NEIGHBOURHOOD OUTLINE BUSINESS CASE

Abstract

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

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

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1 Executive Summary

Stockport Together

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

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

Business Case Overview

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

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

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

The Case for Change

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

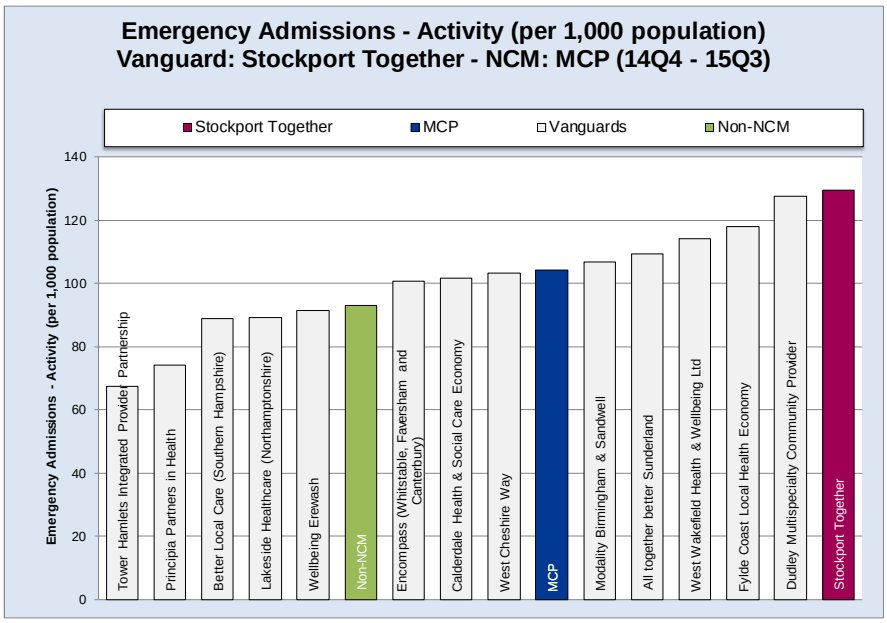
27% of the population (84,700) have at least one long-term condition. By age 60 this rises to 50% and by age 85, 88% of the population have at least one long-term condition. The number of Stockport residents aged 65 and over is set to rise from 55,700 to 61,000 by 2020. It is therefore estimated that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

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

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

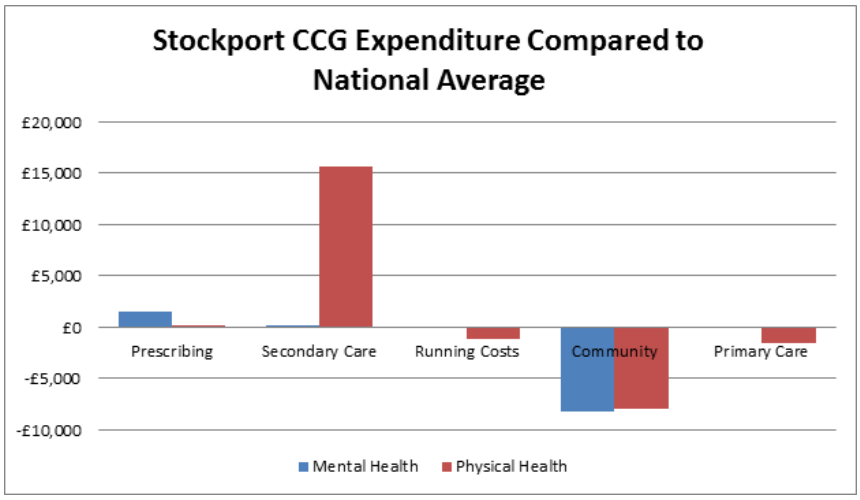
For many years, Stockport has had a much higher rate of emergency hospital admissions than peers or the England average. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it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

