practice, as evidence suggests that the continuity of relationship is important to achieving optimal outcomes.
2. Those who do not have an ongoing long-term health need, but have an acute issue that has arisen will be booked into a neighbourhood clinical triage slot and will receive a phone call from a clinician within a maximum of two hours to assess their condition. After assessment, if a face to face appointment is necessary, this will be booked by the triaging clinician, either at the patient’s usual practice, or (when available) the neighbourhood hub. A neighbourhood level resource will conduct clinical triage on behalf of all the practices in that neighbourhood.

Alternative forms of consultation and advice will also be offered, including video and email consultations and online self-assessment and self-care tools for patients.

National evidence suggests that for patients previously assessed as needing a same day GP appointment, the introduction of telephone triage can lead to a third of these appointments being managed over the phone, a third being managed by a face to face nurse appointment, and a third still requiring a face to face GP appointment, but often not on the same day.

By introducing neighbourhood clinical triage as additional capacity, the expected reduction in urgent face to face GP appointments (33% of urgent slots) could be realised by practices. Given that the proportion of routine to urgent appointments is very variable across practices, it is difficult to accurately calculate the hours released on a daily or weekly basis.

6.8.3 Interventions to reduce GP appointments

Direct access physiotherapy

It is envisaged that Musculoskeletal Physiotherapy (MSK) will operate a direct access service, which will be led by a 'First Contact Practitioner'. The aim is to reduce the number of patients with MSK conditions having consultations with GPs, thus freeing GP capacity. The national evidence is that 20% of GP Consultations are for musculoskeletal conditions and, that 70% of this activity could be managed safely and effectively by a Physiotherapist.³

Practice navigators (**section 6.7.5**) will follow a telephone triage process and for appropriate patients (those with recent MSK issues and no other complications), offer a consultation with a physiotherapist instead of a GP. Physiotherapists will be embedded within primary care and receive referrals from the practices. Physiotherapists will conduct initial telephone triage and offer advice, guidance and access to online resources for patients who do not need a face to face appointment. Where an appointment is indicated, the patient will attend a full assessment with one of the following outcomes;

- Patient provided with self-care care plan and discharged (return only if situation does not improve or deteriorates.)
- Patient offered a GP appointment if required (anticipated to be a low number.)
- Refer to community physio service where longer term direct physiotherapy treatment is required (or access private physio is preferred.)

The benefits of this service are anticipated to be;

- A 6.5% deflection of GP consultations releasing capacity
- Improved access and time to assessment for patients
- Reduced referrals to the community physiotherapy team (by 3124 appointments – based on 2016/17 data)
- In combination with the reshaped AHP team (**section 6.9.1**), a reduction in physiotherapy waiting list of up to 54% could be achievable

Mental Wellbeing Support Accessed Through Social Prescribing

Please read in association with **appendix 1**

³ (Physio First, West Wakefield, NHS England 10 High Impact Actions, Case Study 104)

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Significant numbers of GP consultations are for patients with low level / social needs / mental health related conditions. For those where there is no specific medical intervention required, GP's will be able to refer patients to a care navigator. The care navigator will support people to develop a personalised care and wellbeing plan and access a range of services such as social prescribing, self-help, mental health alliance and other voluntary sector groups. This service development will particularly focus on supporting people with lower level social and wellbeing Mental Health needs.

Specific service aims are to:

- Support people to develop personalised care and support plans which help them to address issues impacting on their ability to achieve improved health, care and wellbeing outcomes.
- Support patients with low level mental health conditions by providing additional time to listen and identify the underlying issues that underpin their conditions.
- Provide a pathway to support, appropriate to their needs.
- Provide quicker access to community support services.
- Provide alternatives to medication accessed through social prescribing.
- Provide support to General Practice in providing additional manpower.
- Facilitate standardisation of good practice across Stockport.
- Support people to access local services and community activities in the neighbourhood.
- Pro-actively prevent patients reaching critical point.
- Support integrated working across Stockport on a neighbourhood footprint.
- Reduce acute admissions and unnecessary secondary care attendances.
- Provide faster referral pathways into secondary care mental health advice services
- Liaise with GP front of house staff in signposting to services.
- Ensure that people have and report a good experience when they access the service.

The key benefits will be;

- Support to General Practice releasing capacity in an already stretched service.
- Patients underlying problems are appropriately identified.
- Improved and appropriate care navigation within the health and social care system for the neighbourhood population, i.e. patients referred to the appropriate services based on their needs.
- Better value for all, i.e. more people can access the service with outcomes that will have a positive impact on both physical and mental well-being.

Find and Prevent

Please read in association with **appendix 2**

This service development focusses on longer-term prevention and finding those who have yet to develop complex care needs.



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

This service development closely links with other parts of the neighbourhood business case where the treatment of those found will be achieved, principally through optimising primary care (core neighbourhoods), improved self-care (healthy communities) and referrals to lifestyle behaviour change and prevention programmes (healthy communities, self-management, education courses and the NHS Diabetes Prevention Programme).

The focus cohorts are;

1. People who have a long-term health condition and do not know about it.
2. People who have a long-term health condition and know about it, but for many reasons their treatment or lifestyle choices may not be optimised to manage that condition.
3. People who do not yet have a long-term health condition but have risk factors and behaviours which mean that they may be more likely to develop long-term health conditions.

These three groups will be better identified and assessed in primary care settings. People will be 'found' through consistent and systematic use of EMIS search and reports. They will then be invited for enhanced health checks within the neighbourhoods. Once people have been identified through the find and prevent service development, they will then be supported through other programmes in this business case (self-care, healthier communities, health coaching, access to third sector service which support people to address situations which are negatively impacting on their health, care and welling outcomes) to address / meet their personal requirements.

The find and prevent service development, in combination with the treatment focused service developments will reduce:

- The development of conditions (i.e. primary prevention.)
- The escalation from simply managed conditions such as hypertension to more complex conditions such as stroke, heart disease or kidney disease (secondary prevention.)
- The numbers of exacerbations, complications and acute care incidents relating to long-term conditions.

We will adapt the national model of risk detection and management to create an evidence based call programme focusing initially on five key conditions:

- Diabetes and pre-diabetes (type 2)
- Hypertension
- Atrial fibrillation
- COPD
- Dementia (via NHS Health Checks no evidence for targeted screening)

This programme will target people at higher risk of developing one of the five key long-term conditions, focusing on those:

- Age 40-74 who have never had a blood pressure recording; or are a smoker without a blood pressure reading in the last five years

- Age 40-74 who have never attended a NHS Health Check; or are a smoker without an attendance in the last five years.
- Any age at risk of diabetes type 2, or with identified but unregistered non-diabetic hyperglycaemia.
- Any age with a diagnosed long-term condition but do not have optimised treatment using tools such as GRASP-AF.
- People with a diagnosed mental health condition who smoke.
- People who have not attended cancer screening opportunities.

As detailed in the benefits section of this document (**section 8**), the find and prevent service development will support a 2020/21 tariff benefit of £1.4 million. This will be achieved through deflection of c3,860 non-elective admission for Diabetes, COPD, Hypertension, Arterial Fibrillation and Dementia.

Self-Care

This service development is described in full in the Healthy Communities Business Case (a description of which can be found in **section 6.10** of this document). There are also close links with the find and prevent, treatment room and navigation service developments described in this document. Included here is an overview and description of the specific self-care elements.

Self-care support and coaching will be offered to people with a long-term condition or at high risk / with risk factors which increase the likelihood of developing a long-term condition. An assessment of people's ability to manage their conditions will be made using the Patient Activation Measure or PAM tool. This will indicate the right level of support for that individual, allowing activity to be tailored.

Improving self-care requires greater personal responsibility for health and wellbeing. People will be supported to take control of their own health and focus on changing what matters to them. Supporting people living with a long-term condition requires a partnership with patients over the longer term rather than providing single, unconnected "episodes" of care.

This service development will offer 5 evidence based interventions which have significant potential to improve quality of life for people with long-term conditions and deliver benefits across the three dimensions of value: Mental and Physical health and wellbeing, NHS sustainability and wider social outcomes. These are:

- Peer support.
- Self-management education.
- Health coaching.
- Group activities to support health and wellbeing.
- Asset-based approaches in a health and wellbeing context.

The programme recognises that person-centred and community-based support needs to be both holistic and tailored around the individual, and there are connections between these approaches and other key enablers such as care and support planning and social prescribing. Interventions linked to these approaches can help to increase people's activation. It is also important to note that efforts to increase levels of patient activation will be more successful when supported by a whole system approach including training of clinicians in these new ways of working.

Once fully operational, the health coaching service will support 2,400 people living with long-term health conditions per year. The programme will deliver a range of synergistic activities which stimulate the growth of individual and community capacity for and engagement in self-care:

- Easy access to informative and motivational online resources, including space for online mutual support.
- Proactive engagement and support for people to improve their self-care, tailored according to need using the Patient Activation Measure.
- Increasing numbers of people actively engaging in voluntary activity, complementing and adding value to the work of Stockport Together to improve health, wellbeing and interdependence.

Medicines reviews

Please read in association with **appendix 3**

This service development aims to centralise prescription management, building resilience and capacity through working at neighbourhood scale. In addition, the additional pharmacist resource will support the other initiatives (find and prevent, healthy communities, self-care etc.) through providing;

- Management of repeat prescriptions (including high cost drugs.)
- Medication reviews (including in patients own homes) which would also include
 - Lifestyle advice
 - Signposting to other support services as part of medication reviews (smoking cessation, self-care courses, community assets etc.)
 - Associated monitoring (e.g. blood test results)
 - Compliance
- Members of the MDT providing support and guidance around prescribing multiple medications for patients with complex need.
- Training and support for care GP's, AHPs, community nurses etc.
- Management of medication ordering for care homes.

Currently practices work individually with a variety of approaches. On average GPs spend at least an hour a day authorising prescriptions and a similar time dealing with queries. The current system leads to significant waste, higher prescription spend and potential poor outcomes or admissions.

In the new neighbourhood model prescription management will be centralised through pharmacist led neighbourhood prescription management and optimisation services. A combination of clinical and non-clinical staff will manage repeat prescriptions, provide medication reviews and ensure therapeutic monitoring. Prescription requests will be accepted by telephone or electronically using trained medicines co-ordinators based on a system tried and tested in Coventry. Core staff groups are;

- Management and professional support will be through senior pharmacists.
- Pharmacists will authorise prescriptions, provide medication reviews, including home visits for housebound patients.
- Technicians will deal with prescription and patient queries, provide enhanced support to care homes to manage medicines, support GPs on care home ward rounds, handle outpatient and discharge communications to process medication changes safely and manage a robust call and recall system for therapeutic monitoring.
- Band 3 staff will support pharmacists and technicians with their work.

The service would be organised on a neighbourhood basis and the senior pharmacist would have a direct relationship with the neighbourhood lead GP. The resilience of the service would be provided by neighbourhoods supporting each other in the event of sickness, leave etc.

It is estimated that there will be up to an 5.5% reduction in GP workload through the introduction of this service development, with a 20/21 tariff benefit of £5 million at a cost of £2m. (see **sections 8 and 10** of this document for more detail). The key operational and patient benefits include;

- Release of GP capacity.
- Reduced number of prescription items.
- Reduced costs of dispensing and drug costs.
- Reduced spend on primary care prescribing.
- Improvements to therapeutic monitoring leading to reduced medication related admissions.
- Reduction in medication related admissions.
- Increased use of patient on line for making requests to achieve the target of 20%
- Released capacity from out of hour's provision as the service currently deals with meds queries.
- Improved patient satisfaction.
- Increased use of Repeat Dispensing, Patient online and EPS in line with national targets.
- Reduced costs to NHS England in disposing of waste medications.
- Reduced medication related safeguarding incidents in care homes.
- Increased use of shared care for medicines releasing FT staff time from managing meds which could be provided in the community.

6.8.4 Specialist GPs and other clinicians (provided via released capacity)

The services developments listed in **section 6.8** will release GP capacity. Each neighbourhood will develop a plan which sets out how this additional capacity will be utilised to develop specialist clinics. In developing their plan, the neighbourhoods will assess the need to develop capacity and skills as set out in the outpatient Business Case. The aim of the specialist clinics is to meet the needs of the population and contribute to the reduction in use of hospital based services.

This released capacity will be used for GP's to develop additional expertise in a clinical area. Using this capacity, the GP will become the link between their neighbourhood and the relevant consultant team and offer specialist clinics for neighbourhood patients. Neighbourhoods will work together to run clinics for the same specialty at the same time. A consultant will be available to support these clinics via remote consultation technology.

Nurses and other appropriate clinical professionals will develop expertise according to neighbourhood need. They will provide neighbourhood wide support in the chosen clinical area working closely with any appropriate specialist nurse team. This will include services such as insulin initiation.

6.8.5 Interventions to release capacity at the hospital

This service development will involve the redevelopment of existing treatment rooms to be able to support a wider variety of patients who currently need to attend outpatients / ED services in the acute trust. The new 'neighbourhood hubs' will offer a range of enhanced services including IV therapy, catheter care, try without catheter (TWOC), phlebotomy, DVT diagnosis and treatment. Capacity will be created through a new staffing model (new posts and re-banding) and a 12% activity shift with ear syringing.

Neighbourhood hubs will enhance accessibility by supporting patients from across the neighbourhood. Dedicated staff will provide expertise to operate a seven-day service, running alongside seven-day access in primary care. Realignment of referral protocols and patient transfer will be required to enable the full impact of this service development to be achieved. For example;

Simple wound care – from February 2016 to January 2017 there were 3226 ED attendances for lacerations. This activity will be redirected to the mixed nursing workforce in the neighbourhood hub where wound care is already major activity (over 27,000 incidents per year).

DVT inpatients – When a patient presents at the GP with suspected DVT, instead of transferring to the hospital, GPs will have direct access to Doppler assessment in the neighbourhood hub. During the assessment in the hub treatment and advice and support will be provided. It is anticipated that only 20% of patients who currently attend hospital for DVT assessment and treatment would need this level of support.

Catheter change / replacement – currently patients who require a catheter changing will attend ED, urology outpatients or inpatient services. Attendance from care homes may be via ambulance transfer with other patients via walk-in or referral from a community based practitioner. With reshaped pathways and patient transfer protocols (and where relevant, contracts), under the new neighbourhood model patients will be redirected to the neighbourhood hubs. To avoid walk-in attendance at ED and outpatient clinics, all staff supporting patients with a catheter will provide education as to the new neighbourhood hub arrangements.

The neighbourhood hubs will operate 8am to 8 pm, Monday to Friday and then offer 5 hours on both Saturday and Sunday, running alongside 7-day access in general practice.

The treatment room service development will support the find and prevent service development, through screening (initial focus on diabetes), immunisations, patient education and self-care support.

6.8.6 Back office support

Medication Review

The medication review service will;

- Manage requests for repeat medication prescriptions.
- Field prescription queries.
- Liaise with the community and hospital pharmacies.
- Ensure safe management of outpatient and discharge prescription changes.
- Manage medication ordering for care homes.
- Develop a call and recall service that will ensure that medication review and monitoring is maintained.

Call and Recall

The medication review call and recall service overlaps with the find and prevent service that will use the clinical systems to identify and call for appointments those people who are;

- At risk of disease,
- Should be offered protection from disease e.g. through immunisation or
- Not optimally managed.

These people will be systematically followed up to provide better and wider coverage particularly in groups harder to engage including military veterans and people with learning difficulties.

Templates

Templates will require agreement across the neighbourhood, or wider, in order for the specialist clinics and services at weekend to link with the weekday service. This will ensure that consistent information is collected that feeds into the clinical record in all practices.

Workflow, System Navigation and Safeguarding.

These services are funded at a practice level and are not part of this outline. However, it is a requirement through this document that practices work together in the solutions developed so that there is a flow of information and working practices across the system that support practices working together.

Delivery of Standards

The Greater Manchester standards as required to be met in full through a combination of this outline and the specification directly with practices. These are identified below and the standards identified in red are applicable to these commissioning intentions.

Support for training

Released capacity for both a GP and another clinical professional (e.g. practice nurse) will be required to support training for other groups of staff. It will be a requirement that there are training places for a mix of GPs, nurses, mentorship for HCAs and non-medical prescribers etc. in each neighbourhood. In this way, the system will be developing its own future workforce.

Neighbourhood working

Following sign up to the specification developed there will be no further payments for neighbourhood meetings including e.g. MDTs GSF meetings, neighbourhood management etc. The developed specification must release time for all practices to take part in neighbourhood work and training. The deployment of this resource is at the discretion of the neighbourhood. Practices will be expected to be able to show how they have contributed to the working of the neighbourhood and the achievement of its targets. The resource they can demonstrate delivering for these outcomes should be no less than 1hour per 1,000 patients per week for both a GP and other member of practice staff including manager nurse and other professional groups. Leadership roles will be employed in addition to the specification developed.

Activity Data

Practices will be provided with a tool to extract data from the appointments book in EMIS. It is a requirement that the specification will ensure that the practice run this quarterly. The identifiable data is owned by the practice and will only be able to be seen by them. Aggregated data should be released to the neighbourhood, GP federation and the CCG. This will facilitate assessment of the increase in demand in practices and allow for planning future staff requirements.

6.9 Core component - Integrated multidisciplinary teams

Care and support for vulnerable adults most at risk of admission to hospital (the top 15%) will be coordinated and managed by multidisciplinary teams (MDT). The main aims of the MDT will to;

- Support the most vulnerable adults living in each neighbourhood with a mix of physical health, mental health and social care needs to retain their independence
- Conduct multidisciplinary assessments which consider all the needs of people in the context of supporting as many people as possible to remain safely at home
- Provide contact, access and triage. Follow-up and maintain proactive contact with the individual as appropriate to need and offering rapid access to advice and support when needed urgently
- Offer information, advice and support to access healthy communities programmes and lifestyle coaching
- Provide personalised care and support planning which considers health (physical and mental, medical and therapeutic), care and wellbeing needs along with personal goals and aspirations
- Coordinating care, support and access to formal and informal services
- Assess and implement in-home adaptations which ensure people can remain safely in their own home for as long as possible. Adaptations will also be implemented which improve quality of life and improve the ability of people to remain active and get out of the house
- Ensure effective medication is in place and reviewed regularly
- Provide enabling technology which supports independent living (e.g. remote monitoring, telecare pendant etc.)
- Support access to voluntary and community sector services which support people to address any situations which are impacting on health, care and wellbeing needs
- Consider the needs of carers and ensure all appropriate support is provided. This will include discussing carer support and providing a carer assessment
- Provide ongoing assessment and review of progress ensuring people are achieving their personal goals
- Provide ongoing monitoring and reporting of progress against measures within the outcomes framework
- Safeguarding

Integrated multidisciplinary teams will bring the following professionals together;

- Neighbourhood GPs (medical input and leadership)
- social workers
- Community nurses
- allied health professionals (physiotherapy, occupational therapy, dietetics, speech and language therapy and podiatry)
- mental health staff
- Pharmacists
- third sector workers

People newly referred to the neighbourhood multidisciplinary team will participate in an assessment either in their own home or in a location close to their home. Where people are able to participate a clinic-style assessment, the full range of MDT members will be present with all applicable professionals and workers contributing to a single assessment covering health (physical and mental), care and wellbeing needs, along with personal aspirations and goals. If people are unable to participate a clinic based assessment, practitioners will conduct home visits. Home visits will also be conducted to assess the need for adaptive aides which help keep people safe in their own homes. The single assessment will replace multiple poorly connected assessments. The MDT will then meet or convene virtually to discuss and contribute to the person-centred care plan. The person will hold and own their care plan, and practitioners will ensure that the person and their carers are integral to its development to ensure the plan is deliverable in the context of their goals, wishes, networks and aspirations. This involvement will ensure;

- Wherever possible key appointments are at suitable times (e.g. weekends to ensure the carer can work regular hours)
- Access to informal support / self-care is coordinated around the person's ability to attend (e.g. ensuring friends are on hand to support access if the main carer is working)
- Wellbeing services are offered which match the person's interests and goals (people are far more likely to achieve personal health and wellbeing goals if they are interested in the activity)
- People are knowledgeable and motivated by their care and support plan. Personal involvement supports ownership, ownership supports the achievement of goals

The impact of this approach will be;

- Improved care and support for those with long-term conditions
- Reduced A&E attendance for those with long-term conditions
- Improved outcomes for people
- Improved patient experience
- Reduced hand-offs between professionals and organisations
- Reduced duplication and waste
- More people supported closer to home with reduced need to attend outpatients
- Reduction in complications due to medication
- Activated patients better able to self-care and self-manage
- More people able to live safely at home for longer

The extended hours offer will be;

- **Weekdays** – 8am to 8pm, with delivery continuing later into the evening and overnight as per demands of neighbourhood (in neighbourhoods)
- **Weekends** – 8am to 8pm to include medical cover to support wider service;
 - Including (chronic kidney disease) CKD and complex LTC management

- Increased nursing and social care contact and access offer
- Increased nursing and social care case management and response to deterioration offer
- Increased nursing and social care delivery capacity at weekend
- Accept hospital discharges and manage complex patients at home
- Booked appointments for complex patients who may deteriorate over the weekend.
- Find & Prevent work to identify and support people at risk of or newly diagnosed with LTCs

Tables 13 and 14 set out the full social work and community nursing offer. As with all the indicative staffing numbers described in this document, the operational distribution will vary in each neighbourhood reflecting differing levels of local need. All residents of Stockport will have access to all the described services.

Table 13 Full community nursing 7-day offer

Times	Functions / Activities	Staff
Day Nursing Service		
8am – 6pm, 7-day service	Core Business, Full Capacity Full Offer e.g. Planned nursing care delivery Case finding Short Term Support, Assessment, Planning, Review Case Coordination / Case Management / Enhanced Case Management	Full complement of staff working a mixture of the current shift pattern 8am –18:00pm and new shifts as per below to ensure core hours are covered.
6pm – 8pm, 7-day service	Focus on planned nursing care delivery Focus on response to deterioration Activity to help prevent admissions to hospital where people do not meet the threshold for Crisis Response Enhanced Duty Offer – ensure that assessment capacity is available to respond in the event of a response to deterioration or necessary urgent response outside of core office hours	Service delivered over a locality footprint. Each locality will have 1 Qualified Nurse and 1 Support Worker (4 Nurses and 4 Support workers across the Borough) complimented by the staff currently on the Evening Visiting Service. Introduction of new shift patterns to cover extended core operating hours: exact working pattern subject to staffing consultation.
Evening Nursing Service		
6pm – 11.30pm, 7-day service	Planned nursing care delivery Nursing care for a response to deterioration	Full complement of staff
Night Nursing Service		
11.30pm – 8.00am, 7-day service	Planned nursing care delivery no capacity for this	Full complement of staff
Treatment Room Service		
8.30pm-4.30pm, Mon – Fri and 9am – 4.30pm weekends and bank holidays	In-clinic planned nursing care delivery	Full complement of staff



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Table 14 Full social work 7-day offer

Times	Functions / Activities	Staff
Monday – Friday 8am – 6pm	<ul style="list-style-type: none"> • Core Business • Full Capacity • Critical Mass therefore needed to cover these hours with vast majority of social care assessors and managers covering these shifts • Full Offer e.g. • Case Finding • Response to Deterioration Maintenance • Case Coordination / Case Management / Enhanced Case Management • Short Term Support, Assessment, Planning, Review • Safeguarding • Mental Capacity Work 	<p>Full complement of assessment staff likely working shift patterns to ensure core hours are covered.</p> <p>Appropriate complement of support staff to support hands on delivery.</p>
Monday – Friday 6pm – 8pm	<ul style="list-style-type: none"> • Some scheduled work – offer to working people and carers • Focus on response to deterioration / crisis / safeguarding work • Activity to help prevent admissions to hospital where people do not meet the threshold for Crisis Response • Enhanced Duty Offer – ensure that assessment capacity is available to respond in the event of a response to deterioration or necessary urgent response outside of core office hours • Ensure that internal home support work capacity is available and aligned to neighbourhoods to provide hands on care following initial assessment • Emphasis will be on a better step up response than is currently available 	<p>Smaller number of assessment staff per neighbourhood, likely 2 Social Workers and 1 Social Care Officer working an agreed 'late' shift in each neighbourhood to ensure the latter part of the day is adequately covered to provide the service outlined. The exact nature of these shift patterns is subject to consultation with staff.</p> <p>Appropriate complement of support staff to support hands on delivery.</p>
Saturday and Sunday 8am - 8pm	As per Monday – Friday 6pm – 8pm	<p>Assessment staff operating on an East / West Split.</p> <p>Likely cover includes:</p> <ul style="list-style-type: none"> • 2 Assistant Team Managers (1 for East, 1 for West) covering an evening shift • 4 Social Workers and 4 Social Care

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		<p>Officers will be available on each weekend day to cover an agreed shift pattern (so 1 Social Worker and 1 Social Care Officer on an agreed 'early' shift and 1 Social Worker and 1 Social Care Officer on an agreed 'late' shift at each of the two bases open)</p> <p>Appropriate complement of support staff to support hands on delivery</p>
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6.9.1 Investment in allied health professional services

Please read in association with **appendix 4**

As discussed in the introduction to **section 6.9**, allied health professionals will be an integral member of the multidisciplinary teams. An analysis of current staffing levels and current waiting times has been conducted.

Presented here in **table 15** is a breakdown of the existing AHP provision in Stockport.

	Current FTE by AHP					Total	% workforce
	Dietetics	OT	Physio	Podiatry	SALT		
Community	2.11	2.6	18.93	20.76	0	44.4	19%
Inpatients	10.65	34.67	56.76	0	11.29	113.37	50%
Outpatients	1.7	4.26	23.2	0	0.56	29.72	13%
Intermediate tier	0.2	13.88	16.26	0	0.2	30.54	13%
Other	1.19	0	9.3	0	0	10.49	5%
Total						228.52	

There is a total annual cost of £8,568,200, inclusive of on-cost but not overheads.

Table 16, below, demonstrates that the current community physiotherapy and dietetic services are under-resourced when compared to benchmark;

Profession	Now	Benchmark	Variance (%)
Dietician	2.11	6.3	-66.5%
OT	2.6	2.6	0%
Physio	18.93	27.3	-30.1%
Podiatry	20.76	20.76	0%

The neighbourhood business case provides additional funding equivalent to bringing staffing levels up to national benchmark of health data. This funding equates to an increase in physiotherapy resource by 8.35 FTE and dieticians by 4.18FTE. However, to reflect the already significant investment elsewhere in the business case in MSK physiotherapy; and experience in a local pilot relating to proactive Occupational Therapy offer to neighbourhoods, this resource has initially been re-profiled to fund a 4.35 FTE increase in Occupational Therapy / Speech and Language Therapy alongside a smaller increase of 4FTE in MSK physiotherapy and static 4.18 FTE dietitians. Operational experts are currently assessing the total AHP resource and will ensure effective deployment in order to meet the needs of individual neighbourhoods in the context of the wider Stockport Together model.

This re-profiled investment, combined with the direct access physio services (described in **section 6.8.3**), is projected to reduce physiotherapy waiting times by 54%. As described in **appendix 4**, other business cases also consider the need for additional AHP capacity.

6.9.2 Enhanced Care Home Team

Care homes and care homes with nursing will receive additional support under this service development. In accordance with the GP development scheme and the British Society of Geriatricians guidance for commissioners, the following support will be in place;

- Practices will do weekly rounds at care homes
- There will be a nominated GP practice(s) for every home
- There will be GP contact for homes from 8am to 8pm, seven days a week (this may not always be the nominated practice).
- The medicines service will support rounds, do the medication ordering and manage the repeat prescriptions. (see **section 6.8.3** of this document)
- Individualised health care plans will be developed in collaboration with patients and their families. These will be used as key documents which means that all clinicians, allied professionals and care home staff are familiar with and following them. These will be reviewed 6 monthly or sooner if the person's health care needs are likely to change rapidly
- There will be ongoing training and support for care homes
- The falls team will support care homes to reduce incidents of falling and associated injury
- Greater use of planned community services and reduced use of unplanned acute services

This service development will also see the development of a quality intervention team. This team will work with care homes and home agencies across Stockport to facilitate sustainable improvement, embedding change and working flexibly out of hours. This initiative will help ensure that providers meet and exceed the required health and social care quality standards.

This intervention will have a positive impact on the avoidance of unnecessary placements, hospital admissions or delayed transfers of care. The principles of the intervention are;

- Intervention will be carefully prioritised/targeted (informed by 'RAG' rated business intelligence triangulated from across the health and social care economy).
- Time limited (intervention timescales will vary but agreed improvements must be sustainable by the provider itself)
- Pro-active (timely intervention will aim to identify difficulties at an early stage and prevent further deterioration in standards)

The following outcomes will be achieved through this model⁴;

- Ensuring prompt recognition of residents requiring imminent end of life care, identifying issues and goals and making appropriate treatment plans within a shorter specified time period
- Conducting regular, structured, multi-dimensional reviews at least every six months, or sooner if clinical needs require it. These should be used to modify healthcare goals, and guide clinical interventions both in and out of hours
- Assessments to include medication review in partnership with the community or care home's pharmacist, at a frequency over and above the basic requirements of the General

⁴ Drawn from the British Society of Geriatricians guidance for commissioners

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Medical Services contract, at least every six months. A medication review should also be completed following discharge from an acute hospital admission

- Assessment to include structured risk assessment, for example for pressure ulcers, continence and nutrition
- Creation of an advanced care plan for acute events and for preferred end of life care, in partnership with residents, their families and advocates
- Agreement of reliable systems with appropriate support tools to enable effective telephone consultation and use of out of hours referrals
- Regular scheduled visits by an appropriate GP or specialist nurse to review particular residents with new needs, perform routine reviews and to liaise with other health and social care professionals
- Clarification of referral pathways and response times for specialist input including community rehabilitation services, palliative care teams, specialist nurses (for example, regarding tissue viability), community mental health teams and geriatricians
- When and where feasible and beneficial, extending the scope of enhanced clinical interventions, for example, through the use of sub-cutaneous fluids and intravenous antibiotics according to locally agreed protocols
- Use of a robust interdisciplinary and interagency clinical governance system which promotes quality improvement and involves the care home manager and relevant staff. The system should support education and training in both core clinical skills and quality improvement methodology and encourage the development or use of clinical tools, protocols and service improvements. It should also allow for review of individual cases involving complaints and adverse incidents, as well as reviewing overall performance of the local system by regular monitoring of chosen outcome measures (see examples under Monitoring and Evaluation).

The key benefit will be that more people are supported effectively in the care home setting, reducing the need for unplanned acute intervention. This service development is included within benefits realisation section of this document (**section 8**)

6.9.3 Additional Mental Health (and IAPT realignment)

There is no additional investment requirement for Initial Access to Psychological Therapies (IAPT) services described in this business case. However, the existing provision of IAPT services will be re-aligned to fit with the neighbourhood model. The other service developments discussed in this document will support the delivery of parity of esteem between physical and mental health and deliver improved access to mental health services for all.

Additional Mental Health Offer

It is widely acknowledged by the Department of Health (DH), NHS England and the King's Fund that current service structures and models are insufficient to effectively address the needs of many patients with complex health conditions and that a much greater **focus on whole person care encompassing both physical and mental health** is required.

A more innovative approach is required in terms of how services are designed to deliver good outcomes for complex people with long-term conditions, whilst recognising their

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mental and physical health needs. The provision of neighbourhood based integrated psychological and physical health support represents one of the biggest areas for transformation and has the potential to improve the quality of life for a significant cohort and create capacity and savings across the health and care system.

The proposed service will bridge the traditional divide between primary and secondary care and physical, mental and social care to best help people with complex physical health difficulties who often fall through the gap between existing services.

The service will operate a person-centred; goal focussed approach and seek to promote understanding, self-care and coping, so people are able to engage more fully with resources available in their local community and to reduce the need for medical input.

The service, working closely with Neighbourhood teams will target the following groups of people:

- People with long-term conditions with unmet psychological needs
- People demonstrating complex behaviours and/or complex health issues
- People who may have substance misuse and other issues impacting on physical and mental health
- Medically Unexplained Symptoms (MUS)
- People with complex polypharmacy
- People who are high users of services (e.g. emergency department, primary care, community services, hospital out-patient or diagnostic services)
- People who may demonstrate 'social chaos' and have complex family issues
- People who are difficult to engage in identified services

The service will focus on delivering both a direct and indirect offer to people with complex health and social care presentations identified by neighbourhood Multi-Disciplinary Teams (MDTs).

Direct Offer

This will involve:

- Enhanced assessment and formulation including medication review, undertaken by the Consultant in Liaison Psychiatrist or Specialist Psychologist
- It is expected that an increased proportion of people will be directed to other services with clear pathways to facilitate engagement
- Intensive goal-focussed treatment interventions will be reserved for people who cannot be supported within existing services
- Each mental health practitioner will manage a caseload of 25 people at any time providing assessed, evidence based treatment interventions.

Indirect Offer

Consultant in Liaison Psychiatry and Specialist Psychologist will provide: -

- Supervision, advice and support to Neighbourhood MDTs for people with complex health and social care presentations
- Training for general practitioners (GPs) and Neighbourhood MDTs in the management of

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- people with complex health and social care presentations (e.g. medically unexplained symptoms)
- Liaison with acute mental health liaison teams (RAID) and other relevant services to reduce impact on usage of urgent care

6.9.4 Falls – ‘Steady in Stockport’

Please read in association with **appendix 5**

This service development aims to improve quality of life for people by reducing the burden of falls and fractures.

This service is required as Stockport has significantly more falls than the England average and the impact of falls is putting substantial pressure on individuals and services:

- Every year about 30% of people 65+ will have at least one fall: 16680
- Locally, data from ED attendances shows us that 47% (13/14: 3236) of ED attendances with falls, 62% of hospital admissions with falls (13/14: 2133 hospital) and 89% of deaths from falls (13/14 49 deaths) are in the 65+ age group
- Compared to the England average, Stockport has significantly more injuries due to falls, for those aged 65-79 and for those 80 years and over.
- Compared to the England average, we are also higher for mortality from accidental falls (this is in part as our coroner investigates all deaths with a fall in the last six months). See figure 3.
- Numbers of falls are fairly stable over the years
- There is no strong trend in month or time of fall; however, 13% of attendances by the older age group are in the early hours of the morning
- Almost a third of hospital admissions in the older age group are not finished after one episode of care, meaning there is a longer spell in hospital
- NHS Right Care data indicates that compared to the best / lowest performing 5 CCGs of our 10 most demographically similar CCGs we could improve in the following areas (**table 17**):

Area for improvement	Quantified opportunity
Hip replacement emergency readmissions 28 days	9
% fractured femur patients returning home within 28 days	69
Hip fracture emergency readmissions 28 days	13
Injuries due to falls in people aged 65+	330
All fracture admissions in people aged 65+	192
Spend on admissions relating to fractures where a fall occurred	£518,000 (potential savings)

The new 'Steady in Stockport' model is an interdisciplinary approach, focussing on primary and secondary prevention. The model consists of an integrated pathway between a new falls, fracture & bone health service and various existing services and facilities in the community;

1) Primary prevention offer in new model (low to moderate risk of falls)

Prevention starts in general for people over age 40 with healthy life style messages and prevention of risk factors related to falls: dementia prevention, smoking cessation, increased exercise and balance training, and reduced alcohol intake. These messages could be part of a wider lifestyle approach whereby staff are aware of the risk factors and will be able to provide advice and signposting in a motivational and encouraging way.

2) Secondary Prevention offer in new model (moderate to severe risk of falls)

An integrated falls, fracture & bone health service will be implemented to provide an in-depth assessment and interventions for people who have had a fall, are at high risk of falling and/or who have had a fragility fracture. The service will also pro-actively be involved in case-finding and screening.

For 2 sessions per week, there will be geriatric consultant involvement providing supervision for the service and partnership working.

6.9.5 Home Care

Please read in association with **appendices 6 and 7**

Home Care provision is currently contracted by Stockport Metropolitan Borough Council (SMBC) on a 'framework contract' which runs from 2014 -2018. At present, there are 26 accredited providers on this framework. For the last week in February 2017, the total number of hours commissioned was 16933 hours per week. This contrasts with the figure of 15502 for the same week in February 2016, showing a significant rise in demand for this service. This also equates to an increase in the number of current service users from 1548 to 1684 over the same 12-month period. There is significant pressure in the system with limited additional capacity and continually rising demand. This service development aims to ensure continued high-quality provision, choice and availability, thus avoiding an escalating negative impact on delayed transfer of care and non-elective admissions.

This service development will see extended re-ablement focus and asset based approaches across the Home Support market. This will ensure that more people are supported to live safely and independently in their own homes. The commissioned and contracted home support providers, all of whom will be on the Council's framework of registered and accredited provision, will be linked to the neighbourhood teams and provide services for a distinct geographical location, thus linking closely to the neighbourhood team and offering a seven-day service.

Key elements of this service development include;

- a) The current 'winter pressures' initiative will continue beyond March 2017.

This supports a more outcomes focused, re-ablement approach to home support, co-produced and

delivered jointly by utilising the enhanced skill sets of both the in-house provider and independent providers. This requires providers and commissioners to adjust their focus from that of delivering long-term support to a shorter-term outcome based approach. This service will be available 24/7, 365 days of the year.

b) Overnight home support assessment element of the approach also continues

This new delivery model short term overnight home support assessments. The purpose of this assessment is to ascertain the individual's support needs, abilities and activities throughout the night, highlighting any aids and equipment and to offer some respite for carers. The team will work between the hours of 10pm -8am and will provide a report at the end of each night.

c) Daytime support will support neighbourhood provision and be embed within multi-disciplinary teams.

This third element of the proposal is to replicate the 1A model across the neighbourhoods, thereby enabling twice as many people to benefit from this new model.

In addition, this service development will see Extra Care Housing provision (ECH) enhanced to meet complex needs, providing more community based options. The overall benefit will be more people supported to remain independent for longer, preventing, reducing or delaying hospital or care home admissions unless appropriate.

6.10 Creating healthier communities

Please read in association with **appendix 8**

The strategic aim of this service development is to contribute to the transformation of the relationship between people, services and communities, through delivery of person and community centred care. This will improve people's physical and mental health and wellbeing while reducing demand on primary care and preventing admissions and readmissions to hospital or intermediate care.

Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities and this proposal is a key part of a broader strategy, which draws on existing resources and projects and seeks to embed a new relationship between services, people and communities.

This service development focuses on three key elements:

- Easy access, and empowering people to access, to the information resources and online support that people need to manage their health including long-term conditions
- Capacity to provide targeted coaching support to help people learn the skills, develop the motivation and confidence to manage their own condition
- Growing networks of peer support and voluntary activity to improve social connection and sustain long-term change

Neighbourhoods will contribute to creating healthier communities both by identifying and addressing the needs of people at high risk of serious illness and also by contributing to the Greater Manchester Population Health Plan which addresses the health burden of issues like obesity, alcohol, tobacco, and physical inactivity.

One of the defining features within the new Neighbourhood model is the emphasis that will be placed on changing the culture within our services. The vision described in the 'Stockport Way' will be key to better supporting people with long-term conditions to self-manage by working with individuals and their support networks. This means working collaboratively in a spirit of equal partnership between individuals, families, community groups, voluntary organisations, social enterprises and businesses that make up a local community, to optimise the use and benefits of informal as well as service-based support and activity. The 'Stockport Way' is;

One approach, working together for Stockport, on purpose, all of the time

- Making a conscious effort to think about how we can work together with people, communities and other organisations
- Considering how to achieve the best possible outcomes for individuals, families and wider communities.

Working *with* people, and building on their strengths

- Working *with* people, not 'doing for' or 'doing to'
- Enabling people to identify and access the strengths and resources available to them, as individuals and within family and community networks

Always connecting through conversations and building relationships

- Actively listening, seeking to understand, rather than assess
- Asking "what matters to you?" rather than "what's the matter with you?"
- Making connections and building relationships, to work collaboratively with each other across organisations
- Helping to connect people with supportive networks

Confident to make decisions, acting for the best outcomes for people

- Empowering staff within their organisations
- Enabling staff to be confident in their decisions, not asking permission but ready and able to explain them.

The 'Stockport Way' is enshrined within the 'Healthier Communities' programme that will be an essential part of the way the Stockport health and social care system works. It will engage with people who are at high risk of developing Long-term Conditions, recently diagnosed or not successfully managing their condition, including those making additional demands on primary care as a result of low mental wellbeing. This model seeks to mobilise existing and potential assets, to strengthen networks and to promote the kind of reciprocity that can maintain and develop the resilience of individuals, families and communities. This will include recruiting volunteers as community health champions, working with primary care and Integrated Neighbourhood Teams to provide an additional level of support to people at high risk of hospital admission and other

vulnerable individuals in the community. In other areas, this has been demonstrated to significantly reduce demand for primary care appointments. A small Community Investment Fund will support this work by facilitating community-led activity around health, wellbeing and resilience, with a focus on developing peer support groups, activities for people with LTCs, tackling loneliness and increasing social connections.

6.10.1 Accessing Healthy Living and Wellbeing Support in the Neighbourhoods

Accessing Healthy Living and Wellbeing Support in the Neighbourhoods

The new model in the neighbourhoods will work with people as individuals and as members of families and communities, to promote personal growth and resilience, working in line with the Stockport Way. A ‘network around the neighbourhood’ will provide a layer of support around the Integrated Neighbourhood Team for both the top 15% and the wider population. The new way of working with people and communities, advocated by NHSE and set out in *Realising the Value* programme, involves moving beyond referrals and pathways:

People’s needs may be primarily clinical or mainly social, but for those needing most support will usually involve elements of both. As far as possible, referrals and multiple assessments will be avoided and, where specialist input and advice is needed, named colleagues, aligned with the neighbourhood team, will be introduced to the individual. The intention of our approach is that the professional boundaries between physical health, mental health and social care roles should become more flexible; holistic care involves broadening of skills, particularly in relation to mental wellbeing, as we change how we connect with and relate to people. This is key to reducing demand and improving health as we work towards diminishing or eliminating the need for statutory services intervention over time.

It is essential that the mental health services are embedded in this network and the INT, so that mental and physical health and wellbeing needs are addressed holistically through a team working together with each other and the person at the centre. In addition to the four old age psychiatry CPNs are already in post as locality liaison nurses in INTs, the new psychological Medicine in Primary Care service will comprise a team of 1.5 Consultant Psychiatrists, 2 Psychologists, 8 Liaison Practitioners embedded in the INTs offering a combination of a form of enhanced case management and additional case formulation advice i.e. face to face and advisory.

Wellbeing conversations start with the question of “What matters to you?” and draw on the Five Ways to Wellbeing framework to facilitate goal setting and wellbeing planning, which identifies ways of accessing the personal, family and community assets and resources available to help achieve these goals. In these conversations, people’s level of ‘activation’, or confidence and existing skills, will be explored in order to ensure the appropriate level of support is offered; while always promoting autonomous motivation and access to the personal and social assets that they have already have available.

Figure 9 illustrates likely journeys though the network around the neighbourhood as people move towards community-based support. It is important to emphasise that the journeys will not always be linear, and an individual may be supported by a number of services working together either alongside each other or consecutively, sometimes alongside a key worker/care coordinator. Four

roles are key to providing access to the network of support.

Case Manager/keyworker

A key worker or case manager will develop an ongoing relationship with people identified as highest need (15% most at risk of hospital admission) and work with them to access the support and assets (including within their family networks) that are most appropriate to their priorities. This will include having wellbeing conversations with people as a key part of the care planning process, and then continuing to offer support to achieve their health and wellbeing goals within the Enhanced Case Management process.

Wellbeing Navigator

The role of the Wellbeing Navigator would be have the initial wellbeing conversations with people experiencing social or psychological needs, identified by a GP, Practice Nurse or other practitioner, (but not in the top 15% risk group) and introduce them to the network of support available.

Find & Prevent workers/Health Coaches

This role will be complemented by the Find and Prevent workers and Health Coaches (which may be integrated into a single role). They will proactively seek to identify, engage and support those people with, or at high risk of, long-term conditions and work with them in wellbeing conversations and where needed, further coaching support. They will work with them to develop their skills and confidence in managing their own health and wellbeing, including accessing community and voluntary sectors assets such as mutual support groups.

START

START is primarily an access route to the Healthy Stockport family of services, and the workers will undertake the initial conversations with people who want to make changes to their lifestyle, to enable them to access the most appropriate support services (including ABL, Pennine Care, CGL, Life Leisure and Public Health provided support). Those services will cultivate and maintain their own connections with community-based groups such as peer support, sports clubs or creative activity groups. At present, both START and the Healthy Stockport services are centrally based, but it is important that these services should work closely with the practice and neighbourhood based services in delivering holistic responses.

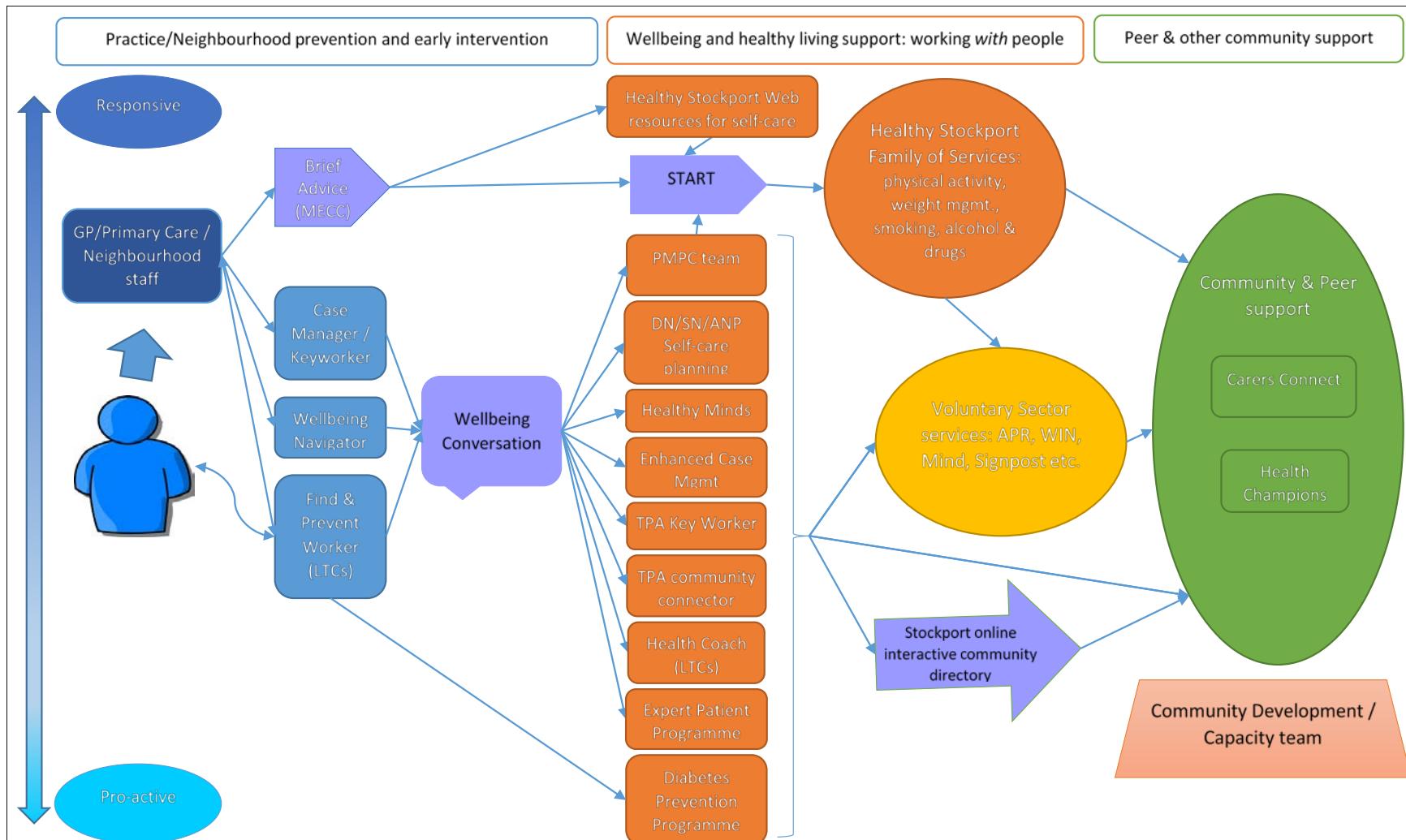
Community Capacity building

To complement this work we will work in partnership with voluntary and community organisations to support them in building their capacity to offer appropriate support when it's needed. The network around the neighbourhood will therefore include the community development workers who are already embedded in the local communities and working with local groups. We are also piloting the practice-based Health Champions – a team of volunteers who can also support and assist people to access community assets and other local resources.

Key to Abbreviations used in diagram:

- ANP Advanced Nurse Practitioner
APR Alliance for Positive Relationships (Domestic abuse prevention and support)
DN District Nurse
INT Integrated Neighbourhood Team
LTC Long-Term Condition
MECC Make Every Contact Count
MH Mental Health
PMPC Psychological Medicine in Primary Care
SN Specialist Nurse
START Stockport Triage, Assessment, and Referral Team (for Lifestyle change support)
TPA The Prevention Alliance
WIN Wellbeing & Independence Network

Figure 9 Wellbeing and Prevention Support Journeys



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6.11 Quality, safe and effective care

Our eight neighbourhood teams will provide appropriate mechanisms and support for a systematic collaborative approach to quality, safety and effectiveness through:

- strong leadership and accountability
- access to specialist advice when required
- the development of transparent care pathways recognising the needs of adults and older people
- sharing of data directly via EMIS and the Stockport Health & Social Care Record to enable shared dashboard to monitor outcomes and identify risks
- multiagency collaboration to ensure safeguarding of children and vulnerable adults
- embedding 'No decision for me without me' with particular focus on consent and supporting people who lack mental capacity to make decisions
- training, monitoring and supporting all staff within each neighbourhood to provide safe, effective care, working in partnership to offer a standardised approach

Our integrated governance framework will ensure quality, clinical safety and effectiveness are embedded across the health and social care system through:

- agreement of overall quality strategy and plans with commissioners, GPs, social care and health providers enabling a shared focus on the delivery of quality outcomes
- clear neighbourhood structures, accountabilities and governance processes which support the delivery of safe, high quality, clinically effective care
- agreed data sets between partners so that quality improvements can be measured and reviewed
- a culture that supports all staff to learn and improve
- Boards and health and social care leadership group review and approve the assurance frameworks (locality and system wide)

Evaluation of services will be informed by feedback from patients, staff and carers.

6.12 The Stockport Together Outcomes Framework

It is intended that the future commissioning arrangements for services described in this business case and others, will be based on a population based weighted capitation contract which will include an Outcomes Framework.

6.12.1 The Outcomes based approach

Stockport Together's ambition is to implement an outcomes-based model of commissioning. Outcomes based commissioning is a way of paying for health and social care services based on rewarding providers for achieving the outcomes that are important to the people using them, regardless of socio-economic status.

Commissioning for outcomes presents a different proposition from current payment mechanisms, such as payment by results and block contracting, which pay health and social care providers to deliver discrete processes or packages of care. Commissioning for outcomes moves the focus away from volume and activity and towards providing whole-person holistic care.

There is an acknowledgement that no single provider of care is likely to deliver true patient outcomes in isolation of other providers. Achieving outcomes must therefore be a collaborative approach supported by appropriate contracting and reimbursement mechanisms. Commissioning for outcomes in a multi-specialty community provider has the ability to drive integration by incentivising providers to work together, share accountability and deliver outcomes collaboratively.

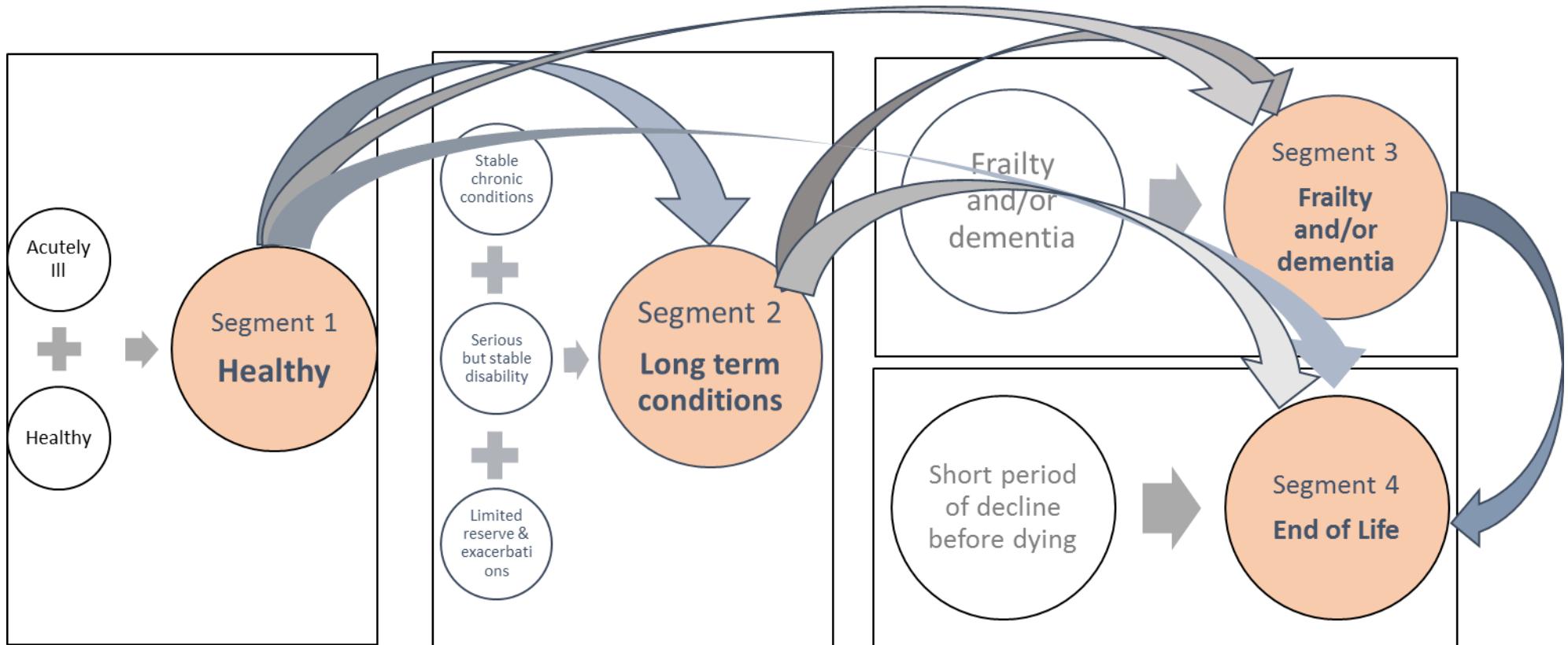
6.12.2 Enabling the delivery of the outcomes based approach

To achieve an outcomes-based model of commissioning, Stockport Together embarked upon identifying outcomes that matter most to the people in Stockport. To ensure that different views from across the system were taken into account, key stakeholders including patients led the development of a Stockport Together ‘Outcomes Framework’.

Commonly, outcomes have been considered in the context of disease groups. However, defining optimal health in this way undermines the ‘whole-person’ holistic approach and retains focus on providers. In support of Stockport Together’s whole population approach, and in view that the responsibility to deliver true patient outcomes is shared amongst multiple providers, the development group agreed that the outcomes should be organised differently to traditional approaches.

In order to identifying sufficiently homogeneous population groups and associated outcomes, Stockport Together adapted the *Bridges to Health* model of segmenting populations. This describes eight population groups which have been condensed into four broader groups each with its own definition of optimal health and priorities among services:

Figure 10: Stockport Together population segments and movement between segments based on the *Bridges to Health* model



N.B. Maternal & Infant Health excluded as the MCP for Stockport Together aims to initially contract for the over-65 population



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6.12.3 Prioritised outcomes

The Stockport Together Outcomes Framework includes both clinical, social and personal outcomes. Clinical and social outcomes tend to describe clinically relevant outcomes for an individual, such as improved health status (reductions in disease incidence, complications and/or exacerbations). Personal outcomes describe the holistic health status of a person such as their confidence in managing their own health and wellbeing.

Whilst clinical and social outcome can be measured by using data already captured in clinical or administrative systems, measuring personal outcomes generally requires administering surveys or Patient Reported Outcome Measure (PROM) tools.

Table 18 outlines the 25 clinical and social outcomes and 14 personal outcomes that have been prioritised by the Outcomes Framework development group. The 25 clinical and social outcomes are measurable and have three-year worth of baseline data. PROM tools are still being reviewed to assess their suitability to measure the 14 personal outcomes prioritised. Some personal outcomes may not be measurable and decisions are still to be made during 2017/18 on some of the more detailed implementation issues associated with measuring personal outcomes.

Table 18 – Stockport together outcomes framework

Stockport Together Outcomes Framework			
	Description of population segment and priorities	Clinical and Social outcomes ⁵	Personal outcomes ⁶
Healthy	Who is in this group? <ul style="list-style-type: none"> - adults in the general population - not in contact with health services - no diagnosed conditions - may have underlying conditions/risk factors - may have unhealthy behaviours What is important to them? <ul style="list-style-type: none"> - staying healthy - avoiding developing a disease/condition - convenient access to services when unwell - longevity - maintaining independence, usual lifestyle and activities - quality of life and social interaction 	REDUCE avoidable acute admissions	Independence
		INCREASE physical activity	Proactive and confidence in managing health
		REDUCE obesity	Able to maintain usual lifestyle and activities, having a full life
		REDUCE smoking	Time with friends and family, not being alone
		REDUCE alcohol consumption	Well-informed
			Mental wellbeing
			Feeling supported and reassured
			Feeling safe and secure
Term Condition	Who is in this group? <ul style="list-style-type: none"> - people aged 65 years and over with a LTC - may have stable/normal function managed by medication, treatment or therapy - may have serious long-term physical or learning disability 	REDUCE premature mortality in people with Serious Mental Illness	Independence
		REDUCE smoking	Proactive and confident about managing health
		REDUCE obesity	Able to maintain usual lifestyle and activities, having a full life

⁵ Three years of baseline data is available for the clinical and social outcomes

⁶ Baseline data for the personal outcomes will be collected during 2017/18



<ul style="list-style-type: none"> - may have limited reserve, serious exacerbations, progressive deteriorating conditions What is important to them? <ul style="list-style-type: none"> - effective self-management - preventing/limiting disease progression - maintaining autonomy - confidence to manage their condition - avoiding exacerbations or complications - avoiding developing more health conditions - minimal disruption to life - co-ordinated care in the most appropriate place 	<ul style="list-style-type: none"> REDUCE episodes of ill health requiring emergency admission REDUCE days disrupted by care REDUCE stroke in people with diabetes and/or circulatory conditions REDUCE diabetes complications REDUCE exacerbations requiring emergency admission in people with organ failure INCREASE cancers diagnosed at an early stage (stage 1 or 2) 	<ul style="list-style-type: none"> Time with friends and family, not being alone In control, involved, listened to Well-informed Mental wellbeing Feeling supported and reassured
<p>Frailty and/or Dementia</p> <p>Who is in this group?</p> <ul style="list-style-type: none"> - people aged 65+ who are frail and/or have dementia - likely to have comorbidities - often vulnerable and dependent on others <p>What is important to them?</p> <ul style="list-style-type: none"> - avoid disruption to life / time away from home - independence - prevention of falls or distress e.g. pressure ulcers - stronger recovery following falls, fractures or admission - timely diagnosis of dementia at an early stage - quality of life and social interaction 	<ul style="list-style-type: none"> INCREASE the proportion of days spent at home REDUCE pressure ulcers REDUCE falls REDUCE delirium REDUCE emergency admissions for UTIs, constipation and incontinence REDUCE the dementia prevalence gap REDUCE people requiring repeat emergency care within 30 days of discharge INCREASE people back to previous level of mobility following a hip fracture 	<ul style="list-style-type: none"> Independence Able to maintain usual lifestyle and activities, having a full life Time with friends and family, not being alone In control, involved, listened to Well-informed Mental wellbeing Dignity and respect Feeling supported and reassured



			Feeling safe and secure
			Anxiety / depression
			Pain and symptom control
			Nutrition
			Disability / functions of daily living
End of Life	Who is in this group? - people with a terminal illness or advanced progressive deterioration - people identified to be in their last 612 months of life	INCREASE people dying at their preferred place	Time with friends and family, not being alone
	What is important to them? - control over their care and place of death - early conversations and planning - support to live as actively and as well as possible - dignity and respect - psychological support to themselves and their family	INCREASE palliative care registrations in people expected to die	In control, involved, listened to
		REDUCE the proportion of days disrupted by emergency care for people in their last days of life	Well-informed
			Dignity and respect
			Feeling supported and reassured
			Anxiety / depression
			Pain and symptom control



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Table 19 Neighbourhood contribution towards achieving the outcomes in the Outcomes Framework

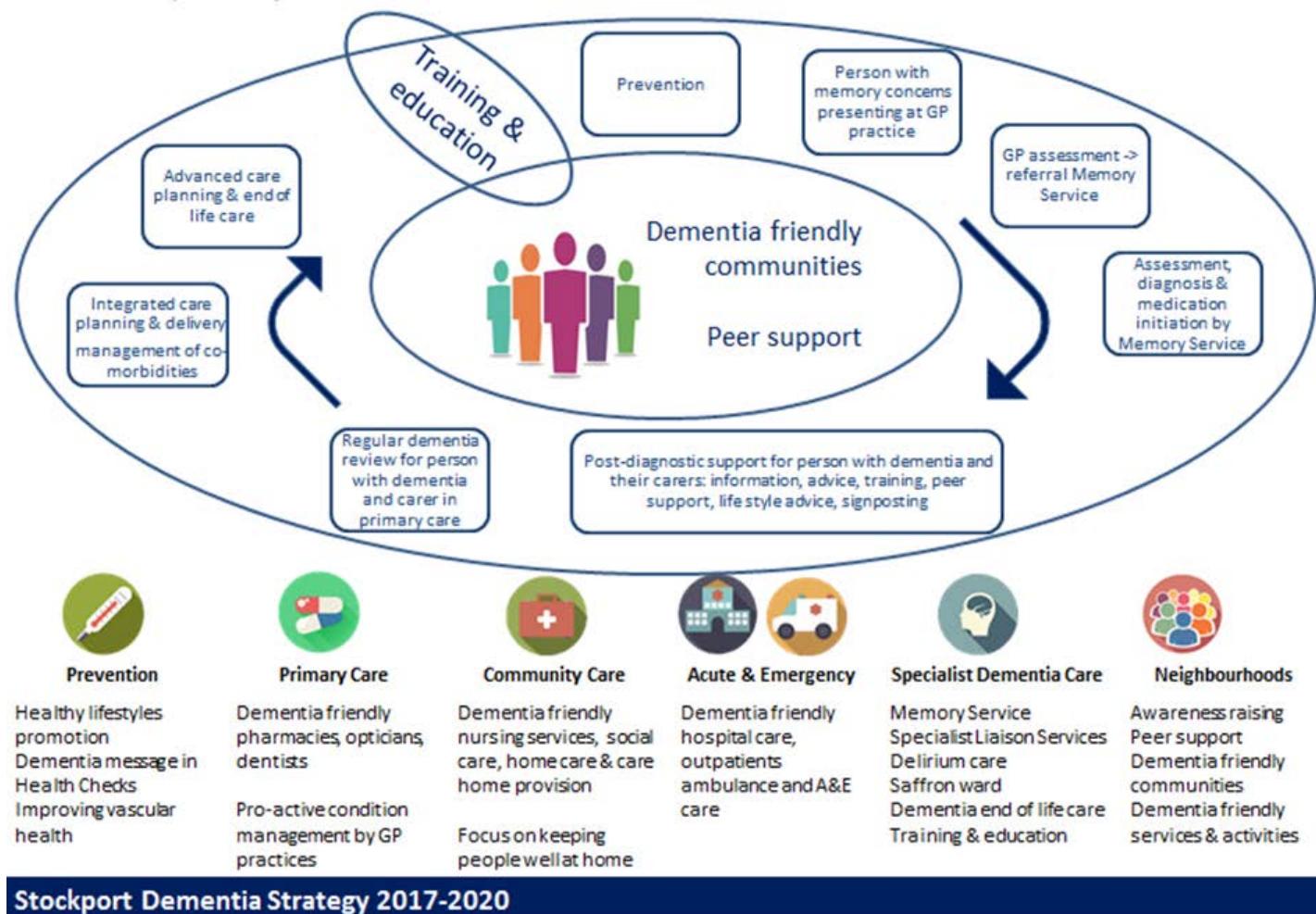
	REDUCE smoking	REDUCE alcohol consumption	REDUCE avoidable acute admissions	REDUCE obesity	Well-informed
Healthy	Healthy communities programme will support people to access smoking cessation	The Falls 'Steady in Stockport' service will raise awareness amongst staff about risk factors related to falls including reduced alcohol intake	'Find and Prevent' services will systematically identify people 'at risk' of developing conditions and offering enhanced health checks to prevent development of complex care needs.		All neighbourhood teams will be trained to provide advice, support and access to wellbeing services
Long Term Conditions	INCREASE cancers diagnosed at an early stage	REDUCE stroke in people with diabetes and/or circulatory conditions	REDUCE days disrupted by care	REDUCE exacerbations requiring emergency admission in people with organ failure	Proactive and confident about managing health
	'Find and Prevent' services will target people at higher risk of developing long-term conditions by identifying people who have not attended cancer screening opportunities	'Find and Prevent' services will identify escalation from simply managed conditions such as diabetes to more complex conditions such as stroke.	'Find and Prevent' services will support people at risk of developing LTCs to make lifestyle adjustments	People with LTCs / complex needs will be given intense support by GPs / crisis response to safely maintain them in their homes	People with LTC will be given support and training to be able to self-manage
Frailty and Dementia	REDUCE emergency admissions for UTIs, constipation and incontinence	INCREASE the proportion of days spent at home	REDUCE falls	Independence	Mental wellbeing
	More evening and weekend GP appointments provide additional support for community teams and patients in exacerbation	Extended hours across all professions improves access and timeliness of support	Specialist falls team provide specific support to reduce incidence of falls Pharmacists supporting medication reviews reducing incidence of falls	MDTs include therapy professionals. Care plans will provide equipment and training to help people remain independent in their own homes	Rapid access to mental wellbeing services will be facilitated by MDTs
End of life	INCREASE people dying at their preferred place	INCREASE palliative care registrations in people expected to die	REDUCE the proportion of days disrupted by emergency care for people in their last days of life		Well-informed
	Training for residential homes and nursing teams to have early conversations around wishes	Increased GP and pharmacist support pain control and other medications	Neighbourhood acute visiting to ensure quicker access to medical support	Increased GP and pharmacist support pain control and other medications	Earlier conversations with people and their families provides information and options

6.12.4 Dementia friendly

Stockport Together's business cases are all aligned with the recently launched Stockport Dementia Strategy 2017-2020 (<http://www.stockportccg.nhs.uk/dementia>) and the Greater Manchester Dementia United initiative. This neighbourhood case supports the following objectives of Stockport's dementia strategy:

- **Dementia prevention** message 'what is good for your heart is also good for your brain' will be disseminated by front-line staff to make the public aware of the positive effect a healthy lifestyle can have on primary and secondary prevention of dementia
- **Dementia diagnosis:** with support from the neighbourhood teams and staff in healthy community initiatives, more people with concerns about their memory will be positively encouraged to seek a dementia diagnosis timely
- A dementia diagnosis will be included in the **health and social care record** to ensure the specific needs of a person with dementia are taken into account at each point of contact with a health or social care staff member
- As dementia affects many aspects of life, like someone's health and wellbeing, carer's wellbeing, social connections and finances, an **holistic and integrated approach** as envisaged to be delivered through the neighbourhood teams will contribute to the quality of life of the person with dementia and their carer. Staff will receive further **dementia awareness training** to understand the specific needs of the person with dementia and their carer throughout the journey
- Through the integration of health, social care and mental health in the offer for people with dementia, there will be more focus on **advanced planning and ongoing proactive care**. This will result in better (self)management and ongoing post-diagnostic support tailored to the person's needs. In addition, more opportunities for **support at home** instead of an admission to an unfamiliar environment of a hospital or a care home will result in better outcomes for the person with dementia
- Improved partnership working will result in a more **joined up approach** to manage dementia in relation to co-morbidities like diabetes, stroke, Parkinson and delirium
- The existing **shared care pathway** between primary and secondary care will be further refined to address the increasing need in the later stages of dementia
- Building on the work undertaken in the hospital, various GP practices and community services, the neighbourhood teams and borough wide services will all become **dementia friendly** and supporting the development of Stockport as a dementia friendly borough.

Figure 11 – Dementia pathway



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7 System impact

7.1 Safe and sustainable general practice

The Stockport system is making a significant investment in general practice to;

- Ensure general practice is safe and sustainable
- Support transformation and delivery of neighbourhood level services
- Provide more local support and services
- Move towards early intervention, prevention and self-care

There is a total investment of £10.04m (£32.41 per head) in primary care, which includes £1.87m (£6.22 per head) to ensure a safe and sustainable general practice and has no additional commissioner requirements, £1.55m (£5 per head) to deliver the GM standards for primary care and £6.28m (£20.27 per head) will deliver collaborative general practice.

Please see **section 6.6.2** – investment in primary care for full breakdown of new funding.

7.2 Narrowing the financial challenge

This business case is the core building block of the whole new approach to care delivery, the full integrated service solution. Therefore, without it the planned net savings envisaged through the Stockport Together programme will not be delivered. The investment into neighbourhoods will specifically contribute £9.48m net (£20.47m gross) benefit towards this total. Please see overarching economic case for full detail.

There will be an investment from the transformational fund and external sources in 2017/18 of £11.21m;

- Making existing services more safe and sustainable
- Address some of the historic underfunding in areas such as general practice and community nursing, and
- Avoid future cost growth by better management of individuals through earlier identification, preventative, integrated and proactive care.

7.3 Narrowing the health outcomes gap

Poor health outcomes and therefore the health inequalities gap is driven by a number of factors. Poor lifestyle and early diagnosis are significant contributors as are low mental wellbeing, social isolation and poor mental health. These challenges vary across the borough. This business case will contribute to addressing these drivers of inequality by:

- Increasing the capability of primary care to identify early the main causes of early mortality and extended morbidity through a proactive data driven approach to find and prevent,

- Investing in greater capacity to support individuals to change their lifestyle once risk factors and or conditions are diagnosed,
- Investing in greater mental wellbeing and mental health services including more effective community based approaches to address social isolation, and
- Giving the neighbourhood health & social care team greater flexibility on how they invest resources in and for their own area.

7.4 Improving patient experience

Through full implementation of this business case, there will be a range of improvements to patients experience;

- Reduced duplication
- Reduced need to tell the story on multiple occasions
- More holistic and personalised care is provided
- Reduced gaps between health and social care planning
- Reduced delays in discharge
- More support and advice at an early stage
- Improved accessibility at a local level
- Greater opportunity to shape health, care and wellbeing support around personal networks and goals
- Greater flexibility with packages of care

7.5 Deflection of activity from the acute setting

This business case will address the growth in demand discussed earlier that would otherwise materialise and reduce the higher than average use of hospital care evidenced in Stockport. The case when fully implemented will result in lower use in hospital services and care home admissions compared to that predicted for the existing service model:

- 6,400 fewer A&E attendances
- 5,100 fewer Non-elective admissions
- 30,200 fewer outpatients,
- 1,300 fewer elective procedures, and
- 721 fewer care home beds.

8 Benefits and evidence base of the Neighbourhood Model

8.1 Benefits

Our goal is to implement a new fully integrated 24/7 neighbourhood based model of health and social care which is based on the best available evidence and which has an emphasis on prevention and self-management. This will create the capacity and capability (in both primary and community care alternatives) to deliver the right care and support in or close to

people's homes rather than in hospital. It will enable delivery of the following high level outcomes;

- Keeping people independent at home for longer
- Ensuring safe and sustainable General Practice
- Reducing avoidable hospital admissions for those most at risk
- Substantially reducing avoidable visits to accident and emergency departments
- Reduce avoidable admissions to care and residential homes
- Reduce the average length of time people stay in hospital
- Transforming the traditional approach to outpatient and elective activity
- Better flow through system
- Providing a workforce available to offer more proactive, real time response for people than current out of hours offer.
- Reduced unnecessary admissions to hospital
- Improved offer to people
- Increased capacity in and support for the external provider market

Quantified benefits can be found in **tables 20a to 20d**, on pages 100 to 103 of this document.

The key patient benefits will be;

- People only tell their story once
- More coordinated, timely care
- Services available over extended hours
- More care provided locally
- Reduced confusing transfer between organisations and services
- Increased breadth of provision in local GP practices

The key system benefits will be;

- Practitioners working to shared population groups and priorities
- Efficiencies through shared assessment, care plan and reduction in formal referral processes
- Parity of esteem given to mental and physical health
- Reduced handoffs and costly repetition
- More appropriate use of resources
- Increased ability to rapidly move resource to where it is most needed
- Greater value achieved for each health and care pound
- Reduced 'gaps' where vulnerable people could be lost
- Greater focus on personalised approaches across the H&SC system – including joint commitment to holistic assessments, personalised planning, shared decision making, better use of community assets, greater focus on self-management

The key benefits for adult social care will be;

- More people are enabled to remain independent for longer
- Greater focus on personalisation across health and social care
- More opportunities to support early intervention and prevention

- 50% increase in capacity
- Greater control over wider resources required to deliver step up in response to deterioration
- Greater support for care homes
- Better planning and use of community resources
- Greater ability to meet care package requirements at a neighbourhood level
- Increased support from primary and community care on a seven-day basis

The key benefits for primary care will be;

- Safe and sustainable model for primary care
- Increased funding
- Great ability to offer a wider range of services at a local level
- Reduced administrative burden
- Increased range of mental health support in the neighbourhoods
- Reduced complexity of referral
- Greater ability to shape local provision for the local population
- Greater strength from scale
- Improved access to community health and social care services

The key benefits for community health will be;

- Greater access to medical expertise and social care support
- Improved range of resources
- Ability to support people more holistically
- Increased range of mental health support in the neighbourhoods
- Quicker access to support when patients are in exacerbation
- Reduced numbers of crisis situations in care and nursing homes
- Simplified access to community resources

The key benefits to care and nursing homes;

- More formal support from health and care practitioners
- Increased training and support opportunities
- Closer working with local teams
- Increased ability to influence the health and care provision setting
- Increased career development opportunities
- Alternative options than 999

The key benefits for mental health;

- Increased opportunity for physical health training for mental health staff (peer to peer)
- Increased opportunity for mental health training for physical health staff (peer to peer)
- Increased multidisciplinary support for those with mental health support needs
- Informal support more aligned with formal support
- More opportunities for raising public awareness and informal guidance

- Parity of esteem for mental and physical health

8.2 Evidence base

The success of this business case is almost entirely contingent on the system's ability to ensure that the 15% of people most at risk of being admitted to hospital are able to manage their care better and that there are sufficient evidence based community alternatives to avoid unnecessary hospital based interventions.

Our analysis shows that there are a relatively small number of people in Stockport who are the heaviest users of health and care services. These are the 36,000 residents (15% of the overall population) who, at any one point in time, have the highest risk of being admitted to hospital in the next 12 months. (based on the Combined Predictive Model). This top 15% of those people most at risk, as at June 2016 accounted for 50% of all A&E attendances and 79% of all emergency admissions during the period July 2015 to June 2016. **Within this cohort at least 36% of these admissions (14,885 admissions) were in some way sensitive to ambulatory care and therefore potentially avoidable**

Consequently, we believe that by deploying the full range of interventions set out in this business case, we will be able to work intensively with this cohort to appropriately deflect activity away from hospital in the following proportions:

- A&E attendances: 19%,
- Non-elective admissions: 25%,
- Outpatient first attendances: 10%,
- Outpatient follow up appointments: 17%
- Elective admissions: 37%.

We are confident that these levels are deliverable because the local, national and international evidence supports both our service model and the underpinning assumptions that we have made about their impact on activity reduction particularly when set in the context that Stockport is an outlier in these areas nationally. A summary of the international evidence on the impact of integrated care by McKinsey 2015 ('The evidence for integrated care', March 2015) and subsequently NHS England 2015 ('Transforming urgent and emergency care services in England', August 2015), concluded that it is the impact of a number of key components operating together that can deliver the sort of step change that systems are seeking.

These are:

- **Implement Case Management within better, more joined up Neighbourhood Teams with greater capacity:** Assertively Managing acutely at risk populations through individual care planning and multi-disciplinary teams delivered primarily in primary and community care
- **Improve and increase Intermediate Care capacity:** Early review by a suitably qualified clinical decision maker supported by responsive intermediate care (with the right balance between step up/step down) can reduce admissions by up to a quarter
- **Implement Ambulatory Emergency Care:** consider all potential acute admissions for ambulatory emergency care unless care needs can only be met by an inpatient stay:

They further concluded that reductions in emergency admission and ED attendances as a result of the implementation of integrated care of between 20-30% could be expected. These components are all at the heart of the implementation of our integrated service solution. This national and international evidence is further supported by recent local evidence. This business case relies heavily for the impact on non-elective activity of what is called the enhanced care and case management approach. In particular, the case has used the findings from the Fylde Coast Extensive Care Approach due to its similarity to the Stockport Neighbourhood Model.

Set out in the tables below, is a detailed analysis of the evidence bases that have been used to support each of the key interventions within the business case. The evidence base is set alongside the benefits in **tables 20a, 20b, 20c and 20d**, below;

Table 20a - Reference guide

5	McKinsey 2015 ('The evidence for integrated care', March 2015)
6	NOS, 2015, Clinical Standards for Fracture Liaison Services, NICE, 2017 Quality Standard QS 86: Falls in Older People, NICE, 2013, Clinical Guideline CG 161: Falls in Older People: assessing risk and prevention
7	http://www.local.gov.uk/documents/10180/12193/Evidence+for+integrated+care+-+Review+November+2013/8f73b31d-4ed8-4a4a-831d-9bfa8b2c1ad3
8	http://www.medeconomics.co.uk/article/1286630/benefits-employing-pharmacists-qp-practices
9	www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/self-referral
10	www.england.nhs.uk/wp-content/uploads/2016/03/releas-capcty-case-study-4-104.pdf
11	http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf

Table 20b – Benefits and evidence for service developments in GP practice

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
GP Practice						
Navigate and Signposting	5.5%		£376,450	£0	0	<ul style="list-style-type: none"> • NHS Alliance 'Making Time in General Practice' suggests that 4% of GP time could be saved through enhanced navigation and signposting in General Practice.¹¹ • Local assessment suggests this could be up to 8% of GP time. • We have used the NHS alliance data which constitutes the lower of the two figures
GM Standards			£1,500,000	£0	0	
Total			£1,876,450	£0		

Table 20c Benefits and evidence for service developments in Collaborative general practice

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Collaborative general practice						
Find & Treat			£286,000	-£1,426,581	3,860 non-elective admission deflected for Diabetes, COPD, Hypertension, AF & Dementia	National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies for each disease group
Enhanced Pharmacy & Repeat Prescribing offer	5.5%		£2,000,000	-£5,000,000	Not applicable	<ul style="list-style-type: none"> • GP 5 year forward view • The Journal of MedEconomics⁸ estimated that employing Pharmacists in Primary Care can save 7% of GP time just in dealing with patient medication queries generated by patient requests for prescriptions. This excludes other areas of GP workload that Pharmacy could impact • GP Magazine reported a reduction in GP workload of 30-40% through the employment of primary care Pharmacists across East London.
Enhanced physio offer	6.5%		£620,000	£0	Not applicable	<ul style="list-style-type: none"> • GP 5 year forward view • The Chartered Society of Physiotherapists suggests that up to 30% of GP appointments are for MSK and could be impacted by Direct Access Physiotherapy⁹ • Physio First, West Wakefield found that 20% of GP appointments were for MSK complaints. They were able to impact 70% of these appointments.¹⁰ <p>For consistency, we have used the lower Wakefield findings which gives a net impact of 14% on GP workload</p>
Mental wellbeing support			£450,556	£0	Not applicable	GP 5 year forward view
Neighbourhood treatment room & minor injury			£250,000	£0	Not applicable	GP 5 year forward view
Back office (EMIS)			£100,000	-£846,385	5632 in Out Patient First appointments	GP 5 year forward view
Healthy Communities	3.5%		£571,514	£0	Not applicable	<ul style="list-style-type: none"> • NHS Five Year Forward View: Empowering People & Communities, • Realising the Value economic modelling & five year key impact: peer support, self-management education & health coaching, group activities to support health & wellbeing, asset based approaches in a health and wellbeing context, JSNA data. • We have assumed that this service supports the deflections already set out in the Extensivist model set out above
Neighbourhood clinical triage	5.0%		£100,000	-£27,175	618 A&E (minors)	
Neighbourhood acute visiting	5.0%		£100,000	£0		
Primary care 7 day service			£1,890,146	£0		
Total			£6,368,216	-£7,300,141		



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Table 20d Benefits and evidence for service developments in integrated services

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Integrated multidisciplinary teams						
Remodelled Neighbourhood Teams	2.5%	20%	£2,115,902	-£10,864,874	5,805 A&E Attendances 4,373 Non-elective admissions 3,058 Outpatient first appointments 21,591 Outpatient follow up appoint 569 Elective	<ul style="list-style-type: none"> The evidence¹ for the impact on non-elective activity of what is called the Extensivist Care and Case Management approach ranges from 25-30% reduction for the high user cohort. This business case has used the findings from the Fylde Coast Extensive Care Approach due to its similarity to the Stockport Neighbourhood Model We have profiled the impact of the model on the top 6% of users in 2017-2019 and the top 15% of users in 2019-2021 The evidence for Falls Prevention is well documented and subject to NICE Guidance²
Home support worker night service			£428,558			
Neighbourhood Teams Extended Hours			£677,485			
Mental Health	3.5%		£704,648			
Integrated Fall Service			£428,200			
Home care support / Care home support		Additional 65 long term care packages (net 4% increase)	£1,190,579	-£2,300,000	97 care home respite admissions 624 care home admissions 624 non elective admissions per week.	The Local Government Association undertook a review of the evidence regarding the impact of integrated care in general and case management specifically and found that there is evidence that it has resulted in a reduction in use of residential and nursing homes and an associated increase in use of home care services ³
Enhanced Allied Health Professionals (Borough wide)			£587,343		Not applicable	
Total			£6,132,715	-13,164,874		
Grand TOTAL			£14,377,381	-£20,465,015		



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9

Capacity and activity diversion (to release GP capacity)

Please read in association with **appendix 9** which gives fully detail per professional group

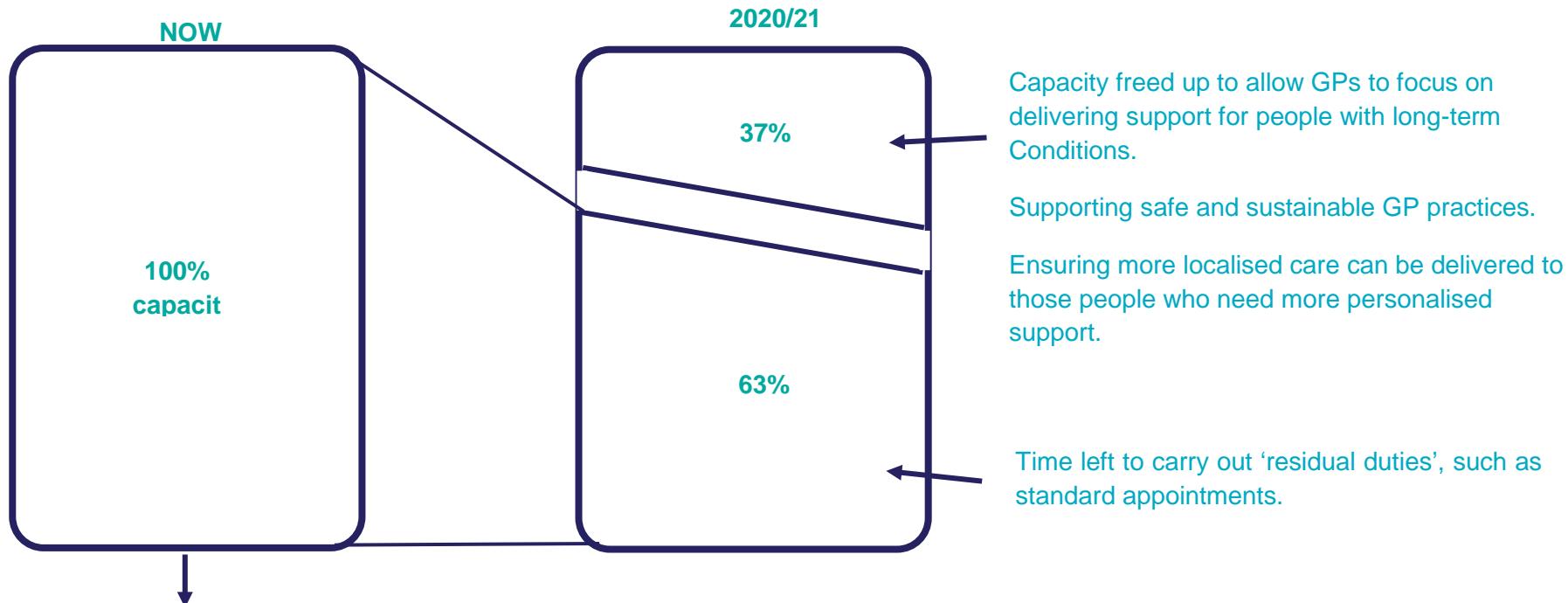
The neighbourhood model is projected to provide a total additional community / primary care capacity of 24% (of professional hours) by 20/21. For the purposes of this business case this is modelled upon national evidence points. A snapshot audit was conducted of potential activity diversion in Stockport, the results of which indicated total achievable diversion was consistent with the national evidence but root of diversion will vary (**Figure 13**). It is therefore acknowledged that the ultimate neighbourhood delivery will vary based upon the needs of the local population. Neighbourhood leads will be able to flex delivery but must ensure equality of service offering across Stockport.

The underpinning model of MDT working, expanded primary care offer, integration and diversion of activity to the most appropriate member of the team will ensure greater efficiency through reduced duplication and reduced hand-offs. Of particular importance to the new model of care is freeing GP capacity, enabling this group to provide greater support for those with long-term conditions. This increased focus will underpin the required activity deflection from the acute setting. As represented in **Figure 12 on p105** the expanded primary care and neighbour team structures will enable the diversion of sufficient activity to release up to 37% of GP time. **Figure 13 on p106** provides detail of where this activity could be picked up. Additional capacity has been built into the service developments which will pick up the diverted activity from GP's (**Table 21**);

Service development	Increased capacity (hours per day across system)
Pharmacists	296
Physiotherapists (direct access)	90
Mental health and wellbeing	120
Neighbourhood teams	146
Healthy communities	135
Practice navigation	0
Neighbourhood clinical triage & acute visiting	30

Note – The anticipated utilisation figure is based solely upon the achievement of levels of activity diversion described in national evidence (**Tables 20a to 20d** on p100 to p103 and **table 22** on p107), cross referenced to the currently provisioned workforce. The figure does not consider additional activities, outside of diverted from GP's.

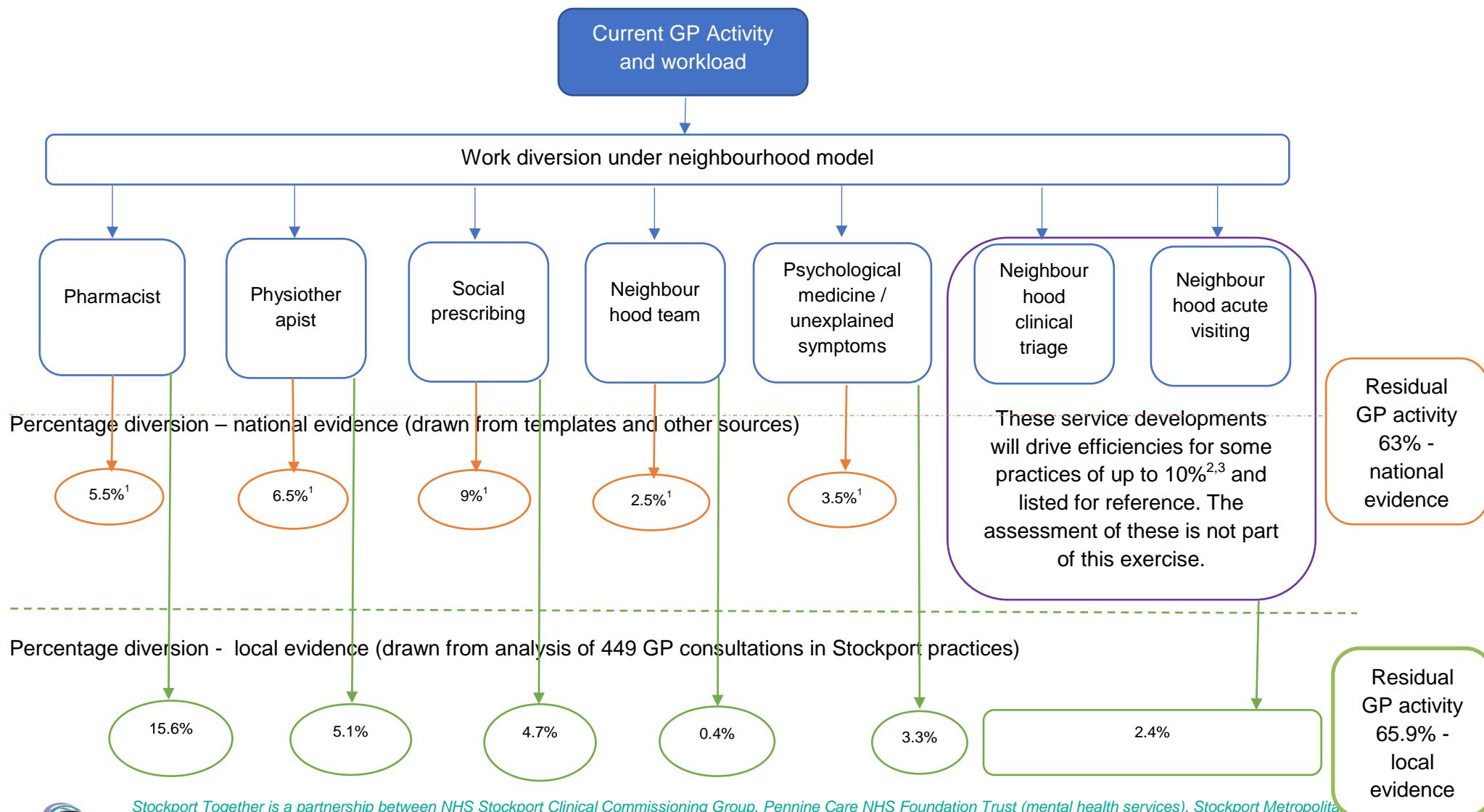
Figure 12 – total diversion of GP activity;



Investment in primary care and increased capacity in neighbourhoods to divert workload from GPs via:

- * Pharmacists
- * Direct access physiotherapists
- * Training for care homes
- * Low level mental health support
- * Improved workflow management
- * Support to meet safeguarding requirements
- * Informal support through 3rd sector and voluntary organisations
- * Support for people to carry out better self-care

Figure 13 – anticipated GP activity diversion by key theme



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Table 22 - Evidence points for GP activity diversion

Ref	Evidence points for GP activity diversion
1	The future of general practice - Releasing the potential. Dr Robert Varnam - Head of general practice development NHSE. Primary Care can divert up to 27% of consultations to other professionals and community opportunities; Data collected from 5,128 consultations http://www.primarycarefoundation.co.uk/urgent-care-in-general-practice.html http://www.stoursurgery.co.uk/website/J00700/files/StourAccessSystemBrochure.pdf
2	https://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading%20Reports/Reports%20and%20Articles/Urgent%20Care%20Centres/Urgent%20Care%20May%2009.pdf http://thelancet.com/journals/lancet/article/PIIS0140-6736(14)61058-8/fulltext?rss%3Dyes http://www.minorillness.co.uk/downloads/derbyshire.pdf http://www.nhsalliance.org/making-time-in-general-practice/ http://gpaccess.uk.wordpress/wp-content/uploads/2013/01/Comparison-of-access-modes-AE-effect-v3-GPA.pdf
3	http://www.pulsetoday.co.uk/home/practical-commissioning/how-our-acute-visiting-service-reduced-emergency-admissions-by-30-per-cent/20002277.fullarticle

9 Capacity and activity diversion (to release GP capacity)

9.1 Modelling assumptions and confidence

9.1.1 Assumptions

The above modelling has a range of associated assumptions;

- The diversions levels within **Figure 13** need refining are representative of the whole of Stockport
- Individual neighbourhoods will have access to data to be able to shape the workforce to meet local need and achieve the required outcomes
- The workforce modelling in Collaborative general practice is based upon individual service lead requests. This has not yet been modelled as a whole workforce. This exercise is likely to identify skill mixing opportunities and further efficiencies
- Equitability of an hour between professionals is not the same but mapped as (e.g. physio time is not equitable to GP time).
- It is thought that there will be patients who fall into multiple categories of diversion but the scale of this is currently unknown
- Future likely workforce of General practice (GP numbers, AHP etc.) is not known
- Growth in population will attract increased funding through national formula
- It is not currently possible to identify what percentage of increased capacity is going to absorb future growth, avoid growth (due to early intervention) and to support acute deflection
- It is not currently possible to confirm how much of the new capacity will be required to ensure safe and sustainable primary care
- The 27% in the Varnam paper refers to GP consultation time – our model is using GP total system hours, which are obviously different things. This will be clarified through the pathway work with clinicians
- The model currently uses ‘hours’ as the currency and assumes activity transfer has equitable time diversion. This is unlikely to be the case and will be clarified through pathway work with clinicians
- Benefit analysis at this stage is based on tariff reduction and further analysis is needed to equate benefit into cost reduction

9.1.2 Confidence

Given the above limitations the following confidence levels should be applied to key information;

Table 23 – confidence in data / modelling

Modelling area	Confidence level
Evidence base	Green
Strategic context	Green
Activity diversion levels	Green
Workforce requirements (overall)	Green
Workforce requirements (at individual neighbourhood level)	Yellow
Deliverability of outcomes framework (at individual neighbourhood level)	Yellow
Funding required	Green
Modelling of benefits realisation (at individual neighbourhood level)	Yellow

Note: Confidence has increased since previous versions of the neighbourhood business due to the completion of additional local modelling and caseload analysis. This work demonstrates that the activity diversion levels described in the national evidence are similar to those achievable in Stockport. Each neighbourhood has a different patient profile so will require a different workforce. Modelling at a neighbourhood levels is underway and once complete, will enable confidence level on the remaining 3 categories to be raised to green.

10 The Economic and financial case

The financing of this business case is contingent upon three factors;

- 1) In the short term (2017/18) initial levels of investment will be funded from a combination of;
 - Transformation Funding secured from Greater Manchester as part of the Investment Agreement
 - External funding bids to cover the costs of the significant additional pharmacist capacity (3 year NHSE funding achieved)
 - CCG allocations relating to specific developments in General Practice and the GP Forward View
- 2) In the medium and longer term (2018/19 – 2020/21) maintaining the CCG allocations and the release of the Stockport Together benefits, delivered through a combination of reducing acute capacity and managing growth in acute demand.
- 3) Across this whole period, a risk share agreement that underwrites the investment risk across the Stockport Together partners. This agreement is described in further detail in the summary economic case.

The profiling of investment and sources of funding are described in the table below;

Table 24 – investment and source profiling

Funding	17/18	18/19	19/20	20/21
	PYE	FYE	FYE	FYE
Savings	£0	-£11,170,168	-£14,907,353	-£20,465,015
Transformation fund	-£5,289,390	-£455,787	£0	£0
CCG funding	-£1,890,146	-£1,890,146	-£1,890,146	-£1,890,146
GM Standards	-£1,500,000	-£1,500,000	-£1,500,000	-£1,500,000
CCG Transformation fund	-£1,750,000	£0	£0	£0
BCF (Falls)	-£75,000	£0	£0	£0
NHSE Pharmacy funding	-£705,000	-£480,000	-£262,500	£0
Total Funding	-£11,209,536	-£15,496,101	-£18,559,999	-£23,855,161

Table 25 describes the detailed investment to be made. In addition to the contributions from Stockport Together savings elsewhere in the system it includes for completeness £3.4m of CCG investment Primary Care 7 day access and Greater Manchester Primary Care standards.

Table 25 – Cost and benefit table

DESCRIPTION	17/18 Phasing	18/19		19/20		20/21		Start date
		Cost	Benefit	Cost	Benefit	Cost	Benefit	
		PYE						
Integrated multidisciplinary teams								
Remodelled neighbourhood teams	£2,528,617	£3,242,223	-£6,395,013	£2,575,420	-£8,148,655	£2,115,902	-£10,864,874	Q1 & 2
Home support workers night service	£321,418	£428,558	£0	£428,558	£0	£428,558	£0	Q2 July 17
Neighbourhood teams extended hours	£508,114	£677,485	£0	£677,485	£0	£677,485	£0	Q2 July 17
Home care support / Care home support	£1,054,000	£1,190,579	-£2,300,000	£1,190,579	-£2,300,000	£1,190,579	-£2,300,000	Q2 July 17
Mental Health	£352,324	£704,648	£0	£704,648	£0	£704,648	£0	Q3 Oct 17
Falls service	£218,350	£428,200	£0	£428,200	£0	£428,200	£0	Q3 Oct 17
Enhanced AHP	£293,672	£587,343	£0	£587,343	£0	£587,343	£0	Q3 Oct 17
Total	£5,276,496	£7,259,037	-£8,695,013	£6,592,233	-£10,448,655	£6,132,715	-£13,164,874	
Collaborative general practice								
Find & Treat	£73,000	£286,000	-£71,329	£286,000	-£570,633	£286,000	-£1,426,581	Q4 Jan 18
Enhanced pharmacy & rpt prescribing offer	£1,000,000	£2,000,000	-£1,500,000	£2,000,000	-£3,000,000	£2,000,000	-£5,000,000	Q3 Oct 17
Enhanced physio offer	£620,000	£620,000	£0	£620,000	£0	£620,000	£0	Q1 Apr 17
Mental wellbeing support	£337,917	£455,062	£0	£455,062	£0	£450,556	£0	Q2 July 17
Neighbourhood treatment room & minor injury	£125,000	£250,000	£0	£250,000	£0	£250,000	£0	Q3 Oct 17
Back Office (EMIS)	£50,000	£100,000	-£870,276	£100,000	-£857,871	£100,000	-£846,385	Q3 Oct 17
Healthy Communities	£142,864	£559,406	£0	£565,424	£0	£571,514	£0	Q4 Jan 18
Neighbourhood clinical triage	£50,000	£100,000	-£33,549	£100,000	-£30,194	£100,000	-£27,175	Q3 Oct 17
Neighbourhood acute visiting	£50,000	£100,000	£0	£100,000	£0	£100,000	£0	Q3 Oct 17
Primary care 7 day service	£1,890,146	£1,890,146	£0	£1,890,146	£0	£1,890,146	£0	
Total	£4,338,928	£6,360,614	-£2,475,154	£6,366,632	-£4,458,698	£6,368,216	-£7,300,141	
GP Practise								
Enhanced admin 'banding'	£94,113	£376,450	£0	£376,450	£0	£376,450	£0	Q4 Jan 18
GM Standards	£1,500,000	£1,500,000	£0	£1,500,000	£0	£1,500,000	£0	
Total	£1,594,113	£1,876,450	£0	£1,876,450	£0	£1,876,450	£0	
TOTAL	£11,209,536	£15,496,101	-£11,170,168	£14,835,316	-£14,907,353	£14,377,381	-£20,465,015	

11 The Commercial Case

The range of services set out within this business case spans a number of pre-existing and future contracts, these are:-

- The national uplift for GP services. This is covered by the national GMS/PMS contract negotiation process. These are contracts in perpetuity and therefore no procurement process will be undertaken.
- The local stability payment to General Practice. This is a payment that can only be made to holders of GMS/PMS contracts in Stockport. The Stockport GP Development Scheme contracts will be varied to include the GM standards and the associated contract payment.
- 7-day access services. NHS Stockport CCG has an existing contract agreement with Viaduct Care to provide 7-day access services.
- Non-recurrent payments for services funded by the Investment Agreement. These will be transacted as fixed term contract variations to existing contracts with the individual providers.
- Integrated 7-day Community Services – there are two potential provider models to deliver these services: -
- A partial or fully integrated MCP. Stockport CCG and Stockport MBC initiated a procurement process in April 2016 for a Stockport MCP. A significant volume and value of the services described within the integrated 7-day community services fall within the scope of this procurement process.
- A virtual integrated MCP. As set out in the national MCP guidance a procurement process is not required where an alliance agreement is established and existing contracts remain fundamentally unchanged. It is anticipated that such an alliance agreement will inevitably be required because;

- a) Service delivery will commence in advance of completion of the procurement process and all services must be delivered within an appropriate contract.
- b) Not all services will fall within the scope of the MCP procurement but these are covered by existing contract agreements.

It should be noted that the most significant funding source is services already included within existing agreements. The impact of this business case is therefore not to increase the value of contracts in aggregate but firstly to reduce the value of the contracts in scope and secondly to redistribute income across services / sectors.

11.1 Strategic Objective

The local commissioners (NHS Stockport CCG and Stockport MBC) have commenced procurement for a Multi-Specialty Community Provider (MCP). The commissioners have identified three fixed-point providers. This is subject to the successful outcome of that procurement process and nothing in this section will prejudice that process.

This business case therefore describes who the commissioners will contract with for the various elements of the service model under existing arrangements. If the procurement of an MCP is concluded successfully contracts will novate accordingly in line with the negotiated agreement and mobilisation timescale of the said MCP.

11.2 Options and Approach

Schedule 1 Commercial Detail (to follow), describes in detail which service elements described in the business case will be contracted with and by whom; the contractual basis of this arrangement, and the time frame.

Given that the majority of these services will be provided by the fixed-point providers or their chosen partners as described above the principle means of contracting in 2017-18 onwards will be via variations to existing contracts. Broadly these can be summarised as:

- Uplift will be applied to existing GMS/PMS contracts by the CCG under its delegated powers from NHS England
- Additional services at GP practice level will be variations to the existing GP Development Scheme held between the CCG and individual practices
- Collaborative general practice services will be via a contract variation of the existing arrangements Between the CCG and Viaduct Care
- Additional investment in community health services will be via a variation in the existing community health service contract held between the CCG and Stockport NHS Foundation Trust
- Additional investment in community mental health services will be via a variation in the existing contract held between the CCG and Pennine Care NHS Foundation Trust

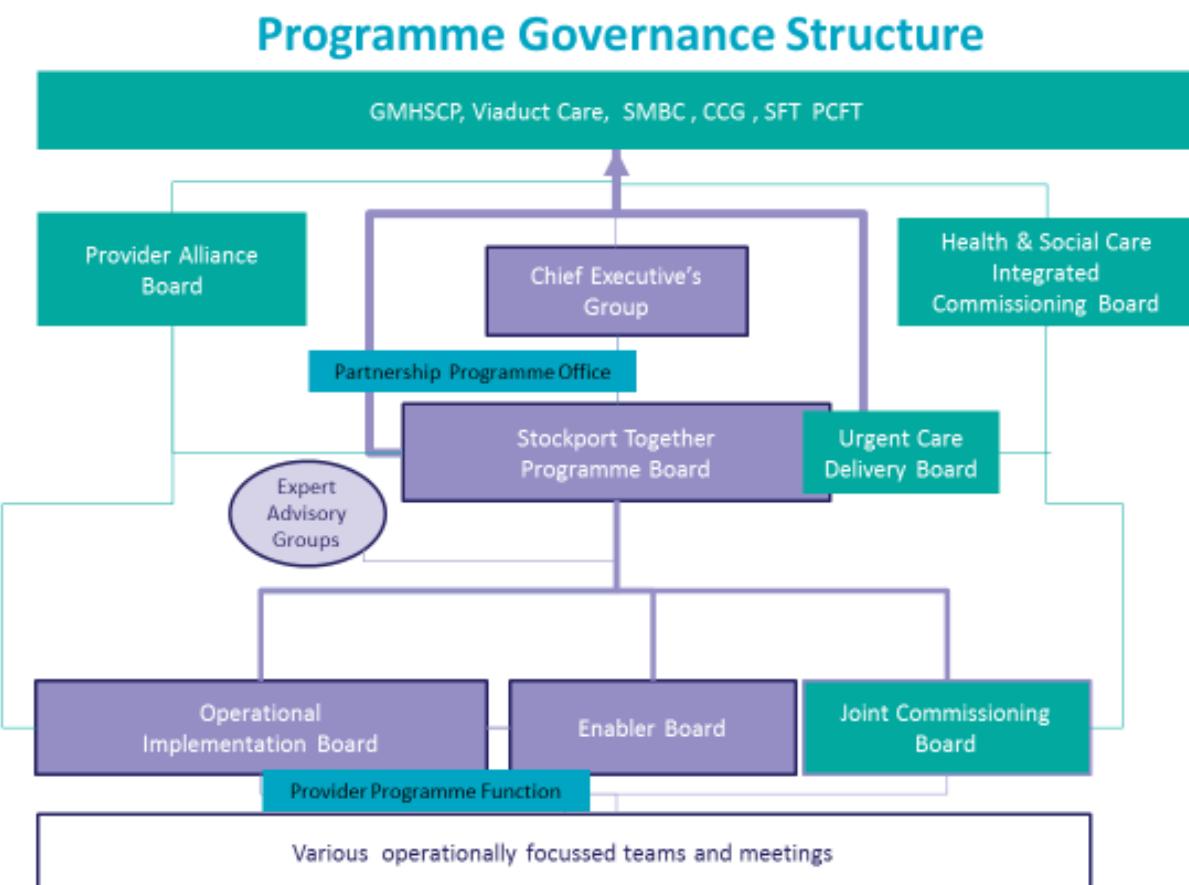
Contracts funded through the Section 75 pooled fund will be overseen by the Health & Social Care Integrated Commissioning Committee of the Council and CCG.

12 The Management Case

It is clear that the effectiveness and robustness of the Service Development Implementation Plan and the supporting governance framework is critical to the success of the business case and to de-risking the benefits realisation.

The Stockport Together programme has had a clear governance structure and formal governance arrangements in place for 2 years which are regularly reviewed. These arrangements have overseen development of the plans and will oversee implementation of the Integrated Service Solution including the Core Neighbourhood Business Case

These are set out below in **Figure 14 – Governance structure**



The Leaders Group is composed of the Chief Executives of all five statutory health and care organisations in Stockport. It provides and communicates the vision and strategic direction for Stockport Together and the Integrated service solution. The group also manages the external messages and relationships and resolves any unresolved issues at Executive Programme Board

The Executive Programme Board is made up of senior representatives from both commissioning and provider organisations in Stockport and has responsibility for the governance of the delivery, quality, safety and sustainability of the integrated service solution. This includes seeking and receiving assurance from Providers that the implementation of the care models is proceeding according to the agreed design and implementation plan. It is also responsible for ensuring formal change control is in place.

To support the effective implementation of the Integrated Service Solution, Providers will implement a formal alliance arrangement in which a newly constituted Provider Board will have delegated authority for all in scope Stockport Together health and social care provider services (to be known as Stockport Neighbourhood Care). A Transitional Management Structure with single line management responsibility will also be implemented to ensure that the new models of care are effectively implemented and the benefits maximised. This will be supported by the implementation of formal integration agreements enabling the Transitional Management Team and Core Neighbourhood leadership to exercise appropriate decision making authority. The Provider Board will create a time limited Implementation Board including commissioner representation to ensure that the Integrated Service Solution is implemented according to the agreed design and implementation plan

The mobilisation and implementation of the business case and benefits realisation will be supported by access to a single integrated Stockport Health and Care Programme Office and Transformation Team augmented with commissioned support from external agencies including AQuA, ECIP and Skills for Health. This will comprise a core team of 25 wte including Programme Managers, Change managers, Workforce Advisers, Communications experts and OD specialists.

External capacity and capability to support a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change is currently being procured under local framework agreements.

A draft Service Development implementation timeline fully aligned to benefits realisation is included as **appendix 10**

13 Risks

The risk assessment was undertaken against a framework of risk areas and then assessed against impact (I) and Likelihood (L) to give a risk rating (R). Each risk was rated on a scale of 1-5 against impact and also 1-5 against likelihood. The overall risk rating is impact x likelihood.

Table 26 – risk matrix

Level	Score	Colour
Extreme	20-25	Red
Very High	15-19	Red
High	10-14	Orange
Moderate	6-9	Yellow
Low	1-5	Green

13.1 Strategic

The strategic risks listed here (**table 27**) are taken from the summary economic case, relating to failure to release benefits across all the business cases.

Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
	Failure to effectively manage demand for acute hospital urgent and planned care interventions as set out in the benefits realisation plan			Red	<ul style="list-style-type: none"> The Integrated Service solution is based on a sound international evidence based General Practice, the Neighbourhood Teams and Intermediate Tier will be resourced to address the demand 			Orange

1		4	5	20	<p>and capacity consequences of working intensively with the 15% of the population most at risk of admission</p> <ul style="list-style-type: none"> • A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme • The implementation of the Financial Early Warning system will provide the system with ability to react quickly to variations from plan • Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services • The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits • The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and 	3	4	12
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					Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health			
2	Failure to effectively implement the new service model, leverage the required change in system and workforce behaviours and implement new ways of working across a disparate workforce	4	5	20	<ul style="list-style-type: none"> • A well-resourced single programme management office will oversee the implementation and change programme • Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services • The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits • The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health • Internal Change teams will be 	3	4	12

						created and staffed by people from across organisations with appropriate external support and facilitation <ul style="list-style-type: none"> • Providers will implement a formal alliance supported by integration agreements setting out delegated authority powers • Leadership will drive system thinking and breaking down of silos • Barriers to joint working will be addressed (whether IT, IG, cultural) 			
3	Failure to increase out of hospital capability and capacity to that required in the business cases to deliver the quality care for people in the community by successfully recruiting a new type of workforce whilst retaining, developing and retraining existing teams	4	4	16		<ul style="list-style-type: none"> • Development of a clear and comprehensive Workforce Strategy integrated across Providers • Implementation of Integrated Recruitment and Retention strategies which make a compelling offer to the unqualified workforce not currently engaged in care • A new offer to the External Homecare market • A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme • Development of HR shared services across Stockport 	3	3	9

					20	<p>Providers</p> <ul style="list-style-type: none"> • Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services • The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health 			12
4	Failure to successfully reduce the system-wide cost of delivering health and social care services to our population cohort against a background of a system with performance issues in Urgent Care and current regulatory intervention	4	5	20		<ul style="list-style-type: none"> • A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme • Providers will implement a formal alliance supported by integration agreements setting out delegated authority powers. The Provider Board will have delegated authority for in scope Stockport Together services and will performance manage the benefits 	3	4	12

				realisation plan				
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- Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services to shorten governance lines
- The implementation of the Financial Early Warning system will provide the system with the ability to react quickly to variations from plan and a mechanism for liquidating loss in the event of failure of the programme
- The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits

The operational risks listed here (**table 28**) are directly applicable to the implementation of the neighbourhood business case and if realised, would ultimately manifest in the non-delivery (partial or full) of the benefits (i.e. realisation of the strategic risks in section 13.1).

Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
1	<p>The availability and suitability of estates within each neighbourhood is not clear. Subsequently it is unclear whether adequate physical space exists to support the delivery of the neighbourhood model.</p> <p>The risk is that the described model is undeliverable due to variable estate options across neighbourhoods and unknown estates constraints.</p>	3	4	12	<ul style="list-style-type: none"> Full neighbourhood estates review planned to be completed by July 2017 The implementation of the model will be different in each neighbourhood, reflecting available resources Co-location of front line staff, enabling integration and collaboration will be prioritised Estate will be considered across sectors rather than in silos (with commitment to avoiding variable and disproportionate pricing) Where less than ideal estates solutions are available applications for new funding through national funding opportunities will be made as and when they arise New working patterns and enabling technology will allow greater flexibility and more efficient use of estate 	2	3	6

2	<p>Assumptions (based on national evidence) have been made as to how much GP activity can be diverted to other professions. The released capacity is required so GP's can support new ways of working and provide additional support to those with LTC's, thus enabling the safe reduction in acute activity.</p> <p>The risk is assumptions around activity diversion are not effectively enacted or base assumptions are inconsistent with what is achievable in Stockport / in an individual neighbourhood. If the risk materialises GP's will be unable to provide the additional time for patients with complex needs meaning the acute activity will not sufficiently reduce. (links to risks 3 and 4)</p>	3	5	15	<ul style="list-style-type: none"> • Neighbourhood level patient need profiling will be conducted prior to implementation, ensuring the prominence of specific service developments and provided workforce match the needs of local people and align with the delivery of overall benefits and outcome measures • Funding will be distributed between neighbourhoods based upon weighting for deprivation and demographic profile • Benchmarking across GM, England and relevant NHSE groups (e.g. new models of care) will be used to support ongoing identification of opportunities for additional gain / sharing of best practice 	2	4	8
3	<p>This business case and the successful implementation of the model is critical to the future sustainability of the Stockport health and social care system. There are significant changes in setting for funding and where activity must be conducted. There are key concerns within the system around this;</p> <p>1. Primary care needs to be</p>	4	5	20	<ul style="list-style-type: none"> • Modelling will be shared with all stakeholder groups prior to implementation (final plans will be post public consultation) • Appropriate contracts will be signed with all relevant parties • Initial 'quick wins' around outpatients (described in the outpatients business case) will be used to build confidence within primary care 	3	4	12

	<p>confident that long-term funding will switch from the acute to primary care setting, thus enabling more patients to be supported out of hospital</p> <p>2. Acute care needs to be assured that sufficient activity will switch in the required time to enable the management of cost base and income diversion</p> <p>These 2 concerns are the same situation but considered from 2 different viewpoints. There are 2 key risks.</p> <p>Risk 1 of 2 – Concerns around timing of funding shift delay the model implementation, leading to insufficient activity switch during the time when transformation funding is available (links to risks 2 and 4)</p>				<ul style="list-style-type: none"> Wide involvement of primary care in the implementation will support ownership and confidence development Commitment from Stockport FT and Viaduct will be joint and widely communicated All GP's will have the opportunity to discuss and inform final plans prior to implementation Viaduct will take a leadership role in ensuring GP's are informed and able to express opinions 			
	<p>This business case and the successful implementation of the model is critical to the future sustainability of the Stockport health and social care system. There are significant changes in setting for funding and where activity must be conducted. There are key concerns within the</p>				<ul style="list-style-type: none"> A single programme management office will oversee the change programme Change teams will be staffed by people from across organisations Leaders from across the system shall taking joint responsibility for the delivery of change 			

4	<p>system around this;</p> <p>1. Primary care needs to be assured that long-term funding will switch from the acute to primary care setting, thus enabling more patients to be supported out of hospital</p> <p>2. Acute care needs to be assured that sufficient activity will switch in the required time to enable the management of cost base and income diversion</p> <p>These 2 concerns are the same situation but considered from 2 different viewpoints. There are 2 key risks.</p> <p>Risk 2 of 2 – All system partners commit to enacting the new model but existing structures fail to adapt quickly enough to enable sufficient activity shift prior to transformation funding running out (links to risks 2 and 3)</p>	4	5	20	<ul style="list-style-type: none"> Providers will jointly sign partnership / integration agreements Providers shall sign risk / gain share agreements, committing to collective responsibility Leadership will drive system thinking and breaking down of silos Barriers to joint working will be addressed (whether IT, IG, cultural) 	3	3	9	
5	<p>The outcomes framework has been developed to ensure improved public health and avoided annual future recurrent costs of £14m by 2020/21.</p> <p>The risk is that current system pressures and focus on managing</p>	4	4	16	<ul style="list-style-type: none"> The draft outcomes framework has been developed to reflect the ability of providers to impact on outcome measures A clear evidence base has been used to build the outcomes framework, ensuring deliverability Performance monitoring will 	2	3	6	



	immediate demand prevents sufficient focus on early intervention and prevention, thus failing to deliver the required changes in public behaviour and improvements in population health.				<p>reflect the achievement of outcomes, giving early indications of variance</p> <ul style="list-style-type: none"> • Service developments such as find and prevent have been designed to target those at risk of developing an LTC • New support around lifestyle change is resourced through this business case and others • The neighbourhood model draws on local knowledge, expertise and assets to ensure maximum impact • Integration will ensure staff learn from other sectors and are able to deliver an holistic, person centred approach which draws on the individual's abilities, networks and ambitions • MDT's will include voluntary sector representation ensuring close working and knowledge of what is available locally • Additional capacity has been built into the voluntary sector, selfcare support and lifestyle coaching services 			
	Sharing data between health and social care has been challenging, reducing the ability to accurately map joint caseloads within the 15% high use cohort.				<ul style="list-style-type: none"> • Information sharing agreements have been signed between all partners (including all individual GP practices) • The implementation of EMIS as the single use community system 			

6	The risk is that operational delivery of the new model / this business case (particularly integrated care / services) will be inhibited due to an inability to effectively share data	3	4	12		<ul style="list-style-type: none"> will ensure shared view and reduce duplication MDT's and integrated working will ensure close practitioner to practitioner relationships, enabling sharing of knowledge in the best interests of patients Medium term data indexing options will provide greater digital integration 	2	3	6	
7	<p>Public consultation is yet to happen and may change the Stockport Together plan.</p> <p>The risk is that changes mean the model does not deliver the required system benefits</p>	4	4	16		<ul style="list-style-type: none"> Financial and clinical benefits will be remodelled following public consultation to understand any changes in benefits The public consultation will make clear the need and rationale for change to ensure the public can provide informed commentary Local press will be engaged with the process Significant elements of the neighbourhood model (particularly integration, MDT approach, community development, early intervention and prevention, selfcare etc.) would not be subject to Public consultation and the development has been driven through significant patient, staff and public engagement 	3	4	12	
8	Some service developments within Primary Care are yet to be fully developed, costed and mapped to					<ul style="list-style-type: none"> All the larger service developments have been more accurately mapped, leaving work 				



	the required level of benefits realisation. The risk is that incorrect amount of resource has been applied to deliver the required benefit (particularly release of GP time) having a knock-on effect of the neighbourhood model having insufficient of the correct resource to be able to support the required numbers of patients in community and primary care setting.	3	3	9	to do on some of the medium to smaller impact developments	2	3	6
9	There are an estimated 51,400 undiagnosed incidents of key long term conditions in Stockport (covering diabetes, pre-diabetes, hypertension, atrial fibrillation, dementia and COPD). The neighbourhood business case anticipates identifying 21,900 of these incidents by 2020/21. This is 41.6% of the total estimate. The Stockport Together / Neighbourhood models are designed to manage this number of people. The risk is that the Find and Prevent service successfully identifies more people than this and the capacity to support these additional people is not in place.	3	4	12	<ul style="list-style-type: none"> • Numbers of cases identified through the find and prevent service will be monitored. Over performance will be escalated • Impact of the find and prevent service will be monitored in terms of released capacity at the acute trust and avoided complications • Should more people be identified / the target be hit sooner than 2020/21, sufficient evidence will have been compiled to accurately evidence cost benefit and justify further diversion of income to fund the early intervention programme. 	2	3	6
	The delivery of the neighbourhood				<ul style="list-style-type: none"> • A new quality and transformation 			

10	<p>model requires the home care and care home market to work in a new way, with adequate capacity to ensure people are able to return home after periods of acute care in a safe and timely way.</p> <p>The risk is that these sectors are unable to respond effectively to the commissioning intentions.</p>	3	4		<p>team is funded through the Neighbourhood business case to support the change programme</p> <ul style="list-style-type: none"> • Initiatives to support effective transfer are being developed / implemented, including discharge to assess • SMBC will implement effective contract management and provider engagement processes to ensure alignment to the Stockport Together model. 	2	3	
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14 Implementation milestones

Please see **appendix 11**, Programme milestone

NEIGHBOURHOOD OUTLINE BUSINESS CASE APPENDICES

SERVICE AREA: MENTAL WELLBEING?

Component	Description
Current. Brief description of existing services (i.e. how many sites, how many staff, functions, opening hours , capacity). (NUMBERS)	<p>Patients with mental health conditions who present at general practice can be complex and time consuming and often the GP appointment is not long enough to explore and manage the underlying issues in great depth. Around 30 % of GP consultations are for patients with low level / social needs / mental health related conditions which could be due to a multitude of reasons. Evidence from a small local pilot and similar services such as those piloted through the Prime Ministers challenge fund show the benefits in GP's having direct access to a service able to explore the issues causing the mental health condition in patients and then connecting the patients to the appropriately services such as social prescribing, self-help, mental health alliance and other voluntary groups.</p> <p>The opportunity of developing a new service provision that particularly focuses on the lower level social and wellbeing Mental Health issues will support the approach of making time and managing demand with greater integration in General practice as recommended by the GPFV and Making Time in General Practice.</p> <p>PILOT Current</p> <p>The provision of navigational services for low level Mental Health / Social and Wellbeing conditions in the Tame Valley Neighbourhood covering 8 practices with a combined list size of 47,500~patients. The service is currently being delivered over 5 sites in GP practices within the neighbourhood. The 2 WTE navigators work 8am to 4.00pm (sometimes later at patient request) and the capacity is spread over the five sites based on room availability and weighted list share of hours per practice. As the service is currently still in development full capacity has not been reached.</p>
Problems & Opportunities: What could change – 2 sentences	<p>The proposed change is to provide general practice and the neighbourhood teams with direct access to Care Navigators in a local setting. Patients will be given the appropriate consultation time and once the underlying issues are established they are navigated to the most appropriate service based on their needs. In some cases patients may be referred back into General practice once the social issues are resolved to deal with any health related conditions. It is envisaged that not all patients will need to follow this pathway as some patients will be treated by medication or will not be suitable or need this support.</p> <p>Opportunities: To train and develop new staff into the role and involve the skills already available in the voluntary sector.</p>

New service: What people, what processes, what use of technology, what additional capacity, what functions, clinical / professional governance (NUMBERS)	<p>The proposed change is to provide general practice and the neighbourhood teams with direct access to Care Navigators in a local setting. The plan is for 16 Care navigator posts to be shared across the neighbourhoods based on weighted list size.</p> <p>The navigator will hold a minimal caseload with the majority of patients only seen once with one follow up and then discharged (primarily consisting of 'frequent users' of GP practices) with the aim that these patients will experience improved health and wellbeing and a reduction in their use of GP practice resources and also attendance at ED.</p> <p>Hubs will be set up across the neighbourhoods and each practice will have access to book direct appointments with the Care Navigators.</p> <p>The aim of the service is to develop and implement effective action plans that will address the individual's non-medical needs. The service is not a support service. Its purpose is to work with individuals to identify their needs and navigate them to support services or encourage self-referral to community groups or other organisations.</p> <p>Patients will be booked into the service directly by receptionists and via referrals from other professionals. Patients will be offered a face to face appointment/ telephone consultation within one week of referral. Patients will be given 40 minute appointments for their initial assessment in order to identify the underlying issues requiring access to other services. The service is not in itself a therapeutic or counselling service but aims to work with the individual patients to promote confidence in self-care, independence and an improved sense of health and wellbeing.</p> <p>The service, when appropriate, will introduce to the patients the different approaches to health care; to assist and encourage them to make their own decisions and choices. The service will use an enabling approach that draws on individuals' strengths, preferences and support networks. Patients will be provided with self-help information and tools.</p> <p>In some cases it may be more appropriate to a telephone discussion to help patients identify their health and well-being goals. Communication with patients will also include email or text for follow-up</p> <p>Specific service aims are:</p> <ul style="list-style-type: none"> • To support patients with mental health conditions by providing additional time to listen and identify the underlying issues that underpin their conditions. • To provide a pathway to support, appropriate to their needs. • To provide quicker access to patients in need. • To provide alternatives to medication such as social prescribing. • To provide support to General Practice in providing additional manpower. • To facilitate standardisation of good practice across Stockport. • To provide local services in the neighbourhood. • To pro-actively prevent patients reaching critical point. • To support integrated working across Stockport on a neighbourhood footprint. • To reduce acute admissions and unnecessary secondary care attendances.
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	<ul style="list-style-type: none"> • To provide faster referral pathways into secondary care mental health advice services. • To liaise with GP front of house staff in signposting to services. • To ensure that people have and report a good experience when they access the service.
7 day service – describe the extent to which service offer is over 7 days and links where appropriate to 7 day services – GP or otherwise	Currently it is not planned to include a Saturday and Sunday service but referral pathways should allow for patients seen on those days to be referred into the service and be seen by the navigators in routine appointments Monday to Friday.
Benefits: What will it deliver in terms of outcomes, benefits to population, and efficiency improvements (Cash & time) (NUMBERS). What evidence is the basis of this (<i>National evidence, Local pilots, Assumptions</i>)	<p>The benefits will be</p> <ul style="list-style-type: none"> • Support to General Practice releasing capacity in an already stretched service. • Patients underlying problems are appropriately identified. • Improved and appropriate care navigation within the health and social care system for the neighbourhood population, i.e. patients referred to the appropriate services based on their needs. • Better value for all, i.e. more people can access the service with outcomes that will have a positive impact on both physical and mental well-being

Costs: What will it cost and how was this derived? (Staffing, technology, start-up non-recurrent and recurrent)	£450,000~ per annum				WTE	Cost	Total
		AFC Band	XN060 2	1			
2017/18 All neighbourhoods							
Workforce						£	£
			XN050 2	2		55865.96	
				12.3			£434,556.1
			XN407 3	3		344413.67	7
Training						£6,000.00	
Estates I&T						£6,000.00	
Management cost						£4,000.00	
						£450,556.1	7
<hr/>							
2018/19 All neighbourhoods							
Workforce						£	£
			XN060 2	1		34619.30	
			XN050 2	2		56424.62	
				12.3			£438,901.7
			XN407 3	3		347857.81	3
Training						£6,060.00	
Estates I&T						£6,060.00	
Management cost						£4,040.00	
						£455,061.7	3

FIND AND PREVENT

Purpose
This business case focuses on three different cohorts of people: <ul style="list-style-type: none"> • People who have a long term health condition and do not know about it. • People who have a long term health condition and know about it, but for many reasons their treatment or lifestyle choices may not be optimised to manage that condition. • People who do not yet have a long term health condition but have risk factors and behaviours which mean that they may be more likely to develop long term health conditions.
This business case looks at how these three groups can be better identified and assessed in primary care settings. By finding people through consistent and systematic use of EMIS search and reports, we can develop protocols and processes to invite people for enhanced health checks within the neighbourhoods, following which appropriate treat responses can be made.
This case links closely to other parts of the neighbourhood business case where the treatment of those found will be achieved, principally through optimising primary care (core neighbourhoods), improved self-care (healthy communities) and referrals to lifestyle behaviour change and prevention programmes (healthy communities, self-management, education courses and the NHS Diabetes Prevention Programme).
By using Healthy Living Pharmacies as well as EMIS Search and Report within General Practice we will further develop our ability to find and assess people in their communities.
These programmes will together reduce: <ul style="list-style-type: none"> • the development of conditions (i.e. primary prevention) • the escalation from simply managed conditions such as hypertension to more complex conditions such as stroke, heart disease or kidney disease (secondary prevention) • the numbers of exacerbations, complications and acute care incidents relating to long term conditions.
Other Stockport Together business cases are focussing on those who already have multiple long term conditions and who are currently at high risk of exacerbation or admission; this business case is focussed on the longer term prevention for those who have yet to develop complex care needs as there is an increasing level of disease, potential disease and levels of complexity due to multiple conditions as the population of Stockport gets older.
The prime rationale is therefore to reduce in the long term the level of disease, providing a better quality of life for patients and their families, and increasing healthy life expectancy, in other words to close the health and wellbeing gap .
The secondary rationale is that the current health system was not established to manage long term health problems. Over time it has adapted to do so but is now under severe pressure from the volume of activity that this requires, and therefore a new approach is needed. If we can get ahead of the development of disease and stabilise or prevent the development of disease we can make the future of the health system more sustainable (closing the funding and efficiency gap) . Without a preventative approach we will continue to be faced with rising demand and soon patients and services will be experiencing the consequences of the predicted diabetes type 2 and other disease time bomb.
A third rationale is to address the variation in health outcomes (inequalities) and care

provision (quality gap) across Stockport. It has been shown that improving the health of the population in our most deprived populations to levels experienced in other parts of the Borough would significantly reduce the burden of disease in the borough. Stockport generally has a high quality of care in General Practice, with many examples of innovation and excellence; there is however still variation between practices. This programme will enable the **standardisation of prevention and the sharing of good practice, reducing variation and enabling the lower performing areas to level up to the best.**

A fourth rationale is to give the necessary support and structure to enable the Stockport system to **quickly mobilise to generate referrals into the NHS Diabetes Prevention Programme.** This programme is being extended across Greater Manchester from April 2017, and is only confirmed to be available for a two year period. We need to ensure that as many people at risk of type 2 diabetes as possible are offered the structured prevention programme, funded by NHS England.

A final rationale is to maximise the opportunities from the existing **Healthy Living Pharmacy** programme to ensure that there are ways to engage people beyond the General Practice setting and additionally to ensure that the pharmacy sector is supported through the transition to the new national contract.

Together these rationales build a case for change based on the five year forward view vision of **a radical upgrade in prevention.** General Practice already have many good examples of proactive and preventative approaches to long term condition management, particularly via the QoF and for early identification, such as the NHS Health Checks. The find and prevent programme aims to build on this by **improving the quality of the existing provision, by reducing variation and by extending these approaches in to more conditions.**

Background

LONG TERM CONDITIONS

Over a quarter of the population in England has a long term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes that, "Long Term Conditions are now a central task of the NHS".

People with long term conditions currently use a significant proportion of health care services

- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and healthcare costs are significant. 15.4 million people in England are recorded as having have a long term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million by 2018).

In Stockport, 27% of the population (84,700) have one of the 8 key conditions and this increases with age, from 2% in the 0-4 age band, to 88% in those aged 85 and over. By age 60, half of the people have one or more of these conditions and 15% of the population have two or more of 8 key long term conditions. Many more may also have a condition which is currently undiagnosed.

The table below shows the most common long term conditions in Stockport:

Long-term conditions overview				
Condition	Number	Gender Profile	Age Profile	Deprivation Profile
Hypertension	44,745		Increasing from mid 40s	Rates increase with deprivation, number decreases
Anxiety (last 10 years)	30,085	Higher in women	Highest from 25 to 50	Rates increase with deprivation
Depression	29,130	Higher in women	Highest in 40s and 50s	Rates increase with deprivation
Asthma	20,545	Slightly higher in women		Rates increase with deprivation, number decreases
Obesity	20,050*			
Diabetes	15,700	Slightly higher in men	Increases from mid 40s	Rates increase with deprivation
Coronary Heart Disease (CHD)	12,230	Higher in men	Increases from mid 40s	Rates increase with deprivation, number decreases
History of Fall	12,150	Higher in women	Increases from 50s, sharply in 80s	Rates increase with deprivation, number decreases
Cancer	8,540		Earlier in women	Rates and numbers decrease with deprivation
Chronic Kidney Disease (CKD)	7,670	Slightly higher in women	Increase from 50s	Rates increase with deprivation, numbers decrease
Chronic Obstructive Pulmonary Disease (COPD)	7,170		Increases from mid 40s	Rates increase with deprivation
Stroke or Transient Ischaemic Attack (TIA)	6,395		Increases from mid 40s	Rates increase with deprivation, numbers decrease
Atrial Fibrillation (AF)	6,200	Slightly higher in men	Increases from 50s	Numbers decrease with deprivation, rates vary
Self harm	3,060*	Higher in women	Highest between 15 and 34	Rates and numbers increase with deprivation
Heart Failure (HF)	3,045	Slightly higher in men	Increases from mid 50s	Rates increase with deprivation
Dementia	2,850	Higher in women	Increases from mid 60s	Rates increase with deprivation, numbers decrease
Severe mental health	2,570		Highest between 30 and 59	Rates increase with deprivation
Glaucoma	2,510		Increases from mid 50s	Numbers decrease with deprivation, rates vary
Epilepsy	2,505			Rates increase with deprivation
Peripheral Arterial Disease (PAD)	2,270	Higher in men	Increases from mid 50s	Rates increase with deprivation
Rickets (last 10 years)	1,895	Higher in women		Numbers decrease with deprivation, rates vary
Rheumatoid Arthritis	1,550	Higher in women	Increases from mid 40s	Numbers decrease with deprivation, rates vary
Acute Macular Degeneration (AMD)	1,520*	Higher in women	Increases from 70s	Rates and numbers decrease with deprivation
Learning disability	1,515	Higher in men		Rates and numbers increase with deprivation
Autism	1,170*	Higher in men		Rates increase with deprivation
Crohn's disease	1,010			
Cerebral palsy	275*			
Down's syndrome	240	Higher in men		
Motor neurone disease	35			

* Undercount of actual prevalence

4

People with long-term conditions are the most intensive users of the most expensive

services, not only in terms of primary and acute services, but also in social care and community services. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are overdue for an appointment for a long-term condition.

It is estimated that nationally the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport this will equate to an additional 47,700 people living with a condition. An increasingly older population also means that it is likely that the prevalence of dementia particularly will rise above the national average and planning care for this group of people will require additional attention.

CURRENT SITUATION IN STOCKPORT

The measure of the known population with long term conditions is usually accepted as the Quality and Outcomes Framework (QoF) disease register. These are the people coded on the general practice clinical system as having a disease.

Stockport practices are good at the identification of disease and the prevalence is generally higher than the national averages. Despite this being the case however the known prevalence is often far short of the predicted prevalence proposed by public health modelling of disease prevalence. The table below shows the situation for the six key conditions which **Find and prevent** will focus on in Stockport and gives an idea of the number of people still to be found. It also shows the benefit measure stretch we have set ourselves for 2020/21 as part of the agreement for Greater Manchester Transformation Fund.

Currently pre-diabetes type 2 (non-diabetic hyperglycaemia) is not included in the QoF, and GP practices are therefore not required to maintain a disease register or report this data. Building this register will be a prerequisite for the NHS Diabetes Prevention Programme.

Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find (GMTF Benefit by 2020/21)
Diabetes (type 1 and 2)	14,600	5,600	2,300
Pre diabetes (type 2)	Unknown	Up to 27,150	13,000*
Hypertension	43,600	11,500	4,300
Atrial Fibrillation	5,700	2,150	1,550
Dementia	2,700	1,300	750
COPD	6,700	3,700	-

*NHS Diabetes Prevention Programme commitment by April 2019

There are a potential **29,000 smokers in Stockport who have yet to develop or be diagnosed with a long term condition**, out of a total 40,000 smokers – this apparent disparity is due to the different age profiles of smokers (who tend to be younger) and those with long term conditions (who tend to be older). At each age group smokers are more likely to have long term conditions than non-smokers, but **as many smokers are young there are a large number who have yet to develop or be diagnosed with long term conditions**. This group will be a key priority.

There are also **5,000 obese people in Stockport who have yet to develop or be diagnosed with a long term condition**, out of a total 20,000 identified by GP practices.

There are three national screening programmes to detect certain cancers early, whilst they are still curable, and the national NHS Health Check programme aims to systematically identify people at risk of cardiovascular disease. The data below shows the numbers of people eligible for these programmes and the numbers that have not attended.

Screening programme	Eligible	Not screened
NHS Health Check	91,000	41,000
Cervical Cancer	77,000	5,500
Breast cancer	40,000	11,500 (in last 3 years)
Bowel cancer	24,000	11,000

The reasons that people do not attend screening are many and complex, although it is recognised that deprivation and activation are a factor. Any new system will never address the total gap, but can reduce it and may be able to address the issues of particular communities and reduce the level of inequality in the prevalence of disease.

The Quality and Outcomes Framework (QoF) also provides some useful benchmarks for the proportion of the known population whose treatment is optimised within primary care. For each long term condition there are a range of treatment indicators and the following serve as an illustration of current performance, which on the whole is good:

Condition	Measure	Performance (QoF 2014/15)	To improve management
Diabetes (type 1&2)	HbA1c ≤ 64mmol/mol	80.4%	2,575
Hypertension	Blood pressure ≤ 150/90mmHg	84.6%	6,552
Atrial Fibrillation	Anti-coagulated	85.1%	441
Dementia	With care plan	87.1%	327
COPD	FEV1 recorded	82.9%	1,010

In 2016/17 Stockport successfully launched the **Healthy Living Pharmacy Scheme** with £20,000 pump priming from vanguard funding. To date 18 of Stockport's 63 pharmacies have joined the programme, and in the first five months of delivery more than 505 preventative brief interventions (as per NICE guidelines) have been offered. Pharmacy staff are being offered structured training programmes in a range of preventative health measures and are developing referral pathways to Healthy Communities services and General Practice. Pharmacies are now being enabled to be able to use straightforward clinical testing within the pharmacy setting to extend the scope of the find and prevent programme.

NATIONAL CONTEXT

The Five Year Forward View highlights that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply

rising burden of avoidable illness. That warning has not been heeded as wholeheartedly as it could have been and the NHS is now on the hook for the consequences.

It goes on to highlight three key gaps:

- The **health and wellbeing gap**: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- The **care and quality gap**: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- The **funding and efficiency gap**: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions -for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes type 2 over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes type 2 prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

The model below describes the national approach to prevention, via risk detection and management in primary care and the key outcomes that could be achieved were this vision to be implemented. This evidence, from NHS Right Care and PHE is the foundation of the Stockport Find and prevent Programme.



Public Health
England

Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care

The Interventions	Cross Cutting: 1. NHS Health Check - systematic detection of high BP, AF, NDH, T2DM, CKD, high cholesterol, CVD risk 2. System level action to support guideline implementation by clinicians 3. Support for patient activation, individual behaviour change and self management		
High BP detection and treatment	AF detection & anticoagulation	Detection, CVD risk assessment, treatment	Type 2 Diabetes preventive intervention
5 million undiagnosed. 40% poorly controlled	30% undiagnosed. Over half untreated or poorly controlled	85% of FH undiagnosed. Most people at high CVD risk don't receive statins	5 million with NDH. Most do not receive intervention
The Opportunities	The Evidence	The Risk Condition	The Outcomes
BP lowering prevents 2/3 of strokes in AF	Behaviour change and statins reduce lifetime risk of CVD	High CVD risk & Familial H/cholesterol	Marked increase in heart attack, stroke, kidney, eye, nerve damage
Non Diabetic Hyperglycemia ('pre-diabetes')	Atrial Fibrillation		Marked increase in CVD, acute kidney injury & renal replacement
Type 1 and 2 Diabetes			
		Detection and 2°/3° Prevention	

National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies from other areas, some of these findings are directly relevant for find



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and prevent, others to wider primary care interventions:

Diabetes type 1 and 2:

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/diabetes/>

- Ensure 100% practice participation in the National Diabetes Audit (**FIND**)
- Use audit data to focus quality improvement initiatives to improve achievement of the eight key processes and three treatment targets (**FIND AND PREVENT**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management (**TREAT**)
- Work with practices and education providers to maximise referral, uptake and retention in patient education programmes (**TREAT**)
- Ensure all patients with diabetes have access to routine care by a trained diabetes nurse (**NOT FIND AND PREVENT**)
- Consider commissioning systematic support for adherence from community pharmacists through medicines use reviews (MURs) (**NOT FIND AND PREVENT**)

Pre-diabetes (type 2):

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/ndh/>

- Undertake systematic audit across practices to identify historical diagnoses of Non-Diabetic Hyperglycemia (NDH) (**FIND**)
- Establish practice registers of individuals with NDH (**FIND**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Work with practices and NHS Health Check providers to maximise referral and uptake in the 'Healthier You' NHS Diabetes Prevention Programme(**TREAT**)

Hypertension:

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/blood-pressure/>

- Undertake systematic audit across practices.
 - Identify people with possible undiagnosed hypertension (**FIND**)
 - Identify people who are not treated to target (**FIND**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management (**TREAT**)
- Use practice-based pharmacists to optimise management of hypertension (**NOT FIND AND PREVENT**)
- Commission ambulatory blood pressure monitoring service for diagnosis (**NOT FIND AND PREVENT**)
- Consider commissioning:
 - Systematic support for adherence from community pharmacists through medicine use reviews (MURs) (**NOT FIND AND PREVENT**)
 - BP self-test units e.g. in surgery waiting rooms, community pharmacies, leisure centres (**HEALTHY LIVING PHARMACIES**)
 - Digital solutions for self-monitoring and treatment optimisation(**NOT FIND AND PREVENT**)

Atrial fibrillation:

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/af/>

- Undertake systematic audit across practices (GRASP-AF audit tool).
 - Identify people with possible undiagnosed AF (**FIND**)
 - Identify people with AF at high risk of stroke who are not anticoagulated or not maintained in the therapeutic range (**FIND**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management (**TREAT**)
- Add pulse checking to existing GP and pharmacy enhanced services for people over 65 (**NOT FIND AND PREVENT**)
- Agree local clinical consensus and pathway for anticoagulation including the place of novel oral anticoagulants (NOACs) (**NOT FIND AND PREVENT**)
- Consider commissioning:
 - Technologies such as WatchBP Home A and AliveCor to support AF detection in routine care. (**HEALTHY LIVING PHARMACIES**)
 - New models of anticoagulation control e.g. self-monitoring and community pharmacy monitoring (**NOT FIND AND PREVENT**)
 - Systematic support for adherence from community pharmacists(**HEALTHY LIVING PHARMACIES**)

Dementia:

<https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf>

- Population screening for dementia is not envisaged.
- 'Timely' diagnosis is when the patient wants it. In some cases it may be when the carers need it.
- The current approach is towards raising awareness, especially in the higher risk population – specifically via NHS Health Checks (**FIND AND PREVENT**)

COPD:

<https://www.england.nhs.uk/wp-content/uploads/2014/02/rm-fs-6.pdf>

- Roll out and implementation of GP audit tools for case finding, such as GRASP-COPD. (**FIND**)
- Audit practice information systems to identify people who receive multiple prescriptions for oral steroids and/or antibiotics (**FIND AND PREVENT**)
- Support implementation of opportunistic COPD case finding in primary care through electronic decision support tools (**FIND AND PREVENT**)
- Discuss the COPD diagnosis with patients and carers, including what they can do to help manage their condition, for example signpost to advice on stop smoking and benefits of exercise (**NOT FIND AND PREVENT**)
- Target case finding based on population segmentation and social marketing described in the COPD Prevention and Early Identification Toolkit 2011 (**FIND**)
- Misdiagnosis of COPD is common so case finding tests should be followed by quality assured diagnostic spirometry, with trained staff interpreting the results. The NHS Improvement guide 'First steps to improving COPD care ' (2012) recommends that COPD diagnoses should have spirometry taken and recorded in the last 15 months other tests may be necessary to confirm the diagnosis, such as a CT scan (**FIND AND PREVENT**)

NHS Health Checks:

www.healthcheck.nhs.uk/commissioners_and_providers/guidance/

Legal duties exist for local authorities to make arrangements:

- for each eligible individual aged 40-74 to be offered an NHS Health Check once in every five years and for each individual to be recalled every five years if they remain eligible
- evidence is emerging about the effectiveness of prioritizing those at the highest risk (**FIND**)

Healthy Living Pharmacies:

<http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/>



What is a Healthy Living Pharmacy?



The impact of Healthy Living Pharmacies



Together these evidence based interventions will lead to a long term reduction in the number of people with disease, and improved health outcomes for those with disease thereby reducing the reliance on acute care settings and removing cost from the system. For each programme estimates of cost effectiveness and cost saving a being identified nationally, for example:

NHS Health Checks:

The original Department of Health (DH) modelling showed the average annual cost of the NHS Health Check programme as £332m each year at full roll out and the benefit as £3.7bn with a cost per quality adjusted life year (QALY) of around £3000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years.

The modelling shows that the NHS Health Check could, on average, prevent 1,600 heart attacks and strokes, saving at least 650 lives each year. As well as preventing over 4,000 people a year from developing diabetes type 2 and detecting at least 20,000 cases of diabetes type 2 or kidney disease earlier, allowing individuals to be better managed.

More recent evidence shows that *NHS Health Checks* :

- a new case of raised blood pressure is found approximately every three to four NHS Health Checks,
- a new diagnosis of hypertension made approximately every 30-40;
- a new diagnosis of diabetes is made for every 80-200 NHS;
- and a person with a cardiovascular disease risk $\geq 20\%$ identified every six to ten.

In Stockport around 50,000 people have had a NHS Health Check – meaning that 1,250-1,650 hypertension diagnosis, 250-625 diabetes diagnosis and 5,000-8,300 people at risk have been found; screening an additional 11,000 would find 275-370 hypertensives, 55-135 diabetics and 1,100-1,800 people at high risk.

NHS Diabetes Prevention Programme

Impact analysis suggests if 390,000 people receive the NHS DPP intervention over 5 years the approximately £1.2bn of health benefits will be gained nationally. On average 15,000 – 24,000 cases of Type 2 diabetes prevented or delayed by the 6th year, which is on average 72 to 115 cases of diabetes per CCG. By year 14, the programme will become cost saving at a national level, and this will be earlier locally as the majority of the intervention costs are born nationally.

Across Stockport implementation plans for the two years suggest that between 135 and 215 cases of type 2 diabetes will be prevented.

LOCAL CONTEXT

Health Outcomes and causes of premature mortality

We have a GP-registered population of around 300,000 people, are one of the healthiest places to live in the North West and are comparable with England in terms of health outcomes. We rank amongst the highest in England in terms of cancer survival rates, and have achieved decreasing mortality over a long period of time.

We know through our Joint Strategic Needs assessment (JSNA) that there are four main disease groups which cause 80% of deaths in Stockport; Cancer, Heart Disease, Lung Disease and Mental Health. The environment and lifestyle choices are contributing significantly to the development of these diseases and the higher burden felt in the most deprived areas. Early identification of disease is also essential to improving outcomes, as is supporting individuals to have the knowledge and the confidence to proactively manage their condition and to modify their lifestyles.

Preventable premature death is driven by a range of factors. Around 25% of adults in Stockport are classified as obese, and 75% are not active enough. Among our population hospital stays resulting from alcohol related harm were 709 per 100,000 in 2013/14, worse than the average for England. On the widest measure a total of 6,900 admissions per year can be attributed to alcohol. Around 18% of adults in Stockport are smokers (slightly better than the England average), but rates show significant inequalities so that people in our most deprived areas are more than twice as likely to smoke as the average.

Health Inequalities

We have one of the largest health inequality gaps in England. The overall borough wide health outcomes mask significant differences between the different neighbourhoods across the borough. There is a life expectancy gap between the most affluent and most deprived neighbourhoods of 11 years (for men) and 8 years (for women).

The deprivation gap for healthy life expectancy is even greater than that in life expectancy.

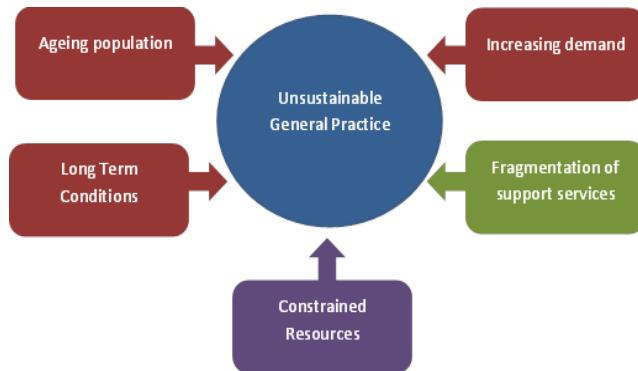
- In the most deprived areas men will on average have 7 years (9.4% of life) in poor health compared to 3 years (3.4%) in the most affluent areas.
- In the most deprived areas women will on average have 5 years (6.8%) poor health compared to 2 years (2.9%) in the most affluent areas.
- In the most deprived areas men will on average have 19 years (25.8%) fair or poor health compared to 12 years (14.1%) in the most affluent areas.
- In the most deprived areas women will on average have 20 years (26.6%) fair or poor health compared to 13 years (15.0%) in the most affluent areas.

In the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas, a gap of 16 years. Even a relatively small increase in healthy life

expectancy in the most deprived boroughs would reduce the 'burden' of ill health and would improve quality of life for a significant number of people, as well as channelling resources back into the economy.

Sustainability

We face a number of challenges to the financial sustainability of the health & social care system. General practice although financed in the main outside the local system, through national GMS or PMS contracts, has similar pressures and is equally unsustainable. Whilst the national funding of health & social care is outside our power we should and can address other local challenges.



Demographic Changes

The number of people aged over 65 in Stockport (19.4%) is above the national average (17.7%) and this figure is expected to continue to grow. By 2020, the proportion of the population of Stockport aged over 65 is expected to reach 21%, an increase of almost 5,000 people.

The number of people aged over 65 will increase from 55,700 in 2014 to 61,000 by 2020 (an increase of 9.7%). The proportion aged over 65 is also significantly higher in some neighbourhoods of the borough than others (already 20.5% in Cheadle and Bramhall).

Older people have greater health needs and a greater probability of developing long term illnesses, meaning co-morbidities increase, thus they account for the most significant amount of health service use. Keeping this group healthy, well and socially active will be vital in reducing the need, and subsequent cost, of health and social care, and improving their quality of life.

Proposed Clinical Model

We wish to create a system that is proactively looking for all people who are at risk of disease and preventing the development of this disease thus improving health and reducing the burden of ill health on people and the health and care system. In this way we wish to reduce the number of people with complex comorbidity in the future and increase healthy life expectancy in all communities.

We will proactively look for people who are at risk of disease and all those with disease whose care could be improved. We aim to ensure that

- more people will take up offers to attend screening either for undiagnosed conditions or as part of national programmes (**FIND**)
- more people with risk factors that put them at risk of developing a long term condition are supported to manage those risk factors (**TREAT**)
- more patients with a long term condition are supported to manage their condition so that complications are minimised (**TREAT**)

We will do this by supporting General Practice and Pharmacies to develop and improve systems that will drive this change. The purchase of **EMIS Search and Reports** will enable validated queries to be written once and shared, before being run either at a practice or

neighbourhood level to identify target groups. We will adapt the national model of risk detection and management (see page 7) to create an evidence based call programme focusing initially on five key conditions:

- Diabetes & pre diabetes (type 2)
- Hypertension
- Atrial fibrillation
- COPD
- Dementia (via NHS Health Checks no evidence for targeted screening)

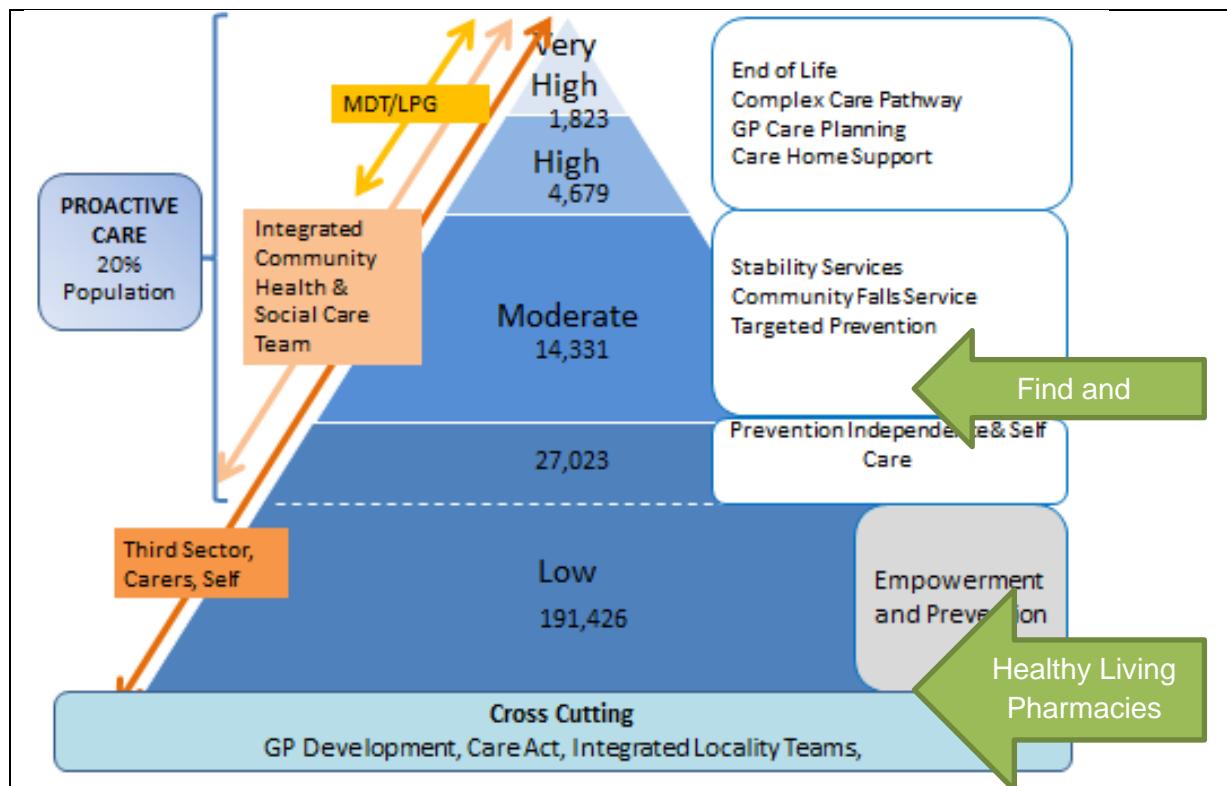
This programme will target people at higher risk of developing one of the five key long term conditions, focusing on those:

- Age 40-74 who have never had a blood pressure recording; or are a smoker without a BP reading in the last 5 years
- Age 40-74 who have never attended a NHS Health Check; or are a smoker without an attendance in the last 5 years
- Any age at risk of diabetes type 2, or with identified but unregistered non-diabetic hyperglycaemia
- Any age with a diagnosed long term condition but do not have optimised treatment using tools such as GRASP-AF
- People with a diagnosed mental health condition who smoke
- People who have not attended cancer screening opportunities

Patients can then be invited to assessment or directly referred into treat services options:

- This programme will be embedded into the core neighbourhoods model and will manage people diagnosed with conditions through the optimising primary care approaches agreed in each neighbourhood (a key element of treat).
- Through the Healthy Communities Business Case we will improve self-care management and empowerment and improve support for behaviour change in neighbourhood and community settings (via referral to START) and using tools such as the PAM (Patient Activation Model); so that patients are supported to make best use of the available assets and resources, and therefore become less reliant on GP and acute services.
- We will use this programme to establish robust referral pathways for the NHS Diabetes Prevention Programme, which goes live across Greater Manchester in April 2017. This programme offers a 12 session structured education course over several months, to people who are at high risk of developing type 2 diabetes.

This programme aims to target those at the moderate tier of care need, preventing and delaying the need for higher intervention levels. Other business cases will target those at more immediate risk.



EXTENSION 1 – GENERAL PRACTICE

The new model of care will lead to a more proactive and systematic method of identifying the population at risk in General Practice via automated searches of the practice systems using EMIS templates and search and reports. Template searches will be built or validated centrally and then practices / neighbourhoods will be supported to run these searches to identify individuals.

It is envisaged that each neighbourhood will chose their priority health need for this programme for the first year, and that a rolling programme of implementation be developed so that eventually all neighbourhoods have completed the programme. Ultimately the find and prevent approach should be embedded in to the general way of working of the neighbourhood teams, and could extend into other conditions.

In addition opportunities to improve and standardise the approaches to NHS Health Checks and opportunistic identification will be maximised, sharing good practice across Stockport and reducing variation in quality.

Once target populations have been identified, a variety of methods may be used to “treat” populations who may benefit from preventative advice. These will be tailored to levels of activation where possible and may include:

- Sending targeted literature through post, digital media or apps
- Adding alert flags to patient records so opportunistic Health Chats and NHS Health Checks can be delivered by practice or neighbourhood staff
- Inviting people to attend additional screening at Weekend Clinics – these clinics are likely to contain an **enhanced preventative element** and may include:
 - group courses such as DESMOND Walking Away from diabetes type 2 delivered by HCAs
 - enhanced NHS health checks incorporating FEV1, memory tests, cancer screening and immunisation status checks, HAD scores and additional blood test (LFT and creatinine) as well as the traditional GPPAQ, Audit C, Smoking,

- BP, Pulse rhythm and blood tests (cholesterol, HbA1C)
- these options are yet to be fully explored, and may impact capacity analysis in terms of staff need, as appointment lengths vary (group sessions = 15min per person, shorter Health Checks = 20 min, enhanced health check = 30 min)
- Inviting people to attend GP Practice review clinics (QoF)
 - Linking to the optimising primary care business case – any investment required for this is not included in this business case
- Referring people onto (included in Healthy Communities and self care business cases):
 - NHS diabetes prevention programme
 - Lifestyles and wellness services (via START and Healthy Stockport)
 - Social prescribing services (via START)
 - Patient education programmes
 - Mental wellbeing support
 - Targeted Prevention Alliance and Wellbeing and Independence Network
- Empowering people to manage their own condition and behaviours (self care).
- Exploring how people with mental health conditions are best supported to make lifestyle changes

EXTENSION 2 – HEALTHY LIVING PHARMACIES

The opportunities for identifying people through **Healthy Living Pharmacies** and linking them either directly into Healthy Communities services or into General Practices will be further developed, ensuring coverage across all neighbourhoods and into at least two thirds of all pharmacies.

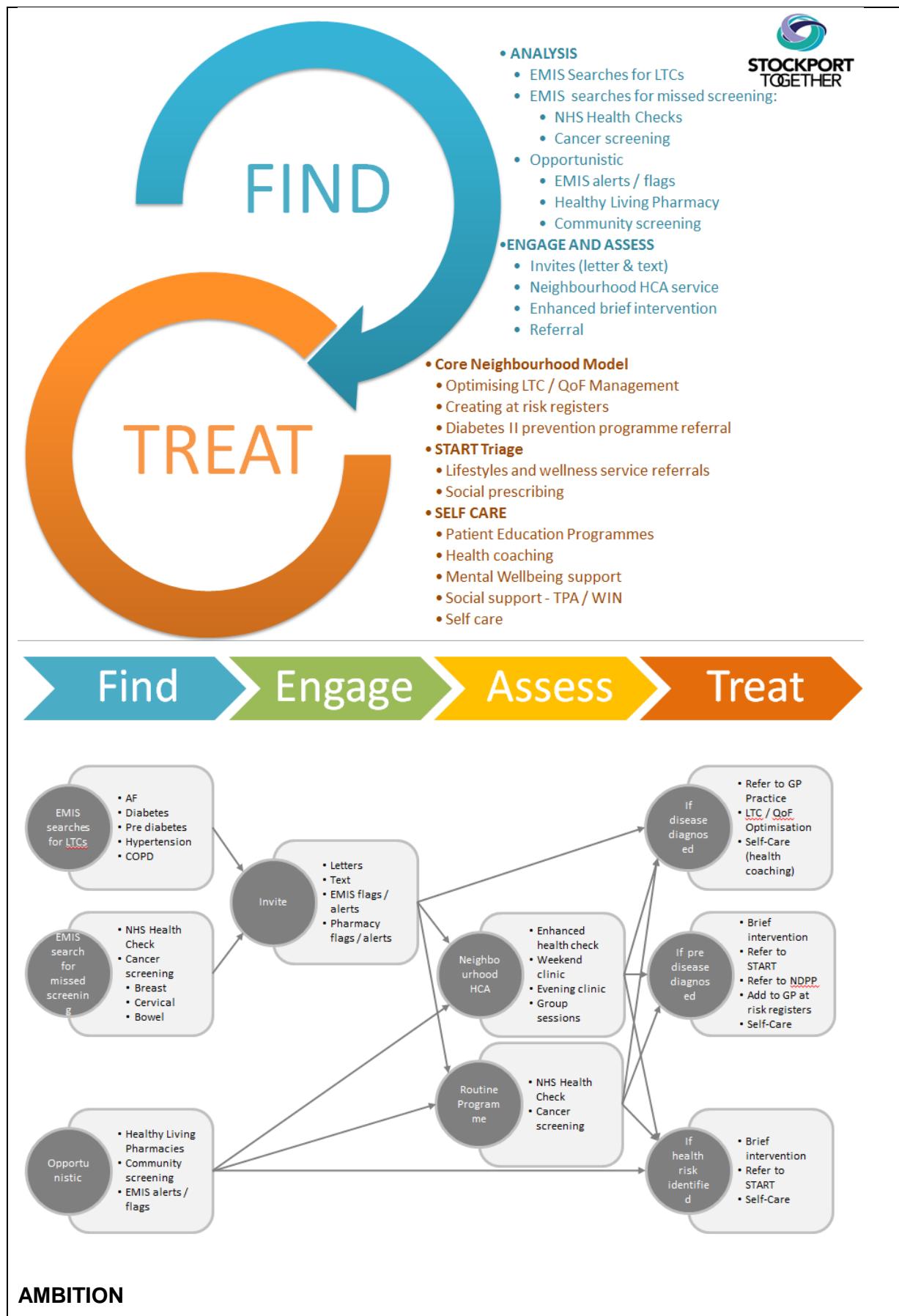
Those achieving HLP Level 2 status will be commissioned to provide a full range of Public Health Enhanced Services (PHES) including smoking cessation and will be encouraged to increase referral rates into lifestyle support services.

Healthy Living Pharmacies in each neighbourhood will be required to focus on the identified priority for each neighbourhood under extension 1; developing local pathways to maximise coverage and impact.

Healthy Living Pharmacies will also be supported to undertake clinical measurements

OVERALL MODEL

The following illustrations show the envisaged **find and prevent** model. Opportunities for identifying people through community engagement will continue to be developed through the Healthy Community business cases and links to other Core Neighbourhood and Healthy Stockport services will be a core part of all pathways.



The ambition for the programme is as follows:

Find

Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find by 2020/21
Diabetes (type 1 and 2)	14,600	5,600	2,300
Pre diabetes (type 2)	Unknown	Up to 27,150	15,000
Hypertension	43,600	11,500	4,300
Atrial Fibrillation	5,700	2,150	1,550
Dementia	2,700	1,300	750
COPD	6,700	3,700	900

Screening programme	Eligible	Not screened	To reduce by 2020/21
NHS Health Check	91,000	41,000	11,000

In total **finding 9,800 new diagnosis of long term conditions and 15,000 people at risk of type 2 diabetes** and screening an additional 11,000 people for general NHS Health Checks in the four year period.

Treat

Condition	Measure	Performance (Qof 2014/15)	To improve to, by 2020/21*
Diabetes	HbA1c ≤ 64mmol/mol	80.4%	85%
Pre diabetes	Referrals into NDPP	-	3,500^
Pre diabetes	Local offer to pre diabetics	-	3,500
Hypertension	Blood pressure ≤ 150/90mmHg	84.6%	90%
Atrial Fibrillation	Anti-coagulated	85.1%	90%
Dementia	With care plan	87.1%	90%
COPD	FEV1 recorded	82.9%	90%

* reducing variations between practices and neighbourhoods

^ NDPP for two years only

In total **improving the management of around 3,900 people** and referring 3,500 people into NDPP programme and 3,500 into local diabetes prevention support offers in the four year period.

Overall this level of ambition **aims to work with around 13,700 patients a year** (excluding double counting of pre diabetes), or 1,700 per neighbourhood; see appendix 1 for more detailed modelling.

COST OF PROGRAMME

More detail is set out in the following two sections but the overall cost of the programme is envisaged to be £962,000 for the five year period:

£000s (k)	2016/17 Yr 1	2017/18 Yr 2	2018/19 Yr3	2019/20 Yr4	2020/21 Yr5
TOTAL	26	72	292	286	286

Cost/Benefit Analysis

POSSIBLE IMPACT

National evidence as set out on pages 7-11 shows the benefit of early identification and prevention in terms of cost effectiveness (QALYs) and patient outcomes – **though it should be noted that this evidence is for the whole pathway and includes interventions included in other business cases such as self-care and optimising primary care.**

Estimating impact on local use of resources is complex. Analysis of admission data suggests that the long term conditions to be targeted by this programme account for 9% of total costs at a total of £12m; two thirds of this activity is emergency care and two thirds for the over 65s (see table below).

2015-16 Stockport registered admissions; SUS data, count of admission and sum of tariff

Primary diagnosis	Elective		Emergency		All admissions (including transfers etc.)		% of all aged 65+
	Count of admission	Sum of Tariff	Count of admission	Sum of Tariff	Total count of admission	Total sum of Tariff	
Diabetes	40	£33,634	250	£418,499	291	£452,969	28.5%
Hypertensive disease	12	£23,527	117	£128,649	129	£152,176	50.4%
Atrial Fibrillation	289	£682,425	548	£838,997	855	£1,595,639	70.5%
Ischaemic heart disease	502	£1,284,489	983	£2,869,496	1,750	£5,219,141	62.8%
Acute myocardial infarction	11	£26,781	493	£1,875,112	562	£2,114,994	65.8%
Cerebrovascular disease	22	£77,884	564	£2,223,033	648	£2,563,684	79.6%
Dementia	1		68	£9,992	71	£9,992	100.0

							%
COPD	25	£47,632	847	£1,954,834	876	£2,015,640	69.2%
All admissions	47,923	£53,114,257	40,131	£67,914,120	98,396	£132,607,821	37.5%
All admissions for key LTCs	891	£2,149,591	3,377	£8,443,500	4,620	£12,009,241	65.9%

People with long term conditions will also have activity in Primary Care, Outpatients and ED, however **costs for these services for people with LTCs are not yet possible to estimate**. For the purposes of this estimate therefore impacts are measured on inpatient admissions only.

Assuming a saving proportional to the national evidence set out in pages 7-11 sections and local modelled ambitions by 2020/21 then a **possible saving of £1.4m in admissions through Find and prevent could be realised**:

This £1.4 million has been derived by using the national evidence of the proportion of admissions which should be preventable, and then applying the percentage improvement anticipated by find and prevent (see page 17-18) to this proportion and to the total 2015/16 admission costs:

Condition	To find		To improve treatment		2015/16 Admission costs	Modelled saving on costs by 20/21	Notes
	Number	as a %	Number	as a %			
Diabetes	2,300	15.8%	670	4.6%	£452,969	£92,195	Improving /detection & management of 20%
Hypertension	4,300	9.9%	2350	5.4%	£152,176	£11,613	50% preventable by improving /detection & management of 15% therefore 15%* 50% =
Atrial Fibrillation	1,550	27.2%	280	4.9%	£1,595,639	£343,099	67% preventable by improving /detection & management of 30% therefore 30%* 67% =
Dementia	750	27.8%	80	2.9%	£9,992	£3,065	Improving /detection & management of 30% with dementia
COPD	900	13.4%	480	7.1%	£2,015,640	£27,076	10% admissions due to undiagnosed, improving /detection and management 25% of COPD therefore 25% = 2.5%
AMI	-	-	-	-	£2,114,994	£161,399	50% preventable by improving /detection & management of 15% therefore 15%* 50% =

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Other IHD	-	-	-	-	£3,104, 147	£236,8 83	50% preventable by BP, improving /detection and management of 15% of BP , therefore 15% * 50% = 7.5%	BP
CVD	-	-	-	-	£2,563, 684	£551,2 51	67% preventable by AF, improving /detection and management of 30% of AF, therefore 30% * 67% = 20%	AF
Total possible saving					£1,426, 581			

The possible phasing of this benefit could be as follows:

	17/18	18/19	19/20	20/21
% of full	0%	5%	40%	100%
Impact	0	£71,329	£570,633	£1,426,581

As a check of the reasonableness of this estimate of £1.4million, analysis of NHS Right Care spend opportunities suggests that in Stockport there is a potential £5.6 million saving to be made from admissions relating to circulation, respiratory and endocrine problems, the previous working therefore suggests that 25% of these savings could be made through prevention and early detection.

Disease area	NHS Right Care Spend area	£000 to save
Circulation problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	<ul style="list-style-type: none"> £305 £2,826
Respiratory problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	<ul style="list-style-type: none"> £642 £1,385
Endocrine, Nutritional and Metabolic Problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	<ul style="list-style-type: none"> £113 £319

RETURN ON INVESTMENT

Assuming that savings could be realised on the level of ambition within two years the following profile of spend to impact has been estimated, leaving a recurrent saving of £1.1m per annum from 2020/21 onwards.

	16/17	17/18	18/19	19/20	20/21	TOTAL
Cost	£26,000	£72,000	£292,000	£286,000	£286,000	£962,000
Impact	0	0	£71,329	£570,633	£1,426,581	£2,068,543
Net effect	-£26,000	-£72,000	-£220,671	£284,633	£1,140,581	£1,106,543

Finance

The table below shows the indicative additional costs for the programme, details to show how these have been calculated are set out below.

£000s (k)	2016/17 Yr 1	2017/18 Yr 2	2018/19 Yr3	2019/20 Yr4	2020/21 Yr5
A. Existing Service Costs	26	0	0	0	0
<i>New Spending Plan:</i>					
Healthy Living Pharmacy	24	24	24	24	24
EMIS Search and Reports	2	15	15	15	15
Call / recall consumables	0	1.875	10	10	10
Training – Walking away from diabetes	0	0	10	4	4
POC Testing x 8	0	0	56	56	56
Band 3 admin (8x 0.2 WTE)	0	6.562	35	35	35
Band 4 HCA (8x 0.5 WTE)	0	18	96	96	96
Band 6 Analysts (8x 0.1 WTE)	0	6.562	35	35	35
Band 6 project officer (1x 0.4 WTE)	0	11	11	11	11
TOTAL	26	72	292	286	286

Most of this investment is recurrent, with only the initial training budget for the HCA staff being non-recurrent.

Non workforce costs

This business case will require the ongoing funding of Healthy Living Pharmacy programme and PharmOutcomes licence. **A total of £24,000 per year.**

This business case will require the annual licencing of EMIS Search & Reports for public health, at a cost of £285 per year per practice + VAT. **A total of £14,706 per year.**

This business case will require the development of EMIS Web referral templates and pathways supported by GMSS Data Quality Team and ability for each neighbourhood team to share records. **These costs are to be met in other business cases and from existing resources.**

This business case will require a programme budget to fund the consumables for the call and recall, including postage / letters / leaflets / texts etc. **An indicative total of £10,000 per year.**

This business case will require a training budget to for the HCAs who will deliver the preventative intervention. For example DESMOND walking away from diabetes (£700 per person), NHS Health Checks (£50 per person). **An indicative total of £10,000 for the first year, with £4,000 for each subsequent year.**

This business case may require additional capacity in Public Health commissioned behaviour change services. **These costs are to be met in other business cases**

This business case may require additional capacity in clinic spaces – meeting rooms for group work and consultation space for 1:1 interventions. **These costs are to be met in other business cases.**

This business case will lead to an increase in the number of blood tests to be taken and analysed, these could be collected and dispatched to Stockport NHS FT for testing as per current procedures, however this reduces the quality of the preventative message given at the appointment and increases administration and referral times. An investment in POCT could be made, current costs are being investigated, but reviews from 2009 for HbA1C only suggested annual costs in the range of £5,919-£6,150 per machine. An indicative total (until better estimates are collected) of **£7,000 per PCOT per year**.

Buyer's guide: Point of Care testing for HbA1c. June 2009 <http://www.healthcheck.nhs.uk/document.php?o=12>

Buyers' guide: Point of Care testing for cholesterol measurement. September 2009
<http://www.healthcheck.nhs.uk/document.php?o=11>

This programme is also likely to lead to increased use of the services referred onto, and potentially increase prescribing and long term condition management requirements within General Practices. **These have not been costed in this business case, as they should be offset by increases in QoF income and savings in acute care.**

Workforce needs are as follows:

Per neighbourhood:

- 0.1 WTE for Business Intelligence Analysts based in neighbourhoods, (neighbourhood business case proposal) (**new resource**)
- 0.2 WTE for administrative staff to manage call and recall in neighbourhoods (neighbourhood business case proposal) (**new resource**)
- HCA led preventative clinics at Weekend General Practice – 0.3 HCA per neighbourhood (see below for modelling) (**new resource**)
- HCA led preventative clinics at weekday General Practice – 0.2 HCA per neighbourhood (see below for modelling) (**new resource**)
- Support and governance from neighbourhood leadership team (**existing resource**)

Centrally:

- 0.2 WTE for Specialist Public Health Business Intelligence Analysts, LA (**existing resource**)
- 0.4 WTE for Data Quality Officers, GMSS (**existing resource**)
- 0.4 WTE for Primary Care Engagement Officer (**existing resource**)
- 0.4 WTE for project officer (**new resource**)

Phasing for 17/18

It is proposed to phase the roll out of find and prevent, so that the first six months of 17/18 are focused on continuing the implementation of the Healthy Living Pharmacy and in developing the modelling with EMIS search and reports. Over this period the NHS diabetes Prevention Programme will also be rolled out across two neighbourhoods, enabling further testing of the model.

The full programme will go live in two neighbourhoods in October 2017, a further two in January 2018 with extension to the final four neighbourhoods in April 2018. The programme will then run for the three years 2018/19 -2020/21.

This phasing leads to a 17/18 cost of £72,000, 25% of the total annual spend; with:

- £39,000 needed in April 2017
- £22,000 needed in October 2017 (or access to staffing resource of similar value)

- £11,000 needed in January 2018 (or access to staffing resource of similar value)

Find and prevent	Posts (fte)	Grade	2017-8	Spend start	Comment
Healthy Living Pharmacy			£24,000	Apr-17	Continue current programme
EMIS Search and Reports			£15,000	Apr-17	Develop find modelling
Band 3 admin (8x 0.2 WTE)	0.4	Band 3	£8,750	Oct-17	Go Live in 2 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	1	Band 4	£24,000	Oct-17	Go Live in 2 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.2	Band 6	£8,750	Oct-17	Go Live in 2 neighbourhoods
Call / recall consumables			£2,500	Oct-17	Go Live in 2 neighbourhoods
Band 3 admin (8x 0.2 WTE)	0.4	Band 3	£8,750	Jan-18	Go Live in further 2 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	1	Band 4	£24,000	Jan-18	Go Live in further 2 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.2	Band 6	£8,750	Jan-18	Go Live in further 2 neighbourhoods
Call / recall consumables			£2,500	Jan-18	Go Live in further 2 neighbourhoods
Band 3 admin (8x 0.2 WTE)	0.8	Band 3	£17,500	Apr-18	Go Live in final 4 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	2	Band 4	£48,000	Apr-18	Go Live in final 4 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.4	Band 6	£17,500	Apr-18	Go Live in final 4 neighbourhoods
Call / recall consumables			£5,000	Apr-18	Go Live in final 4 neighbourhoods
Training – Walking away from diabetes			£10,000	Apr-18	Enhance programme
POC Testing x 8			£56,000	Apr-18	Enhance programme
Band 6 project officer (1x 0.4 WTE)	0.4	Band 6	£11,000	Apr-18	Cover by self care programme lead until Apr-18
Find and prevent Total			£292,000		

Contractual Arrangements

The only procurement requirements are for **EMIS Search and Reports**, an existing contract is in place for 7 practices already and procurement under normal STaR business procedures will be undertake to extend to all practices.

There are already existing contracts in place for NHS Health Checks and cancer screening programmes.

It is not intended that this programme will directly employ staff, instead these would be woven into the wider neighbourhood model and staff time allocated to the programme – most likely with a lead GP practice or by each neighbourhood or by SNHSFT as part of the neighbourhood based community services team. The programme manager will be employed by the Council within either the Public Health team, Corporate Support Services or the Stockport Together Programme management team.

