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

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

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**	**2020/21**
Stockport MBC	£0	£0	£6,726	£10,362	£16,518
Stockport CCG	(£2,750)	(£4,067)	£4,384	£3,801	£3,198
Stockport FT	£5,562	£27,400	£24,400	£33,622	£45,764
Pennine Care	0	£1,661	£2,266	£2,871	£3,476
Stockport Together Saving	0	0	(£3,853)	(£14,341)	(£26,484)
GM Themes	0	(£3,000)	(£7,000)	(£12,000)	(£22,000)
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)**

It is important to note that the savings contained within all the Stockport Together business cases have been calculated using **national tariff[1].** 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							**£'000**
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%	-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%**

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 in 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			
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 Stockport[2].

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

[2] Stockport JSNA click here

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.

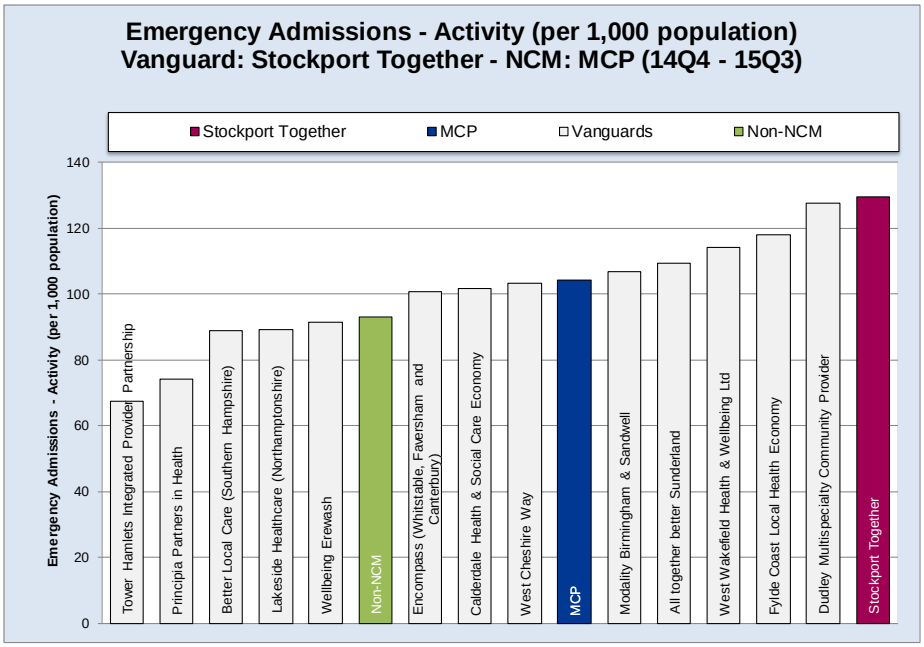
We know that currently 70% of all health & social care spend is driven by people with one or more long-term conditions and 50% of GP appointments and 7 out of 10 hospital beds are utilised by these individuals. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are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

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 Board[4] (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

- 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).