Figure 1: Emergency Admissions Rates



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

Figure 2: Stockport CCG Spending Compared to the National Average



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

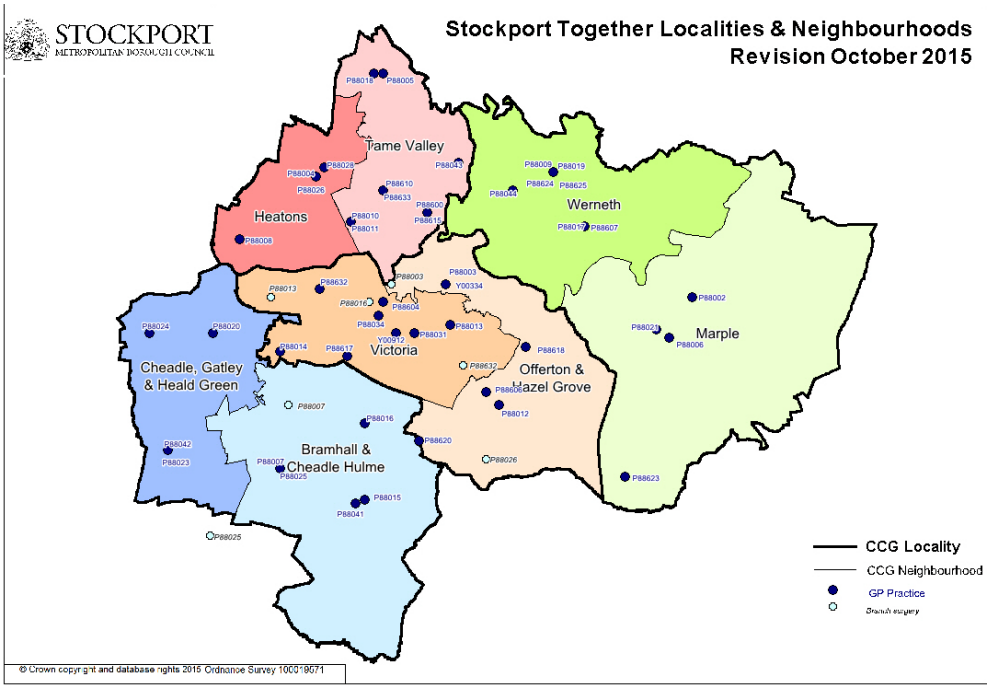
The Proposed Model

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

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

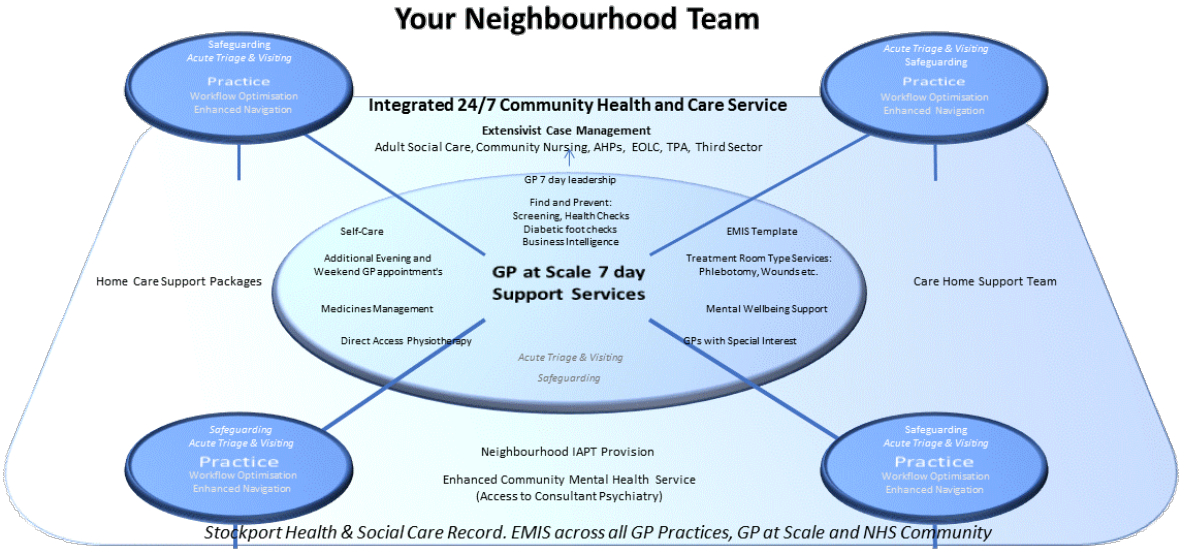
The fundamental building block of our new health and care system will be 8 integrated neighbourhood teams which will bring together primary care, community healthcare, mental health and adult social care services, as well as some aspects of third sector provision.

Figure 3: Neighbourhoods Map



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

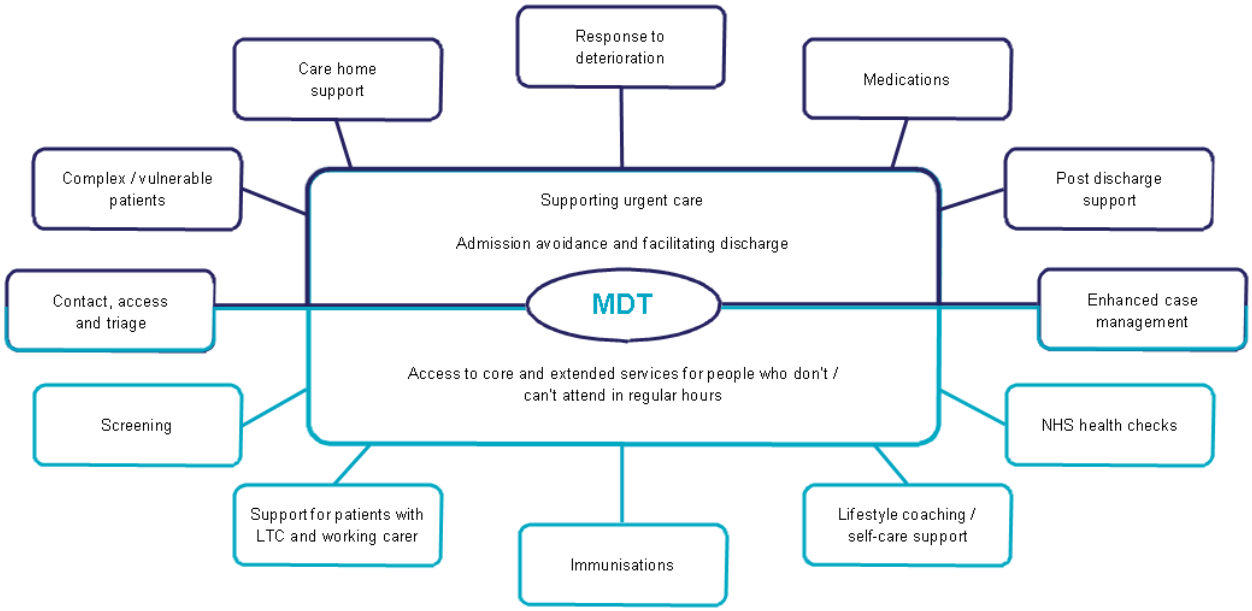
3. ***Integrated 24/7 Community Health and Care Teams*** serving GP registered populations in multidisciplinary teams to support those most at risk of admission through: Intensive Case Management and a co-ordinated Response to Deterioration; a new falls prevention service; new blended roles across Health 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 **£12.1m** in 2018/189 into neighbourhood teams. By 2020/21 a recurrent investment of **£10.98m** from savings elsewhere plus £3.4m additional investment into primary care will deliver a benefit of **£20.47m** and a net benefit position of **£9.477m**. As indicated in the table below this is one of the two major contributors to the overall financial benefit of the programme.