For point of care testing discussions with the neighbourhood teams about the options, in discussion with SNHSFT Point of Care Testing Coordinator.

Implementation Plan

As detailed in the model above it is planned to implement Find and prevent in a phased approach across neighbourhoods. The recent announcement of the NHS Diabetes Prevention Programme has led to this becoming the highest priority, as we now have a two year window to make maximal use of the service offer.

Current plans (subject to engagement with primary care) are to:

- Roll out the National Diabetes Prevention Programme on a neighbourhood basis,
 - starting with Victoria as this has best levels of NHS Health Check, a number of practices piloting DESMOND and a significant deprived and BME community (i.e. more people at risk)
 - second neighbourhoods to be Cheadle & Gately
- Work with selected pharmacies and GP Practices to pilot the more general find and prevent model for Atrial Fibrillation

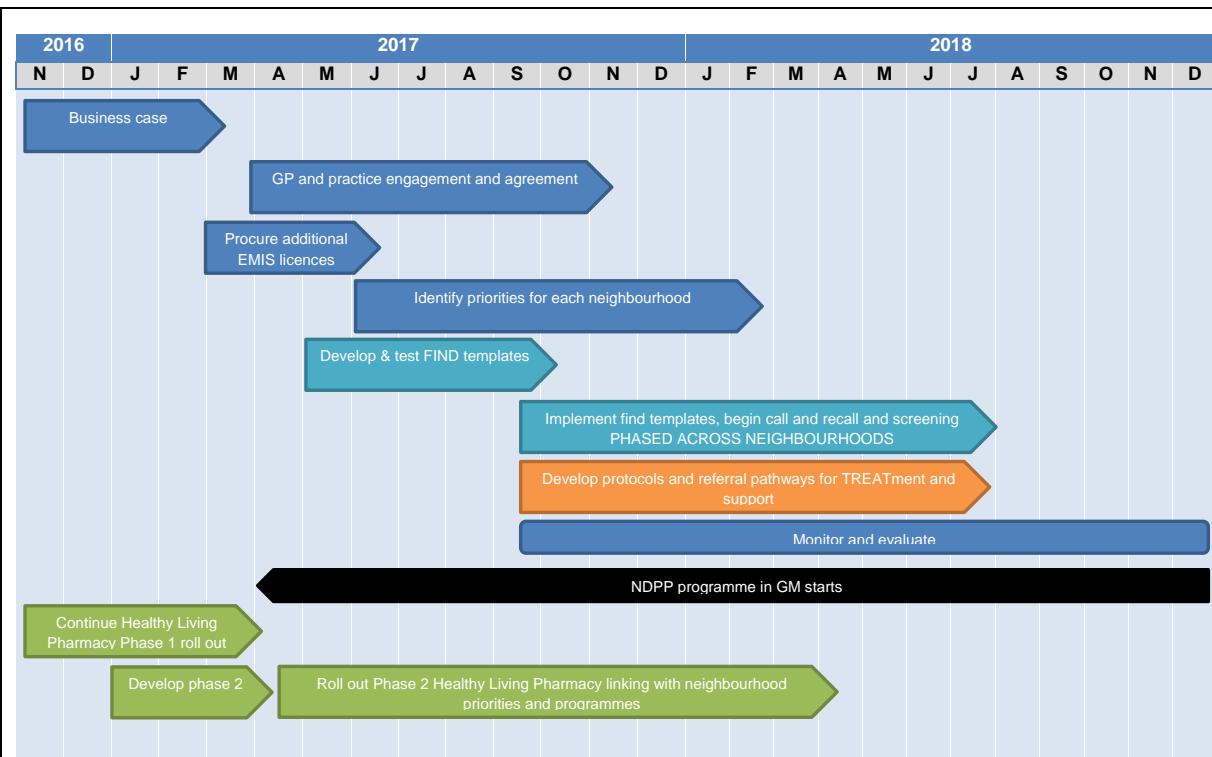
The full find and prevent programme will go live in two neighbourhoods in October 2017, a further two in January 2018 with extension to the final four neighbourhoods in April 2018. The programme will then run for the three years 2018/19 -2020/21. Decisions about the phasing of neighbourhoods are likely to be made in August 2017, in consultation with Primary Care.

In the meantime all neighbourhoods will be supported to improve **the quality of the NHS Health Check** process and onward referral and supported with **cancer screening**; as these programmes are already running within the neighbourhoods.

Healthy Living Pharmacies will continue to implement phase 1 and the achievement of objectives and outcomes will be monitored. Engagement with Pharmacies and neighbourhood teams will identify the phase 2 approach which will include the integration of pharmacy Enhanced Services and extension into other primary care settings.

This business case assumes that a 0.4 WTE Band 6 project officer will support the roll out from April 2018 onwards under the leadership of the existing Early Intervention and Prevention lead in Public Health. During 2017/18 the self-care programme lead will cover this implementation work as well as the self care programme.

An indicative timeline is included below:



RISKS

RISK	Mitigation
<p>Primary care capacity to manage this additional programme and activity</p> <ul style="list-style-type: none"> Support for the call and recall and the initial identification are costed into this model, but may rely on existing staff and expertise as well, More particularly the on-going management of patients identified with disease or at risk of disease are likely to increase activity. Many of these patients will require at least an annual review following diagnosis. 	<ul style="list-style-type: none"> Risk acknowledged and capacity for optimising primary care built into wider core neighbourhood model. Ongoing monitoring of impact throughout implementation
<p>Variations in primacy care coding practices and quality</p> <ul style="list-style-type: none"> This programme relies on the analysis of patient records to initially identify target patients. Outside of core QoF measurements, or other programmes where READ / SNOMED codes are specified it is likely that each GP Practice will have their own coding conventions which will mean queries will need to be written to cover a range of options. Some practices may not code and may rely on written notes. 	<ul style="list-style-type: none"> By purchasing EMIS Search and report six months prior to go live it is hoped to understand the impact of this risk, and put in place mitigating actions. Liaise closely with GMSS data quality team

<ul style="list-style-type: none"> In some practices this may mean that the volume of patients identified is lower than expected 	
<p>Patients not engaging with prevention in other words low take up</p> <ul style="list-style-type: none"> Cancer screening and other preventative services are seeing a reduction in the proportion of patients who accept invitations to attend services. There is a risk that the capacity provided for prevention will not be utilised to its full extent. A further risk is that those who take up the offer are likely to be the engaged population, and that without effective targeting this programme risks increasing health inequalities 	<ul style="list-style-type: none"> Targeting and considering inequalities at the outset of this programme Embedding patient activation wherever possible Using social marketing and other behavioural insights in a targeted way The programme will be monitored closely and implementation varied to meet the needs of local populations. New approaches to support people with mental health issues
<p>Increased activity for prevention as a contrast to the above risk:</p> <ul style="list-style-type: none"> if more patients than expected take up provision there is a risk that existing services will not be able to meet demand. 	<ul style="list-style-type: none"> Risk acknowledged and capacity for self-care built into healthy communities model. Ongoing monitoring of impact throughout implementation

Appendix 1

CAPACITY / ACTIVITY MODELLING FOR HCA WORKFORCE

To assess the likely capacity need for HCAs to deliver find and prevent, the ambitions described in section 9.3 have been modelled into a one year impact so that an anticipated workload can be estimated:

FIND Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find by 2020/21	To find in year 1
Diabetes	14,600	5,600	2,300	575
Hypertension	43,600	11,500	4,300	3750
Atrial Fibrillation	5,700	2,150	1,550	1075
Dementia	2,700	1,300	750	390
COPD	6,700	3,700	900	190
SUB TOTAL new cases of disease			9,800	2,455
Pre diabetes	Unknown	Up to 27,150	15,000^	7,500
SUB TOTAL new diabetes at risk			15,000	7,500
NHS Health Check	50,000	41,000	11,000	2,750
SUB TOTAL new health check			11,000	2,750
TOTAL FIND			35,800	12,705

TREAT Condition	Measure	Performance (Qof 2014/15)	To improve by 2020/21	Number of people to improve in 4 years	Number of people to improve in 1 year
Diabetes	HbA1c ≤ 64mmol/mol	80.40%	85%	670	170
Hypertension	Blood pressure ≤ 150/90mmHg	84.60%	90%	2350	590
Atrial Fibrillation	Anti-coagulated	85.10%	90%	280	70
Dementia	With care plan	87.10%	90%	80	20
COPD	FEV1 recorded	82.90%	90%	480	120
SUB TOTAL improved management				3,860	970
Pre diabetes	Referrals into NDPP	-	3,500	3,500^	1,750
Pre diabetes	Local offer to pre diabetics	-	3,500	3,500	875
SUB TOTAL diabetes prevention				7,000	2,625
TOTAL TREAT				10,860	3,595

[^] 2 years

TOTAL FIND AND PREVENT (removing pre diabetes duplicates)	39,660	13,675
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Taking this anticipated workload of 13,675 interventions as a starting point the following table models through the required WTE if a 20 minute appointment was used:

20 minute appointments	Total per annum for ST	Per neighbourhood
Number of people to see	13,675	1,710
Fraction of hour per appointment	0.4	0.4
No hours needed	5470	683.75
No hrs /day in clinical time	6	6
No days required per year	912	114
Working days per week	5	5
No weeks	182.3	22.8
Working weeks/yr	50	50
WTE needed	3.6	0.5

At 20 minutes per appointment therefore the Find and prevent programme requires 0.5 HCA per neighbourhood. With the pattern of neighbourhood weekend working to be decided, it is estimated that 0.3 to be delivered at the weekend (2 Saturday sessions, 1 Sunday) and a further 0.2 during the week, although this balance is to be confirmed.

If 30 minute appointments were needed (depending on the offer given) this rises to a requirement of 0.6 WTE per neighbourhood, however use of group sessions at 15 minutes per person would reduce this to 0.3 WTE per neighbourhood. An average of 20 minutes has been used as the best proxy.

SERVICE AREA:

PHARMACY LED REPEAT PRESCRIPTION MANAGEMENT

Component	Description
Current. Brief description of existing services (i.e. how many sites, how many staff, functions, opening hours , capacity). (NUMBERS)	<p>Currently individual practices do this with varying methodology, i.e. from over 40 sites involving well over 200 staff and GPs. It takes up a significant amount of time for administrative and GP staff. In an average practice a GP spends at least an hour a day authorising prescriptions and a similar time dealing with queries. At least 1 FTE is needed to produce the prescriptions for a GP to authorise. Services operate usually Monday to Friday in core and extended hours.</p> <p>In addition to this GPs and practice nurses spend a huge amount of time reviewing medication. The current call and recall systems for medication review and therapeutic monitoring are not robust leading to the potential for negative impacts including drug related admissions.</p>
Problems & Opportunities: What could change – 2 sentences	<p>The current system leads to significant waste, higher prescription spend and potential poor outcomes or admissions.</p> <p>There is an opportunity to centralise prescription management with benefits from working at scale , using clinical staff alongside non-clinical staff to manage repeat prescriptions, provide medication reviews and ensure therapeutic monitoring.</p>
New service: What people, what processes, what use of technology, what additional capacity, what functions, clinical / professional governance (NUMBERS)	<p>A pharmacist led neighbourhood prescription management and optimisation service is being developed</p> <p>Prescription requests would be accepted by telephone or electronically using trained medicines co-ordinators based on a system tried and tested in Coventry.</p> <p>Staffing required is:</p> <p>40 FTE band 3 staff some of which may be recruited from existing practice staff.</p> <p>Technicians (20 FTE band 5 staff) would train and support these staff and deal with prescription and patient queries. Provide enhanced support to care homes to manage medicines and support GPs on care home ward rounds. Handle outpatient and discharge communications to process medication changes safely. They would also manage a robust call and recall system for therapeutic monitoring.</p> <p>Pharmacists (20FTE band 7) would authorise prescriptions, provide medication reviews, including home visits for housebound patients.</p> <p>The team would be managed and supported professionally by senior pharmacists 10FTE band 8a.</p> <p>The professional governance would be provided by an enhanced management team who would oversee the service and provide the operational work of the current provision.</p> <p>The service would be organised on a neighbourhood basis and the 8a pharmacist would have a direct relationship with the neighbourhood lead GP. The resilience of the service would be provided by neighbourhoods supporting each other in the event of sickness, leave tec.</p>

7 day service – describe the extent to which service offer is over 7 days and links where appropriate to 7 day services – GP or otherwise	The service would operate between 8am and 8pm on weekdays and offer a reduced service on Saturday and Sunday mornings when the out of hour's service receives a significant number of medication related calls.
Benefits: What will it deliver in terms of outcomes, benefits to population, and efficiency improvements (Cash & time) (NUMBERS). What evidence is the basis of this (<i>National evidence, Local pilots, Assumptions</i>)	Benefits are as follows when fully implemented: GP capacity released. Estimated value at £3 million based just 10 minutes per year per patient for managing prescriptions/ meds queries plus completing meds reviews. Evidence from this and NHS Alliance (http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf ,) Reduced number of prescription items (estimate an 8% reduction over current levels when the service is fully operational. Based on the work in Walsall (http://arms.evidence.nhs.uk/resources/qipp/1040169/attachment) and Coventry. Value £500k in dispensing fees plus circa £1.5million in drug costs Reduced spend on primary care prescribing (to below the England average). Improvements to therapeutic monitoring leading to reduced medication related admissions. National estimate is 10% of admissions are meds related, Assumption a 2% reduction in this. Increased use of patient on line for making requests to achieve the target of 20% Released capacity from out of hour's provision as the service deals with meds queries. Improved patient satisfaction – evidence from national pilot practice based pharmacists. Increased use of Repeat Dispensing, Patient online and EPS in line with national targets. Demonstrating we are implementing the 5 year forward view. Reduced costs to NHSE in disposing of waste meds Reduced medication related safeguarding incidents in care homes. Increased use of shared care for medicines releasing FT staff time from managing meds which could be provided in the community.
Costs: What will it cost and how was this derived? (Staffing, technology, start-up non-recurrent and recurrent)	The service integrates the current CCG team and some cost may be covered by the NHSE Phase 2 pilot funding for practice Pharmacists. Total additional staff cost £2.5m Funding from NHSE pilot for pharmacists (if successful) It is anticipated premises will be available from the current estate and a number of potential sites have been identified. Costs associated with supportive infrastructure and delivered through the enabler plan.

ALLIED HEALTH PROFESSIONALS (AHP) IN STOCKPORT

Business Case: To determine the role of AHP's as part of the Multi-Disciplinary Teams within the neighbourhood offer

Aim:

To ensure AHP resource is recognised and included in the evolving eight neighbourhood teams. To identify 'gaps' in current capacity and calculate what is required to meet the need of the population cohorts. To align with the aims and objectives specified in the broader neighbourhood business case.

Introduction:

The transformation of Stockport's Health and Social Care system aims to significantly shift activity from secondary to primary and community care. This will mean fundamental change in the provision of some of the current AHP services. A culture of multi skilled healthcare professionals working together as a multidisciplinary team (MDT) to provide pathways of care.

Who are Allied Health Professionals (AHP's)?

Allied health professionals (AHP's) are a diverse group of healthcare professionals. They work across a wide range of locations and sectors in acute, primary and community care. Operating across the holistic pathway of care they provide prevention, assessment, diagnosis, treatment, recovery, maintenance and palliation. AHP's will play an essential role in the integrated MDT neighbourhood offer.

National Context:

Allied Health Professionals (AHP's) make up 6% of the NHS workforce and are the third largest workforce in health and social care in England.

Supporting Case Studies:

Below are two examples of patient case studies.

Example Case Study 1

As someone with an array of long term conditions, I have personally experienced and benefitted from the knowledge and expertise of many caring allied health professionals including prosthetists, orthotists, physiotherapists, occupational therapists, radiographers and dietitians. Whilst these individual professions seem distinctly different in the skills they possess and the services they provide, they share many common goals, including trying to keep people mobile, independent, dexterous and out of hospital. So as someone who continues to benefit from the mobility and independence afforded to me, I feel it can only be to the benefit of all that these opportunities are shared and made as widely accessible as possible.

Steve McNeice - Expert by experience
Centre for Workforce Intelligence
March 2013

Example Case Study 2

I had a case whereby the proactive AHP resource was very helpful. Their ability to visit in a timely fashion and sort out equipment needed meant that this lady could be supported at home and maintain her independence without the need for home care or more costly interventions. Originally I tried to refer to the EAAT team but they were not able to treat the case as high priority. Therefore without proactive AHP resource in our team it would have taken over a week or two rather than the quick response we had for this lady who was high risk of falls.

Having proactive AHP resource in the office is very valuable if we are truly aiming to be integrated with health colleagues as her expertise and willingness to joint work is improving our service as a whole to Bramhall and Cheadle neighbourhood.

Janet Bradbury – Interim Principal Lead (West Localities)
Stockport

The scope of Phase 1 of this Business Case (as below):

Allied Health Profession	In Scope (Phase 1)	Out of Scope
Physiotherapy – Inpatient / Outpatient / Primary Care**/ Community	✓	
Dietetics –Community / Inpatient / Outpatient	✓	
Occupational Therapy –Community / Inpatient / Outpatient	✓	
Chiropody / Podiatry	✓	
Speech & Language Therapy (SALT) – Community / Inpatient / Outpatient	✓	
Orthoptists		✓
Radiographers – Diagnostic / Therapeutic		✓
Paramedics		✓
Prosthetists / Orthotists		✓
Osteopaths		✓
Operating Department Practitioners (OPD's)		✓
Therapies – Music / Drama / Art		✓
Intermediate Tier aligned therapy services *		✓
MSK Direct Access Physiotherapy (Primary Care) **		✓
Falls Service ***		✓

* **The Intermediate Tier business case addresses the specific needs of any aligned therapy services**

** **The Transformed Primary Care resource associated with the ‘direct access physiotherapy pilot’ (Marple & Bramhall) will not be included in the scope of this business case.**

*** **Falls Service is called Steady in Stockport and is a separate programme within the Neighbourhood Business Case.**

Further break down of the AHP roles within the scope of Phase 1 of this Business Case can be viewed in Appendix A including general details of service delivery by person cohort and setting.

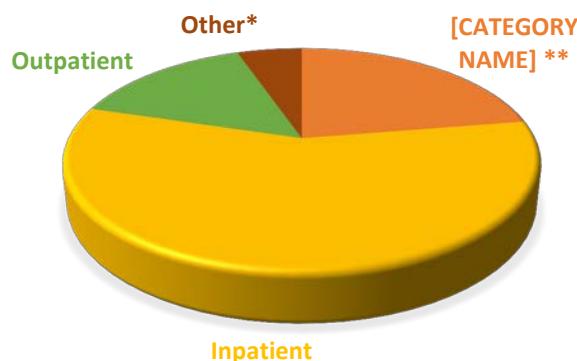
Current Position:

Current AHP resource in Stockport is summarised below. A more detailed breakdown of this resource can be found in Appendix B.

Allied Health Service	Current FTE	Current Cost
Dietitians (94% Qualified)	15.85	£ 544,800
Occupational Therapists * (69% Qualified)	71.91	£ 2,642,019
Physiotherapists (84% Qualified)	124.45	£ 4,769,200
Podiatrists (100% Qualified)	20.76	£ 844,400
Speech and Language Therapists (85% Qualified)	12.05	£ 391,700

*Data includes SMBC staffing. Note that SMBC staffing operates on 55% qualified ratios.

CURRENT DISTRIBUTION OF AHP RESOURCE (FTE)



*Patient education
(Dietetics and CD Physio;
Occupational Health; Cardiac rehab; T&O; EPR;
Uro-dynamics (Physiotherapy).

** community data based on health staffing only

Currently the majority of AHP resource is operating in a hospital setting. As part of the implementation phase of this programme we aim to redistribute some of this resource into a community setting in accordance with the needs of the population. The exact % of redistribution of resource will be calculated as part of the implementation phase of this programme and in conjunction with the Outpatient's Business Case removal of activity from the hospital setting. The focus will be on prevention, self-management and treatment within a home or community setting with AHP's as part of a community multi-disciplinary team.

There are two population cohorts to be considered in this phase: Frailty and Musculoskeletal

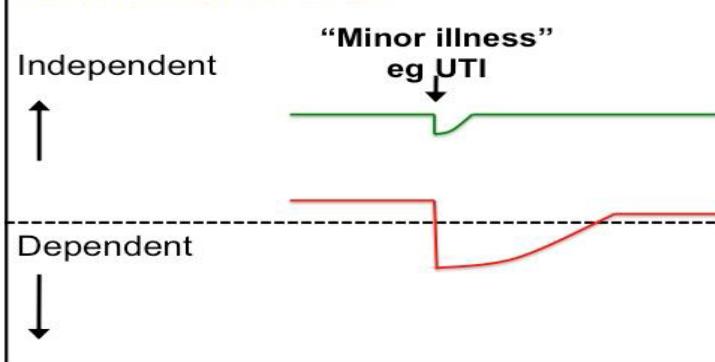
Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an

apparently minor event which challenges their health, such as an infection or new medication.

Loss of Physiological Reserve Model

FUNCTIONAL ABILITIES



1

The eFrailty Index (eFI) counts deficits (symptoms, signs, disease or disability). The greater the deficit the greater the loss of physiological reserve.

eFI uses the cumulative deficit model of frailty. The eFI comprises thirty-six deficits, constructed using around 2,000 primary care clinical codes (Read codes). The eFI calculates a frailty score by dividing the number of deficits present by the total possible. The score is a robust predictor of those who are at greater risk of adverse outcomes (e.g. long-term care and mortality).

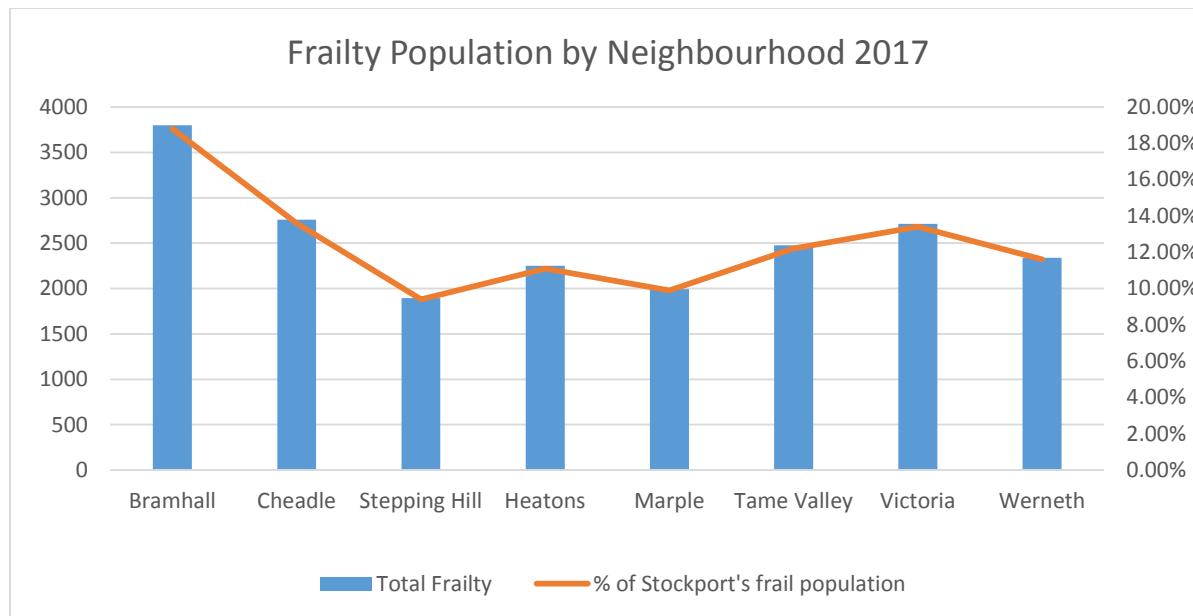
Below shows the 91% of Stockport registered patients over the age of 65 years. As at January 2017, there were 53,000 people aged over 65 years of which, 48,000 have an eFI score recorded.

Stockport's eFrailty Index (>65's)

eFI Score	Definition	Stockport As at January 2017	
		%	Number
0-0.12	Fit - People who have no or few long-term conditions that are usually well controlled. This group would be mainly independent in day to day living activities.	58%	28,000
0.13-0.24	Mild Frailty - People who are slowing up in older age and may need help with daily living, such as finances, shopping, transportation.	33%	16,000
0.25-0.36	Moderate Frailty - People who have difficulties with outdoor activities and may have mobility problems, such as washing and dressing.	8%	4,000
>0.36	Severe Frailty - People who are often dependent for personal care and have a range of long-term conditions/multi-morbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6-12 months.	1%	500

Frailty population broken down between the neighbourhoods as below:

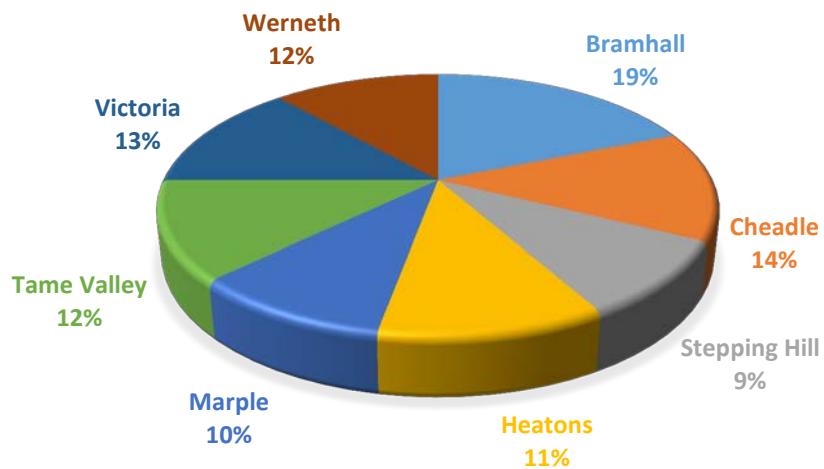
¹ Clegg, Young, Iliffe, Olde-Rikkert & Rockwood, Frailty in Elderly People - Lancet 2013; 381: 752-762)



The chart opposite shows the distribution of AHP resource required to meet the **frailty needs** of the eight areas identified within the Neighbourhood Business Case.

this will be viewed alongside neighbourhood data on population size, condition prevalence, and risk of admission when allocating AHP resources to neighbourhoods.

% TOTAL AHP RESOURCE ALLOCATION BY NEIGHBOURHOOD BASED ON FRAILTY



Musculoskeletal

The national evidence is that 20% of GP Consultations are for musculoskeletal conditions and, that 70% of this activity could be managed safely and effectively by a Physiotherapist².

The current Primary Care Physiotherapy service sits within the Diagnostics and Clinical Support Services Business Group. The service is delivered across all eight neighbourhoods. Waiting time for a first appointment was 8 weeks in December 2014 (lowest recorded

² (*Physio First, West Wakefield, NHS England 10 High Impact Actions, Case Study 104*)

available). Waiting times have shown a steady increase and are currently at 12 weeks (December 2016).

There is growing national evidence that moving from a GP referral model (current) to a self-referral model is a safe and cost effective model of delivery. There is no evidence that it creates a 'surge' in demand unless there is already unmet need. It has been shown that self-referrers need fewer appointments and will seek treatment sooner with minor problems preventing more chronic conditions developing. A self-referral model encourages individual empowerment, self-management and the aim of treating people in their own home or community setting.

Compared with the national average, the current Stockport Primary Care Physiotherapy service has a shortfall of 8.4 FTE staff. However, any proposals relating to investment in MSK physiotherapy must be viewed in conjunction with significant aligned investment in MSK physiotherapy within the Transformed Primary Care element of the business case.

Proposed model

MSK within the neighbourhood would be accessed directly to provide initial triage and direct activity as appropriate; Urgent contact / non-urgent contact / virtual contact / referral for medical opinion. Intervention provided will be either; direct (with a physiotherapist) / indirect (exercise programme, including on-line applications) / advice and guidance only / review and/or discharge.

It is proposed that additional investment through this business case into MSK physiotherapy will primarily support the delivery of longer term direct physiotherapy treatment (identified through own service or Transformed Primary care offer), and MSK physiotherapy support to complex patients receiving enhanced case management from the neighbourhood teams.



Current Position Summary:

There is currently a lack of consistency within and across service provision in relation to patient – centred pathways. This is due to poor communication and coordination across services.

A proportion of AHP services operate integrated pathways across both acute and community settings providing comprehensive care for specific conditions, whilst others operate exclusively in the community or other settings creating the risk of duplication and multiple patient attendances.

AHP services are currently operating with different skill mixes and bandings for potentially similar functions.

There is a need to review the current configuration of AHP services and to make the case for

change to optimise the delivery of patient centred care at neighbourhood level.

Future Model:

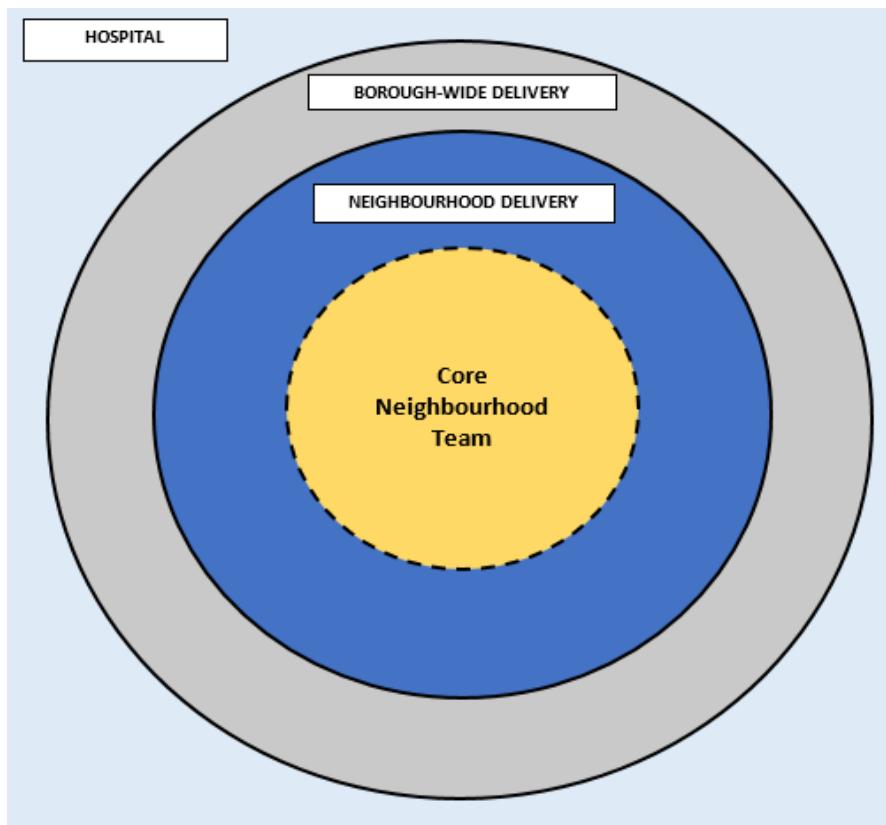


Diagram 1 below provides a visual outline of the proposed future model for delivering borough-wide and neighbourhood services within which AHP services sit as part of the MDT.

There is clearly an opportunity to unlock a huge resource for the benefit of the patient and public, and particularly in the area of early intervention and prevention.

Public Health England. 2014

The guiding principles for the above model are that the service will be:

- Centralised within the community
- Deployed across the health and social care system
- Delivered as close to home as possible

Design focus for AHP services:

Below outlines the initial guiding principles to be considered in determining the configuration and delivery of future AHP services as part of a multi-disciplinary team within the neighbourhood offer:

- AHP services delivering 'in-reach' from the community into hospital as standard ensuring a seamless pathway and continuity of care for patients.
- AHP services focussing on the most complex cases as part of an MDT within the neighbourhoods to manage care closer to home (specialist advice & guidance, and rapid access to assessment and treatment where required)
- Neighbourhoods having the right capacity and capability to provide person-centred care and enhanced case management in accordance with neighbourhood needs
- AHP services focussing on prevention and self-management to deflect unnecessary

activity from GP / Acute/ longer term social care settings.

- Using technology to enable alternative methods of delivery and improve efficiency.

Proposed AHP Delivery Model:

Proposal	Benefits
The AHP resource is centralised within the community	<ul style="list-style-type: none"> ➤ Consistent patient pathways ➤ Optimise resilience ➤ Maximise opportunity for skill mix and cross cover, building on existing examples of good practice ➤ Enable interdisciplinary assistant practitioner / support worker roles ➤ Provide clear, effective management structure ➤ Clarify roles and responsibilities ➤ Reduce duplication of service creating a more efficient patient pathway ➤ Ensure consistent banding of staff ➤ Enable sufficient, flexible capacity to deliver over extended operating hours as required by model.
AHP resource is deployed across the health and social care system, including in-patients	<ul style="list-style-type: none"> ➤ A more reliable service for patients ➤ Flexibility ➤ Capacity consistent with demand ➤ Target priority areas ➤ Enable shift in resource as activity transfers from secondary care
AHP resource is delivered as close to home as possible	<ul style="list-style-type: none"> ➤ Patient get the right care in the right place at the right time ➤ Default is delivery in neighbourhood unless valid clinical reason for other location ➤ Enables virtual/actual MDT working with core teams, including skills sharing

Current State

Benchmarked average

Row Labels	Sum of FTE	% workforce	Row Labels	Sum of NEW FTE	% change	% of workforce
Community	44.4	19%	Community	56.9	28%	24%
Dietician	2.11		Dietician	6.3		
OT	2.6		OT	2.6		
Physio	18.93		Physio	27.3		
Podiatrist	20.76		Podiatrist	20.8		
Inpatient	113.37	50%	Inpatient	113.4	0%	47%
Dietician	10.65		Dietician	10.7		
OT	34.67		OT	34.7		
Physio	56.76		Physio	56.8		
SALT	11.29		SALT	11.3		
Outpatient	29.72	13%	Outpatient	29.7	0%	12%
Dietician	1.7		Dietician	1.7		
OT	4.26		OT	4.3		
Physio	23.2		Physio	23.2		
SALT	0.56		SALT	0.6		
Intermediate Tier	30.54	13%	Intermediate Tier	30.54	0%	13%
Dietician	0.2		Dietician	0.2		
OT	13.88		OT	13.88		
Physio	16.26		Physio	16.26		
SALT	0.2		SALT	0.2		
Other	10.49	5%	Other	10.49	0%	4%
Dietician	1.19		Dietician	1.19		
Physio	9.3		Physio	9.3		
Grand Total	228.52	100%	Grand Total	241.07	5%	100%

INVESTMENT REQUIRED

The investment in AHP's totals £587k. It is proposed that £294k is released in 2017-18, which represents 50% of the total.

Provisional proposals for the investment are as follows. These aim to bring AHP provision up to benchmark, where appropriate. However it should be noted that current benchmarking relates to existing models of reactive care, and also only includes health staffing data. Therefore further analysis in the context of a proactive model of neighbourhood care is required to ensure that AHP investment reflects the needs of the neighbourhoods. These proposals must also be viewed alongside significant additional investment into MSK Physiotherapy within a transformed primary care offer.

DESCRIPTION	INVESTMENT	WORKFORCE		BENEFITS
		Now	Future*	
Physiotherapy	395k	124.45	128.45	Reduce waiting times**; Enable release of GP capacity for MSK conditions;

Occupational Therapy / SaLT		83.96	88.36	Reduce waiting times Enable faster throughput of enhanced case management offer Reduction in longer term packages of home care N'hood contribution to falls reduction pathway
Dietetics	193k	15.88	20.05	Reduce waiting times Frailty is often associated with malnutrition. Malnutrition increases susceptibility to disease, impairs clinical outcomes and increases healthcare use and costs. Dietetic input is vital in resolving malnutrition.

***Estimates based on fully qualified workforce increases. Further increases in FTE again investment are anticipated as understanding of new skill mix options are explored.**

****See table 5 below for potential waiting list impact**

(Based on Primary Care Physiotherapy – 2016-17 year to date)

Patients with a 'Primary care physio' referral, but no activity	3124
Additional physio FTE	4
Caseload (Benchmarked average)	201.78
Cases immediately removed from list**	1684.863
Remaining wait list **	1439.137
Reduction in waiting list	-54%

If we employ 4 physios today and gave each a 'benchmark average' caseload size, alongside aligned investment in Transformed Primary Care physio access, then we could achieve a reduction in the waiting list of up to 54%.

****Including impact of aligned investment in Transformed Primary Care physio access**

Next Steps:

In order to develop the implementation stage of this programme a number of actions have been identified:

- Further analysis of benchmarking and pilot data to ensure investment reflects needs of proactive model of neighbourhood care, and makes best use of investment in alignment with benefits outlined in Transformed Primary Care AHP plans.
- Clarification of the current MSK & Frailty pathways including access, resource, gaps,

blockages, duplication of activity. Where support currently sits on the pathways to determine an accurate and informed current position to enable efficient and sustainable transformation supported by all affected parties. This will be achieved through process mapping activity, workshop events and other change management tools as appropriate.

- To develop clear Terms of Reference for the implementation phase of the programme focussed on improving patient pathways, patient experience and providing a neighbourhood offer in line with the needs of the population with emphasis on prevention, self-management (advice and guidance), providing treatment in the home/community setting and reducing unnecessary GP / Acute activity.
- Governance plan - to include a robust centralised management structure, clear project plan with monitored milestone activity, risk analysis, roles and responsibilities. Use key performance indicators to evaluate progress, improvement and adjustments to the milestones as necessary in line with a flexible Agile approach.
- Communications strategy – to include staff engagement activity and regular, relevant updates of information to all parties involved in the programme. This will aid the cultural change aspect of the programme which is recognised as a significant contributor to the success of the programme.
- Resource – Upskilling, cross cover, rotation, training opportunities to be explored to enable a successful and effective multi-disciplinary team culture within the neighbourhood teams. Ensure the right capacity and capability is available in the right place at the right time. Such work will also provide a consistency of skill mix across the system, based on patient needs rather than historical practice and a greater use of unregistered workforce (AfC Band 4 or below) will be incorporated into the future model.
- To research best practice and shared learning and action where appropriate.

Appendix A: Brief summary of Phase 1 Allied Health Professions service delivery by person cohort and location.

AHP:	Examples of service delivery person cohort:	Examples of service delivery settings
Physiotherapy	<ul style="list-style-type: none"> neurological (stroke, multiple sclerosis, Parkinson's) neuromusculoskeletal (back pain, whiplash associated disorder, sports injuries, arthritis) cardiovascular (chronic heart disease, rehabilitation after heart attack) respiratory (asthma, chronic obstructive pulmonary disease, cystic fibrosis) manual therapy (such as massage) therapeutic exercise electrotherapy (such as ultrasound, heat or cold) 	<ul style="list-style-type: none"> outpatients' departments elderly care stroke services orthopaedics mental health and learning disability services occupational health
Dietitians	<ul style="list-style-type: none"> have digestive problems need to put on / lose weight after an illness have an eating disorder have an allergy. 	<ul style="list-style-type: none"> mainstream and special schools community clinics prisons and young offenders institutions patients' own homes
Occupational Therapy	<ul style="list-style-type: none"> someone adapt to life after major surgery such as a hip replacement dementia sufferers develop strategies stroke patients people suffering from mental illness get back into everyday activities such as work or volunteering elderly people stay in their own homes by providing adaptation such as level access showers or stair lifts 	<ul style="list-style-type: none"> social services departments hospital departments GP Practice patients' own homes
Podiatry (Chiropody)	<ul style="list-style-type: none"> diabetes sufferers with circulation problems who may be at risk of amputation people with sports injuries people needing minor procedures such as nail surgery or laser treatment, using local anaesthetic people wanting advice about footwear or foot health 	<ul style="list-style-type: none"> hospital departments or clinics GPs surgeries patients' own homes •
Speech & Language Therapy (SALT)	<ul style="list-style-type: none"> physical disabilities communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke, head injury, Parkinson's disease and dementia head, neck or throat cancer mental health issues specific language impairment cleft palate voice disorders selective mutism learning difficulties 	<ul style="list-style-type: none"> mainstream and special schools community clinics prisons and young offenders institutions patients' own homes

Health Education England
 Health Careers



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STOCKPORT
 TOGETHER

Appendix B: AHP Current Resource

AHP	Community			Inpatient			Outpatient			Intermediate Tier			Other***			
	FTE	16/17 Cost	Activity**	FTE	16/17 Cost	Activity**	FTE	16/17 Cost	Activity*	FTE	16/17 Cost	Activity**	FTE	16/17 Cost	Total FTE	Total 16/17 Cost
Dietitian	2.11	£77,200	740	10.65	£334,800	5068	1.7	£73,500	760	0.2	£6,000		1.19	£53,300	15.85	£544,800
OT, M&H, EAO	16.5	xx	/													
OT	2.6	£100,200	28353	34.67	£1,123,800	27343	4.26	£166,400	2131	13.88	£627,700	9783			55.41	£2,018,100
Physio	18.93	£783,900		56.76	£1,799,400	68576	23.2	£1,111,800	32632	16.26	£643,400		9.3	£430,700	124.45	£4,769,200
Podiatrist	20.76	£844,400	43105												20.76	£844,400
SALT				11.29	£358,900	1502	0.56	£25,600	983	0.2	£7,200	77			12.05	£391,700
Grand Total	44.4	£1,805,700		113.37	£3,616,900		29.72	£1,377,300		30.54	£1,278,300		10.49	£484,000	228.52	£8,568,200

* 15/16 full year PLUS est. 20% additional for non-Stockport patients

**16/17 FOT, Stockport incl. non-Stockport patients. SMBC employed OT, M&H, EAO activity measured differently

*** Patient education (Dietetics) and CD physio; Occupational health; Cardiac rehab; T&O; EPR; Uro-dynamics (Physiotherapy)



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STEADY IN STOCKPORT

Business case: Prevention and management of falls and (fragility) fractures and improving bone health

Aim:

The aim of the 'Steady in Stockport' programme is to improve quality of life for people by reducing the burden of falls and fractures.

What are we trying to accomplish?

Through an interdisciplinary pathway we want to offer:

Primary prevention:

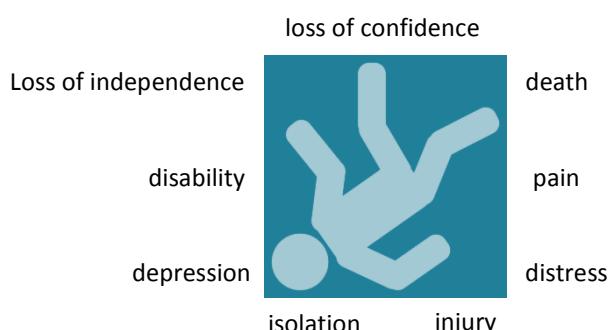
- Increase the number of people engaging in physical activity throughout their life course.
- Identify people at potential risk of falling or fracture and raise awareness of actions they can take to reduce their risk through a multi-agency approach.

Secondary prevention:

- Identify people who have a high risk of falling including people with fractures, fragility fractures and/or osteoporosis and provide treatment, restore function and undertake multi-factorial assessments and targeted interventions to prevent falls and improve function.
- Work with care providers to prevent falls and fractures in their care environment through multifactorial interventions at an individual and system level.
- Cluster current staff and resources to organise an integrated and interdisciplinary approach across Stockport.

Why?

- A fall can have significant physiological and psychological consequences and impacts negatively on people's quality of life. A fall can lead to:



*1 in 10 will die within one month and
1 in 4 will die in a year after a fractured hip*

- Falls are the largest cause of emergency hospital admissions for older people.
- The estimated cost to the NHS is more than £2 billion per year, of which £1.1 billion are costs for social care.
- Cost of hospital, community and social care services for patients who fall can be almost four times as much in the 12 months after admission as the costs of the admission itself.
- Many falls are preventable and people who had a fall are more likely to fall again.

Stockport Figures

Data on falls

Table 1: Number and % of the population with a history of fall

	All		Female		Male	
	Number	% of pop'n	Number	% of pop'n	Number	% of pop'n
All	12,150	4%	7,700	5%	4,450	3%
Age 0-19	1,685	2%	805	2%	880	2%
Age 20-64	4,725	3%	2,875	3%	1,845	2%
Age 65+	5,745	10%	4,020	13%	1,725	7%

- Every year about 30% of people 65+ will have at least one fall: 16680.
- Locally, data from Emergency Department (ED) attendances shows us that 47% (13/14: 3236) of ED attendances with falls, 62% of hospital admissions with falls (13/14: 2133 hospital) and 89% of deaths from falls (13/14 49 deaths) are in the 65+ age group.
- Numbers of falls are fairly stable over the years.
- There is no strong trend in month or time of fall; however 13% of attendances by the older age group are in the early hours of the morning.
- The home is the most likely place for a fall to occur.
- People in the older age group are more likely to arrive by ambulance and more likely to be admitted to hospital rather than discharged from ED.
- Almost a third of hospital admissions in the older age group are not finished after one episode of care, meaning there is a longer spell in hospital.
- Rate of falls generally increases with deprivation. However, there are more people with a history of falls in the more affluent areas of Stockport.
- Compared to the England average, Stockport has significantly more injuries due to falls, for those aged 65-79 and for those 80years and over. This is the case for males and females (see figure 2).
- Compared to the England average, we are also higher for mortality from accidental falls (this is in part as our coroner investigates all deaths with a fall in the last six months). See figure 3.
- NHS Right Care data indicates that compared to the best / lowest performing 5 CCGs of our 10 most demographically similar CCGs we could improve in the following areas (figure 1):

Figure 1: Right Care data

Area for improvement	Quantified opportunity
Hip replacement emergency readmissions 28 days	9
% fractured femur patients returning home within 28 days	69
Hip fracture emergency readmissions 28 days	13
Injuries due to falls in people aged 65+	330
All fracture admissions in people aged 65+	192
Spend on admissions relating to fractures where a fall occurred	£518,000 (potential savings)

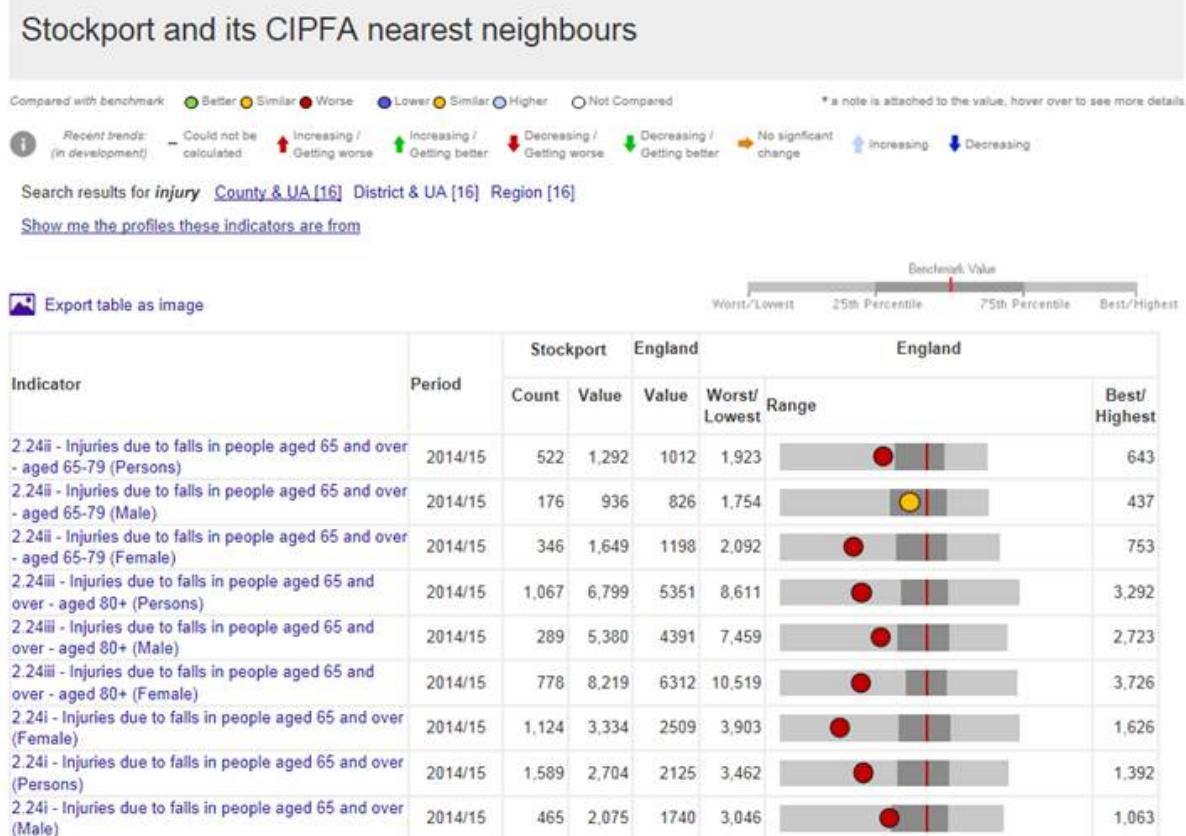
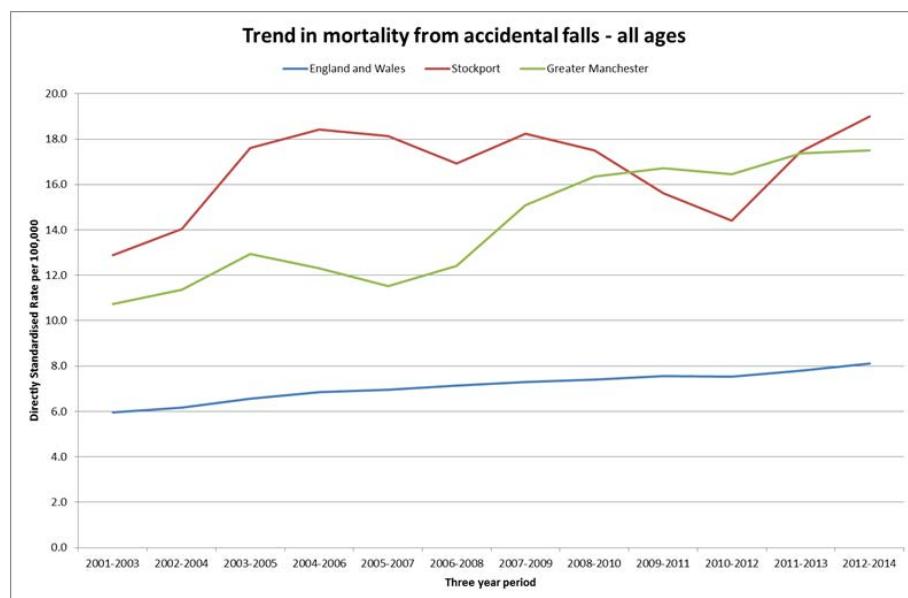
Figure 2: Stockport compared to England, Injuries due to falls


Figure 3: Trends in mortality from accidental falls

Figure 4: Fall Related Admissions age 50+ - Jan 2016-Jan 2017

DiagFig	Values					
	Spell Count	Spells for Falls At Home	Spells for Falls at Care Homes	Spell Cost	A&E Cost	
# at wrist and hand level	23	8	3	£43,243	£3,558	
# of femur	365	195	70	£2,487,275	£54,119	
# of Forearm	93	47	3	£193,442	£11,531	
# of lower leg, inc ankle	117	60	5	£376,594	£16,460	
# of lumbar spine and pelvis	110	73	15	£384,169	£16,145	
# of shoulder and upper arm	90	46	8	£269,058	£13,129	
# of skull and facial bones	34	13	1	£131,537	£5,857	
Open wound of head	263	138	37	£644,091	£46,494	
Open wound of wrist and hand	14	7	1	£29,365	£1,951	
Other and unspecified injuries of head	143	98	13	£341,086	£24,751	
Superficial injury of head	313	171	53	£604,254	£54,602	
Other	598	364	65	£1,711,995	£92,485	
Grand Total	2,163	1,220	274	£7,216,109	£341,082	

What is the need for change?

We currently have an inconsistent response to preventing and managing falls. People are identified as high risk of falling by various staff in the community but are not systematically assessed and followed up. Many professionals identify people at risk / high risk of falling like

third sector parties, fire and rescue service and Life Leisure (fitness provider) staff but there is no falls service for them to refer these people at risk to. There is an offer of balance and strength programmes but people at risk are not systematically referred and the balance improvement activities are not provided consistently across Stockport. People with fractures receive an intervention through the hospital's fracture clinic and/or falls clinic but this service cannot meet demand and is not providing a full fracture liaison intervention as recommended by NICE guidance. GPs of people over 50 attending ED with a fracture will be advised to arrange a DXA-scan but currently 40% of GPs follow up this advice (SHH, audit 2016). We are not screening for fragility fractures to provide timely interventions in improving bone health and there is an underdiagnoses of osteoporosis and not everybody diagnosed with osteoporosis receives treatment. As a result Stockport:

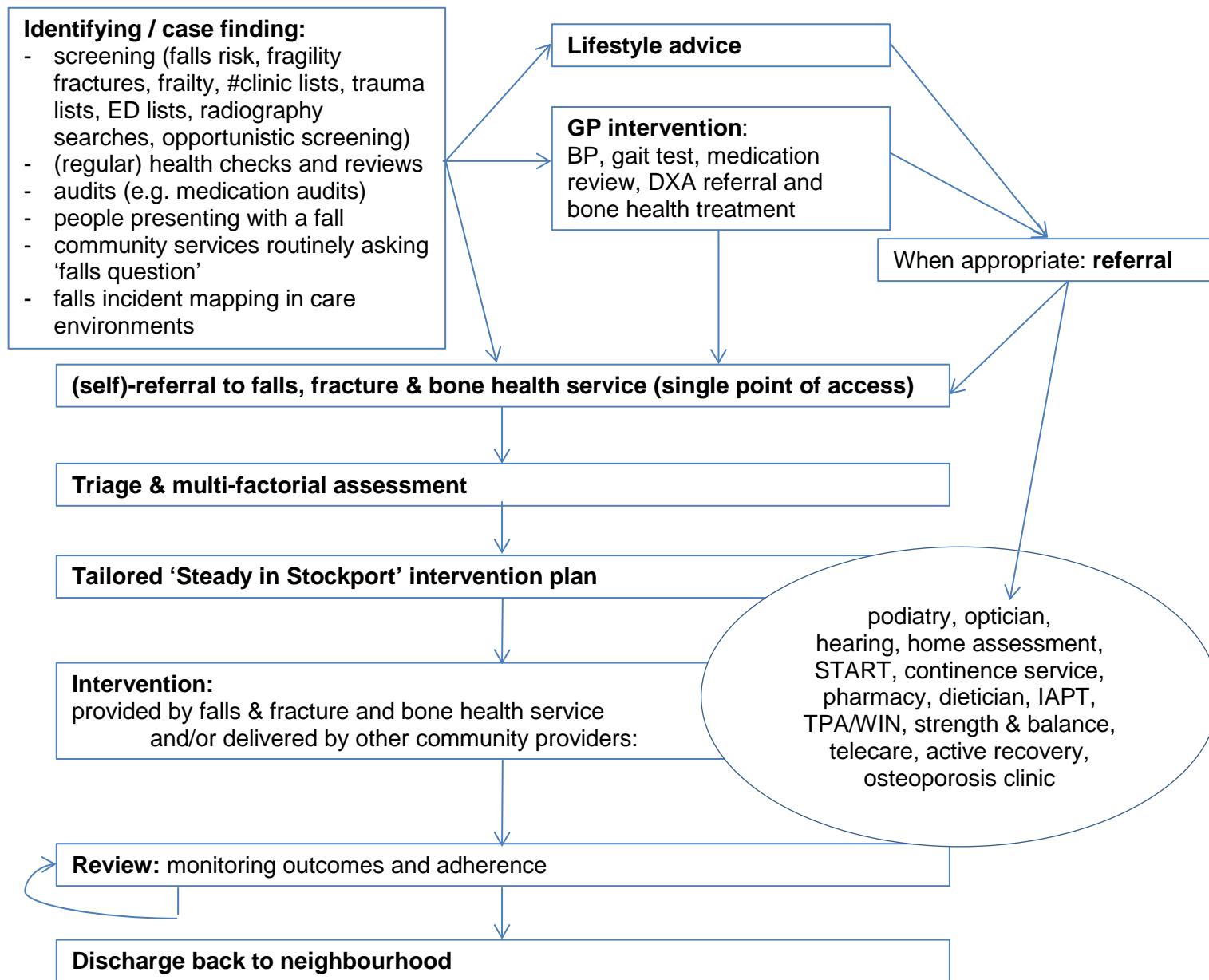
- Is an outlier in ED attendance as result of a fall,
- Has a diagnosis gap regarding osteoporosis.
- Has a higher number than average of frequent fallers.
- Has a higher number of people with injured falls (65+) than England's average.
- Has a high number of falls in care homes / hospital environments.

'Steady in Stockport' model

The new 'Steady in Stockport' model is an interdisciplinary approach, focussing on primary and secondary prevention. The model consists of an integrated pathway between a new falls, fracture and bone health service and various existing services and facilities in the community.

The pathway is as follows:

The pathway is as follows:



	Case finding	Assessment	Interventions
<p>General public level:</p> <ul style="list-style-type: none"> - Generic lifestyle improvements which also includes preventing falls risk factors <p>System level:</p> <ul style="list-style-type: none"> - Improving care environments to prevent falls 	<p>→ People aged 40 and older through health checks and other health screening and promotion activities</p> <p>→ Falls incidents monitoring</p>	<p>→ Self-assessment through online webtool Health check</p>	<p>Supporting health improvement and self-management through falls awareness and prevention initiatives:</p> <ul style="list-style-type: none"> • Falls Awareness Leaflet • Advice regarding maintenance of health and wellbeing / active ageing / falls prevention • Signposting to address specific falls risk factors <p>Systematic falls prevention management in care environments incl. assistive technology (care homes / hospitals)</p>
<p>Individual level:</p> <ul style="list-style-type: none"> - reducing risk of falls and fragility fractures and improving quality of life - restoring function after fall / fragility fracture - improving bone health <p>High risk of falls: a history of falls, muscle weakness, poor balance, visual impairment, polypharmacy and the use of psychotropic and anti-arrhythmic medicines, environmental hazards and a number of specific conditions (including arthritis, cognitive impairment, depression, diabetes,</p>	<p>→ Staff working in the community routinely asking people 65+: "have you had a fall / trip / stumble in the last 12 months"?</p> <p>FRAT score 1 or more</p> <p>EMIS-frailty index: mild, moderate, severe</p> <p>FRAX and Q-fracture</p> <p>Audits (hip fracture) / opportunistic screening</p> <p>People presenting with an injurious fall or (unexplained)</p>	<p>Falls prevention, fracture & bone health service:</p> <p>Interdisciplinary multifactorial assessment following NICE guidance (nurse, OT, physio, TPA, pharmacist)</p> <p>Service has direct access to consultants as and when needed and access to diagnostics like DXA scan, blood tests</p> <p>Urgent access based on triage</p>	<p>Tailored intervention plan based on one or more of the following elements delivered in the community:</p> <ul style="list-style-type: none"> • bone health treatment – part of FLS • medication adjustments • rehabilitation • mental wellbeing • mobility • telecare • strength & balance, exercise (home/group) • safe home environment, incl. equipment • feet and footwear advice • vision/hearing /aids advice • vitamins & nutrition advice • medicines optimisation • continence advice • lifestyle advice and interventions

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<p>high alcohol consumption, incontinence, Parkinson's disease, stroke and syncope).</p> <p>High risk of fractures: low bone mineral density, previous fracture, age, female sex, history of falls, glucocorticoids, rheumatoid arthritis, smoking, low BMI, high alcohol consumption, and visual impairment.</p>	<p>fracture (GP, Carecall, NWAS, A&E, CRT)</p> <p>People with poor bone health</p> <p>High risk groups (because of health condition or certain medication usage)</p>	<p>Clinics in community and hospital. Hospital clinic is predominantly a fracture liaison and bone health service (FLS)</p> <p>Telephone advice & reviews / clinic appointments / home visits</p>	<p>(including alcohol, nutrition, diet and smoking)</p> <ul style="list-style-type: none"> • social work referral <p>Access to consultant / specialist advice (telephone / virtual / clinic)</p> <p>Monitoring and evaluation of intervention plan including medication adherence</p>
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1) Primary prevention offer in new model (low to moderate risk of falls)

Prevention starts in general for people over age 40 with healthy life style messages and identification of risk factors related to falls: dementia prevention, smoking cessation, increased exercise and balance training and reduced alcohol intake. These messages could be part of a wider lifestyle approach whereby staff are aware of the risk factors and are able to provide advice and signposting in a motivational and encouraging way.

In addition there are specific target groups that have a higher risk of falling and fractures: people with certain medication, people with certain medical conditions, people living in certain areas or sheltered housing / care facilities and people over the age of 65. For these groups a more targeted approach is needed related to 'making every contact count' (MECC) to identify people at risk and to positively stimulate people to get the best possible outcomes in falls prevention. This means that we need to raise public awareness, signpost them to postural stability classes in each neighbourhood and promote home environment checks from Age UK and the Fire & Rescue service.

Various staff members in contact with at risk groups will need to be falls risk aware, able to undertake a FRAT-assessment and need to know when and where to refer people at risk to depending on their needs, e.g. mobility, sensory impairment, balance, medication, cognition, and footwear. All prevention messages need to be aimed at empowerment and support rather than creating fear. Some of this is already in place and it is building on the good work being delivered by the fire and rescue service, Targeted Prevention Alliance (TPA) / Wellbeing and Independence Network (WIN), Age UK and various other health and social care staff groups.

Apart from working with health and social care staff, pharmacies, third sector, fire and rescue service and home care and housing providers, it is also worthwhile engaging with other public facing services like hair dressers, community shops and taxi drivers asking them to give falls prevention messages and hand out a falls prevention leaflet.

It is crucial that when people are identified who could potentially benefit from falls prevention, an easy access to falls prevention intervention is available including a simple online assessment tool on the Healthy Stockport Website that will direct them to the most appropriate interventions (leaflet, strength & balance improvements, visit local pharmacist etc.). This tool can also indicate a higher falls risk and the need to contact their GP for further investigation and/or (self-) referral to the falls, fracture and bone health service.

2) Secondary Prevention offer in new model (moderate to severe risk of falls)

An integrated falls, fracture and bone health service will be implemented to provide an in-depth assessment and interventions for people who have had a fall, are at high risk of falling and/or who have had a fragility fracture. The service will also pro-actively be involved in case-finding and screening.

Case-finding

It is important to find people at high risk of (another) fall, a fragility fracture or with low bone health. Several actions will be undertaken in the new model:

- Auditing and undertaking opportunistic screening to find people with low bone health and/or with fragility / vertebral fractures.

- Identifying people at high risk of falls or fragility fractures based on frailty, medical conditions and medication usage (GP / practice nurse assessments EMIS-frailty index, FRAX and/or DXA scan, medication audits related to high falls risk or impact on bone health.)
- Identifying people at high risk when they report a (non-injury) fall.
- Identifying people at high risk of falling in care environments (hospital, care homes, extra care housing.)

For all those people at a higher risk of falls and fragility fractures a simple referral pathway into a falls, fracture and bone health service will be available to support the neighbourhood teams with assessing and developing individual intervention plans. This service has two elements:

A) Fracture And Bone Health element of the service (community based with hospital in-reach)¹

This evidence based service focusses on people 50+ presenting with a new fragility fracture in hospital (ED attendees) or who are found through opportunistic identification of vertebral fractures in routine scans taken for other purposes. All people identified will be offered written information about bone health, lifestyle, nutrition and bone-protection treatments.

People will have a bone health assessment and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident fracture.

People at increased risk of further fractures will be offered appropriate bone-protection treatments.

People at increased risk of further falls will receive a multi-factorial assessment and tailored intervention plan to reduce future falls.

Management plans will be person-centred and integrated between primary and secondary care.

People who are recommended drug therapy to reduce risk of fracture will be reviewed within 4 months of initiation to ensure appropriate treatment has been started, and every 12 months to monitor adherence with the treatment plan (clinic or telephone appointment.)

B) Falls prevention element of the service (community based)^{2,3}

Falls prevention interventions will be offered to everybody at high risk of falls. People will receive a multifactorial and holistic assessment to identify areas of improvement in conjunction with the person's own goals.

This assessment is provided by an interdisciplinary team from the 'falls, fracture and bone health service'. Part of the assessment is providing education and information. Following the assessment a multifactorial intervention plan will be developed delivered partly by the service and partly by providers in the community.

The service will also provide training and advice to staff working in 24/7 care environments or providing home care on how to prevent falls, how to raise falls awareness and how to identify people at risk of falling.

C) Service delivery

The falls, fracture and bone health service runs weekly clinics in the community at locality level, provides telephone consultation and runs an in-reach service in the hospital (fracture liaison and bone

¹ NOS, 2015, Clinical Standards for Fracture Liaison Services

² NICE, 2017 Quality Standard QS 86: Falls in Older People

³ NICE, 2013, Clinical Guideline CG 161: Falls in Older People: assessing risk and prevention

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health element). The staff provides case finding, assessment, interventions, training and education includes the following core disciplines:

- Nurse (fracture liaison, case finding, education)
- Telephone triage nurse
- Occupational Therapist (falls prevention, education)
- Physiotherapy (falls prevention, education)
- Technical instructors to work in 1-1 situations with people at highest risk of falls
- Administrarive staff

The service will be managed by the borough wide active recovery team and will work in partnership and will be aligned to various services in the community (third sector, fire and rescue service, continence service, community pharmacists, opticians, hearing aid and mobility services) and will especially work closely together with neighbourhood teams (GPs, pharmacists, physiotherapists and TPA/WIN staff in the neighbourhood), LifeLeisure (strength and balance training), active recovery therapists and health coaches.

The service has good working relationships and fast track access to consultants as and when needed: rheumatologists, cardiologists, orthopaedics, geriatricians, ENT, old age psychiatrists and radiologists.

The service has also direct access to diagnostics, like DXA scans and blood tests and the equipment and adaptations service.

The professionals working in the ‘falls, fracture and bone health service’ have apart from their clinical role (80% of staff time) also a training and education role to promote falls awareness, to train people in undertaking FRAT assessment and prevention techniques and to support residential care providers with falls management (about 20% of staff time).

When appropriate staff of the service can undertake a home visit but it is expected that the majority of the people will attend a clinic or receive their intervention through a telephone appointment. Based on a triage system people can be seen more urgently e.g. to support hospital discharge but normally a referral will be followed up within 3 weeks. People can self-refer and based on a telephone triage will be booked in for an appointment or will receive tailored falls preventing advice via (e-)mail.

3) Investments needed

The key steps in implementing an evidence based ‘Steady in Stockport’ model are:

- 1) Find and prevent: increasing case finding and screening activities to find people at high risk of falls, having had an injurious fall and/or identified with fragility fractures
- 2) Establishing a new ‘falls, fracture and bone health service’ with a focus on secondary prevention
- 3) Increasing postural stability / strength and balance interventions across the borough for the high at risk group
- 4) Joined up interdisciplinary approach in the community regarding primary prevention and case-finding of people at low/medium falls risk / reduced bone health
- 5) Working with 24/7 care providers to improve a systematic falls prevention approach.

The following actions and investments will be needed to implement an interdisciplinary falls and fracture prevention and bone health improvement pathway for Stockport.

Actions	Deadline	Costs
Promotion material		
Update current falls prevention education material	01.10.2017	£ print costs
Update current bone health education material	01.10.2017	£ print costs
Training package for community staff	15.01.2018	--
Develop and publish falls awareness assessment tool and intervention advice on Healthy Stockport website	01.12.2017	--
Online resource with up to date information about preventative interventions	01.12.2017	None: managed by falls, fracture and bone health service
Pathway material		
Assessment tool	01.10.2017	--
Template intervention plan	01.10.2017	--
Simple referral form in EMIS / H&SC record including what actions have already been undertaken and what advice has already been given to avoid duplication	01.10.2017	--
Training		
GP masterclass to include frailty assessment, initial falls assessment	01.02.2018	--
Falls awareness training for community / public facing staff / building community assets to raise falls awareness and to inform where to signpost people to	Ongoing start per 01.01.2018	None: delivered by staff in conjunction with community capacity builders and TPA/WIN
Case finding		
Targeted audits / risk stratifications to find risk groups: sensory impairment, polypharmacy, psychotropic medication or steroid users, low BMI	audit plan developed by 01.11.2017	Undertaken by existing staff
Opportunistic screening to find fragility fractures (vertebral fractures) 1. audit to identify most effective approach 2. implementing service	1. audit 01.05.2017 2. identify target group 01.08.2017 3. start screening service 01.10.2017	
Service delivery		
Establishing an integrated 'falls, fracture and bone health service' across Stockport	01.10.2017	
Identify venue for clinics	01.09.2017	
Access to diagnostics: investment to meet increased demand for DXA scans in hospital and scan availability in the community (heel ultrasound)	01.11.2017	
Increased capacity for access to postural stability and other balance improvement activity programs (Otago) for high at risk groups	01.01.2018	
Increased prescribing for osteoporosis drugs	TBC	

Increased use of assistive technology to prevent falls	TBC	
Develop and roll out falls management system in care homes and other residential community care environments: reporting, monitoring, intervention & workshops	15.01.2018 – 15.01.2019	None: delivered by existing staff in conjunction with neighbourhood staff
Availability of strength and balance and other lifestyle activities across Stockport (SMILE, health coaches, START)	Already available	

4) Benefits and savings

Apart from the improved quality of life, a systematic approach to falls and fracture prevention and improved bone health will also deliver financial benefits to the system.

The NOS evidence based benefit calculator identified the following savings for Stockport when implementing a fracture liaisons service following clinical guidelines including opportunistic screening: Stockport CCG would realise about £2.4 million savings after 5 years of implementation:

Total benefits

Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total
2016	£169,580	£14,399	£4,032	£14,934	£202,945
2017	£305,244	£20,570	£5,760	£29,868	£361,442
2018	£440,908	£26,741	£7,488	£44,802	£519,939
2019	£525,698	£30,855	£8,640	£49,780	£614,973
2020	£576,572	£34,969	£9,792	£54,758	£676,091
Total benefits	£2,018,002	£127,534	£35,712	£194,142	£2,375,390

Local HES data over the last 3 years has highlighted a steady increase in total patients with osteoporosis that have suffered a pathological fracture resulting in an increase of non-elective in-patient costs from £41,331 to £89,023.

12% of NWAS conveyances to ED (average of 50 attendances a week / 3500 a year) are a direct result of a fall. A further 500 falls related to ED attendances are conveyed by relatives or through patients attending directly. The costs for transport are not included in the NOS benefit calculator.

Recent published evidence⁴ indicates that home hazard assessments reduce the rate of falls by 19% and risk of falling by 12% (Cochrane review). This is often undertaken as part of a multi-factorial assessment. These assessments can reduce rate of falls by 24%. Intervention of postural stability also reduces the risk of falling with 20-40% depending on the intensity of the intervention (NICE guidance). Interventions in high-risk care environments will reduce risk of falling with 20-30% (NICE guidance).

⁴ Public Health England, January 2017: Falls and Fracture consensus statement – supporting commissioning for prevention

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The NOS benefit calculator focusses on costs related to fractures that can be prevented by implementing a fracture liaison service. Other injuries indicate a further spent on acute care that can be prevented. Figures for one year (Jan 2016-2017) were as follows:

Fall Related Hospital Admissions 50+					
DiagFig	Values				
	Spell Count	Spells for Falls At Home	Spells for Falls at Care Homes	Spell Cost	A&E Cost
# at wrist and hand level	23	8	3	£43,243	£3,558
# of femur	365	195	70	£2,487,275	£54,119
# of Forearm	93	47	3	£193,442	£11,531
# of lower leg, inc ankle	117	60	5	£376,594	£16,460
# of lumbar spine and pelvis	110	73	15	£384,169	£16,145
# of shoulder and upper arm	90	46	8	£269,058	£13,129
# of skull and facial bones	34	13	1	£131,537	£5,857
Open wound of head	263	138	37	£644,091	£46,494
Open wound of wrist and hand	14	7	1	£29,365	£1,951
Other and unspecified injuries of head	143	98	13	£341,086	£24,751
Superficial injury of head	313	171	53	£604,254	£54,602
Other	598	364	65	£1,711,995	£92,485
Grand Total	2,163	1,220	274	£7,216,109	£341,082

The table above presents the spells regarding hospital. In addition costs are made in primary care, social care, transport and by Care Call but these are difficult to distinguish from the total costs for these services.

	Average benefits per year
Fracture prevention impact NOS benefit calculator FLS Benefits Calculator v2.23 Stepping Hill 1-3-17.pdf	£ 475,078
Falls prevention impact: Reduction of care call follow up, crisis team activity, primary care time, Mastercall & pathfinder activity, NWAS journeys, DN time, therapy time, ED attendance and hospital admissions for wounds and head injuries related to a fall. And delayed admission into long-term care and reduced need for home care packages.	It is envisaged that savings are included in the overall calculated benefits of Stockport Together's business case. A falls, fracture and bone health pathway will be one of the interventions to ensure savings in 65+ category will be made. It is difficult to distinguish the specific contribution of the pathway to the overall savings. An estimate of direct contribution is based on: 15% reduction in ED & admissions related to injured falls (not a fracture as this is already included in benefit calculator above). 15% of 3,551,073 = £

	532.661 (excl social care, primary care, NWAS etc.)
Indication of annual savings	£ 1.007,739

	17/18 – 6 months start date 1.10.2017	18/19	19/20	20/21	21/22
Total costs^{b,c)}:	£ 239,600^{a)}	£ 428,200	£428,200	£428,200	£428,200

- a) Included are additional costs of £ 17,000 are for investment of a portable heel ultrasound device to pre-screen osteoporosis in the community clinics. Further research is needed to finalise decision making
- b) Total costs include opportunistic screening, an audit is planned to establish optimum cohort for screening.
- c) Assumptions made that pharmacist input is covered in neighbourhood business case and TPA/WIN, health coaches and generic postural stability classes are included in healthy communities' business case.

See excel document for more detailed cost calculation:

[Copy of C902-17 Falls Fracture_Bone Health Service_email.xlsx](#)

Appendix 1: Pathway cohorts and key stakeholders regarding assessment and treatment

<p>People at risk of falls ¹⁾</p> <ul style="list-style-type: none"> • History of falls • Muscle weakness • Poor balance • Visual impairment • Polypharmacy and use of psychotropic and anti-arrhythmic medicines • Environmental hazards • Medical conditions including: arthritis, cognitive impairment, depression, diabetes, high alcohol consumption, incontinence, stroke, Parkinson's disease, stroke and syncope 	<p>People at risk of fractures and fragility fractures ^{1,2)}</p> <ul style="list-style-type: none"> • Age: women over 65 and men over 75 • Case finding 50+ - vertebral fractures • In women aged under 65 years and men aged under 75 years in the presence of risk factors: <ul style="list-style-type: none"> • Low bone mineral density • Previous fragility fracture • History of falls • Family history of hip fracture • Use of glucocorticoids • Rheumatoid arthritis • Smoking • High alcohol consumption (14 units women 21 units men) • Low BMI (less than 18.5 kg) • Visual impairment • Other causes of secondary osteoporosis • People under 50 with major high risk factors (use of glucocorticoids, untreated premature menopause or previous fragility fracture)
<p>Case finding:</p> <p>Health and social care staff, third sector, public sector staff, carers, families, lifestyle services: people pro-actively asked about falls at routine assessments or are reporting a fall / trip / stumble / slowing down;</p> <p>Pharmacists: polypharmacy</p> <p>GPs: FRAX / e-frailty index / up & go / Medsreview NWAS / Carecall / A&E / Crisis response team / GPs / Mastercall: referral related to a fall</p>	<p>Case finding:</p> <p>GPs: FRAX and bone densitometry (DXA), certain medical condition, medication reviews</p> <p>Opportunistic screening for vertebral fractures</p> <p>People presenting with fractures</p>
<p>Falls prevention pathway ⁵⁾</p> <ol style="list-style-type: none"> 1) Multifactorial assessment for everybody at risk of falling with priority for people who had a fall 2) Individualised multifactorial intervention including interventions such as strength and balance training, home hazard assessment, medication review, hearing / eye-sight review 	<p>Bone Health and Fracture Liaison</p> <p>Treatment fractures / (high risk of) fragility fractures ^{3,4)}:</p> <ol style="list-style-type: none"> 1) an assessment of fracture risk, maintenance of mobility, correction of nutritional deficiencies, multifactorial assessment of falls risks 2) people diagnosed with osteoporosis are offered bone-sparing drug treatment (bisphosphonates, calcium vitamins). 3) people with osteoporosis prescribed bone-sparing drug treatment are asked about adverse effects and adherence to treatment at each routine medication review. 4) people with osteoporosis who have been taking bisphosphonates for at least 3 years have a review of the risks and benefits of continuing treatment.
<p>Multifactorial approach in care environments: assessing falls risks, providing strength and balance exercise programs (care homes, extra care housing providers), falls monitoring system</p>	

January 2017

²⁾ NICE Guidance, Osteoporosis: assessing the risk of fragility fracture, Clinical guideline [CG146], February 2017.

³⁾ NICE Quality Standard, Osteoporosis, draft for consultation, January 2017.

⁴⁾ NOGG, Guideline for the diagnosis and management of osteoporosis, March 2014.

⁵⁾ NICE Quality Standard (QS86), Falls in older people, January 2017.

REPORT DATED 27 FEBRUARY 2017

External Workforce Business Case; Future Investment Proposal

'Investment in a package of measures to improve both the quality of provision and market capacity across the Care Home and Home Care markets in Stockport'

1.0 Executive Summary

This paper proposes a recurrent investment of approximately £1.2m per annum, to extend the quality and availability of externally commissioned services in Stockport across the health and social care economy. This proposal is based on the need to achieve both sustainable and transformational change across the external provider market. This will realise many benefits in terms of improved outcomes for people and more effective support at home and will also help reduce expenditure on avoidable hospital admissions and delayed transfers of care. This will be achieved, in partnership with others, through a pro-active change management programme incorporating a package of measures as outlined below.

2.0 The Case for Change

2.1 The national/regional context:

- Demographic Pressures; rapidly increasing demand for care and rising complexity of need.
- Market capacity strained to breaking point; significant numbers of care home beds lost in the last two years and the closure of several home care agencies in the borough.
- Problems with recruitment and retention which can include poor terms and conditions, poor rates of pay, DBS check delays, the image of the sector, training and performance issues and a frequent turnover of staff.

2.2 Partnership working, change management and competing priorities

- Context of change e.g. Stockport Together developments, Devolution Manchester.
- Delayed transfers of Care (DTOC) impacting on the whole system.
- Need to look at whole system including housing, community services, fire services etc. to find new approaches to prevention and asset based models.
- Scarce resources
- Any suspended home or closure represents a loss of potential provision; how to ensure quality, choice and availability of support for vulnerable people;

2.3 Financial context

- Challenge to identify fair costs of care
- Challenges from providers regarding the costs of care, top ups and private market
- Overall financial pressures across the health and social care system

2.4 Care Quality Commission (CQC) context and the urgency of local issues

- The size, scale and composition of the market in Stockport (further information available via the CQC area profile). Some homes not physically fit for purpose, and loss of 151

beds in the last two years

- The regulatory context; until last year due to CQC staffing levels, many homes had not been inspected for some time. In the last year the CQC has ensured a new regime of timely inspections. This has created a useful baseline in terms of the quality of the market but also significantly increased the numbers of homes deemed 'inadequate' or in 'special measures'; detailed below. This new baseline does offer an enhanced opportunity to directly measure the rate of improvement across the market going forward.
- At the present time there are several areas of provision where intervention of this kind is urgently required, to avert further crises and reduce the increase risk of the problems noted above. Emergency arrangements have been deployed where required in recent months, to address identified risks and help meet joint agency responsibilities. However, a dedicated intervention team delivering a collaborative and supportive approach will offer a much more cost effective and proportionate response.

3.0 Outline of the Proposal

There are four distinct but related elements to this proposal:

3.1 Extended home support based
on re-ablement approach;
£690,000

3.2 Further development of the
Extra Care Housing model
£90,600

3.3 Investment in a joint quality
intervention team to work across
the external market
£238,779 (recurrent funding) and
£9,000 (one-off investment)

3.4 Supporting seven day flexibility
across the sector with weekend on
costs £171,200

3.1 Proposal One:

Extending re-ablement focused, asset based approaches across the Home Support market to ensure that more people are supported to live safely and independently in their own homes.

Based on two successful pilot initiatives involving a partnership between the REaCH service and independent home care providers in Stockport, this service will provide more support to

people in their own homes with an increased focus on re-abllement, independence and asset based approaches in the community. This will also incorporate an extension of the existing pilot service to provide overnight home support assessments to avoid hospital admissions or care home placements where appropriate.

Funding is sought to:

- a) Ensure that the aligned overnight home support assessment element of the approach also continues beyond March 2017.
- b) Roll out the day time support further to support neighbourhood provision and embed the service within multi-disciplinary teams.

This is consistent with the direction of travel for Greater Manchester as endorsed by the Joint Commissioning Board in November 2016, which has recognised the need for new models of care in terms of support to live at home, particularly those which adopt a re-abllement focus. Further work would still be required to roll out the approach across the whole sector, but this proposed approach creates the potential for further development and flexibilities through locality working and blended roles in future.

Description of service

This proposal, based on the above successful pilot, supports a more outcomes focused, re-abllement approach to home support, co-produced and delivered jointly by utilising the enhanced skill sets of both the in-house provider and independent providers. This requires providers and commissioners to adjust their focus from that of delivering long term support to a shorter term outcome based approach. This service will be available 24/7, 365 days of the year.

This model of care is evidence based and has been shaped by previous market tests and also by testing the new winter pressures model, to explore how the home care market can be developed to improve outcomes for the individuals supported. Within this model and in broad terms, referrals are received via the Council's in-house 'REaCH' service which undertakes an initial holistic assessment of the individual's needs. This assessment encompasses a 'Wellbeing planning' approach whereby the worker and the individual explore community network offers whilst working within the principles of self-care. Once the Wellbeing plan has been agreed and the individual's needs have been assessed, the short term package of care transfers to the linked locality provider, who will continue to work to the wellbeing plan with individuals to:

- Prevent further decline by responding to deterioration.
- Optimise the individual's wellbeing and resilience
- Continue to engage people with community activities – reducing Social isolation and loneliness

This wraparound approach also aims to reduce avoidable hospital admissions by providing increased support to people in their own home, supported by additional therapy and Social worker input.

Benefits

Locality based

The commissioned and contracted providers, all of whom will be on the Council's framework of registered and accredited provision, will be linked to the neighbourhood teams and



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provide services for a distinct geographical location. This will be aligned to the neighbourhood teams; this will support the recruitment of local people and will aim to reduce the number of 'crossover and handover' between providers in geographical areas, thus improving the continuity for people receiving the service.

Outcome based model

Two pilots have taken place to test the above model. The first took place between April and September 2016. This pilot was an opportunity to respond to an immediate need, when a home care provider served notice to withdraw from ten longstanding packages of care in the local area. A local provider engaged with Adult Social Care and agreed to work to an outcome focused framework to establish that in order to achieve a better outcome for people, we need to take a different approach in planning their support needs and this would:

- Reduce overall avoidable spend on care management.
- Improve the wellbeing of people receiving services and support, making wider and better use of community assets.
- Develop a new model of care that improves the lives of people who need different levels and types of support ranging from profound and basic care through to minimal intervention.
- Identify the skill gap within the private provider market – so we know what we need to offer in order to help them develop.
- Continue to promote the role of social care.

Objectives based on outcome based model

- People are supported to live as fulfilling a life as they can and wish to.
- Staff understand their role and have permission to 'Go to the person not the task'.
- Staff are able to identify all needs and assets for people they work with.
- The profile of home care work is raised and improved.
- People with packages of care do not remain isolated and lonely.
- Staff are aware of the assets in the area or how to access this information.
- The work experience for staff is more rewarding and hopeful of what?.

Demonstrable successes from the pilot

- Staff felt valued.
- Remuneration was increased and based on being able to work flexibly, using initiative and understanding how to make person centred care a reality (e.g. connecting beyond front door).
- Staff now have quality conversations with the people they support and can create a wellbeing plan with the person, their family and care team.
- People with complex needs and clients in a crisis would always have one consistent person to contact, who would be able to access fast track required joint assessments for things like equipment.
- When care workers recognise need for small to medium changes or variation in care or support they are able to get quick decisions and permission.
- All work is judged on outcomes – how has the life of the person supported improved?

- Money is invested in the right things based on ground up feedback—e.g. the consistent contact role.
- People have a named keyworker (with a backup) within home care teams. The whole care team [including the family] will know who the keyworker is.
- Family and friend carers, volunteers care workers etc. are part of the person's care team.
- The keyworker will be on an equal footing with the whole of the person's care team.
- Older people have the option to live in smaller shared space with networks of care with a keyworker, team around the person and situated within communities.
- Contracts that span care and support enable providers to prioritise the persons changing needs with the person and their family—whether that includes basic care, community support wellbeing and social connections.

The Council also secured contracts for additional temporary provision as in previous years, for 'winter pressures', but adapted this to the new model of care.

Scheme*	Details of scheme	Value	Contract period
(1A) Home Support – Winter Pressures/System resilience	Over a period of 22 weeks, there will need to be sufficient additional capacity to provide (as a minimum) an additional 280 hours of support per week, across the borough.	£92,400	1 st Nov 2016 – 31 st March 2017
(1B) Overnight Home Support	Over a period of 22 weeks, there will need to be sufficient additional capacity to provide an additional 280 hours of support per week, across the borough.	£92,400	1 st Nov 2016 – 31 st March 2017

*This business case relates only to the continuation and extension of the provision procured externally from the independent sector; the elements of the model relating to REaCH are included in the intermediate tier business case and hence not listed here, to avoid duplication.

Within this tested model and in broad terms, referrals are made via the Council's in-house 'REaCH' service who undertake an initial holistic assessment of the individual's needs. This assessment encompasses a 'Wellbeing planning' approach whereby the worker and the individual explore community network offers whilst working within the principles of Self-care. Once the Wellbeing plan has been agreed and the individual's needs have been assessed and stabilised, the short-term package of care transfers to the linked locality provider, who will continue to work to the wellbeing plan with individuals to:

- Prevent further decline by responding to deterioration.
- Optimise the individual's wellbeing and resilience
- Continue to engage people with community activities – reducing social isolation and loneliness
- This approach supports a more outcomes focused, reablement approach to home support, co-produced and delivered jointly by utilising the enhanced skill sets of both

the in-house provider and independent providers to adjust their focus from that of delivering long term support to a shorter term outcome based approach. This service will be available 24/7, 365 days of the year.

- This wraparound approach aims to reduce avoidable hospital admittances by providing increased support to people in their own home, supported by additional therapy and Social Worker input.

Furthermore, incorporating providers in the wider neighbourhood offer, by inclusion in the neighbourhood Triage and Multi-Disciplinary Team (MDT) will be able to reduce the number of 'organisation to organisation' referrals and improve relationships and communications.

Anticipated outcomes for people

The model will follow a person-centred approach; with the individual at the centre of all decision –making. This will be captured in the wellbeing plan which is based on the 7 principles of self-care which supports the ethos of a guided conversation approach; the focus for the plan will be on the individual's abilities, wants, wishes and aspirations.

At the beginning and at the end of the short term service, people will be asked to gauge their own feelings of wellbeing, supported by family and carers if appropriate. People will also be asked to complete a questionnaire at the end of the service to enable us to capture what worked well and what we can improve in the future.

1B Overnight Support and assessment

The purpose of this assessment is to ascertain the individual's support needs, abilities and activities throughout the night, highlighting any aids and equipment and to offer some respite for carers. The team will work between the hours of 10pm -8am and will provide a report at the end of each night. During the period of 1 November 2016 to 30 January 2017, a total of 32 people were supported by the night assessment service. Through discussion with the referring social worker, the feedback about the service was overwhelmingly positive, which helped ensure that people who wished to remain at home were supported to do so and received appropriate support.

1(C) This third element of the proposal is to replicate the 1A model across the neighbourhoods, thereby enabling twice as many people to benefit from this new model. It is recognised for all three elements of this first proposal that recruitment and retention is a significant challenge and that the development of the external workforce in future may require a different approach to employment across the sector, such as the option of 'blended roles' (see below). This would not be an immediate feature of the proposed schemes but would be explored further going forward; both as part of the work of the Joint Commissioning Strategy and as part of our broader input to Greater Manchester and North West market shaping initiatives.

Blending roles

This developmental work in Stockport is exploring the benefits of blended roles, whether this is across the registered professional cohort of employees, using the Trusted Assessor as an example or enhancing the skills of frontline domiciliary care workers, enabling them to undertake a number of clinical and therapy tasks. The drive to implement blended roles is underpinned by;

- Full utilisation of the provider market.



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- Smarter use of the available capacity.
- The reduction in the referral and assessment processes.
- Reduction in organisation to organisation handoffs.
- An improved seamless service for people in receipt

3.2 **Proposal Two:** **Developing more flexible and innovative models of extra care in the community as an alternative to residential care**

There is already an Extra Care Housing Support Service in Stockport but this investment will enable the model to be enhanced and further developed.

Ability of Extra Care Housing (ECH) to meet complex needs

Whilst ECH can meet the need of people with needs at standard residential level, the service can also meet higher needs. Higher dependency and occasionally **EMI** and nursing level needs have been met. Whilst people with this level of need are unlikely to be moved into ECH, if they are already resident and their needs increase, every effort is made to meet them and prevent (or delay) them being forced to move on into a residential or nursing placement. There are currently 2 people living in ECH who have care packages of over 40 hours and who moved from a nursing home environment in order to live a more independent life.

This proposal tests the hypothesis that enhanced support would enable the scheme to support people with a broader range of needs as an alternative to residential care. In a recent consultation with health and social care staff, the following issues were raised as being required in a new model; all of which this proposal would seek to address, both through a greater overnight presence and further developmental support.

- Dementia care.
- On site night care support (is currently a mobile service across all sites) – families are concerned about night times
- Mental health teams are not aware of extra care therefore poor relationship with the community psychiatric nurses.
- Age restrictions policy is limiting – there needs to be discretion based on needs, not age.
- Chronic Obstructive Pulmonary Disease (COPD)/Long term conditions specialism.

Extra Care background:

Extra care housing offers an additional housing option for older people; particularly relevant when considering solutions for hospital discharge and to prevent, reduce or delay the need for hospital or residential care. People are motivated to move to extra care housing for physical and emotional security, availability of support and an accessible environment and social contact. People value the opportunities for friendship and social interaction.

The potential of extra care provision is more diverse than our existing Stockport model: the key element of our model is self-contained accommodation and support accessible 24 hours. Meal provision, leisure and other facilities on site vary site to site and the benefit is rarely to the wider community. This proposal offers an opportunity to begin to test more

innovative and diverse options for extending this model.

3.3 Proposal Three; The creation of a quality intervention team:

Based on a successful pilot intervention with a Care Home in Stockport, this joint team of skilled staff from health and social care will work with Care Homes and Home Care agencies across the Borough

This will involve planned, pro-active intervention in partnership with providers (not 'doing to' or 'doing for') to facilitate sustainable improvement, embedding change and working flexibly out of hours and across the borough. Based on successful pilot approaches, this initiative will help ensure that providers meet and exceed required quality standards. This intervention will consequently have a positive impact on the avoidance of unnecessary placements, hospital admissions or delayed transfers of care.

Proposed Team Composition

- Joint team/Programme lead (costed as an assistant team manager or similar.)
- Three quality improvement officer.s
- Experienced nurse/clinical input (two part time.)
- Experienced Social Worker (proportion of hours) to ensure review.s
- Access to relevant specialist support depending on nature of provision (e.g. pharmaceutical/medication, occupational therapy, dementia specialism.)
- Change Management/service improvement co-ordinator (to influence and embed change.)

Wider team access to expertise & supporting systems

- Care home officer (medication specialism) and medical colleagues.
- Existing quality, safeguarding and contracts staff who monitor and identify concerns for resolution, complaints, corporate services, information governance, procurement support and legal services, training and HR
- Healthwatch Stockport 'enter and view', patient panels and advocacy services,
- Neighbourhood Teams,
- Public Health such as infection control expertise
- Education and training leads across health and social care,

Other

- IT solutions (a one-off investment is also sought for a joint quality dashboard being developed) and business intelligence
- Moving and handling, occupational therapy, equipment and adaptations, infection control, neighbouring authorities' quality/contracts teams
 - Police, CQC, NHS England, NICE, LGO, Elected Members,
 - TPA, WIN, Alzheimer's Society, Age UK and other 3rd sector/charities
 - National vanguard sites, North West market shapers, Greater Manchester new care models sites (for ideas to enhance the quality of provision)

Principles of intervention

- Intervention will be carefully prioritised/targeted (informed by 'RAG' rated business

intelligence triangulated from across the health and social care economy.

- Time limited (intervention timescales will vary but agreed improvements must be sustainable by the provider itself.)
- Pro-active (timely intervention will aim to identify difficulties at an early stage and prevent further deterioration in standards.)
- Locality based (linked to broader support systems as part of ensuring sustainability going forward.)
- Joint approach (Health and Social Care plus others depending on the nature of the support required.)
- Focuses on delivering sustainable changes using change management approaches.
- Provides an educational resource to reinforce key learning.
- Flexible working, not '9 – 5' e.g. an agreed support package may include an out of hours help line or support and quality checks at agreed times during evenings, nights or weekends.)
- Evidence based; the intervention model will build on a recent successful pilot as a starting model – but it will also be a learning process which will evolve based on experience. It will be evaluated through a range of measures, both quantitative and qualitative.
- Aligned to specific standards, i.e. CQC and NICE standards. Also using the NHS Quality Surveillance risk tool or other appropriate tools as part of inter-agency approach.
- Asset focused; building on strengths and assets (both at an individual service user level and provider level.)
- Co-production; working constructively with service users, families and providers to identify solutions to problems.
- Use of the joint commissioners' existing legal and contractual frameworks to support the above, to ensure compliance and ultimately take appropriate action if this is not successful to protect quality and safety for service users.
- Support the improvement process but ensure that the legal responsibility associated with regulatory accountability would still stay with the registered providers (normally the independent sector agency which owns/manages the provision.)

Anticipated Benefits of the Above:

Quality

Improving the quality and choice of external market provision in Stockport for service users and their families through;

- Improving outcomes, and quality of experience for the people living in the homes and their families
- Improving and continually developing management and leadership skills to ensure sustained improvement.
- A joint approach ensuring a holistic, asset focused approach to quality.
- Meeting statutory obligations, CQC requirements, NHS England, Care Act and the '5 Cs', mitigating reputational risk in relation to quality and safety.
- Embedding strong multi-agency working, safeguarding and communication; co-ordinating and prioritising quality, health and safety concerns and issues in conjunction with MDT professionals both within and in liaison with, the core team.

- Reducing instances of safeguarding alerts, complaints and critical incidents.
 - Ensuring the approach to support is consistent and standards improved

Capacity

Maximising market capacity and financial sustainability through;

- Influencing change to reduce the risk of market failure (where issues can be addressed through active intervention.)
- Reducing the need to suspend placements (via commissioners or regulators.)
- Keeping 'good' providers in the market, encouraging innovation and opportunities for development, enhancement of facilities or support 'in kind' e.g. links to training.
- Linking to broader strategies such as staff recruitment and retention of staff to support the deployment of an effective workforce with sufficient, appropriately trained, nurses and carers.
- Sustainability of leadership to continue improvements without further intervention (above in partnership with other agencies offering expertise such as 'Skills for Care'); developing a network of similar resources.
- Help maximise any community assets (assisting with the prevention agenda elsewhere) – e.g. a well led home will begin to attract volunteers, maximising social value, helping to engage more residents and supporting people who may wish to enter the workforce in the future.
- Financial stability as lack of capacity is creating huge costs in terms of ad hoc payments and top ups and legal/reputational risk.
- The alternative is that we put more emphasis on contract compliance to address poor standards which could result in a further loss of provision, and where prevention is a better option.
- Helping to reduce unnecessary hospital admissions or avoidable health interventions/pressure on primary care from care homes or home care agencies.
- Facilitating greater capacity and responsiveness within homes to address market pressures and reduce delayed transfers of care.

Summary of Key Costs:

Role	Grade	Cost
Joint team/programme manager (inc on costs)	ATM /SO3	£45,492
Three Quality improvement Officers (inc on costs)	3 x SO1	£115,602
Service Improvement Co-ordinator	1 x 0.5 wte Band 5	£17,674.
Two part time Nurses (or job share)	1 x 0.5 wte Band 6 1 x 0.5 wte Band 6	£44,011

Part time social work resource / backfill		£16,000
TOTAL recurrent funding		£238.779
Additional one-off investment*		£9,000*

*Additional one-off cost of £9,000 for the software development costs of a shared system wide Quality Dashboard to improve data in relation to the quality of provision

*Benefits are quantified in the summary cost/benefit sheet in Appendix One.

3.4 Proposal Four; Extending the Flexibility of existing Models of Care

This proposition involves looking at the services we already have in the community and considering what would be required to enhance the flexibility and responsiveness of those services.

One of these is the existing Care Home market, which could be enhanced through the provision of additional infrastructure support in relation to weekend admissions

At present there is unprecedented demand on the acute sector to facilitate timely discharges from hospital care for adults over the age of 65. A significant area of pressure is the availability and accessibility of both nursing and residential care. This proposal will outline the support required to improve the ability of both types of residential care to undertake weekend admissions and allow for timely discharge for those medically fit.

It is proposed that this will be undertaken with a specific group of homes and will thus create a 'proof of concept' for wider roll out taking into consideration both the longer term 'infrastructure' costs and the contractual expectations of our externally commissioned residential and nursing care homes.

It has been evidenced that during the weekend period there is a marked reduction in resource and capacity to undertake admissions into nursing/residential homes. As a result of this there is virtually no ability for an individual who is medically fit to be discharged to the preferred place of residence over the weekend and this results in a further delay of at least 48 hours and often longer if an assessment cannot be carried out until the following Monday. To alleviate this pressure during the winter period a ring-fenced capacity of 10 beds was blocked purchased to ensure facilitation of weekend admissions. Whilst these beds have been well used the ability to undertake weekend admissions has not been consistent and limited evidence to suggest assessments were done. The main challenges for this are:

- Sufficient staffing with the appropriate level of experience to undertake an admission at the weekend period in a home.
- Limited social work support to assist in assessment and admissions into a home as well as support with social care needs.
- Limited additional health related support available in particular GP coverage for nursing care and district nursing support for residential care.
- Lack of an appropriate discharge summary from the hospital, medication supply available to cover the weekend period, implementation of trusted assessor model not fully rolled out;
- People discharged to the winter pressure beds were unknown to the care homes.

The obvious case for change to address this current situation is to improve capacity in both our internal systems and the external market to undertake weekend admissions from hospital. This will in turn reduce pressure in the acute sector and ensure beds are free for those requiring hospital care and not occupied by those that are medically fit for discharge. It is clear that homes need to have the reassurance that the needs of those requiring discharge over a weekend period will have the necessary support available to allow for confidence, security and patient safety within the system.

The benefits of improving the ability for homes to undertake weekend admissions would:

- Improve performance for DTOC's over the weekend period;
- Improve efficiency in discharge and admissions into homes (trusted assessor);
- Collaborative approach with external providers to improve processes and outcomes;
- Appropriate place of residence for medically fit individuals with overall improved outcomes for well-being;
- Social and rehabilitative needs met in an appropriate environment;

The proposed approach to improve performance over the weekend period via access to admissions into care homes would entail a combination of comprehensive engagement with providers and a strengthening of the internal resources available within the Stockport Together Programme specifically within the intermediate tier and core neighbourhoods. In the first instance this will build on the trusted assessor model as piloted within the winter pressure beds at Hilltop Court and Plane Tree Court. The preference is to extend capacity to current intermediate tier teams to ensure continuity, staff rotation and more flexibility in cover arrangements, rather than creating a stand-alone team for weekend support.

The specific elements of this proposal:

- A new process for assessing the appropriate of admitting residents will need to be co-produced with providers to allow for consideration of the impact it will have on their capacity and ability to make these admissions in a timely manner. This will be undertaken through a full workshop session that will outline requirements and negotiate the appropriate conditions to ensure acceptance. This will in turn inform short-term requirements where there are providers willing to cooperate but also longer-term contractual arrangements.
- Currently within the service there is a crisis response team (intermediate tier) and this service has the potential to support residential and nursing care support on a daily basis including weekends and out of hours. To improve weekend admissions this team would need to be strengthened and would require the following investments:
- GP support to make visits to the home in particular for end of life pathways or medically complex patients. This would require additional GP hours for the crisis response team or additional 'home visit' capacity provided by Mastercall Out Of Hours / or GP pathfinder over the weekend period from Friday 16.30 to Monday 08:30.
- Social work support would be required for complex social care cases. This would include those without capacity or where there is dispute within families. This would include social work coverage from Friday 16.30 to Monday 08:30 either in the Crisis Response Team or Active Recovery Team.

- Therapeutic support for residents to access physiotherapy and occupational therapy at the point of discharge to facilitate improved physical well-being outcomes and speedier discharge from short-term placements. Two therapist (one OT and one Physio) would need to be available from the Active Recovery Team from 10-3 Saturday / Sunday.
- For those homes that do not provide nursing care, access to nursing support would be required. This would ensure that those that may have less complex medical needs could be supported more effectively in a residential care environment and reduce the potential of readmissions. This would require additional nursing hours to either the Crisis Response Team or Active Recovery Team from Friday 16.30 to Monday 08:30.

The following table provides a full cost breakdown of this proposal and includes pro-rata salaries to cover the winter period.

0.26 (10 hrs) OT band 6 (£44.011)	£ 11,443 + weekend oncosts = £ 13K
0.26 (10 hrs) physio band 6 (£44.011)	£ 11,443 + weekend oncosts = £ 13K
0.5 fte nurse band 6 (£44.011)	£ 22,006 + weekend oncosts = £ 25K
0.5 GP (£90K a year)	£ 45,000 + weekend oncosts = £ 50K
0.5 Social Work (SO3, £45.492)	£ 22,746 + weekend oncosts = £ 25K
	£126,000 before weekend on costs
TOTAL COST	£171,200 with weekend on costs

4.0 Key Partners in relation to the above four proposals;

- Stockport Council Adult Social Care
- Stockport NHS Clinical Commissioning Group
- Stockport Foundation Trust
- Pennine
- Healthwatch Stockport Ltd.
- 3rd sector and community groups
- Neighbourhood Teams including GPs, District Nurses and colleagues across MDTs
- Colleagues in housing, place based services, fire service etc.

5.0 Further strategic outcomes/benefits

Impact on the wider system

Following reviews of the care home and domiciliary care sectors, the priority is to develop a plan that will transform the sector effectively to achieve a stable market and manage the

demand and supply of care in these markets.

The key areas of focus over the next year will be on joint working with the Clinical Commissioning Group (CCG) and others to commission or further develop new models of care to address issues of capacity in the market and improve outcomes for individuals, ensuring strategic links to both 'Stockport Together' and 'Greater Manchester' developments. Service quality has been identified as a key theme within this joint commissioning approach, as we further develop a holistic and pro-active quality assurance function in partnership with providers, to prevent or address issues relating to business failure whilst ensuring financial sustainability across the market. As such these initiatives are fundamental to the neighbourhoods business case, since the development of new and enhanced models of community support and the provision of good quality services in the community is not only the core business of Stockport Together but fundamental to its future strategy of reducing reliance on emergency and inpatient services.

Robust planning and partnership links to facilitate all the above will be supported by an Ethical Care framework. The impact of home closure or business failure severely impacts across the whole Health and Social care market. It is increasingly evident that the role Social Care providers play within the community is a fundamental resource required to reduce the number of people admitted to Hospital and to reduce hospital delayed transfers & ultimately fulfil the broader preventative agenda, as part of the Stockport Together vision, to enable people to benefit from an appropriate choice and quality of support in their own homes and in the community.

In conclusion, the above proposals will help ensure both a prompt response and a preventative approach regarding 'market failure' and incorporate robust contingency planning. They will help promote market stability, develop strong relationships and build on best practice, influence change in processes and culture, seek to achieve a consistent supply of good quality provision in the market, and work with colleagues across the system to help address delays for people waiting for packages of care, with providers causing concern. Along with a range of colleagues and partner agencies, they will work in alignment with the neighbourhood teams to promote good relationships with commissioners and providers. This dedicated resource will enhance the ability of the local health and social care economy, to address its strategic aims, not only in relation to people with high levels of need but also in relation to its most fundamental aims of keeping people with long term conditions or health and wellbeing needs, safe and well at home and/or in receipt of appropriate support in the community.

STOCKPORT TOGETHER BUSINESS CASE APPENDIX 1; EXTERNAL MARKET;
SUMMARY OF INVESTMENT PROPOSAL (280217)

Proposal	TOTAL COST	Lag/Phasing	Description of Benefits	ESTIMATED TOTAL BENEFITS
1. a) Investment of £230K for delivery of short term re-ablement support (this is the cost of continuing with the current successful pilot, based on a full year's costs, rather than ending this intervention in March 2017.	£1.2m £230k	No lag – Extension of current contract under winter pressures needs to continue from 1 April.	Avoidance or reduction in need for long term home support Avoidance of 60 DTOC or non-elective admissions per year	£496k £176k £672k
1. b) Further investment of £230K to roll out this model further and thus extend delivery of the anticipated outcomes across the neighbourhoods	£230k	Estimated time to bring online following agreement to proceed is 3 months.	Avoidance or reduction in need for long term home support Avoidance of 60 DTOC or non-elective admissions	£496k £176k £672k
1. c) £230K to continue with the current pilot for overnight home support	£230k	No lag – Extension of current contract under winter pressures needs to continue from 1 April.	Avoidance of 24 care home respite admissions (based on 4 weeks duration at £475); Avoidance of 12 care home admissions (52 weeks x £475 x 12);	£46k £296k



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			Avoidance of 12 non elective admissions*; £39K	£381k
2. Further investment in Extra Care Housing; (ECH) <p>The Extra Care model in Stockport offers accommodation with support as an alternative to residential care, with more support than domiciliary care. One of the Extra Care Schemes will be given additional staffing cover to extend its offer so that it can take people with more complex needs and avoid unnecessary care home or hospital admissions.</p> <p>This is a pilot to test the hypothesis that increasing the level of support within Extra Care Housing would enable the scheme to admit residents with higher needs and avoid hospital admission. Recent consultations with practitioners indicated that they would have chosen the Extra Care scheme more readily if there had</p>	£91k	Estimated time to bring online following agreement to proceed is 3 months.	This is proof of concept but this additional investment could pay for itself, through avoiding residential admissions, non-elective admissions and delayed transfers of care (estimated at £96k in total)	£96k



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<p>been more support at night. The additional day time support identified would complement this support but also work to develop the scheme further.</p>																
<p>3. Joint Quality Intervention Team (JQIT)</p> <p>The focus of this approach is on raising standards thus the quality and choice of support for vulnerable people and their families.</p>	<p><u>Summary of Key Costs:</u></p> <table border="1" data-bbox="601 600 1073 1338"> <tbody> <tr> <td>Joint team/programme manager (inc on costs)</td><td>ATM /SO3</td><td>£45,492</td></tr> <tr> <td>Three Quality improvement Officers (inc on costs)</td><td>3 x SO1</td><td>£115,602</td></tr> <tr> <td>Service Improvement Co-ordinator</td><td>1 x 0.5 wte Band 5</td><td>£17,674.</td></tr> <tr> <td>Two part time Nurses (or job share)</td><td>1 x 0.5 wte Band 6 1 x 0.5 wte Band 6</td><td>£44,011</td></tr> </tbody> </table>	Joint team/programme manager (inc on costs)	ATM /SO3	£45,492	Three Quality improvement Officers (inc on costs)	3 x SO1	£115,602	Service Improvement Co-ordinator	1 x 0.5 wte Band 5	£17,674.	Two part time Nurses (or job share)	1 x 0.5 wte Band 6 1 x 0.5 wte Band 6	£44,011	<p>Estimated time for recruitment following agreement to proceed 3 months – could start to recruit at risk prior to agreement to reduce any time lag.</p>	<p>Through the approach outlined, the Joint Quality Intervention team will seek to raise standards, ensuring appropriate transitions or transfers of care where needed and intervening to address avoidable <u>care home/nursing home</u> closures or emergency intervention. Avoiding one NEL p.a for 40 residents would save the health economy</p> <p>£128k</p> <p>Intervening in a similar way with home support agencies, the JQIT would seek to avoid emergency intervention for a further 20 people</p> <p>£64k</p> <p>If, as a result of JQIT the care homes that are currently rated as</p>	
Joint team/programme manager (inc on costs)	ATM /SO3	£45,492														
Three Quality improvement Officers (inc on costs)	3 x SO1	£115,602														
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	Part time social work resource / backfill		£16,000		‘inadequate’ improve their quality rating and as a result their emergency admission ‘rate per bed’, it is estimated that this could deflect 86 emergency admissions per year from the acute health economy, saving £276k	
	TOTAL recurrent funding		£238.779			
	Additional one-off investment*		£9,000*			
			£248K			
	<p>*Additional one-off cost of £9,000 for the software development costs of a shared system wide Quality Dashboard to improve data in relation to the quality of provision</p>					
4. Investment to enable care homes to undertake weekend admissions and reduce delayed transfers of care.	<u>GP support</u> to make visits to the home in particular for End of Life pathways or medically complex patients. This would require additional GP hours over the weekend period from Friday 16.30 to Monday 08:30 <u>Social work support</u> would be required for complex social care cases. This would include those without capacity or where there is dispute within families. This would include social work coverage from Friday 16.30 to	Propose align to timescale for implementing extended operating hours in the neighbourhoods i.e. early June. However could look to bring on earlier if needed to	The benefits of improving the ability for homes to undertake weekend admissions will include <ul style="list-style-type: none"> • Improved performance for DTOCs over the weekend period; • Improved efficiency in discharge and admissions into homes (trusted assessor); • Collaborative approach with external providers to improve processes and outcomes; 			



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	<p>Monday 08:30</p> <p><u>Therapeutic support for residents to access physiotherapy and occupational therapy at the point of discharge to facilitate improved physical well-being outcomes and speedier discharge from short-term placements.</u> Two therapists (one OT & one PT) would need to be available from 10-3 Saturday / Sunday</p> <p><u>For those homes that do not provide nursing care, access to nursing support would be required.</u> This would ensure that those that may have less complex medical needs could be supported more effectively in a residential care environment and reduce the potential of readmissions. This would require additional nursing hours to the Crisis Response Team in Friday 16.30 to Monday 08:30 . Total for the above;</p> <p style="text-align: right;">£171k</p>	<p>support hospital discharge.</p>	<ul style="list-style-type: none"> Appropriate place of residence for medically fit individuals with overall improved outcomes for well-being; Social and rehabilitative needs met in an appropriate environment; The cost of single day's stay in an hospital bed offset against the cost of residential nursing placement represents quantifiable savings to the wider system; <p>The proposed approach to improve performance over the weekend period via access to admissions into care homes would require a combination of comprehensive engagement with providers and a strengthening of the internal resources available within the Stockport Together Programme specifically within the intermediate tier and core neighbourhoods. In the first instance this will build on the trusted assessor model as piloted within the winter pressure beds at Hilltop Court and Plane Tree Court. Benefits related to the improved effectiveness of DTOC (Delayed Transfers of Care), will be evaluated in addition to the benefits listed here.</p>	
TOTAL COST	£1.2M		TOTAL BENEFITS	£2.289m



HEALTHY COMMUNITIES BUSINESS CASE

	<p>Purpose</p> <p>1. <i>Case for Change</i></p> <p>The strategic aim of this proposal is to contribute to the transformation of the relationship between people, services and communities, through delivery of person and community centred care. This will improve people's physical and mental health and wellbeing while reducing demand on primary care and preventing admissions and re-admissions to hospital or intermediate care.</p> <p>Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities and this proposal is a key part of a broader strategy, which draws on existing resources and projects and seeks to embed a new relationship between services, people and communities. This business case is focused on three key elements:</p> <ul style="list-style-type: none"> • Easy access and empowering people to access, the information resources and online support that people need to manage their health including long-term condition. • Capacity to provide targeted coaching support to help people develop the skills, motivation and confidence to manage their own conditions • Growing networks of peer support and voluntary activity to improve social connection and sustain long-term change. <p>Our aim is to enable person centred care which begins with the question "What matters to you?" rather than "What is the matter with you?" in order to understand and address people's needs in a holistic way. This assets-based approach will help people to access their own internal social and psychological resources as well as external resources including those within their family and those generated through collective community activity. The investment proposed responds to the evidence for effectiveness of these approaches as set in the <i>Realising the Value</i> (Nesta) and NICE guidance¹</p> <p>The theory of change (Appendix 1) draws on Self Determination Theory, an established and tested model, which identifies three key factors for personal growth and wellbeing: autonomy, (acting of one's own volition), competence, (self-efficacy and achievement) and relatedness (social connection, caring and belonging).² The elements described set out to address these factors in order to deliver outcomes in improved health and wellbeing and impacts on the quality and sustainability of the Health and Social Care system by reducing demand.</p> <p>The focus of the model addresses the human experiences of health and wellbeing and relationships between the people giving and receiving care. These are not only important in themselves but also as the drivers of need and demand on health and social care, as people with unmet social needs are likely to experience poorer health, including anxiety and depression as well as the physical health consequences of these. Their experiences also</p>
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¹ NICE, 2016 *Community engagement: improving health and wellbeing and reducing health inequalities*. www.nice.org.uk/guidance/ng44

² See <http://selfdeterminationtheory.org/theory/>

	<p>create demand for health and other public services as they seek help from services which are unable to respond appropriately. Viewing demand through the lens of the medical model often leads to medical responses to social problems, while the complexity and fragmentation can lead to ‘failure demand’ (“demand caused by a failure to do something or do something right for the customer”³). This often involves considerable waste of resources in undertaking different assessments and referring people on, or providing no service, due to thresholds and criteria. By failing to address the needs of the person, we generate further presentations or ‘demand’.</p> <p>Changing the culture within our services towards the vision described in the ‘Stockport Way’ (Appendix 2) is key to better supporting people with long-term conditions to self-manage by working with individuals and their support networks. This means working collaboratively to optimise the use and benefits of informal as well as service-based support and activity in a spirit of equal partnership between individuals, families, community groups, voluntary organisations, social enterprises and businesses that make up a local community.</p> <p>Workforce development and culture change will be key to delivery of these objectives, including changing the processes through which we assess people to shift the focus from solely capturing specific ‘treatment’ needs to working with people to identify their own priorities and the resources they can access to achieve them, including but going beyond services. This is being addressed through the Enabler programmes and cross-cutting transformation work including integrating services in neighbourhoods.</p> <p><i>Programme Interdependencies</i></p> <p>The components of the Healthy Communities approach outlined in this case are closely aligned to the core neighbourhood model. Where the core neighbourhood will work in a multi-disciplinary team to support individuals identified most at need (the top 6-15%), this programme of work will support those who are on the border of this cohort, currently not managing their condition as well as they could. Additionally, this approach will form part of the offer to those newly diagnosed with a long-term condition, or at high risk of developing a long-term condition, identified through the Find and prevent Project. Finally, this approach also links with the revised model of outpatient support. When an individual with a long-term condition is not currently managing their condition well, but does not warrant referral to a specialist consultant, the health coaching model will be able to support them to improve their self-management of the condition, which will provide primary care clinicians with a suitable route to ensure the individual receives additional support.</p>
2.	<p>Background</p> <p><i>Current Situation</i></p> <p>Over a quarter of the population in England has a long term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes that,</p>

³ Vanguard and Locality, 2014. *Saving money by doing the right thing: Why ‘local by default’ must replace ‘diseconomies of scale’*

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“Long Term Conditions are now a central task of the NHS”.

People with long term conditions currently use a significant proportion of health care services;

- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

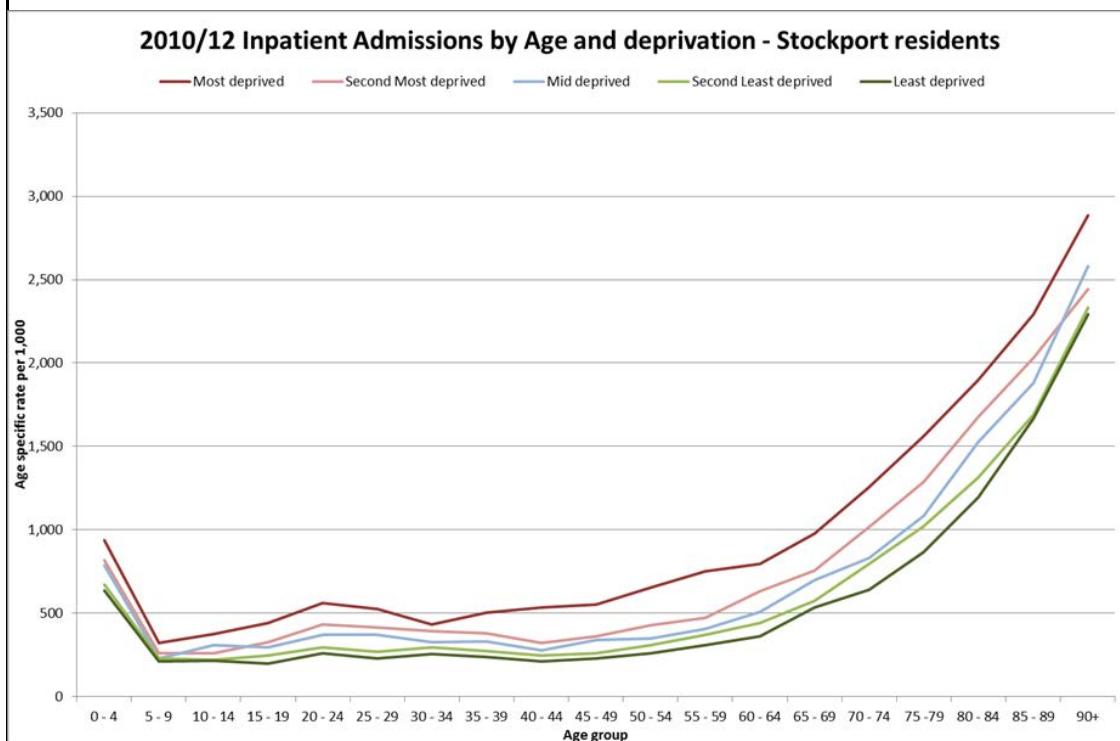
There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and healthcare costs are significant. 15.4 million people in England are recorded as having have a long-term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9million in 2008 to 2.9million by 2018). By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.

In Stockport, 41% of the population (124,000) have one or more long term health condition, and this increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over. By age 55, half of the people have one or more of these conditions and 9% of the population have two or more of 8 key long term conditions. Many more may also have a condition which is currently undiagnosed (see Appendix 3). There are 26,000 people registered with a Stockport GP with a history of depression and there are 40,000 people registered with a history of anxiety. These are commonly associated with other long-term conditions and physical health problems, as well as social isolation. Capacity in mental wellbeing Improving Access to Psychological Therapies (IAPT) services and mental wellbeing prevention is increasing, but the use of anti-depressant prescribing is still increasing and is a significant pressure to the health system.

Rates of hospital admission increase with age and are higher at each age in areas with higher levels of deprivation as shown in the graph below. While the older population is lower in size in the more deprived areas, the people living in these areas tend to have fewer social and economic assets to draw on and therefore may need more support from public and voluntary services. Additionally, people with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people. As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly. In addition, the costs of providing care to this group of people are increased as a result of less effective self-care and other complicating factors related to poor mental health.

We have a range of services and activities working with people who have long term conditions to make lifestyle changes that will support them in the management of their health. These include the Expert Patient programmes; Healthy Stockport family of services;

Cancer Champions; Social prescribers including Walking for Health; voluntary sector alliances (The Prevention Alliance (TPA), Wellbeing and Independence Network (WIN) & Alliance for Positive Relationships (APR)); as well partner agencies such as Stockport Homes, and non-commissioned voluntary and community organisation activity. These are complemented by workforce development such as Connect 5 and Health Chat training. However, clinicians and other front-line staff lack the time to invest in coaching people with long-term conditions (LTCs) to engage with and utilise the resources available in services and communities. This means there is a gap in the capacity to proactively identify, engage with and coach the people who could benefit from better self-care and self-management that is required to bring about the scale of impact on demand that is needed to make the system sustainable.



Research Evidence/Best Practice

Self-care support & coaching

The evidence demonstrates that there is a willingness amongst patients to self-manage, yet current practice shows that there are still millions of appointments nationally for minor ailments and that people with long term conditions are among the biggest users of health care. This occurs due to a lack of confidence in understanding and managing a condition or symptoms; the perceived duration or severity of symptoms; or for reassurance or 'cure' seeking.

Improving self-care requires greater personal responsibility for health and wellbeing. People should be supported to take control of their own health and focus on changing what matters to them. This support can come from informal carers and the organisations and practitioners who provide health and social care. The essence of this support is a collaborative, trusted

relationship between people ('patients' and 'service users') and practitioners (service providers).

When healthcare is designed to empower self-management, people with long term conditions and their carers play a more active role in managing their own health and reduce their need for help from the NHS and social care. NHS England, The Health Foundation and Nesta have recently published findings suggesting that effective self-management is the key to person centred care i.e. care that is personalised, coordinated and enabling. Furthermore, care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes.

Supporting people living with a long term condition requires a partnership with patients over the longer term rather than providing single, unconnected "episodes" of care. Helping patients thrive in the presence of these diseases requires a paradigm shift in health care delivery models; moving from "What's the matter" to "What matters to you?", as described in the "Stockport Way" vision. This means moving away from a paternalistic and dependent consultation model of 'fixing' to one that is empowering and increases patient knowledge, skills, confidence, self-efficacy and healthy behaviours, which are all needed to improve outcomes and reduce healthcare costs. As such it is part of an asset-based approach recognising what people and communities can do for themselves and each other rather than viewing people simply through the lens of 'needs'.

This business case draws on the evidence from the *Realising the Value* programme⁴ which addressed the NHS Five Year Forward View vision for a new relationship with people and communities. Based on a review of the evidence, the programme identifies five areas as showing significant potential to improve quality of life for people with long-term conditions and deliver benefits across the three dimensions of value: Mental and Physical health and wellbeing, NHS sustainability and wider social outcomes. These are:

- Peer support
- Self-management education
- Health coaching
- Group activities to support health and wellbeing
- Asset-based approaches in a health and wellbeing context.

The programme recognises that person-centred and community-based support needs to be both holistic and tailored around the individual, and there are connections between these approaches and other key enablers such as care and support planning and social prescribing. Interventions linked to these approaches can help to increase people's activation. It is also important to note that efforts to increase levels of patient activation will be more successful when supported by a whole system approach including training of clinicians in these new ways of working.

⁴ Nesta, 2016. **Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing:** www.nesta.org.uk/realising-value-programme-reports-tools-and-resources

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Nuffield Trust (2017) *Shifting the balance of care: Great expectations*⁵ states that programmes that aim to change patient behaviours are likely to be more successful than those that simply provide information. Where sufficiently supported and funded across the system, IT can be a useful tool in engaging patients and encouraging them to adopt more positive health behaviours. Evidence shows that self-care initiatives, particularly those that rely on e-health or digital tools, are more successful when they are supported by professionals.

Patient Activation

People who have the knowledge, skills and confidence to manage their own health experience better health outcomes. Yet the ability of people to successfully manage their LTCs and to stay well at home can vary considerably from person to person. This is why understanding people's ability to manage their conditions is so important. The Patient Activation Measure (PAM) is a validated tool which enables this and captures the extent to which people feel engaged and confident in taking care of their health. This can be described as their level of activation.

Evidence shows that people at higher levels of activation tend to experience better health, have better health outcomes and fewer episodes of emergency care, and engage in healthier behaviours. On the other hand, patients with lower activation have low confidence in their ability to have an impact on their health and often feel overwhelmed with the task of managing their health and wellbeing.

It has been estimated in the USA that between 25 and 40 percent of the population have low levels of activation (levels 1 and 2)⁶. These people are unlikely to respond to opportunities to improve their health through self-management. They do not understand their role in care process and have limited problem solving skills. Often they have experienced failure in trying to manage and have consequently become passive with regard to their health and wellbeing. As a result, they engage less with preventative healthcare and are involved in more costly emergency care episodes.

Measuring patient activation can drive real improvements as:

- Understanding activation levels help patients and clinicians to determine the realistic "next steps" for individuals to take in term of self-management;
- It allows for training and education resources to be tailored to the levels of activation of different individuals within the population;
- It can support more appropriate allocation of resources towards people at lower levels of activation and who are less confident about their ability to manage their own care.
- It can enable equality and health inequalities to be tackled more effectively by targeting interventions at disadvantaged groups to increase their health literacy and patient activation.

⁵ <https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

⁶ Hibbard JH, Cunningham PJ, 2008. How engaged are consumers in their health and health care, and why does it matter? Res Brief. 2008 Oct; (8):1-9.

Studies show that targeted interventions can increase people's activation scores and their capacity to self-manage their condition more effectively; and when appropriately supported, patients with lowest levels of activation make the most gains⁷. Typically the programmes focus on gaining new skills, encouraging a sense of ownership of their health, supporting changes in their social environment, health coaching and educational classes. People with lower levels of activation are likely to need more in-depth one to one support as compared to people with higher levels of activation.

All of these help to empower people to take greater control of their health, leading to better outcomes and improved experience of the health service and resulting in reduced healthcare costs of these patients in the NHS. A study found that less activated patients had 8 percent higher costs in the base year and 21 percent higher costs in the following year than more activated patients.

Peer and Voluntary support

Around 25% of adults in Stockport report that they volunteer once a month or more. There is considerable evidence for the health and wellbeing benefits of active involvement in voluntary activity, particularly among older people⁸, while the increasing numbers of retired people bring enormous personal assets, representing a huge potential resource for health and wellbeing in the borough.

Robin Lane General Practice in Leeds, is one of 60 GP Practices in 16 CCG areas where the Altogether Better approach to generating social action through health and community champions has been delivered and evaluated. By recruiting more than 50 Practice Health Champions, the Practice has been able to increase its patient list by 57% from 8,500 to 13,000 patients without any increase in Primary or Secondary Referrals and a 10% reduction in use of A&E. There is evidence of increased efficiency by dealing with failure demand and the practice have reconfigured their staff team and redesigned their offer to respond to the new challenges, choosing not to appoint to a vacant salaried GP post but instead choosing to invest in a Community Matron and a Wellbeing Coordinator.

Evaluation of work in 30 General Practices, drawing on evidence from the UK Government's Foresight Project and the New Economics Foundation, shows that 216 'types' of Practice Health Champion-led activities brought about improvements in patients' wellbeing, resilience and ability to adapt, cope and live well with long term conditions as well as a gaining a better understanding of how to use services. The evidence tells us that when it works for patients we see significant improvements in mental health and wellbeing and overwhelming support from practice staff to sustain the work:

- 94% of patients surveyed had improved mental health and wellbeing
- 95% of staff surveyed recommend and want to continue after the funded period has ended⁹

⁷ See www.kingsfund.org.uk/publications/supporting-people-manage-their-health

⁸ JENKINSON, C.E. et al., 2013. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health*, 13, pp. 773

⁹ Altogether Better, *Reducing the pressure in General Practice: A new model of care*.

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	<p>In other areas patient empowerment approaches have demonstrated significant impacts on demand for health and social care services: Challis et al (2010) found they improved health outcomes, with patients reporting increases in physical functioning). ‘Ways to Wellness’ is a Newcastle primary care social prescribing initiative providing people with long-term conditions with one-to-one Link Worker support. The net savings to Newcastle West CCG are estimated to be between £2m-£7m. (NHS Constitution, 2014). It has also been shown to reduce unplanned hospital admissions for COPD and asthma (Purdy 2010). Empowering patients to self-care for long-term conditions can reduce visits to GPs by up to 69%; and reduce hospital admissions by up to 50%. (NHS Alliance)</p>
3.	<p><i>Proposed Clinical Model</i></p> <p><i>Who is it for?</i></p> <p>The approach encompasses the entire adult population of Stockport, as everyone brings their own potential assets, including knowledge, experience skills and values that may directly or indirectly impact on their own and other people’s need for health and social care services. However, the strategic focus is on the needs and assets of those adults who currently make most use of health and social care services and the staff and carers working with those people. It will work with four of the five cohorts identified in Stockport Together’s Greater Manchester Transformation Fund programme Locality Proposal:</p> <ol style="list-style-type: none"> 1. The 6% of the population accounting for 60% of non-elective admissions; 2. A further 9% at high risk of soon becoming users of hospital services; 3. 60,000 who have an unidentified long-term condition/high risk of developing one; 4. People who account for the 30% of current GP appointments which are not an appropriate use of GP time for whom we can provide better alternative care <p>To deliver this supported self-management of long-term conditions requires enabling individuals to develop the knowledge, skills and confidence in managing their condition(s), and empowering them to know where to seek the right support if and when they need additional help in managing their condition. To ensure that support is tailored appropriately and that patient education courses are well used, co-production methods should be used to develop appropriate systems of support for people with long-term conditions.</p> <p>Therefore this model seeks to both mobilise existing and potential assets and to strengthen networks and promote the kind of reciprocity that can maintain and develop the resilience of individuals, families and communities. As such the greatest impact will be seen among people currently making most demands on services, and those who will do so in future.</p> <p><i>Health Coaching</i></p> <p>A model of health coaching will be implemented which provides for two health coaches in each of Stockport’s eight neighbourhoods (16WTE AfCBand4). Each of the health coaches will be supported by a nurse (2WTE AfCBand7) who oversees management and the clinical knowledge required by the coaches. These nurses may be existing District or Practice Nurses working within the Integrated Neighbourhood Teams, but will require specialist knowledge and skills in health coaching as well as clinical knowledge in relation to long-term condition management.</p>

Patients will be eligible for the service if they have at least one long-term health condition. The service will be targeted at two groups initially – those who are living with a long-term health condition currently not well managed and those newly diagnosed with a long-term health condition (identified through general practice including via the Find and prevent approach).

The Coaches will work in person-centred way, empowering the patient to develop knowledge, skills and confidence in managing their condition, including both one to one and some group work, such as the 'Reclaim Your Life' programme. This will include linking people into existing courses or relevant groups and building their skills including understanding when it is appropriate to seek further help and the different routes to the appropriate care.

They will provide an initial session of 1 hour, which will include using the Patient Activation Measure tool to help the individual and their coach understand how well 'activated' the individual is. The PAM score will help the individual and their coach determine the frequency and type of future session (face to face or telephone). The coach will work with the individual for a period to be determined in the initial session, up to a maximum of 12 months. At the end of the intervention the individual will be have their PAM score re-assessed and will be discharged back to primary care, with support from the wider community as per Stockport Together's Healthy Communities approach.

Health coaches will be able to support individuals to access existing services for example:

- Condition specific and general long-term condition patient education courses.
- Disease prevention courses (e.g. DESMOND Walking Away from Diabetes.)
- Lifestyle/behaviour change courses including (via START.)
- Support for other social issues (via TPA.)
- Existing support groups in the community.
- Mental health and wellbeing programmes such as Living Life to the Full and mindfulness training.

The use of the PAM will guide the health coach in tailoring the offer for the individual's level of activation and as such the total time an individual spends with their coach, and the referrals to other services will vary accordingly. As Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities, provision of the PAM licences is now available through NHS England. As well as in health coaching, we will use PAM to tailor and outcome monitor for people accessing Physical Activity Referral in Stockport (Life Leisure - provider). This service will act as a pilot for using PAM in behaviour change services and we will explore extending its use into other services.

Development of online resources

Many people identified through the Find and prevent process or already known to be living with LTCs will have higher levels of activation and therefore will not need the intensive coaching support, but will need access to trustworthy information and advice about their condition and wider health needs. Online and app-based information and resources for self-care offer a significant opportunity to empower people to take more control and successfully

manage their health and wellbeing. We will build on the newly updated Healthy Stockport website to create a trusted point of information and advice on a range of LTCs in order to make it easy to find the information needed. This will link with and complement the directory of community organisations and activities in Stockport, currently being developed by Stockport Council's Digital by Design programme.

The new web-resources will include interactive information about apps for health and wellbeing to help people navigate the plethora of competing apps available to find those that are both evidence-based and useful. As well as recommendations based on expert opinion it will include opportunities to people to share their experiences of using these apps and tools. It will also have the confidence of clinicians who will be able to recommend this to patients.

In addition to receiving 1:1 coaching, the individuals who are engaged with a coach will be encouraged to assist the development of the online resources, sharing their experience of self-care support information, condition specific advice, and useful web-links etc., which can be shared with others using the service, and other Stockport residents. This will form part of existing web offer (i.e. Healthy Stockport) to ensure that all relevant information is available through one place and the development will be supported by 0.5WTE web developer on a fixed term contract.

Health Champions within the Collaborative Practice and Peer Support

A renewed and expanded approach to growing community health champions who will work with primary care and Integrated Neighbourhood Teams to provide an additional level of support to people at high risk of hospital admission and other vulnerable individuals in the community will be developed. The Health Champions within the Collaborative Practice model is currently being tested in three GP practices, drawing on limited non-recurrent ASC funding, to enable evaluation of the impact initially with a view to extending the model if its impact is demonstrated locally. This is being facilitated by an external provider, Altogether Better. The Altogether Better evidence based approach is normally embedded and becomes self-sustaining within 12-16 months; ASC funding has enabled the approach to be tested for six months but note the need to extend for a further 6 month period.

Building a team of 'Health Champion' volunteers to work with primary care has been demonstrated by Altogether Better to significantly reduce the demand for GP appointments. Health Champions, as members of the local community, can offer time as well as local knowledge to support people who may present to General Practice with non-medical problems, as well as providing social and psychological support to help people cope with and manage their health conditions. Health Champions may play a part in the coproduction of services as well as helping to represent the views and needs of the local community through their engagement with health and social care services.

Community Health Investment Fund

We would propose to develop a small grants investment fund that would be designed to stimulate activity around health, wellbeing and resilience that would primarily focus on developing peer support groups and activities for people with LTCs and for tackling

loneliness and increasing social connections. The small grants would be available to community groups and voluntary organisations across Stockport, including micro grants of £250 and small grants of up to £2,500 and would be awarded on a locality basis with full engagement and support of the Neighbourhood teams, who would outline the local priorities from their needs assessment. Criteria for funding could include:

- Projects/activities that result in groups and communities of people becoming more active in their own communities' health and wellbeing.
- Projects/activities that result in people feeling a greater sense of control of their lives and how they manage their health.
- Ideas that come from communities that bring the communities together to address local issues around isolation or loneliness.
- Ideas that inspire others to get involved and take action in a voluntary role to support health and well-being.

Note that as one of six selected Vanguards for testing 'Health as a Social Movement', small grant funding of £20k has been made in the year 2016-17 with excellent and encouraging results for growing community groups and activities which will impact on health and care demand.

Further non recurrent funding from Adult Social Care has been used to generate community activities linking to this Business Case, for example the Good Gym, a Centre for Social Action Innovation Fund project sponsored by the Cabinet office will be established in Stockport early in 2017, see <https://www.goodgym.org/> Adult Social Care has provided half of the £25k needed to establish the Good Gym, the remainder underwritten by Age UK Stockport and the TPA. It will generate 1600 hours of new volunteering time in Stockport in 2017 and over two years, as it becomes self-sustaining through membership fees, will support 78 older, frail individuals referred through the Neighbourhood Teams reducing their use of services. The Community Investment Fund would support evaluated initiatives like the Good Gym to develop in Stockport.

Stockport Council is also developing proposals for an Investment Fund for growing more independent and self-sustaining communities; through aligning these funds the growth of community groups and networks which will have a demonstrable impact on health and wellbeing and demand activity will be ensured, securing empowered and engaged communities built on increased social action and volunteering.

Self-Care Programme Management

As part of our work embedding the Stockport Way, it is proposed that each neighbourhood team should be supported in a self-assessment of how it facilitates self-care, alongside the training to be delivered to all staff (included in the Workforce Enabler business case), and roll-out of the Find and prevent and self-care programmes across neighbourhoods. A tool for this purpose has been developed by Pennine Care and it is recommended that this should be adopted or adapted for use within Stockport Together.

At present we have several education programmes and services supporting people with

long-term conditions, but these have limited capacity. It is proposed that this provision should be reviewed in a collaboration with the Neighbourhood Teams and people eligible to use these services, drawing on the learning from the self-assessment process.

A fixed-term programme manager for self-care will be recruited to:

- Plan, manage and coordinate the development of the new roles and recruitment.
- Commission and plan the training of new and existing staff in coaching skills and methods.
- Develop and deliver the neighbourhood team self-assessment (which would then be owned and maintained within neighbourhoods.)
- Support the development and adoption of tools and resources for asset-based wellbeing conversations and planning in place of deficit-based assessments.
- Manage the piloting, evaluation and roll out PAM.
- Develop and map resources which enable people to access (in a way they understand and want to use) the information they need to care for and support their own health and wellbeing (ensuring that any resources are developed in a sustainable manner.)
- Evaluate the impact of the project and develop and embed a self-care plan for Stockport, which continues to thread this work in to our culture

Activity

Once fully operational, the health coaching service will support 2,400 people living with long-term health conditions per year. The capacity building approach will help ensure the progress made by people engaged is supported in the longer term through engagement in peer support and other community activities which enable continuing mutual support and personal growth. This will mean the numbers benefitting from involvement in such informal support networks will increase cumulatively each year, in addition to the direct support provided, and the benefits of improved self-care will be sustained.

The Health Champions work will engage at least 50 people in volunteering connected to their GP practices and deliver support to at least 250 individuals in their communities. This will be complemented by the establishment and growth of peer support and other health-related community activities in the community. The Community Health Investment Fund will support an estimated 50 health-related community activities per year, depending on their scale and this will bring health and wellbeing benefits to at least 500 people.

The programme will deliver a range of synergistic activities which stimulate the growth of individual and community capacity for and engagement in self-care:

- Easy access to informative and motivational online resources, including space for online mutual support.
- Proactive engagement and support for people to improve their self-care, tailored according to need using the Patient Activation Measure.
- Increasing numbers of people actively engaging in voluntary activity, complementing and adding value to the work of Stockport Together to improve health, wellbeing and interdependence.

4. Benefits

A self-care approach to health and social care is expected to have three main benefits:

- **Empowering patients.** People will be encouraged to participate as equal partners in decisions about their care. This gives people an opportunity to take control of their health and wellbeing rather than health professionals being in control and will lead to improved quality of care and patient satisfaction levels.
- **Managing Demand.** The Department of Health estimates that 15% of A&E attendances and 40% of GP time could be avoided through improved self-care. Over two-thirds of GP visits result in prescribing drugs that are available over the counter. The Wanless review (2002) estimated that for every £100 spent on helping patients care for themselves, £150 could be saved by the reduction of GP and outpatient visits.
- **Improving outcomes.** When people self-care and are effectively supported to do this, a range outcomes are improved. These include: they are more likely to experience better health and well-being; reduce the perceived severity of their symptoms; improve medicines compliance; prevent the need for emergency health and social services; prevent unnecessary hospital admissions; have better planned and co-ordinated care; remain in their own home; and have better mental health and less depression.

In reviewing the likely impact of interventions proposed in this Business Case we have considered three key types of outcomes:

- **Financial outcomes:** translates into net financial impact on Commissioners due to the intervention (i.e. activity reductions, cashable savings). NB. Some of these have not been possible to calculate for the business case i.e. social care cost avoidance, Community Health services demand reduction.
- **Health and wellbeing outcomes:** represents the non-financial positive impacts on the health and wellbeing of service users including: clinical outcomes and wellbeing outcomes; long-term health preventative benefits; and reduced health inequalities.
- **Wider social outcomes:** financial and non-financial benefits that wider society will experience due to the intervention, but are not attributable to commissioners savings' (i.e. absenteeism reduction, voluntary, value of social inclusion, workforce health, wellbeing and engagement.)

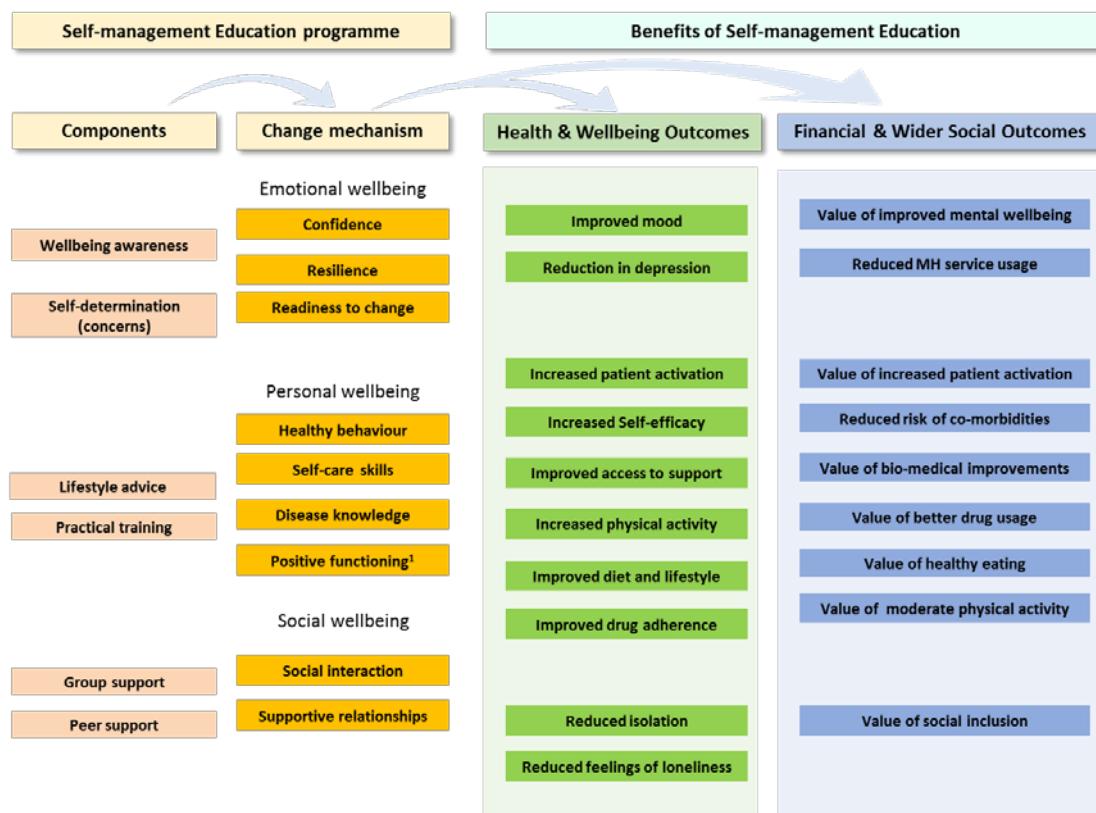
Self-care: Evidence suggests that self-care can have a positive impact, although it is often not clear which component makes it effective. Self-care in long-term conditions has been shown to reduce A&E attendances, in particular for adults with Chronic Obstructive Pulmonary Disease (COPD) and asthma, and possibly heart failure. It can also improve adherence to treatment. A systematic review found self-management support was associated with reductions in cost, a small significant improvement in quality of life and significant reductions in health care utilisation, with evidence being strongest for respiratory and cardiovascular disorders. This covered a number of conditions, such as respiratory, cardiovascular, mental health, arthritis and other pain conditions¹⁰.

Self-management education: Self-management education programmes provide people with knowledge about their condition and provide them with tools and skills to manage it on a daily basis. When people are able to manage their condition, this reduces its impact on their daily life, leads to considerable health improvements and reduction in health care use.

¹⁰ <https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

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Overall health and wellbeing improvements have been noted like engaging in physical activity and therapy compliance, but also more particular improvements like control of blood glucose levels in diabetes patients. Such improvements have been shown to reduce the need for health care currently (A&E and hospitalisations), but also reduce the risk of long-term complications that potentially have a large impact on people's life and would require intensive care.



¹Positive Functioning elements : (competence, purpose, value in life)

Peer Support

Peer support is defined as “a range of approaches through which people with similar long-term conditions or health experiences support each other in order to better understand the condition and aid recovery or self-management.”

People receive support and coaching from a person that has experienced similar challenges or health conditions. This person can help to better understand their conditions, support recovery and self-management. Peer support can be delivered on a one-to-one basis, which may be in person or through telephone support, or through a peer support group.

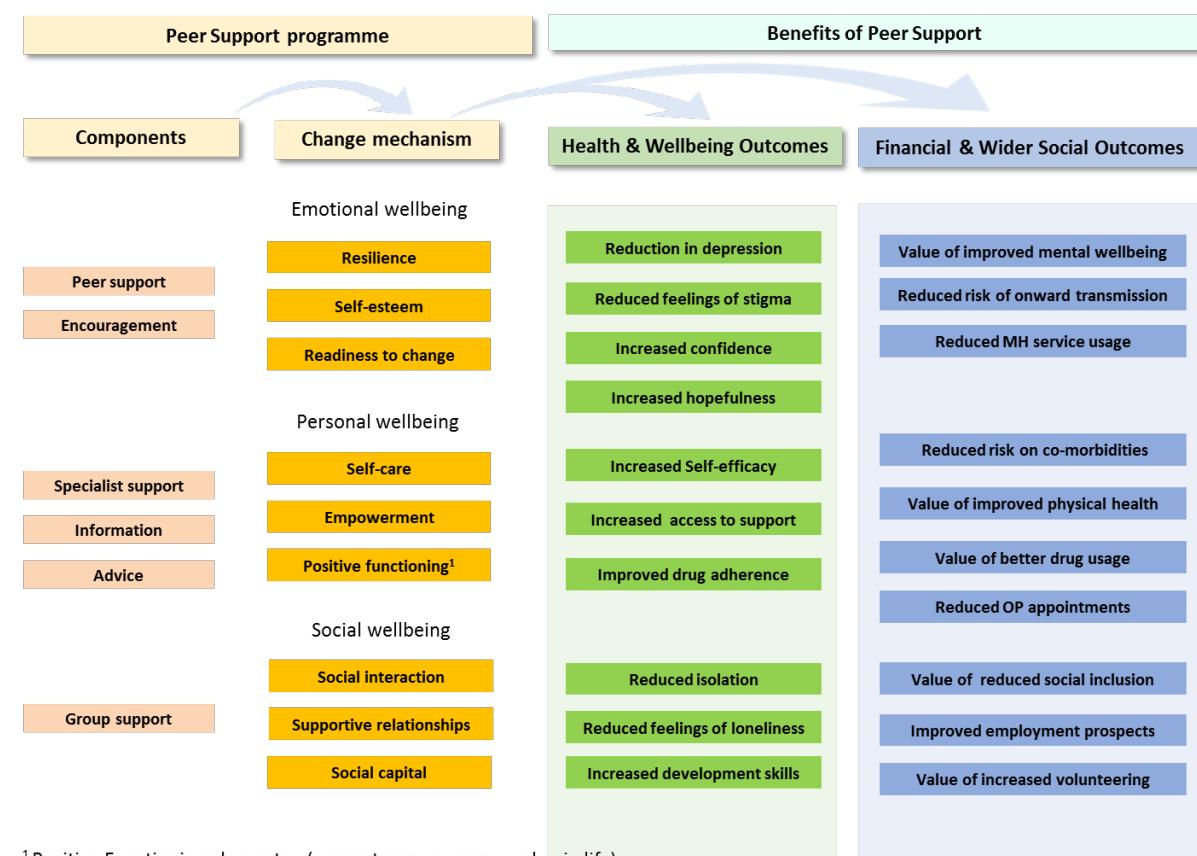
The benefits map below shows that social support is the driving force behind many of the outcomes. The strength of peer support as an intervention lies in the emotional and constructive support that a peer brings with his or her unique perspective based on their own experience.

In terms of health and wellbeing, peer support makes people feel more socially supported and participants report to benefit from increased confidence, resilience and readiness to

change. This places social support as a driver for empowerment and self-efficacy. Research evidence as well as local experience shows that peer support reduces depressive feelings and increases feelings of hopefulness.

Additionally, a number of behavioural ‘health’ improvements were reported. Elderly people with Coronary Heart Disease (CHD) spent an over 1.5 hour more on physical activity per week (compared to a control group) (Coull, et al., 2004). Also, improvements in glucose-control were noted (Dale, 2012).

The benefits extend beyond the individual as population improvements in mental wellbeing are of considerable value to the wider society. For example, a programme in Canada supporting people with serious mental health conditions reported a reduction of 116 days in length of stay following peer support compared to the control group which received usual care (Forchuk et al., 2005, in Repper et al., 2001).



Health coaching: There is a substantial variety of indicators that depict potential financial savings for local health systems. Together health coaches and participants improve the participant’s self-esteem and patient activation. Reported benefits include change towards more healthy behaviours, a reduction of depressive symptoms and reduction in health care use amongst people with mental health issues, diabetes and cardio-vascular diseases.

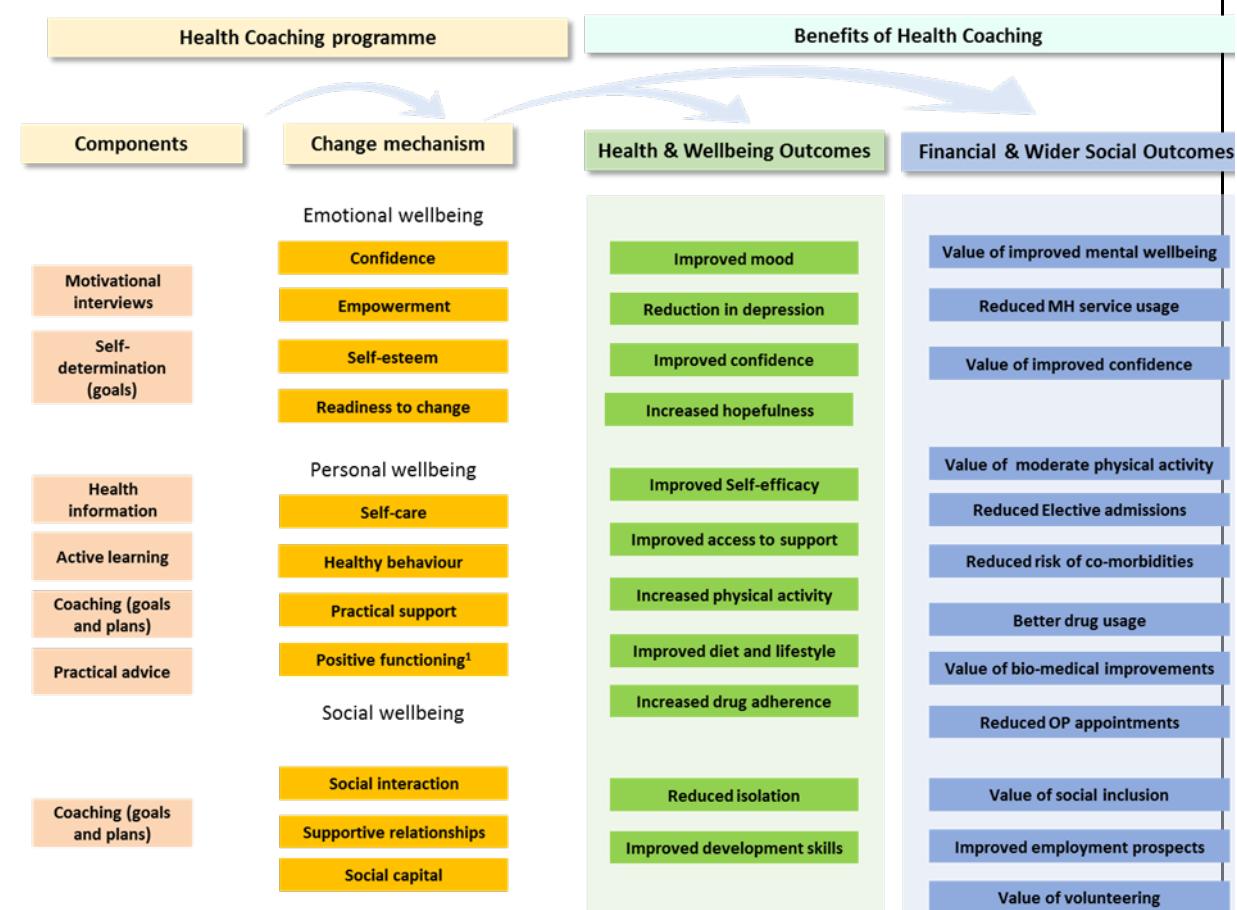
In order for individuals to experience behavioural change, a strong sense of emotional wellbeing needs to be experienced. With the support from the health coaches, the person’s self-esteem and confidence are strengthened, which increases their ‘readiness to change’,

or in other terms their level of patient activation. This in itself has shown to improve people's mood and even reduce depressive symptoms.

From a more physical health and wellbeing perspective, people will have a better understanding of the factors that influence their health and how they can personally influence these through their behaviours. Empowered and equipped with the right tools, the individuals engage more in healthy behaviours, for example improving their diet, exercising more and taking their medications regularly as prescribed.

Health coaching also has the potential to improve people's social wellbeing. This will depend on the approach that is chosen to support behaviour change. For example, this can involve measuring wellbeing in strengthening familiar relationships, or undertaking activities in group format. Although improving social wellbeing may not be the dominating primary goal across health coaching interventions, health coaching has been found to successfully reduce social isolation in elderly individuals.

These behaviour and wellbeing improvements correlate with a wider reaching impact that goes beyond the individual. Most notably, with healthy behaviour and adequate disease management, the need to use health care resources could be reduced.



5. Financial Case

Costs

The costings for the proposals described is set out below, not including the costs which fall within the enabler business case.

Healthy Communities Business Case costings						
Item	Posts (fte)		2017-8	2018-19	2019-20	2020-21
Self Care Programme lead	1	M Band 4	£40,019	£53,887		
Self Care digital & web developer	0.5	Band 7	£9,730	£19,652		
Self Care Lead Nurses	2	Band 7	£20,200	£81,608	£82,424	£83,248
Self Care Coaches	16	Band 4	£72,720	£391,680	£395,597	£399,553
Programme Development Budget			£10,000	£8,000	£8,000	£8,000
Health Champions Pilot			£32,000	£3,000	£3,000	£3,000
Community Health Investment Fund			£25,000	£25,000	£25,000	£25,000
Total			£209,669	£582,827	£514,021	£518,801

Impact on demand and costs

Due to the nature of the outcomes described in section 4, the impact of this business case will result in savings which are accounted for within the Outpatients business case. These savings have therefore not been included in the impact modelling which follows, but it should be noted that those savings will be in part dependent on the delivery of this model. Furthermore, it should be noted that this modelling does not account for cost avoidance in relation to social care, community nursing and ambulance services which would be realised due to this programme (e.g. care and support following a stroke).

The savings identified in the Find and prevent model, copied below, are dependent on the provision of coaching and peer support to the people identified as having lower levels of activation. Given this interdependency and the benefits of continuity of care, it is proposed that the workforce requirements for specialist Healthcare Assistants HCAs in the two business cases are combined into one generic Health Coach role.

Condition	To find		To improve treatment		2015/16 Admission costs	Modelled saving on costs by 20/21	Notes
	Number	as a %	Number	as a %			
Diabetes	2,300	15.8%	670	4.6%	£452,969	£92,195	Improving /detection and management of 20% of diabetics
Hypertension	4,300	9.9%	2350	5.4%	£152,176	£11,613	50% preventable by BP, improving /detection and management of 15% of BP, therefore $15\% * 50\% = 7.5\%$
Atrial Fibrillation	1,550	27.2%	280	4.9%	£1,595,639	£343,099	67% preventable by AF, improving /detection and management of 30% of AF, therefore $30\% * 67\% = 20\%$
Dementia	750	27.8%	80	2.9%	£9,992	£3,065	Improving /detection and management of 30% of people with dementia
COPD	900	13.4%	480	7.1%	£2,015,640	£27,076	10% admissions due to undiagnosed, improving /detection and management of 25% of COPD therefore $10\% * 25\% = 2.5\%$
AMI	-	-	-	-	£2,114,994	£161,399	50% preventable by BP, improving /detection and management of 15% of BP , therefore $15\% * 50\% = 7.5\%$
Other IHD	-	-	-	-	£3,104,147	£236,883	50% preventable by BP, improving /detection and management of 15% of BP , therefore $15\% * 50\% = 7.5\%$
CVD	-	-	-	-	£2,563,684	£551,251	67% preventable by AF, improving /detection and management of 30% of AF, therefore $30\% * 67\% = 20\%$
Total possible saving					£1,426,581		

The possible phasing of this benefit could be as follows:

	17/18	18/19	19/20	20/21
% of full	0%	5%	40%	100%
Impact	0	£71,329	£570,633	£1,426,581

The proposals in this business case are essential to addressing the short-term demand created by uncovering previously unidentified need for prevention and self-care support through Find and prevent, and further to this, based on the evidence cited above, it is estimated that demand for other primary care services will be reduced as set out in the following table.

	Number of appointments per year ¹	Number due to LTCs (50%) ²	Number saved due to self care (6% of LTC)	Average cost of appointment (15 mins for GP, 20 for nurses) ³	Estimated saving
GP	349,499	174,750	10,485	£ 50.00	£ 524,249
Nurse	138,728	69,364	4,162	£ 12.00	£ 49,942
HCA	114,672	57,336	3,440	£ 12.00	£ 41,282
OOH GP	92,122	46,061	2,764	£ 50.00	£ 138,183
OOH Nurse	50,592	25,296	1,518	£ 12.00	£ 18,213
TOTAL	745,613	372,807	22,368	-	£ 771,869

1 Stockport Together

2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

3 www.pssru.ac.uk/project-pages/unit-costs/2016/index.php

Return on Investment

The combined impact of the Find and prevent and Healthy Communities proposals are set out below:

	17/18	18/19	19/20	20/21	TOTAL
F&T cost	£72,000	£292,000	£286,000	£286,000	£936,000
HC cost	£209,669	£582,827	£514,021	£518,801	£1,825,317
Combined cost	£281,669	£874,827	£800,021	£804,801	£2,761,317
F&T Impact	0	£71,329	£570,633	£1,426,581	£2,068,543
HC add impact	£72,362	£385,934	£771,869	£771,869	£2,002,034
Total impact	0	£457,263	£1,342,502	£2,198,450	£4,070,577
Net effect	£281,669	£417,564	-£542,481	-£1,393,649	-£1,309,260

Sources of Funding

Funding sources	2016-7	2017-8	2018-19	2019-20	2020-21	Total
GM Transformation Fund		£281,669	£874,827			£1,156,496
Recurrent funding required				£800,021	£804,801	£1,604,822
NHS England (PAM licence provision)		£600	£1,260	£1,800	£1,800	£5,460
Total		£282,269	£876,087	£801,821	£806,601	£2,766,778

6.	Contractual Arrangements & Implementation Plan
	<p>It is proposed that the Self-care Coaches and Lead Nurses will be employed by either a lead GP practice for each neighbourhood or by SNHSFT as part of the neighbourhood based community services team. The programme manager and digital and web development posts will be employed by the Council within either the Public Health team, Corporate Support Services or the Stockport Together Programme management team.</p>

It is proposed the implementation of the programme will be phased across neighbourhoods and as set out below. This will enable planning and engagement with the neighbourhoods and the people expected to benefit from the services, as well as testing and learning from the early adoption neighbourhoods and refinement of the model.

	Total Posts	Grade	Total staff in post					
			Apr-17	Jul-17	Oct-17	Jan-18	2018/19	2019-20
Self Care Staffing Requirements								
Self-Care Programme lead	1	M Band 4		1	1	1	1	0
Self-Care Lead Nurses	2	Band 7			1	1	2	2
Self-Care Coaches	16	Band 4			4	8	16	16
Self-Care digital & web developer	0.5	Band 7			0.5	0.5	0.5	0
Self Care Total FTE	19.5		0	1	6.5	10.5	19.5	18

Key milestones for implementation are set out below:

Milestone	Date
Funding approval	April - June 17
Health Champions contract extension decision	June 17
Programme Manager appointed	July 17
Community Health Investment Fund launched	September 17
Self-care coaches & Nurse lead in two neighbourhoods	October 17
Self-care digital and web-develop in post	October 17
Self-care support extended to four neighbourhoods	January 18
Initial implementation review completed	February 18
Self-care support extended to all neighbourhoods	April 18
Full implementation review completed	October 18
Initial impact evaluation completed	March 19
Implementation project closed	March 19

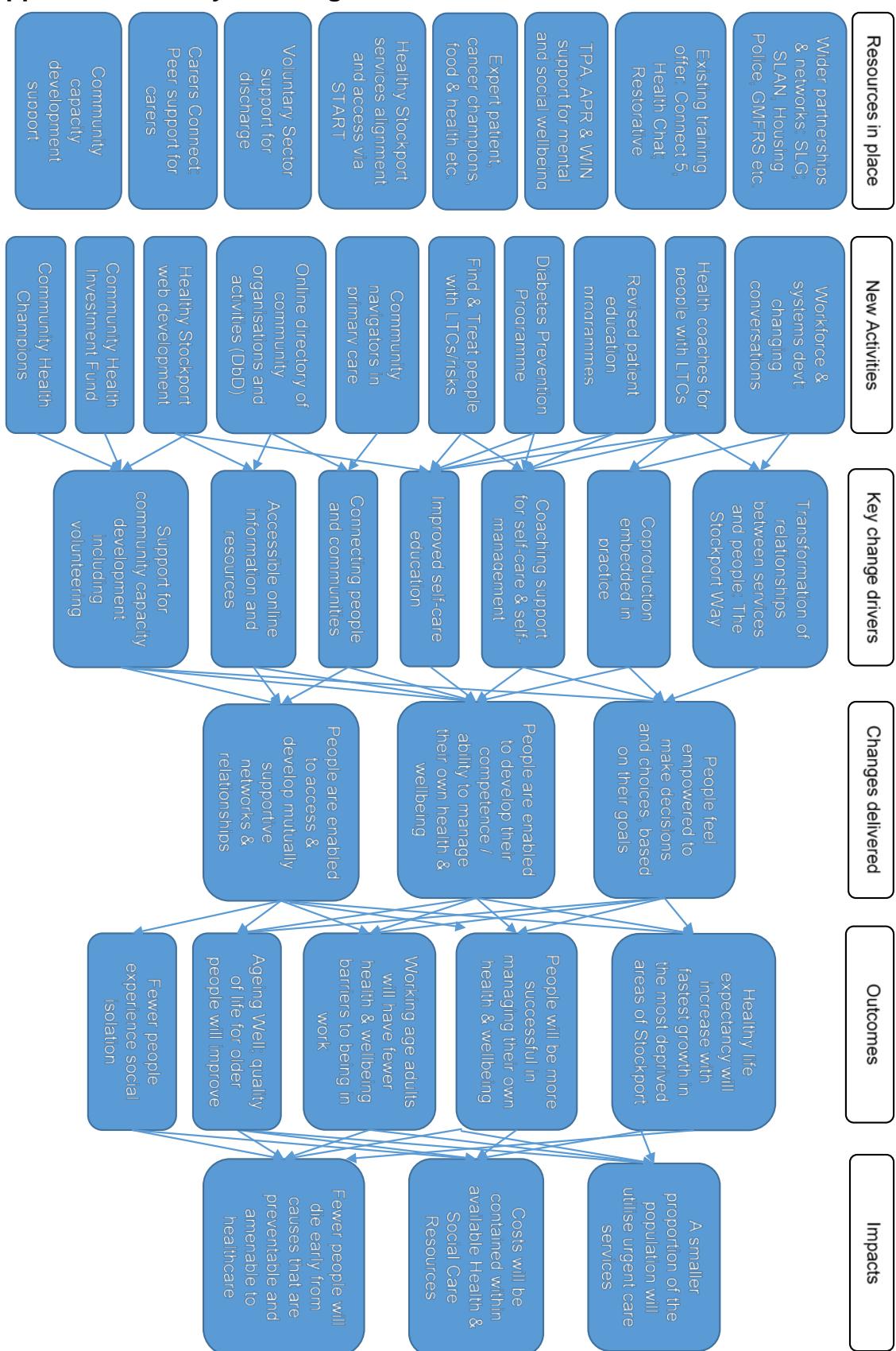
Risks

Risk	Mitigation action
The programme relies heavily on co-production and whilst this has been initiated in many areas of the Business plan we feel that this can be extended further	We are working with the active support of Christine Morgan to guide this work and utilising the information secured from previous consultations. However all this work will be scaled up in the implementation phase.
Failure to achieve cultural change or adopt new values and behaviours	Be active participants in the neighbourhoods work to design own values and behaviours through the ongoing series of workshops with both INS and IT Team Leaders. Investment in OD support to the project
Self-care apps and resources are being developed alongside the Digital by Design work and this may impact on proposed timescales	Active engagement in the DbD programme and extensive integration of the Business case programme timescales to be prioritised

	Lack of cohesion with other Stockport Together work streams/models &/or wider Council	Review of all programmes by PMO to explore synergies, identify duplication and streamline work programmes
	Failure of new model to prevent forecast level of acute admissions, ED attendance and free up primary care services.	Utilise evidence base from other areas and pilot changes within speedy implementation plan
	Not possible to increase capacity due to delays in recruiting workforce with the required level of skills, mean cannot prove concept &/or fully implement model.	Early discussion with the providers to explore capacity and realignment of existing staff to prioritise the ways of working
	Variability in neighbourhood understanding and engagement in this area of work.	Work with the willing neighbourhoods and use successes in these areas of work to engage other neighbourhoods
	Lack of co-location solution (physical location) reduces ability to work in an integrated way. Clinical services may be prioritized to such an extent that there are fewer facilities for delivery of community programmes	Neighbourhood and Integrated Team estates requirement identified. Proposals and options developed and being discussed with the Estates Enabler group
	Limited resources at scale to make detrimental impact on all aspects of programme delivery through failure to change our relationships with people	Identify and explore other external funding mechanisms via partners to accelerate and extend this work
	Limited senior level buy in to embed transformation of the ways in which we work with people and communities throughout Stockport Together	Improve communication and engagement with Senior leaders and Senior clinicians and ensure that Cllr members champion this way of working
	Immature and multiple recording systems in partners prevent difficulty in assessing impact	Extend the work currently being developed by the TPA outcome recording system and seek out further work with the New Economy to develop new ways of evaluation to capture the outcomes of this work programme



Appendix 1: Theory of Change



Appendix 2: The Stockport Way

One approach, working together for Stockport, on purpose, all of the time

- Making a conscious effort to think about how we can work together with people, communities and other organisations
- Considering how to achieve the best possible outcomes for individuals, families and wider communities.

Working *with* people, and building on their strengths

- Working *with* people, not ‘doing for’ or ‘doing to’
- Enabling people to identify and access the strengths and resources available to them, as individuals and within family and community networks

Always connecting through conversations and building relationships

- Actively listening, seeking to understand, rather than assess
- Asking “what matters to you?” rather than “what’s the matter with you?”
- Making connections and building relationships, to work collaboratively with each other across organisations
- Helping to connect people with supportive networks

Confident to make decisions, acting for the best outcomes for people

- Empowering staff within their organisations
- Enabling staff to be confident in their decisions, not asking permission but ready and able to explain them.



Appendix 3 Long-term Conditions Data

Key Findings – long term conditions



Stockport JSNA

joint strategic needs assessment

Condition	Number (Aug 15)	Gender pattern	Age trend	Deprivation	Information about the number of people in Stockport with certain illnesses or disabilities has been analysed from Stockport GP practice registers - this excludes acute health needs, for example infections, so is not a measure of all needs and demands.
Hypertension	43,589		Highest 45+	Increase with dep	
Anxiety	40,114	Higher In F.	Highest 40-59	Increase with dep	
Depression (18+)	26,088	Higher In F.	Highest 40-54	Increase with dep	
Obesity (16+)	20,544*			Increase with dep	
Asthma	19,933			Increase with dep	
Diabetes	14,816		Highest 45+	Increase with dep	
Coronary Heart Disease (CHD)	12,304	Higher In M.	Highest 45+	Increase with dep	
History of Fall	11,433	Higher In F.	Highest 75+	Increase with dep	
Cancer	7,992			Decrease with dep	
Chronic Kidney Disease (CKD)	7,698		Highest 50+	Increase with dep	
Chronic Obstructive Pulmonary Disease (COPD)	6,959		Highest 45+	Increase with dep	
Stroke or Transient Ischaemic Attack (TIA)	6,224		Highest 45+	Increase with dep	
Self harm	6,054*	Higher In F.		Increase with dep	
Atrial Fibrillation (AF)	5,903		Highest 50+		
Heart Failure (HF)	2,812		Highest 55+	Increase with dep	
Dementia	2,695	Higher In F.	Highest 65+	Increase with dep	
Glaucoma	2,504		Highest 55+		
Severe mental health	2,434			Increase with dep	
Epilepsy	2,389			Increase with dep	
Peripheral Ararterial Disease (PAD)	2,233	Higher In M.	Highest 55+	Increase with dep	
Rickets	1,570	Higher In F.			
Learning disability	1,495	Higher In M.		Increase with dep	
Rheumatoid Arthritis (16+)	1,482	Higher In F.	Highest 45+		
Acute Macular Degeneration (AMD)	1,428*	Higher In F.	Highest 75+	Decrease with dep	
Autism	927*	Higher In M.			
Cerebral palsy	275*				
Downs Syndrome	234	Higher In M.			

* Undercount of actual prevalence

- Overall, 41% (124,000) of the people registered with Stockport GPs have one or more of the conditions analysed

- It is important to note that the 59% of people not in this analysis may have undiagnosed conditions or have poor health generally, and equally the people with long-term conditions may be healthy and well self-managed.
- The proportion with at least one condition increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over
- By age 55, half of the people in Stockport have one or more of these conditions.
- Asthma is the major condition affecting school aged children in the borough (more than 2,000 cases aged 5-14), anxiety affect those aged 15-24 in particular (more than 2,700 cases).

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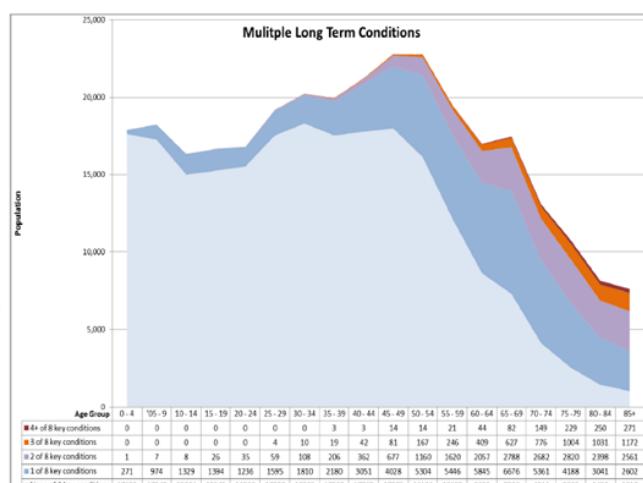
Key Findings – multiple long term conditions



Stockport JSNA

joint strategic needs assessment

Number of key conditions	Number of people	% of people
0	222,993	73.0%
1	56,331	18.4%
2	19,575	6.4%
3	5,588	1.8%
4	984	0.3%
5+	96	<0.1%



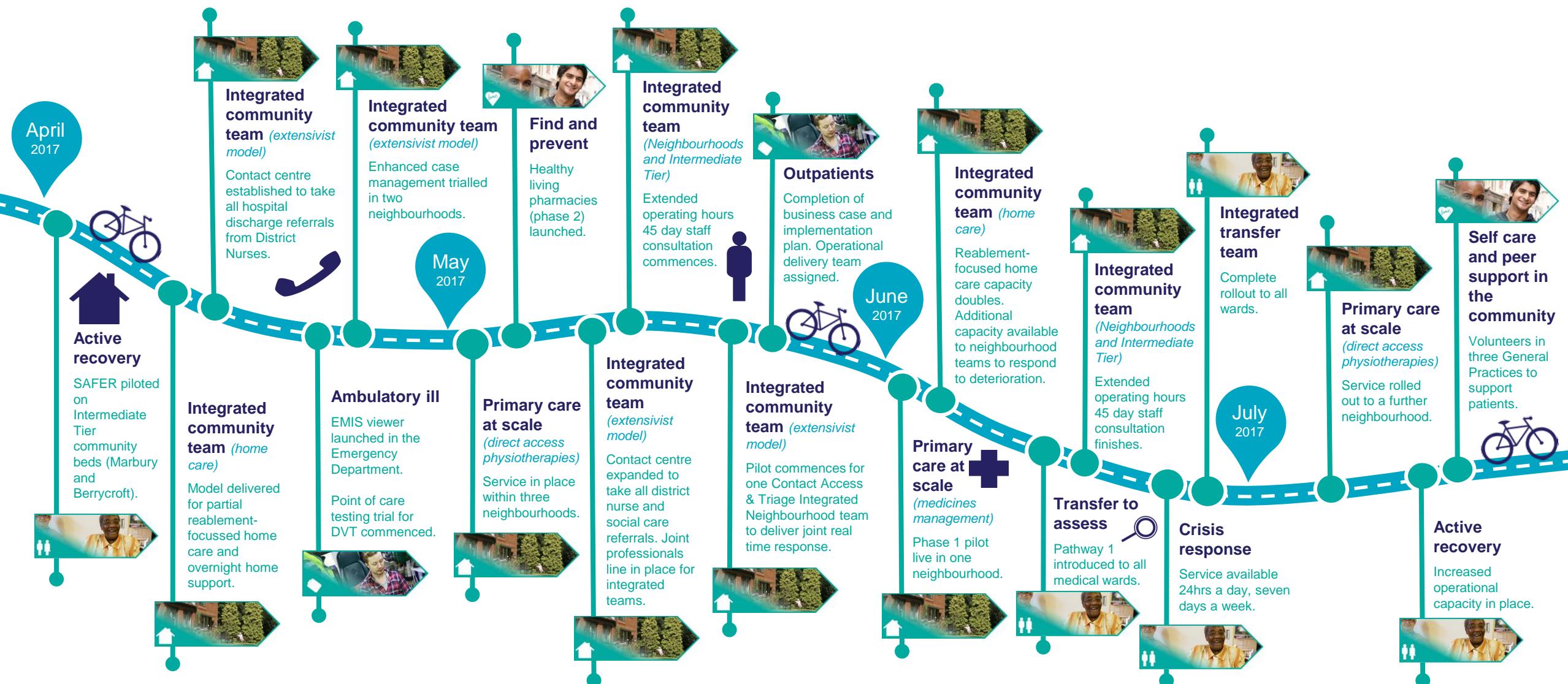
The rates of these key conditions show a strong deprivation profile. As the number of conditions increase, the deprivation profile becomes more pronounced.