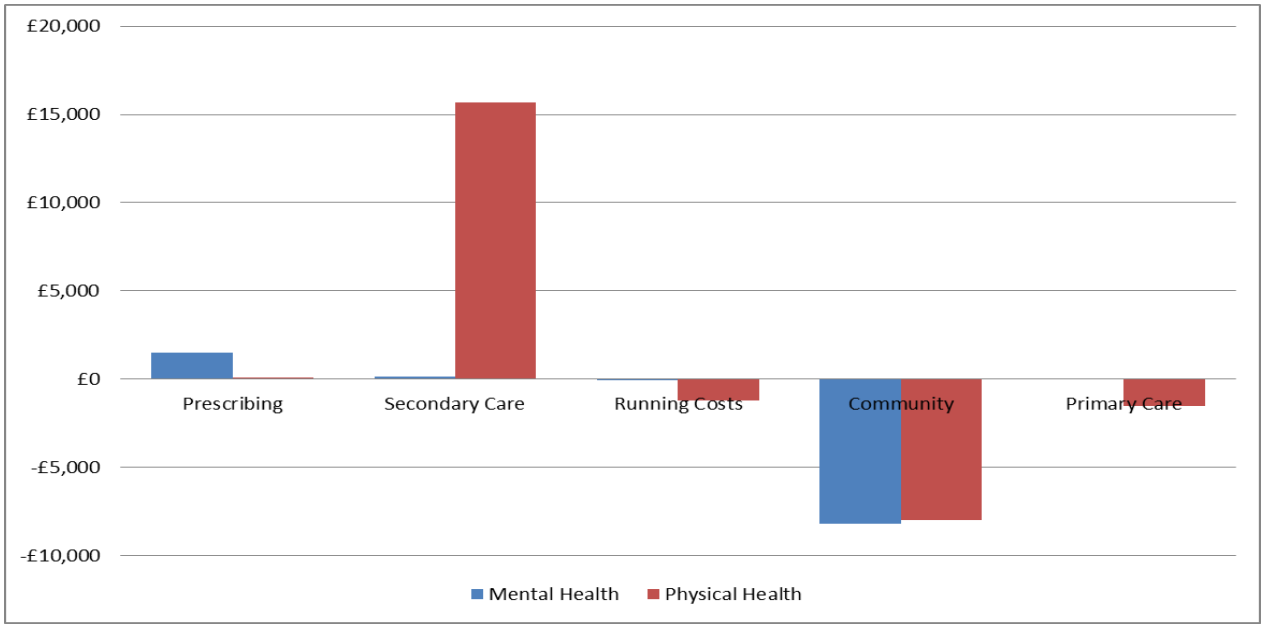
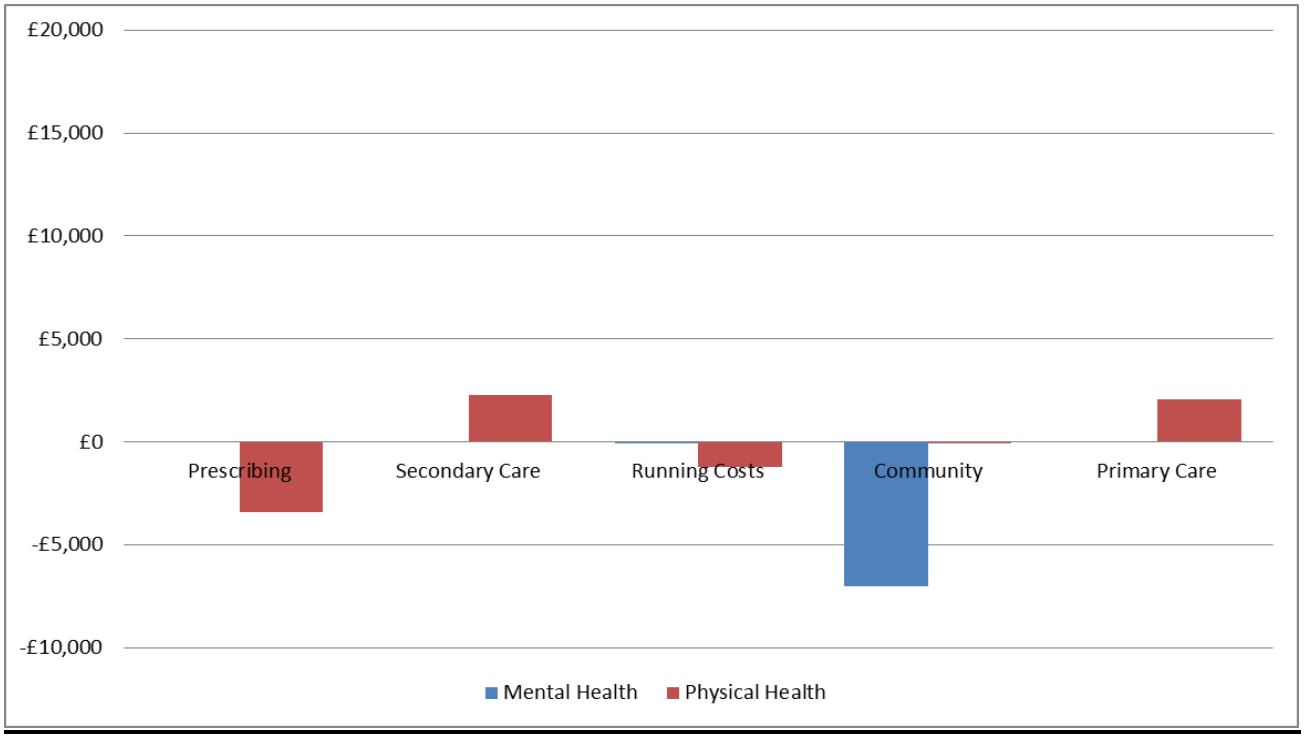