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

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

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

Risk Management

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

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

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

Next Steps and Implementation

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

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

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

2 Introduction

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

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

The key concepts contained within this business case are;

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

3 Public consultation

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

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

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

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

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

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

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

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

4 Vision

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

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

5 Case for Change

Local drivers

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

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

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

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

Table 5, below details the eight most prevalent long-term conditions in Stockport[1].

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

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

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

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

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

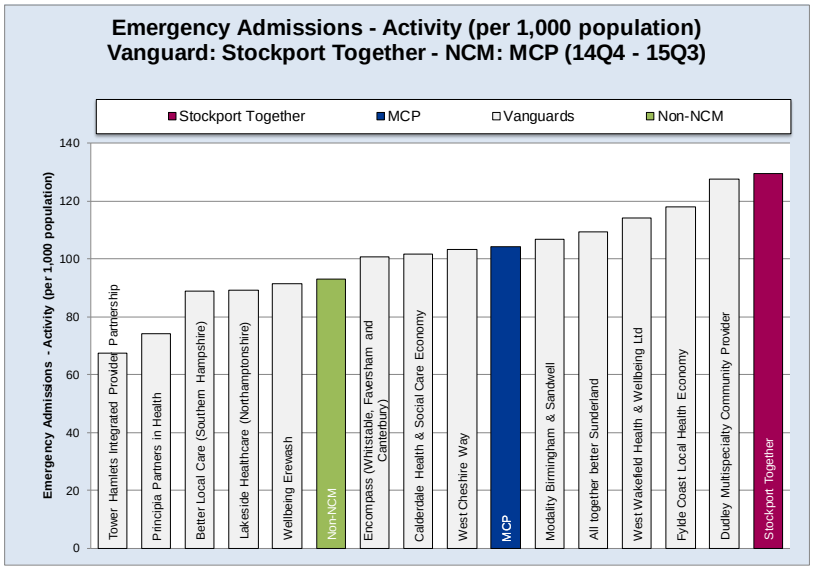
[1] Stockport JSNA click here
[2] Undercount of actual prevalence

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

5.1.2 High Non-Elective Bed Utilisation

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

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



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

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

5.1.3 Underfunding of community and primary care services

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

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

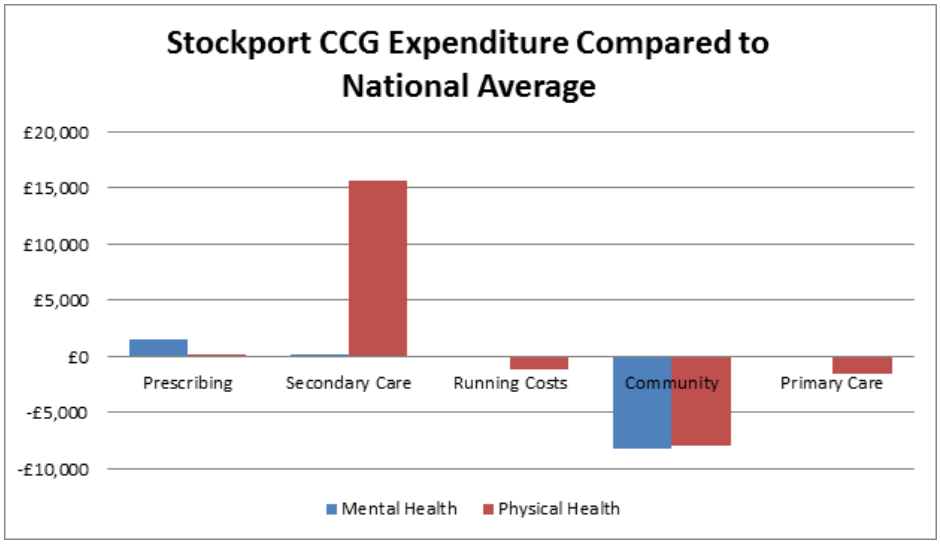
More specifically, Stockport General Practices are the lowest funded per head of population in Greater Manchester. Much of this reflects ***national weighting of population need***, but as we have seen there is national recognition of under-funding in general practices across the board.