CAPACITY MODEL

Complete columns B, C, D, G, I & K		Available resource		Activity under new neighbourhood model										Utilised hours			Assumptions	
Core Component (of neighbourhood model)	Specialism / grade	Number of staff (FTE)		Hours available per		Retained activity (from existing		Activity diversion (under neighbourhood model)				Time dedicated to managing growth in demand	% diverted	Per individual	System	Utilisation (%)		
		Current	Future (20/21)	Current	Future	Per individual per day	System level per day	Hours diverted per individual per day to other professionals (diverting away)	System level - total hours diverted to other professional groups (per day)	Diverted from?	NEW activity taken on per individual per day (hours)	System level - total NEW activity taken on (hours)						
General practice	GPs	161.0	161.0	1207.5	1207.5	4.725	760.73	2.78	446.78				4.7	760.7	63.0%			
	ANP	12.0	12.0	90.0	90.0	7.5	90						7.5	90.0	100.0%			
	Practice nurses	55.0	55.0	412.5	412.5	7.5	412.5						7.5	412.5	100.0%			
	HCA's	42.0	42.0	315.0	315.0	7.5	315						7.5	315.0	100.0%			
	Managers	58.0	58.0	435.0	435.0	7.5	435						7.5	435.0	100.0%			
	Other non clinical	460.0	460.0	3450.0	3450.0	7.5	3450						7.5	3450.0	100.0%			
	Pharmacy/prescribing	50.5	90.0	378.8	675.0	7.5	378.75			GP	0.74	66.41	5.5%	4.9	445.2	66%		
	Psychological medicine/unexplained symptoms	0.0	5.0	0.0	37.5	0	0			GP	0.00	0.00	0.0	0.0	0.0	0.0%	NO VARNAM EVIDENCE FOR THIS	
Primary Care at Scale	Direct access Physiotherapists	0.0	12.0	0.0	90.0	0	0			GP	6.54	78.49	6.5%	6.5	78.5	87.2% 12 band 7s		
	Dietitians	2.1	6.3	15.8	47.3	7.5	15.75				7.5	31.5		7.5	47.3	100.0%		
	GP's (Acute visiting and clinical triage)	0.0	8.0	0.0	60.0					GP	15.09	120.75	10.0%	15.1	120.8	201.3%		
	Find & Treat - Admin	0.0	1.6	0.0	12.0						7.50	12.00		7.5	12.0	100.0%		
	Find & Treat - HCA	0.0	4.0	0.0	30.0						7.50	30.00		7.5	30.0	100.0%		
	Find & Treat - Analyst	0.0	8.0	0.0	60.0						7.50	60.00		7.5	60.0	100.0%		
	Find & Treat - project officer	0.0	0.4	0.0	3.0						7.50	3.00		7.5	3.0	100.0%		
	Mental wellbeing navigators	0.0	16.0	0.0	120.0					GP	1.91	30.55	2.5%	1.9	30.5	25.5%		
	Safeguarding	0.0	6.4	0.0	48.0						7.50	48.00		7.5	48.0	100.0%		
	Healthy Communities - Self care coach	0.0	16.0	0.0	120.0					GP	1.91	30.55	2.5%	1.9	30.5	25.5%		
	Healthy Communities - Self care nurse	0.0	2.0	0.0	15.0					GP	1.93	3.86	0.3%	1.9	3.9	25.8%		
Integrated Community Teams (Excludes non-recurring BCF funded posts)	Navigation (practice reception)	45.0	45.0	337.5	337.5	7.5	337.5			GP	1.91	85.97	7.1%	9.4	423.5	125.5%		
	Workflow optimisation																	
	SMBC - Neighbourhood Team Leader	4.0	4	30.0	30.0	7.5	30	0.00		GP	0.07	0.3	0.9%	0.02%	7.6	30.3	100.0%	
	SMBC - Neighbourhood Senior Practitioner	5.3	8	39.8	60.0	7.5	39.825	20.18		GP	0.07	20.7	1.8%	0.04%	7.6	60.5	100.0%	
	SMBC - Neighbourhood Practitioner	49.9	48	374.5	360.0	7.5	374.475	-14.48		GP	0.07	-11.2	10.8%	0.27%	7.6	363.3	100.0%	
	SMBC - Neighbourhood Key Worker	39.9	59	299.3	442.5	7.5	299.325	143.18		GP	0.07	147.2	13.3%	0.33%	7.6	446.5	100.0%	
	SMBC - Assistant Neighbourhood Practitioner	31.9	48	239.1	360.0	7.5	239.1	120.90		GP	0.07	124.2	10.8%	0.27%	7.6	363.3	100.0%	
	SMBC - Neighbourhood Support Worker	0.0	26	0.0	195.0	7.5	195.00			GP	0.07	196.8	5.8%	0.15%	7.6	196.8	100.0%	
	SFT - Senior Clinician	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	SFT - Neighbourhood Team Leader	4.0	4	30.0	30.0	7.5	30	0.00		GP	0.07	0.3	0.9%	0.02%	7.6	30.3	100.0%	
Integrated Community Teams (Excludes non-recurring BCF funded posts)	SFT - Neighbourhood Senior Practitioner	25.8	20	193.6	150.0	7.5	193.575	-43.58		GP	0.07	-42.2	4.5%	0.11%	7.6	151.4	100.0%	
	SFT - Neighbourhood Practitioner	64.1	49	480.5	367.5	7.5	480.45	-112.95		GP	0.07	-109.6	11.0%	0.28%	7.6	370.8	100.0%	
	SFT - Assistant Neighbourhood Practitioner	9.6	19	72.2	142.5	7.5	72.15	70.35		GP	0.07	71.6	4.3%	0.11%	7.6	143.8	100.0%	
	SFT - Neighbourhood Support Worker	8.1	39	60.6	292.5	7.5	60.6	231.90		GP	0.07	234.5	8.8%	0.22%	7.6	295.1	100.0%	
	SFT - Neighbourhood Support Worker	6.2	31	46.7	232.5	7.5	46.65	185.85		GP	0.07	188.0	7.0%	0.17%	7.6	234.6	100.0%	
	PenCare - Mental Health Liaison Workers	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	JQIT - Programme manager	0.0	1.0	0.0	7.5	7.5	7.50			GP	0.07	7.6	0.2%	0.01%	7.6	7.6	100.0%	
	JQIT - Quality improvement officers	0.0	3.0	0.0	22.5	7.5	22.50			GP	0.07	22.7	0.7%	0.02%	7.6	22.7	100.0%	
	JQIT - Service improvement coordinator	0.0	0.5	0.0	3.8	7.5	3.75			GP	0.07	3.8	0.1%	0.00%	7.6	3.8	100.0%	
	JQIT - Nurse	0.0	1.0	0.0	7.5	7.5	7.50			GP	0.07	7.6	0.2%	0.01%	7.6	7.6	100.0%	
Community	SMBC overnight - Neighbourhood Senior Practitioner	0.0	2	0.0	15.0	7.5	15.00			GP	0.07	15.1	0.4%	0.01%	7.6	15.1	100.0%	
	SMBC overnight - Neighbourhood Practitioner	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	SMBC overnight - Neighbourhood Key Worker	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	Physiotherapists	18.9	27.3	142.0	204.8	7.5	141.98	62.78		GP	0.07	64.6	6.1%	0.15%	7.6	206.6	100.0%	
	Occupational therapists	2.6	2.6	19.5	19.5	7.5	19.5	0.00		GP	0.07	0.2	0.6%	0.01%	7.6	19.7	100.0%	

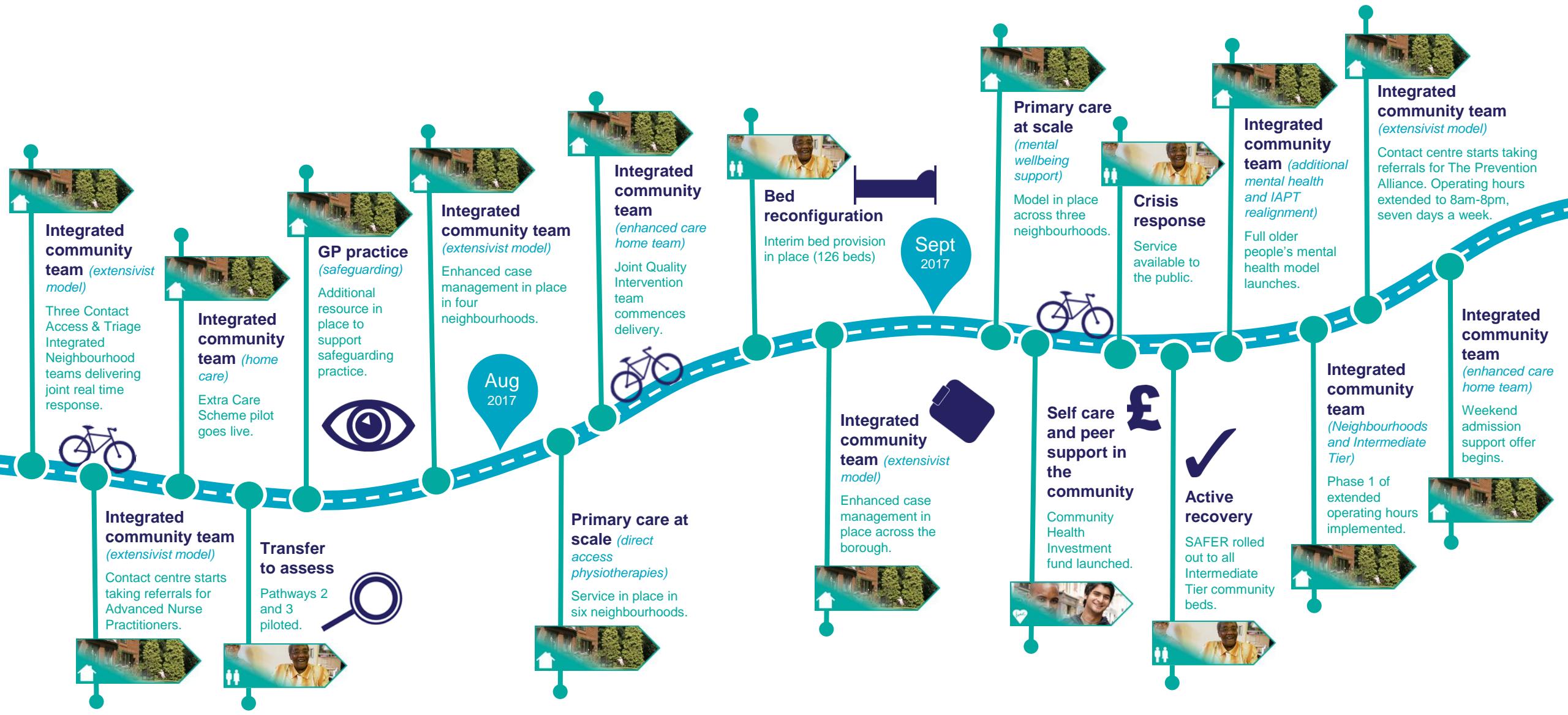
The Stockport Together Programme

Our journey



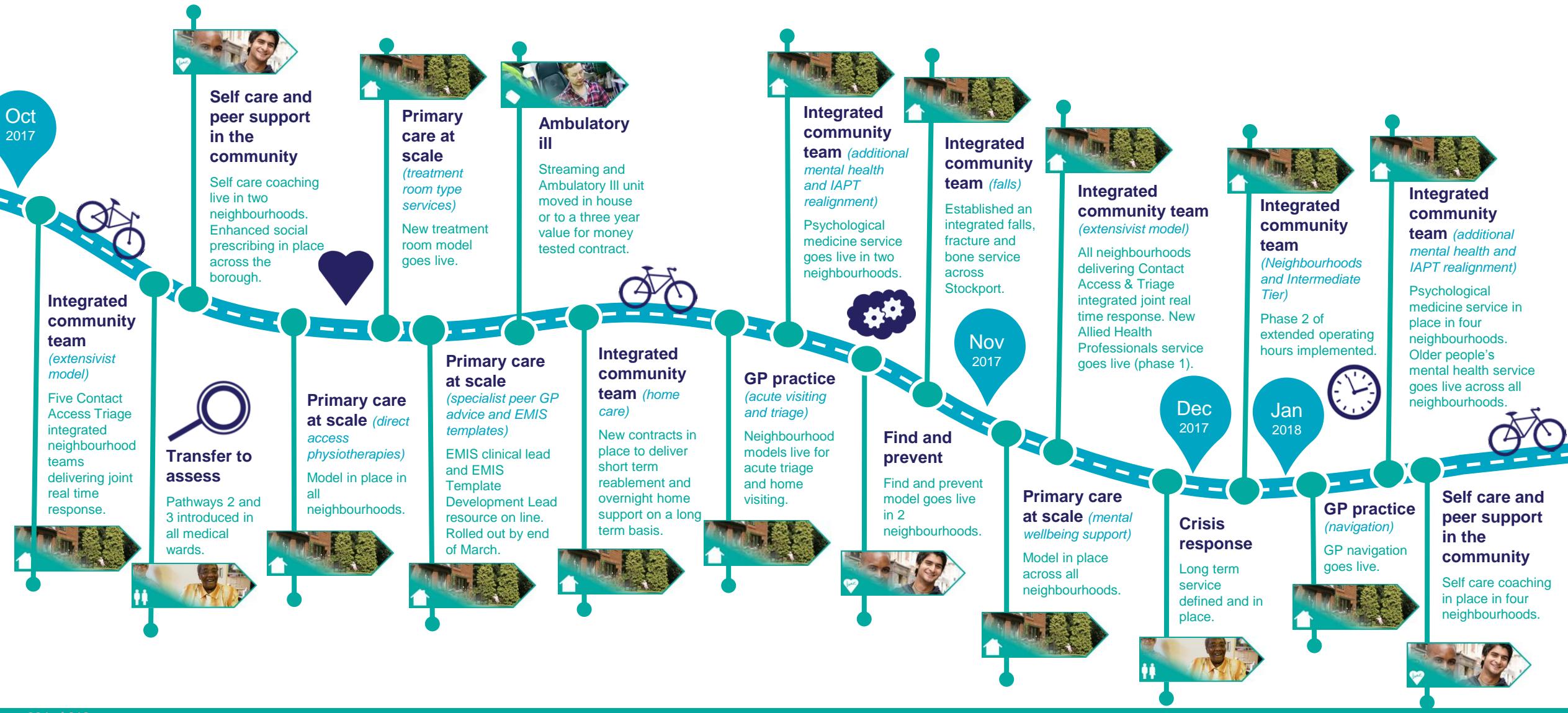
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Our journey



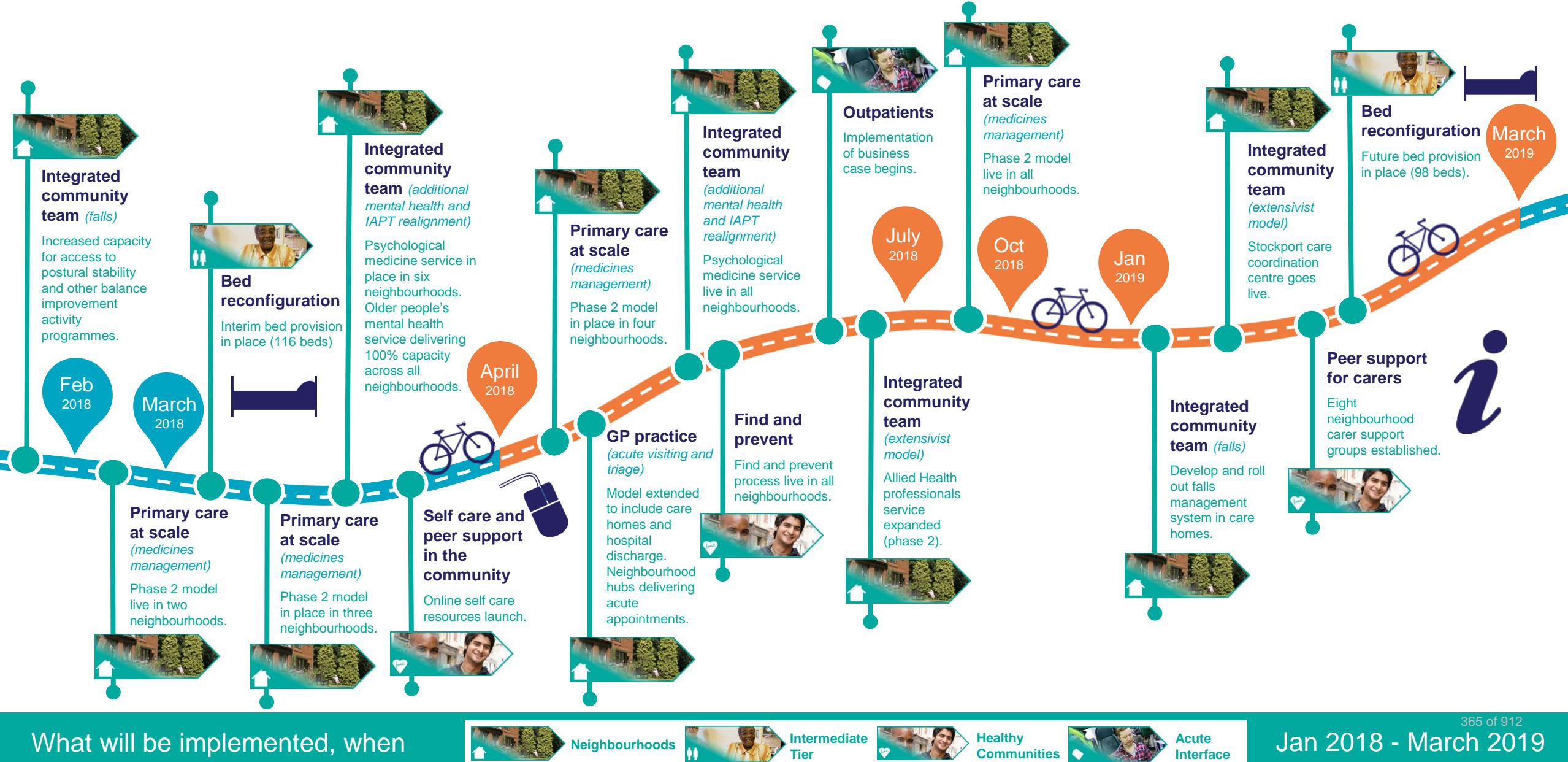
The Stockport Together Programme

Our journey



The Stockport Together Programme

Our journey



Stockport Together | Key Implementation Milestones

Workstream	2017-18 Monthly												2018-19 Quarterly								
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-June 2018	July-Sept 2018	Oct-Dec 2018	Jan-March 2019	2019-20	2020-21			
Neighbourhoods																					
Primary Care at scale- Direct access physiotherapy				Primary care at scale Direct access physiotherapy service in place within three neighbourhoods.		Primary care at scale Direct access physiotherapy service in place within four neighbourhoods.	Primary care at scale Direct access physiotherapy service in place within six neighbourhoods.	Primary care at scale Model in place in all neighbourhoods.													
Primary Care at scale - Mental Wellbeing Support						Contract in place for mental wellbeing support service	Recruitment of Mental Health Navigators	Model in place across three neighbourhoods	Model in place across all neighbourhoods.												
Primary Care at scale - Medicines management		Recruitment of staff for pilot	Phase 1 pilot live in one neighbourhood										Phase 2 model live in two neighbourhoods	Phase 2 model live in three neighbourhoods	Phase 2 model live in four neighbourhoods	Phase 2 model live in all neighbourhoods					
Collaborative General Practice - Specialist peer GP advice and EMIS templates			EMIS Clinical Lead and EMIS Templates developed.					EMIS clinical lead and EMIS Template Development Lead resource online. Rolled out by end of March.													
Primary care at scale - Treatment room type services			Relevant recruitment commences					New treatment room model goes live													
GP practice - navigation				Practice navigator training commences								GP navigation goes live.									
GP practice - acute visiting and triage								Neighbourhood models live for acute triage and acute home visiting.							Model extended to include care homes and hospital discharge.						
GP practice - safeguarding		Recruitment to additional posts commences, where required.		Additional resource in place to support safeguarding practice.																	
GP 7 Day Service	GP 7 Day Service piloted in the Heaton's.				GP 7 Day Service in place in two neighbourhoods	GP 7 Day Service in place in four neighbourhoods	GP 7 Day Service commences in six neighbourhoods	7 Day Service live in place in all neighbourhoods													
Integrated community team - additional Mental Health (and IAPT realignment)	Additional older peoples mental health recruitment commences		Commence recruitment to additional psychological medicine posts.	Additional older peoples mental health recruitment fully in post.		Key psychological medicine capacity in post.	Psychological medicine service goes live in two neighbourhoods.			Psychological medicine service in place in four neighbourhoods.		Psychological medicine service in place in six neighbourhoods.	Psychological medicine service live in all neighbourhoods.								
Integrated community team - Falls:							Establish an integrated falls, fracture & bone service (Steady in Stockport) across Stockport			Increased capacity for access to postural stability and other balance improvement activity programmes					Develop and roll out falls management system in care homes.						
Integrated community team - home care	Model delivered for partial re-alignment focussed home care and overnight home support.	Recruitment to workforce for Extra Care scheme pilot commences.	Re-alignment focussed home care capacity doubles. Additional capacity available to neighbourhood teams to respond to deterioration.	Extra Care Scheme pilot goes live.			New contracts in place to deliver short term re-alignment and overnight home support on a long term basis														
Integrated community team - enhanced care home team		Joint Quality Intervention Team recruitment commences		Recruitment commences on resources to support weekend care home admission	Joint Quality Intervention Team in post.	Joint Quality Intervention Team commences delivery.	Care homes weekend admission support offer commences.					Formal joint evaluation of progress.	Full rollout of the Joint Quality Intervention team,								
Integrated community team - extensivist model		Extended operating hours Extended operating hours 45 day consultation commences.	Extended operating hours Extended operating hours 45 day consultation ends.			Extended operating hours Phase 1 of extended operating hours implemented.		Extended operating hours Phase 2 of extended operating hours implemented.													
	Contact Access & Triage (CAT) Contact centre established to take all hospital discharge referrals from district nurses.	CAT Contact centre expanded to take all district nurse and social care referrals.	Joint professionals line in place for integrated teams.	CAT Contact centre recruitment complete.		CAT Contact centre starts taking referrals for Advanced Nurse Practitioners.	CAT Contact centre starts taking referrals for The Prevention Alliance.								CAT Stockport Care Coordination Centre goes live						
		CAT Integrated neighbourhood teams (INT) Real time response pilot commences in one neighbourhood.		CAT integrated neighbourhood teams (INT) Three neighbourhood teams delivering integrated real time response.			CAT integrated neighbourhood teams (INT) Five neighbourhood teams delivering integrated real time response.	CAT integrated neighbourhood teams (INT) All neighbourhood teams delivering integrated real time response.													
								Allied Health Professionals Recruitment to 17/18 posts	Allied Health Professionals New Allied Health Professionals service goes live (phase 1).						Allied Health Professionals Allied Health Professionals Recruitment to 18/19 posts						
		Enhanced case management Enhanced case management Full implementation plan (including percentage of population covered) complete.	Enhanced case management Enhanced case management in place in four neighbourhoods.											Allied Health Professionals Allied Health Professionals service expanded (Phase 2)							
		100% 17/18 senior and support worker capacity online.	1st July - 100% key worker capacity online.	100% neighbourhood practitioner capacity online		50% ANP capacity in place			100% Assistant Practitioner capacity online			100% ANP capacity in place	Small reduction in Neighbourhood Practitioners (ASC), 100% 18/19 DN support worker capacity online				Reduction in senior and neighbourhood practitioners (Nursing and ASC)				

Stockport Together | Key Implementation Milestones

Workstream	2017-18 Monthly												2018-19 Quarterly						
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-June 2018	July-Sept 2018	Oct-Dec 2018	Jan-March 2019	2019-20	2020-21	
Health Champions			Health Champions Extension Decision	Volunteers in three general practices to support patients.				Evaluation & forward plan completed											
Peer Support for Carers												400 carers accessing online support				Eight neighbourhood Carer Support Groups established			
Self Care & Peer Support in the community	NHS E approval of Patient Activation Model (PAM)	Recruitment of project manager	Decisions re use of patient activation measure as part of the NDPP	Project Manager in post	Recruitment of self care coaches	Community Health Investment fund launched	Self care coaching live in two neighbourhoods.	Enhanced social prescribing in place across the borough.		Self care coaching in place in four neighbourhoods	Online self care resources launch.	Self care coaching live across all neighbourhoods.							
Find & Prevent	National Diabetes Prevention programme GM provider for NDPP (National Diabetes Prevention Programme) appointed	Healthy Living Pharmacies (phase 2) launched	National Diabetes Prevention programme NDPP live in Victoria			National Diabetes Prevention programme NDPP live in Cheadle	Find & Prevent model goes live in two neighbourhoods		National Diabetes Prevention programme NDPP live in Tame Valley				Find & Prevent model live in all neighbourhoods - April	National Diabetes Prevention programme NDPP live in Heaton's (Sept)	National Diabetes Prevention programme NDPP live in Bramhall (Dec)	National Diabetes Prevention programme NDPP live in Marple (March)			
Place based integration	Place based work Approval of the Heaton's Joined Up Services programme	Place based work Launch of the Heaton's joined up service programme and start of community conversation	Place based work Programme deliverables confirmed																

Acute Interface

Ambulatory I	EMIS Viewer launched in the Emergency Department.	Cost benefit analysis of AI completed with options appraisal	Future requirements spec for delivery of AI from October 1st completed include market testing. Commission future AI service delivery and complete any legal requirements.	Commence recruitment of permanent ACU capacity			Streaming and Ambulatory I unit moved in house or to a three year value for money tested contract.	Contract variation completed										
	Point of care testing (POCT) 3 month trial for DVT go live commenced (1st Apr)	Mid point review of POCT	Review trial of POCT															
	ACU operating at full capacity.	Audit effectiveness of ACU pathways.																
Outpatients	Completion of outpatients business case and implementation plan. Operational delivery team											Implementation of business case begins.						

Boroughwide services

Crisis Response:		Service available 24hours a day, 7 days a week.		Recruitment to 17/18 posts	Service available to the public	Phase 2 & 3 - Optimised	Long term service defined and in place											
Active Recovery:	SAFER piloted on Intermediate Tier community beds (Marbury and Berrycroft)		Increased operational capacity in place.	Recruitment to 17/18 posts	SAFER rolled out to all Intermediate Tier community beds													
Bed Reconfiguration:				Interim bed provision in place (126 beds)	Phase 2 - Optimised							Interim bed provision in place (116 beds)			Further bed provision in place (98 beds)			
Integrated Transfer Team:		Complete rollout to all wards.			Pathways 2 and 3 introduced to all medical wards.		Optimise Transfer To Assess pathways 2 & 3											
Transfer to Assess:		Transfer to assess pathway 1 introduced to all medical wards.	Pathways 2 and 3 piloted.		Optimise T2A pathway 1							Implement Phase 4 - Care Homes	Implement Phase 5 - Nhoods					
Trusted Assessor Development:		Implement Phase 1 - T2A	Implement Phase 2 - Active Recovery	Implement Phase 3 - Crisis Response														

NEIGHBOURHOOD OUTLINE BUSINESS CASE APPENDICES

SERVICE AREA: MENTAL WELLBEING?

Component	Description
Current. Brief description of existing services (i.e. how many sites, how many staff, functions, opening hours , capacity). (NUMBERS)	<p>Patients with mental health conditions who present at general practice can be complex and time consuming and often the GP appointment is not long enough to explore and manage the underlying issues in great depth. Around 30 % of GP consultations are for patients with low level / social needs / mental health related conditions which could be due to a multitude of reasons. Evidence from a small local pilot and similar services such as those piloted through the Prime Ministers challenge fund show the benefits in GP's having direct access to a service able to explore the issues causing the mental health condition in patients and then connecting the patients to the appropriately services such as social prescribing, self-help, mental health alliance and other voluntary groups.</p> <p>The opportunity of developing a new service provision that particularly focuses on the lower level social and wellbeing Mental Health issues will support the approach of making time and managing demand with greater integration in General practice as recommended by the GPFV and Making Time in General Practice.</p> <p>PILOT Current</p> <p>The provision of navigational services for low level Mental Health / Social and Wellbeing conditions in the Tame Valley Neighbourhood covering 8 practices with a combined list size of 47,500~patients. The service is currently being delivered over 5 sites in GP practices within the neighbourhood. The 2 WTE navigators work 8am to 4.00pm (sometimes later at patient request) and the capacity is spread over the five sites based on room availability and weighted list share of hours per practice. As the service is currently still in development full capacity has not been reached.</p>
Problems & Opportunities: What could change – 2 sentences	<p>The proposed change is to provide general practice and the neighbourhood teams with direct access to Care Navigators in a local setting. Patients will be given the appropriate consultation time and once the underlying issues are established they are navigated to the most appropriate service based on their needs. In some cases patients may be referred back into General practice once the social issues are resolved to deal with any health related conditions. It is envisaged that not all patients will need to follow this pathway as some patients will be treated by medication or will not be suitable or need this support.</p> <p>Opportunities: To train and develop new staff into the role and involve the skills already available in the voluntary sector.</p>

New service: What people, what processes, what use of technology, what additional capacity, what functions, clinical / professional governance (NUMBERS)	<p>The proposed change is to provide general practice and the neighbourhood teams with direct access to Care Navigators in a local setting. The plan is for 16 Care navigator posts to be shared across the neighbourhoods based on weighted list size.</p> <p>The navigator will hold a minimal caseload with the majority of patients only seen once with one follow up and then discharged (primarily consisting of 'frequent users' of GP practices) with the aim that these patients will experience improved health and wellbeing and a reduction in their use of GP practice resources and also attendance at ED.</p> <p>Hubs will be set up across the neighbourhoods and each practice will have access to book direct appointments with the Care Navigators.</p> <p>The aim of the service is to develop and implement effective action plans that will address the individual's non-medical needs. The service is not a support service. Its purpose is to work with individuals to identify their needs and navigate them to support services or encourage self-referral to community groups or other organisations.</p> <p>Patients will be booked into the service directly by receptionists and via referrals from other professionals. Patients will be offered a face to face appointment/ telephone consultation within one week of referral. Patients will be given 40 minute appointments for their initial assessment in order to identify the underlying issues requiring access to other services. The service is not in itself a therapeutic or counselling service but aims to work with the individual patients to promote confidence in self-care, independence and an improved sense of health and wellbeing.</p> <p>The service, when appropriate, will introduce to the patients the different approaches to health care; to assist and encourage them to make their own decisions and choices. The service will use an enabling approach that draws on individuals' strengths, preferences and support networks. Patients will be provided with self-help information and tools.</p> <p>In some cases it may be more appropriate to a telephone discussion to help patients identify their health and well-being goals. Communication with patients will also include email or text for follow-up</p> <p>Specific service aims are:</p> <ul style="list-style-type: none"> • To support patients with mental health conditions by providing additional time to listen and identify the underlying issues that underpin their conditions. • To provide a pathway to support, appropriate to their needs. • To provide quicker access to patients in need. • To provide alternatives to medication such as social prescribing. • To provide support to General Practice in providing additional manpower. • To facilitate standardisation of good practice across Stockport. • To provide local services in the neighbourhood. • To pro-actively prevent patients reaching critical point. • To support integrated working across Stockport on a neighbourhood footprint. • To reduce acute admissions and unnecessary secondary care attendances.
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	<ul style="list-style-type: none"> • To provide faster referral pathways into secondary care mental health advice services. • To liaise with GP front of house staff in signposting to services. • To ensure that people have and report a good experience when they access the service.
7 day service – describe the extent to which service offer is over 7 days and links where appropriate to 7 day services – GP or otherwise	Currently it is not planned to include a Saturday and Sunday service but referral pathways should allow for patients seen on those days to be referred into the service and be seen by the navigators in routine appointments Monday to Friday.
Benefits: What will it deliver in terms of outcomes, benefits to population, and efficiency improvements (Cash & time) (NUMBERS). What evidence is the basis of this (<i>National evidence, Local pilots, Assumptions</i>)	<p>The benefits will be</p> <ul style="list-style-type: none"> • Support to General Practice releasing capacity in an already stretched service. • Patients underlying problems are appropriately identified. • Improved and appropriate care navigation within the health and social care system for the neighbourhood population, i.e. patients referred to the appropriate services based on their needs. • Better value for all, i.e. more people can access the service with outcomes that will have a positive impact on both physical and mental well-being

Costs: What will it cost and how was this derived? (Staffing, technology, start-up non-recurrent and recurrent)	£450,000~ per annum			
			WTE	Cost
2017/18 All neighbourhoods				
Workforce				
	AFC Band	XN060 2 XN050 2 12.3 XN407	1 2 3	£34276.53 55865.96 £434,556.17 344413.67
Training				
Estates I&T				
Management cost				
2018/19 All neighbourhoods				
Workforce				
	AFC Band	XN060 2 XN050 2 12.3 XN407	1 2 3	£34619.30 56424.62 £438,901.73 347857.81
Training				
Estates I&T				
Management cost				

FIND AND PREVENT

Purpose
This business case focuses on three different cohorts of people: <ul style="list-style-type: none"> • People who have a long term health condition and do not know about it. • People who have a long term health condition and know about it, but for many reasons their treatment or lifestyle choices may not be optimised to manage that condition. • People who do not yet have a long term health condition but have risk factors and behaviours which mean that they may be more likely to develop long term health conditions.
This business case looks at how these three groups can be better identified and assessed in primary care settings. By finding people through consistent and systematic use of EMIS search and reports, we can develop protocols and processes to invite people for enhanced health checks within the neighbourhoods, following which appropriate treat responses can be made.
This case links closely to other parts of the neighbourhood business case where the treatment of those found will be achieved, principally through optimising primary care (core neighbourhoods), improved self-care (healthy communities) and referrals to lifestyle behaviour change and prevention programmes (healthy communities, self-management, education courses and the NHS Diabetes Prevention Programme).
By using Healthy Living Pharmacies as well as EMIS Search and Report within General Practice we will further develop our ability to find and assess people in their communities.
These programmes will together reduce: <ul style="list-style-type: none"> • the development of conditions (i.e. primary prevention) • the escalation from simply managed conditions such as hypertension to more complex conditions such as stroke, heart disease or kidney disease (secondary prevention) • the numbers of exacerbations, complications and acute care incidents relating to long term conditions.
Other Stockport Together business cases are focussing on those who already have multiple long term conditions and who are currently at high risk of exacerbation or admission; this business case is focussed on the longer term prevention for those who have yet to develop complex care needs as there is an increasing level of disease, potential disease and levels of complexity due to multiple conditions as the population of Stockport gets older.
The prime rationale is therefore to reduce in the long term the level of disease, providing a better quality of life for patients and their families, and increasing healthy life expectancy, in other words to close the health and wellbeing gap .
The secondary rationale is that the current health system was not established to manage long term health problems. Over time it has adapted to do so but is now under severe pressure from the volume of activity that this requires, and therefore a new approach is needed. If we can get ahead of the development of disease and stabilise or prevent the development of disease we can make the future of the health system more sustainable (closing the funding and efficiency gap) . Without a preventative approach we will continue to be faced with rising demand and soon patients and services will be experiencing the consequences of the predicted diabetes type 2 and other disease time bomb.
A third rationale is to address the variation in health outcomes (inequalities) and care

provision (quality gap) across Stockport. It has been shown that improving the health of the population in our most deprived populations to levels experienced in other parts of the Borough would significantly reduce the burden of disease in the borough. Stockport generally has a high quality of care in General Practice, with many examples of innovation and excellence; there is however still variation between practices. This programme will enable the **standardisation of prevention and the sharing of good practice, reducing variation and enabling the lower performing areas to level up to the best.**

A fourth rationale is to give the necessary support and structure to enable the Stockport system to **quickly mobilise to generate referrals into the NHS Diabetes Prevention Programme.** This programme is being extended across Greater Manchester from April 2017, and is only confirmed to be available for a two year period. We need to ensure that as many people at risk of type 2 diabetes as possible are offered the structured prevention programme, funded by NHS England.

A final rationale is to maximise the opportunities from the existing **Healthy Living Pharmacy** programme to ensure that there are ways to engage people beyond the General Practice setting and additionally to ensure that the pharmacy sector is supported through the transition to the new national contract.

Together these rationales build a case for change based on the five year forward view vision of **a radical upgrade in prevention.** General Practice already have many good examples of proactive and preventative approaches to long term condition management, particularly via the QoF and for early identification, such as the NHS Health Checks. The find and prevent programme aims to build on this by **improving the quality of the existing provision, by reducing variation and by extending these approaches in to more conditions.**

Background

LONG TERM CONDITIONS

Over a quarter of the population in England has a long term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes that, "Long Term Conditions are now a central task of the NHS".

People with long term conditions currently use a significant proportion of health care services

- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and healthcare costs are significant. 15.4 million people in England are recorded as having have a long term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million by 2018).

In Stockport, 27% of the population (84,700) have one of the 8 key conditions and this increases with age, from 2% in the 0-4 age band, to 88% in those aged 85 and over. By age 60, half of the people have one or more of these conditions and 15% of the population have two or more of 8 key long term conditions. Many more may also have a condition which is currently undiagnosed.

The table below shows the most common long term conditions in Stockport:

Long-term conditions overview				
Condition	Number	Gender Profile	Age Profile	Deprivation Profile
Hypertension	44,745		Increasing from mid 40s	Rates increase with deprivation, number decreases
Anxiety (last 10 years)	30,085	Higher in women	Highest from 25 to 50	Rates increase with deprivation
Depression	29,130	Higher in women	Highest in 40s and 50s	Rates increase with deprivation
Asthma	20,545	Slightly higher in women		Rates increase with deprivation, number decreases
Obesity	20,050*			
Diabetes	15,700	Slightly higher in men	Increases from mid 40s	Rates increase with deprivation
Coronary Heart Disease (CHD)	12,230	Higher in men	Increases from mid 40s	Rates increase with deprivation, number decreases
History of Fall	12,150	Higher in women	Increases from 50s, sharply in 80s	Rates increase with deprivation, number decreases
Cancer	8,540		Earlier in women	Rates and numbers decrease with deprivation
Chronic Kidney Disease (CKD)	7,670	Slightly higher in women	Increase from 50s	Rates increase with deprivation, numbers decrease
Chronic Obstructive Pulmonary Disease (COPD)	7,170		Increases from mid 40s	Rates increase with deprivation
Stroke or Transient Ischaemic Attack (TIA)	6,395		Increases from mid 40s	Rates increase with deprivation, numbers decrease
Atrial Fibrillation (AF)	6,200	Slightly higher in men	Increases from 50s	Numbers decrease with deprivation, rates vary
Self harm	3,060*	Higher in women	Highest between 15 and 34	Rates and numbers increase with deprivation
Heart Failure (HF)	3,045	Slightly higher in men	Increases from mid 50s	Rates increase with deprivation
Dementia	2,850	Higher in women	Increases from mid 60s	Rates increase with deprivation, numbers decrease
Severe mental health	2,570		Highest between 30 and 59	Rates increase with deprivation
Glaucoma	2,510		Increases from mid 50s	Numbers decrease with deprivation, rates vary
Epilepsy	2,505			Rates increase with deprivation
Peripheral Arterial Disease (PAD)	2,270	Higher in men	Increases from mid 50s	Rates increase with deprivation
Rickets (last 10 years)	1,895	Higher in women		Numbers decrease with deprivation, rates vary
Rheumatoid Arthritis	1,550	Higher in women	Increases from mid 40s	Numbers decrease with deprivation, rates vary
Acute Macular Degeneration (AMD)	1,520*	Higher in women	Increases from 70s	Rates and numbers decrease with deprivation
Learning disability	1,515	Higher in men		Rates and numbers increase with deprivation
Autism	1,170*	Higher in men		Rates increase with deprivation
Crohn's disease	1,010			
Cerebral palsy	275*			
Down's syndrome	240	Higher in men		
Motor neurone disease	35			

* Undercount of actual prevalence

4

People with long-term conditions are the most intensive users of the most expensive

services, not only in terms of primary and acute services, but also in social care and community services. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are overdue for an appointment for a long-term condition.

It is estimated that nationally the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport this will equate to an additional 47,700 people living with a condition. An increasingly older population also means that it is likely that the prevalence of dementia particularly will rise above the national average and planning care for this group of people will require additional attention.

CURRENT SITUATION IN STOCKPORT

The measure of the known population with long term conditions is usually accepted as the Quality and Outcomes Framework (QoF) disease register. These are the people coded on the general practice clinical system as having a disease.

Stockport practices are good at the identification of disease and the prevalence is generally higher than the national averages. Despite this being the case however the known prevalence is often far short of the predicted prevalence proposed by public health modelling of disease prevalence. The table below shows the situation for the six key conditions which **Find and prevent** will focus on in Stockport and gives an idea of the number of people still to be found. It also shows the benefit measure stretch we have set ourselves for 2020/21 as part of the agreement for Greater Manchester Transformation Fund.

Currently pre-diabetes type 2 (non-diabetic hyperglycaemia) is not included in the QoF, and GP practices are therefore not required to maintain a disease register or report this data. Building this register will be a prerequisite for the NHS Diabetes Prevention Programme.

Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find (GMTF Benefit by 2020/21)
Diabetes (type 1 and 2)	14,600	5,600	2,300
Pre diabetes (type 2)	Unknown	Up to 27,150	13,000*
Hypertension	43,600	11,500	4,300
Atrial Fibrillation	5,700	2,150	1,550
Dementia	2,700	1,300	750
COPD	6,700	3,700	-

*NHS Diabetes Prevention Programme commitment by April 2019

There are a potential **29,000 smokers in Stockport who have yet to develop or be diagnosed with a long term condition**, out of a total 40,000 smokers – this apparent disparity is due to the different age profiles of smokers (who tend to be younger) and those with long term conditions (who tend to be older). At each age group smokers are more likely to have long term conditions than non-smokers, but **as many smokers are young there are a large number who have yet to develop or be diagnosed with long term conditions**. This group will be a key priority.

There are also **5,000 obese people in Stockport who have yet to develop or be diagnosed with a long term condition**, out of a total 20,000 identified by GP practices.

There are three national screening programmes to detect certain cancers early, whilst they are still curable, and the national NHS Health Check programme aims to systematically identify people at risk of cardiovascular disease. The data below shows the numbers of people eligible for these programmes and the numbers that have not attended.

Screening programme	Eligible	Not screened
NHS Health Check	91,000	41,000
Cervical Cancer	77,000	5,500
Breast cancer	40,000	11,500 (in last 3 years)
Bowel cancer	24,000	11,000

The reasons that people do not attend screening are many and complex, although it is recognised that deprivation and activation are a factor. Any new system will never address the total gap, but can reduce it and may be able to address the issues of particular communities and reduce the level of inequality in the prevalence of disease.

The Quality and Outcomes Framework (QoF) also provides some useful benchmarks for the proportion of the known population whose treatment is optimised within primary care. For each long term condition there are a range of treatment indicators and the following serve as an illustration of current performance, which on the whole is good:

Condition	Measure	Performance (QoF 2014/15)	To improve management
Diabetes (type 1&2)	HbA1c ≤ 64mmol/mol	80.4%	2,575
Hypertension	Blood pressure ≤ 150/90mmHg	84.6%	6,552
Atrial Fibrillation	Anti-coagulated	85.1%	441
Dementia	With care plan	87.1%	327
COPD	FEV1 recorded	82.9%	1,010

In 2016/17 Stockport successfully launched the **Healthy Living Pharmacy Scheme** with £20,000 pump priming from vanguard funding. To date 18 of Stockport's 63 pharmacies have joined the programme, and in the first five months of delivery more than 505 preventative brief interventions (as per NICE guidelines) have been offered. Pharmacy staff are being offered structured training programmes in a range of preventative health measures and are developing referral pathways to Healthy Communities services and General Practice. Pharmacies are now being enabled to be able to use straightforward clinical testing within the pharmacy setting to extend the scope of the find and prevent programme.

NATIONAL CONTEXT

The Five Year Forward View highlights that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply

rising burden of avoidable illness. That warning has not been heeded as wholeheartedly as it could have been and the NHS is now on the hook for the consequences.

It goes on to highlight three key gaps:

- The **health and wellbeing gap**: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- The **care and quality gap**: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- The **funding and efficiency gap**: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions -for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes type 2 over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes type 2 prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

The model below describes the national approach to prevention, via risk detection and management in primary care and the key outcomes that could be achieved were this vision to be implemented. This evidence, from NHS Right Care and PHE is the foundation of the Stockport Find and prevent Programme.



Public Health
England

Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care

The Interventions	Cross Cutting: 1. NHS Health Check - systematic detection of high BP, AF, NDH, T2DM, CKD, high cholesterol, CVD risk 2. System level action to support guideline implementation by clinicians 3. Support for patient activation, individual behaviour change and self management		
High BP detection and treatment	AF detection & anticoagulation	Detection, CVD risk assessment, treatment	Type 2 Diabetes preventive intervention
5 million undiagnosed. 40% poorly controlled	30% undiagnosed. Over half untreated or poorly controlled	85% of FH undiagnosed. Most people at high CVD risk don't receive statins	5 million with NDH. Most do not receive intervention
The Opportunities	The Evidence	The Risk Condition	The Outcomes
BP lowering prevents 2/3 of strokes in AF	Behaviour change and statins reduce lifetime risk of CVD	High CVD risk & Familial H/cholesterol	Marked increase in heart attack, stroke, kidney, eye, nerve damage
Non Diabetic Hyperglycemia ('pre-diabetes')	Atrial Fibrillation		Marked increase in CVD, acute kidney injury & renal replacement
Type 1 and 2 Diabetes			

Detection and 2°/3° Prevention

National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies from other areas, some of these findings are directly relevant for find



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

and prevent, others to wider primary care interventions:

Diabetes type 1 and 2:

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/diabetes/>

- Ensure 100% practice participation in the National Diabetes Audit (**FIND**)
- Use audit data to focus quality improvement initiatives to improve achievement of the eight key processes and three treatment targets (**FIND AND PREVENT**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management (**TREAT**)
- Work with practices and education providers to maximise referral, uptake and retention in patient education programmes (**TREAT**)
- Ensure all patients with diabetes have access to routine care by a trained diabetes nurse (**NOT FIND AND PREVENT**)
- Consider commissioning systematic support for adherence from community pharmacists through medicines use reviews (MURs) (**NOT FIND AND PREVENT**)

Pre-diabetes (type 2):

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/ndh/>

- Undertake systematic audit across practices to identify historical diagnoses of Non-Diabetic Hyperglycemia (NDH) (**FIND**)
- Establish practice registers of individuals with NDH (**FIND**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Work with practices and NHS Health Check providers to maximise referral and uptake in the 'Healthier You' NHS Diabetes Prevention Programme(**TREAT**)

Hypertension:

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/blood-pressure/>

- Undertake systematic audit across practices.
 - Identify people with possible undiagnosed hypertension (**FIND**)
 - Identify people who are not treated to target (**FIND**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management (**TREAT**)
- Use practice-based pharmacists to optimise management of hypertension (**NOT FIND AND PREVENT**)
- Commission ambulatory blood pressure monitoring service for diagnosis (**NOT FIND AND PREVENT**)
- Consider commissioning:
 - Systematic support for adherence from community pharmacists through medicine use reviews (MURs) (**NOT FIND AND PREVENT**)
 - BP self-test units e.g. in surgery waiting rooms, community pharmacies, leisure centres (**HEALTHY LIVING PHARMACIES**)
 - Digital solutions for self-monitoring and treatment optimisation(**NOT FIND AND PREVENT**)

Atrial fibrillation:

<https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/af/>

- Undertake systematic audit across practices (GRASP-AF audit tool).
 - Identify people with possible undiagnosed AF (**FIND**)
 - Identify people with AF at high risk of stroke who are not anticoagulated or not maintained in the therapeutic range (**FIND**)
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up (**FIND AND PREVENT**)
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management (**TREAT**)
- Add pulse checking to existing GP and pharmacy enhanced services for people over 65 (**NOT FIND AND PREVENT**)
- Agree local clinical consensus and pathway for anticoagulation including the place of novel oral anticoagulants (NOACs) (**NOT FIND AND PREVENT**)
- Consider commissioning:
 - Technologies such as WatchBP Home A and AliveCor to support AF detection in routine care. (**HEALTHY LIVING PHARMACIES**)
 - New models of anticoagulation control e.g. self-monitoring and community pharmacy monitoring (**NOT FIND AND PREVENT**)
 - Systematic support for adherence from community pharmacists(**HEALTHY LIVING PHARMACIES**)

Dementia:

<https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf>

- Population screening for dementia is not envisaged.
- 'Timely' diagnosis is when the patient wants it. In some cases it may be when the carers need it.
- The current approach is towards raising awareness, especially in the higher risk population – specifically via NHS Health Checks (**FIND AND PREVENT**)

COPD:

<https://www.england.nhs.uk/wp-content/uploads/2014/02/rm-fs-6.pdf>

- Roll out and implementation of GP audit tools for case finding, such as GRASP-COPD. (**FIND**)
- Audit practice information systems to identify people who receive multiple prescriptions for oral steroids and/or antibiotics (**FIND AND PREVENT**)
- Support implementation of opportunistic COPD case finding in primary care through electronic decision support tools (**FIND AND PREVENT**)
- Discuss the COPD diagnosis with patients and carers, including what they can do to help manage their condition, for example signpost to advice on stop smoking and benefits of exercise (**NOT FIND AND PREVENT**)
- Target case finding based on population segmentation and social marketing described in the COPD Prevention and Early Identification Toolkit 2011 (**FIND**)
- Misdiagnosis of COPD is common so case finding tests should be followed by quality assured diagnostic spirometry, with trained staff interpreting the results. The NHS Improvement guide 'First steps to improving COPD care ' (2012) recommends that COPD diagnoses should have spirometry taken and recorded in the last 15 months other tests may be necessary to confirm the diagnosis, such as a CT scan (**FIND AND PREVENT**)

NHS Health Checks:

www.healthcheck.nhs.uk/commissioners_and_providers/guidance/

Legal duties exist for local authorities to make arrangements:

- for each eligible individual aged 40-74 to be offered an NHS Health Check once in every five years and for each individual to be recalled every five years if they remain eligible
- evidence is emerging about the effectiveness of prioritizing those at the highest risk (**FIND**)

Healthy Living Pharmacies:

<http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/>



What is a Healthy Living Pharmacy?



The impact of Healthy Living Pharmacies



Together these evidence based interventions will lead to a long term reduction in the number of people with disease, and improved health outcomes for those with disease thereby reducing the reliance on acute care settings and removing cost from the system. For each programme estimates of cost effectiveness and cost saving a being identified nationally, for example:

NHS Health Checks:

The original Department of Health (DH) modelling showed the average annual cost of the NHS Health Check programme as £332m each year at full roll out and the benefit as £3.7bn with a cost per quality adjusted life year (QALY) of around £3000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years.

The modelling shows that the NHS Health Check could, on average, prevent 1,600 heart attacks and strokes, saving at least 650 lives each year. As well as preventing over 4,000 people a year from developing diabetes type 2 and detecting at least 20,000 cases of diabetes type 2 or kidney disease earlier, allowing individuals to be better managed.

More recent evidence shows that *NHS Health Checks* :

- a new case of raised blood pressure is found approximately every three to four NHS Health Checks,
- a new diagnosis of hypertension made approximately every 30-40;
- a new diagnosis of diabetes is made for every 80-200 NHS;
- and a person with a cardiovascular disease risk $\geq 20\%$ identified every six to ten.

In Stockport around 50,000 people have had a NHS Health Check – meaning that 1,250-1,650 hypertension diagnosis, 250-625 diabetes diagnosis and 5,000-8,300 people at risk have been found; screening an additional 11,000 would find 275-370 hypertensives, 55-135 diabetics and 1,100-1,800 people at high risk.

NHS Diabetes Prevention Programme

Impact analysis suggests if 390,000 people receive the NHS DPP intervention over 5 years the approximately £1.2bn of health benefits will be gained nationally. On average 15,000 – 24,000 cases of Type 2 diabetes prevented or delayed by the 6th year, which is on average 72 to 115 cases of diabetes per CCG. By year 14, the programme will become cost saving at a national level, and this will be earlier locally as the majority of the intervention costs are born nationally.

Across Stockport implementation plans for the two years suggest that between 135 and 215 cases of type 2 diabetes will be prevented.

LOCAL CONTEXT

Health Outcomes and causes of premature mortality

We have a GP-registered population of around 300,000 people, are one of the healthiest places to live in the North West and are comparable with England in terms of health outcomes. We rank amongst the highest in England in terms of cancer survival rates, and have achieved decreasing mortality over a long period of time.

We know through our Joint Strategic Needs assessment (JSNA) that there are four main disease groups which cause 80% of deaths in Stockport; Cancer, Heart Disease, Lung Disease and Mental Health. The environment and lifestyle choices are contributing significantly to the development of these diseases and the higher burden felt in the most deprived areas. Early identification of disease is also essential to improving outcomes, as is supporting individuals to have the knowledge and the confidence to proactively manage their condition and to modify their lifestyles.

Preventable premature death is driven by a range of factors. Around 25% of adults in Stockport are classified as obese, and 75% are not active enough. Among our population hospital stays resulting from alcohol related harm were 709 per 100,000 in 2013/14, worse than the average for England. On the widest measure a total of 6,900 admissions per year can be attributed to alcohol. Around 18% of adults in Stockport are smokers (slightly better than the England average), but rates show significant inequalities so that people in our most deprived areas are more than twice as likely to smoke as the average.

Health Inequalities

We have one of the largest health inequality gaps in England. The overall borough wide health outcomes mask significant differences between the different neighbourhoods across the borough. There is a life expectancy gap between the most affluent and most deprived neighbourhoods of 11 years (for men) and 8 years (for women).

The deprivation gap for healthy life expectancy is even greater than that in life expectancy.

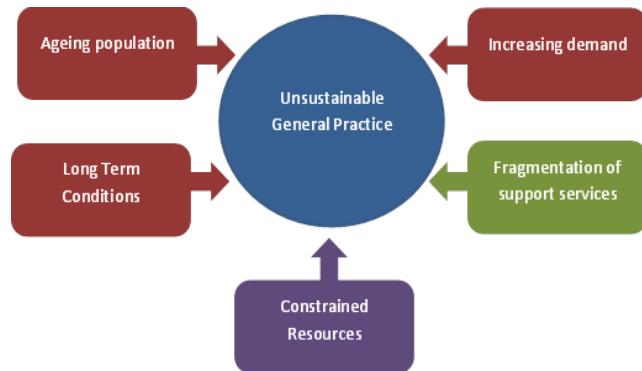
- In the most deprived areas men will on average have 7 years (9.4% of life) in poor health compared to 3 years (3.4%) in the most affluent areas.
- In the most deprived areas women will on average have 5 years (6.8%) poor health compared to 2 years (2.9%) in the most affluent areas.
- In the most deprived areas men will on average have 19 years (25.8%) fair or poor health compared to 12 years (14.1%) in the most affluent areas.
- In the most deprived areas women will on average have 20 years (26.6%) fair or poor health compared to 13 years (15.0%) in the most affluent areas.

In the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas, a gap of 16 years. Even a relatively small increase in healthy life

expectancy in the most deprived boroughs would reduce the 'burden' of ill health and would improve quality of life for a significant number of people, as well as channelling resources back into the economy.

Sustainability

We face a number of challenges to the financial sustainability of the health & social care system. General practice although financed in the main outside the local system, through national GMS or PMS contracts, has similar pressures and is equally unsustainable. Whilst the national funding of health & social care is outside our power we should and can address other local challenges.



Demographic Changes

The number of people aged over 65 in Stockport (19.4%) is above the national average (17.7%) and this figure is expected to continue to grow. By 2020, the proportion of the population of Stockport aged over 65 is expected to reach 21%, an increase of almost 5,000 people.

The number of people aged over 65 will increase from 55,700 in 2014 to 61,000 by 2020 (an increase of 9.7%). The proportion aged over 65 is also significantly higher in some neighbourhoods of the borough than others (already 20.5% in Cheadle and Bramhall).

Older people have greater health needs and a greater probability of developing long term illnesses, meaning co-morbidities increase, thus they account for the most significant amount of health service use. Keeping this group healthy, well and socially active will be vital in reducing the need, and subsequent cost, of health and social care, and improving their quality of life.

Proposed Clinical Model

We wish to create a system that is proactively looking for all people who are at risk of disease and preventing the development of this disease thus improving health and reducing the burden of ill health on people and the health and care system. In this way we wish to reduce the number of people with complex comorbidity in the future and increase healthy life expectancy in all communities.

We will proactively look for people who are at risk of disease and all those with disease whose care could be improved. We aim to ensure that

- more people will take up offers to attend screening either for undiagnosed conditions or as part of national programmes (**FIND**)
- more people with risk factors that put them at risk of developing a long term condition are supported to manage those risk factors (**TREAT**)
- more patients with a long term condition are supported to manage their condition so that complications are minimised (**TREAT**)

We will do this by supporting General Practice and Pharmacies to develop and improve systems that will drive this change. The purchase of **EMIS Search and Reports** will enable validated queries to be written once and shared, before being run either at a practice or

neighbourhood level to identify target groups. We will adapt the national model of risk detection and management (see page 7) to create an evidence based call programme focusing initially on five key conditions:

- Diabetes & pre diabetes (type 2)
- Hypertension
- Atrial fibrillation
- COPD
- Dementia (via NHS Health Checks no evidence for targeted screening)

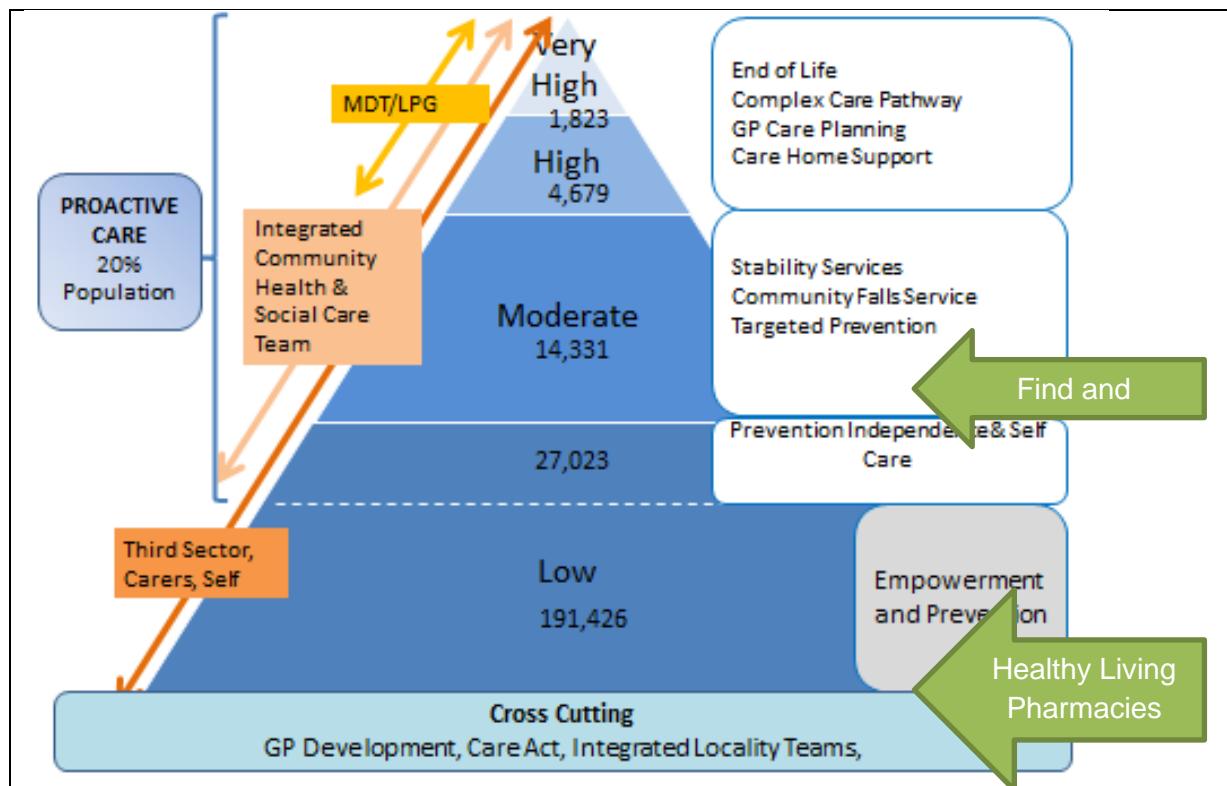
This programme will target people at higher risk of developing one of the five key long term conditions, focusing on those:

- Age 40-74 who have never had a blood pressure recording; or are a smoker without a BP reading in the last 5 years
- Age 40-74 who have never attended a NHS Health Check; or are a smoker without an attendance in the last 5 years
- Any age at risk of diabetes type 2, or with identified but unregistered non-diabetic hyperglycaemia
- Any age with a diagnosed long term condition but do not have optimised treatment using tools such as GRASP-AF
- People with a diagnosed mental health condition who smoke
- People who have not attended cancer screening opportunities

Patients can then be invited to assessment or directly referred into treat services options:

- This programme will be embedded into the core neighbourhoods model and will manage people diagnosed with conditions through the optimising primary care approaches agreed in each neighbourhood (a key element of treat).
- Through the Healthy Communities Business Case we will improve self-care management and empowerment and improve support for behaviour change in neighbourhood and community settings (via referral to START) and using tools such as the PAM (Patient Activation Model); so that patients are supported to make best use of the available assets and resources, and therefore become less reliant on GP and acute services.
- We will use this programme to establish robust referral pathways for the NHS Diabetes Prevention Programme, which goes live across Greater Manchester in April 2017. This programme offers a 12 session structured education course over several months, to people who are at high risk of developing type 2 diabetes.

This programme aims to target those at the moderate tier of care need, preventing and delaying the need for higher intervention levels. Other business cases will target those at more immediate risk.



EXTENSION 1 – GENERAL PRACTICE

The new model of care will lead to a more proactive and systematic method of identifying the population at risk in General Practice via automated searches of the practice systems using EMIS templates and search and reports. Template searches will be built or validated centrally and then practices / neighbourhoods will be supported to run these searches to identify individuals.

It is envisaged that each neighbourhood will chose their priority health need for this programme for the first year, and that a rolling programme of implementation be developed so that eventually all neighbourhoods have completed the programme. Ultimately the find and prevent approach should be embedded in to the general way of working of the neighbourhood teams, and could extend into other conditions.

In addition opportunities to improve and standardise the approaches to NHS Health Checks and opportunistic identification will be maximised, sharing good practice across Stockport and reducing variation in quality.

Once target populations have been identified, a variety of methods may be used to “treat” populations who may benefit from preventative advice. These will be tailored to levels of activation where possible and may include:

- Sending targeted literature through post, digital media or apps
- Adding alert flags to patient records so opportunistic Health Chats and NHS Health Checks can be delivered by practice or neighbourhood staff
- Inviting people to attend additional screening at Weekend Clinics – these clinics are likely to contain an **enhanced preventative element** and may include:
 - group courses such as DESMOND Walking Away from diabetes type 2 delivered by HCAs
 - enhanced NHS health checks incorporating FEV1, memory tests, cancer screening and immunisation status checks, HAD scores and additional blood test (LFT and creatinine) as well as the traditional GPPAQ, Audit C, Smoking,

- BP, Pulse rhythm and blood tests (cholesterol, HbA1C)
- these options are yet to be fully explored, and may impact capacity analysis in terms of staff need, as appointment lengths vary (group sessions = 15min per person, shorter Health Checks = 20 min, enhanced health check = 30 min)
- Inviting people to attend GP Practice review clinics (QoF)
 - Linking to the optimising primary care business case – any investment required for this is not included in this business case
- Referring people onto (included in Healthy Communities and self care business cases):
 - NHS diabetes prevention programme
 - Lifestyles and wellness services (via START and Healthy Stockport)
 - Social prescribing services (via START)
 - Patient education programmes
 - Mental wellbeing support
 - Targeted Prevention Alliance and Wellbeing and Independence Network
- Empowering people to manage their own condition and behaviours (self care).
- Exploring how people with mental health conditions are best supported to make lifestyle changes

EXTENSION 2 – HEALTHY LIVING PHARMACIES

The opportunities for identifying people through **Healthy Living Pharmacies** and linking them either directly into Healthy Communities services or into General Practices will be further developed, ensuring coverage across all neighbourhoods and into at least two thirds of all pharmacies.

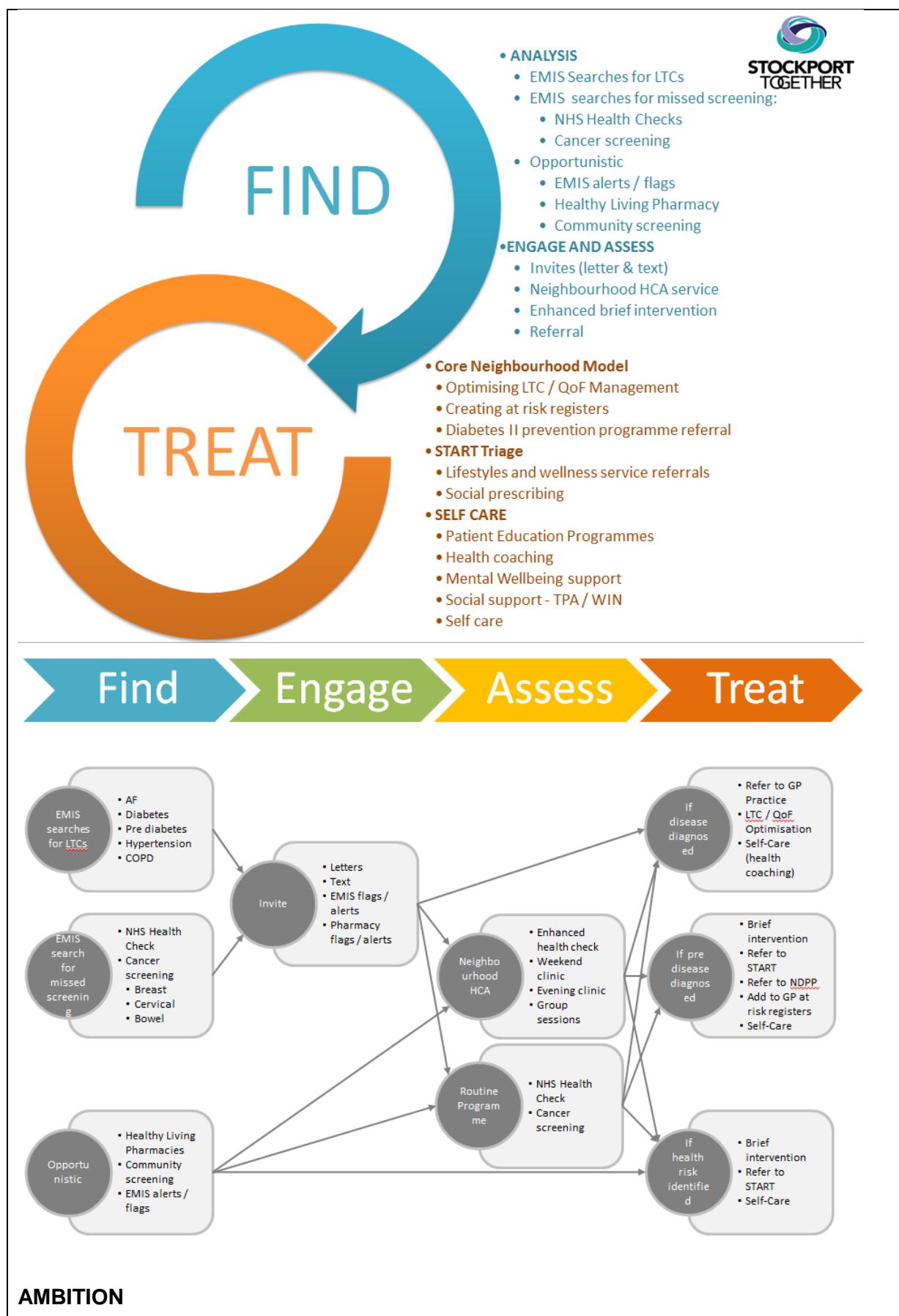
Those achieving HLP Level 2 status will be commissioned to provide a full range of Public Health Enhanced Services (PHES) including smoking cessation and will be encouraged to increase referral rates into lifestyle support services.

Healthy Living Pharmacies in each neighbourhood will be required to focus on the identified priority for each neighbourhood under extension 1; developing local pathways to maximise coverage and impact.

Healthy Living Pharmacies will also be supported to undertake clinical measurements

OVERALL MODEL

The following illustrations show the envisaged **find and prevent** model. Opportunities for identifying people through community engagement will continue to be developed through the Healthy Community business cases and links to other Core Neighbourhood and Healthy Stockport services will be a core part of all pathways.



The ambition for the programme is as follows:

Find

Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find by 2020/21
Diabetes (type 1 and 2)	14,600	5,600	2,300
Pre diabetes (type 2)	Unknown	Up to 27,150	15,000
Hypertension	43,600	11,500	4,300
Atrial Fibrillation	5,700	2,150	1,550
Dementia	2,700	1,300	750
COPD	6,700	3,700	900

Screening programme	Eligible	Not screened	To reduce by 2020/21
NHS Health Check	91,000	41,000	11,000

In total **finding 9,800 new diagnosis of long term conditions and 15,000 people at risk of type 2 diabetes** and screening an additional 11,000 people for general NHS Health Checks in the four year period.

Treat

Condition	Measure	Performance (Qof 2014/15)	To improve to, by 2020/21*
Diabetes	HbA1c ≤ 64mmol/mol	80.4%	85%
Pre diabetes	Referrals into NDPP	-	3,500^
Pre diabetes	Local offer to pre diabetics	-	3,500
Hypertension	Blood pressure ≤ 150/90mmHg	84.6%	90%
Atrial Fibrillation	Anti-coagulated	85.1%	90%
Dementia	With care plan	87.1%	90%
COPD	FEV1 recorded	82.9%	90%

* reducing variations between practices and neighbourhoods

^ NDPP for two years only

In total **improving the management of around 3,900 people** and referring 3,500 people into NDPP programme and 3,500 into local diabetes prevention support offers in the four year period.

Overall this level of ambition **aims to work with around 13,700 patients a year** (excluding double counting of pre diabetes), or 1,700 per neighbourhood; see appendix 1 for more detailed modelling.

COST OF PROGRAMME

More detail is set out in the following two sections but the overall cost of the programme is envisaged to be £962,000 for the five year period:

£000s (k)	2016/17 Yr 1	2017/18 Yr 2	2018/19 Yr3	2019/20 Yr4	2020/21 Yr5
TOTAL	26	72	292	286	286

Cost/Benefit Analysis

POSSIBLE IMPACT

National evidence as set out on pages 7-11 shows the benefit of early identification and prevention in terms of cost effectiveness (QALYs) and patient outcomes – **though it should be noted that this evidence is for the whole pathway and includes interventions included in other business cases such as self-care and optimising primary care.**

Estimating impact on local use of resources is complex. Analysis of admission data suggests that the long term conditions to be targeted by this programme account for 9% of total costs at a total of £12m; two thirds of this activity is emergency care and two thirds for the over 65s (see table below).

2015-16 Stockport registered admissions; SUS data, count of admission and sum of tariff

Primary diagnosis	Elective		Emergency		All admissions (including transfers etc.)		% of all aged 65+
	Count of admission	Sum of Tariff	Count of admission	Sum of Tariff	Total count of admission	Total sum of Tariff	
Diabetes	40	£33,634	250	£418,499	291	£452,969	28.5%
Hypertensive disease	12	£23,527	117	£128,649	129	£152,176	50.4%
Atrial Fibrillation	289	£682,425	548	£838,997	855	£1,595,639	70.5%
Ischaemic heart disease	502	£1,284,489	983	£2,869,496	1,750	£5,219,141	62.8%
Acute myocardial infarction	11	£26,781	493	£1,875,112	562	£2,114,994	65.8%
Cerebrovascular disease	22	£77,884	564	£2,223,033	648	£2,563,684	79.6%
Dementia	1		68	£9,992	71	£9,992	100.0

							%
COPD	25	£47,632	847	£1,954,834	876	£2,015,640	69.2%
All admissions	47,923	£53,114,257	40,131	£67,914,120	98,396	£132,607,821	37.5%
All admissions for key LTCs	891	£2,149,591	3,377	£8,443,500	4,620	£12,009,241	65.9%

People with long term conditions will also have activity in Primary Care, Outpatients and ED, however **costs for these services for people with LTCs are not yet possible to estimate**. For the purposes of this estimate therefore impacts are measured on inpatient admissions only.

Assuming a saving proportional to the national evidence set out in pages 7-11 sections and local modelled ambitions by 2020/21 then a **possible saving of £1.4m in admissions through Find and prevent could be realised**:

This £1.4 million has been derived by using the national evidence of the proportion of admissions which should be preventable, and then applying the percentage improvement anticipated by find and prevent (see page 17-18) to this proportion and to the total 2015/16 admission costs:

Condition	To find		To improve treatment		2015/16 Admission costs	Modelled saving on costs by 20/21	Notes
	Number	as a %	Number	as a %			
Diabetes	2,300	15.8%	670	4.6%	£452,969	£92,195	Improving /detection & management of 20%
Hypertension	4,300	9.9%	2350	5.4%	£152,176	£11,613	50% preventable by improving /detection & management of 15% therefore 15%* 50% =
Atrial Fibrillation	1,550	27.2%	280	4.9%	£1,595,639	£343,099	67% preventable by improving /detection & management of 30% therefore 30%* 67% =
Dementia	750	27.8%	80	2.9%	£9,992	£3,065	Improving /detection & management of 30% with dementia
COPD	900	13.4%	480	7.1%	£2,015,640	£27,076	10% admissions due to undiagnosed, improving /detection and management 25% of COPD therefore 25% = 2.5%
AMI	-	-	-	-	£2,114,994	£161,399	50% preventable by improving /detection & management of 15% therefore 15%* 50% =

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Other IHD	-	-	-	-	£3,104, 147	£236,8 83	50% preventable by BP, improving /detection and management of 15% of BP , therefore 15% * 50% = 7.5%	BP
CVD	-	-	-	-	£2,563, 684	£551,2 51	67% preventable by AF, improving /detection and management of 30% of AF, therefore 30% * 67% = 20%	AF
Total possible saving					£1,426, 581			

The possible phasing of this benefit could be as follows:

	17/18	18/19	19/20	20/21
% of full	0%	5%	40%	100%
Impact	0	£71,329	£570,633	£1,426,581

As a check of the reasonableness of this estimate of £1.4million, analysis of NHS Right Care spend opportunities suggests that in Stockport there is a potential £5.6 million saving to be made from admissions relating to circulation, respiratory and endocrine problems, the previous working therefore suggests that 25% of these savings could be made through prevention and early detection.

Disease area	NHS Right Care Spend area	£000 to save
Circulation problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	<ul style="list-style-type: none"> £305 £2,826
Respiratory problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	<ul style="list-style-type: none"> £642 £1,385
Endocrine, Nutritional and Metabolic Problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	<ul style="list-style-type: none"> £113 £319

RETURN ON INVESTMENT

Assuming that savings could be realised on the level of ambition within two years the following profile of spend to impact has been estimated, leaving a recurrent saving of £1.1m per annum from 2020/21 onwards.

	16/17	17/18	18/19	19/20	20/21	TOTAL
Cost	£26,000	£72,000	£292,000	£286,000	£286,000	£962,000
Impact	0	0	£71,329	£570,633	£1,426,581	£2,068,543
Net effect	-£26,000	-£72,000	-£220,671	£284,633	£1,140,581	£1,106,543

Finance

The table below shows the indicative additional costs for the programme, details to show how these have been calculated are set out below.

£000s (k)	2016/17 Yr 1	2017/18 Yr 2	2018/19 Yr3	2019/20 Yr4	2020/21 Yr5
A. Existing Service Costs	26	0	0	0	0
<i>New Spending Plan:</i>					
Healthy Living Pharmacy	24	24	24	24	24
EMIS Search and Reports	2	15	15	15	15
Call / recall consumables	0	1.875	10	10	10
Training – Walking away from diabetes	0	0	10	4	4
POC Testing x 8	0	0	56	56	56
Band 3 admin (8x 0.2 WTE)	0	6.562	35	35	35
Band 4 HCA (8x 0.5 WTE)	0	18	96	96	96
Band 6 Analysts (8x 0.1 WTE)	0	6.562	35	35	35
Band 6 project officer (1x 0.4 WTE)	0	11	11	11	11
TOTAL	26	72	292	286	286

Most of this investment is recurrent, with only the initial training budget for the HCA staff being non-recurrent.

Non workforce costs

This business case will require the ongoing funding of Healthy Living Pharmacy programme and PharmOutcomes licence. **A total of £24,000 per year.**

This business case will require the annual licencing of EMIS Search & Reports for public health, at a cost of £285 per year per practice + VAT. **A total of £14,706 per year.**

This business case will require the development of EMIS Web referral templates and pathways supported by GMSS Data Quality Team and ability for each neighbourhood team to share records. **These costs are to be met in other business cases and from existing resources.**

This business case will require a programme budget to fund the consumables for the call and recall, including postage / letters / leaflets / texts etc. **An indicative total of £10,000 per year.**

This business case will require a training budget to for the HCAs who will deliver the preventative intervention. For example DESMOND walking away from diabetes (£700 per person), NHS Health Checks (£50 per person). **An indicative total of £10,000 for the first year, with £4,000 for each subsequent year.**

This business case may require additional capacity in Public Health commissioned behaviour change services. **These costs are to be met in other business cases**

This business case may require additional capacity in clinic spaces – meeting rooms for group work and consultation space for 1:1 interventions. **These costs are to be met in other business cases.**

This business case will lead to an increase in the number of blood tests to be taken and analysed, these could be collected and dispatched to Stockport NHS FT for testing as per current procedures, however this reduces the quality of the preventative message given at the appointment and increases administration and referral times. An investment in POCT could be made, current costs are being investigated, but reviews from 2009 for HbA1C only suggested annual costs in the range of £5,919-£6,150 per machine. An indicative total (until better estimates are collected) of **£7,000 per PCOT per year**.

Buyer's guide: Point of Care testing for HbA1c. June 2009 <http://www.healthcheck.nhs.uk/document.php?o=12>

Buyers' guide: Point of Care testing for cholesterol measurement. September 2009
<http://www.healthcheck.nhs.uk/document.php?o=11>

This programme is also likely to lead to increased use of the services referred onto, and potentially increase prescribing and long term condition management requirements within General Practices. **These have not been costed in this business case, as they should be offset by increases in QoF income and savings in acute care.**

Workforce needs are as follows:

Per neighbourhood:

- 0.1 WTE for Business Intelligence Analysts based in neighbourhoods, (neighbourhood business case proposal) (**new resource**)
- 0.2 WTE for administrative staff to manage call and recall in neighbourhoods (neighbourhood business case proposal) (**new resource**)
- HCA led preventative clinics at Weekend General Practice – 0.3 HCA per neighbourhood (see below for modelling) (**new resource**)
- HCA led preventative clinics at weekday General Practice – 0.2 HCA per neighbourhood (see below for modelling) (**new resource**)
- Support and governance from neighbourhood leadership team (**existing resource**)

Centrally:

- 0.2 WTE for Specialist Public Health Business Intelligence Analysts, LA (**existing resource**)
- 0.4 WTE for Data Quality Officers, GMSS (**existing resource**)
- 0.4 WTE for Primary Care Engagement Officer (**existing resource**)
- 0.4 WTE for project officer (**new resource**)

Phasing for 17/18

It is proposed to phase the roll out of find and prevent, so that the first six months of 17/18 are focused on continuing the implementation of the Healthy Living Pharmacy and in developing the modelling with EMIS search and reports. Over this period the NHS diabetes Prevention Programme will also be rolled out across two neighbourhoods, enabling further testing of the model.

The full programme will go live in two neighbourhoods in October 2017, a further two in January 2018 with extension to the final four neighbourhoods in April 2018. The programme will then run for the three years 2018/19 -2020/21.

This phasing leads to a 17/18 cost of £72,000, 25% of the total annual spend; with:

- £39,000 needed in April 2017
- £22,000 needed in October 2017 (or access to staffing resource of similar value)

- £11,000 needed in January 2018 (or access to staffing resource of similar value)

Find and prevent	Posts (fte)	Grade	2017-8	Spend start	Comment
Healthy Living Pharmacy			£24,000	Apr-17	Continue current programme
EMIS Search and Reports			£15,000	Apr-17	Develop find modelling
Band 3 admin (8x 0.2 WTE)	0.4	Band 3	£8,750	Oct-17	Go Live in 2 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	1	Band 4	£24,000	Oct-17	Go Live in 2 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.2	Band 6	£8,750	Oct-17	Go Live in 2 neighbourhoods
Call / recall consumables			£2,500	Oct-17	Go Live in 2 neighbourhoods
Band 3 admin (8x 0.2 WTE)	0.4	Band 3	£8,750	Jan-18	Go Live in further 2 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	1	Band 4	£24,000	Jan-18	Go Live in further 2 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.2	Band 6	£8,750	Jan-18	Go Live in further 2 neighbourhoods
Call / recall consumables			£2,500	Jan-18	Go Live in further 2 neighbourhoods
Band 3 admin (8x 0.2 WTE)	0.8	Band 3	£17,500	Apr-18	Go Live in final 4 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	2	Band 4	£48,000	Apr-18	Go Live in final 4 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.4	Band 6	£17,500	Apr-18	Go Live in final 4 neighbourhoods
Call / recall consumables			£5,000	Apr-18	Go Live in final 4 neighbourhoods
Training – Walking away from diabetes			£10,000	Apr-18	Enhance programme
POC Testing x 8			£56,000	Apr-18	Enhance programme
Band 6 project officer (1x 0.4 WTE)	0.4	Band 6	£11,000	Apr-18	Cover by self care programme lead until Apr-18
Find and prevent Total			£292,000		

Contractual Arrangements

The only procurement requirements are for **EMIS Search and Reports**, an existing contract is in place for 7 practices already and procurement under normal STaR business procedures will be undertake to extend to all practices.

There are already existing contracts in place for NHS Health Checks and cancer screening programmes.

It is not intended that this programme will directly employ staff, instead these would be woven into the wider neighbourhood model and staff time allocated to the programme – most likely with a lead GP practice or by each neighbourhood or by SNHSFT as part of the neighbourhood based community services team. The programme manager will be employed by the Council within either the Public Health team, Corporate Support Services or the Stockport Together Programme management team.

For point of care testing discussions with the neighbourhood teams about the options, in discussion with SNHSFT Point of Care Testing Coordinator.

Implementation Plan

As detailed in the model above it is planned to implement Find and prevent in a phased approach across neighbourhoods. The recent announcement of the NHS Diabetes Prevention Programme has led to this becoming the highest priority, as we now have a two year window to make maximal use of the service offer.

Current plans (subject to engagement with primary care) are to:

- Roll out the National Diabetes Prevention Programme on a neighbourhood basis,
 - starting with Victoria as this has best levels of NHS Health Check, a number of practices piloting DESMOND and a significant deprived and BME community (i.e. more people at risk)
 - second neighbourhoods to be Cheadle & Gately
- Work with selected pharmacies and GP Practices to pilot the more general find and prevent model for Atrial Fibrillation

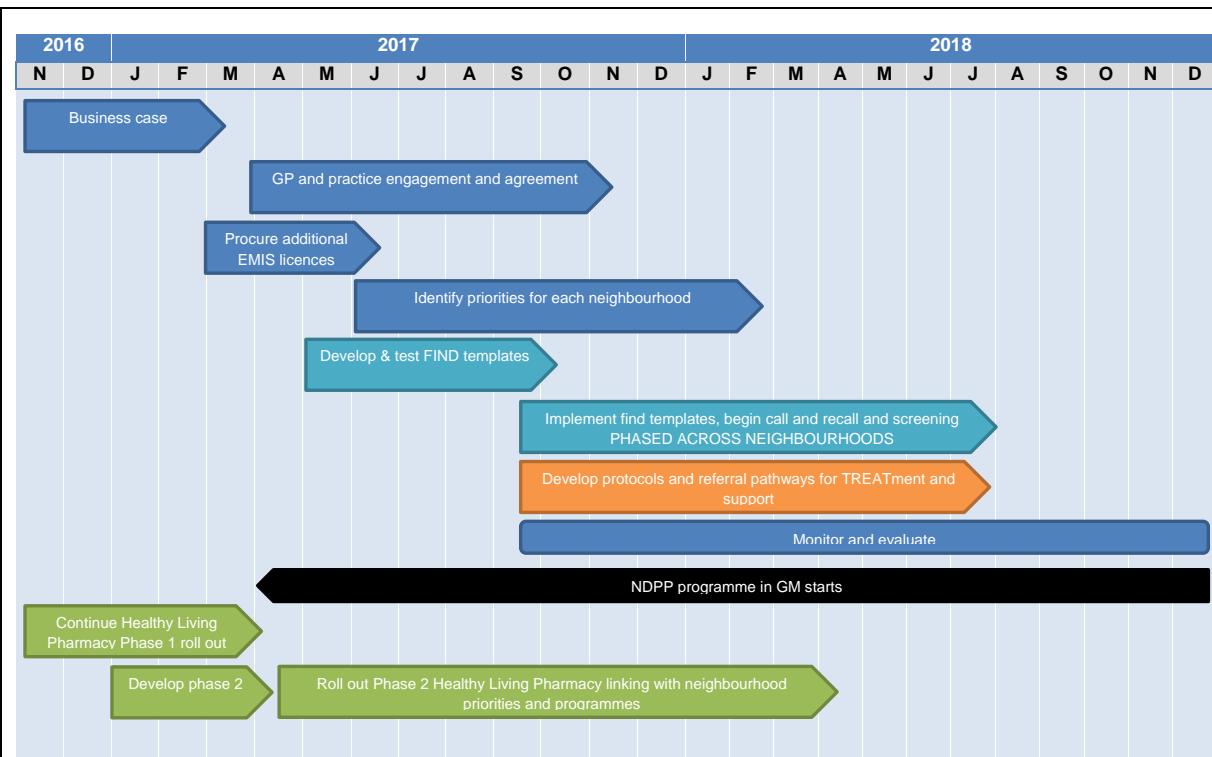
The full find and prevent programme will go live in two neighbourhoods in October 2017, a further two in January 2018 with extension to the final four neighbourhoods in April 2018. The programme will then run for the three years 2018/19 -2020/21. Decisions about the phasing of neighbourhoods are likely to be made in August 2017, in consultation with Primary Care.

In the meantime all neighbourhoods will be supported to improve **the quality of the NHS Health Check** process and onward referral and supported with **cancer screening**; as these programmes are already running within the neighbourhoods.

Healthy Living Pharmacies will continue to implement phase 1 and the achievement of objectives and outcomes will be monitored. Engagement with Pharmacies and neighbourhood teams will identify the phase 2 approach which will include the integration of pharmacy Enhanced Services and extension into other primary care settings.

This business case assumes that a 0.4 WTE Band 6 project officer will support the roll out from April 2018 onwards under the leadership of the existing Early Intervention and Prevention lead in Public Health. During 2017/18 the self-care programme lead will cover this implementation work as well as the self care programme.

An indicative timeline is included below:



RISKS

RISK	Mitigation
Primary care capacity to manage this additional programme and activity <ul style="list-style-type: none"> Support for the call and recall and the initial identification are costed into this model, but may rely on existing staff and expertise as well, More particularly the on-going management of patients identified with disease or at risk of disease are likely to increase activity. Many of these patients will require at least an annual review following diagnosis. 	<ul style="list-style-type: none"> Risk acknowledged and capacity for optimising primary care built into wider core neighbourhood model. Ongoing monitoring of impact throughout implementation
Variations in primacy care coding practices and quality <ul style="list-style-type: none"> This programme relies on the analysis of patient records to initially identify target patients. Outside of core QoF measurements, or other programmes where READ / SNOMED codes are specified it is likely that each GP Practice will have their own coding conventions which will mean queries will need to be written to cover a range of options. Some practices may not code and may rely on written notes. 	<ul style="list-style-type: none"> By purchasing EMIS Search and report six months prior to go live it is hoped to understand the impact of this risk, and put in place mitigating actions. Liaise closely with GMSS data quality team

<ul style="list-style-type: none"> In some practices this may mean that the volume of patients identified is lower than expected 	
<p>Patients not engaging with prevention in other words low take up</p> <ul style="list-style-type: none"> Cancer screening and other preventative services are seeing a reduction in the proportion of patients who accept invitations to attend services. There is a risk that the capacity provided for prevention will not be utilised to its full extent. A further risk is that those who take up the offer are likely to be the engaged population, and that without effective targeting this programme risks increasing health inequalities 	<ul style="list-style-type: none"> Targeting and considering inequalities at the outset of this programme Embedding patient activation wherever possible Using social marketing and other behavioural insights in a targeted way The programme will be monitored closely and implementation varied to meet the needs of local populations. New approaches to support people with mental health issues
<p>Increased activity for prevention as a contrast to the above risk:</p> <ul style="list-style-type: none"> if more patients than expected take up provision there is a risk that existing services will not be able to meet demand. 	<ul style="list-style-type: none"> Risk acknowledged and capacity for self-care built into healthy communities model. Ongoing monitoring of impact throughout implementation

Appendix 1

CAPACITY / ACTIVITY MODELLING FOR HCA WORKFORCE

To assess the likely capacity need for HCAs to deliver find and prevent, the ambitions described in section 9.3 have been modelled into a one year impact so that an anticipated workload can be estimated:

FIND Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find by 2020/21	To find in year 1
Diabetes	14,600	5,600	2,300	575
Hypertension	43,600	11,500	4,300	3750
Atrial Fibrillation	5,700	2,150	1,550	1075
Dementia	2,700	1,300	750	390
COPD	6,700	3,700	900	190
SUB TOTAL new cases of disease			9,800	2,455
Pre diabetes	Unknown	Up to 27,150	15,000^	7,500
SUB TOTAL new diabetes at risk			15,000	7,500
NHS Health Check	50,000	41,000	11,000	2,750
SUB TOTAL new health check			11,000	2,750
TOTAL FIND			35,800	12,705

TREAT Condition	Measure	Performance (Qof 2014/15)	To improve by 2020/21	Number of people to improve in 4 years	Number of people to improve in 1 year
Diabetes	HbA1c ≤ 64mmol/mol	80.40%	85%	670	170
Hypertension	Blood pressure ≤ 150/90mmHg	84.60%	90%	2350	590
Atrial Fibrillation	Anti-coagulated	85.10%	90%	280	70
Dementia	With care plan	87.10%	90%	80	20
COPD	FEV1 recorded	82.90%	90%	480	120
SUB TOTAL improved management				3,860	970
Pre diabetes	Referrals into NDPP	-	3,500	3,500^	1,750
Pre diabetes	Local offer to pre diabetics	-	3,500	3,500	875
SUB TOTAL diabetes prevention				7,000	2,625
TOTAL TREAT				10,860	3,595

[^] 2 years

TOTAL FIND AND PREVENT (removing pre diabetes duplicates)	39,660	13,675
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Taking this anticipated workload of 13,675 interventions as a starting point the following table models through the required WTE if a 20 minute appointment was used:

20 minute appointments	Total per annum for ST	Per neighbourhood
Number of people to see	13,675	1,710
Fraction of hour per appointment	0.4	0.4
No hours needed	5470	683.75
No hrs /day in clinical time	6	6
No days required per year	912	114
Working days per week	5	5
No weeks	182.3	22.8
Working weeks/yr	50	50
WTE needed	3.6	0.5

At 20 minutes per appointment therefore the Find and prevent programme requires 0.5 HCA per neighbourhood. With the pattern of neighbourhood weekend working to be decided, it is estimated that 0.3 to be delivered at the weekend (2 Saturday sessions, 1 Sunday) and a further 0.2 during the week, although this balance is to be confirmed.

If 30 minute appointments were needed (depending on the offer given) this rises to a requirement of 0.6 WTE per neighbourhood, however use of group sessions at 15 minutes per person would reduce this to 0.3 WTE per neighbourhood. An average of 20 minutes has been used as the best proxy.

SERVICE AREA:

PHARMACY LED REPEAT PRESCRIPTION MANAGEMENT

Component	Description
Current. Brief description of existing services (i.e. how many sites, how many staff, functions, opening hours , capacity). (NUMBERS)	<p>Currently individual practices do this with varying methodology, i.e. from over 40 sites involving well over 200 staff and GPs. It takes up a significant amount of time for administrative and GP staff. In an average practice a GP spends at least an hour a day authorising prescriptions and a similar time dealing with queries. At least 1 FTE is needed to produce the prescriptions for a GP to authorise. Services operate usually Monday to Friday in core and extended hours.</p> <p>In addition to this GPs and practice nurses spend a huge amount of time reviewing medication. The current call and recall systems for medication review and therapeutic monitoring are not robust leading to the potential for negative impacts including drug related admissions.</p>
Problems & Opportunities: What could change – 2 sentences	<p>The current system leads to significant waste, higher prescription spend and potential poor outcomes or admissions.</p> <p>There is an opportunity to centralise prescription management with benefits from working at scale , using clinical staff alongside non-clinical staff to manage repeat prescriptions, provide medication reviews and ensure therapeutic monitoring.</p>
New service: What people, what processes, what use of technology, what additional capacity, what functions, clinical / professional governance (NUMBERS)	<p>A pharmacist led neighbourhood prescription management and optimisation service is being developed</p> <p>Prescription requests would be accepted by telephone or electronically using trained medicines co-ordinators based on a system tried and tested in Coventry.</p> <p>Staffing required is:</p> <p>40 FTE band 3 staff some of which may be recruited from existing practice staff.</p> <p>Technicians (20 FTE band 5 staff) would train and support these staff and deal with prescription and patient queries. Provide enhanced support to care homes to manage medicines and support GPs on care home ward rounds. Handle outpatient and discharge communications to process medication changes safely. They would also manage a robust call and recall system for therapeutic monitoring.</p> <p>Pharmacists (20FTE band 7) would authorise prescriptions, provide medication reviews, including home visits for housebound patients.</p> <p>The team would be managed and supported professionally by senior pharmacists 10FTE band 8a.</p> <p>The professional governance would be provided by an enhanced management team who would oversee the service and provide the operational work of the current provision.</p> <p>The service would be organised on a neighbourhood basis and the 8a pharmacist would have a direct relationship with the neighbourhood lead GP. The resilience of the service would be provided by neighbourhoods supporting each other in the event of sickness, leave tec.</p>

7 day service – describe the extent to which service offer is over 7 days and links where appropriate to 7 day services – GP or otherwise	The service would operate between 8am and 8pm on weekdays and offer a reduced service on Saturday and Sunday mornings when the out of hour's service receives a significant number of medication related calls.
Benefits: What will it deliver in terms of outcomes, benefits to population, and efficiency improvements (Cash & time) (NUMBERS). What evidence is the basis of this (<i>National evidence, Local pilots, Assumptions</i>)	Benefits are as follows when fully implemented: GP capacity released. Estimated value at £3 million based just 10 minutes per year per patient for managing prescriptions/ meds queries plus completing meds reviews. Evidence from this and NHS Alliance (http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf ,) Reduced number of prescription items (estimate an 8% reduction over current levels when the service is fully operational. Based on the work in Walsall (http://arms.evidence.nhs.uk/resources/qipp/1040169/attachment) and Coventry. Value £500k in dispensing fees plus circa £1.5million in drug costs Reduced spend on primary care prescribing (to below the England average). Improvements to therapeutic monitoring leading to reduced medication related admissions. National estimate is 10% of admissions are meds related, Assumption a 2% reduction in this. Increased use of patient on line for making requests to achieve the target of 20% Released capacity from out of hour's provision as the service deals with meds queries. Improved patient satisfaction – evidence from national pilot practice based pharmacists. Increased use of Repeat Dispensing, Patient online and EPS in line with national targets. Demonstrating we are implementing the 5 year forward view. Reduced costs to NHSE in disposing of waste meds Reduced medication related safeguarding incidents in care homes. Increased use of shared care for medicines releasing FT staff time from managing meds which could be provided in the community.
Costs: What will it cost and how was this derived? (Staffing, technology, start-up non-recurrent and recurrent)	The service integrates the current CCG team and some cost may be covered by the NHSE Phase 2 pilot funding for practice Pharmacists. Total additional staff cost £2.5m Funding from NHSE pilot for pharmacists (if successful) It is anticipated premises will be available from the current estate and a number of potential sites have been identified. Costs associated with supportive infrastructure and delivered through the enabler plan.

ALLIED HEALTH PROFESSIONALS (AHP) IN STOCKPORT

Business Case: To determine the role of AHP's as part of the Multi-Disciplinary Teams within the neighbourhood offer

Aim:

To ensure AHP resource is recognised and included in the evolving eight neighbourhood teams. To identify 'gaps' in current capacity and calculate what is required to meet the need of the population cohorts. To align with the aims and objectives specified in the broader neighbourhood business case.

Introduction:

The transformation of Stockport's Health and Social Care system aims to significantly shift activity from secondary to primary and community care. This will mean fundamental change in the provision of some of the current AHP services. A culture of multi skilled healthcare professionals working together as a multidisciplinary team (MDT) to provide pathways of care.

Who are Allied Health Professionals (AHP's)?

Allied health professionals (AHP's) are a diverse group of healthcare professionals. They work across a wide range of locations and sectors in acute, primary and community care. Operating across the holistic pathway of care they provide prevention, assessment, diagnosis, treatment, recovery, maintenance and palliation. AHP's will play an essential role in the integrated MDT neighbourhood offer.

National Context:

Allied Health Professionals (AHP's) make up 6% of the NHS workforce and are the third largest workforce in health and social care in England.

Supporting Case Studies:

Below are two examples of patient case studies.

Example Case Study 1

As someone with an array of long term conditions, I have personally experienced and benefitted from the knowledge and expertise of many caring allied health professionals including prosthetists, orthotists, physiotherapists, occupational therapists, radiographers and dietitians. Whilst these individual professions seem distinctly different in the skills they possess and the services they provide, they share many common goals, including trying to keep people mobile, independent, dexterous and out of hospital. So as someone who continues to benefit from the mobility and independence afforded to me, I feel it can only be to the benefit of all that these opportunities are shared and made as widely accessible as possible.

Steve McNeice - Expert by experience
Centre for Workforce Intelligence
March 2013

Example Case Study 2

I had a case whereby the proactive AHP resource was very helpful. Their ability to visit in a timely fashion and sort out equipment needed meant that this lady could be supported at home and maintain her independence without the need for home care or more costly interventions. Originally I tried to refer to the EAAT team but they were not able to treat the case as high priority. Therefore without proactive AHP resource in our team it would have taken over a week or two rather than the quick response we had for this lady who was high risk of falls.

Having proactive AHP resource in the office is very valuable if we are truly aiming to be integrated with health colleagues as her expertise and willingness to joint work is improving our service as a whole to Bramhall and Cheadle neighbourhood.

Janet Bradbury – Interim Principal Lead (West Localities)
Stockport

The scope of Phase 1 of this Business Case (as below):

Allied Health Profession	In Scope (Phase 1)	Out of Scope
Physiotherapy – Inpatient / Outpatient / Primary Care**/ Community	✓	
Dietetics –Community / Inpatient / Outpatient	✓	
Occupational Therapy –Community / Inpatient / Outpatient	✓	
Chiropody / Podiatry	✓	
Speech & Language Therapy (SALT) – Community / Inpatient / Outpatient	✓	
Orthoptists		✓
Radiographers – Diagnostic / Therapeutic		✓
Paramedics		✓
Prosthetists / Orthotists		✓
Osteopaths		✓
Operating Department Practitioners (OPD's)		✓
Therapies – Music / Drama / Art		✓
Intermediate Tier aligned therapy services *		✓
MSK Direct Access Physiotherapy (Primary Care) **		✓
Falls Service ***		✓

* **The Intermediate Tier business case addresses the specific needs of any aligned therapy services**

** **The Transformed Primary Care resource associated with the ‘direct access physiotherapy pilot’ (Marple & Bramhall) will not be included in the scope of this business case.**

*** **Falls Service is called Steady in Stockport and is a separate programme within the Neighbourhood Business Case.**

Further break down of the AHP roles within the scope of Phase 1 of this Business Case can be viewed in Appendix A including general details of service delivery by person cohort and setting.

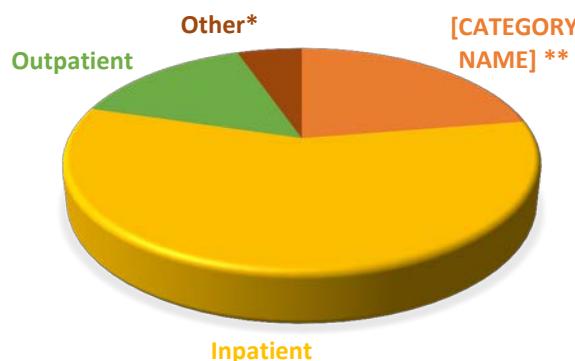
Current Position:

Current AHP resource in Stockport is summarised below. A more detailed breakdown of this resource can be found in Appendix B.

Allied Health Service	Current FTE	Current Cost
Dietitians (94% Qualified)	15.85	£ 544,800
Occupational Therapists * (69% Qualified)	71.91	£ 2,642,019
Physiotherapists (84% Qualified)	124.45	£ 4,769,200
Podiatrists (100% Qualified)	20.76	£ 844,400
Speech and Language Therapists (85% Qualified)	12.05	£ 391,700

*Data includes SMBC staffing. Note that SMBC staffing operates on 55% qualified ratios.

CURRENT DISTRIBUTION OF AHP RESOURCE (FTE)



*Patient education
(Dietetics and CD Physio;
Occupational Health; Cardiac rehab; T&O; EPR;
Uro-dynamics (Physiotherapy).

** community data based on health staffing only

Currently the majority of AHP resource is operating in a hospital setting. As part of the implementation phase of this programme we aim to redistribute some of this resource into a community setting in accordance with the needs of the population. The exact % of redistribution of resource will be calculated as part of the implementation phase of this programme and in conjunction with the Outpatient's Business Case removal of activity from the hospital setting. The focus will be on prevention, self-management and treatment within a home or community setting with AHP's as part of a community multi-disciplinary team.

There are two population cohorts to be considered in this phase: Frailty and Musculoskeletal

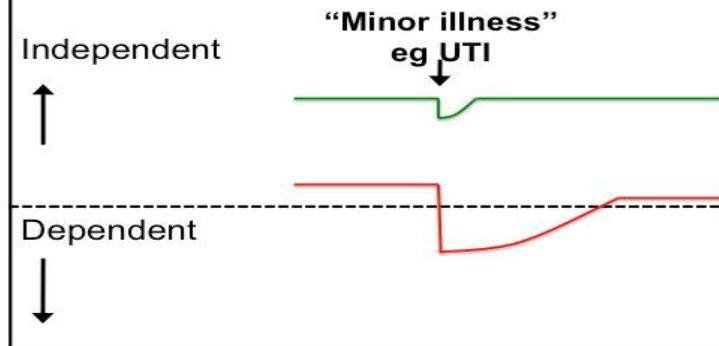
Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an

apparently minor event which challenges their health, such as an infection or new medication.

Loss of Physiological Reserve Model

FUNCTIONAL ABILITIES



1

The eFrailty Index (eFI) counts deficits (symptoms, signs, disease or disability). The greater the deficit the greater the loss of physiological reserve.

eFI uses the cumulative deficit model of frailty. The eFI comprises thirty-six deficits, constructed using around 2,000 primary care clinical codes (Read codes). The eFI calculates a frailty score by dividing the number of deficits present by the total possible. The score is a robust predictor of those who are at greater risk of adverse outcomes (e.g. long-term care and mortality).

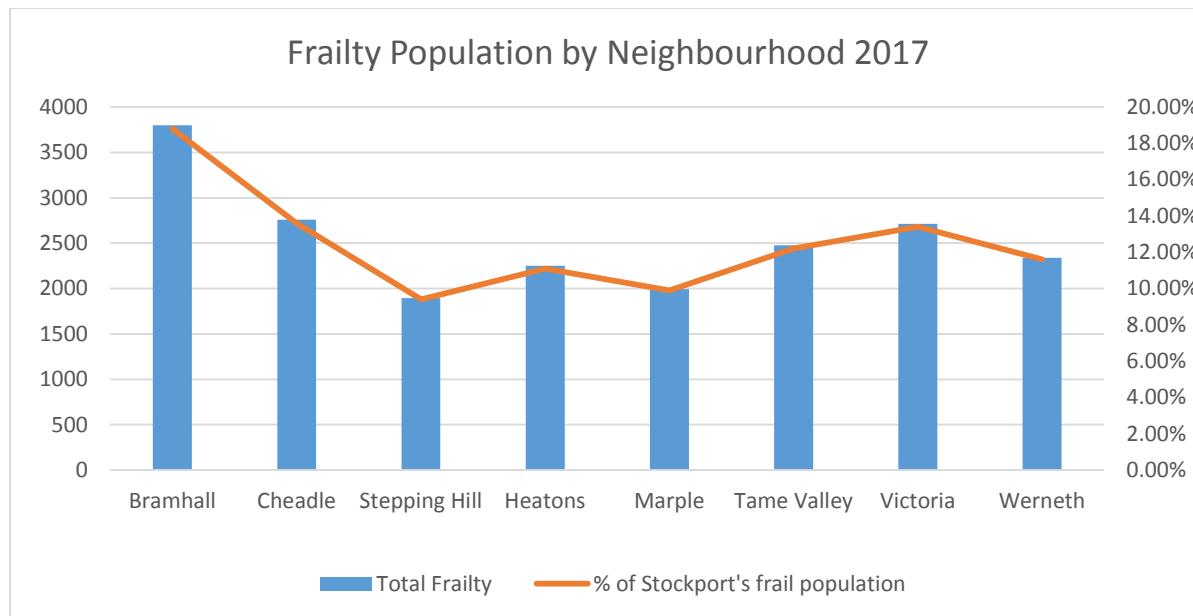
Below shows the 91% of Stockport registered patients over the age of 65 years. As at January 2017, there were 53,000 people aged over 65 years of which, 48,000 have an eFI score recorded.

Stockport's eFrailty Index (>65's)

eFI Score	Definition	Stockport As at January 2017	
		%	Number
0-0.12	Fit - People who have no or few long-term conditions that are usually well controlled. This group would be mainly independent in day to day living activities.	58%	28,000
0.13-0.24	Mild Frailty - People who are slowing up in older age and may need help with daily living, such as finances, shopping, transportation.	33%	16,000
0.25-0.36	Moderate Frailty - People who have difficulties with outdoor activities and may have mobility problems, such as washing and dressing.	8%	4,000
>0.36	Severe Frailty - People who are often dependent for personal care and have a range of long-term conditions/multi-morbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6-12 months.	1%	500

Frailty population broken down between the neighbourhoods as below:

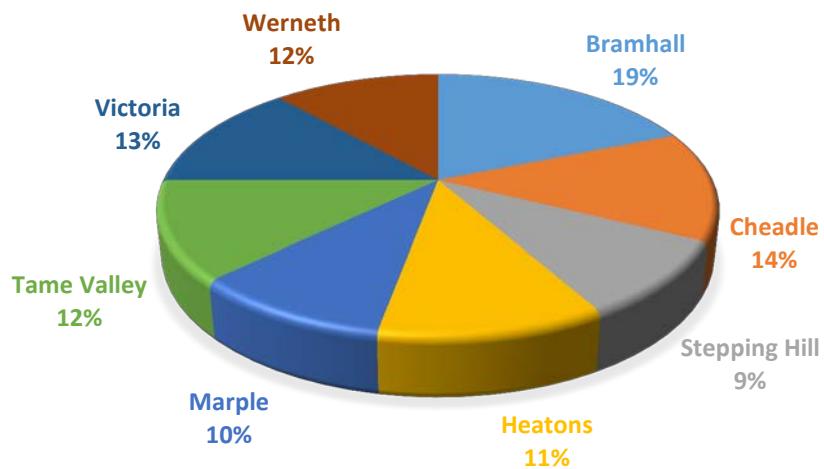
¹ Clegg, Young, Iliffe, Olde-Rikkert & Rockwood, Frailty in Elderly People - Lancet 2013; 381: 752-762)



The chart opposite shows the distribution of AHP resource required to meet the **frailty needs** of the eight areas identified within the Neighbourhood Business Case.

this will be viewed alongside neighbourhood data on population size, condition prevalence, and risk of admission when allocating AHP resources to neighbourhoods.

% TOTAL AHP RESOURCE ALLOCATION BY NEIGHBOURHOOD BASED ON FRAILTY



Musculoskeletal

The national evidence is that 20% of GP Consultations are for musculoskeletal conditions and, that 70% of this activity could be managed safely and effectively by a Physiotherapist².

The current Primary Care Physiotherapy service sits within the Diagnostics and Clinical Support Services Business Group. The service is delivered across all eight neighbourhoods. Waiting time for a first appointment was 8 weeks in December 2014 (lowest recorded

² (*Physio First, West Wakefield, NHS England 10 High Impact Actions, Case Study 104*)

available). Waiting times have shown a steady increase and are currently at 12 weeks (December 2016).

There is growing national evidence that moving from a GP referral model (current) to a self-referral model is a safe and cost effective model of delivery. There is no evidence that it creates a 'surge' in demand unless there is already unmet need. It has been shown that self-referrers need fewer appointments and will seek treatment sooner with minor problems preventing more chronic conditions developing. A self-referral model encourages individual empowerment, self-management and the aim of treating people in their own home or community setting.

Compared with the national average, the current Stockport Primary Care Physiotherapy service has a shortfall of 8.4 FTE staff. However, any proposals relating to investment in MSK physiotherapy must be viewed in conjunction with significant aligned investment in MSK physiotherapy within the Transformed Primary Care element of the business case.

Proposed model

MSK within the neighbourhood would be accessed directly to provide initial triage and direct activity as appropriate; Urgent contact / non-urgent contact / virtual contact / referral for medical opinion. Intervention provided will be either; direct (with a physiotherapist) / indirect (exercise programme, including on-line applications) / advice and guidance only / review and/or discharge.

It is proposed that additional investment through this business case into MSK physiotherapy will primarily support the delivery of longer term direct physiotherapy treatment (identified through own service or Transformed Primary care offer), and MSK physiotherapy support to complex patients receiving enhanced case management from the neighbourhood teams.



Current Position Summary:

There is currently a lack of consistency within and across service provision in relation to patient – centred pathways. This is due to poor communication and coordination across services.

A proportion of AHP services operate integrated pathways across both acute and community settings providing comprehensive care for specific conditions, whilst others operate exclusively in the community or other settings creating the risk of duplication and multiple patient attendances.

AHP services are currently operating with different skill mixes and bandings for potentially similar functions.

There is a need to review the current configuration of AHP services and to make the case for

change to optimise the delivery of patient centred care at neighbourhood level.

Future Model:

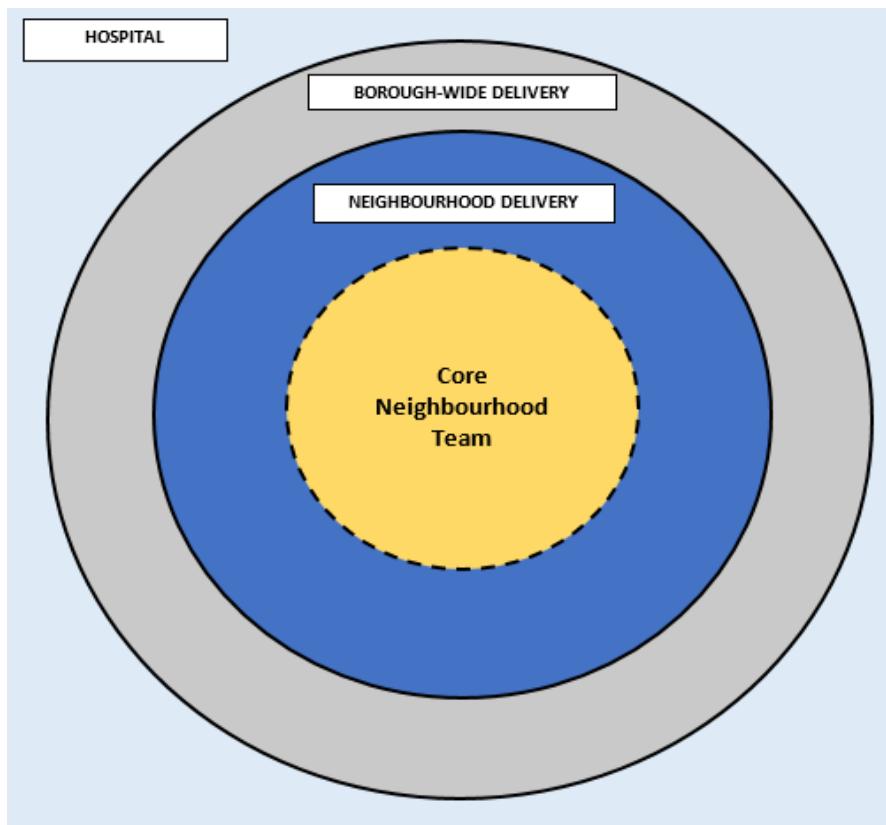


Diagram 1 below provides a visual outline of the proposed future model for delivering borough-wide and neighbourhood services within which AHP services sit as part of the MDT.

There is clearly an opportunity to unlock a huge resource for the benefit of the patient and public, and particularly in the area of early intervention and prevention.

Public Health England. 2014

The guiding principles for the above model are that the service will be:

- Centralised within the community
- Deployed across the health and social care system
- Delivered as close to home as possible

Design focus for AHP services:

Below outlines the initial guiding principles to be considered in determining the configuration and delivery of future AHP services as part of a multi-disciplinary team within the neighbourhood offer:

- AHP services delivering 'in-reach' from the community into hospital as standard ensuring a seamless pathway and continuity of care for patients.
- AHP services focussing on the most complex cases as part of an MDT within the neighbourhoods to manage care closer to home (specialist advice & guidance, and rapid access to assessment and treatment where required)
- Neighbourhoods having the right capacity and capability to provide person-centred care and enhanced case management in accordance with neighbourhood needs
- AHP services focussing on prevention and self-management to deflect unnecessary

activity from GP / Acute/ longer term social care settings.

- Using technology to enable alternative methods of delivery and improve efficiency.

Proposed AHP Delivery Model:

Proposal	Benefits
The AHP resource is centralised within the community	<ul style="list-style-type: none"> ➤ Consistent patient pathways ➤ Optimise resilience ➤ Maximise opportunity for skill mix and cross cover, building on existing examples of good practice ➤ Enable interdisciplinary assistant practitioner / support worker roles ➤ Provide clear, effective management structure ➤ Clarify roles and responsibilities ➤ Reduce duplication of service creating a more efficient patient pathway ➤ Ensure consistent banding of staff ➤ Enable sufficient, flexible capacity to deliver over extended operating hours as required by model.
AHP resource is deployed across the health and social care system, including in-patients	<ul style="list-style-type: none"> ➤ A more reliable service for patients ➤ Flexibility ➤ Capacity consistent with demand ➤ Target priority areas ➤ Enable shift in resource as activity transfers from secondary care
AHP resource is delivered as close to home as possible	<ul style="list-style-type: none"> ➤ Patient get the right care in the right place at the right time ➤ Default is delivery in neighbourhood unless valid clinical reason for other location ➤ Enables virtual/actual MDT working with core teams, including skills sharing

Current State

Benchmarked average

Row Labels	Sum of FTE	% workforce	Row Labels	Sum of NEW FTE	% change	% of workforce
Community	44.4	19%	Community	56.9	28%	24%
Dietician	2.11		Dietician	6.3		
OT	2.6		OT	2.6		
Physio	18.93		Physio	27.3		
Podiatrist	20.76		Podiatrist	20.8		
Inpatient	113.37	50%	Inpatient	113.4	0%	47%
Dietician	10.65		Dietician	10.7		
OT	34.67		OT	34.7		
Physio	56.76		Physio	56.8		
SALT	11.29		SALT	11.3		
Outpatient	29.72	13%	Outpatient	29.7	0%	12%
Dietician	1.7		Dietician	1.7		
OT	4.26		OT	4.3		
Physio	23.2		Physio	23.2		
SALT	0.56		SALT	0.6		
Intermediate Tier	30.54	13%	Intermediate Tier	30.54	0%	13%
Dietician	0.2		Dietician	0.2		
OT	13.88		OT	13.88		
Physio	16.26		Physio	16.26		
SALT	0.2		SALT	0.2		
Other	10.49	5%	Other	10.49	0%	4%
Dietician	1.19		Dietician	1.19		
Physio	9.3		Physio	9.3		
Grand Total	228.52	100%	Grand Total	241.07	5%	100%

INVESTMENT REQUIRED

The investment in AHP's totals £587k. It is proposed that £294k is released in 2017-18, which represents 50% of the total.

Provisional proposals for the investment are as follows. These aim to bring AHP provision up to benchmark, where appropriate. However it should be noted that current benchmarking relates to existing models of reactive care, and also only includes health staffing data. Therefore further analysis in the context of a proactive model of neighbourhood care is required to ensure that AHP investment reflects the needs of the neighbourhoods. These proposals must also be viewed alongside significant additional investment into MSK Physiotherapy within a transformed primary care offer.

DESCRIPTION	INVESTMENT	WORKFORCE		BENEFITS
		Now	Future*	
Physiotherapy	395k	124.45	128.45	Reduce waiting times**; Enable release of GP capacity for MSK conditions;

Opposite outlines the proposed 28% increase in AHP resource in Stockport community based provision to ensure we are operating in accordance with the national average.

Note that this benchmarking data will require further review for accuracy and relates to existing models of care, and only includes health staffing data.

A benchmarking exercise is currently underway to address this issue.

Occupational Therapy / SaLT		83.96	88.36	Reduce waiting times Enable faster throughput of enhanced case management offer Reduction in longer term packages of home care N'hood contribution to falls reduction pathway
Dietetics	193k	15.88	20.05	Reduce waiting times Frailty is often associated with malnutrition. Malnutrition increases susceptibility to disease, impairs clinical outcomes and increases healthcare use and costs. Dietetic input is vital in resolving malnutrition.

***Estimates based on fully qualified workforce increases. Further increases in FTE again investment are anticipated as understanding of new skill mix options are explored.**

****See table 5 below for potential waiting list impact**

(Based on Primary Care Physiotherapy – 2016-17 year to date)

Patients with a 'Primary care physio' referral, but no activity	3124
Additional physio FTE	4
Caseload (Benchmarked average)	201.78
Cases immediately removed from list**	1684.863
Remaining wait list **	1439.137
Reduction in waiting list	-54%

If we employ 4 physios today and gave each a 'benchmarked average' caseload size, alongside aligned investment in Transformed Primary Care physio access, then we could achieve a reduction in the waiting list of up to 54%.

****Including impact of aligned investment in Transformed Primary Care physio access**

Next Steps:

In order to develop the implementation stage of this programme a number of actions have been identified:

- Further analysis of benchmarking and pilot data to ensure investment reflects needs of proactive model of neighbourhood care, and makes best use of investment in alignment with benefits outlined in Transformed Primary Care AHP plans.
- Clarification of the current MSK & Frailty pathways including access, resource, gaps,

blockages, duplication of activity. Where support currently sits on the pathways to determine an accurate and informed current position to enable efficient and sustainable transformation supported by all affected parties. This will be achieved through process mapping activity, workshop events and other change management tools as appropriate.

- To develop clear Terms of Reference for the implementation phase of the programme focussed on improving patient pathways, patient experience and providing a neighbourhood offer in line with the needs of the population with emphasis on prevention, self-management (advice and guidance), providing treatment in the home/community setting and reducing unnecessary GP / Acute activity.
- Governance plan - to include a robust centralised management structure, clear project plan with monitored milestone activity, risk analysis, roles and responsibilities. Use key performance indicators to evaluate progress, improvement and adjustments to the milestones as necessary in line with a flexible Agile approach.
- Communications strategy – to include staff engagement activity and regular, relevant updates of information to all parties involved in the programme. This will aid the cultural change aspect of the programme which is recognised as a significant contributor to the success of the programme.
- Resource – Upskilling, cross cover, rotation, training opportunities to be explored to enable a successful and effective multi-disciplinary team culture within the neighbourhood teams. Ensure the right capacity and capability is available in the right place at the right time. Such work will also provide a consistency of skill mix across the system, based on patient needs rather than historical practice and a greater use of unregistered workforce (AfC Band 4 or below) will be incorporated into the future model.
- To research best practice and shared learning and action where appropriate.

Appendix A: Brief summary of Phase 1 Allied Health Professions service delivery by person cohort and location.

AHP:	Examples of service delivery person cohort:	Examples of service delivery settings
Physiotherapy	<ul style="list-style-type: none"> neurological (stroke, multiple sclerosis, Parkinson's) neuromusculoskeletal (back pain, whiplash associated disorder, sports injuries, arthritis) cardiovascular (chronic heart disease, rehabilitation after heart attack) respiratory (asthma, chronic obstructive pulmonary disease, cystic fibrosis) manual therapy (such as massage) therapeutic exercise electrotherapy (such as ultrasound, heat or cold) 	<ul style="list-style-type: none"> outpatients' departments elderly care stroke services orthopaedics mental health and learning disability services occupational health
Dietitians	<ul style="list-style-type: none"> have digestive problems need to put on / lose weight after an illness have an eating disorder have an allergy. 	<ul style="list-style-type: none"> mainstream and special schools community clinics prisons and young offenders institutions patients' own homes
Occupational Therapy	<ul style="list-style-type: none"> someone adapt to life after major surgery such as a hip replacement dementia sufferers develop strategies stroke patients people suffering from mental illness get back into everyday activities such as work or volunteering elderly people stay in their own homes by providing adaptation such as level access showers or stair lifts 	<ul style="list-style-type: none"> social services departments hospital departments GP Practice patients' own homes
Podiatry (Chiropody)	<ul style="list-style-type: none"> diabetes sufferers with circulation problems who may be at risk of amputation people with sports injuries people needing minor procedures such as nail surgery or laser treatment, using local anaesthetic people wanting advice about footwear or foot health 	<ul style="list-style-type: none"> hospital departments or clinics GPs surgeries patients' own homes
Speech & Language Therapy (SALT)	<ul style="list-style-type: none"> physical disabilities communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke, head injury, Parkinson's disease and dementia head, neck or throat cancer mental health issues specific language impairment cleft palate voice disorders selective mutism learning difficulties 	<ul style="list-style-type: none"> mainstream and special schools community clinics prisons and young offenders institutions patients' own homes

Health Education England
 Health Careers



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STOCKPORT
 TOGETHER

Appendix B: AHP Current Resource

AHP	Community			Inpatient			Outpatient			Intermediate Tier			Other***			
	FTE	16/17 Cost	Activity**	FTE	16/17 Cost	Activity**	FTE	16/17 Cost	Activity*	FTE	16/17 Cost	Activity**	FTE	16/17 Cost	Total FTE	Total 16/17 Cost
Dietitian	2.11	£77,200	740	10.65	£334,800	5068	1.7	£73,500	760	0.2	£6,000		1.19	£53,300	15.85	£544,800
OT, M&H, EAO	16.5	xx	/													
OT	2.6	£100,200	28353	34.67	£1,123,800	27343	4.26	£166,400	2131	13.88	£627,700	9783			55.41	£2,018,100
Physio	18.93	£783,900		56.76	£1,799,400	68576	23.2	£1,111,800	32632	16.26	£643,400		9.3	£430,700	124.45	£4,769,200
Podiatrist	20.76	£844,400	43105												20.76	£844,400
SALT				11.29	£358,900	1502	0.56	£25,600	983	0.2	£7,200	77			12.05	£391,700
Grand Total	44.4	£1,805,700		113.37	£3,616,900		29.72	£1,377,300		30.54	£1,278,300		10.49	£484,000	228.52	£8,568,200

* 15/16 full year PLUS est. 20% additional for non-Stockport patients

**16/17 FOT, Stockport incl. non-Stockport patients. SMBC employed OT, M&H, EAO activity measured differently

*** Patient education (Dietetics) and CD physio; Occupational health; Cardiac rehab; T&O; EPR; Uro-dynamics (Physiotherapy)



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STEADY IN STOCKPORT

Business case: Prevention and management of falls and (fragility) fractures and improving bone health

Aim:

The aim of the 'Steady in Stockport' programme is to improve quality of life for people by reducing the burden of falls and fractures.

What are we trying to accomplish?

Through an interdisciplinary pathway we want to offer:

Primary prevention:

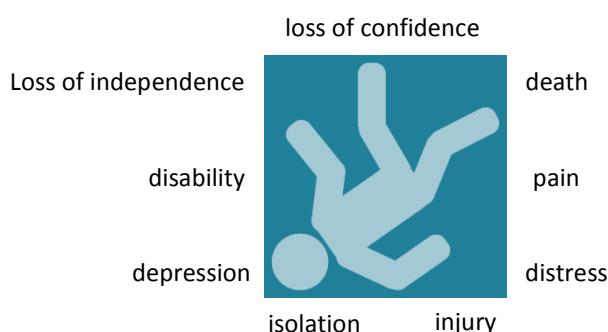
- Increase the number of people engaging in physical activity throughout their life course.
- Identify people at potential risk of falling or fracture and raise awareness of actions they can take to reduce their risk through a multi-agency approach.

Secondary prevention:

- Identify people who have a high risk of falling including people with fractures, fragility fractures and/or osteoporosis and provide treatment, restore function and undertake multi-factorial assessments and targeted interventions to prevent falls and improve function.
- Work with care providers to prevent falls and fractures in their care environment through multifactorial interventions at an individual and system level.
- Cluster current staff and resources to organise an integrated and interdisciplinary approach across Stockport.

Why?

- A fall can have significant physiological and psychological consequences and impacts negatively on people's quality of life. A fall can lead to:



*1 in 10 will die within one month and
1 in 4 will die in a year after a fractured hip*

- Falls are the largest cause of emergency hospital admissions for older people.
- The estimated cost to the NHS is more than £2 billion per year, of which £1.1 billion are costs for social care.
- Cost of hospital, community and social care services for patients who fall can be almost four times as much in the 12 months after admission as the costs of the admission itself.
- Many falls are preventable and people who had a fall are more likely to fall again.

Stockport Figures

Data on falls

Table 1: Number and % of the population with a history of fall

	All		Female		Male	
	Number	% of pop'n	Number	% of pop'n	Number	% of pop'n
All	12,150	4%	7,700	5%	4,450	3%
Age 0-19	1,685	2%	805	2%	880	2%
Age 20-64	4,725	3%	2,875	3%	1,845	2%
Age 65+	5,745	10%	4,020	13%	1,725	7%

- Every year about 30% of people 65+ will have at least one fall: 16680.
- Locally, data from Emergency Department (ED) attendances shows us that 47% (13/14: 3236) of ED attendances with falls, 62% of hospital admissions with falls (13/14: 2133 hospital) and 89% of deaths from falls (13/14 49 deaths) are in the 65+ age group.
- Numbers of falls are fairly stable over the years.
- There is no strong trend in month or time of fall; however 13% of attendances by the older age group are in the early hours of the morning.
- The home is the most likely place for a fall to occur.
- People in the older age group are more likely to arrive by ambulance and more likely to be admitted to hospital rather than discharged from ED.
- Almost a third of hospital admissions in the older age group are not finished after one episode of care, meaning there is a longer spell in hospital.
- Rate of falls generally increases with deprivation. However, there are more people with a history of falls in the more affluent areas of Stockport.
- Compared to the England average, Stockport has significantly more injuries due to falls, for those aged 65-79 and for those 80years and over. This is the case for males and females (see figure 2).
- Compared to the England average, we are also higher for mortality from accidental falls (this is in part as our coroner investigates all deaths with a fall in the last six months). See figure 3.
- NHS Right Care data indicates that compared to the best / lowest performing 5 CCGs of our 10 most demographically similar CCGs we could improve in the following areas (figure 1):

Figure 1: Right Care data

Area for improvement	Quantified opportunity
Hip replacement emergency readmissions 28 days	9
% fractured femur patients returning home within 28 days	69
Hip fracture emergency readmissions 28 days	13
Injuries due to falls in people aged 65+	330
All fracture admissions in people aged 65+	192
Spend on admissions relating to fractures where a fall occurred	£518,000 (potential savings)

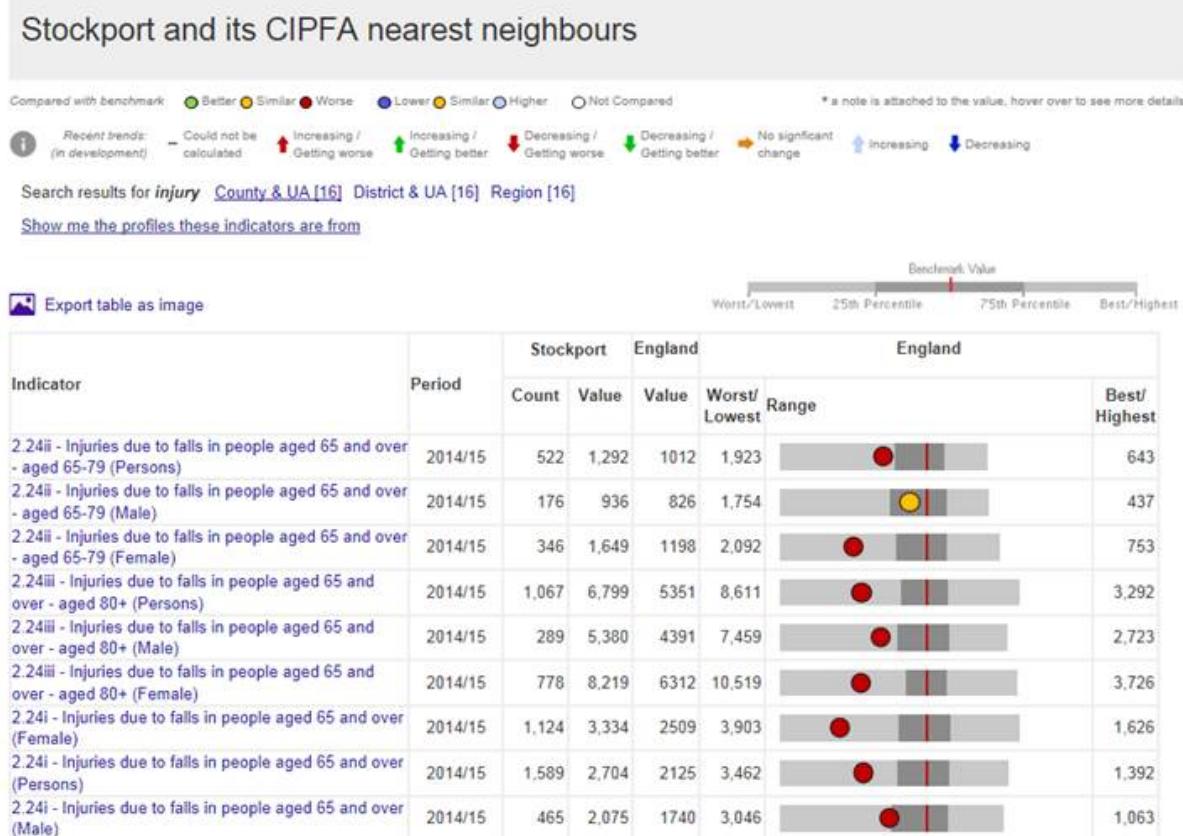
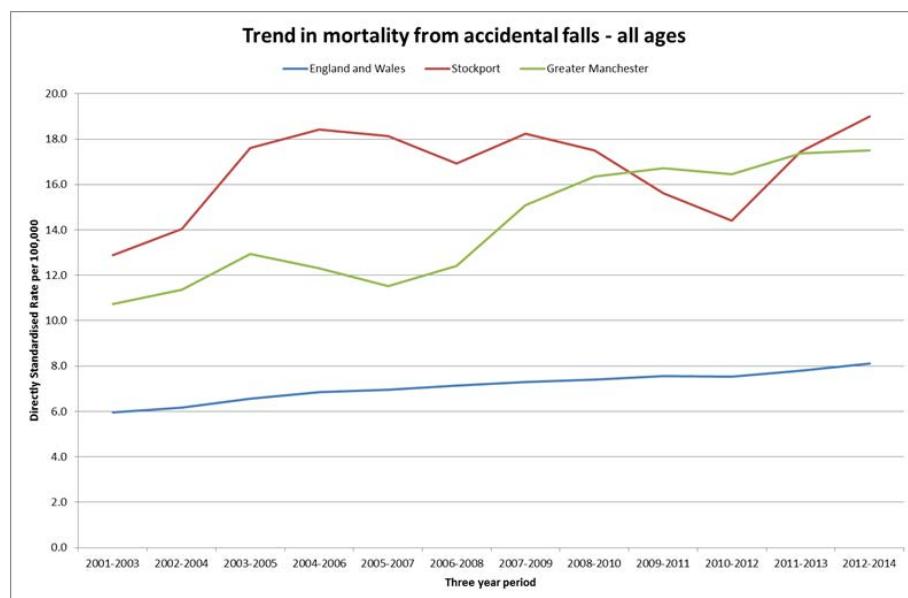
Figure 2: Stockport compared to England, Injuries due to falls


Figure 3: Trends in mortality from accidental falls

Figure 4: Fall Related Admissions age 50+ - Jan 2016-Jan 2017

DiagFig	Values					
	Spell Count	Spells for Falls At Home	Spells for Falls at Care Homes	Spell Cost	A&E Cost	
# at wrist and hand level	23	8	3	£43,243	£3,558	
# of femur	365	195	70	£2,487,275	£54,119	
# of Forearm	93	47	3	£193,442	£11,531	
# of lower leg, inc ankle	117	60	5	£376,594	£16,460	
# of lumbar spine and pelvis	110	73	15	£384,169	£16,145	
# of shoulder and upper arm	90	46	8	£269,058	£13,129	
# of skull and facial bones	34	13	1	£131,537	£5,857	
Open wound of head	263	138	37	£644,091	£46,494	
Open wound of wrist and hand	14	7	1	£29,365	£1,951	
Other and unspecified injuries of head	143	98	13	£341,086	£24,751	
Superficial injury of head	313	171	53	£604,254	£54,602	
Other	598	364	65	£1,711,995	£92,485	
Grand Total	2,163	1,220	274	£7,216,109	£341,082	

What is the need for change?

We currently have an inconsistent response to preventing and managing falls. People are identified as high risk of falling by various staff in the community but are not systematically assessed and followed up. Many professionals identify people at risk / high risk of falling like

third sector parties, fire and rescue service and Life Leisure (fitness provider) staff but there is no falls service for them to refer these people at risk to. There is an offer of balance and strength programmes but people at risk are not systematically referred and the balance improvement activities are not provided consistently across Stockport. People with fractures receive an intervention through the hospital's fracture clinic and/or falls clinic but this service cannot meet demand and is not providing a full fracture liaison intervention as recommended by NICE guidance. GPs of people over 50 attending ED with a fracture will be advised to arrange a DXA-scan but currently 40% of GPs follow up this advice (SHH, audit 2016). We are not screening for fragility fractures to provide timely interventions in improving bone health and there is an underdiagnoses of osteoporosis and not everybody diagnosed with osteoporosis receives treatment. As a result Stockport:

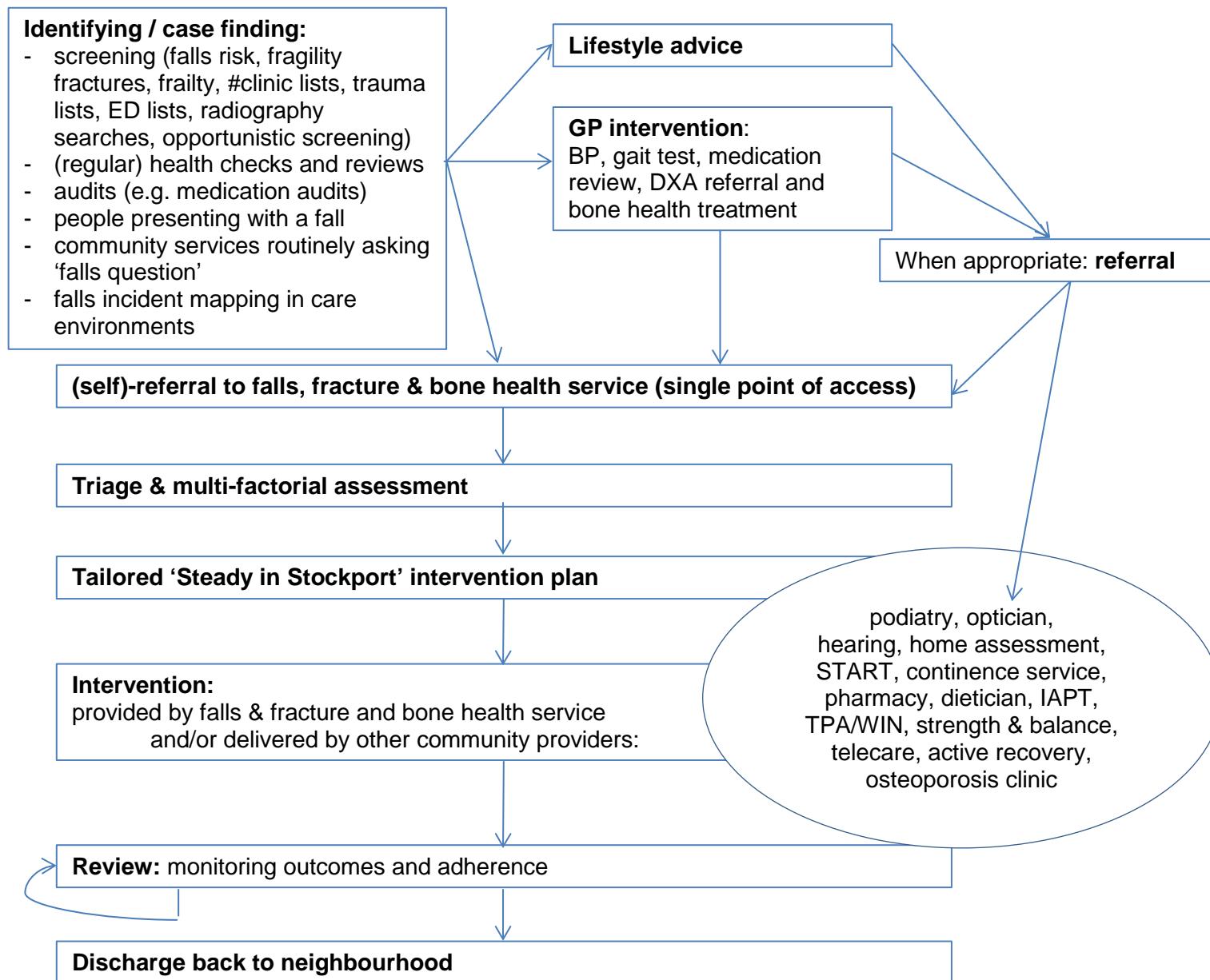
- Is an outlier in ED attendance as result of a fall,
- Has a diagnosis gap regarding osteoporosis.
- Has a higher number than average of frequent fallers.
- Has a higher number of people with injured falls (65+) than England's average.
- Has a high number of falls in care homes / hospital environments.

'Steady in Stockport' model

The new 'Steady in Stockport' model is an interdisciplinary approach, focussing on primary and secondary prevention. The model consists of an integrated pathway between a new falls, fracture and bone health service and various existing services and facilities in the community.

The pathway is as follows:

The pathway is as follows:



	Case finding	Assessment	Interventions
<p>General public level:</p> <ul style="list-style-type: none"> - Generic lifestyle improvements which also includes preventing falls risk factors <p>System level:</p> <ul style="list-style-type: none"> - Improving care environments to prevent falls 	<p>→ People aged 40 and older through health checks and other health screening and promotion activities</p> <p>→ Falls incidents monitoring</p>	<p>→ Self-assessment through online webtool Health check</p>	<p>Supporting health improvement and self-management through falls awareness and prevention initiatives:</p> <ul style="list-style-type: none"> • Falls Awareness Leaflet • Advice regarding maintenance of health and wellbeing / active ageing / falls prevention • Signposting to address specific falls risk factors <p>Systematic falls prevention management in care environments incl. assistive technology (care homes / hospitals)</p>
<p>Individual level:</p> <ul style="list-style-type: none"> - reducing risk of falls and fragility fractures and improving quality of life - restoring function after fall / fragility fracture - improving bone health <p>High risk of falls: a history of falls, muscle weakness, poor balance, visual impairment, polypharmacy and the use of psychotropic and anti-arrhythmic medicines, environmental hazards and a number of specific conditions (including arthritis, cognitive impairment, depression, diabetes,</p>	<p>→ Staff working in the community routinely asking people 65+: "have you had a fall / trip / stumble in the last 12 months"?</p> <p>FRAT score 1 or more</p> <p>EMIS-frailty index: mild, moderate, severe</p> <p>FRAX and Q-fracture</p> <p>Audits (hip fracture) / opportunistic screening</p> <p>People presenting with an injurious fall or (unexplained)</p>	<p>Falls prevention, fracture & bone health service:</p> <p>Interdisciplinary multifactorial assessment following NICE guidance (nurse, OT, physio, TPA, pharmacist)</p> <p>Service has direct access to consultants as and when needed and access to diagnostics like DXA scan, blood tests</p> <p>Urgent access based on triage</p>	<p>Tailored intervention plan based on one or more of the following elements delivered in the community:</p> <ul style="list-style-type: none"> • bone health treatment – part of FLS • medication adjustments • rehabilitation • mental wellbeing • mobility • telecare • strength & balance, exercise (home/group) • safe home environment, incl. equipment • feet and footwear advice • vision/hearing /aids advice • vitamins & nutrition advice • medicines optimisation • continence advice • lifestyle advice and interventions

<p>high alcohol consumption, incontinence, Parkinson's disease, stroke and syncope).</p> <p>High risk of fractures: low bone mineral density, previous fracture, age, female sex, history of falls, glucocorticoids, rheumatoid arthritis, smoking, low BMI, high alcohol consumption, and visual impairment.</p>	<p>fracture (GP, Carecall, NWAS, A&E, CRT)</p> <p>People with poor bone health</p> <p>High risk groups (because of health condition or certain medication usage)</p>	<p>Clinics in community and hospital. Hospital clinic is predominantly a fracture liaison and bone health service (FLS)</p> <p>Telephone advice & reviews / clinic appointments / home visits</p>	<p>(including alcohol, nutrition, diet and smoking)</p> <ul style="list-style-type: none"> • social work referral <p>Access to consultant / specialist advice (telephone / virtual / clinic)</p> <p>Monitoring and evaluation of intervention plan including medication adherence</p>
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1) Primary prevention offer in new model (low to moderate risk of falls)

Prevention starts in general for people over age 40 with healthy life style messages and identification of risk factors related to falls: dementia prevention, smoking cessation, increased exercise and balance training and reduced alcohol intake. These messages could be part of a wider lifestyle approach whereby staff are aware of the risk factors and are able to provide advice and signposting in a motivational and encouraging way.

In addition there are specific target groups that have a higher risk of falling and fractures: people with certain medication, people with certain medical conditions, people living in certain areas or sheltered housing / care facilities and people over the age of 65. For these groups a more targeted approach is needed related to 'making every contact count' (MECC) to identify people at risk and to positively stimulate people to get the best possible outcomes in falls prevention. This means that we need to raise public awareness, signpost them to postural stability classes in each neighbourhood and promote home environment checks from Age UK and the Fire & Rescue service.

Various staff members in contact with at risk groups will need to be falls risk aware, able to undertake a FRAT-assessment and need to know when and where to refer people at risk to depending on their needs, e.g. mobility, sensory impairment, balance, medication, cognition, and footwear. All prevention messages need to be aimed at empowerment and support rather than creating fear. Some of this is already in place and it is building on the good work being delivered by the fire and rescue service, Targeted Prevention Alliance (TPA) / Wellbeing and Independence Network (WIN), Age UK and various other health and social care staff groups.

Apart from working with health and social care staff, pharmacies, third sector, fire and rescue service and home care and housing providers, it is also worthwhile engaging with other public facing services like hair dressers, community shops and taxi drivers asking them to give falls prevention messages and hand out a falls prevention leaflet.

It is crucial that when people are identified who could potentially benefit from falls prevention, an easy access to falls prevention intervention is available including a simple online assessment tool on the Healthy Stockport Website that will direct them to the most appropriate interventions (leaflet, strength & balance improvements, visit local pharmacist etc.). This tool can also indicate a higher falls risk and the need to contact their GP for further investigation and/or (self-) referral to the falls, fracture and bone health service.

2) Secondary Prevention offer in new model (moderate to severe risk of falls)

An integrated falls, fracture and bone health service will be implemented to provide an in-depth assessment and interventions for people who have had a fall, are at high risk of falling and/or who have had a fragility fracture. The service will also pro-actively be involved in case-finding and screening.

Case-finding

It is important to find people at high risk of (another) fall, a fragility fracture or with low bone health. Several actions will be undertaken in the new model:

- Auditing and undertaking opportunistic screening to find people with low bone health and/or with fragility / vertebral fractures.

- Identifying people at high risk of falls or fragility fractures based on frailty, medical conditions and medication usage (GP / practice nurse assessments EMIS-frailty index, FRAX and/or DXA scan, medication audits related to high falls risk or impact on bone health.)
- Identifying people at high risk when they report a (non-injury) fall.
- Identifying people at high risk of falling in care environments (hospital, care homes, extra care housing.)

For all those people at a higher risk of falls and fragility fractures a simple referral pathway into a falls, fracture and bone health service will be available to support the neighbourhood teams with assessing and developing individual intervention plans. This service has two elements:

A) Fracture And Bone Health element of the service (community based with hospital in-reach)¹

This evidence based service focusses on people 50+ presenting with a new fragility fracture in hospital (ED attendees) or who are found through opportunistic identification of vertebral fractures in routine scans taken for other purposes. All people identified will be offered written information about bone health, lifestyle, nutrition and bone-protection treatments.

People will have a bone health assessment and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident fracture.

People at increased risk of further fractures will be offered appropriate bone-protection treatments.

People at increased risk of further falls will receive a multi-factorial assessment and tailored intervention plan to reduce future falls.

Management plans will be person-centred and integrated between primary and secondary care.

People who are recommended drug therapy to reduce risk of fracture will be reviewed within 4 months of initiation to ensure appropriate treatment has been started, and every 12 months to monitor adherence with the treatment plan (clinic or telephone appointment.)

B) Falls prevention element of the service (community based)^{2,3}

Falls prevention interventions will be offered to everybody at high risk of falls. People will receive a multifactorial and holistic assessment to identify areas of improvement in conjunction with the person's own goals.

This assessment is provided by an interdisciplinary team from the 'falls, fracture and bone health service'. Part of the assessment is providing education and information. Following the assessment a multifactorial intervention plan will be developed delivered partly by the service and partly by providers in the community.

The service will also provide training and advice to staff working in 24/7 care environments or providing home care on how to prevent falls, how to raise falls awareness and how to identify people at risk of falling.

C) Service delivery

The falls, fracture and bone health service runs weekly clinics in the community at locality level, provides telephone consultation and runs an in-reach service in the hospital (fracture liaison and bone

¹ NOS, 2015, Clinical Standards for Fracture Liaison Services

² NICE, 2017 Quality Standard QS 86: Falls in Older People

³ NICE, 2013, Clinical Guideline CG 161: Falls in Older People: assessing risk and prevention

health element). The staff provides case finding, assessment, interventions, training and education includes the following core disciplines:

- Nurse (fracture liaison, case finding, education)
- Telephone triage nurse
- Occupational Therapist (falls prevention, education)
- Physiotherapy (falls prevention, education)
- Technical instructors to work in 1-1 situations with people at highest risk of falls
- Administrarive staff

The service will be managed by the borough wide active recovery team and will work in partnership and will be aligned to various services in the community (third sector, fire and rescue service, continence service, community pharmacists, opticians, hearing aid and mobility services) and will especially work closely together with neighbourhood teams (GPs, pharmacists, physiotherapists and TPA/WIN staff in the neighbourhood), LifeLeisure (strength and balance training), active recovery therapists and health coaches.

The service has good working relationships and fast track access to consultants as and when needed: rheumatologists, cardiologists, orthopaedics, geriatricians, ENT, old age psychiatrists and radiologists.

The service has also direct access to diagnostics, like DXA scans and blood tests and the equipment and adaptations service.

The professionals working in the ‘falls, fracture and bone health service’ have apart from their clinical role (80% of staff time) also a training and education role to promote falls awareness, to train people in undertaking FRAT assessment and prevention techniques and to support residential care providers with falls management (about 20% of staff time).

When appropriate staff of the service can undertake a home visit but it is expected that the majority of the people will attend a clinic or receive their intervention through a telephone appointment. Based on a triage system people can be seen more urgently e.g. to support hospital discharge but normally a referral will be followed up within 3 weeks. People can self-refer and based on a telephone triage will be booked in for an appointment or will receive tailored falls preventing advice via (e-)mail.

3) Investments needed

The key steps in implementing an evidence based ‘Steady in Stockport’ model are:

- 1) Find and prevent: increasing case finding and screening activities to find people at high risk of falls, having had an injurious fall and/or identified with fragility fractures
- 2) Establishing a new ‘falls, fracture and bone health service’ with a focus on secondary prevention
- 3) Increasing postural stability / strength and balance interventions across the borough for the high at risk group
- 4) Joined up interdisciplinary approach in the community regarding primary prevention and case-finding of people at low/medium falls risk / reduced bone health
- 5) Working with 24/7 care providers to improve a systematic falls prevention approach.

The following actions and investments will be needed to implement an interdisciplinary falls and fracture prevention and bone health improvement pathway for Stockport.

Actions	Deadline	Costs
Promotion material		
Update current falls prevention education material	01.10.2017	£ print costs
Update current bone health education material	01.10.2017	£ print costs
Training package for community staff	15.01.2018	--
Develop and publish falls awareness assessment tool and intervention advice on Healthy Stockport website	01.12.2017	--
Online resource with up to date information about preventative interventions	01.12.2017	None: managed by falls, fracture and bone health service
Pathway material		
Assessment tool	01.10.2017	--
Template intervention plan	01.10.2017	--
Simple referral form in EMIS / H&SC record including what actions have already been undertaken and what advice has already been given to avoid duplication	01.10.2017	--
Training		
GP masterclass to include frailty assessment, initial falls assessment	01.02.2018	--
Falls awareness training for community / public facing staff / building community assets to raise falls awareness and to inform where to signpost people to	Ongoing start per 01.01.2018	None: delivered by staff in conjunction with community capacity builders and TPA/WIN
Case finding		
Targeted audits / risk stratifications to find risk groups: sensory impairment, polypharmacy, psychotropic medication or steroid users, low BMI	audit plan developed by 01.11.2017	Undertaken by existing staff
Opportunistic screening to find fragility fractures (vertebral fractures) 1. audit to identify most effective approach 2. implementing service	1. audit 01.05.2017 2. identify target group 01.08.2017 3. start screening service 01.10.2017	
Service delivery		
Establishing an integrated 'falls, fracture and bone health service' across Stockport	01.10.2017	
Identify venue for clinics	01.09.2017	
Access to diagnostics: investment to meet increased demand for DXA scans in hospital and scan availability in the community (heel ultrasound)	01.11.2017	
Increased capacity for access to postural stability and other balance improvement activity programs (Otago) for high at risk groups	01.01.2018	
Increased prescribing for osteoporosis drugs	TBC	

Increased use of assistive technology to prevent falls	TBC	
Develop and roll out falls management system in care homes and other residential community care environments: reporting, monitoring, intervention & workshops	15.01.2018 – 15.01.2019	None: delivered by existing staff in conjunction with neighbourhood staff
Availability of strength and balance and other lifestyle activities across Stockport (SMILE, health coaches, START)	Already available	

4) Benefits and savings

Apart from the improved quality of life, a systematic approach to falls and fracture prevention and improved bone health will also deliver financial benefits to the system.

The NOS evidence based benefit calculator identified the following savings for Stockport when implementing a fracture liaisons service following clinical guidelines including opportunistic screening: Stockport CCG would realise about £2.4 million savings after 5 years of implementation:

Total benefits

Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total
2016	£169,580	£14,399	£4,032	£14,934	£202,945
2017	£305,244	£20,570	£5,760	£29,868	£361,442
2018	£440,908	£26,741	£7,488	£44,802	£519,939
2019	£525,698	£30,855	£8,640	£49,780	£614,973
2020	£576,572	£34,969	£9,792	£54,758	£676,091
Total benefits	£2,018,002	£127,534	£35,712	£194,142	£2,375,390

Local HES data over the last 3 years has highlighted a steady increase in total patients with osteoporosis that have suffered a pathological fracture resulting in an increase of non-elective in-patient costs from £41,331 to £89,023.

12% of NWAS conveyances to ED (average of 50 attendances a week / 3500 a year) are a direct result of a fall. A further 500 falls related to ED attendances are conveyed by relatives or through patients attending directly. The costs for transport are not included in the NOS benefit calculator.

Recent published evidence⁴ indicates that home hazard assessments reduce the rate of falls by 19% and risk of falling by 12% (Cochrane review). This is often undertaken as part of a multi-factorial assessment. These assessments can reduce rate of falls by 24%. Intervention of postural stability also reduces the risk of falling with 20-40% depending on the intensity of the intervention (NICE guidance). Interventions in high-risk care environments will reduce risk of falling with 20-30% (NICE guidance).

⁴ Public Health England, January 2017: Falls and Fracture consensus statement – supporting commissioning for prevention

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The NOS benefit calculator focusses on costs related to fractures that can be prevented by implementing a fracture liaison service. Other injuries indicate a further spent on acute care that can be prevented. Figures for one year (Jan 2016-2017) were as follows:

Fall Related Hospital Admissions 50+					
DiagFig	Values				
	Spell Count	Spells for Falls At Home	Spells for Falls at Care Homes	Spell Cost	A&E Cost
# at wrist and hand level	23	8	3	£43,243	£3,558
# of femur	365	195	70	£2,487,275	£54,119
# of Forearm	93	47	3	£193,442	£11,531
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Other	598	364	65	£1,711,995	£92,485
Grand Total	2,163	1,220	274	£7,216,109	£341,082

The table above presents the spells regarding hospital. In addition costs are made in primary care, social care, transport and by Care Call but these are difficult to distinguish from the total costs for these services.

	Average benefits per year
Fracture prevention impact NOS benefit calculator FLS Benefits Calculator v2.23 Stepping Hill 1-3-17.pdf	£ 475,078
Falls prevention impact: Reduction of care call follow up, crisis team activity, primary care time, Mastercall & pathfinder activity, NWAS journeys, DN time, therapy time, ED attendance and hospital admissions for wounds and head injuries related to a fall. And delayed admission into long-term care and reduced need for home care packages.	It is envisaged that savings are included in the overall calculated benefits of Stockport Together's business case. A falls, fracture and bone health pathway will be one of the interventions to ensure savings in 65+ category will be made. It is difficult to distinguish the specific contribution of the pathway to the overall savings. An estimate of direct contribution is based on: 15% reduction in ED & admissions related to injured falls (not a fracture as this is already included in benefit calculator above). 15% of 3,551,073 = £

	532.661 (excl social care, primary care, NWAS etc.)
Indication of annual savings	£ 1.007,739

	17/18 – 6 months start date 1.10.2017	18/19	19/20	20/21	21/22
Total costs^{b,c)}:	£ 239,600^{a)}	£ 428,200	£428,200	£428,200	£428,200

- a) Included are additional costs of £ 17,000 are for investment of a portable heel ultrasound device to pre-screen osteoporosis in the community clinics. Further research is needed to finalise decision making
- b) Total costs include opportunistic screening, an audit is planned to establish optimum cohort for screening.
- c) Assumptions made that pharmacist input is covered in neighbourhood business case and TPA/WIN, health coaches and generic postural stability classes are included in healthy communities' business case.

See excel document for more detailed cost calculation:

[Copy of C902-17 Falls Fracture_Bone Health Service_email.xlsx](#)

Appendix 1: Pathway cohorts and key stakeholders regarding assessment and treatment

<p>People at risk of falls ¹⁾</p> <ul style="list-style-type: none"> • History of falls • Muscle weakness • Poor balance • Visual impairment • Polypharmacy and use of psychotropic and anti-arrhythmic medicines • Environmental hazards • Medical conditions including: arthritis, cognitive impairment, depression, diabetes, high alcohol consumption, incontinence, stroke, Parkinson's disease, stroke and syncope 	<p>People at risk of fractures and fragility fractures ^{1,2)}</p> <ul style="list-style-type: none"> • Age: women over 65 and men over 75 • Case finding 50+ - vertebral fractures • In women aged under 65 years and men aged under 75 years in the presence of risk factors: <ul style="list-style-type: none"> • Low bone mineral density • Previous fragility fracture • History of falls • Family history of hip fracture • Use of glucocorticoids • Rheumatoid arthritis • Smoking • High alcohol consumption (14 units women 21 units men) • Low BMI (less than 18.5 kg) • Visual impairment • Other causes of secondary osteoporosis • People under 50 with major high risk factors (use of glucocorticoids, untreated premature menopause or previous fragility fracture)
<p>Case finding:</p> <p>Health and social care staff, third sector, public sector staff, carers, families, lifestyle services: people pro-actively asked about falls at routine assessments or are reporting a fall / trip / stumble / slowing down;</p> <p>Pharmacists: polypharmacy</p> <p>GPs: FRAX / e-frailty index / up & go / Medsreview NWAS / Carecall / A&E / Crisis response team / GPs / Mastercall: referral related to a fall</p>	<p>Case finding:</p> <p>GPs: FRAX and bone densitometry (DXA), certain medical condition, medication reviews</p> <p>Opportunistic screening for vertebral fractures</p> <p>People presenting with fractures</p>
<p>Falls prevention pathway ⁵⁾</p> <ol style="list-style-type: none"> 1) Multifactorial assessment for everybody at risk of falling with priority for people who had a fall 2) Individualised multifactorial intervention including interventions such as strength and balance training, home hazard assessment, medication review, hearing / eye-sight review 	<p>Bone Health and Fracture Liaison</p> <p>Treatment fractures / (high risk of) fragility fractures ^{3,4)}:</p> <ol style="list-style-type: none"> 1) an assessment of fracture risk, maintenance of mobility, correction of nutritional deficiencies, multifactorial assessment of falls risks 2) people diagnosed with osteoporosis are offered bone-sparing drug treatment (bisphosphonates, calcium vitamins). 3) people with osteoporosis prescribed bone-sparing drug treatment are asked about adverse effects and adherence to treatment at each routine medication review. 4) people with osteoporosis who have been taking bisphosphonates for at least 3 years have a review of the risks and benefits of continuing treatment.
<p>Multifactorial approach in care environments: assessing falls risks, providing strength and balance exercise programs (care homes, extra care housing providers), falls monitoring system</p>	

January 2017

²⁾ NICE Guidance, Osteoporosis: assessing the risk of fragility fracture, Clinical guideline [CG146], February 2017.

³⁾ NICE Quality Standard, Osteoporosis, draft for consultation, January 2017.

⁴⁾ NOGG, Guideline for the diagnosis and management of osteoporosis, March 2014.

⁵⁾ NICE Quality Standard (QS86), Falls in older people, January 2017.

REPORT DATED 27 FEBRUARY 2017

External Workforce Business Case; Future Investment Proposal

'Investment in a package of measures to improve both the quality of provision and market capacity across the Care Home and Home Care markets in Stockport'

1.0 Executive Summary

This paper proposes a recurrent investment of approximately £1.2m per annum, to extend the quality and availability of externally commissioned services in Stockport across the health and social care economy. This proposal is based on the need to achieve both sustainable and transformational change across the external provider market. This will realise many benefits in terms of improved outcomes for people and more effective support at home and will also help reduce expenditure on avoidable hospital admissions and delayed transfers of care. This will be achieved, in partnership with others, through a pro-active change management programme incorporating a package of measures as outlined below.

2.0 The Case for Change

2.1 The national/regional context:

- Demographic Pressures; rapidly increasing demand for care and rising complexity of need.
- Market capacity strained to breaking point; significant numbers of care home beds lost in the last two years and the closure of several home care agencies in the borough.
- Problems with recruitment and retention which can include poor terms and conditions, poor rates of pay, DBS check delays, the image of the sector, training and performance issues and a frequent turnover of staff.

2.2 Partnership working, change management and competing priorities

- Context of change e.g. Stockport Together developments, Devolution Manchester.
- Delayed transfers of Care (DTOC) impacting on the whole system.
- Need to look at whole system including housing, community services, fire services etc. to find new approaches to prevention and asset based models.
- Scarce resources
- Any suspended home or closure represents a loss of potential provision; how to ensure quality, choice and availability of support for vulnerable people;

2.3 Financial context

- Challenge to identify fair costs of care
- Challenges from providers regarding the costs of care, top ups and private market
- Overall financial pressures across the health and social care system

2.4 Care Quality Commission (CQC) context and the urgency of local issues

- The size, scale and composition of the market in Stockport (further information available via the CQC area profile). Some homes not physically fit for purpose, and loss of 151

beds in the last two years

- The regulatory context; until last year due to CQC staffing levels, many homes had not been inspected for some time. In the last year the CQC has ensured a new regime of timely inspections. This has created a useful baseline in terms of the quality of the market but also significantly increased the numbers of homes deemed 'inadequate' or in 'special measures'; detailed below. This new baseline does offer an enhanced opportunity to directly measure the rate of improvement across the market going forward.
- At the present time there are several areas of provision where intervention of this kind is urgently required, to avert further crises and reduce the increase risk of the problems noted above. Emergency arrangements have been deployed where required in recent months, to address identified risks and help meet joint agency responsibilities. However, a dedicated intervention team delivering a collaborative and supportive approach will offer a much more cost effective and proportionate response.

3.0 Outline of the Proposal

There are four distinct but related elements to this proposal:

3.1 Extended home support based
on re-ablement approach;
£690,000

3.2 Further development of the
Extra Care Housing model
£90,600

3.3 Investment in a joint quality
intervention team to work across
the external market
£238,779 (recurrent funding) and
£9,000 (one-off investment)

3.4 Supporting seven day flexibility
across the sector with weekend on
costs £171,200

3.1 Proposal One:

Extending re-ablement focused, asset based approaches across the Home Support market to ensure that more people are supported to live safely and independently in their own homes.

Based on two successful pilot initiatives involving a partnership between the REaCH service and independent home care providers in Stockport, this service will provide more support to

people in their own homes with an increased focus on re-abllement, independence and asset based approaches in the community. This will also incorporate an extension of the existing pilot service to provide overnight home support assessments to avoid hospital admissions or care home placements where appropriate.

Funding is sought to:

- a) Ensure that the aligned overnight home support assessment element of the approach also continues beyond March 2017.
- b) Roll out the day time support further to support neighbourhood provision and embed the service within multi-disciplinary teams.

This is consistent with the direction of travel for Greater Manchester as endorsed by the Joint Commissioning Board in November 2016, which has recognised the need for new models of care in terms of support to live at home, particularly those which adopt a re-abllement focus. Further work would still be required to roll out the approach across the whole sector, but this proposed approach creates the potential for further development and flexibilities through locality working and blended roles in future.

Description of service

This proposal, based on the above successful pilot, supports a more outcomes focused, re-abllement approach to home support, co-produced and delivered jointly by utilising the enhanced skill sets of both the in-house provider and independent providers. This requires providers and commissioners to adjust their focus from that of delivering long term support to a shorter term outcome based approach. This service will be available 24/7, 365 days of the year.

This model of care is evidence based and has been shaped by previous market tests and also by testing the new winter pressures model, to explore how the home care market can be developed to improve outcomes for the individuals supported. Within this model and in broad terms, referrals are received via the Council's in-house 'REaCH' service which undertakes an initial holistic assessment of the individual's needs. This assessment encompasses a 'Wellbeing planning' approach whereby the worker and the individual explore community network offers whilst working within the principles of self-care. Once the Wellbeing plan has been agreed and the individual's needs have been assessed, the short term package of care transfers to the linked locality provider, who will continue to work to the wellbeing plan with individuals to:

- Prevent further decline by responding to deterioration.
- Optimise the individual's wellbeing and resilience
- Continue to engage people with community activities – reducing Social isolation and loneliness

This wraparound approach also aims to reduce avoidable hospital admissions by providing increased support to people in their own home, supported by additional therapy and Social worker input.

Benefits

Locality based

The commissioned and contracted providers, all of whom will be on the Council's framework of registered and accredited provision, will be linked to the neighbourhood teams and



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

provide services for a distinct geographical location. This will be aligned to the neighbourhood teams; this will support the recruitment of local people and will aim to reduce the number of 'crossover and handover' between providers in geographical areas, thus improving the continuity for people receiving the service.

Outcome based model

Two pilots have taken place to test the above model. The first took place between April and September 2016. This pilot was an opportunity to respond to an immediate need, when a home care provider served notice to withdraw from ten longstanding packages of care in the local area. A local provider engaged with Adult Social Care and agreed to work to an outcome focused framework to establish that in order to achieve a better outcome for people, we need to take a different approach in planning their support needs and this would:

- Reduce overall avoidable spend on care management.
- Improve the wellbeing of people receiving services and support, making wider and better use of community assets.
- Develop a new model of care that improves the lives of people who need different levels and types of support ranging from profound and basic care through to minimal intervention.
- Identify the skill gap within the private provider market – so we know what we need to offer in order to help them develop.
- Continue to promote the role of social care.

Objectives based on outcome based model

- People are supported to live as fulfilling a life as they can and wish to.
- Staff understand their role and have permission to 'Go to the person not the task'.
- Staff are able to identify all needs and assets for people they work with.
- The profile of home care work is raised and improved.
- People with packages of care do not remain isolated and lonely.
- Staff are aware of the assets in the area or how to access this information.
- The work experience for staff is more rewarding and hopeful of what?.

Demonstrable successes from the pilot

- Staff felt valued.
- Remuneration was increased and based on being able to work flexibly, using initiative and understanding how to make person centred care a reality (e.g. connecting beyond front door).
- Staff now have quality conversations with the people they support and can create a wellbeing plan with the person, their family and care team.
- People with complex needs and clients in a crisis would always have one consistent person to contact, who would be able to access fast track required joint assessments for things like equipment.
- When care workers recognise need for small to medium changes or variation in care or support they are able to get quick decisions and permission.
- All work is judged on outcomes – how has the life of the person supported improved?

- Money is invested in the right things based on ground up feedback—e.g. the consistent contact role.
- People have a named keyworker (with a backup) within home care teams. The whole care team [including the family] will know who the keyworker is.
- Family and friend carers, volunteers care workers etc. are part of the person's care team.
- The keyworker will be on an equal footing with the whole of the person's care team.
- Older people have the option to live in smaller shared space with networks of care with a keyworker, team around the person and situated within communities.
- Contracts that span care and support enable providers to prioritise the persons changing needs with the person and their family—whether that includes basic care, community support wellbeing and social connections.

The Council also secured contracts for additional temporary provision as in previous years, for 'winter pressures', but adapted this to the new model of care.

Scheme*	Details of scheme	Value	Contract period
(1A) Home Support – Winter Pressures/System resilience	Over a period of 22 weeks, there will need to be sufficient additional capacity to provide (as a minimum) an additional 280 hours of support per week, across the borough.	£92,400	1 st Nov 2016 – 31 st March 2017
(1B) Overnight Home Support	Over a period of 22 weeks, there will need to be sufficient additional capacity to provide an additional 280 hours of support per week, across the borough.	£92,400	1 st Nov 2016 – 31 st March 2017

*This business case relates only to the continuation and extension of the provision procured externally from the independent sector; the elements of the model relating to REaCH are included in the intermediate tier business case and hence not listed here, to avoid duplication.

Within this tested model and in broad terms, referrals are made via the Council's in-house 'REaCH' service who undertake an initial holistic assessment of the individual's needs. This assessment encompasses a 'Wellbeing planning' approach whereby the worker and the individual explore community network offers whilst working within the principles of Self-care. Once the Wellbeing plan has been agreed and the individual's needs have been assessed and stabilised, the short-term package of care transfers to the linked locality provider, who will continue to work to the wellbeing plan with individuals to:

- Prevent further decline by responding to deterioration.
- Optimise the individual's wellbeing and resilience
- Continue to engage people with community activities – reducing social isolation and loneliness
- This approach supports a more outcomes focused, reablement approach to home support, co-produced and delivered jointly by utilising the enhanced skill sets of both

the in-house provider and independent providers to adjust their focus from that of delivering long term support to a shorter term outcome based approach. This service will be available 24/7, 365 days of the year.

- This wraparound approach aims to reduce avoidable hospital admittances by providing increased support to people in their own home, supported by additional therapy and Social Worker input.

Furthermore, incorporating providers in the wider neighbourhood offer, by inclusion in the neighbourhood Triage and Multi-Disciplinary Team (MDT) will be able to reduce the number of 'organisation to organisation' referrals and improve relationships and communications.

Anticipated outcomes for people

The model will follow a person-centred approach; with the individual at the centre of all decision -making. This will be captured in the wellbeing plan which is based on the 7 principles of self-care which supports the ethos of a guided conversation approach; the focus for the plan will be on the individual's abilities, wants, wishes and aspirations.

At the beginning and at the end of the short term service, people will be asked to gauge their own feelings of wellbeing, supported by family and carers if appropriate. People will also be asked to complete a questionnaire at the end of the service to enable us to capture what worked well and what we can improve in the future.

1B Overnight Support and assessment

The purpose of this assessment is to ascertain the individual's support needs, abilities and activities throughout the night, highlighting any aids and equipment and to offer some respite for carers. The team will work between the hours of 10pm -8am and will provide a report at the end of each night. During the period of 1 November 2016 to 30 January 2017, a total of 32 people were supported by the night assessment service. Through discussion with the referring social worker, the feedback about the service was overwhelmingly positive, which helped ensure that people who wished to remain at home were supported to do so and received appropriate support.

1(C) This third element of the proposal is to replicate the 1A model across the neighbourhoods, thereby enabling twice as many people to benefit from this new model. It is recognised for all three elements of this first proposal that recruitment and retention is a significant challenge and that the development of the external workforce in future may require a different approach to employment across the sector, such as the option of 'blended roles' (see below). This would not be an immediate feature of the proposed schemes but would be explored further going forward; both as part of the work of the Joint Commissioning Strategy and as part of our broader input to Greater Manchester and North West market shaping initiatives.

Blending roles

This developmental work in Stockport is exploring the benefits of blended roles, whether this is across the registered professional cohort of employees, using the Trusted Assessor as an example or enhancing the skills of frontline domiciliary care workers, enabling them to undertake a number of clinical and therapy tasks. The drive to implement blended roles is underpinned by;

- Full utilisation of the provider market.

- Smarter use of the available capacity.
- The reduction in the referral and assessment processes.
- Reduction in organisation to organisation handoffs.
- An improved seamless service for people in receipt

3.2 Proposal Two:
Developing more flexible and innovative models of extra care in the community as an alternative to residential care

There is already an Extra Care Housing Support Service in Stockport but this investment will enable the model to be enhanced and further developed.

Ability of Extra Care Housing (ECH) to meet complex needs

Whilst ECH can meet the need of people with needs at standard residential level, the service can also meet higher needs. Higher dependency and occasionally **EMI** and nursing level needs have been met. Whilst people with this level of need are unlikely to be moved into ECH, if they are already resident and their needs increase, every effort is made to meet them and prevent (or delay) them being forced to move on into a residential or nursing placement. There are currently 2 people living in ECH who have care packages of over 40 hours and who moved from a nursing home environment in order to live a more independent life.

This proposal tests the hypothesis that enhanced support would enable the scheme to support people with a broader range of needs as an alternative to residential care. In a recent consultation with health and social care staff, the following issues were raised as being required in a new model; all of which this proposal would seek to address, both through a greater overnight presence and further developmental support.

- Dementia care.
- On site night care support (is currently a mobile service across all sites) – families are concerned about night times
- Mental health teams are not aware of extra care therefore poor relationship with the community psychiatric nurses.
- Age restrictions policy is limiting – there needs to be discretion based on needs, not age.
- Chronic Obstructive Pulmonary Disease (COPD)/Long term conditions specialism.

Extra Care background:

Extra care housing offers an additional housing option for older people; particularly relevant when considering solutions for hospital discharge and to prevent, reduce or delay the need for hospital or residential care. People are motivated to move to extra care housing for physical and emotional security, availability of support and an accessible environment and social contact. People value the opportunities for friendship and social interaction.

The potential of extra care provision is more diverse than our existing Stockport model: the key element of our model is self-contained accommodation and support accessible 24 hours. Meal provision, leisure and other facilities on site vary site to site and the benefit is rarely to the wider community. This proposal offers an opportunity to begin to test more

innovative and diverse options for extending this model.

3.3 Proposal Three; The creation of a quality intervention team:

Based on a successful pilot intervention with a Care Home in Stockport, this joint team of skilled staff from health and social care will work with Care Homes and Home Care agencies across the Borough

This will involve planned, pro-active intervention in partnership with providers (not 'doing to' or 'doing for') to facilitate sustainable improvement, embedding change and working flexibly out of hours and across the borough. Based on successful pilot approaches, this initiative will help ensure that providers meet and exceed required quality standards. This intervention will consequently have a positive impact on the avoidance of unnecessary placements, hospital admissions or delayed transfers of care.

Proposed Team Composition

- Joint team/Programme lead (costed as an assistant team manager or similar.)
- Three quality improvement officer.s
- Experienced nurse/clinical input (two part time.)
- Experienced Social Worker (proportion of hours) to ensure review.s
- Access to relevant specialist support depending on nature of provision (e.g. pharmaceutical/medication, occupational therapy, dementia specialism.)
- Change Management/service improvement co-ordinator (to influence and embed change.)

Wider team access to expertise & supporting systems

- Care home officer (medication specialism) and medical colleagues.
- Existing quality, safeguarding and contracts staff who monitor and identify concerns for resolution, complaints, corporate services, information governance, procurement support and legal services, training and HR
- Healthwatch Stockport 'enter and view', patient panels and advocacy services,
- Neighbourhood Teams,
- Public Health such as infection control expertise
- Education and training leads across health and social care,

Other

- IT solutions (a one-off investment is also sought for a joint quality dashboard being developed) and business intelligence
- Moving and handling, occupational therapy, equipment and adaptations, infection control, neighbouring authorities' quality/contracts teams
 - Police, CQC, NHS England, NICE, LGO, Elected Members,
 - TPA, WIN, Alzheimer's Society, Age UK and other 3rd sector/charities
 - National vanguard sites, North West market shapers, Greater Manchester new care models sites (for ideas to enhance the quality of provision)

Principles of intervention

- Intervention will be carefully prioritised/targeted (informed by 'RAG' rated business

intelligence triangulated from across the health and social care economy.

- Time limited (intervention timescales will vary but agreed improvements must be sustainable by the provider itself.)
- Pro-active (timely intervention will aim to identify difficulties at an early stage and prevent further deterioration in standards.)
- Locality based (linked to broader support systems as part of ensuring sustainability going forward.)
- Joint approach (Health and Social Care plus others depending on the nature of the support required.)
- Focuses on delivering sustainable changes using change management approaches.
- Provides an educational resource to reinforce key learning.
- Flexible working, not '9 – 5' e.g. an agreed support package may include an out of hours help line or support and quality checks at agreed times during evenings, nights or weekends.)
- Evidence based; the intervention model will build on a recent successful pilot as a starting model – but it will also be a learning process which will evolve based on experience. It will be evaluated through a range of measures, both quantitative and qualitative.
- Aligned to specific standards, i.e. CQC and NICE standards. Also using the NHS Quality Surveillance risk tool or other appropriate tools as part of inter-agency approach.
- Asset focused; building on strengths and assets (both at an individual service user level and provider level.)
- Co-production; working constructively with service users, families and providers to identify solutions to problems.
- Use of the joint commissioners' existing legal and contractual frameworks to support the above, to ensure compliance and ultimately take appropriate action if this is not successful to protect quality and safety for service users.
- Support the improvement process but ensure that the legal responsibility associated with regulatory accountability would still stay with the registered providers (normally the independent sector agency which owns/manages the provision.)