Table 15: Programme Budget Analysis for NHS Stockport CCG – Expected expenditure variance to national average after Investment and Activity Reductions (scale is £000).



* 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 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

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

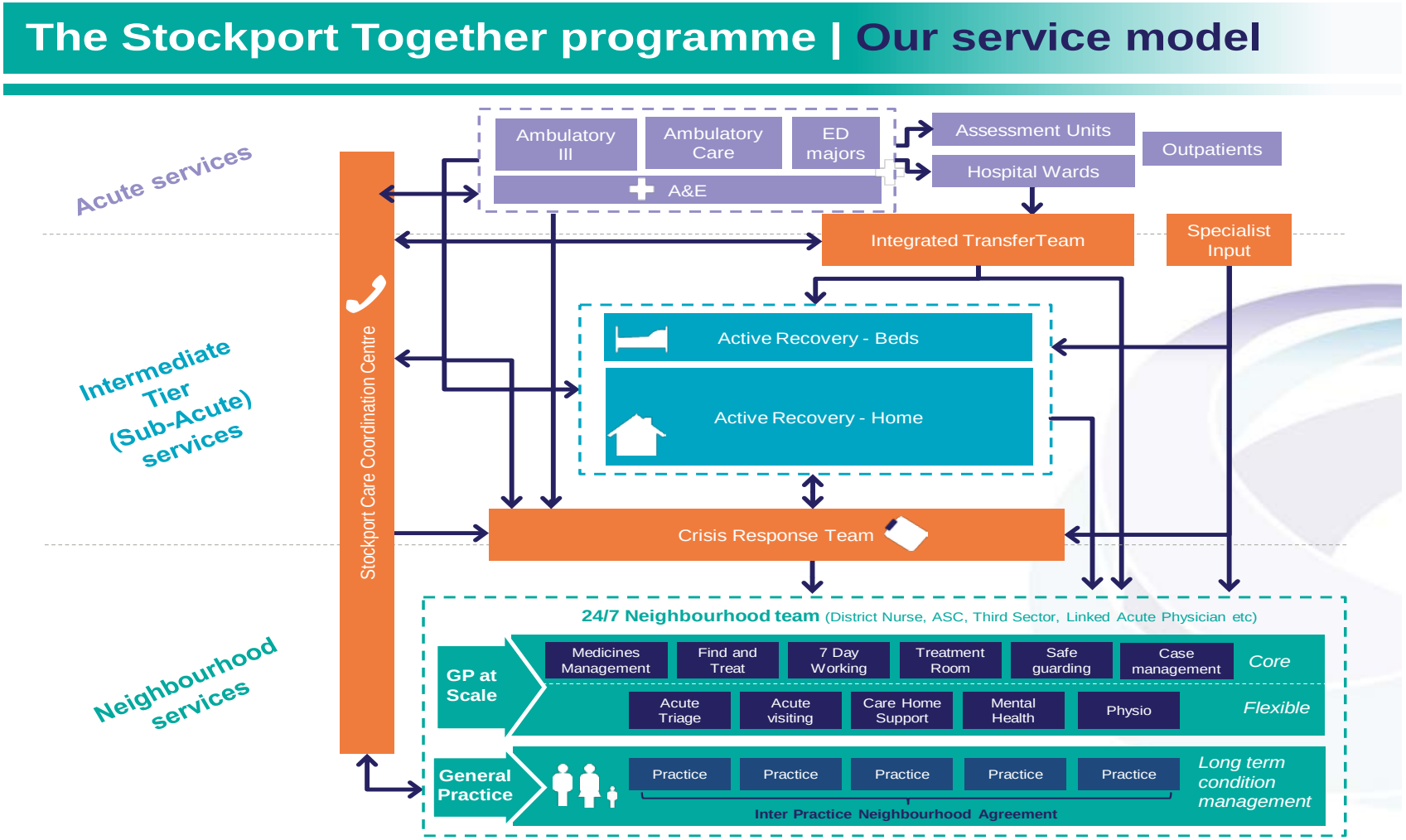
The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with a commissioned programme of support 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 with 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 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 Car**e: 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 Higgins[5]. 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