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

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

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

Figure 2 – Stockport CCG expenditure compared to national average



5.1.4 Resource allocation and redistribution

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

Table 7 Spend benchmarking

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

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

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

5.1.5 Fragmentation and inefficiency in existing services

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

5.1.6 Recruitment

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

5.1.7 Adult social care capacity

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

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

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

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

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

National and regional drivers

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

5.2.1 NHS Five Year Forward View

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

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

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

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

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

5.2.2 GP Forward View

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

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

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

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

5.2.3 Care Act 2014 and Deprivation of Liberty Safeguards

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

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

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

5.2.4 High Impact Changes

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

Table 8 – high impact changes - DTOC

High Impact Change	Intervention / Service Development
1: Early discharge planning	• In reach approach via integrated teams and Multi-Disciplinary Team (MDT) planning (urgent care). • Additional community resources (integrated teams, reablement, voluntary and community sector) on hand to enable discharge plans across 7 days per week.
2: Monitoring patient flow	• Single integrated discharge team in place as part of Intermediate Tier arrangements able to track in-patient and care home bed capacity electronically across system.
3: Multi-Disciplinary Team approach	• MDT's with GP at the centre delivered by neighbourhood business case. • Top 15% of users supported via MDTs. • Voluntary sector and care navigators key MDT members.
4: Discharge to assess	• Intermediate Tier business case implementing transfer to assess and already operational in a number of areas. • Investment within neighbourhood case into packages of care is essential to enable this.
5: Seven-day services	• Neighbourhood business case delivers 7-day services. • Up to 2000 addition hours per day provided by neighbourhood business case. • Expanded GP and integrated models provide more services closer to home, 7 days per week.
6: Trusted assessor	• Integrated teams and intermediate tier

	are moving to trusted assessor approach. • Those returning to residential homes after an episode hospitalisation through assessment of other appropriately trained staff (no need for home staff to make in hospital assessment).
7: Focus on choice	• Personalised care planning to be introduced. • Care navigators to provide additional personalised planning to support access to third sector.
8: Enhancing health in care homes	• Increased support for care homes provided by neighbourhood business case. • Increased GP and pharmacist time for care homes. • New care home support team to support quality improvement.

5.2.5 Greater Manchester Health and Social Care Partnership

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

Radical upgrade in population health & prevention

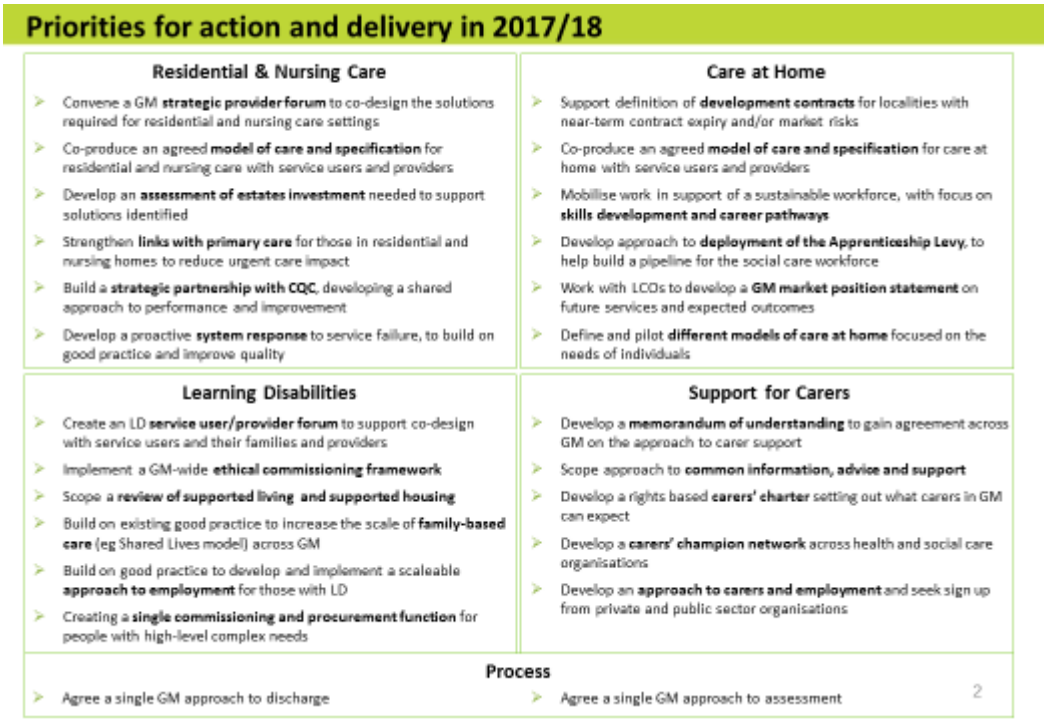
It is expected that in each locality there will be a fundamental change in the way people and communities take charge of – and responsibility for – managing their own health and wellbeing, whether they are well or ill. It is expected that this will include exploring the development of new relationships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