Anticipated Benefits of the Above:

Quality

Improving the quality and choice of external market provision in Stockport for service users and their families through;

- Improving outcomes, and quality of experience for the people living in the homes and their families
- Improving and continually developing management and leadership skills to ensure sustained improvement.
- A joint approach ensuring a holistic, asset focused approach to quality.
- Meeting statutory obligations, CQC requirements, NHS England, Care Act and the '5 Cs', mitigating reputational risk in relation to quality and safety.
- Embedding strong multi-agency working, safeguarding and communication; co-ordinating and prioritising quality, health and safety concerns and issues in conjunction with MDT professionals both within and in liaison with, the core team.

- Reducing instances of safeguarding alerts, complaints and critical incidents.
 - Ensuring the approach to support is consistent and standards improved

Capacity

Maximising market capacity and financial sustainability through;

- Influencing change to reduce the risk of market failure (where issues can be addressed through active intervention.)
- Reducing the need to suspend placements (via commissioners or regulators.)
- Keeping 'good' providers in the market, encouraging innovation and opportunities for development, enhancement of facilities or support 'in kind' e.g. links to training.
- Linking to broader strategies such as staff recruitment and retention of staff to support the deployment of an effective workforce with sufficient, appropriately trained, nurses and carers.
- Sustainability of leadership to continue improvements without further intervention (above in partnership with other agencies offering expertise such as 'Skills for Care'); developing a network of similar resources.
- Help maximise any community assets (assisting with the prevention agenda elsewhere) – e.g. a well led home will begin to attract volunteers, maximising social value, helping to engage more residents and supporting people who may wish to enter the workforce in the future.
- Financial stability as lack of capacity is creating huge costs in terms of ad hoc payments and top ups and legal/reputational risk.
- The alternative is that we put more emphasis on contract compliance to address poor standards which could result in a further loss of provision, and where prevention is a better option.
- Helping to reduce unnecessary hospital admissions or avoidable health interventions/pressure on primary care from care homes or home care agencies.
- Facilitating greater capacity and responsiveness within homes to address market pressures and reduce delayed transfers of care.

Summary of Key Costs:

Role	Grade	Cost
Joint team/programme manager (inc on costs)	ATM /SO3	£45,492
Three Quality improvement Officers (inc on costs)	3 x SO1	£115,602
Service Improvement Co-ordinator	1 x 0.5 wte Band 5	£17,674.
Two part time Nurses (or job share)	1 x 0.5 wte Band 6 1 x 0.5 wte Band 6	£44,011

Part time social work resource / backfill		£16,000
TOTAL recurrent funding		£238.779
Additional one-off investment*		£9,000*

*Additional one-off cost of £9,000 for the software development costs of a shared system wide Quality Dashboard to improve data in relation to the quality of provision

*Benefits are quantified in the summary cost/benefit sheet in Appendix One.

3.4 Proposal Four; Extending the Flexibility of existing Models of Care

This proposition involves looking at the services we already have in the community and considering what would be required to enhance the flexibility and responsiveness of those services.

One of these is the existing Care Home market, which could be enhanced through the provision of additional infrastructure support in relation to weekend admissions

At present there is unprecedented demand on the acute sector to facilitate timely discharges from hospital care for adults over the age of 65. A significant area of pressure is the availability and accessibility of both nursing and residential care. This proposal will outline the support required to improve the ability of both types of residential care to undertake weekend admissions and allow for timely discharge for those medically fit.

It is proposed that this will be undertaken with a specific group of homes and will thus create a 'proof of concept' for wider roll out taking into consideration both the longer term 'infrastructure' costs and the contractual expectations of our externally commissioned residential and nursing care homes.

It has been evidenced that during the weekend period there is a marked reduction in resource and capacity to undertake admissions into nursing/residential homes. As a result of this there is virtually no ability for an individual who is medically fit to be discharged to the preferred place of residence over the weekend and this results in a further delay of at least 48 hours and often longer if an assessment cannot be carried out until the following Monday. To alleviate this pressure during the winter period a ring-fenced capacity of 10 beds was blocked purchased to ensure facilitation of weekend admissions. Whilst these beds have been well used the ability to undertake weekend admissions has not been consistent and limited evidence to suggest assessments were done. The main challenges for this are:

- Sufficient staffing with the appropriate level of experience to undertake an admission at the weekend period in a home.
- Limited social work support to assist in assessment and admissions into a home as well as support with social care needs.
- Limited additional health related support available in particular GP coverage for nursing care and district nursing support for residential care.
- Lack of an appropriate discharge summary from the hospital, medication supply available to cover the weekend period, implementation of trusted assessor model not fully rolled out;
- People discharged to the winter pressure beds were unknown to the care homes.

The obvious case for change to address this current situation is to improve capacity in both our internal systems and the external market to undertake weekend admissions from hospital. This will in turn reduce pressure in the acute sector and ensure beds are free for those requiring hospital care and not occupied by those that are medically fit for discharge. It is clear that homes need to have the reassurance that the needs of those requiring discharge over a weekend period will have the necessary support available to allow for confidence, security and patient safety within the system.

The benefits of improving the ability for homes to undertake weekend admissions would:

- Improve performance for DTOC's over the weekend period;
- Improve efficiency in discharge and admissions into homes (trusted assessor);
- Collaborative approach with external providers to improve processes and outcomes;
- Appropriate place of residence for medically fit individuals with overall improved outcomes for well-being;
- Social and rehabilitative needs met in an appropriate environment;

The proposed approach to improve performance over the weekend period via access to admissions into care homes would entail a combination of comprehensive engagement with providers and a strengthening of the internal resources available within the Stockport Together Programme specifically within the intermediate tier and core neighbourhoods. In the first instance this will build on the trusted assessor model as piloted within the winter pressure beds at Hilltop Court and Plane Tree Court. The preference is to extend capacity to current intermediate tier teams to ensure continuity, staff rotation and more flexibility in cover arrangements, rather than creating a stand-alone team for weekend support.

The specific elements of this proposal:

- A new process for assessing the appropriate of admitting residents will need to be co-produced with providers to allow for consideration of the impact it will have on their capacity and ability to make these admissions in a timely manner. This will be undertaken through a full workshop session that will outline requirements and negotiate the appropriate conditions to ensure acceptance. This will in turn inform short-term requirements where there are providers willing to cooperate but also longer-term contractual arrangements.
- Currently within the service there is a crisis response team (intermediate tier) and this service has the potential to support residential and nursing care support on a daily basis including weekends and out of hours. To improve weekend admissions this team would need to be strengthened and would require the following investments:
- GP support to make visits to the home in particular for end of life pathways or medically complex patients. This would require additional GP hours for the crisis response team or additional 'home visit' capacity provided by Mastercall Out Of Hours / or GP pathfinder over the weekend period from Friday 16.30 to Monday 08:30.
- Social work support would be required for complex social care cases. This would include those without capacity or where there is dispute within families. This would include social work coverage from Friday 16.30 to Monday 08:30 either in the Crisis Response Team or Active Recovery Team.

- Therapeutic support for residents to access physiotherapy and occupational therapy at the point of discharge to facilitate improved physical well-being outcomes and speedier discharge from short-term placements. Two therapist (one OT and one Physio) would need to be available from the Active Recovery Team from 10-3 Saturday / Sunday.
- For those homes that do not provide nursing care, access to nursing support would be required. This would ensure that those that may have less complex medical needs could be supported more effectively in a residential care environment and reduce the potential of readmissions. This would require additional nursing hours to either the Crisis Response Team or Active Recovery Team from Friday 16.30 to Monday 08:30.

The following table provides a full cost breakdown of this proposal and includes pro-rata salaries to cover the winter period.

0.26 (10 hrs) OT band 6 (£44.011)	£ 11,443 + weekend oncosts = £ 13K
0.26 (10 hrs) physio band 6 (£44.011)	£ 11,443 + weekend oncosts = £ 13K
0.5 fte nurse band 6 (£44.011)	£ 22,006 + weekend oncosts = £ 25K
0.5 GP (£90K a year)	£ 45,000 + weekend oncosts = £ 50K
0.5 Social Work (SO3, £45.492)	£ 22,746 + weekend oncosts = £ 25K
	£126,000 before weekend on costs
TOTAL COST	£171,200 with weekend on costs

4.0 Key Partners in relation to the above four proposals;

- Stockport Council Adult Social Care
- Stockport NHS Clinical Commissioning Group
- Stockport Foundation Trust
- Pennine
- Healthwatch Stockport Ltd.
- 3rd sector and community groups
- Neighbourhood Teams including GPs, District Nurses and colleagues across MDTs
- Colleagues in housing, place based services, fire service etc.

5.0 Further strategic outcomes/benefits

Impact on the wider system

Following reviews of the care home and domiciliary care sectors, the priority is to develop a plan that will transform the sector effectively to achieve a stable market and manage the

demand and supply of care in these markets.

The key areas of focus over the next year will be on joint working with the Clinical Commissioning Group (CCG) and others to commission or further develop new models of care to address issues of capacity in the market and improve outcomes for individuals, ensuring strategic links to both 'Stockport Together' and 'Greater Manchester' developments. Service quality has been identified as a key theme within this joint commissioning approach, as we further develop a holistic and pro-active quality assurance function in partnership with providers, to prevent or address issues relating to business failure whilst ensuring financial sustainability across the market. As such these initiatives are fundamental to the neighbourhoods business case, since the development of new and enhanced models of community support and the provision of good quality services in the community is not only the core business of Stockport Together but fundamental to its future strategy of reducing reliance on emergency and inpatient services.

Robust planning and partnership links to facilitate all the above will be supported by an Ethical Care framework. The impact of home closure or business failure severely impacts across the whole Health and Social care market. It is increasingly evident that the role Social Care providers play within the community is a fundamental resource required to reduce the number of people admitted to Hospital and to reduce hospital delayed transfers & ultimately fulfil the broader preventative agenda, as part of the Stockport Together vision, to enable people to benefit from an appropriate choice and quality of support in their own homes and in the community.

In conclusion, the above proposals will help ensure both a prompt response and a preventative approach regarding 'market failure' and incorporate robust contingency planning. They will help promote market stability, develop strong relationships and build on best practice, influence change in processes and culture, seek to achieve a consistent supply of good quality provision in the market, and work with colleagues across the system to help address delays for people waiting for packages of care, with providers causing concern. Along with a range of colleagues and partner agencies, they will work in alignment with the neighbourhood teams to promote good relationships with commissioners and providers. This dedicated resource will enhance the ability of the local health and social care economy, to address its strategic aims, not only in relation to people with high levels of need but also in relation to its most fundamental aims of keeping people with long term conditions or health and wellbeing needs, safe and well at home and/or in receipt of appropriate support in the community.

STOCKPORT TOGETHER BUSINESS CASE APPENDIX 1; EXTERNAL MARKET;
SUMMARY OF INVESTMENT PROPOSAL (280217)

Proposal	TOTAL COST	Lag/Phasing	Description of Benefits	ESTIMATED TOTAL BENEFITS
1. a) Investment of £230K for delivery of short term re-ablement support (this is the cost of continuing with the current successful pilot, based on a full year's costs, rather than ending this intervention in March 2017.	£1.2m £230k	No lag – Extension of current contract under winter pressures needs to continue from 1 April.	Avoidance or reduction in need for long term home support Avoidance of 60 DTOC or non-elective admissions per year	£496k £176k £672k
1. b) Further investment of £230K to roll out this model further and thus extend delivery of the anticipated outcomes across the neighbourhoods	£230k	Estimated time to bring online following agreement to proceed is 3 months.	Avoidance or reduction in need for long term home support Avoidance of 60 DTOC or non-elective admissions	£496k £176k £672k
1. c) £230K to continue with the current pilot for overnight home support	£230k	No lag – Extension of current contract under winter pressures needs to continue from 1 April.	Avoidance of 24 care home respite admissions (based on 4 weeks duration at £475); Avoidance of 12 care home admissions (52 weeks x £475 x 12);	£46k £296k



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			Avoidance of 12 non elective admissions*; £39K	£381k
2. Further investment in Extra Care Housing; (ECH) <p>The Extra Care model in Stockport offers accommodation with support as an alternative to residential care, with more support than domiciliary care. One of the Extra Care Schemes will be given additional staffing cover to extend its offer so that it can take people with more complex needs and avoid unnecessary care home or hospital admissions.</p> <p>This is a pilot to test the hypothesis that increasing the level of support within Extra Care Housing would enable the scheme to admit residents with higher needs and avoid hospital admission. Recent consultations with practitioners indicated that they would have chosen the Extra Care scheme more readily if there had</p>	£91k	Estimated time to bring online following agreement to proceed is 3 months.	This is proof of concept but this additional investment could pay for itself, through avoiding residential admissions, non-elective admissions and delayed transfers of care (estimated at £96k in total)	£96k



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<p>been more support at night. The additional day time support identified would complement this support but also work to develop the scheme further.</p>																
<p>3. Joint Quality Intervention Team (JQIT)</p> <p>The focus of this approach is on raising standards thus the quality and choice of support for vulnerable people and their families.</p>	<p><u>Summary of Key Costs:</u></p> <table border="1" data-bbox="601 595 1073 1338"> <tbody> <tr> <td>Joint team/programme manager (inc on costs)</td><td>ATM /SO3</td><td>£45,492</td></tr> <tr> <td>Three Quality improvement Officers (inc on costs)</td><td>3 x SO1</td><td>£115,602</td></tr> <tr> <td>Service Improvement Co-ordinator</td><td>1 x 0.5 wte Band 5</td><td>£17,674.</td></tr> <tr> <td>Two part time Nurses (or job share)</td><td>1 x 0.5 wte Band 6 1 x 0.5 wte Band 6</td><td>£44,011</td></tr> </tbody> </table>	Joint team/programme manager (inc on costs)	ATM /SO3	£45,492	Three Quality improvement Officers (inc on costs)	3 x SO1	£115,602	Service Improvement Co-ordinator	1 x 0.5 wte Band 5	£17,674.	Two part time Nurses (or job share)	1 x 0.5 wte Band 6 1 x 0.5 wte Band 6	£44,011	<p>Estimated time for recruitment following agreement to proceed 3 months – could start to recruit at risk prior to agreement to reduce any time lag.</p>	<p>Through the approach outlined, the Joint Quality Intervention team will seek to raise standards, ensuring appropriate transitions or transfers of care where needed and intervening to address avoidable <u>care home/nursing home</u> closures or emergency intervention. Avoiding one NEL p.a for 40 residents would save the health economy</p> <p>£128k</p> <p>Intervening in a similar way with home support agencies, the JQIT would seek to avoid emergency intervention for a further 20 people</p> <p>£64k</p> <p>If, as a result of JQIT the care homes that are currently rated as</p>	
Joint team/programme manager (inc on costs)	ATM /SO3	£45,492														
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	Part time social work resource / backfill		£16,000		`inadequate' improve their quality rating and as a result their emergency admission 'rate per bed', it is estimated that this could deflect 86 emergency admissions per year from the acute health economy, saving £276k	
	TOTAL recurrent funding		£238.779			
	Additional one-off investment*		£9,000*			
			£248K			
	<p>*Additional one-off cost of £9,000 for the software development costs of a shared system wide Quality Dashboard to improve data in relation to the quality of provision</p>					
4. Investment to enable care homes to undertake weekend admissions and reduce delayed transfers of care.	<u>GP support</u> to make visits to the home in particular for End of Life pathways or medically complex patients. This would require additional GP hours over the weekend period from Friday 16.30 to Monday 08:30 <u>Social work support</u> would be required for complex social care cases. This would include those without capacity or where there is dispute within families. This would include social work coverage from Friday 16.30 to	Propose align to timescale for implementing extended operating hours in the neighbourhoods i.e. early June. However could look to bring on earlier if needed to	The benefits of improving the ability for homes to undertake weekend admissions will include <ul style="list-style-type: none"> • Improved performance for DTOCs over the weekend period; • Improved efficiency in discharge and admissions into homes (trusted assessor); • Collaborative approach with external providers to improve processes and outcomes; 			



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	<p>Monday 08:30</p> <p><u>Therapeutic support for residents to access physiotherapy and occupational therapy at the point of discharge to facilitate improved physical well-being outcomes and speedier discharge from short-term placements.</u> Two therapists (one OT & one PT) would need to be available from 10-3 Saturday / Sunday</p> <p><u>For those homes that do not provide nursing care, access to nursing support would be required.</u> This would ensure that those that may have less complex medical needs could be supported more effectively in a residential care environment and reduce the potential of readmissions. This would require additional nursing hours to the Crisis Response Team in Friday 16.30 to Monday 08:30 . Total for the above;</p> <p style="text-align: right;">£171k</p>	<p>support hospital discharge.</p>	<ul style="list-style-type: none"> Appropriate place of residence for medically fit individuals with overall improved outcomes for well-being; Social and rehabilitative needs met in an appropriate environment; The cost of single day's stay in an hospital bed offset against the cost of residential nursing placement represents quantifiable savings to the wider system; <p>The proposed approach to improve performance over the weekend period via access to admissions into care homes would require a combination of comprehensive engagement with providers and a strengthening of the internal resources available within the Stockport Together Programme specifically within the intermediate tier and core neighbourhoods. In the first instance this will build on the trusted assessor model as piloted within the winter pressure beds at Hilltop Court and Plane Tree Court. Benefits related to the improved effectiveness of DTOC (Delayed Transfers of Care), will be evaluated in addition to the benefits listed here.</p>	
TOTAL COST	£1.2M		TOTAL BENEFITS	£2.289m



HEALTHY COMMUNITIES BUSINESS CASE

	<p>Purpose</p> <p>1. <i>Case for Change</i></p> <p>The strategic aim of this proposal is to contribute to the transformation of the relationship between people, services and communities, through delivery of person and community centred care. This will improve people's physical and mental health and wellbeing while reducing demand on primary care and preventing admissions and re-admissions to hospital or intermediate care.</p> <p>Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities and this proposal is a key part of a broader strategy, which draws on existing resources and projects and seeks to embed a new relationship between services, people and communities. This business case is focused on three key elements:</p> <ul style="list-style-type: none"> • Easy access and empowering people to access, the information resources and online support that people need to manage their health including long-term condition. • Capacity to provide targeted coaching support to help people develop the skills, motivation and confidence to manage their own conditions • Growing networks of peer support and voluntary activity to improve social connection and sustain long-term change. <p>Our aim is to enable person centred care which begins with the question "What matters to you?" rather than "What is the matter with you?" in order to understand and address people's needs in a holistic way. This assets-based approach will help people to access their own internal social and psychological resources as well as external resources including those within their family and those generated through collective community activity. The investment proposed responds to the evidence for effectiveness of these approaches as set in the <i>Realising the Value</i> (Nesta) and NICE guidance¹</p> <p>The theory of change (Appendix 1) draws on Self Determination Theory, an established and tested model, which identifies three key factors for personal growth and wellbeing: autonomy, (acting of one's own volition), competence, (self-efficacy and achievement) and relatedness (social connection, caring and belonging).² The elements described set out to address these factors in order to deliver outcomes in improved health and wellbeing and impacts on the quality and sustainability of the Health and Social Care system by reducing demand.</p> <p>The focus of the model addresses the human experiences of health and wellbeing and relationships between the people giving and receiving care. These are not only important in themselves but also as the drivers of need and demand on health and social care, as people with unmet social needs are likely to experience poorer health, including anxiety and depression as well as the physical health consequences of these. Their experiences also</p>
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¹ NICE, 2016 *Community engagement: improving health and wellbeing and reducing health inequalities*. www.nice.org.uk/guidance/ng44

² See <http://selfdeterminationtheory.org/theory/>

	<p>create demand for health and other public services as they seek help from services which are unable to respond appropriately. Viewing demand through the lens of the medical model often leads to medical responses to social problems, while the complexity and fragmentation can lead to ‘failure demand’ (“demand caused by a failure to do something or do something right for the customer”³). This often involves considerable waste of resources in undertaking different assessments and referring people on, or providing no service, due to thresholds and criteria. By failing to address the needs of the person, we generate further presentations or ‘demand’.</p> <p>Changing the culture within our services towards the vision described in the ‘Stockport Way’ (Appendix 2) is key to better supporting people with long-term conditions to self-manage by working with individuals and their support networks. This means working collaboratively to optimise the use and benefits of informal as well as service-based support and activity in a spirit of equal partnership between individuals, families, community groups, voluntary organisations, social enterprises and businesses that make up a local community.</p> <p>Workforce development and culture change will be key to delivery of these objectives, including changing the processes through which we assess people to shift the focus from solely capturing specific ‘treatment’ needs to working with people to identify their own priorities and the resources they can access to achieve them, including but going beyond services. This is being addressed through the Enabler programmes and cross-cutting transformation work including integrating services in neighbourhoods.</p> <p><i>Programme Interdependencies</i></p> <p>The components of the Healthy Communities approach outlined in this case are closely aligned to the core neighbourhood model. Where the core neighbourhood will work in a multi-disciplinary team to support individuals identified most at need (the top 6-15%), this programme of work will support those who are on the border of this cohort, currently not managing their condition as well as they could. Additionally, this approach will form part of the offer to those newly diagnosed with a long-term condition, or at high risk of developing a long-term condition, identified through the Find and prevent Project. Finally, this approach also links with the revised model of outpatient support. When an individual with a long-term condition is not currently managing their condition well, but does not warrant referral to a specialist consultant, the health coaching model will be able to support them to improve their self-management of the condition, which will provide primary care clinicians with a suitable route to ensure the individual receives additional support.</p>
2.	<p>Background</p> <p><i>Current Situation</i></p> <p>Over a quarter of the population in England has a long term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes that,</p>

³ Vanguard and Locality, 2014. *Saving money by doing the right thing: Why ‘local by default’ must replace ‘diseconomies of scale’*

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“Long Term Conditions are now a central task of the NHS”.

People with long term conditions currently use a significant proportion of health care services;

- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

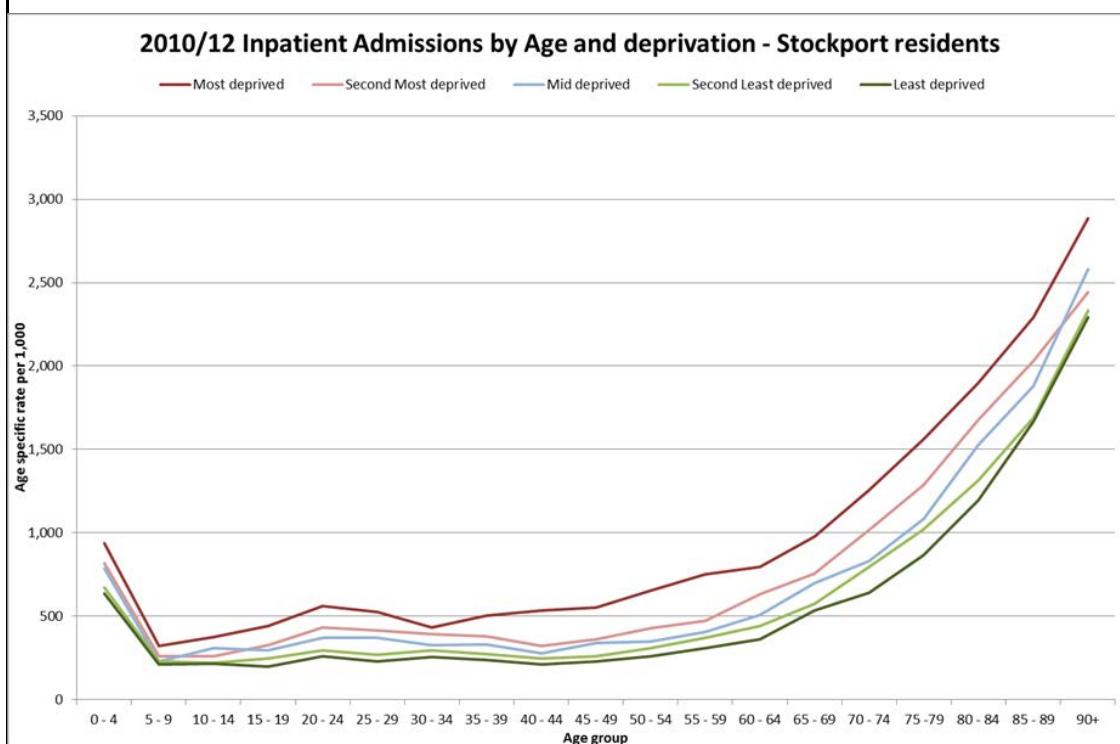
There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and healthcare costs are significant. 15.4 million people in England are recorded as having have a long-term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9million in 2008 to 2.9million by 2018). By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.

In Stockport, 41% of the population (124,000) have one or more long term health condition, and this increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over. By age 55, half of the people have one or more of these conditions and 9% of the population have two or more of 8 key long term conditions. Many more may also have a condition which is currently undiagnosed (see Appendix 3). There are 26,000 people registered with a Stockport GP with a history of depression and there are 40,000 people registered with a history of anxiety. These are commonly associated with other long-term conditions and physical health problems, as well as social isolation. Capacity in mental wellbeing Improving Access to Psychological Therapies (IAPT) services and mental wellbeing prevention is increasing, but the use of anti-depressant prescribing is still increasing and is a significant pressure to the health system.

Rates of hospital admission increase with age and are higher at each age in areas with higher levels of deprivation as shown in the graph below. While the older population is lower in size in the more deprived areas, the people living in these areas tend to have fewer social and economic assets to draw on and therefore may need more support from public and voluntary services. Additionally, people with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people. As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly. In addition, the costs of providing care to this group of people are increased as a result of less effective self-care and other complicating factors related to poor mental health.

We have a range of services and activities working with people who have long term conditions to make lifestyle changes that will support them in the management of their health. These include the Expert Patient programmes; Healthy Stockport family of services;

Cancer Champions; Social prescribers including Walking for Health; voluntary sector alliances (The Prevention Alliance (TPA), Wellbeing and Independence Network (WIN) & Alliance for Positive Relationships (APR)); as well partner agencies such as Stockport Homes, and non-commissioned voluntary and community organisation activity. These are complemented by workforce development such as Connect 5 and Health Chat training. However, clinicians and other front-line staff lack the time to invest in coaching people with long-term conditions (LTCs) to engage with and utilise the resources available in services and communities. This means there is a gap in the capacity to proactively identify, engage with and coach the people who could benefit from better self-care and self-management that is required to bring about the scale of impact on demand that is needed to make the system sustainable.



Research Evidence/Best Practice

Self-care support & coaching

The evidence demonstrates that there is a willingness amongst patients to self-manage, yet current practice shows that there are still millions of appointments nationally for minor ailments and that people with long term conditions are among the biggest users of health care. This occurs due to a lack of confidence in understanding and managing a condition or symptoms; the perceived duration or severity of symptoms; or for reassurance or 'cure' seeking.

Improving self-care requires greater personal responsibility for health and wellbeing. People should be supported to take control of their own health and focus on changing what matters to them. This support can come from informal carers and the organisations and practitioners who provide health and social care. The essence of this support is a collaborative, trusted

relationship between people ('patients' and 'service users') and practitioners (service providers).

When healthcare is designed to empower self-management, people with long term conditions and their carers play a more active role in managing their own health and reduce their need for help from the NHS and social care. NHS England, The Health Foundation and Nesta have recently published findings suggesting that effective self-management is the key to person centred care i.e. care that is personalised, coordinated and enabling. Furthermore, care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes.

Supporting people living with a long term condition requires a partnership with patients over the longer term rather than providing single, unconnected "episodes" of care. Helping patients thrive in the presence of these diseases requires a paradigm shift in health care delivery models; moving from "What's the matter" to "What matters to you?", as described in the "Stockport Way" vision. This means moving away from a paternalistic and dependent consultation model of 'fixing' to one that is empowering and increases patient knowledge, skills, confidence, self-efficacy and healthy behaviours, which are all needed to improve outcomes and reduce healthcare costs. As such it is part of an asset-based approach recognising what people and communities can do for themselves and each other rather than viewing people simply through the lens of 'needs'.

This business case draws on the evidence from the *Realising the Value* programme⁴ which addressed the NHS Five Year Forward View vision for a new relationship with people and communities. Based on a review of the evidence, the programme identifies five areas as showing significant potential to improve quality of life for people with long-term conditions and deliver benefits across the three dimensions of value: Mental and Physical health and wellbeing, NHS sustainability and wider social outcomes. These are:

- Peer support
- Self-management education
- Health coaching
- Group activities to support health and wellbeing
- Asset-based approaches in a health and wellbeing context.

The programme recognises that person-centred and community-based support needs to be both holistic and tailored around the individual, and there are connections between these approaches and other key enablers such as care and support planning and social prescribing. Interventions linked to these approaches can help to increase people's activation. It is also important to note that efforts to increase levels of patient activation will be more successful when supported by a whole system approach including training of clinicians in these new ways of working.

⁴ Nesta, 2016. **Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing:** www.nesta.org.uk/realising-value-programme-reports-tools-and-resources

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Nuffield Trust (2017) *Shifting the balance of care: Great expectations*⁵ states that programmes that aim to change patient behaviours are likely to be more successful than those that simply provide information. Where sufficiently supported and funded across the system, IT can be a useful tool in engaging patients and encouraging them to adopt more positive health behaviours. Evidence shows that self-care initiatives, particularly those that rely on e-health or digital tools, are more successful when they are supported by professionals.

Patient Activation

People who have the knowledge, skills and confidence to manage their own health experience better health outcomes. Yet the ability of people to successfully manage their LTCs and to stay well at home can vary considerably from person to person. This is why understanding people's ability to manage their conditions is so important. The Patient Activation Measure (PAM) is a validated tool which enables this and captures the extent to which people feel engaged and confident in taking care of their health. This can be described as their level of activation.

Evidence shows that people at higher levels of activation tend to experience better health, have better health outcomes and fewer episodes of emergency care, and engage in healthier behaviours. On the other hand, patients with lower activation have low confidence in their ability to have an impact on their health and often feel overwhelmed with the task of managing their health and wellbeing.

It has been estimated in the USA that between 25 and 40 percent of the population have low levels of activation (levels 1 and 2)⁶. These people are unlikely to respond to opportunities to improve their health through self-management. They do not understand their role in care process and have limited problem solving skills. Often they have experienced failure in trying to manage and have consequently become passive with regard to their health and wellbeing. As a result, they engage less with preventative healthcare and are involved in more costly emergency care episodes.

Measuring patient activation can drive real improvements as:

- Understanding activation levels help patients and clinicians to determine the realistic "next steps" for individuals to take in term of self-management;
- It allows for training and education resources to be tailored to the levels of activation of different individuals within the population;
- It can support more appropriate allocation of resources towards people at lower levels of activation and who are less confident about their ability to manage their own care.
- It can enable equality and health inequalities to be tackled more effectively by targeting interventions at disadvantaged groups to increase their health literacy and patient activation.

⁵ <https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

⁶ Hibbard JH, Cunningham PJ, 2008. How engaged are consumers in their health and health care, and why does it matter? Res Brief. 2008 Oct; (8):1-9.

Studies show that targeted interventions can increase people's activation scores and their capacity to self-manage their condition more effectively; and when appropriately supported, patients with lowest levels of activation make the most gains⁷. Typically the programmes focus on gaining new skills, encouraging a sense of ownership of their health, supporting changes in their social environment, health coaching and educational classes. People with lower levels of activation are likely to need more in-depth one to one support as compared to people with higher levels of activation.

All of these help to empower people to take greater control of their health, leading to better outcomes and improved experience of the health service and resulting in reduced healthcare costs of these patients in the NHS. A study found that less activated patients had 8 percent higher costs in the base year and 21 percent higher costs in the following year than more activated patients.

Peer and Voluntary support

Around 25% of adults in Stockport report that they volunteer once a month or more. There is considerable evidence for the health and wellbeing benefits of active involvement in voluntary activity, particularly among older people⁸, while the increasing numbers of retired people bring enormous personal assets, representing a huge potential resource for health and wellbeing in the borough.

Robin Lane General Practice in Leeds, is one of 60 GP Practices in 16 CCG areas where the Altogether Better approach to generating social action through health and community champions has been delivered and evaluated. By recruiting more than 50 Practice Health Champions, the Practice has been able to increase its patient list by 57% from 8,500 to 13,000 patients without any increase in Primary or Secondary Referrals and a 10% reduction in use of A&E. There is evidence of increased efficiency by dealing with failure demand and the practice have reconfigured their staff team and redesigned their offer to respond to the new challenges, choosing not to appoint to a vacant salaried GP post but instead choosing to invest in a Community Matron and a Wellbeing Coordinator.

Evaluation of work in 30 General Practices, drawing on evidence from the UK Government's Foresight Project and the New Economics Foundation, shows that 216 'types' of Practice Health Champion-led activities brought about improvements in patients' wellbeing, resilience and ability to adapt, cope and live well with long term conditions as well as a gaining a better understanding of how to use services. The evidence tells us that when it works for patients we see significant improvements in mental health and wellbeing and overwhelming support from practice staff to sustain the work:

- 94% of patients surveyed had improved mental health and wellbeing
- 95% of staff surveyed recommend and want to continue after the funded period has ended⁹

⁷ See www.kingsfund.org.uk/publications/supporting-people-manage-their-health

⁸ JENKINSON, C.E. et al., 2013. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health*, 13, pp. 773

⁹ Altogether Better, *Reducing the pressure in General Practice: A new model of care*.

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	<p>In other areas patient empowerment approaches have demonstrated significant impacts on demand for health and social care services: Challis et al (2010) found they improved health outcomes, with patients reporting increases in physical functioning). ‘Ways to Wellness’ is a Newcastle primary care social prescribing initiative providing people with long-term conditions with one-to-one Link Worker support. The net savings to Newcastle West CCG are estimated to be between £2m-£7m. (NHS Constitution, 2014). It has also been shown to reduce unplanned hospital admissions for COPD and asthma (Purdy 2010). Empowering patients to self-care for long-term conditions can reduce visits to GPs by up to 69%; and reduce hospital admissions by up to 50%. (NHS Alliance)</p>
3.	<p><i>Proposed Clinical Model</i></p> <p><i>Who is it for?</i></p> <p>The approach encompasses the entire adult population of Stockport, as everyone brings their own potential assets, including knowledge, experience skills and values that may directly or indirectly impact on their own and other people’s need for health and social care services. However, the strategic focus is on the needs and assets of those adults who currently make most use of health and social care services and the staff and carers working with those people. It will work with four of the five cohorts identified in Stockport Together’s Greater Manchester Transformation Fund programme Locality Proposal:</p> <ol style="list-style-type: none"> 1. The 6% of the population accounting for 60% of non-elective admissions; 2. A further 9% at high risk of soon becoming users of hospital services; 3. 60,000 who have an unidentified long-term condition/high risk of developing one; 4. People who account for the 30% of current GP appointments which are not an appropriate use of GP time for whom we can provide better alternative care <p>To deliver this supported self-management of long-term conditions requires enabling individuals to develop the knowledge, skills and confidence in managing their condition(s), and empowering them to know where to seek the right support if and when they need additional help in managing their condition. To ensure that support is tailored appropriately and that patient education courses are well used, co-production methods should be used to develop appropriate systems of support for people with long-term conditions.</p> <p>Therefore this model seeks to both mobilise existing and potential assets and to strengthen networks and promote the kind of reciprocity that can maintain and develop the resilience of individuals, families and communities. As such the greatest impact will be seen among people currently making most demands on services, and those who will do so in future.</p> <p><i>Health Coaching</i></p> <p>A model of health coaching will be implemented which provides for two health coaches in each of Stockport’s eight neighbourhoods (16WTE AfCBand4). Each of the health coaches will be supported by a nurse (2WTE AfCBand7) who oversees management and the clinical knowledge required by the coaches. These nurses may be existing District or Practice Nurses working within the Integrated Neighbourhood Teams, but will require specialist knowledge and skills in health coaching as well as clinical knowledge in relation to long-term condition management.</p>

Patients will be eligible for the service if they have at least one long-term health condition. The service will be targeted at two groups initially – those who are living with a long-term health condition currently not well managed and those newly diagnosed with a long-term health condition (identified through general practice including via the Find and prevent approach).

The Coaches will work in person-centred way, empowering the patient to develop knowledge, skills and confidence in managing their condition, including both one to one and some group work, such as the 'Reclaim Your Life' programme. This will include linking people into existing courses or relevant groups and building their skills including understanding when it is appropriate to seek further help and the different routes to the appropriate care.

They will provide an initial session of 1 hour, which will include using the Patient Activation Measure tool to help the individual and their coach understand how well 'activated' the individual is. The PAM score will help the individual and their coach determine the frequency and type of future session (face to face or telephone). The coach will work with the individual for a period to be determined in the initial session, up to a maximum of 12 months. At the end of the intervention the individual will be have their PAM score re-assessed and will be discharged back to primary care, with support from the wider community as per Stockport Together's Healthy Communities approach.

Health coaches will be able to support individuals to access existing services for example:

- Condition specific and general long-term condition patient education courses.
- Disease prevention courses (e.g. DESMOND Walking Away from Diabetes.)
- Lifestyle/behaviour change courses including (via START.)
- Support for other social issues (via TPA.)
- Existing support groups in the community.
- Mental health and wellbeing programmes such as Living Life to the Full and mindfulness training.

The use of the PAM will guide the health coach in tailoring the offer for the individual's level of activation and as such the total time an individual spends with their coach, and the referrals to other services will vary accordingly. As Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities, provision of the PAM licences is now available through NHS England. As well as in health coaching, we will use PAM to tailor and outcome monitor for people accessing Physical Activity Referral in Stockport (Life Leisure - provider). This service will act as a pilot for using PAM in behaviour change services and we will explore extending its use into other services.

Development of online resources

Many people identified through the Find and prevent process or already known to be living with LTCs will have higher levels of activation and therefore will not need the intensive coaching support, but will need access to trustworthy information and advice about their condition and wider health needs. Online and app-based information and resources for self-care offer a significant opportunity to empower people to take more control and successfully

manage their health and wellbeing. We will build on the newly updated Healthy Stockport website to create a trusted point of information and advice on a range of LTCs in order to make it easy to find the information needed. This will link with and complement the directory of community organisations and activities in Stockport, currently being developed by Stockport Council's Digital by Design programme.

The new web-resources will include interactive information about apps for health and wellbeing to help people navigate the plethora of competing apps available to find those that are both evidence-based and useful. As well as recommendations based on expert opinion it will include opportunities to people to share their experiences of using these apps and tools. It will also have the confidence of clinicians who will be able to recommend this to patients.

In addition to receiving 1:1 coaching, the individuals who are engaged with a coach will be encouraged to assist the development of the online resources, sharing their experience of self-care support information, condition specific advice, and useful web-links etc., which can be shared with others using the service, and other Stockport residents. This will form part of existing web offer (i.e. Healthy Stockport) to ensure that all relevant information is available through one place and the development will be supported by 0.5WTE web developer on a fixed term contract.

Health Champions within the Collaborative Practice and Peer Support

A renewed and expanded approach to growing community health champions who will work with primary care and Integrated Neighbourhood Teams to provide an additional level of support to people at high risk of hospital admission and other vulnerable individuals in the community will be developed. The Health Champions within the Collaborative Practice model is currently being tested in three GP practices, drawing on limited non-recurrent ASC funding, to enable evaluation of the impact initially with a view to extending the model if its impact is demonstrated locally. This is being facilitated by an external provider, Altogether Better. The Altogether Better evidence based approach is normally embedded and becomes self-sustaining within 12-16 months; ASC funding has enabled the approach to be tested for six months but note the need to extend for a further 6 month period.

Building a team of 'Health Champion' volunteers to work with primary care has been demonstrated by Altogether Better to significantly reduce the demand for GP appointments. Health Champions, as members of the local community, can offer time as well as local knowledge to support people who may present to General Practice with non-medical problems, as well as providing social and psychological support to help people cope with and manage their health conditions. Health Champions may play a part in the coproduction of services as well as helping to represent the views and needs of the local community through their engagement with health and social care services.

Community Health Investment Fund

We would propose to develop a small grants investment fund that would be designed to stimulate activity around health, wellbeing and resilience that would primarily focus on developing peer support groups and activities for people with LTCs and for tackling

loneliness and increasing social connections. The small grants would be available to community groups and voluntary organisations across Stockport, including micro grants of £250 and small grants of up to £2,500 and would be awarded on a locality basis with full engagement and support of the Neighbourhood teams, who would outline the local priorities from their needs assessment. Criteria for funding could include:

- Projects/activities that result in groups and communities of people becoming more active in their own communities' health and wellbeing.
- Projects/activities that result in people feeling a greater sense of control of their lives and how they manage their health.
- Ideas that come from communities that bring the communities together to address local issues around isolation or loneliness.
- Ideas that inspire others to get involved and take action in a voluntary role to support health and well-being.

Note that as one of six selected Vanguards for testing 'Health as a Social Movement', small grant funding of £20k has been made in the year 2016-17 with excellent and encouraging results for growing community groups and activities which will impact on health and care demand.

Further non recurrent funding from Adult Social Care has been used to generate community activities linking to this Business Case, for example the Good Gym, a Centre for Social Action Innovation Fund project sponsored by the Cabinet office will be established in Stockport early in 2017, see <https://www.goodgym.org/> Adult Social Care has provided half of the £25k needed to establish the Good Gym, the remainder underwritten by Age UK Stockport and the TPA. It will generate 1600 hours of new volunteering time in Stockport in 2017 and over two years, as it becomes self-sustaining through membership fees, will support 78 older, frail individuals referred through the Neighbourhood Teams reducing their use of services. The Community Investment Fund would support evaluated initiatives like the Good Gym to develop in Stockport.

Stockport Council is also developing proposals for an Investment Fund for growing more independent and self-sustaining communities; through aligning these funds the growth of community groups and networks which will have a demonstrable impact on health and wellbeing and demand activity will be ensured, securing empowered and engaged communities built on increased social action and volunteering.

Self-Care Programme Management

As part of our work embedding the Stockport Way, it is proposed that each neighbourhood team should be supported in a self-assessment of how it facilitates self-care, alongside the training to be delivered to all staff (included in the Workforce Enabler business case), and roll-out of the Find and prevent and self-care programmes across neighbourhoods. A tool for this purpose has been developed by Pennine Care and it is recommended that this should be adopted or adapted for use within Stockport Together.

At present we have several education programmes and services supporting people with

long-term conditions, but these have limited capacity. It is proposed that this provision should be reviewed in a collaboration with the Neighbourhood Teams and people eligible to use these services, drawing on the learning from the self-assessment process.

A fixed-term programme manager for self-care will be recruited to:

- Plan, manage and coordinate the development of the new roles and recruitment.
- Commission and plan the training of new and existing staff in coaching skills and methods.
- Develop and deliver the neighbourhood team self-assessment (which would then be owned and maintained within neighbourhoods.)
- Support the development and adoption of tools and resources for asset-based wellbeing conversations and planning in place of deficit-based assessments.
- Manage the piloting, evaluation and roll out PAM.
- Develop and map resources which enable people to access (in a way they understand and want to use) the information they need to care for and support their own health and wellbeing (ensuring that any resources are developed in a sustainable manner.)
- Evaluate the impact of the project and develop and embed a self-care plan for Stockport, which continues to thread this work in to our culture

Activity

Once fully operational, the health coaching service will support 2,400 people living with long-term health conditions per year. The capacity building approach will help ensure the progress made by people engaged is supported in the longer term through engagement in peer support and other community activities which enable continuing mutual support and personal growth. This will mean the numbers benefitting from involvement in such informal support networks will increase cumulatively each year, in addition to the direct support provided, and the benefits of improved self-care will be sustained.

The Health Champions work will engage at least 50 people in volunteering connected to their GP practices and deliver support to at least 250 individuals in their communities. This will be complemented by the establishment and growth of peer support and other health-related community activities in the community. The Community Health Investment Fund will support an estimated 50 health-related community activities per year, depending on their scale and this will bring health and wellbeing benefits to at least 500 people.

The programme will deliver a range of synergistic activities which stimulate the growth of individual and community capacity for and engagement in self-care:

- Easy access to informative and motivational online resources, including space for online mutual support.
- Proactive engagement and support for people to improve their self-care, tailored according to need using the Patient Activation Measure.
- Increasing numbers of people actively engaging in voluntary activity, complementing and adding value to the work of Stockport Together to improve health, wellbeing and interdependence.

4. Benefits

A self-care approach to health and social care is expected to have three main benefits:

- **Empowering patients.** People will be encouraged to participate as equal partners in decisions about their care. This gives people an opportunity to take control of their health and wellbeing rather than health professionals being in control and will lead to improved quality of care and patient satisfaction levels.
- **Managing Demand.** The Department of Health estimates that 15% of A&E attendances and 40% of GP time could be avoided through improved self-care. Over two-thirds of GP visits result in prescribing drugs that are available over the counter. The Wanless review (2002) estimated that for every £100 spent on helping patients care for themselves, £150 could be saved by the reduction of GP and outpatient visits.
- **Improving outcomes.** When people self-care and are effectively supported to do this, a range outcomes are improved. These include: they are more likely to experience better health and well-being; reduce the perceived severity of their symptoms; improve medicines compliance; prevent the need for emergency health and social services; prevent unnecessary hospital admissions; have better planned and co-ordinated care; remain in their own home; and have better mental health and less depression.

In reviewing the likely impact of interventions proposed in this Business Case we have considered three key types of outcomes:

- **Financial outcomes:** translates into net financial impact on Commissioners due to the intervention (i.e. activity reductions, cashable savings). NB. Some of these have not been possible to calculate for the business case i.e. social care cost avoidance, Community Health services demand reduction.
- **Health and wellbeing outcomes:** represents the non-financial positive impacts on the health and wellbeing of service users including: clinical outcomes and wellbeing outcomes; long-term health preventative benefits; and reduced health inequalities.
- **Wider social outcomes:** financial and non-financial benefits that wider society will experience due to the intervention, but are not attributable to commissioners savings' (i.e. absenteeism reduction, voluntary, value of social inclusion, workforce health, wellbeing and engagement.)

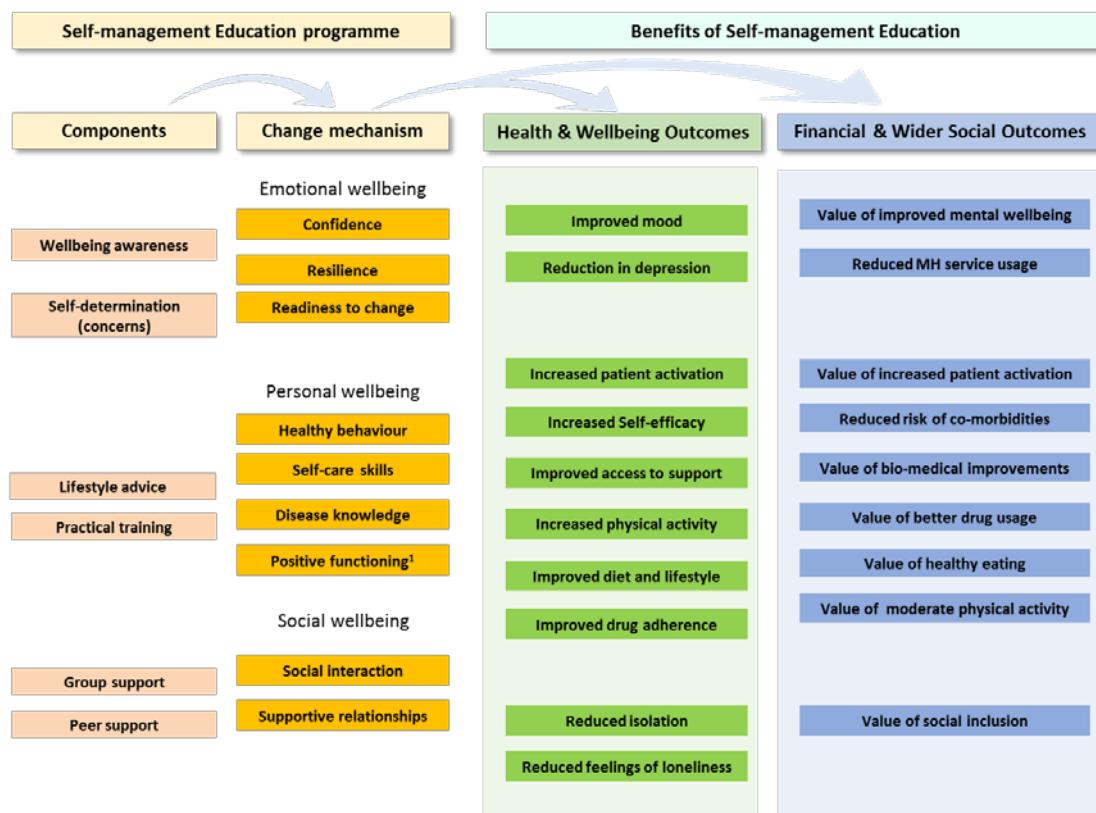
Self-care: Evidence suggests that self-care can have a positive impact, although it is often not clear which component makes it effective. Self-care in long-term conditions has been shown to reduce A&E attendances, in particular for adults with Chronic Obstructive Pulmonary Disease (COPD) and asthma, and possibly heart failure. It can also improve adherence to treatment. A systematic review found self-management support was associated with reductions in cost, a small significant improvement in quality of life and significant reductions in health care utilisation, with evidence being strongest for respiratory and cardiovascular disorders. This covered a number of conditions, such as respiratory, cardiovascular, mental health, arthritis and other pain conditions¹⁰.

Self-management education: Self-management education programmes provide people with knowledge about their condition and provide them with tools and skills to manage it on a daily basis. When people are able to manage their condition, this reduces its impact on their daily life, leads to considerable health improvements and reduction in health care use.

¹⁰ <https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf>

 *Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)*

Overall health and wellbeing improvements have been noted like engaging in physical activity and therapy compliance, but also more particular improvements like control of blood glucose levels in diabetes patients. Such improvements have been shown to reduce the need for health care currently (A&E and hospitalisations), but also reduce the risk of long-term complications that potentially have a large impact on people's life and would require intensive care.



¹ Positive Functioning elements : (competence, purpose, value in life)

Peer Support

Peer support is defined as “a range of approaches through which people with similar long-term conditions or health experiences support each other in order to better understand the condition and aid recovery or self-management.”

People receive support and coaching from a person that has experienced similar challenges or health conditions. This person can help to better understand their conditions, support recovery and self-management. Peer support can be delivered on a one-to-one basis, which may be in person or through telephone support, or through a peer support group.

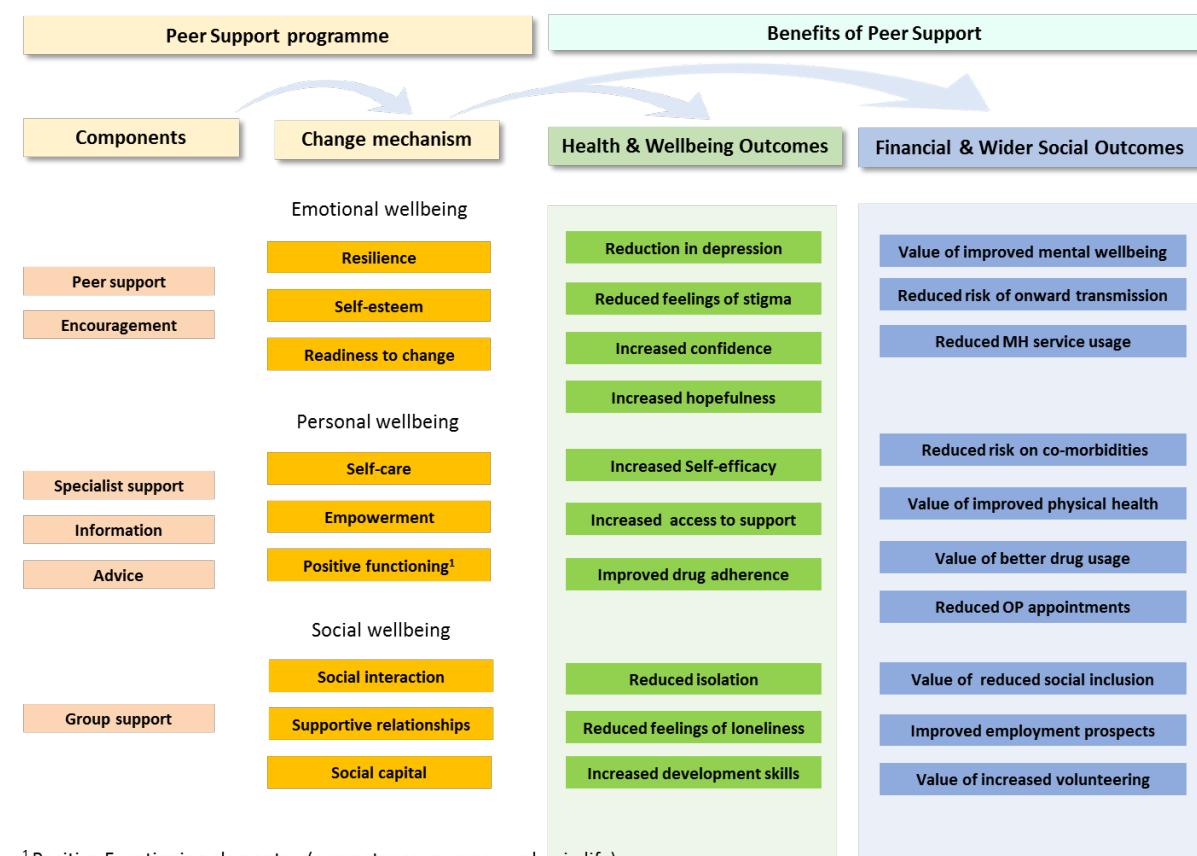
The benefits map below shows that social support is the driving force behind many of the outcomes. The strength of peer support as an intervention lies in the emotional and constructive support that a peer brings with his or her unique perspective based on their own experience.

In terms of health and wellbeing, peer support makes people feel more socially supported and participants report to benefit from increased confidence, resilience and readiness to

change. This places social support as a driver for empowerment and self-efficacy. Research evidence as well as local experience shows that peer support reduces depressive feelings and increases feelings of hopefulness.

Additionally, a number of behavioural ‘health’ improvements were reported. Elderly people with Coronary Heart Disease (CHD) spent an over 1.5 hour more on physical activity per week (compared to a control group) (Coull, et al., 2004). Also, improvements in glucose-control were noted (Dale, 2012).

The benefits extend beyond the individual as population improvements in mental wellbeing are of considerable value to the wider society. For example, a programme in Canada supporting people with serious mental health conditions reported a reduction of 116 days in length of stay following peer support compared to the control group which received usual care (Forchuk et al., 2005, in Repper et al., 2001).



Health coaching: There is a substantial variety of indicators that depict potential financial savings for local health systems. Together health coaches and participants improve the participant’s self-esteem and patient activation. Reported benefits include change towards more healthy behaviours, a reduction of depressive symptoms and reduction in health care use amongst people with mental health issues, diabetes and cardio-vascular diseases.

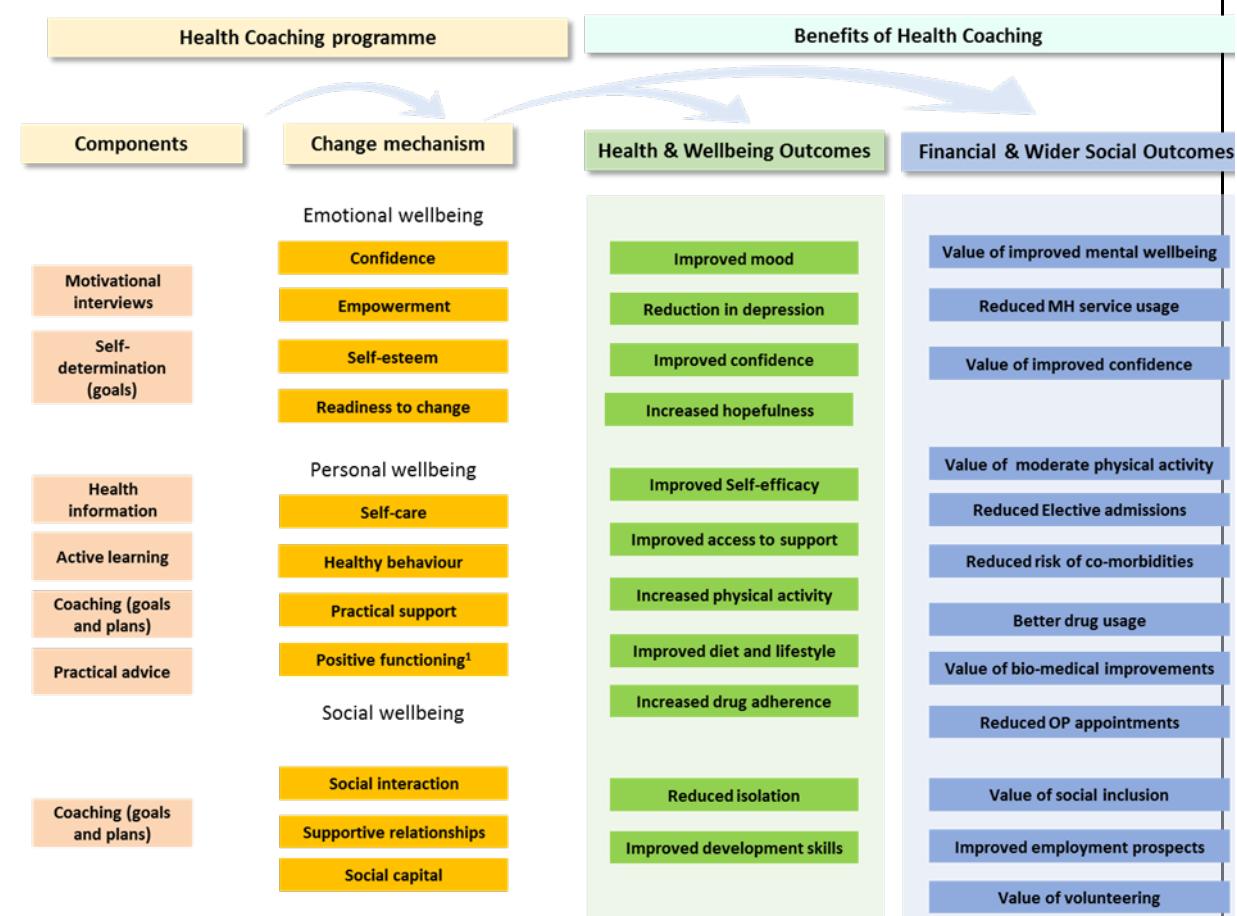
In order for individuals to experience behavioural change, a strong sense of emotional wellbeing needs to be experienced. With the support from the health coaches, the person’s self-esteem and confidence are strengthened, which increases their ‘readiness to change’,

or in other terms their level of patient activation. This in itself has shown to improve people's mood and even reduce depressive symptoms.

From a more physical health and wellbeing perspective, people will have a better understanding of the factors that influence their health and how they can personally influence these through their behaviours. Empowered and equipped with the right tools, the individuals engage more in healthy behaviours, for example improving their diet, exercising more and taking their medications regularly as prescribed.

Health coaching also has the potential to improve people's social wellbeing. This will depend on the approach that is chosen to support behaviour change. For example, this can involve measuring wellbeing in strengthening familiar relationships, or undertaking activities in group format. Although improving social wellbeing may not be the dominating primary goal across health coaching interventions, health coaching has been found to successfully reduce social isolation in elderly individuals.

These behaviour and wellbeing improvements correlate with a wider reaching impact that goes beyond the individual. Most notably, with healthy behaviour and adequate disease management, the need to use health care resources could be reduced.



5. Financial Case

Costs

The costings for the proposals described is set out below, not including the costs which fall within the enabler business case.

Healthy Communities Business Case costings						
Item	Posts (fte)		2017-8	2018-19	2019-20	2020-21
Self Care Programme lead	1	M Band 4	£40,019	£53,887		
Self Care digital & web developer	0.5	Band 7	£9,730	£19,652		
Self Care Lead Nurses	2	Band 7	£20,200	£81,608	£82,424	£83,248
Self Care Coaches	16	Band 4	£72,720	£391,680	£395,597	£399,553
Programme Development Budget			£10,000	£8,000	£8,000	£8,000
Health Champions Pilot			£32,000	£3,000	£3,000	£3,000
Community Health Investment Fund			£25,000	£25,000	£25,000	£25,000
Total			£209,669	£582,827	£514,021	£518,801

Impact on demand and costs

Due to the nature of the outcomes described in section 4, the impact of this business case will result in savings which are accounted for within the Outpatients business case. These savings have therefore not been included in the impact modelling which follows, but it should be noted that those savings will be in part dependent on the delivery of this model. Furthermore, it should be noted that this modelling does not account for cost avoidance in relation to social care, community nursing and ambulance services which would be realised due to this programme (e.g. care and support following a stroke).

The savings identified in the Find and prevent model, copied below, are dependent on the provision of coaching and peer support to the people identified as having lower levels of activation. Given this interdependency and the benefits of continuity of care, it is proposed that the workforce requirements for specialist Healthcare Assistants HCAs in the two business cases are combined into one generic Health Coach role.

Condition	To find		To improve treatment		2015/16 Admission costs	Modelled saving on costs by 20/21	Notes
	Number	as a %	Number	as a %			
Diabetes	2,300	15.8%	670	4.6%	£452,969	£92,195	Improving /detection and management of 20% of diabetics
Hypertension	4,300	9.9%	2350	5.4%	£152,176	£11,613	50% preventable by BP, improving /detection and management of 15% of BP, therefore $15\% * 50\% = 7.5\%$
Atrial Fibrillation	1,550	27.2%	280	4.9%	£1,595,639	£343,099	67% preventable by AF, improving /detection and management of 30% of AF, therefore $30\% * 67\% = 20\%$
Dementia	750	27.8%	80	2.9%	£9,992	£3,065	Improving /detection and management of 30% of people with dementia
COPD	900	13.4%	480	7.1%	£2,015,640	£27,076	10% admissions due to undiagnosed, improving /detection and management of 25% of COPD therefore $10\% * 25\% = 2.5\%$
AMI	-	-	-	-	£2,114,994	£161,399	50% preventable by BP, improving /detection and management of 15% of BP , therefore $15\% * 50\% = 7.5\%$
Other IHD	-	-	-	-	£3,104,147	£236,883	50% preventable by BP, improving /detection and management of 15% of BP , therefore $15\% * 50\% = 7.5\%$
CVD	-	-	-	-	£2,563,684	£551,251	67% preventable by AF, improving /detection and management of 30% of AF, therefore $30\% * 67\% = 20\%$
Total possible saving					£1,426,581		

The possible phasing of this benefit could be as follows:

	17/18	18/19	19/20	20/21
% of full	0%	5%	40%	100%
Impact	0	£71,329	£570,633	£1,426,581

The proposals in this business case are essential to addressing the short-term demand created by uncovering previously unidentified need for prevention and self-care support through Find and prevent, and further to this, based on the evidence cited above, it is estimated that demand for other primary care services will be reduced as set out in the following table.

	Number of appointments per year ¹	Number due to LTCs (50%) ²	Number saved due to self care (6% of LTC)	Average cost of appointment (15 mins for GP, 20 for nurses) ³	Estimated saving
GP	349,499	174,750	10,485	£ 50.00	£ 524,249
Nurse	138,728	69,364	4,162	£ 12.00	£ 49,942
HCA	114,672	57,336	3,440	£ 12.00	£ 41,282
OOH GP	92,122	46,061	2,764	£ 50.00	£ 138,183
OOH Nurse	50,592	25,296	1,518	£ 12.00	£ 18,213
TOTAL	745,613	372,807	22,368	-	£ 771,869

1 Stockport Together

2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

3 www.pssru.ac.uk/project-pages/unit-costs/2016/index.php

Return on Investment

The combined impact of the Find and prevent and Healthy Communities proposals are set out below:

	17/18	18/19	19/20	20/21	TOTAL
F&T cost	£72,000	£292,000	£286,000	£286,000	£936,000
HC cost	£209,669	£582,827	£514,021	£518,801	£1,825,317
Combined cost	£281,669	£874,827	£800,021	£804,801	£2,761,317
F&T Impact	0	£71,329	£570,633	£1,426,581	£2,068,543
HC add impact	£72,362	£385,934	£771,869	£771,869	£2,002,034
Total impact	0	£457,263	£1,342,502	£2,198,450	£4,070,577
Net effect	£281,669	£417,564	-£542,481	-£1,393,649	-£1,309,260

Sources of Funding

Funding sources	2016-7	2017-8	2018-19	2019-20	2020-21	Total
GM Transformation Fund		£281,669	£874,827			£1,156,496
Recurrent funding required				£800,021	£804,801	£1,604,822
NHS England (PAM licence provision)		£600	£1,260	£1,800	£1,800	£5,460
Total		£282,269	£876,087	£801,821	£806,601	£2,766,778

6.	Contractual Arrangements & Implementation Plan
	<p>It is proposed that the Self-care Coaches and Lead Nurses will be employed by either a lead GP practice for each neighbourhood or by SNHSFT as part of the neighbourhood based community services team. The programme manager and digital and web development posts will be employed by the Council within either the Public Health team, Corporate Support Services or the Stockport Together Programme management team.</p>

It is proposed the implementation of the programme will be phased across neighbourhoods and as set out below. This will enable planning and engagement with the neighbourhoods and the people expected to benefit from the services, as well as testing and learning from the early adoption neighbourhoods and refinement of the model.

	Total Posts	Grade	Total staff in post					
			Apr-17	Jul-17	Oct-17	Jan-18	2018/19	2019-20
Self Care Staffing Requirements								
Self-Care Programme lead	1	M Band 4		1	1	1	1	0
Self-Care Lead Nurses	2	Band 7			1	1	2	2
Self-Care Coaches	16	Band 4			4	8	16	16
Self-Care digital & web developer	0.5	Band 7			0.5	0.5	0.5	0
Self Care Total FTE	19.5		0	1	6.5	10.5	19.5	18

Key milestones for implementation are set out below:

Milestone	Date
Funding approval	April - June 17
Health Champions contract extension decision	June 17
Programme Manager appointed	July 17
Community Health Investment Fund launched	September 17
Self-care coaches & Nurse lead in two neighbourhoods	October 17
Self-care digital and web-develop in post	October 17
Self-care support extended to four neighbourhoods	January 18
Initial implementation review completed	February 18
Self-care support extended to all neighbourhoods	April 18
Full implementation review completed	October 18
Initial impact evaluation completed	March 19
Implementation project closed	March 19

Risks

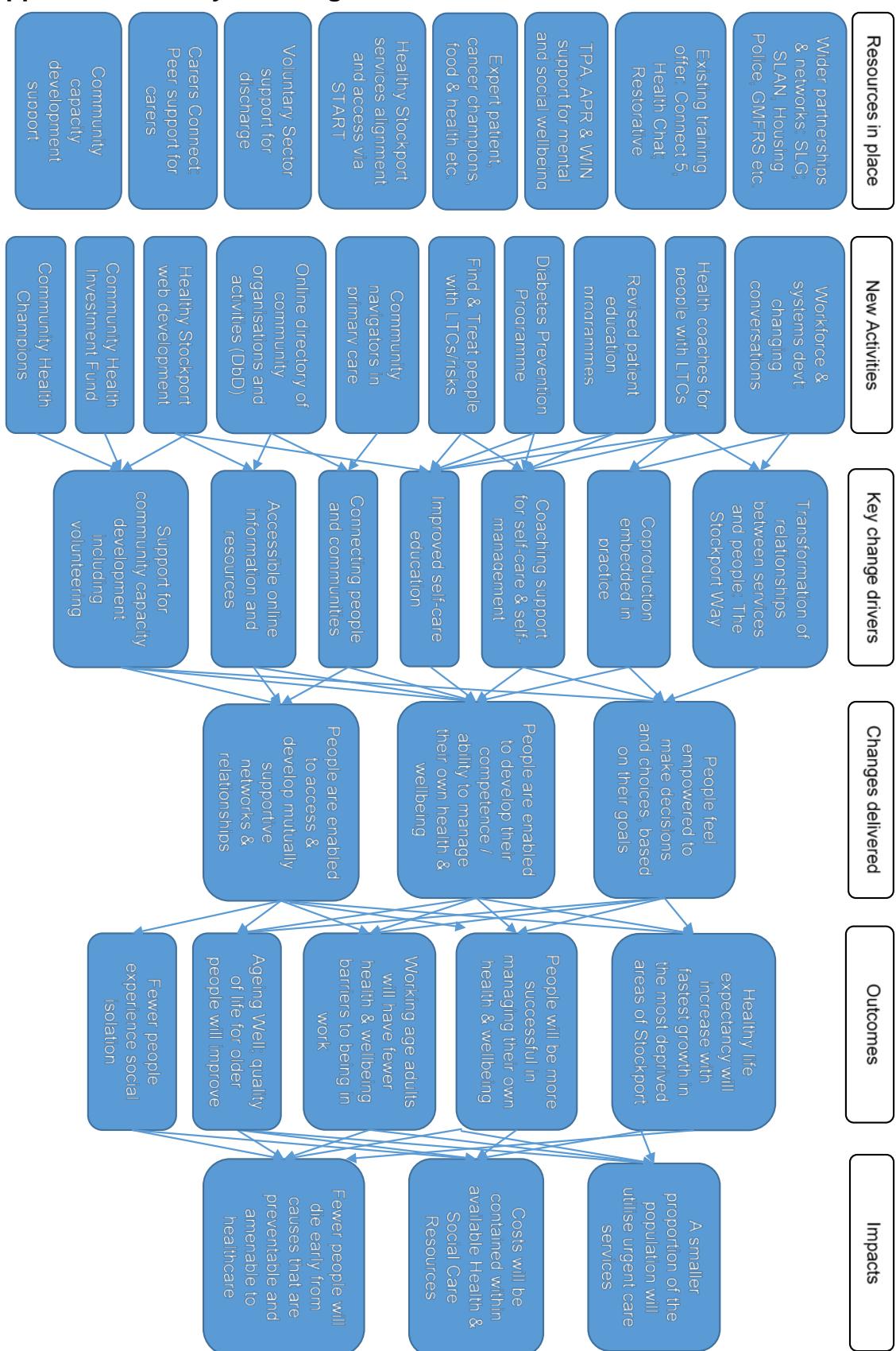
Risk	Mitigation action
The programme relies heavily on co-production and whilst this has been initiated in many areas of the Business plan we feel that this can be extended further	We are working with the active support of Christine Morgan to guide this work and utilising the information secured from previous consultations. However all this work will be scaled up in the implementation phase.
Failure to achieve cultural change or adopt new values and behaviours	Be active participants in the neighbourhoods work to design own values and behaviours through the ongoing series of workshops with both INS and IT Team Leaders. Investment in OD support to the project
Self-care apps and resources are being developed alongside the Digital by Design work and this may impact on proposed timescales	Active engagement in the DbD programme and extensive integration of the Business case programme timescales to be prioritised



	Lack of cohesion with other Stockport Together work streams/models &/or wider Council	Review of all programmes by PMO to explore synergies, identify duplication and streamline work programmes
	Failure of new model to prevent forecast level of acute admissions, ED attendance and free up primary care services.	Utilise evidence base from other areas and pilot changes within speedy implementation plan
	Not possible to increase capacity due to delays in recruiting workforce with the required level of skills, mean cannot prove concept &/or fully implement model.	Early discussion with the providers to explore capacity and realignment of existing staff to prioritise the ways of working
	Variability in neighbourhood understanding and engagement in this area of work.	Work with the willing neighbourhoods and use successes in these areas of work to engage other neighbourhoods
	Lack of co-location solution (physical location) reduces ability to work in an integrated way. Clinical services may be prioritized to such an extent that there are fewer facilities for delivery of community programmes	Neighbourhood and Integrated Team estates requirement identified. Proposals and options developed and being discussed with the Estates Enabler group
	Limited resources at scale to make detrimental impact on all aspects of programme delivery through failure to change our relationships with people	Identify and explore other external funding mechanisms via partners to accelerate and extend this work
	Limited senior level buy in to embed transformation of the ways in which we work with people and communities throughout Stockport Together	Improve communication and engagement with Senior leaders and Senior clinicians and ensure that Cllr members champion this way of working
	Immature and multiple recording systems in partners prevent difficulty in assessing impact	Extend the work currently being developed by the TPA outcome recording system and seek out further work with the New Economy to develop new ways of evaluation to capture the outcomes of this work programme



Appendix 1: Theory of Change



Appendix 2: The Stockport Way

One approach, working together for Stockport, on purpose, all of the time

- Making a conscious effort to think about how we can work together with people, communities and other organisations
- Considering how to achieve the best possible outcomes for individuals, families and wider communities.

Working *with* people, and building on their strengths

- Working *with* people, not ‘doing for’ or ‘doing to’
- Enabling people to identify and access the strengths and resources available to them, as individuals and within family and community networks

Always connecting through conversations and building relationships

- Actively listening, seeking to understand, rather than assess
- Asking “what matters to you?” rather than “what’s the matter with you?”
- Making connections and building relationships, to work collaboratively with each other across organisations
- Helping to connect people with supportive networks

Confident to make decisions, acting for the best outcomes for people

- Empowering staff within their organisations
- Enabling staff to be confident in their decisions, not asking permission but ready and able to explain them.



Appendix 3 Long-term Conditions Data

Key Findings – long term conditions



Stockport JSNA

joint strategic needs assessment

Condition	Number (Aug 15)	Gender pattern	Age trend	Deprivation
Hypertension	43,589		Highest 45+	Increase with dep
Anxiety	40,114	Higher In F.	Highest 40-59	Increase with dep
Depression (18+)	26,088	Higher In F.	Highest 40-54	Increase with dep
Obesity (16+)	20,544*			Increase with dep
Asthma	19,933			Increase with dep
Diabetes	14,816		Highest 45+	Increase with dep
Coronary Heart Disease (CHD)	12,304	Higher In M.	Highest 45+	Increase with dep
History of Fall	11,433	Higher In F.	Highest 75+	Increase with dep
Cancer	7,992			Decrease with dep
Chronic Kidney Disease (CKD)	7,698		Highest 50+	Increase with dep
Chronic Obstructive Pulmonary Disease (COPD)	6,959		Highest 45+	Increase with dep
Stroke or Transient Ischaemic Attack (TIA)	6,224		Highest 45+	Increase with dep
Self harm	6,054*	Higher In F.		Increase with dep
Atrial Fibrillation (AF)	5,903		Highest 50+	
Heart Failure (HF)	2,812		Highest 55+	Increase with dep
Dementia	2,695	Higher In F.	Highest 65+	Increase with dep
Glaucoma	2,504		Highest 55+	
Severe mental health	2,434			Increase with dep
Epilepsy	2,389			Increase with dep
Peripheral Ararterial Disease (PAD)	2,233	Higher In M.	Highest 55+	Increase with dep
Rickets	1,570	Higher In F.		
Learning disability	1,495	Higher In M.		Increase with dep
Rheumatoid Arthritis (16+)	1,482	Higher In F.	Highest 45+	
Acute Macular Degeneration (AMD)	1,428*	Higher In F.	Highest 75+	Decrease with dep
Autism	927*	Higher In M.		
Cerebral palsy	275*			
Downs Syndrome	234	Higher In M.		

* Undercount of actual prevalence

Information about the number of people in Stockport with certain illnesses or disabilities has been analysed from Stockport GP practice registers - this excludes acute health needs, for example infections, so is not a measure of all needs and demands.

- Overall, 41% (124,000) of the people registered with Stockport GPs have one or more of the conditions analysed
- It is important to note that the 59% of people not in this analysis may have undiagnosed conditions or have poor health generally, and equally the people with long-term conditions may be healthy and well self-managed.
- The proportion with at least one condition increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over
- By age 55, half of the people in Stockport have one or more of these conditions.
- Asthma is the major condition affecting school aged children in the borough (more than 2,000 cases aged 5-14), anxiety affect those aged 15-24 in particular (more than 2,700 cases).

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Key Findings – multiple long term conditions

In addition to looking at each of the conditions individually it is also useful to understand trends in the number of conditions people are living with, and how this varies over the life course – as this gives some measure of the complexity of issues, co-morbidities and treatments patients and health carers may be dealing with. Analysis focussed on 8 groups of diagnoses, excluding some conditions where data quality is lower or where people may not need clinical management permanently.

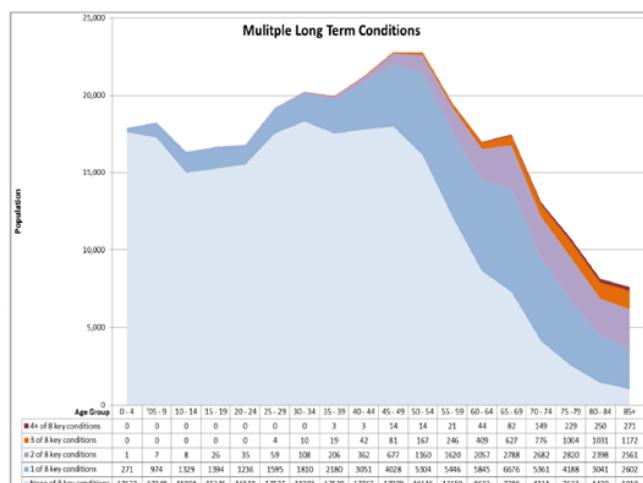
9% (26,250) of the population have two or more of 8 key long term conditions

These key conditions are strongly age related.

- By age 65, 58% of the population have at least one of the key conditions, with 20% having two or more.
- In the oldest age group, 87% have at least one condition, with 53% having two or more of the conditions

The rates of these key conditions show a strong deprivation profile. As the number of conditions increase, the deprivation profile becomes more pronounced.

Number of key conditions	Number of people	% of people
0	222,993	73.0%
1	56,331	18.4%
2	19,575	6.4%
3	5,588	1.8%
4	984	0.3%
5+	96	<0.1%

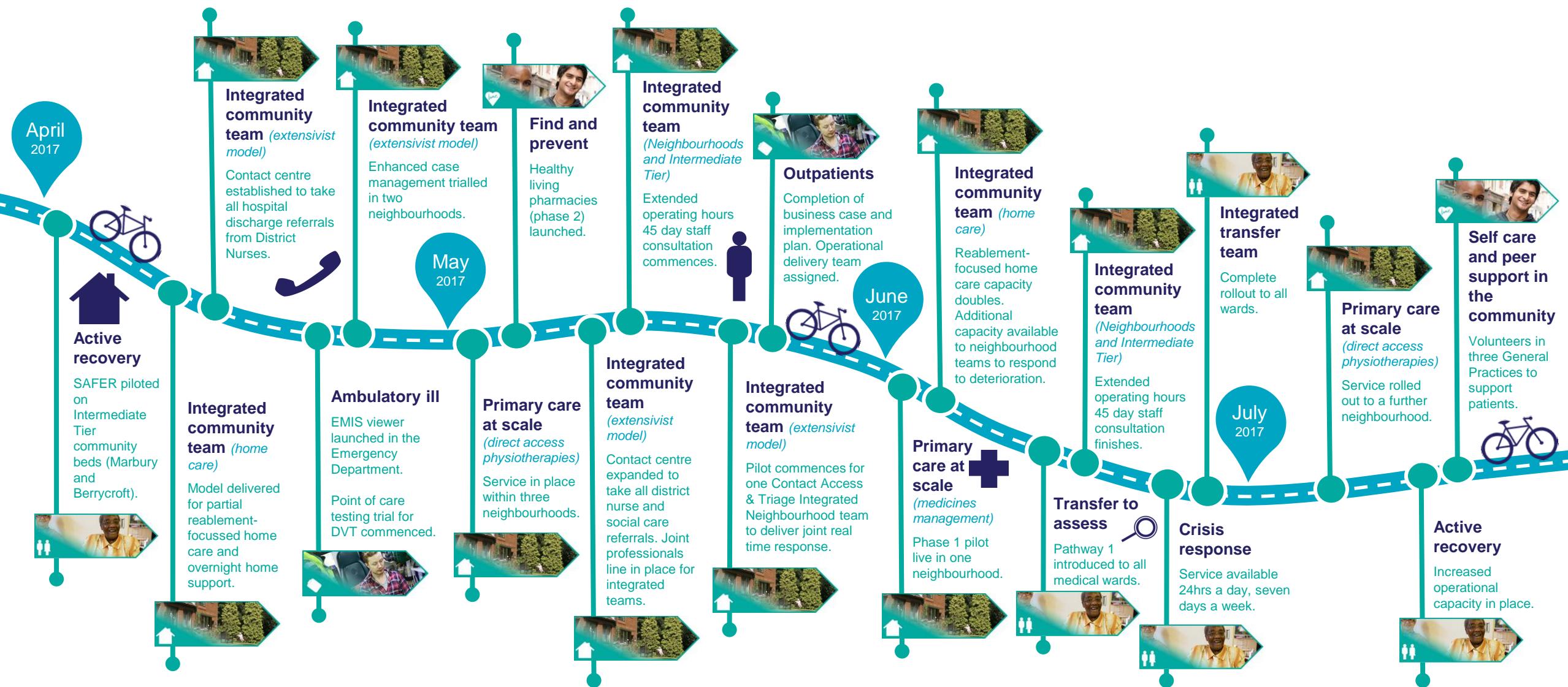


CAPACITY MODEL

Complete columns B, C, D, G, I & K		Available resource		Activity under new neighbourhood model										Utilised hours			Assumptions	
Core Component (of neighbourhood model)	Specialism / grade	Number of staff (FTE)		Hours available per		Retained activity (from existing		Activity diversion (under neighbourhood model)				Time dedicated to managing growth in demand	% diverted	Per individual	System	Utilisation (%)		
		Current	Future (20/21)	Current	Future	Per individual per day	System level per day	Hours diverted per individual per day to other professionals (diverting away)	System level - total hours diverted to other professional groups (per day)	Diverted from?	NEW activity taken on per individual per day (hours)	System level - total NEW activity taken on (hours)						
General practice	GPs	161.0	161.0	1207.5	1207.5	4.725	760.73	2.78	446.78				4.7	760.7	63.0%			
	ANP	12.0	12.0	90.0	90.0	7.5	90						7.5	90.0	100.0%			
	Practice nurses	55.0	55.0	412.5	412.5	7.5	412.5						7.5	412.5	100.0%			
	HCA's	42.0	42.0	315.0	315.0	7.5	315						7.5	315.0	100.0%			
	Managers	58.0	58.0	435.0	435.0	7.5	435						7.5	435.0	100.0%			
	Other non clinical	460.0	460.0	3450.0	3450.0	7.5	3450						7.5	3450.0	100.0%			
	Pharmacy/prescribing	50.5	90.0	378.8	675.0	7.5	378.75			GP	0.74	66.41	5.5%	4.9	445.2	66%		
	Psychological medicine/unexplained symptoms	0.0	5.0	0.0	37.5	0	0			GP	0.00	0.00	0.0	0.0	0.0	0.0%	NO VARNAM EVIDENCE FOR THIS	
Primary Care at Scale	Direct access Physiotherapists	0.0	12.0	0.0	90.0	0	0			GP	6.54	78.49	6.5%	6.5	78.5	87.2% 12 band 7s		
	Dietitians	2.1	6.3	15.8	47.3	7.5	15.75				7.5	31.5		7.5	47.3	100.0%		
	GP's (Acute visiting and clinical triage)	0.0	8.0	0.0	60.0					GP	15.09	120.75	10.0%	15.1	120.8	201.3%		
	Find & Treat - Admin	0.0	1.6	0.0	12.0						7.50	12.00		7.5	12.0	100.0%		
	Find & Treat - HCA	0.0	4.0	0.0	30.0						7.50	30.00		7.5	30.0	100.0%		
	Find & Treat - Analyst	0.0	8.0	0.0	60.0						7.50	60.00		7.5	60.0	100.0%		
	Find & Treat - project officer	0.0	0.4	0.0	3.0						7.50	3.00		7.5	3.0	100.0%		
	Mental wellbeing navigators	0.0	16.0	0.0	120.0					GP	1.91	30.55	2.5%	1.9	30.5	25.5%		
	Safeguarding	0.0	6.4	0.0	48.0						7.50	48.00		7.5	48.0	100.0%		
	Healthy Communities - Self care coach	0.0	16.0	0.0	120.0					GP	1.91	30.55	2.5%	1.9	30.5	25.5%		
Integrated Community Teams (Excludes non-recurring BCF funded posts)	Healthy Communities - Self care nurse	0.0	2.0	0.0	15.0					GP	1.93	3.86	0.3%	1.9	3.9	25.8%		
	Navigation (practice reception)	45.0	45.0	337.5	337.5	7.5	337.5			GP	1.91	85.97	7.1%	9.4	423.5	125.5%		
	Workflow optimisation																	
	SMBC - Neighbourhood Team Leader	4.0	4	30.0	30.0	7.5	30	0.00		GP	0.07	0.3	0.9%	0.02%	7.6	30.3	100.0%	
	SMBC - Neighbourhood Senior Practitioner	5.3	8	39.8	60.0	7.5	39.825	20.18		GP	0.07	20.7	1.8%	0.04%	7.6	60.5	100.0%	
	SMBC - Neighbourhood Practitioner	49.9	48	374.5	360.0	7.5	374.475	-14.48		GP	0.07	-11.2	10.8%	0.27%	7.6	363.3	100.0%	
	SMBC - Neighbourhood Key Worker	39.9	59	299.3	442.5	7.5	299.325	143.18		GP	0.07	147.2	13.3%	0.33%	7.6	446.5	100.0%	
	SMBC - Assistant Neighbourhood Practitioner	31.9	48	239.1	360.0	7.5	239.1	120.90		GP	0.07	124.2	10.8%	0.27%	7.6	363.3	100.0%	
	SMBC - Neighbourhood Support Worker	0.0	26	0.0	195.0	7.5	195.00			GP	0.07	196.8	5.8%	0.15%	7.6	196.8	100.0%	
	SFT - Senior Clinician	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	SFT - Neighbourhood Team Leader	4.0	4	30.0	30.0	7.5	30	0.00		GP	0.07	0.3	0.9%	0.02%	7.6	30.3	100.0%	
	SFT - Neighbourhood Senior Practitioner	25.8	20	193.6	150.0	7.5	193.575	-43.58		GP	0.07	-42.2	4.5%	0.11%	7.6	151.4	100.0%	
	SFT - Neighbourhood Practitioner	64.1	49	480.5	367.5	7.5	480.45	-112.95		GP	0.07	-109.6	11.0%	0.28%	7.6	370.8	100.0%	
	SFT - Assistant Neighbourhood Practitioner	9.6	19	72.2	142.5	7.5	72.15	70.35		GP	0.07	71.6	4.3%	0.11%	7.6	143.8	100.0%	
	SFT - Neighbourhood Support Worker	8.1	39	60.6	292.5	7.5	60.6	231.90		GP	0.07	234.5	8.8%	0.22%	7.6	295.1	100.0%	
	SFT - Neighbourhood Support Worker	6.2	31	46.7	232.5	7.5	46.65	185.85		GP	0.07	188.0	7.0%	0.17%	7.6	234.6	100.0%	
	PenCare - Mental Health Liaison Workers	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	QIOT - Programme manager	0.0	1.0	0.0	7.5	7.5	7.50			GP	0.07	7.6	0.2%	0.01%	7.6	7.6	100.0%	
	QIOT - Quality improvement officers	0.0	3.0	0.0	22.5	7.5	22.50			GP	0.07	22.7	0.7%	0.02%	7.6	22.7	100.0%	
	QIOT - Service improvement coordinator	0.0	0.5	0.0	3.8	7.5	3.75			GP	0.07	3.8	0.1%	0.00%	7.6	3.8	100.0%	
	QIOT - Nurse	0.0	1.0	0.0	7.5	7.5	7.50			GP	0.07	7.6	0.2%	0.01%	7.6	7.6	100.0%	
	SMBC overnight - Neighbourhood Senior Practitioner	0.0	2	0.0	15.0	7.5	15.00			GP	0.07	15.1	0.4%	0.01%	7.6	15.1	100.0%	
	SMBC overnight - Neighbourhood Practitioner	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	SMBC overnight - Neighbourhood Key Worker	0.0	8	0.0	60.0	7.5	60.00			GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.0%	
	Physiotherapists	18.9	27.3	142.0	204.8	7.5	141.98	62.78		GP	0.07	64.6	6.1%	0.15%	7.6	206.6	100.0%	
	Occupational therapists	2.6	2.6	19.5	19.5	7.5	19.5	0.00		GP	0.07	0.2	0.6%	0.01%	7.6	19.7	100.0%	
	SALT	0.0	0															

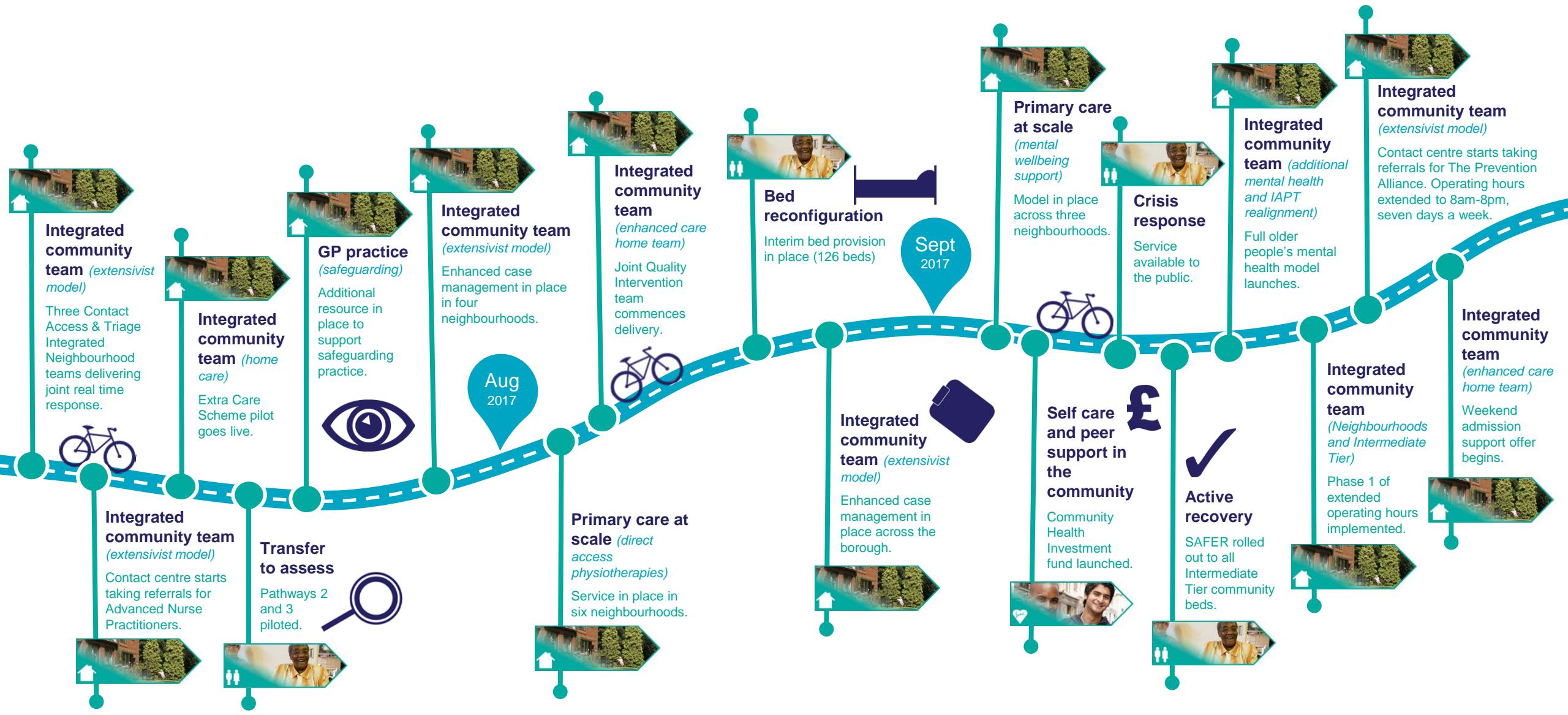
The Stockport Together Programme

Our journey



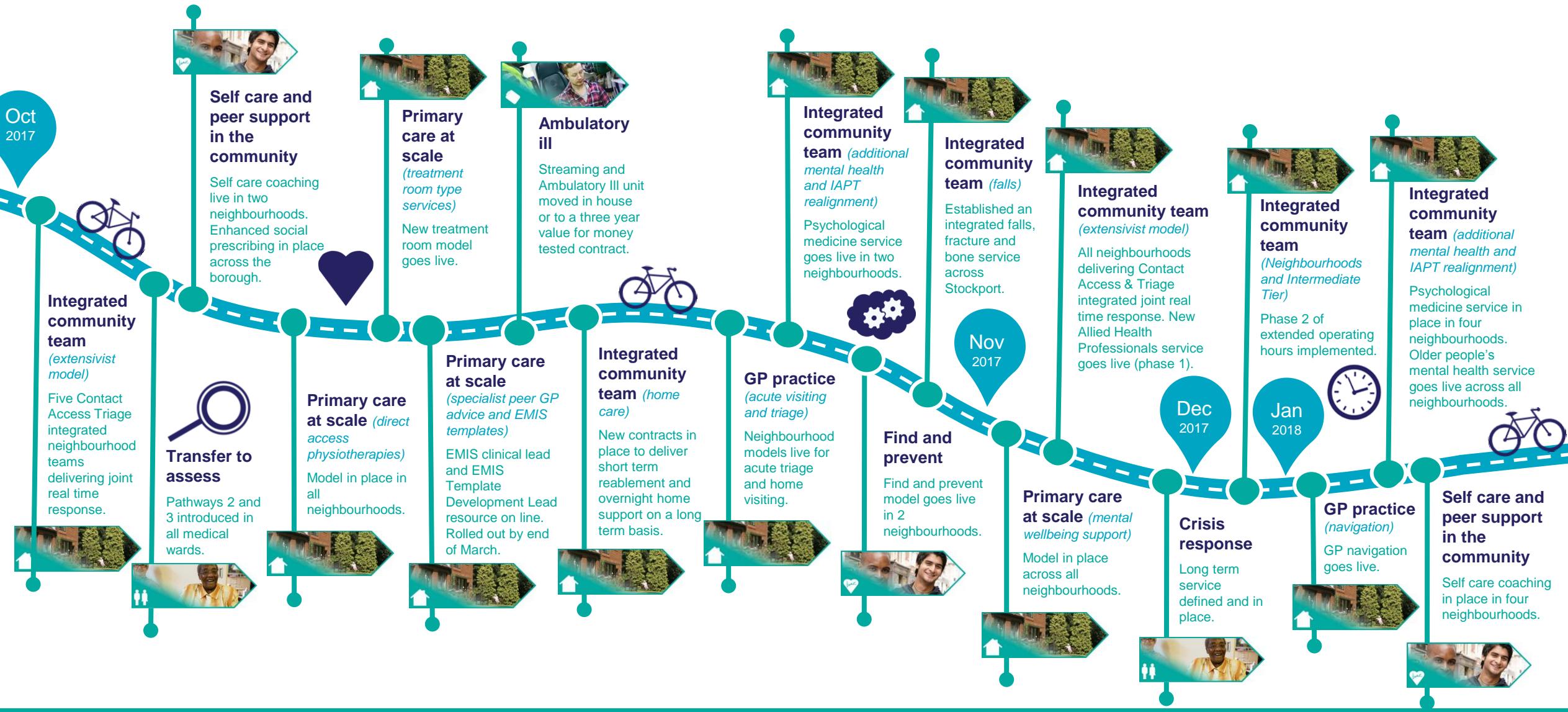
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Our journey



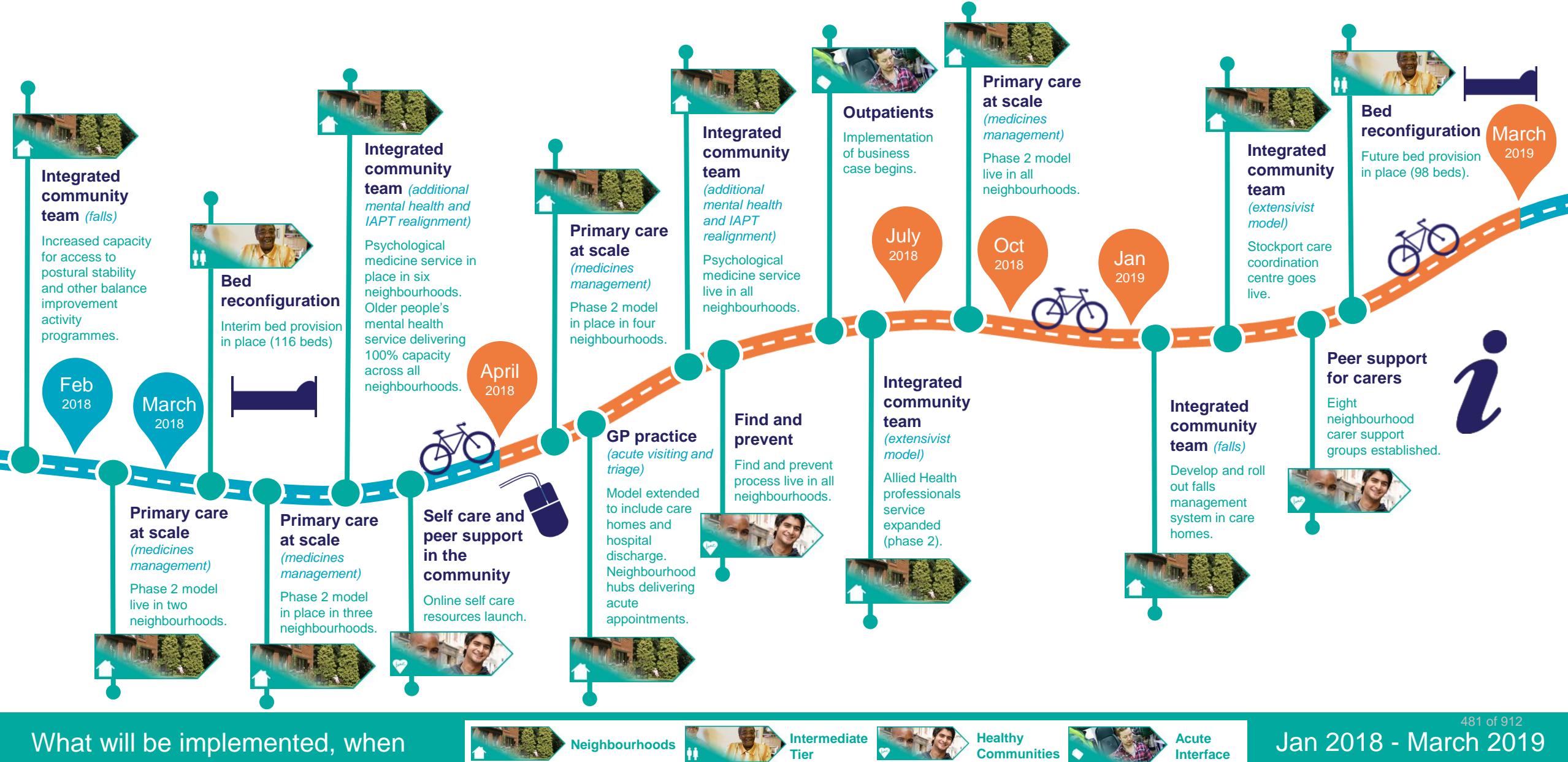
The Stockport Together Programme

Our journey



The Stockport Together Programme

Our journey



Stockport Together | Key Implementation Milestones

Workstream	2017-18 Monthly												2018-19 Quarterly						
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-June 2018	July-Sept 2018	Oct-Dec 2018	Jan-March 2019	2019-20	2020-21	
Neighbourhoods																			
Primary Care at scale- Direct access physiotherapy				Primary care at scale Direct access physiotherapy service in place within three neighbourhoods.		Primary care at scale Direct access physiotherapy service in place within four neighbourhoods.	Primary care at scale Direct access physiotherapy service in place within six neighbourhoods.	Primary care at scale Model in place in all neighbourhoods.											
Primary Care at scale - Mental Wellbeing Support					Contract in place for mental wellbeing support service	Recruitment of Mental Health Navigators	Model in place across three neighbourhoods	Model in place across all neighbourhoods.											
Primary Care at scale - Medicines management		Recruitment of staff for pilot	Phase 1 pilot live in one neighbourhood								Phase 2 model live in two neighbourhoods	Phase 2 model live in three neighbourhoods	Phase 2 model live in four neighbourhoods	Phase 2 model live in all neighbourhoods					
Collaborative General Practice - Specialist peer GP advice and EMIS templates		EMIS Clinical Lead and EMIS Templates developed.					EMIS clinical lead and EMIS Template Development Lead resource online. Rolled out by end of March.												
Primary care at scale - Treatment room type services			Relevant recruitment commences				New treatment room model goes live												
GP practice - navigation				Practice navigator training commences						GP navigation goes live.									
GP practice - acute visiting and triage							Neighbourhood models live for acute triage and acute home visiting.						Model extended to include care homes and hospital discharge.	Neighbourhood hubs delivering acute appointments.					
GP practice - safeguarding		Recruitment to additional posts commences, where required.		Additional resource in place to support safeguarding practice.															
GP 7 Day Service	GP 7 Day Service piloted in the Heaton's.				GP 7 Day Service in place in two neighbourhoods	GP 7 Day Service in place in four neighbourhoods	GP 7 Day Service commences in six neighbourhoods	7 Day Service live in place in all neighbourhoods											
Integrated community team - additional Mental Health (and IAPT realignment)	Additional older peoples mental health recruitment commences		Commence recruitment to additional psychological medicine posts.	Additional older peoples mental health recruitment fully in post.		Key psychological medicine capacity in post.	Psychological medicine service goes live in two neighbourhoods.			Psychological medicine service in place in four neighbourhoods.		Psychological medicine service in place in six neighbourhoods.	Psychological medicine service live in all neighbourhoods.						
Integrated community team - Falls:							Establish an integrated falls, fracture & bone service (Steady in Stockport) across Stockport			Increased capacity for access to postural stability and other balance improvement activity programmes				Develop and roll out falls management system in care homes.					
Integrated community team - home care	Model delivered for partial re-alignment focussed home care and overnight home support.	Recruitment to workforce for Extra Care scheme pilot commences.	Re-alignment focussed home care capacity doubles. Additional capacity available to neighbourhood teams to respond to deterioration.	Extra Care Scheme pilot goes live.			New contracts in place to deliver short term re-alignment and overnight home support on a long term basis												
Integrated community team - enhanced care home team		Joint Quality Intervention Team recruitment commences		Recruitment commences on resources to support weekend care home admission	Joint Quality Intervention Team in post.	Joint Quality Intervention Team commences delivery.	Care homes weekend admission support offer commences.					Formal joint evaluation of progress.	Full rollout of the Joint Quality Intervention team,						
Integrated community team - extensivist model		Extended operating hours Extended operating hours 45 day consultation commences.	Extended operating hours Extended operating hours 45 day consultation ends.			Extended operating hours Phase 1 of extended operating hours implemented.		Extended operating hours Phase 2 of extended operating hours implemented.											
	Contact Access & Triage (CAT) Contact centre established to take all hospital discharge referrals from district nurses.	CAT Contact centre expanded to take all district nurse and social care referrals.	Joint professionals line in place for integrated teams.	CAT Contact centre recruitment complete.		CAT Contact centre starts taking referrals for Advanced Nurse Practitioners.	CAT Contact centre starts taking referrals for The Prevention Alliance.							CAT Stockport Care Coordination Centre goes live					
		CAT Integrated neighbourhood teams (INT) Real time response pilot commences in one neighbourhood.		CAT integrated neighbourhood teams (INT) Three neighbourhood teams delivering integrated real time response.			CAT integrated neighbourhood teams (INT) Five neighbourhood teams delivering integrated real time response.	CAT integrated neighbourhood teams (INT) All neighbourhood teams delivering integrated real time response.											
							Allied Health Professionals Recruitment to 17/18 posts	Allied Health Professionals New Allied Health Professionals service goes live (phase 1).					Allied Health Professionals Allied Health Professionals Recruitment to 18/19 posts						
		Enhanced case management Enhanced case management Full implementation plan (including percentage of population covered) complete.	Enhanced case management Enhanced case management in place in four neighbourhoods.										Allied Health Professionals Allied Health Professionals service expanded (Phase 2)						
		100% 17/18 senior and support worker capacity online.	1st July - 100% key worker capacity online.	100% neighbourhood practitioner capacity online		50% ANP capacity in place			100% Assistant Practitioner capacity online			100% ANP capacity in place	Small reduction in Neighbourhood Practitioners (ASC), 100% 18/19 DN support worker capacity online			Reduction in senior and neighbourhood practitioners (Nursing and ASC)			

Stockport Together | Key Implementation Milestones

Workstream	2017-18 Monthly												2018-19 Quarterly					2019-20	2020-21
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-June 2018	July-Sept 2018	Oct-Dec 2018	Jan-March 2019			
Health Champions			Health Champions Extension Decision	Volunteers in three general practices to support patients.				Evaluation & forward plan completed											
Peer Support for Carers												400 carers accessing online support				Eight neighbourhood Carer Support Groups established			
Self Care & Peer Support in the community	NHS E approval of Patient Activation Model (PAM)	Recruitment of project manager	Decisions re use of patient activation measure as part of the NDPP	Project Manager in post	Recruitment of self care coaches	Community Health Investment fund launched	Self care coaching live in two neighbourhoods.	Enhanced social prescribing in place across the borough.		Self care coaching in place in four neighbourhoods	Online self care resources launch.	Self care coaching live across all neighbourhoods.							
Find & Prevent	National Diabetes Prevention programme GM provider for NDPP (National Diabetes Prevention Programme) appointed	Healthy Living Pharmacies (phase 2) launched	National Diabetes Prevention programme NDPP live in Victoria			National Diabetes Prevention programme NDPP live in Cheadle	Find & Prevent model goes live in two neighbourhoods		National Diabetes Prevention programme NDPP live in Tame Valley				Find & Prevent model live in all neighbourhoods - April	National Diabetes Prevention programme NDPP live in Heaton's (Sept)	National Diabetes Prevention programme NDPP live in Bramhall (Dec)	National Diabetes Prevention programme NDPP live in Marple (March)			
Place based integration	Place based work Approval of the Heaton's Joined Up Services programme	Place based work Launch of the Heaton's joined up service programme and start of community conversation	Place based work Programme deliverables confirmed																

Acute Interface

Ambulatory In	EMIS Viewer launched in the Emergency Department.	Cost benefit analysis of AI completed with options appraisal	Future requirements spec for delivery of AI from October 1st completed include market testing. Commission future AI service delivery and complete any legal requirements.	Commence recruitment of permanent ACU capacity			Streaming and Ambulatory In unit moved in house or to a three year value for money tested contract.	Contract variation completed										
	Point of care testing (POCT) 3 month trial for DVT go live commenced (1st Apr)	Mid point review of POCT	Review trial of POCT															
	ACU operating at full capacity.	Audit effectiveness of ACU pathways.													Implementation of business case begins.			
Outpatients	Completion of outpatients business case and implementation plan. Operational delivery team																	

Boroughwide services

Crisis Response:		Service available 24hours a day, 7 days a week.		Recruitment to 17/18 posts	Service available to the public	Phase 2 & 3 - Optimised	Long term service defined and in place											
Active Recovery:	SAFER piloted on Intermediate Tier community beds (Marbury and Berrycroft)		Increased operational capacity in place.	Recruitment to 17/18 posts	SAFER rolled out to all Intermediate Tier community beds													
Bed Reconfiguration:				Interim bed provision in place (126 beds)	Phase 2 - Optimised								Interim bed provision in place (116 beds)			Further bed provision in place (98 beds)		
Integrated Transfer Team:		Complete rollout to all wards.			Pathways 2 and 3 introduced to all medical wards.		Optimise Transfer To Assess pathways 2 & 3											
Transfer to Assess:		Transfer to assess pathway 1 introduced to all medical wards.	Pathways 2 and 3 piloted.		Optimise T2A pathway 1								Implement Phase 4 - Care Homes	Implement Phase 5 - N'hoods				
Trusted Assessor Development:		Implement Phase 1 - T2A	Implement Phase 2 - Active Recovery	Implement Phase 3 - Crisis Response	Implement Phase 4 - Care Homes													

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INTERMEDIATE TIER OUTLINE BUSINESS CASE EXECUTIVE SUMMARY

Abstract

This business case describes the proposal for the intermediate tier of services, which will be delivered in Stockport from 2017/18 to 2020/21.

Senior Responsible Officers:

Tim Ryley, Director of Strategy, Stockport CCG

Keith Spencer, Provider Director, Stockport Together

Executive Summary

Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to deliver the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

Business Case Overview

This paper sets out the case for a revised Intermediate Tier of services that collectively support people to recover from ill health and prevent unnecessary admission to hospital or long-term residential care.

The document describes in detail the design of the new model. It sets out investment requirements and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business identifies anticipated risks to delivery of transformation and the mitigations in place to maximise benefits.

The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Intermediate Tier of services is defined as those services that: promote faster recovery from illness; prevent unnecessary acute hospital admission and premature admission to long-term residential care; support timely discharge from hospital; and maximise independent living. In Stockport there are over 20 such services which have developed in isolation over the past ten years. While each service has significant strengths, collectively the Intermediate Tier is fragmented and difficult to navigate.

The current range of services has been designed to manage the effects of the system, rather than tackling its causes. The majority of staff and financial resources are spent on facilitating a hospital discharge - or 'step-down' from secondary care. Much less capacity is used for 'step-up' activity – intensive support to prevent unnecessary hospital admissions. This means that there is not a strong alternative offer to respond to people in crisis and prevent hospital admissions, placing additional demand on the hospital and the Emergency Department in particular. And many patients receive intermediate care interventions in a hospital bed due to the lack of capacity in the community.



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

Most of the budget is spent on delivering care in community facilities and not an individual's home, reducing independence. As a result, people spend longer in intermediate tier beds than patients in other parts of the country. A point prevalence study of Intermediate Care beds in 2015 found that 33% of patients did not need an intermediate tier bed at that moment in time – resulting in 1,257 excess bed days. The knock on effect can be seen in the simultaneous review of 6 hospital wards, which found that 44.53% of people no longer required a hospital bed, but could not be discharged due to a lack of capacity in community services. The longer patients spend in a bed, the harder it can be for them return home and live independently.

Table 1: Point Prevalence Study of Patients in Intermediate Tier Beds

Bed Based Service	No. of patients	No. who did not need an Intermediate Tier bed	Resulting Excess Bed Days
Blue Bell	24	3	1,126
Saffron Ward	18	9	76
Marbury	38	13	25
Berrycroft	14	6	30
Total	94	31	1,257

Fragmentation of the 20+ services means that many service users rely on multiple teams and referrers are unsure of the availability of services or the criteria for access. Patients report multiple assessments being duplicated by different services. In addition, the current range of services lacks enough mental health and dementia input to support the needs of service users. This situation will only intensify as Stockport's population continues to age. By 2020, the number of people aged over 65 will increase from 55,700 in 2014 to 61,000. Currently 51% of the total adult population of Stockport are known to have one or more long-term conditions. By the age of 85, 87% have at least one and 53% have two or more. And by 2030 dementia prevalence will rise by 50%.

The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets. Our vision for the intermediate tier is to create a responsive and person-centred service that supports people's active recovery and provides a strong bridge to transition both to and from hospital.

This business case describes a model of care delivered in a person's normal place of residence or as close to home as possible. It describes a continuum of 24 hour, home and bed based care that works closely with and links hospital and primary care services. Services will urgently wrap around a person to meet their physical, mental health and social care needs and prevent an unnecessary hospital admission. Services will also actively reach into hospital wards to facilitate early discharge and support people to recover at home. The integrated services will promote faster recovery from illness and maximise independence to avoid premature long-term care.

The model will target two population cohorts:

- STEP-UP: people in crisis at high risk of a hospital admission (14,079 individuals)
- STEP-DOWN: people in hospital who are medically optimised but require additional time and support to recover (14,079 individual plus a proportion of elective admissions).

The model is built around six core components:

1. **Intermediate Tier Hub** - there will be one single access point for assessment and triage 24 hours 7 days a week via one telephone number.
2. **Crisis Response** - multidisciplinary team able to respond to crisis response within an hour or to urgently arrange an alternative care offer in the community to avoid hospital admission; 24 hours a day, 7 day per week. Teams will include nurses, physiotherapists, occupational therapists, health & social care support workers, social workers and mental health practitioners. They will also have access to overnight support, pharmacists, and specialist medical input.
3. **Bed reconfiguration and management** - a community bed-based service that brings together health & social care professionals to offer a multi-disciplinary range of care to ensure all needs are met in a short period of time. This will be used to support intensive rehabilitation, sub-acute care, recovery and crisis care. It will combine physical and mental health provision and reduce spot-purchasing of beds by 50 by 2019.
4. **Active Recovery at Home** – a community, home based service that brings together health & social care professionals to meet all care needs in a short period of time. This team will support both step-up and step-down pathways. The functions provided by the team at a person's place of residence include: transfer to assess; rehabilitation; reablement; time to recover; and clinically enhanced care.
5. **Transfer to Assess** – Once immediate needs have been met, it is important that patients are discharged from hospital in an appropriate and timely manner. This service will ensure speedy transfer from hospital to home and deliver assessment for ongoing needs as close to home as possible.

Changes will be introduced in two stages:

- Phase 1 will create additional capacity and capability to respond to crisis and keep people at home
- Phase 2 will look at the reconfiguration of the community bed base and supporting systems to optimise flow in and out of hospital.

To deliver this model, the business case proposes a considerable increase in capacity to provide more care in a patient's home. Over time, this will allow us to reduce the number of community beds from 150 to 98 by April 2019. This would include the creation of a single facility of 40 intermediate tier beds to be used flexibly to deliver assessments, intensive rehabilitation, reablement and recovery services with nursing, mental health and therapy input.

Table 2: Staffing Levels

Pathway	Current Staffing WTE (%)	Future Staffing WTE (%)
Step down	125.23 (74%)	95.60 (38%)
Step up	45.02 (26%)	154.57 (62%)
Total	170.25 (100%)	250.17 (100%)

Significant improvements will be required in IM&T systems including ensuring 24/7 access, a more robust version of the Stockport Health & Social Care Record, the introduction of a bed management system and care home IM&T capability. There will also be a need for estates

changes to enhance the bringing together of the new teams. This and the required organisational development are described more fully in the **Enabler Business Case**.

Benefits of the Model

Stockport Together's proposed service solution will integrate health and social care services, providing a comprehensive service that meets the increasingly complex care needs of our ageing population.

The Intermediate Tier will provide care as close to home as possible, with the aim to deliver most care in a person's normal place of residence. This will reduce the length of stay in intermediate care beds from the current average of 4 weeks to the national best practice standard of 2 weeks. Reducing length of stay in intermediate care beds and providing more care at home will significantly reduce the cost to health and social care services of spot-purchasing beds in care homes.

There will be a considerable increase in capacity, resulting in services working 24/7. The new model will address the balance of step-up - step-down services to meet local need and prevent unnecessary hospitalisation, taking pressure off the local hospital and cost out of the system.

These changes will contribute significantly to the high level benefits of the Stockport Together programme, though the exact contribution of the Intermediate Tier cannot be extrapolated:

- By increasing access to proactive care for people with complex needs, we will promote independence and reduce ED attendances by 30% per year from current levels
- 24/7 access to crisis response services will reduce emergency admissions by up to 30%
- Investment in out of hospital care will support a reduction in readmissions to hospital within 30 days of discharge and reduce the rate of Delayed Transfers of Care
- As support at home or in a community setting is increased, the average length of stay in hospital will be reduced by 50%
- As we reduce over-hospitalisation and length of stay in hospital, we will support people to remain independent, cutting admissions to care homes by 8%.

By 2020, the financial benefit of these changes is calculated to be around **£45m**. £19m of these savings will be then be re-invested each year in out of hospital services, delivering a net benefit to the system of £26.3m by 2020/21.

Investment Plan

In 2017/18 the Intermediate Tier will require additional transitional funding of **£2.5m**, falling to £473,000 in 2018/19.

Table 3: Transformation Funding (including double running)

Planned Investments:	2016/17	2017/18	2018/19
Commissioning hub & health element of crisis response	£289,000	£543,300	
Workforce	£509,300	£1,254,700*	
Non-pay	£24,000	£68,200	
Hydration Service/IV Fluids		£170,000	
Additional step up beds (10 beds)	£238,900	£485,300	£473,500*
Total	£1,061,200	£2,521,500	£473,500

* Proportion funded from baseline budget and additional funding from Stockport Together

Going forward, the Intermediate Tier will require recurrent investment of around £13m. From 2019/20 onwards it is anticipated that workforce efficiencies of 5% a year will be generated.

Table 4: Cost Profile

	2016/17	2017/18	2018/19	2019/20	2020/21
Recurrent Funding:					
Workforce (recurrent)	£5,571,868	£6,071,502	£9,106,125	£9,109,653	£8,657,752
Workforce efficiency				-£455,483	-£432,888
Beds	£6,560,489	£6,060,855	£5,010,013	£5,010,013	£5,010,013
Total	£12,132,357	£12,132,357	£14,116,138	£13,664,183	£13,234,878
Transitional Funding:					
Workforce and beds	£1,838,534	£2,521,469	£473,492	£0	£0
Total	£1,838,534	£2,521,469	£473,492	£0	£0
Total Funding:	£13,970,891	£14,653,826	£14,589,630	£13,664,183	£13,234,878

Risk Management

The main risks and their mitigation plans are set out in the table below:

Table 5: Risks & Mitigations

Risk	Mitigation
Staff/resources required to make changes are not released to support implementation, impacting success of delivery.	Obtain commitment from executive team/partner organisations to release staff to support implementation.
Timescales associated with full public/staff consultations impact ability to implement significant changes before Winter period.	Identify and plan for asap and flag up any potential impact. Develop phased approach to implement early changes that are not reliant on consultation.
Lack of cohesion with other Stockport Together workstreams/models &/or wider GM transformation result in disjointed pathways.	PMO and close working across programme/workstreams with key stakeholders to ensure connections/dependencies/issues managed.
Failure of new model to prevent forecast level of acute admissions.	Ongoing monitoring/PDSA cycles, benefit reviews at regular intervals to be conducted by the Programme Office.
Not possible to increase capacity (double run) due to workforce shortages with the required level of skills, mean cannot prove concept &/or fully implement model.	Ongoing review/management of plans and close working workforce enabler to develop solutions.
Hospital bed capacity is reduced before the new model is able to demonstrate impact/deflect acute activity, negatively impacting quality/performance.	Ongoing monitoring/PDSA cycles. Engage hospital (FT) stakeholders to develop aligned plans.
Lack of co-location solution (physical location) reduces ability to work in an integrated way.	Ensure early involvement with planning implementation with estates enabler.
The proposed investment required is not made available and therefore unable to implement the model as intended.	Proposed model to be implemented in a phased manner, which would recognise only limited investment could be secured initially and this could be invested wisely if the service was

	managed in an integrated way with fewer teams and one provider taking the lead in its operational management.
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Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans.

Stockport Together will undertake a 'listening period' from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

If agreed, the business case would be implemented over an approximate 12-15 month period.

INTERMEDIATE TIER OUTLINE BUSINESS CASE

Abstract

This business case describes the proposal for the intermediate tier of services, which will be delivered in Stockport from 2017/18 to 2020/21.

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1. Executive Summary

1.1 Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to deliver the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

1.2 Business Case Overview

This paper sets out the case for a revised Intermediate Tier of services that collectively support people to recover from ill health and prevent unnecessary admission to hospital or long-term residential care.

The document describes in detail the design of the new model. It sets out investment requirements and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business identifies anticipated risks to delivery of transformation and the mitigations in place to maximise benefits.

1.3 The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Intermediate Tier of services is defined as those services that: promote faster recovery from illness; prevent unnecessary acute hospital admission and premature admission to long-term residential care; support timely discharge from hospital; and maximise independent living. In Stockport there are over 20 such services which have developed in isolation over the past ten years. While each service has significant strengths, collectively the Intermediate Tier is fragmented and difficult to navigate.

The current range of services has been designed to manage the effects of the system, rather than tackling its causes. The majority of staff and financial resources are spent on facilitating a hospital discharge - or 'step-down' from secondary care. Much less capacity is used for 'step-up' activity – intensive support to prevent unnecessary hospital admissions. This means that there is not a strong alternative offer to respond to people in crisis and prevent hospital admissions, placing additional demand on the hospital and the Emergency Department in particular. And many patients receive intermediate care interventions in a hospital bed due to the lack of capacity in the community.

Most of the budget is spent on delivering care in community facilities and not an individual's home, reducing independence. As a result, people spend longer in

intermediate tier beds than patients in other parts of the country. A point prevalence study of Intermediate Care beds in 2015 found that 33% of patients did not need an intermediate tier bed at that moment in time – resulting in 1,257 excess bed days. The knock on effect can be seen in the simultaneous review of 6 hospital wards, which found that 44.53% of people no longer required a hospital bed, but could not be discharged due to a lack of capacity in community services. The longer patients spend in a bed, the harder it can be for them return home and live independently.

Table 1: Point Prevalence Study of Patients in Intermediate Tier Beds

Bed Based Service	No. of patients	No. who did not need an Intermediate Tier bed	Resulting Excess Bed Days
Blue Bell	24	3	1,126
Saffron Ward	18	9	76
Marbury	38	13	25
Berrycroft	14	6	30
Total	94	31	1,257

Fragmentation of the 20+ services means that many service users rely on multiple teams and referrers are unsure of the availability of services or the criteria for access. Patients report multiple assessments being duplicated by different services. In addition, the current range of services lacks enough mental health and dementia input to support the needs of service users. This situation will only intensify as Stockport's population continues to age. By 2020, the number of people aged over 65 will increase from 55,700 in 2014 to 61,000. Currently 51% of the total adult population of Stockport are known to have one or more long-term conditions. By the age of 85, 87% have at least one and 53% have two or more. And by 2030 dementia prevalence will rise by 50%.

1.4 The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets. Our vision for the intermediate tier is to create a responsive and person-centred service that supports people's active recovery and provides a strong bridge to transition both to and from hospital.

This business case describes a model of care delivered in a person's normal place of residence or as close to home as possible. It describes a continuum of 24 hour, home and bed based care that works closely with and links hospital and primary care services. Services will urgently wrap around a person to meet their physical, mental health and social care needs and prevent an unnecessary hospital admission. Services will also actively reach into hospital wards to facilitate early discharge and support people to recover at home. The integrated services will promote faster recovery from illness and maximise independence to avoid premature long-term care.

The model will target two population cohorts:

- STEP-UP: people in crisis at high risk of a hospital admission (14,079 individuals)
- STEP-DOWN: people in hospital who are medically optimised but require additional time and support to recover (14,079 individual plus a proportion of elective admissions).



The model is built around six core components:

1. **Intermediate Tier Hub** - there will be one single access point for assessment and triage 24 hours 7 days a week via one telephone number.
2. **Crisis Response** - multidisciplinary team able to respond to crisis response within an hour or to urgently arrange an alternative care offer in the community to avoid hospital admission; 24 hours a day, 7 day per week. Teams will include nurses, physiotherapists, occupational therapists, health & social care support workers, social workers and mental health practitioners. They will also have access to overnight support, pharmacists, and specialist medical input.
3. **Bed reconfiguration and management** - a community bed-based service that brings together health & social care professionals to offer a multi-disciplinary range of care to ensure all needs are met in a short period of time. This will be used to support intensive rehabilitation, sub-acute care, recovery and crisis care. It will combine physical and mental health provision and reduce spot-purchasing of beds by 50 by 2019.
4. **Active Recovery at Home** – a community, home based service that brings together health & social care professionals to meet all care needs in a short period of time. This team will support both step-up and step-down pathways. The functions provided by the team at a person's place of residence include: transfer to assess; rehabilitation; reablement; time to recover; and clinically enhanced care.
5. **Transfer to Assess** – Once immediate needs have been met, it is important that patients are discharged from hospital in an appropriate and timely manner. This service will ensure speedy transfer from hospital to home and deliver assessment for ongoing needs as close to home as possible.

Changes will be introduced in two stages:

- Phase 1 will create additional capacity and capability to respond to crisis and keep people at home
- Phase 2 will look at the reconfiguration of the community bed base and supporting systems to optimise flow in and out of hospital.

To deliver this model, the business case proposes a considerable increase in capacity to provide more care in a patient's home. Over time, this will allow us to reduce the number of community beds from 150 to 98 by April 2019. This would include the creation of a single facility of 40 intermediate tier beds to be used flexibly to deliver assessments, intensive rehabilitation, reablement and recovery services with nursing, mental health and therapy input.

Table 2: Staffing Levels

Pathway	Current Staffing WTE (%)	Future Staffing WTE (%)
Step down	125.23 (74%)	95.60 (38%)
Step up	45.02 (26%)	154.57 (62%)
Total	170.25 (100%)	250.17 (100%)

Significant improvements will be required in IM&T systems including ensuring 24/7 access, a more robust version of the Stockport Health & Social Care Record, the introduction of a bed management system and care home IM&T capability. There will also be a need for estates changes to enhance the bringing together of the new teams. This and the required organisational development are described more fully in the **Enabler Business Case**.

1.5 Benefits of the Model

Stockport Together's proposed service solution will integrate health and social care services, providing a comprehensive service that meets the increasingly complex care needs of our ageing population.

The Intermediate Tier will provide care as close to home as possible, with the aim to deliver most care in a person's normal place of residence. This will reduce the length of stay in intermediate care beds from the current average of 4 weeks to the national best practice standard of 2 weeks. Reducing length of stay in intermediate care beds and providing more care at home will significantly reduce the cost to health and social care services of spot-purchasing beds in care homes.

There will be a considerable increase in capacity, resulting in services working 24/7. The new model will address the balance of step-up - step-down services to meet local need and prevent unnecessary hospitalisation, taking pressure off the local hospital and cost out of the system.

These changes will contribute significantly to the high level benefits of the Stockport Together programme. Whilst the exact contribution of the Intermediate Tier cannot be extrapolated with certainty work has been done to estimate this based on the intention that the case:

- Increases access to proactive care for people with complex needs, we will promote independence and reduce ED attendances by 30% per year from current levels
- 24/7 access to crisis response services will reduce emergency admissions by up to 30%
- Investment in out of hospital care will support a reduction in readmissions to hospital within 30 days of discharge and reduce the rate of Delayed Transfers of Care
- As support at home or in a community setting is increased, the average length of stay in hospital will be reduced by 50%
- As we reduce over-hospitalisation and length of stay in hospital, we will support people to remain independent, cutting admissions to care homes by 8%.

In 2017/18 the Intermediate Tier will require additional transitional funding of **£2.5m**, falling to **£1.1m** in 2020/21.

Table 3: Investments and Benefits

Investment & Savings by business case	£'000						
	Investment			Benefit			Net Benefit
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2020/21
Acute Interface	£2,500	£2,334	£2,168	(£4,871)	(£6,089)	(£6,089)	(£3,921)

Intermediate Care	£2,457	£1,532	£1,103	(£3,275)	(£4,003)	(£4,730)	(£3,628)
Neighbourhood	£12,106	£11,445	£10,987	(£11,170)	(£14,907)	(£20,465)	(£9,478)
Outpatients	£2,280	£2,128	£2,117	(£6,833)	(£9,150)	(£11,765)	(£9,647)
TOTAL	£19,344	£17,439	£16,375	(£26,150)	(£34,149)	(£43,049)	(£26,674)

1.6 Risk Management

The main risks and their mitigation plans are set out in the table below:

Table 5: Risks & Mitigations

Risk	Mitigation
Staff/resources required to make changes are not released to support implementation, impacting success of delivery.	Obtain commitment from executive team/partner organisations to release staff to support implementation.
Timescales associated with full public/staff consultations impact ability to implement significant changes before Winter period.	Identify and plan for asap and flag up any potential impact. Develop phased approach to implement early changes that are not reliant on consultation.
Lack of cohesion with other Stockport Together workstreams/models &/or wider GM transformation result in disjointed pathways.	PMO and close working across programme/workstreams with key stakeholders to ensure connections/dependencies/issues managed.
Failure of new model to prevent forecast level of acute admissions.	Ongoing monitoring/PDSA cycles, benefit reviews at regular intervals to be conducted by the Programme Office.
Not possible to increase capacity (double run) due to workforce shortages with the required level of skills, mean cannot prove concept &/or fully implement model.	Ongoing review/management of plans and close working workforce enabler to develop solutions.
Hospital bed capacity is reduced before the new model is able to demonstrate impact/deflect acute activity, negatively impacting quality/performance.	Ongoing monitoring/PDSA cycles. Engage hospital (FT) stakeholders to develop aligned plans.
Lack of co-location solution (physical location) reduces ability to work in an integrated way.	Ensure early involvement with planning implementation with estates enabler.
The proposed investment required is not made available and therefore unable to implement the model as intended.	Proposed model to be implemented in a phased manner, which would recognise only limited investment could be secured initially and this could be invested wisely if the service was managed in an integrated way with fewer teams and one provider taking the lead in its operational management.

1.7 Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans.

Stockport Together will undertake a 'listening period' from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

If agreed, the business case would be implemented over an approximate 12-15 month period.

2. Introduction

Currently there are over 20 health & social care services providing various forms of intermediate tier services (home & bed based) that are predominantly focused on supporting discharge from hospital.

Each service has been setup discretely over the past 10 years creating a complicated system that is not easily understood (by public & professionals) which have been designed to manage the 'effects' of the system rather than tackle its 'causes'.

This means there is not a strong alternative offer to respond to people in crisis and prevent acute admission, placing additional demand on the hospital/A&E.

This business case has been developed to outline how Stockport Together intends to implement a new model of care for intermediate tier services that is more assertive in reducing acute activity and improving outcomes for service users.

This proposal outlines how improvements will be delivered and aims to redress an imbalance between intermediate tier services provided in people's own home and those provided in community beds and hospital.

3. What is Intermediate Care/Tier?

Intermediate Care has been a key element of health and social care systems within the UK for years. A large amount of guidance on this area has been published since 2001, but the key definition in use regarding intermediate care services is provided by the Department of Health (*Intermediate Care – Halfway Home*, DH 2009). This document defines intermediate care services as:

"a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living"

The guidance makes it clear that intermediate care services usually involve multi-disciplinary team working, often across both health and social care agencies. "Halfway Home" describes intermediate care services as:

- targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care;
- provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery and free at the point of delivery;
- having a planned outcome of maximising independence and typically enabling patients and service users to resume living at home;

- being time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less;
- involving cross-professional working, with a single assessment framework, single professional records and shared protocols.

Recent policy and strategy documents have made a shift from intermediate care to intermediate tier ('intermediate care plus') to acknowledge the clear links between intermediate care and its integration with rapid response, reablement and other rehabilitative community based services supporting people 'in transition' to maximise independence for people. Intermediate tier therefore offers a whole system approach of short-term services.

This document adopts this broader definition of intermediate tier with a system approach, in conjunction with the neighbourhood teams/model, based on people's short-term increased needs to either facilitate:

- 'step up' care: urgent response to deterioration to people in the neighbourhood giving them maximal opportunity to recover and avoid a hospital admission where possible or
- 'step down' care: early discharge support for people recovering from an illness, fall or post-operation who do not require inpatient treatment and can be cared for in the community.

4. Scope & Exclusions

4.1 Scope

The scope of this business case includes the following

- All Intermediate tier services delivered by all partner organisations (see appendix 1)
- All adults over the age of 18
- Intermediate tier commissioning & service provision arrangements
- All community beds and associated acute beds (health and social care) that could be utilised for Intermediate tier purposes
- All staff (health and social care) within Intermediate tier services including the voluntary sector
- Service model for all Intermediate tier services, including referral protocols and processes, assessment, acute step down pathways and step up from integrated neighbourhood teams.
- Performance management tools and metrics utilised by health and local authority, Better Care Fund and standards and measures within the national audit of intermediate care.

4.2 Exclusions

These may move into scope in a later phase of development if considered appropriate but for now are considered out of scope. These are:

- People under the age of 18
- Long-term care arrangements in Care Homes and with Home Care providers (part of Neighbourhood workstream)
- Specialist care in the community e.g. COPD (although there is an interface)
- Ambulatory Sensitive Conditions / Care (although there is an interface)
- Core neighbourhood offer (although there is an interface)
- Palliative care, respite team (although there is an interface)
- Development of an integrated falls service (part of Neighbourhood workstream)

5. Vision Statement

Our vision for intermediate tier services is to create:

"a responsive and person centred Intermediate tier that supports peoples active recovery at home and provides a strong bridge to transition to/from hospital"

We firmly believe that care and treatment should be delivered in a person's own home/place of residence or as close to home as possible. To achieve this we will deliver a continuum of 24 hour, integrated, responsive, flexible, person-centred home and bed based intermediate tier services that collaborate with and bridge the transition between acute hospital and primary care settings.

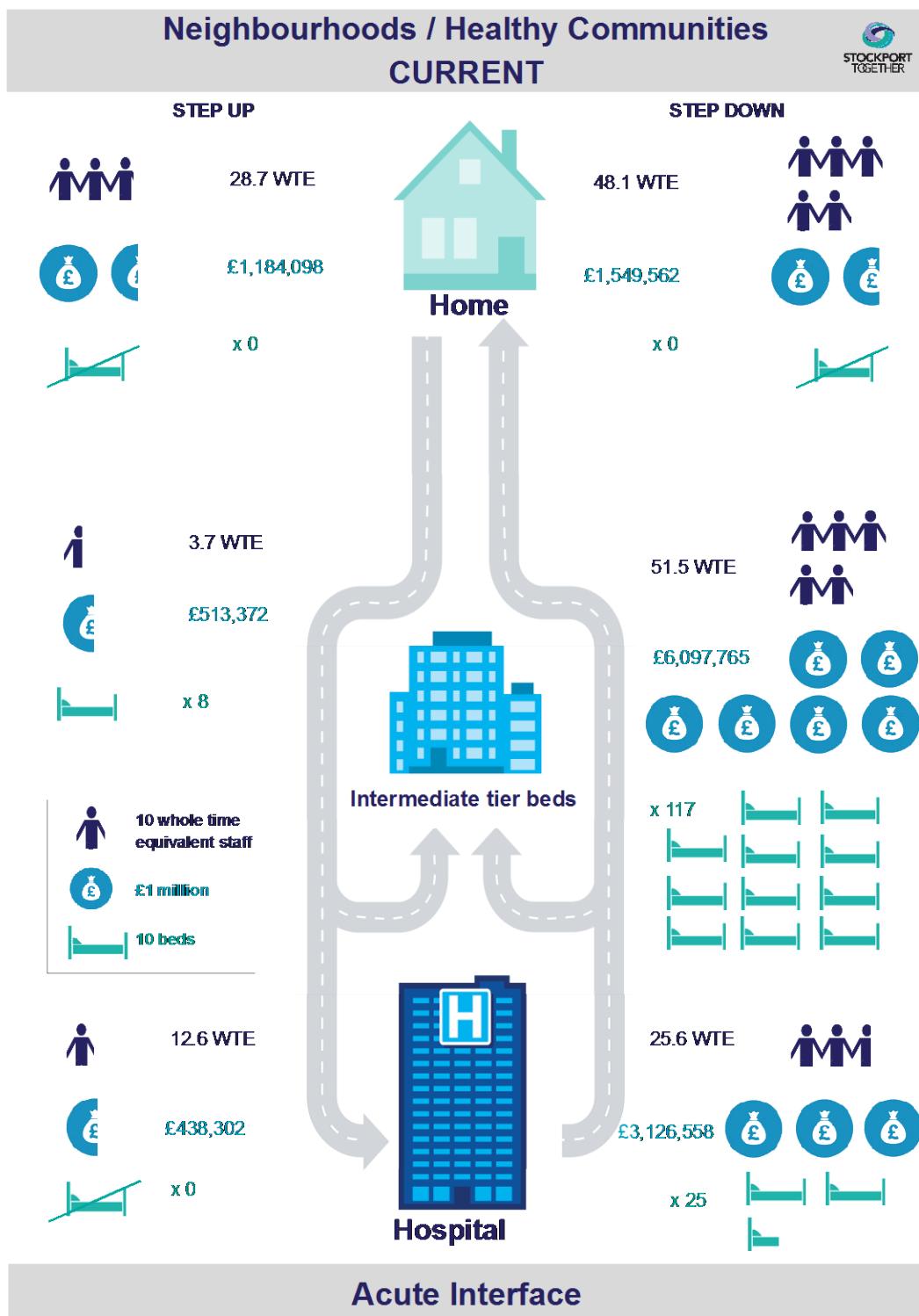
These services will urgently wrap care around a person at home to meet their physical, mental health and social care needs to prevent an unnecessary acute hospital admission and quickly in-reach to those needing admission to facilitate early discharge and support recovery at home. They will promote faster recovery from illness and maximise independence to avoid premature long term care.

6. Current Situation

Over the years Stockport has successfully developed a range of intermediate tier services to meet the needs of patients and their carers and to support the health economy. Some services are fully integrated health and social care facilities commissioned through 'section 75' and 'better care fund' arrangements, other services are initiatives funded on a non-recurrent year by year basis or through non-recurrent winter pressure monies.

In appendix 1 a more detailed overview can be found of the various intermediate tier services in scope of this project, below a high level description of the current situation is presented.

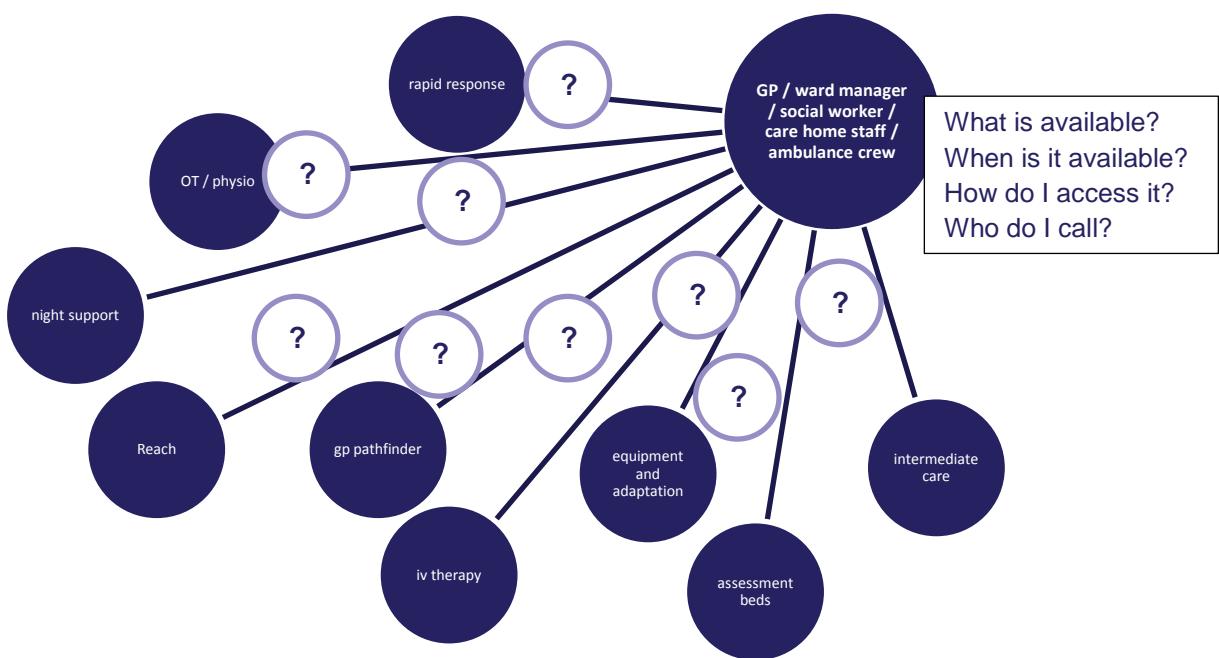
Figure 1. Current State – Resource distribution across system



The picture tells us that:

- Majority of staff and financial resources are spent on facilitating a hospital discharge pathway (step down)
- Majority of the budget is spent on delivering intermediate tier in community beds instead of in the person's place of residence
- Various patients receive intermediate tier type of interventions in an acute hospital bed instead of in the community.

In addition the current service delivery is fragmented and lacks enough mental health / dementia input:



Apart from a highly confusing service delivery model, consultation with patients, staff and key stakeholders resulted in a further analysis of Stockport's current situation and flagged up several other aspects that needs addressing in the future intermediate tier model. In appendix 2 an overview of the list of the Strengths, Opportunities, Weaknesses and Limitations can be found.

6.1 Inpatient review Stepping Hill hospital (CSU April 2015)

An Inpatient Review at Stepping Hill Hospital followed a random cohort of 97 'medical' speciality patients aged 75 and over for two weeks or till discharge. Of this cohort 42% lived in their own home with another capable adult, 38% lived alone and 12% resided in a care home. Of this cohort 36% (n=35) were in receipt of social care inputs prior to admission.

The point prevalence study (CSU April 2015) showed:

- 11% of people admitted via A&E (N=11) had potential for attendance avoidance.
 - If GPs could have admitted directly, if people had potential to visit a GP prior to attendance, if a step up intermediate tier bed had been available or if DN had been available
- 34% of reviewed bed days of this cohort were deemed inappropriate because no acute medical bed was needed
- 'waits' were observed on 54% of the 797 bed days reviewed for this patient cohort, including wait for transport and 'take home' medication:
 - Diagnostics (26.60%, n=212 days)
 - Medical (14.30%, n=114 days)
 - Social (4.89%, n=39 days)
 - Intermediate care (3.39%, n=27 days)
 - Nursing 92.67%, n=22 days)
 - Family (1%, n=8 days)
 - Therapy (0.63%, n=5 days)
 - Mental health (0.5%, n=4 days)

The CSU report identified the following opportunities to improve discharge planning:

- Establishing at the 'front door' the nature and level of community service support received by the patient prior to admission
- Pro-active discharge planning at the point of admission
- Improved identification and recording of estimated discharge date (only 46% at that time had an estimated discharge date) and medically fit for discharge date
- Planning for morning instead of afternoon discharges

Based on a small patient cohort it was suggested that 5 days could be saved if patients are discharged when deemed to be 'medically fit for discharge' i.e. no longer require inpatient treatment and the appropriate services in the community are available.

6.2 Point prevalence review (CSU February 2015)

The CSU undertook a point prevalence review of Bluebell Ward, Saffron Ward, Marbury House, and Berrycroft, based on 94 admitted patients at that time. Gaps identified were:

- Capacity for step up pathway
- Facilities for patients with sub-acute health needs
- Increased capacity for patients with physical and mental health (including cognitive impairment) needs

- Admission to the services outside core hours is not always possible.

The point prevalence study identified that:

- 3 of 24 Blue Bell patients (1126 excess bed days)
- 9 of 18 Saffron patients (76 excess bed days)
- 13 of 38 Marbury patients (25 excess bed days)
- 6 of 14 Berrycroft patients (30 excess bed days)

didn't need an intermediate tier bed at that moment in time.

A point prevalence review was also undertaken on certain hospital wards (E2, M4, A10, A11, A15 and SSOP), regarding 137 patients.

44.53% (n=61) were deemed not to require an acute hospital bed (12 patients on E2, 14 patients on M4, 18 patients on A10, 8 patients on A11, 4 patients on A15 and 5 patients on SSOP). Of these 61 patients, 40 patients had potential for discharge with **existing** services of which 17 patients could have been referred to a community intermediate tier bed.

19 patients of these 61 (31%) had potential for discharge but only with **enhanced services**: combination of therapy and mental health provision in intermediate tier beds, availability of a discharge to assess facility, short-term additional health and/or therapy input in care homes to support discharge.

Several patients were both referred to A10 and a community intermediate care bed (Marbury / Berrycroft) for their rehabilitation needs to access the first available bed for the patient.

6.3 Benchmarking

Compared to the National Intermediate Care Audit (2015) Stockport's intermediate care service performs as follows:

Key Outcome	NAIC Benchmark 2015			Intermediate Care Stockport available data
Workforce (WTE) per 100 service users	Home based Bed Based Reablement	3.0 clinical 1.4 clinical 4.0 clinical		Not provided
Investment per 100.000 population	Bed based Reablement	£1.3M £0.6M		Not provided
Referrals per 100.000 population	Crisis response Home based Bed based Reablement	543 808 266 497		Not provided
Beds commissioned per 100.000 population	25.6			54 per 280.000 population (excl. spot purchases)

Waiting times	Crisis response Home based Bed based Reablement	3.7 hours 6.3 days 3.0 days 8.7 days	0.8 hours 0 days 1 day --
Cost per service user	Crisis response Home based Bed based Reablement	£ 521 £1,205 £5,672 £1,484	£ 859 -- £5,610 £ 1,032
Length of stay	Home based Bed based Reablement	29.3 days 26.8 days 34.5 days	27 days 31 days 26.01 Saffron Newlands 29 days 46 days
Outcomes	Destination on discharge Crisis 67% own home Bed based 62% own home Home based 73% own home		81% own home 96% own home 99% own home

In summary, Stockport economy has an excellent foundation to build on regarding its future intermediate tier model. The current intermediate tier teams are accustomed to integrated working across health and social care, are flexible in offering a person-centred approach and are supporting each other in delivering care to Stockport residents. Saffron ward is a unique facility offering intermediate tier to people with combined physical and mental health needs.

Patients admitted to the intensive rehabilitation units (Marbury and Berrycroft) show better long-term outcomes than the national benchmark average. It has been acknowledged that the hospital together with the intermediate tier service could undertake better forward planning for certain patient cohorts. This would work particularly well for those with a fractured neck of femur or a hip-replacement or patients with a urine tract infection and delirium to develop smooth pathways and timely transitions from hospital into intermediate tier.

However, the pressure in the system on facilitating hospital discharges has transferred intermediate tier to almost a 95% 'step down' service over the years. The current rapid response service is able to deflect some people at risk of a hospital admission but is currently not fully effective and well utilised. There is a need for rapid access to diagnostics, for support overnight and Stockport also lacks a step-up facility in the community for patients with sub-acute needs. In addition, the reablement teams have only limited capacity to provide 'step up' care (5%) due to the pressure on supporting hospital discharges.

Despite the vast number of intermediate tier beds, 'spot purchases' are still being made on a regular basis to meet the demand. All intermediate tier beds have a high occupancy rate (above 90%) with some beds having a higher than national average length of stay. This is part caused by the fact that Stockport has an older population and part because the length of stay is high due to delays in discharging from the intermediate tier service and time needed for recovery before rehabilitation can start.

At the moment the bed based facilities are spread out across ten different care homes with ten different GP-cover arrangements. Most of the patients admitted to the beds receive an excellent and well valued intermediate tier offer (as viewed by the patients). However some

patients miss out on nursing and therapy input, especially when admitted to the 'step up' beds, assessment beds and the 'spot purchase' beds.

Finally, a group of patients are directly admitted into long-term placements without being offered the opportunity to recover first before making decisions about future care, or patients are staying in an acute hospital bed waiting till an assessment of future needs have been undertaken. Both groups would have benefitted from an intermediate tier offer if a discharge to assess or 'time to think' facility would have been available.

With partners working collaboratively through Stockport Together there is a real opportunity to shift resources from hospital into the community to enhance the step up pathway to prevent unnecessary hospital admissions and redesign the step down pathway to offer early discharge support at the person's place of residence or community bed.

7. Learning from others

As part of an initial exercise to identify best practice in intermediate tier, we have looked at services in other parts of England. The literature search focused on the following areas; Sunderland, Wakefield, South Warwickshire, Sheffield, Nottingham, Bradford and Leeds.

The common themes identified in these areas are:

- Admission Avoidance
- Supported Acute Discharge
- Supporting patient independence

The most common service elements in these areas are:

- **24/7 access:** Services available 24/7 every day of the year, based on need.
- **Single point of access:** A central point manned by skilled call handlers and navigators to transfer and triage all Intermediate Care referrals received to ensure the appropriate response is provided to the patient.
- **Discharge to Assess:** Patients are discharged once medially fit and have an assessment with the appropriate members of the social care and community intermediate care team in their own home.
- **Community Rehabilitation/Care at Home:** Rehabilitation and reablement services with multi-disciplinary teams providing care packages within the patient's normal residence.
- **Crisis Response:** 24/7 response and support through health and social care crisis where an acute hospital admission is not to be the best option for the patient. The patient is assessed, diagnosed, treated and supported at home.

8. Rationale

When the summary of evidence above is reviewed, alongside Stockport's current capacity

and use of Intermediate tier services, then the following conclusions are evident:

- There are currently over 20 health & social care services providing various forms of intermediate care (home & bed based).
- Referrers are unsure of the availability of intermediate tier services, and the criteria for accessing these services.
- There are a number of points in the 'system' at which assessments for intermediate tier are carried out with patients experiencing multiple assessments. This results in significant duplication, fragmentation and a lack of consistency in approach.
- Too few patients/service users are provided with home-based services, with limited capacity and capabilities to provide enhanced sub-acute care at home e.g. IV-therapy and sub-cutaneous fluids.
- Professionals unable to access care at home err on the side of caution and access the next safest intermediate care resource in a care home bed. This is true of Stockport and reflected in the larger than expected admission levels to beds.
- We know people spend longer in intermediate beds than they typically do elsewhere, and this can make it much harder for them to return home and live independently. By providing home-based services, patients recover more quickly and have an improved experience of care.
- The NAIC 2015 states that currently the average number of Intermediate care beds per 100,000 population across England is 25.6. Whilst it is difficult to draw a direct comparison under the broader definition of Intermediate tier, there is considered to be an over reliance on bed based care within the health economy.
- Too many services concentrate on discharge from hospital (c.90% of activity), utilising resources that could be directed towards hospital diversion, where greater cost effectiveness has been proven.
- As a result of over-investment in beds, Stockport lacks a robust sub-acute admission avoidance service offering (medical response) as an alternative to unnecessary and avoidable hospital admissions.
- Services need to be realigned in order that the best outcomes are delivered across the whole spectrum of intermediate tier services from a finite resource.
- Stockport is lacking an integrated falls service offering primary, secondary and tertiary falls prevention. As a result Stockport as an economy is an outlier in spend on health and social care costs related to falls. (1,300 admissions a year from falls aged 65+; 11,400 people in Stockport have a history of falling, a key risk for loss of independence)
- The current provision is lacking mental health / dementia care input across all elements of intermediate tier, especially regarding rapid response and intermediate tier (rehabilitation and reablement) at the place of residence.

It is apparent from the above that focus and resource within Stockport is not afforded to admission avoidance services to the same degree as found in other areas of the country.

In light of this it is considered that significant improvements could be achieved by moving away from the current collection of services which often lead to duplication, fragmented and uncoordinated care. To designing a fully integrated intermediate tier service which most

effectively meets patient/service user needs and makes the most effective use of available resources.

9. Options

In reviewing the possibilities for improving Intermediate tier services for local people as well as taking into consideration the cost effectiveness (current & future), four options were considered:

9.1 Option 1

Do nothing

To continue with the current Intermediate tier service provision, although this option presents a greater risk around achieving national and strategic aims and will lead to continued gaps in Intermediate tier services.

The services will continue to operate in an isolated fashion leading to people's needs not being met within the most appropriate and cost effective environment and potentially extending their requirements for longer term services.

Not recommended: Will present a significant level of risk and is highly likely existing services will be unable to cope with increasing demand and will be unable to support reducing acute admissions and attendances to A&E.

9.2 Option 2

Generate efficiencies and reduce resources in Intermediate tier services

To reshape current service provision in order to realise efficiencies and enable a reduction in resources within Intermediate tier services. The services will operate in a more integrated way and ensure improvements in productivity and performance are achieved in line with comparative health economies.

Not recommended: Will present a level of risk that potentially increases acute impact and whilst realising savings in the short term, is considered to be a false economy given the greater level of resources that are held in the hospital. Additionally it is unlikely that the services will be able cope with forecasted increased demand for Intermediate services.

9.3 Option 3

Develop and enhance existing Intermediate tier services to form a single borough wide service

The proposal is to build on and further develop services to form a single team that is more assertive and driven by people's needs rather than the individual services/professions. This will rebalance provision in favour of home based & step-up services, reducing reliance on acute / bed based care to allow far more people to remain at home or go straight home from hospital.

This will ensure the provision of high quality care delivered by the right person in the right

locations, at the right time for the person and at the right cost for the commissioner.

Recommended: Presents improved level of risk with regards to impacting acute admissions, viewed as optimum solution to meet the design challenges, adopts a system wide perspective to achieve the best outcomes for the current & future population within the available resources.

9.4 Option 4

Devolve all home based Intermediate tier services to neighbourhood teams

The option is to devolve a greater level of services including all home based Intermediate tier services that are currently delivered on borough wide/locality basis to the Neighborhood teams.

This builds on the MCP model that puts the Neighborhood at the heart of the model of care, with teams developing services wrapped around the needs of the local population.

Not recommended: Assuming resources are in place potentially presents lowest level of risk with regards to impacting acute admissions by allowing people to remain at home. However with finite resources available this is not considered possible to create the economies of scale to do this.

Additionally the Neighbourhood model is not viewed as mature enough to take additional responsibility at present. There is a possibility to review this in 18 to 24 months when the neighbourhood is more established.

10. New Model of Care

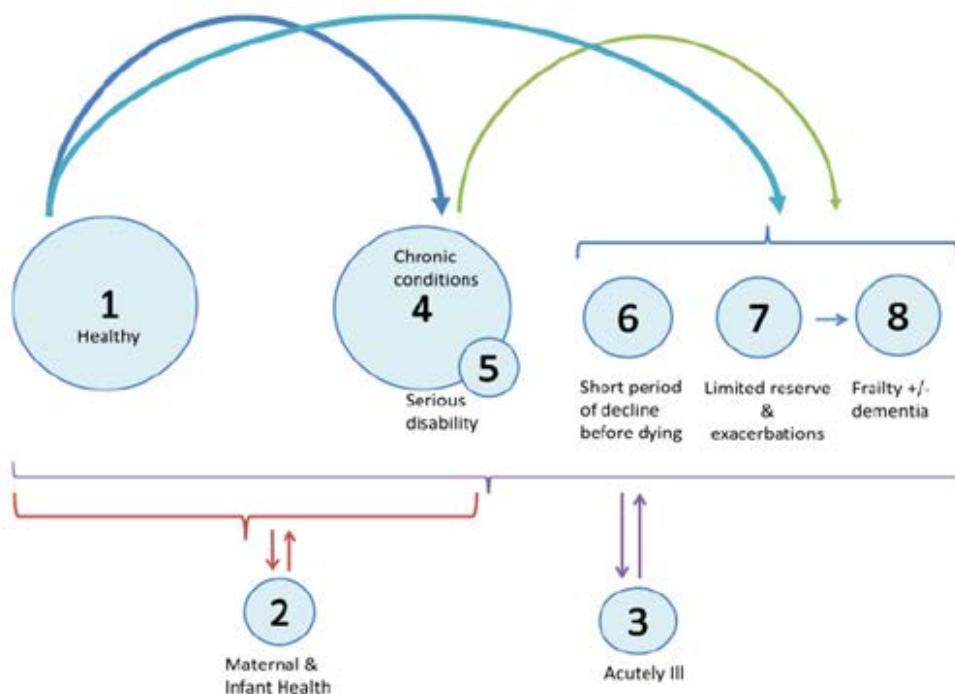
10.1 Population

Our new model is targeting two population cohorts.

1. People in crisis that are at high risk of acute admission (step up). Population size: 14,079
2. People in hospital who are medically optimised but require additional time and rehabilitation to recover (step down). Population size: 14,079 + proportion of elective admissions

The future commissioning arrangements for a population based weighted capitation contract will look to commission specific outcomes for specific population segments. The approach being taken to this is built on the *Bridges to Health* approach identifying 8 population segments. These are described diagrammatically below. At any given time nobody is in more than one of the six upper segments and can exacerbate from any of these to the Acutely ill segment (3).

Figure 2. Evaluation of Whole Population Segmentation and an Implementation Approach for the 'Bridges to Health' Segmentation Model" (OBH, August 2016).

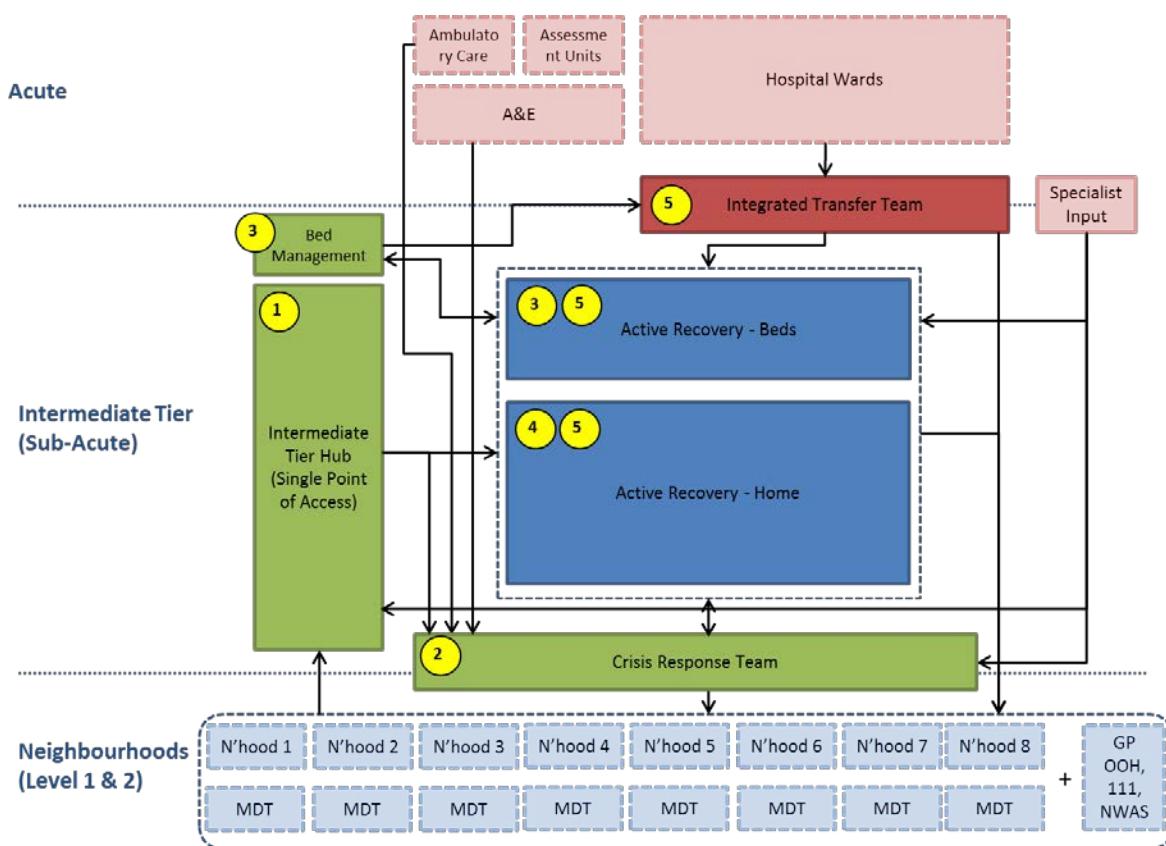


The Intermediate Tier business case when considering step-up functions will be predominantly dealing with significant exacerbations of people in Segments 4 and 5 (chronic Conditions) and Segment 7 (Limited reserve & exacerbations), but may also occasionally support people in Segments 6 and 8. When it is looking at step-down it will be focussed on how it transfers individuals back home from an acutely ill state (Segment 3) in such a way as to minimise their decline towards limited reserve and further exacerbations (Segment 7) or towards frailty and dementia (Segment 8).

10.2 Outline operating model

The new intermediate tier model offers a 'stronger and faster' response to deterioration/crisis by supporting people's recovery at home and facilitating early discharge, in order to prevent unnecessary acute hospital admission. The new model is outlined in the below figure:

Figure 3. Intermediate tier operating model



Note. The model is not exhaustive nor is it likely to be 100% accurate at this stage, this will be further developed through detailed design of the target operating model during implementation.

10.3 Model Components

This section details the 6 core model components (referenced above) that have been developed by the intermediate tier design team that will support the development of a transformed acute care system, care delivered in the neighbourhoods and is aligned with the new MCP model.

1. Intermediate tier hub
2. Crisis response
3. Bed reconfiguration & management
4. Active recovery at home
5. Transfer to assess

It is important to highlight that each component is dependent on the whole system being in place to function effectively (including the core neighbourhood & the acute interface). It is considered the cumulative effect of the components working together as part of a whole system that will have the biggest impact on reducing acute activity, positively impact on health & social care budgets and improve outcomes for patients and carers.

10.3.1 Model Component 1: Intermediate tier hub

One single access point for assessment and triage 24 hours, 7 days a week.

The new Intermediate tier hub will provide a single point of access via one telephone number to Intermediate tier services, ensuring that each person referred is placed on the most appropriate care pathway.

The hub will operate 24/7 with a new team of health and social care professionals working together to signpost, screen, triage, assess and design wrap-around care at or close to home.

It is envisaged the service will initially be restricted to referrals from professional staff only and not the public. However as the model further develops this will be reviewed and access could in the first instance be opened up to patients and carers as part of their contingency planning.

Professional staff (referrers) will phone when they have an individual with an urgent care need and are looking for community alternatives to admission or to support discharge from hospital or care home.

GPs will also be encouraged to use the service for all unplanned hospital admissions with the exception of children or those patients with clear life threatening conditions.

The hub will be operated by a multi-disciplinary team, co-located to promote effective co-working in and out of hours, will screen all referrals ensuring that each person (and their family) is seen by the right team members. Using a multi-disciplinary approach, team members with the appropriate skills and competencies will carry out joint assessments and initiate and provide the right levels of personalised health and social care support.

Note. In the future it is considered the hub may form part of borough wide care co-ordination centre, the scope of which goes beyond the remit of intermediate tier model and discussions on this are at a very early stage.

The intermediate care hub will be made up of the following disciplines:

- Clinical triage practitioner (health & social care)
- Administrative and clerical support staff

In order to maintain clinical skills staff working in the hub will rotate with teams delivering interventions, i.e. crisis response team. Some of the above disciplines will have mental health expertise.

The hub will have full access and visibility of all Intermediate tier services (Directory of Services, staff and bed availability), following triage and assessment will immediately refer onto the most appropriate care pathway. These will include:

- Step up to an hospital acute bed;
- Step up to a community based bed with nursing/therapist support;
- Step up to a community based bed within residential setting with nursing input;
- Step up in the person's own home with an integrated social and health care plan, including crisis response;
- step down into persons own home with an integrated social and health care plan;



- Step down from a hospital to community based bed/home
- Step down from a community based bed to home;
- Step up or step down for end of life care pathway.

Patient scenario:

...Now

A GP receives phone call from a distressed lady. Mrs Stone, the main carer for her husband with dementia. She is unwell due to a bad migraine and feels she can't cope with caring for her husband at the moment. The son of the family is on holiday and would normally have stepped in. The GP involves the social worker. After trying several care homes, taking an hour and a half, finally a respite placement for the husband has been arranged. Mr Stone is admitted later that day. Mrs Stone receives two days respite care in an unfamiliar place which caused challenges. Mr Stone was unable to settle, became agitated and as a result was put on sedative medication. Being out of his familiar environment has also worsened his dementia symptoms.

Future...

The GP calls the intermediate tier hub. Within an hour a support worker is arranged to support the family at home for 48 hours to give Mrs Stone time to recover from her migraine. Overnight support was not needed but Mrs and Mr Stone were connected to the care call system in case support would have been needed. After 48 hours the intermediate tier service referred Mr and Mrs Stone back to the neighbourhood for future care planning and contingency planning.

***Admission to A&E or care home avoided
Better outcomes for patient with dementia
Time released for GP and social worker***

10.3.2 Model Component 2: Crisis Response

A 24/7 service able to respond to patients in the community needing a crisis response within an hour or to urgently arrange an alternative care offer in the community to avoid hospital admission.

It is envisaged that the new neighbourhood working model will meet a proportion of health and social care needs by being more proactive to manage the population cohort who are at risk of emergency admission and prevent deterioration.

However for some patients in crisis there will be a need for a more immediate (sub-acute) response that cannot be offered by the neighbourhood at that moment in time or need a rapid offer to prevent admission to hospital from A&E, MAU or SSOP, this will be the role of the crisis response team.

The neighbourhood teams will be supported by the crisis response team to support patients at home until other services can be activated. The crisis response team will be available 24 hours a day 7 days a week and have a presence at the front-end of the hospital and also be based in the community. The team will have access to (via consultant

connect) specialist input for appropriate assessment and additional support to manage crisis at home.

This model ensures that the service is responsive to the need for immediate support to prevent an unnecessary admission, but also allows access to and back up from the clinical expertise for situations where a patient's condition begins to deteriorate or additional input is required – for example review by a consultant, or admission to an intermediate bed.

The service is also able to step in where the neighbourhood team is not able to provide imminent support for example because the crisis is at the boundary of a shift or is out of hours, the neighbourhood team has capacity challenges or a patient is not known to the neighbourhood and a crisis response would therefore take up a lot of time from the team.

The crisis response service will provide intense and focused health and social care to assist people through worsening crisis to remain living in their own home and maintain independent living skills.

Where a more supportive environment is needed patients can be transferred to a temporary placement such as a community bed, or a transitional placement such as extra care housing, until such time the person can be supported to return home.

The key elements of the service are an urgent response (aim 30 min response, up to maximum 2 hours) in the individuals' place of residence (including care homes), a full assessment (health & social needs) and an integrated care package, allowing for short term results and planning for a longer term solution in conjunction with the neighbourhood team. The intermediate tier hub will support the crisis response team with the brokerage of the care package. The service will also be accessible for NWAS and 111.

A multidisciplinary team made up of the following disciplines will provide the service:

- Practitioners (including Nursing, OT, Physiotherapists)
- Health and social care assistants/support workers
- Social workers
- Mental Health practitioners (see Appendix 7 for further detail on mental health liaison model)

It is envisaged that the current GP Pathfinder service as currently provided by Mastercall will become part of the crisis response team.

The team has access to overnight support, equipment, dedicated crisis response telecare, consultant, pharmacist and GP Mastercall in case of OOH.

The team will operate a fleet of vehicles kitted out with equipment for medication, oxygen, wound management, venepuncture, cannulation and resuscitation.

This service will also see the extension of intra-venous (IV) and sub-cutaneous fluid pathways and pull from ambulatory care. A team of appropriately skilled community based nurses will administer IV medication in a patient's home to prevent admission to hospital and will be supported where necessary by the GP.

The crisis response team will provide a 'stop-gap', in order to ensure the team is able to respond to new referrals it is essential there is flow through the system. It is therefore anticipated 90% of patients will be referred onto other intermediate tier services/back to the neighbourhood teams or discharged within 3 days.

Patient scenario:

...Now

A GP gets a call during a busy surgery from Ms Bolton, an 86 year old lady with early dementia. It is 4pm on a Friday before the GP gets a chance to visit the patient at home. The lady suffers from dehydration. The GP is not aware of any community service that can offer support at home and refers Ms Bolton to hospital.

Future...

The GP is concerned about Ms Bolton but can't leave his surgery till the afternoon and therefore calls the hub which send out the crisis response team within an hour to undertake a home visit. The crisis worker administers sub-cutaneous fluids and arrange for a crisis support worker to stay with Ms Bolton until her daughter arrives later in the afternoon. Monitoring will take place through regular phone calls with the daughter who stays over. The next afternoon the crisis team undertakes a follow-up visit, takes bloods and baseline observations. The blood results are satisfactory and treatment is stopped. Ms Bolton is much more responsive and is feeling better. Ms Bolton is advised to book an appointment with her GP for Monday to further assess her needs. The patient's electronic record is updated with observations and results and an email to Ms Bolton's GP is sent the same day.

A&E visit and hospital admission avoided

At least 2 days hospital stay avoided

Person with dementia treated in familiar environment

10.3.3 Model Component 3: Bed reconfiguration & management

A community bed based intermediate tier service that brings together health and social care professionals who are able to offer a multi-disciplinary range of elements to wrap around a service user and ensure all needs are met in a short period of time.

As previously highlighted, there is perceived to be an excess of beds in the Stockport health system, despite this within intermediate tier beds access remains difficult at times, which in part is considered to be due the tight criteria for each of the facilities concerned and/or because of high occupancy levels.

It is the ambition of the partners presenting this business case to have a flexible, needs-based intermediate bed model across the borough. In order to achieve this, there needs to be a cultural shift in thinking and working in relation to bed based services.

It is difficult to predict how many beds are required in the community across Stockport. Historical data is based on services functioning as they did/do and does not inform future demand with new ways of working. There is no set formula to calculate the optimum configuration of intermediate tier beds at a population level.

If Stockport is to rebalance its provision in favour of home-based service, and bring its capacity, activity, and outcomes more in line with productive health economies, then many more people would be expected to remain at home, have a shorter stay in a bed based facility or go straight home from hospital. However, we also need to factor in that Stockport

has on average an older population using intermediate tier facilities than many other health economies.

Various functions for the beds have been identified and depending on the needs of the person the right care and therapy input can be organised in the future multi-functional intermediate tier beds.

- Intensive rehabilitation – therapy led with nursing input
- Sub-acute – 24hr nursing led with therapy input
- Recovery / assessment / crisis respite beds – combination of care and therapy input as and when needed
- Combined physical and mental health provision

The bed based service will be managed at a borough wide footprint by a single bed management / patient flow function (adjacent to the hub) and be provided from a reduced number of units. The current geographical spread of smaller units has proven not to be economical viable.

Patients admitted to the beds will receive an estimated discharge date at the start of the admission and the team will be monitored against achieving this. People should not stay longer in the bed as necessary and pro-active discharge planning with potential continuation of care plan in the person's own home is part of the offer.

It is proposed that the future intermediate tier bed-based service is provided across 3 locations, rather than the current 10 locations in Stockport (January 2106) and where possible these will be aligned to localities.

As the new operating models within Stockport Together are embedded and more services are delivered at home preventing acute admission, there will be less reliance on hospital bed usage but as a result an increased demand on sub-acute community beds might occur

During this transition it is envisaged the total number of intermediate tier beds will gradually reduce in anticipation of the increased delivery of intermediate tier at home. However if future demand shows that an even lower number of beds is needed, the bed capacity can be relatively easily further reduced by 19 beds by decommissioning one of the current locations.

Figure 4. Phased reduction in bed capacity



Current capacity: 150 beds (8 step up / 142 step down) across 10 locations	Future capacity: 98 beds (flexible step up & down) across 4 locations
<ul style="list-style-type: none"> ▪ 8 step up beds ▪ 9 step down SMBC transfer to assess beds ▪ 66 step down intensive rehabilitation beds <p>Total = 83 beds</p>	<ul style="list-style-type: none"> ▪ 1 facility of 40 beds divided in several units for reasons of infection control. ▪ Service is providing intensive rehabilitation, reablement, recovery, assessment <p>Total = 40 beds</p>

19 step down combined CHC / SMBC assessment beds Total = 19 beds	19 step up and down beds with increased therapy and nursing input to be able to admit patient with nursing and therapy needs. → Can be decommissioned if demand is decreasing in favour of home based intervention Total = 19 Beds (reducing to 10 beds)?
23 step down Mental Health and Physical health beds (Saffron) Total = 23 beds	Continuation but mixture of step up and step down admissions Total = 23 beds
25 Generalist palliative care beds (Bluebell) Total = 25 beds	Recommissioning Bluebell to become a sub-acute nurse led ward with step up and step down function, able to care for bariatric patients and patients with intensive nursing needs including end of life patients Creating additional capacity in community palliative care team to meet increased demand in community for end of life care in care homes with nursing and at home Total = 25 beds

The biggest change will be the commissioning of one facility of 40 intermediate tier beds. The beds can be used flexibly as part of a step up or step down pathway and all staff would be trained in delivering a reablement model. The facility is able to deliver the following functions:

- Intensive rehabilitation
- Reablement / recovery
- Assessment

Nursing, mental health and therapy input will be available depending on the needs of the patients.

The facility could be a new build or an existing care home building. Depending on the commissioning arrangements, hotel facilities and basic care is either provided by a third party, contracted out or provided by the intermediate tier itself.

A change of use will also apply to a new sub-acute bed based facility in Bluebell, which is currently an expensive geriatrician led end of life / continuing care ward. It is envisaged that with extra capacity in the palliative care team, including geriatrician input, the majority of patients currently being admitted to Bluebell could be managed in the community. In addition other palliative care patients in care homes will benefit from the increased capacity in the community and all palliative care patients will receive the same level of care. This shift will free up at least 12 beds on Bluebell ward to work in conjunction with Saffron as an intermediate tier facility. Bluebell will focus on patients with sub-acute needs, will be nursing led and can support bariatric patients and patients needing intensive nursing interventions, including end of life, whose care currently cannot be delivered by care homes with nursing. If needed the new Bluebell ward could also support day cases.

Both Bluebell and Saffron will be accessible for step up and step down patients.

Whilst the system is shifting resources from hospital to community it is envisaged that existing capacity in Newlands is still required to support the current pressure on hospital discharge. However, if the demand on community beds further decreases because as an economy it is possible to manage most people at home, the intermediate tier bed based capacity could further reduce and the unit at Newlands could be utilised for a different patient

cohort. The CHC assessment function could then be met in the other bed facilities.

A central borough wide bed management team will co-ordinate and support the intermediate tier to optimise use and help manage flow through the system. The team will be co-located within the hub and closely working with the integrated transfer team.

By consolidating to 3 locations it should be much easier to ensure care delivery is of a consistent quality and is considered to be the safest way to provide care (rather than 10 sites).

It would be possible to use staff more efficiently and flexibly and should cut down on duplication of tasks, which ultimately will mean staff would have more time to spend with patients, impacting positively on outcomes and length of stay. Some staff will be working from a dedicated unit, other staff e.g. therapy staff, support workers and nursing staff will work across bed and home based to avoid hand overs when patients are transferred from bed based to home based intermediate tier.

It is acknowledged that with fewer sites this may make it harder for some people to visit a relative or friend. However it is considered that the benefits to patients will make it worthwhile and in a majority of instances people are already travelling to facilities outside their neighbourhood, so hoped not too inconvenienced. With an increasing older population a further consideration will be to commission more patient / carers transport / community transport. A review of current patient transport is needed to support early discharges without patients having to wait too long in a discharge lounge impacting negatively on their condition.

In the future with the enhancements to Intermediate tier services it is expected that additional home based services will meet the majority of surge demand during times of pressure i.e. Winter. For those unable to be supported at home, a dedicated budget will be set aside to allow spot-purchased beds on an as-needed basis, should demand require. The team will support the spot-purchased beds with therapy and social work input to ensure the care will meet the person's needs and to manage the patient's length of stay closely.

Intermediate bed based services will be provided by the following disciplines:

- Reablement / rehabilitation support workers.
- Social workers.
- Nursing staff.
- Therapists.
- GPs.
- A specialist team of allied health professionals like speech and language therapist, pharmacist, dietician.

It is envisaged some of the above disciplines would have mental health expertise as well as access to a community geriatrician and an old age psychiatrist.

As part of the future state of the bed based service, another business case is in development specifically exploring the most viable option for a new building. Various options are being considered like a council owned building, a longer-term arrangement with a care provider, refurbishment of current building or a longer-term arrangement with a project developer.