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 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 tariff[6].** 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

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**	**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)**

- 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						
	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)**

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)**

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				
	£'000			
POD	**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:

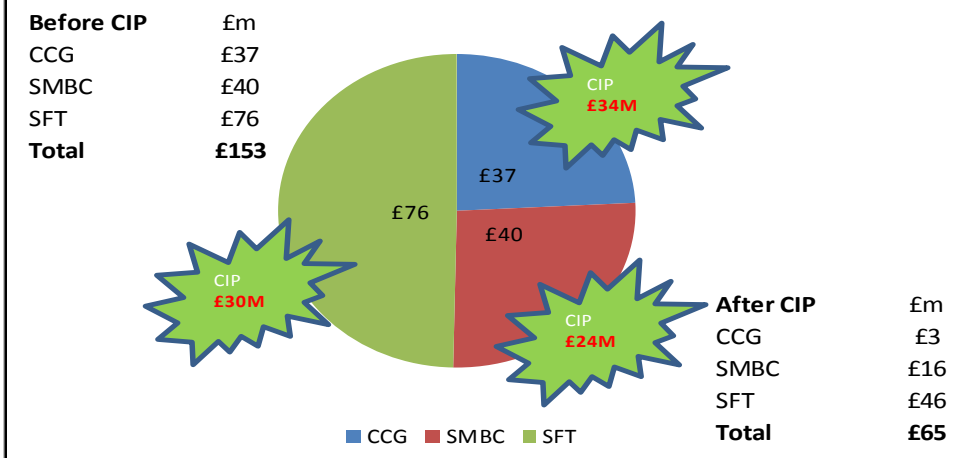
- Stockport CCG: 33.3%
- Stockport MBC: 33.3%
- Stockport Providers: 33.3%

The Risk/ Gain share Process

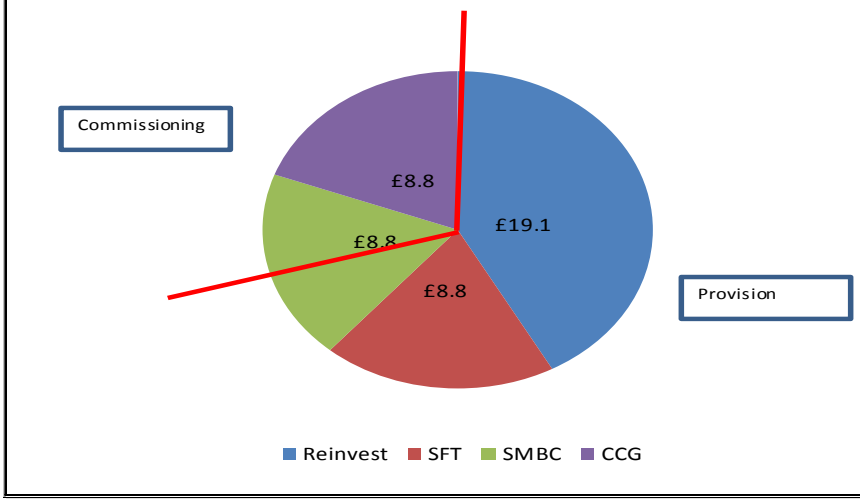
The practical operation of the proposed risk and gain share process is set out visually below:

Stockport - Risk / Gain Share Agreement

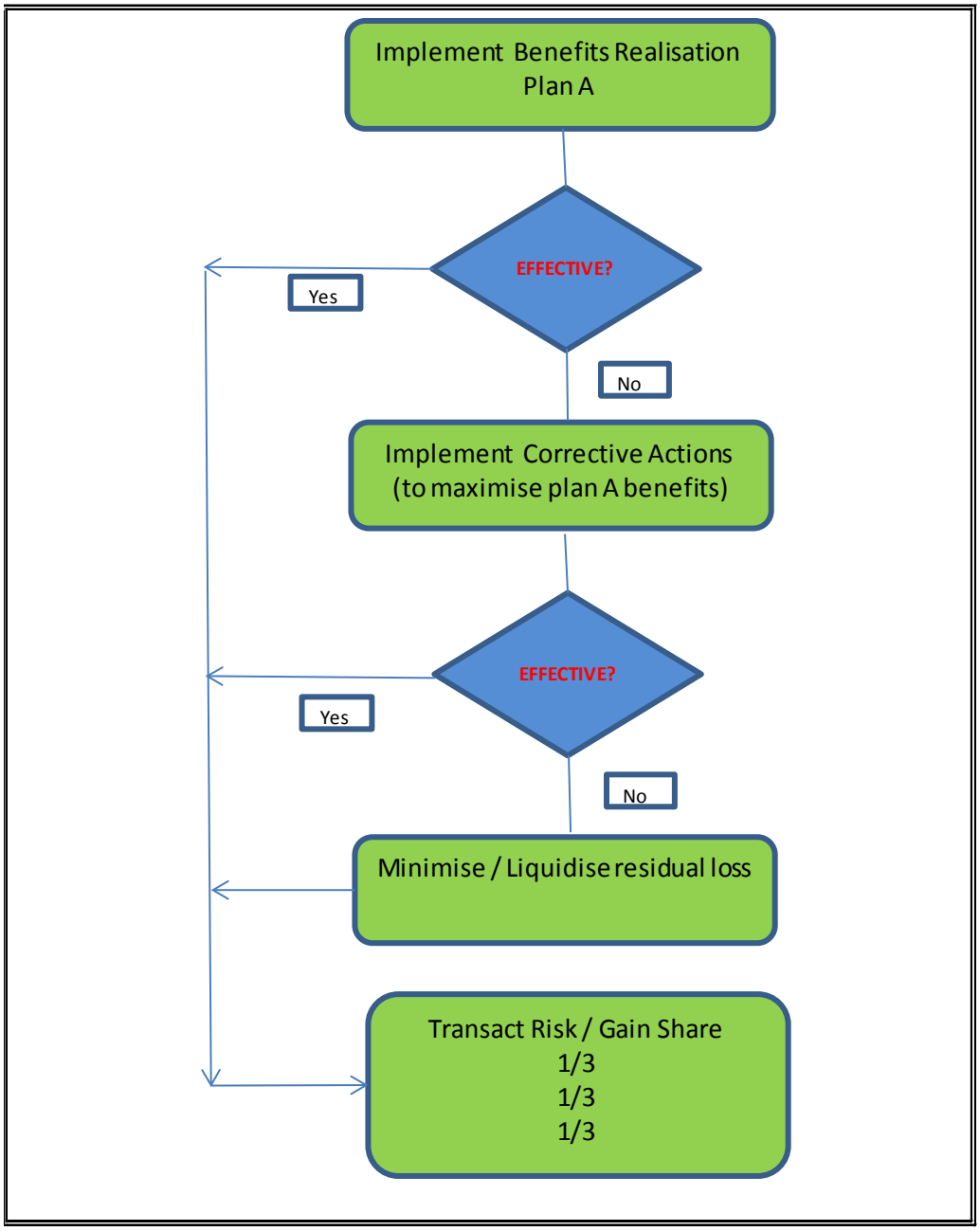
(1) Each Organisation owns its own risk on the key elements of both "Do Nothing" and impact of individual CIP