Transforming care in neighbourhoods

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

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

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



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

5.3 In-scope

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

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

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

6 The proposed Neighbourhood model

6.1 Model Introduction

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

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

6.2 The high-level neighbourhood model

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

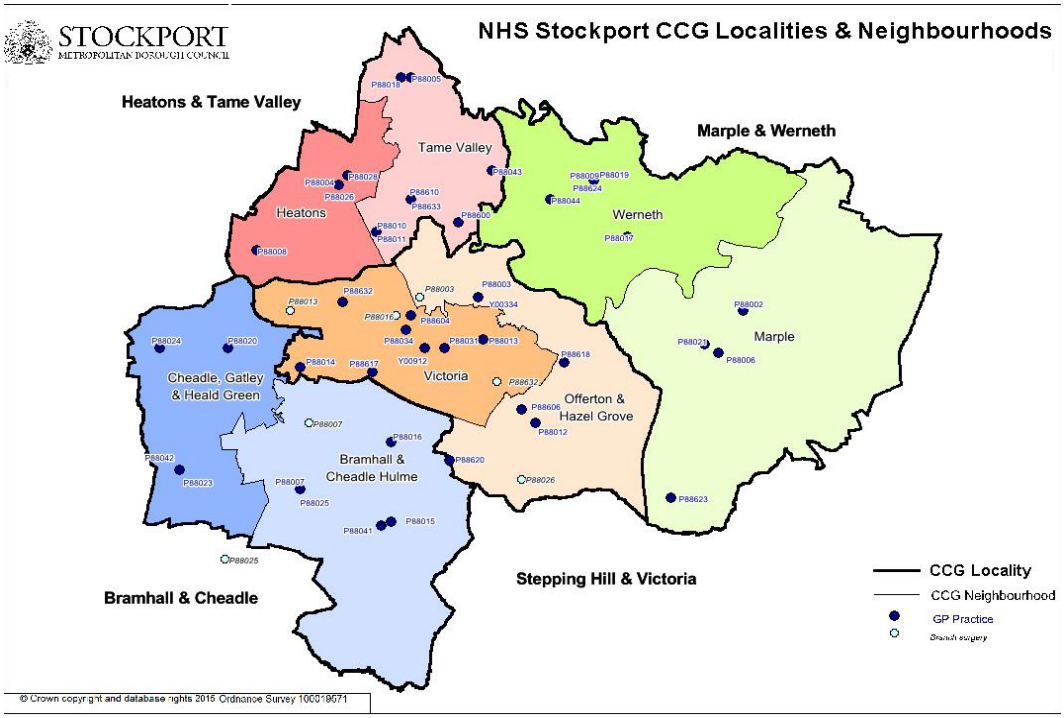
- High quality care and support is delivered that is personalised, joined up and coordinated around the person.
- People will be more in control of their own health and wellbeing.
- Primary care is sustainable and is the fundamental building block upon which integrated health and social care is delivered.

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

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

Future services will be delivered from eight neighbourhoods;

Figure 3 – Localities and neighbourhoods



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

Figure 4 – Neighbourhood structure

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

Safe and Sustainable General Practice:

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

Collaborative General Practice Operating at Scale:

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

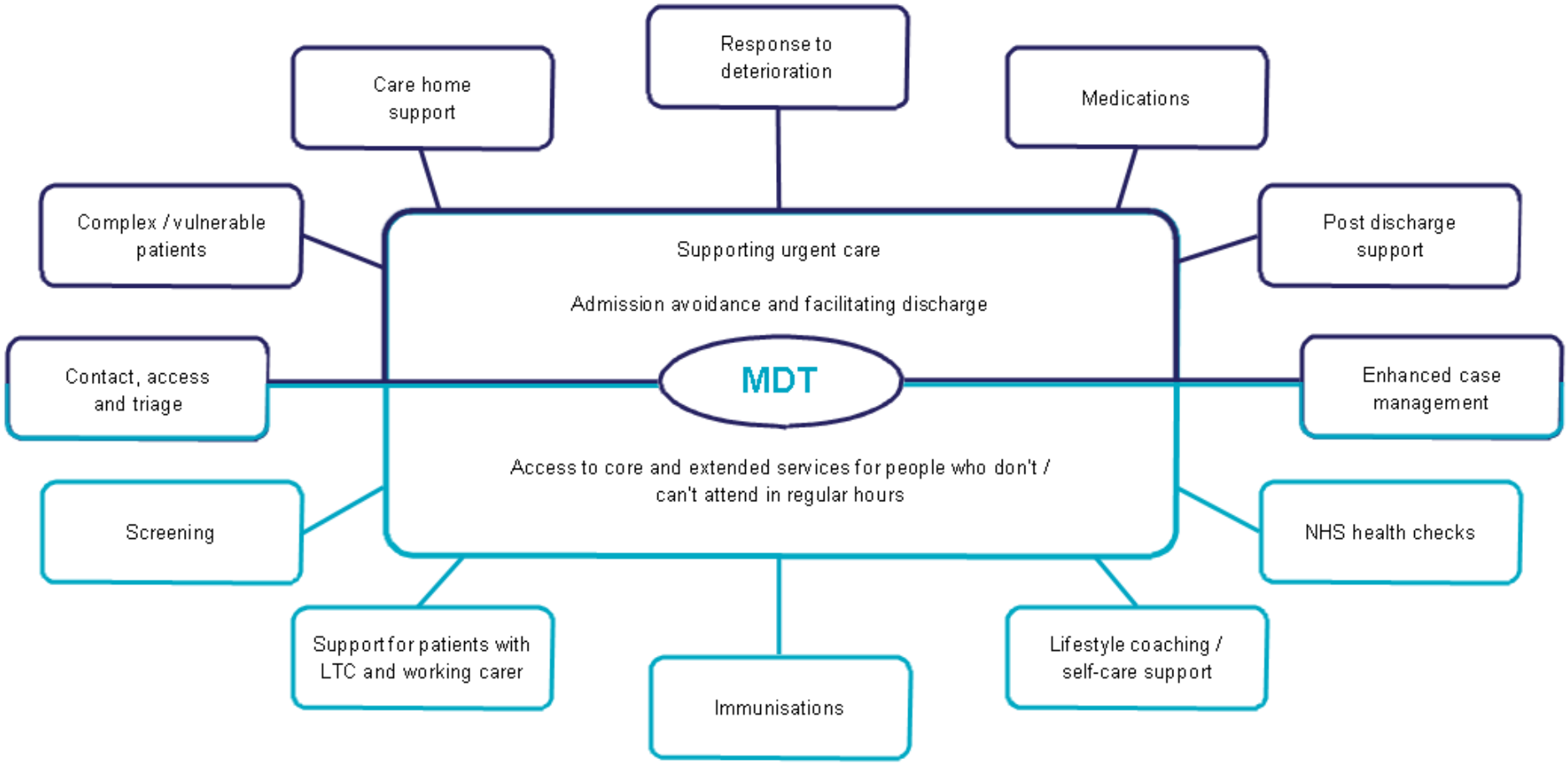
Integrated 24/7 Community Health and Care Teams