As previously outlined the core of our new model is to care for people in their home, with a home first default and care within intermediate beds will only be followed if it is felt absolutely necessary to do so because of patient's health and care needs and/or safety aspects.

10.3.4 Model Component 4: Active Recovery at Home*

A community home based intermediate tier service that brings together health and social care professionals who are able to offer a multi-disciplinary range of elements to wrap around a service user and ensure all needs are met in a short period of time.

The active recovery at home team supports both step up and step down pathways. It could be a short-term intervention following treatment in hospital or it could be a response to deterioration for someone living in one of the neighbourhoods. The active recovery at home team will deliver care in addition to the offer provided by the neighbourhood teams or a borough wide long-term condition team. The team can also provide step down care for people discharged from the intermediate tier beds.

The functions provided by the team at the person's place of residence are:

- Transfer to assess
- Rehabilitation
- Reablement
- Time to recover
- Clinically enhanced care
- Care brokerage (equipment, handy man, key safe, care call)

A patient's care plan can be based around one or more of these functions, whatever and whenever needed. Based on the assessment information from the intermediate tier hub, the crisis response team, the hospital transfer team or a neighbourhood team, the active recovery at home team will establish a short-term care offer meeting the needs of the patient and his/her carer. The main patient pathways will be:

- Supported discharge (from hospital or from an intermediate tier bed) in a patient's own home, with nursing and/or therapeutic support, night support, home care support and community equipment where necessary, to allow rehabilitation and recovery at home.
- Supported discharge back to the care home the person is living, providing extra nursing / rehabilitation / mental health support to the care home staff in managing the resident's temporarily changed needs.
- Reablement support which is typically provided in a person's own home, providing an active period of short-term intense activity and support (including night support) designed to promote people's independence, thereby enabling them to live at home for longer and requiring a reduced amount of long-term health and social care services.
- Sub-acute care with nursing and/or therapy support, home care support, night support, community equipment and IV-therapy support to allow recovery at home from a physical deterioration or to arrange observations over a short period of time to ensure patient is stable after for example a fall or operation. This will prevent hospital admissions, will reduce the number of one to three night admissions and will aid follow on support in the community from SSOP / MAU / A&E.
- In addition, where applicable, assessment for future long-term care needs can be undertaken.

The core team consists of:

- Nursing staff, assistant practitioners
- Social work
- Reablement Workers
- Third sector home after Hospital staff / support workers
- Night support staff
- OT / Physiotherapist

It is envisaged some of the above disciplines would have mental health expertise.

The enhanced active recovery at home service will have direct access to:

Night Support (part of the core team)

To prevent hospital admissions, to avoid one night stay in hospital and to facilitate early discharge, night support for up to five nights could be provided. This could be in the form of night sitter, night visits or regular telephone checks. Ideally the service will be aligned to Care Call to enable people to raise the alarm as and when needed to Care Call's 24/7 contact centre. The active recovery at home team will follow up these calls with a home visit during the night if needed, including providing a lifting service for people who have had a fall.

The night support staff could use telecare devises like 'just checking' and bed sensors to monitor patients from a distance where appropriate. It will be crucial that the telecare can be installed within hours.

Equipment & Adaptations (separate team – borough wide)

To provide a response service, access to equipment (small equipment and equipment for complex care needs) is crucial. The service will have a small stock of frequently needed pieces of equipment and a process will be in place to order other types of equipment as and when needed.

Mastercall: IV Therapy Service & GP pathfinder (commissioned separately)

Mastercall has been commissioned to deliver short-term IV therapy in the community. This IV-service can work together with the crisis response team and active recovery at home team to prevent hospital admissions or to support an early discharge from hospital. All intermediate tier services will work closely with Mastercall's IV therapy service and GP pathfinder service. In the future, integration of the pathfinder model and the crisis response team is proposed.

Third sector services: support workers, home after hospital, placement service

It is envisaged that existing and additional third sector services can contribute positively to the patient flow from hospital and through the active recovery service. Third sector workers will be able to support reablement workers on the first day of the patient's discharge from hospital / intermediate tier beds. At the moment reablement workers spend a lot of time sorting out medication, arranging equipment and a key safe, shopping for food and drinks, and rearranging furniture to make the house safe to manoeuvre for the patient. Third sector workers seconded to the recovery at home service would free up reablement capacity.

Telehealth / telecare

Where possible the use of telecare and telehealth for assessment, monitoring or support in daily living will be encouraged. Urgent access to telecare (same day installation) is needed to support early discharges and monitoring overnight.

Patient scenario:

...Now

Mr. Bell is a frail, 84 year old care home resident with short-term memory loss, a history of urinary tract infections and is unsteady on his feet. Because of a fall in the late afternoon Mr Bell was admitted to hospital to assess a head injury. The A&E staff admits Mr Bell to a bed on the elderly medicine ward for observation at 8pm. Mr Bell is considered fit for discharge two days after admission. The care home is however not supportive in arranging Mr Bell's discharge back to the home and request further assessment. After many meetings, assessments and family meetings it is decided that Mr Bell will be placed in a care home with nursing.

Future...

In the new model the active recovery team will accompany Mr Bell back to the care home on the day that he is declared as being medically fit for discharge. The active recovery at home team will work with the care home staff to develop a care plan that helps Mr Bell in managing his condition. A multi factorial falls risk assessment is undertaken including mobility, environment, nutrition, medication, feet and footwear, vision and cognition. An OT, nurse and mental health worker work alongside the care home staff in supporting Mr Bell for the next 3 days. After that Mr Bell is feeling much better and the care staff feels equipped to look after Mr Bell again with support from Mr Bell's GP. As a result Mr Bell is able to stay in his care home, which is his familiar environment and is close to where he lived before which enables him to remain visiting his local church.

Hospital admission of at least 10 days avoided

Mr Bell can stay in current placement of care home without nursing

10.3.5 Model Component 5: Transfer to Assess (T2A)

The 'Transfer to Assess' model is intended to ensure speedy transfer from hospital to home and to deliver assessment for ongoing needs in the best place.

Once peoples acute and immediate needs have been met, it is important that patients are discharged from hospital in an appropriate and timely manner. The risks of a prolonged length of stay in hospital are infection, worsened state of confusion/disorientation, physical deterioration, institutionalisation and reduced independence.

To support early discharge for people who don't need an acute bed, we will adopt a model commonly referred to as Discharge to Assess, which is considered to be best practice (NHSE), however here in Stockport we feel Transfer to Assess (T2A) better describes the function of the model/pathways.

The T2A pathways identify people's ongoing care and support requirements as well as the resources available to them including self-care, carers' support, informal community and structured voluntary sector support. These take place in a more suitable environment, in most cases this will either be a person's own place of residence or a community bed.

Under the current arrangements a complex discharge, meaning someone that does not require inpatient treatment but has ongoing needs, entails the patient undertaking a series of ward based assessments involving tasks such as making a cup of tea and using the stairs to

identify what kinds of home support they will need, all whilst the patient remains in hospital.

The patient is only discharged from hospital once all the appropriate support resources are in place e.g. home care, equipment such as walking aids, as this can cause delays, with no benefit to the patient and may actually worsen the situation.

Within the T2A pathway identified patients are discharged as soon as they are medically optimised and have an assessment (within 2 hours of arrival) with appropriate members of the social care and Intermediate tier teams in their place of residence or community bed. This enables them to access the right level of home care (same day) and support much more quickly.

This approach is proven at truncating a discharge process of up to 2 weeks, to care packages being put in place directly with the patient at home, enabling the hospital to reduce length of stay and therefore shortening the overall patient pathway. (Reference Health Foundation Improving the flow of older people)

Based on existing models across the country, it is envisaged for patients who fit T2A these will be grouped into 3 care pathways, these are:

- **Pathway 1:** Supported transfer home assessment.
- **Pathway 2:** Unable to go home – will require residential care with a view to transfer home after a period of assessment & enablement.
- **Pathway 3:** Unable to go home – needs are very complex and long term nursing home care is more likely. Continuing Health Care assessment and long term placement.

Duration of length of stay on these pathways follows patient's needs and is closely monitored to ensure patients are timely moved on as soon goals are met. Consideration should be given to previous history to ensure the right level of care is identified and minimising the number of moves for individuals.

The T2A pathway will be supported by the integrated transfer team who will reach-in to pull the patient out of the hospital, followed closely by assessment in the patient's own place of residence by the active recovery team. The hub will be referred to as and when required to support the co-ordinated discharge.

In addition the patients on this T2A pathway will be offered support to navigate access to community and voluntary assets to support them to go home and remain well at home in the longer term, through the Voluntary Sector Support for Discharge project. The Wellbeing at Home service will lead and coordinate the service through the Integrated Transfer Team, where it ??already has the infrastructure, building and telecommunication resources, partner agency relationships, skills and experience.

A coordinator role (2 FTE posts) based in the hospital will oversee the virtual team which will be made up of support workers/handy person (3 FTE posts), and four TPA key workers based in the localities. Evidence suggests that moving identified patients to an alternative location for assessment of their on-going needs and some rehabilitation will free up much needed acute beds. It will also afford a better environment for patients to achieve their rehabilitation potential, possibly reduce their dependency on health and social care services in the future and reduce the reliance on the wider residential economy in general.

Patient scenario:

On the day Mr Brown is declared as being medically fit for discharge, Mr Brown is transferred to a transfer ? to assess bed. He benefits of further time to recover from his infection and gradually build up some strength and weight. Mr Brown however admits that he is struggling to manage at home due to his dementia and he and his daughter feel that a placement in a care home is the best next step for him. However, if he would have gone from hospital straight to a long-term care home placement he would have gone to a care home with nursing. The two weeks spent in an intermediate tier assessment bed and the OT, physio, dietitian and mental health input he received as part of his care plan, meant that he now qualifies for a care home without nursing. Mr Brown and his daughter receive support from a placement worker attached to the intermediate tier service, who explores with them the various care home options. A choice for a particular home is being made and in the next four days till transfer the placement worker and intermediate tier staff work with Mr Brown and his daughter to prepare for the move. They develop a life story booklet to inform care home staff about Mr Brown, they collect important belongings for Mr Brown to make him feel at home in his new place and help him settling in over the next three days after his move. Mr Brown's daughter feels confident that this new home is the best solution for her father.

***11 days hospital stay saved
Admission to a lower level long-term placement
Successful and well prepared transition to care home***

10.4 Management arrangements

To organise the future intermediate tier service a single (integrated) management structure will be crucial with a lead provider to ensure the smooth running of the various components.

The form this will take will be dependent on the outcome of the MCP organisational form options appraisal and in the interim it is likely an aligned arrangement will operate.

10.5 Clinical governance

The proposed outline operating model will be used as a basis for developing a suite of protocols/pathways to ensure easy access, use and exit to and from intermediate tier services. These will be designed for in-house use to support training/development, awareness and help ensure new ways of working are embedded, as well as help develop key interfaces, namely with neighbourhood teams, primary care, secondary care, 111, NWAS etc.

Handover of clinical responsibility, what this entails and the points at which it occurs will be clearly identified within each aspect of the patient journey between neighbourhoods, intermediate and secondary/acute care services. A clinical governance protocol will be developed that ensures that the right specialist input and care pathway is available when needed.

10.6 Staffing/Capacity Requirements

It is envisaged the new intermediate tier service will broadly operate within the existing financial envelope of in scope services (as listed in appendix 1), however there will be an increased workforce and a shift towards increased step up? capacity to enable people to remain at home and avoid admission into hospital.

Detailed workforce modelling has been undertaken taking into consideration anticipated demand on the service and the skill mix required to support the new model, in summary the staffing will look as follows:

Pathway	Current Staffing WTE (%)	Future Staffing WTE (%)
Step down	125.23 (74%)	95.60 (38%)
Step up	45.02 (26%)	154.57 (62%)
Total	170.25 (100%)	250.17 (100%)

See appendix 3 for detailed workforce analysis.

The additional capacity will enable a greater number of people to be cared for at home, for example once all permanent Home Support Workers are in post within Active Recovery this will enable a total of 13 teams across the borough, each team supporting up to 7/8 people, based on 4 visits per day between the hours of 7am -10pm this equates to approx 100 people on any given day.

The number of daily visits should reduce quickly for individuals once in service, therefore the number of people able to be supported will increase - it isn't an exact science or calculation as individual's needs are fluid and can change.

What we hope is that the LOS will also reduce from currently 4 weeks to 2 weeks for the majority of people coming through the service, by providing a person centred wraparound service which includes utilising the 3rd sector TPA/WIN alliance. The ability to hand over POC is also dependent on a system wide solution and having a robust private provider market in place, which presents a current challenge.

To enable this rebalancing of resource to create the new model there is a requirement for pump prime investment to enable the following additional staffing for an estimated 18 month transition period.

Note. See Resource Profile –Transformation Funding section (14.1) for associated investment costs.

11. Enabler Requirements / Impacts

11.1 Workforce

The new model of care depends upon an integrated, multi-disciplinary and responsive team. This will in the immediacy require disparate teams, who are employed across a number of

different organisations, to come together under one leadership structure, common governance systems and operate within an integrated support services function.

In order to deliver the model to the ambition described a review of the existing workforce will be required to inform the development of a detailed workforce plan. This will describe the sequence of the proposed service changes and the associated impact on the workforce across the services. This proposal should include plans to deliver a: integrated structure; clear clinical and organisational governance; common values and a training and development programme.

An organisational change proposal can then be drafted in accordance with the appropriate change policies and a co-ordinated consultation process can take place with the affected staff.

This will detail the skill mix of staff required to operate the new model of care and the process in place to consult with staff and their representatives. Once the final structures and approaches are agreed, the recruitment and development programmes can be initiated.

Workforce and Organisational change within the Intermediate Tier workforce will need to factor in the implications of any staff / workforce transition across the economy.

11.2 Information Management and Technology (IM&T)

IM&T is a key enabler for the new intermediate tier model of care, particularly in order to deliver a:

- Stockport Health and Care Record;
- 24/7 Working
- Bed Management / Patient Flow System

Stockport Health and Care Record:

Practitioners need a holistic view of the patient at the point of care, including their relevant history, care plans and preferences. It is imperative that in-depth knowledge of an individual is not owned by a single professional and that it moves with the individual should they access other parts of the health and care system. System integration provides the basis for an holistic view of records and information across all settings and enables automation of processes.

An integrated Stockport Health and Care Record (SHCR) already exists which provides an holistic view of patient's health and care information to those working across the intermediate tier service. The SHCR will continue to be enhanced, with a new mobile friendly interface and live data feeds from key systems due to be implemented over the next 6-18 months. Representatives from IM&T will need to work with the work stream teams and practitioners to understand the systems and working practices within their existing teams, and how they intend to operate under the new arrangements. IM&T proposals will then emerge for systems integration/rationalisation and continued SHCR developments to support the new way of working. It is important that additional functionality is brought on as quickly as possible, such as live feeds, but this will be dependent upon timescales for the implementation of new systems. The SHRC is not currently being used by all of the teams it is available to and the reasons for this need to be understood and addressed.

Underpinning the SHCR are integrated care plans. A Care Plan sets out how a person's care needs will be met and will usually be put in place where a patient has a long term condition or requirement for a prolonged period of treatment/care including palliative (end of life) care.

Giving secure, electronic, read-write access to these plans for all relevant care providers is essential to provide continuity of care and improve safety and quality. People receiving care, and their carers, should also be given electronic access to the Care Plan to ensure that they have the most up to date and relevant information about their care.

24/7 Working:

It is proposed that the new intermediate tier Hub will operate on a 24/7 basis which will present staffing challenges. IM&T can provide solutions that allow greater flexibility with the workforce. Off-site support can be provided through tele-care and mobile working solutions. This could allow workers to provide support on-call from their own homes, or allow specialists to cover multiple locations. A key consideration is how these types of services will be staffed; technical solutions can be introduced that allow Stockport Together employees to fulfil these roles or the whole service can be externally procured including the technical and employee aspects.

Bed Management / Patient Flow System:

Management of the current c.150 beds that span across ten intermediate care locations presents a real challenge. The planned reduction to four locations and the introduction of a bed management system would significantly improve the allocation and release of this important resource. Further work is required on developing the specification for the proposed bed management solution as it is expected this will be a patient tracking system rather than the type of bed management systems typically found within an acute setting. The solution should be integrated with community and acute electronic records with the ability to monitor progress down care pathways to prevent exit log jams in the community and to support a continual MDT discharge process.

Care Home IM&T Capability:

A number of the proposed solutions for intermediate tier are dependent upon care homes having adequate IT capability, i.e. network connectivity, WiFi. How this dependency is assured will need to be considered; should it be contractual, directly funded, grants etc. This requirement also aligns with those identified within core neighbourhoods workstream.

11.3 Estates

Estates is a key enabler for Stockport Together to deliver the future service model, and therefore service design and clinical need will be the main factor that will drive and influence the configuration of our future estate.

This influence manifests itself at two levels, firstly the service redesign process being undertaken by Stockport Together and secondly the impact of developments and programmes that may be driven across the Greater Manchester area.

In terms of intermediate tier services the main investment and estates requirement is with regard to supporting the revised bed configuration.

To enable this there may be a need to have temporary or flexible estates solutions as well as different estates solutions during the transition phase of service redesign (including providing for upcoming potential winter pressures capacity). This highlights a key dependency

between the implementation of IM&T solutions and workforce transformation which should enable a reduced reliance upon estates.

The overall estates investment programme already includes £8m for a single intermediate care unit, however there may also be other potential solutions available to meet this need that need exploring through a market testing exercise.

It is envisaged the estate need of the single point of access hub to be minimal and probably best sat in existing assets. As this service workstream develops, so the estates investment programme to support intermediate tier services will evolve.

12. Implementation Proposal

12.1 Priorities & Approach

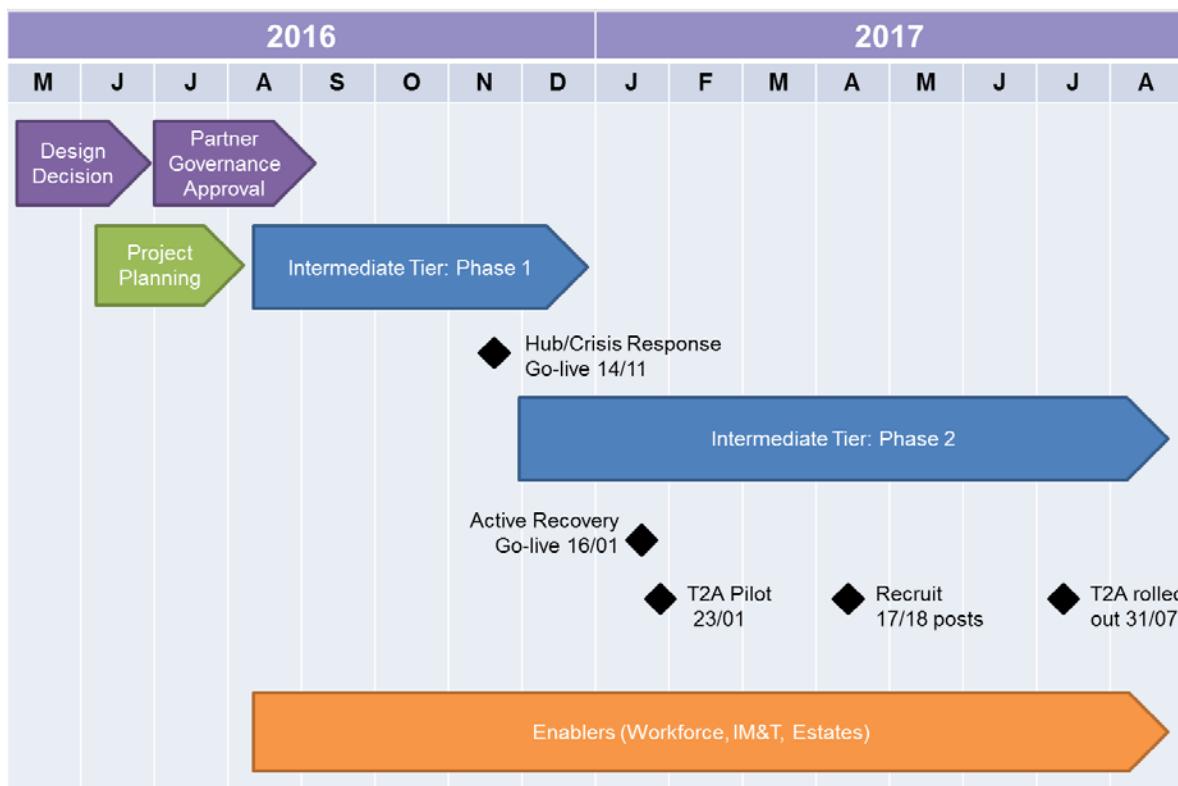
In order to manage transition to the new model a phased approach will be adopted, allowing for engagement & co-production with services/users and for learning to inform the subsequent stages of roll-out.

- **Phase 1:** Create additional capacity & capability (including training) to respond to crisis and keep people at home, thus avoiding admission into hospital.
- **Phase 2:** Reconfigure bed base and supporting processes/systems to optimise flow in/out of hospital (including T2A)

Within Phase 1 there will be a requirement for additional capacity (pump/prime) for an approximate 12 month period to enable the rebalancing of intermediate tier resources between step-down & step-up.

It is also anticipated this approach will allow any required consultation (staff/public) to take place if considered necessary.

12.2 High Level Plan



12.3 Programme delivery arrangements

The implementation of the new intermediate tier model will be programme managed through the defined governance/PMO arrangements of Stockport Together.

The project will be co-produced and implemented through a number of workstreams, still to be determined although likely aligned to the 6 core components of the new model.

12.4 Commissioning Approach

At present the various intermediate tier services are commissioned through several arrangements:

Commissioning arrangement	Service
S75 – Joint funding SMBC and CCG	Intermediate care home and bed based Reablement Equipment & Adaptation
Better Care Fund – joint funding SMBC and CCG	Rapid response Locality beds
CHC / SMBC	Newlands beds
SMBC	Hospital social work Meadway beds

SCCG	CAIR Mastercall (IV therapy, GP Pathfinder) Saffron A10, Bluebell ACTT Patient transport (NWAS)
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In the future model all budgets will be pooled into one SMBC & CCG joint budget. The new elements of the intermediate tier model are:

- Intermediate tier hub
- Crisis response
- Active Recovery
- Integrated transfer team
- Community intermediate tier beds

And these will be commissioned as a single service from the MCP based on a service description and set targets through an outcomes framework. The MCP is expected to design patient pathways and service specifications and to provide monitoring and performance information on a quarterly basis to inform a quarterly intermediate tier contract meeting and to provide daily and monthly overviews for the intermediate tier dashboard.

As part of the new service model the MCP can commission provision from the third sector and other health care providers to deliver the objectives of the new service model and outcomes framework (tactical commissioning).

Some of the current intermediate tier services are already provided by other partners, e.g. Mastercall and the service provision of these elements will continue for the duration of the contract. It is between the MCP and these external providers to agree pathways and the best way of partnership working. Some elements of provision can be aligned to the MCP offer (e.g. IV therapy), other elements might need to become integrated in the new intermediate tier model to avoid duplication and to streamline service delivery (e.g. GP pathfinder).

The CCG and SMBC commissioning arm will further determine a commissioning framework with corresponding responsibilities and budget transfer arrangements for the MCP over the next four months. Decisions about new built and/or longer term contracts with care home providers for the bed based service will remain the responsibility of CCG and SMBC through the Joint Health and Social care Commissioning Board

12.5 Key milestones

Over an approximate 12 to 15 month implementation timeframe the following key milestones will be delivered:

No.	Milestone Description	Status	Due date
Phase 1 (Jul 16 to Dec 16):			
M1	Detailing implementation planning	Complete	Jul-16
M2	Stakeholder engagement	Complete	Aug-16

M3	Establish Intermediate Tier dashboard/KPIs	In progress	Aug-16
M4	Develop target operating model/pathways	Complete	Aug-16
M5	Detailed capacity/demand modelling (bed model)	Complete	Aug-16
M6	Detailed workforce modelling	Complete	Aug-16
M7	Develop and roll out OD plan	In progress	Sep onwards
M8	Carry out consultation with any staff affected	Delayed	Sep-16
M9	Align staff to new service model/teams	Complete	Oct-16
M10	Establish and expand Active Recovery at Home service	Complete	Nov-16
M11	Establish & expand Crisis Response team (Phase 1)	Complete	Nov-16
M12	Intermediate Tier Hub go-live (Phase 1)	Complete	Nov-16
	Complete T2A – pathway 1 trials on SSOP	Complete	Feb-17

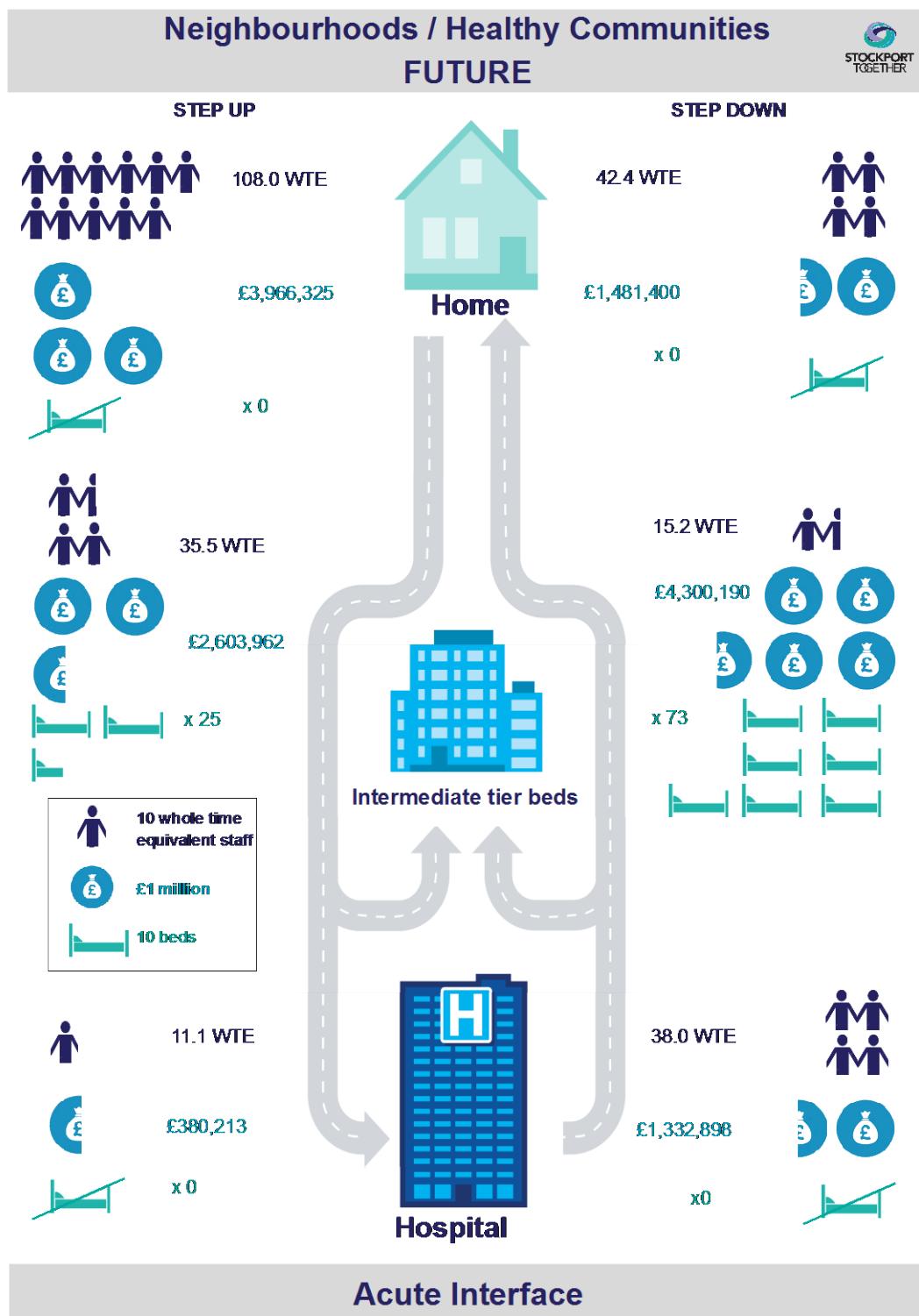
Phase 2 (Jan 17 to Aug 17):

M13	Intermediate Tier Hub go-live (Phase 2)	Delayed	Dec-16
M14	Commence recruitment to new workforce 17/18 posts	Complete	Jan-17
M15	Complete T2A – pathway 1 trials on SSOP	Complete	Feb-17
M16	Recruitment to 17/18 posts complete	In progress	Apr-17
M17	Crisis response 24/7 (Phase 2)		Jun-17
M18	Market testing & public engagement on beds		May-17
M19	Complete options appraisal on beds		Jun-17
M20	Implement interim arrangement for beds		Sep-17
M21	Complete rollout of T2A – pathway 1	In progress	Jul-17
M22	New management structure in place	In progress	Jul-17
M23	Establish base/accommodation to support model	In progress	Jul-17
M24	IM&T (inc mobile devices) in place to support model	In progress	Jul-17
M25	Implement new community bed management system	In progress	Aug-17
M26	Crisis response open to public (Phase 3)		Sep-17
M27	Implement interim arrangement for beds		Sep-17
M28	Implement new bed model		TBD

See appendix 5 for detailed implementation plan.

13. Resource Profile

Figure 5. Future State – Resource distribution across system



13.1 Transformation Funding (including double running)

Area	16/17*	17/18	18/19	Comments
	£000	£000	£000	
Commissioning of hub & acute/health element of crisis response	289	543.3		In accordance with revised (v2) Mastercall proposal
Workforce	509.3	1,254.7 **		See appendix 4 & 6 for further details
Non-pay	24	68.2		See appendix 4 & 6 for further details
Hydration Service/IV Fluids		170		
Additional step up beds (10 beds)	238.9	485.3	473.5**	See appendix 4 & 6 for further details
Bed management/flow system		n/a		Costs within enabler business case
Total	1,061.2	2,521.5	473.5	

** Proportion funded from baseline budget and additional funding from Stockport Together (see section 14.3 for further detail)

13.2 Change Resource

Role	WTE	Duration	In Post / Need	Likely source
SRO	0.2	15 months	In post	SFT
Programme Manager	1.0	15 months	In post	GM Transformation Fund
Project/Change Manager	2.0	15 months	Need	GM Transformation Fund
Business Analyst	0.4	6 months	Need	
Clinical Lead	0.2	15 months	In post	SFT
Workforce Lead	0.5	6 months	Need	
Engagement Lead	0.5	6 months	Need	
OD support	1.0	15 months	Need	
Total	7.6			

Note. Enabler costs not accounted for, assumed to be picked up by enabler business case.

13.3 Cost Profile

Recurrent Funding Required:

	2016/17	2017/18	2018/19	2019/20	2020/21
Workforce recurrent	£5,571,868	£6,071,502	£9,106,125	£9,109,653	£8,657,752
Workforce efficiency (5%) per annum from 19/20			-£455,483	-£432,888	
Beds	£6,560,489	£6,060,855	£5,010,013	£5,010,013	£5,010,013
Total	£12,132,357	£12,132,357	£14,116,138	£13,664,183	£13,234,878

Transitional Funding Required:

Workforce and beds transitional funding	£1,838,534	£2,521,469	£473,492	£0	£0
Total	£1,838,534	£2,521,469	£473,492	£0	£0

Total Funding Required:

£13,970,891	£14,653,826	£14,589,630	£13,664,183	£13,234,878
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Note. See appendix 4 for further detail and assumptions applied.

When compared to existing funding the total required funding in 20/21 is £1,103,000. The

investment profile is shown in the table at 13 below.

14. Financial Benefits

The bringing together of a number of fragmented services into a single integrated systems will have some benefits in terms of skill mix and required managerial capacity that will be released over the next three years. This is reflected in table 12.3 with the workforce efficiency of £450k per year in the latter stages of implementation.

The implementation of this model will also contribute to the impact on non-elective capacity required across the system. It will through aspects such as crisis response contribute to fewer admissions as people will be stabilised and supported to stay at home through provision of short-term intensive support. It will also reduce length of stay through better supported discharge and step down capacity. In both senses it will be working closely with the neighbourhood teams enhanced case management and it is not easy or certain the exact contribution of each. The summary economic case sets out the best evidence for the impact of changing both the intermediate care system and enhanced case management. Therefore, a number of assumptions have been made about the relative contribution of each. These are set out in the table below and it will be seen that by 20/21 the net benefit and thus contribution to the system will be £3,628k.

Investment & Savings by business case	£'000						
	Investment			Benefit			Net Benefit
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2020/21
Acute Interface	£2,500	£2,334	£2,168	(£4,871)	(£6,089)	(£6,089)	(£3,921)
Intermediate Care	£2,457	£1,532	£1,103	(£3,275)	(£4,003)	(£4,730)	(£3,628)
Neighbourhood	£12,106	£11,445	£10,987	(£11,170)	(£14,907)	(£20,465)	(£9,478)
Outpatients	£2,280	£2,128	£2,117	(£6,833)	(£9,150)	(£11,765)	(£9,647)
TOTAL	£19,344	£17,439	£16,375	(£26,150)	(£34,149)	(£43,049)	(£26,674)

15. Non-Financial Benefits

15.1 High level Benefits

The intermediate tier model will impact on the following overall system (high level) benefits, however it is not easy to attribute the level of contribution it will have on these.

Key Benefit/Outcome	Metric	Data Source
Reduce admission to long term residential or nursing care	Number of admissions per year to long term care	BCF data via local authority
Reduce emergency admissions	Emergency admissions	NHS SUS
Reduce A&E attendances	Number of A&E attendances	NHS SUS
Reduce emergency readmissions within 30 days		NHS SUS
Reduce delayed discharges from hospital	Delayed Transfers of Care (DTOC)	NHS SUS
Reduce overall acute hospital bed days	Hospital Bed days	NHS SUS
Improve patient experience of out of hospital care	Reporting of negative experiences by complaints	Friends & family Test
Improved staff experience		Various
Increased number of people die in their preferred place of choice	Number of people	
Secure additional years of life	The difference in life expectancy locally from national average	Public Health

15.2 Contributory Benefits

The intermediate tier model will be responsible for enabling the following benefits to be realised:

Enabler Benefit/Outcome	Metric	Data Source
Proportion of older people (65+) still at home 91 days after discharge from hospital into Reablement/rehabilitation services	Number of people in this category who are still at home after 91 days	SMBC Adult Social Care
Increase response time to crisis	Response time	SMBC Adult Social Care & SFT
Reduce waiting time for package of care	Waiting time (assessment to care package)	SMBC Adult Social Care
Reduce length of stay in hospital in elderly and medical wards.	Length of stay information	SFT
Reduce length of stay in community beds	Length of stay information	SRG data

Reduction in length of stay/faster recovery for home based services	Length of stay/recovery time	SRG data
Reduce the number of people who go from hospital to a community bed (so go straight home instead)	Number of people who go into community beds from hospital	SMBC Adult Social Care & SFT Community
Reduce number of people admitted in care home with nursing	Balance between admissions to care home with and without nursing	SMBC Adult Social Care (per 100k population)
Improve patient and carer experience (service level data)	Surveys and questionnaires	User surveys from REACH / IC/ Rapid Response etc.
Ratio of activity 'step up' v 'step down'		Various
Reduction in short term placements	£ value/volume of spot purchases	SMBC Adult Social Care & SFT Community
Reduced ambulance conveyancing		SCCG

16. Engagement

The approach to developing the new intermediate tier service model and business case has engaged a number of stakeholders between June 2015 and June 2016, these include the following activities:

1. Patient survey intermediate care (July 2015)
2. Staff / stakeholder online survey intermediate tier (July 2015)
3. GP consultation via pin board at various meetings (July 2015)
4. GP consultation on rapid response via online survey (March 2015)
5. A series of one-to-one discussions with key individuals to inform and help identify the key issues and any critical issues from either a particular organisational or professional perspective. (June 2015 to June 2015)
6. Task & Finish group work with service managers/staff (August - November 2015).
7. Stakeholder workshops at key stages of design:
 - a) Current state validation
 - b) Design workshop
 - c) Check-in & Interface workshop with other workstreams to define boundaries and understand key questions to be addressed.
8. Presentation of outline model to the Stockport Together Practitioner Design & Steering Group (June 2016)
9. Presentation and discussions at Citizens Panel (June 2016)
10. Engagement events with all staff within scope of Intermediate Tier (September 2016)

11. Engagement at Neighbourhood leadership event (September 2016)

As the project moves into implementation further engagement is required. The project will engage face to face with stakeholders (including service users) with a significant interest in the project and with those stakeholders where alternative communication methods are more appropriate, e.g. newsletters, briefings, etc.

A communications & engagement plan will be developed to ensure that there is effective two way communication with all those affected by the changes to the intermediate tier.

The project will seek to empower staff groups who will be delivering a new capability and a new patient centred service so that the design, development and implementation has the full involvement and engagement of health and social care professionals, as well as end users of the intermediate tier services .

It is also anticipated that given the proposed changes to the provision of bed based services, that the intermediate tier service changes may require public consultation and the implementation plan has been developed on that basis.

17. Risk

The high level risks to the successful delivery and achievement of benefits are as follows:

Risk	Mitigation
Staff/resources required to make changes are not released to support implementation, impacting success of delivery.	Obtain commitment from executive team/partner organisations to release staff to support implementation.
Timescales associated with full public/staff consultations impact ability to implement significant changes before Winter period.	Identify and plan for asap and flag up any potential impact. Develop phased approach to implement early changes that are not reliant on consultation.
Lack of cohesion with other Stockport Together workstreams/models &/or wider GM transformation result in disjointed pathways.	PMO and close working across programme/workstreams with key stakeholders to ensure connections/dependencies/issues managed.
Failure of new model to prevent forecast level of acute admissions.	Ongoing monitoring/PDSA cycles, benefit reviews at regular intervals to be conducted by the Programme Office.
Not possible to increase capacity (double run) due to workforce shortages with the required level of skills, mean cannot prove concept &/or fully implement model.	Ongoing review/management of plans and close working workforce enabler to develop solutions.

Hospital bed capacity is reduced before the new model is able to demonstrate impact/deflect acute activity, negatively impacting quality/performance.	Ongoing monitoring/PDSA cycles. Engage hospital (FT) stakeholders to develop aligned plans.
Lack of co-location solution (physical location) reduces ability to work in an integrated way.	Ensure early involvement with planning implementation with estates enabler.
The proposed investment required is not made available and therefore unable to implement the model as intended.	Proposed model to be implemented in a phased manner, which would recognise only limited investment could be secured initially and this could be invested wisely if the service was managed in an integrated way with fewer teams and one provider taking the lead in its operational management.

Note. A supporting risk management approach with supporting risk register will be adopted throughout implementation.

INTERMEDIATE TIER BUSINESS CASE APPENDICES

Appendix 1 - List of current intermediate tier services

Service name	Step up / down	Service Description	Annual cost	Activity 15/16	Staffing
Adult Community Therapy Team (ACTT)	Step up and down	Short-term community therapy intervention (OT & Physio)	£722,010	8415 ftf contacts 301 telephone contacts 3264 referrals	11.26 WTE (SFT)
Assessment& recovery Beds (19 Newlands & 9 Meadway)	Step down	Community beds for recovery & assessments regarding longer term care needs	£607,820 + £ 18,200 GP cover + £40,000 consultant	Weekly ward rounds 120 admissions Newlands, LOS 46days	Newlands: CHC nurse and social worker (CHC)
Bluebell Ward (The Meadows)	Step down	Continuing health care and end of life care	£2,098,750 (£230 per day per bed / staffing: £ 681,963)	9,125 bed days	30.64 WTE (SFT)
Community Assertive In Reach (CAIR-ID)	Step up (A&E, MAU 1&2, SSOP)	Facilitating hospital discharge up to 72hrs after discharge	£1,300,000 • £634,000 (CCG 6 months)	5231 ftf contacts 33 telephone contacts 2428 referrals	21.94 WTE (SFT)
Community beds in residential care homes	Step down / step up	Spot purchases to support recovery and carer breakdown (SMBC)	£568,000 (based on £142k Q1 2014-15)	Estimate: 400 placements spot purchased	Some ACTT and IC input
Equipment & Adaptations Services	Step down / up	Equipment, home adaptations, moving & handling for independent living	£632,000 (CCG and SMBC)		
GP cover to intermediate tier beds	Step down and up	Medical support to patients in Intermediate tier	£368,040 (included in IC GP costs below (£182,700)	Variation of daily and weekly ward rounds	
Community Rehabilitation Workers	100% step down	Supporting patients with transfer from bed based to home based intermediate care	£479,000		18.5 WTE (SFT)

Intermediate Care – bed based (Marbury & Berrycroft)	95% step down / 5% step up	Intensive rehabilitation in high dependency 24/7 care facility	S75 budget: £ 5,985,000 38% of costs are home based 62% of costs are bed based	Step up home 74 admissions Step up bed 53 admissions Step down home 300 Step down bed 459 LOS step up 26 days LOS step down 32 days	49.35 WTE (SMBC & SFT)
Intermediate Care – home based (East & West teams)	95% step down / 5% step up	Clinically led therapeutic intervention & rehabilitation			
IV Therapy (Mastercall)	30% step down / 70% step up	IV antibiotics in the home – up to 3 times a day	£487,500	645 referrals; 530 accepted of which 377 GP referrals; 3781 visits; 3448 bed days saved (average of 7 per patient)	
NWAS Pathfinder (NWAS & Mastercall)	100% step up	Ambulance redirect to community provision	£351,000	2042 referrals; deflection rate 88%; average referral 5 a day	
Rapid Response Assessments (in hours 9am-5pm and out of hours 4:30pm-8.30pm; weekends and BH 12:30-8.30pm)	100% step up	Assessments in the community to prevent hospital admissions	£481,000 staffing in hours (195K nurses / 286K social work) £408,000 OOH (part of IC budget)	527 referrals in hours; 45% admitted to hub bed 789 referrals (13-14 OOH)	In hours: 4 district nurses and 8 social workers OOH: part of intermediate care staff
20 Rapid Response hub beds (4 localities)	Step up	Recovery beds where unsafe for patients to stay at home or carers breakdown	£ 479,000		Some ACTT / Intermediate care input
Re-ablement / REACH 7am-10pm 7d; limited night support	95% step down / 5% step up	Support after care to regain independence (incl. night cover)	£1,200,000	1184 episodes (1050 referrals), avg length 29 days	59.7 2 WTE including night support
Saffron Ward – 23 beds (The Meadows)	Step down	Community beds for intermediate mental health care	£862,000 (about £1000 per week per bed)	9125 bed days; average length of stay 29 days	25 WTE (Pennine Care)

A10	Rehabilitation ward	Hospital ward	Staff: £673,187		31.71 WTE (SFT)
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Location	Number of beds	Day rate	Spend 14/15
Saffron	15 beds 5 winter pressure (12 months) 1 winter pressure bed (6 months) 15/16: 23 beds £1000 per week per bed	£131 £72 £46 £142	£720,000 £132,000 £10,000 £1,196,000
Assessment beds	10 Newlands – CHC step down assessment and recovery 9 Newlands – SMBC step down discharge assessment 9 Meadoway – SMBC step down discharge assessment	£85 £85 £65	£ 310,000 £ 278,460 £ 191,360
Rapid Response Locality beds	5 Hillbrook Grange 5 Richard House 5 Appleton Manor 5 Hilltop Hall	£65 £65 £65 £65	£479,000
Intermediate Care intensive rehabilitation	10 Berrycroft (contract ends 31.10.2016) 40 Marbury (5 spot purchase winter pressure beds)	£72 £72 £72	£1,434,000
Spot purchase	Ad hoc purchase of 400 placements across 62 care homes (14-15)	variable	£568,000
Generalist palliative care	25 beds Bluebell	£230	£2,051,913
Hospital rehabilitation	25 beds A10		£1,500,000
TOTAL:	171 intermediate tier beds (+ spot purchases from care homes) at a cost of:		£8,008,733 (est)

Facility	Beds	GP Practice	Sessions	Cost pa	Contractual Status
Newlands	19	Heaton Moor	1 x weekly visit + ad hoc consultations	£ 18,200	Annual review 31 March 3 month notice required
Marbury	26	Heaton Norris	5 weekly sessions (incl MDT + 2 ward rounds)	£ 91,000	Contract till Oct 2016 3 month notice required
Marbury & Berrycroft	14 + 10	Brinnington		£ 91,000	
Hilltop (RR)	5	Eastholme	Weekly ward round, assessment, visit + phone consultations + discharge letters	£ 37,440	Contract till Oct 2016
Richard House (RR)	5	Vernon Park			
Hillbrook (RR)	5	Village Surgery			
Appleton (RR)	5	Brinnington	Daily patient review Weekly MDT ward round	£ 46,800	Pennine Care contract
Saffron Ward	23	Marple Cottage			
Meadway	9	Village Surgery	2 x 3hr sessions + phone consultations + 2 weekly visits	£ 41,600	SMBC contract
 					
Newlands	19	FT consultants	consultant cover	£ 40,000	CHC – CCG contract
Bluebell ward	25	Marple Cottage	GP cover	£ 20,000	FT
		FT consultants	consultant cover 2 sessions a week		FT
Total medical cover	£ 368,040				

	Budget 15-16	ftf contacts
Primary Care Physiotherapy	£977,009	20,742
Transport		
Age UK home after hospital		
TPA / WIN		

Appendix 2 - Summary of outcomes from stakeholder engagement

STRENGTHS	OPPORTUNITIES
<ul style="list-style-type: none"> ▪ Excellent intermediate tier services available ▪ Variety of services and bed based facilities available ▪ Passionate and skilled staff working in intermediate tier services ▪ Willingness and flexibility to innovate and pilot new initiatives ▪ Positive feedback from service users, carers and professionals about quality of delivered services ▪ Tested systems in place for integrated working between health and social care ▪ Better outcomes for intermediate care service users than national benchmark ▪ Underutilisation of certain staff groups, i.e. assistant practitioners 	<ul style="list-style-type: none"> ▪ Focus on community / neighbourhood out of hospital care ▪ Great emphasis on partnership working between health and social care professionals ▪ Positive benchmark outcomes regarding results of intermediate care interventions ▪ Opportunity to further integrate and make optimal use of resources ▪ Intermediate tier function acknowledged as bridge between community and hospital ▪ Opportunities for workforce development and investing in better skill mix / career paths within intermediate tier ▪ Resources within intermediate tier and in the wider economy that allows shift between bed to home and from hospital to community
WEAKNESSES	LIMITATIONS
<ul style="list-style-type: none"> ▪ Lack of mental health capacity within the current Intermediate tier offer ▪ Limited capacity in overnight support at home ▪ Some services running on under-capacity (i.e. NWAS pathfinder, IV therapy) and other services receiving a higher demand than being able to act upon (i.e. Reach). ▪ No fast access to diagnostics to facilitate step up community care at the person's place of residence ▪ Unclear & multiple access routes to a variety of services and duplication in assessments between intermediate tier services ▪ Reablement and intermediate care capacity is predominantly used for step down ▪ Limited use of third sector ▪ Myth of 6 week time limit ▪ Delays in receiving actual patient information & medication at point of hospital discharge 	<ul style="list-style-type: none"> ▪ Financial climate, need for cost savings ▪ SFT currently admits 37% more patients than national average ▪ Delayed transfers of care ▪ Increased demand through older population ▪ High pressure on facilitating hospital discharges ▪ Lack of capacity of home care packages – need for high intensive packages (combined mental and physical health) to facilitate discharge from intermediate tier ▪ Lack of intermediate tier capacity in care homes with nursing in Stockport ▪ No clear frailty pathway and no integrated falls service which contribute to readmissions of certain patient cohorts

- | | |
|--|--|
| <ul style="list-style-type: none">■ IT: not all staff have access to same IT record and planning systems; not all staff have access to mobile devices; no central bed-management system■ Various small service contracts on non-recurrent funding basis for services■ Fragmented commissioning of GP cover for the community beds■ No clear integrated outcomes & performance framework | |
|--|--|

Appendix 3 – Workforce & Bed Analysis (Summary)

Current workforce baseline 2016/17		Base Budget FTE	BCF FTE	FTE Total 16/17	Base Staffing (£)	BCF (£)	Revised Staffing (£)	Comments
Service								
Intermediate Tier		149.25	21.00	170.25	5,618,664	730,504	6,349,168	
Intermediate Tier beds							6,560,489	
Total 2016/17		149.25	21.00	170.25	5,618,664	730,504	12,909,657	
Exclude Non Recurrent BCF investment - Intermediate Tier (CAIR)						-605,000	-605,000	
Exclude Non Recurrent Other Investment - Intermediate Tier (Hospital Discharge Team)						-172,300	-172,300	
Recurrent Total		149.25	21.00	170.25	5,618,664	-46,796	12,132,357	
New costed workforce 2020/21								
Service				WTE			Cost (£)	Comments
Intermediate Tier				251.67			9,497,654	Includes Mastercall contract
Workforce efficiency (5%) per annum from 19/20							925,851	
Intermediate Tier beds							5,010,013	
Total				251.67			13,581,816	
Variation				81.42			1,449,460	
NOTE:								
- New workforce currently only includes additional enhancements for Night Support workers.								

Appendix 3 - Intermediate Tier Only

CURRENT WORKFORCE BASELINE 2016/17							
Service	Base Budget FTE	BCF FTE	FTE Total 16/17	Base Staffing (£)	BCF (£)	Revised Staffing (£)	Comments
Intermediate Tier	149.25	21.00	170.25	5,618,664	730,504	6,349,168	
Intermediate Tier beds						6,560,489	
Total 2016/17	149.25	21.00	170.25	5,618,664	730,504	12,909,657	
Exclude Non Recurrent BCF investment - Intermediate Tier (CAIR)					-605,000	-605,000	
Exclude Non Recurrent Other Investment - Intermediate Tier (Hospital Discharge Team)					-172,300	-172,300	
Recurrent Total	149.25	21.00	170.25	5,618,664	-46,796	12,132,357	
New costed workforce 2020/21							
Service			WTE			Cost (£)	Comments
Intermediate Tier			250.17			9,113,235	Includes non clinical element of Mas
Workforce efficiency (5%) per annum from 19/20						-888,370	
Intermediate Tier beds						5,010,013	
Total			250.17			13,234,878	
Variation			79.92			1,102,522	
NOTE:							
- New workforce currently only includes additional enhancements for Night Support workers and Mental Health workers.							

tercall contract

Intermediate Tier Costings Future Workforce 2020/21 - Based on top of scale and includes oncosts

1. Intermediate Tier - Hub/Single Point of Access (SPA):

Operation of the Hub - Access & Triage function will be procured from Mastercall, workforce requirements to be determined by Mastercall based on estimated demand on service (Activity modelling work to confirm forecast volumes by 16/09). Follow up meeting with Mastercall to commence contract arrangements on 19/09.

Narrative	Band/Scale	WTE	Costs (£)	Rotation	Trusted Assessor	Comments
Mastercall Contract			355,829			Only assumed non clinical element in 20/21 analysis, clinical element in Crisis Response

2. Crisis response:

Post	Band/Scale	WTE	Costs (£)	Rotation	Trusted Assessor	Comments
Driver/assistant	Band 2	7.50	164,382	Y		To cover Cars - 2 in the day, 1 overnight
Support Worker	Band 3	12.00	288,789	Y		Sitter and care provider
Therapist (OT / Physio)	6	5.50	242,060	Y	Y	
Clinical Practitioner	6	7.50	330,082	Y	Y	Rotated between hub and crisis response. Cars - 2 in the day, 1 overnight.
Mental Health Liaison Practitioners	6	3.00	139,771			Includes weekend enhancements
Mental Health Support Workers	3	6.00	168,991			Includes weekend and night enhancements
Mental Health Admin support	3	0.50	10,665			
Social worker	32-37	6.00	249,606	Y	Y	
Hub Triage practitioners	5	5.50	194,411			
Lead Practitioner	7	1.00	51,887			
Advanced Nurse Practitioner	8a	1.00	60,419			
	Total WTE	55.50	1,901,063			

3. Active Recovery – Home based (includes integrated discharge team):

Post	Band/Scale	WTE	Costs (£)	Rotation	Trusted Assessor	Comments
Physiotherapist	6	4.00	176,044	Y	Y	To work across integrated discharge team and Recovery at Home (acute & community delivery)
Physiotherapist	5	4.00	141,390	Y		To work across integrated discharge team and Recovery at Home (acute & community delivery)
Occupational Therapist	6	4.00	176,044	Y	Y	To work across integrated discharge team and Recovery at Home (acute & community delivery)
Occupational Therapist	5	4.00	141,390	Y		To work across integrated discharge team and Recovery at Home (acute & community delivery)
Moving & Handling coordinator	JNC S03	1.00	45,492			
Home Support Worker	JNC 4	40.00	1,014,689	Y		To provide 4 teams to support overnight Assessment following Hospital discharge and to prevent Hospital Admission possibly following 72 hr Crisis response. (Equivalent nursing band 3)
Home Support Worker (Night)	JNC 4	21.00	749,971	Y		Equivalent nursing band 3. Includes enhancements
Nurse	6	6.00	264,066		Y	
Nurse	5	12.00	424,171	Y		To work across Recovery at Home
Social Worker	JNC SO2	16.00	665,616	Y	Y	To work across integrated discharge team and Recovery at Home (acute & community delivery)
Wellbeing lead	JNC 5	4.00	114,720	Y		To work across integrated discharge team and Recovery at Home (acute & community delivery)
Dietitian	6	3.00	132,033	Y		To enable 1 per day in core hours (9am to 5pm)
Pharmacist	8a	2.00	120,839	Y		Prescribing pharmacist

SALT	6	2.00	88,022	Y		
Discharge co-ordinator	6	6.00	264,066			
Ward Trackers	3	6.00	144,395			
Support Workers (TPA/WIN)		3.00	59,604			
TPA Key Workers		4.00	95,168			
WIN co-ordinator		2.00	58,558			
	Total WTE	144.00	4,876,276			

4. Active Recovery – Bed based:

The numbers below are provisional and based on the perceived needs of existing clinical leads. There remains an urgent need to future proof this staffing model to ensure safe and effective alignment with the function of the beds.

Post	Band	WTE	Costs (£)	Rotation	Trusted Assessor	Comments
Support Worker	3	12.00	288,789	Y		7 days. Mon-fri 8:30 - 9. Sat/sun - 8:30 - 4:30
Nurse	6	2.40	105,626	Y	Y	7 days. Mon-fri 8:30 - 9. Sat/sun - 8:30 - 4:30
Nurse	5	11.00	388,823	Y		24/7 across 2 locations
Assistant Practitioner	4	1.50	41,485	Y		7 days. Mon-fri 8:30 - 9. Sat/sun - 8:30 - 4:30
Nurse	7	1.00	51,887	Y		
Physiotherapist	5	2.80	98,973	Y		
Physiotherapist	6	1.60	70,418	Y	Y	
Physiotherapist	7	1.00	51,887	Y	Y	
Occupational Therapist	5	2.80	98,973	Y		
Occupational Therapist	6	1.60	70,418	Y	Y	
Occupational Therapist	7	1.00	51,887	Y	Y	
Social Worker	32-37	5.97	248,358	Y	Y	
Administration	3	4.00	96,263			09:00 - 5:00
Pharmacy technician	6	2.00	88,022	Y		7 days - 8:30 - 4:30
	Total WTE	50.67	1,751,807			

SW grade SO2 points 32-37

5. Hydration Service

Narrative	Band/Scale	WTE	Costs (£)	Rotation	Trusted Assessor	Comments
Hydration Service Contract			170,000			

Non Pay Voluntary Support for discharge **49,028.00**

Non Pay Mental Health workers **20,471.00**

Post ascimilation balance **-11,239.00**

TOTAL recurrent workforce **250.17** **£9,113,235**

Exclude workforce efficiency from 2019/20 - 2020/21 **-£888,370** Cumulative

Revised workforce 2020/21 **£8,224,865**

excludes calculation of enhancements other than for night support workers and mental health workers

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Nurse	7	1.00	51,887	Y		
Physiotherapist	5	2.80	98,973	Y		
Physiotherapist	6	1.60	70,418	Y	Y	
Physiotherapist	7	1.00	51,887	Y	Y	
Occupational Therapist	5	2.80	98,973	Y		
Occupational Therapist	6	1.60	70,418	Y	Y	
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Social Worker	32-37	5.97	248,358	Y	Y	
Administration	3	4.00	96,263			09:00 - 5:00
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	Total WTE	50.67	1,751,807			

SW grade SO2 points 32-37

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Revised workforce 2020/21 **£8,224,865**

excludes calculation of enhancements other than for night support workers and mental health workers

Bed Commissioning - Intermediate Tier Budgets		Beds				Budget						
		Current 2016.17	Interim 2017.18	Interim 2018.19	Future 2019.20		Current 2016.17	Interim 2017.18	Interim 2018.19	Future 2019.20		
Current (September 2016)		No of beds	No of beds	No of beds	No of beds	Rate per Bed (£)	Annual Cost (£)	Budget (£)	Budget (£)	Budget (£)	Budget (£)	Commissioner
Saffron		15	15	15	15		720,000	720,000	720,000	720,000	SCCG commissioned and funded via Pennine Care contract	
		8	8	8	8		264,000	264,000	264,000	264,000	SCCG - funded through the SRG (non-recurrent)	
							199,696	199,696	199,696	199,696	Pennine contribution to Saffron Ward. Total costing provided by Pennine to balance. Includes £46,800 GP Costs - Marple Cottage.	
Marbury		40	40	40	0	520	1,084,512	1,084,512	1,084,512	1,084,512	0	
Berrycroft		14	0	0	0	570	416,077	416,077	0	0	SMBC & SCCG funded through S75 arrangement; beds commissioned by SMBC	
Spot Purchases					0		115,411	115,411	115,411	115,411	SMBC & SCCG funded through S75 arrangement; beds commissioned by SMBC - estimate 4 beds @ £500 per bed.	
Marbury GP Costs							148,909	148,909	148,909	148,909	GP Costs - Heaton Norris/Brinnington - from S75 arrangement	
Berrycroft GP Costs							33,091	33,091	0	0	GP Costs - Brinnington - from S75 arrangement	
Meadway		9	9	9	0	550	258,093	258,093	258,093	258,093	0	
Meadway GP Costs							36,400	36,400	36,400	36,400	0	
Hillbrook Grange		5	0	0	0	453	118,097	118,097	0	0	SMBC & SCCG funded as part of Better Care Fund; beds commissioned by SMBC	
Richard House (withdrawn services)		2	0	0	0	460	47,969	47,969	0	0	SMBC & SCCG funded as part of Better Care Fund; beds commissioned by SMBC	
Richard House (withdrawn services)		3	0	0	0	446	69,763	69,763	0	0	SMBC & SCCG funded as part of Better Care Fund; beds commissioned by SMBC	
Appleton Manor (withdrawn services)		5	0	0	0	467	121,747	121,747	0	0	SMBC & SCCG funded as part of Better Care Fund; beds commissioned by SMBC	
Hilltop Hall (withdrawn services)		5	0	0	0	453	118,097	118,097	0	0	SMBC & SCCG funded as part of Better Care Fund; beds commissioned by SMBC	
Hillbrook Grange GP Costs							9,360	9,360	0	0	GP costs - Village Surgery - SMBC & SCCG funded as part of Better Care Fund	
RH,AM & HH GP Costs (withdrawn services)							28,080	28,080	0	0	GP costs - Village Surgery - SMBC & SCCG funded as part of Better Care Fund	
New Premises		0	0	0	40					1,147,080	Estimate for new building from 2018.19 based on 40 beds at £550 per week. No costs included for creation of new premises if required.	
New Premises GP Costs										170,000	Estimate for GP cover for new premises.	
Newlands		10	10	10	10	589	307,105	350,000	350,000	350,000	CCG commissions 15 beds but SMBC buys 5 back	
							139	36,237	36,237	36,237	difference between CCG rate and SMBC rate for 5 beds	
		5	5	0	0	450	117,315	117,315	117,315	0	SMBC purchase 5 beds from CCG	
		4	4	0	0	475	99,066	99,066	99,066	0	SMBC purchase 4 beds from home direct	
Newlands GP Costs								35,568	52,936	30,000	30,000	
Newlands GP Costs (FT consultants)								40,000	0	0	GP costs - FT Consultants - from CHC budget	
Bluebell		25	25	25	25			2,093,000	2,093,000	2,093,000	2,093,000	
Additional Step Up assessment beds		10	10	9	0			0	485,280	147,247	0	
Total Budgets		160	126	116	98			6,560,489	6,060,855	5,483,505	5,010,013	
Total Savings								-499,633	-1,076,983	-1,550,475		Estimated savings will be dependent on appraisal for new premises.

Current workforce analysis

MOU Heading	Service Description	Designation	Employer	Base Budget		FTE Total	Base Staffing	BCF	Revised Staffing	Base Non Staffing	Total		Workstream	Working Paper
				FTE	BCF						Investment	Workstream		
REaCH (excludes management)	REaCH - Other	Customer Lead Advisory Worker (CLAWs)	SMBC	4.73	0.00	4.73	145,078		145,078		145,078	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCH - Other	Facilitator	SMBC	2.00	0.00	2.00	47,071		47,071		47,071	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCh Reablement Intermediate Care	Home Support Worker	SMBC	13.93	0.00	13.93	374,111		374,111		374,111	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCh Reablement Intermediate Care	Customer Lead Advisory Worker (CLAWs)	SMBC	0.95	0.00	0.95	29,016		29,016		29,016	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCH Reablement Night Support	Home Support Worker	SMBC	10.66	0.00	10.66	381,731		381,731		381,731	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCH Reablement Night Support	Customer Lead Advisory Worker (CLAWs)	SMBC	1.46	0.00	1.46	44,767		44,767		44,767	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW East Team	Intermediate Care SW East Team	Senior Prac	SMBC	1.00	0.00	1.00	45,492		45,492		45,492	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW East Team	Intermediate Care SW East Team	Social Worker	SMBC	3.00	0.00	3.00	124,804		124,804		124,804	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW West Team	Intermediate Care SW West Team	Senior Prac	SMBC	1.00	0.00	1.00	45,492		45,492		45,492	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW West Team	Intermediate Care SW West Team	Social Worker	SMBC	3.50	0.00	3.50	145,605		145,605		145,605	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW West Team	Intermediate Care SW West Team	Snr Suppot Officer	SMBC	1.00	0.00	1.00	49,481		49,481		49,481	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Hospital Team	Social Worker	SMBC	12.81	0.00	12.81	532,949		532,949		532,949	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Reablement	Moving & Handling Coordinator	SMBC	1.00	0.00	1.00	45,492		45,492		45,492	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Reablement	Social Worker	SMBC	4.00	0.00	4.00	158,033		158,033		158,033	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Reablement	Agency	SMBC	0.00	0.00	32,984			32,984		32,984	Intermediate Tier	Boroughwide (in MOU)	
Rapid Response	Rapid Response	Social Worker	SMBC	9.00	0.00	9.00	471,558		471,558		471,558	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 7 A & C	FT	0.49	0.00	0.49	25,000		25,000		25,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 6 A & C	FT	1.00	0.00	1.00	42,800		42,800		42,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 4 Nursing	FT	0.93	0.00	0.93	29,000		29,000		29,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 3 - Nursing	FT	14.73	0.00	14.73	378,000		378,000		378,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 8a - Nursing	FT	0.60	0.00	0.60	32,000		32,000		32,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - Nursing	FT	1.98	0.00	1.98	101,700		101,700		101,700	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Nursing	FT	6.08	0.00	6.08	286,600		286,600		286,600	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 5 - Nursing	FT	7.96	0.00	7.96	288,900		288,900		288,900	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 4 - Nursing	FT	1.00	0.00	1.00	26,000		26,000		26,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 3 - Nursing	FT	1.20	0.00	1.20	36,000		36,000		36,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Nursing Bank Band 3	FT	0.78	0.00	0.78	17,500		17,500		17,500	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Nursing Bank Band 5	FT	0.57	0.00	0.57	17,300		17,300		17,300	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Nursing Bank Band 7	FT	0.19	0.00	0.19	8,000		8,000		8,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 3 - A & C	FT	1.00	0.00	1.00	24,100		24,100		24,100	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - Occ Therapy	FT	4.80	0.00	4.80	247,800		247,800		247,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Occ Therapy	FT	1.43	0.00	1.43	65,200		65,200		65,200	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 5 - Occ Therapy	FT	1.00	0.00	1.00	33,300		33,300		33,300	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - Physiotherapist	FT	2.30	0.00	2.30	113,800		113,800		113,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Physiotherapist	FT	4.00	0.00	4.00	155,300		155,300		155,300	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 5 - Physiotherapist	FT	1.00	0.00	1.00	27,800		27,800		27,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - SALT	FT	0.20	0.00	0.20	7,200		7,200		7,200	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Dietician	FT	0.20	0.00	0.20	6,000		6,000		6,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Contingency Pay Budget	FT	0.00	0.00	0.00	6,200		6,200		6,200	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 3 - A & C	FT	0.11	0.00	0.11	2,400		2,400		2,400	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 5 - Nursing	FT	2.00	0.00	2.00	70,600		70,600		70,600	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 6 - Nursing	FT	1.00	0.00	1.00	44,000		44,000		44,000	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 7 - Nursing	FT	1.00	0.00	1.00	51,900		51,900		51,900	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Assistant Practitioner	FT	3.00	0.00	3.00	82,200		82,200		82,200	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 5 - Physiotherapist	FT	2.00	0.00	2.00	54,000		54,000		54,000	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 6 - Physiotherapist	FT	1.40	0.00	1.40	57,200		57,200		57,200	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 7 - Physiotherapist	FT	2.56	0.00	2.56	127,100		127,100		127,100	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 7 - Occ Therapy	FT	2.65	0.00	2.65	135,800		135,800		135,800	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 5 - Dietician	FT	0.40	0.00	0.40	10,400		10,400		10,400	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 6 - Dietician	FT	1.35	0.00	1.35	39,500		39,500		39,500	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 7 - Dietician	FT	0.50	0.00	0.50	30,300		30,300		30,300	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 7 - Occ Therapy	FT	0.00	1.00	1.00	0	51,900	51,900		51,900	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 6 - Nursing	FT	0.00	2.00	2.00	0	75,200	75,200		75,200	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 6 - Physiotherapist	FT	0.00	3.00	3.00	0	132,000	132,000		132,000	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 6 - Occ Therapy	FT	0.00	3.00	3.00	0	112,200	112,200		112,200	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 4 - Assistant Practitioner	FT	0.00	2.00	2.00	0	55,400	55,400	</td				

MOU Heading Total	Service Description	Designation	Employer	Base Budget		FTE Total 16/17	Base Staffing	BCF	Revised Staffing	Base Non Staffng	Total Investment	Workstream	Working Paper
				FTE	BCF FTE								
<u>BCF Non Recurrent</u>													
CAIR								-605,000	-605,000		-605,000		
<u>Other Non Recurrent</u>													
Hospital Discharge Team								-172,300			-172,300		
Revised Recurrent funding Total				149.25	21.00	170.25	5,618,664	730,504	6,349,168	0	6,349,168		
				149.25	21.00	170.25	5,618,664	125,504	5,571,868	0	5,571,868		

2016/17 Payscale with Oncosts

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17
2	1.00	XN0202	15,251	2,181	992	18,424
3	1.00	XN0203	15,516	2,219	1,029	18,764
4	1.00	XN0204	15,944	2,280	1,088	19,312
5	1.00	XN0205	16,372	2,341	1,147	19,860
6	1.00	XN0206	16,800	2,402	1,206	20,409
7	1.00	XN0207	17,351	2,481	1,282	21,114
8	1.00	XN0208	17,978	2,571	1,369	21,918
6	1.00	XN0301	16,800	2,402	1,206	20,409
7	1.00	XN0302	17,351	2,481	1,282	21,114
8	1.00	XN0303	17,978	2,571	1,369	21,918
9	1.00	XN0304	18,152	2,596	1,393	22,140
10	1.00	XN0305	18,653	2,667	1,462	22,782
11	1.00	XN0306	19,217	2,748	1,540	23,505
12	1.00	XN0307	19,655	2,811	1,600	24,666
11	1.00	XN0401	19,217	2,748	1,540	23,505
12	1.00	XN0402	19,655	2,811	1,600	24,666
13	1.00	XN0403	20,348	2,910	1,696	24,954
14	1.00	XN0404	21,052	3,010	1,793	25,855
15	1.00	XN0405	21,692	3,102	1,881	26,675
16	1.00	XN0406	21,909	3,133	1,911	26,953
17	1.00	XN0407	22,458	3,211	1,987	27,656
16	1.00	XN0501	21,909	3,133	1,911	26,953
17	1.00	XN0502	22,458	3,211	1,987	27,656
18	1.00	XN0503	23,363	3,341	2,112	28,816
19	1.00	XN0504	24,304	3,475	2,242	30,021
20	1.00	XN0505	25,298	3,618	2,379	31,294
21	1.00	XN0506	26,302	3,761	2,517	32,581
22	1.00	XN0507	27,361	3,913	2,664	33,937
23	1.00	XN0508	28,462	4,070	2,815	35,348
21	1.00	XN0601	26,302	3,761	2,517	32,581
22	1.00	XN0602	27,361	3,913	2,664	33,937
23	1.00	XN0603	28,462	4,070	2,815	35,348
24	1.00	XN0604	29,333	4,195	2,936	36,463
25	1.00	XN0605	30,357	4,341	3,077	37,775
26	1.00	XN0606	31,383	4,488	3,219	39,089
27	1.00	XN0607	32,407	4,634	3,360	40,401
28	1.00	XN0608	33,560	4,799	3,519	41,878
29	1.00	XN0609	35,225	5,037	3,749	44,011
26	1.00	XN0701	31,383	4,488	3,219	39,089
27	1.00	XN0702	32,407	4,634	3,360	40,401
28	1.00	XN0703	33,560	4,799	3,519	41,878
29	1.00	XN0704	35,225	5,037	3,749	44,011
30	1.00	XN0705	36,250	5,184	3,890	45,324
31	1.00	XN0706	37,403	5,349	4,049	46,801
32	1.00	XN0707	38,683	5,532	4,226	48,441
33	1.00	XN0708	40,028	5,724	4,412	50,164
34	1.00	XN0709	41,373	5,916	4,597	51,887
33	1.00	XN0801	40,028	5,724	4,412	50,164
34	1.00	XN0802	41,373	5,916	4,597	51,887
35	1.00	XN0803	43,038	6,154	4,827	54,019
36	1.00	XN0804	44,703	6,393	5,057	56,152
37	1.00	XN0805	46,625	6,667	5,322	58,614
38	1.00	XN0806	48,034	6,869	5,516	60,419
37	1.00	XN0901	46,625	6,667	5,322	58,614
38	1.00	XN0902	48,034	6,869	5,516	60,419
39	1.00	XN0903	50,467	7,217	5,852	63,536
40	1.00	XN0904	53,285	7,620	6,241	67,146
41	1.00	XN0905	56,104	8,023	6,630	70,757
42	1.00	XN0906	57,640	8,243	6,842	72,725
41	1.00	XN1001	56,104	8,023	6,630	70,757
42	1.00	XN1002	57,640	8,243	6,842	72,725
43	1.00	XN1003	59,606	8,524	7,113	75,243
44	1.00	XN1004	62,397	8,923	7,499	78,818
45	1.00	XN1005	66,582	9,521	8,076	84,179
46	1.00	XN1006	68,484	9,793	8,339	86,616
45	1.00	XN1101	66,582	9,521	8,076	84,179
46	1.00	XN1102	68,484	9,793	8,339	86,616
47	1.00	XN1103	71,338	10,201	8,732	90,272
48	1.00	XN1104	74,825	10,700	9,214	94,739
49	1.00	XN1105	78,629	11,244	9,739	99,611
50	1.00	XN1106	82,434	11,788	10,264	104,486
49	1.00	XN1201	78,629	11,244	9,739	99,611
50	1.00	XN1202	82,434	11,788	10,264	104,486
41	1.00	XN1203	86,390	12,354	10,810	109,553
52	1.00	XN1204	90,537	12,947	11,382	114,866
43	1.00	XN1205	94,883	13,568	11,982	120,433
54	1.00	XN1206	99,437	14,219	12,610	126,267

Hourly Rate / Costs

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17
2	1.00	XN0202	7.80	1.12	0.51	9.42
3	1.00	XN0203	7.94	1.13	0.53	9.60
4	1.00	XN0204	8.15	1.17	0.56	9.88
5	1.00	XN0205	8.37	1.20	0.59	10.16
6	1.00	XN0206	8.59	1.23	0.62	10.44
7	1.00	XN0207	8.87	1.27	0.66	10.80
8	1.00	XN0208	9.19	1.31	0.70	11.21
6	1.00	XN0301	8.59	1.23	0.62	10.44
7	1.00	XN0302	8.87	1.27	0.66	10.80
8	1.00	XN0303	9.19	1.31	0.70	11.21
9	1.00	XN0304	9.28	1.33	0.71	11.32
10	1.00	XN0305	9.54	1.36	0.75	11.65
11	1.00	XN0306	9.83	1.41	0.79	12.02
12	1.00	XN0307	10.05	1.44	0.82	12.31
11	1.00	XN0401	9.83	1.41	0.79	12.02
12	1.00	XN0402	10.05	1.44	0.82	12.31
13	1.00	XN0403	10.41	1.49	0.87	12.76
14	1.00	XN0404	10.77	1.54	0.92	13.22
15	1.00	XN0405	11.09	1.59	0.96	13.64
16	1.00	XN0406	11.20	1.60	0.98	13.78
17	1.00	XN0407	11.49	1.64	1.02	14.14
16	1.00	XN0501	11.20	1.60	0.98	13.78
17	1.00	XN0502	11.49	1.64	1.02	14.14
18	1.00	XN0503	11.95	1.71	1.08	14.74
19	1.00	XN0504	12.43	1.78	1.15	15.35
20	1.00	XN0505	12.94	1.85	1.22	16.00
21	1.00	XN0506	13.45	1.92	1.29	16.66
22	1.00	XN0507	13.99	2.00	1.36	17.36
23	1.00	XN0508	14.56	2.08	1.44	18.08
21	1.00	XN0601	13.45	1.92	1.29	16.66
22	1.00	XN0602	13.99	2.00	1.36	17.36
23	1.00	XN0603	14.56	2.08	1.44	18.08
24	1.00	XN0604	15.00	2.15	1.50	18.65
25	1.00	XN0605	15.52	2.22	1.57	19.32
26	1.00	XN0606	16.05	2.30	1.65	19.99
27	1.00	XN0607	16.57	2.37	1.72	20.66
28	1.00	XN0703	17.16	2.45	1.80	21.42
29	1.00	XN0704	18.01	2.58	1.92	22.51
30	1.00	XN0705	18.54	2.65	1.99	23.18
31	1.00	XN0706	19.13	2.74	2.07	23.93
32	1.00	XN0707	19.78	2.83	2.16	24.77
33	1.00	XN0708	20.47	2.93	2.26	25.65
34	1.00	XN0709	21.16	3.03	2.35	26.54
33	1.00	XN0801	20.47	2.93	2.26	25.65
34	1.00	XN0802	21.16	3.03	2.35	26.54
35	1.00	XN0803	22.01	3.15	2.47	27.63
36	1.00	XN0804	22.86	3.27	2.59	28.72
37	1.00	XN0805	23.84	3.41	2.72	29.98
38	1.00	XN0806	24.57	3.51	2.82	30.90
37	1.00	XN0901	23.84	3.41	2.72	29.98
38	1.00	XN0902	24.57	3.51	2.82	30.90
39	1.00	XN0903	25.81	3.69	2.99	32.49
40	1.00	XN0904	27.25	3.90	3.19	34.34
41	1.00	XN0905	28.69	4.10	3.39	36.19
42	1.00	XN1001	29.48	4.22	3.50	37.19
43	1.00	XN1003	30.48	4.36	3.64	38.48
44	1.00	XN1004	31.91	4.56	3.83	40.31
45	1.00	XN1005	34.05	4.87	4.13	43.05
46	1.00	XN1006	35.02	5.01	4.26	44.30
45	1.00	XN1101	34.05	4.87	4.13	43.05
46	1.00	XN1102	35.02	5.01	4.26	44.30
47	1.00	XN1103	36.48	5.22	4.47	46.17
48	1.00	XN1104	38.27	5.47	4.71	48.45
49	1.00	XN1105	40.21	5.75	4.98	50.94
50	1.00	XN1106	42.16	6.03	5.25	53.44
49	1.00	XN1201	40.21	5.75	4.98	50.94
50	1.00	XN1202	42.16	6.03	5.25	53.44
41	1.00	XN1203	44.18	6.32	5.53	56.03
52	1.00	XN1204	46.30	6.62	5.82	58.74
43	1.00	XN1205	48.52	6.94	6.13	61.59
54	1.00	XN1206	50.85	7.27	6.45	64.57

2016/17 Payscale with Oncosts

Current workforce analysis

MOU Heading	Service Description	Designation	Employer	Base Budget		FTE Total	Base Staffing	BCF	Revised Staffing	Base Non Staffing	Total		Workstream	Working Paper
				FTE	BCF						Investment	Workstream		
REaCH (excludes management)	REaCH - Other	Customer Lead Advisory Worker (CLAWs)	SMBC	4.73	0.00	4.73	145,078		145,078		145,078	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCH - Other	Facilitator	SMBC	2.00	0.00	2.00	47,071		47,071		47,071	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCh Reablement Intermediate Care	Home Support Worker	SMBC	13.93	0.00	13.93	374,111		374,111		374,111	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCh Reablement Intermediate Care	Customer Lead Advisory Worker (CLAWs)	SMBC	0.95	0.00	0.95	29,016		29,016		29,016	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCH Reablement Night Support	Home Support Worker	SMBC	10.66	0.00	10.66	381,731		381,731		381,731	Intermediate Tier	Boroughwide (in MOU)	
REaCH (excludes management)	REaCH Reablement Night Support	Customer Lead Advisory Worker (CLAWs)	SMBC	1.46	0.00	1.46	44,767		44,767		44,767	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW East Team	Intermediate Care SW East Team	Senior Prac	SMBC	1.00	0.00	1.00	45,492		45,492		45,492	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW East Team	Intermediate Care SW East Team	Social Worker	SMBC	3.00	0.00	3.00	124,804		124,804		124,804	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW West Team	Intermediate Care SW West Team	Senior Prac	SMBC	1.00	0.00	1.00	45,492		45,492		45,492	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW West Team	Intermediate Care SW West Team	Social Worker	SMBC	3.50	0.00	3.50	145,605		145,605		145,605	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care SW West Team	Intermediate Care SW West Team	Snr Suppot Officer	SMBC	1.00	0.00	1.00	49,481		49,481		49,481	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Hospital Team	Social Worker	SMBC	12.81	0.00	12.81	532,949		532,949		532,949	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Reablement	Moving & Handling Coordinator	SMBC	1.00	0.00	1.00	45,492		45,492		45,492	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Reablement	Social Worker	SMBC	4.00	0.00	4.00	158,033		158,033		158,033	Intermediate Tier	Boroughwide (in MOU)	
18+ Hospital Service	Reablement	Agency	SMBC	0.00	0.00	32,984			32,984		32,984	Intermediate Tier	Boroughwide (in MOU)	
Rapid Response	Rapid Response	Social Worker	SMBC	9.00	0.00	9.00	471,558		471,558		471,558	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 7 A & C	FT	0.49	0.00	0.49	25,000		25,000		25,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 6 A & C	FT	1.00	0.00	1.00	42,800		42,800		42,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 4 Nursing	FT	0.93	0.00	0.93	29,000		29,000		29,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care and Rehabilitation	Community Rehab Work	Band 3 - Nursing	FT	14.73	0.00	14.73	378,000		378,000		378,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 8a - Nursing	FT	0.60	0.00	0.60	32,000		32,000		32,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - Nursing	FT	1.98	0.00	1.98	101,700		101,700		101,700	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Nursing	FT	6.08	0.00	6.08	286,600		286,600		286,600	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 5 - Nursing	FT	7.96	0.00	7.96	288,900		288,900		288,900	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 4 - Nursing	FT	1.00	0.00	1.00	26,000		26,000		26,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 3 - Nursing	FT	1.20	0.00	1.20	36,000		36,000		36,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Nursing Bank Band 3	FT	0.78	0.00	0.78	17,500		17,500		17,500	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Nursing Bank Band 5	FT	0.57	0.00	0.57	17,300		17,300		17,300	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Nursing Bank Band 7	FT	0.19	0.00	0.19	8,000		8,000		8,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 3 - A & C	FT	1.00	0.00	1.00	24,100		24,100		24,100	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - Occ Therapy	FT	4.80	0.00	4.80	247,800		247,800		247,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Occ Therapy	FT	1.43	0.00	1.43	65,200		65,200		65,200	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 5 - Occ Therapy	FT	1.00	0.00	1.00	33,300		33,300		33,300	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - Physiotherapist	FT	2.30	0.00	2.30	113,800		113,800		113,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Physiotherapist	FT	4.00	0.00	4.00	155,300		155,300		155,300	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 5 - Physiotherapist	FT	1.00	0.00	1.00	27,800		27,800		27,800	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 7 - SALT	FT	0.20	0.00	0.20	7,200		7,200		7,200	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Band 6 - Dietician	FT	0.20	0.00	0.20	6,000		6,000		6,000	Intermediate Tier	Boroughwide (in MOU)	
Intermediate Care	Intermediate Care	Contingency Pay Budget	FT	0.00	0.00	0.00	6,200		6,200		6,200	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 3 - A & C	FT	0.11	0.00	0.11	2,400		2,400		2,400	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 5 - Nursing	FT	2.00	0.00	2.00	70,600		70,600		70,600	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 6 - Nursing	FT	1.00	0.00	1.00	44,000		44,000		44,000	Intermediate Tier	Boroughwide (in MOU)	
Enhanced Rapid Response	Rapid Response	Band 7 - Nursing	FT	1.00	0.00	1.00	51,900		51,900		51,900	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Assistant Practitioner	FT	3.00	0.00	3.00	82,200		82,200		82,200	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 5 - Physiotherapist	FT	2.00	0.00	2.00	54,000		54,000		54,000	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 6 - Physiotherapist	FT	1.40	0.00	1.40	57,200		57,200		57,200	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 7 - Physiotherapist	FT	2.56	0.00	2.56	127,100		127,100		127,100	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 7 - Occ Therapy	FT	2.65	0.00	2.65	135,800		135,800		135,800	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 5 - Dietician	FT	0.40	0.00	0.40	10,400		10,400		10,400	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 6 - Dietician	FT	1.35	0.00	1.35	39,500		39,500		39,500	Intermediate Tier	Boroughwide (in MOU)	
Adult Community Therapy Team	Adult Community Therapy Team	Band 7 - Dietician	FT	0.50	0.00	0.50	30,300		30,300		30,300	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 7 - Occ Therapy	FT	0.00	1.00	1.00	0	51,900	51,900		51,900	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 6 - Nursing	FT	0.00	2.00	2.00	0	75,200	75,200		75,200	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 6 - Physiotherapist	FT	0.00	3.00	3.00	0	132,000	132,000		132,000	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 6 - Occ Therapy	FT	0.00	3.00	3.00	0	112,200	112,200		112,200	Intermediate Tier	Boroughwide (in MOU)	
CAIR	CAIR	Band 4 - Assistant Practitioner	FT	0.00	2.00	2.00	0	55,400	55,400		55,400	Intermediate Tier	Boroughwide (in MOU)	

MOU Heading Total	Service Description	Designation	Employer	Base Budget		FTE Total	Base Staffing	Revised BCF	Base Non Staffng	Total Investment	Workstream	Working Paper
				FTE	BCF	16/17 FTE	5,618,664	730,504	6,349,168	0	6,349,168	
<u>BCF Non Recurrent</u>												
CAIR								-605,000	-605,000		-605,000	
<u>Other Non Recurrent</u>												
Hospital Discharge Team								-172,300		-172,300		
Revised Recurrent funding Total				149.25	21.00	170.25	5,618,664	125,504	5,571,868	0	5,571,868	

2016/17 Pay scales with Oncosts

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17	
2	1.00	XN0202	15,251	2,181	992	18,424	
3	1.00	XN0203	15,516	2,219	1,029	18,764	
4	1.00	XN0204	15,944	2,280	1,088	19,312	
5	1.00	XN0205	16,372	2,341	1,147	19,860	
6	1.00	XN0206	16,800	2,402	1,206	20,409	
7	1.00	XN0207	17,351	2,481	1,282	21,114	
8	1.00	XN0208	17,978	2,571	1,369	21,918	
6	1.00	XN0301	16,800	2,402	1,206	20,409	
7	1.00	XN0302	17,351	2,481	1,282	21,114	
8	1.00	XN0303	17,978	2,571	1,369	21,918	
9	1.00	XN0304	18,152	2,596	1,393	22,140	
10	1.00	XN0305	18,653	2,667	1,462	22,782	
11	1.00	XN0306	19,217	2,748	1,540	23,505	
12	1.00	XN0307	19,655	2,811	1,600	24,066	
11	1.00	XN0401	19,217	2,748	1,540	23,505	
12	1.00	XN0402	19,655	2,811	1,600	24,066	
13	1.00	XN0403	20,348	2,910	1,696	24,954	
14	1.00	XN0404	21,052	3,010	1,793	25,855	
15	1.00	XN0405	21,692	3,102	1,881	26,675	
16	1.00	XN0406	21,909	3,133	1,911	26,953	
17	1.00	XN0407	22,458	3,211	1,987	27,656	
16	1.00	XN0501	21,909	3,133	1,911	26,953	
17	1.00	XN0502	22,458	3,211	1,987	27,656	
18	1.00	XN0503	23,363	3,341	2,112	28,816	
19	1.00	XN0504	24,304	3,475	2,242	30,021	
20	1.00	XN0505	25,298	3,618	2,379	31,294	
21	1.00	XN0506	26,302	3,761	2,517	32,581	
22	1.00	XN0507	27,361	3,913	2,664	33,937	
23	1.00	XN0508	28,462	4,070	2,815	35,348	
21	1.00	XN0601	26,302	3,761	2,517	32,581	
22	1.00	XN0602	27,361	3,913	2,664	33,937	
23	1.00	XN0603	28,462	4,070	2,815	35,348	
24	1.00	XN0604	29,333	4,195	2,936	36,463	
25	1.00	XN0605	30,357	4,341	3,077	37,775	
26	1.00	XN0606	31,383	4,488	3,219	39,089	
27	1.00	XN0607	32,407	4,634	3,360	40,401	
28	1.00	XN0608	33,560	4,799	3,519	41,878	
29	1.00	XN0609	35,225	5,037	3,749	44,011	
26	1.00	XN0701	31,383	4,488	3,219	39,089	
27	1.00	XN0702	32,407	4,634	3,360	40,401	
28	1.00	XN0703	33,560	4,799	3,519	41,878	
29	1.00	XN0704	35,225	5,037	3,749	44,011	
30	1.00	XN0705	36,250	5,184	3,890	45,324	
31	1.00	XN0706	37,403	5,349	4,049	46,801	
32	1.00	XN0707	38,683	5,532	4,226	48,441	

Hourly Rate / Costs

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17	
2	1.00	XN0202	7.80	1.12	0.51	9.42	
3	1.00	XN0203	7.94	1.13	0.53	9.60	
4	1.00	XN0204	8.15	1.17	0.56	9.88	
5	1.00	XN0205	8.37	1.20	0.59	10.16	
6	1.00	XN0206	8.59	1.23	0.62	10.44	
7	1.00	XN0207	8.87	1.27	0.66	10.80	
8	1.00	XN0208	9.19	1.31	0.70	11.21	
6	1.00	XN0301	8.59	1.23	0.62	10.44	
7	1.00	XN0302	8.87	1.27	0.66	10.80	
8	1.00	XN0303	9.19	1.31	0.70	11.21	
9	1.00	XN0304	9.28	1.33	0.71	11.32	
10	1.00	XN0305	9.54	1.36	0.75	11.65	
11	1.00	XN0306	9.83	1.41	0.79	12.02	
12	1.00	XN0307	10.05	1.44	0.82	12.31	
11	1.00	XN0401	9.83	1.41	0.79	12.02	
12	1.00	XN0402	10.05	1.44	0.82	12.31	
13	1.00	XN0403	10.41	1.49	0.87	12.76	
14	1.00	XN0404	10.77	1.54	0.92	13.22	
15	1.00	XN0405	11.09	1.59	0.96	13.64	
16	1.00	XN0406	11.20	1.60	0.98	13.78	
17	1.00	XN0407	11.49	1.64	1.02	14.14	
16	1.00	XN0501	11.20	1.60	0.98	13.78	
17	1.00	XN0502	11.49	1.64	1.02	14.14	
18	1.00	XN0503	11.95	1.71	1.08	14.74	
19	1.00	XN0504	12.43	1.78	1.15	15.35	
20	1.00	XN0505	12.94	1.85	1.22	16.00	
21	1.00	XN0506	13.45	1.92	1.29	16.66	
22	1.00	XN0507	13.99	2.00	1.36	17.36	
23	1.00	XN0508	14.56	2.08	1.44	18.08	
21	1.00	XN0601	13.45	1.92	1.29	16.66	
22	1.00	XN0602	13.99	2.00	1.36	17.36	
23	1.00	XN0603	14.56	2.08	1.44	18.08	
24	1.00	XN0604	15.00	2.15	1.50	18.65	
25	1.00	XN0605	15.52	2.22	1.57	19.32	
26	1.00	XN0606	16.05	2.30	1.65	19.99	
27	1.00	XN0607	16.57	2.37	1.72	20.66	
28	1.00	XN0608	17.16	2.45	1.80	21.42	
29	1.00	XN0609	18.01	2.58	1.92	22.51	
26	1.00	XN0701	16.05	2.30	1.65	19.99	
27	1.00	XN0702	16.57	2.37	1.72	20.66	
28	1.00	XN0703	17.16	2.45	1.80	21.42	
29	1.00	XN0704	18.01	2.58	1.92	22.51	
30	1.00	XN0705	18.54	2.65	1.99	23.18	
31	1.00	XN0706	19.13	2.74	2.07	23.93	
32	1.00	XN0707	19.78	2.83	2.16	24.77	

33	1.00	XN0708	40,028	5,724	4,412	50,164			33	1.00	XN0708	20.47	2.93	2.26	25.65
34	1.00	XN0709	41,373	5,916	4,597	51,887			34	1.00	XN0709	21.16	3.03	2.35	26.54
33	1.00	XN0801	40,028	5,724	4,412	50,164			33	1.00	XN0801	20.47	2.93	2.26	25.65
34	1.00	XN0802	41,373	5,916	4,597	51,887			34	1.00	XN0802	21.16	3.03	2.35	26.54
35	1.00	XN0803	43,038	6,154	4,827	54,019			35	1.00	XN0803	22.01	3.15	2.47	27.63
36	1.00	XN0804	44,703	6,393	5,057	56,152			36	1.00	XN0804	22.86	3.27	2.59	28.72
37	1.00	XN0805	46,625	6,667	5,322	58,614			37	1.00	XN0805	23.84	3.41	2.72	29.98
38	1.00	XN0806	48,034	6,869	5,516	60,419			38	1.00	XN0806	24.57	3.51	2.82	30.90
37	1.00	XN0901	46,625	6,667	5,322	58,614			37	1.00	XN0901	23.84	3.41	2.72	29.98
38	1.00	XN0902	48,034	6,869	5,516	60,419			38	1.00	XN0902	24.57	3.51	2.82	30.90
39	1.00	XN0903	50,467	7,217	5,852	63,536			39	1.00	XN0903	25.81	3.69	2.99	32.49
40	1.00	XN0904	53,285	7,620	6,241	67,146			40	1.00	XN0904	27.25	3.90	3.19	34.34
41	1.00	XN0905	56,104	8,023	6,630	70,757			41	1.00	XN0905	28.69	4.10	3.39	36.19
42	1.00	XN0906	57,640	8,243	6,842	72,725			42	1.00	XN0906	29.48	4.22	3.50	37.19
41	1.00	XN1001	56,104	8,023	6,630	70,757			41	1.00	XN1001	28.69	4.10	3.39	36.19
42	1.00	XN1002	57,640	8,243	6,842	72,725			42	1.00	XN1002	29.48	4.22	3.50	37.19
43	1.00	XN1003	59,606	8,524	7,113	75,243			43	1.00	XN1003	30.48	4.36	3.64	38.48
44	1.00	XN1004	62,397	8,923	7,499	78,818			44	1.00	XN1004	31.91	4.56	3.83	40.31
45	1.00	XN1005	66,582	9,521	8,076	84,179			45	1.00	XN1005	34.05	4.87	4.13	43.05
46	1.00	XN1006	68,484	9,793	8,339	86,616			46	1.00	XN1006	35.02	5.01	4.26	44.30
45	1.00	XN1101	66,582	9,521	8,076	84,179			45	1.00	XN1101	34.05	4.87	4.13	43.05
46	1.00	XN1102	68,484	9,793	8,339	86,616			46	1.00	XN1102	35.02	5.01	4.26	44.30
47	1.00	XN1103	71,338	10,201	8,732	90,272			47	1.00	XN1103	36.48	5.22	4.47	46.17
48	1.00	XN1104	74,825	10,700	9,214	94,739			48	1.00	XN1104	38.27	5.47	4.71	48.45
49	1.00	XN1105	78,629	11,244	9,739	99,611			49	1.00	XN1105	40.21	5.75	4.98	50.94
50	1.00	XN1106	82,434	11,788	10,264	104,486			50	1.00	XN1106	42.16	6.03	5.25	53.44
49	1.00	XN1201	78,629	11,244	9,739	99,611			49	1.00	XN1201	40.21	5.75	4.98	50.94
50	1.00	XN1202	82,434	11,788	10,264	104,486			50	1.00	XN1202	42.16	6.03	5.25	53.44
41	1.00	XN1203	86,390	12,354	10,810	109,553			41	1.00	XN1203	44.18	6.32	5.53	56.03
52	1.00	XN1204	90,537	12,947	11,382	114,866			52	1.00	XN1204	46.30	6.62	5.82	58.74
43	1.00	XN1205	94,883	13,568	11,982	120,433			43	1.00	XN1205	48.52	6.94	6.13	61.59
54	1.00	XN1206	99,437	14,219	12,610	126,267			54	1.00	XN1206	50.85	7.27	6.45	64.57

2016/17 Payscales with Oncosts

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17
34	1.00	XR0709	41,373	5,916	4,597	51,887

Hourly Rate / Costs

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17
34	1.00	XR0709		21.16	3.03	2.35

Spine Point	Band/Point	Group	Description	1% Pay Award		1% Pay Award - for staff upto and including spine point 42		Assume 1%		Assume 1%		% increase on points	
						Points 34 - 54 have no incremental progression		No Pay Award		Pay Award for 14/15			
				16/17	15/16	14/15	14/15	13/14	%				
1 XN0101			Admin	0		14,294	14,437	14,294				0 0	
2 XN0102			Admin	15,251	15,100	14,653	14,800	14,653	1.00%			15,251 15,451 15,451	
3 XN0103			Admin	15,516	15,363	15,013	15,163	15,013	1.00%	1.74%		15,517 15,717 15,717	
1 XN0201			Admin	0		14,294	14,437	14,294				0 0 0	
2 XN0202			Admin	15,251	15,100	14,653	14,800	14,653	1.00%			15,251 15,451 15,451	
3 XN0203			Admin	15,516	15,363	15,013	15,163	15,013	1.00%	1.74%		15,517 15,717 15,717	
4 XN0204			Admin	15,944	15,786	15,432	15,586	15,432	1.00%			15,944 16,144 16,144	
5 XN0205			Admin	16,372	16,210	15,851	16,010	15,851	1.00%	2.68%		16,372 16,572 16,572	
6 XN0206			Admin	16,800	16,633	16,271	16,434	16,271	1.00%	2.61%		16,799 16,999 16,999	
7 XN0207			Admin	17,351	17,179	16,811	16,979	16,811	1.00%	3.28%		17,351 17,551 17,551	
8 XN0208			Admin	17,978	17,800	17,425	17,599	17,425	1.00%	3.61%		17,978 18,178 18,178	
6 XN0301			Admin	16,800	16,633	16,271	16,434	16,271	1.00%			16,799 16,999 16,999	
7 XN0302			Admin	17,351	17,179	16,811	16,979	16,811	1.00%	3.28%		17,351 17,551 17,551	
8 XN0303			Admin	17,978	17,800	17,425	17,599	17,425	1.00%	3.61%		17,978 17,978 17,978	
9 XN0304			Admin	18,152	17,972	17,794	17,972	17,794	1.00%	0.97%		18,152 18,152 18,152	
10 XN0305			Admin	18,653	18,468	18,285	18,468	18,285	1.00%	2.76%		18,653 18,653 18,653	
11 XN0306			Admin	19,217	19,027	18,838	19,026	18,838	1.00%	3.02%		19,217 19,217 19,217	
12 XN0307			Admin	19,655	19,461	19,268	19,461	19,268	1.00%	2.28%		19,656 19,656 19,656	
11 XN0401			Admin	19,217	19,027	18,838	19,026	18,838	1.00%			19,217 19,217 19,217	
12 XN0402			Admin	19,655	19,461	19,268	19,461	19,268	1.00%	2.28%		19,656 19,656 19,656	
13 XN0403			Admin	20,348	20,147	19,947	20,146	19,947	1.00%	3.53%		20,348 20,348 20,348	
14 XN0404			Admin	21,052	20,844	20,638	20,844	20,638	1.00%	3.46%		21,052 21,052 21,052	
15 XN0405			Admin	21,692	21,477	21,265	21,478	21,265	1.00%	3.04%		21,692 21,692 21,692	
16 XN0406			Admin	21,909	21,692	21,388	21,602	21,388	1.00%	1.00%		21,909 21,909 21,909	
17 XN0407			Admin	22,458	22,236	22,016	22,236	22,016	1.00%	2.51%		22,458 22,458 22,458	
16 XN0501			Admin	21,909	21,692	21,388	21,602	21,388	1.00%			21,909 21,909 21,909	
17 XN0502			Admin	22,458	22,236	22,016	22,236	22,016	1.00%	2.51%		22,458 22,458 22,458	
18 XN0503			Admin	23,363	23,132	22,903	23,132	22,903	1.00%	4.03%		23,363 23,363 23,363	
19 XN0504			Admin	24,304	24,063	23,825	24,063	23,825	1.00%	4.03%		24,304 24,304 24,304	
20 XN0505			Admin	25,298	25,047	24,799	25,047	24,799	1.00%	4.09%		25,297 25,297 25,297	
21 XN0506			Admin	26,302	26,032	25,783	26,041	25,783	1.00%	3.97%		26,301 26,301 26,301	
22 XN0507			Admin	27,361	27,090	26,822	27,090	26,822	1.00%	4.03%		27,361 27,361 27,361	
23 XN0508			Admin	28,462	28,180	27,901	28,180	27,901	1.00%	4.02%		28,462 28,462 28,462	
21 XN0601			Admin	26,302	26,041	25,783	26,041	25,783	1.00%			26,301 26,301 26,301	
22 XN0602			Admin	27,361	27,090	26,822	27,090	26,822	1.00%	4.03%		27,361 27,361 27,361	
23 XN0603			Admin	28,462	28,180	27,901	28,180	27,901	1.00%	4.02%		28,462 28,462 28,462	
24 XN0604			Admin	29,333	29,043	28,755	29,043	28,755	1.00%	3.06%		29,333 29,333 29,333	
25 XN0605			Admin	30,357	30,057	29,759	30,057	29,759	1.00%	3.49%		30,358 30,358 30,358	
26 XN0606			Admin	31,383	31,072	30,764	31,072	30,764	1.00%	3.38%		31,383 31,383 31,383	
27 XN0607			Admin	32,407	32,086	31,768	32,086	31,768	1.00%	3.26%		32,407 32,407 32,407	
28 XN0608			Admin	33,560	33,227	32,898	33,227	32,898	1.00%	3.56%		33,559 33,559 33,559	
29 XN0609			Admin	35,225	34,876	34,530	34,875	34,530	1.00%	4.96%		35,225 35,225 35,225	
26 XN0701			Admin	31,383	31,072	30,764	31,072	30,764	1.00%			31,383 31,383 31,383	
27 XN0702			Admin	32,407	32,086	31,768	32,086	31,768	1.00%	3.26%		32,407 32,407 32,407	
28 XN0703			Admin	33,560	33,227	32,898	33,227	32,898	1.00%	3.56%		33,559 33,559 33,559	
29 XN0704			Admin	35,225	34,876	34,530	34,875	34,530	1.00%	4.96%		35,225 35,225 35,225	
30 XN0705			Admin	36,250	35,891	35,536	35,891	35,536	1.00%	2.91%		36,250 36,250 36,250	
31 XN0706			Admin	37,403	37,032	36,666	37,033	36,666	1.00%	3.18%		37,402 37,402 37,402	
32 XN0707			Admin	38,683	38,300	37,921	38,300	37,921	1.00%	3.42%		38,683 38,683 38,683	
33 XN0708			Admin	40,028	39,632	39,239	39,631	39,239	1.00%	3.48%		40,028 40,028 40,028	
34 XN0709			Admin	41,373	40,964	40,558	40,964	40,558	1.00%	3.36%		40,964 40,964 40,964	
33 XN0801			Admin	40,028	39,632	39,239	39,631	39,239	1.00%			39,632 39,632 39,632	
34 XN0802			Admin	41,373	40,964	40,558	40,964	40,558	1.00%	3.36%		40,964 40,964 40,964	
35 XN0803			Admin	43,038	42,612	42,190	42,612	42,190	1.00%	4.02%		42,612 42,612 42,612	
36 XN0804			Admin	44,703	44,261	43,822	44,260	43,822	1.00%	3.87%		44,261 44,261 44,261	
37 XN0805			Admin	46,625	46,164	45,707	46,164	45,707	1.00%	4.30%		46,164 46,164 46,164	
38 XN0806			Admin	48,034	47,559	47,088	47,559	47,088	1.00%	3.02%		47,559 47,559 47,559	
37 XN0901			Admin	46,625	46,164	45,707	46,164	45,707	1.00%			46,164 46,164 46,164	
38 XN0902			Admin	48,034	47,559	47,088	47,559	47,088	1.00%	3.02%		47,559 47,559 47,559	
39 XN0903			Admin	50,467	49,968	49,473	49,968	49,473	1.00%	5.07%		49,968 49,968 49,968	
40 XN0904			Admin	53,285	52,757	52,235	52,757	52,235	1.00%	5.58%		52,757 52,757 52,757	
41 XN0905			Admin	56,104	55,548	54,998	55,548	54,998	1.00%	5.29%		55,548 55,548 55,548	
42 XN0906			Admin	57,640	57,069	56,504	57,069	56,504	1.00%	2.74%		57,069 57,069 57,069	
41 XN1001			Admin	56,104	55,548	54,998	55,548	54,998	1.00%			55,548 55,548 55,548	
42 XN1002			Admin	57,640	57,069	56,504	57,069	56,504	1.00%	2.74%		57,069 57,069 57,069	
43 XN1003			Admin	59,606	59,016	59,016	59,606	59,016	1.00%	3.41%		59,016 59,016 59,016	
44 XN1004			Admin	62,397	61,779	61,779	62,397	61,779	1.00%	4.68%		61,779 61,779 61,779	
45 XN1005			Admin	66,582	65,922	65,922	66,581	65,922	1.00%	6.71%		65,922 65,922 65,922	
46 XN1006			Admin	68,484	67,805	67,805	68,483	67,805	1.00%	2.86%		67,805 67,805 67,805	
45 XN1101			Admin	66,582	65,922	65,922	66,581	65,922	1.00%			65,922 65,922 65,922	

46 XN1102	Admin	68,484	67,805	67,805	68,483	67,805	1.00%	2.86%	67,805	67,805
47 XN1103	Admin	71,338	70,631	70,631	71,337	70,631	1.00%	4.17%	70,631	70,631
48 XN1104	Admin	74,825	74,084	74,084	74,825	74,084	1.00%	4.89%	74,084	74,084
49 XN1105	Admin	78,629	77,850	77,850	78,629	77,850	1.00%	5.08%	77,850	77,850
50 XN1106	Admin	82,434	81,618	81,618	82,434	81,618	1.00%	4.84%	81,618	81,618
49 XN1201	Admin	78,629	77,850	77,850	78,629	77,850	1.00%		77,850	77,850
50 XN1202	Admin	82,434	81,618	81,618	82,434	81,618	1.00%	4.84%	85,291	81,618
41 XN1203	Admin	86,390	85,535	85,535	86,390	85,535	1.00%	4.80%		85,535
52 XN1204	Admin	90,537	89,640	89,640	90,536	89,640	1.00%	4.80%		89,640
43 XN1205	Admin	94,883	93,944	93,944	94,883	93,944	1.00%	4.80%		93,944
54 XN1206	Admin	99,437	98,453	98,453	99,438	98,453	1.00%	4.80%		98,453
1 XR0101	Medical	0	14,294	14,437	14,294	14,294	1.00%		0	0
2 XR0102	Medical	15,251	15,100	14,653	14,800	14,653	1.00%		15,251	15,451
3 XR0103	Medical	15,516	15,363	15,013	15,163	15,013	1.00%	1.74%	15,517	15,717
1 XR0201	Medical	0	14,294	14,437	14,294	14,294	1.00%		0	0
2 XR0202	Medical	15,251	15,100	14,653	14,800	14,653	1.00%		15,251	15,451
3 XR0203	Medical	15,516	15,363	15,013	15,163	15,013	1.00%	1.74%	15,517	15,717
4 XR0204	Medical	15,944	15,786	15,432	15,586	15,432	1.00%	2.76%	15,944	16,144
5 XR0205	Medical	16,372	16,210	15,851	16,010	15,851	1.00%	2.68%	16,372	16,572
6 XR0206	Medical	16,800	16,633	16,271	16,434	16,271	1.00%	2.61%	16,799	16,999
7 XR0207	Medical	17,351	17,179	16,811	16,979	16,811	1.00%	3.28%	17,351	17,551
8 XR0208	Medical	17,978	17,800	17,425	17,599	17,425	1.00%	3.61%	17,978	18,178
6 XR0301	Medical	16,800	16,633	16,271	16,434	16,271	1.00%		16,799	16,999
7 XR0302	Medical	17,351	17,179	16,811	16,979	16,811	1.00%	3.28%	17,351	17,551
8 XR0303	Medical	17,978	17,800	17,425	17,599	17,425	1.00%	3.61%	17,978	17,978
9 XR0304	Medical	18,152	17,972	17,794	17,972	17,794	1.00%	0.97%	18,152	18,152
10 XR0305	Medical	18,653	18,468	18,285	18,468	18,285	1.00%	2.76%	18,653	18,653
11 XR0306	Medical	19,217	19,027	18,838	19,026	18,838	1.00%	3.02%	19,217	19,217
12 XR0307	Medical	19,655	19,461	19,268	19,461	19,268	1.00%	2.28%	19,656	19,656
11 XR0401	Medical	19,217	19,027	18,838	19,026	18,838	1.00%		19,217	19,217
12 XR0402	Medical	19,655	19,461	19,268	19,461	19,268	1.00%	2.28%	19,656	19,656
13 XR0403	Medical	20,348	20,147	19,947	20,146	19,947	1.00%	3.53%	20,348	20,348
14 XR0404	Medical	21,052	20,844	20,638	20,844	20,638	1.00%	3.46%	21,052	21,052
15 XR0405	Medical	21,692	21,477	21,265	21,478	21,265	1.00%	3.04%	21,692	21,692
16 XR0406	Medical	21,909	21,692	21,388	21,602	21,388	1.00%	1.00%	21,909	21,909
17 XR0407	Medical	22,458	22,236	22,016	22,236	22,016	1.00%	2.51%	22,458	22,458
16 XR0501	Medical	21,909	21,692	21,388	21,602	21,388	1.00%		21,909	21,909
17 XR0502	Medical	22,458	22,236	22,016	22,236	22,016	1.00%	2.51%	22,458	22,458
18 XR0503	Medical	23,363	23,132	22,903	23,132	22,903	1.00%	4.03%	23,363	23,363
19 XR0504	Medical	24,304	24,063	23,825	24,063	23,825	1.00%	4.03%	24,304	24,304
20 XR0505	Medical	25,298	25,047	24,799	25,047	24,799	1.00%	4.09%	25,297	25,297
21 XR0506	Medical	26,302	26,041	25,783	26,041	25,783	1.00%	3.97%	26,301	26,301
22 XR0507	Medical	27,361	27,090	26,822	27,090	26,822	1.00%	4.03%	27,361	27,361
23 XR0508	Medical	28,462	28,180	27,901	28,180	27,901	1.00%	4.02%	28,462	28,462
21 XR0601	Medical	26,302	26,041	25,783	26,041	25,783	1.00%		26,301	26,301
22 XR0602	Medical	27,361	27,090	26,822	27,090	26,822	1.00%	4.03%	27,361	27,361
23 XR0603	Medical	28,462	28,180	27,901	28,180	27,901	1.00%	4.02%	28,462	28,462
24 XR0604	Medical	29,333	29,043	28,755	29,043	28,755	1.00%	3.06%	29,333	29,333
25 XR0605	Medical	30,357	30,057	29,759	30,057	29,759	1.00%	3.49%	30,358	30,358
26 XR0606	Medical	31,383	31,072	30,764	31,072	30,764	1.00%	3.38%	31,383	31,383
27 XR0607	Medical	32,407	32,086	31,768	32,086	31,768	1.00%	3.26%	32,407	32,407
28 XR0608	Medical	33,560	33,227	32,898	33,227	32,898	1.00%	3.56%	33,559	33,559
29 XR0609	Medical	35,225	34,876	34,530	34,875	34,530	1.00%	4.96%	35,225	35,225
26 XR0701	Medical	31,383	31,072	30,764	31,072	30,764	1.00%		31,383	31,383
27 XR0702	Medical	32,407	32,086	31,768	32,086	31,768	1.00%	3.26%	32,407	32,407
28 XR0703	Medical	33,560	33,227	32,898	33,227	32,898	1.00%	3.56%	33,559	33,559
29 XR0704	Medical	35,225	34,876	34,530	34,875	34,530	1.00%	4.96%	35,225	35,225
30 XR0705	Medical	36,250	35,891	35,536	35,891	35,536	1.00%	2.91%	36,250	36,250
31 XR0706	Medical	37,403	37,032	36,666	37,033	36,666	1.00%	3.18%	37,402	37,402
32 XR0707	Medical	38,683	38,300	37,921	38,300	37,921	1.00%	3.42%	38,683	38,683
33 XR0708	Medical	40,028	39,632	39,239	39,631	39,239	1.00%	3.48%	40,028	40,028
34 XR0709	Medical	41,373	40,964	40,558	40,964	40,558	1.00%	3.36%	40,964	40,964
33 XR0801	Medical	40,028	39,632	39,239	39,631	39,239	1.00%		39,632	39,632
34 XR0802	Medical	41,373	40,964	40,558	40,964	40,558	1.00%	3.36%	40,964	40,964
35 XR0803	Medical	43,038	42,612	42,190	42,612	42,190	1.00%	4.02%	42,612	42,612
36 XR0804	Medical	44,703	44,261	43,822	44,260	43,822	1.00%	3.87%	44,261	44,261
37 XR0805	Medical	46,625	46,164	45,707	46,164	45,707	1.00%	4.30%	46,164	46,164
38 XR0806	Medical	48,034	47,559	47,088	47,559	47,088	1.00%	3.02%	47,559	47,559
37 XR0901	Medical	46,625	46,164	45,707	46,164	45,707	1.00%		46,164	46,164
38 XR0902	Medical	48,034	47,559	47,088	47,559	47,088	1.00%	3.02%	47,559	47,559
39 XR0903	Medical	50,467	49,968	49,473	49,968	49,473	1.00%	5.07%	49,968	49,968
40 XR0904	Medical	53,285	52,757	52,235	52,757	52,235	1.00%	5.58%	52,757	52,757
41 XR0905	Medical	56,104	55,548	54,998	55,548	54,998	1.00%	5.29%	55,548	55,548
42 XR0906	Medical	57,640	57,069	56,504	57,069	56,504	1.00%	2.74%	57,069	57,069
41 XR1001	Medical	56,104	55,548	54,998	55,548	54,998	1.00%		55,548	55,548

42 XR1002	Medical	57,640	57,069	56,504	57,069	56,504	1.00%	2.74%	57,069	57,069
43 XR1003	Medical	59,606	59,016	59,016	59,606	59,016	1.00%	3.41%	59,016	59,016
44 XR1004	Medical	62,397	61,779	61,779	62,397	61,779	1.00%	4.68%	61,779	61,779
45 XR1005	Medical	66,582	65,922	65,922	66,581	65,922	1.00%	6.71%	65,922	65,922
46 XR1006	Medical	68,484	67,805	67,805	68,483	67,805	1.00%	2.86%	67,805	67,805
45 XR1101	Medical	66,582	65,922	65,922	66,581	65,922	1.00%		65,922	65,922
46 XR1102	Medical	68,484	67,805	67,805	68,483	67,805	1.00%	2.86%	67,805	67,805
47 XR1103	Medical	71,338	70,631	70,631	71,337	70,631	1.00%	4.17%	70,631	70,631
48 XR1104	Medical	74,825	74,084	74,084	74,825	74,084	1.00%	4.89%	74,084	74,084
49 XR1105	Medical	78,629	77,850	77,850	78,629	77,850	1.00%	5.08%	77,850	77,850
50 XR1106	Medical	82,434	81,618	81,618	82,434	81,618	1.00%	4.84%	81,618	81,618
49 XR1201	Medical	78,629	77,850	77,850	78,629	77,850	1.00%		77,850	77,850
50 XR1202	Medical	82,434	81,618	81,618	82,434	81,618	1.00%	4.84%	81,618	81,618
41 XR1203	Medical	86,390	85,535	85,535	86,390	85,535	1.00%	4.80%	85,535	85,535
52 XR1204	Medical	90,537	89,640	89,640	90,536	89,640	1.00%	4.80%	89,640	89,640
43 XR1205	Medical	94,883	93,944	93,944	94,883	93,944	1.00%	4.80%	93,944	93,944
54 XR1206	Medical	99,437	98,453	98,453	99,438	98,453	1.00%	4.80%	98,453	98,453

not updated yet KC1000 Discretionary points ??

KC1001
KC1002
KC1003
KC1004
KC1005
KC1006
KC1007

KC1100
KC1101
KC1102
KC1103
KC1104

KC5702
KC5903
KC5904

KC1104

CPHM

LA5100 PCT Dental Service Dentist / Salari Community Dental Officer - Band 1

LA5101 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA5102 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA5103 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA5104 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA5105 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA5106 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA5107 Salaried Personal Dental Service D Community Dental Officer - Band 1

LA6100 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA6101 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA6102 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA6103 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA6104 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA6105 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA6106 Senior Dental Officer / Senior PCT Senior Dental Officer - Band 2

LA7100 Assistant Clinical Director of PCT D Assistant Clinical Director - Band 3

LA7101 Assistant Clinical Director of PCT D Assistant Clinical Director - Band 3

LA7102 Assistant Clinical Director of PCT D Assistant Clinical Director - Band 3

LA7103 Assistant Clinical Director of PCT D Assistant Clinical Director - Band 3

LA7104 Assistant Clinical Director of PCT C Assistant Clinical Director - Band 3

LA7105 Assistant Clinical Director of PCT C Assistant Clinical Director - Band 3

LA8100 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8101 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8102 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8103 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8104 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8105 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8106 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8107 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8108 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LA8109 Clinical Director of PCT Dental Ser Clinical Director - Band 4

LD0101 Dental Band A Salary Point 1

LD0102 Dental Band A Salary Point 2

LD0103 Dental Band A Salary Point 3

LD0104 Dental Band A Salary Point 4

LD0105 Dental Band A Salary Point 5

LD0106 Dental Band A Salary Point 6

LD0107 Dental Band A Salary Point 6

LD0108 Dental Band A Salary Point 6

LD1101 Dental Band B Salary Point 7a

LD1102 Dental Band B Salary Point 8

Pay scale no longer used
should now be LD

LD1103	Dental Band B Salary Point 9		0	
LD1104	Dental Band B Salary Point 10		0	
LD1105	Dental Band B Salary Point 11		0	
LD1106	Dental Band B Salary Point 12		0	
LD2101	Dental Band C Salary Point 13bc		0	
LD2102	Dental Band C Salary Point 14c		0	
LD2103	Dental Band C Salary Point 15c		0	
LD2104	Dental Band C Salary Point 16		0	
LD2105	Dental Band C Salary Point 17		0	
LD2106	Dental Band C Salary Point 18		0	
MC0100	Associate Specialist		0	
MC0101	Associate Specialist		0	
MC0102	Associate Specialist		0	
MC0103	Associate Specialist		0	
MC0104	Associate Specialist		0	
MC0105	Associate Specialist		0	
MC0106	Associate Specialist		0	
MC0107	Associate Specialist		0	
MC0200	Associate Specialist	Discretionary Points	0	
MC0201	Associate Specialist	Discretionary Points	0	
MC0202	Associate Specialist	Discretionary Points	0	
MC0203	Associate Specialist	Discretionary Points	0	
MC0204	Associate Specialist	Discretionary Points	0	
MC0205	Associate Specialist	Discretionary Points	0	
MC1000	Consultant Old Contract	Discretionary Points	0	
MC1001	Consultant Old Contract	Discretionary Points	0	
MC1002	Consultant Old Contract	Discretionary Points	0	
MC1003	Consultant Old Contract	Discretionary Points	0	
MC1004	Consultant Old Contract	Discretionary Points	0	
MC1005	Consultant Old Contract	Discretionary Points	0	
MC1006	Consultant Old Contract	Discretionary Points	0	
MC1007	Consultant Old Contract	Discretionary Points	0	
MC2100	Consultant Old Contract		0	
MC2101	Consultant Old Contract		0	
MC2102	Consultant Old Contract		0	
MC2103	Consultant Old Contract		0	
MC2104	Consultant Old Contract		0	
MC2200	Locum Consultant Old Contract		0	
MC3100	Locum Consultant New Contract	Paid Maximum Prior to Retirement	0	
MC4601	Specialty Doctor		0	
MC4602	Specialty Doctor		0	
MC4603	Specialty Doctor		0	
MC4604	Specialty Doctor		0	
MC4605	Specialty Doctor		0	
MC4606	Specialty Doctor		0	
MC4607	Specialty Doctor		0	
MC4608	Specialty Doctor		0	
MC4609	Specialty Doctor		0	
MC4610	Specialty Doctor		0	
MC4611	Specialty Doctor		0	
MC4612	Specialty Doctor		0	
MC4613	Specialty Doctor		0	
MC4614	Specialty Doctor		0	
MC4615	Specialty Doctor		0	
MC4616	Specialty Doctor		0	
MC4617	Specialty Doctor		0	
MC4618	Specialty Doctor		0	
MC51	Consultants appointed before 31 O 1 On transfer to new contract		0	
MC510*	Consultants appointed before 31 O 1 year after transfer		0	
MC5103	Consultants appointed before 31 O 2 years after transfer		0	
MC5104	Consultants appointed before 31 O 3 years after transfer		0	
MC5105	Consultants appointed before 31 O 4 years after transfer		0	
MC5106	Consultants appointed before 31 O 9 years after transfer		0	
MC5107	Consultants appointed before 31 O 14 years after transfer		0	
MC5108	Consultants appointed before 31 O 19 years after transfer		0	
MC52	Consultants appointed before 31 O 2 On transfer to new contract		0	
MC5102	Consultants appointed before 31 O 1 year after transfer		0	
MC4904	Consultants appointed before 31 O 2 years after transfer		0	
MC4805	Consultants appointed before 31 O 3 years after transfer		0	
MC4706	Consultants appointed before 31 O 8 years after transfer		0	
MC4607	Consultants appointed before 31 O 13 years after transfer		0	
MC4508	Consultants appointed before 31 O 18 years after transfer		0	
MC53	Consultants appointed before 31 O 3 On transfer to new contract		0	
MC530*	Consultants appointed before 31 O 1 year after transfer		0	
MC5304	Consultants appointed before 31 O 2 years after transfer		0	

MC6906	Consultants appointed before 31 Oct years completed as a consultant 0	0	
MC6907	Consultants appointed before 31 Oct years completed as a consultant 1	0	
MC6908	Consultants appointed before 31 Oct years completed as a consultant 2	0	
MC70	Consultants appointed before 31 Oct years completed as a consultant 3	0	
MC7006	Consultants appointed before 31 Oct years completed as a consultant 4	0	
MC7007	Consultants appointed before 31 Oct years completed as a consultant 5	0	
MC7008	Consultants appointed before 31 Oct years completed as a consultant 6	0	
MC7009	Consultants appointed before 31 Oct years completed as a consultant 7	0	
MC7010	Consultants appointed before 31 Oct years completed as a consultant 8	0	
MC7001	Consultants appointed before 31 Oct years completed as a consultant 9	0	
MC7011	Consultants appointed before 31 Oct years completed as a consultant 10	0	
MC7012	Consultants appointed before 31 Oct years completed as a consultant 11	0	
MC7013	Consultants appointed before 31 Oct years completed as a consultant 12	0	
MC7014	Consultants appointed before 31 Oct years completed as a consultant 13	0	
MC7015	Consultants appointed before 31 Oct years completed as a consultant 14	0	
MC7016	Consultants appointed before 31 Oct years completed as a consultant 15	0	
MC7017	Consultants appointed before 31 Oct years completed as a consultant 16	0	
MC7018	Consultants appointed before 31 Oct years completed as a consultant 17	0	
MC7019	Consultants appointed before 31 Oct years completed as a consultant 18	0	
YM7200	Consultants appointed before 31 Oct years completed as a consultant 19	0	
YM7201	Consultants appointed after 31 Oct years completed as a consultant 0	0	
YM7202	Consultants appointed after 31 Oct years completed as a consultant 1	0	
YM7203	Consultants appointed after 31 Oct years completed as a consultant 2	0	
YM7204	Consultants appointed after 31 Oct years completed as a consultant 3	0	
YM7205	Consultants appointed after 31 Oct years completed as a consultant 4	0	
YM7206	Consultants appointed after 31 Oct years completed as a consultant 5	0	
YM7207	Consultants appointed after 31 Oct years completed as a consultant 6	0	
YM7208	Consultants appointed after 31 Oct years completed as a consultant 7	0	
YM7209	Consultants appointed after 31 Oct years completed as a consultant 8	0	
YM7210	Consultants appointed after 31 Oct years completed as a consultant 9	0	
YM7211	Consultants appointed after 31 Oct years completed as a consultant 10	0	
YM7212	Consultants appointed after 31 Oct years completed as a consultant 11	0	
YM7213	Consultants appointed after 31 Oct years completed as a consultant 12	0	
YM7214	Consultants appointed after 31 Oct years completed as a consultant 13	0	
YM7215	Consultants appointed after 31 Oct years completed as a consultant 14	0	
YM7216	Consultants appointed after 31 Oct years completed as a consultant 15	0	
YM7217	Consultants appointed after 31 Oct years completed as a consultant 16	0	
YM7218	Consultants appointed after 31 Oct years completed as a consultant 17	0	
YM7219	Consultants appointed after 31 Oct years completed as a consultant 18	0	
YM7200	Consultants appointed after 31 Oct years completed as a consultant 19	0	
MH0100	Staff Grade Practitioner	Old Contract	0
MH0101	Staff Grade Practitioner	Old Contract	0
MH0102	Staff Grade Practitioner	Old Contract	0
MH0103	Staff Grade Practitioner	Old Contract	0
MH0104	Staff Grade Practitioner	Old Contract	0
MH0105	Staff Grade Practitioner	Old Contract	0
MH0106	Staff Grade Practitioner	Old Contract	0
MH0107	Staff Grade Practitioner	Old Contract	0
MH0300	Staff Grade Practitioner	New Contract	0
MH0301	Staff Grade Practitioner	New Contract	0
MH0302	Staff Grade Practitioner	New Contract	0
MH0303	Staff Grade Practitioner	New Contract	0
MH0304	Staff Grade Practitioner	New Contract	0
MH0305	Staff Grade Practitioner	New Contract	0
MH0500	Staff Grade Practitioner	New Contract Optional Points	0
MH0501	Staff Grade Practitioner	New Contract Optional Points	0
MH0502	Staff Grade Practitioner	New Contract Optional Points	0
MH0503	Staff Grade Practitioner	New Contract Optional Points	0
MH0504	Staff Grade Practitioner	New Contract Optional Points	0
MH0505	Staff Grade Practitioner	New Contract Optional Points	0
MN0100	House Officer with provisional		0
MN0101	House Officer		0
MN1100			0
MN1101			0
MN1102			0

MN2100	Senior House Officer			0
MN2101				0
MN2102				0
MN2103				0
MN2104				0
MN2105				0
MN2106				0
MN2500	Specialist Registrar	Senior House Officer	Senior House Officer	0
MN2501				0
MN2502				0
MN2503				0
MN2504				0
MN2505				0
MN2506				0
MN2507				0
MN2508				0
MN3100	Registrar			0
MN3101				0
MN3102				0
MN3103				0
MN3104				0
MN4100	Senior Registrar			0
MN4101				0
MN4102				0
MN4103				0
MN4104				0
MN4105				0
NP0600	Nurse Grade A			0
NP0601	Nurse Grade A			0
NP0602	Nurse Grade A			0
NP0603	Nurse Grade A			0
NP0604	Nurse Grade A			0
NP0605	Nurse Grade A			0
NP0606	Nurse Grade A			0
NP1600	Nurse Grade B			0
NP1601	Nurse Grade B			0
NP1602	Nurse Grade B			0
NP1603	Nurse Grade B			0
NP1604	Nurse Grade B			0
NP2100	Nurse Grade C			0
NP2101	Nurse Grade C			0
NP2102	Nurse Grade C			0
NP2103	Nurse Grade C			0
NP2104	Nurse Grade C			0
NP2105	Nurse Grade C			0
NP2106	Nurse Grade C			0
NP2600	Nurse Grade D			0
NP2601	Nurse Grade D			0
NP2602	Nurse Grade D			0
NP2603	Nurse Grade D			0
NP3100	Nurse Grade D			0
NP3101	Nurse Grade D			0
NP3102	Nurse Grade D			0
NP3103	Nurse Grade D			0
NP3600	Nurse Grade E			0
NP3601	Nurse Grade E			0
NP3602	Nurse Grade E			0
NP3603	Nurse Grade E			0
NP3604	Nurse Grade E			0
NP3605	Nurse Grade E			0
NP4100	Nurse Grade F			0
NP4101	Nurse Grade F			0
NP4102	Nurse Grade F			0
NP4103	Nurse Grade F			0
NP4104	Nurse Grade F			0
NP4105	Nurse Grade F			0
NP4106	Nurse Grade F			0
NP4300	Nurse Grade F (Discretionary)			0
NP4301	Nurse Grade F (Discretionary)			0
NP4600	Nurse Grade G			0
NP4601	Nurse Grade G			0
NP4602	Nurse Grade G			0
NP4603	Nurse Grade G			0
NP4604	Nurse Grade G			0
NP4605	Nurse Grade G			0

NP4800	Nurse Grade G (Discretionary)	0
NP4801	Nurse Grade G (Discretionary)	0
NP5100	Nurse Grade H	0
NP5101	Nurse Grade H	0
NP5102	Nurse Grade H	0
NP5103	Nurse Grade H	0
NP5104	Nurse Grade H	0
NP5105	Nurse Grade H	0
NP5300	Nurse Grade H (Discretionary)	0
NP5301	Nurse Grade H (Discretionary)	0
NP5600	Nurse Grade I	0
NP5601	Nurse Grade I	0
NP5602	Nurse Grade I	0
NP5603	Nurse Grade I	0
NP5604	Nurse Grade I	0
NP5605	Nurse Grade I	0
NP5700	Nurse Grade I (Discretionary)	0
NP5701	Nurse Grade I (Discretionary)	0

not updated yet

no new scales available as at 10-05-12

increased by 1 %

Grade/Scale		SCP	ANNUAL 1-Apr-16	MTHLY 1-Apr-16	HRLY RATE 1-Apr-16	Emps NI IN LGPS	Emps NI NOT LGPS	Super 19.0%	TOTAL IN LGPS	TOTAL NOT LGPS
N/A		5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Scale 1	Scale 2	6	14,514	1,209.50	7.52	891	891	2,758	18,162	15,405
		7	14,615	1,217.92	7.58	905	905	2,777	18,296	15,520
		8	14,771	1,230.92	7.66	926	926	2,806	18,504	15,697
		9	14,975	1,247.92	7.76	954	954	2,845	18,775	15,929
		10	15,238	1,269.83	7.90	991	991	2,895	19,124	16,229
		11	15,507	1,292.25	8.04	1,028	1,028	2,946	19,481	16,535
		12	15,823	1,318.58	8.20	1,071	1,071	3,006	19,901	16,894
		13	16,191	1,349.25	8.39	1,122	1,122	3,076	20,389	17,313
		14	16,481	1,373.42	8.54	1,162	1,162	3,131	20,774	17,643
		15	16,772	1,397.67	8.69	1,202	1,202	3,187	21,161	17,974
Scale 3	Scale 4	16	17,169	1,430.75	8.90	1,257	1,257	3,262	21,688	18,426
		17	17,547	1,462.25	9.10	1,309	1,309	3,334	22,190	18,856
		18	17,891	1,490.96	9.27	1,357	1,357	3,399	22,648	19,248
		19	18,560	1,546.67	9.62	1,449	1,449	3,526	23,535	20,009
		20	19,239	1,603.21	9.97	1,543	1,543	3,655	24,436	20,781
		21	19,939	1,661.62	10.34	1,639	1,639	3,788	25,367	21,579
		22	20,456	1,704.63	10.60	1,711	1,711	3,887	26,053	22,166
		23	21,057	1,754.77	10.91	1,794	1,794	4,001	26,852	22,851
		24	21,746	1,812.15	11.27	1,889	1,889	4,132	27,766	23,634
		25	22,434	1,869.52	11.63	1,984	1,984	4,263	28,680	24,418
Scale 6	SO1	26	23,166	1,930.51	12.01	2,085	2,085	4,402	29,652	25,251
		27	23,935	1,994.59	12.41	2,191	2,191	4,548	30,674	26,126
		28	24,717	2,059.71	12.81	2,299	2,299	4,696	31,711	27,015
		29	25,694	2,141.17	13.32	2,433	2,433	4,882	33,009	28,128
		30	26,556	2,212.99	13.76	2,552	2,552	5,046	34,154	29,108
		31	27,394	2,282.84	14.20	2,668	2,668	5,205	35,267	30,062
		32	28,203	2,350.28	14.62	2,780	2,780	5,359	36,342	30,983
		33	29,033	2,419.44	15.05	2,894	2,894	5,516	37,444	31,928
		34	29,854	2,487.82	15.47	3,008	3,008	5,672	38,534	32,861
		35	30,479	2,539.95	15.80	3,094	3,094	5,791	39,364	33,573
Band 4	SO2	36	31,288	2,607.30	16.22	3,205	3,205	5,945	40,438	34,493
		37	32,164	2,680.33	16.67	3,326	3,326	6,111	41,601	35,490
		38	33,105	2,758.78	17.16	3,456	3,456	6,290	42,852	36,562
		39	34,195	2,849.62	17.72	3,607	3,607	6,497	44,299	37,802
		40	35,093	2,924.45	18.19	3,731	3,731	6,668	45,492	38,824
		41	36,018	3,001.52	18.67	3,858	3,858	6,843	46,720	39,877
		42	36,937	3,078.08	19.15	3,985	3,985	7,018	47,940	40,922
		43	37,858	3,154.81	19.62	4,112	4,112	7,193	49,163	41,970
		44	38,789	3,232.40	20.11	4,241	4,241	7,370	50,399	43,029
		45	39,660	3,305.00	20.56	4,361	4,361	7,535	51,556	44,021
Band 3	SO3	46	40,619	3,384.91	21.05	4,493	4,493	7,718	52,830	45,112
		47	41,551	3,462.58	21.54	4,622	4,622	7,895	54,067	46,173
		48	42,474	3,539.48	22.02	4,749	4,749	8,070	55,293	47,223
		49	43,386	3,615.52	22.49	4,875	4,875	8,243	56,505	48,261
		50	44,417	3,701.45	23.02	5,017	5,017	8,439	57,874	49,435
		51	45,419	3,784.89	23.54	5,156	5,156	8,630	59,204	50,574
		52	46,429	3,869.10	24.07	5,295	5,295	8,822	60,546	51,724
		53	47,447	3,953.92	24.59	5,435	5,435	9,015	61,897	52,882
		54	48,470	4,039.16	25.12	5,577	5,577	9,209	63,256	54,047
		55	49,487	4,123.89	25.65	5,717	5,717	9,402	64,606	55,204
Band 2	Band 1	56	50,504	4,208.71	26.18	5,857	5,857	9,596	65,958	56,362
		57	51,518	4,293.18	26.70	5,997	5,997	9,788	67,304	57,515
		58	52,542	4,378.51	27.23	6,139	6,139	9,983	68,664	58,681
		59	53,551	4,462.55	27.76	6,278	6,278	10,175	70,003	59,828
		60	54,569	4,547.45	28.28	6,418	6,418	10,368	71,356	60,988
		61	55,638	4,636.47	28.84	6,566	6,566	10,571	72,775	62,203
		62	56,696	4,724.64	29.39	6,712	6,712	10,772	74,180	63,407
		63	57,767	4,813.93	29.94	6,860	6,860	10,976	75,603	64,627
		64	58,834	4,902.87	30.50	7,007	7,007	11,179	77,020	65,841
		65	59,900	4,991.64	31.05	7,154	7,154	11,381	78,435	67,054
		66	60,964	5,080.33	31.60	7,301	7,301	11,583	79,848	68,265

2,037,247 213,291 387,077 2,637,614 2,250,537

INCREMENTAL PROGRESSION MISSES OUT SCPs 7 and 9.

Pro-Rata Adjustment							
Contracted Hours = 37.0							
66	60,964	5,080.33	31.60	7,301	7,301	11,583	79,848
Non-NJC Pay							
75,000 6,250.00 9,238 9,238 14,250 98,488 84,238							

Appendix 4 - Costing Summary

INTERMEDIATE TIER - FUNDING SUMMARY

Recurrent Funding Required:

	2016/17	2017/18	2018/19	2019/20	2020/21
Workforce recurrent	£5,571,868	£6,071,502	£9,106,125	£9,109,653	£8,657,752
Workforce efficiency (5%) per annum from 19/20				-£455,483	-£432,888
Beds	£6,560,489	£6,060,855	£5,010,013	£5,010,013	£5,010,013
Total	£12,132,357	£12,132,357	£14,116,138	£13,664,183	£13,234,878

Transitional Funding Required:

Workforce and beds transitional funding	£1,838,534	£2,521,469	£473,492	£0	£0
Total	£1,838,534	£2,521,469	£473,492	£0	£0

Total Funding Required:

£13,970,891	£14,653,826	£14,589,630	£13,664,183	£13,234,878
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Indicative Proposed Resourcing:

Workforce and Beds baseline cash limit	£12,132,357	£12,132,357	£12,132,357	£12,132,357	£12,132,357
Transformation Fund	£1,061,234	£2,521,469	£473,492		
Better Care Fund		£605,000			
Base Budget Foundation Trust		£172,300			
Additional Funding from Stockport Together			£1,983,781	£1,531,826	£1,102,521
Total	£13,970,891	£14,653,826	£14,589,630	£13,664,183	£13,234,878

Assumptions:

Assumed new workforce profiled in stages in 2017/18, all in place for 2018/19

2017/18 'recurrent funding required' realigned saving from beds into workforce prior to calculating transitional fund ask.

2018/19 'Transitional funding required' £473k reflects decreased bed capacity but full new workforce in place recurrently, therefore funding from Transformation Fu

Note:

Indicative Proposed Resourcing needs agreement from Locality Finance Group

Workforce based on top of scale inclusive of oncosts

Any additional enhancement from weekend / overnight working are not currently costed in the plan other than for Night Support Workers and Mental health worker

Analysis does not include £1.500m saving required from the Council aligned to Intermediate Tier from 15/16 savings plan

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Title: Intermediate Tier - Transformation Funding (Oct 16 to Mar 17)

23rd Sept 16

Post	Band/Scale	WTE	16/17 Costs (£ 6 months, mid point scale)	Comments	start date	recurrent from 17/18
Intermediate Tier Hub (SPA)	Awaiting Mastercall, CCG commissioning for 6-12 months		288,968	Meeting with Mastercall 22nd Sept. They will undertake HUB function, commissioned by CCG. Initially an 8-8 model 7 days a week	11th Nov 16	Need to await costs from Mastercall but will be recurrent Y
IM&T to enable Hub	Enabler Function			Software to access health and social care information and support patient data flow - in IM&T enabler bid?		
Crisis Response - Cars/Equipment/Staffing	Awaiting Mastercall, CCG commissioning for 6-12 months		as above	Total 2 cars in first 6 months (2 cars in days & 1 car at night) - see cars & equipment tab for breakdown: cars (£ 14,707) and 3 observation bags (£ 9084) Following Meeting with Mastercall they will support this function, commissioned by CCG. Awaiting Costs. 8-8 model 7 days a week	11th Nov 16	Awaiting costs from Mastercall but will be recurrent Y
Training Costs for Health Element of Crisis Response	Course is £800 to train each individual		2,400		31st Oct 16	N
Crisis Response	Enabler Function			5 mobile devices with SHCR software and potentially EMIS viewer - IM&T to decide what device	11th Nov 16	Contract will be recurrent Y
CAIR	Current Team are not commissioned recurrently	PG to discuss with JE	tbd	Current out turn forecast £ 740K for a year (recurrent work force for Intermediate Tier) - for finance to agree funding for that i.e transformation fund, BCF	Already operational	Y
Clinical Practitioner Rapid Response funding to be verified	NHS (B6)			To operate new crisis response in car (2 cars in days & 1 car at night) - assumed can use of existing staff (CAIR & RR teams) - Continuation of non-recurrent Rapid Response budget needed in 17/18, although staff will now work 7 days, 8-8 model		Y
Mental Health Practitioner	NHS (B6)	2.00	35,348	Based on MH liaison model arrangement dedicated to Intermediate Tier	01.12.2016	Y
Hydration service	n/a	n/a		Based on costings provided by SRG proposal: to avoid 6 admissions per week based on 3 people being on service over 72 hours with 2 rehydration visits per day - 6 months provided by Mastercall, after April recurrent IT provision. Not currently supported by SRG.	1swt April 16	Provided by Intermediate Tier after April 17 and will be recurrent
Active Recovery	NHS OT (B6)	1.00	29,360	for step up and step down support beds and home 7 day service. Working up to 10pm	01.11.2016	Y
	NHS physio (B5)	1.00	23,725	for step up and step down support beds and home, 7 day service. Working up to 10pm	01.11.2016	Y
	1 Social Worker	1.00	12,876	for step up and step down support beds and home, 7 day service. Working up to 10pm	01.11.2016	Y
Computers for Active Recovery Base	31 computers Enabler Function			This is dependant on how many computers the existing staff will move with to their new base, Paul need to discuss with you on Tuesday		
Additional night support	Level 3 SC with night and weekend increments	8.00	127,408	Additional night sitters to support people at home . Night enhancements	01.11.2016	Y
Scheduler for night support	Level 3 SC	1.00	11,768		01.11.16	Y
Discharge to assess staff	8a Pharmacist	1.00	23,417	To support Early supported Discharge	01.11.16	Y
Pharmacy Technician	6	1.00	15,750		01.12.16	
	Band 3 Admin Enabler Function	1.00	10,042	To support Early supported Discharge	1.11.16	Y
Mobile phones	Enabler Function			33: 5 crisis support, 8 night support, 17 community rehabilitation workers, 3 additional staff Active Recovery - included in IM&T enabler?		
Additional Intermediate Tier beds (block contract) Breakdown below	10 Beds and GP Cover	n/a	238,941	Additional bed capacity (Step up/Assessment) to enable shift in activity & enable D2A model: 10 beds GPwith cover: 24 weeks start 24 October 2016 with 2 weeks in April to cover length of stay of final admitted patients (£234,000 block contract) + GP cover (£8640)	24.10.2016	N
Uniforms	n/a		0	average costs £30 per uniform * 300 staff members (200 FTE) * set of 5?		
Marketing/promotion materials	n/a		0			
Temporary Social Workers Crisis response (Agency)			50,000			
HSW Support			79,659	Jan to March funding of HSW 12 posts and travel		
Balance			4,964			
	Total WTE	17.00	954,626			

Additional requirements outside of Intermediate Tier:

1. Extra long term care package capacity in market place **Critical to enable flow~**

2. Costings are excluding SRG investments in extra capacity in home care market, reach community capacity to support new way of working in home care market

3. Overview is only regarding intermediate tier - not total boroughwide services

Title: Support for Discharge - Transformation Funding 16/17 (Part Year)

Post/item	FTE	Budget 2016.17
VS Support for Discharge		
WIN Coordinator	2.00	23,333
TPA Key workers	4.00	37,921
Support Workers	3.00	23,750
Non Pay		21,604
Total	9.00	106,608

17/18 Comments

New workforce requirement	£9,290,148 If all posts were filled by April 2017
Baseline Cash Limit	<u>£5,571,868</u>
Additional workforce cost	£3,718,280

Recruitment profile for 17/18

50% recruited April 2017	£1,859,140 Some posts already in place but funding was non recurrent
25% recruited July 17	£697,178
25% recruited October 17	<u>£464,785</u>
Requirement for 17/18	£3,021,103
Contribution from beds reduction	£499,634
Balance from Transformation Fund	<u>£2,521,469</u>
	£3,021,103

2016/17 Payscale with Oncosts

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17
2	1.00	XN0202	15,251	2,181	992	18,424
3	1.00	XN0203	15,516	2,219	1,029	18,764
4	1.00	XN0204	15,944	2,280	1,088	19,312
5	1.00	XN0205	16,372	2,341	1,147	19,860
6	1.00	XN0206	16,800	2,402	1,206	20,409
7	1.00	XN0207	17,351	2,481	1,282	21,114
8	1.00	XN0208	17,978	2,571	1,369	21,918
6	1.00	XN0301	16,800	2,402	1,206	20,409
7	1.00	XN0302	17,351	2,481	1,282	21,114
8	1.00	XN0303	17,978	2,571	1,369	21,918
9	1.00	XN0304	18,152	2,596	1,393	22,140
10	1.00	XN0305	18,653	2,667	1,462	22,782
11	1.00	XN0306	19,217	2,748	1,540	23,505
12	1.00	XN0307	19,655	2,811	1,600	24,666
11	1.00	XN0401	19,217	2,748	1,540	23,505
12	1.00	XN0402	19,655	2,811	1,600	24,666
13	1.00	XN0403	20,348	2,910	1,696	24,954
14	1.00	XN0404	21,052	3,010	1,793	25,855
15	1.00	XN0405	21,692	3,102	1,881	26,675
16	1.00	XN0406	21,909	3,133	1,911	26,953
17	1.00	XN0407	22,458	3,211	1,987	27,656
16	1.00	XN0501	21,909	3,133	1,911	26,953
17	1.00	XN0502	22,458	3,211	1,987	27,656
18	1.00	XN0503	23,363	3,341	2,112	28,816
19	1.00	XN0504	24,304	3,475	2,242	30,021
20	1.00	XN0505	25,298	3,618	2,379	31,294
21	1.00	XN0506	26,302	3,761	2,517	32,581
22	1.00	XN0507	27,361	3,913	2,664	33,937
23	1.00	XN0508	28,462	4,070	2,815	35,348
21	1.00	XN0601	26,302	3,761	2,517	32,581
22	1.00	XN0602	27,361	3,913	2,664	33,937
23	1.00	XN0603	28,462	4,070	2,815	35,348
24	1.00	XN0604	29,333	4,195	2,936	36,463
25	1.00	XN0605	30,357	4,341	3,077	37,775
26	1.00	XN0606	31,383	4,488	3,219	39,089
27	1.00	XN0607	32,407	4,634	3,360	40,401
28	1.00	XN0608	33,560	4,799	3,519	41,878
29	1.00	XN0609	35,225	5,037	3,749	44,011
26	1.00	XN0701	31,383	4,488	3,219	39,089
27	1.00	XN0702	32,407	4,634	3,360	40,401
28	1.00	XN0703	33,560	4,799	3,519	41,878
29	1.00	XN0704	35,225	5,037	3,749	44,011
30	1.00	XN0705	36,250	5,184	3,890	45,324
31	1.00	XN0706	37,403	5,349	4,049	46,801
32	1.00	XN0707	38,683	5,532	4,226	48,441
33	1.00	XN0708	40,028	5,724	4,412	50,164
34	1.00	XN0709	41,373	5,916	4,597	51,887
33	1.00	XN0801	40,028	5,724	4,412	50,164
34	1.00	XN0802	41,373	5,916	4,597	51,887
35	1.00	XN0803	43,038	6,154	4,827	54,019
36	1.00	XN0804	44,703	6,393	5,057	56,152
37	1.00	XN0805	46,625	6,667	5,322	58,614
38	1.00	XN0806	48,034	6,869	5,516	60,419
37	1.00	XN0901	46,625	6,667	5,322	58,614
38	1.00	XN0902	48,034	6,869	5,516	60,419
39	1.00	XN0903	50,467	7,217	5,852	63,536
40	1.00	XN0904	53,285	7,620	6,241	67,146
41	1.00	XN0905	56,104	8,023	6,630	70,757
42	1.00	XN0906	57,640	8,243	6,842	72,725
41	1.00	XN1001	56,104	8,023	6,630	70,757
42	1.00	XN1002	57,640	8,243	6,842	72,725
43	1.00	XN1003	59,606	8,524	7,113	75,243
44	1.00	XN1004	62,397	8,923	7,499	78,818
45	1.00	XN1005	66,582	9,521	8,076	84,179
46	1.00	XN1006	68,484	9,793	8,339	86,616
45	1.00	XN1101	66,582	9,521	8,076	84,179
46	1.00	XN1102	68,484	9,793	8,339	86,616
47	1.00	XN1103	71,338	10,201	8,732	90,272
48	1.00	XN1104	74,825	10,700	9,214	94,739
49	1.00	XN1105	78,629	11,244	9,739	99,611
50	1.00	XN1106	82,434	11,788	10,264	104,486
49	1.00	XN1201	78,629	11,244	9,739	99,611
50	1.00	XN1202	82,434	11,788	10,264	104,486
41	1.00	XN1203	86,390	12,354	10,810	109,553
52	1.00	XN1204	90,537	12,947	11,382	114,866
43	1.00	XN1205	94,883	13,568	11,982	120,433
54	1.00	XN1206	99,437	14,219	12,610	126,267

Hourly Rate / Costs

Spine Point	wte	Pay Scale	Basic Pay	Superann	NI	Gross Cost 16/17
2	1.00	XN0202	7.80	1.12	0.51	9.42
3	1.00	XN0203	7.94	1.13	0.53	9.60
4	1.00	XN0204	8.15	1.17	0.56	9.88
5	1.00	XN0205	8.37	1.20	0.59	10.16
6	1.00	XN0206	8.59	1.23	0.62	10.44
7	1.00	XN0207	8.87	1.27	0.66	10.80
8	1.00	XN0208	9.19	1.31	0.70	11.21
6	1.00	XN0301	8.59	1.23	0.62	10.44
7	1.00	XN0302	8.87	1.27	0.66	10.80
8	1.00	XN0303	9.19	1.31	0.70	11.21
9	1.00	XN0304	9.28	1.33	0.71	11.32
10	1.00	XN0305	9.54	1.36	0.75	11.65
11	1.00	XN0306	9.83	1.41	0.79	12.02
12	1.00	XN0307	10.05	1.44	0.82	12.31
11	1.00	XN0401	9.83	1.41	0.79	12.02
12	1.00	XN0402	10.05	1.44	0.82	12.31
13	1.00	XN0403	10.41	1.49	0.87	12.76
14	1.00	XN0404	10.77	1.54	0.92	13.22
15	1.00	XN0405	11.09	1.59	0.96	13.64
16	1.00	XN0406	11.20	1.60	0.98	13.78
17	1.00	XN0407	11.49	1.64	1.02	14.14
16	1.00	XN0501	11.20	1.60	0.98	13.78
17	1.00	XN0502	11.49	1.64	1.02	14.14
18	1.00	XN0503	11.95	1.71	1.08	14.74
19	1.00	XN0504	12.43	1.78	1.15	15.35
20	1.00	XN0505	12.94	1.85	1.22	16.00
21	1.00	XN0506	13.45	1.92	1.29	16.66
22	1.00	XN0507	13.99	2.00	1.36	17.36
23	1.00	XN0508	14.56	2.08	1.44	18.08
21	1.00	XN0601	13.45	1.92	1.29	16.66
22	1.00	XN0602	13.99	2.00	1.36	17.36
23	1.00	XN0603	14.56	2.08	1.44	18.08
24	1.00	XN0604	15.00	2.15	1.50	18.65
25	1.00	XN0605	15.52	2.22	1.57	19.32
26	1.00	XN0606	16.05	2.30	1.65	19.99
27	1.00	XN0607	16.57	2.37	1.72	20.66
28	1.00	XN0703	17.16	2.45	1.80	21.42
29	1.00	XN0704	18.01	2.58	1.92	22.51
30	1.00	XN0705	18.54	2.65	1.99	23.18
31	1.00	XN0706	19.13	2.74	2.07	23.93
32	1.00	XN0707	19.78	2.83	2.16	24.77
33	1.00	XN0708	20.47	2.93	2.26	25.65
34	1.00	XN0709	21.16	3.03	2.35	26.54
33	1.00	XN0801	20.47	2.93	2.26	25.65
34	1.00	XN0802	21.16	3.03	2.35	26.54
35	1.00	XN0803	22.01	3.15	2.47	27.63
36	1.00	XN0804	22.86	3.27	2.59	28.72
37	1.00	XN0805	23.84	3.41	2.72	29.98
38	1.00	XN0806	24.57	3.51	2.82	30.90
37	1.00	XN0901	23.84	3.41	2.72	29.98
38	1.00	XN0902	24.57	3.51	2.82	30.90
39	1.00	XN0903	25.81	3.69	2.99	32.49
40	1.00	XN0904	27.25	3.90	3.19	34.34
41	1.00	XN0905	28.69	4.10	3.39	36.19
42	1.00	XN0906	29.48	4.22	3.50	37.19
43	1.00	XN1003	30.48	4.36	3.64	38.48
44	1.00	XN1004	31.91	4.56	3.83	40.31
45	1.00	XN1005	34.05	4.87	4.13	43.05
46	1.00	XN1006	35.02	5.01	4.26	44.30
45	1.00	XN1101	34.05	4.87	4.13	43.05
46	1.00	XN1102	35.02	5.01	4.26	44.30
47	1.00	XN1103	36.48	5.22	4.47	46.17
48	1.00	XN1104	38.27	5.47	4.71	48.45
49	1.00	XN1105	40.21	5.75	4.98	50.94
50	1.00	XN1106	42.16	6.03	5.25	53.44
49	1.00	XN1201	40.21	5.75	4.98	50.94
50	1.00	XN1202	42.16	6.03	5.25	53.44
41	1.00	XN1203	44.18	6.32	5.53	56.03
52	1.00	XN1204	46.30	6.62	5.82	58.74
43	1.00	XN1205	48.52	6.94	6.13	61.59
54	1.00	XN1206	50.85	7.27	6.45	64.57

2016/17 Payscale with Oncosts

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increased by 1 %

Grade/Scale		SCP	ANNUAL 1-Apr-16	MTHLY 1-Apr-16	HRLY RATE 1-Apr-16	Emps NI IN LGPS	Emps NI NOT LGPS	Super 19.0%	TOTAL IN LGPS	TOTAL NOT LGPS
N/A		5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Scale 1	Scale 2	6	14,514	1,209.50	7.52	891	891	2,758	18,162	15,405
		7	14,615	1,217.92	7.58	905	905	2,777	18,296	15,520
		8	14,771	1,230.92	7.66	926	926	2,806	18,504	15,697
		9	14,975	1,247.92	7.76	954	954	2,845	18,775	15,929
		10	15,238	1,269.83	7.90	991	991	2,895	19,124	16,229
		11	15,507	1,292.25	8.04	1,028	1,028	2,946	19,481	16,535
		12	15,823	1,318.58	8.20	1,071	1,071	3,006	19,901	16,894
		13	16,191	1,349.25	8.39	1,122	1,122	3,076	20,389	17,313
		14	16,481	1,373.42	8.54	1,162	1,162	3,131	20,774	17,643
		15	16,772	1,397.67	8.69	1,202	1,202	3,187	21,161	17,974
Scale 3	Scale 4	16	17,169	1,430.75	8.90	1,257	1,257	3,262	21,688	18,426
		17	17,547	1,462.25	9.10	1,309	1,309	3,334	22,190	18,856
		18	17,891	1,490.96	9.27	1,357	1,357	3,399	22,648	19,248
		19	18,560	1,546.67	9.62	1,449	1,449	3,526	23,535	20,009
		20	19,239	1,603.21	9.97	1,543	1,543	3,655	24,436	20,781
		21	19,939	1,661.62	10.34	1,639	1,639	3,788	25,367	21,579
		22	20,456	1,704.63	10.60	1,711	1,711	3,887	26,053	22,166
		23	21,057	1,754.77	10.91	1,794	1,794	4,001	26,852	22,851
		24	21,746	1,812.15	11.27	1,889	1,889	4,132	27,766	23,634
		25	22,434	1,869.52	11.63	1,984	1,984	4,263	28,680	24,418
Scale 6	SO1	26	23,166	1,930.51	12.01	2,085	2,085	4,402	29,652	25,251
		27	23,935	1,994.59	12.41	2,191	2,191	4,548	30,674	26,126
		28	24,717	2,059.71	12.81	2,299	2,299	4,696	31,711	27,015
		29	25,694	2,141.17	13.32	2,433	2,433	4,882	33,009	28,128
		30	26,556	2,212.99	13.76	2,552	2,552	5,046	34,154	29,108
		31	27,394	2,282.84	14.20	2,668	2,668	5,205	35,267	30,062
		32	28,203	2,350.28	14.62	2,780	2,780	5,359	36,342	30,983
		33	29,033	2,419.44	15.05	2,894	2,894	5,516	37,444	31,928
		34	29,854	2,487.82	15.47	3,008	3,008	5,672	38,534	32,861
		35	30,479	2,539.95	15.80	3,094	3,094	5,791	39,364	33,573
Band 4	SO2	36	31,288	2,607.30	16.22	3,205	3,205	5,945	40,438	34,493
		37	32,164	2,680.33	16.67	3,326	3,326	6,111	41,601	35,490
		38	33,105	2,758.78	17.16	3,456	3,456	6,290	42,852	36,562
		39	34,195	2,849.62	17.72	3,607	3,607	6,497	44,299	37,802
		40	35,093	2,924.45	18.19	3,731	3,731	6,668	45,492	38,824
		41	36,018	3,001.52	18.67	3,858	3,858	6,843	46,720	39,877
		42	36,937	3,078.08	19.15	3,985	3,985	7,018	47,940	40,922
		43	37,858	3,154.81	19.62	4,112	4,112	7,193	49,163	41,970
		44	38,789	3,232.40	20.11	4,241	4,241	7,370	50,399	43,029
		45	39,660	3,305.00	20.56	4,361	4,361	7,535	51,556	44,021
Band 3	SO3	46	40,619	3,384.91	21.05	4,493	4,493	7,718	52,830	45,112
		47	41,551	3,462.58	21.54	4,622	4,622	7,895	54,067	46,173
		48	42,474	3,539.48	22.02	4,749	4,749	8,070	55,293	47,223
		49	43,386	3,615.52	22.49	4,875	4,875	8,243	56,505	48,261
		50	44,417	3,701.45	23.02	5,017	5,017	8,439	57,874	49,435
		51	45,419	3,784.89	23.54	5,156	5,156	8,630	59,204	50,574
		52	46,429	3,869.10	24.07	5,295	5,295	8,822	60,546	51,724
		53	47,447	3,953.92	24.59	5,435	5,435	9,015	61,897	52,882
		54	48,470	4,039.16	25.12	5,577	5,577	9,209	63,256	54,047
		55	49,487	4,123.89	25.65	5,717	5,717	9,402	64,606	55,204
Band 2	Band 1	56	50,504	4,208.71	26.18	5,857	5,857	9,596	65,958	56,362
		57	51,518	4,293.18	26.70	5,997	5,997	9,788	67,304	57,515
		58	52,542	4,378.51	27.23	6,139	6,139	9,983	68,664	58,681
		59	53,551	4,462.55	27.76	6,278	6,278	10,175	70,003	59,828
		60	54,569	4,547.45	28.28	6,418	6,418	10,368	71,356	60,988
		61	55,638	4,636.47	28.84	6,566	6,566	10,571	72,775	62,203
		62	56,696	4,724.64	29.39	6,712	6,712	10,772	74,180	63,407
		63	57,767	4,813.93	29.94	6,860	6,860	10,976	75,603	64,627
		64	58,834	4,902.87	30.50	7,007	7,007	11,179	77,020	65,841
		65	59,900	4,991.64	31.05	7,154	7,154	11,381	78,435	67,054
		66	60,964	5,080.33	31.60	7,301	7,301	11,583	79,848	68,265

2,037,247 213,291 387,077 2,637,614 2,250,537

INCREMENTAL PROGRESSION MISSES OUT SCPs 7 and 9.

Pro-Rata Adjustment							
Contracted Hours = 37.0							
66	60,964	5,080.33	31.60	7,301	7,301	11,583	79,848
Non-NJC Pay							
75,000 6,250.00 9,238 9,238 14,250 98,488 84,238							

Appendix 5 - IT Workstream Milestones

Intermediate Tier (High Level Milestones)							Last Updated:	28/02/2017
ID	Task Description	Ops lead	Project Support	Planned End Date	Forecast End Date	Status	Progress update	
3 Crisis Response:		LL AM	AM	24-Feb		Red	23/02: In progress to PF/LL to liaise/align 22/02: Looking at options to utilise interim solution from ART until 8a in post 28/02: Follow up meeting with LL/PF/MM to agree interim as priority	
3.1	Management structure agreed			28-Feb		Amber	22/02: Looking at options to utilise interim solution from ART until 8a in post 28/02: Follow up meeting with LL/PF/MM to agree interim as priority	
3.2	Robust management/supervision arrangements in place			17-Feb		Red	10/2: Escalated issue to AA 24/02: JA drafted plan to be reviewed/approved by LL, GP survey results received	
3.3	KPIs in place & reported against			17-Feb		Amber	24/02: Various issues outstanding	
3.4	Engagement plan in place			23-Feb	08-Mar	Red	22/02: LL updated will be complete for 08/03	
3.5	Develop standard operating procedure			28-Feb		Amber	23/02: MH posts under review	
3.6	Recruitment to 16/17 posts			28-Feb		Red	24/02: Various issues outstanding	
3.7	Phase 1 (8am to 10pm) - Optimised			01-Apr		Green	24/02: In progress	
3.8	Recruitment to 17/18 posts			31-Mar		Amber	24/02: Assumption made within enabler business case, Estates team reviewing options	
3.9	Establish base/accommodation for team			30-Jun		Green		
3.10	Phase 2 (24/7) - Go-Live			30-Aug		Amber		
3.11	Phase 3 - Open access into service for public							
2 Active Recovery:		PF ND/RR	ND/RR	23-Feb		Amber	23/02: In progress to PF/LL to liaise/align 28/02: Structure drafted	
2.1	Management structure agreed			30-Mar		Amber	20/02: This needs to be supported by HR	
2.2	Robust management/supervision arrangements in place			28-Feb	31-Mar	Red	10/2: Escalated issue to AA 24/02: JA drafting plan	
2.3	KPIs in place & reported against			01-Mar		Green	20/02: SOP in place, requires minimum amendments	
2.4	Engagement plan in place			20-Feb		Complete	20/02: Recruitment on going, encountered delays	
2.5	Develop standard operating procedure			28-Feb		Amber	28/02: Recruitment on going	
2.6	Recruitment to 16/17 posts			15-Apr		Green	20/02: Recruitment on going	
2.7	Phase 1 (Alignment) - Optimised			01-Apr		Green	24/02: Assumption made within enabler business case, Estates team reviewing options	
2.8	Recruitment to 17/18 posts			30-Jun		Amber		
2.9	Establish base/accommodation for team			30-Jun		Green		
2.10	Phase 2 (Fully integrated) - Go-Live			30-Sep		Green		
2.11	Phase 2 - Optimised							
3 Bed Reconfiguration:		VF NA	NA	17-Feb		Complete		
3.1	Community Unit - post implementation evalution			15-Mar		Green		
3.2	Agree vision (Provider & Commissioner)			01-May		Green		
3.3	Market testing & public engagement			30-Jun		Green		
3.4	Option appraisal - Interim plan, draft business case future plan			15-Jul		Green		
3.5	Decision making (business case approval)			01-Aug		Green		
3.6	Start preparing procurement process			15-Sep		Green		
4 Integrated Discharge Team:		TBC TBC	TBC					
4.1	Management structure agreed							
4.2	Robust management/supervision arrangements in place							
4.3	Develop engagement plan							
4.4	To complete following accommodation and management							
4.5	Establish base for team							
4.6	Align staff to team							
5 Transfer to Assess:		SP NF	NF	23-Dec	28-Feb	Red	24/02: ECIP agreed to complete, awaiting update	
5.1	Map Capacity & Demand			23-Dec	28-Feb	Red	10/2: Escalated issue to AA	
5.2	KPIs in place & reported against			23-Jan		Complete		
5.3	Complete trials (pilot phase) on SSOP			13-Feb		Complete		
5.4	Finalise T2A pathway 1 & assessment tool			28-Feb		Amber	24/02: Delays to recruitment of HSWs in ART	
5.5	Secure additional home care packages (full rollout)			10-Mar		Amber	28/02: SM to escalate to WDP approval for 12 agency workers	
5.6	Implemented Wave 1 (Wards A1, A11, E2)			24-Mar		Green	24/02: Engagement on wards commenced	
5.7	Implemented Wave 2 (Wards 4, 5, 6)			07-Apr		Green		
5.8	Implemented Wave 3 (Wards 7, 8, 9)			15-Apr		Green		
5.9	Review and revise further rollout							
6 Trusted Assessor Development:		SP SM	SM	11-Jan		Complete		
6.1	Identify leads from all areas of Intermediate Tier			08-Feb		Red	24/02: SP to collate names	
6.2	Identify hospital leads for T2A rollout			13-Feb		Red	24/02: Awaiting approval of backfill for SSOP therapist	
6.3	Develop inhouse training programme			06-Feb		Amber	28/02: SP/SM to meet to review model	
6.4	Workforce briefings			24-Feb		Amber	28/02: In progress engagement plan needed JA to follow up	
6.5	Rollout Wave 1 (Wards A1, A11, E2) training			10-Mar		Red	24/02: Awaiting confirmation of 6.2 & 6.3	
6.6	Rollout Wave 2 (Wards 4, 5, 6) training			24-Mar		Green		
6.7	Rollout Wave 3 (Wards 7, 8, 9) training			22-Mar		Green		
6.8	Trusted Assessor training at Sheffield Hallam			15-Apr		Green		
6.9	Review and revise further rollout							

Further development needed

Appendix 6 -

PROJECT BUSINESS CASE: VOLUNTARY SECTOR SUPPORT FOR DISCHARGE

Project Responsible Owner	Donna Sager	Programme SRO	Donna Sager
Project Manager	Sarah Newsam & Clare Mullins	Programme Manager	Simon Armour

1. Project Objectives

The strategic aim of this proposal is to contribute to the prevention of avoidable hospital attendance and to reduce the number of delayed discharge days, as part of the intermediate tier business case particularly the Recovery at Home service.

This will be achieved through the development of a virtual hospital voluntary sector team as part of the wider Intermediate Tier work; offering a coordinated, responsive, flexible approach. The team will work with the hospital, integrated neighbourhood teams and other partners to streamline discharge planning, reduce frequent attenders to ED / Short stay and prevent unnecessary ED attendances and hospital admissions.

Context

NHS England delayed discharge figures for June 2016 indicate that more than 6,000 older people are trapped in hospital beds each month because there are insufficient facilities to cater for them in nursing homes, with families or elsewhere.

In Stockport the numbers of Delayed Transfers of Care (DToC) has increased considerably over the last year: in June 2016, (on the last Thursday of the month when the snapshot was taken) there were 63 patients awaiting discharge and a total number of 1,703 bed days lost that month. While some of these may be unavoidable, this project will help reduce the numbers back to those achieved in the years 2013/14, when the average number of bed days lost was 354 per month.

Until 2015/16, the majority of DToC were due to patient or family choice, with waiting for further NHS non acute care and awaiting care packages in own home the next most common reason. Completion of assessment has increased and since January 2016 has been the most common cause of DToC (26.7% in April to June 2016) while awaiting care package in own home or community equipment and adaptations account for 18.1%, and patient or family choice a further 14.7%. (see appendix 1).

In 2014, Age UK Stockport and Flag (both alliance members of the TPA) carried out a short pilot (4 months) with the REACH team, supporting people after hospital/reablement discharge. The service was offered to all people using the REACH service in that period; half of those people took up additional support offered by Age UK Stockport and Flag. The pilot was evaluated by SMBC, who compared those who had received additional support from AUKS and Flag and those that hadn't. The evaluation evidenced that those receiving the additional support from AUKS and Flag were less likely to need or have other services / support in place 6 weeks post discharge.

Project overview

Whilst some of these delays require long term strategic change which will be addressed in other business cases, for example capacity issues in Long Term Care (residential) and domiciliary care / support packages, there are others that can be addressed through prevention, early intervention and building individual, family and community resilience.

The proposed service will increase capacity within existing third sector hospital discharge services and deliver new activities that will target specific areas to alleviate hospital pressures as an integral part of the Intermediate Tier work. Specifically, it will address avoidable admissions / readmissions via pathway development and early hospital discharge planning for pre-planned treatment / hospital access. The service will address the above pressures by providing non-clinical person-centred practical, emotional and solution focused support, including for example shopping, visiting people and linking into support available in local voluntary and community activities. It will work within the hospital with individual patients to remove barriers stopping them getting home. The service will continue to work with people, once home, as required to prevent future hospital attendance.



2. Benefits Performance

Activity

The activity to be delivered by the project is set out in the table below. The new capacity will enable an increase of 260 people per month on top of the existing WIN hospital-based service which supports around 60 people per month, to work with 320 per month in 2017-18 and further increasing as the service is increasingly embedded in both clinical and community settings. The nature of the service provided will also change with the inclusion of community-based TPA element.

	Baseline 2015/16	Target 2016/17	Target 2017/18	Target 2018/19
Number of people benefiting from voluntary sector support to return home (monthly average)	60 per month (Jan –Mar 16)	200/month by q4	320/month 3,840/year	320/month 3,840/year

Quality and Effectiveness

The effectiveness and quality of the service will be measured through routine data collection by the service including

- Self-reported health & wellbeing in cohort supported
- Reporting of social isolation/loneliness in the cohort supported
- Levels of satisfaction with the service among people supported, including carers, and professionals
- Qualitative feedback from people using the services and health and social care professionals

Impact

The impacts of this service will be embedded within those of the wider work to improve discharge and prevent admissions, and as such these cannot be attributed to any particular element (but see section 4 for modelled estimates of impact). The impacts will therefore be monitored as part the monitoring of the aligned range of services working to improve performance and people's experience of discharge from hospital or intermediate care, as well as wider measures of support. Those will aligned with those identified in the Intermediate Tier business case and will include:

- Reduction in bed days lost to delayed discharges (8,841 in 2015-16)
- Increase in proportion of older people (65+) still at home 91 days after discharge from hospital into Reablement/rehabilitation services (88.6% in 2015-16)
- Reduced length of stay in hospital in elderly and medical wards.
- Reduced length of stay in community beds
- Proportion of people feeling supported to manage their (long term) condition (Better Care Fund Measure): Stockport target for 2015/2016: 87.8%; target for 2018: 90%

3. Service Model / Solution Options

The service is dedicated to working with and complementing other work streams and business cases. The model has been developed in conjunction with the Intermediate, Acute and Core Neighbourhoods work-streams. The offer is being developed to ensure increased capacity to meet growing demand; whilst ensuring there is no duplication with other developmental areas. The structure and model has been designed to complement the developing Recovery at Home model.

The Wellbeing at Home service will lead and coordinate the service from the hospital base, where it already has the infrastructure, building and telecommunication resources, partner agency relationships skills and experience. The current provision of one part-time worker provides support to around 60 people per month. A coordinator role based in the hospital will oversee the virtual team which will be made up of support workers/handy person, and TPA key workers based in the localities. It will work with individuals, families, carers and communities to build resilience and reduce dependency / need on health and social care services.

The coordinator (2 FTE posts – expected to be 3-4 people) will be specifically recruited to work generically, but with a unique skill base in relation to mental health, occupational therapy and social care. They will liaise between hospital, individual and community service providers and strengthen existing and create new partnerships and pathways with other service providers in the community. In addition the co-ordinators will work with pre-op clinics to support and help people plan their discharge prior to admission, working on supporting people towards the development of a speedier discharge process.

The support workers/handy help staff (3 FTE posts – expected to be 4-5 people) will provide the practical support individuals and their carers require to get back home quickly and safely. The support provided will be person-centred and developed to meet the needs of each person identified, and will include any practical support that can remove barriers to produce a safe and speedy discharge.

The TPA Keyworkers (4 FTE posts – expected to be 4 – 8 people) will work generically within the community through a targeted, proactive, person centred, asset based approach to prevent avoidable hospital admission or readmission; connecting people to community resources. The Keyworkers will work proactively with GP's, the hospital and other agencies to prevent avoidable hospital admissions as well as working with people following discharge where further support is required to improve health and wellbeing, to prevent avoidable attendance in the future. We anticipate that the TPA Keyworkers will deliver follow on work to around 30% of people supported by the WIN hospital. Each Keyworker would provide a responsive approach to around 240 people discharged from hospital each year, in addition to working with the people proactively identified at risk of avoidable admission.

The service will be available 8am to 8pm weekdays with contact for urgent support available 9am to 6pm at weekends. The service will support all adults over 18, but will have a specific emphasis on older people, people with disability, carers, and people with anxiety or low level depression and/or challenging lifestyles.

It is expected that the new service will proactively support an additional 260 people being discharged per month, (including 60 identified at pre-op assessment) increasing total capacity from the current 60 to 320 per month in 2017-18, (3,840 per year), complementing the Recovery at Home and other discharge support provision. As the project becomes more established and strengthens its links with new and existing community assets, capacity is expected to increase. The service will work with individuals, their carers/families:

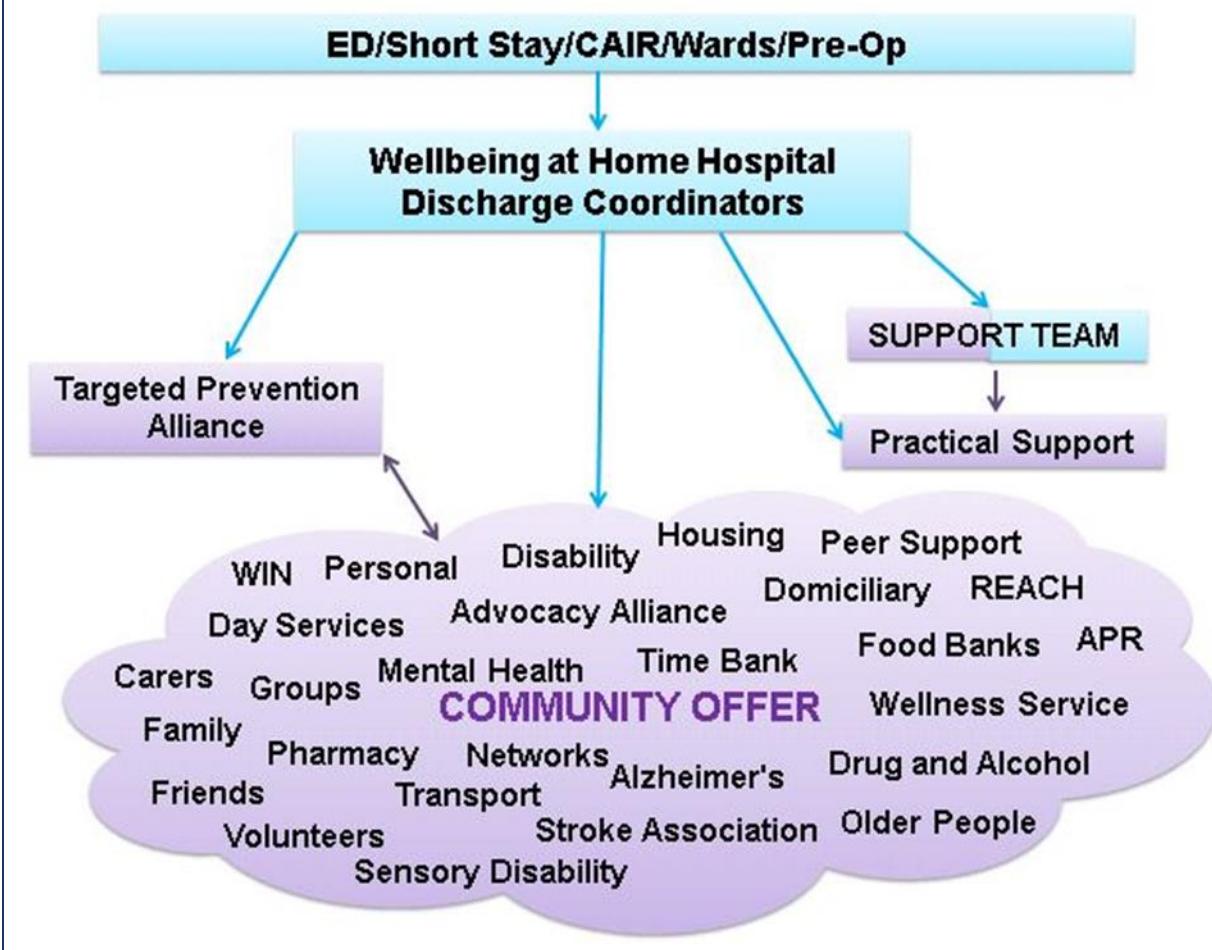
- Prior to admission for planned procedures / hospital attendance to start planning their discharge before admittance
- Within the ED / Short stay wards to respond to and address social support / practical needs
- In specifically identified wards within the hospital setting for those people admitted in an emergency, planning discharge at the earliest opportunity
- To plan discharge and address social / health care issues - removing / reducing the need for ongoing health and social care services



There is a wealth of services available offering support which can reduce avoidable attendance at hospital and support people once home. The structure diagram below shows the complexity of the support available to individuals. The proposed service will ensure ease of access to these community services through the provision of a single point of contact for patients and hospital staff.

In addition to the core offer detailed above the service will hold a small fund that will be used for individuals with specific needs or requirements not delivered through the core offer. It will be used to support individuals where a specific response would be beneficial for example providing someone at risk of falls with a non-slip shower mat, or fitting a key safe to someone who is unable to allow access to support workers / carers).