(2) The £45m Stockport Together Benfits 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	• 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	• 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

					• 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	• 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	• 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

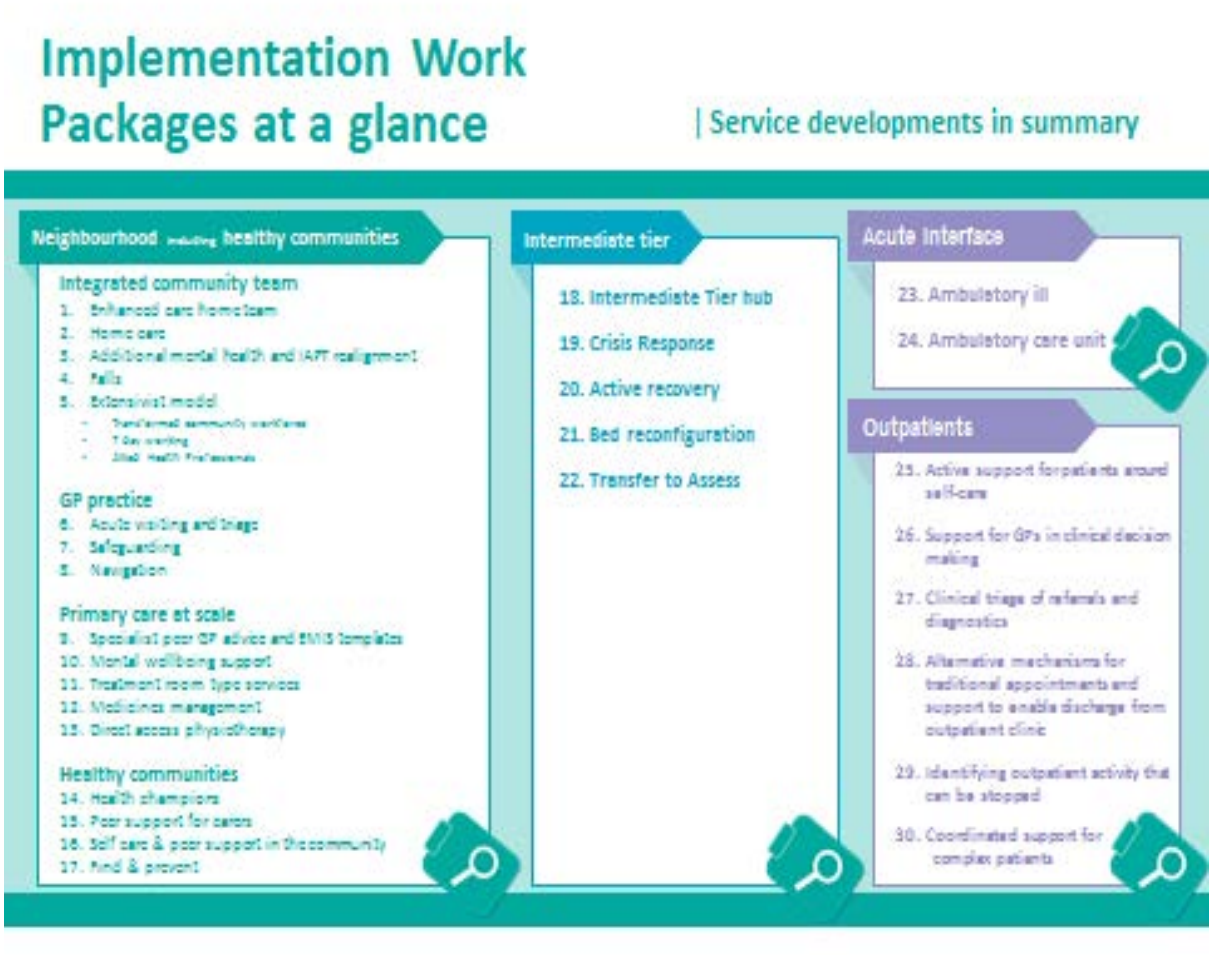
					lines • The implementation of the Financial Early Warning system will provide the system with the ability to react quickly to variations from plan and a mechanism for liquidating loss in the event of failure of the programme • The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits			

