NEIGHBOURHOOD OUTLINE BUSINESS CASE EXECUTIVE SUMMARY

Abstract

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

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

Executive Summary

Stockport Together

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

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

Business Case Overview

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

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

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

The Case for Change

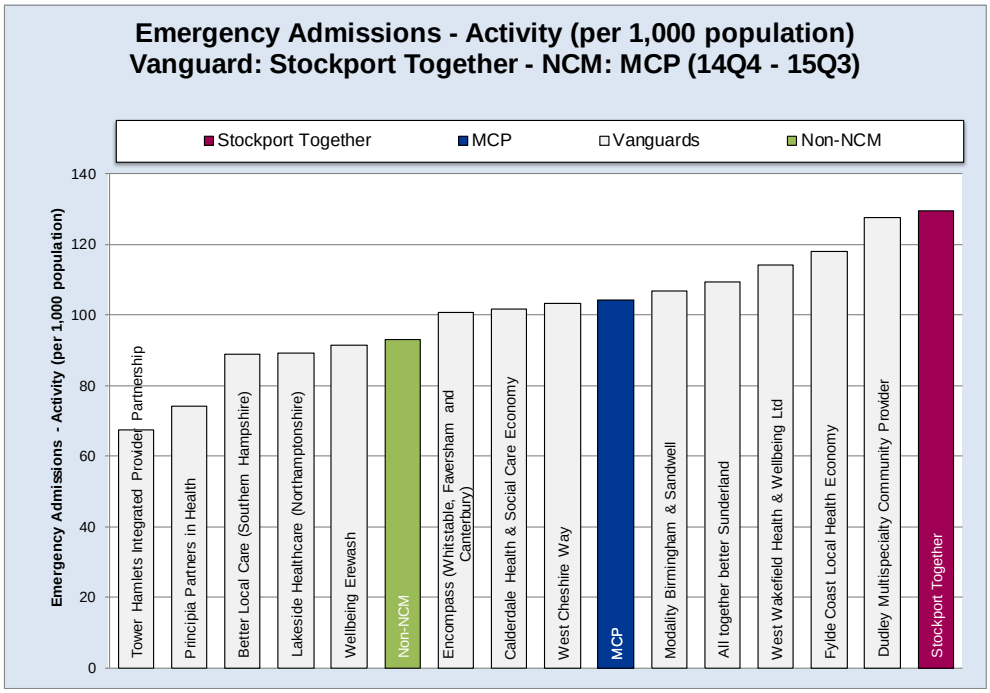
Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current form, Stockport's health and social care system is unsustainable. If working practices do not change, by 2020/21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

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

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

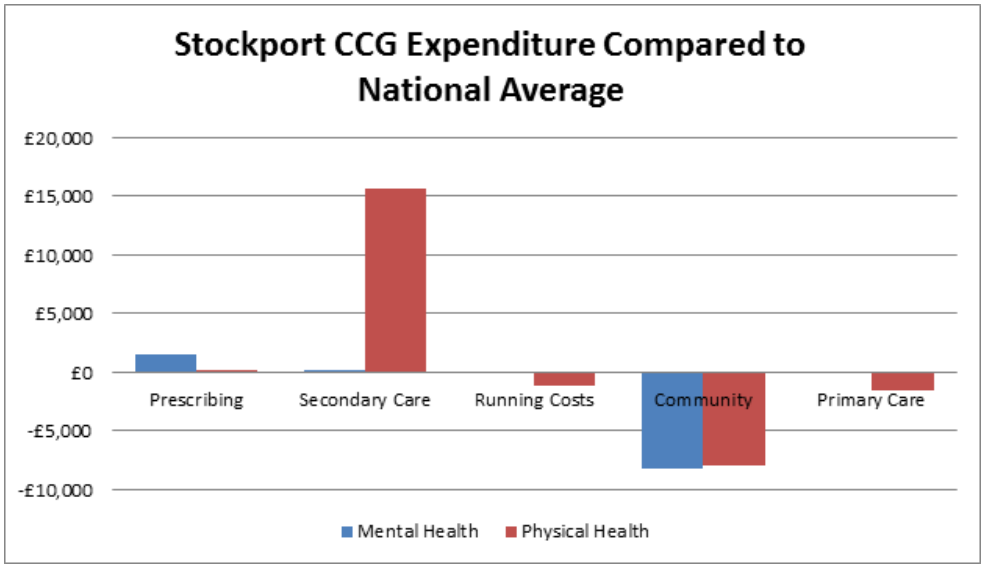
For many years, Stockport has had a much higher rate of emergency hospital admissions than peers or the England average. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it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