Overall the service will work to offer a coordinated, flexible and responsive service that complements the New Model of Care developed by Stockport Together, and will work to help achieve the system-wide targets for reducing hospital admissions, length of stay and ED attendances as well as reducing pressure on primary care:



4. Financial Investment and benefits

Procurement

In order to expedite implementation and ensure integration with the existing TPA and WIN activity, it is proposed to procure the service by a variation to the existing three-year alliance contracts. The current contracts are 3+2 years and started on 1st June 2015. It is proposed that GM transformation funding should be released for the period to the end of the three years (May 2018) at which point a decision can be made on whether to extend the provision for the two year extension of the contract through reinvestment of the savings delivered on a recurrent basis, or to cease or to re-procure a service, based on an interim evaluation in early 2018.

A full evaluation of the service will be completed by September 2018 in order to enable a decision on recurrent investment beyond March 2018, providing six months' notice if the contract is to be discontinued. Funding for 2016-7 has already been agreed by the Stockport Together Executive Board as part of the Healthy Communities workstream.

Funding sources	2016/7	2017-8	2018-19	2019-20	2020-21
GM Transformation Fund	£106,609	£251,771	£42,541		
Recurrent funding required			£212,706	£258,776	£262,358
Total	£106,609	£251,771	£255,248	£258,776	£262,358
Gap	£0	£0	£0	£0	£0

The costs below take account of economies of scale achieved by managing additional staff within existing resources, thus keeping overhead costs to a minimum, while cost growth is capped at 1.5% per annum with any costs above this being absorbed by the providers.

Item	Posts (fte)	2016/7 (5 months)	2017-8	2018-19	2019-20	2020-21
WIN Coordinator	2	£23,333	£56,000	£56,840	£57,693	£58,558
TPA Key workers	4	£37,921	£91,011	£92,376	£93,762	£95,168
Support Workers	3	£23,750	£57,000	£57,855	£58,723	£59,604
Facilitation fund		£8,333	£20,000	£20,000	£20,000	£20,000
IT & Equipment for team			£2,640	£2,680	£2,720	£2,761
Travel costs		£900	£4,560	£4,628	£4,698	£4,768
Management & overheads		£12,371	£20,560	£20,868	£21,181	£21,499
Total		£106,609	£251,771	£255,248	£258,776	£262,358

Financial Benefits

Modelling of the impact has been undertaken to indicate the potential cost savings, using PLICS data on actual costs in 2015-16, together with current year figures (to August) on the rate of readmission within 30 days of discharge, for the cohort identified as the 15% most at risk of hospital admission.

30 day readmission rates 2016-17 to end August	
Overall	8.4%
Top 15%	11.4%
Annual figures 2015-16 (PLICS)	
Total hospital spells of top 15%	15,754
Readmissions within 30 days (11.4%)	1,612
Average admission cost (PLICS)	£ 1,910
10% reduction in readmissions	161
Cost saving of 10% reduction	£ 307,895

It is expected that the average length of stay will be reduced for the cohort supported by the service, who will be those most likely to experience delays to discharge. For the modelling we have used the PLICS data on costs of admissions of the 15% most at risk of admission, excluding all treatment costs, which provides an average cost of £251 for each unnecessary day in hospital. If the team can reduce delays by one day for each person they support, an annual saving of £783,000 will be delivered to the system through a 4.4% saving in bed days of this cohort.

Length of stay	
Total bed days of 15%	71,708
Cost per excess bed day (PLICS)	£ 251
People engaged by VSSD team	3,120
Assume 1 bed day saved per intervention	4.4%
Cost savings	£ 783,120

These models do not take account of other expected benefits such as admissions prevented through the work delivered in the community with those at risk of hospital admission.

Cost Benefit ratio

Based on these assumptions, the investment of £252K in 2017-18 could deliver savings to the system of nearly £1.1M, indicating a return on investment of over 4.3:1. It is recognised that a combination of investments to improve discharge performance will be working together and it will not be possible to directly attribute the savings generated to individual elements, but these estimates are believed to be a reasonable forecast of the potential impact of this project.

5. Quality and Equality Impact Assessments

The service will provide support to people based on their needs, and therefore targeting those with limited assets and resources. As such it will help contribute to reducing the gaps in life expectancy, quality of life and wellbeing across Stockport's communities. The team will work in partnership with community and statutory organisations to ensure the needs of people facing disadvantage due to for example education levels, disability, language, ethnicity, sexual orientation or socio-economic status are enabled to access culturally appropriate and acceptable support.

6. Plan – Key Milestones

Milestone Description	Owner	Due date
Investment Decision approved	Donna Sager	7/11/16
Processes and readiness to identify and engage people are established in each setting	Clare Mullins	28/10/16
New staff functions and capacity are in place and trained as per specification	Clare Mullins	31/10/16
Awareness and communications plan completed	Clare Mullins	10/10/16
Service as described goes live	Clare Mullins	17/10/16
Initial implementation review	Sarah Newsam	30/1/17
Initial benefits review complete	Simon Armour	30/5/17
Second benefits review complete	Simon Armour	30/11/17
Evaluation and future funding decision	Donna Sager	30/9/18
Project Close	Donna Sager	31/10/18

7. Dependencies

The project's impact will be interdependent with the Recovery at Home service and depend on effective joint working with Integrated Neighbourhood Teams and primary care. The success of the service will depend on the engagement and support of existing staff and clinicians in the settings in which it will be working, including the hospital, neighbourhoods and intermediate tier. This will require a communications plan including briefings and information and promotional resources. This service will be an essential element of the work to release resources in the acute system by reducing admissions and length of stay.

8. Risk & Opportunities

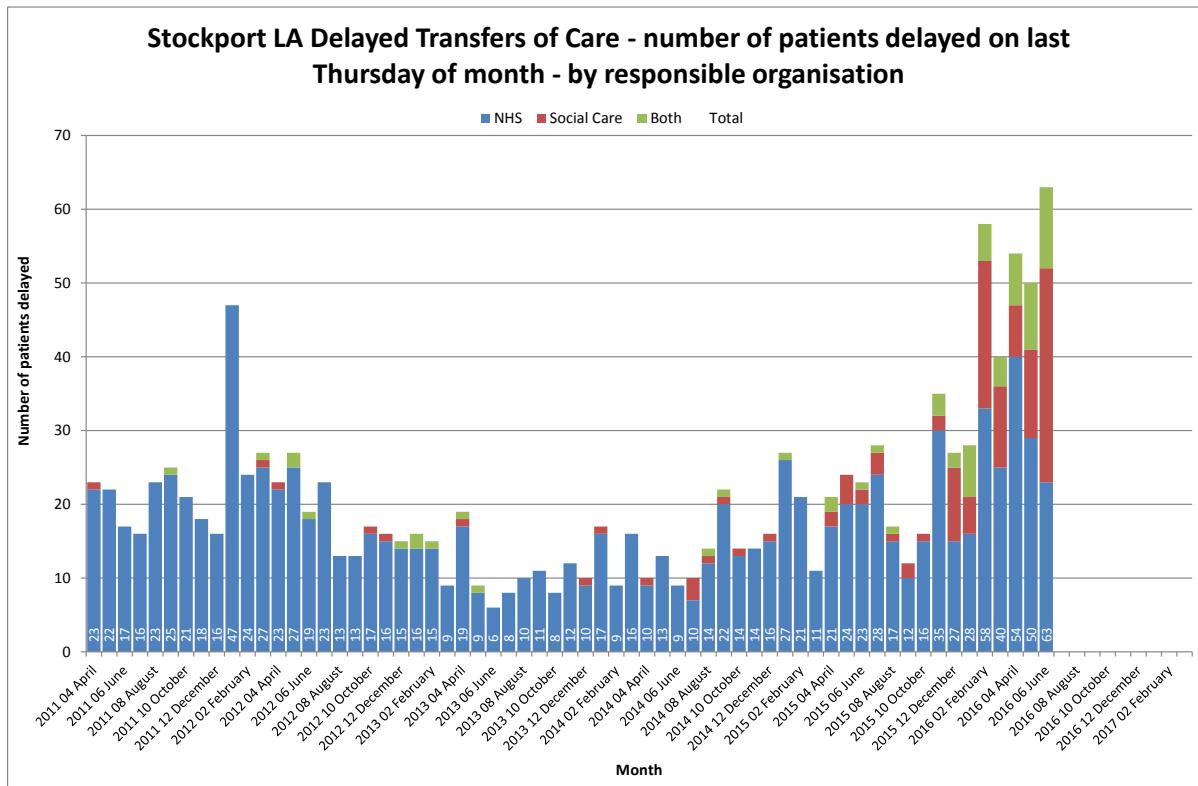
Risk/Opportunity description	Action	Score	Owner
Difficulties of delays in recruitment	Flexible use of existing staff and backfill arrangements will be used	12	Clare Mullins
Service not able to support anticipated numbers of patients due to lack of integration with	Management to be closely aligned with existing services and	9	Clare Mullins

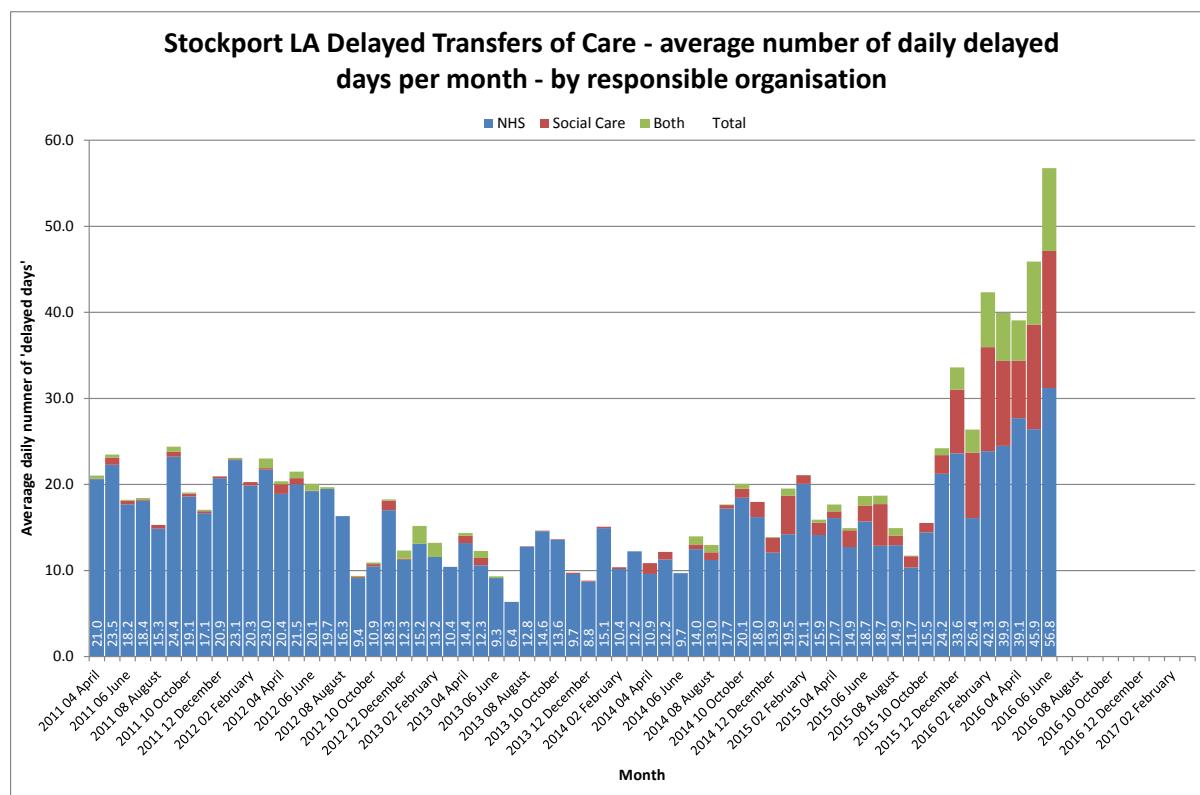
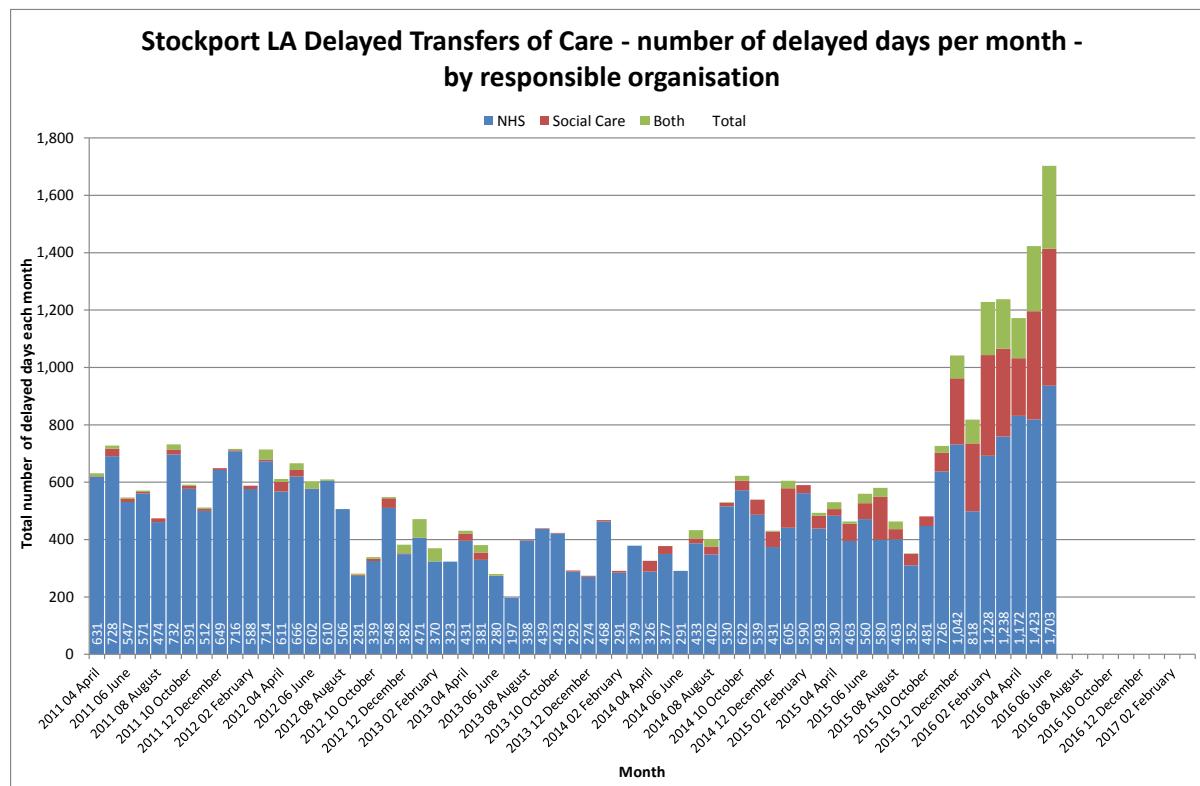
existing services	communications plan developed		
Capacity of team or community and voluntary organisations is not adequate to meet demand	Means of increasing capacity within communities will be developed in collaboration with partners and elements of the Healthy Communities workstream	12	Clare Mullins

Appendix 1

Delayed Transfers of Care – to June 2016

The following graphs shows trends in Delayed Transfers of Care for Stockport LA area. Most recent published data is for June 2016.





Trends show an increase in DToC over the period since August 2014, and especially since November 2015. Data shows that in November 2015, on the last Thursday of the month (when the snapshot was taken) that there were 35 patients with a DToC, and a total of 726 bed days had been lost that month due to DToC, by June 2016 these figures had increased to 63 patients and a total number of

1,703 days. In November 2014 the equivalent figures were 14 people and 539 days, and in November 2013 the figures were 10 people and 292 days.

The majority of the DToC to date are attributed to the NHS, with the rest attributable either solely to social care or to both NHS and Social Care – however there has been an increase over time in the proportion attributed to Social Care, from 2.8% in 13/14 to 39.9% for the first three months of 16/17.

Responsible Organisation	2016/17 to date	2015/16	2014/15	2013/14
NHS	60.2%	73.4%	89.6%	97.2%
Social Care	24.6%	18.7%	8.4%	1.8%
Both NHS and Social Care	15.3%	7.9%	2.0%	1.0%

Until 2015/16 the majority of DToC were due to patient or family choice, in other words the viable alternative to hospital is not an option that the patient or family wish to take, with waiting for further NHS non acute care and awaiting care packages in own home the next most common reason. Completion of assessment has increased and since January 2016 has been the most common cause of DToC.

Reason for Delay	2016/17 to date	2015/16	2014/15	2013/14
Completion of assessment	26.7%	16.4%	7.3%	2.4%
Public funding	0.0%	0.7%	0.0%	0.4%
Waiting further NHS non-acute care	13.5%	11.1%	14.4%	19.6%
Awaiting residential home placement or availability	13.4%	7.2%	3.5%	5.1%
Awaiting nursing home placement or availability	13.6%	6.3%	5.7%	5.2%
Awaiting care package in own home	14.1%	10.9%	5.1%	0.9%
Awaiting community equipment and adaptions	4.0%	3.6%	4.3%	3.5%
Patient or family choice	14.7%	43.2%	53.6%	60.6%
Disputes	0.0%	0.0%	1.1%	1.2%
Housing - patients not covered by NHS / community care act	0.0%	0.6%	4.9%	1.2%

Appendix 7 -

Proposal for development of Older People's Mental Health Liaison to support the Neighbourhoods and Intermediate Tier

1. Introduction

As part of the neighbourhood vision to keep patients out of hospital and better integrate services we have discussed the role of how mental health services delivered by Pennine Care NHS Foundation Trusts can contribute to delivering on the key aims of the Stockport Together Programme, which are to: -

- Maintain a focus on the individual and support empowerment.
- Shift the delivery of care from an acute and reactive focus towards a proactive focus in neighbourhood settings.
- Maintain a focus on integration, strong alignment and developing key relationships.
- Manage crises closer to home in both physical and mental health presentations.

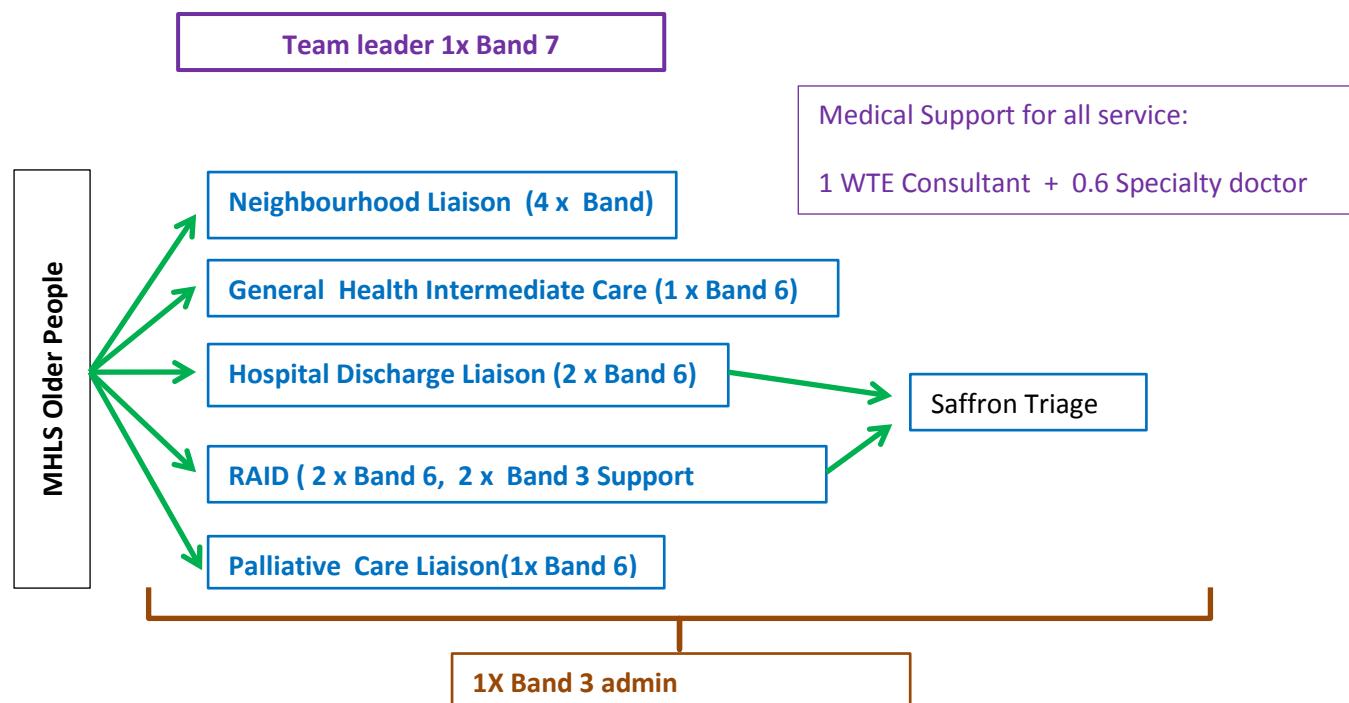
Stockport has an older people population of 55,600 people, which accounts for 19.5% of the Stockport population, compared to 17.6% in England. 2.6% of Stockport's population are aged over 85 years. As people age, they increasingly live with co-morbidities and require a multi-disciplinary approach for their physical and mental health and social care needs.

The development of this paper has been supported by a task and finish group which has been looking at how mental health can best support the Stockport Together programme. The group has agreed to look at ways of supporting older people who present with depression, dementia and delirium and a further business case looking at how to support people of all ages with complex presentations that do not reach secondary care thresholds.

2. Current Position

At present there are four mental health liaison practitioners for older people aligned to the neighbourhood teams. These practitioners each work across two neighbourhoods to support the multi disciplinary teams by providing mental health assessment, care planning, support and signposting for older people with either a diagnosed or undiagnosed mental health problem who are not supported by secondary care mental health services.

The practitioners that are aligned to the neighbourhood teams are part of a wider mental health liaison service offer for Older People in both hospital and community settings, which includes hospital discharge provision, RAID, palliative care liaison, intermediate liaison. The service is supported by a dedicated consultant psychiatrist and a specialty grade doctor. The total number of practitioners and their function is set out in chart below:



This service is in essence one team working in several different settings in a co-ordinated and integrated manner under the leadership of one team manager

This means that the current structure and management of the Liaison service allows us to reach into the majority of the settings where older people who may have a co-morbid functional and/or organic illness present. This ensures that practitioners in

those settings have access to prompt mental health assessments and support.

The structure also supports the service being able to, through its various arms, follow a patient along their care pathway i.e patients identified through the liaison service working in the hospital can be followed up by the liaison services working in the neighbourhood. Appropriate interventions can then be delivered to care for people at home and prevent re-admission.

This current position is a combination of existing mental health provision that is contained within the current block contract supported by a £325,000 investment which allowed for the recent addition of 4 neighbourhood practitioners and additional medical support. The table below is the costing for this current provision.

Post Title	FTE	Grade	salary with oncosts
Specialty Doctor	0.60		53,144
Consultant Psychiatrist	0.50		47,052
Nurses	1.00	Band 6	38,288
Nurses	1.00	Band 6	38,288
Nurses	1.00	Band 6	38,288
Medical Secretary	1.00	Band 4	25,574
		Band 6	
Admin	1.00	Band 3	22,230
Travel/Other Non-Pay (at 5% staff costs)			13,143
Mobile Device			10,800
Mobile Device			4,200
Trust Overheads (at 10%)			29,101
Surplus (at 1%)			3,201
			323,309

3. Future Proposal

There has been some concerns expressed within the CCG regarding mental health

investment in to the Stockport Together programme and how this has been reflected in the business cases particularly the neighbourhood business case. A Mental Health Task and Finish group has been reviewing this. The group has included Commissioners, providers and the clinical leads from the neighbourhood and intermediate tier. Discussions around the older people's mental health involvement identified some concerns in relation to crisis and intermediate tier input.

A previous proposal has been to employ an additional 7 mental health band 6 practitioners to work across the Intermediate Tier over 24 hours. The purpose of the proposal had been to ensure that there was always a mental health crisis response available within the intermediate tier, working alongside the physical health services. Further discussions have emphasised the need to provide a comprehensive liaison service to both the neighbourhood and intermediate tier that has the ability to offer a crisis across both. Splitting the mental health offer between the two would lead to less flexibility and a less co-ordinated/integrated service.

The patient group the liaison service currently serves can fluctuate rapidly between Primary Care and Secondary Care services and in order to function effectively the Liaison team needs access to the mental health crisis function currently available in the HIT team. This is the Home Intervention Team, based at the Meadows that offers a service prevents admission to mental health beds. An important component of this team is a highly skilled support work team.

In recognition of the crossover of these patients and a wish to integrate and co-ordinate services where possible the vision is to align Liaison and HIT especially out of hours. This is so that they can offer a service that protects mental health in-patient beds and supports the neighbourhood and intermediate tier in avoiding admission to general hospital beds for those with co-morbid mental and physical health problems

The service aims to offer a range of interventions which are designed to improve patient outcomes. These are contained in Appendix 1.

The new proposal would be as follows:

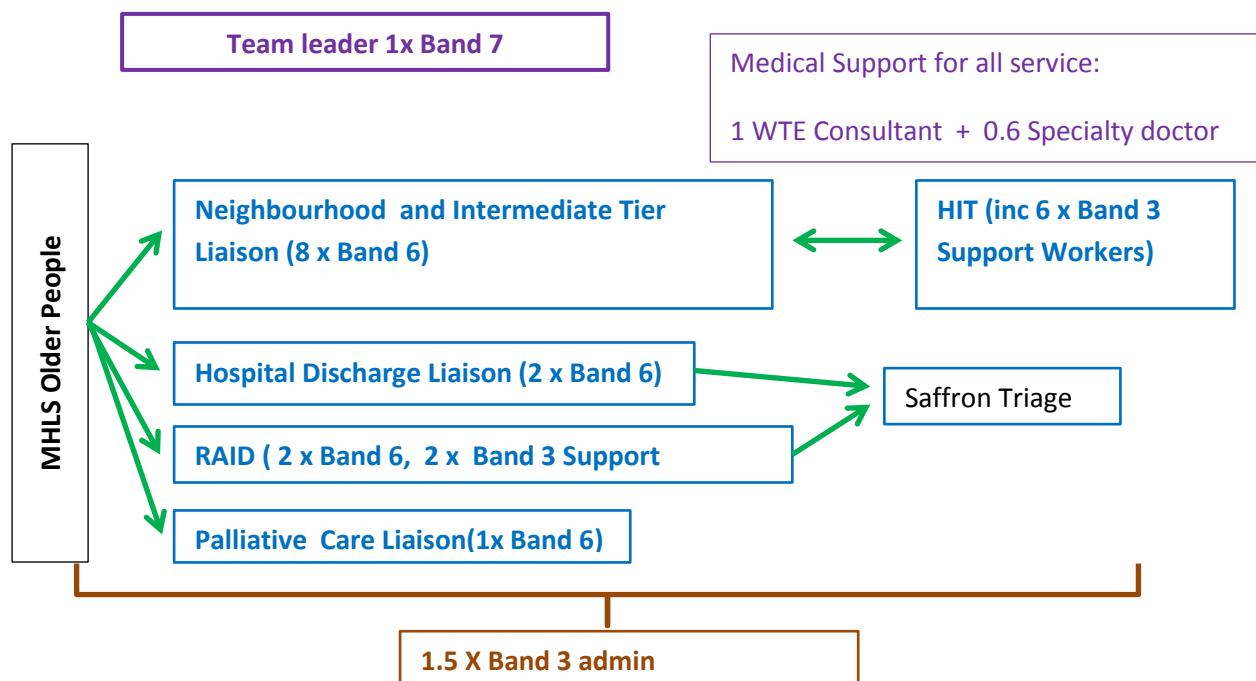
8 WTE Mental Health Liaison Practitioners to provide a service 8am- 8pm 7 days per week that will be accessible for both the neighbourhood teams and the intermediate tier teams to provide assessment, care planning, support, signposting, information and advice. These eight posts will consist of the existing four practitioners already in the neighbourhood, the one intermediate care liaison post and three additional posts which would require new investment.

These practitioners will be located in the neighbourhoods with the integrated teams but will retain close links with the overall Liaison/HIT service in order that they maintain their mental health specialism and are adequately supervised and managed. This will also afford them easy access to the wider mental health offer.

These Mental Health practitioners would be supported by a team of Mental Health support workers 8am-8pm 7 days a week , with a Mental Health support worker also available as part of the crisis response offer 8pm-8am 7 days a week. This would require investment to recruit to six band 3 support workers. Where possible the Mental Health practitioners will utilise existing mainstream support and care services however, feedback and experience has shown, that the integrated health and social care teams have often referred to Mental Health services in order to gain access to the mental health support work team as mainstream services have been unable to meet the needs of their caseload when they become complex.

The support workers will be aligned to the Crisis Response team at night on a rotational basis to provide access to skills, knowledge and expertise to support individuals with co-morbid acute physical and mental health needs. In the daytime the support workers will sit with the HIT team. This ensures that we do not have a number of small support work teams without capacity and resilience.

We outlined the current structure diagrammatically and the following diagram shows the new structure:

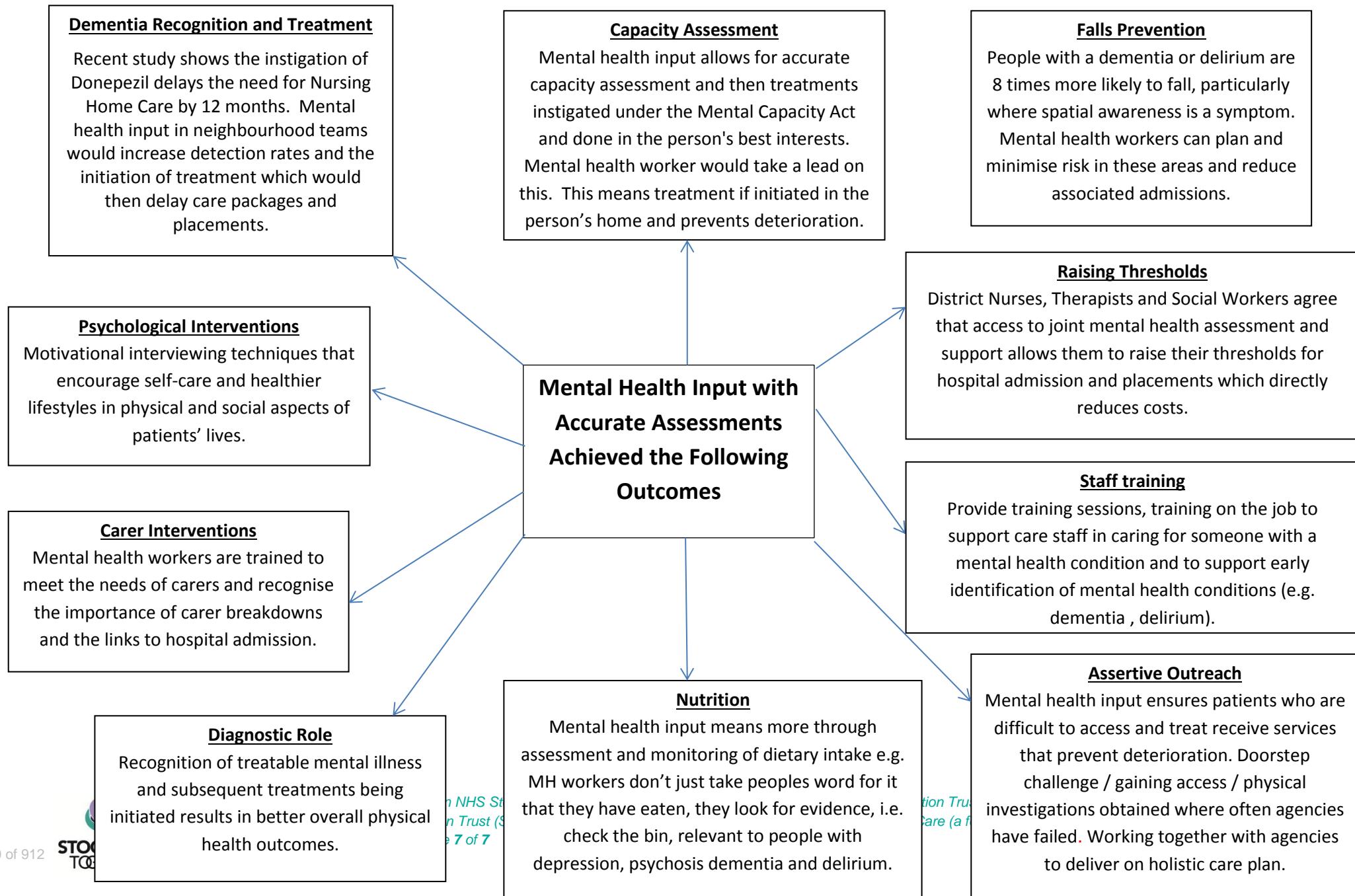


This re-organisation does not affect hospital based services or the Palliative Care post which is a very specialised post aligned to the Palliative Care Team.

In Summary

The additional resources required to implement the proposed enhanced mental health liaison service offer are:

3 WTE Band 6 Mental Health Liaison Practitioners (plus weekend enhancements)
6 WTE Band 3 Mental Health Support Workers (plus weekend and night
enhancements)
0.5 WTE Band 3 additional admin support
Travel and Mobile phone costs



AMBULATORY CARE OUTLINE BUSINESS CASE EXECUTIVE SUMMARY

Abstract

This business case describes changes to the management of people with ambulatory illnesses and conditions within the Emergency Department that will be embedded between 2017/18 to 2020/21.

Senior Responsible Officers:
Tim Ryley, Director of Strategy, Stockport CCG
Keith Spencer, Provider Director, Stockport Together

Executive Summary

Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to ensure the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

Business Case Overview

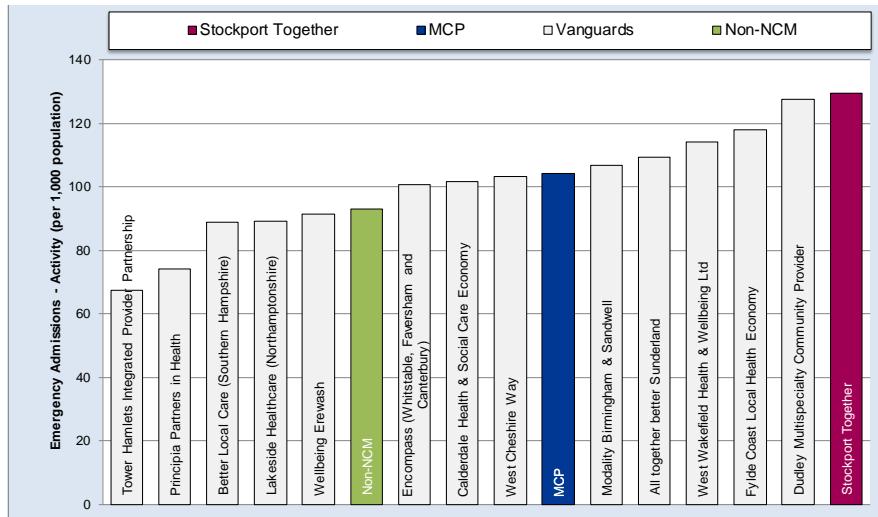
This paper sets out the case for changes to the way the Emergency Department (ED) and Ambulatory Care Unit (ACU) are managed at Stockport NHS Foundation Trust. The document describes the new model of ambulatory care and how this will support improvements in the local system. It sets out investment requirements and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business case identifies risks to delivery of the changes and the mitigations in place to maximise benefits.

The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

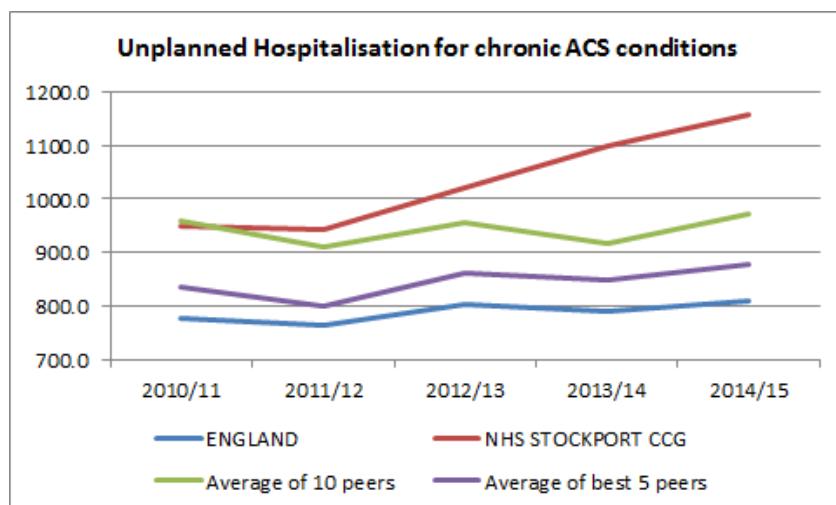
Within Stockport we admit many more people to hospital than similar systems across Greater Manchester and England – around 30%. This is the case particularly among people aged over 65. A significant driver of this high rate of admissions is the variation in the number of admissions of people with ambulatory care sensitive (ACS) conditions – those conditions commonly accepted as not normally requiring a hospital admission.

Figure 1: Emergency Admissions per 1,000 population



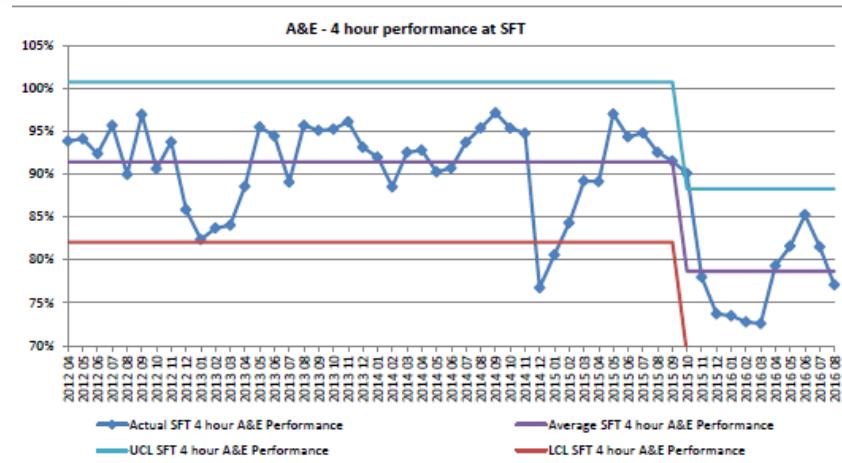
Compared with our peers and the England average, Stockport admits significantly more people with chronic ACS conditions and the gap between our performance and our peers is growing

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We also face a number of performance challenges in meeting national waiting time standards within the Emergency Department.

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This situation will only worsen if no changes are made due to demographic pressure from an ageing population outstripping any growth in resources.

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Activity:	2016/17	2017/18	2018/19	2019/20	2020/21
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The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets.

Changes to the operation of the Emergency Department will be introduced to include:

- Implementing primary and secondary care ***Collaborative Triage***;
- Providing of a co-located primary care ***Ambulatory Illness Team***;
- and extending the operating hours of the ***Ambulatory Care Unit***.

The proposed model will strengthen triage arrangements improving the seniority of front-end decision makers, including primary care expertise access to clinical staff to patients' electronic record with appropriate safeguards, and improving decision making protocols and pathways.

Behind the ED triage there will be a new primary care service operating 8am to midnight 7 days per week to address peak periods of demand. It will meet the needs of the ambulatory ill who do not require full ED services. It is anticipated this service will see 315 people per week on average, leaving ED staff free to meet more serious needs more promptly.

This business case proposes increasing the Ambulatory Care Unit's capacity and opening hours so that it will go from seeing 160 people per week to seeing 350 people per week and be open 8am to midnight 7 days per week – reflecting known periods of demand. The unit will diagnose, treat, stabilise and discharge people where their condition does not require overnight hospital care but short-term medical input. Planned additional capacity along with access to GP records for the clinical team, revised pathways and dedicated specialist staff and equipment will reduce admissions through ED by 40 per week. More importantly it will ensure people who need a brief

medical intervention are treated quickly and returned home safely rather than being admitted unnecessarily.

Benefits of the Model

The proposed model will strengthen the management of care for acutely ill people, contributing to improvements in local achievement of the NHS Constitutional standard that 95% of people are seen, treated, and admitted or discharged within 4 hours.

A primary care ambulatory illness team co-located in the ED will help ensure that people are treated by the most appropriate clinician, taking unnecessary pressure off the busy emergency department.

Improved processes and management in the ED will also contribute towards the delivery of 7 day working, improved safety and patient experience, and an improved working environment.

The model will reduce the number of people using the ED by 500 people per week and reduce unnecessary emergency admissions of people with ACS conditions by 40 per week.

By deploying the full range of interventions set out in these business cases, we will be able to work intensively with patients to treat people appropriately and deflect 505 ED attendances a week – a 28% reduction.

Table 2: Current and Planned Flow through the ED

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Change		505		26,260

Over a three year period, the plans will deliver a sustainable urgent care system, with financial benefits of the change greater than costs incurred by year three.

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Net Benefit / Loss	-£966,000	£1,318,195	£2,371,154	£3,754,963	£3,920,963

Risk Management

The main risks identified to deliver of this change include:

- capacity to deliver change
- recruitment of permanent staff to the new unit
- ongoing pressures in ED performance divert the focus from transformation and pull staff from ACU into the ED
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- Appendix 3: Costs - Ambulatory Care

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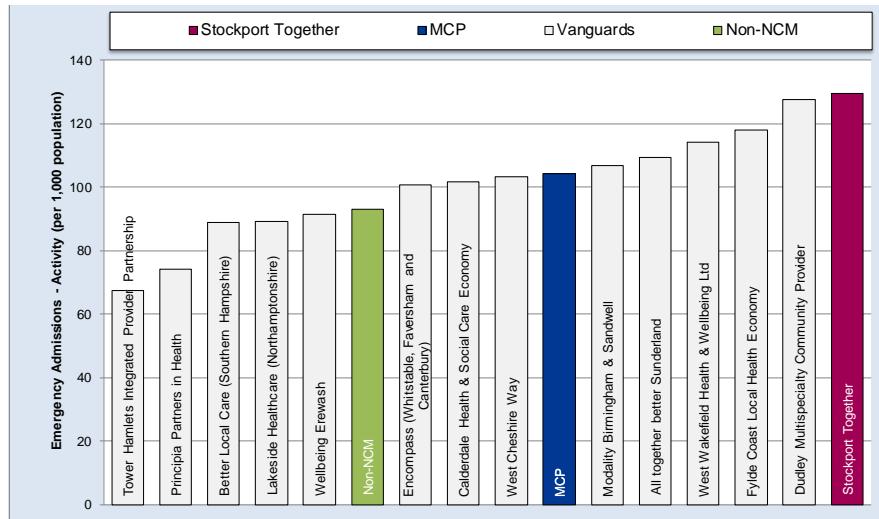
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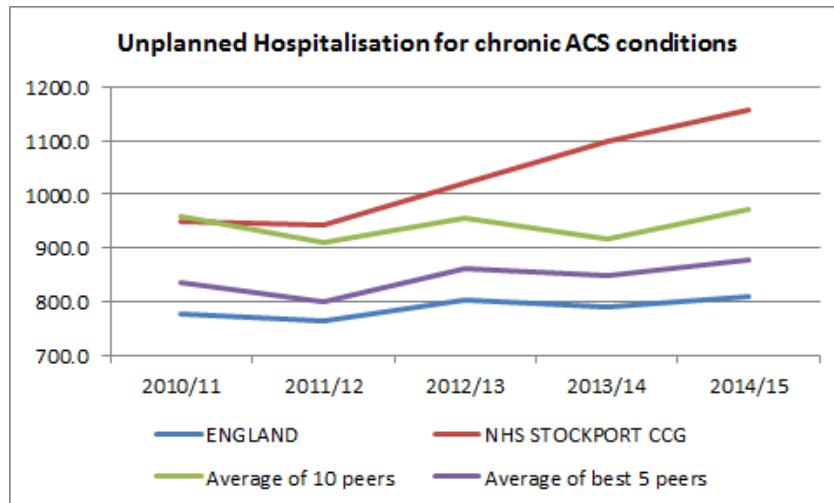
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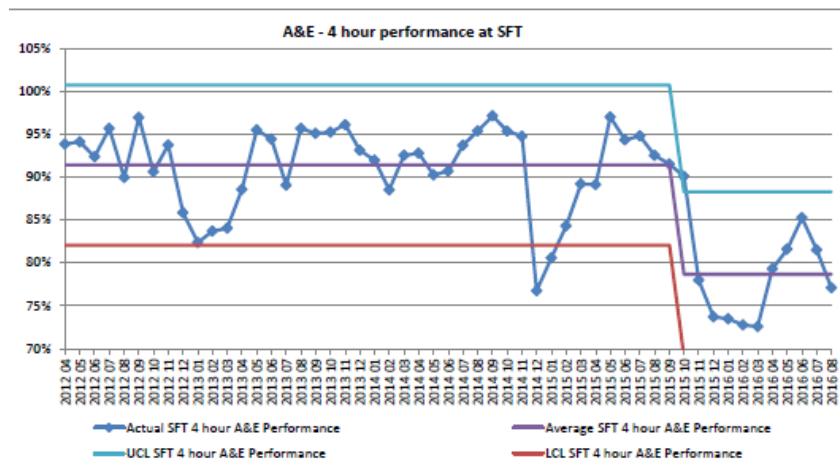
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2 Strategic Case

2.1

Introduction

The Stockport Together partners are undertaking a fundamental change in the way health and social care services are delivered, organised and commissioned. The full strategic case for change was set out in the **Stockport Together Overview Business Case** published in July 2016 in which we described a series of more detailed business cases that were to follow. This business case is one of that series of cases which together will collectively build a system level change in the way services are delivered. We refer to this new service model in its totality as the Integrated Service Solution.

This case will particularly focus on the management of patients presenting at ED with an ambulatory care condition or undefined ambulatory illness including the Ambulatory Care Unit and necessary changes to triage and streaming in the Emergency Department (ED).

2.2

Scope of this Business Case

2.2.1

Service Areas

In this business case the services directly in scope are:

- The NHS Stockport Foundation Trust Emergency Department (ED), in particular improvements in the front-end triage arrangements and the management of Ambulatory Illness, and
- The NHS Stockport Foundation Trust Ambulatory Care Unit

Other elements of the Accident and Emergency department and inpatient medical beds will be in view of the business case but the improvement proposed is specifically related to the two service areas described above.

2.2.2

Population in Scope

The model will be developed for all attendees (of all ages) at Stockport NHS Foundation Trust ED irrespective of their GP registration. It will not capture changes for Stockport registered patients using other hospital ED and/or Ambulatory Care Units.

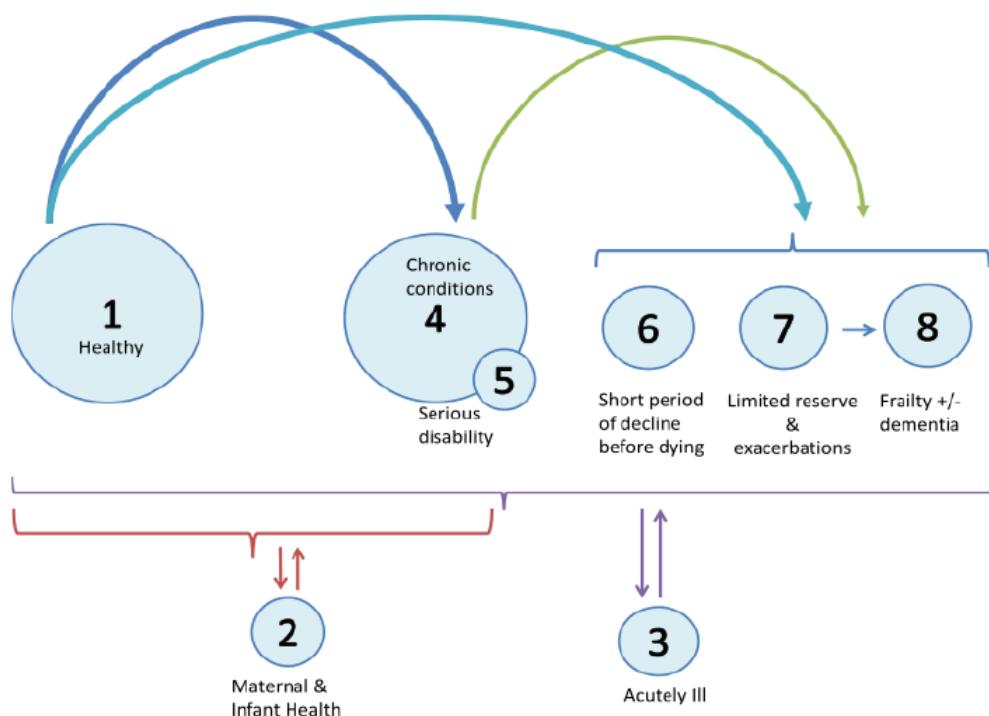
2.2.3

Segmentation Cohorts

The future commissioning arrangements for a population based weighted capitation contract will look to commission specific outcomes for specific

population segments. The approach being taken to this is built on the *Bridges to Health* approach identifying 8 population segments. These are described diagrammatically below. At any given time nobody is in more than one of the six upper segments and can exacerbate from any of these to the *Acutely III* segment (3).

Figure 1: Outcome Framework Segments



Evaluation of Whole Population Segmentation and an Implementation Approach for the ‘Bridges to Health’ Segmentation Model” (OBH, August 2016).

This business case is particularly focussed on the **Acutely III** population segment. The Ambulatory Illness team will be predominantly dealing with people exacerbating (or perceiving themselves to be) from the generally Healthy – segment 1. The Ambulatory Care Unit will be dealing with exacerbations predominantly of people in Segments 4 and 5 (chronic conditions) and Segment 7 (Limited reserve & exacerbations), but may also occasionally support people in segments 6 and 8. There will be a small impact on children with ambulatory illness that attend ED but otherwise existing paediatric arrangements are not affected by this case.

2.3

Business Objectives

The Business Case is designed to deliver the following objectives:

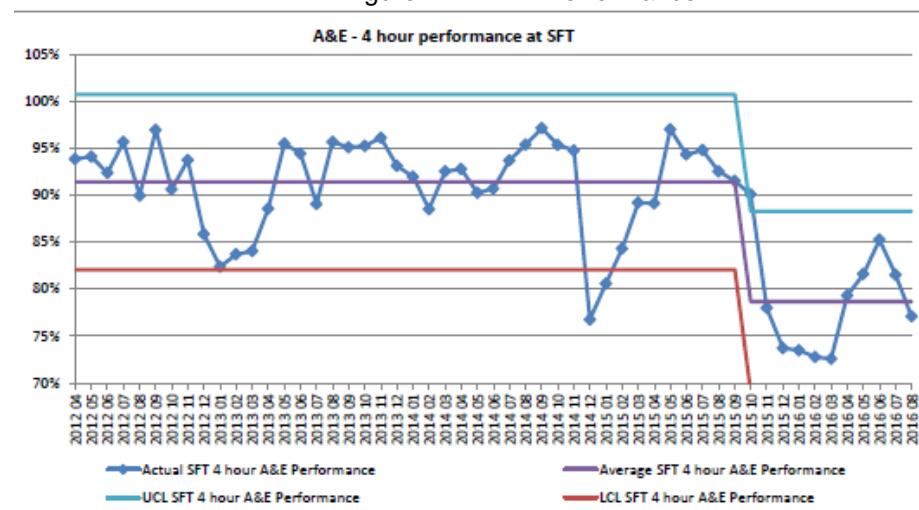
- Reduce the number of patients who when presenting at ED with an ambulatory care condition are then subsequently admitted to a hospital bed;
- Reduce the proportion of people who when presenting at the front door of ED are then subsequently managed in the existing ED;
- Improve the management and flow of undifferentiated ambulatory care patients through the ED;
- Contribute to the reduction in the number of admissions of patients with ambulatory care conditions admitted to hospital across the economy;
- Contribute to the reduction in the proportion of people attending ED who are admitted for any reason
- Contribute to delivering the ED NHS constitution indicator of 95% of people seen within 4 hours
- Contribute to the move towards 7-day working
- Contribute to an improved working environment in the ED
- Ensure that the financial benefits of the changes will be greater than the costs incurred across a 3 year period.

2.4

Current State

The Stockport Health Economy is one of the poorest performing in relation to the national ED constitution standard and the Care Quality Commission (CQC) has rated the ED as *requiring improvement*. This poor performance has been persistent across a number of years.

Figure 2: ED 4hr Performance

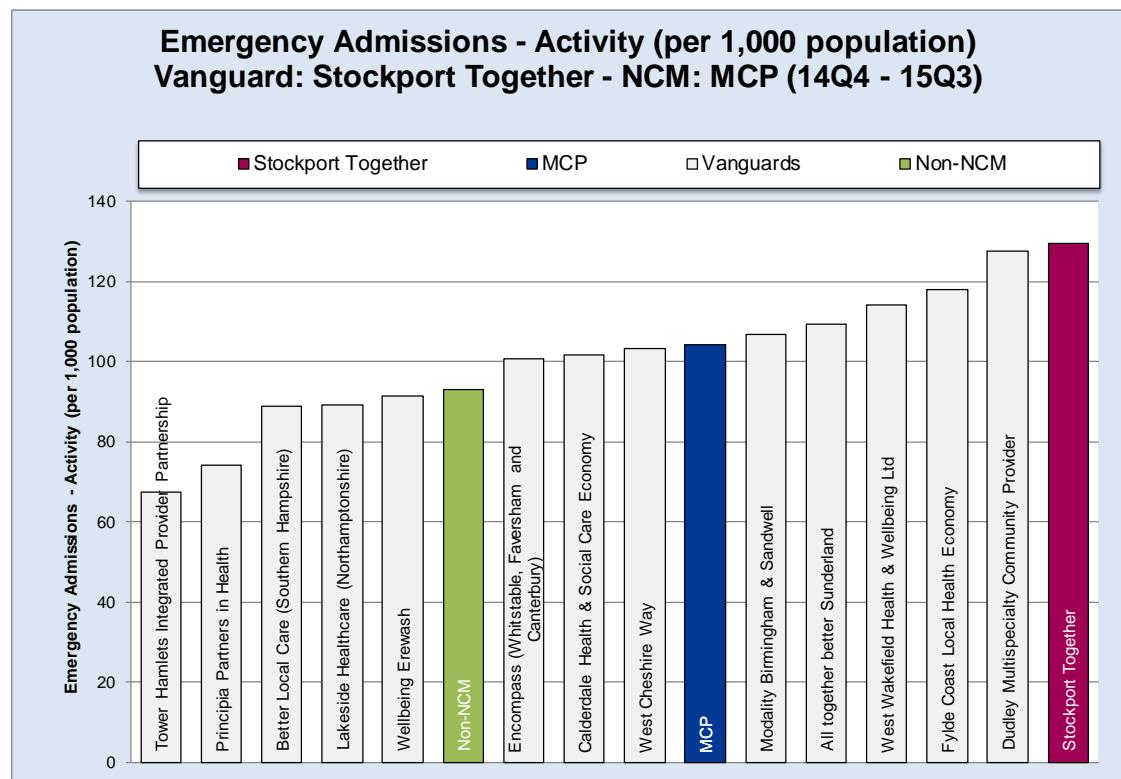


There are **numerous system-wide factors** contributing to this. Two of those **that are pertinent** to this particular case are the ineffective streaming of

patients at arrival, and the capacity and flow through the Ambulatory Care Unit

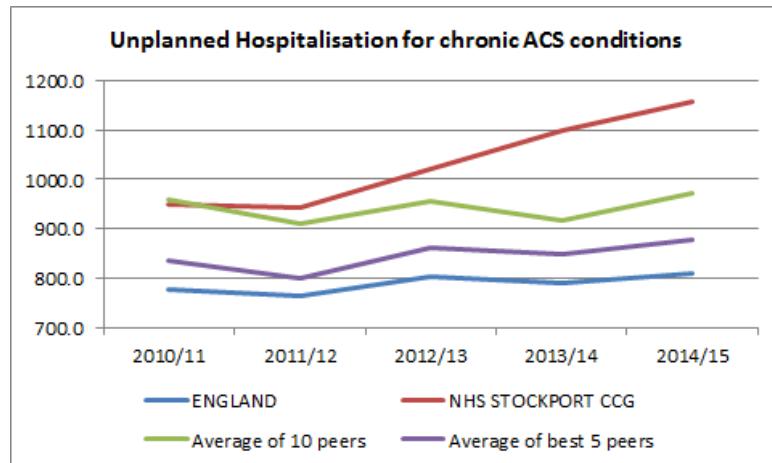
Stockport also has an especially high non-elective admission rate per head of population, and a higher than typical proportion of those attending the ED are admitted (c30%).

Figure 3: All Emergency Admissions – MCP Sites & England



Ambulatory care conditions are those conditions commonly accepted as not normally requiring an inpatient stay. There are a number of lists used to define this; the basis of this business case is the Directory of Ambulatory & Emergency Care for Adults v4. Using this definition in Stockport we again admit more than other similar areas and up until April 2016 the gap was growing.

Figure 4: Unplanned Hospitalisation for those with ACS conditions



2.5

Strategic Fit

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the *Five Year Forward View* (5YFV). The *Urgent and Emergency Care Review* proposes a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that they deliver more care closer to home and reduce hospital attendances and admissions. We need a system which is safe, sustainable and that provides consistently high quality.

The *Urgent and Emergency Care Review* goes on to highlight five key elements for change, which must be taken forward to ensure success:

1. To provide better support for self-care.
2. To help people with urgent care needs get the right advice in the right place, first time.
3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in ED.
4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise, to maximize chances of survival and a good recovery.
5. To connect all urgent and emergency care services together, so the overall system becomes more than just the sum of its parts.

This business case is particularly **focussed on element 4 above**, but as indicated previously is part of a package of changes (the Integrated Service Solution) that collectively address this whole agenda.

Similarly, the Greater Manchester Health and Social Care Strategic Partnership Board have described the direction of travel for urgent and emergency care in a report approved on 29th July 2016. It states that the urgent care system must be seen within the context of the new care models

evolving within and across localities, and locally this business case as described above is an essential element of the creation of the local Multi-Specialty Community Provider and addressing our persistent over-hospitalisation of the population.

Turning to the specific scope of this business case within the overall urgent care system, the national **A&E Improvement Plan** proposes five specific mandated improvement initiatives that all systems must implement. Among these are **streaming at the front door to ambulatory and primary care within the department**. Another is a requirement to **look at enhancing patient flow**. This business case describes the mechanism locally for addressing specifically the first of these and in doing so will support the second.

In February 2017 NHSE published *Primary Care Streaming*: stating that as part of the wider transformation of urgent and emergency care services, all systems now need to ensure they have a robust primary care streaming service in place, following best principles, examples and minimum standards which are set out in the document. It recognises that there is already a range of streaming and other services co-located within many emergency departments, and therefore there are multiple implementation routes available:

- a) Where there is already an Urgent Treatment Centre (UTC) on site, the existing protocols need to be adapted to comply with best practice set out in this document
- b) Where there is some kind of streaming in place (but not involving a co-located UTC), the service needs to be redesigned to comply with best practice (or the elements of it not currently in place, which will achieve the necessary positive impact on the ED)
- c) Where there is no service in place, the best practice in this document needs to be implemented to the greatest extent possible locally, based on a robust cost-benefit analysis

Where successful alternative arrangements are already in place which can be thoroughly demonstrated that they are achieving the desired positive impact on their ED, adopting best practice will not be mandated. The proposal in this business case sits broadly within a) above.

Nationally there is also a push towards greater 7-day working and requirements across the health & social care system to ensure improvements in this area are in place. This case will contribute by making the Ambulatory Care Unit operate at the same level 7 days per week.

2.6

Business Case Development

This case has been developed by the Stockport Together Partnership **Ambulatory Care Interface Workstream**. This has involved clinicians and managers working in the service areas described and GPs from the CCG and Viaduct Health led by the former Deputy Chief Executive at Stockport NHS Foundation Trust acting as the Senior Responsible Officer. It has developed from early thinking over a two-year period and has the support of the Clinical Director in ED, the Senior Consultant in the Ambulatory Care Unit, and the GP Chair of the Urgent Care Delivery Board (formerly the System Resilience Group).

The Citizens' Reference Panel have had opportunities to feed into the development of the service. Section 4.5.1 gives more detail on public and patient involvement.

3

Proposed Service Model and Economic Case

3.1

Existing Service Model April 2016

It is important to note in reading this section that ***changes have already commenced*** to move the elements described in this case forward alongside other changes in ED, and that for the purposes of the business case the current state describes ***a baseline position at April 2016*** when describing the current model of care. It therefore ***uses 2015-16 data*** as the baseline activity position. Using 2016-17 data would not enable evaluation as it includes the commencement of the changes described. The performance challenges in ED have necessitated rapid implementation.

In April 2016 all patients arrived at the reception of ED and were triaged by a nurse-led team. This triage process streamed patients into the ED directly and to a particular function within it; minor injuries, paediatric ED, Medical Admissions Unit etc. The Ambulatory Care Unit previously sat within an area including the Medical Assessment Unit (MAU) and the Clinical Decision Unit (CDU) which collectively were not fully disaggregated. This had the value of cross sharing of skills but had limited the full effectiveness of the Ambulatory Care Unit.

The teams had access to hospital records but no access to GP records and were therefore dependent on the information that they already had, which is rarely up to date, or on the information patients and their families are able to provide with all the safety issues this implied.

The ED itself had to manage people with a wide range of conditions from majors through to undifferentiated ambulatory illnesses and minor concerns people may have.

At that time the Ambulatory Care Unit was open Monday-Friday 8am to 10pm with last admission at 6pm, and Saturday and Sunday 8am to 6pm with last admission at 3pm. The average number of people it saw per day was 27, and on the days it was actually operational it saw between 8 and 37 people indicating considerable variation in the triage arrangements.

The flows as at April 2016 baseline for the key aspects of the ED in scope are shown diagrammatically below.

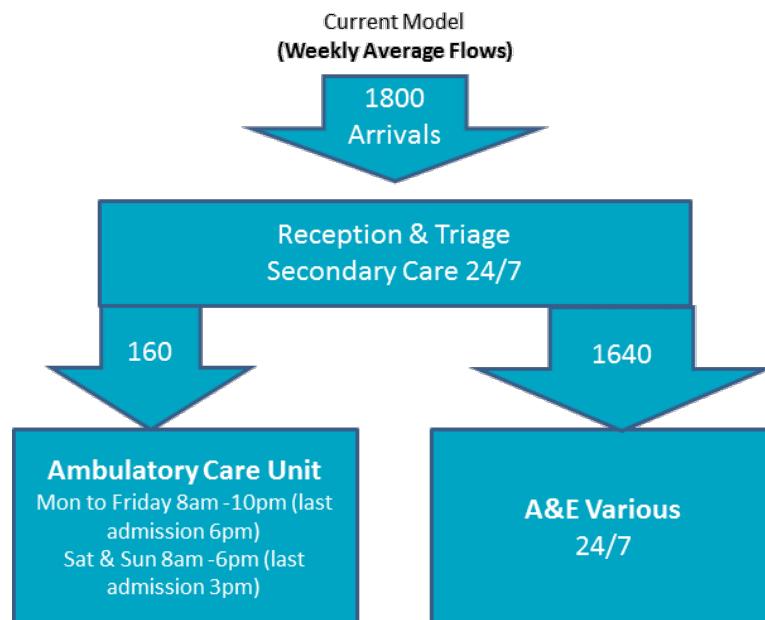


Figure 5: ED Flow as of April 16

3.2

Evidence Base

When considering the best way to improve the current situation, the evidence suggests that a service that can provide effective management of ambulatory care sensitive conditions will reduce emergency admissions by 20-30%. Ambulatory care is clinical care which may include diagnosis, observation, treatment, and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services.

The Royal College of Physicians – Ambulatory Care Medicine Task Force & the College of Emergency Medicine, 2012 Implementing Ambulatory Emergency Care agree that, where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to Ambulatory Emergency Care (AEC) type units, to be diagnosed and treated on the same day with ongoing clinical care. In such units processes are streamlined, including review by a consultant, timely access to diagnostics and treatments, all being delivered within one working day. This has been demonstrated to improve both clinical outcomes and patient experience, whilst reducing costs.

Effective implementation requires a whole-system approach to include primary care, community teams and ambulance services working with the Ambulatory Care Units to establish patient pathways. This approach is based

on the *Directory of Ambulatory Emergency Care for Adults*, first published by the NHS Institute for Innovation and Improvement in December 2007: version 3 was published in 2012 www.ambulatoryemergencycare.org.uk/directory.

Clinical teams using this approach report managing significant numbers of emergency patients quickly, without the need for full admission, converting at least 20–30% of emergency admissions to ambulatory care. Pioneers of ambulatory care approaches have achieved good results, with growing evidence of the impact:

Additional evidence reviewed included:

- *Ambulatory Emergency Care, The Middlesbrough Experience*, NHS Institute for Innovation and Improvement
- *Directory of Ambulatory Emergency Care for Adults*, NHS Institute for Innovation and Improvement, November 2012
- *Kettering General Hospital NHS Foundation Trust Case Study*, June 2016

3.3

Proposed Service Model

This case proposes changes to the previous service model built on this evidence base and the national urgent care review and describes ***three specific improvements***.

- 1. Implementing primary & secondary care collaborative triage** to streaming function on arrival at ED between 8am and 12midnight 7 days per week. (Normal ED triage will continue to operate as now between midnight and 8am)
- 2. Provision of co-located primary care (Ambulatory Illness Team) from 8am to midnight**
- 3. Extending hours and capacity of Ambulatory Care Unit from 8am – midnight with last admission at 10pm 7 days per week and optimise the utilisation of people being managed on ambulatory care sensitive conditions pathways**

These three changes are each described in more detail below. The changes to the flow of people through the new system as a result of these three changes is summarised in the diagram and described in more detail at Section 3.4. In order to keep the summary simple and focus on the actual changes, the “ED various” heading captures all the remaining flows not affected directly by the changes in this business case.

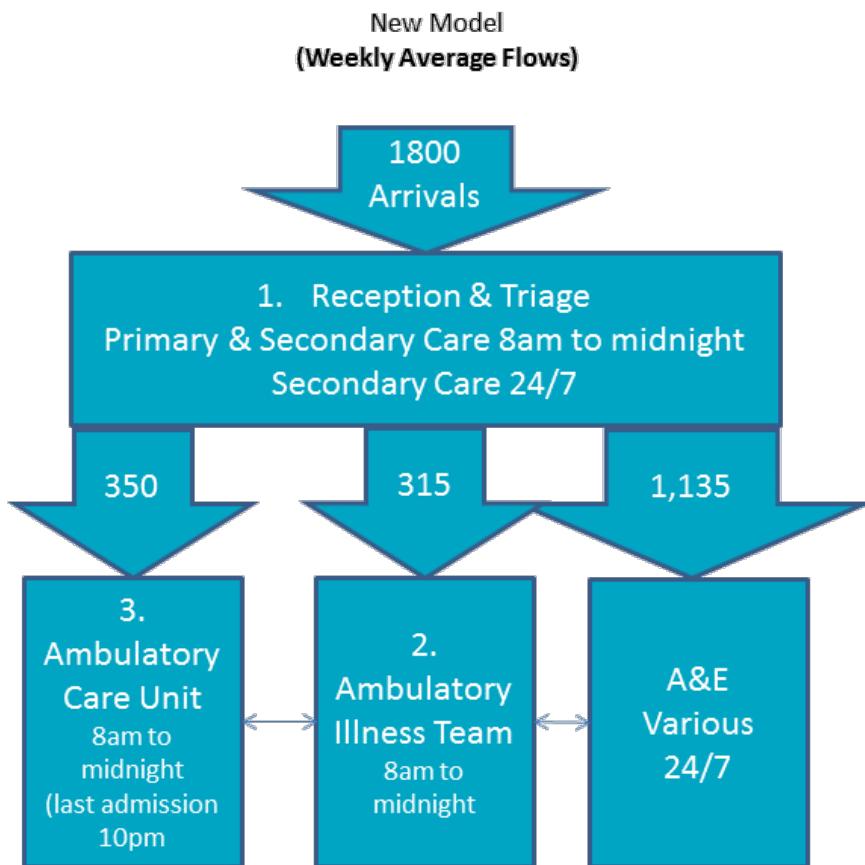


Figure 6: Anticipated ED Flow in New Model

3.3.1

Change 1: Reception & Triage Function

For other changes to work effectively triage capability at the front-door will have to be considerably strengthened and this is a clear expectation of this case. In the new model the workforce will have both the Ambulatory Care Unit and primary care clinicians at the front door of the Emergency Department. This combination of primary & Ambulatory Care Unit experience and expertise will support decision making about what is capable of being managed outside an ED. To ensure that the benefit of this experience is maintained it will be important that the primary care clinicians continue to practise regularly in a primary care setting as well as in the triage function.

The enhanced ED triage capability will be in place between 8am and midnight each day in line with the peak period of demand. The additional workforce will consist of a senior primary care nurse at all times during this period.

The triage staff will use a clear and standard set of protocols to enable safe and consistent streaming including the use of Early Warning Scores (EWS). These protocols will stream some people directly on to an Ambulatory Care Pathway and thus straight out of the Emergency Department to the

Ambulatory Care Unit, or where people present with undifferentiated ambulatory care and are deemed low risk into the Ambulatory Illness team where clinicians with primary care expertise will address their issues. All other individuals will continue into the existing ED pathways as now. Other changes here are outside the scope of this case. Triage should be completed within 15 minutes of arrival.

Currently all children are triaged to the Paediatric Emergency Department. Children triaged as capable of being managed by the Ambulatory Illness team will in the new model still be sent to the Paediatric Emergency Department to ensure an appropriate environment **but** will be managed by the Ambulatory Illness team in the same way the adults are. The split is expected to be 30 adults, and 15 children on average.

On arrival at ED individuals will start the clock on the 4hr wait standard. Once triaged either into the Ambulatory Care Unit or to the Ambulatory Illness team they will effectively be discharged from ED and the clock will stop. Given the relatively straightforward nature of concerns referred to the Ambulatory Illness team people will be seen quickly and there will be local key performance indicators to support this.

Whilst the Ambulatory Care Unit and Ambulatory Illness team are not technically part of the ED there will be in place protocols and working practices to ensure advice can be accessed quickly from the whole team and people moved between the three areas rapidly should the need arise. All three elements will be on the existing hospital site.

The triage team will be supported with EMIS viewer enabling them to view the GP records of all patients attending the department. This will improve decision making at the start of the process and allow teams to identify those who have already seen a GP within the last few hours.

Outside the core opening hours of the Ambulatory Care Unit and the Ambulatory Illness team the triage team will send all patients through the current ED routes as currently happens.

3.3.2

Change 2: Ambulatory Illness Team

This service will be staffed by clinicians with primary care expertise, specifically GPs and Advanced Nurse Practitioners (ANPs). They will have rapid access to the Emergency Department and Ambulatory Care Unit advice if required and will work alongside this wider team.

The Ambulatory Illness team will operate between 8am and midnight each day. This reflects the current demand described at Section 2.2 above and the

scaling back of triage functions at midnight. There will be a GP on site from 12noon to 10pm and Advanced Nurse Practitioner (ANP) from 10am to midnight. Between 8am and 10am when flows are lower the senior primary care nurse in triage team will fulfil this function.

To ensure that the staff have the necessary primary care skills and risk tolerance, experience and approach, it has been decided that an external provider should set the service up initially, but that this will be reviewed by Summer 2017. Therefore, once a patient is transferred to the Ambulatory Illness team they will be managed by that provider and sit within their clinical governance. However, as noted elsewhere in other respects such as access to advice and diagnostics the boundaries between the teams described in this model will be porous.

Patients transferred out of ED to this team will be seen within 2 hours and normally discharged. Key Performance Indicators will monitor this. Decision making staff in this area will also have access to GP records through the use of EMIS viewer and hence live information on medication, latest appointments, allergies etc.

The clinical team in this area will have the ability to transfer patients directly to the Ambulatory Care Unit or ED should the need arise. This will include access to the RAID team where mental health issues can be addressed.

3.3.3 **Change 3: Ambulatory Care Unit**

Improved Pathways

Further work will be done to add to and strengthen the Ambulatory Care Sensitive (ACS) conditions pathways. The intention is to focus on processes across the front end of the hospital working on symptom presentation rather than simply those already diagnosed as having an Ambulatory Case Sensitive condition being placed on very disease specific pathways. The new pathways will include the provision of prevention advice. This approach will then be actively embedded utilising training and protocol driven processes, and audited on a regular basis to ensure that there is full compliance in both the streaming and management of patients in the Ambulatory Care Unit.

Extended Hours and Capacity

Whilst there might be a case for having the Ambulatory Care Unit open 24/7 the local evidence suggests that the optimum opening times should be 8am to 12 midnight. However, unlike the pre-existing service going forward it will open for the full period seven days per week.

The business case therefore proposes an extension of the hours from Monday to Friday 8am to 10pm (last admission 6pm) to 8am to midnight (last

admission 10pm) and also to opening on a Saturday and Sunday across the same time frame instead of the current shorter hours. In total this will be an additional 34 hours per week during which patients can be admitted, a 33% increase.

The disaggregation of the unit from other similar units will roughly doubled capacity going from 4 spaces to 7, with a waiting area.

There has been a phased increase. The new enlarged Ambulatory Care Unit opened in late October 2016 and phase 1 optimised existing pathways to increase capacity and ensure the staffing complement was in place. Then in late November 2016 the unit commenced operating 7 days a week at current operating hours. In February 2017 it moved to operating at the full capacity described here.

3.4 Impact on Activity and Flow

3.4.1 Flow Through Department

The table below describes the previous (2015-16) and expected flow (full effect) through the department when fully implemented as both a weekly average and an annual position.

Table 1: Current and Planned flow through ED

Annual Activity	Weekly Average		Annual		
	Baseline	New Model Full Effect	Baseline	New Model Full Effect	
Attendance at ED Department	1800	1800	93,600	93,600	
Ambulatory Illness Stream	0	315	0	16,380	
Ambulatory Care Unit	160	350	8,320	18,200	
Rest of ED Department	1640	1135	85,280	59,020	
Change		505		26,260	

In calculating this flow a number of assumptions have been made and these are set out in full in **Appendix 1a: Impact on ED**. In summary we have used the existing 2015-16 attendances and flow as the basis; the 45 per day into the Ambulatory Illness team is based on an audit from Autumn 2016 triangulated with retrospective coding reviews; and the increase from 190 to 350 going into the Ambulatory Care Unit is based on the increase in capacity and early evidence from the first few months of service piloting.

3.4.2

Impact on admissions via ED (flow beyond department)

The table below describes the anticipated impact of the changes within Ambulatory Care Unit (ACU) on admissions into the wider hospital. Again this is shown on both a weekly average and an annual basis.

Table 2: Current and planned admissions via ED

Annual Activity	Weekly Average		Annual	
	Baseline	Full Effect	Baseline	Full Effect
Admitted via ACU	34	53	1,768	2,756
Admitted via Ambulatory Illness	N/A	N/A	0	0
Admitted via Rest of ED	508	451	26,416	23,452
Total	542	504	28,184	26,208
Difference		39		1,976

In calculating these numbers assumptions have been made and these are set out in full in **Appendix 1b: Impact on Admissions**. In summary, we have assumed that the admission rate of those being managed within the Ambulatory Care Unit will decrease from 21% to 15%. This assumption is in line with similar units elsewhere in the country. We have also assumed that of the 190 additional Ambulatory Care Unit patients coming from the other areas of ED 30% will currently have been admitted to hospital and 70% discharged.

3.5

Cost Benefit Analysis (CBA)

The table below shows the costs associated with the new schemes and the benefits of those schemes. The costs are based on specific work done on the additional capacity required to run the Ambulatory Care Unit and separate units as a result of an increase in capacity and disaggregation. They are actual costs. It is assumed tests undertaken either in ED or on admission will still be required albeit more prior to admission, and therefore there is no assumption made on savings for this area.

Table 3: Cost Benefit Analysis – annual costs and benefits by year

ANNUAL BENEFIT	16-17 (5)	17-18 (6)	18-19	19-20	20-21	
Additional Costs of Ambulatory Care Unit 1	£550,000	£1,607,000	£1,622,300	£1,456,300	£1,290,300	
Additional Costs AI team and Triage 2	£416,000	£1,032,684	£877,781	£877,781	£877,781	
Total Costs	£966,000	£2,639,684	£2,500,081	£2,334,081	£2,168,081	
Benefit of reduced A&E department 3	£0	-£1,502,072	-£1,848,704	-£2,310,880	-£2,310,880	
Benefit of reduced admissions 4	£0	-£2,455,807	-£3,022,531	-£3,778,164	-£3,778,164	
Total Benefits	£0	-£3,957,879	-£4,871,235	-£6,089,044	-£6,089,044	
Net Benefit /Loss	£966,000	-£1,318,195	-£2,371,154	-£3,754,963	-£3,920,963	

Once more a number of assumptions have been made and these are set out in more detail in **Appendix 2a: Cost Benefit Analysis Plan**. In summary the

key assumptions are firstly that the costs for both the Ambulatory Care Unit and Ambulatory Illness stream will decline slightly as a consequence of reducing dependency on agency staff and short-term external contract for Ambulatory Illness team; and secondly, given the significant deflections out of the existing ED there will be a reduction in associated costs.

The additional costs of the Ambulatory Care Unit and other associated changes are set out in **Appendix 3: Costs – Ambulatory Care**.

3.6

Sensitivity Analysis

Clearly the above cost benefit analysis makes assumptions about the benefits and costs and assumes that the risks of implementation [See Section 6.2] and procurement do not materialise (downside). There is likely to be a degree of optimism bias therefore in these assumptions. However, equally there are a few areas where greater benefits and further cost reductions could be made (upside). We have therefore undertaken some sensitivity analysis **on both down and upsides**. The full detail of this analysis including the assumptions can be found in Appendix 2: Cost Benefit Analysis. The outputs of this work are that there is a range of **net benefit** by 2020-21 of £0.6m to £5.7m with the most likely scenario being £3.9m per annum by 2020-21. For the purposes of the financing of the transformation we are using the planned **£3.9m net benefit** for benefits and costs.

3.7

Impact on Partner Organisations

Decision makers should note that these are calculated on **the most likely scenario** in the sensitivity analysis and increases in cost or reductions in benefits described in the downside and upside scenarios will impact. The primary impact in pure tariff terms will fall on NHS Stockport Foundation Trust with the benefit accruing to NHS Stockport CCG. However, the work on MCP development, the joint commitment locally to bring the whole system back to sustainability and the reality of the phasing of cost reduction to take into account fixed, semi-fixed and variable capacity will all need to be addressed as part of the contract and risk share negotiations. These are described in the Economic Business Case. The total number of bed days no longer required by 20/21 is estimated as 10,342 based on 2028 fewer admissions at an average length of stay of 5.1.

3.8

Other Financial and Non-Financial Benefits

- The evidence of rapid loss of long-term independence of older people on admission to an inpatient bed means that the greater number of people treated in the Ambulatory Care Unit and discharged will increase independence at a population level and therefore reduce dependency on

community health & social care services. This economic benefit has not been calculated for this case, but this will contribute to the overall planned reduction in care home admission.

- By reducing by 505 (28% of ED activity) the number of people per week requiring the main ED and discharging them to either the Ambulatory Illness team or the Ambulatory Care Unit within minutes of clock start it is expected that this will contribute to delivery of the 4hr waiting time target within ED.
- Less pressure in the department will also contribute to improving safety and patient experience. The latter will be reflected in improvements in the friends and family score.
- A less tangible benefit will be the closer working of hospital, primary care and voluntary sector staff and therefore contribute to the sense of a single wider team within the emerging MCP.

4 Financial Case

4.1 Funding the New Model

Decision makers should note that the funding requirements are **calculated from the most likely scenario** in the sensitivity analysis described above and increases or reductions in cost or benefits described in the downside and upside scenarios will impact on the financing required.

The five principle sources of funding identified are the *Current Contracts*, *GM Transformation Fund* (non-recurrent), *Winter Pressures Funding*, *reduced ED capacity*, and *reduced non-elective activity*.

The investment required falls from a peak of £2,539,684 in 2017-18 to £2,068,081 by 2021 as the previously described agency and short-term external contract issues are addressed. In 2017-18 there is significant investment from non-recurrent sources (GM Transformation Fund etc.) by 2021 this is funded through a reformed ED infrastructure.

The costs and funding sources across each year are described in the table below:

Table 4: Cost and financing of new model by year

Additional Costs		16-17 ⁵	17-18 ⁶	18-19	19-20	20-21
Total Additional Costs		966,000	2,639,684	2,400,081	2,234,081	2,068,081
Less Benefit of reduced ED department		0	-544,433	-2,311,764	-2,234,081	-2,068,081
Less Contribution from reduced admissions		0	-890,118	-88,317	0	0
Less GM Transformation /Winter Pressures		-966,000	-1,205,133	0	0	0
Unfunded Balance		0	0	0	0	0

How these investments relate to the wider economic case is set out in the system level Summary Economic Case.

5

Commissioning Arrangements and Assurance

5.1

Current Arrangements

The ED at NHS Stockport Foundation Trust is currently commissioned by NHS Stockport CCG and forms part of the total contract between these two parties.

5.2

Commissioning Approach

The CCG with its partners at Stockport Metropolitan Borough Council, with which it has pooled a significant proportion of the funding for this area, has made it known (MCP) which includes aspects of hospital care including all those services directly in scope of this business case.

5.3

Commissioning These Changes

Therefore, in the future from the date at which an MCP contract is in place the responsibility for identifying the best mechanism for providing the services to be provided as described above will rest with the MCP as both integrated provider and a tactical commissioner.

However, in the meantime the following steps have been and will be in place:

Phase 1

November 16 to April 17: The additional capacity and changes within the Ambulatory Care Unit formed a contract variation between Stockport NHS Foundation Trust (the Provider) and NHS Stockport CCG (the Commissioner). NHS Stockport CCG released GM Transformation Funding to pump prime the changes as described in the financial section above.

The Ambulatory Illness team and streaming at the front door formed a contract between Stockport NHS Foundation Trust (The Contract Holder) and MasterCall (the Provider). This was in effect a sub-contract of activity commissioned by NHS Stockport CCG and funded through a contract variation utilising Winter Pressures resources as set out in the financial section above. This sub-contract arrangement will be in place for 12 months from October 2016.

Phase 2

On approval of the business case Stockport NHS Foundation Trust will look to recruit permanent staff to replace locum staff within the Ambulatory Care Unit

and reduce costs as outlined in the economic and financial case; and consider additional cost reduction measures such as consultant on-call rather than on-site cover.

Further, Stockport NHS Foundation Trust as the provider of the triage streaming and ED services including the Ambulatory Illness stream will test value-for-money provision of these services either through bringing services back in-house, or procurement, by October 2017 to bring the contract value in line with the economic and financial case set out above.

Given that funding for this service is based on first presentation then NHS Stockport CCG will vary the contract value accordingly back to the existing arrangements.

5.4

Monitoring of Contract

Until such time as an MCP contract is in place the CCG as the commissioner will monitor the implementation of plans, any variations from plan and benefits delivery. It will do this through the Stockport Together partnership as described in Section 5 of this case and through the Urgent Care Delivery Board.

5.5

Application of 5 National Tests

The design process has addressed the four tests set out in the 2014/15 mandate from the Government to NHS England. Proposed service changes must be able to demonstrate evidence of each of these. Simon Stevens has since added a 5th test which is also addressed.

5.5.1

Strong public and patient engagement;

There have been 60 public engagement events that have reached nearly 2000 members of the public across Stockport. Citizen Space, the CCG's online survey website has been used to survey 1000s of people about various topics during development of the plans.

One of the themes in the engagement was about making choices simple. Several people felt that alternatives to ED are too confusing because there are different opening times and phone numbers to remember, at least with ED it is open 24 hours and everything is on one site. People felt that for this reason the problems will never really improve.

Example quote: "*Why don't you consider a porta-cabin on the hospital site for GPs to staff. The patients can then be treated and sent home or redirected to ED for further treatment/investigation.*"

Education about self-care and care closer to home came up as a regular theme. People were often surprised to find that by attending ED it would not necessarily expedite their test results or clinic appointments. Regularly people mentioned that education in schools would be part of the solution.

Engagement has been built into the governance of Stockport Together with the appointment of a Citizens' Representation Panel. The Chair and HealthWatch member of this panel also sit on the executive committee. The Citizens Panel discussed the Ambulatory Care Unit interface work at their 2016 meetings on 15th June and 13th September and received information about the ambulatory care business case at their meeting on 18th October.

At the first two meetings listed above, the panel asked that when there are any changes in ED that patients be provided with appropriate, clear and simple information. They also asked that the needs of mental health patients be considered in all developments.

In the discussions about the ambulatory care pathway the panel wanted to ensure that there is a focus on educating patients about self-care, particularly for those patients that are streamed to the 'Ambulatory Illness' area. They also asked that the different providers have a shared 'glossary of terms' that they use amongst staff and patients.

There has been detailed staff involvement in the plans for the new Ambulatory Care Unit and primary care streaming and the staff have greatly appreciated that their views have been heard in the developments.

5.5.2

Consistency with current and prospective need for patient choice;

The choice agenda is not directly impacted by the service changes proposed as they happen behind the front door of ED. They are not therefore affecting a decision on where to attend rather better managing care once that choice has been made.

5.5.3

A clear clinical evidence base

See Section 3.2 describing the evidence reviewed by the team undertaking the design. As set out in section 2.4 these proposals are in line with national reviews of Urgent Care Review and ED.

5.5.4

Support for proposals from clinical commissioners

As described in Section 2.6 these proposals were jointly designed by CCG and provider colleagues and the business case is to be approved by the CCG Governing Body in July 2017.

5.5.5

New capacity is in place if bed capacity is likely to reduce

The business case will result in fewer admissions. It will therefore contribute to a review of the overall bed base necessary as a consequence of wider service changes described in the full Integrated Service Solution and through Healthier Together. The reduced levels of admissions described in this case are as a consequence of increased capacity to manage people in the Ambulatory Care Unit where a full admission is not in their best interest. Therefore, additional capacity is being provided to meet potential reductions.

6 Management Plan

6.1 Milestones

The key delivery milestones are described below. Those marked with a C are already complete.

Milestone	Date	Lead
Phase 1 Streaming & Ambulatory Illness Team in place C	Oct 16	SFT
Full Streaming & Ambulatory Illness Teams in place C	Dec 16	SFT
Monitoring Framework in place and reporting	Dec 16	PO
EMIS Viewer in Triage and Ambulatory Illness team C	April 17	SFT / CCG
All ACS pathways approved and in place C	Jan 17	SFT
Evaluation of first 3 months report C	Feb 17	UCDB
Ambulatory Care Unit operating at full capacity C	April 17	SFT
Business Case Approval	June 17	SFT/ CCG
Full business review of model and decision	July 17	UCDB
Audit of effectiveness of new ACS pathways	July 17	UCDB
Commence Market Testing of Streaming & Ambulatory Illness	July 17	SFT
Commence Recruitment of permanent Ambulatory Care Unit capacity	July 17	SFT
Move Streaming & Ambulatory Illness Unit in-house or to 3year value for money (VFM) tested contract	Oct 17	SFT
Contract variation issued	Nov 17	CCG

6.2 Risks and Mitigation (review and score)

The risk assessment was under-taken against a framework of risk areas and then assessed against impact (I) and Likelihood (L) to give a risk rating (R). Each risk was rated on a scale of 1-5 against impact and also 1-5 against likelihood. The overall risk rating is impact multiplied by likelihood.

Level	R Risk	Colour
Extreme	20-25	Red
Very High	15-19	Red
High	10-14	Orange
Moderate	6-9	Yellow
Low	1-5	Green



Risk Area	Risk	Impact & Score	L	R	Mitigation
Workforce related issues	1. Recruitment of permanent staff to new unit and become over reliant on locums	Will prevent cost reduction in later years Locum use will reduce adoption of good practice (4)	3	12	- Business case commitment to ongoing funding - Recycling of staff in ED as case assumes no overall change in demand - GM level recruitment plans
	2. ACU staff are pulled into ED at pressure points	Under-utilisation leading to reduced benefits – financial and care (3)	3	9	- Strengthen triage to ensure unit full - Agreement to ring fence ACU staff with dedicated team
	3. Staff are do not agree to working extra hours	Locum use will increase costs and reduce good practice adoption (3)	3	9	- Staff side engagement - Recruitment to redress - Consider on-call rather than on-site cover for medical
Procurement & Commercial	4. Market not yet tested for primary care support in AI stream	Cost reductions post 17-18 not realised (4)	3	9	- Bring service in-house - Offer longer-term contract
Regulatory challenges	5. Ongoing pressures in ED Performance divert focus	Model not implemented and benefits not realised (4)	3	12	- Single accountable person for both aspects - Urgent Care Delivery Board oversight for both - Benefits Realisation Plan in place and monitored
Organisation Developm't	6. Leadership to adopt and embed changes in process and mind set not sustained	Revert to old patterns and benefits not realised (4)	3	12	- Urgent Care Delivery Board oversight - Benefits Realisation Plan in place and monitored - Named clinical leader for each aspect
Dependency	7. Changes in wider system do not address growth	Existing system overwhelmed and benefits lost (4)	2	8	- Robust programme management across system - Business cases and investment out-of-hospital - Growth slowing
	8. IM&T infrastructure & IG not in place	Records not accessible increasing risk adverse approach (3)	2	6	- IG protocols and Privacy Impact Assessments in place and indemnity across partners - EMIS viewer in ED and ACU - Training for staff on system
	9. Ambulatory Illness stream attracts business	Increased numbers requiring additional capacity and costs (2)	3	6	- Not advertised and behind ED triage - To meet safety capacity higher than actually required already - Considerable investment in General Practice access
Change Capacity	10. Regulatory pressures divert change resources	Model of care not fully implemented or embedded and benefits not realised	4	12	- Single accountable person for both aspects - Urgent Care Delivery Board oversight for both



		(3)				- Benefits Realisation Plan in place and monitored - Capacity resource plan
	11. Change resource moved too quickly	Model of care not fully implemented or embedded and benefits not realised (4)	4	16		
Benefits Realisation	12. Lack of detailed benefits realisation plan	Model of care not fully implemented Activity reductions do not result in reductions in cost base in ED or specialty wards (4)	3	12		- Benefits Realisation Plan

6.3

Resources

Under local arrangements for the Stockport Together the specific change resources required will be managed by the Provider Board and its associated partners. This case will be signed up to by relevant partners and in so doing will commit to using their own operational management capacity supplemented by GM Transformation Fund resources to implement the case over the timeframes described in Section 6.1.

The specific resource needs to deliver the change are shown below.

Role	WTE	Duration	In Post	/ Funding Need	
Change Manager	1.0	15 months	Need	GM Transformation	
SRO	0.2	15 months	In post	SFT	
Programme manager	1.0	15 months	In post	GM Transformation	
Clinical lead (CCG)	0.4	15 months	In post	CCG	
Clinical lead (FT)	0.2	15 months	In post	SFT	
Business Manager (FT)	0.4	15 months	In post	SFT	
Business Analyst	0.4	6 months	Need	Various	
ED Nurse consultant (FT)	0.5	6 months	In post	SFT	
Clinical lead (community)	0.2	15 months	In post	SFT	
TOTAL	4.3				

6.4 Monitoring

6.4.1 Key Performance Indicators

The following measures are in place to enable monitoring of implementation and evaluate benefits delivery:

1. Number of people utilising Ambulatory Illness team – target 315 per week
2. Proportion of people discharged directly by the Ambulatory Illness team – target 100%
3. Number of people in the Ambulatory Care Unit – target 350 per week
4. Proportion of people discharged from the Ambulatory Care Unit – target 85%
5. Proportion of people admitted within 48hrs following treatment by Ambulatory Care Unit or Ambulatory Illness team – target 0%
6. Percentage of people presenting at ED discharged or admitted with 4hrs – target 95%
7. Percentage of people streamed to the Ambulatory Illness team discharged within 2hrs – target 95%
8. Friends and family test of all those presenting at ED – no specific target except improvement.

6.4.2 Monitoring Process

The Urgent Care Delivery Board and Stockport Together Programme Board will monitor these indicators on a monthly basis.

6.5 Evaluation

There will be no formal academic evaluation of this business change except that completed within the wider programme. However, there will be a full business review of progress against the indicators in Section 6.4.1 and a review of the impact on bed capacity and thus cost reduction at Stockport NHS FT. This will be completed in time to undertake market testing and switch to permanent employees beyond the period of initial contracts.

6.6 Equality Impact Assessment

An equality impact assessment (EIA) has been drafted and is attached. Further work is required on this.

7

Conclusion and Recommendation

This business case is recommended by the Stockport Together Executive Board as the most cost effective solution to meeting the strategic business objectives described at section 2.3 and thereby contributing to the sustainability of the local health & social care economy:

- It will reduce the number of patients with an ambulatory care condition presenting at ED who are subsequently admitted to a hospital bed
- It will reduce the proportion of people presenting at the front door of ED who are subsequently managed in the ED from 1640 per week in 2015-16 to 1135 per week by 2020/21
- It will address the management and flow of undifferentiated ambulatory care patients through the ED resulting in an increase in the number of people seen in the Ambulatory Care Unit from 160 per week in 2015-16 to 350 per week by 2020/21
- It will contribute to the reduction in the number of admissions of patients with ambulatory care conditions admitted to hospital across the economy.
- It will contribute to the reduction in the proportion of people attending ED who are admitted for any reason from c30% in 2015-16 to c25% by 2020/21
- It will contribute to delivering the ED NHS constitution indicator of 95% of people seen within 4hours by triaging c95 people per day straight out of the department and allowing the ED team to focus on more critical patients
- It will contribute to the move towards 7 day working by having in place dedicated services to address Ambulatory Illness and ambulatory sensitive conditions 7 days a week.
- It will improve the experience of people and their families attending ED by creating a safer and less pressured environment
- It will ensure that the financial benefits of the changes will be greater than the costs incurred across a 5 year period and contribute a net benefit to the Stockport Health economy per annum by 2020/21 of £3.9m.

Work has already commenced on implementation of this model and decision makers across the partnership are asked to approve the business case to ensure long-term delivery subject to the appropriate ongoing monitoring and evaluation as described above

AMBULATORY CARE OUTLINE BUSINESS CASE APPENDICES

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Appendix 1a: Impact on Emergency Department (ED)

The table below indicates the current (April 2016) and the expected flow through ED, and the impact in terms of numbers. The assumptions taken in making this assessment are shown underneath.

Annual Activity	Weekly Average			Annual		
	Baseline		New Model	Baseline		New Model
			Full Effect			Full Effect
Attendance at ED Department¹	1800	1800		93,600	93,600	
Ambulatory Illness Stream ²	0	315		0	16,380	
Ambulatory Care Unit ³	160	350		8,320	18,200	
Rest of ED Department⁴	1640	1135		85,280	59,020	
Change⁵		505			26,260	

Assumptions and impact

1: We have assumed a static position for ED attendances based on existing information for two reasons. Firstly, the benefit of this piece of work needs be demonstrable without having to assume success of out-of-hospital initiatives. Secondly, if the other initiatives succeed they will at worse simply remove activity from the Ambulatory Care Unit and possibly allow for a reduction in costs whilst delivering the same benefits; at best they will add to the benefit described here which is the assumption in the wider Stockport Together Summary Economic Case.

2: We have assumed 45 people a day can be streamed to the Ambulatory Illness Team. Using an audit in Autumn 2016 we have assumed 34 adult, 11 paediatric. This also triangulates with analysis from the 2015-16 data that describes treatments that do not require ED level services. The breakdown is set out in the table below. This indicates 60 per day but it is easier to retrospectively identify people and hence we have utilised the more conservative assumption.

Row Labels	Count of InternalPatientNumber
Administer Oral T'ment	8538
Administer Per Rectum	17
Administer Skin Cream	4
Loan of Walking Aid	47
No Treatment Given	1641
Prescription	426
Recording Vital Signs	8449
Removal Sutures/Clips	15
Verbal Advice	2841
Written Advice	607
Grand Total	22585

This is further reinforced when looking at the number of patients discharged who did not require diagnostic services to advise or treat prior to discharge, as the table below indicates. The slight discrepancy in numbers is because some people may have had more than one test, and a few conditions that are ambulatory in nature but would not be seen by the team were included in this second group. The message is clear that treatment happens without need for diagnostics.

Row Labels	Count of InternalPatientNumber
Biochemistry	219
Electrocardiogram ECG	386
None	24222
Pregnancy Test	3
Urinalysis	148
Grand Total	24978

3. We have assumed that 350 people will go through the Ambulatory Care Unit weekly, an additional 190 above current levels. This is based on the changes that are being put in place including better streaming, improved protocols, an increase in hours and a doubling of the available capacity.
4. If we adopt these assumptions then there will be only 1,135 people seen in the rest of the department per week.
5. This is 505 fewer than currently. This figure of 505 is then used within the financial benefits modelling in Appendix 2.

Appendix 1b: Impact on Admissions

The table below sets out the current (April 2016) position and the anticipated change as a result of implementing the case. The assumptions in coming to this conclusion are described below.

Annual Activity	Weekly Average		Annual	
	Baseline	Full Effect	Baseline	Full Effect
Admitted via ACU ¹	34	53	1,768	2,756
Admitted via Ambulatory Illness ²	N/A	N/A	0	0
Admitted via Rest of ED ³	508	451	26,416	23,452
Total	543	504	28,184	26,208
Difference⁴		39		1,976

Assumptions and Impact

1: We have assumed that the admission rate of those being managed within the Ambulatory Care Unit will decrease from 21% to 15%. This assumption is in line with evidence from similar units elsewhere in the country. The improved pathways, dedicated space, and specialist team are expected to support this improvement. Opening later hours, and stronger links to community teams will also increase ability to handle individuals later in the day and discharge with greater confidence. Therefore, currently 21% of the 180 people seen per week in the Ambulatory Care Unit are admitted (34) whereas in the future only 15% of the 350 people will be admitted (53).

2: The Ambulatory Illness stream will be seeing people who are all currently discharged and we are assuming that nothing about the Ambulatory Illness team will alter this.

3: The reduction in admissions from ED is based on the following.

Annual Activity	Change in ED	
	Admitted	Discharged
Current Position	508	1132
Less Moving to AMBULATORY ILLNESS unit (315)	0	-315
Less Moving to AMBULATORY CARE UNIT (190)	-57	-133
Total	451	684

The critical assumption in this table is that of the 190 additional Ambulatory Care Unit patients coming from the other ED work-streams, 30% will currently have been admitted in a non-specialist area and 70% discharged. We cannot assume all will currently be admitted. Given 21% are currently admitted by

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

specialists operating in a dedicated environment and approach focussed on discharge, this assumption feels right for others without this specialist expertise operating in a busy routine EDED within a 4 hour time window and reflects broader existing admission rates.

4. This results in a reduction of 39 admissions per week and this figure has been used as the basis for the financial calculations in the cost benefit analysis.

Appendix 2a: Cost Benefit Analysis Plan

ANNUAL BENEFIT	16-17 (5)	17-18 (6)	18-19	19-20	20-21
Additional Costs of Ambulatory Care Unit 1	£550,000	£1,607,000	£1,622,300	£1,456,300	£1,290,300
Additional Costs AI team and Triage 2	£416,000	£1,032,684	£877,781	£877,781	£877,781
Total Costs	£966,000	£2,639,684	£2,500,081	£2,334,081	£2,168,081
Benefit of reduced A&E department 3	£0	-£1,502,072	-£1,848,704	-£2,310,880	-£2,310,880
Benefit of reduced admissions 4	£0	-£2,455,807	-£3,022,531	-£3,778,164	-£3,778,164
Total Benefits	£0	-£3,957,879	-£4,871,235	-£6,089,044	-£6,089,044
Net Benefit /Loss	£966,000	-£1,318,195	-£2,371,154	-£3,754,963	-£3,920,963
Model assumptions of impact		65%	80%	100%	100%
A&E Deflections		17,069	21,008	26,260	26,260
Assumptions:					
1 Costs provided by the Foundation Trust for 16/17 to 18/19 (dated 03/08/16) assumption for 19/20 is a reduction of agency costs by 50% and fully removed in 20/21. 2016/17 £250k is a part year cost until the end of December which was agreed by Executive Board and will be subject to additional request so as a proxy £300k has been added for Jan - March 2017.					
2 This is the cost of the front end primary care input currently supplied by Mastercall. The value for 16/17 and 17/18 is as per the proposal received from Mastercall. For 18/19 onwards the cost has been reduced by 15% which will be made from contract review.					
3 For 17/18 it is assumed 65% of the 505 people per week will no longer go into the existing A&E workstreams as they currently do (315 Ambulatory III Team plus additional 190 into the ACU) and 80% for 18/19 and 100% for 19/20 onwards. The assumption therefore is that capacity can be reshaped to some extent. Assumed cost reduction based on £88 per person as an average A&E tariff.					

Appendix 2b: Cost Benefit Analysis Downside

	ANNUAL COST BENEFIT	16-17	17-18	18-19	19-20	20-21
Additional Costs of Ambulatory Care Unit (1)		£550,000	£1,607,000	£1,622,300	£1,622,300	£1,622,300
Additional Costs AI team and Triage (2)		£416,000	£1,032,684	£1,032,684	£1,032,684	£1,032,684
Total Costs		£966,000	£2,639,684	£2,654,984	£2,654,984	£2,654,984
Benefit of reduced A&E department (3)		£0	-£751,036	-£924,352	-£1,155,440	-£1,155,440
Benefit of reduced admissions (4)		£0	-£1,385,327	-£1,705,018	-£2,131,272	-£2,131,272
Total Benefits		£0	-£2,136,363	-£2,629,370	-£3,286,712	-£3,286,712
Net Benefit /Loss		£966,000	£503,321	£25,614	-£631,728	-£631,728
Model assumptions of impact			65%	80%	100%	100%
Assumptions:						
1 The assumption that initial high start-up costs for the Triage and Ambulatory Illness team cannot be reduced through competitive process or similar and remain as high throughout as in year 1 and 2.						
2 The assumption that locum use will be replaced in ACU with permanent staff is not realised						
3 A&E deflections of 505 patients do not materialise and only 50% reduction in activity						
4 190 increase in patients being directed to ACU instead of ED per week. The change in this assumption is that 20% rather than 30% were being admitted to a speciality. Therefore there is less benefit gained through going into ACU. The assumption therefore is a reduction in the Non Elective attendance deflection.						

Appendix 2c: Cost Benefit Analysis Upside

ANNUAL COST BENEFIT	16-17	17-18 (3)	18-19	19-20	20-21
Additional Costs of Ambulatory Care Unit (1)	£550,000	£1,607,000	£1,290,300	£1,290,300	£1,290,300
Additional Costs AI team and Triage (1)	£416,000	£1,032,684	£877,781	£877,781	£877,781
Total Costs	£966,000	£2,639,684	£2,168,081	£2,168,081	£2,168,081
Benefit of reduced A&E department	£0	-£1,848,704	-£2,310,880	-£2,310,880	-£2,310,880
Benefit of reduced admissions (2)		-£4,495,046	-£5,618,808	-£5,618,808	-£5,618,808
Total Benefits	£0	-£6,343,750	-£7,929,688	-£7,929,688	-£7,929,688
Net Benefit /Loss	£966,000	-£3,704,066	-£5,761,607	-£5,761,607	-£5,761,607
Model assumptions of impact		80%	100%	100%	100%
Assumptions:					
1 Downside risks do not materialise and dependencies deliver on schedule					
2 190 increase in patients being directed to ACU instead of ED per week. The change in assumption is that 40% would of converted to a speciality admission rather than 30%. There is therefore a greater gain through transfer to the ACU than the original set of assumptions and therefore is an additional reduction in the Non Elective attendance.					
3 Deliver more quickly in 17-18 than expected, 80% rather than 65%					

Appendix 3: Costs: Ambulatory Care

Price base at: 18/19
 Brief Description of Scheme:

Description	Times	mm ents Rate	Pay Band	Incremental Date	Allow. Addl	Allow. Enh. %	No of Hours	WTE	Set-up costs		PYE	FYE	FYE
									Oct 18 - Mar 17		Year 1	Year 2	17/18
									Year 1	Year 1	Cost 2018/17	Cost 2017/18	Cost 2018/19

Pay

1. Extended opening hours of ACU

Consultant (available for telephone advice)	Monday to Friday 8pm - 12 midnight	2% Intensity payment with frequency between 1:5 - 1:8							9,100	18,600	18,600		
Consultant (onsite presence) - agency	Saturday and Sunday 8am - 10pm	Agency - £120 p/h							87,600	175,200	177,000		
Senior Clinical Fellow - agency	Monday to Friday 10pm - 12 midnight	Agency - £70 p/h							18,300	36,600	37,000		
Senior Clinical Fellow - agency	Saturday and Sunday 8am - 12 midnight	Agency - £70 p/h							58,400	116,800	118,000		
Junior Clinical Fellow - agency	Monday to Friday 10pm - 12 midnight	Agency - £60 p/h							15,600	-	-		
Junior Clinical Fellow - agency	Saturday and Sunday 8am - 4pm	Agency - £60 p/h							25,000	-	-		
Junior Clinical Fellow - agency	Saturday and Sunday 8am - 5pm	Agency - £60 p/h							25,000	-	-		
Junior Clinical Fellow - agency	Saturday and Sunday 12noon - 12 midnight	Agency - £60 p/h							37,500	-	-		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
sub-total Medical									0	278,600	662,100	667,800	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	29.25	0.78		15,300	30,900	31,200	
Band 2 HCA - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0205	VAC		30.25	18.00	0.48		6,200	12,500	12,600	
sub-total Nursing									7.28	0	134,000	270,100	272,800

2. Junior Clinical Fellow for CDU

Junior Clinical Fellow - agency	Monday to Sunday 8am - 12 midnight	Agency - £60 p/h							350,400				
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
sub-total Medical									3.00	0	360,400	204,900	207,000

3. Extended opening hours of Primary Care Assessment (PCA on ground floor D block)

Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	30.00	0.80		15,700	31,700	32,000	
Band 2 HCA - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0205	VAC		30.25	30.00	0.80		10,700	21,500	21,700	
sub-total Nursing									1.80	0	26,400	63,200	63,700

4. Creation of ED Ambulatory Majors (EDAM)

Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	

Price base at: 16/17

Brief Description of Scheme:

Business Finance

Prepared by: P Caldwell

Description	Times	mm ents Rate	Pay Band	Incremental Date	Allow. Addl	Enh. %	No of Hours	WTE	Set-up costs		PYE Oct 16 - Mar 17	FYE 17/18	FYE 18/19
									Year 1		Year 1	Year 2	Year 3
									Cost 2016/17	Cost 2017/18	Cost 2017/18	Cost 2018/19	
Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0506	VAC		20.63	15.75	0.42		8,000	16,100	16,300	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	13.88	0.37		4,600	9,400	9,500	
sub-total Nursing									6.78	0	112,600	226,800	228,200
5. Creation of 3rd triage													
Band 7 Nurse - substantive	Monday to Sunday 8pm - 2am	SNHSFT staff only, not F	XR0709	TOS		22.05	37.50	1.00		31,800	64,200	64,800	
Band 7 Nurse - substantive	Monday to Sunday 8pm - 2am	SNHSFT staff only, not F	XR0709	TOS		22.05	13.88	0.37		11,400	23,000	23,200	
sub-total Nursing									1.37	0	43,200	87,200	88,000
6. ED trackers													
Band 3 A&C - substantive	Monday to Sunday - 11 hours per day		XN0307	TOS		30.52	37.50	1.00		15,900	32,100	32,400	
Band 3 A&C - substantive	Monday to Sunday - 11 hours per day		XN0307	TOS		30.52	37.50	1.00		15,900	32,100	32,400	
Band 3 A&C - substantive	Monday to Sunday - 11 hours per day		XN0307	TOS		30.52	37.50	1.00		15,900	32,100	32,400	
sub-total A&C									3.00	0	47,700	98,300	97,200
7. One-off to support implementation													
Band 7 Nurse (2 weeks backlog)				XR0709	TOS				37.50	1.00	2,300		
ED - 1 additional hour paid training time for all staff in ED, based on Band 6 average				XR0609	TOS				120.00	3.20	2,700		
sub-total implementation									4.20	6,000	0	0	0
Total Pay									28.72	6,000	980,700	1,480,800	1,506,700

Non-Pay

Recurrent staff costs

Training													
Uniforms												2,200	

One-off set-up costs:

1. Relocation of ACU on TU

Examination couches/reciner chairs	4	1095.60	4,400
Trolies	2	5489.06	11,000
Curtains and rails - disposable			2,000
Observation machines	2	1440.00	2,900
Tympanic Thermometers	2	180.00	400
Large plasma screen	1	2000.00	2,000

Price base at: 16/17
 Brief Description of Scheme:

Business Finance

Prepared by: P Caldwell

Description	Times	mm ents Rate	Pay Band	Incremental Date	Allow. Addl	Allow.	Enh. %	No of Hours	WTE	Set-up costs		PYE 17/18	FYE 18/19
										Year 1	Year 2	Cost 2016/17	Cost 2017/18
Piping oxygen													
Estates work - curtain rails to divide bays, new door entry system												3,000	
Estates work - reconfigure shower into WC and small office												6,600	
2. Creation of EDAM													
Workstations including computers x4 for Primary Care staff			4	480.00								1,900	
Large plasma screen			1	2000.00								2,000	
Waiting room chairs			15	130.00								2,000	
Examination couches/recliner chairs			4	1095.60								4,400	
3. Creation of PCA													
Large plasma screen			1	2000.00								2,000	
4. Creation of 3rd triage													
Monitors x 2 (desktop computer)			2	480.00								1,000	
Workstation x 1 desktop and computer			1	480.00								500	
Desk/fixtures and fittings												1,000	
Estates work - create 3rd triage cubicle												5,000	
5. POC testing													
D-Dimer POC equipment - query will be rental?													
Kit/reagent costs													
6. Advantis Development													
IT developer time at overtime rates			5	450.00								2,300	
Tablets x 5			5	428.87								2,100	
Total Non-Pay												58,700	10,800
TOTAL EXPENDITURE												58,700	1,001,800
Margin (positive indicates a shortfall against income)												58,700	1,607,000
													1,622,300

AMBULATORY CARE BUSINESS CASE

APPENDICES

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Appendix 1a: Impact on Emergency Department (ED)

The table below indicates the current (April 2016) and the expected flow through ED, and the impact in terms of numbers. The assumptions taken in making this assessment are shown underneath.

Annual Activity	Weekly Average			Annual		
	Baseline		New Model	Baseline		New Model
			Full Effect			Full Effect
Attendance at ED Department¹	1800	1800		93,600		93,600
Ambulatory Illness Stream ²	0	315		0		16,380
Ambulatory Care Unit ³	160	350		8,320		18,200
Rest of ED Department⁴	1640	1135		85,280		59,020
Change⁵		505				26,260

Assumptions and impact

1: We have assumed a static position for ED attendances based on existing information for two reasons. Firstly, the benefit of this piece of work needs be demonstrable without having to assume success of out-of-hospital initiatives. Secondly, if the other initiatives succeed they will at worse simply remove activity from the Ambulatory Care Unit and possibly allow for a reduction in costs whilst delivering the same benefits; at best they will add to the benefit described here which is the assumption in the wider Stockport Together Summary Economic Case.

2: We have assumed 45 people a day can be streamed to the Ambulatory Illness Team. Using an audit in Autumn 2016 we have assumed 34 adult, 11 paediatric. This also triangulates with analysis from the 2015-16 data that describes treatments that do not require ED level services. The breakdown is set out in the table below. This indicates 60 per day but it is easier to retrospectively identify people and hence we have utilised the more conservative assumption.

Row Labels	Count of InternalPatientNumber
Administer Oral T'ment	8538
Administer Per Rectum	17
Administer Skin Cream	4
Loan of Walking Aid	47
No Treatment Given	1641
Prescription	426
Recording Vital Signs	8449
Removal Sutures/Clips	15
Verbal Advice	2841
Written Advice	607
Grand Total	22585

This is further reinforced when looking at the number of patients discharged who did not require diagnostic services to advise or treat prior to discharge, as the table below indicates. The slight discrepancy in numbers is because some people may have had more than one test, and a few conditions that are ambulatory in nature but would not be seen by the team were included in this second group. The message is clear that treatment happens without need for diagnostics.

Row Labels	Count of InternalPatientNumber
Biochemistry	219
Electrocardiogram ECG	386
None	24222
Pregnancy Test	3
Urinalysis	148
Grand Total	24978

3. We have assumed that 350 people will go through the Ambulatory Care Unit weekly, an additional 190 above current levels. This is based on the changes that are being put in place including better streaming, improved protocols, an increase in hours and a doubling of the available capacity.
4. If we adopt these assumptions then there will be only 1,135 people seen in the rest of the department per week.
5. This is 505 fewer than currently. This figure of 505 is then used within the financial benefits modelling in Appendix 2.

Appendix 1b: Impact on Admissions

The table below sets out the current (April 2016) position and the anticipated change as a result of implementing the case. The assumptions in coming to this conclusion are described below.

Annual Activity	Weekly Average		Annual	
	Baseline	Full Effect	Baseline	Full Effect
Admitted via ACU ¹	34	53	1,768	2,756
Admitted via Ambulatory Illness ²	N/A	N/A	0	0
Admitted via Rest of ED ³	508	451	26,416	23,452
Total	543	504	28,184	26,208
Difference⁴		39		1,976

Assumptions and Impact

1: We have assumed that the admission rate of those being managed within the Ambulatory Care Unit will decrease from 21% to 15%. This assumption is in line with evidence from similar units elsewhere in the country. The improved pathways, dedicated space, and specialist team are expected to support this improvement. Opening later hours, and stronger links to community teams will also increase ability to handle individuals later in the day and discharge with greater confidence. Therefore, currently 21% of the 180 people seen per week in the Ambulatory Care Unit are admitted (34) whereas in the future only 15% of the 350 people will be admitted (53).

2: The Ambulatory Illness stream will be seeing people who are all currently discharged and we are assuming that nothing about the Ambulatory Illness team will alter this.

3: The reduction in admissions from ED is based on the following.

Annual Activity	Change in ED	
	Admitted	Discharged
Current Position	508	1132
Less Moving to AMBULATORY ILLNESS unit (315)	0	-315
Less Moving to AMBULATORY CARE UNIT (190)	-57	-133
Total	451	684

The critical assumption in this table is that of the 190 additional Ambulatory Care Unit patients coming from the other ED work-streams, 30% will currently have been admitted in a non-specialist area and 70% discharged. We cannot assume all will currently be admitted. Given 21% are currently admitted by

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specialists operating in a dedicated environment and approach focussed on discharge, this assumption feels right for others without this specialist expertise operating in a busy routine EDED within a 4 hour time window and reflects broader existing admission rates.

4. This results in a reduction of 39 admissions per week and this figure has been used as the basis for the financial calculations in the cost benefit analysis.

Appendix 2a: Cost Benefit Analysis Plan

ANNUAL BENEFIT	16-17 (5)	17-18 (6)	18-19	19-20	20-21
Additional Costs of Ambulatory Care Unit 1	£550,000	£1,607,000	£1,622,300	£1,456,300	£1,290,300
Additional Costs AI team and Triage 2	£416,000	£1,032,684	£877,781	£877,781	£877,781
Total Costs	£966,000	£2,639,684	£2,500,081	£2,334,081	£2,168,081
Benefit of reduced A&E department 3	£0	-£1,502,072	-£1,848,704	-£2,310,880	-£2,310,880
Benefit of reduced admissions 4	£0	-£2,455,807	-£3,022,531	-£3,778,164	-£3,778,164
Total Benefits	£0	-£3,957,879	-£4,871,235	-£6,089,044	-£6,089,044
Net Benefit /Loss	£966,000	-£1,318,195	-£2,371,154	-£3,754,963	-£3,920,963
Model assumptions of impact		65%	80%	100%	100%
A&E Deflections		17,069	21,008	26,260	26,260
Assumptions:					
1 Costs provided by the Foundation Trust for 16/17 to 18/19 (dated 03/08/16) assumption for 19/20 is a reduction of agency costs by 50% and fully removed in 20/21. 2016/17 £250k is a part year cost until the end of December which was agreed by Executive Board and will be subject to additional request so as a proxy £300k has been added for Jan - March 2017.					
2 This is the cost of the front end primary care input currently supplied by Mastercall. The value for 16/17 and 17/18 is as per the proposal received from Mastercall. For 18/19 onwards the cost has been reduced by 15% which will be made from contract review.					
3 For 17/18 it is assumed 65% of the 505 people per week will no longer go into the existing A&E workstreams as they currently do (315 Ambulatory III Team plus additional 190 into the ACU) and 80% for 18/19 and 100% for 19/20 onwards. The assumption therefore is that capacity can be reshaped to some extent. Assumed cost reduction based on £88 per person as an average A&E tariff.					

Appendix 2b: Cost Benefit Analysis Downside

	ANNUAL COST BENEFIT	16-17	17-18	18-19	19-20	20-21
Additional Costs of Ambulatory Care Unit (1)		£550,000	£1,607,000	£1,622,300	£1,622,300	£1,622,300
Additional Costs AI team and Triage (2)		£416,000	£1,032,684	£1,032,684	£1,032,684	£1,032,684
Total Costs		£966,000	£2,639,684	£2,654,984	£2,654,984	£2,654,984
Benefit of reduced A&E department (3)		£0	-£751,036	-£924,352	-£1,155,440	-£1,155,440
Benefit of reduced admissions (4)		£0	-£1,385,327	-£1,705,018	-£2,131,272	-£2,131,272
Total Benefits		£0	-£2,136,363	-£2,629,370	-£3,286,712	-£3,286,712
Net Benefit /Loss		£966,000	£503,321	£25,614	-£631,728	-£631,728
Model assumptions of impact			65%	80%	100%	100%
Assumptions:						
1 The assumption that initial high start-up costs for the Triage and Ambulatory Illness team cannot be reduced through competitive process or similar and remain as high throughout as in year 1 and 2.						
2 The assumption that locum use will be replaced in ACU with permanent staff is not realised						
3 A&E deflections of 505 patients do not materialise and only 50% reduction in activity						
4 190 increase in patients being directed to ACU instead of ED per week. The change in this assumption is that 20% rather than 30% were being admitted to a speciality. Therefore there is less benefit gained through going into ACU. The assumption therefore is a reduction in the Non Elective attendance deflection.						

Appendix 2c: Cost Benefit Analysis Upside

ANNUAL COST BENEFIT	16-17	17-18 (3)	18-19	19-20	20-21
Additional Costs of Ambulatory Care Unit (1)	£550,000	£1,607,000	£1,290,300	£1,290,300	£1,290,300
Additional Costs AI team and Triage (1)	£416,000	£1,032,684	£877,781	£877,781	£877,781
Total Costs	£966,000	£2,639,684	£2,168,081	£2,168,081	£2,168,081
Benefit of reduced A&E department	£0	-£1,848,704	-£2,310,880	-£2,310,880	-£2,310,880
Benefit of reduced admissions (2)		-£4,495,046	-£5,618,808	-£5,618,808	-£5,618,808
Total Benefits	£0	-£6,343,750	-£7,929,688	-£7,929,688	-£7,929,688
Net Benefit /Loss	£966,000	-£3,704,066	-£5,761,607	-£5,761,607	-£5,761,607
Model assumptions of impact		80%	100%	100%	100%
Assumptions:					
1 Downside risks do not materialise and dependencies deliver on schedule					
2 190 increase in patients being directed to ACU instead of ED per week. The change in assumption is that 40% would of converted to a speciality admission rather than 30%. There is therefore a greater gain through transfer to the ACU than the original set of assumptions and therefore is an additional reduction in the Non Elective attendance.					
3 Deliver more quickly in 17-18 than expected, 80% rather than 65%					

Appendix 3: Costs: Ambulatory Care

Price base at: 18/19
 Brief Description of Scheme:

Description	Times	mm ents Rate	Pay Band	Incremental Date	Allow. Addl	Allow. Enh. %	No of Hours	WTE	Set-up costs		PYE	FYE	FYE
									Oct 18 - Mar 17		Year 1	Year 2	17/18
									Year 1	Year 1	Cost 2018/17	Cost 2017/18	Cost 2018/19

Pay

1. Extended opening hours of ACU

Consultant (available for telephone advice)	Monday to Friday 8pm - 12 midnight	2% Intensity payment with frequency between 1:5 - 1:8							9,100	18,600	18,600		
Consultant (onsite presence) - agency	Saturday and Sunday 8am - 10pm	Agency - £120 p/h							87,600	175,200	177,000		
Senior Clinical Fellow - agency	Monday to Friday 10pm - 12 midnight	Agency - £70 p/h							18,300	36,600	37,000		
Senior Clinical Fellow - agency	Saturday and Sunday 8am - 12 midnight	Agency - £70 p/h							58,400	116,800	118,000		
Junior Clinical Fellow - agency	Monday to Friday 10pm - 12 midnight	Agency - £60 p/h							15,600	-	-		
Junior Clinical Fellow - agency	Saturday and Sunday 8am - 4pm	Agency - £60 p/h							25,000	-	-		
Junior Clinical Fellow - agency	Saturday and Sunday 9am - 5pm	Agency - £60 p/h							25,000	-	-		
Junior Clinical Fellow - agency	Saturday and Sunday 12noon - 12 midnight	Agency - £60 p/h							37,500	-	-		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
sub-total Medical									0	278,600	662,100	667,800	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	29.25	0.78		15,300	30,900	31,200	
Band 2 HCA - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0205	VAC		30.25	18.00	0.48		6,200	12,500	12,600	
sub-total Nursing									7.28	0	134,000	270,100	272,800

2. Junior Clinical Fellow for CDU

Junior Clinical Fellow - agency	Monday to Sunday 8am - 12 midnight	Agency - £60 p/h							350,400				
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
Junior Clinical Fellow - substantive	new 10 line rota		MN2105	VAC		50.00	40.00	1.00		68,300	69,000		
sub-total Medical									3.00	0	360,400	204,900	207,000

3. Extended opening hours of Primary Care Assessment (PCA on ground floor D block)

Band 5 Nurse - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0505	VAC		20.63	30.00	0.80		15,700	31,700	32,000	
Band 2 HCA - substantive	Monday to Sunday 8.15pm - 12 midnight	based on rota	XR0205	VAC		30.25	30.00	0.80		10,700	21,500	21,700	
sub-total Nursing									1.80	0	26,400	63,200	63,700

4. Creation of ED Ambulatory Majors (EDAM)

Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	
Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0505	VAC		20.63	37.50	1.00		19,800	39,900	40,300	

Price base at: 16/17

Brief Description of Scheme:

Business Finance

Prepared by: P Caldwell

Description	Times	mm ents Rate	Pay Band	Incremental Date	Allow. Addl	Enh. %	No of Hours	WTE	Set-up costs		PYE Oct 16 - Mar 17	FYE 17/18	FYE 18/19
									Year 1		Year 1	Year 2	Year 3
									Cost 2016/17	Cost 2017/18	Cost 2017/18	Cost 2018/19	
Band 5 Nurse - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0506	VAC		20.63	15.75	0.42		8,000	16,100	16,300	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	37.50	1.00		13,500	27,200	27,500	
Band 2 HCA - substantive	Monday to Sunday 8am - 12 midnight	based on rota	XR0205	VAC		30.25	13.88	0.37		4,600	9,400	9,500	
sub-total Nursing									6.78	0	112,600	226,800	228,200
5. Creation of 3rd triage													
Band 7 Nurse - substantive	Monday to Sunday 8pm - 2am	SNHSFT staff only, not F	XR0709	TOS		22.05	37.50	1.00		31,800	64,200	64,800	
Band 7 Nurse - substantive	Monday to Sunday 8pm - 2am	SNHSFT staff only, not F	XR0709	TOS		22.05	13.88	0.37		11,400	23,000	23,200	
sub-total Nursing									1.37	0	43,200	87,200	88,000
6. ED trackers													
Band 3 A&C - substantive	Monday to Sunday - 11 hours per day		XN0307	TOS		30.52	37.50	1.00		15,900	32,100	32,400	
Band 3 A&C - substantive	Monday to Sunday - 11 hours per day		XN0307	TOS		30.52	37.50	1.00		15,900	32,100	32,400	
Band 3 A&C - substantive	Monday to Sunday - 11 hours per day		XN0307	TOS		30.52	37.50	1.00		15,900	32,100	32,400	
sub-total A&C									3.00	0	47,700	98,300	97,200
7. One-off to support implementation													
Band 7 Nurse (2 weeks backlog)				XR0709	TOS				37.50	1.00	2,300		
ED - 1 additional hour paid training time for all staff in ED, based on Band 6 average				XR0609	TOS				120.00	3.20	2,700		
sub-total implementation									4.20	6,000	0	0	0
Total Pay									28.72	6,000	980,700	1,480,800	1,506,700

Non-Pay

Recurrent staff costs

Training													
Uniforms												2,200	

One-off set-up costs:

1. Relocation of ACU on TU

Examination couches/reciner chairs	4	1095.60	4,400
Trolies	2	5489.06	11,000
Curtains and rails - disposable			2,000
Observation machines	2	1440.00	2,900
Tympanic Thermometers	2	180.00	400
Large plasma screen	1	2000.00	2,000

Price base at: 16/17
 Brief Description of Scheme:

Business Finance

Prepared by: P Caldwell

Description	Times	mm ents Rate	Pay Band	Incremental Date	Allow. Addl	Allow.	Enh. %	No of Hours	WTE	Set-up costs		PYE Year 1	FYE 17/18	FYE 18/18	
										Cost 2016/17	Cost 2017/18				
Piping oxygen															
Estates work - curtain rails to divide bays, new door entry system												3,000			
Estates work - reconfigure shower into WC and small office												6,600			
2. Creation of EDAM															
Workstations including computers x4 for Primary Care staff			4	480.00								1,900			
Large plasma screen			1	2000.00								2,000			
Waiting room chairs			15	130.00								2,000			
Examination couches/recliner chairs			4	1095.60								4,400			
3. Creation of PCA															
Large plasma screen			1	2000.00								2,000			
4. Creation of 3rd triage															
Monitors x 2 (desktop computer)			2	480.00								1,000			
Workstation x 1 desktop and computer			1	480.00								500			
Desk/fixtures and fittings												1,000			
Estates work - create 3rd triage cubicle												5,000			
5. POC testing															
D-Dimer POC equipment - query will be rental?															
Kit/reagent costs															
6. Advantis Development															
IT developer time at overtime rates			5	450.00								2,300			
Tablets x 5			5	428.87								2,100			
Total Non-Pay												68,700	10,800	18,400	18,800
TOTAL EXPENDITURE												68,700	1,001,800	1,607,000	1,622,300
Margin (positive indicates a shortfall against income)												68,700	1,001,800	1,607,000	1,622,300

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OUTPATIENTS OUTLINE BUSINESS CASE EXECUTIVE SUMMARY

Abstract

This business case describes the integrated neighbourhood-based health and social care services, with primary care at the centre, which will be delivered in Stockport from 2017/18 to 2020/21.

Senior Responsible Officers:

Tim Ryley, Director of Strategy, Stockport CCG

Keith Spencer, Provider Director, Stockport Together

Executive Summary

Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to deliver the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

Business Case Overview

This paper sets out the case for a transformation in the way outpatients are managed across the system, so that patients are seen in the right setting, by the most appropriate health professional avoiding wasted appointments and taking cost out of the system.

The document describes the proposed service model and the impact on the local system. It sets out investment requirements of the changes and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business case identifies risks to delivery of the changes and the mitigations in place to maximise benefits.

The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

Since 2008/09 the rate of first outpatient appointments has risen by 26% nationally. Outpatient attendances have grown by 17% locally – a 15% growth in GP referrals and 20% growth in referrals from other professionals, including hospital consultants. These trends are likely to be magnified in future by demographic and epidemiological pressures. 51% of the adult population of Stockport are known to have at least one long-term condition, rising to 87% for people aged 85 and older. Stockport already has an older population, compared to neighbouring boroughs. The number of people aged 65 and over in Stockport will increase to 61,000 by 2020.

Table 1: Outpatient Activity Changes

Outpatient Activity at Stockport NHS FT**:	First Appointments		Follow-up Appointments	
	2015/16	2016/17	2015/16	2016/17
Trauma & Orthopaedics	12,206	12,378	19,710	19,324
General Medicine *	9,386	10,609	4,800	14,968
Ophthalmology	6,130	6,300	7,719	17,067
Ear Nose & Throat	5,992	5,993	8,557	7,164

General Surgery	5,875	6,047	6,647	6,430
Anti-Coagulant	560	536	44,259	40,902

* General Medicine includes Cardiology, Respiratory, Gastroenterology, Diabetes and Endocrinology

** This activity only relates to outpatient appointments commissioned at Stockport FT.

In our current model, people are referred to hospital and receive specialist advice and support, often followed by recurrent follow-ups. Around 40-50% of outpatient appointments in Stockport result in advice and / or pharmaceutical treatment only, without the need for the patient to physically visit the hospital. Alternative approaches to the traditional model could deliver more effective solutions outside of the hospital setting, using technology to enable communications, advice and treatment between patients, GPs and specialists.

The Proposed Model

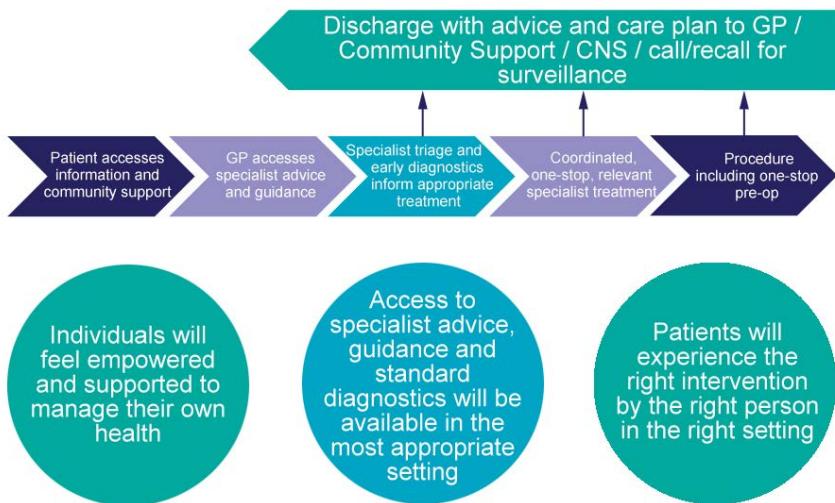
We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets.

Building upon national and local learning, this business case proposes a new model of care for the outpatient pathway, underpinned by the following design principles:

- Individuals will feel empowered and supported to manage their own health
- Access to specialist advice, guidance and standard diagnostics will be available in the most appropriate setting
- Patients will experience the right intervention by the right person in the right setting.

This business case adopts a holistic, system-wide approach, with outpatient teams working collectively with neighbourhood and intermediate tier teams to reduce outpatient activity. It proposes changing the outpatient pathway focusing on six key priorities:

1. **Active support for patients** to enable them to take more control of their condition including decision making aids, patient activation, self-care and provision of advice to release savings of **£0.8m**
2. **Support for GPs** in clinical decision making through GP development / upskilling and improved clinician communications including Consultant Connect and a direct messaging service, planned to release **£2.7m**
3. **Appropriate clinical triage** of referrals and diagnostics through systematic triage and reducing consultant-to-consultant referrals is planned to release **£1.2m**
4. **Alternative mechanisms for traditional appointments** and support to enable discharge from outpatient clinic through virtual and nurse-led clinics, enhanced, discharge protocols and a call/recall surveillance infrastructure, releasing **£3.5m**
5. **Coordinated support for complex patients** through Multi-Disciplinary Team style lead clinician support is planned to release **£0.06m**
6. **Identifying outpatient activity that can be stopped** through clinician led reviews and improved training of junior doctors and locums is planned to release **£3.5m**

Figure 1: Outpatient Model

Benefits of the Model

This business case proposes a pathway that improves patient care by providing increased support and education, better communications, consistent triage and alternatives to hospital-based appointments.

The proposal aims to reduce the amount of outpatient activity commissioned in Stockport by 38% over a three year period (2018/19-2020/21). This equates to a reduction of over 107,500 outpatient appointments (first and follow-up) which will generate a financial benefit of £11.76m by 2020/21.

Table 2: Planned Reduction in Outpatient Activity

Year	Planned Reduction in Traditional Outpatient Activity	
	In-Year	Cumulative Reduction
2017/18	0%	N/A
2018/19	- 15%	- 15%
2019/20	- 15%	- 30%
2020/21	- 8%	- 38%

Most deflections will be made in follow-up appointments, though the aim is to deflect over 30% of first outpatient appointments:

Table 3: Planned Deflections

Planned Deflections:	Activity	Percentage
First Outpatient Appointments	-29,442	-31.5%
Follow-Up Outpatient Appointments	-78,071	-42.0%
Total Outpatient Deflections	-107,513	-38.5%

By 2020/21, the financial benefit of these changes is calculated to be £11.76 million.

Table 4: Anticipated Savings

Component of the Model	Savings
Active Support for Patients	£0.8m
Support for GPs	£2.7m
Appropriate Clinical Triage	£1.2m
Alternative Mechanisms for outpatient appointments	£3.5m
Coordinated support for complex patients	£0.06m
Identifying outpatient activity that can be stopped	£3.5m
Total	£11.76m

In addition, the new model should benefit the system by:

- reducing GP appointments by offering more self-care options
- reducing the need to go to hospital, by offering a more comprehensive offer close to home
- reducing waiting times, by providing timely access to specialist advice.

Investment Plan

Delivery of this new model will require upfront investment of **£2m** over three years to enable planned pathway changes. This will support double running and associated transitional costs, additional specialist nursing capacity in addition to investment in technology to support and enable delivery of the new pathway through virtual appointments, enhanced communication channels and systems between clinicians and additional patient information and support.

In the short-term (2017/18) investment will be funded from the Greater Manchester Transformation Fund. Medium and longer-term (2018/19-2020/21) financing is dependent on the maintenance of CCG allocations and the release of Stockport Together benefits.

Table 5: Cost-Benefit Analysis

Outpatient Model Component::	2018/19		2019/20		2020/21	
	Cost	Saving	Cost	Saving	Cost	Saving
Active Support for Patients	£41,000	-£573,432	£41,000	-1,245,194	£41,000	-£1,833,892
Support for GP decision making	£243,442	-£409,013	£168,442	-£895,928	£157,442	-£1,683,751
Appropriate Clinical Triage of referrals	£172,296	£1,227,718	£147,296	£1,227,718	£147,296	-£1,227,718
Alternative appointments	£1,448,954	£2,281,807	£1,396,913	£2,860,813	£1,396,913	-£3,479,722
Outpatient activity that can be stopped	£9,555	-£59,718	£9,555	-£59,718	£9,555	-£59,718
Coordinated support for complex patients	£365,089	£2,281,807	£365,089	£2,860,813	£365,089	-£3,479,722
GRAND TOTAL	£2,280,336	£6,833,495	£2,128,295	£9,150,184	£2,117,295	£11,764,523

Risk Management

The risks associated with delivering this transformational change include:

- continued growth in demand despite changes to outpatient pathway
- impact of activity from outside Stockport on capacity in the Trust

- insufficient capacity in neighbourhood infrastructure to manage demand out of hospital
- excessive demand shifted onto already stretched GP Practices
- national shortage of specialist nurses
- failure to adopt new pathways by professionals working in the system
- negative impact of the changes on performance against NHS waiting standards.

Plans to mitigate against these risks are detailed in the full business case.

Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans.

Stockport Together will undertake a 'listening period' from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

If agreed, during 2017/18 new models of outpatient care would be developed through the 100 day rapid testing work to include Trauma & Orthopaedics, Gastro, and Diabetes pathways. The other main components of the scheme would be developed over 2018/19-2020/21.

OUTPATIENTS OUTLINE BUSINESS CASE

Abstract:

This business case describes the integrated neighbourhood-based health and social care services, with primary care at the centre, which will be delivered in Stockport from 2017/18 to 2020/21.

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APPENDIX68

Appendix 1 Clinical and Patient Questionnaire ResponsesError! Bookmark not defined.



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

1 Executive Summary

1.1 Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to deliver the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

1.2 Business Case Overview

This paper sets out the case for a transformation in the way outpatients are managed across the system, so that patients are seen in the right setting, by the most appropriate health professional avoiding wasted appointments and taking cost out of the system.

The document describes the proposed service model and the impact on the local system. It sets out investment requirements of the changes and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business case identifies risks to delivery of the changes and the mitigations in place to maximise benefits.

1.3 The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

Since 2008/09 the rate of first outpatient appointments has risen by 26% nationally. Outpatient attendances have grown by 17% locally – a 15% growth in GP referrals and 20% growth in referrals from other professionals, including hospital consultants. These trends are likely to be magnified in future by demographic and epidemiological pressures. 51% of the adult population of Stockport are known to have at least one long-term condition, rising to 87% for people aged 85 and older. Stockport already has an older population, compared to neighbouring boroughs. The number of people aged 65 and over in Stockport will increase to 61,000 by 2020.

Table 1: Outpatient Activity Changes



Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

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In our current model, people are referred to hospital and receive specialist advice and support, often followed by recurrent follow-ups. Around 40-50% of outpatient appointments in Stockport result in advice and / or pharmaceutical treatment only, without the need for the patient to physically visit the hospital. Alternative approaches to the traditional model could deliver more effective solutions outside of the hospital setting, using technology to enable communications, advice and treatment between patients, GPs and specialists.

1.4 The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets.

Building upon national and local learning, this business case proposes a new model of care for the outpatient pathway, underpinned by the following design principles:

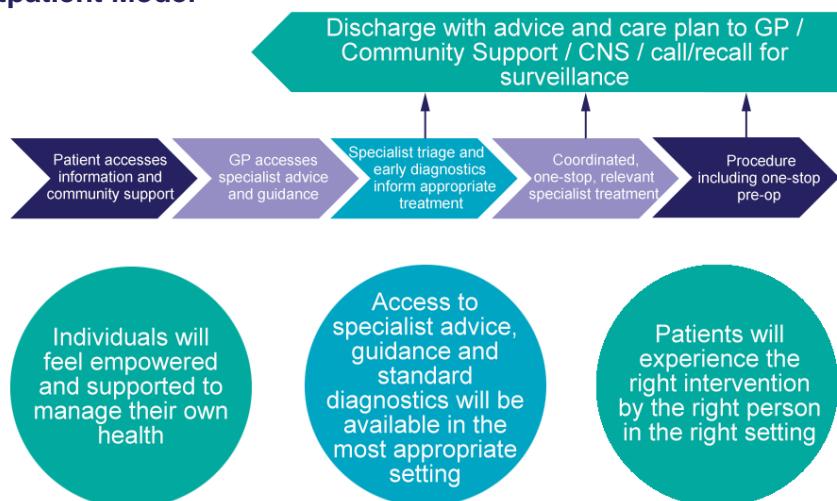
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4. **Alternative mechanisms for traditional appointments** and support to enable discharge from outpatient clinic through virtual and nurse-led clinics, enhanced, discharge protocols and a call/recall surveillance infrastructure, releasing **£3.5m**

5. **Coordinated support for complex patients** through Multi-Disciplinary Team style lead clinician support is planned to release £0.06m
6. **Identifying outpatient activity that can be stopped** through clinician led reviews and improved training of junior doctors and locums is planned to release £3.5m

Figure 1: Outpatient Model



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The proposal aims to reduce the amount of outpatient activity commissioned in Stockport by 38% over a three year period (2018/19-2020/21). This equates to a reduction of over 107,500 outpatient appointments (first and follow-up) which will generate a financial benefit of £11.76m by 2020/21.

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Total	£11.76m

In addition, the new model should benefit the system by:

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- reducing the need to go to hospital, by offering a more comprehensive offer close to home
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Delivery of this new model will require upfront investment of £2m over three years to enable planned pathway changes. This will support double running and associated transitional costs, additional specialist nursing capacity in addition to investment in technology to support and enable delivery of the new pathway through virtual appointments, enhanced communication channels and systems between clinicians and additional patient information and support.

In the short-term (2017/18) investment will be funded from the Greater Manchester Transformation Fund. Medium and longer-term (2018/19-2020/21) financing is dependent on the maintenance of CCG allocations and the release of Stockport Together benefits.

Table 5: Cost-Benefit Analysis

Outpatient Model Component::	2018/19		2019/20		2020/21	
	Cost	Saving	Cost	Saving	Cost	Saving
Active Support for Patients	£41,000	-£365,783	£41,000	-£615,955	£41,000	-£816,622
Support for GP decision making	£243,442	-£616,662	£168,442	-£1,525,168	£157,442	-£2,701,022
Appropriate Clinical Triage of referrals	£172,296	-£1,227,718	£147,296	-£1,227,718	£147,296	-£1,227,718

Alternative appointments	£1,448,954	-£2,281,807	£1,396,913	-£2,860,813	£1,396,913	-£3,479,722
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GRAND TOTAL	£2,280,336	-£6,833,495	£2,128,295	-£9,150,184	£2,117,295	-£11,764,523

1.7 Risk Management

The risks associated with delivering this transformational change include:

- continued growth in demand despite changes to outpatient pathway
- impact of activity from outside Stockport on capacity in the Trust
- insufficient capacity in neighbourhood infrastructure to manage demand out of hospital
- excessive demand shifted onto already stretched GP Practices
- national shortage of specialist nurses
- failure to adopt new pathways by professionals working in the system
- negative impact of the changes on performance against NHS waiting standards.

Plans to mitigate against these risks are detailed in the full business case.

1.8 Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans – subject to appropriate public involvement.

Stockport Together will undertake a ‘listening period’ from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

If agreed, during 2017/18 new models of outpatient care would be developed through the 100 day rapid testing work to include Trauma & Orthopaedics, Gastro, and Diabetes pathways. The other main components of the scheme would be developed over 2018/19-2020/21.

2 Strategic Case for Change

2.1 Introduction

The Stockport Together partners are undertaking a fundamental change in the way health and social care services are delivered, organised and commissioned for our population. The full strategic case for change was set out in the ***Stockport Together Overview Business Case*** published in July 2016 and underpinned by a series of more detailed business cases focusing on specific proposals for change. This Outpatients business case, focusing on the holistic management of patients through a redesigned outpatient pathway, is ***one of that series of cases*** that together will collectively build a ***system level change*** in the way services are delivered. This new service model in its totality is referred to as the ***Integrated Service Solution***.

It is known that circa 40-50% of outpatient appointments in Stockport result in advice and/or pharmaceutical treatment only. In line with the overarching Stockport Together approach, it has been identified that there is potential to develop alternative approaches to traditional models to deliver more effective solutions outside of the hospital setting particularly using technology to enable communications, advice and treatment between patients, GPs and specialists.

This business case therefore adopts a holistic system-wide approach proposing solutions across the whole outpatient pathway and recognising the dependencies, contributions and impacts on the wider health and social care economy in Stockport, in particular the requirement to work collectively with neighbourhood teams, intermediate tier services, healthy communities and key enablers to reduce outpatient activity.

2.2 Scope of this Business Case

2.2.1 In-scope

This business case incorporates the outpatient pathway for all outpatient attendances registered to Stockport GPs across a range of providers commissioned by Stockport CCG. The pathway includes:

- The patient identifying a problem and need to access health services
 - traditionally a GP appointment

- GP consideration that additional specialist input may be required – traditionally a referral for an outpatient appointment
- Requirement for diagnostic tests to inform possible diagnosis and treatment
- Arrangement of and attendance at an outpatient appointment
- Specialist input and decision making regarding a diagnosis and treatment including:
 - Patient advice to manage a condition or signposting to additional support
 - Requirement for further intervention e.g. surgical procedure
 - Requirement for a follow-up and/or ongoing monitoring and surveillance appointments
 - Discharge back to GP

The scope of this business case will also contribute to the movement of activity across the four zones identified within the Stockport Together model (see page 18). This model transitions patients to receive care through the most appropriate channel and setting. As it incorporates all outpatient attendances registered to Stockport GPs across a range of providers commissioned by Stockport CCG it will also include cancer pathway patients and people under the age of 18 although it should be noted that activity data from these groups have not been included within costings.

2.2.2 Out of Scope

It is recognised that outpatient attendances at provider sites may originate from non-Stockport GPs. These are not included within the scope of this business case but it is anticipated that there may be scope to extend the models developed within this case to other areas in future phases of outpatient pathway development.

While initially patients from outside Stockport will not have access to the new models of pre-hospital care, once within Stockport providers, it is anticipated that they will follow the new transformed pathways.

2.3 Drivers

2.3.1 National Drivers

Since 2008/09 the rate of first outpatient appointments has risen by 26% nationally. Outpatient attendances have grown by 17% locally – a 15% growth

in GP referrals and 20% growth in referrals from other professionals, including hospital consultants. These trends are likely to be magnified in future by demographic and epidemiological pressures. 51% of the adult population of Stockport are known to have at least one long-term condition, rising to 87% for people aged 85 and older. Stockport already has an older population, compared to neighbouring boroughs. The number of people aged 65 and over in Stockport will increase to 61,000 by 2020.

A recent report by the Nuffield Trust (March 2017) entitled 'Shifting the Balance of Care', analyses the effectiveness of new and emerging alternative approaches to models of care. The report provides helpful evidence that many of the approaches proposed within this business case are effective. These include:

- Support for self-care
- GP continuity of care for patients
- Improved GP access to specialist expertise
- Rapid access clinics

The report indicates that shared decision-making, shared care models and direct access to diagnostics for GPs have well-evidenced benefits for patients and professionals, but less conclusive findings on their capacity to reduce hospital activity and deliver savings.

National elective care programme

Elective care is planned, non-emergency care such as an outpatient appointment, with complex flows of activity between pathway phases. In this way, patients enter the system at different points and move between different parts of the primary and secondary care system dependent on their clinical needs and often multiple, long-term conditions.

NHS England are currently running a programme of rapid testing work to look at testing innovative ways to deliver elective care differently and to determine which initiatives could be delivered at scale. Stockport Together is at the centre of this work as the only area to be a part of both the first and second waves of activity in this area.

As outlined later in this business case (see 2.3.7) this is already delivering pathway improvements within the chosen specialties e.g. Diabetes, T&O (Trauma & Orthopaedics), Gastroenterology, Cardiology & Respiratory. The learning from these focused initiatives is being captured and used to inform future developments throughout this business case.

2.3.2 Local Drivers

National trends are reflected locally, particularly in relation to the demographic pressures of an ageing population. The latest Joint Strategic Needs Assessment (JSNA) indicates that around 51,000 of the 100,000 first appointments (FA) and 175,500 of the 250,000 follow up appointments (FUs) are attributable to the cohort 'all adults over the age of 18 that are in the 15% of the registered adult population identified as most at risk of emergency admission.

It is also known that nationally an average of ~10% of patients do not attend their appointment although this is less in Stockport.

The top five specialties by first outpatient attendance volume together account for over 40% of the total first attendances. They have remained stable in the last four years.

The highest specialty attendances (2016/17 data):

	First Appointments		Follow-up Appointments	
	2015/16 Stockport SFT**	2016/17 Stockport SFT**	2015/16 Stockport SFT**	2016/17 Stockport SFT**
Trauma & Orthopaedics	12,206	12,378	19,710	19,324
General Medicine *	9,386	10,609	4,800	14,968
Ophthalmology	6,130	6,300	7,719	17,067
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General Surgery	5,875	6,047	6,647	6,430
Anti-Coagulant	560	536	44,259	40,902

* General Medicine includes Cardiology, Respiratory, Gastroenterology, Diabetes and Endocrinology

** It should be noted that this activity only relates to outpatient appointments commissioned with Stockport FT. Stockport CCG also commissions ~40%

outpatient activity with other providers.

2.3.3 The Stockport Together Outcomes Framework

Stockport Together aims to adopt a holistic, whole system view of patients and their interactions with the health and social care economy.

It is intended that the future commissioning arrangements for services described in this business case and others, will be based on a population based weighted capitation contract which will include an Outcomes Framework.

The Outcomes Based Approach

Stockport Together's ambition is to implement an outcomes-based model of commissioning. Outcomes based commissioning is way of paying for health and social care services based on rewarding providers for achieving the outcomes that are important to the people using them, regardless of socio-economic status.

Commissioning for outcomes presents a different proposition from current payment mechanisms, such as payment by results and block contracting, which pay health and social care providers to deliver discrete processes or packages of care. Commissioning for outcomes moves the focus away from volume and activity and towards providing whole-person holistic care.

There is an acknowledgement that no single provider of care is likely to deliver true patient outcomes in isolation of other providers. Achieving outcomes must therefore be a collaborative approach supported by appropriate contracting and reimbursement mechanisms. Commissioning for outcomes in a multi-specialty community provider has the ability to drive integration by incentivising providers to work together, share accountability and deliver outcomes collaboratively.

Enabling the delivery of the outcomes based approach

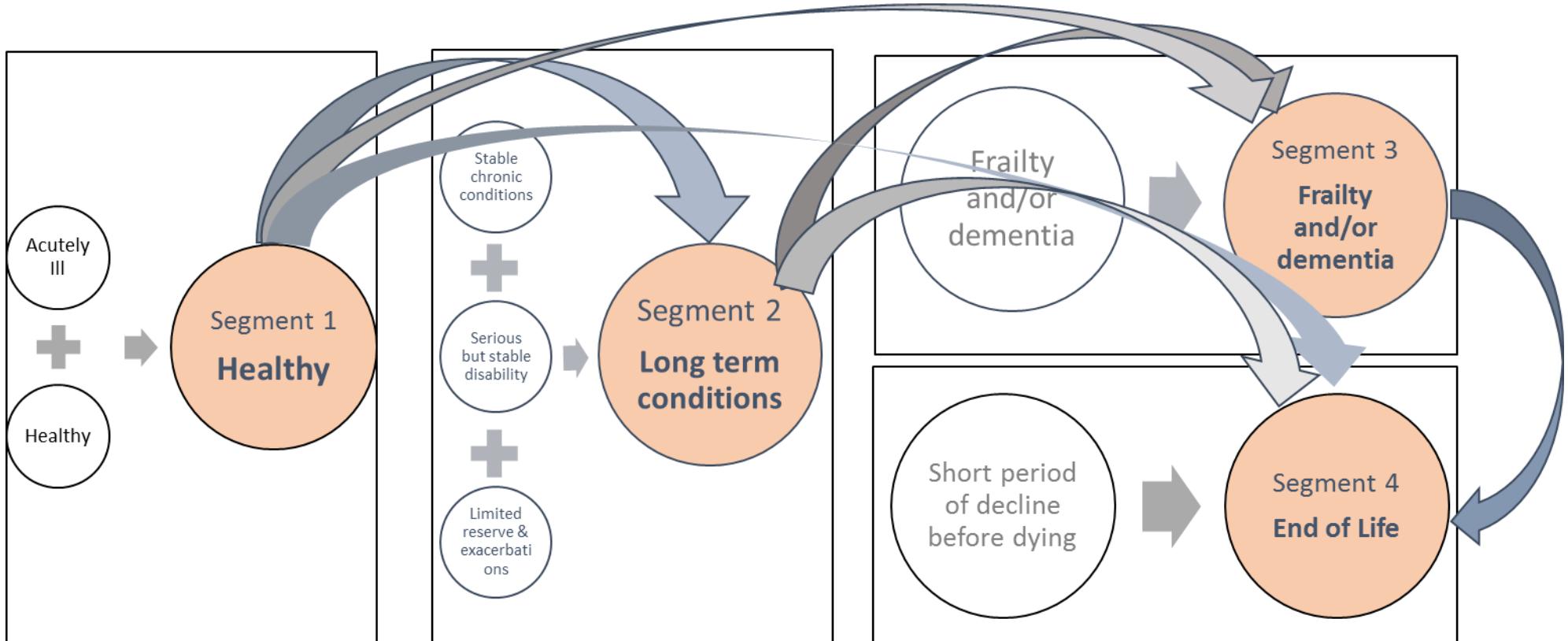
To achieve an outcomes-based model of commissioning, Stockport Together embarked upon identifying outcomes that matter most to people in Stockport. To ensure that different views from across the system were taken into

account, key stakeholders including patients and the third sector led the development of a Stockport Together ‘Outcomes Framework’.

Commonly, outcomes have been considered in the context of disease groups. However, defining optimal health in this way undermines the ‘whole-person’ holistic approach and retains focus on providers. In support of Stockport Together’s whole population approach, and in view that the responsibility to deliver true patient outcomes is shared amongst multiple providers, the development group agreed that the outcomes should be organised differently to traditional approaches.

In order to identify sufficiently homogeneous population groups and associated outcomes, Stockport Together adapted the *Bridges to Health* model of segmenting populations. This describes eight population groups that have been condensed into four broader groups each with its own definition of optimal health and priorities among services.

Diagram 1: Stockport Together population segments and movement between segments based on the *Bridges to Health* model



N.B. Maternal & Infant Health excluded as the MCP for Stockport Together aims to initially contract for the over-65 population

Prioritised Outcomes

The Stockport Together Outcomes Framework includes clinical, social and personal outcomes. Clinical and social outcomes tend to describe clinically relevant outcomes for an individual, such as improved health status (reductions in disease incidence, complications and/or exacerbations). Personal outcomes describe the holistic health status of a person such as their confidence in managing their own health and wellbeing.

Whilst clinical and social outcome can be measured by using data already captured in clinical or administrative systems, measuring personal outcomes generally requires administering surveys or Patient Reported Outcome Measure (PROM) tools.

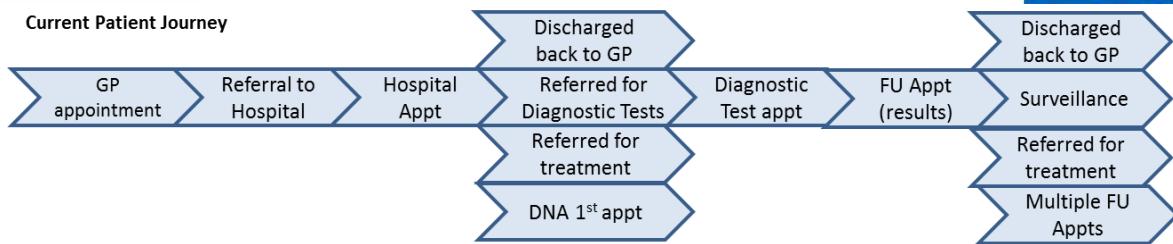
The PROM tool outlines 25 clinical and social outcomes and 14 personal outcomes that have been prioritised by the Outcomes Framework development group. The 25 clinical and social outcomes are measurable and have three year worth of baseline data. PROM tools are still being reviewed to assess their suitability to measure the 14 personal outcomes prioritised. Some personal outcomes may not be measurable and decisions are still to be made during 2017/18 on some of the more detailed implementation issues associated with measuring personal outcomes.

2.4 Current System

2.4.1 Patient Journey

Currently the majority of outpatient appointments are delivered in the traditional way i.e. patients are referred by their GP and attend face to face first appointment (FA) and where necessary follow up appointments (FU) at a hospital outpatient clinic. The current outpatient journey is described in diagram 2 below

Diagram 2 – Current Outpatient Journey



Follow up appointments may occur recurrently, adding extra visits to the hospital for patients and the value of this is often not clearly understood. In the current system, patients often rely on the specialist for advice and may not challenge the offer of further appointments, even if they are unclear of the purpose of these.

As shown in diagram 2, there is significant scope to streamline and redesign the current patient pathway to provide a more effective and improved experience that reduces bureaucracy and removes the requirement for unnecessary and repeated hospital visits that do not add clinical value to the patient.

2.4.2 Patient Case Study

Case Study A

Sarah – a working mother of 3 young children – was referred to Outpatients with palpitations.

Sarah presents to the GP and she undergoes some blood tests and an ECG which is found to be normal. However, her palpitations occur regularly and so she is referred to the clinic. She waits 7 weeks to be seen and then has a face to face consultation with a doctor. This doctor decides that she requires further monitoring and she is referred for a 72 hour heart tracing and booked a 3 month follow up appointment for her results to be reviewed. She has a further wait to have this test done of 4 weeks. The results then go back to the consultant who sees her in clinic to discuss the results and discharge back to GP.

An alternative approach to this referral would be for the GP to refer direct to an arrhythmia clinic. In a streamlined system the referral would be triaged by a clinician and she would be sent for diagnostics and the clinician would then review the results of the ECG, bloods, trace and letter. The patient would then either have contact face to face or via electronic means (e.g. Skype, Phone, email) to discuss the results and any required treatment, or be contacted in writing and given reassurance that test results are ok, together with any advice e.g. self-care.

Case Study B

An 80 year old patient has dementia, diabetes and ischaemic heart disease/valve disease, as well as a foot ulcer. She is a reasonably high functioning diabetic, although on insulin. She has been administering insulin with help of her elderly husband, but he has become more frail recently. Her husband has usually taken her to hospital appointments.

Some problems with blood sugar control have prompted attendance at the hospital clinic where she was noted to have a diabetic foot ulcer. She was therefore referred to the foot ulcer clinic for this to be monitored and addressed.

The District Nurse team have now been instated to administer her insulin through twice daily visits.

She is under follow up at the Community Heart failure clinic and also at the hospital for echo surveillance and 6-12 monthly follow up. She has become confused with receiving differing advice in the two clinics who tell her different things. She is unclear about her management and has also had different advice from the Diabetic team.

She relies now on her family to take her to appointments – they are ‘busy with work and their own lives’ and she/her daughter has asked if there any appointments that she doesn’t need to go to.

She also goes to the Alzheimer’s society each week and receives good support there.

In an alternative pathway, her appointments would be coordinated and she would have a lead clinician, supported by specialist nurses, ensuring that she does not receive confusing or potentially conflicting advice. Her management would be captured in a clear plan that she and her family understood and there would be a specific contact for them if she ran into problems. This care would be supported throughout by her GP.

Case Study C

An 84 year old lady with previous stomach cancer treated with a local procedure and monitored at a local hospital.

She had an incidental finding of a renal tumour and has some shadows on her lungs which are presumed to be lung metastases. She knows this and as far as she knows, she is not fit for any treatment. She attends urology for follow up of the renal tumour at a different local hospital.

She worries about her health but worries as much about going to her appointments and being told that she is going to die. Although the hospitals

are local, she struggles to travel to these appointments as she relies on public transport. She intermittently asks to cancel all her appointments and be left alone.

She has a husband who is supportive, but gets frustrated by her mood changes and worry. Last year she was admitted with depression for a short while, prompted by one of her appointments – she is seen occasionally by the old age psychiatry team and her mood has not improved.

An alternative approach would be to coordinate her care and to engage her in shared decision making about her future treatment. This lady would be supported from the practice. At a future appointment, she could then decide to decline further follow up at the hospital and if required stay under the care of her GP until such as time as she feels she requires specialist input.

3 Proposed Outpatients Service Model

3.1 Overview

In our current health care model, people are going to hospital to receive specialist advice and support that could be obtained either through Primary Care or directly from specialist care, without the need for the patient to physically visit the hospital. Patients also wait longer than necessary to access specialist diagnostics because of the current requirement for some diagnostics to be requested only by secondary care teams, frequently subsequent to a first outpatient appointment.

If current trends continue, there is likely to be an increase in outpatient demand in the future as a result of increases in prevalence of long term conditions and an ageing population. It is therefore vital that we review our current outpatient systems and identify new and innovative ways in which we can deliver care to Stockport patients.

3.2 Strategic Objectives and priorities

Building upon national and local learning, and on an understanding of what works best for patients, this business case proposes a new model of care for the outpatient pathway that introduces some potentially radical changes to the ways that outpatients are currently managed across the health economy. Based on a sound understanding of what works best for patients, the proposals also reflect the strategic aims of the Stockport Together future

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

model of care (including the Neighbourhood business case). It is recognised that while there is emerging evidence both locally and nationally that it is achieving positive results, the full impact of introducing such widespread and whole-scale change across the outpatient system is, as yet broadly untested. As such this presents an element of risk that will require careful management and control.

The model of care proposed within this business case is predicated on three overarching design principles, underpinned by six key priorities that together will support and enable the achievement of thirteen strategic objectives:

Design Principles		
Individuals will feel empowered and supported to manage their own health	Access to specialist advice, guidance and standard diagnostics will be available in the most appropriate setting through contact, access and triage (CAT)	Patients will experience the right intervention by the right person in the right setting
Priorities		
1. Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice	2. Support for GPs in clinical decision making 3. Appropriate clinical triage of referrals and diagnostics	4. Alternative mechanisms for traditional appointments and support to enable discharge from outpatient clinic 5. Coordinated support for complex patients 6. Identifying outpatient activity that can be stopped
Strategic Objectives		
1. Patients access self-help, signposting and support at the earliest opportunity. 2. Patients are confident and supported to take control and make positive decisions about their conditions and planning their care.	3. Primary Care has access to specialist advice and support to encourage and enable management of conditions in a local, neighbourhood setting. 4. GPs have access to appropriate training and education to manage patients in primary care that might otherwise have been referred to secondary care. 5. Referrals are triaged systematically and specialists provide suitable advice to ensure that patients are managed in the most applicable setting by the most appropriate health professional. 6. Diagnostic tests take place at the earliest opportunity in a patient pathway to inform the most appropriate treatment. This	7. The amount of traditional outpatient activity is reduced by up to 38% over a 4 year period (2017/18-2020/21) including the identification and removal of unnecessary outpatient activity. 8. Patient pathways are optimised and streamlined. 9. Alternatives models of outpatient care are developed to move away from traditional specialist outpatient face-to-face appointments where appropriate. 10. Patients have more flexible access to a specialism rather than having to attend traditional face-to-face appointments. 11. Patients receive care in a hospital setting only when it is needed. 12. Patients receive one-stop coordinated care where possible. 13. Unnecessary urgent care is reduced through


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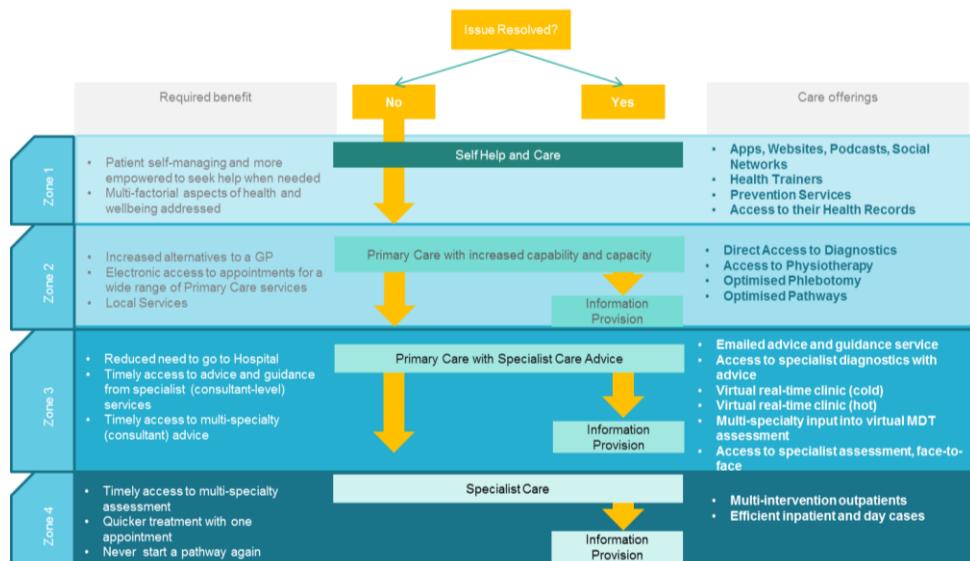
	<p>includes discharge with advice for patient and GP, and review by allied health professionals in non-acute settings.</p>	<p>strengthened planned and urgent outpatient (OP) care.</p>
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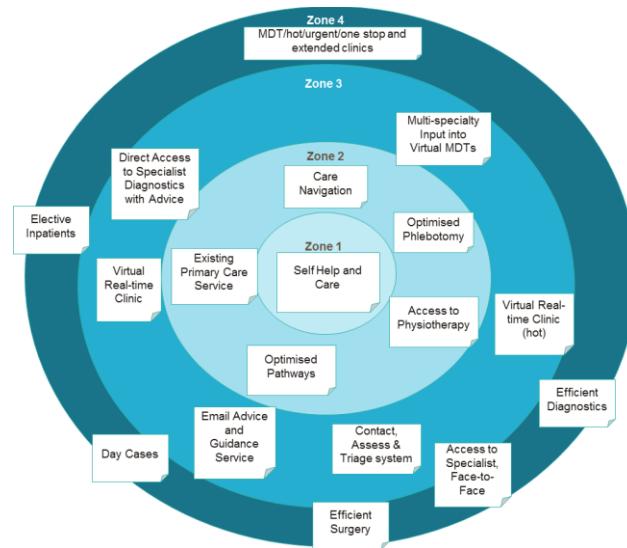


In line with the broader Stockport Together model of care, the changes proposed for outpatients can be explained using a zone system.

Under this model there are 4 zones in which an individual can travel. The unique aspect of this structure and process will be for individuals to be ‘fast tracked’ between zones (step up and step down in care provision), and more importantly where specialist and urgent care (zone 3 and 4) is required, used for those who really need this level of care. The Outpatients Business case looks to ensure that only those who require specialist care/active intervention enter zone 3, whilst those that require advice and support stay in zones 1 and 2, linked to other parts of the system virtually for ongoing care.

Diagram 3 – The Original 4 Zone Model, with proposed outpatient activity distribution.



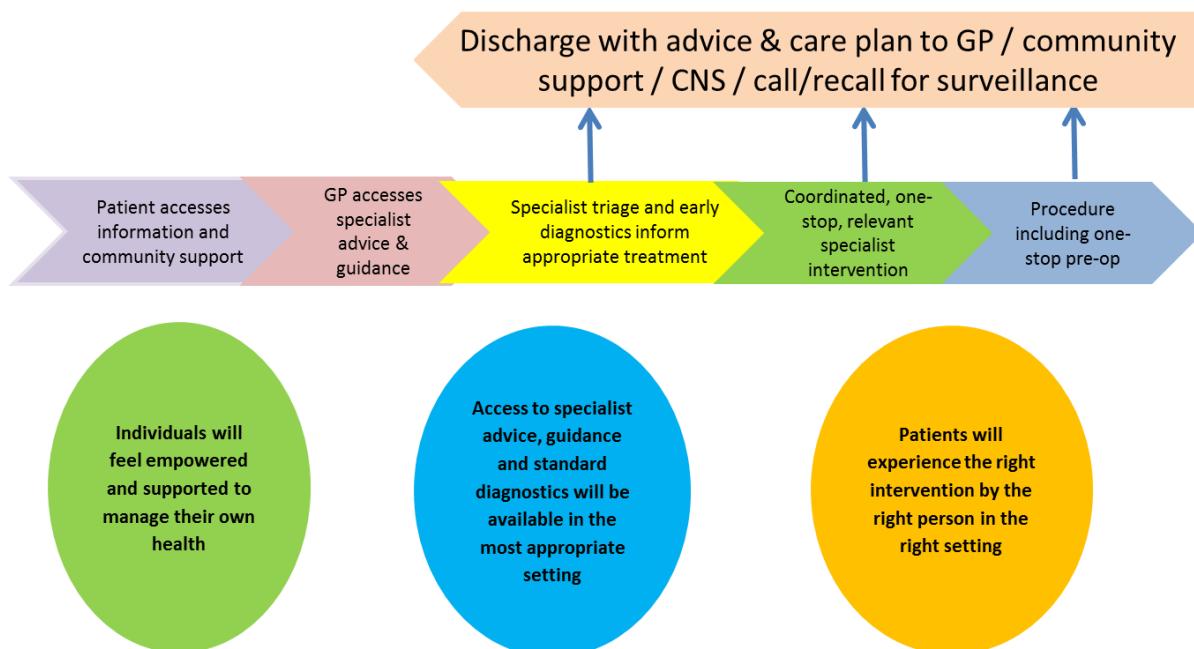


3.3 Proposed Service Model

Building upon the design principles, priorities and strategic objectives outlined above, the following outpatient pathway and model of care is proposed:

Diagram 4 provides an overview of the proposed future pathway for outpatients and aims to provide an improved model of care where patients receive the most appropriate treatment by the most appropriate health professional in the most appropriate setting.

Diagram 4 – Proposed Outpatient Model



Building on the design principles identified above, the following sections describe how each of the priorities will be achieved. The detailed descriptions include proposed activities and the solutions required to redesign the outpatient pathway.

As part of this work there will be a focus on learning from the work that is implemented, with results of changes being published wherever possible to enable shared learning across Greater Manchester (GM) and the rest of the country. With respect to this business case, research should focus on gathering evidence and learning in relation to each of the priorities e.g.:

- Use of patient-reported outcome measurement (PROM) tool as part of an outcomes-based capitation contract.
- Learning from and extending findings from 100 day rapid test projects e.g. breathlessness clinics/small group teaching focused on specific conditions/patient education for specific conditions.
 - Reduced duplication of follow up appointments in related clinics e.g. Heart Failure, COPD, Diabetes.
- Lead specialists to coordinate care and share learning across different specialties for complex patients with multiple conditions.
- Effective care planning takes place with the patient so that they own and hold the management plan for their condition(s).
- The design of a streamlined, effective and proactive pathway that:
 - Avoids waste and duplication.
 - Optimises the use of technology.
 - Treats patients in a single episode e.g. via a virtual MDT wherever possible.

3.3.1 Patient Empowerment – Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice

Self-care is a model where the patient is engaged and an active participant in their own health and well-being. It is recognised that despite the positive evidence for self-care, there is a lack of clarity in relation to which initiatives are most effective. This requires and relies on behaviour change on the part of both patients and professionals.

It is recognised that much of this will be addressed through the Healthy Communities Strategy and the ‘Stockport Way’ identified in the

Neighbourhood business case. It is important that activity to achieve this is well supported and given sufficient time to develop and demonstrate benefits.

Patient Activation Measurement (PAM) is a tool that can be used to help measure how activated a patient is in their own health care. Patients complete a questionnaire which provides an activation score between 1 and 4 (1 being the lowest and 4 being the highest). Evidence ¹for moving a patient from level 1 to level 4 (as stated in the Neighbourhood business case) is that, for the top 15% of service users, this could reduce first outpatient appointments by 10% and follow up appointments could be reduced by 17%.

Within the Outpatient business case it is intended that the PAM tool will be applied to the remaining 85% of patients and that increasing activation will have a similar effect in reducing demand for health services²as it does on the top 15%. It is acknowledged that activation at this scale will be more difficult but is vital to improving the health of the wider population. As such it is expected that reductions in outpatient demand are likely to be smaller for this population.

Patient education is a key enabler to patient activation both in terms of digital technology and literacy and access to community support, promotions and events. This is required to support and encourage engagement that which is currently available from health care professionals. This provides ready access to information for people at any time and provides a mechanism for people to engage across the system. This approach includes sharing of information between clinicians and patients and relies on patients becoming increasingly activated to self-care and to improve and maintain their own health including:

- Providing the people of Stockport with locally supported self-help information such as nutrition and healthy living advice, and also high quality advice for managing minor injuries and health complaints without the need to contact health services.
- Patients having control of their own records and management plans, supported by the development of technology including apps that will provide the opportunity to record personal health information and share this health professionals across the system. Results from a survey³ of patients within a GP Practice in Lewisham found that 46% said that they felt more confident about their health and half said they felt more able to help themselves when having access to their electronic records.

¹ Hibbard et al

² Wanless Report – Our Future Health Secured – A review of NHS Funding and Performance - 2008

³ Care Study in Lewisham by Dr B. Fisher Lewisham GP 2012 survey of patients

- Providing patients with information and access to the expansion of existing health promotion services and self-care coaches e.g. health walks, walk away from diabetes and mental health support. This will be expanded to include local workshops, run by health professionals to advise on self-care in conditions such as knee and hip pain, as is currently being trialled in the 100 day rapid testing model in Stockport. It is indicated that incorporating this into the pathway will help enable patients to take greater control of their own health. This could include signposting to local groups and charities – for people to talk to ‘other people like me’ – e.g. Osteoporosis Society and Diabetes UK, BDA for lifestyle and diet, Healthy Stockport, Stockport Targeted Prevention Alliance (TPA) and locally recognised health champions for person to person support.

Using the evidence within the Neighbourhood business case and extending this to the wider population, it is anticipated that this has the potential to reduce activity by up to 5% for first appointments and 7% for follow-up appointments.

3.3.2 Advice, Guidance & Diagnostics – Support for Clinicians in Clinical Decision Making

Attending an outpatient appointment in a hospital setting can be a significant event for an individual. In practical terms this may involve taking time off work either to attend the appointment or to support a family member attending an appointment.

Referrals are generated when a clinician is unable to manage an element of patient care. This may be due to an intervention being required, a specific test being needed that is not available to them, or may be because the clinician is unsure how to manage the condition.

The referral generates an outpatient appointment at a future date that can create delays in reaching a diagnosis and agreeing a management plan. They may also involve unnecessary hospital visits with sometimes lengthy waits in outpatients to see busy specialists when their care could be streamlined or offered in different ways.

The proposed redesign of the outpatient pathway seeks to address these issues by providing early advice and guidance between clinicians as to whether a referral is required or if, with appropriate advice, the condition can be managed without the need for traditional outpatient referral.

This business case proposes two communication channels to enable advice and guidance between clinicians to be provided both verbally via Consultant Connect and in writing via an e-messaging system (within eRS – formerly Choose & Book).

Consultant Connect provides a mechanism for immediate, verbal communications to occur directly between the referrer and specialist. The immediacy of this interaction, together with the ability to communicate information in real time makes a difference to a decision whether or not to refer a patient. The evidence collected to date from a pilot across 8 specialties indicates that up to 40% of referrals can be avoided. This data should be interpreted carefully, accepting that impacts will not be equal across all specialties and that to have a full, system-wide impact, the service will need to be available across the whole of outpatients.

It is also recognised that enabling written communication services between clinicians (via email or contact in shared IT platforms) may offer a more convenient mechanism of obtaining advice to support patient management when advice is not as urgent, may be more complex or requires more time for consideration. It is proposed that a direct messaging advice and guidance tool via eRS messaging / email could provide a potential solution. Advice may be provided by a specialist nurse or doctor, or a GP with special interest (GPwSI). Evidence from Calderdale and Huddersfield indicates a 57% reduction in referrals following the introduction of specialist / GP advice and guidance using the eRS messaging system.

In addition to providing advice and guidance, it is recognised that upskilling GPs will also have a positive impact on outpatient referral rates. Providing increased, targeted education to GPs has been shown to decrease the number of patients referred to outpatients. Within NHS Greenwich, a GP improvement and education programme was used to improve diabetes care. This resulted in a 12% decrease in outpatient attendances for diabetes.

The ‘Super 6’ is a model of care for diabetes developed by a GP with special interest in diabetes. The main drive behind this redesign was to define roles to increase the ability of primary care to deliver diabetes care, and provide rapid access to specialist care as required. As a result, between 2010 and 2011, 94%⁴ of people with diabetes were discharged from hospital-based care. One of the projects being undertaken in the 100 day rapid testing work in diabetes involves support to primary care clinicians to extend their knowledge and services and the evidence gathered from this will influence this part of the business case.

The work of this business case will also continue and extend current education programmes in Stockport to enable:

- An improved relationship between Stockport clinicians with a mutual respect and trust for their respective roles in the care of patients.
- Clarity of responsibility between primary and acute care for the management of different aspects of patient conditions.
- Facilitated Peer review of cases.
- Improved knowledge of and access to specialty pathways and protocols and information for all clinicians across primary and secondary care.