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.

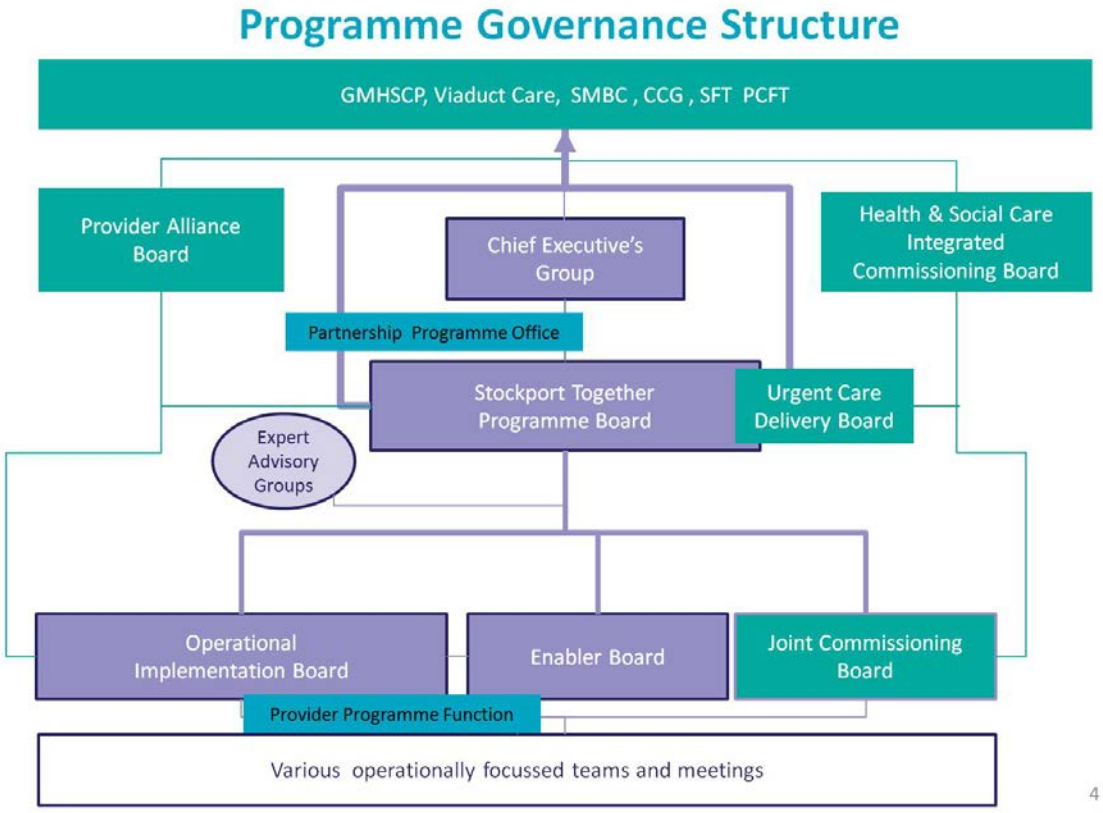


To support the effective implementation of the Integrated Service Solution, Providers will implement a formal alliance arrangement in which a newly constituted Provider Alliance Board will have delegated authority for all in scope Stockport Together health and social care provider services (to be known 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:

- 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:



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 with 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