Figure 1: Emergency Admissions Rates



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

Figure 2: Stockport CCG Spending Compared to the National Average



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

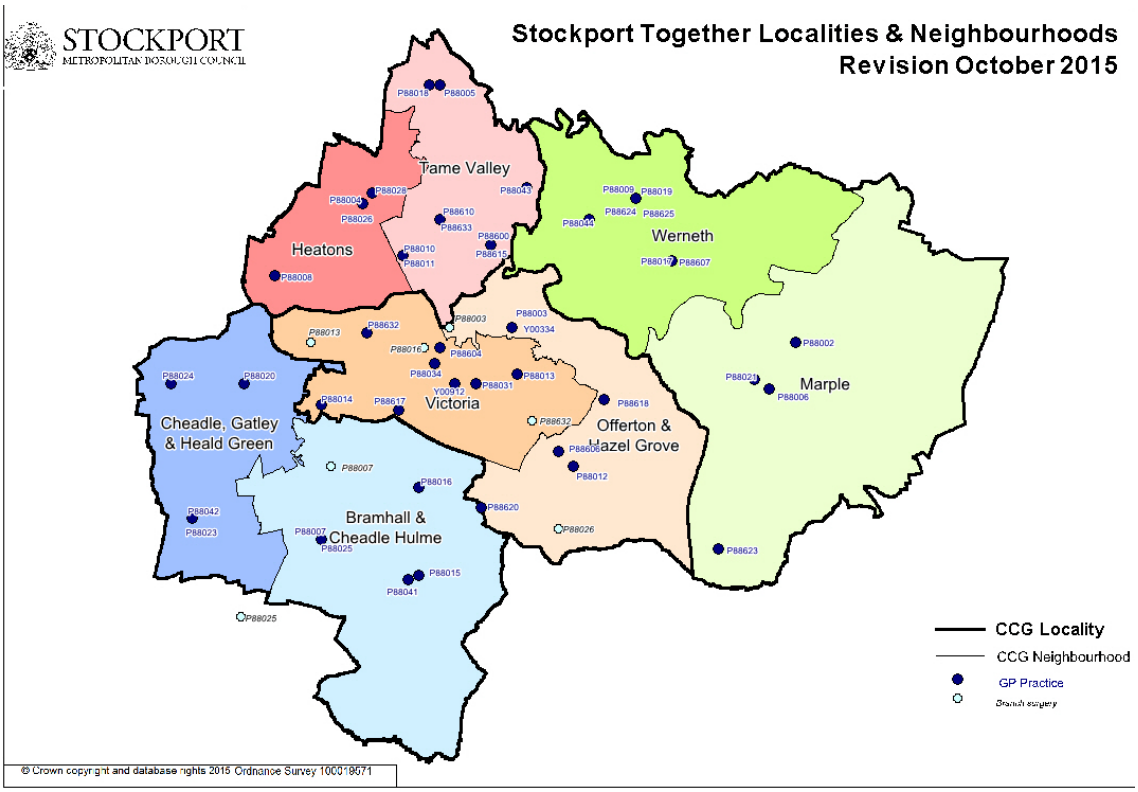
The Proposed Model

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

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

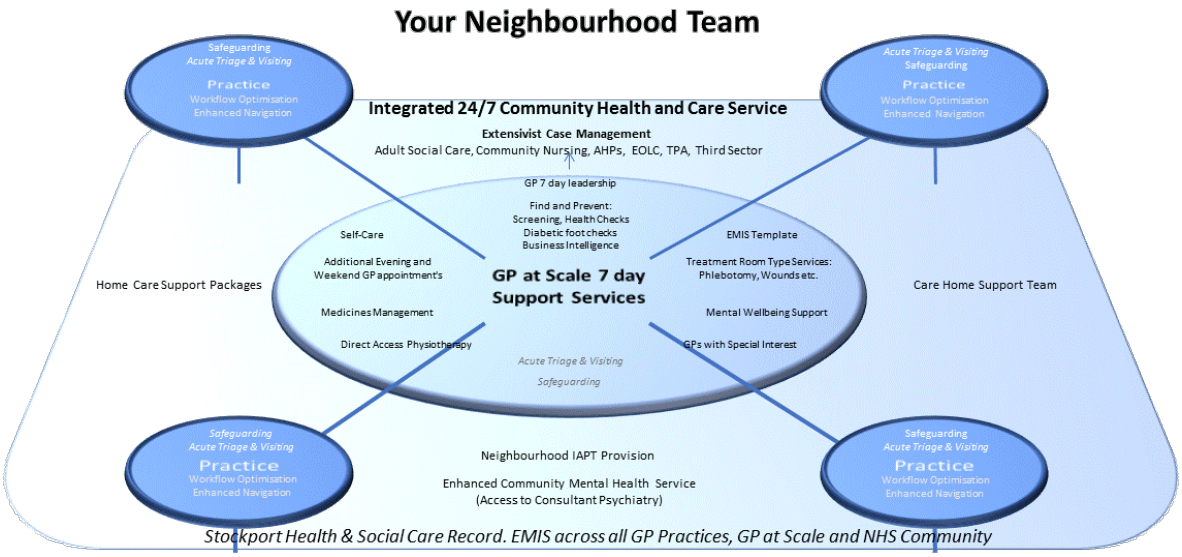
The fundamental building block of our new health and care system will be 8 integrated neighbourhood teams which will bring together primary care, community healthcare, mental health and adult social care services, as well as some aspects of third sector provision.

Figure 3: Neighbourhoods Map



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

Figure 4: Neighbourhoods Structure



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

1. ***Safe and Sustainable General Practice*** where the capacity is created to enable GPs to focus on delivering more intensive, proactive and personalised care for people with long-term conditions at practice level

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

3. ***Integrated 24/7 Community Health and Care Teams*** serving GP registered populations in multidisciplinary teams to support those most at risk of admission through: Intensive Case Management and a co-ordinated Response to Deterioration; a new falls prevention service; new blended roles across Health and Social Care; a Stockport Care Co-ordination Centre; self-care and self-management through a comprehensive Third Sector offer; investment in Mental Health Services embedded in neighbourhood teams; a new enhanced home care offer and a step-change in the quality and capacity of the external social care workforce to support independence.