⁴ Dr Partha Kar, Clinical Director Endocrinology/Diabetes, Consultant Physician, Portsmouth Hospitals NHS Trust, UK (<https://www.diabetes.org.uk/Professionals/Position-statements-reports/Integrated-diabetes-care/Portsmouth/>)

Based on the evidence outlined above, anticipated activity reductions are predicated on the expectation that up to 35% of GPs will seek advice and guidance via verbal and written channels prior to making a referral and of this circa 40% of referrals will be avoided or deflected.

3.3.3 Advice, Guidance & Diagnostics – Appropriate clinical triage of referrals and diagnostics through contact, access & triage (CAT)

As mentioned above, it is recognised that patients are sometimes referred for outpatient appointments that can involve a significant wait for an appointment and may ultimately add little value to the patient and the treatment of their condition. This may be due to a number of factors, including:

- Further information from diagnostic tests is required that could have been anticipated prior to the appointment.
- A referral is made to the wrong clinic or specialist.
- The outcome of the appointment is advice or information that may not have required a face-to-face meeting with a specialist.

Specialty or condition-specific clinical triage will be provided through consistent and structured contact, access and triage (CAT) arrangements. Appropriate clinical triage of referrals and diagnostics will enable:

- Referrals to be triaged by a specialist clinician or appropriate health professional including specialist nurses prior to an appointment to ensure that the patient is provided with the most appropriate treatment by the most appropriate healthcare professional.
- Decisions regarding alternative methods of care delivery e.g. community services, nurse specialists.
- Ensuring that required diagnostics are completed and reviewed as part of clinical triage to inform decisions about future care. This will result in either patients being discharged with a management plan without the need to be seen or a more efficient and effective one-stop outpatient appointment.
- Reduced requirement for consultant-to-consultant referrals through the implementation of clear protocols and processes.
- Advice and guidance to GPs to manage patients in primary care if a specialist appointment is not required.

The financial impact of this priority focuses on the avoidance of referrals to the wrong clinic or specialist. In addition, it is recognised that the introduction of a systematic CAT approach will also realise benefits across the whole outpatient programme particularly in removing unnecessary first and follow-up appointments. As such a conservative estimate of a 1% reduction GP referrals is expected.

Examples of evidence to support this approach includes:

- A case review by a local COPD Nurse Specialist⁵ found that from 72 patients reviewed, 46% were discharged and 22% referred back to GP care.
- University College London Hospitals found that 50%⁶ of patients could be discharged from gastrointestinal (GI) after the diagnostic results were reviewed without having to come back to clinic.
- An initiative focusing on Chronic Kidney Disease (CKD) in Tower Hamlets resulted in an 80% reduction in face-to-face patient consultations through the use of consultant access to EMIS web to view patient records. As part of the outpatient business case it is proposed that this could be deployed to the relevant specialist services.
- Evidence from a clinical triage in a MSK service by Ashford CCG resulted in a 40% reduction in referrals received by the acute trust T&O service. This is also reflected in reductions following the introduction of triage in the Stockport system as part of the rapid testing models in T&O and Gastro. Evidence⁷ from another study found that in a six month period, 768 patients were scheduled for review in the medical outpatient department, but following pre-screening, only 59% (458) of cases were found to need review.

3.3.4 Right intervention – Alternative mechanisms to traditional follow up appointments and support to enable discharge from outpatient clinic

This priority involves looking at other ways of undertaking traditional follow up appointments and the provision of an effective CAT infrastructure to enable outpatients to be discharged to community based care for surveillance and monitoring of long-term conditions. Alternative follow up mechanisms will include virtual and group consultations, rapid access to specialist nurse led

⁵ Feb 2015 – Chest Clinic Report by COPD Nurse

⁶ Lean Service Redesign in Gi Project sponsor - Richard Cohen, Project Lead - Esther Rainbow - Assistant General Manager, GI Services, Clinical Lead - Mr Jonathan McCullough - GI Consultant

⁷ Donnellan F, Hussain T, Aftab AR, McGurk C. Reducing unnecessary outpatient attendances. International Journal of Health Care Quality Assurance 2010;(5):527-31

clinics or using of technology to support patient contact and offer direct advice.

Further important changes to the outpatient pathway will include:

- Earlier discharge of patients with appropriate support and information following procedures or first appointments, with a philosophy that the default position is to discharge and that reasons for a follow up appointment are clear. This needs to be supported by patient activation to drive self-care and a trust between clinicians that plans will be adhered to, enabled by technology as appropriate.
- Offering telephone, email or text follow-up after procedures where there are no clinical issues.
- Only arranging face-to-face follow up appointments where clinically necessary.

To enable this, the provision of clear discharge protocols/criteria to support and inform action plans for patients and neighbourhood teams will be required. These will need to give clear guidance for factors that trigger a change of plan and/or re-referral. It should be noted that patients with ongoing necessary interventions (e.g. orthotic reviews) on an ongoing basis e.g. annually should be able to stay in follow up systems and opt back in when required rather than being discharged.

Where possible, group follow-up (FU) appointments for long-term conditions will be established. This may be appropriate where the same message can be given to a small group of people and has been shown to contribute to significant savings in a study undertaken in a primary care setting⁸.

Further alternative mechanisms of follow up will be explored and investigated, including virtual appointments with specialists or other appropriate health professionals. There is currently little evidence in this field and so any work done locally will be published and support the redesign of outpatient services in Greater Manchester and national settings.

To support discharge from outpatient clinics for patients with long term conditions, an effective surveillance and monitoring infrastructure will be developed drawing upon the neighbourhood CAT model. This will enable patients with long term conditions that require regular tests and surveillance

⁸ Smethwick practice team achieved a £2.5m saving from freed practice capacity and quality improvement

e.g. PSA, Echo, completion of specific follow up registries to be co-ordinated through one central site, with results being reviewed virtually and plans amended without the requirement to attend an outpatient appointment. This model will support the whole health care system by providing one place through which all call/recall can be coordinated.

This business case also proposes the introduction of neighbourhood phlebotomy services (for bloods required prior to procedures etc.) utilising the redevelopment of treatment rooms and 7 day model proposed within the Neighbourhood business case. This will offer an open access site for phlebotomy in neighbourhoods/localities where patients requiring blood tests from primary and secondary care can attend in a more flexible way than is currently on offer, reducing pressure across the system.

Where procedures are required, streamlined one-stop access will be further developed as part of pre-operative processes on the day of the outpatient appointment, thus reducing the number of trips a patient needs to make.

A key enabler to this priority is the development and expansion of specialist nurse roles across a range of specialties. Specialist nurse capacity will support the effective management of patients along their pathway. Specialist nurses are dedicated to a particular area of nursing, caring for patients suffering from long-term conditions. Within Stockport these include diabetes, heart failure, respiratory and continence teams. Specialist nurses provide direct patient care and can play a vital role in educating patients on how best to manage their symptoms, as well as offering support following diagnosis and in ongoing management of their condition. In many cases the involvement of a specialist nurse can prevent patients being re-hospitalised.

Specialist nurses also take a leading role in making sure patients get the best care possible. Several studies have shown that as a substitute for other health care professionals, including doctors, specialist nurses are both clinically and cost effective. A report by the British Heart Foundation (2008)^[9] revealed that close monitoring of patient symptoms by a nurse specialist reduced readmission rates by 35%, saving CCGs £1,826 per patient. Furthermore, patients in contact with a heart failure specialist nurse experienced less impact from their condition on their daily lives.

^[9] British Heart Foundation G234 HF nurse service in England 25/09/08
<https://www.bhf.org.uk/publications/about-bhf/g234-heart-failure-nurse-services-in-england---full-final-report-2008>

Areas that specialist nurses could get involved in include:

- Providing advice, help and support for GP Practices.
- Working with clinicians to ensure the correct case mix is achieved.
- Setting up 'One Stop' clinics with clinicians.

A further option may include expanding the specialist nurses nursing team to support other areas of high prevalence, moving them out of the outpatient or secondary care setting and providing clinics in the neighbourhoods. An example of this is IBD, Dementia or Epilepsy specialist nurses.

Based on the evidence outlined above, anticipated activity reductions are predicated on the expectation that up to 14% of traditional outpatient activity will be avoided or deflected.

3.3.5 Right intervention – Coordinated support for complex patients

The number of people across the UK with three or more long-term conditions is predicted to rise to 2.9 million by 2018⁹. Given the increasing numbers of people managing one or more long-term conditions, and that 64% of all outpatient appointments are for those patients with at least one long term condition there is clear scope to realise significant benefits for outpatients in transforming the care offered to those with chronic illness.

Patients with more than one long term condition can be under the care of several different specialties, requiring multiple visits to different outpatient clinics often in the same week or month. These visits may result in contradictory management plans and confusion for patients as reflected in the patient case study examples at section 1.4.2.

Creating a more person-centred, MDT style outcome based approach to treat the patient in a more holistic manner is therefore planned to better manage the care of complex patients. This will ensure that the patient receives one consistent plan led by a single specialist who is working with colleagues to provide coordinated appointments and care across different specialities. This clarity will enable our population to feel empowered to self-care with confidence.

[10] Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

Based on the evidence outlined above and in the Neighbourhood business case, a conservative estimate is that circa 0.5% of the top 15% service users of traditional outpatient activity will be avoided or deflected.

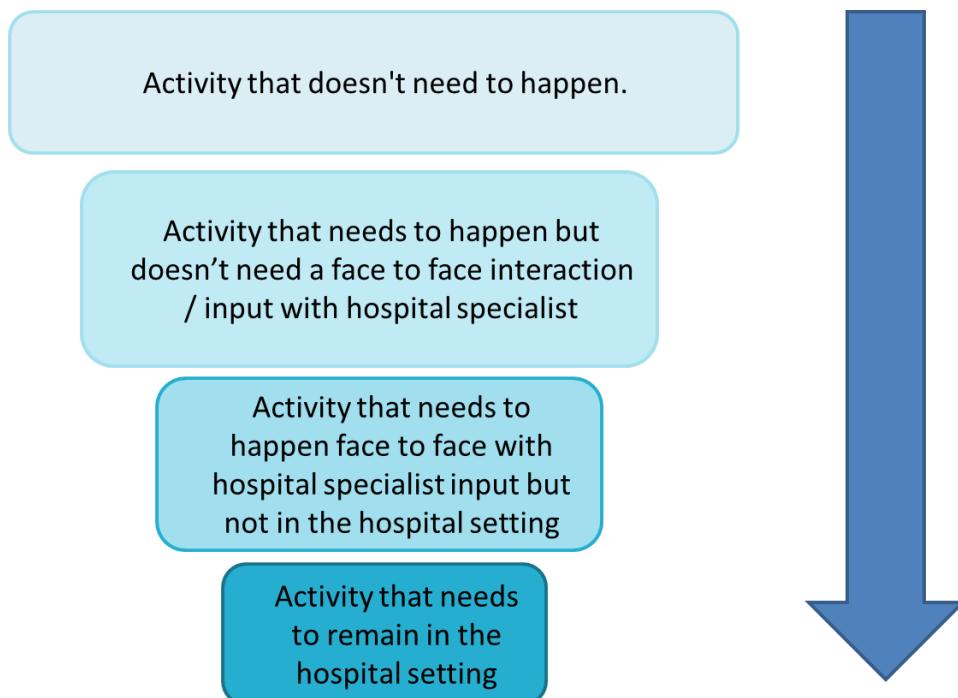
3.3.6 Right intervention – Identifying outpatient activity that can be stopped

This priority will focus on identifying any follow up appointments that may be unnecessary as a result of:

- The introduction of the system wide changes identified above.
- A clinician-led specialty review of outpatient activities, protocols and processes to identify improvements and alternative approaches.
- Upskilling and supporting junior doctors and locums. This will give them confidence and the necessary guidance to discharge patients either back to their GP or elsewhere in the system eg. Reviewing caseloads and where appropriate discharging to specialist nurses to manage.

This work will focus on redesigning the outpatient pathway and reducing activity as indicated in the diagram below.

Diagram 5 - Areas of Activity to be reduced



The projections below are recognised as very ambitious and aspirational. They will be dependent on the delivery of the supporting infrastructure; the successful implementation of cultural and workforce changes; in addition to the availability of appropriate technology and the management of the risks and assumptions outlined elsewhere in this business case. Based on the evidence outlined above, anticipated activity reductions are predicated on the expectation that up to 14% of traditional outpatient activity will be avoided or deflected.

It should be noted that while these reductions are based on the baseline of current activity, they do not factor in the continuing trend towards an overall increase and growth across outpatient activity.

Year	Traditional Outpatient Activity Reduction
0 (17/18)	0%
1 (18/19)	-15%
2 (19/20)	-15% (-30% cumulative)
3 (20-21)	-8% (-38% cumulative)

2.3.7 National Elective Care Rapid Testing – emerging results

As part of the NHS England Elective Care Work Programme, Stockport was chosen to be part of the National Elective Care Rapid Testing Programme. Using the People Powered Results structure innovation method key stakeholders across agreed specialties came to apply a new models of outpatient care are also being developed through the 100 day rapid test work. This work is testing various aspects of the proposed outpatient model and providing an element of proof of concept for the approaches outlined in this business case. As can be seen, within the specialties that involved this is already starting to deliver results and demonstrating the clear benefits both to patients and across the health economy. It is recognised that one of the challenges will be to extend and implement these models at scale but achievements to date are positive and include:

- **Diabetes** – aiming to reduce diabetic referrals into secondary care by 65% in 3 high referring practices by:
 - Buddy clinics - experienced ANPs with an interest in diabetes are going into local practices and working alongside less experienced practice nurses in diabetic clinics to help upskill. These have highlighted the variation in knowledge across practices.
 - Virtual clinics – consultants are working with GPs to discuss case studies and are building positive relationships.
- **T&O** – aiming to reduce the number of face to face outpatient FU appointments for hand, shoulder, knee and hip patients by 20%. To date this has achieved the following:
 - Knee pain masterclass for >55s improving confidence to self-manage
 - Introduction of a patient passport including information, useful contacts, patient logs for appointments , measurements and test results
 - Telephone follow-up (FU) clinics successfully introduced for spinal patients in September 2016 and extended to other areas with 19% of FUs now undertaken in this way
 - Pharmacist and physiotherapist enhanced triage resulted in 75% of referrals being discharged without seeing a consultant
- **Gastroenterology** – introduced a rapid access, specialist nurse led IBD flare up clinic reducing waiting times for the cohort involved from 10 weeks to 15 days; introduction of a ‘flare up’ advice line offering telephone and text advice in addition to telephone follow-up clinics. The rapid test approach has recently been extended as part of the second wave of the programme. This project is aiming to increase

the proportion of newly diagnosed patients in Stockport with non-alcoholic fatty liver disease managed in primary care to 95%. Patient education and self-management will be key as lifestyle changes are the main area of treatment. A group education session is planned together with the Diabetes team given the linkage between these conditions. In addition, a nurse specialist will be providing a training programme for GP nurses to enable lifestyle advice to be given in primary care.

- **Cardiology and Respiratory** – introduced a one-stop joint cardiology and respiratory ‘breathe’ clinic reducing the demand for multiple consultant appointments; joint triage and a new referral process that standardized GP referrals for consistency; reducing duplicate testing; post-appointment condition management discussions with community health and care professional and the provision of a patient-held self-management plan to enable self-management and reduce inappropriate follow-up appointments.

3.4 Consultation Feedback

Consultation exercises with clinicians and patients have been undertaken to test and identify opportunities to support and enable this approach. Feedback and comments from both clinicians and patients provide valuable insights into the proposed model of care for outpatients and provide important considerations that will inform future implementation plans. Key findings are summarised as follows and full details are provided at Appendix 3:

3.4.1 Clinician Feedback

Feedback from consultants provided a number of responses when asked to identify how outpatient activity could be reduced or managed differently included:

- More joint working.
- Call/recall for surveillance patients, ongoing assessments and blood monitoring.
- Virtual appointments and questionnaire led post-op follow-up.
- GPwSi or nurse led outpatient clinics.
- One-stop clinics and pre-op assessment.

Consultants were also asked to identify infrastructure changes that would be required to enable the pathway changes identified in their responses:

- IT and technology e.g. video conferencing, E-referral, Consultant Connect, Email.
- Better systems and relationships between primary and secondary care.
- Change and flexibility to adopt rapid access, open appointments, specialist nurse advice lines.
- Support to enable patient self-management.
- Robust call and recall system.

3.4.2 Patient Feedback

Patients were asked a range of questions relating to their experience in the clinic they attended and their views about possible alternative approaches:

- 81% would consider seeing other appropriate healthcare professionals within the community.
- 54% would be happy for your care to be delivered in other ways rather than face to face.
- 90% would be happy to become involved in ways of directly managing/ monitoring your own health.

3.5 Stakeholder Analysis

3.5.1 Key Stakeholders

It is recognised that the proposed new model of care for outpatients is complex and involves a range of stakeholders whose engagement and active participation will be key to the successful delivery of this business case. Key stakeholders include:

- **Patients** – are central to the proposed model of care in relation to becoming activated and taking greater control of their own care and in accepting the proposed changes to their care.
- **GPs** – will work in closer partnership with specialist clinicians to manage the care of their patients with appropriate advice and support from clinicians and healthcare professionals.
- **Specialist clinicians** – will be expected to work differently providing specialist advice, guidance, protocols and care management plans so that where appropriate patients can self-manage or be managed by other

healthcare professionals. Their knowledge, expertise and specialist clinical judgement is vital to informing the feasibility of future plans.

- **Appointment booking teams** – will be required to operate potentially more varied and flexible approaches to provide patient access to the most appropriate clinical support. This will require more streamlined approaches and flexibility to adapt to changing pathways.
- **Neighbourhood and borough wide teams and other health professionals** – will be responsible for delivering different aspects of patient care including specialist nurses, pharmacists, physiotherapists etc. in addition to the provision of an effective contact, access and triage infrastructure to enable the ongoing care of patients with long-term conditions.
- **Third sector and community support groups** – are essential to providing a support mechanism for patients to share experiences, learning and support.

3.6 Dependencies

It is recognised that the challenges in implementing this business case are considerable as schemes with great potential can fail without careful management and positive implementation. This is often because the business case will be dependent on a range of organisational and individual factors across the Stockport-wide system. As an example, the proposed shift in care cannot be achieved without significantly increasing capacity and capability in primary and community care, and solving some of the prevailing social care challenges. Further dependencies also relate to required changes to workforce, technology and communication.

As such, the redesign of the outpatient model will depend on a number of key factors including:

- The availability of an appropriate neighbourhood and community infrastructure with sufficient capacity to manage the re-provision of care for patients that may transfer out of the traditional outpatient services into new, integrated models of care.
- The development of key enabling infrastructures relating to workforce, technology and the physical estate that will be required to achieve the strategic objectives set out in this business case.
- The ability to innovate and test new initiatives and ways of working, learning quickly what works and what doesn't.
- Successfully adapting clinician working practices to meet the needs of the proposed model.

- Acceptance and willingness of the general population to take responsibility for and be more involved in their own care.
- The alignment and development of complementary arrangements across the wider Stockport infrastructure reflected in other business cases.

3.6.1 Other business cases

Neighbourhood Business Case

The Neighbourhood business case proposes making an investment of £7.9m in financial year 2017/18 which will enable fundamental transformation of services. With full implementation by 2020/21 the investment will deliver a gross net benefit position of £9.4m (investment of £11.0m and a benefit £20.5m)

Through the Neighbourhood business case there will be significant investment in:

- GP practices
- Primary Care at scale
- Integrated community teams

Services will operate out of neighbourhood teams which bring together primary care, physical and mental health and social care services. Neighbourhood leadership will be provided by a general practitioner, supported by senior nursing, therapeutic and social work colleagues, who will ensure that services meet the needs of local people. Services will offer seven-day access and support people to remain healthy, build independence and personal resilience and address risk factors associated with developing a long-term condition.

The success of the Neighbourhood business case is heavily contingent on the system's ability to ensure that the 15% of people most at risk of being admitted to hospital are able to better manage their care in the community setting. The Neighbourhood business case delivers the evidence based community alternatives which avoid unnecessary hospital based interventions. By deploying the full range of interventions set out in the Neighbourhood business case, the teams will be able to work intensively with

this cohort to appropriately deflect activity away from hospital in the following proportions:

- A&E attendances: 19%
- Non-elective admissions: 25%
- Outpatient first attendances: 10%
- Outpatient follow up appointments: 17%
- Elective admissions: 37%

People will be supported to achieve positive personal health, care and wellbeing outcomes, whilst maintaining their independence.

Intermediate Tier Business Case

The intermediate Tier business case has been developed to outline how Stockport Together intends to implement a new model of care for intermediate tier services that is more assertive in reducing acute activity and improving the outcome for the people of Stockport. The business case helps to identify how improvements will be delivered and aims to redress the imbalance between intermediate tier services provided in people's own home and those provided in community beds and hospital.

Within Stockport there are over 20 health and social care services providing various forms of intermediate tier services (home and bed based) that are predominantly focused on supporting discharge from hospital.

Each service has been set up discretely over the past 10 years creating a complicated system that is not easily understood which have been designed to manage the 'effects' of the system rather than tackle its 'causes'.

This means there is not a strong alternative offer to respond to people in crisis and prevent acute admission, placing additional demand on the hospital particularly A&E.

3.6.2 Enablers (IT / Workforce / Estates)

IT

The development of the proposed outpatient model is clearly dependent upon being able to provide alternatives to traditional outpatient appointments. This will be achieved by optimising technology and adopting a ‘digital by default’ where possible to ensure minimal impact to workloads across primary and secondary care. As such the improved use of information and systems will be key. In particular this will be supported through close working and alignment with the Stockport IM&T strategy to Connect, Integrate, Empower and Understand. Specific areas of focus relating to this business case will include:

- Integration of key systems to enable health professionals to access and transfer patient information across the outpatient system e.g. from EMIS (Stockport Health and Care Record), national E-Referral System (eRS), Trakcare (Trust EPR) etc.
- Improved communication channels for advice and guidance including Consultant Connect and eRS messaging.
- Development of a patient portal to enable patient activation and control.
- Virtual solutions including text messaging, video conferencing, telephone appointments and email.
- Effective data analytics to measure and monitor impact of initiatives.
- Patient access to health records.

There is also a key dependency with the implementation of IM&T solutions within Neighbourhoods and Intermediate Tier workstreams, in particular mobile working and assistive technology. Through the implementation of these enabling requirements it is expected that there will be a reduction in demand and a responsive step-down and community offer (e.g. through mobile working). These requirements are outlined within the associated business cases.

Workforce

The new model of care for outpatients depends upon a more integrated and aligned approach. The redesigned pathway moves away from a traditional approach where a patient is passed from GP to specialist to involve a wider spectrum of health professionals, who may be better placed to provide different aspects of patient care throughout the patient journey. This will inevitably require a more flexible, responsive and potentially complex approach to bring the right skill-mix of people together, at different points across the pathway e.g. community support, specialist nurses, pharmacists, GPwSI, GPs, specialists and other health professionals as required.

In order to deliver the model to the ambitions described a review of the existing workforce will be required to inform the development of a detailed workforce plan which, describes the sequence of the proposed service changes and the associated impact on the workforce across the services. This proposal should include plans to deliver:

- Clear clinical governance
- New job roles
- Training and development programme

As such, timely Human Resources and Outpatient support will be critical. Workforce and organisational change within the outpatient workforce will also need to factor in the implications of any staff / workforce transition across the economy.

Estates

Estates is a key enabler for Stockport Together to deliver the future service model, and therefore service design and clinical need will be the main factors that will drive and influence the configuration of our future estate.

This influence manifests itself at two levels, firstly the service redesign process being undertaken by Stockport Together and secondly the impact of

developments and programmes that may be driven across the Greater Manchester area.

In terms of outpatient services the main estates implications will be with regards to the impact on the hospital and outpatient estate. There is potential to rationalise the acute estate in response to the strategy to reduce admissions and undertake a number of services in the locality as part of the redesign of the health care in Stockport. This would release land and property on the Stepping Hill Hospital estate for alternative development opportunities. The Strategic Estates Plan will be further developed to respond to transformation of services to identify opportunities to rationalise the estate.

In addition, there is also a dependency with estates requirements within the neighbourhoods, in particular in terms of identifying possible alternative venues for face-to-face outpatient appointments with a variety of different health professionals.

Estates requirements will need to be considered over the longer term as the redesign of the outpatient pathway develops, including any understanding of investment required to support services.

3.6.3 Behaviour change and capacity

In addition to the dependencies already identified, the proposed future model of care for outpatients relies on both changes to behaviours across all of the stakeholders identified above in addition to the provision of sufficient capacity and skills at the different stages of the outpatient pathway.

Key aspects of behaviour change and capacity include:

- The ability for patients to take more control of their own care.
- Trust and confidence of:
 - Patients to accept support from other professionals across the broader health economy.
 - Different groups of health professionals to provide healthcare previously provided by specialist clinicians.

- Specialist clinicians to discharge their patients into the care of other health professionals in the system.
- Increased integration and joint working to manage patient care, particularly those with multiple, complex conditions.
- The provision of time for specialist clinicians to enable clinical triage and the provision of advice and guidance to GPs.
- Capacity of specialist and community nurses to manage increasing workloads.
- Community capacity to provide an effective contact, access and triage infrastructure and phlebotomy service.

4 The Economic and Financial Case

4.1 Financing

The financing of this business case is contingent upon three factors:

- 1) In the short term (2017/18) initial levels of investment will be funded from the Transformation Funding secured from Greater Manchester as part of the Investment Agreement.
- 2) In the medium and longer term (2018/19 – 2020/21) maintaining the CCG allocations and the release of the Stockport Together benefits, delivered through a combination of reducing acute capacity and managing growth in acute demand.
- 3) Across this whole period, a risk share agreement that underwrites the investment risk across the Stockport Together partners.

There are particular challenges in delivering economic benefits. A number of factors may inhibit the delivery of system-wide savings including:

- A number of the proposed approaches are, as yet, untested at scale across the health economy. As such, whilst there may be some high level academic research, it will be necessary to validate the impact of introducing these approaches system-wide at scale. As such, the impact in financial terms is as yet unknown.
- Local demographics and national trends indicate anticipated growth in the demand for specialist care and treatment. As such, as initiatives

start to create capacity in the outpatient system, it is expected that this will be replaced by increased growth and demand.

There is also the risk of supply-induced demand; any strategy that aims to reduce over-use is also likely to identify under-use and unmet need. The challenge of demonstrating economic benefits is part of the broader issue of the way in which success is measured. While initiatives may not deliver savings, they may increase 'value' by addressing unmet need, or encouraging need to be met in ways that deliver better outcomes for people. As such, a more coordinated approach linking packages of initiatives and multifaceted programmes targeting high-risk populations are likely to be more effective than those involving single approaches.

Outpatients will continue to be commissioned as a block contract. In line with projections set out in this business case in relation to anticipated reductions in activity over the four year period of this programme, future commissioning will be informed by planned reductions resulting from the redesign of the outpatients pathway.

In terms of current activity it is recognised that the CCG commission a total of 344,320 outpatient appointment (101,315 first appointments (FA) and 243,005 follow-up (FU) appointments) across a range of providers. The scope of this business case is to focus on activity commissioned within Stockport which accounts for 81% of that activity (93,364 FA and 185,664 FU appointments totalling 279,028 appointments overall).

Through the proposed service model outlined within this business case, the following deflections are proposed:

Deflections	OP Activity	Percentage
FA	-29,442	-31.5%
FU	-78,071	-42%
Total	-107,513	-38.5%

4.2 Investment required

Priority	Reprovision Requirement	2018/19		2019/20		2020/21	
		Cost	Saving	Cost	Saving	Cost	Saving
1. Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice	PAM tool licence costs	£20,000		£20,000		£20,000	
	Staff time to complete / train patients (0.5 WTE band 3 admin)	£11,000		£11,000		£11,000	
	Development of a patient app	£10,000		£10,000		£10,000	
Total		£41,000	-£365,783	£41,000	-£615,955	£41,000	-£816,622
2. Support for GPs in clinical decision making	Consultant Connect licence costs (£50K p.a.)	£50,000		£50,000		£50,000	
	ERS Messaging - resourcing to set up directory of service (0.5 WTE band 3 admin)	£11,000		£11,000			
	Consultant time to provide:						
	* Advice and guidance including admin resource to coordinate and manage						
	* GP education and training - to prepare and deliver, training material and comms, e-learning package	£100,000		£25,000		£25,000	
	(initial double running with traditional appointments)						

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Priority	Reprovision Requirement	2018/19		2019/20		2020/21	
		Cost	Saving	Cost	Saving	Cost	Saving
	Communication resource to promote use of advice and guidance channels (0.5 WTE band 5 Comms officer)	£17,000		£17,000		£17,000	
	Consultant cost not removed @ 16%	£65,442		£65,442		£65,442	
	Total	£243,442	-£616,662	£168,442	-£1,525,168	£157,442	-£2,701,022
3. Appropriate clinical triage of referrals and diagnostics	Consultant time to vet referrals, order and review diagnostics (initial double running with traditional appointments)						
	EPR enhancements and system interfaces to enable A&G	£50,000		£25,000		£25,000	
	Increased demand for diagnostic services (staffing and resources)						
	Consultant cost not removed @ 16%	£122,296		£122,296		£122,296	
	Total	£172,296	£1,227,718	£147,296	£1,227,718	£147,296	-£1,227,718
4. Alternative mechanisms for traditional appointments and support to enable discharge from outpatient clinic	Community nursing additional capacity to manage deflections from consultants (10 WTE band 7 nurses: COPD, HF, IBD, Continence and Diabetes)	£518,865		£524,054		£529,295	
	CAT infrastructure - call/recall - development and management - nursing and admin time (5 WTE band 7 nurse & 1 WTE band 3 admin)	£277,000		£279,770		£282,568	

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Priority	Reprovision Requirement	2018/19		2019/20		2020/21	
		Cost	Saving	Cost	Saving	Cost	Saving
5. Identifying outpatient activity that can be stopped	Consultant time to run virtual clinics (initial double running with traditional appointments)						
	Video conference/email/text technology costs	£100,000		£100,000		£100,000	
	GM Docman contract (£60K p.a.)	£60,000					
	Phlebotomy service	£128,000		£128,000		£128,000	
	Consultant cost not removed @ 16%	£365,089		£365,089		£365,089	
Total		£1,448,954	£2,281,807	£1,396,913	£2,860,813	£1,396,913	-£3,479,722
6. Coordinated support for complex patients	Consultant time to upskill and support for junior doctors / locums including production and distribution of protocols etc.						
	(initial double running with traditional appointments)						
	Consultant cost not removed @ 16%	£365,089		£365,089		£365,089	
Total		£365,089	£2,281,807	£365,089	£2,860,813	£365,089	-£3,479,722
Lead specialists coordinating care across specialties	£9,555		£9,555		£9,555		
Total	£9,555	-£59,718	£9,555	-£59,718	£9,555	-£59,718	
GRAND TOTAL	£2,280,336	£6,833,495	£2,128,295	£9,150,184	£2,117,295	£11,764,523	

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Cost-benefit analysis 2018 - 2021

		2018/19				2019/20				2019/20	2020/21					
		FA	FU	Total	FA	FU	Total	FA	FU	Total	FA	FU	Total			
Strategic Priorities																
1. Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice	Support for patients in decision making and advice	617	£96,316	2,933	£269,467	£365,783	1,834	£286,058	3,591	£329,896	£615,955	2,964	£462,461	3,855	£354,161	£816,622
2. Support for GPs in clinical decision making	GP development and upskill	611	£95,353	1,222	£112,296	£207,649	1,852	£288,948	3,704	£340,292	£629,240	2,994	£467,132	5,989	£550,138	£1,017,271
	Clinician Communications - Consultant connect & ERS Messaging	1,204	£187,819	2,408	£221,193	£409,013	2,637	£411,412	5,275	£484,516	£895,928	4,956	£773,181	9,913	£910,569	£1,683,751
	ERS messaging															
3. Appropriate clinical triage of referrals and diagnostics	Clinical Triage	886	£138,210	1,772	£162,768	£300,978	886	£138,210	1,772	£162,768	£300,978	886	£138,210	1,772	£162,768	£300,978
	Consultant 2 Consultant	2,728	£425,561	5,456	£501,179	£926,740	2,728	£425,561	5,456	£501,179	£926,740	2,728	£425,561	5,456	£501,179	£926,740
4. Alternative mechanisms for traditional appointments and support to enable discharge from outpatient clinic	Alternative mechanisms for traditional FU appts	4,897	£763,891	16,524	£1,517,916	£2,281,807	6,420	£1,001,460	20,241	£1,859,353	£2,860,813	7,407	£1,155,530	25,301	£2,324,192	£3,479,722
5. Coordinated support for complex patients	Complex patients	98	£15,314	483	£44,405	£59,718	98	£15,314	483	£44,405	£59,718	98	£15,314	483	£44,405	£59,718
6. Identifying outpatient activity that can be stopped	Support discharge from OP clinics (links to 4)															
	Stopping OP activity	4,897	£763,891	16,524	£1,517,916	£2,281,807	6420	£1,001,460	20,241	£1,859,353	£2,860,813	7407	£1,155,530	25,301	£2,324,192	£3,479,722
	TOTAL	15,938	£2,486,354	47,324	£4,347,141	£6,833,495	22,874	£3,568,421	60,764	£5,581,763	£9,150,184	29,442	£4,592,919	78,071	£7,171,604	£11,764,523

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4.3 Non-financial benefits associated with this business case:

Non-Financial Benefit	Measure
Increased alternatives to a GP focusing on patient activation and control (prevention and proactive) - Patients will have more self-care options to enhance their knowledge and skills to manage their condition and access community support without the need for GP intervention	Reduction in GP attendances
Reduced need to go to hospital - Patients will be better-looked after in a community or primary care setting reducing the need to go to hospital	Reduction in traditional outpatient appointments
Timely access to specialist advice and guidance - GPs and other healthcare professionals will be able to manage their patients better as they can obtain specialist advice when necessary	Reduction in referrals Reduction in waiting times e.g. for test results
Reduced need for referrals - GPs will be incentivised to use NHS pathways where appropriate, before deciding if a referral is required. The increased access to specialists' advice and patient advice and support will help GPs to manage their own patients more without the need for referrals	Reduction in referrals

5 Management Plan

5.1 Mobilisation governance

It is recognised that the proposed outpatient pathway and model of care introduces some potentially radical changes to the ways that outpatients are currently managed across the health economy. While it is based on a sound understanding of what works best for patients and informed by emerging evidence both locally and nationally that is achieving positive results, the full impact of introducing such widespread and whole-scale change across the outpatient system is, as yet broadly untested. As such this presents an element of risk that will require careful management and control. As such, a robust and shared approach to programme governance will be developed in accordance with Stockport Together programme governance arrangements.

5.2 Benefits realisation

The financial and non-financial benefits are captured in the previous sections above. All benefits will be captured and managed in line with the Stockport Together Benefits Strategy. This will include the development and regular review of a benefits register.

5.3 Resources

Under local arrangements for Stockport Together the specific change resources required will be managed by the Provider Board and its associated partners. This case will be signed up to by relevant partners and in so doing they will commit to using their own operational management capacity supplemented by GM Transformation Fund resources to implement the projects over the agreed timeframes.

This will include but not be limited to:

- Staff resources e.g. community specialist nursing capacity.
- Technology e.g. EPR system enhancements, Consultant Connect, system interfaces e.g. eRS and EPR, PAM tool licences, telephony and enhanced communications technology e.g. video conferencing.
- Health promotion and GP development education materials and support services.

- Clinician time and transition costs to new pathways e.g. to provide advice and guidance and triage.

5.4 Phasing, deliverables and milestones

5.4.1 Proposed phasing

It is well recognised that the redesign of the outpatient pathway is complex and in part reliant on other parts of the Stockport Together health economy and a readiness by patients and healthcare providers to take a different approach. As such, a phased approach is proposed for the duration of the four year timescale of this business case. This will provide time to learn what works and to ensure alignment with other areas of work so that appropriate infrastructures and arrangements are developed to enable the re-provision of some aspects of the outpatient journey in other parts of the system e.g. neighbourhoods and borough wide services.

The following summary of proposed activities is provided for illustrative purposes based on current knowledge and understanding. This will be refined as the redesign of the outpatient pathway progresses and will be supported by some specialty specific implementation plans to reflect the variation in approaches, phasing and timescales across different specialties.

It is recognised that the Foundation Trust has an established Outpatients programme as part of its CIP programme. Within this a range of projects are being progressed to improve efficiencies across outpatients and it is anticipated that these will have a positive impact to better manage outpatients pathways during 2017/18 in advance of the commencement of the implementation of this business case. The Trust programme includes the following projects:

- E-referral CQUIN
- Clinician communications (advice & guidance)
- Clinical triage/vetting
- Consultant-to-consultant referrals
- Partial booking for follow-up appointments
- Patient communications (text reminders/hybrid mail)
- Booking Team review
- Clinic capacity and utilisation optimisation (including Buxton & Cavendish)

- Room Booking optimisation

The following table provides an indication of possible phasing of the activities planned to achieve the strategic objectives, priorities and financial targets set out in this business case. Each project will incorporate a specific Workstream to analyse, document and share learning to provide evidence of what works and to inform future phases of work. As such, each year will begin with an assessment and base-lining exercise.

Year	Initiatives & Deliverables	Lead	Timescale
0 (17/18)	<ul style="list-style-type: none"> • Programme set up, governance and resourcing including Enabler support requirements • Development of culture change, workforce planning and infrastructure requirements • Establish project teams and workstreams • Develop a robust communications and engagement strategy to ensure appropriate and timely communication and engagement with key stakeholders • Review non-Stockport FT activity, identify and engage with key provider stakeholders • Commence phase 1 - 2018/19 projects 	OP Programme Lead	Jul-Oct Nov-Dec Jan-Mar
1 (18/19)	<p>Assess and baseline current position</p> <p>Patient Activation:</p> <ul style="list-style-type: none"> • Identify target patient cohorts/GP practices • Obtain PAM Tool licences • Drawing on patient activation (PAM) and delivery of the Healthy Communities Strategy, develop patient activation plans based on a person centered outcome approach and patient reported outcome measurement (PROM) tool. (This work will be aligned to implementation of neighbourhood GP navigation and roll-out of community self-care coaching and peer support from Jan-Apr '18). • Identify community and peer support resources • Monitor impact and document learning <p>Clinician Communications:</p> <ul style="list-style-type: none"> • Deploy/ extend Advice & Guidance channels e.g. Consultant Connect for both GPs and for consultants, • Deploy eRS messaging across target specialties • Deploy the alternative way/s for consultants to get advice from colleagues in other specialties to reduce the need for consultant to consultant referrals • Develop approaches for GP education and development <p>Triage and Diagnostics:</p> <ul style="list-style-type: none"> • Baseline consultant triage and pre-appointment diagnostic levels across specialties and identify where 	Stockport Together Stockport Together, SFT & other providers SFT & other	Q1-4 Q1-4 Q1-4

Year	Initiatives & Deliverables	Lead	Timescale
	<p>this can be increased</p> <ul style="list-style-type: none"> • Deploy possible approaches to diagnostic and discharge • Link to EMIS roll-out of specialist peer GP advice due to be implemented as part of the Neighborhood business case. • Develop alternative ways for consultants to get advice from colleagues in other specialties to reduce the need for consultant to consultant referrals • Continue to embed clinical triage with supporting advice and guidance and sending patients for required diagnostic tests prior to first appointment <p>Stop OP activity:</p> <ul style="list-style-type: none"> • T&O – reduce the number of face to face outpatient FU appointments for hand, shoulder, knee and hip patients by further 20% • Continue to identify and implement ways to reduce Follow Up appointments focusing on all pathways <p>Alternative Mechanisms:</p> <ul style="list-style-type: none"> • Identify pathway changes and developments required including pathways that can be managed virtually • Design and plan call recall system / surveillance aligned to neighborhood CAT infrastructure and discharge patients as appropriate and link to work looking at neighborhood hubs delivering acute appointments • Identify additional community nursing capacity requirements • Apply learning from 100 day testing models to extend and operationalise • Build support and further engagement for changes • Start to deliver IT infrastructure changes • Review and evaluate progress <p>Complex patients:</p> <ul style="list-style-type: none"> • Assess and develop a coordinated, one-stop model for complex patients <p>Non-SFT providers:</p> <ul style="list-style-type: none"> • Work with commissioner and non-SFT providers to confirm projects to be implemented 	<p>providers</p> <p>SFT & other providers</p> <p>Stockport Together</p> <p>Stockport Together, SFT & other providers</p>	<p>Q1-4</p> <p>Q3-4</p> <p>Q3-4</p>
2 (19/20)	<p>Assess and baseline current position</p> <p>Patient Activation:</p> <ul style="list-style-type: none"> • Influence and inform development of patient portal/ apps to enable self-management and increase control of conditions <p>Clinician Communications:</p> <ul style="list-style-type: none"> • Extend, embed and streamline advice and guidance channels • Deploy eRS messaging to remaining areas 	<p>Stockport Together</p> <p>Stockport Together, SFT & other providers</p>	<p>Q1-4</p> <p>Q1-4</p>

Year	Initiatives & Deliverables	Lead	Timescale
	<ul style="list-style-type: none"> Implement call recall system / surveillance aligned to neighborhood infrastructure and discharge patients as appropriate and link to work looking at neighborhood hubs delivering acute appointments <p>Clinician triage and diagnostics:</p> <ul style="list-style-type: none"> Streamline and improve triage and diagnostic processes informed by learning to date <p>Alternative mechanisms:</p> <ul style="list-style-type: none"> Continue to embed pathway and culture change Virtual appointment channels operational and extended Specialist nurse led clinic models extended Continue deploy operationalise rapid testing models <p>Complex patients:</p> <ul style="list-style-type: none"> Phased implementation of 1 stop clinics / MDTs for complex patients by specialty Review and evaluate progress <p>Non-SFT providers: Work with commissioner and non-SFT providers to confirm projects to be implemented</p>	<p>providers</p> <p>Stockport Together, SFT & other providers</p> <p>Stockport Together, SFT & other providers</p>	<p>Q1-4</p> <p>Q1-4</p>
3 (20/21)	<p>Assess and baseline current position</p> <p>Patient Activation:</p> <ul style="list-style-type: none"> Implement and extend patient portal/ apps to enable self-management and increase control of conditions <p>Clinician Communications:</p> <ul style="list-style-type: none"> Review and develop additional advice and guidance channels CAT call recall system / surveillance aligned to neighbourhood infrastructure embedded <p>Clinician triage and diagnostics:</p> <ul style="list-style-type: none"> Further streamlining and improvement of triage and diagnostic processes informed by learning to date <p>Alternative mechanisms:</p> <ul style="list-style-type: none"> Continue to embed pathway and culture change Virtual appointment channels including telehealth operational and extended Specialist nurse led clinic models further extended Further learning and development of rapid testing models <p>Complex patients:</p> <ul style="list-style-type: none"> Extend implementation 1 stop clinics / MDTs for complex patients 	<p>Stockport Together</p> <p>Stockport Together, SFT & other providers</p> <p>SFT & other providers</p> <p>Stockport Together, SFT & other providers</p>	<p>Q1-4</p> <p>Q1-4</p> <p>Q1-4</p> <p>Q1-4</p>

5.5 Delivery risks and mitigation

The table below provides an overview of the risks associated with this business case, alongside the proposed mitigations to limit the impact of these risks. All risks and issues identified will be incorporated and reported in line with the Stockport Together Risk Management approach.

The key risks associated with delivering this transformational change include:

- Potential for the planned changes to pathways to result in increased workload in general practice. The design of this business case has focused on ensuring that work does not deflect into general practice, but that where outpatient activity is stopped, this is supported by patient education and activation to self-care, voluntary sector support and access to continued specialist input through specialist nursing teams where required. It is acknowledged that more appropriate, supported decision making will occur in general practice, but that other work such as phlebotomy services, call/recall and changes to letter handling through the neighbourhood business case should mean that over all workload is stable. Coordinated transformational change across the system will be required to ensure no part of the system is compromised as a result of changes elsewhere. This will need to be monitored and carefully managed to ensure that the impact is spread across the system and where necessary there will be funding to support the transformational changes.
- Demand continues to increase and capacity created by the redesigned pathways in Stockport is replaced by out of area patients following a more traditional pathway. Capacity and demand modelling will be used to manage this and learning will be shared with commissioners from other areas to enable them to adopt new practices.
- New pathways are not adopted as working practices do not change in line with the proposed model of care for outpatients. To manage this, robust programme, project and performance management arrangements will be in place in addition to extensive communications, engagement and training to support and enable behaviour change.
- As indicated elsewhere in this business case, there is also an overarching risk that the proposed service model and anticipated financial savings, while based on understanding, research and available evidence available to date, are ambitious and in some areas untested. As such, the impact in terms of reducing outpatient activity cannot be guaranteed. To manage and mitigate this, robust programme, project and performance management in addition to strong governance is essential to ensure:

- Project deliverables and milestones are achieved
- Early identification and management of risks and issues
- Robust business intelligence and analysis
- Gateway reviews evaluate the impact of activities
- Learning is captured, documented and shared

Risk	Impact	Mitigation	Residual Risk Score		
			Likelihood	Consequence	Total
FINANCIAL & CAPACITY RISKS					
Demand continues to increase despite changes in the outpatient pathway	Planned cost reductions are not achieved	Programme and project management to ensure successful delivery of projects, timely and systematic evaluation of initiatives, performance management of projects	3	4	12
Capacity freed up by changes to the Stockport pathway is taken up by outpatients appointments from other geographical areas	Planned cost reductions are not achieved	Extend initiatives and learning to other areas to manage demand	3	3	9
Outpatient practices do not change	Increased demand on secondary care clinicians to triage/see face to face and telephone contact	Training and engagement with all stakeholders and OD to support change	3	4	12
Pathway changes result in excessive demand on GP practices that are already stretched	Additional pressures on GP practices Increased patient waiting times, reversion to traditional pathway and increased costs	Strong GP engagement and the development of alternative neighbourhood based channels	3	4	12



Insufficient capacity across neighbourhood infrastructure to manage demand	Increased patient waiting times, reversion to traditional pathway and increased costs	Effective capacity and demand management infrastructure to align needs with resources	3	3	9
New models are more costly in the short term	Financial targets not achieved	Careful financial monitoring and evaluation of initiatives	4	3	12
Lack of engagement across the full range of providers commissioned by Stockport	Financial targets not achieved	Early identification and engagement with all providers with strong support from Stockport CCG.	4	3	12
PERFORMANCE RISKS					
National performance targets are negatively affected during the period of pathway redesign e.g. RTT & OWL	Failure to achieve national targets and negative impact on funding	National lobbying and communications. Close monitoring of performance	4	4	16
Other change and improvement programmes impact on staff morale	A number of programmes and projects will be running together, staff may suffer change fatigue	Continued communication with staff, regular engagement and reassurance	3	3	9
DELIVERY RISKS					
Link to Neighbourhood teams and intermediate tier not joined up	No benefit gained from integration	All programmes to understand and incorporate the integrated model (no work stream to work in isolation)	3	2	6
Fragmented approach and lack of stakeholder engagement and	Implementation will not be successful without communicating with key	Build on current engagement activities. Agree cohesive and	3	2	6

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communication	stakeholders, particularly about the perception from GPs that they will have a greater workload	consistent communication with key messages and the ability to articulate 'what's in it for me' for each stakeholder group. Work with citizen's reference panel and voluntary sector representatives closely. Programme managers to have a stakeholder session and agree a lead for each stakeholder			
Rapid testing models fail to be effectively operationalised	Deflection to new models of care doesn't happen. Patient care issues	Evaluation of models to understand how to extend and operationalise. Project management and monitoring of impact to operationalise	3	3	9
Behaviours and pathways do not change	Increased patient waiting times, reversion to traditional pathway and increased costs	Engagement with and alignment to 'Stockport Together workforce and OD plans. Behaviour change integral to all project and delivery plans	3	4	12
The significant cultural shift that the programme requires to deliver the integrated model does not change.	New model will not be implemented or is poorly implemented.	Take learning from other areas that have delivered successful significant cultural change and replicate in a plan (look at NHS and wider commercial organisations)	3	4	12
Mental health not included in the data	Patients parity of care is not delivered. Opportunities not addressed	Work with Pennine Care to address this.	4	3	12

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National guidance e.g. BMA contradicts proposed model of care	Limits ability to implement and provides inconsistent messaging to stakeholders	Horizon scanning, lobbying relevant national bodies to align emerging policy.	3	3	9
ENABLER RISKS:					
Technology solutions are not developed in line with programme requirements	Increased patient waiting times, reversion to traditional pathway and increased costs, increased work for clinical staff	Engagement with and alignment to `Stockport Together / GM IM&T strategy, close working with relevant IT leads and stakeholders	4	4	16
Insufficient clinical detail in Stockport Health & Care Record (SHCR) to inform specialist advice and guidance particularly if there is not a real time feed and 'free text' information	Clinical risk if specialists don't have access to all relevant patient information when providing advice and guidance Increase in re-provision cost for integration between EMIS and EPR and possible delay in rolling out some projects	Clinicians to lead and be engaged in developing appropriate communication channels SHCR will be integrated into EPR at go live, real time feed expected May 2017 and free text agreed. Develop EMIS access for specialists	3	3	9
National shortage of specialist nurses, therefore may not be able to recruit to posts	Ability to fully implement pathway changes given existing capacity pressures specialist nurses already work beyond capacity so would not be able to take on any more without further staff	Review skill mix, potential to employ lower bands and train up on job to level required (via appropriate competence levels)	3	3	9
Changes to workforce are not aligned to programme requirements	Increased patient waiting times, reversion to traditional pathway and increased costs	Engagement with and alignment to `Stockport Together workforce plan	3	3	9



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5.6 Performance monitoring and evaluation

5.6.1 Key Performance Indicators

The following measures will be in place to enable monitor delivery and evaluate benefits delivery:

Priorities	Measures
1. Active support for patients to enable them to take more control of their condition including decision making, self-care and provision of advice	Number of patients feeling in control of their management (taken from the PAM outcome framework) Number of GP attendances as a % of registered population
2. Support for GPs in clinical decision making	% Referrals avoided as a result of Advice and Guidance
3. Clinical triage	% Triage outcomes (by specialty) e.g.: <ul style="list-style-type: none"> • Sent for diagnostics • Discharge back to GP • Discharge after diagnostics • OP clinic: <ul style="list-style-type: none"> ◦ Telephone ◦ Face-to-face
4. Alternative mechanisms for traditional Follow Up appointments and supporting discharge from OP clinics	New face-to-face appointments: <ul style="list-style-type: none"> • Number • % increase/ decrease
5. Complex patients	

Priorities	Measures
6. Stopping OP activity	FU appointments: <ul style="list-style-type: none"> • Number. • % increase/ decrease % of virtual non-face to face appointments Number of group appointments offered and attendance rate Demand variation by specialty Referral rates: <ul style="list-style-type: none"> • GP • Consultant to consultant Incomplete RTT performance by specialty Overdue OWL ASI rate Number of patients reviewed by consultant MDT meetings and under lead clinician care Number of appointments attended by complex patients
7. Enabling measures:	Education: <ul style="list-style-type: none"> • Number of master classes provided by specialty • Number and % of GP attendance at master classes • Number and % of specialties providing access to and availability of specialty information Advice & Guidance: <ul style="list-style-type: none"> • Usage of eRS • Use of Consultant Connect Triage: <ul style="list-style-type: none"> • % referrals triaged Stopping OP activity: <ul style="list-style-type: none"> • Number of discharge protocols by specialty

5.6.2 Monitoring Process

The Provider Board will monitor these indicators on a monthly basis from January 2017. In the first three months the Executive Board will monitor them monthly dropping to quarterly from April 2017 subject to satisfactory implementation. Indicator 6 will continued to be monitored daily as part of national Urgent Care and NHS Constitution standards.

5.6.3 Evaluation

There will be no formal academic evaluation of this business change except that within the wider programme. Reviews will be put in place at various times to ensure the impact and cost reductions are being delivered.

6 Conclusion

This business case is recommended by the Stockport Together Executive Board as the most cost effective solution to achieve the strategic business objectives and priorities described in this business case and thereby contributing to the sustainability of the local health & social care economy.

APPENDIX

Clinician and Patient Questionnaire responses



Outpatient BC Patient
and clinican Question:

OUTPATIENTS OUTLINE BUSINESS CASE

APPENDIX

CLINICIAN FEEDBACK

Feedback from consultants provided the following responses when asked to identify how outpatient activity could be reduced or managed differently:

Outpatient activity/appointments currently seen in clinics that with an appropriate supporting infrastructure, may not need to take place at all:

- More joint working e.g. Geriatric appointments identifying possible underlying dementia (could reduce by approx. 10%)
- Surveillance patients (could reduce by up to 35%)
- Patients attending for blood monitoring (e.g. could reduce. 80% of liver patients and approximately 20% follow up appointments)

Outpatient activity/appointments that you currently see in your clinics and that need to happen but may not require a face-to-face interaction with a hospital professional:

- Patients that are stable and have early stage disease.
- Appointments that could be run via a helpline by specialist nurses and pharmacists with direct access to consultant advice.
- Post-op and FU appointments that could have a questionnaire at 6, 12 and 24 months via an online portal.
- Specific age cohorts in specialties could have diagnostics, review and discharge with management plan as required. Pre-op style questionnaires.
- Patient is informed of treatment decision – follow-up by specialist nurse phone call.
- Once stable most do not require face-to-face appointments e.g. ~25% telephone follow up.

Outpatient activity/appointments that you currently see in your clinics that need to happen with specialist input but may not need to happen in a hospital setting:

- Ongoing assessments/investigations/monitoring.
- Attendances for services could be delivered as outreach e.g. lung function.
- Outpatient appointments that could be seen by GPwSi.
- Appointments for access to x-ray and phlebotomy.

- 75-80% follow ups deemed not required in hospital (some specialties do not see routine follow up).
- Attends for services that exist in community (e.g. Heart Failure service)

Outpatient activity/appointments that need to remain in a hospital setting:

- One-stop assessment (pre-filled questionnaires) to minimise time in clinic.
- One-stop clinics (some already in place).
- 10-20% in some specialties to remain in a hospital setting.
- Complex management.

Consultants were also asked to identify infrastructure changes that would be required to enable the pathway changes identified in their responses:

- IT and technology e.g. video conferencing, E-referral, Consultant Connect, Email.
- Better systems and relationships between primary and secondary care including GP engagement, shared protocols and clear guidance.
- Change and flexibility to adopt rapid access, open appointments, specialist nurse advice lines.
- Support to enable patient self-management.
- Robust call and recall system with capacity to see patients at required follow up intervals to prevent destabilisation.

Patient Feedback

A consultation took place across a range of outpatient clinics during a sample week (when 2016).

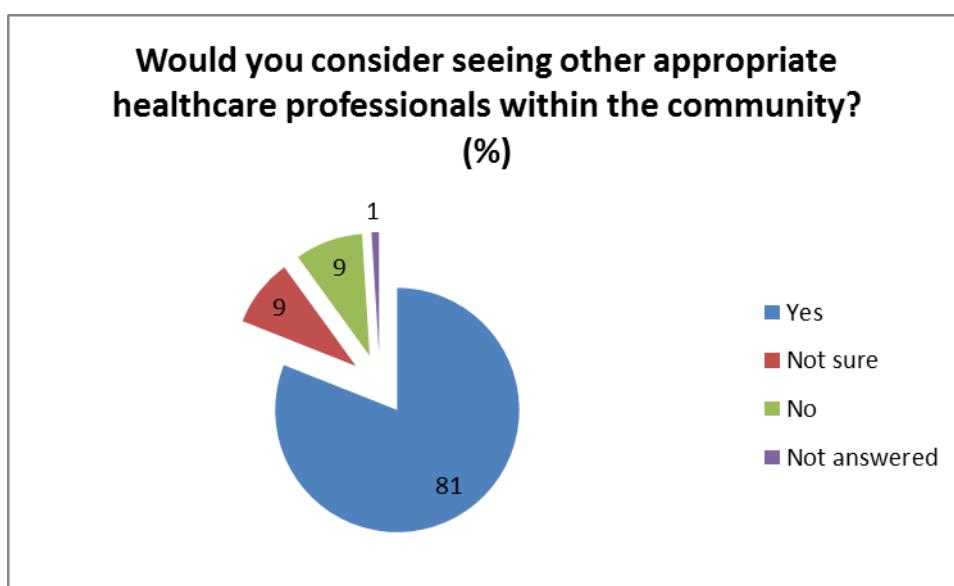
Patients were asked a range of questions relating to their experience in the clinic they attended and their views about possible alternative approaches.

There were a number of questions asked, and these included

- Would you consider seeing other appropriate healthcare professionals within the community?

- Would you be happy for your care to be delivered in other ways rather than face to face?
- Would you be happy to become involved in ways of directly managing/ monitoring your own health?

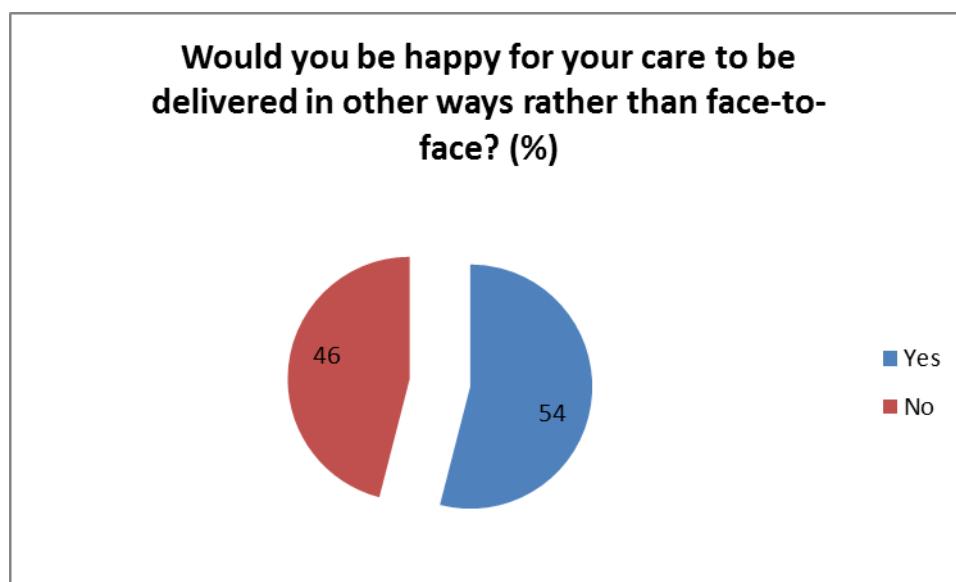
Responses were more mixed but generally positive and included the following:



Patient's comments included:

- Eases the workload on hospitals and easy for me.
- Closer to home and parking, nearer to home would be beneficial.
- More convenient – had to have a half day off work.
- Helps get people seen sooner.
- 3 times to clinic for 4 minute appointments – specialist in the community would be good.
- Would be happy if the standard of service was the same – knowledge and expertise needs to be there.

- Coming into hospital is fine as well – getting to one person is best, they have access to all the relevant information.
- Prefer to meet with a consultant – if you've been referred to a consultant it's because they're a specialist.
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- Depends on healthcare professional experience – rather see a good doctor or consultant instead of a stand-in.

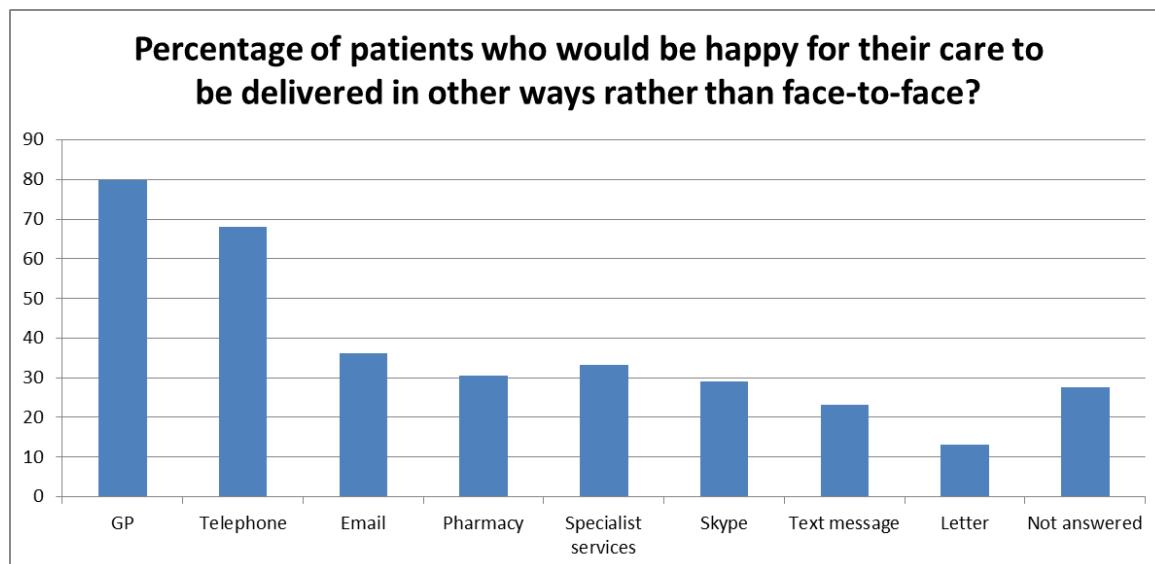


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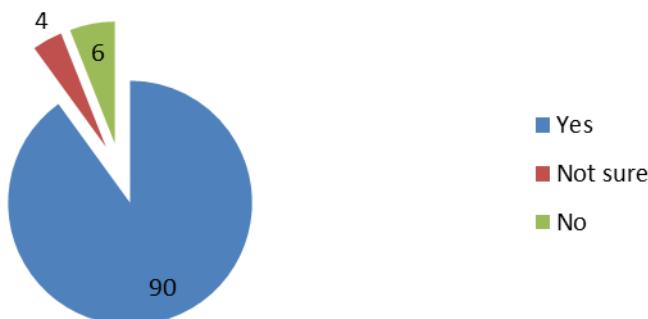
- Happy either way, as long as you could just explain what the problem is.
- Saves having to come out for an appointment.
- Had a telephone consultation last summer as a follow up to a procedure – worked well.

- Yes, as long as I communicate with a professional....a hospital visit is to see/talk to the consultant.
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- Don't feel I would pay the same attention on the phone – letters are likely to be lost or discarded.
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The graph below shows of the patient that would be happy to see other people whom they would be happy to see



Would you be happy to become involved in ways of directly managing/monitoring your own health? (%)



Patient's comments included:

- I already take my own blood pressure and blood sugar. I would like to monitor my own INR.
- Yes, it's really important people take more ownership. People have fitbits etc.
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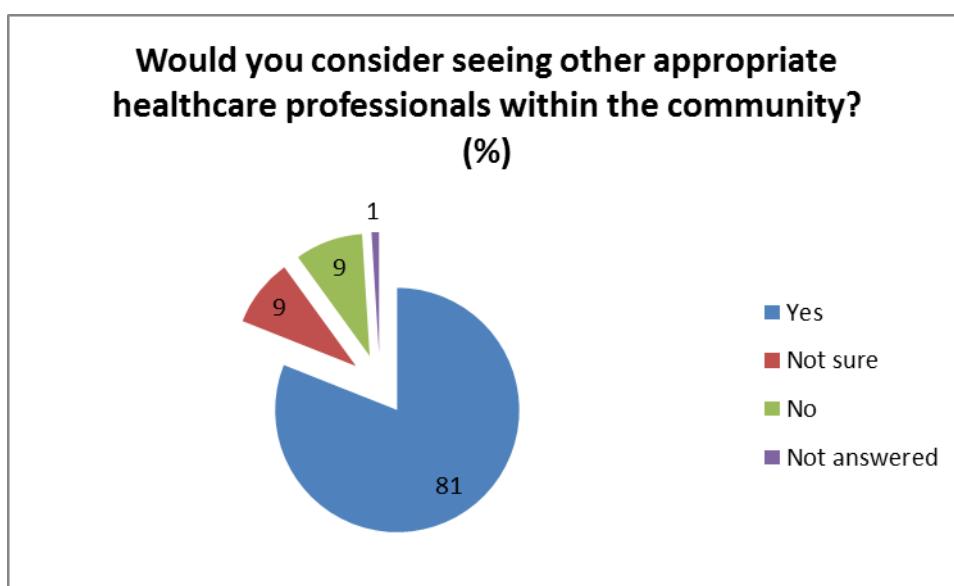
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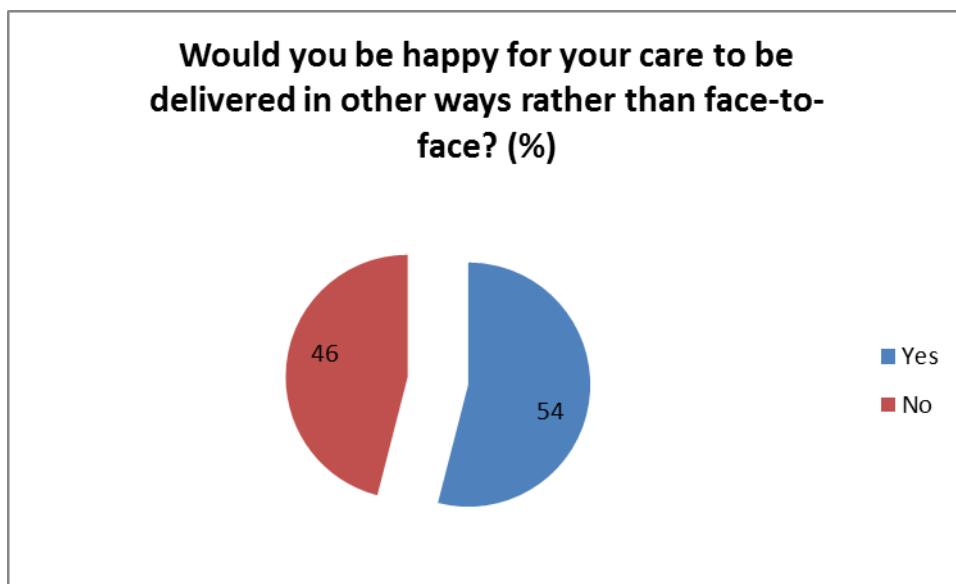
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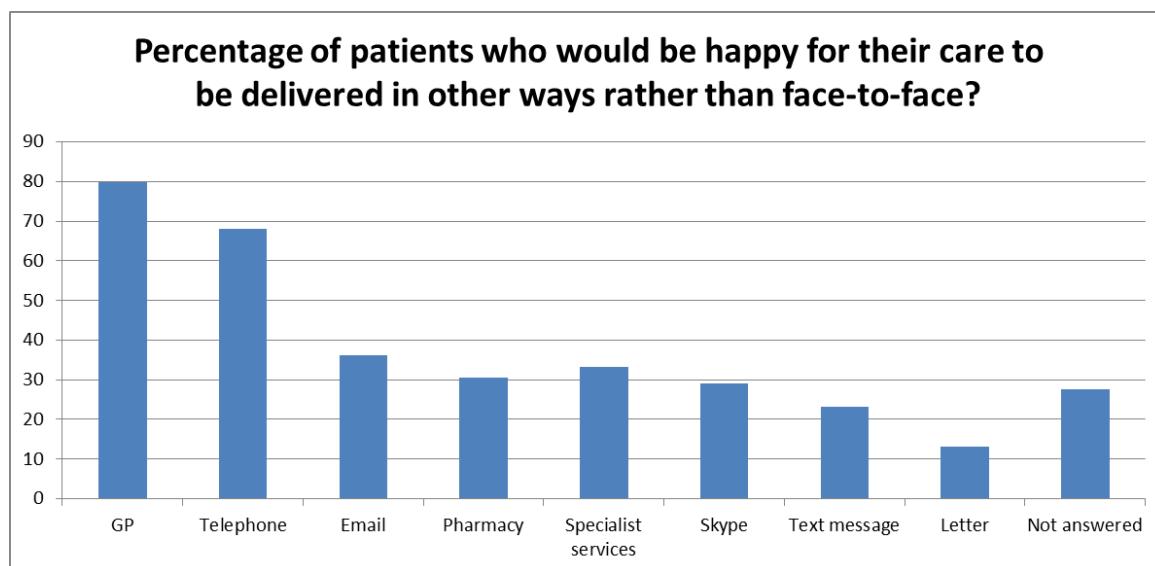


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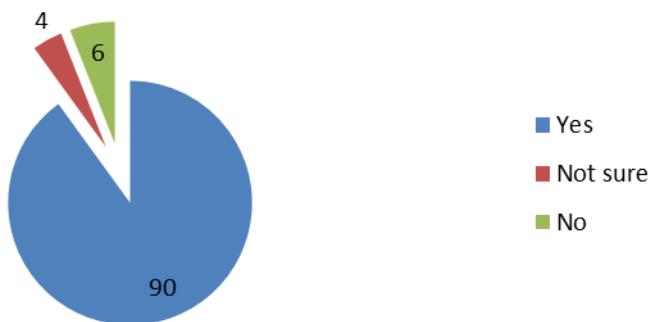
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ENABLER SUPPORT PLAN EXECUTIVE SUMMARY

Abstract

This business case describes the enabling plans necessary to deliver the Stockport Together Transformation programme, which will be delivered from 2017/18 to 2020/21.

Senior Responsible Officers:

Tim Ryley, Director of Strategy, Stockport CCG

Keith Spencer, Provider Director, Stockport Together

Executive Summary

Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to ensure the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

Business Case Overview

This paper sets out plans for the supporting work required to deliver the full Stockport Together transformation programme. It covers: Information Management & Technology; Business Intelligence; Information Governance; Workforce; Business Support; Programme Management; Estates and Finance.

The document sets out the enabler work plans, investment requirements, and anticipated risks to delivery as well as the mitigations in place to maximise benefits.

The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of £156m across Stockport's health and social care services.

Stockport's Health and Social Care system is made up of a range of statutory bodies who commission local services; NHS, public, private and voluntary organisations delivering health and social care services. The economy is committed to undertaking significant whole system change that will improve services to meet growing and changing health and care needs within limited budgets. As described within the detailed business cases, this requires both a significant number of service reforms and an integrated approach to change. Responsive and ambitious enabling support is critical to delivering this change at the pace required in a consistent and coordinated way.

The Stockport Together partners have agreed a single approach to enabler plans, including a centralised coordination of resources with the intention of shaping a shared service for the health and social care economy. This pooling of resources will create a more resilient and cost effective service at a time when all partners are increasingly calling on these teams to support the transformation agenda.

Enabler Plan



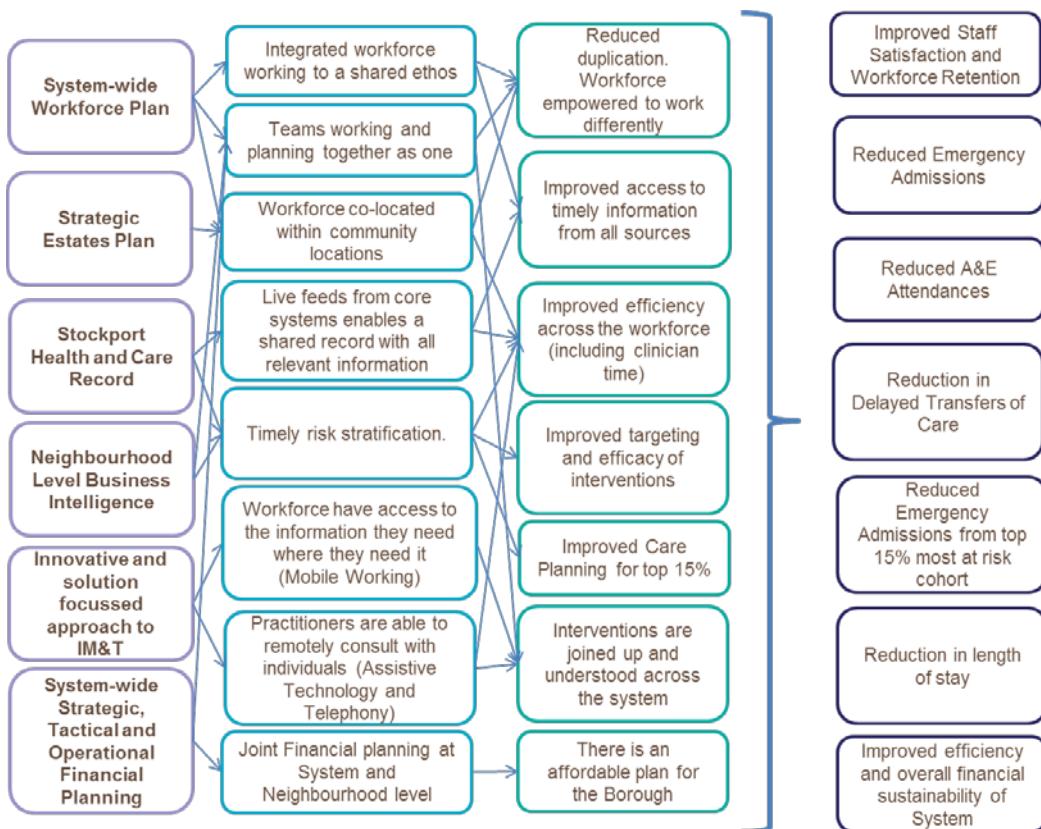
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To deliver change, the system needs support services which are transformational, delivering integrated solutions and support to ensure that Stockport is able to fully achieve its ambitions. To that end, this plan aims to develop:

- An **innovative and solution-focussed approach to Information Management and Technology** which enables Stockport's Health and Social Care workforce to work in the right place, with the right information at the right time. In addition this approach needs to empower people (service users and patients) through ensuring individuals can access their own information as well as tools and resources for self-care and information about support within their own community.
- A **cohesive workforce** with the right skills which is engaged and well informed, working in the right place and working to an integrated and person centred ethos
- **Joined up, cost effective Business Support** which ensures that work is done at an appropriate level and that maximises the time made available to front line practitioners to support people in the community
- An **intelligent and outcomes led** approach to planning, resource allocation and interventions which enables the system to proactively rather than reactively address need and risk effectively and efficiently;
- **Systems and person level information** which are integrated and contain a 'single version of people's needs, choices and assets';
- A **strategic estates plan** which enables integrated services to work closer to the community and in buildings that are fit for the future and able to respond to changing needs and priorities;
- **An approach to transformation and programme management** which is perceived to add value, sufficiently agile to respond to a changing landscape and joined up across different parts of the health and social care economy

Benefits

This support plan contributes directly towards the delivery of the outcomes and financial objectives summarised within the overarching and work stream business cases. An outline of the headline benefits that enablers will contribute towards are outlined below.

Figure 1: Enabler Outcomes & Objectives


Investment Plan

This business case sets out a total investment requirement of **£7.8m** over 4 years.

Table 1: Planned Investment

Planned Investments:	2016/17	2017/18	2018/19	2019/20	TOTAL
Co-located Accommodation	£301,000	£505,000	£327,000	£327,000	£1,460,000
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Information Governance	£21,815	£21,815			£43,630
BI Platform	£246,063	£209,000	£70,500	£13,500	£539,063
Stockport Shared Record	£180,000	£270,000	£360,000	£360,000	£1,170,000
System Development & Integration	£622,000	£455,000			£1,077,000
System Integration capacity	£87,817	£350,290	£181,887		£619,994
Mobile Working Kit and Infrastructure	£210,000	£300,000	£31,000	£31,000	£572,000
Organisational Development	£25,000	£100,000	£100,000		£225,000
HR and Workforce Planning)	£10,000	£20,000	£20,000	£20,000	£70,000
Workforce and HR Capacity	£60,225	£351,503	£318,493		£730,221
Accountancy Support		£78,508	£78,508		£157,016
Programme & Project Management		£104,458			£104,458
TOTAL	£1,903,920	£2,765,574	£1,487,388	£751,500	£7,803,924

Investment will be sought from baseline support service spending, recurrent investment by partners and the Greater Manchester Transformation fund.

Table 2: Indicative Funding Sources

Funding Source:	2016/17	2017/18	2018/19	2019/20	2020/21
Baseline Support Service Spend*	£52,000,000	£52,000,000	£52,000,000	£52,000,000	£52,000,000
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GM Transformation Funding	-£1,869,200 (approved)	-£2,765,574 (requested)	-£1,487,388 (requested)		

* This baseline figure makes no assumption around potential support service efficiencies.

Other external funding sources have been identified to resource enabler investment requirements:

- **Digital Excellence Fund** - Stockport Foundation Trust has put in a bid in for £5m under the second tranche of the Digital Excellence Fund to become a Centre of Global Digital Excellence.
- **GM Capital (Estates)** - This support plan contains a number of capital investment requirements. There are limited opportunities for capitalisation beyond existing organisational sources. However some GM monies have been identified which Stockport has bid in to. The original bid totals £56m and is to deliver new community hubs and an intermediate tier bed unit. The outcome of this process is not yet known. Should Stockport be unsuccessful in this bid, the capital requirements will need to be reviewed in terms of deliverability and in line with other capital funding routes.
- **GM Capital (IM&T)** – Some capital monies have been identified to support IM&T transformation. Stockport has submitted a bid equating to £2.6m which would cover those IM&T requirements identified above.

This investment plan will be reviewed once the outcome of the bid has been received.

Risk Management

The main risks to delivery of the enabler plans are set out in the table below with mitigation plans to support the full realisation of benefits.

Table 3: Risk and Mitigation

Risk	Mitigation
Conflicting priorities amongst the Stockport Together organisations. This can affect capacity and pace.	An agreed Enabler Product Plan which is shared regularly with Provider Board and where necessary Executive Board, to ensure clear cross partnership support. Where necessary additional capacity to be supported through the Enabler allocation of the Transformation Fund.
Difficulty in establishing detailed requirements for implementation.	Close working with workstreams to jointly develop requirements and specifications. Enabler Plan to ensure transparency in agreed priorities and scope.
Delays in developing standard or streamlined support service approaches.	Joint working arrangements in place initially, which support initial alignment of services with the next phase of work to further integrate prioritised within the programme.
A lack of alignment between the plans and priorities within the Workstreams and Enablers.	An agreed Enabler Product Plan which is shared regularly with Provider Board and where necessary Executive Board, to ensure clear cross partnership support.

Next Steps and Implementation

All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans.

Stockport Together will undertake a 'listening period' from 20th June - 31st July 2017 enabling the public to further influence how health and social care will be provided. A report summarising the feedback and key themes will be taken to the Stockport Together programme board in August who will agree how local views will be taken forward in the plans.

ENABLER OUTLINE SUPPORT PLAN

Abstract

This business case describes the enabling plans necessary to deliver the Stockport Together Transformation programme, which will be delivered from 2017/18 to 2020/21.

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1. EXECUTIVE SUMMARY

1.1 Stockport Together

Stockport Together is an ambitious partnership between Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP Federation - Viaduct Health - working alongside GPs and voluntary organisations to fundamentally reform the way health and social care is delivered in Stockport.

It aims to ensure the best possible outcomes for local people at a time of growing demand and restricted funding. To achieve this, we are proposing new integrated forms of care underpinned by a significant investment in out of hospital care.

1.2 Business Case Overview

This paper sets out plans for the supporting work required to deliver the full Stockport Together transformation programme. It covers: Information Management & Technology; Business Intelligence; Information Governance; Workforce; Business Support; Programme Management; Estates and Finance.

The document sets out the enabler work plans, investment requirements, and anticipated risks to delivery as well as the mitigations in place to maximise benefits.

1.3 The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

Stockport's Health and Social Care system is made up of a range of statutory bodies who commission local services; NHS, public, private and voluntary organisations delivering health and social care services. The economy is committed to undertaking significant whole system change that will improve services to meet growing and changing health and care needs within limited budgets. As described within the detailed business cases, this requires both a significant number of service reforms and an integrated approach to change. Responsive and ambitious enabling support is critical to delivering this change at the pace required in a consistent and coordinated way.

The Stockport Together partners have agreed a single approach to enabler plans, including a centralised coordination of resources with the intention of shaping a shared service for the

health and social care economy. This pooling of resources will create a more resilient and cost effective service at a time when all partners are increasingly calling on these teams to support the transformation agenda.

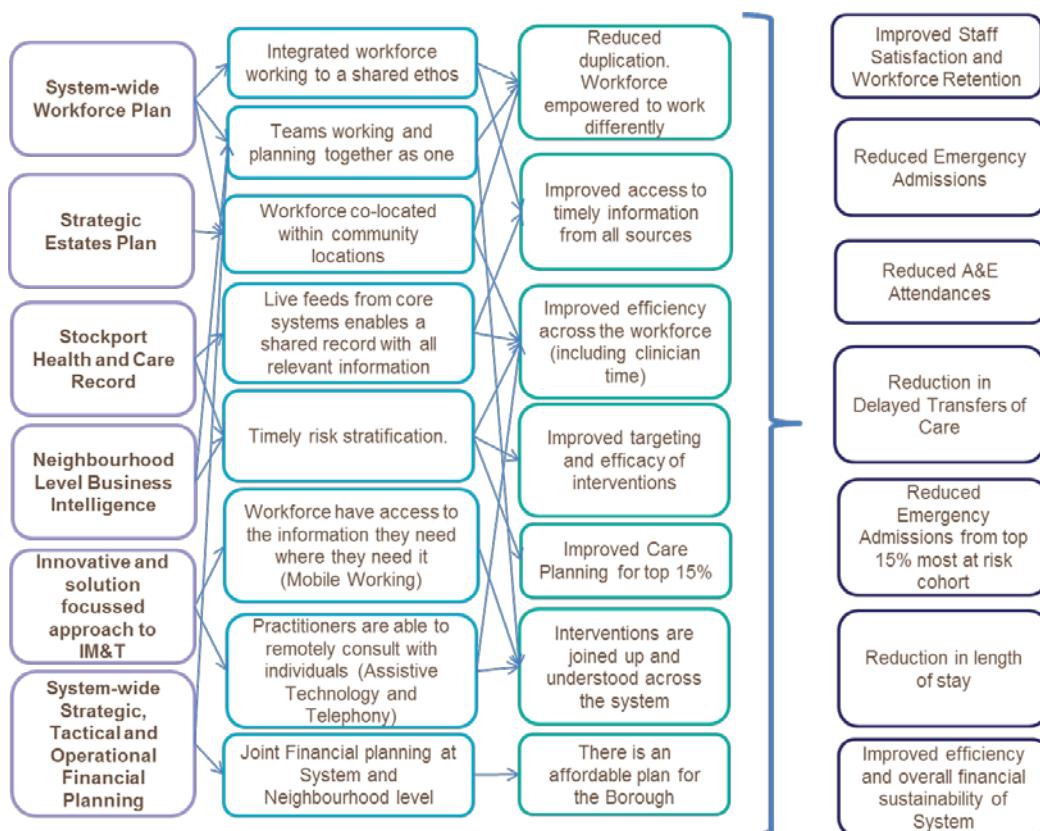
1.4 Enabler Plan

To deliver change, the system needs support services which are transformational, delivering integrated solutions and support to ensure that Stockport is able to fully achieve its ambitions. To that end, this plan aims to develop:

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All of the business cases for Stockport Together will be taken through the formal governance processes in each of the partner organisations to agree the new models of care, levels of investment and implementation plans.

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2. INTRODUCTION, PURPOSE AND SCOPE

2.1 Introduction

Stockport Together

The health and social care organisations in Stockport see the next five years as a challenging, but pivotal period. There is a strong desire to transform the way in which health and social care is delivered and to generate improved outcomes. The local partnership, Vanguard status and Greater Manchester Devolution provide an opportunity to tackle the challenges, develop innovative approaches and transform services to create a sustainable and vibrant health and social care economy.

The key provider and commissioner organisations that form the health and social care economy of Stockport have been working together in partnership. These partner organisations are Pennine Care NHS Foundation Trust, NHS Stockport CCG, Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust and Viaduct (Stockport’s GP Federation). Mastercall Healthcare, Independent Health and Care providers (e.g. Home Care and Care Homes) and the Voluntary and Community Sector are also important partners in this work.

The collective vision is to provide a sustainable health and care system driven by improved health outcomes, reduced health inequalities and lower bed-based care. This reform is described as ‘Stockport Together’. The expected outcomes from the Stockport Together partnership are: Healthier People, Quality Services and a Sustainable System. There are a number of key challenges that the partners collectively face and in particular:- financial sustainability of the system, the high inequality gap across the borough, the

ageing population and a system that is over-reliant on the urgent care system.

The Stockport Together work is constructed around four work streams that form an integrated service solution delivering improvements for the locality. These work streams are:



Core Neighbourhood: collectively moving to a model of care for adults, built on strong integrated working at a neighbourhood level



Borough-wide: transforming intermediate and other borough-wide community based services to align to neighbourhoods



Acute Interface: implementing significant changes in the way acute hospital services interface with primary and community services



Healthy Communities: transforming the way the public are empowered to support each other, take control of their own health and engage in the creation of healthy communities

2.2 National, Regional and Local Drivers for Change

NHS Five Year Forward View

The NHS five year forward view sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. In response, it places much greater emphasis on integration of systems and ways of working. The 2016-17 planning guidance pushes this forward with a much greater emphasis on locality based planning, transformation and transparency. In particular the forward view focuses on:

- Prevention and empowerment
- Greater patient and service user control and choice
- Removal of barriers between care organisations
- A new deal for GP practice
- Requirement to rebalance demand, efficiency and funding of the NHS.

NHS Vanguard

NHS 'Vanguard' sites for new models of care are one of the first steps towards delivering the Five Year Forward View and the integration of services. A number of sites have been selected to build and test new models of care and new organisational forms. Central to this NHS England and NHS Improvement have committed themselves to work together to support these sites. Stockport Together is an NHS Vanguard site, one of 15 MCP (Multispecialty Community Provider) sites in England.

The Care Act 2014

The Care Act aims to provide a coherent approach to adult social care. It



**STOCKPORT
TOGETHER**

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Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)

consolidates previous health and social care laws, regulations and guidance. As an integrated piece of legislation, different sections of the Act are designed to work together, and will encourage local authorities to collaborate and cooperate with other public authorities. The key impact is that it changes the eligibility criteria and offers a more ‘universal offer’ to a wider population. It is anticipated by some that the Care Act will increase the demand for Social Care services.

Greater Manchester Devolution

Greater Manchester Devolution is important in shaping the thinking within our plans. The GM (Greater Manchester) Integrated Health and Social Care Strategy describes five specific areas where change is envisaged and each GM locality is required to demonstrate delivery in these areas. In addition, there is significant work underway as part of this which is of specific relevance to enabling areas, including: Estates, Workforce and IM&T. Stockport’s enabling approaches are aligned to the sub-regional direction and are actively engaging in this work.

2.3 Scope and Purpose of document

Purpose of document

The Stockport Health and Care economy is committed to undertaking large whole system change. As described within the overarching business case, this requires both a significant number of specific service changes and an integrated approach to that change. Responsive and ambitious enabling support is critical to delivering this change and without it there would be a less than consistent and coordinated approach and we will not achieve change at the pace required.

In addition, there has been agreement for the development of a single approach to enablers, including a centralised coordination of the resource with the intention that the approach could shape a shared service for the health and social care economy. Whilst this is in development the approach to enablers should afford us the opportunity to test out both assumptions and ability to effectively combine and collaborate where possible to create a more resilient and cost effective offer and manage competing priorities. It also enables a better ability to pull on short term core resource from each partner organisation when required. The approach therefore to a single enabler offer is therefore critical to ensure that synergies can be achieved as early as possible with the evidence of the benefits seen in practice.

This document however specifically describes the approach for enabling the change required across the overarching system to deliver Stockport Together implementation and identifies the resource requirements to deliver this. This is based upon discussions to date with the workstreams regarding priorities and timescales. It is recognised though that the enabler plan will need to be reviewed following discussion and agreement of final business cases for the

models of care so that enablers can respond to any changes to the model or changes to priorities that are made at the sign off stage.

Scope and exclusions

Scope

This support plan will particularly cover enabling support required to deliver the integrated service solution described within the overarching business case. Specifically, those services within the context of this support plan, are:

- HR;
- OD and Training;
- Estates;
- Information Management and Technology;
- Information Governance;
- Business Intelligence;
- Business Support;
- Finance;
- PMO (Programme Management Office) and change resource: for the delivery of the programme as a whole including the separate components.

Exclusions

Enablers ‘enable’ change within the System and as such separate benefit metrics will not be included within this support plan – although an outline of how enabling activity will support the system and workstreams to meet benefits will be outlined. This is based on the assumption that the ambition and activity described in this support plan will support the delivery of key programme and system benefits identified within other business cases.

In addition, at present the Enablers are largely focussed on supporting transformation within Provider led areas (e.g. operational delivery), albeit mainly in the MCP arm of the ACT (Accountable Care Trust); with the exception of Business Intelligence and Information Governance which have distinct deliverables to support Stockport Together commissioners. This reflects the current status of the programme but the work programme of the Enablers needs to be further revised to ensure that Commissioners are fully supported.

This document indicates the recurrent and future requirements for support services within Stockport. These will be critical to the effective and sustainable delivery of the integrated model solution but do not form part of the approval of the Enabler support plan. A specification for support services will be prepared separately and follow to relevant partners.

2.4 Strategic Enabling Requirements

The strategic vision for Stockport Together is centred on implementing a new

model of care which will deliver the right care and support in or close to people's homes rather than in hospital. This new model will be designed by patients, carers, clinicians and social care professionals and will enable more appropriate evidence based primary and community alternatives to hospital admission and attendance. Stockport Together seeks to deliver £38m recurrent savings for the Health and Social Care economy through delivering this transformation.

In order to achieve this, a number of strategic enabling priorities have been identified, including:

- **A cohesive workforce** with the right skills which is engaged and well informed, working in the right place and working to an integrated and person centred ethos;
- **Joined up, cost effective Business Support** which ensures that work is done at an appropriate level and that maximises the time made available to front line practitioners to support people in the community;
- An **intelligent and outcomes led** approach to planning, resource allocation and interventions which enables the system to proactively rather than reactively address need and risk effectively and efficiently;
- **Systems and person level information which are integrated and contain a 'single version of people's needs, choices and assets';**
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- **An approach to transformation and programme management** which is perceived to add value, sufficiently agile to respond to a changing landscape and joined up across different parts of the health and social care economy
- An **innovative and solution focussed approach to Information Management and Technology** which enables Stockport's Health and Social Care workforce to work in the right place, with the right information at the right time. In addition this approach needs to empower people (service users and patients) through ensuring individuals can access their own information as well as tools and resources for self-care and information about support within their own community.

Ultimately, the system needs support services which are transformational, delivering integrated solutions and support to ensure Stockport is able to fully achieve the ambition outlined within its new integrated service solution.

2.5 Requirements from the Workstreams

Underneath those areas identified above, each of the Stockport Together Workstreams have developed detailed business cases, including enabler requirements.

2.5.1 Short Term Requirements

The table below shows a summary of the short term requirements against the key Workstream milestones.

Healthy Communities

Component	Milestone	Enabler requirements
Business case	Complete business case alongside neighbourhood business case	Workforce: Organisational and communications strategy for culture change to embed person and community-centred approaches, including coproduction, in all areas of work
Healthy Living Pharmacies	Agreement for continuation of current work	Included in Find & Treat – see below
Voluntary Support for Discharge	Agree funding to continue service for 17/18 via approval at Exec Management Board	IG- support to enable TPA access to EMIS/SHCR
Health Champions	Pilot approach across 3 GP practices	Estates: Access to meeting and event spaces in practices and neighbourhood hubs
Peer support for carers	Website operational	
Self-care	Commence implementation of model	IM&T: Explore potential for tele-health approach. IM&T: IT support for 16 fte self-care coaches, including mobile technology and access to EMIS /SHCR. IM&T: Development of online resources that will form part of the existing Healthy Stockport website. Estates: Flexible accommodation in the neighbourhood hubs/practices for face to face work and desk based work. Workforce: Recruitment support

Component	Milestone	Enabler requirements
Find & Treat	Commence implementation of mode	IM&T: Development of EMIS Web referral templates and pathways; IM&T: PharmOutcomes to support the development of Healthy Living Pharmacies health. Estates: Flexible accommodation for 4fte posts in neighbourhoods. BI: Support for EMIS Search & Reports for public health Workforce: Recruitment support
Place based integration	Commence 2 nd place based pilot in Heaton's neighbourhood	Workforce: OD support to embed the ethos and values and develop skills and for people and community-centred working, including leadership, team and personal development approaches.

Core Neighbourhoods

Component	Milestone	Enabler Requirements
Enhanced case management (ECM)	Trial and refine approach in Tame Valley and Marple Go live of two further neighbourhoods Complete roll out of ECM model to all neighbourhoods	IM&T: Mobile access to the Stockport Health and Care Record and IM&T: Access to other health assessments IM&T: System flags, notifications and reminders for staff IM&T: Custom health assessment views for Social Workers, District Nurses and ANPs
Contact, access and triage (CAT)	Phase 1 offer for hospital discharge Phase 2 offer Full CAT model	IM&T: Laptops/PCs /Phones /printing facilities for District Nurses IM&T: Fax alternative for work allocation to neighbourhoods IM&T: Secure method of transferring work between District Nurses and ASC. IM&T: Phone system for District Nurses/ASC – linked with ASC contact centre and crisis response hub IM&T: Electronic Nurse scheduling system Estates: Co-location of the team
Enhanced Primary Care (EPC)	Mental Health, Medicines Optimisation and Physio offered across 25 GP practices	

Component	Milestone	Enabler Requirements
Integrated Neighbourhood Teams (INT)	DNs and caseload aligned to neighbourhoods (excluding existing complex LTCs & EoLC) INTs and caseloads fully aligned with increased capacity Agreed model for extended hours working & process approved by Provider Board Implementation of full extended hours offer Phase 2 - embedding integrated leadership in 3 neighbourhoods commences (based on co-location)	IM&T: Shared access to printers IM&T: IT equipment for District Nurses IM&T: Shared network folders for team IM&T: Shared access to staff management system (iTrent) IM&T: GP access to shared folders IM&T: On call system support for staff operating outside of core hours IM&T: Secure email for SWs, DNs, ANPs, GPs, Admin staff, TPA, OT Estates: 6 co-located Neighbourhood hubs IM&T and Estates: support for 7 day and extended hours service delivery. IG – data sharing support

Borough Wide Services

Component	Milestone	Enabler Requirements
Active Recovery	Single service go live with one point of contact Development of beds options appraisal and business case	IM&T: Support for developing integrated working. Estates: Team co-location Estates: Support for developing a bed care centre
Transfer to Assess	Complete trial on SSOP (Short Stay Older People's Unit) Review and revise model, agree SOP (Standard Operating Procedure) Roll out implementation to wards E2 and M4 Commence roll out of pathway 1 Complete roll out of pathway 1 Scope roll out of pathway 2 Commence implementation of Trusted assessor Full implementation of Trusted assessor role	IM&T: Development of CareFirst to support information from rapid assessment tool to Active Recovery Team Workforce: Support to develop Trusted Assessor role (Phase 1 – T2A, Phase 2 wider to be scoped)
Crisis response	Optimise CRT to ensure that full capacity is utilised and contract fulfilled Review first 6 months and develop future commissioning and delivery plan	IM&T: Support for developing integrated working IM&T: Support to assess viability of a dedicated bed management system Estates: Team co-location
Integrated Transfer Team	Integrated team established and service goes live	IM&T: Support for integrated working Estates: Team co-location Workforce: Support for integrated working
Community Specialist Services	Commence review following sign off of scope and design challenges at EMB Draft model and implementation plan complete Business case approval complete	Workforce: Support for a staffing review
Cross cutting support	All areas:	Workforce: Support to transition to new workforce/management structure Workforce: Recruitment support BI: Development of KPIs and reporting arrangement to track impact of new model

Acute Interface Implementation

Component	Milestone	Enabler Requirements
Ambulatory III	Optimise collaborative streaming pathway to achieve projected numbers: EMIS viewer in triage Substantive staff in place Implement see and treat Implement agreed POCT (Point of Care Testing) Rapid access to angio Fully optimise increased capacity on ACU	IM&T: Implementation of EMIS viewer in the Emergency Department triage.
Outpatient business case	Complete outpatient business case with implementation and benefits plan Approval of outpatient business case by all partner organisations	IM&T: IT software solutions to support new ways of working in Outpatients eg Telehealth Estates: Review of the out-patients estates to identify opportunities for efficiencies and possible locations for delivery of services in the community e.g. capacity in GP surgeries. Workforce: A review of the workforce capacity and skills to ensure it supports the future delivery model.

2.6 Evidence base

Public and Staff Insight

As described within the overarching business case, the Stockport Together programme has undertaken continual engagement with the public and staff.

A number of specific overarching thematic views from this engagement relate directly to enabling activity. An example of this is outlined below:

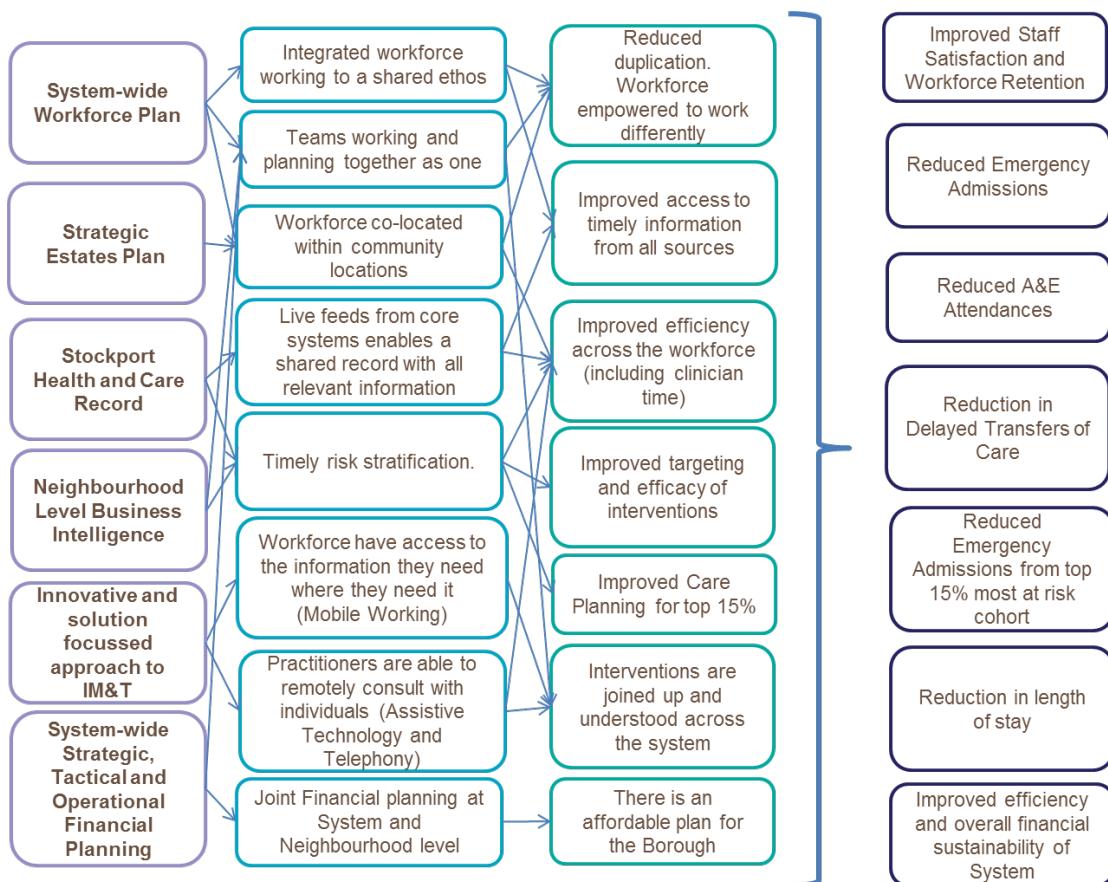
Public View	Economy Response	Enabling Activity
Many services currently provided in hospital should be closer to home.	Our plans will move much more outpatient activity and diagnostics to neighbourhoods.	Activity based within community bases (estates) with teams able to work mobile where required.
People don't want to keep repeating their story at each appointment.	We are creating a single shared record and single neighbourhood teams will create greater continuity of care.	Stockport Health and Care record.
Online access viewed as right thing to do but some fear less IT empowered people will be disadvantaged.	Online is an enhancement for those who wish to use and not the only route.	Public portal.
The sharing of care records to improve care is generally supported.	A Stockport Health and Care record, underpinned by strong Information Governance agreements in place.	Stockport Health and Care Record and cross-organisational IG sharing agreement.

2.7 Strategic Fit of this support plan

This enabling support plan is aligned to national, sub-regional and local strategic direction. As with the Integrated Service Solution model, the enabling work is closely aligned with the Devolution agenda across Greater Manchester (GM). The integration of Health and Social Care is a key priority for the Greater Manchester Combined Authority (GMCA) and work is taking place across IM&T, Estates and Workforce to look at opportunities for alignment of strategies, sharing of best practice, and GM approaches to resourcing. This is particularly well developed within Estates and IM&T and Stockport's local strategies in these areas both align with those at GM. Stockport Enabler leads are also represented on relevant GM groups (e.g. IG, IM&T, Estates and Workforce). As such interim, as well as longer term transformation within these areas will be developed with this sub-regional direction in view.

2.8 Outcomes and Objectives

This support plan contributes directly towards the delivery of the outcomes and financial objectives summarised within the overarching and work stream business cases. An outline of the headline benefits that enablers will contribute towards are outlined below.



A spotlight on a small number of these areas is provided below:

1) Stockport Integrated Health and Social Care Record

Process Change / Improvement

The Stockport Health and Care Record provides a holistic view of the patient at the point of care, including their relevant history, care plans, preferences and relevant history.

The enhanced version due in April 17 will allow for live feeds from host systems and will provide an improved mobile version. Initial launch will include a live feed into the GP system Emis Web.

Benefits

- Provides in-depth knowledge of an individual to all health and care professionals
- Safer, more appropriate and timely care for individuals across care settings
- Improved coordination of care across services and providers
- Greater opportunities to create and monitor care pathways;
- Reduced costs associated with avoided acute (re)admissions and diagnostic tests
- Improved patient experience, avoids the need for patients to re-tell their history
- Reduced risk of medicines interactions and improved patient safety;
- Reduction in time spent looking for information freeing up additional time

2) Shared Wi-Fi

Process Change / Improvement

Employees can now connect back to their own office network via secure Wi-Fi, as if they were at their normal place of work. Shared Wi-Fi is available at the following locations: Stockport NHS Foundation Trust buildings, Stockport Council buildings, NHS CCG buildings, Stockport GP Practices and Health Centres.

Benefits

- Provides flexibility to employees who can now work in any Stockport Together organisation building that has Wi-Fi
- Supports the mobile working initiative
- Improved productivity of employees
- Avoids cost of providing additional IT infrastructure to support multi-agency working
- Improved Health and Wellbeing of employees, as they are able to more efficiently deliver their work

3) Mobile Working

Process Change / Improvement

Mobile working to be introduced across Core Neighbourhoods, Borough wide and Health Communities.

Currently being piloted with Active Recovery and Neighbourhood officers

Benefits

- Access to care records in patient's homes, care/nursing homes, and away from the office or surgery
- The ability to maintain the same level of access to information no matter which location employees are in, ensuring that care is delivered safely
- Negate the need to regularly return to the surgery or office, and reduce data duplication and double entry
- Improved workflow and scheduling
- More time to spend with patients clarifying care issues, resulting in reduced demand on health services, and/or to see more patients
- Improved Health and Wellbeing of employees, as they are able to more efficiently deliver their work

Enabler contributions to System and Workstream benefits will be further refined as system wide benefits are developed further. For clarity, and to avoid duplication, System and Workstream benefits will remain out of scope of this support plan.

3 THE ENABLERS

This section sets out the vision and detailed delivery plans for each enabler service.

3.1 Information Management and Technology (IM&T)

Health and Social Care IM&T is fundamental to the delivery of Stockport. Together, it links information management, systems, technology and telecommunications across health and care to improve the quality and safety of care for our population. At its simplest it is about getting the right information, to the right person, at the right time.

The work in this area will be structured around the following themes:

1. Connect: Connected infrastructure

Resilient infrastructure enabling practitioners, services and patients to connect across the health and care setting.

2. Integrate: Integrated Systems and Digital Care Records

Providing integrated systems and records that have the ability to be interlinked across Stockport and beyond. Establishing a consent and information sharing model and robust data standards, security and quality.

3. Understand: New insights using health & care intelligence

Using data in new ways to lead to earlier intervention and enabling improved outcomes and wellbeing for people and the population. Provide an evidence base to inform service delivery and commissioning.

4. Empower: A consistent, multi-channel user and patient experience

A common, digital front door to our services, complementing traditional interactions. Enabling increased public and patient control and empowerment, moving away from a paternalistic culture of care.

Key Deliverables:

1. Connect

- Connected networks and infrastructure (e.g. Wi-Fi, a shared resource domain, unified communications and Neighbourhood Hub IT infrastructure)
- Mobile and flexible working
- Responsive support arrangements

2. Integrate

- Improvements to Care Centric/Graphnet (Stockport Integrated Health and Care Record)
- System consolidation & integration
- New systems / modules

- Extending access to existing systems
- Document management and messaging

3. Understand

- A business intelligence platform and tools (see *Business Intelligence section below*)

4. Empower

- Personalised online information, advice and guidance
- Personal health records
- Telehealth and Telecare

Work to date:

The Connect and Integrate work streams have made good progress with IM&T colleagues from across each of the partner organisations working together to deliver solutions. Shared Wi-Fi, shared printing for some locations, and a joined up approach to IT support have enabled the co-location of frontline practitioners from different organisations. The implementation of the EMIS Community EPR and the imminent improvements to the SHCR provide a platform for improved data sharing, the removal of paper and manual processes, and the rollout of mobile working.

Looking ahead:

IM&T can be a significant enabler of service transformation but for this to be successful IM&T and the frontline management teams and practitioners need to work closely at the outset to identify and deliver IT solutions that are embedded into new ways of working.

The digital transformation aspects of the programme have so far remained largely unexplored. Requirements are starting to emerge out of the work stream business cases for improved digital self-service, telehealth and telecare solutions. There is huge potential in this area so the IM&T team will work with colleagues to explore digital opportunities.

3.2 Business Intelligence

There is a need to develop an integrated sustainable and quality Business Intelligence information system with the capability and resource to meet the current and future needs of Stockport Together for intelligence at the operational, tactical and strategic levels. Business Intelligence will also use person and population data in innovative ways to lead to healthier outcomes and better lifestyles for the Stockport population. The aim is to develop “one version of the truth and an easy way to capture process and understand it”.

The work in this area will be structured around the following themes:

- To develop high quality data sources for all areas which are consistent and capable of being linked
- To be able to integrate systems to do analysis of whole system impacts of people and conditions
- To identify people early so that the system can intervene before crisis point and make prevention a core function
- Have robust outcome and performance reporting, so that we can track what difference is being made (including supporting the system level Outcomes Framework)
- Support the new contractual forms and commissioning activities
- To identify people in the highest risk throughout the population through risk stratification
- Develop a BI system that is proactive and steers models of care and strategy
- To develop the wider workforce so that they are equipped to use data and be led.

Key Deliverables

An overarching strategy is required for Business Intelligence, this is currently being developed and will support the identification and clarification of key deliverables. However, in the meantime, headline deliverables are identified below:

- To improve data quality to ensure a single data set across the health and social care system.
- An agreed approach to Risk Stratification, including the development of systems either through existing or new tools to allow more detailed data analysis to be undertaken at operational, tactical and strategic levels.
- Training, development and resource to support evidence led interventions and decision making at neighbourhood levels.
- Outcomes Framework to inform and support strategic commissioning.
- Performance Monitoring at operational, tactical and strategic levels.

Work to date:

So far the Business Intelligence teams across Stockport have delivered a coordinated range of support to each of the programmes including the development of neighbourhood profiles, provision of detailed risk stratification to MDTs and the creation of an integrated dataset for monitoring outcomes, which has been described as the most complete in the country.

Looking ahead:

For the future we need to continue to develop an overall strategy, lining up the development of BI capacity, skills and datasets with the emerging needs of the workstreams and the new organisational forms. Our linked dataset will be a key

enabler for this, progressing with the inclusion of adult social care and community health data - priorities for this work.

3.3 Information Governance

To develop robust information governance processes, that meet legislative and integrated working requirements to support the current and future priorities of the Stockport Together partnership.

To include:

- To develop effective processes for sharing information to support direct care in a multi-agency setting;
- To develop effective processes for sharing information to enable risk stratification, outcomes monitoring and case finding;
- To create information governance protocols that allow teams to work in an integrated, co-located environment;
- To develop protocols and procedures to allow integrated teams to access new or partner systems;
- To develop information governance advice and support arrangements for teams and managers within the Stockport Together partnership.

Key Deliverables:

- To review and develop a revised Privacy Impact Assessment process, that covers all co-location requirements and multi-disciplinary team arrangements.
- Agreed approach to consent model and role based access.
- Development of effective training and communication activities that allow timely and positive engagement on information governance with all stakeholders, including alignment with wider engagement work for GPs, staff and third party providers.
- Development of single aligned information governance coordinated support including working arrangements, templates, toolkits and breach procedures.

Work to date

Work has been progressing on the development of effective Information Sharing Agreements. Responding to feedback and concerns about information sharing, and working closely with key interested parties including primary care representatives, a series of Privacy Impact Assessments have been undertaken in selected areas to understand the implications of changes to how information is shared, and who with, and to best inform practice in the future. As well as this, work has been undertaken to align, where possible, policies and processes across organisations to ensure a shared understanding of information sharing is in place.

Looking ahead

The work undertaken to date forms the foundation of a safe but enabling

approach to information sharing. Information Governance will work closely with workstreams and front-line practitioners to understand how they are now and in the future, working and continue to progress towards the establishment of partnership information sharing agreements. Working closely with Communication, OD (Organisational Development) and Change Management, there will be activity and communication to ensure that the public and practitioners are fully informed and empowered to use information effectively and safely.

3.4 Workforce

The success of the Stockport Together programme is dependent on the ability to create a cohesive workforce with staff that will be working in multiple settings and organisations. This in itself is a challenge due to the complexity of contractual arrangements, differing JD's (job descriptions) with similar skill sets, and differing pay scales.

Currently there are multiple cultures and ways of working, and the new model is reliant on the development of an aligned culture across multiple organisations and a fundamental and radical change to the way people think and work. Simply co-locating staff is therefore not sufficient to embed true integration, and investment in the development of teams and leaders is vital in ensuring the vision of integration is delivered. As such, in order to realise the vision for the programme, Workforce including organisational development, IM&T and Estates must all be in place to support the successful functioning of the integrated teams.

In addition to the challenges identified above there are specific challenges relating to the recruitment and retention of key skills and professions within Stockport (including Primary Care). Whilst Stockport is not alone with this, it requires a truly joined up and innovative approach to organisational development, engagement and workforce planning to ensure Stockport is identified as a beacon for best practice and innovative ways of working which will recruit the talent needed to deliver the ambition of the new integrated service delivery model.

The work in this area will be structured around the following themes:

- Developing a leadership culture across the sector which works well together, drawing upon individual strengths and working together in order to achieve a clearly defined shared ambition;
- Formal and informal consultation and engagement with our collective workforces and their representatives in order to implement new ways of working as defined in the emerging business cases;
- Delivery of the approach and process for implementing workforce change across organisations, including support at an individual level to help people make the transition from old ways of working to new ways of working;

- Ensuring that our workforce is appropriately trained in order to meet our ‘business as usual’ requirements, and developed so that they can thrive in the new setting. Making sure this training is delivered in a way which is efficient and effective. Embedding a shared ethos and culture which is based around core values (incorporating Healthy Community principles);
- Supporting the design of new roles and new ways to recruit, develop and retain staff; designing a flexible workforce which is able to respond to the changing environment.

Key Deliverables:

- To respond to the emerging priorities of the Business Cases, joining up areas of shared HR and OD needs and looking for economies of scale in terms of consultation, recruitment and service redesign.
- To operationalise the Business Cases, working with Senior Managers and Programme Managers to develop staff-facing consultation exercises, particularly in relation to extended working hours, integrated management structures (including spans of control and layers of hierarchy), relocation/co-location and changes to contractual arrangements.
- To review emerging job roles across the whole system, looking for opportunities to develop a flexible workforce and embedding ‘The Stockport Way’ into HR-related activity (job descriptions, person specifications, contracts, recruitment etc.) across the whole system.
- To join up recruitment, selection, induction and ongoing development activity, taking steps to streamline where we can, create consistency in our processes and the ability to ‘passport’ staff from one part of the organisation to another with limited bureaucracy.
- To work with managers to develop their ‘business as usual’ training plans, whilst also identifying transformational training needs and new ways of engaging with providers to help them develop the type of workforce we need in the future
- To ensure that Stockport continues to be aligned to GMCA Health and Social Care Transformation and takes a proactive approach to ensure opportunities at a sub-regional level meet our local needs and can therefore be fully utilised
- To build upon existing leadership and management development activity, enabling us to work to our new Vision and Values, reinforcing the message that we are not in competition with each other and continuing to put the community of Stockport at the heart of our decision making and interactions with each other.

- To support the workforce through this change, providing effective internal communication, engagement and development opportunities where appropriate to directly affected employees.

Work to date

The Supporting People Through Change programme has had a positive impact with initial teams and the further implementation of this approach will be explored to support teams at key transitional periods. The Workforce Team have also been working with strategic leads to support high level workforce planning activity to inform the development of the new models of care.

Looking ahead

At the heart of Stockport Together is Stockport's Health and Social Care workforce. All parts of Stockport's workforce will be progressing through a period of significant change and this will be particularly challenging over this next phase of the Programme as new models of care are implemented and different organisational forms are developed at an ambitious pace. Access to joined-up and timely HR expertise alongside the investment in time and approaches to support the workforce during this period will be fundamental and needs to cut across all workstreams and enabling areas to ensure this is effective.

3.5 Programme Management & Change Management

At its best, HR-related activity, training, communications, project management, programme management and workforce engagement activity all contribute to effective organisational change and development. Within a complex, co-dependent system, the impact of change is rarely contained within the neatly defined limitations of a structure chart. We are therefore developing a single and coordinated approach to Programme Management and Change Management that provides relevant and appropriate resource for longer term programme management and assurance and joined up change management support (which may include HR and OD capacity). There are a variety of roles working in this space that will benefit from single leadership and direction, working to the requirements of the Interim Provider Director and the Programme Director. A joined up resource deployed appropriately would enable the most cost effective means of delivery and would allow flexibility across the economy to better meet competing demands. This will also enable short term resource to be deployed from mainstream activity with the creation of small teams at the core of the programme with the appropriate resources to pull on.

The work in this area will be structured around the following themes:

- To develop a system of programme management and transformation that has clearly defined governance and leadership which is able to keep the whole system in view, reducing duplication, making connections and prioritising the use of limited resources

- To develop a flexible Programme Management and Transformation workforce which has clearly defined roles and responsibilities that can be deployed flexibility according to need and can move between
- To reduce ‘internal competition’ for Programme Management, Project Management and Change management capacity, eliminating scenarios where key personnel effectively move to another part of the same system for more money
- To agree an approach to programme, project and change management methodology in order to facilitate our aspiration to develop a flexible workforce in this arena
- To clarify the relationship between the SRO (Senior Responsible Officer?) and the Programme Managers, and how these two key stakeholders work together to commission the capacity they may need to implement change

Key Deliverables:

It is recognised that PMO will be informed and directed by the leaders in the system responsible for delivery of the range of programme activity. This would include:

- Bringing into scope all programme management, project management and change resource for redesign into a new single model as described with alignment in the first instance of the support needed for the FT CIP programme.
- Establishment of an agreed approach to Programme Management across the Council, Trust and CCG with all change and transformation capacity ‘in view’ within a centrally managed team within the enabler programme.
- Appropriate deployment of this centrally managed programme management capacity across the programme to work directly with Senior Management in order to progress the development of commissioning, organisational form and new models of care.
- Development of a shared approach to Change Management and implementation of the model across the system; effective alignment of change management capacity (including HR and OD capacity) to key projects with clear accountability for delivery of change required.
- Alignment with the enabler support provided as outlined in this paper.

Work to date

A range of change and programme management support has been in place to enable the Stockport Together programme to reach its current phase of development but sits uncoordinated.

Looking ahead

As the Programme reaches a critical period of delivery, a coordinated approach is vital to enabling the Programme to deliver the pace and outcomes required. Establishing a joined-up resource will enable partners to do this in a cost-effective and efficient way.

3.6 Estates

Estates is a key enabler for Stockport Together to deliver the future service model, and therefore service design and clinical need will be the main factor that will drive and influence the configuration of our future estate.

This influence manifests itself at two levels, firstly the service redesign process being undertaken by Stockport Together and secondly the impact of developments and programmes that may be driven across the Greater Manchester area.

The work in this area will be structured around the following themes:

- **Neighbourhood hubs** – the development of six accommodation hubs located in the communities that the Neighbourhood teams support. The hubs will allow Council Adult Social Care Workers and NHS District Nurses to be based in the same location facilitating a more integrated way of working. The hubs will also provide a drop in space for staff from the Targeted Prevention Alliance, Mental Health Services and Public Health.
- **Intermediate Tier Hubs** – The development of co-located accommodation for teams within the Intermediate Tier to support the organisational integration of teams.
- **Estates utilisation studies** – studies into the utilisation of estates across the Foundation Trust and Primary Care estates to understand the impact of service changes and any areas for improvement.
- **Community Hubs** - community based hubs to co-locate Health and Care services, including Neighbourhood Teams, Intermediate Tier Services, Primary Care and Outpatients.

Key Deliverables:

Co-location of the Core Neighbourhood Teams

- Werneth Team to be established at either Woodley Health Centre or

Werneth Young People's Centre

- The Heatons Team & Tame Valley Team to be established at Baker Street. (This is a co-location with REACH and Pennine NHS Mental Health Trust).
- Bramhall and Cheadle teams to be established at Eden Point (proposed).
- Co-located contact, access and triage service at Fred Perry House.

Intermediate Tier Services Accommodation

- Provision of a new bed care facility.
- Creation of a new Crisis Response team hub, bringing together several teams into one location.
- Creation of an Active Recovery Team hub location to support the transformation of service for several teams, currently in several locations.
- Creation of an Integrated Discharge Team hub at Stepping Hill Hospital.

Review of Primary Care and Foundation Trust Estate

Foundation Trust Estate:

- To carry out a review of the hospital and outpatient estate to understand the impact of change in service delivery on the hospital and outpatient estate (such as AMU wards and 24/7 Ambulatory Care).
- To explore possible alternative accommodation for face to face outpatient's services.
- Investigate rationalising the Acute estate in response to the strategy to reduce admissions and undertake a number of services in the locality, as part of the redesign of the health care in Stockport.

Primary Care Estate:

- To carry out a review of the Primary Care estate to understand the impact of change in service delivery on the existing estate and to identify any short, medium and long term requirements (from improvements to existing estate to consideration of new community hub facilities).

Community Hubs

1. Capital Investment programme to deliver provision of new community based hubs to co-locate Health and Care services, including Neighbourhood Teams, Intermediate Tier Services, Primary Care and Outpatients.
2. To develop specification jointly across the Programme and with Operational Leads, Staff and the Public.

The development of a longer term Estates and Asset Management Strategy across the shared public sector estate is also a key deliverable in this area.

Work to date

Co-located neighbourhood team bases have been delivered within 3 of the 8

neighbourhoods to date. Learning from these bases is being built into the planning for further co-located accommodation solutions which are expected over the course of the next 12 months. Alongside this work, Estates have been surveying the existing health and social care estate to inform long-term and strategic planning and the identification of future estate needs.

Looking ahead

Estates is an important enabler of service transformation both in terms of how and where our workforce operate, but also how our services are accessed. For this opportunity to be realised, Estates will work closely with Workstreams, other enabling areas (such as Workforce and IM&T) and Stockport's communities to shape and design Stockport's long-term estates offer, looking beyond just Health and Social Care estate footprints, as well as the delivery of immediate accommodation solutions.

3.7 Business Support

To develop a Business Support infrastructure that will support the frontline practice by providing competent, organised and professional business support staff, deployed as appropriate to the MCP. Staff will be trained to fully understand and adhere to systems and processes to ensure we meet legal and technical business requirements and support the current and future priorities of Stockport Together.

The work in this area will be structured around the following themes:

- Baseline assessment of existing resources and deployment overview aligned to Estates Strategy and in particular the development of community based hubs
- Documented understanding of business processes and workflow undertaken site by site including areas of potential service improvement (linked to IM&T activity and digitalisation)
- Development of an aligned general administrative support offer delivered via integrated teams with single line management arrangements where appropriate; a balance of locally delivered and remotely delivered support
- Where appropriate dedicated staff focused on specific activities e.g. Aids and Adaptations, Blue Badges, Intermediate Tier bed management etc.

Key Deliverables:

It is recognised that Business Support activity will be informed and directed by the services we support and will change as the models of community delivery evolve. As such, the Business Support offer will change over time. As a foundation to this evolution, the Business Support deliverables are currently:

- A fully costed baseline assessment of staff and resources.
- A fully costed business support staffing model to support the integrated care model.
- Business Support Core Offer (outlining the scope and range of work)
- Updated JD/PSs (Person Specification).
- A base by base manual of protocols and activities compiled into allocated work-programme and deployment plan.
- Options appraisal (outlining potential working models).

Work to date

Working closely with operational teams, business support have been supporting teams as they trial and implement new approaches to service delivery (e.g. MDTs). Alongside this, an initial baselining exercise is underway to understand existing business support requirements as well as future need.

Looking ahead

As the Business Support Core Offer is developed, the alignment of this work with broader workforce planning and the identification and implementation of digital solutions (such as mobile working and the digitalisation of transactional business processes) will need to be key to ensuring that Business Support provides the appropriate support to front line services.

3.8 Finance

Finance deliverables cut across all parts of the Stockport Together programme, commissioning, provider, strategic, operational and tactical and include an overarching responsibility around programme and organisational governance. A Finance sub-group is in place which reports in to the Executive Board and consists of Directors of Finance from the Foundation Trust, Clinical Commissioning Group and the SMBC Borough Treasurer. In addition, a senior Finance lead has been established for the Provider Board. This Support plan does not seek to duplicate finance requirements identified within other parts of the Programme, however it recognises the critical enabling role performed by Finance (e.g. advice, financial modelling, strategic financial agreements and oversight) and the alignment with support service considerations.

3.9 Cost Benefit Analysis (CBA)

In line with earlier in this support plan, a separate CBA won't be produced for the Enabler support plan as enablers support the delivery of benefits elsewhere within the system. However an approach to understanding the delivery of the benefits identified above will be developed jointly between the workstreams, enablers and the Programme in line with both the Outcomes Framework and the operational level benefit tracking.

3.10 Impact on Partner Organisations

The enabling vision outlined within this support plan, as well as the overarching strategic case will involve partners across the Health and Social Care economy developing integrated enabling approaches to ensuring the integrated vision of the model can be achieved. This is likely to involve critical changes to organisational led policies, processes and solutions to ensure in the interim, as a minimum, existing arrangements are more greatly aligned. Longer term opportunities for greater integration of support services may need to be considered. This isn't part of the scope of this support plan at present.

4. INVESTMENT PLAN

To ensure the Enabler Plan can be delivered at scale and pace it will need to have effective resourcing. This will come from both non-recurrent sources (e.g. GM Transformation Fund and Better Care Fund), in kind resources from partner organisations and capital funds.

Due to the nature of enabling services there will be recurrent resource requirements. This includes leasehold costs, software licence, data connections and system development. It is expected that this will be met through agreement with provider organisations in the first instance, however, it is recognised that work to review, align and integrate support services will need to include agreements relating to ongoing revenue costs. To reflect this, break clauses within 2018/19 have been built into agreements, where resources have been met through the Transformation Fund in the interim.

4.1 Investment Plan Assumptions

The following assumptions have been made in relation to the Investment plan for the Enabler work:

- a) This Investment Plan sets out the first significant wave of resources requested from the Enabler services by the Workstreams and is based on the current models of care prepared. It is anticipated that there will be further requirements and future waves of investments identified (such as for Telecare and Telehealth and Business Support capacity) in line with the future development of models of care (e.g. the wider Boroughwide Care services model, Outpatients and Primary Care) and the future model of support services.
- b) There will be a review of the support service provision to the MCP and across Stockport Together. It is anticipated that the integration of support services can deliver significant efficiencies to economy. Full financial modelling is required however, it is envisaged that due to the scale of opportunity resulting from support service integration that any additional

recurrent costs identified now would be met through efficiencies released through integration.

- c) Central to the Stockport Together model is a system-wide workforce plan that ensures we manage changes for employees and support culture and skills changes. It is anticipated that to deliver this will require further resources in terms of staffing (e.g. HR and TUPE expertise) and non-staffing (e.g. training costs, redundancy costs). The exact requirement will need to be developed and incorporated into an updated iteration of this investment plan but where possible, with a single approach to a PMO this will also be supported where possible from core organisational resource.
- d) Finally, the deliverables identified within this Support plan, and the requirements outlined within the Investment Plan, are dependent upon the continued commitment of all partners to ensure leadership is in place within enabling services across their organisation to deliver key enabling products.
- e) This support plan has been developed in response to the overcommitted ask of the transformation fund and as such is scaled back from earlier versions. As a result, it is expected that funding for business as usual IT equipment such as computers and peripherals for new staff, will be funded by the services and not from the Enabler budget.
- f) The coordinated approach to PMO is a key part of ensuring that there is a single view across the whole programme where short term resource can be released for stipulated activity as key points in the implementation plan.

4.2 Investment Requirements

The additional investment requirements are considered within staffing and non staffing.

4.2.1. Table.1: Detailed investment requirements

Please note, this table does not include the capital funding required to enable significant capital investment into any future developments. This is considered separately below.

Theme	Investment Description	2016.17 Costs (£)	2017.18 Costs (£)	2018.19 Costs (£)	2019.20 Costs (£)	Total costs (£)
Estates	Co-located Accommodation Bases <i>(includes Eden Point Accommodation; Carillion project management support)</i>	301,000	505,000	327,000	327,000	1,460,000
Estates	Primary Care Estates	140,000	-	-	-	140,000
IG	Information Governance <i>(IG Lead)</i>	21,815	21,815	-	-	43,630

Stockport Together is a partnership between NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust (mental health services), Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (Stepping Hill hospital and community health services) and Viaduct Care (a federation representing all Stockport GPs)



	Understand (Business Intelligence Platform; BI Managers and Developers)	246,063	209,000	70,500	13,500	539,063
IM&T	Integrate - Stockport Shared Record (including linked DOCMAN systems developments)	180,000	270,000	360,000	360,000	1,170,000
IM&T	Integrate – System Development and Integration (Includes Community EPR, EMIS Web Rollout, Telephony Platform, Alert and Messaging System, EMIS Enterprise, Bed Management System, IG tools and shared repository)	622,000	455,000	-	-	1,077,000
IM&T	Integrate – System Development and Integration capacity (IM&T Lead, Project managers, Business Analysts and Developer)	87,817	350,290	181,887	-	619,994
IM&T	Connect - Mobile Working Kit and Infrastructure (Includes Video Conferencing, Infrastructure and Devices)	210,000	300,000	31,000	31,000	572,000
Workforce	Organisational Development and Training (includes: Culture Change Training and Development Programme)	25,000	100,000	100,000	-	225,000
Workforce	HR and Workforce Planning (includes Legal Advice and WRAPT)	10,000	20,000	20,000	20,000	70,000

It should be noted that investment requirements shown above do not include the investment to establish a Provider Programme Management Office which are captured in the Programme Office and Provider Board business cases.

4.2.2 Table 2: Summary of investment requirements

	16/17 Costs (£)	17/18 Costs (£)	18/19 Costs (£)	19/20 Costs (£)
Non Staffing	1,583,000	1,750,000	851,500	751,000
Staffing	320,920	1,015,574	635,888	0
Total	1,903,920	2,765,574	1,487,388	751,500

4.3 Funding Sources

Outlined below is the overall indicative investment summary

4.3.1 Table.3 – Total Indicative Investment Required

	2016/17	2017/18	2018/19	2019/20	2020/21
Baseline Support Service Spend*	£52,000,000	£52,000,000	£52,000,000	£52,000,000	£52,000,000
Additional Investment / Recurrent spend Identified	£1,903,920	£2,765,574	£1,487,388	£751,000	£700,500
GM Transformation Funding	-£1,869,200 (approved)	-£2,765,574 (requested)	-£1,487,388 (requested)		

*Please note, this is a baseline figure and makes no assumption around potential support service efficiencies.

It is anticipated that enabler requirements will be met through one of the following funding routes:

- Organisational Cash Limit
- Reshaping Support Services
- GM Transformation Fund
- Other External Funding (e.g. GM Capital Fund, Digital Excellent Fund, GM IM&T capital fund, Care Act)

Outlined below is a summary of how those investment requirements will break down across the four funding sources

4.3.2 Organisational Cash Limit

A number of requirements are currently being met through organisational cash limit, this includes:

- Ongoing revenue costs (including leases) on interim co-located accommodation bases (e.g. Hollins House, Hazel Grove Clinic and Baker Street);
- Implementation capacity (e.g. developers, client relationship managers and administrative support);
- Strategic organisational and enabler leadership;

There is a value to enabling activity being delivered as part of and in line with core organisational priorities and by the teams which will be delivering the support longer term. As such where possible and appropriate resource requirements are considered in the first instance through reprioritisation of existing organisation's resource and capacity and embedded within 'business as usual'. However, in some areas this is not a sustainable model of resourcing change nor does it deliver at the pace required to support operational change. In these instances additional resourcing requirements have been identified (and summarised within the tables above).

4.3.3 Reshaping Support Services

Support Services are critical to enabling operational services and supporting

the implementation of the new Integrated Service Delivery model and MCP within Stockport. As the two largest employers in Stockport, Stockport MBC and Stockport NHS Foundation Trust (FT) both retain significant public support services, with a shared value of approximately £49m, employing around 1,225 Whole Time Equivalents (WTE). Other Stockport Together partners also draw on important support services from a variety of sources.

Work to date, through the Enablers workstream within Stockport Together, has created an ethos of collaborative working across support services and delivered important early value however there is an opportunity to further build on this through a greater integration of support. This has led to a decision for the Council to lead the development of a proposal for a shared service.

The benefits associated with integration in individual service areas are diverse, ranging from the creation of efficiency savings to improving joint working between Partners. To this end, the starting position for this work would be that all support services are in scope. Which services are integrated at what phase in the transformation process will depend upon Stockport's priorities for change and commitment from partners to proceed with reshaping support services. Overarching benefits that have been identified from a Stockport-led integration of support services include:

- The local health and care economy retaining direct influence over support service quality and model, so that it can be adapted to meet future changes
- Greater local resilience through integration, with shared support services that can efficiently flex and respond to changing demands and priorities
- Value for Money through identifying cross-organisational efficiencies and economies of scale
- Integration challenges, cultural norms through sharing learning, skills and experience across the entirety of both organisations
- A clear focus on meeting immediate transformational requirements by reducing organisational barriers and therefore ensuring pace and responsive support; and
- Retaining a strong local employment offer with good careers in and across Stockport public services, enabling Stockport to recruit and retain talent thereby driving up quality and improving outcomes for local people.

Financial modelling is required to fully understand the breakdown of current services and the scale of opportunity. However initial indications are that this could not only release efficiencies (which in part could be used to cover new recurrent costs) but also align systems, workforce and processes to ensure a joined-up approach is embedded. It is envisaged that this piece of work will be critical to enabling operational transformation through innovation as well as supporting the economy to become more resilient and financially sustainable.

4.3.4 GM Transformation Fund

	17/18* Costs (£)	18/19* Costs (£)
Non Staffing	1,750,000	851,500
Staffing	1,015,574	635,888
Total	2,765,574	1,487,388

Below is a summary of the indicative Enabler investment requirements from the Transformation Fund.

*Year 2 and 3 asks are indicative and are based upon identified enabling requirements. This will need to be considered in line with a Programme wide approach to Transformation Fund allocation, Support Services review and the outcome of external funding bids.

Contract Break Points

Table.3 above identifies recurrent spending requirements beyond the transformation funding period. The key areas are:

- Eden Point Accommodation
- Stockport Health and Care Record

As outlined within the Investment Plan assumptions it is the intention that recurrent costs will be picked up through efficiencies within support services however in order to progress these key deliverables and in recognition that work to understand support service opportunities needs to take place, a break clause in contracts for both the above areas has been negotiated at the end of year 3. As such Stockport Partners would not be financially committed to either of these areas of spend beyond the end period of the GM Transformation Fund.

4.3.5 Other External Funding

Other external funding has been identified to resource Enabler investment requirements:

- *Digital Excellence Fund* - Stockport Foundation Trust has put in a bid in for £5m under the second tranche of the Digital Excellence Fund to become a Centre of Global Digital Excellence.
- *GM Capital (Estates)* - This support plan contains a number of capital investment requirements. There are limited opportunities for capitalisation beyond existing organisational sources. However some GM monies have been identified which Stockport has bid in to. The original bid totals £56m and is to deliver new community hubs and an intermediate tier bed unit. The outcome of this process is not yet known. Should Stockport be unsuccessful in this bid, the capital requirements will need to be reviewed in terms of deliverability and in line with other capital funding routes.

- **GM Capital (IM&T)** – Some capital monies have been identified to support IM&T transformation. Stockport has submitted a bid equating to £2.6m which would cover those IM&T requirements identified above.

This investment plan will be reviewed once the outcome of the bid has been received.

5. TIMELINE, RISKS AND MONITORING

5.1 Enabler Headline Milestones

Enabler	Phase 1 Milestones (August to October 2016) – completed
IM&T	IT infrastructure in place for the refurbished A15 "Community" Ward
IM&T	IT infrastructure in place for the SSOP (Short Stay for Older People) ward
IM&T	Mobile Working solutions provided for the Crisis Response Team
IM&T	Neighbourhood Hub IT infrastructure for Victoria, Marple & Stepping Hill
IM&T	Shared IT support arrangements in place
IM&T	Shared resource domain implemented
IM&T	Shared Wi-Fi implemented
Estates	Neighbourhood Team co-locations (Phase 1) Victoria, Marple, Stepping Hill
Workforce	Workforce Plans produced for Community Specialist Services and Core Neighbourhoods
Workforce	Workforce development plan - data collection (Phase 1)
Business support	Integrated working guide developed

Enabler	Phase 2 Milestones (November 2016 to March 2017)
IM&T	Bed Management system research
IM&T	Council Social Care System replacement - procurement decision
IM&T	District Nurses migrated from Dominic to EMIS Web
IM&T	EMIS EPR viewer access in A&E
IM&T	EMIS form for automated referral to START team
IM&T	EMIS Remote Consultation - pilot with 3 GP practices
IM&T	EMIS Web Community
IM&T	IT infrastructure for Ward A14
IM&T	Mobile Working offer developed
IM&T	Shared resource domain established for BI Teams
IM&T	SHCR – upgrade to Care Centric v3
IM&T	Single sign on for Social Workers to the SHCR
Workforce	Workforce plans for Borough Wide and Acute
Workforce	Workforce Development Plan
Workforce	Leadership development
Workforce	Organisation change and re-design
Workforce	Supporting People Through Change programme
Workforce	Recruitment
Estates	Co-location requirements of Intermediate Tier Services established
Estates	Co-location of contact, access and triage staff

Estates	Review of the Primary Care and Foundation Trust Estate
Estates	Strategic Estates Plan revised
IG	Privacy Impact Assessments
IG	Training and communication
IG	Alignment of Information Sharing policies and procedures
BI	Single data set identified for Outcomes Framework
BI	Discovery Workshops
Business support	Baseline staff assessment

Enabler	Phase 3 Milestones (April 2017 to March 2018)
IM&T	Bed Management System implemented
IM&T	Co-location IT infrastructure support
IM&T	Community EPR
IM&T	Council Social Care System replacement implementation
IM&T	Development of online resources for Healthy Communities
IM&T	EMIS Community EPR Mobile app & Phase 1 live
IM&T	EMIS Remote Consultation
IM&T	EMIS Web consolidation
IM&T	Federation of email systems
IM&T	i Docman pilot
IM&T	Integrated / aligned networks
IM&T	Integrated support arrangements
IM&T	Intermediate Tier co-location IT infrastructure
IM&T	Intersystems TrackCare EPR mobile app & Phase 1 live
IM&T	Support for Healthy Communities IT and digital initiatives
IM&T	Support for Outpatients Programme IT and digital initiatives
IM&T	Mobile working rollout
IM&T	Pennine Care added to the shared Wi-Fi network
IM&T	Proof of concept for extending the shared Wi-Fi network to Care Homes
IM&T	Shared resource domain extended to Pennine Care & FT printers added
IM&T	Stockport Health and Care Record (live feeds and apps)
IM&T	Tailored IT support for extended hours and 7 day service delivery
IM&T	Support for PharmOutcomes
IM&T	System consolidation / interoperability charter
IM&T	Telehealth pilot in Care Homes
IM&T	Unified telecommunications solutions investigated
IM&T	Patient Activation measure questionnaire system integration
Workforce	A system-wide workforce plan developed
Workforce	'Supporting People through Change' offer developed
Workforce	Development of a Training and Development plan for the Borough
Workforce	Development of integrated roles
Workforce	A shared ethos and culture embedded, which is based around core values (incorporating Healthy Community principles);
Workforce	Recruitment and retention planning and support

Workforce	Implementation of extended hours working
Estates	Community Hubs
Estates	Intermediate Tier Services co-located
Estates	Bed Care Facility
Estates	Review of the Outpatients estate
BI	Business Intelligence platform and tools developed for operational teams
BI	Business Intelligence Insight and Tools provided to support Enhanced Case Management
Business support	Integrated Business Support service implemented

5.2 Risk and Mitigation

The following table shows the risks that have been identified for the Enabler work and the mitigating action that will be taken to manage them.

Ref.	Risk	Mitigation
1.	Conflicting priorities amongst the Stockport Together organisations. This can affect capacity and pace.	An agreed Enabler Product Plan which is shared regularly with Provider Board and where necessary Executive Board, to ensure clear cross partnership support. Where necessary additional capacity to be supported through the Enabler allocation of the Transformation Fund.
2.	Difficulty in establishing detailed requirements for implementation.	Close working with workstreams to jointly develop requirements and specifications. Enabler Plan to ensure transparency in agreed priorities and scope.
3.	Delays in developing standard or streamlined support service approaches.	Joint working arrangements in place initially, which support initial alignment of services with the next phase of work to further integrate prioritised within the programme.
4.	A lack of alignment between the plans and priorities within the Workstreams and Enablers.	An agreed Enabler Product Plan which is shared regularly with Provider Board and where necessary Executive Board, to ensure clear cross partnership support.

5.3 Programme Management Resources

The Enablers programme will require dedicated programme management resources to effectively deliver this support plan, including:

- Programme Manager;
- Project Managers (to be deployed flexibly across the programme but to be

initially deployed to support IM&T).

This has been built into the resource requirements outlined above, but is currently funded from cash limit, and will work closely with wider programme resources to ensure a sharing of approach and best practice.

5.4 Monitoring and Evaluation

Monitoring and evaluation of this support plan will be aligned to the Programme reporting mechanisms to ensure that benefit realisation targets are considered across both the operational and enabling activity change. This will consist of weekly update reports and monthly highlight reports.

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Report to:	Board of Directors	Date:	26 th June 2017
Subject:	Trust Performance Report (reporting period : Month 2 2017/18)		
Report of:	Chief Operating Officer	Prepared by:	Joanne Pemrick Head of Performance

REPORT FOR APPROVAL

Corporate objective ref:	-----	Summary of Report <ul style="list-style-type: none"> • ED was non-compliance against the Single Oversight Framework metrics, however, the improvement trajectory target of 85% has been achieved in months 1 and 2, with the quarter to date position standing at 86.0% • RTT performance remains compliant with the National standard • Cancer 62 day standard is indicating a fail for month 2 due to a combination of factors. A focus on reducing pathway delays is underway and action plans are being developed. • Clinical correspondence performance improved in month, outsourcing of letters has now been extended to Paediatric and Cardiology services.
Equality Impact Assessment:	Completed Not required	
	<input type="checkbox"/>	
	<input checked="" type="checkbox"/>	
Attachments:		

Appendix 1
Monitor score card

This subject has previously been reported to:	<input checked="" type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input checked="" type="checkbox"/> Executive Team <input checked="" type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> FSI Committee	<input type="checkbox"/> Workforce & OD Committee <input type="checkbox"/> BaSF Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input checked="" type="checkbox"/> Other
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1. Introduction

This report provides a summary of performance against the NHSI Single Oversight Framework for the month of May 2017, including the key issues and risks to delivery. It also provides, in section 4, a summary of the key risk areas from the Trust Integrated Performance Report which is attached in full in Annex A.

2. Compliance against Single Oversight Framework

The table below shows performance against the indicators in the Single Oversight Framework that came into effect 1st October 2016. The forecast position for May is also indicated by a red (non-compliant) or green (compliant) box.

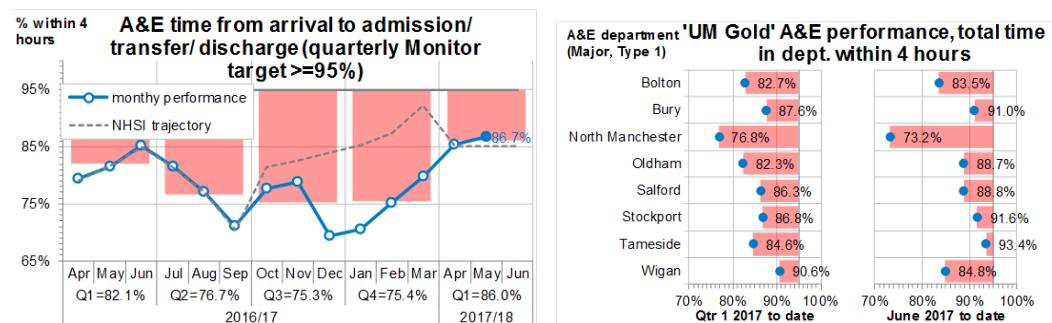
	Standard	Monitoring Period	Oct-16	Nov-16	Dec-16	Q3	Jan-17	Feb-17	Mar-17	Q4	Apr-17	May-17	Jun-17 (f/cast)
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate: Patients on an incomplete pathway	92%	Monthly	91.5%	92.4%	92.1%	92.0%	92.1%	92.5%	92.6%	92.4%	92.5%	93.3%	
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge:	95%	Monthly	77.6%	78.9%	69.4%	75.3%	70.5%	75.2%	79.8%	75.4%	85.3%	86.7%	
All cancers: Maximum 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	Monthly	81.4%	85.1%	89.1%	86.0%	85.4%	87.3%	91.2%	88.1%	91.3%	74.5%	
All cancers: maximum 62-day wait for first treatment from: NHS Cancer Screening Service referral			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Maximum 6-week wait for diagnostic procedures	99%	Monthly	99.7%	99.8%	99.6%	99.7%	99.8%	99.7%	99.8%	99.8%	99.6%	99.8%	

3. Month 2 2017/18: Performance against Single Oversight Framework

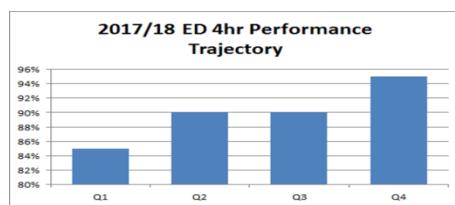
There were two areas of non-compliance against the regulatory framework in month 2:

i) A&E 4hr target

A) 4hr standard



An improvement trajectory has been agreed with NHSI for the new financial year:



Performance in May was 86.7%, which brings the quarter to date position to 86.0% and in-line with the improvement trajectory.

The Urgent Care Plan, which is owned by the Unscheduled Care Delivery Board, is a Stockport Health Economy-wide plan which is being implemented based on 5 themes:

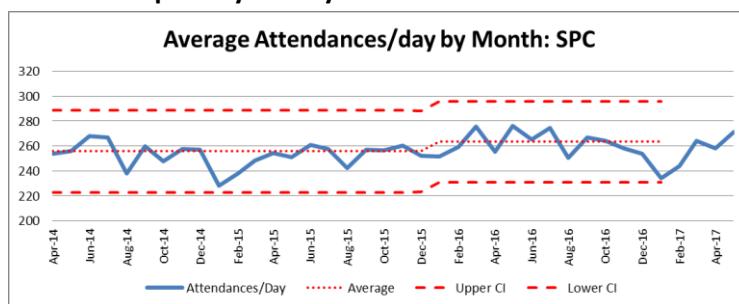
- Front end processes
- Inappropriate admissions
- 7 day working
- Discharge processes
- Delayed transfers of care

During Q1 to date, actions have already been taken to improve the number of patients being streamed through the Ambulatory III facility and the Clinical Decisions Unit.

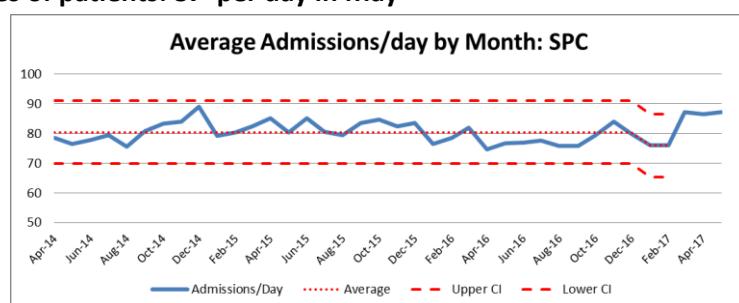
The key actions for Q2 are:

- **Discharge Process:** Implement the SAFER bundle in the Intermediate Tier
- **Front End Process:** Review Site and Bed Management processes
- **Inappropriate Attendances:** Develop the Directory of Services (DOS) to provide patients with a clear “menu” of services available to them as an alternative to ED.

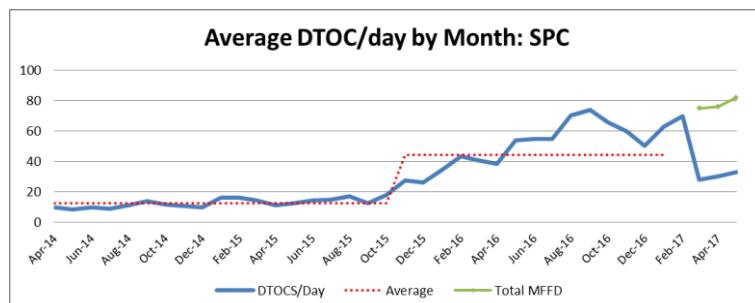
B) Average attendances: 271 per day in May



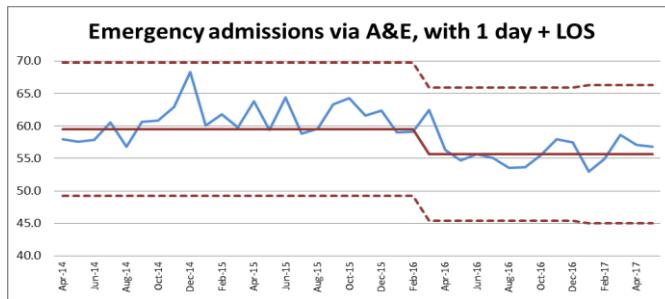
C) Admission rates of patients: 87 per day in May



D) DTOC levels were an average of 33 per day in May. However, the average number of patients medically fit for discharge was 82.



E) Emergency admissions via A&E > 1day LOS: average 57/day in May.



ii) Cancer 62 day standard

Following 2 consecutive months of particularly strong performance, a significant reduction was experienced in May.

A number of factors have contributed to this position:

- A cohort of complex and cross-specialty patients that have required an increased number of diagnostics and interventions
- Patient choice to delay appointments and treatments during the Easter period
- Increased demand. Highest number of 2ww referrals received in March translating into a significantly higher number of patients being seen in the month of March, which in turn increased demand across services.
- Increased wait for 1st appointments and some diagnostic procedures.

There is a focus on minimising waits at each step of the pathway and action plans are in the process of being developed.

Future risks to compliance against the new Single Oversight Framework

Future risks to compliance with the new framework are:

- ED
 - Recruitment and retention of medical and nursing staff
 - Fragility of the market for out of hospital services
 - Speed and pace required to deliver cultural change associated with large scale transformation

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

• Discharge Summary

The percentage of discharge summaries published within 48 hours was 85.3% in May.

• Clinical Correspondence

The overall Trust performance for clinical correspondence typed within 7 days improved this month as anticipated. Paediatrics and Cardiology have commenced outsourcing their clinical correspondence in June so a reduction in the wait times should be reflected next month. Rheumatology has filled a vacant post and is assigning further resource to support accordingly.

• Patient Experience

Overall in May, the trust scored 93% extremely likely or likely to recommend. The ED score improved to 89.8%.

4.2 Performance

- **Cancelled operations**

In May, 59 cancellations were reported on the day for non-clinical reasons. 23 of these were due to more urgent cases taking priority following the major incident which occurred on the evening of 22nd May. The top reasons for cancellation were:

- 23 due to urgent cases taking priority
- 9 due to staff sickness
- 8 due to lack of theatre time

- **Outpatient Waiting Lists:**

Gastroenterology

The Consultant who was due to leave at the end of June is able to stay in post for longer which will mitigate the expected loss of capacity. Mid July a liver CNS returns from maternity leave (part time) and will start to complete some clinics to support the Hepatology team. Clinical revalidation is to be revisited.

Cardiology

Patients continue to be cohorted based on diagnosis, this is helping to manage capacity and align patients with the correct consultant/ service. One locum is to see follow-up patients only and extra capacity is provided by other consultants through WLIs . Clinical validation is ongoing and patients who do not need follow-up appointments are discharged back to GP.

Respiratory

Clinical Validation is ongoing to identify patients who do not need follow up appointments and can be discharged back to GP. Extra capacity is being provided through WLIs. Clinic templates for some consultants have changed to facilitate more follow up slots. Clinically urgent patients are being prioritised.

Ophthalmology

The vacant Optometrist post has been appointed to with the successful applicant due to start in September whilst the lead Consultants for Glaucoma have reviewed the Junior doctors templates to increase clinic capacity, meaning that an additional 19 slots per week are being provided from June, rising to 40 in August when the new trainees come into post.

An extensive service review is currently being across Ophthalmology with input from the Trust's Transformation Team and plans are now being taken to support these new initiatives whilst maintaining clinic capacity.

4.3 Finance

- **CIP**

At the end of May CIP is £0.1m behind plan; £0.8m (5%) was expected by this stage in the year when £0.7m (4%) has been transacted. The majority of this is non-recurrent in-month savings for salary sacrifice and vacancy slippage.

- **Financial sustainability**

NHSI have now released the calculation template for the 2017/18 financial year for the Trust's Use of Resources (UOR) score under the Single Oversight Framework. The Trust has scored a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for May 2017 and our actual performance is in line with this.

For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

In the first month two months of the financial year the Trust has made a £6.42m loss. The planned deficit was £6.77m so this is £0.35m favourable to plan. The Trust has made an average loss of £105,000 per day to the end of May.

The financial position for the two months to 31st May 2017 is £0.35m better than the planned deficit. This is driven by income performance above planned levels, as differences in expenditure between categories balance out overall.

- **Agency Ceiling**

Agency expenditure in May was £1.1m. This is in excess of the profiled NHSI agency ceiling to date.

Agency costs to date are £2.3m, which represents 6% of total pay costs. Bank costs, including NHS Professionals, internal locums and waiting list initiative payments, are a further £2.0m, another 6% of total pay costs. Temporary staffing therefore makes up 12% of overall pay expenditure.

The NHSI template has now been released which tracks agency spend within the Use of Resources (UoR) metric of the Single Oversight Framework. This has confirmed that the Trust is continuing to be monitored against the published £12.1m ceiling, but with a soft target to reduce expenditure by 10%.

4.4 Workforce

- **Essentials training**

In May 2017 compliance is 85%, no change from April 2017.

Learning & Education continue to provide drop-in sessions and remote telephone support for those who require additional support.

The Training Needs Analysis (TNA) is under review to ensure all staff are fully confident in the learning and specific competencies required for their role.

- **Appraisals**

The Trust's total appraisal compliance for May 2017 is 90.06%, an increase of 1.27% since April 2016 (88.79%).

The Head of OD, Learning and Development is undertaking an Appraisal audit to quality assure the process and ensure staff have a positive Appraisal experience. .

- **Turnover**

The Trust staff in post for May 2017 is 92.25% of the establishment, which is a marginal decrease of 0.25% from 92.5% in April 2017.

Registered Nursing and Midwifery roles have the highest vacancy rate at 163.21 FTE in May 2017.

Work continues to look to recruit to vacancies from international recruitment processes, the launch of a nursing recruitment campaign and ongoing recruitment days. A number of key appointments have been made to our hard to fill medical vacancies via both domestic and international recruitment routes. Timescales for start dates are July-September 2017.

- **Efficiency**

- Bank & Agency costs**

Bank and agency account for 11.8% of the £17.9m total pay costs. This is a small decrease on the position reported in April 2017 (12.2%).

A small number of agency doctors within Medicine have agreed to join the Trust's internal bank and are expected to have completed their checks by the end of June.

- **Sickness Absence**

The in-month unadjusted sickness absence figure for May 2017 is 3.46%. This is a decrease of 0.41% compared to the April 2017 adjusted figure of 3.87%. The sickness rate for comparison in May 2016 was 3.80%.

The unadjusted cost of sickness absence in May 2017 is £408,606, a decrease of £47,582 from the adjusted figure of £47,582 in April 2016. This does not include the cost to cover the sickness absence.

Community Healthcare, Corporate Services and Diagnostic & Clinical Services and Surgical & Critical Care Business Groups are below the 3.5% target in May 2017.

The top 3 known reasons for sickness in May 2017 are back problems and other musculoskeletal problems including injury/fracture at 28.77% (a 1.03% decrease from 29.80% in April 2017), stress at 25.64% (a 2.41% decrease from 28.05% in April 2017), and cough, cold influenza, asthma, chest & respiratory problems at 9.85% (a 1.63% increase from 8.22% in April 2017).

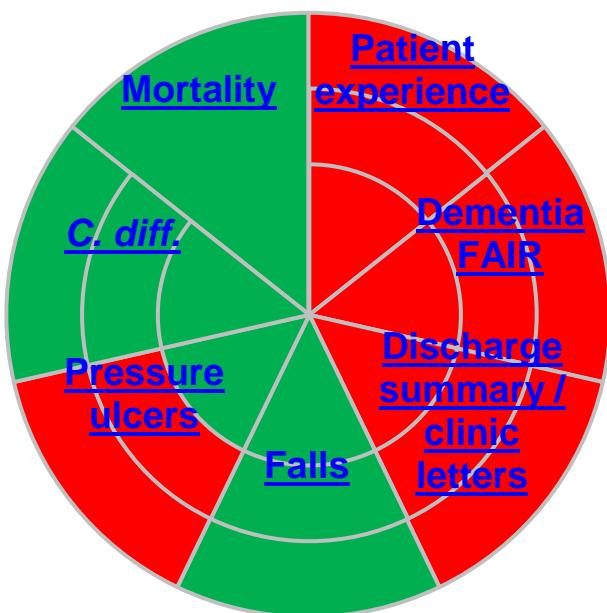
5. Recommendations

The Board is asked to:

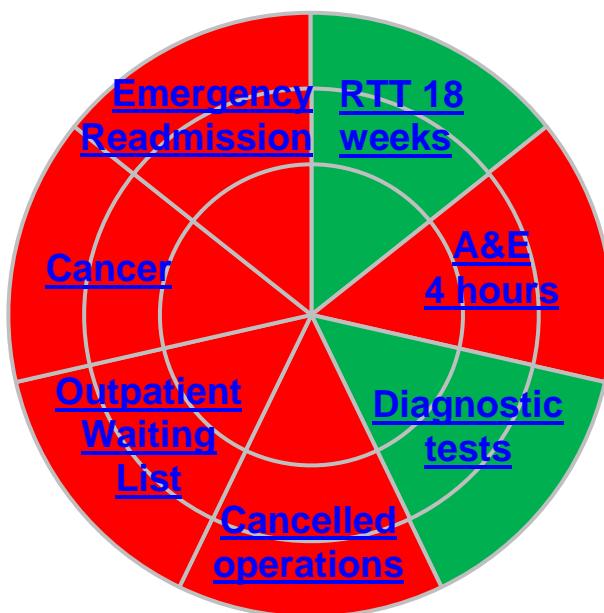
- Note the current position for month 2 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report.

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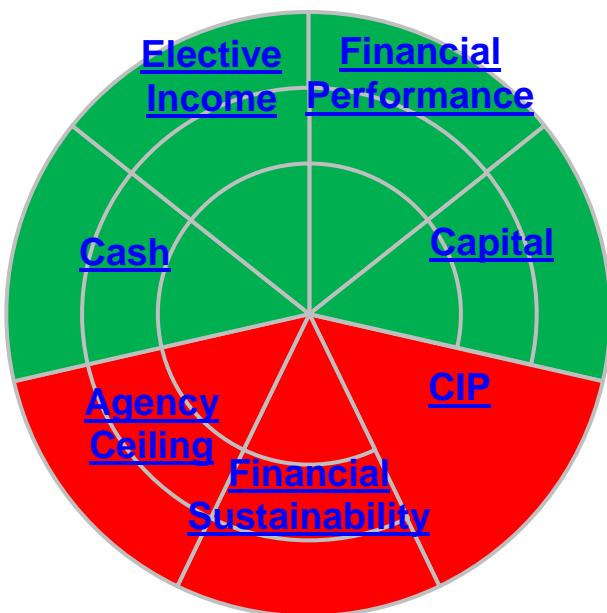
1.Quality



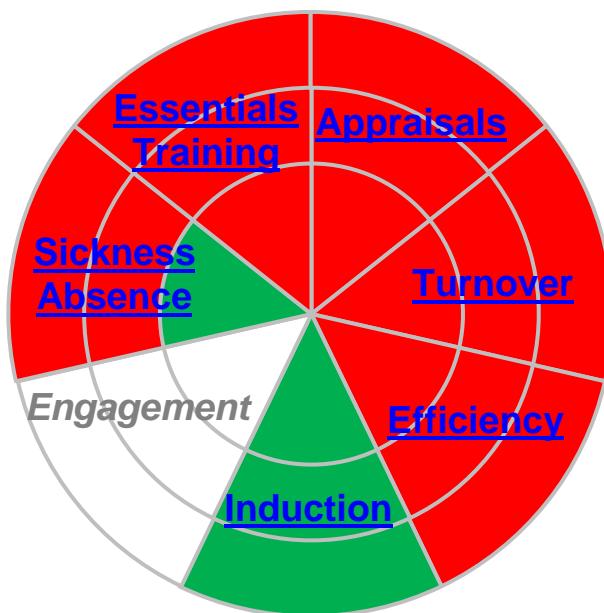
2.Performance



3.Finance



4.Workforce



Key to wheels:

Outer ring; Year-to-date performance. Middle ring, latest quarter. Inner ring, latest month.

Mortality is assessed on the latest 12 months, CIP (Cost Improvement Programme) on the year-to-date.

Your Health. Our Priority.

Integrated Performance Report

Changes to this month's report May 2017:

- The method of reporting Delayed Transfers of Care (chart 41) has changed to reselect only those attributable to the NHS.
- The target for Workforce Turnover (chart 75) has changed to <14% -in line with the National target.
- The target for staff in post (chart 79) has changed to >90%.

Key to indicators:

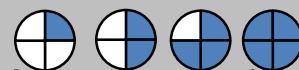
Monitor indicators (in Risk Assessment Framework): M

Monitor indicators for which we have made forward declaration: M

Corporate Strategic Risk Register rating (current or residual): 15

Risks rated on severity of consequence multiplied by likelihood, both based on a scale from 1 to 5. Ratings could range from 1 (low consequence and rare) to 25 (catastrophic and almost certain), but are only shown for significant risks which have an impact on the stated aims of the Trust, with an initial rating of 15+.

Data Quality: Kite Marking given to each indicator in this report



This scoring allows the reader to understand the source of each indicator, the time frame represented, and the way it is calculated and if the data has been subject to validation. The diagram below explains how the marking works.

Filled Trust Data	Blank National Data	→	Filled Validated	Blank Unvalidated
Filled Automated	Blank Not Automated		Filled Current Month	Blank Not Current Month
		→		

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Patient Experience

Chart 1

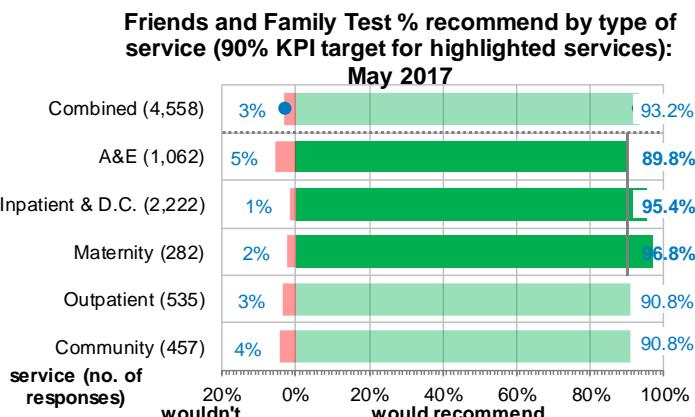


Chart 2

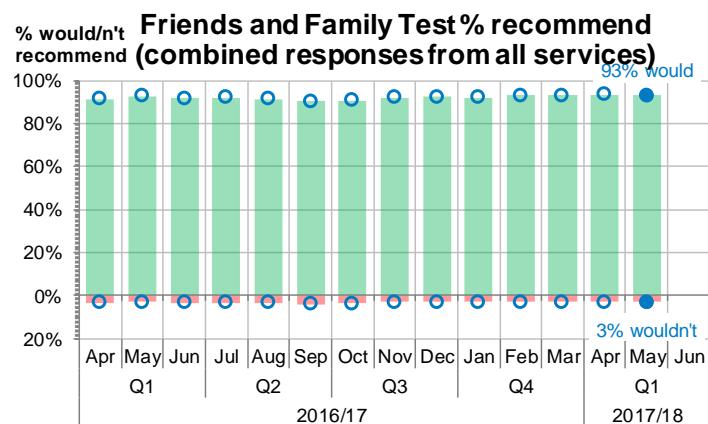
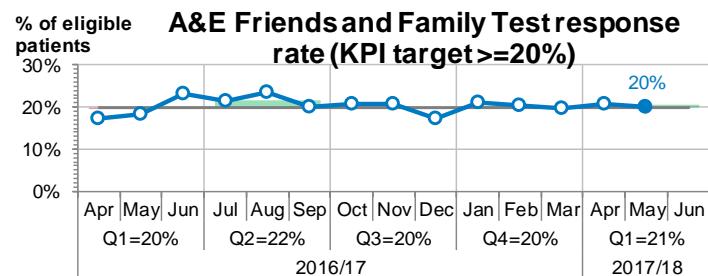


Chart 3



Overall in May, the Trust scored 93% extremely likely or likely to recommend, total responses were 4558. Broken down:

AREA	Response rate March	Variance on previous month (RR)	% extremely likely / likely to recommend March	Variance on previous month (% Rec)
ED inc children's ED	20%	-1%	90%	+1%
Inpatients	34%	+7%	96%	-1%
Maternity (Birth)	45%	-9%	92%	+5%
Outpatients	35%	+1%	92%	-1%
Daycase	35%	-2%	95%	same
Community	24%	-1%	91%	same

Feedback Themes (acute):

ED (adult) Positive comments received related to very friendly and efficient staff. Reference was made on numerous occasions to how well the departments are organised despite being very busy, and how patient centered the care was providing patients with great confidence. Negative comments continue to be related to long waiting times.

Inpatients (adults) Positive comments related to kind and compassionate nurses who deliver excellent, efficient care. There were also many positive comments relating to the attitude of staff. There were very few negative comments however the majority of these are again related to poor communication amongst staff.

Maternity All comments received were positive and related to excellent, friendly and caring staff. The theme evident throughout is centred on the high standard of care provided and the positive experiences patients have had.

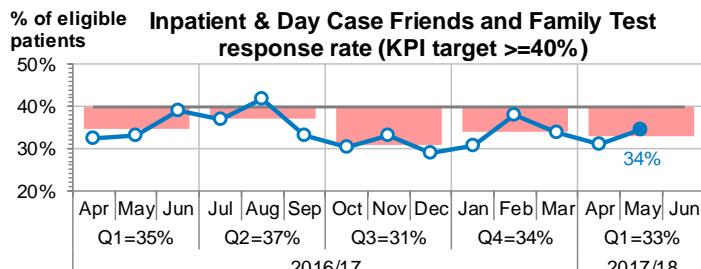
Paediatrics (inpatients) All comments received were positive and included staff attitude, family centered care and good facilities.

Daycase: Positive comments related to staff attitude, excellent care and an efficient service. There were a negligible number of negative comments relating to poor communication.

OutPatients Positive comments predominantly related to staff attitude, very caring and efficient staff who made patients feel at ease. Albeit there were negative comments relating to long waiting times these were very few and patients made positive comments about the excellent communication, and being kept informed regarding clinic delays.

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Chart 4



IPad Inpatient Surveys

In May 229 inpatient iPad surveys were undertaken, which is an increase of 12 compared to the number completed in April.

In comparison to the data from April results for May have shown an improvement of 6% where patients feel there were enough nurses on duty and consequently a 2% increase in call bell's being answered in a timely manner and a 9% increase in patients receiving assistance with eating. There were also a 7% improvement for having the opportunity to talk to a doctor, and a 2% improvement for being involved in decisions about care.

Results in May have shown an improvement with noise at night, there has been a increase of 8% where patients were asked if they have been bothered by noise at night from other patients, and a 2% increase to being bothered by noise from staff. Despite this improvement overall results remain poor and results from a recent noise at night audit were also very disappointing. There has been a deterioration in maintaining the Standards and only one ward was 100% compliant.

The night sisters are continuing to remind the ward staff about the noise at night standards and results continue to be shared with the Business groups to action accordingly, and with relevant departments.

Less positively patients felt dissatisfied with the quality of the food with a decrease of 7%, and a 6% decrease in being offered a napkin with their meal. A trial for ensuring patients receive napkins took place on one of the wards however this was unsuccessful. Following this a meeting took place with the Matron for Patient Experience, the Catering Manager and Head Chef to discuss an alternative process and there is currently a retrial underway on the same ward. Actions will continuously be monitored via the Trusts Nutrition and Hydration Group.

There has also been a decrease of 9% where patients haven't been asked if pain relief administered had any effect, a 4% decrease relating to privacy and dignity when discussing conditions or treatment and a 5% decrease relating to the cleanliness of the toilets on the wards.

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Dementia



Chart 5

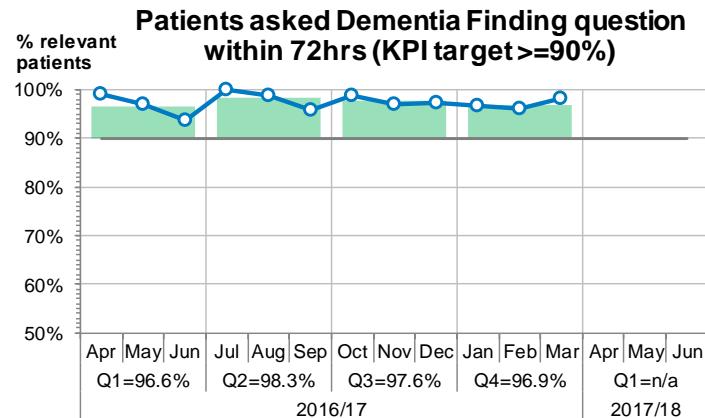


Chart 6

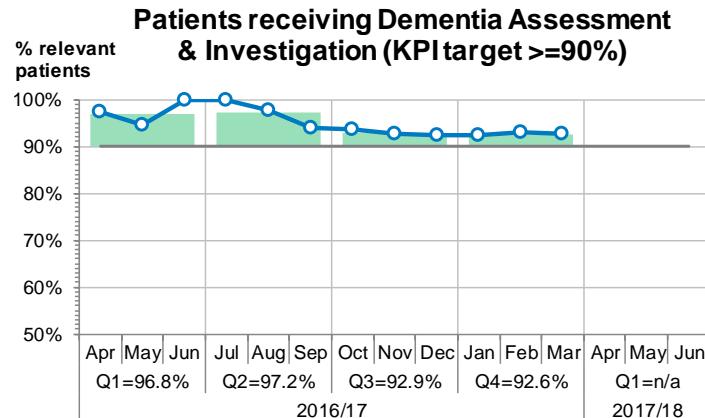
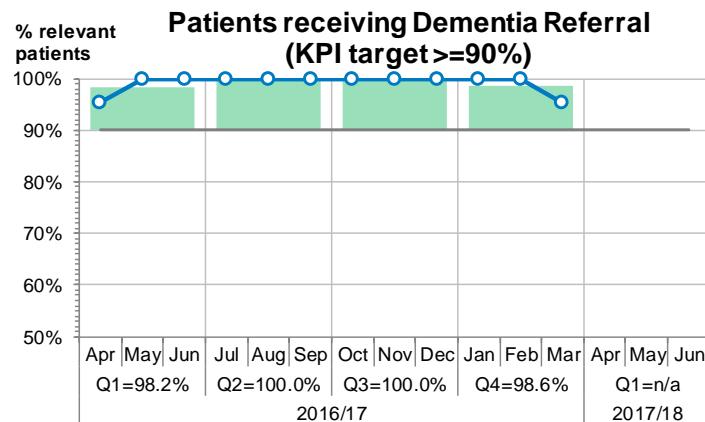


Chart 7



Charts 5 to 7 show performance against the dementia standards.

Technical issues have been encountered which has affected the reporting for April.

The data for April will be available once the issues have been resolved.

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Discharge Summary



Chart 8

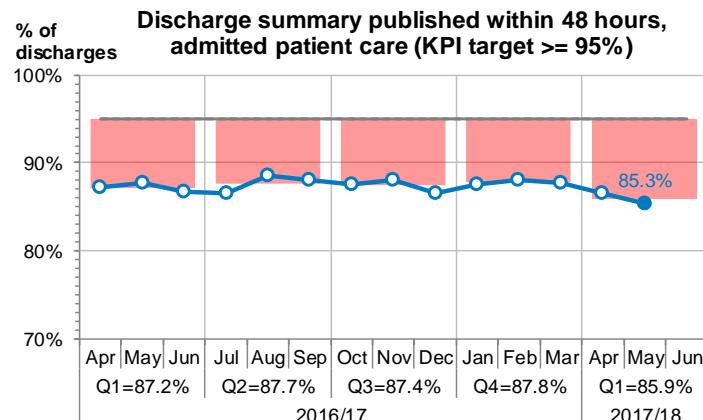


Chart 8 shows compliance with discharge summary completion within 48hrs.

The percentage of discharge summaries published within 48 hours was 85.3% in May

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Clinical correspondence (typing backlog)



Chart 9

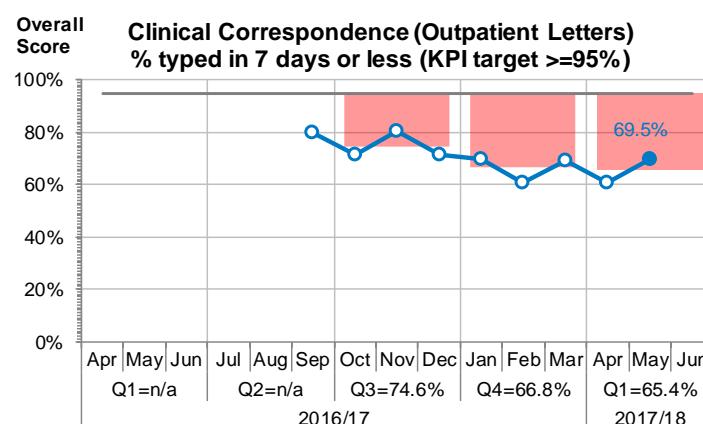


Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 7 days.

The overall Trust performance for clinical correspondence typed within 7 days improved this month as anticipated.

Paediatrics and Cardiology have commenced outsourcing their clinical correspondence in June so a reduction in the wait times should be reflected next month. Rheumatology has filled a vacant post and is assigning further resource to support accordingly.

Chart 10

Department	Longest wait (days)
Paediatrics	35
Rheumatology	28
Cardiology	23
Maxfax	20
DMOP	15
General Surgery	15
Gynae	14
Chest	13
Gastroenterology	10
T&O	9

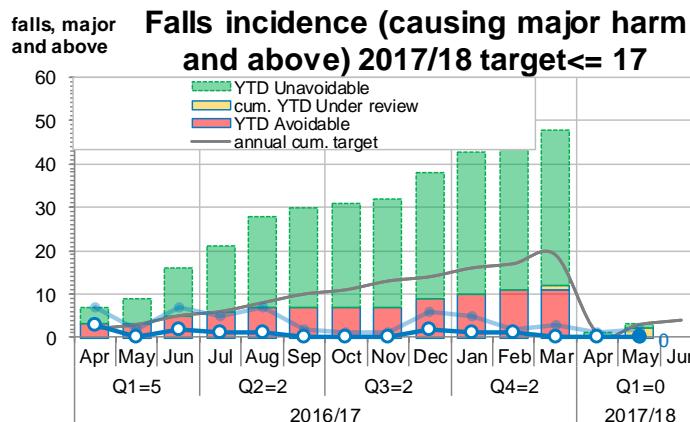
Chart 10 details the longest wait for those specialties not achieving the 7 day turn-round in May.

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Falls 16

Chart 11

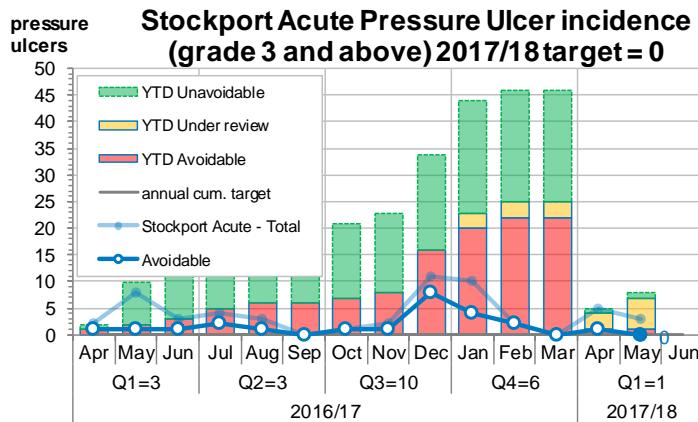


This year's target is 17 or below avoidable falls. In May there have been 2 falls both are still undergoing investigation. To date there has been 1 avoidable fall.

Work continues to identify patients at risk of falls and ensure the falls bundle is implemented. A further meeting has taken place with community colleagues to review joint documentation across the whole health economy and the Royal College of Physicians annual falls audit has commenced.