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

6.3 7 day / extended hours

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

Figure 5 – Extended hours and weekend services



6.4 Structure and responsibilities within the neighbourhood model

6.4.1 Structure

The neighbourhood model is one of integrated health and social care, with primary care at its centre, embedded in local neighbourhoods. All components of the model are responsible for and focused on delivering improved, person centred health and social care outcomes. **Figure 7**, below, shows where the neighbourhood teams sit in the overall Stockport Model;

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

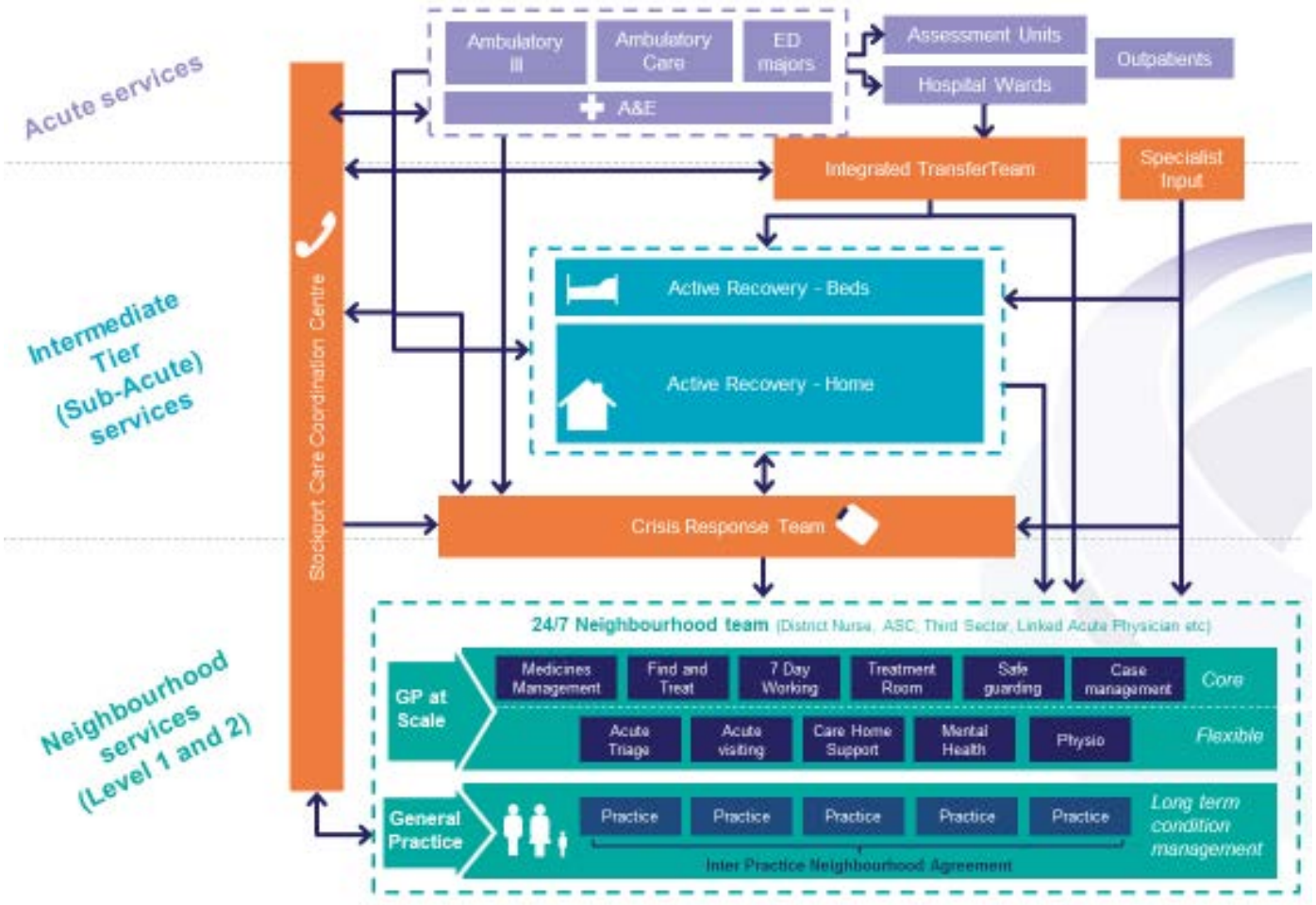


Table 1, below sets out the detail of the specific service developments that are contained within each of the three core components of the Neighbourhood model;