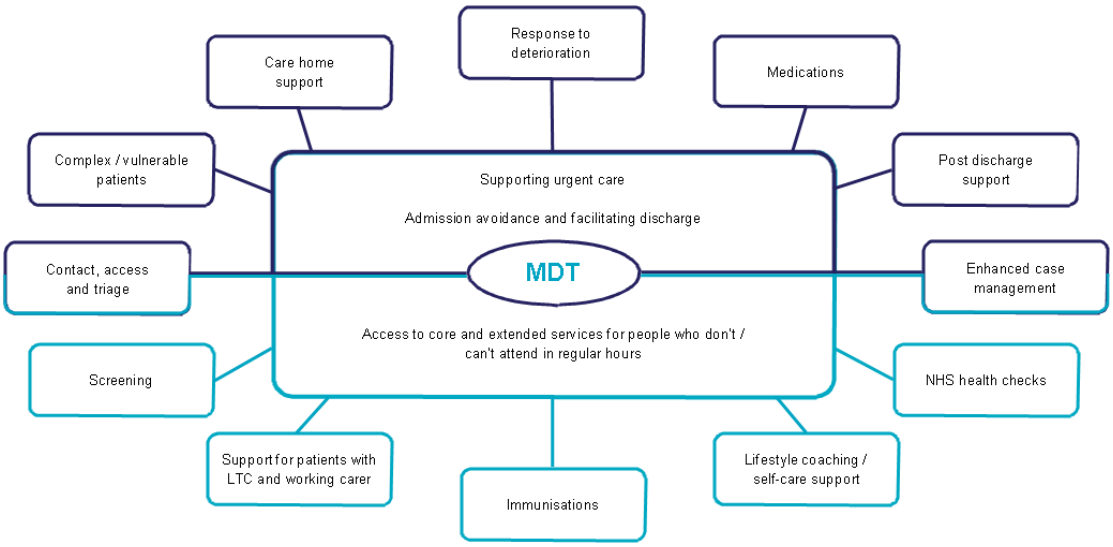
Table 1: Core Components of the Neighbourhood Model

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

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

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

Figure 5: Extended Hours and Weekend Service



Benefits of the Model

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

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

Table 2: Anticipated Activity Deflections

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

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

Table 3: Increase in workforce capacity

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

Investment Plan

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

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

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

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

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

Risk Management

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

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

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

Next Steps and Implementation

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

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

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