Pressure Ulcers 16

Chart 12



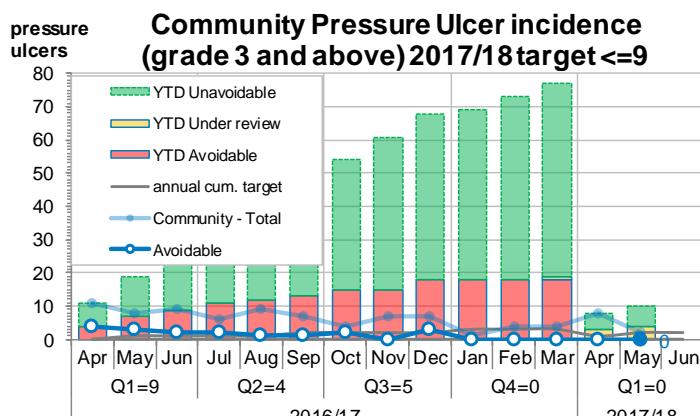
The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017/18. In May, there have been three, category 3 and above pressure ulcers reported in the hospital, all are currently under review.

The stretch target for Stockport Community is a 50% reduction in grade 3 and 4 avoidable pressure ulcers by the end of 2017/18. The target is 9 avoidable pressure ulcers for the year. In May there have been 2 new grade 3 or 4 pressure ulcers reported, 1 of which is still under review, and 1 has been deemed unavoidable.

Definitions relating to pressure ulcers and how they should be measured and reported have been debated with national consensus of some terms already reached. This should bring neighbouring trusts reporting of pressure ulcers into alignment over the next 12 months. Going forward, Greater Manchester NHS Trusts have agreed to share pressure ulcer data monthly to provide baseline data locally, and evaluate pressure ulcer reduction strategies such as React to Red, or other Stop the Pressure prevention initiatives.

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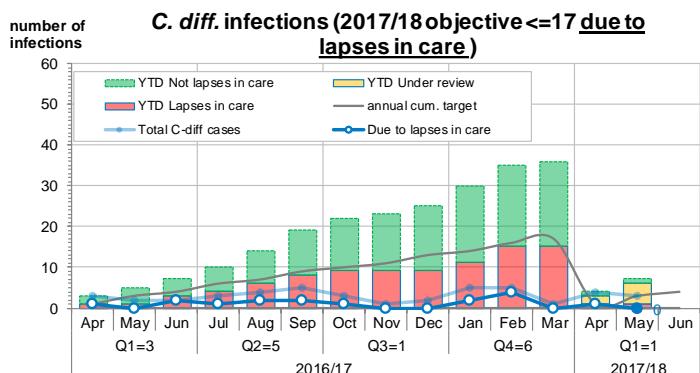
Chart 13



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Clostridium difficile (C. diff.) infections M

Chart 14



There has been 3 case of Clostridium difficile in May, the total number YTD is 7. Of these 7 cases 2 have been reviewed with the other 5 case still under review.

We have been advised by the CCG that 1 case reviewed by them does not have significant lapses in care and does not reach the threshold for reporting; however 1 case does have significant lapses in care and does reach the threshold for reporting. Therefore 1 case would not count towards the trajectory of 17 significant lapses in care but 1 case will.

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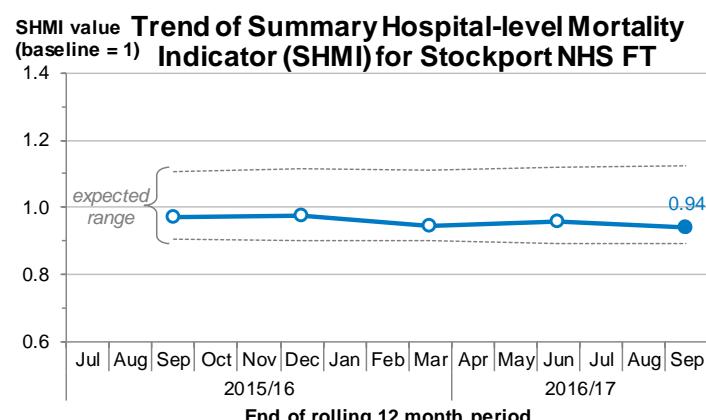
Mortality

Summary Hospital-level Mortality Indicator (SHMI)

This is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

Data source: Health and Social Care Information Centre

Chart 15



Mortality analysis now includes 3 measures, SHMI, RAMI, and HSMR (not Dr Foster HSMR but a proxy provided by the CHKS software). Where possible data is shown to represent performance over time, against peers and with weekend/week comparisons.

Whilst overall mortality profile is good and reported as Green, investigation is needed into the varying mortality at the weekend compared to the week. This would be in tandem with the Trust 7 day services action plan

Chart 16

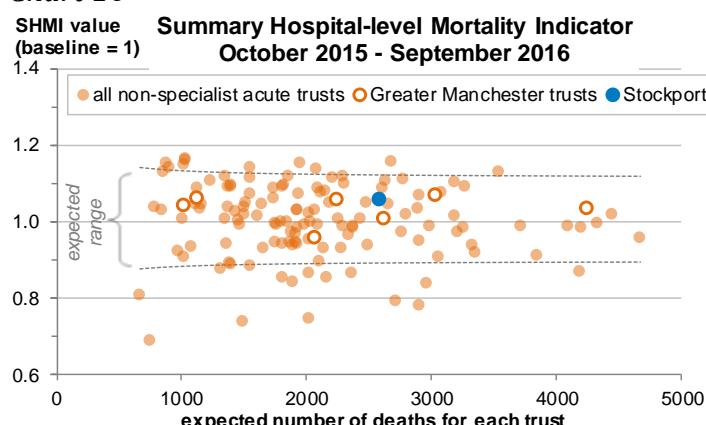
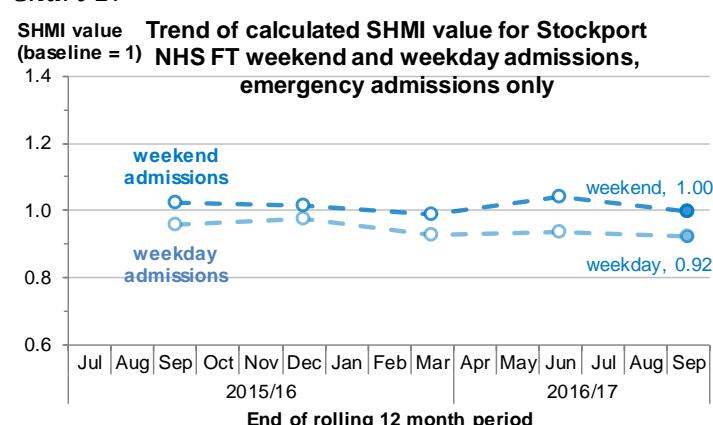


Chart 17



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Risk Adjusted Mortality Index (RAMI)

The main differences in calculation from SHMI are: RAMI only includes in-hospital deaths; it excludes patients admitted as emergencies with a zero length of stay discharged alive, and patients coded with receiving palliative care; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest 2014 benchmarks; RAMI includes data from the whole patient spell rather than just the first two admitting consultant episodes.

Data source: CHKS

Chart 18

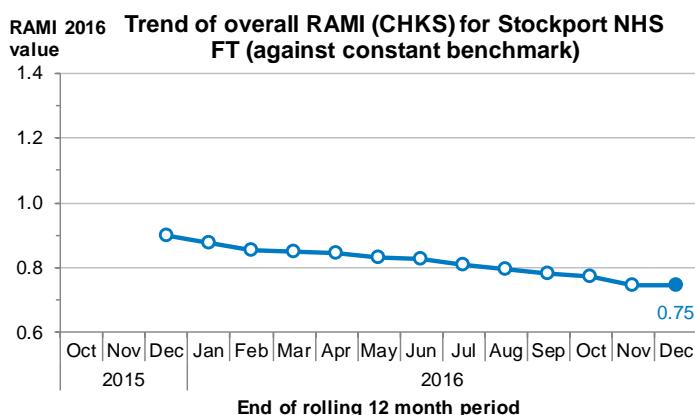


Chart 19

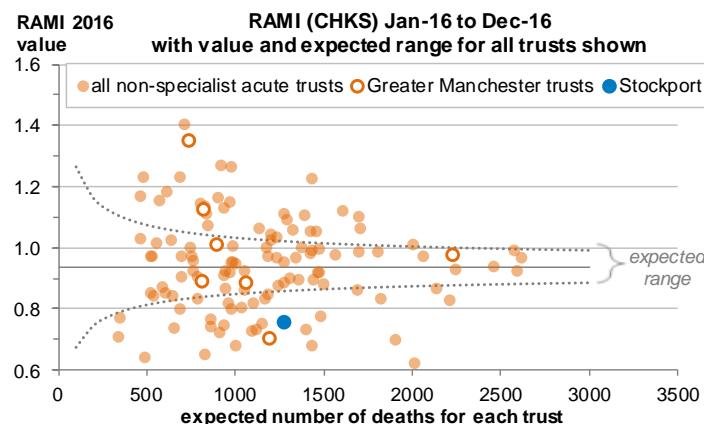
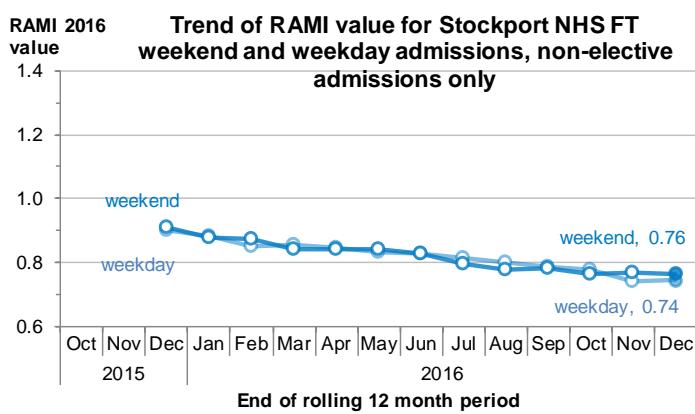


Chart 20



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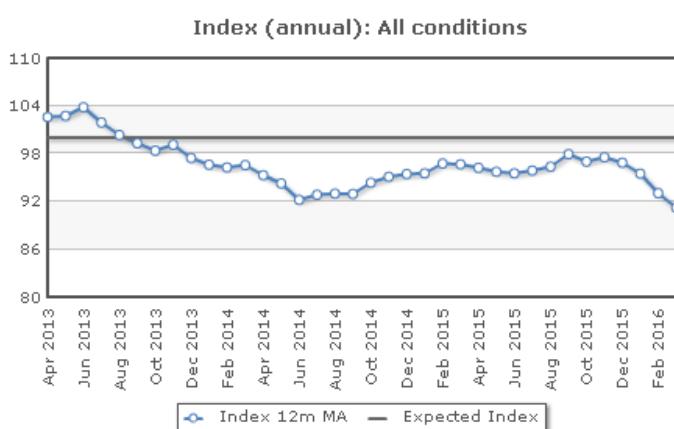
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Hospital Standardised Mortality Data (HMSR)

The main differences in calculation from SHMI are: HMSR only includes in-hospital deaths; the factors used in estimating the number of patients that would be expected to die includes whether patients are coded with receiving palliative care, and socio-economic deprivation; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest benchmarks.

Data source: CHKS (using Dr Foster Intelligence methodology)

Chart 21



Referral to Treatment (RTT) waiting times M 16

Chart 22

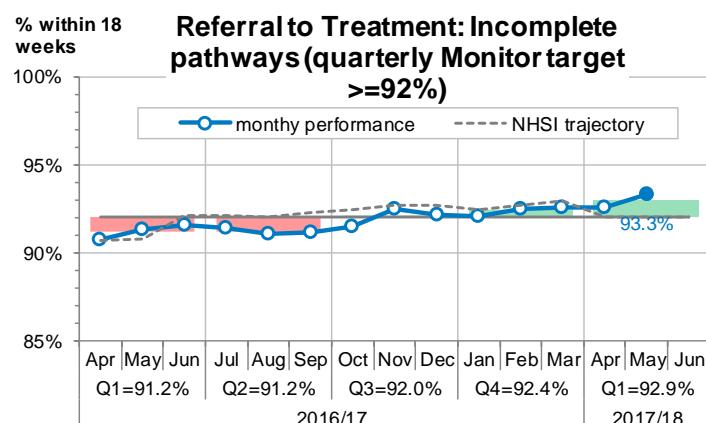
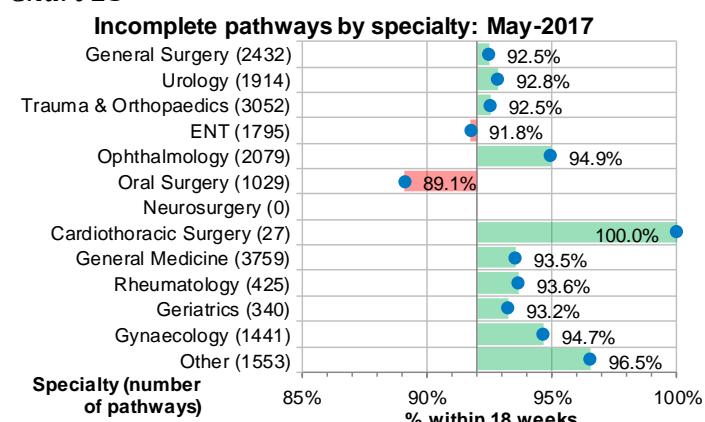


Chart 22 shows performance against the RTT Incomplete standard.

The Trust achieved 93.3% against the National standard in May.

Chart 23



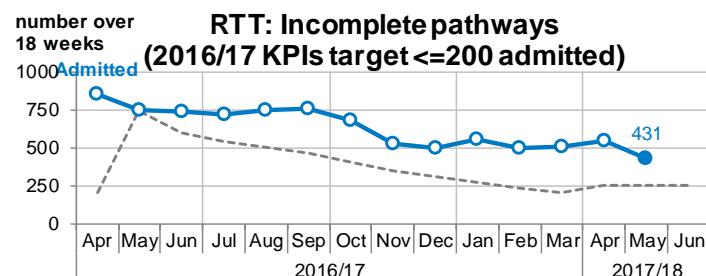
Two specialties remain non-compliant but continue to show improving positions.

ENT has improved from 90.7% to 91.8%.

Oral Surgery has significantly improved as predicted, from 84.4% to 89.1%

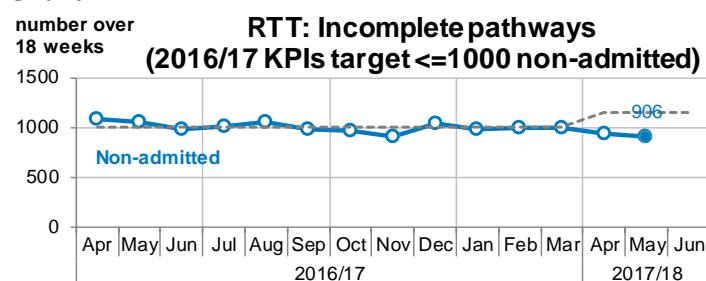
The admitted backlog reduced significantly in month from 547 at the end of April to 431 at the end of May.

Chart 24



Charts 24 and 25 show the number of patients waiting beyond 18 weeks split by admitted and non-admitted pathways.

Chart 25



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Accident & Emergency, Urgent Care & Flow



Chart 26

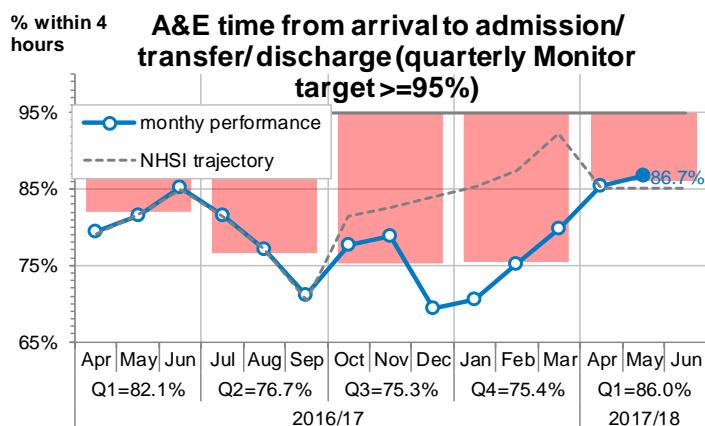


Chart 26 shows compliance against the 4hr A&E standard.

An improvement trajectory has been agreed with NHSI for the new financial year as shown:

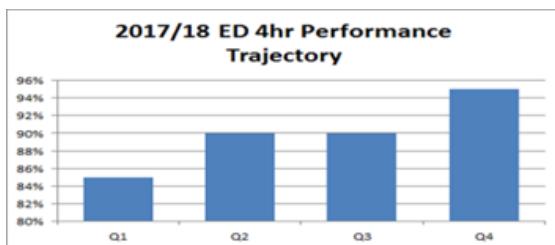
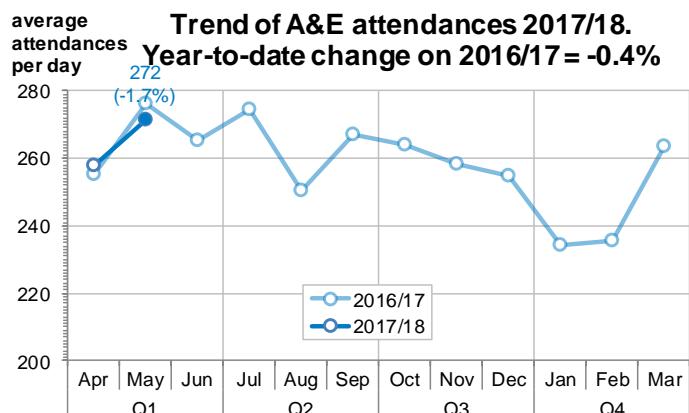


Chart 27



Performance in May was 86.7%, which brings the quarter to date position to 86.0% and in-line with the improvement trajectory.

The Urgent Care Plan, which is owned by the Unscheduled Care Delivery Board, is a Stockport Health Economy-wide plan which is being implemented based on 5 themes:

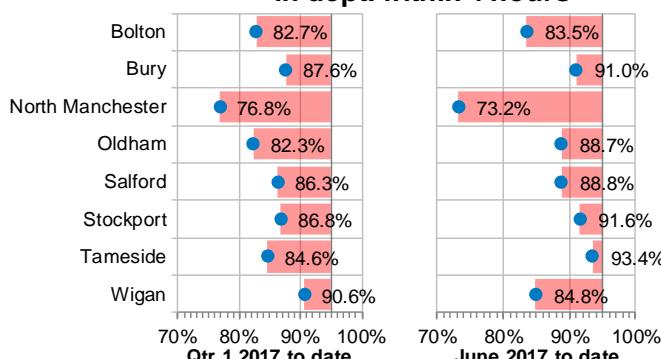
- Front end processes
- Inappropriate admissions
- 7 day working
- Discharge processes
- Delayed transfers of care

During Q1 to date, actions have already been taken to improve the number of patients being streamed through the Ambulatory Ill facility and the Clinical Decisions Unit.

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Chart 28

A&E department 'UM Gold' A&E performance, total time (Major, Type 1) in dept. within 4 hours



Source: Greater Manchester Academic Health Science Network.

The key actions for Q2 are:

- Discharge Process:** Implement the SAFER bundle in the Intermediate Tier
- Front End Process:** Review Site and Bed Management processes
- Inappropriate Attendances:** Develop the Directory of Services (DOS) to provide patients with a clear "menu" of services available to them as an alternative to ED.

Chart 29

Ambulance handovers - NWAS only, financial exclusions applied (KPI target = 0 per month)

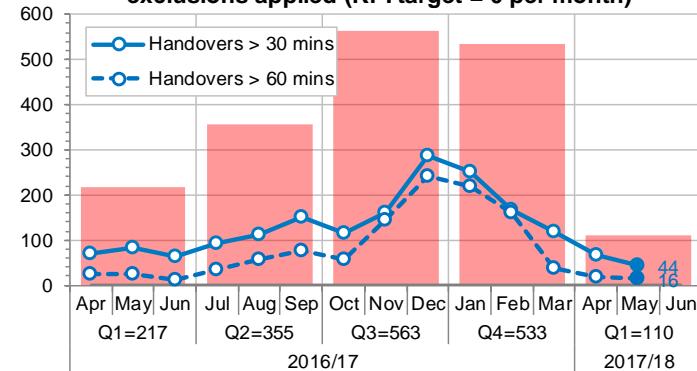


Chart 30

>12 hour ED trolley waits & >=8 hour total time in ED (KPI targets = 0)

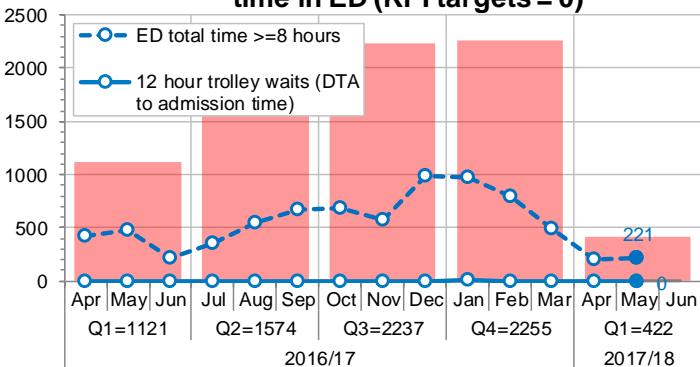


Chart 31

Time to Initial Assessment (95th percentile)
Arrivals by Ambulance

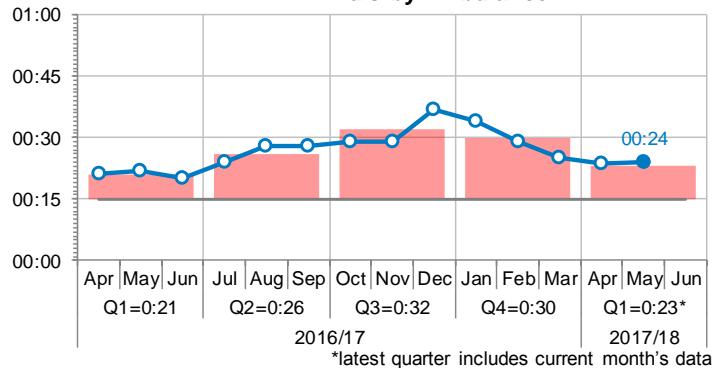
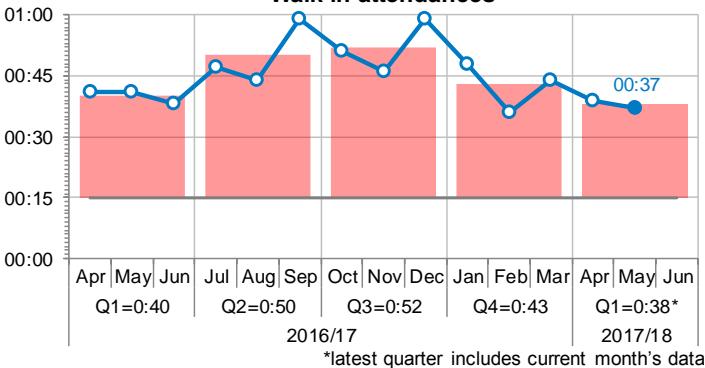


Chart 32

Time to Initial Assessment (95th percentile)
Walk in attendances



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Chart 33

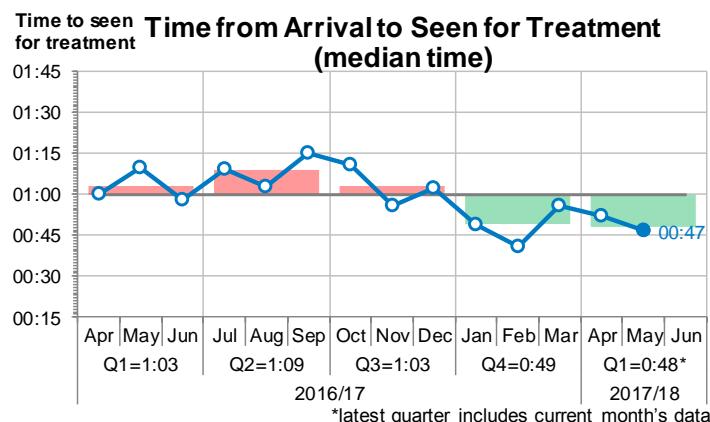


Chart 34

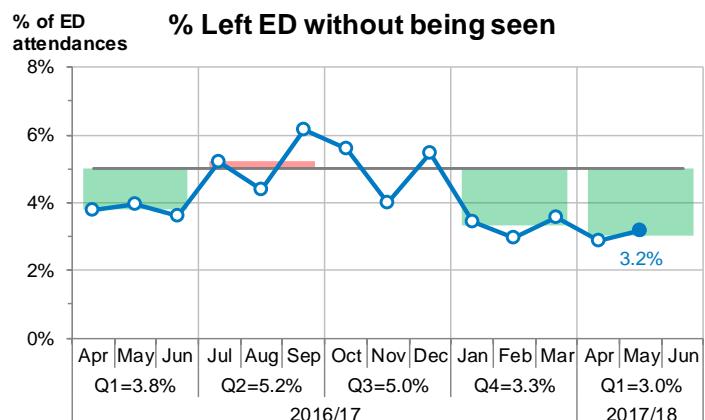


Chart 35

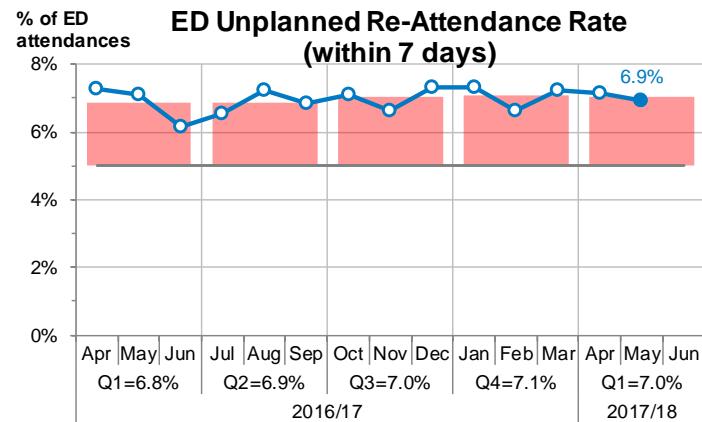
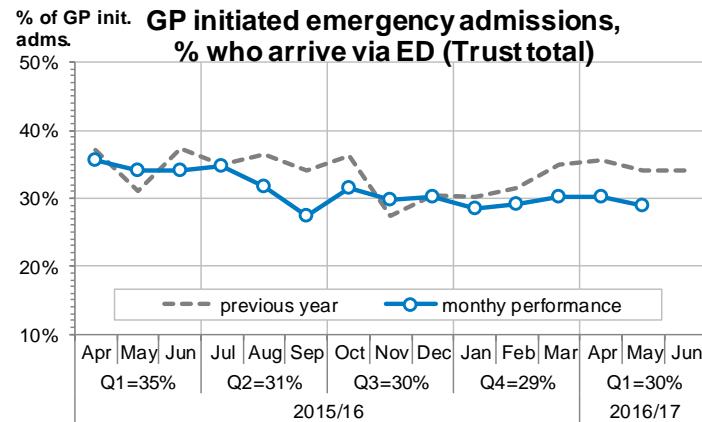


Chart 36



The following charts (36 to 44) are the high level KPIs to measure progress realized through the implementation of the Urgent care 90 day plan.

Integrated Performance Report

May 2017

Chart 37

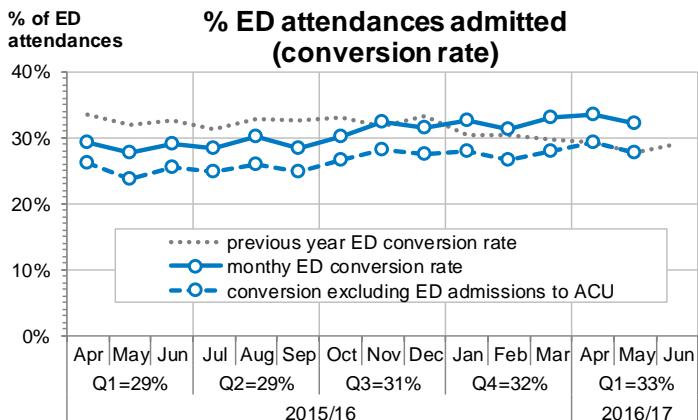


Chart 38

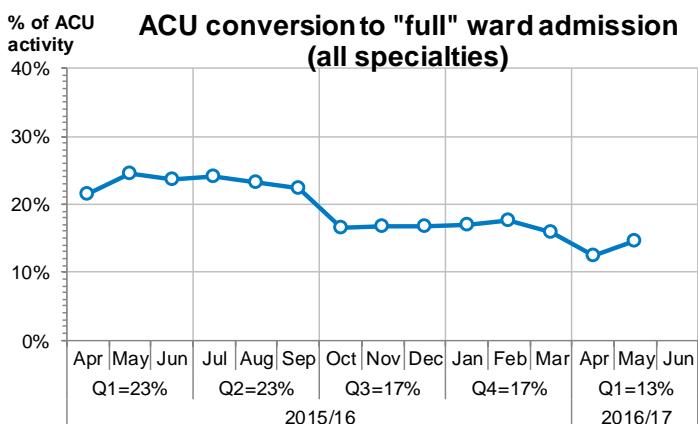
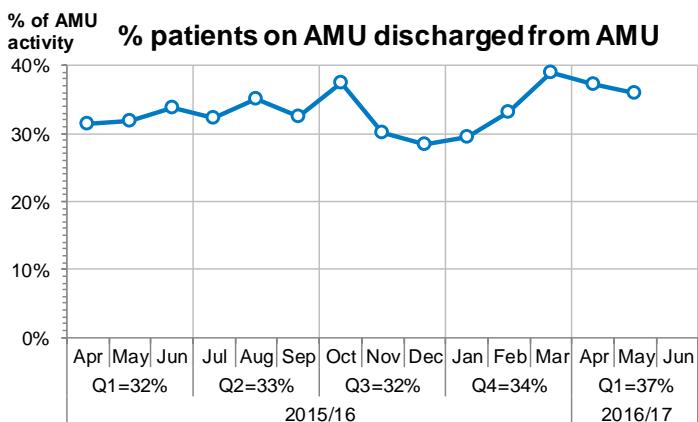


Chart 39



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Chart 40

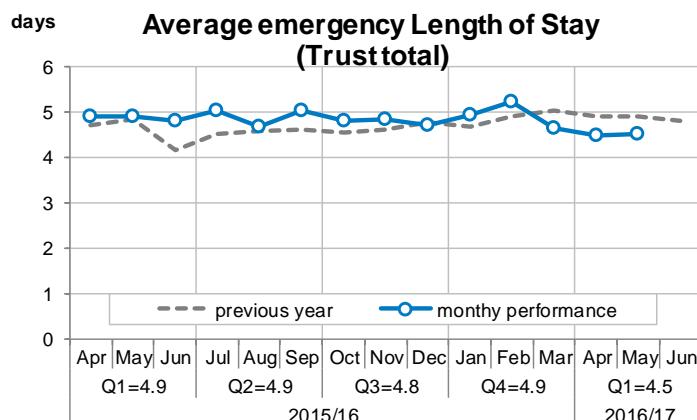
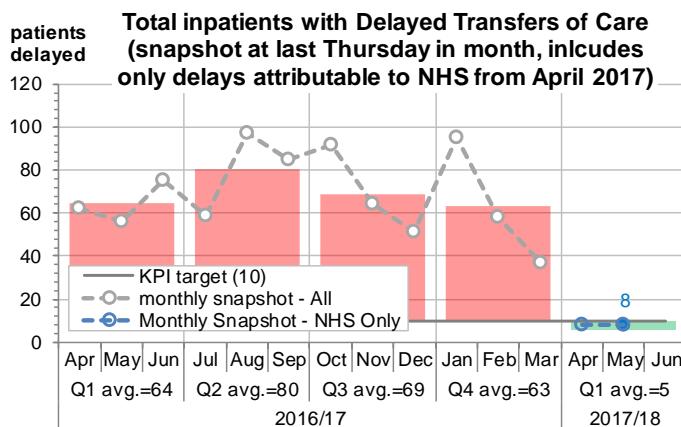


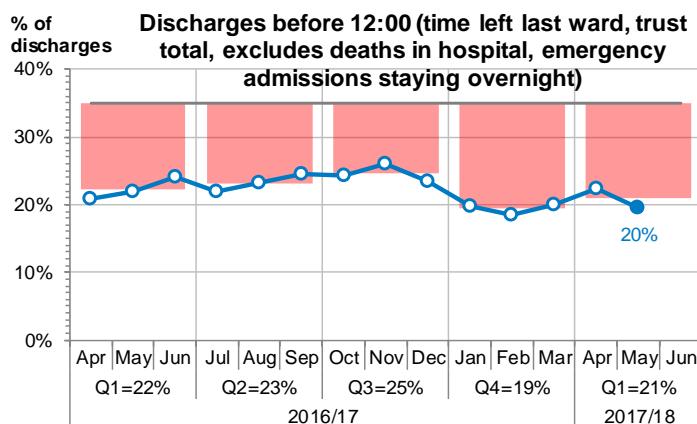
Chart 41



SAFER - is intended to improve the patient journey by ensuring an efficient pathway from admission to discharge by delivering timely appropriate care at the right time in the right place.

Key metrics have been agreed to measure SAFER performance which includes discharges before 12md and 16:30hrs as shown in chart 33 and 34. All wards are invited to attend monthly performance meetings to report compliance against these key metrics and actions plans developed as appropriate.

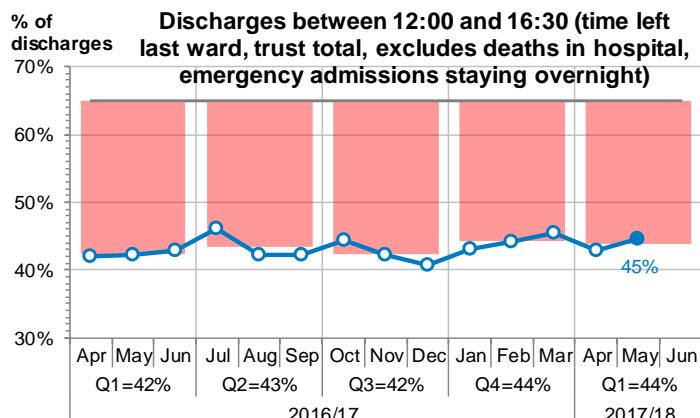
Chart 42



A team from the Emergency Care Improvement Programme (ECIP) is supporting further implementation of SAFER. Work has commenced on three wards, namely: A1, A11 and E2 for an 8 week period until the end of Jan 2017.

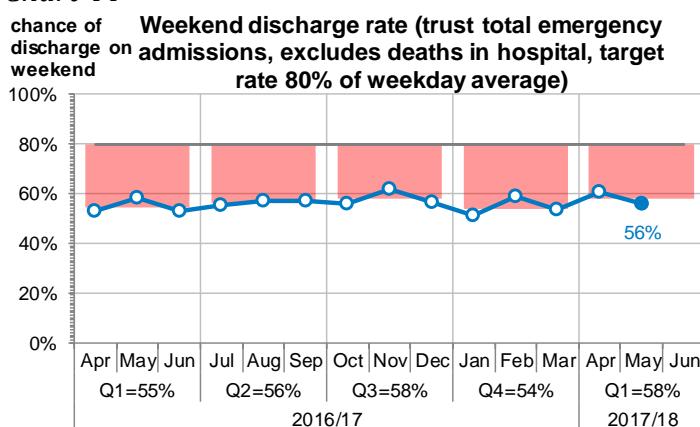
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Chart 43



Identifying patients for discharge at the weekend is just as important as weekday discharges to continue flow and create capacity. An action plan has been developed to strengthen roles and responsibilities' of the on call team at weekend in order to ensure robust plans are in place and adhered to.

Chart 44



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Diagnostic tests (6 week wait) 16

Chart 45

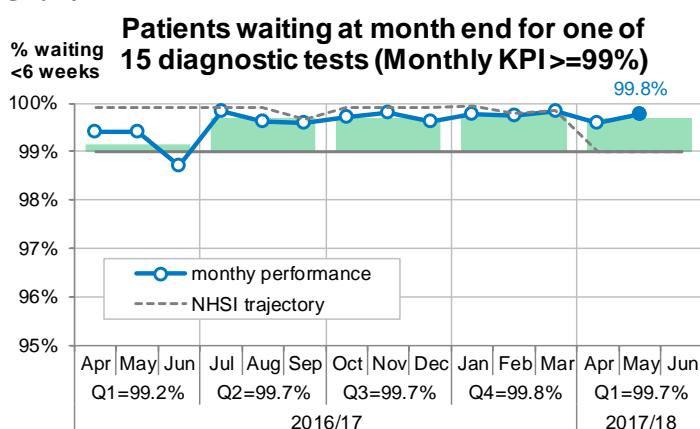


Chart 45 shows performance against the diagnostic standard.

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Cancelled Operations 20

Chart 46

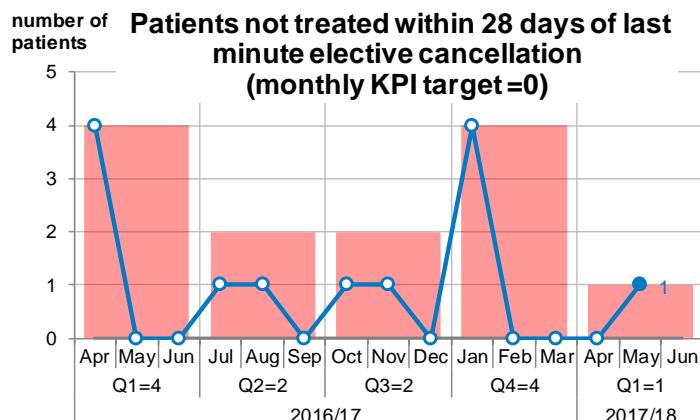


Chart 46 shows one breach of standard in month.

This related to a General Surgery patient whose procedure was cancelled twice due to no HDU bed availability.

Chart 47

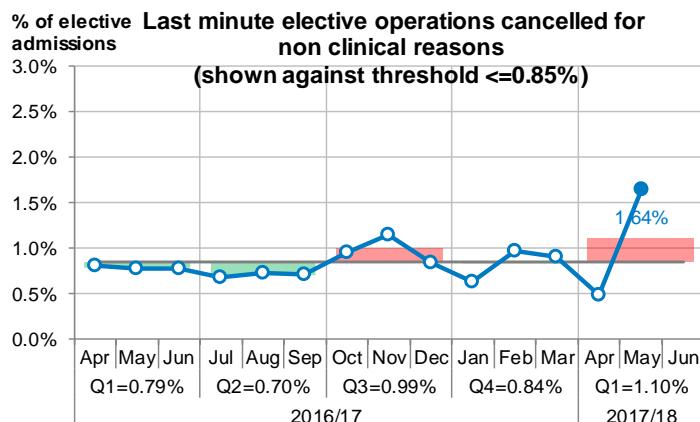


Chart 47 shows performance for last minute elective operations for non-clinical reasons.

In May, 59 cancellations were reported on the day for non-clinical reasons. 23 of these were due to more urgent cases taking priority following the major incident which occurred on the evening of 22nd May.

The top reasons for cancellation were:

- 23 due to urgent cases taking priority
- 9 due to staff sickness
- 8 due to lack of theatre time

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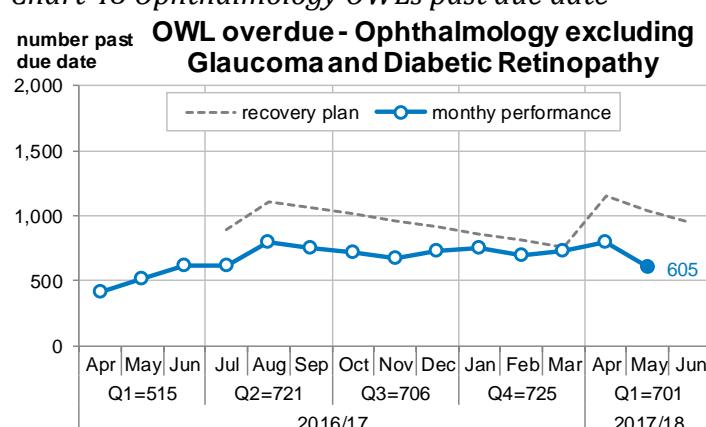
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Outpatient Waiting List (OWL) 20

The Outpatient Waiting List (OWL) is where patients are placed when awaiting a future follow up appointment. When capacity and demand are mismatched, the numbers of patients who are overdue their follow up by a certain date will increase and delay these patients.

There are four specialties within the Trust where this is a current problem. This situation is being monitored by the Quality Assurance Committee (a sub-committee of the Board of Directors). This committee requested that the data should be shared with the Board through the Integrated Performance Report.

Chart 48 Ophthalmology OWLs past due date

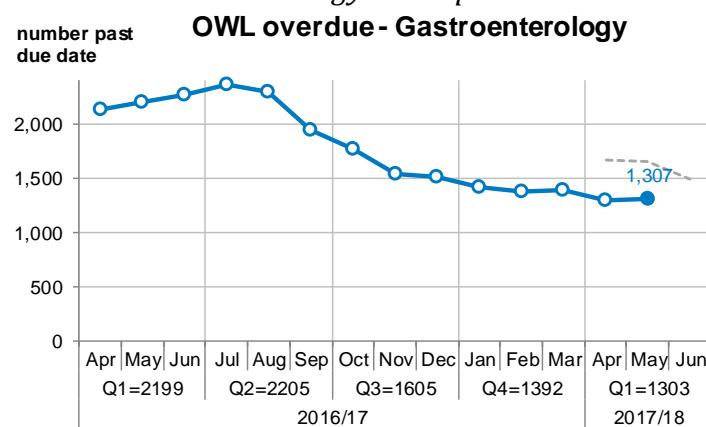


Ophthalmology

The vacant Optometrist post has been appointed to with the successful applicant due to start in September whilst the lead Consultants for Glaucoma have reviewed the Junior doctors templates to increase clinic capacity, meaning that an additional 19 slots per week are being provided from June, rising to 40 in August when the new trainees come into post.

An extensive service review is currently being across Ophthalmology with input from the Trust's Transformation Team and plans are now being taken to support these new initiatives whilst maintaining clinic capacity.

Chart 49 Gastroenterology OWLs past due date

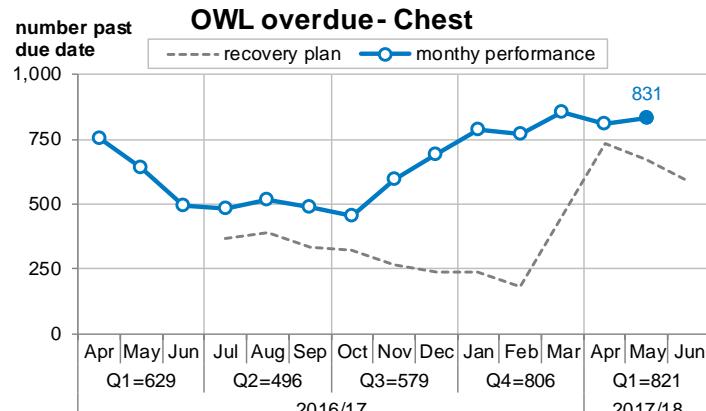


Gastroenterology

Chart 49 shows the number of Gastroenterology patients on the Outpatient waiting list beyond their due date.

The Consultant who was due to leave at the end of June is able to stay in post for longer which will mitigate the expected loss of capacity. Mid July a liver CNS returns from maternity leave (part time) and will start to complete some clinics to support the Hepatology team. Clinical revalidation is to be revisited.

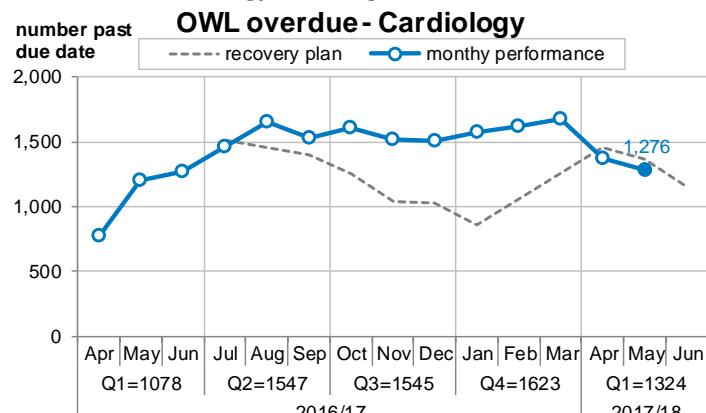
Chart 50 Respiratory Medicine OWLs past due date



Respiratory Medicine

Clinical Validation is ongoing to identify patients who do not need follow up appointments and can be discharged back to GP. Extra capacity is being provided through WLIs. Clinic templates for some consultants have changed to facilitate more follow up slots. Clinically urgent patients are being prioritised.

Chart 51 Cardiology OWLs past due date

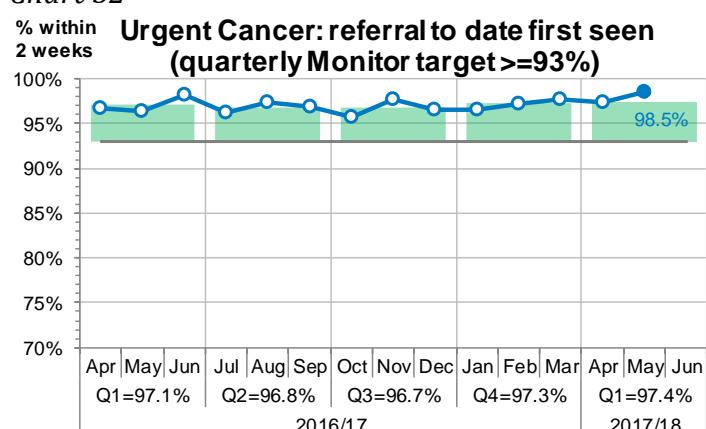


Cardiology

Patients continue to be cohorted based on diagnosis, this is helping to manage capacity and align patients with the correct consultant/ service. One locum is to see follow-up patients only and extra capacity is provided by other consultants through WLIs . Clinical validation is ongoing and patients who do not need follow-up appointments are discharged back to GP.

Cancer waiting times M 16

Chart 52



Compliance with the urgent referral standard continues.

Your Health. Our Priority.

Integrated Performance Report

May 2017

Stockport NHS Foundation Trust

Chart 53

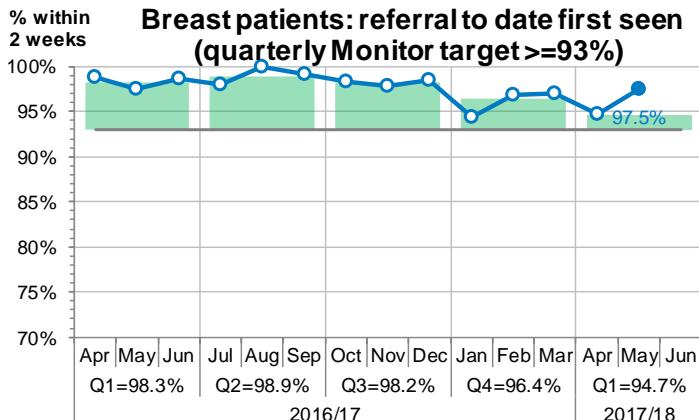


Chart 54

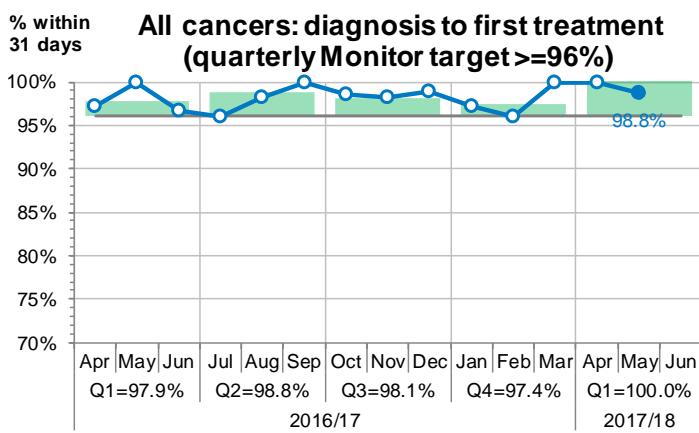
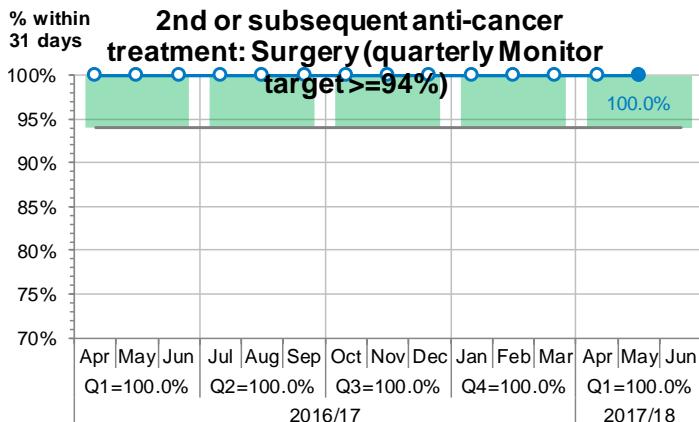


Chart 55



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Chart 56

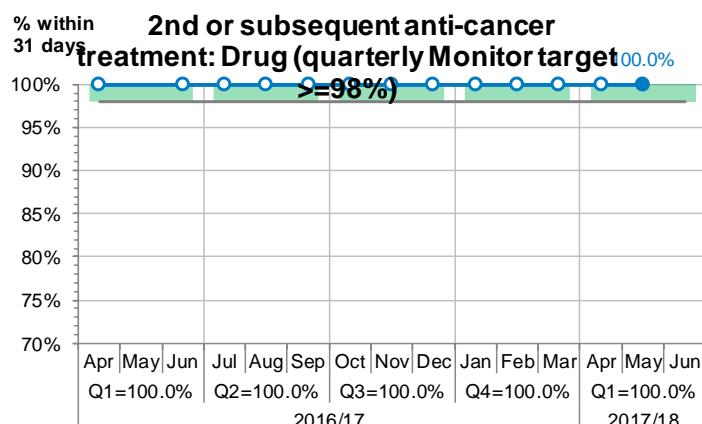


Chart 57

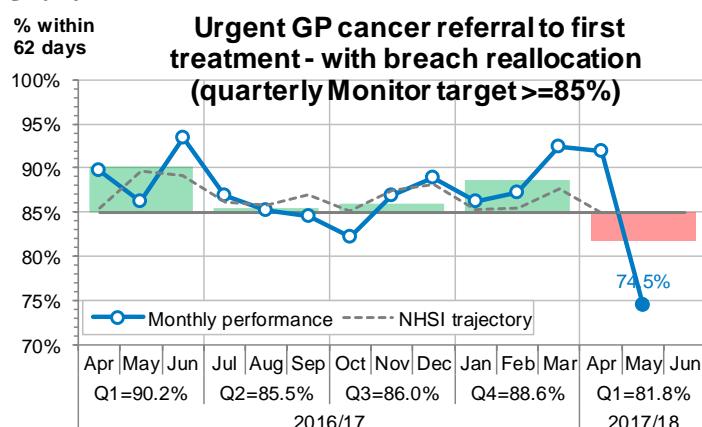


Chart 57 shows performance against the 62 day cancer standard.

Following 2 consecutive months of particularly strong performance, a significant reduction was experienced in May.

A number of factors have contributed to this position:

- A cohort of complex and cross-specialty patients that have required an increased number of diagnostics and interventions
- Patient choice to delay appointments and treatments during the Easter period
- Increased demand. Highest number of 2ww referrals received in March translating into a significantly higher number of patients being seen in the month of March, which in turn increased demand across services.
- Increased wait for 1st appointments and some diagnostic procedures.

There is a focus on minimising waits at each step of the pathway and action plans are in the process of being developed.

Chart 58 GP referral to first treatment with breach reallocation, by tumour group.

Tumour Group (May-17 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Colorectal	3.5 / 7	50%	
Urology	2 / 21.5	91%	
Breast	1.5 / 9	83%	
Gynaecology	1 / 3	67%	
Lung	1 / 2	50%	
Head & Neck	1 / 1.5	33%	
Haematology	0.5 / 3.5	86%	
Upper GI	0.5 / 1.5	67%	

Chart 58 shows performance against the 62 day standard by tumour group.

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Emergency Readmissions

Chart 59

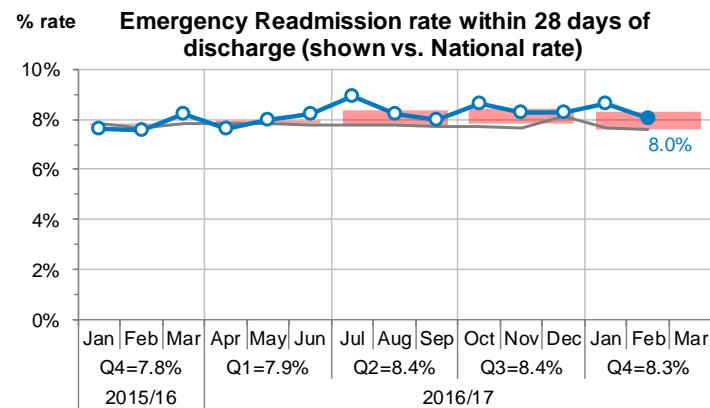


Chart 59 shows the Emergency Readmission rate within 28 days of discharge.

Data source: CHKS / Health and Social Care Information Centre

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Financial Performance M

Chart 60

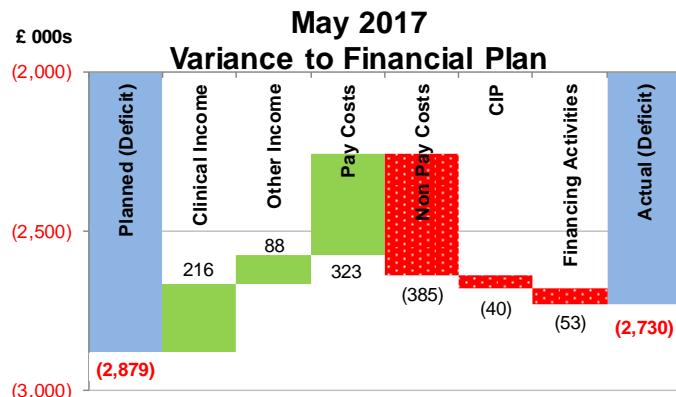


Chart 61

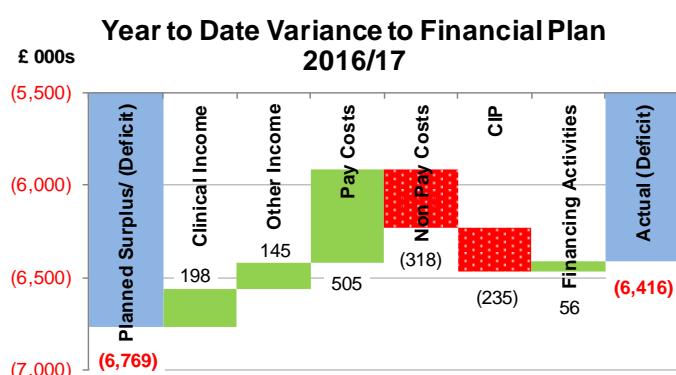
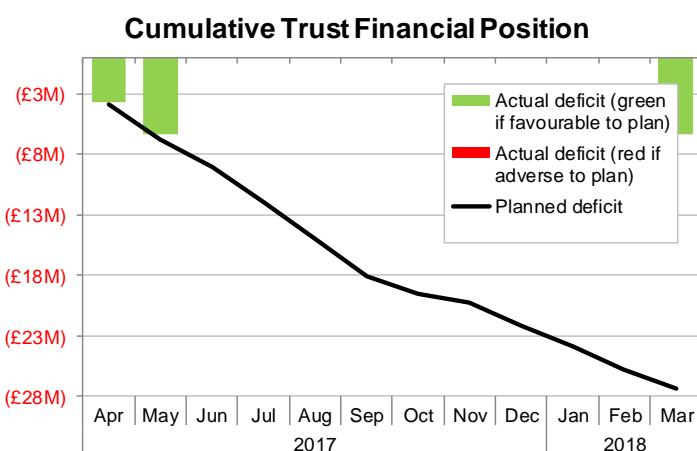
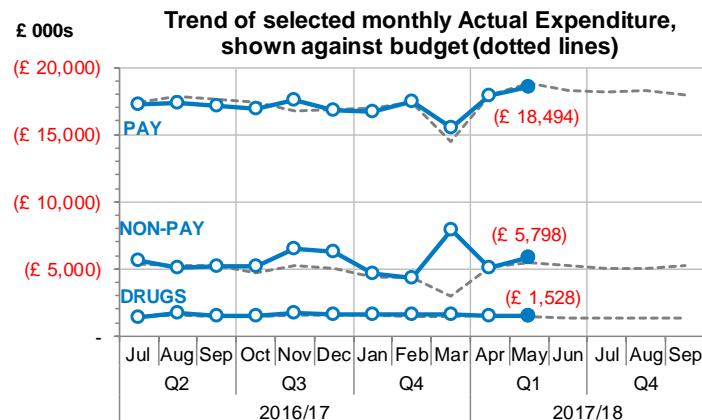


Chart 62



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Chart 63



Pay budgets are underspent to date excluding CIP by £0.5m, as the Trust level of vacancies remains high. Agency costs to date are £2.3m and above the planned agency ceiling, but this is offset by vacancies not covered mainly in the non-clinical areas of the Trust. However non-pay is overspent by £0.3m, which includes £0.2m of out-sourcing costs for surgical specialties, plus £0.2m of outsourced radiology reporting. The areas where outsourcing is used is part of efficiency CIP plans and therefore has a double impact as CIP is not being delivered. In radiology this is linked to shortfalls in recruitment.

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Capital Programme

Chart 64

Description	Plan 2017/18		Month 2 - YTD May 2017/18		
	Year £'000	Plan £'000	Actual £'000	Variance £'000	
Healthier Together Schemes					
ED Resus Expansion	2,400	250	45	205	
Ward Refurbishments	1,200	-	-	-	
Endoscopy Building	250	120	-	120	
Equipment - Critical Care & IT	280	-	-	-	
	4,130	370	45	325	
Internally Funded Schemes					
<i>Equipment</i>					
Endoscopy	250	-	-	-	
Other Diagnostics	1,139	-	92	(92)	
Surgery and Critical Care	848	-	-	-	
Other Medical Equipment	812	18	(5)	23	
Estates and Facilities Equipment	610	30	6	24	
	3,659	48	93	(45)	
<i>Information Management & Technology</i>					
Wireless Network	650	-	33	(33)	
Hardware for Electronic Patient Records (EPR)	380	175	35	140	
Software for EPR - Interfaces & Voice Recognition	590	-	-	-	
Other Hardware	910	324	0	324	
Other Software	120	-	-	-	
	2,650	499	68	431	
Estates					
Backlog Maintenance	335	5	26	(21)	
Non Backlog Maintenance	500	23	321	(298)	
Other Projects	863	20	-	20	
	1,698	48	347	(299)	
Revenue to Capital		-	-	28	(28)
Capital Expenditure Plan (Excluding Finance Leases)	12,137	965	581	384	
Specific Finance Leases					
Acute EPR - Intersystems - Capital repayments	1,422	287	287	(0)	
Community EPR - EMIS- Capital repayments	68	12	12	0	
	1,490	299	299	0	
Capital Expenditure Plan (Including Finance Leases)	13,627	1,264	880	384	
Funded by:					
Depreciation	9,982	1,648	1,428	220	
QCNW & Stockport Pharmaceuticals Surpluses	-	-	26	(26)	
Loan Repayment	(1,551)	-	-	-	
Cash Resources	5,196	(384)	(574)	190	
	13,627	1,264	880	384	

Capital costs of £0.9m have been incurred to date against a plan of £1.3m so is £0.4m behind plan.

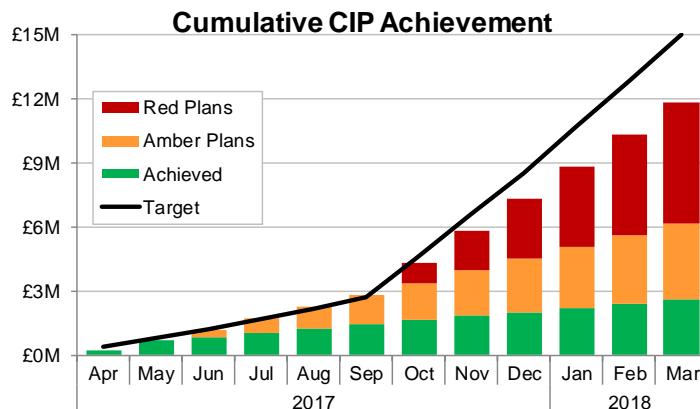
This is due to a delay in commencement in schemes linked to Healthier Together of £0.3m and planned spend for 2017/18 being brought forward at the end of 2016/17.

The full funding of Healthier Together schemes is crucial to the delivery of the capital programme but is reliant on external parties and NHSI.

Cost Improvement Programme 20 M

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Chart 65



CIP is £0.1m behind plan; £0.8m (5%) was expected by this stage in the year when £0.7m (4%) has been transacted. The majority of this is non-recurrent in-month savings for salary sacrifice and vacancy slippage. £2.6m (18%) of the £15.0m annual saving has been achieved, as covered in section 3, but only £0.1m of this is recurrent.

Financial Use of Resources Rating M

Chart 66

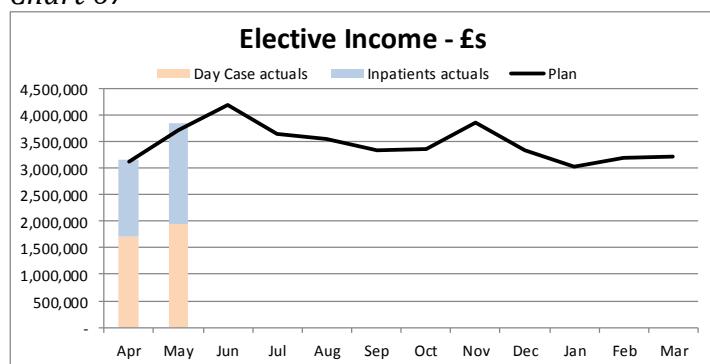
Finance & Use of Resources Metrics	Rating	Trigger Override	Excellent				Poor		Weight	Weighted score
			1	2	3	4				
Financial sustainability	Capital service cover	4	Yes	2.50	1.75	1.25	< 1.25	20%	0.8	
Financial sustainability	Liquidity (days)	1	No	0	-7	-14	< -14	20%	0.2	
Financial efficiency	I&E margin (%)	4	Yes	1.0%	0.0%	-1.0%	<-1.0%	20%	0.8	
Financial controls	Distance from financial plan (%)	1	No	0.0%	-1.0%	-2.0%	<-2.0%	20%	0.2	
Financial controls	Agency spend	2	No	< 0%	0%	25%	50%	20%	0.4	
Finance Use of Resource Metric (UOR) - Calculated										3
OVERRIDE TRIGGERED?										Yes
Finance Use of Resource Metric (UOR) - Final Reportable										3

NHSI have now released the calculation template for the 2017/18 financial year for the Trust's Use of Resources (UOR) score under the Single Oversight Framework. The Trust has scored a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for May 2017 and our actual performance is in line with this.

For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

Elective Income vs. Plan M

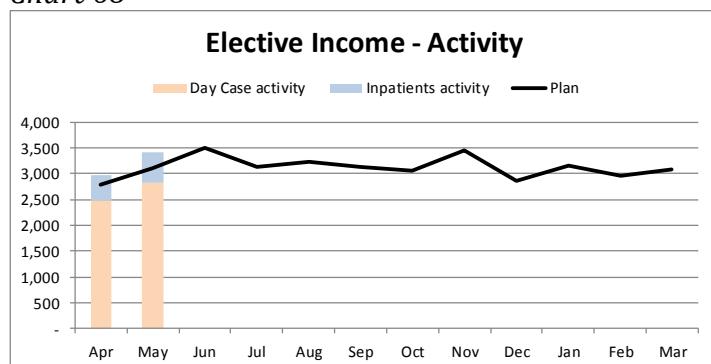
Chart 67



The elective activity plan has been re-profiled for 2017-18 in line with the delivery pattern of actual activity from 2016-17. Inpatient income is currently behind plan by £0.1m, but day case activity is £0.2m favourable. 3% of activity has been delivered at premium rates, but there are significant variances between specialties. In oral surgery 46% of activity is at waiting list initiative rates. Mediscan have undertaken 32 weekend endoscopy lists, and total outsourcing has cost £0.2m across the Surgery business group.

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Chart 68

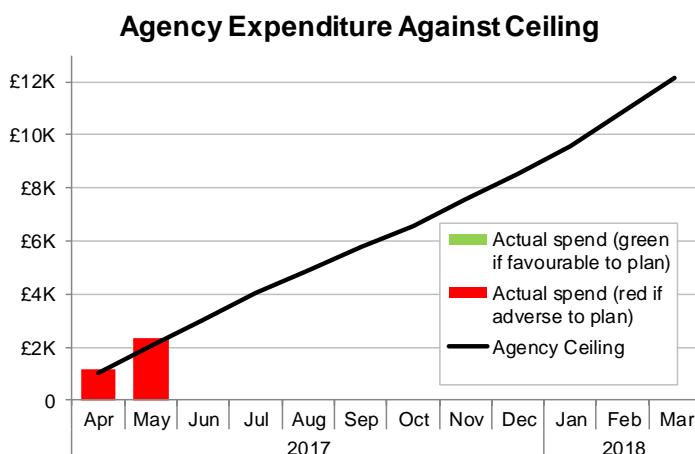


Elective in-patient activity is 89 spells behind plan. Urology is the main specialty adverse to plan to date and is 69 spells below target. Day case activity is 571 spells above plan; endoscopy is the main area above plan and is 259 cases above target to the end of May, plus 168 ophthalmology cases above plan.

Whilst overall income is favourable to date, this is mainly due to additional activity delivered from extra lists over and above the profiled activity requirement, which will be offset in future months when annual leave is forecast to be taken. As the FourEyes programme continues the theatre productivity board continues to monitor improvements in efficiency and drive CIP savings.

Agency Ceiling

Chart 69



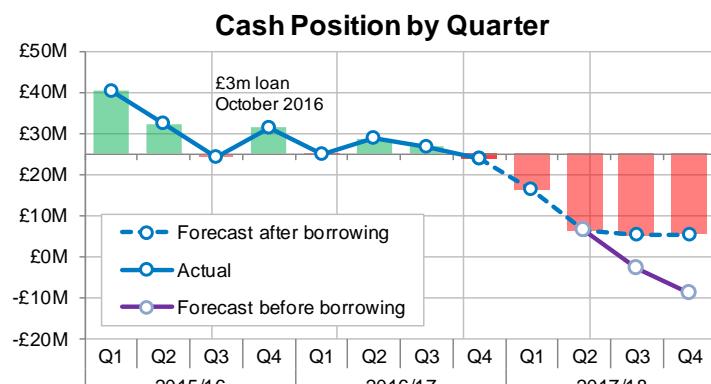
Agency expenditure in May was £1.1m. This is in excess of the profiled NHSI agency ceiling to date.

Agency costs to date are £2.3m, which represents 6% of total pay costs. Bank costs, including NHS Professionals, internal locums and waiting list initiative payments, are a further £2.0m, another 6% of total pay costs. Temporary staffing therefore makes up 12% of overall pay expenditure.

The NHSI template has now been released which tracks agency spend within the Use of Resources (UoR) metric of the Single Oversight Framework. This has confirmed that the Trust is continuing to be monitored against the published £12.1m ceiling, but with a soft target to reduce expenditure by 10%.

Cash

Chart 70

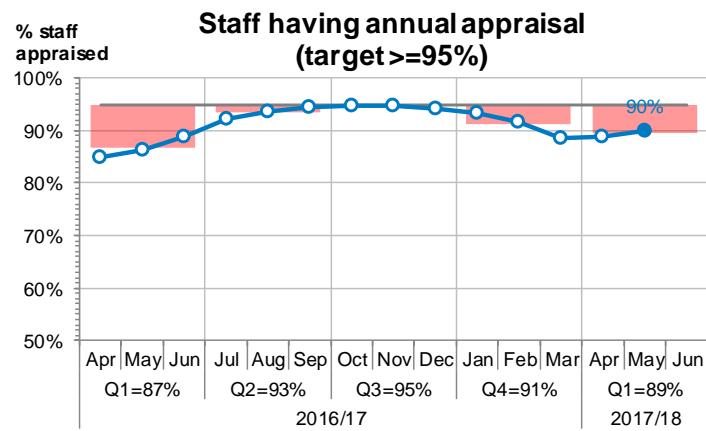


Cash in the bank on 31st May 2017 was £22.3m, which is a decrease of £0.9m from last month but is £4.6m better than planned. This is a continuation of the higher than expected cash balance at the start of the year following on from the end of March 2017, including receipt of Quarter 3 2016/17 STF, settlement of year end commissioner contracts and, lower creditor payments including capital of £1.4m.

Within Q1 the cash position does not drop to the £5m cash floor which would trigger the need for a working capital support facility loan. This is now expected to be required from the autumn, with a total borrowing requirement of over £14m in Q3 and Q4. This is contingent on CIP plans being delivered as forecast and business groups spending in line with or less than agreed budgets. The cash position of the Trust is monitored on a daily basis.

Workforce Appraisals

Chart 71



The Trust's total appraisal compliance for May 2017 is 90.06%, an increase of 1.27% since April 2016 (88.79%).

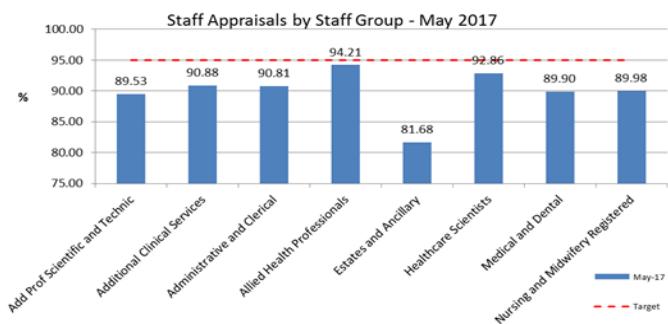
The Head of OD, Learning and Development is conducting an Appraisal audit to quality assure the process and ensure staff have a positive Appraisal experience. The results of this audit will be presented to PPC and appropriate actions implemented.

Chart 72



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Chart 73

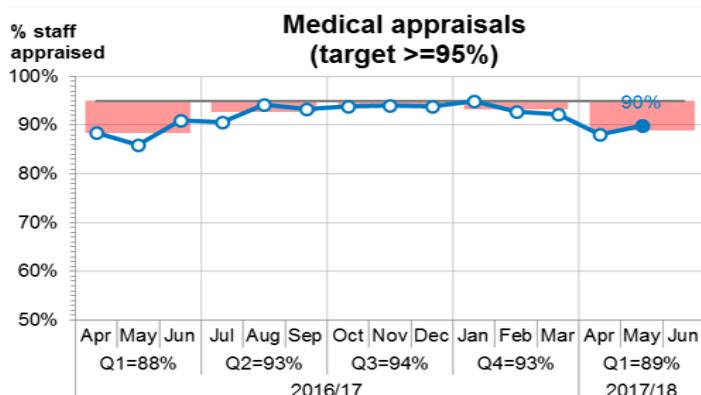


The medical appraisal rate for May 2017 is 90%, an increase of 1.85% from April 2017 (88.05%).

Medical appraisers have now been re-allocated in accordance with the new guidance.

The recent AOA (Annual Organisational Audit) has been submitted; and 8 doctors have been classified in Category 3. This means that they have failed to have an appraisal within 15 months of their previous appraisal, without an approved deferral. This is disappointing, and we are putting in place additional measures to prevent this in the future. The Deputy Medical Director has contacted the doctors concerned, and 4 have already completed their appraisal.

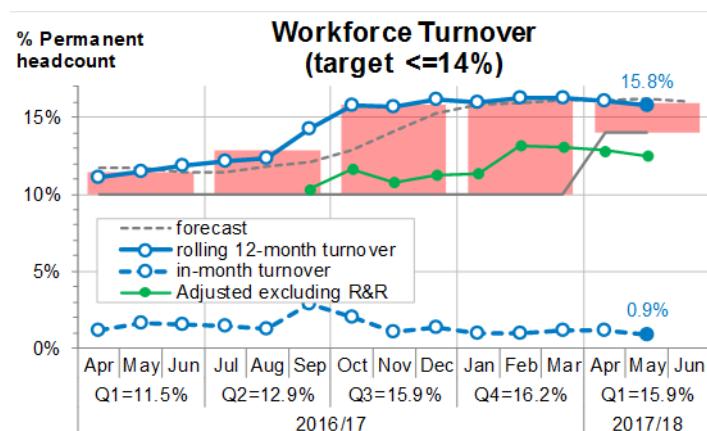
Chart 74



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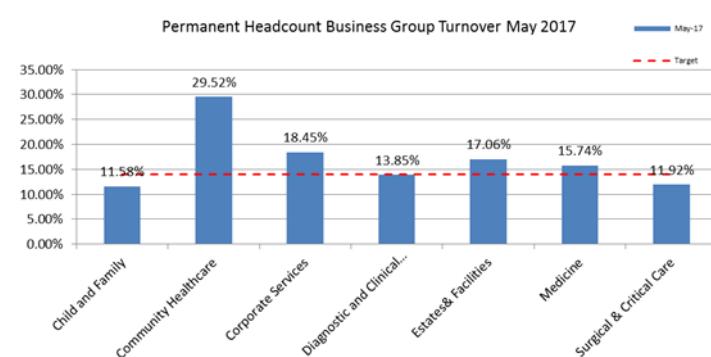
Workforce Turnover

Chart 75



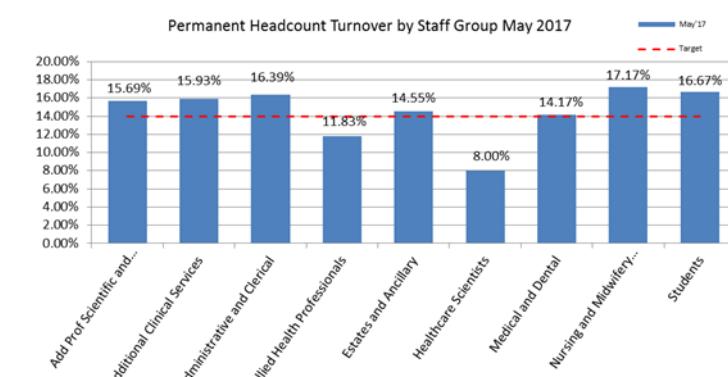
The Trust's adjusted permanent headcount turnover figure for the 12 months ending May 2017, excluding retire and return and TUPE transfers, is 12.50% against a national unadjusted average rate of 14%. This is a decrease of 0.36% compared to the adjusted April figure of 12.86%. The unadjusted permanent headcount turnover figure is 15.78% for the 12 months ending May 2017. The unadjusted turnover rate for comparison to May 2016 was 11.49%.

Chart 76



Community Healthcare has the highest turnover rate at 29.52%, attributed to the TUPE transfer of several services. Corporate Services, Medicine, and Estates & Facilities Business Groups are also above the Trust target of 13.93% in May 2017.

Chart 77



Registered Nursing & Midwifery continue to have the highest turnover. Further details of the staff in post FTE against the budgeted FTE can be found in Chart 81.

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Workforce Efficiency

Chart 79

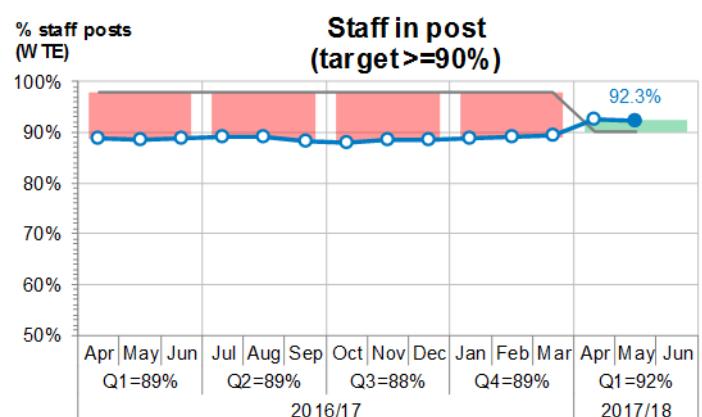


Chart 80

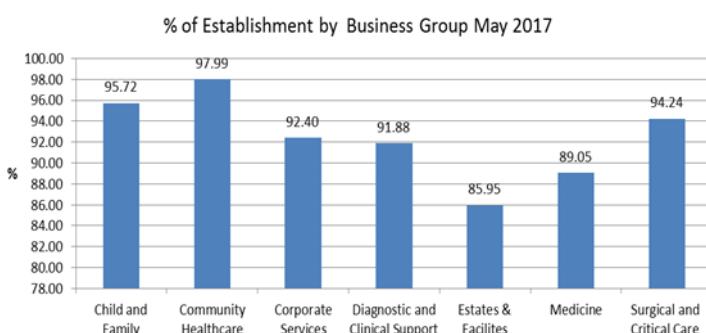
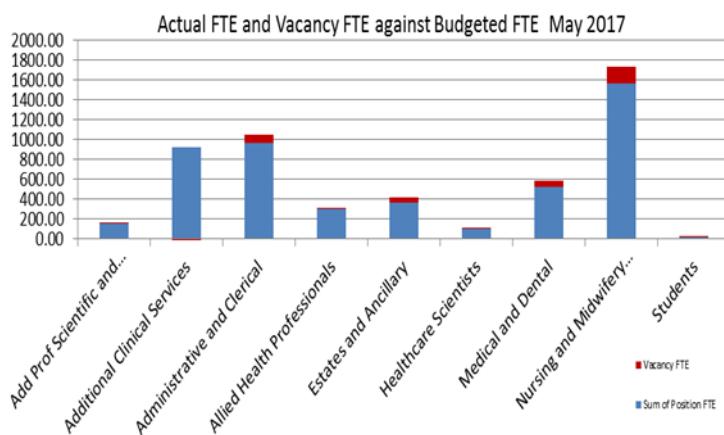


Chart 81



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The Trust staff in post for May 2017 is 92.25% of the establishment, which is a marginal decrease of 0.25% from 92.5% in April 2017.

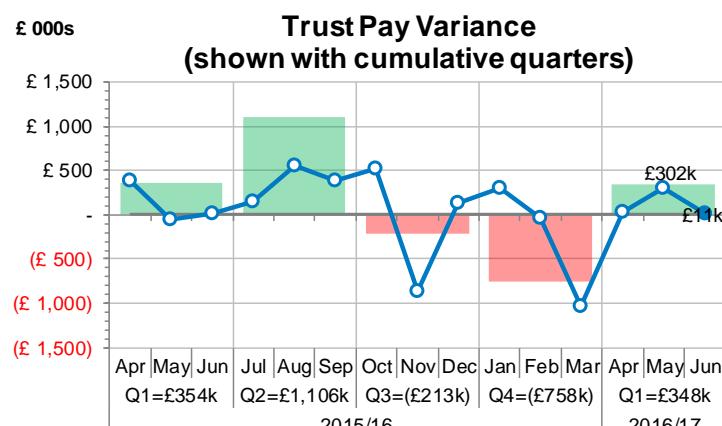
The Trust have amended the target for this metric to be more reflective of the time taken to recruit.

Registered Nursing and Midwifery roles have the highest vacancy rate at 163.21 FTE in May 2017.

Work continues to look to recruit to vacancies from the nursing recruitment campaign supported by ongoing recruitment days.

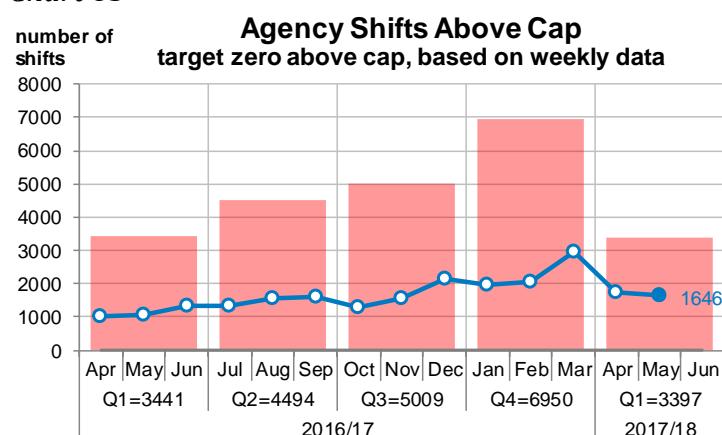
A number of key appointments have been made to our hard to fill medical vacancies via both domestic and international recruitment routes. Timescales for start dates are July-September 2017

Chart 82



Pay is underspent by £0.302m in May 2017.

Chart 83

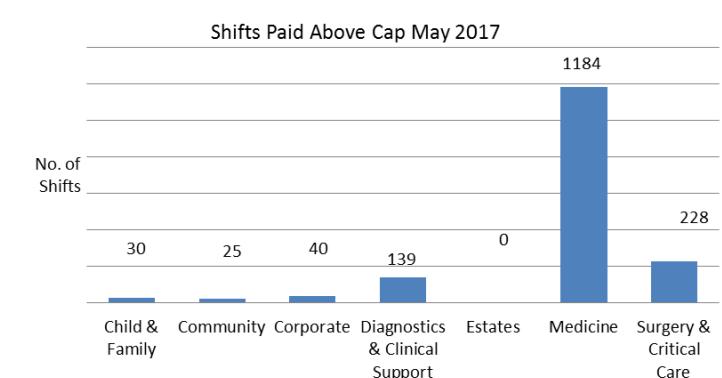


For the period 1st to 28th May 2017, there were 1,646 shifts worked that were above the agency cap. This equates to an average of 411 per week which is a decrease from the average of 438 shifts reported in the previous month.

When compared to the previous month, the number of medical shifts above agency cap has remained at an average of 260 shifts per week. Qualified nursing shifts booked through NHSP have also been unchanged, with an average of 93 shifts per week above cap. The number of unqualified nursing shifts. However, has reduced significantly from a weekly average of 26 shifts in the previous month to 4 per week in the current month.

A small number of agency doctors within Medicine have agreed to join the Trust's internal bank and are expected to have completed their checks by the end of June.

Chart 84



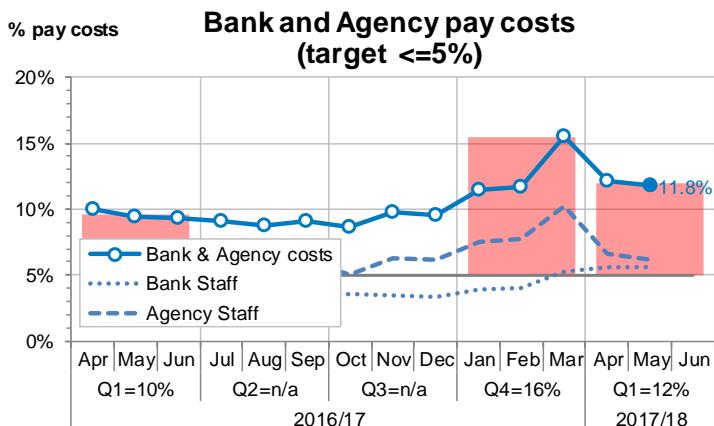
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Integrated Performance Report

May 2017

Stockport NHS Foundation Trust

Chart 85

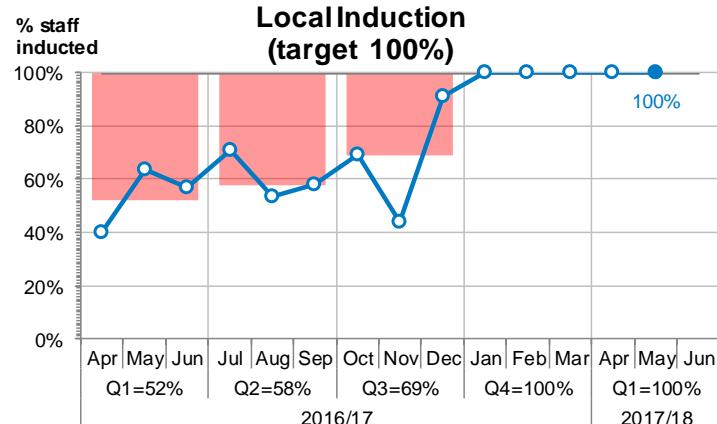


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Workforce Induction

Chart 86



Corporate Welcome attendance is 100% in May 2017.

Evaluations are now being sent to staff who have completed their induction asking for feedback to inform any necessary changes to the programme.

Local induction has remained at 100% in May 2017 with all Business Groups achieving the 100% compliance with the local induction target.

To support the staff experience new starter events are being held quarterly, with the first in April 17, attended by the Chief Executive. All feedback has been captured and reported via PPC.

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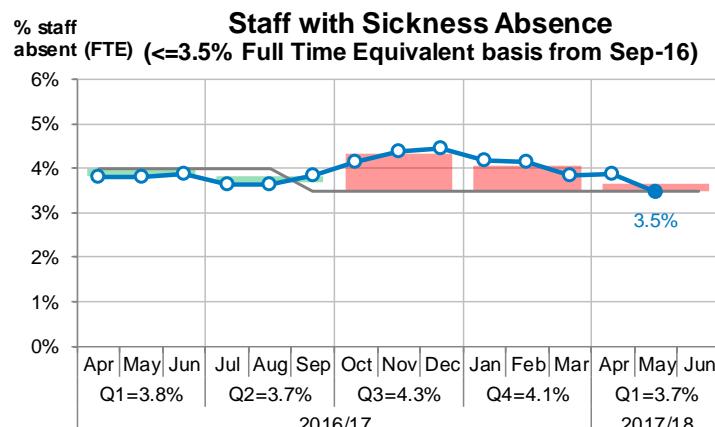
Staff Engagement

To be developed

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Sickness Absence

Chart 87



The in-month unadjusted sickness absence figure for May 2017 is 3.46%. This is a decrease of 0.41% compared to the April 2017 adjusted figure of 3.87%. The sickness rate for comparison in May 2016 was 3.80%.

The unadjusted cost of sickness absence in May 2017 is £408,606, a decrease of £47,582 from the adjusted figure of £47,582 in April 2016. This does not include the cost to cover the sickness absence.

Community Healthcare, Corporate Services and Diagnostic & Clinical Services and Surgical & Critical Care Business Groups are below the 3.5% target in May 2017.

The top 3 known reasons for sickness in May 2017 are back problems and other musculoskeletal problems including injury/fracture at 28.77% (a 1.03% decrease from 29.80% in April 2017), stress at 25.64% (a 2.41% decrease from 28.05% in April 2017), and cough, cold influenza, asthma, chest & respiratory problems at 9.85% (a 1.63% increase from 8.22% in April 2017).

The unadjusted short term sickness for June 2016 to May 2017 is 1.14%, which is a decrease on the adjusted short term sickness from May 2016 to April 2017 of 1.17%.

The long term sickness for June 2016 to May 2017 is 2.80% which is the same as the adjusted long term sickness from May 2016 to April 2017 of 2.80% over a 12-month rolling period.

The 12-month rolling sickness percentage for the period June 2016 to May 2017 is 3.94%.

Chart 88

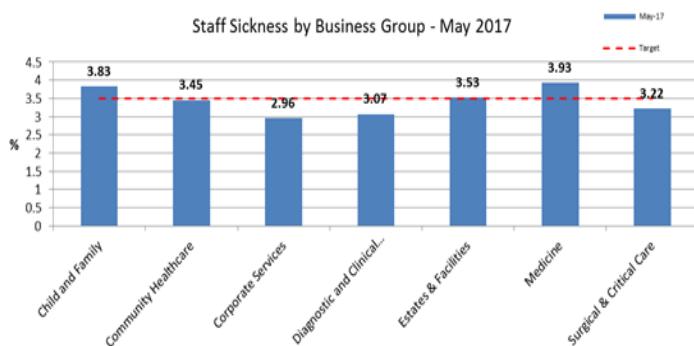
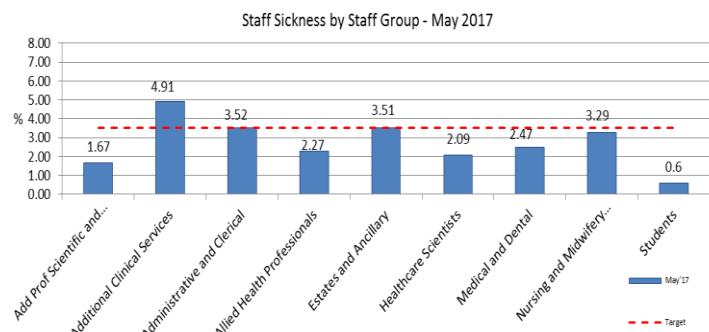


Chart 89

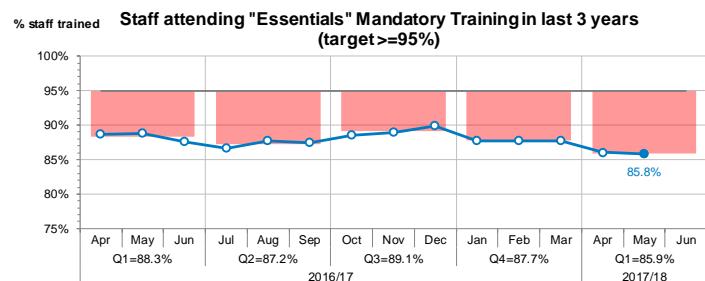


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Essentials Training

Chart 90



In May 2017 compliance is 85%, no change from April 2017.

Learning & Education will continue to provide drop-in sessions and remote telephone support for those who require additional support.

The Training Needs Analysis (TNA) review contributes to a wider e-learning improvement plan to ensure all staff are fully confident in the learning and specific competencies required for their role.

Chart 91

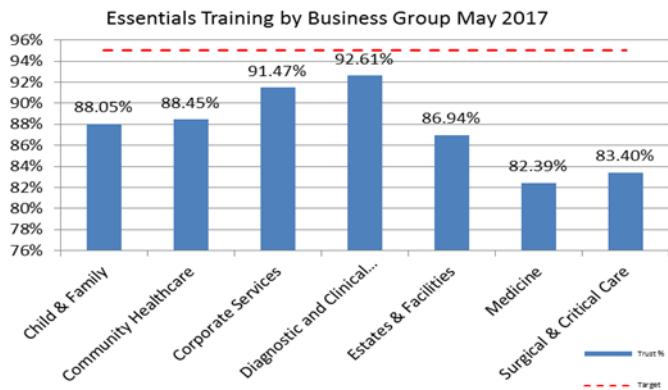
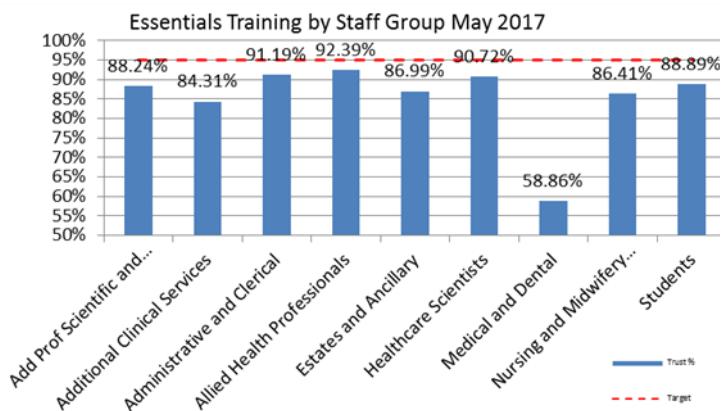


Chart 92



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Integrated Performance Report

May 2017 Financial Table

Stockport NHS Foundation Trust

Income and Expenditure Statement	Trust Annual Plan
	£k
<u>INCOME</u>	
Elective	41,146
Non Elective	80,546
Outpatient	31,557
A&E	13,048
Community Services	26,563
Non-tariff income	54,127
Clinical Income from Patient Care Activities	246,987
Private Patients	55
Other Non-NHS Clinical Income	917
Other Clinical Income	972
Research & Development	486
Education and Training	6,964
Stockport Pharmaceuticals/RQC	5,417
Other income	14,197
Other Income	27,064
TOTAL INCOME	275,023
<u>EXPENDITURE</u>	
Pay Costs	(211,990)
Drugs	(15,741)
Clinical Supplies & services	(21,502)
Other Non Pay Costs	(37,863)
TOTAL COSTS	(287,096)
EBITDA	(12,073)
Depreciation	(9,982)
Interest Receivable	63
Interest Payable	(1,003)
Other Non-Operating Expenses	-
Fixed Asset Impairment Reversal	-
Unwinding of Discount	(30)
Profit/(Loss) on disposal of fixed assets	-
Donations of cash for PPE	-
PDC Dividend	(4,375)
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	(27,400)

Year to Date		
Plan	Actual	Variance
£k	£k	£k
6,767	6,843	76
13,187	13,317	130
4,846	4,953	107
2,165	2,150	(15)
5,043	5,044	0
8,612	8,542	(70)
40,620	40,848	228
9	27	18
153	106	(47)
162	133	(29)
75	73	(2)
1,250	1,282	32
902	940	38
2,868	2,948	79
5,096	5,244	148
45,878	46,224	346
(36,731)	(36,394)	336
(2,976)	(3,053)	(77)
(3,748)	(3,866)	(118)
(6,836)	(7,028)	(192)
(50,291)	(50,341)	(50)
(4,413)	(4,117)	296
(1,488)	(1,427)	61
10	8	(2)
(149)	(149)	(0)
-	-	-
-	-	-
-	(3)	(3)
-	-	-
(729)	(729)	(0)
(6,769)	(6,416)	352

Your Health. Our Priority.

Report to:	Board of Directors	Date: 26 th June 2017
Subject:	Safe Staffing report	
Report of:	Director of Nursing and Midwifery	Prepared by: Deputy Director of Nursing and Midwifery (Acting)

REPORT FOR APPROVAL

Corporate objective ref: -----	Summary of Report The report provides an overview by exception of actual versus planned staffing levels for the month of May 2017.
Board Assurance Framework ref: -----	Key points of note are as follows; Average fill rate for Registered Nurses (RN) is 92.8% on day duty and 94.8% on night duty in month. Average Care Staff rates remains above 100% to support Registered Nurse rates.
CQC Registration Standards ref: -----	The Board is asked to note the contents of this report which highlights seven wards in Medicine with sub optimal RN staffing levels, one ward in Surgery & Critical Care and two departments in Child & Family.
Equality Impact Assessment:	<input type="checkbox"/> Completed <input type="checkbox"/> Not required

This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> FSI Committee <input type="checkbox"/> Workforce & OD Committee <input type="checkbox"/> BaSF Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input checked="" type="checkbox"/> Other
Attachments	 SafeStaffing_May17.xls

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1	INTRODUCTION									
1.1	<p>As part of the ongoing monitoring of nursing and midwifery staffing levels, this paper presents to the Board of Directors a report to show actual staff in place compared to staffing that was planned, for the month of May 2017. Work-streams to support safe staffing continue, with a monthly Safe staffing group chaired by the Director of Nursing and Midwifery.</p> <p>The Board of Directors is asked to note the contents of this report.</p>									
2.	BACKGROUND									
2.1	<p>NHS England is not currently RAG (Red, Amber and Green) rating fill rates. A review of local organisations shows that fill rates of 90% and over are adopted with exception reports provided for those areas falling under this level.</p> <table border="1"> <thead> <tr> <th>May 2017</th> <th>DAY</th> <th>NIGHT</th> </tr> </thead> <tbody> <tr> <td>RN/RM Average Fill Rate</td> <td>92.8% ↑</td> <td>94.8% ↓</td> </tr> <tr> <td>Care Staff Average Fill Rate</td> <td>105.7% ↓</td> <td>123.7% ↑</td> </tr> </tbody> </table> <p>Whenever wards report reduced staffing levels on a shift basis, the ward manager and matron first decide if the shift needs to be filled to retain safe staffing; if it does then existing staff may be moved between wards to equalize numbers and skill mix, and temporary staff (bank and/or agency staff) are requested. Every day the matrons maintain and update staffing records for their wards. Out of hours this is maintained by a nominated ward manager on 'professional cover' and by the senior nurse on 'site cover'.</p>	May 2017	DAY	NIGHT	RN/RM Average Fill Rate	92.8% ↑	94.8% ↓	Care Staff Average Fill Rate	105.7% ↓	123.7% ↑
May 2017	DAY	NIGHT								
RN/RM Average Fill Rate	92.8% ↑	94.8% ↓								
Care Staff Average Fill Rate	105.7% ↓	123.7% ↑								
3.1	<p>Medicine</p> <p>The medicine business group is continuing to experience significant RN staffing issues. They are reporting an 18.35% vacancy rate, 21.30 % factoring in long term sick and maternity leave, which equates to 94 wte.</p> <p>In May 2017, 7 wards reported sub-optimal RN staffing levels. Of these, 3 wards reported between 80% and 90% RN levels, four wards reported between 65% and 79% RN levels. Care staff have been increased to support the wards with day duty levels at 141% of establishment and night duty levels at 163% of establishment.</p>									
3.2	<p>Surgery and Critical Care</p> <p>Surgery and critical care business group's recruitment and retention programme is continuing to show improved rates in many areas. The only ward that is not meeting the 90% rate is Ward M4 which in May reported 73% RN day duty levels (65 % last month). Care staff has been increased to support M4. All other surgery and critical care wards are reporting safe RN staffing levels above 90%. The business group has an overall vacancy rate of 6.9%, including maternity leave and long term sick leave this equates to 13.35%, 47WTE.</p>									
3.3	<p>Community</p> <p>The community unit continues to cover some shifts with agency staff including occasional off framework agency. Band 6 RN vacancies continue to be a pressure within the business group, as recruits need to have specific qualifications to achieve a band 6.</p>									
3.4	<p>Child and Family</p> <p>Neonatal day duty and Treehouse continue to report below 90%. This is due to short term sickness and is being closely monitored by the Business Group. Safe Staffing is maintained by managing acuity and capacity within their networks across Greater Manchester.</p>									

3.5	<p>Recruitment and Retention</p> <p>The open day on the 10th June 2017 and supporting events in the month, including Skype interviews, resulted in 10 RNs being recruited. 40 Care Staff were recruited for the wards and 1 for outpatients. There will be a specific focus on enhancing our student nurse recruitment initiatives over forthcoming months to 'future-proof' our workforce. Our EU recruitment has dramatically reduced (following the UK trend) with a 90% reduction in recruits from the EU in the last 5 months.</p> <p>Of the 12 nurses from India 2 have failed their practical exams and will have to return to India.</p> <p>The two adaptation courses (converting Band 2 Care Staff registered in their country of origin to Band 5) are continuing. One third is failing to attend or complete the required level of self-directed study to attain a pass rate and 4 have now come off the course. Selection processes will be strengthened for cohort 3 and 4 to improve these rates.</p> <p>Local NHS hospitals in the North West are improving their offer to student nurses as regards pre-registration banding at band 4 rather than band 2 and paying their initial NMC and DBS. Costings are now in place and a business case has been presented via the SMG process for consideration.</p>																												
3.6	<p>Care hours per patient day (CHPPD)</p> <p>Of note the care hours per patient day is 7.8 in the month. The care hours calculate the total amount of nursing (Registered and care staff) available during a month divided by the number of patients present on the inpatient areas at midnight. This gives an overall average for the daily care hours per patient day.</p>																												
3.7	<p>Temporary Staffing</p> <p>We continued to book off-framework agency in May 2017 for the medicine business group but in decreasing numbers. The total percentage of temporary staffing on the wards is 4.7%. The overall total which includes all nursing staff areas is 3.6%.</p> <table border="1" data-bbox="287 1365 1378 1747"> <thead> <tr> <th></th><th>MAY 17</th><th>APR 17</th><th>MAR 17</th><th>FEB 17</th><th>JAN 17</th><th>DEC 16</th></tr> </thead> <tbody> <tr> <td>Medicine, ED and Wards Registered Nurse temporary staffing</td><td>17%</td><td>18%</td><td>21%</td><td>18%</td><td>17%</td><td>10.1%</td></tr> <tr> <td>Surgery & Critical Care Registered Nurse temporary staffing</td><td>9%</td><td>8%</td><td>12%</td><td>11%</td><td>12%</td><td>8.0%</td></tr> <tr> <td>ED Registered Nurse temporary staffing</td><td>17%</td><td>19%</td><td>27%</td><td>26%</td><td>23%</td><td>20%</td></tr> </tbody> </table>		MAY 17	APR 17	MAR 17	FEB 17	JAN 17	DEC 16	Medicine, ED and Wards Registered Nurse temporary staffing	17%	18%	21%	18%	17%	10.1%	Surgery & Critical Care Registered Nurse temporary staffing	9%	8%	12%	11%	12%	8.0%	ED Registered Nurse temporary staffing	17%	19%	27%	26%	23%	20%
	MAY 17	APR 17	MAR 17	FEB 17	JAN 17	DEC 16																							
Medicine, ED and Wards Registered Nurse temporary staffing	17%	18%	21%	18%	17%	10.1%																							
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ED Registered Nurse temporary staffing	17%	19%	27%	26%	23%	20%																							
4	<p>RISK & ASSURANCE</p> <p>4.1 Sub-optimal Registered Nurse levels are reported with a continued reliance on bank and agency staff, which has contributed to a day duty overall coverage of above 90% with 8 wards and 2 child and family areas reporting below optimum levels. Daily safety huddles and continuous support by the Heads of Nursing and Matrons, site managers, Senior Nurse Managers and Executives continues to address this.</p>																												
5.	<p>CONCLUSION</p> <p>5.1 There is continued pressure on the Registered Nurse staffing levels across the wards and in particular in Medicine. Every effort is being made to provide sufficient numbers of staff to</p>																												

	support the wards and departments.	
6.	RECOMMENDATIONS	The Board is asked to note the contents of the report

Appendix A – Previous months' staffing fill rates

April 2017	DAY	NIGHT
RN/RM Average Fill Rate	91.9% ↑	95.0% ↔
Care Staff Average Fill Rate	106.0% ↑	117.6% ↓

March 2017	DAY	NIGHT
RN/RM Average Fill Rate	89.0% ↓	95.0% ↓
Care Staff Average Fill Rate	103.0% ↑	118.7% ↑

February 2017	DAY	NIGHT
RN/RM Average Fill Rate	90.80% ↓	96.1% ↔
Care Staff Average Fill Rate	101.7% ↑	116.4% ↓

Jan 2017	DAY	NIGHT
RN/RM Average Fill Rate	91.2% ↓	96.1% ↑
Care Staff Average Fill Rate	100% ↓	117.5% ↑

Dec 2016	DAY	NIGHT
RN/RM Average Fill Rate	93.3% ↓	95.7 % ↓
Care Staff Average Fill Rate	100.5% ↑	110.4% ↓

NOVEMBER 2016	DAY	NIGHT
RN/RM Average Fill Rate	93.4% ↑	97.3% ↑
Care Staff Average Fill Rate	99.3%↓	115.4%↓

OCTOBER 2016	DAY	NIGHT
RN/RM Average Fill Rate	93.0% ↑	95.6% ↑
Care Staff Average Fill Rate	101.3%↓	119.4%↑

SEPTEMBER 2016	DAY	NIGHT
RN/RM Average Fill Rate	92.4% ↑	95.5%↑
Care Staff Average Fill Rate	101.7%↓	116.9%↓

AUGUST 2016	DAY	NIGHT
RN/RM Average Fill Rate	91.9% ↑	95.3%↓
Care Staff Average Fill Rate	103.6%↓	117.2%↓

JULY 2016	DAY	NIGHT
RN/RM Average Fill Rate	90.5% ↓	96.6 % ↑
Care Staff Average Fill Rate	104.9% ↑	117.9% ↑

June 2016	DAY	NIGHT
------------------	-----	-------

RN/RM Average Fill Rate	91.1%↓	95.7 % ↑
Care Staff Average Fill Rate	103.6%↓	114.3%↓

May 2016	DAY	NIGHT
RN/RM Average Fill Rate	91.9% ↑	95.2% ↓
Care Staff Average Fill Rate	106.3% ↓	125.1% ↑

Fill rate indicator return Staffing: Nursing, midwifery and care staff

Org: RWJ - Stockport NHS Foundation Trust

Period: May_2017-18

Please provide the URL to the page on your trust website where your staffing information is available

www.stockport.nhs.uk/112/safe-staffing

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day			Night			Day			Night			Care Hours Per Patient Per Day (CHPPD)					
					Total monthly planned staff hours	Total monthly actual staff hours	Care Staff	Total monthly planned staff hours	Total monthly actual staff hours	Care Staff	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/nurses	Care Staff	Overall	Head of Nursing Comment	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Neonatal Unit	420 - PAEDIATRICS		2325	1950.5	0	0	1627.5	1281	0	0	83.9%	n/a	78.7%	n/a	321	10.1	0.0	10.1		
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Tree House	420 - PAEDIATRICS		2640	2482.5	405	405	1620	1334	0	0	94.0%	100.0%	82.3%	n/a	570	6.7	0.7	7.4		
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Jasmine Ward	502 - GYNAECOLOGY		930	922.5	465	450	620	620	0	0	99.2%	96.8%	100.0%	n/a	207	7.5	2.2	9.6	Staffing levels stable	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Birth Centre	560 - MIDWIFE LED CARE	501 - OBSTETRICS	1860	1785	465	465	1240	1170	310	310	96.0%	100.0%	94.4%	100.0%	72	41.0	10.8	51.8	Acknowledged staffing deficit due to rotation of staff to cover sickness.	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Delivery Suite	501 - OBSTETRICS		2790	2625	465	442.5	1860	1820	310	290	94.1%	95.2%	97.8%	93.5%	318	14.0	2.3	16.3	Staffing deficit due to vacancy factor and ongoing sickness within team.	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Maternity 2	501 - OBSTETRICS	560 - MIDWIFE LED CARE	1627.5	1605	930	930	620	620	310	310	98.6%	100.0%	100.0%	100.0%	624	3.6	2.0	5.6	Staffing levels stable	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4650	4524	775	739	4092	4013	0	0	97.3%	95.4%	98.1%	n/a	335	25.5	2.2	27.7		
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Surgical Unit	100 - GENERAL SURGERY	101 - UROLOGY	2111.5	2081.5	802.5	783.5	891	869	682	688	98.6%	97.6%	97.5%	100.9%	600	4.9	2.5	7.4		
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C6	101 - UROLOGY	100 - GENERAL SURGERY	1395	1389	1395	1419	682	682	792	792	99.6%	101.7%	100.0%	116.1%	623	3.3	3.5	6.9	There has been occasional use of additional Care Staff at night to support dependency and acuity on the ward	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS			1627.5	1479	1395	1420.5	682	682	682	1089	90.9%	101.8%	100.0%	159.7%	686	3.2	3.7	6.8	Additional Care Staff have been used at night to support dependency and acuity on the ward
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS			1395	1371	1162.5	1064.5	682	682	682	693	98.3%	91.6%	100.0%	101.6%	492	4.2	3.6	7.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D4	110 - TRAUMA & ORTHOPAEDICS			942	1048.75	1009.5	972	682	682	495	495	111.3%	96.3%	100.0%	100.0%	407	4.3	3.6	7.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D6	100 - GENERAL SURGERY			1395	1341	1162.5	1156.5	682	693	682	748	96.1%	99.5%	101.6%	109.7%	678	3.0	2.8	5.8	There has been occasional use of additional Care Staff at night due to increased dependency
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS			1567.5	1128	1674	2367	682	660	1023	1672	72.0%	141.4%	96.8%	163.4%	810	2.2	5.0	7.2	There are a significant number of Registered Nurse vacancies some have been recruited to and are awaiting pre-employment checks, other vacancies remain outstanding. Care Staff numbers have been increased to ensure safe numbers of staff are present on the ward. Matrons are ensuring presence on the ward daily and staff are reallocated to support the area as required.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SAU	100 - GENERAL SURGERY	101 - UROLOGY	1627.5	1597.5	1116	1068	868	846	682	693	98.2%	95.7%	97.5%	101.6%	369	6.6	4.8	11.4		
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A1	300 - GENERAL MEDICINE			1395	1312.5	1209	1224	1023	946	682	664	94.1%	101.2%	92.5%	97.4%	810	2.8	2.3	5.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A3	320 - CARDIOLOGY			1423	1400	976.5	961.5	1023	924	682	660	98.4%	98.5%	90.3%	96.8%	729	3.2	2.2	5.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE			1581	1431	1627.5	2040	682	682	2002	90.5%	125.3%	100.0%	293.5%	840	2.5	4.8	7.3	Additional Care Staff to support night time 1:1 care	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A11	300 - GENERAL MEDICINE			1906.5	1694	1441.5	1644	682	694	682	1054	88.9%	114.0%	101.8%	154.5%	845	2.8	3.2	6.0	Additional Care Staff to support night time 1:1 care
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU	300 - GENERAL MEDICINE			4092	3828	3348	3402	3720	3478	3069	3162	93.5%	101.6%	93.5%	103.0%	1308	5.6	5.0	10.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B2	430 - GERIATRIC MEDICINE			1674	1332	837	975	1364	1034	682	759	79.6%	116.5%	75.8%	111.3%	440	5.4	3.9	9.3	Suboptimal Registered Nurse levels, supported by stroke sleep senior nurse and Matron. Never less than 2 Registered Nurses.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	300 - GENERAL MEDICINE			1209	886.5	604.5	798.5	682	682	726	726	73.3%	132.1%	100.0%	106.5%	477	3.3	3.2	6.5	Suboptimal day duty Registered Nurses supported by increased care staff levels. Successful recruitment, awaiting start dates.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE			837	868	837	770.5	682	648	682	825	103.7%	92.1%	95.0%	121.0%	408	3.7	3.9	7.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE		1209	886.5	1069.5	990	682	682	836	836	73.3%	92.6%	100.0%	122.6%	639	2.5	2.9	5.3	Suboptimal day duty Registered Nurses, always 2 Registered staff on duty. Recruitment ongoing.
RWJ09	THE MEADOWS - RWJ88	Bluebell Ward	318 - INTERMEDIATE CARE			1209	1013	2077	1813	682	682	748	748	83.8%	87.3%	100.0%	109.7%	671	2.5	3.8	6.3	Long term and short term sickness impacted on day duty staffing levels. Additional support by Matron to assure safe care.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C2	430 - GERIATRIC MEDICINE			1284	1284	744	928.5	682	682	1001	1001	100.0%	124.8%	100.0%	146.8%	493	4.0	3.9	7.9	Additional care staff to support 1:1 care 24/7
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	300 - GENERAL MEDICINE			1209	961.5	604.5	1066.5	682	682	922	922	79.5%	176.4%	100.0%	135.2%	466	3.5	4.3	7.8	Additional care staff to support suboptimal day duty Registered Nurse levels. Never less than 2 Registered Nurses. Recruitment ongoing.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Coronary Care Unit	320 - CARDIOLOGY			837	837	465	476	682	682	341	374	100.0%	102.4%	100.0%	109.7%	144	10.5	5.9	16.5	
RWJ03	STEPPING HILL HOSPITAL - RWJ09	Clinical Decisions Unit	300 - GENERAL MEDICINE			372	372	372	341	341	341	341	341	100.0%	100.0%	100.0%	100.0%	99	7.2	7.2	14.4	
RWJ09	CHERRY TREE HOSPITAL - RWJ03	Devonshire Centre for Neuro-Rehabilitation	314 - REHABILITATION			1069.5	1015.5	1999.5	1795.5	682	671	1023	95.0%	89.8%	98.4%	150.0%	610	2.8	4.6	7.4		
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE			1951.5	1681.5	2309.5	2197	1023	880	1364	1356.5	86.2%	95.1%	86.0%	99.5%	936	2.7	3.8	6.5	Sub optimal Registered Nurse staffing , never less than 2 Registered Staff. Recruitment ongoing .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE			2278.5	2254.5	1581	2269.5	1023	1012	1023	1606	98.9%	143.5%	98.9%	157.0%	1063				Additional care staff to support patient dependency
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE			2278.5	2263.5	1581	1750	1023	1001	1023	1386	99.3%	110.7%	97.8%	135.5%	1058	3.1	3.0	6.0	Additional care staff to support patient dependency
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Olders People's Unit	430 - GERIATRIC MEDICINE			1162.5	1050	790.5	670.5	682	682	693	90.3%	84.8%	100.0%	101.6%	660	2.6	2.1	4.7	Successful care staff recruitment will support suboptimal care staff day duty numbers from next month .	
		Total				57861.5	53701.25	37696.5	39826.5	35572.5	33739	22567	27918.5	92.8%	105.7%	94.8%	123.7%	19808	4.4	3.4	7.8	

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Report to:	Board of Directors	Date:	26 June 2017
Subject:	Strategic Risk Register		
Report of:	Director of Nursing & Midwifery	Prepared by:	Risk & Claims Team Lead

REPORT FOR APPROVAL

Corporate objective ref:	<p>Summary of Report</p> <p>The strategic risk register reports on distribution of risk across the Trust and presents in greater detail those risks which have an impact upon the stated aims of the Trust.</p> <p>The headlines for this report are:</p> <ul style="list-style-type: none"> • Currently there is one unacceptable risk scoring 25: <ul style="list-style-type: none"> • Risk 1881 - Failure to deliver 4 hour Performance Target within ED • There have been three strategic risks closed or mitigated to a lower risk rating <p>The Board of Directors is asked to note the contents of the risk register</p>
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assessment:	Not required

Attachments:	Strategic Risk Register
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This subject has previously been reported to:	<input checked="" type="checkbox"/> Board of Directors	<input type="checkbox"/> Workforce & OD Committee
	<input type="checkbox"/> Council of Governors	<input type="checkbox"/> BaSF Committee

- | | |
|---|--|
| <input type="checkbox"/> Audit Committee
<input type="checkbox"/> Executive Team
<input type="checkbox"/> Quality Assurance Committee
<input type="checkbox"/> FSI Committee | <input type="checkbox"/> Charitable Funds Committee
<input type="checkbox"/> Nominations Committee
<input type="checkbox"/> Remuneration Committee
<input type="checkbox"/> Joint Negotiating Council
<input type="checkbox"/> Other |
|---|--|

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Trust Wide Risk & Severity Distribution

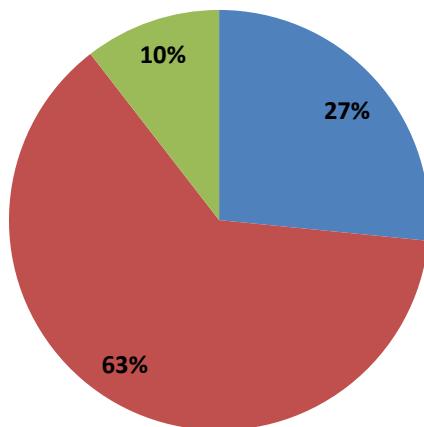
1.1 There are currently 286 live risks recorded on the Trust Risk Register system compared to 296 last month. 13 of these are considered to impact upon the strategy of the Trust.

1.2 Trust wide distribution of corporate risk is shown below.

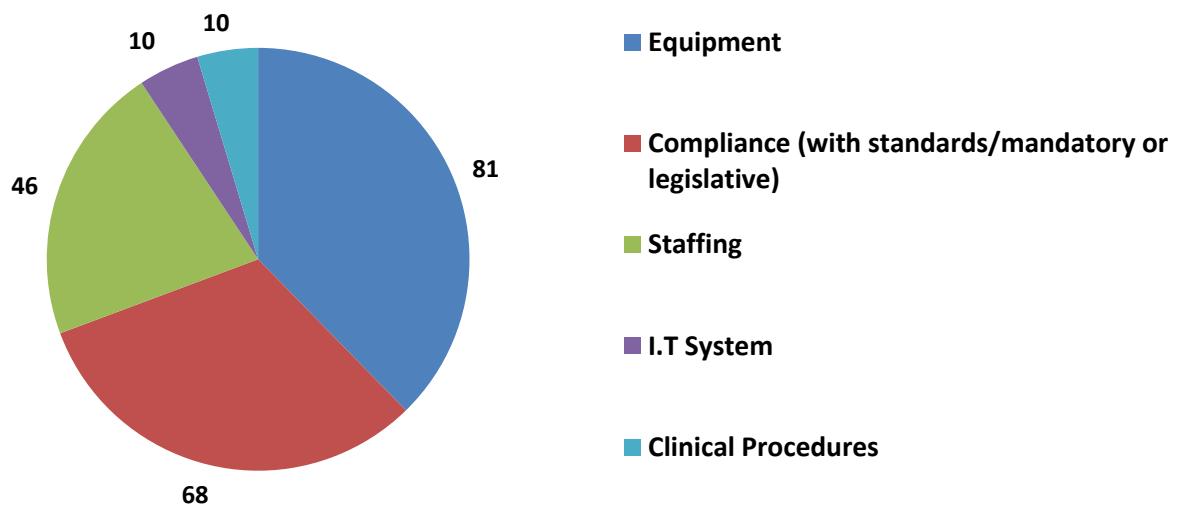
	Low				Significant			High			Very High		Severe	Unacceptable
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
June 2017	1	6	17	52	2	37	31	36	4	70	4	17	8	1

Severity Distribution Trust Wide

■ Low ■ Significant/High ■ V High/Severe/ Unacceptable



1.2 Top Five Sources of Risk across the Trust



2.1 Strategic risk distribution across business groups (These are all the risks 15 and above where the impact is on the strategy of the Trust not just within the service delivered by the business group)

Very High		Severe	Unacceptable	
15	16	20	25	Total
Medicine				
0	0	0	0	0
Child and Family				
0	0	0	0	0
Community Healthcare				
0	0	0	0	0
Surgery and Critical Care				
0	1	1	0	2
Estate and Facilities				
0	0	0	0	0
Corporate Risk (Nursing, Finance, I.T. Executive Team, HR.)				
1	5	3	1	10
Diagnostics and Clinical Support				
0	1	0	0	1
Total Corporate Risks Trust wide (score 15 and above)				
1	7	4	1	13

3.1 Closed Risks & Mitigated Risks

In this month, there have been three strategic risks closed or mitigated to a lower risk rating.

- Risk **2977** – Compliance with RTT 92% Incomplete Monitor Standard.
- Risk **3015** – Year on year reduction of single rooms
- Risk **3003** – RTT Pathway Recording - Compliance

3.2 New Strategic Risks

There are no new strategic risks added this month

3.3 Changes in Risk Rating

All strategic risks are reviewed monthly.

Currently there are 13 strategic risks on the register with a rating of 15 or over, 4 of these have a current risk rating of 20 and so are considered severe:

- **2879** - Use of Temporary Staffing
- **2889** - 7 day working
- **3104** - Non Delivery of the 2017/18 CIP
- **3115** - Upper GI Bleed Service Provision

One risk has a score of 25 which is considered unacceptable:

- **1881** - Failure to deliver 4 hour Performance Target within ED

Key for Committees:
 QAC – Quality Assurance Committee
 WOD – Workforce & Organisational Development Committee
 FS&I – Finance, Strategy & Investment Committee

Strategic Risk Register

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive team	1881	Compliance	23-Jun-2011	Sue Toal	QAC	ST	Failure to deliver 4 hour Performance Target within ED <i>Failure to achieve this target would represent a significant corporate risk to the Foundation Trust both financially and reputation.</i>	Existing internal escalation processes Daily monitoring of staffing rotas in ED and on-call The Health Economy Urgent Care Plan and 4hr Performance Improvement trajectory - weekly meetings with all stakeholders to monitor progress and compliance. Whole health economy collaboration to deliver this target with oversight from NHSI and GM H&SC Partnership National and International recruitment campaign to ensure robust, sustainable medical and nursing staffing model	20	5	5	25	DTOCs - Ownership of longer term issues DTOCs - Clarity of Roles and Responsibilities Clarity of Roles and Responsibilities Junior Doctors Batching of jobs e.g. TTO's RAT Model - 1hr from arrival to consultant (95th Centile) Triage Plus Model - 15 min to Triage (95th Centile)	10	Achieving 95% in the 4 hour Performance Target within ED	Jan 2016 20 ↓ Dec 2016 20 ↓ Feb 2017 25

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Human Resources	2879	Finance	7-Jan-2016	Emma Cain	WOD	JSh	Use of Temporary Staffing <i>Risk to patient care through ongoing or increasing use of temporary staffing</i>	<p>Weekly ECP meetings/Nursing Staffing Meeting/Weekly Agency Usage Review Meetings/ Weekly Temporary Staffing Tracker meetings/ Agency Partnership Programme Board/ Reporting to BoD/F&P & PPC.</p> <p>Agency Partnership Programme Board in place.</p> <p>Completion of the agency diagnostic tool and development of associated action plan.</p> <p>Review of current expenditure in order to ascertain the current position against the NHSI cap rates and the impact of the future sliding scale. Action taken to address those who are outside the agency cap levels to bring the cost within the available cap parameters, whilst continuing to review the rationale for the use of the temporary staff to identify actions to reduce overall need for continued use.</p> <p>Implementation of weekly tracker meetings, development of a centralised Temporary Staffing Team. Daily SITREP meeting. Medicine Business Group to address staffing and agree appropriate arrangements for medical cover.</p>	20	5	4	20	<p>For nursing shifts, the Trust continues to attend Agency Partnership Programme meetings - a collaborative approach in agreeing agency usage and agreed rates.</p> <p>Reduce medical agency usage by inviting agency workers to join our internal bank</p> <p>Currently in discussions with Sth Mcr regarding a collaborative bank scheme for medical locums</p>	12	Reduction in cost and use of Temporary Staffing	 <p>The timeline shows the progression of the risk reduction journey from January 2016 to June 2017. It consists of five red boxes with downward arrows between them, each containing a date and a score. The first box is 'Jan 2016 20'. The second is 'Aug 2016 16'. The third is 'Oct 2016 16'. The fourth is 'April 2017 25'. The fifth is 'June 2017 20'.</p>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Finance	3104	Financial	02-May-2017	Kay Wiss	FS&I	FP	Non Delivery of the 2017/18 CIP	<p>In order to improve decision making and financial control within the Trust, the Trust agreed a new framework for delivery of its Transformation and CIP through the FIP in May 2016. Due to the change in Executive responsibilities, an independent review of the CIP governance and process was commissioning and for the new financial year the Trust has agreed to some amendments and further steps to ensure control and accountability, these included:</p> <p>"Weekly key issues report to the Executive Management Team on the development of ideas and opportunities into CIP projects at pace to deliver the overall target;</p> <p>"The merging of Financial Improvement Group (FIG) A and FIG B, which will now be chaired by the CEO, to ensure Accountable Officers (Executive Directors) and Senior Responsible Officers (Business Group Directors) are held to account for their delivery/change programmes. This new approach will support communications across the Trust to assist in understanding the inter-dependencies between projects and how we can mitigate the impacts and deliver change together;</p> <p>"Ensuring the Transformation Resource is utilised by the Business Groups to help develop major change programmes to enable sustainable clinical change but still ensuring the ownership of the target remains with the SROs;</p> <p>"The Performance Management Framework implemented in April 2017 is used to ensure under performance is escalated and managed. The framework will aim to set expectations in terms of translating divisional plans and objectives into agreed targets and aligning with finance, workforce and operational risks of delivery.</p> <p>"Revised programme and project documentation, which can capture 'cause' and 'effect', including financial and non-financial benefits.</p>	20	5	4	20	<p>Present to Finance and Performance Committee in June</p> <p>The Trust is completing a Financial Recovery Plan at the request of NHSI</p> <p>Identify further actions from Financial Recovery Plan</p>	15	CIP delivery	May 2017 20

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Trust Executive Team	2889	Compliance	13-Jan-2016	Collin Wasson	QAC	CW	7 day working <i>The Keogh Review has recommended 10 standards to support the NHS in improving clinical outcomes and patient experience at weekends. 4 of these standards have been prioritized. Full national delivery is expected by 2020</i>	Participation in rolling national audit facilitating comparison with peers. Bi-monthly presentations to QAC Development of seven day implementation team - SIT (may 2017) meeting monthly	20	4	5	20	All business groups tasked with presenting existing shortfalls to SIT Development of GI bleeder rota Development of radiological intervention service Increase general surgical presence with Healthier together	12	National audit data showing above average compliance with required standards	<div style="background-color: red; color: white; padding: 5px; text-align: center;">Jan 2016 20</div> <div style="text-align: center; margin-top: 10px;"></div> <div style="background-color: red; color: white; padding: 5px; text-align: center;">Jan 2017 20</div>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Surgery & Critical care	3115	Staffing	13-Jun-2017	Fiona Wheelton	QAC	CW	Upper GI Bleed Service Provision (Non-Compliance with NCEPOD Gastrointestinal Haemorrhage (Time to Get Control) published in 2015 and NICE Guidance 141) NICE Clinical Guidance 141 has Quality standards at present the Trust is fully compliant with 2 standards, partially compliant with 3 standards and non-compliant with 4 (claim of breach of duty).	<p>Trust has protocol for Upper GI Bleeding and for Transfusion in Massive haem.</p> <p>Access to Medical Senior Decision Maker for ED (9am-7pm Acute Phy, 7pm-9am Gen Phy)</p> <p>Updated Gastro consultant job plans : Gastro consultant in endoscopy every session of the week bar one (access to experienced endoscopists)</p> <p>Access to Theatres for Unstable patients</p> <p>Endoscopy within 24 hrs can be offered to patients with the exception of those being admitted on Saturdays and on Sundays preceding bank holidays (NICE Standard 3)</p> <p>Currently the agreement 'Out of Hours' if there isn't a gastroenterologist or surgeon available who can carry out the relevant therapeutics, (typically variceal banding), a Sengstaken tube is inserted or where possible the patient is transferred to another Gastro Unit such as MRI or UHSM.</p> <p>The responsibility to co-ordinate the care remains with the admitting team (usually a Consultant Physician) as does relevant resuscitation, but all staff 'on call' in surgery, medicine and critical care have a collective role in ensuring patient is as safe as can be delivered within the available resources.</p>	20	4	5	20	<p>Implement daily consultant endoscopy sessions 7/7</p> <p>Business case to recruit gastroenterologists to a 24/7 'bleeder rota' has been approved.</p> <p>24/7 bleeder rota will be implemented once staff in post.</p>	12	Service to have improved staffing out of hours	New Risk

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Corporate Nursing	2806	Compliance	23-Oct-2015	Head of Risk and Customer Services	QAC	JM	Non Compliance with the Trust Alert & Hazards SOP	Trust process in place to circulate alerts through Risk & Safety Team	16	4	4	16	Introduction of new Datix module to monitor alerts	8	Staff compliance with Alert and Hazard notices SOP	<div style="display: flex; align-items: center; justify-content: space-between;"> Jan 2016 16 ↓ June 2016 16 ↓ Sept 2016 16 ↓ Feb 2017 16 </div>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Corporate Nursing	2969	Falls	9-Jun-2016	Cathy Gibson	QAC	JM	Reduce the number and harm of Major to Catastrophic Patient Falls- 2016–2017 <i>A number of major to catastrophic falls has increased in 2015–2016. Target of avoidable falls was not met.</i>	Hospital falls group meets 6 weekly to review corporate falls data report. Severe and catastrophic falls reported to Trust Incident Review Meeting, reported to commissioners and full root cause investigation undertaken by business groups. Policies and procedures in place regarding falls prevention and management. Initiatives to assist in the management and prevention of falls - low profiling beds, sensor alarms, slipper project etc. Risk and Safety Team review falls incidents and escalate as and when required for investigation. Wards notify Risk & safety team/business group of falls which result in fracture or serious injury. Specialised falls prevention and management training mandatory every three years for nursing and therapy staff. For potential serious falls incidents, falls pro-forma completed by wards and reviewed by Assistant Director of Nursing and escalated to TIRM for full investigation where required. Lead person for falls identified for medicine and surgery, role defined	16	4	4	16	Project plan for falls to be agreed at the Optimising Capacity board Training to be reviewed consider e-learning work with community to devise falls pathway	12	To have less than 19 avoidable falls in a year.	<div style="display: flex; align-items: center; justify-content: space-between;"><div style="flex-grow: 1; text-align: center;"><div style="background-color: red; padding: 5px; border-radius: 5px; display: inline-block;">June 2016 16</div><div style="margin: 0 10px;"></div><div style="background-color: red; padding: 5px; border-radius: 5px; display: inline-block;">Sept 2016 16</div><div style="margin: 0 10px;"></div><div style="background-color: red; padding: 5px; border-radius: 5px; display: inline-block;">Dec 2016 16</div><div style="margin: 0 10px;"></div><div style="background-color: red; padding: 5px; border-radius: 5px; display: inline-block;">Feb 2017 16</div></div></div>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Diagnostic & Clinical Support	2130	Clinical procedures	22-Aug-2012	Sara Wilson	QAC	ST	Insufficient capacity in Endoscopy to meet the current demand resulting in a breach in targets	<p>A business case written in 2014 demonstrated the need for an expanded and updated unit. An options paper was submitted to Exec team in July 16 requesting decision on next steps.</p> <p>The department has referral criteria to support effective and appropriate decision making on whether care is required on an inpatient or outpatient basis. The nurse inpatient coordinator triages and works with referring medical colleagues with the aim of ensuring the correct care is delivered on an IP basis.</p> <p>Referrals are triaged by nurse endoscopists to validate full information receipt and suitability to progress request.</p> <p>Nurse endoscopists and nursing team are working flexibly to cover maximum number of unused lists as possible, including WLIs where required to increase capacity</p> <p>Weekly demand and capacity review meetings match nurse availability with list coverage.</p> <p>Weekend lists are currently not being undertaken due to limited nursing team capacity.</p> <p>Mediscan are commissioned to deliver 10 additional weekend lists a month.</p> <p>When a patient cancellation occurs, the admin team and inpatient coordinator work together to try ensure this capacity is used by an in/outpatient.</p> <p>Targets are closely monitored through regular validation process, with concerns escalated to senior team</p> <p>Endoscopy cancellation procedure has been developed</p> <p>Nursing and nurse endoscopist teams are now being managed and supported in accordance with the attendance management policy.</p>	20	4	4	16	<p>Commencement of a weekly Endoscopy utilisation meeting with involvement from Gastro and Surgery business groups using 6 4 2 methodology.</p> <p>Improve sessional productivity, adding 1 unit to selected endoscopists list in discussion with Endoscopy Lead Clinician</p> <p>Urgent review of acute GI bleed patient pathway and gastro bleed slot rotas.</p> <p>Compile daily start and finish audit of endoscopy lists, to be reported back monthly at endoscopy steering group</p> <p>Undertake endoscopy nurse workforce review to optimise service delivery, to include nurse led consent and nurse led pre assessment.</p> <p>Continue to support estates/procurement in establishing plans for unit expansion.</p>	12	Endoscopy target to be achieved	<pre> graph TD A[Jan 2016 16] --> B[March 2016 20] B --> C[June 2016 20] C --> D[Sept 2016 20] D --> E[Nov 2016 16] E --> F[Jan 2017 16] </pre>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Corporate Nursing	3031	Tissue Viability	8-Nov-2016	Joanne Convey	QAC	JM	Reducing the Incidence of Avoidable Pressure Ulcers	<p>Integrated Tissue Viability Service advises/disseminates evidence based guidelines Trust wide on pressure ulcer prevention and management strategies to support staff in clinical practice.</p> <ul style="list-style-type: none"> - Equipment contract to supply pressure relieving mattresses, cushions and bedframes (Hillrom/Nightingale contract in acute and Ross Care contract in the community) - Static mattress audit within acute hospital. - Monthly nursing indicator audits which includes pressure area care, - Monthly data collection for safety thermometer survey across hospital and community sites. - Safety cross completed on all wards for grade 2 and above hospital acquired pressure sores (incidence) which is reported externally each month via open and honest reporting. - All organisationally acquired category 2 and above ulcers are reported locally as a clinical incident. - All organisational acquired pressure ulcers have a pressure ulcer Proforma completed to identify any lapses in care. - RCA and investigation of all avoidable organisational pressure ulcers meeting the criteria of an SI - TV link nurses with signed R&R on all wards/community teams - Quarterly Risk reports indicating prevalence and numbers of pressure ulcers developing in hospital and on community caseloads. Feedback to contracts monitoring, Community/hospital nursing managers and to the Board. - Pressure Ulcer prevention and management training is mandatory for all clinical staff including, nursing, medical and AHP staff. - Training database maintained of all staff who have attended PU prevention and equipment training who are employed by SFT 	16	4	4	16	<p>Work streams within key areas to be established (1) Critical Care and Surgery (2) Theatres (3) Community (4) Urgent Care (5) Women and Children's (6) Medicine including elderly care and rehab</p> <p>Standardised wound care formulary and promotion of direct purchasing to minimise dressing spend and standardisation of wound care practice</p> <p>React to Red to be disseminated to care homes</p> <p>All organisational avoidable pressure ulcers to be raised as a safeguarding concern</p> <p>Introduce pressure ulcer reporting process that enables determination of avoidable/unavoidable within 48 hours for (1) Acute</p> <p>Quarterly trends/changes in practice report to commissioners.</p> <p>Care homes to commence PU proforma completion DATIX/TV referrals to include photograph of pressure ulcer, DATIX software to be updated and community media systems improved to facilitate this action</p>	12	Reduction in pressure ulcers incidents	<p>Aug 2016 16</p> <p>↓</p> <p>Jan 2017 16</p>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Diagnostics & Clinical Support	1555	Compliance	28-April-2010	Caroline Culverwell	QAC	ST	Failure to meet the 62 day Cancer target standards	<p>Monthly Cancer Board chaired by Trust Lead Cancer Clinician</p> <p>There is an established team of experienced Cancer Trackers and Cancer MDT Coordinators who are tracking all cancer patients to ensure they are treated within 31 and 62 days.</p> <p>Cancer Services Manager monitors performance on a daily basis using the 'Predictor tool'</p> <p>Cancer Access Manager undertakes weekly Tumour specific PTL meetings with Business Manager and Cancer Pathway Tracker.</p> <p>Weekly Trust-wide PTL chaired by the Director of Operations</p> <p>An escalation policy is in place to alert business groups of any issues causing delay to patient pathways</p>	12	4	4	16	<p>Cancer Services Manager to spend more time reviewing PTLs/Predictor as no Cancer Access Manager currently in place.</p> <p>Implementation of pathway improvement plans to support improvement of 62 day performance</p> <p>Replace Cancer Access Manager or provide other support to enable Cancer Services Manager to devote time to service Improvements</p> <p>Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)</p> <p>Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets</p>	8	Compliance with National Standards	<div style="display: flex; align-items: center; justify-content: space-between;"> Jan 2016 12  </div> <div style="display: flex; align-items: center; justify-content: space-between;"> Oct 2016 16  </div> <div style="display: flex; align-items: center; justify-content: space-between;"> Feb 2017 16 </div>

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016/17
Corporate Nursing	3088	Infection Prevention and Control	23-March-2017	Nesta Featherstone	QAC	JM	Upsurge in the IP agenda against decreasing Medical hours and Nursing personnel.	<p>The Health & Social Care Act (H&SCA). Introduced in 2006, it was a requirement for provider registration with regulator, requirement for providers to ensure protection against HCAI, and new code of practice on infections</p> <p>This was updated in 2008, which required registration with the Care Quality commission with a duty to protect patients against HCAIs.</p> <p>This was updated in 2010 and in 2014 and now includes community practices. The H&SCA 2008 and regulations are law and must be complied with</p> <p>Mandatory Surveillance</p> <p>Introduced in 2001 but has expanded exponentially. Since the last job plan was written for the IP doctor role mandatory surveillance has been introduced for MSSA bacteraemias and E coli bacteraemias in 2011; all MRSA bacteraemias have to have a Post Infection Review since 2013; since April 2015 all patients with C difficile who have been in-patients for 72hrs or more have to have a root cause analysis (RCA) carried out (53 patients for 2015/16) and the community -acquired cases (84 patients) have to have a mini RCA carried out. There has also been a requirement to investigate the MSSA bacteraemias more thoroughly (56 in 2015/16) and from April 2017 there is a Quality Premium to reduce E coli bacteraemias by 10% (221 cases in 2016/17) - so there will need to be consideration for each of these will each needing a mini RCA</p> <p>The Care Quality Commission (CQC)</p> <p>As the regulator will judge compliance around 10 compliance criteria's as well as regulation 15. The CQC has enforcement powers that it may use if registered providers do not comply with the law.</p> <p>Infection prevention and control- NICE quality standard 61</p> <p>Healthcare-associated infection NICE quality standard 113</p>	15	3	5	15	<ul style="list-style-type: none"> To develop an action plan following the workshop To review clerical support for the IP service & microbiology as a whole service Pathology manager and IT data analyst to learn each other's collection process to assist in cross working Due to the loss of two consultant microbiologists a new job description and job plan to be reviewed. To review & develop whole IV service 	6	Achieve the IP agenda	April 2017 15

6. RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

LEVEL	DESCRIPTOR	DESCRIPTION
5	Almost certain	Likely to occur on many occasions, a persistent issue - 1 in 10
4	Likely	Will probably occur but is not a persistent issue - 1 in 100
3	Possible	May occur/recur occasionally - 1 in 1000
2	Unlikely	Do not expect it to happen but it is possible - 1 in 10,000
1	Rare	Can't believe that this will ever happen - 1 in 100,000

The risk factor = severity x likelihood

By using the equation, a risk factor can be determined ranging from 1 (low severity and unlikely to happen) to 25 (just waiting to happen with disastrous and widespread consequences). This risk factor can now form a quantitative basis upon which to determine the urgency of any actions.

LIKELIHOOD	CONSEQUENCE				
	1	2	3	4	5
	Low	Minor	Moderate	Major	Catastrophic
5 - Almost Certain	AMBER (significant)	AMBER (high)	RED (very high)	RED (severe)	RED (unacceptable)
4 - Likely	GREEN (low)	AMBER (significant)	AMBER (high)	RED (very high)	RED (severe)
3 - Possible	GREEN (low)	AMBER (significant)	AMBER (high)	AMBER (high)	RED (very high)
2 - Unlikely	GREEN (low)	GREEN (low)	AMBER (significant)	AMBER (significant)	AMBER (high)
1 - Rare	GREEN (low)	GREEN (low)	GREEN (low)	GREEN (low)	AMBER (significant)

QUALITATIVE MEASURE OF CONSEQUENCE

Impact Score	1	2	3	4	5
Domains / Description	NEGLIGIBLE / LOW	MINOR	MODERATE	MAJOR	CATASTROPHIC
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <7 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 7-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Fatality Multiple permanent injuries/irreversible health effects	An event which impacts on a large number of patients Multiple Fatalities
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Inquest / ombudsman negative finding	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice Register concern	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Local Press >1 Potential for public concern	Local media coverage >1 Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. Full Public Inquiry MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims / cost	Small loss Risk of claim remote < £2k	Loss of 0.1–0.25 per cent of Trust budget Claim / cost less than £2- 20k	Loss of 0.25–0.5 per cent of Trust budget Claim(s) / cost between £20k -£1M	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of Trust budget Claim(s) / cost between £1m and £5m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >5 per cent of Trust budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£5 million
Service / business interruption Environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment in more than one critical area	Permanent loss of service or facility Catastrophic impact on environment
Project related	Insignificant impact on planned benefits	Variance on planned benefits <5% and <£50k	Variance on planned benefits >5% or >£50k	Variance on planned benefits >10% or >£500k	Variance on planned benefits >25% or >£1m

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Report to:	Board of Directors	Date:	26 June 2017
Subject:	Board Assurance Framework		
Report of:	Chief Executive	Prepared by:	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	Summary of Report <i>Identify key facts, risks and implications associated with the report content.</i> The purpose of this report is to present the current Board Assurance Framework for consideration and approval by the Board of Directors.
Board Assurance Framework ref:	BAF Risk 2	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Not required	

Attachments:	Annex A – Board Assurance Framework
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This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> FSI Committee	<input type="checkbox"/> Workforce & OD Committee <input type="checkbox"/> BaSF Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input type="checkbox"/> Other
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1. INTRODUCTION

1.1 The purpose of this report is to present the current Board Assurance Framework for consideration and approval by the Board of Directors.

2. BACKGROUND

2.1 Assurance Frameworks vary across organisations and, in some instances, can be lengthy documents that are not always well understood. This can prevent the Framework's effective use for managing the business and its strategic priorities. To be of real value to an organization, the Board Assurance Framework must be clear, concise and tailored to the organisation's needs.

2.2 The format for the Trust's current Board Assurance Framework was designed in partnership with Mersey Internal Audit Agency (MIAA) with scope of content and presentation informed by best practice identified by MIAA. In March 2016, the Board adopted a revised approach based on formal closure of the Board Assurance Framework at year-end and the opening of a new Board Assurance Framework from 1 April for the new financial year. This process was completed by the Board on 30 March 2017 and the document included at Annex A represents the 're-opened Board Assurance Framework for 2017/18.

3. CURRENT SITUATION

3.1 The current Board Assurance Framework, which is included for reference at Annex A of the report, has been reviewed by the relevant risk owners and updated accordingly. Movements in residual risk are summarised as follows:

- Risk 1: Delivery of Trust's Five Year Strategy – 12 to 16
- Risk 2: Strategic Change programmes – 8 to 12
- Risk 5: Cost Improvement delivery – 20 to 25

3.2 With regard to Risk 2, Strategic Change Programmes, Board members will be aware of the complexities of the individual programmes i.e. Stockport Together, Healthier Together, Greater Manchester Health & Social Care Partnership. The degree of 'overlay' of these programmes adds to the complexity and, while the Board will need to maintain oversight of the overall picture, the Board should consider whether the Board Assurance Framework should be expanded to incorporate a specific entry for each programme. This would enable the Board to assess the effectiveness of controls and degree of assurance associated with the individual developments.

4. LEGAL IMPLICATIONS

4.1 There are no legal implications arising out of the subject matter of this report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Consider and approve the content of the current Board Assurance Framework at Annex A.
- Consider the proposal set out at s3.2 of the report.

SO1	To achieve full implementation and delivery of the Trust's Five Year Strategy 2015-20.																																																																																								
Risk 1	Emphasis on day to day operational delivery, in response to environmental pressures, results in lack of focus on strategic change programmes with consequent impairment or failure to deliver the Trust's Five Year Strategy.	Risk Owner: Chief Executive																																																																																							
<p><i>Board Risk Rating</i></p> <table border="1" style="margin-bottom: 10px;"> <tr> <td style="padding: 2px;">Initial</td> <td style="padding: 2px; text-align: center;">3</td> <td style="padding: 2px; text-align: center;">4</td> <td style="padding: 2px; text-align: center;">12</td> </tr> <tr> <td style="padding: 2px;">Current</td> <td style="padding: 2px; text-align: center;">4</td> <td style="padding: 2px; text-align: center;">4</td> <td style="padding: 2px; text-align: center;">16</td> </tr> <tr> <td colspan="4" style="text-align: center; padding: 2px;">L x C = Level</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">Opened Date</td> <td style="width: 90%;">01/04/2017</td> </tr> <tr> <td>Review Date</td> <td>16/06/2017</td> </tr> <tr> <td>Review Date</td> <td></td> </tr> </table>	Initial	3	4	12	Current	4	4	16	L x C = Level				Opened Date	01/04/2017	Review Date	16/06/2017	Review Date		Review Date		Review Date		Review Date		<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">LIKELIHOOD</th> <th style="width: 10%;">Impact / Consequence</th> <th style="width: 10%;">1</th> <th style="width: 10%;">2</th> <th style="width: 10%;">3</th> <th style="width: 10%;">4</th> <th style="width: 10%;">5</th> </tr> </thead> <tbody> <tr> <td>Almost Certain</td> <td>Minor</td> <td style="background-color: #FFFFCC;">5</td> <td style="background-color: #FFCCCC;">10</td> <td style="background-color: #FF9999;">15</td> <td style="background-color: #FFCC99;">20</td> <td style="background-color: #FF6666;">25</td> </tr> <tr> <td>Likely</td> <td>Moderate</td> <td style="background-color: #FFCCCC;">4</td> <td style="background-color: #FF9999;">8</td> <td style="background-color: #FF6666;">12</td> <td style="background-color: #FFCC99;">16</td> <td style="background-color: #FF6666;">20</td> </tr> <tr> <td>Possible</td> <td>Major</td> <td style="background-color: #CCFFCC;">3</td> <td style="background-color: #FFFFCC;">6</td> <td style="background-color: #FFCCCC;">9</td> <td style="background-color: #FFCC99;">12</td> <td style="background-color: #FF6666;">15</td> </tr> <tr> <td>Unlikely</td> <td>Severe</td> <td style="background-color: #CCFFCC;">2</td> <td style="background-color: #FFFFCC;">4</td> <td style="background-color: #FFCCCC;">6</td> <td style="background-color: #FFCC99;">8</td> <td style="background-color: #FF6666;">10</td> </tr> <tr> <td>Rare</td> <td>Catastrophic</td> <td style="background-color: #CCFFCC;">1</td> <td style="background-color: #CCFFCC;">2</td> <td style="background-color: #CCFFCC;">3</td> <td style="background-color: #CCFFCC;">4</td> <td style="background-color: #CCFFCC;">5</td> </tr> <tr> <td colspan="2" style="text-align: left; font-size: small;">Likelihood x Impact = Score</td><td style="font-size: small;">1</td><td style="font-size: small;">2</td><td style="font-size: small;">3</td><td style="font-size: small;">4</td><td style="font-size: small;">5</td></tr> <tr> <td colspan="2" style="text-align: left; font-size: small;">Very Low</td><td style="font-size: small;">Minor</td><td style="font-size: small;">Moderate</td><td style="font-size: small;">Major</td><td style="font-size: small;">Severe</td><td style="font-size: small;">Catastrophic</td></tr> <tr> <td colspan="2" style="text-align: center; font-size: small;">IMPACT / CONSEQUENCE</td><td style="font-size: small;">1</td><td style="font-size: small;">2</td><td style="font-size: small;">3</td><td style="font-size: small;">4</td><td style="font-size: small;">5</td></tr> </tbody> </table>	LIKELIHOOD	Impact / Consequence	1	2	3	4	5	Almost Certain	Minor	5	10	15	20	25	Likely	Moderate	4	8	12	16	20	Possible	Major	3	6	9	12	15	Unlikely	Severe	2	4	6	8	10	Rare	Catastrophic	1	2	3	4	5	Likelihood x Impact = Score		1	2	3	4	5	Very Low		Minor	Moderate	Major	Severe	Catastrophic	IMPACT / CONSEQUENCE		1	2	3	4	5	<p>RISK CONTENT</p> <p>The Board and Executive Team need to spend protected time on ensuring delivery of the Strategy, ensuring congruence with other significant strategic partnerships programmes of Healthier Together, Stockport Together and GM Devolution. The Strategy needs refresh to ensure it is fit for purpose. Business Groups need to be engaged in the identification and implementation of the Strategy.</p> <p>BOARD RISK APPETITE</p> <p>The Trust is not risk averse in this area and accepts that there may be exposure to reputation and staff engagement risks in pursuing service transformation. The communication and engagement of staff and key stakeholders is recognised as essential. However, the Trust remains risk averse to any negative quality, safety or patient experience issues and understands the balance required for financial efficiency. Reduction of 50% of strategic Board discussions would require immediate review. Board Strategy refresh being incomplete by start of Q3 would need escalating.</p>
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<p>CONTROLS</p> <ul style="list-style-type: none"> • Dedicated Board Strategy sessions. • Programme of staff and stakeholder engagement resulting in refreshed Strategy to Board for approval • Realignment of strategic and operational management under the Chief Operating Officer • Assurance reports to the Finance & Performance Committee on financial delivery of the strategic projects. • Assurance reports to the Finance and Performance Committee on operational delivery of the strategic projects. 		<p>BOARD ASSURANCE</p> <ul style="list-style-type: none"> • Regular CEO reports on progress with strategic programmes. • Quarterly review of progress against key organisational objectives. • Start the Year: 11th and 16th May 2017 and rollout for all staff planned. • Active Board engagement and understanding on strategic issues 																																																																																							

GAPS IN CONTROLS		GAPS IN ASSURANCE		
• Lack of Executive capacity to cover external strategy portfolio		<ul style="list-style-type: none"> • Risk that concurrent strategic programmes will impair senior management capacity. • Regular strategy updates are partial as the external environment remains very fluid 		
ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Chief Executive	Board to be given dedicated time for strategic discussion	Board to hold monthly strategy sessions	Ongoing
	Chief Operating Officer	Interim Associate Director Planning and Strategy to arrange programme of engagement with staff and stakeholders to test the strategy refresh and bring a revised draft to the Board of Directors	Further engagement events in progress.	By 31 Aug 17
	Chief Executive	GM Devolution Theme 3 work programme on acute and specialist clinical services is being undertaken across GM and will result in changes to service provision over the next 1-4 years. This will need to be incorporated into the future Trust strategy as details develop. (Healthier Together is the most advanced of the service changes in Theme 3).	Cases for change are being developed for a number of acute services which will then have work streams on option development and co-design by commissioners and providers. Trust is the Lead Transformation Provider for Benign Urology and has the post holder for Clinical Director for Trauma and Orthopaedics	Jun-Sep 17
	Chief Executive	Report to be produced recommending increase in substantive executive capacity	New Theme 3 GM Chair has reset the timetable for all strategic services changes to be agreed within 12 months	Jun 18
	Chief Operating Officer	Alignment of strategy and operational management groups to develop a matrix of linkages across Trust work to ensure clarity of responsibilities and timescales	Report being drafted for consideration	By 30 Jun 17
			Draft prepared for consideration by Executive Team	

SO2	To achieve best outcomes for patients through full and effective participation in local strategic change programmes including; Stockport Together, Healthier Together & Greater Manchester Devolution.																																					
Risk 2	Failure to plan, resource and engage effectively with strategic change programme impairs level of control and influence with a consequent detrimental impact on patient services.					Risk Owner: Chief Executive																																
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<p>CONTROLS</p> <ul style="list-style-type: none"> Dedicated Board Strategy sessions and specific sessions on Stockport Together. Chief Executive and other Executives (especially Finance and HR) participation in Greater Manchester Devolution developments. Chair committed to engaging with partner organisations Chairs Chair attends the Greater Manchester Chairs meeting Chair and Chief Executive members of the Greater Manchester Health and Social Care Partnership Board Chief Executive and Executive Director participation in the Stockport Together programme. Chief Executive, Medical Director and Clinical Lead attendance at South East Sector Healthier Together Planning Committee. Chief Executive is a member of the Procurement for MCP Commissioners and Providers meeting Programme Director for SE Sector Healthier Together implementation with 			<p>BOARD ASSURANCE</p> <ul style="list-style-type: none"> Regular Board reports on progress with strategic programmes. Increased capacity and focus at senior level on Stockport Together programme implemented from April 2016 from Chief Executive and Director of Finance. Director of Support Services member of the Shared Services Programme Board Board approval of GM Devolution governance arrangements. Appointment of interim Director of Provider MCP (all providers) Interim Director of Provider MCP and Director of Adult Social Care attend Board meetings from February 2017 Board involvement and agreements required on all strategic decisions relating to MCP including in scope functions and options for organisational form Council of Governors to be kept informed of all strategic matters relating to the MCP and to be a key partner in decisions on organisational form 																																			

<p>consultancy resource support.</p> <ul style="list-style-type: none"> • Locality plan for Stockport consistent with Trust Strategic Plan and planning assumptions but needs checking on refresh. • The Director of Corporate Affairs is a member of a new Stockport Together (ST) Governance Sub-Group regarding organisational form discussions and other ST governance matters. • Governance arrangements to be established to manage an Alliance contract • Risk and Gain share Stockport Together partnership agreement in principle • Chief Executive and Deputy Chief Executive members of Leaders Group • Director of Finance working closely with partner Directors of Finance • Chief Executive is a member of Greater Manchester Theme 3 Board and Health and Social Care Partnership Executive. 				
GAPS IN CONTROLS	GAPS IN ASSURANCE			
<ul style="list-style-type: none"> • Resource pressure associated with strategic change programmes increased. • Chief Executive and Director of Nursing and Midwifery leaving in December 2017 will create a knowledge loss re the partnership strategic proposals and an experience capacity gap. • New procurement regulation has resulted in the need to revisit some of the MCP procurement processes which has resulted in a “pause” of the process. • Alliance Provider Agreement to be finalised • Procurement process of MCP form to be restarted 	<ul style="list-style-type: none"> • Risk that concurrent strategic programmes will impair senior management capacity. • Until the Theme 3 work programme is completed in the summer of 2018 it is not possible to identify potential risks to service changes in the acute sector. The risk/gain share agreement between GM commissioners and providers is finalised as a principle. Once details emerge the Trust Strategy may require further refresh. • Greater Manchester Theme 3 and 4 focus is intensifying and is challenging Executives capacity to manage all aspects of strategic changes and programmes 			
ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Chief Executive	Board to be given dedicated time for strategic discussion	Board to hold monthly strategy sessions and additional sessions as required	Ongoing
	Chief Executive	Actively involved in working with Stockport Together partners on the procurement and interim arrangements to provide new models of care delivery.	Board to receive regular updates on progress.	Ongoing

	<p>CEO/ Director of Corporate Affairs/Interim Director of MCP Provider</p> <p>Chief Executive/Director of Corporate Affairs/Head of Communications/Medical Director/Director of Nursing and Midwifery</p> <p>Chief Operating Officer</p> <p>Chief Executive</p> <p>Director of Finance</p> <p>Director of Support Services</p>	<p>Completion of New Models of Care Business cases to be considered by Board of Directors and approved by the Board alongside all Providers and the CCG.</p> <p>To participate in the Commissioners public engagement on the new models of care to ensure understanding of the Trust and partners strategic positions</p> <p>Subject to approval of a new organisational form an interim structure needs updating and agreeing to ensure appropriate management capacity with change programmes and operational delivery</p> <p>Member of Theme 3 Board and Lead Provider Benign Urology and Healthier Together Delivery Board.</p> <p>Member of Theme 4 Board and Lead Provider on Procurement</p> <p>Member of Stockport Together Shared Services Board</p>	<p>Business Cases being considered by Board for final approval in June 2017.</p> <p>Engagement to commence in June</p> <p>Consultation with staff undertaken</p> <p>Monthly meetings</p> <p>Monthly meetings</p> <p>Regular meetings</p>	<p>By 30 Jun 17</p> <p>Jun-Jul 17</p> <p>Jun-Jul 17</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
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SO3	To secure full compliance with requirements of the NHS Provider Licence through fit for purpose governance arrangements.																																														
Risk3	Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention.																																														
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					<p>RISK CONTENT</p> <p>Meeting national standards is key to maintaining the provider license. Failure to meet standards may adversely affect patient experience and have a negative impact on the Trust's reputation. There may also be contractual penalties imposed by commissioners.</p> <p>BOARD RISK APPETITE</p> <p>The Board is prepared to take informed risks to resolve performance issues such as a period of planned underperformance against standard in order to resolve patient wait times more quickly.</p>																																										
CONTROLS			BOARD ASSURANCE																																												
<ul style="list-style-type: none"> Executive accountability and capacity enhanced with substantive appointment of Chief Operating Officer Weekly Urgent Care Task & Finish Group implementing and tracking actions Plans for Medicine Bed reconfiguration to enhance flow and ED capacity Daily Breach validation Weekly and Monthly performance dashboards in place. Dedicated daily Operational management focus on patient flow and ED Performance. 			<ul style="list-style-type: none"> Key Issues Reports from Finance & Performance Committee Escalation process to Board via Integrated Performance Report (IPR) Monthly Business Group performance reviews External reports on areas of underperformance, e.g. Cancer or ED through ECIST or other bodies NHSI & NHS England support for medium/long term plans for Stockport Together as sustainable solution. NHSI approval of revised trajectory for 4-hour standard in 2017/18. Urgent Care Action Plan in place to support the delivery of the 4-hour trajectory. 																																												
GAPS IN CONTROLS			GAPS IN ASSURANCE																																												
<ul style="list-style-type: none"> Ability to maintain sustainable levels of DToC. Continuing increases impact on hospital flow during periods of high demand. Emergency Department standard is still reliant on reduced demand which has not yet manifested despite actions taken by commissioners. 			<ul style="list-style-type: none"> Matching capacity and demand within clinical services to best mitigate failure Effectiveness of Stockport Together New Models of Care in supporting long term sustainability against the 4 hour target; to avoid admissions and discharge to assess. 																																												

	<i>Assigned to</i>	<i>Action Detail</i>	<i>Progress to Date</i>	<i>Due Date</i>
ACTION PLAN	Chief Operating Officer, Chief Executive & Director of Finance	Continue to work with the Health and Social Care Economy leaders on the gaps in Urgent Care Provision across the health economy to enable achievement of the ED target	Urgent Care Delivery Board in place with representation from across the Health Economy.	Ongoing
	Chief Operating Officer	Introduction of effective assurance reporting of outcomes from the monthly Performance & Planning meeting to the Quality Assurance Committee.	Action superseded by introduction of monthly Business Group performance reviews which are now fully established.	

SO4	To achieve, and maintain, a minimum 'Good' rating under the Care Quality Commission inspection regime.																									
Risk 4	Inability to maintain and improve compliance with Care Quality Commission standards impairs patient experience, damages Trust reputation and results in regulatory intervention.		Risk Owner: Director of Nursing & Midwifery																							
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CONTROLS <ul style="list-style-type: none"> Monitoring of performance with commissioners Programme of activity forward to Board assurance through visibility and structured clinical activity for senior nursing staff Nursing & Midwifery Dashboard and escalation process for agreed triggers, including action plans for 'turnaround' wards Implementation of Trust Quality Improvement Strategy 		BOARD ASSURANCE <ul style="list-style-type: none"> Key Issues Reports from Quality Assurance Committee Patient stories / complaints / incidents / patient experience quarterly report / High Profile Report – shared widely throughout organisation Quality elements of Integrated Performance Report Annual Quality Report Infection prevention and control reports Independent internal reviews of ongoing compliance CQC inspection results and any resultant action plans Twice yearly nursing and midwifery staffing reviews Outcomes of patient surveys Monitoring of CQC Action Plan 2016 																								
GAPS IN CONTROLS <ul style="list-style-type: none"> Ongoing recruitment issues for some areas of nursing and medical workforce may jeopardise compliance with CQC standards 		GAPS IN ASSURANCE <ul style="list-style-type: none"> Overall rating for the Trust is 'Requires Improvement' 																								

	<i>Assigned to</i>	<i>Action Detail</i>	<i>Progress to Date</i>	<i>Due Date</i>
ACTION PLAN	Director of Nursing & Midwifery	Develop an overall Trust Quality Improvement plan to include all actions from the CQC report, Northwest Deanery action plan and urgent care delivery plan.	Template agreed with NHSI	Draft by end June 2017
	Director of Nursing & Midwifery	Lead on the use of NHSI improvement support monies to develop medical / clinical leadership, quality improvement capacity and capability and Board oversight and scrutiny.	Bid submitted to NHSI	TBC
	Director of Nursing & Midwifery	With changes to the local CQC managers ensure that engagement meetings are in place to enable monitoring of progress and proactive sharing of local issues.	To be arranged	Bi-monthly

SO5	To achieve the level of financial sustainability necessary to ensure provision of good quality services and facilitate delivery of the Trust's Five Year Strategy																																																						
Risk 5	Failure to achieve the required level of cost improvement to deliver the Trust's financial plan with a consequent impact on patient services, increasing the likelihood of regulatory intervention.					Risk Owner: Director of Finance																																																	
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		<p>RISK CONTENT</p> <p>Failure to pay staff and suppliers to continue to provide safe and effective services.</p> <p>Triggering the need for distress financing which would increase the risk of regulatory intervention.</p> <p>Not being able to provide the range of services and failing respective access and contract targets / clauses leading to financial penalties.</p> <p>Not being able to support Strategic Development initiatives including the need to modernise the estate and replace aging medical equipment.</p>																																																					
		<p>BOARD RISK APPETITE</p> <p>Necessity to take risks to deliver the cost improvement and significantly challenging programmes to achieve financial resilience with a willingness to review core services with a view to third party delivery and/or outsourcing of corporate departments.</p>																																																					
CONTROLS <ul style="list-style-type: none"> Detailed financial planning process including activity, workforce and capital planning Revised and updated CIP Governance and Arrangements following independent assurance Agreed Accountable Executive Officers for each CIP Theme Implementation of the Performance Management Framework Business Group Finance and Performance Review Meetings Establishment Control Panel & Staff Absence Panel Detailed financial report to F&P Committee 			BOARD ASSURANCE <ul style="list-style-type: none"> Finance and CIP Performance reports Budget and Plan approval CQUIN update Finance & Performance Committee review of progress reported to Board Financial Improvement Group – monthly monitoring 																																																				

GAPS IN CONTROLS		GAPS IN ASSURANCE		
<ul style="list-style-type: none"> Wider clinical ownership and accountability for programme delivery CQUIN objectives need to be devolved to those charged with delivery Prioritisation of capital investment for Medical Equipment replacement Financial impact of final CQC report. Performance Management Framework 		<ul style="list-style-type: none"> Well defined and realistic efficiency programme for 2017-18 Appropriate targeting and deployment of additional resources to deliver savings and improvements – capacity and capability Potential conflict between Trust plans and those of wider health economy Programme management experience amongst senior managers across the Trust 		
ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Director of Finance	Hold Business Group Directors to account for delivery of their Balanced Scorecard Plans	<p>Performance Meetings Terms of References agreed</p> <p>Performance Management Framework implemented</p> <p>Agreed format of the meeting including reporting of exceptional items</p> <p>Through this process, the Trust has seen demonstrable successes in the appraisal and sickness rates.</p>	On-going
	Director of Finance	Progress application for a working capital facility to aid the external audit process.	<p>Formal communication initiated between the Trust and ITFF for the application of a short-term working capital facility and a medium term loan.</p> <p>Cash Action Group in place and implemented</p> <p>Developed 13 week rolling cash flow to provide early warning to request revolving working capital</p>	Ongoing
	Director of Finance	To develop a financial recovery plan to reduce the overall deficit burden on the Trust and report to the Finance and Performance Committee	Report scheduled to be presented to the Finance & Performance Committee on 21 June 2017.	By 30 Jun 17

	Director of Finance	Agree mitigating actions with Stockport CCG, NHSI and GMH&SCP and ensure all available resources are accounted for in the achievement of the Control Total	Utilise the NHSI Financial Improvement Checklist to ensure all possible actions are undertaken to mitigate any loss of CIP.	Completed
	Acting COO / Director of Finance	Develop a demand and capacity model incorporating growth, impact of CIP/strategic programmes and impact of delivering agreed trajectories.	The Trust has engaged with 4 Eyes (recommended by NHSI and other Trusts) to review the utilisation of Theatres. As part of the project the company have agreed to review the utilisation of outpatients and radiology. Representatives from Finance, BIT and HR are due to undertake site visits where Trust have demand and capacity models with a view to replicating at Stockport	Completed
	Director of Workforce & OD	Preparation of a workforce plan which incorporates current and future vacancies in order to establish workforce requirements over the next 24 months.	A workforce transformation tracker has been developed and was presented to the PPC and a Board Development session in April 2017. The tracker details a baseline against which vacancies and workforce implications enabling an overview of movement and the highlighting of workforce capacity risks.	

SO6	To develop, and maintain, a flexible, motivated and proficient workforce																																																								
Risk 6	Failure to prepare and deliver effective workforce plans supported by continuous professional development impairs the availability of workforce resources with a consequent impact on the delivery of patient services.	Risk Owner: Director of Workforce & Organisational Development																																																							
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<p>CONTROLS</p> <ul style="list-style-type: none"> • Policies and procedures • Performance Appraisal Policy • Mandatory training • Establishment Control Panel • Quarterly Pulse Surveys, including Staff Friends & Family Test • Operational Plan 2017/18 • Leadership plan • Staff focus groups • Business group performance meetings. • Pay Progression Policy • Recruitment and Retention Implementation Plan • Centralised temporary staffing processes • Revised terms of reference for Establishment Control Panel 																																																									
<p>BOARD ASSURANCE</p> <ul style="list-style-type: none"> • People Performance Committee • Business Group assurance reporting • Assurance reporting on attendance, sickness, absence, mandatory training, turnover and medical appraisal & temporary staffing spend • Annual Staff Survey results and Friends & Family results (3 x per year) • Freedom to Speak Up Guardian to commence in post 1 January 2017 • Health & Wellbeing Strategy & Workforce Group • Recruitment & Retention Strategy approved by Board of Directors • OD Strategy approved by Board of Directors • Leadership Strategy approved by Board of Directors • Talent management strategy approved by Board of Directors • NHS England Annual Organisational Audit – Comparator Report 2015/16 																																																									

<ul style="list-style-type: none"> Learning & Development Plan Clinical Skills Development Plan Executive Emergency Resilience Plan 				
GAPS IN CONTROLS		GAPS IN ASSURANCE		
<ul style="list-style-type: none"> Staff Engagement Plan Workforce Plan aligned to capacity and demand modelling. 		•		
ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Head of Organisational Development and Learning	<p>To ensure staff survey results are widely shared and robust action plans are developed in response to the annual staff survey and quarterly pulse surveys.</p> <p>Further information to be sought through focus group engagement.</p>	<p>Results shared. Business group action plans monitored via WEG.</p> <p>National annual survey results shared in line with communications plan</p> <p>Business Groups developed action plans and presented at WEEF in April 2017. Head of OD & Learning presented new model for delivering the corporate action plan.</p> <p>Listening event focus groups held with over 300 staff attending from all disciplines. Focus groups captured the experiences of staff and 'what good would look like'. All feedback has been captured for the corporate plan.</p> <p>A staff engagement group has been formed to take actions forward in a collaborative way.</p> <p>Presentation prepared for June 2017 Team Brief to share feedback from staff and how the plan has been developed.</p>	<p>Ongoing</p> <p>March 2017</p> <p>April 2017</p> <p>May 2017</p> <p>June 2017</p> <p>June 2017</p>
	Director of Workforce and Organisational Development	Workforce KPIs reviewed for 2016/17 and approved by Workforce Organisational Development Committee.	Business group performance monitored in Performance meetings and via monthly HR KPI Performance meetings with the Deputy Director of Workforce.	Ongoing

	Deputy Director of Workforce	<p>Workforce planning cycle to be aligned to business planning and workforce numbers monitored monthly.</p>	<p>Workforce planning update shared with People Performance Committee. HEE workforce planning return submitted and reviewed by PP Committee Sep 16.</p> <p>Business group planning template approved.</p> <p>Refreshed approach to workforce planning continues with the implementation of training and development with Business Groups.</p> <p>Workforce Transformation tracker developed and presented to PPC and Board in April 2017.</p>	Ongoing
	Head of Organisational Development and Leadership	<p>Engagement plan to be developed aligned to the internal communications plan.</p> <p>Listening events held to improve engagement for all areas of culture and establishment of a Staff Engagement Group to see through delivery of all staff survey and culture plans.</p>	<p>Internal communications plan developed</p> <p>Engagement plan to be integrated into the Communications Plan.</p> <p>Listening events held during May and June 2017 and Staff Engagement Group established.</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p>

SO7	To implement and embed an Electronic Patient Record (EPR) system.																																																																																
Risk 7	Failure to ensure efficient management of the EPR project will mean the inability to realise the benefits expected to accrue from implementation of a comprehensive electronic system.	Risk Owner: Director of Support Services																																																																															
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<ul style="list-style-type: none"> EPR programme board chaired by CEO Programme and project governance Policies and procedures Audit programme IG Toolkit 	<ul style="list-style-type: none"> External and internal audit reporting of design and operation of plans External 'gateway' review process prior to key stages of implementation Approval of strategies and plans through Finance & Performance Committee Data integrity assurance – through data quality strategy IGT assurance – through HIS Board Project and programme assurance – through HIS Board & Capital Programme Development Group EPR Governance Assurance Report – Audit Committee 17 May 2016 EPR Trust Board presentation – 23 Feb 17 Monthly Programme Progress Reports to Finance & Performance Committee Quarterly Benefits Update Reports to Finance & Performance Committee 																																																																																
GAPS IN CONTROLS	GAPS IN ASSURANCE																																																																																
<ul style="list-style-type: none"> Gaps in IT systems Difficulty in recruitment of Benefits Analysts 	<ul style="list-style-type: none"> Benefits realisation on large scale IT projects – further work required 																																																																																

	<i>Assigned to</i>	<i>Action Detail</i>	<i>Progress to Date</i>	<i>Due Date</i>
ACTION PLAN	Director of Support Services	<p>Ensure Electronic Patient Record programme has suitable governance process in place</p> <p>Ensure a process for developing benefits realisation is in place linked with the Trust's transformation agenda.</p> <p>Benefits analyst recruitment to the EPR Programme has been unsuccessful. Need to look at alternative methods of recruitment through either different scope or terms and conditions.</p>	<p>Programme Board in place with terms of reference and executive leadership and meetings held on a monthly basis with good attendance. Risk register reviewed monthly and updates received on EPR Benefits Work Stream.</p> <p>Internal Audit have looked at EPR programme governance and report states 'significant assurance' on this.</p> <p>InterSystems (strategic partner) have brought in Channel 3 to work with the EPR programme on benefits realisation process. Presentation on approach endorsed by EPR Programme Board in July 2016.</p> <p>EPR & Transformation Teams continue to work with Channel 3 to develop comprehensive benefits register to support the baseline process to be completed by 30 Sep 17 (planned date for Roll-out 1). The work is supported by the Finance Team. Continual work on identification of benefits and baselining being undertaken by CCIO with support from the EPR team.</p> <p>EPR Programme Lead is reviewing this and talking to other sites. Also looking at recruitment agency support. Work currently being undertaken with the EPR team to enable this work to continue. Benefits realisation programme is underway and has been successful in identifying high level benefits as a starting point. There is no delay in the programme associated with this.</p>	<p>On-going</p> <p>Nov 2016</p> <p>30 Sep 2017</p> <p>31 Aug 2017</p>

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Report to:	Board of Directors	Date:	26 June 2017
Subject:	Governance Declarations		
Report of:	Director of Corporate Affairs	Prepared by:	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	Summary of Report <i>Identify key facts, risks and implications associated with the report content.</i> The purpose of this report is to present draft Governance Declarations for consideration and approval by the Board of Directors.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Not required	

Attachments:	Appendix 1 – Draft Governance Declarations
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This subject has previously been reported to:	<input type="checkbox"/> Board of Directors <input type="checkbox"/> Council of Governors <input type="checkbox"/> Audit Committee <input type="checkbox"/> Executive Team <input type="checkbox"/> Quality Assurance Committee <input type="checkbox"/> F&P Committee	<input type="checkbox"/> PP Committee <input type="checkbox"/> SD Committee <input type="checkbox"/> Charitable Funds Committee <input type="checkbox"/> Nominations Committee <input type="checkbox"/> Remuneration Committee <input type="checkbox"/> Joint Negotiating Council <input type="checkbox"/> Other
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1. INTRODUCTION

- 1.1 The purpose of this report is to present draft Governance Declarations for consideration and approval by the Board of Directors.

2. BACKGROUND

- 2.1 Declarations relating to Provider Licence Condition FT4, 'the Corporate Governance Statement', and Governor Training are required to be self-certified by the Board of Directors by the deadline of 30 June 2017.

- 2.2 Guidance issued by NHS Improvement in late April 2017 advised that, while Boards are still required to complete relevant self-certifications, there is no longer a requirement to automatically submit the declarations to NHS Improvement. Instead, an audit process has been introduced whereby NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified.

3. CURRENT SITUATION

- 3.1 A draft self-certification template is included for consideration by the Board at Appendix 1 to this report. In considering responses to the various elements, the Board should take into account assurances recently provided in relation to the Annual Report & Accounts 2016/17 such as:

- External Audit reports on audit of the 2016/17 Financial Statements and Annual Quality Report
- Director of Internal Audit Opinion 2016/17
- Internal Audit Opinion on the Board Assurance Framework
- Compliance declarations in relation to the NHS Foundation Trust Code of Governance
- Annual Governance Statement 2016/17

- 3.2 Other relevant factors to consider include enhancements to governance arrangements resulting from the Financial Improvement Programme and implementation of a Performance Management Framework. A number of risks to continued compliance are included in the draft template at Appendix 1. The Board should consider whether there are any additional risks to forward compliance that are relevant for inclusion.

4. RECOMMENDATIONS

- 4.1 The Board of Directors is recommended to:

- Consider and approve the draft declarations included at Appendix 1 to the report.

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Self-Certification Template - Condition FT4
Stockport NHS Foundation Trust



Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These Declarations are set out in this template.

How to use this template

- 1) Save this file to your Local Network or Computer.
- 2) Enter responses and information into the yellow data-entry cells as appropriate.
- 3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one		
	Response	Risks and Mitigating actions
1 Corporate Governance Statement		
1 The Board is satisfied that the Licencee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board continues to apply principles and standards of good corporate governance and developments during 2016/17 were informed by outcomes of both a CQC Inspection and participation in the Financial Improvement Programme during the period May-September 2016. Please complete Risks and Mitigating actions
2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board has robust systems in place to assess and to guidance issued by NHS Improvement. Please complete Risks and Mitigating actions
3 The Board is satisfied that the Licencee has established and implemented:		
(a) Effective board and committee structures;	Confirmed	The Board adopts a continuous improvement approach to both Board and Committee arrangements with developments informed by best practice and outcomes of relevant reviews. Committee arrangements were reviewed and revised during 2016/17 as a result of recommendations arising from the Financial Improvement Programme.
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and		
(c) Clear reporting lines and accountabilities throughout its organisation.		
4 The Board is satisfied that the Licencee has established and effectively implements systems and/or processes:		
(a) To ensure compliance with the Licencee's duty to operate efficiently, economically and effectively;	Confirmed	The Board confirms that the Trust meets this requirement in the context of both continued application of an additional licence condition relating to achievement of the 4-hour A&E standard and a Requires Improvement outcome of the CQC inspection in March 2017. The Board has agreed to review its systems and processes to regular review by NHS Improvement with formal monitoring through a monthly Quality Improvement Board involving regulatory and local system stakeholders.
(b) To ensure timely and effective scrutiny and oversight by the Board of the Licencee's operations;		
(c) To ensure compliance with health care standards binding on the Licencee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;		
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licencee's ability to continue as a going concern);		
(e) To have in place systems and processes to ensure accurate, comprehensive, timely and up to date information for Board and Committee decision-making;		
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;		
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and		
(h) To ensure compliance with all applicable legal requirements.		
5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:		
(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	Confirmed	With regard to requirement 5c, the Board notes that the limited assurance report on the Annual Quality Report 2016/17 resulted in a qualified opinion on the Referral to Treatment incomplete mandatory indicator. Whilst improvements during 2016/17 were noted, the remediation work was made on the basis of voluntary self-assessment management process and practice. A mandatory training programme has been implemented to address weaknesses and progress will be monitored by the Audit Committee.
(b) That the Licencee's planning and decision-making processes take timely and appropriate account of quality of care considerations;		
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;		
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;		
(e) That the Licencee, and its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and		
(f) That there is clear accountability for quality of care throughout the Licencee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6 The Board is satisfied that there are systems to ensure that the Licencee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Robust recruitment and selection processes are in place for both Non-Executive Director and Executive Director positions. Risks associated with timely recruitment to the Chief Executive and Director of Nursing positions have been mitigated through scheduling to ensure that appointees are in place by 1 January 2018. Please complete Risks and Mitigating actions
Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors		
Signature	Signature	
Name Adrian Batson	Name Ann Barnes	
Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.		
		Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

- 1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name

Name

Capacity

Capacity

Date

Date

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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