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

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

6.4.2 Neighbourhood leadership

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

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

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

6.4.3 Neighbourhood management

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

6.4.4 Business intelligence

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

6.4.5 Multidisciplinary integrated teams with primary care at the centre

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

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

6.4.6 Neighbourhood relationship with boroughwide services

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

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

6.4.7 Neighbourhood relationship with the Acute setting

Neighbourhoods will work closely with acute colleagues to;

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

6.4.8 Indemnity

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

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

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

6.5 Neighbourhood workforce

6.5.1 System level

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

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

- The move towards early intervention and prevention.

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

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

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

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

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

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

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

6.5.2 Neighbourhood level

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

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

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

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

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

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

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

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

6.6 Safe and Sustainable General Practice and Collaborative general practice

6.6.1 Built from the GP forward view

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

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

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

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

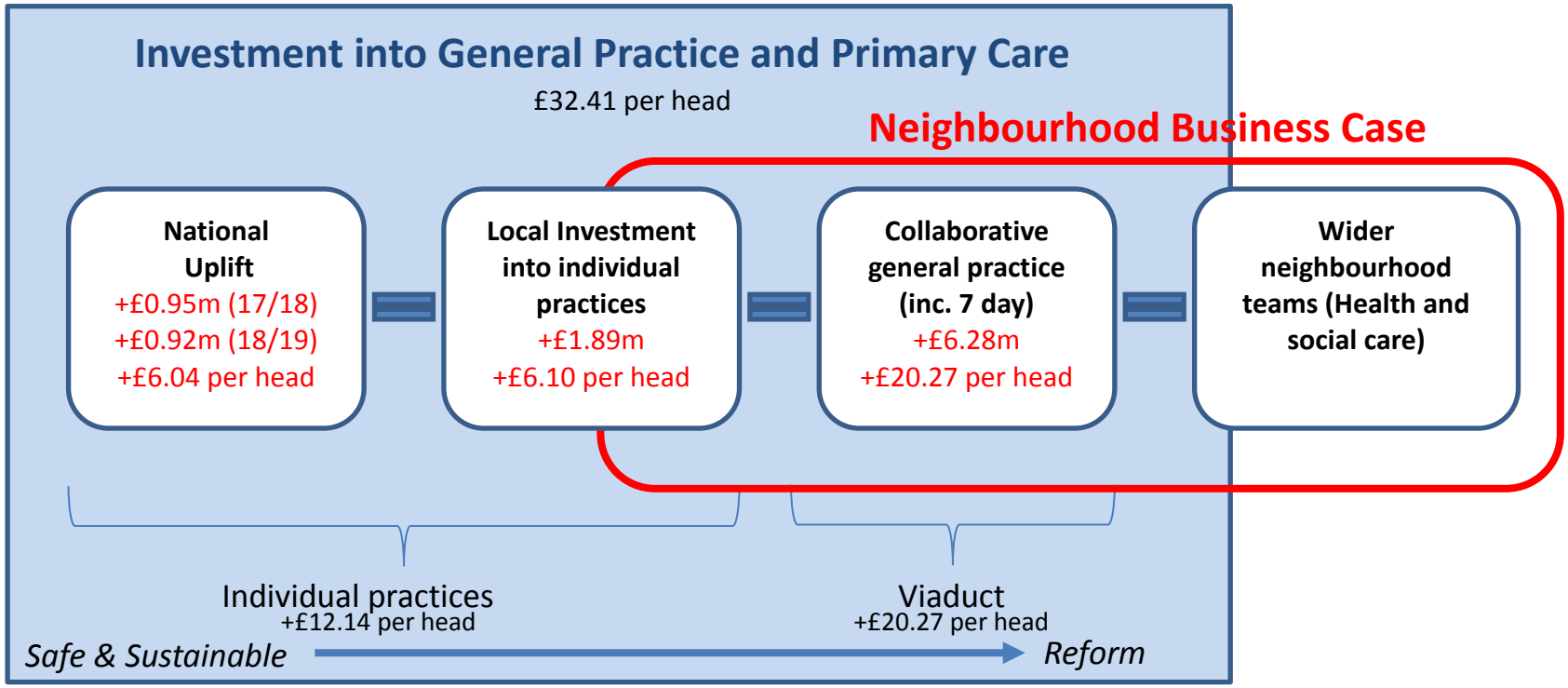
High Impact Action	Delivered through
Active signposting	• Receptionists will be provided with additional training to enable them to direct patients to the most appropriate source of help. • Self-help and self-management resources will be available in print and digital formats.
New consultation type	• Expanded use of phone, remote and e-mail consultation will ensure convenience for all patients and improve capacity and efficiency.
Reduced DNAs (did not attend)	• Increased number and variety of appointments will ensure relevance and convenience for patients. • 7-day services will support patients to gain appointments at the most appropriate time for them so reducing the likelihood of DNA. • Online booking and cancellation will support slots to be simply freed up. • E-mail and text reminders will be used routinely.
Develop the team	• Multidisciplinary teams will support the most complex patients. • New primary care workforce models will bring together GP's, physiotherapists, community pharmacists and nursing staff to ensure patients can see the right person, first time.
Productive workflows	• Reduced organisational boundaries will simplify workflow and the patient journey. • Introduction of standardised processes across pathways will reduce variation and simplify working practices. • Continued increase in the use of digital workflow management approaches will increase efficiency and productivity.
Personal productivity	• Routine processes will be simplified. • Standardisation of IT systems will occur. • Enhanced skills training will be available to all staff.
Partnership working	• General practice will be supported and encouraged to build new ways of working across neighbourhoods which build resilience and efficiency. • Barriers to partnership working will be reduced through partnership agreements, blurring of organisational boundaries and a neighbourhood approach to governance (rather than organisational.)
Social prescribing	• A full healthier communities programme will support patients to address wider determinants of good health, care and wellbeing outcomes. • Community navigators will be embedded on primary care.

	• Online directories will support people to find the right support for them.
Support self-care	• Self-care coaches will support those at high risk of developing long-term conditions, recently diagnosed or not successfully managing their condition, including those making additional demands on primary care as a result of low mental wellbeing. • Specific support programmes will be introduced / expanded (e.g. diabetes.)
Develop QI expertise	• Multidisciplinary quality improvement will operate at neighbourhood level, supporting service redesign and continuous quality improvement. • Best practice will be shared between neighbourhoods. • Standardisation will support smarter and more efficient working.

6.6.2 Investment in Primary Care

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

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



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

Table 12 – breakdown of funding for primary care

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

6.7 Core Component - GP practice

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

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

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

The impact will be:

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

6.7.1 National financial uplift

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

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

6.7.2 Greater Manchester Standards

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

6.7.3 Long-term conditions management

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

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

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

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

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

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

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

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

6.7.4 Improved workflow

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

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

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

6.7.5 Navigation

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

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

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

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

6.8 Core component – Collaborative general practice

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

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

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

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

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

6.8.1 7-day access

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

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

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

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

The main aims are to;

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

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

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

Key benefits of this service development include;

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

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

6.8.2 Acute visiting and clinical triage

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

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

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

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

Acute home visiting

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

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

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

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

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

The key benefits of this service development will be;

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

Clinical Triage

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

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

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

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

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

6.8.3 Interventions to reduce GP appointments

Direct access physiotherapy

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

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

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

The benefits of this service are anticipated to be;

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

Mental Wellbeing Support Accessed Through Social Prescribing

Please read in association with **appendix 1**

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

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

Specific service aims are to:

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

The key benefits will be;

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

Find and Prevent

Please read in association with **appendix 2**

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

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

The focus cohorts are;

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

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

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

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

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

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

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

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

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

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

Self-Care

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

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

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

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

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

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

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

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

Medicines reviews

Please read in association with **appendix 3**

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

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

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

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

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

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

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

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

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

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

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

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

6.8.5 Interventions to release capacity at the hospital

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

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

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

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

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

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

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

6.8.6 Back office support

Medication Review

The medication review service will;

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

Call and Recall

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

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

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

Templates

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

Workflow, System Navigation and Safeguarding.

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

Delivery of Standards

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

Support for training

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

Neighbourhood working

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

Activity Data

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

6.9 Core component - Integrated multidisciplinary teams

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

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

Integrated multidisciplinary teams will bring the following professionals together;

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

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

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

The impact of this approach will be;

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

The extended hours offer will be;

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

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

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

Table 13 Full community nursing 7-day offer

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

Table 14 Full social work 7-day offer

Times	Functions / Activities	Staff
Monday – Friday 8am – 6pm	• Core Business • Full Capacity • Critical Mass therefore needed to cover these hours with vast majority of social care assessors and managers covering these shifts • Full Offer e.g. • Case Finding • Response to Deterioration Maintenance • Case Coordination / Case Management / Enhanced Case Management • Short Term Support, Assessment, Planning, Review • Safeguarding • Mental Capacity Work	Full complement of assessment staff likely working shift patterns to ensure core hours are covered. Appropriate complement of support staff to support hands on delivery.
Monday – Friday 6pm – 8pm	• Some scheduled work – offer to working people and carers • Focus on response to deterioration / crisis / safeguarding work • Activity to help prevent admissions to hospital where people do not meet the threshold for Crisis Response • Enhanced Duty Offer – ensure that assessment capacity is available to respond in the event of a response to deterioration or necessary urgent response outside of core office hours • Ensure that internal home support work capacity is available and aligned to neighbourhoods to provide hands on care following initial assessment • Emphasis will be on a better step up response than is currently available	Smaller number of assessment staff per neighbourhood, likely 2 Social Workers and 1 Social Care Officer working an agreed 'late' shift in each neighbourhood to ensure the latter part of the day is adequately covered to provide the service outlined. The exact nature of these shift patterns is subject to consultation with staff. Appropriate complement of support staff to support hands on delivery.
Saturday and Sunday 8am - 8pm	As per Monday – Friday 6pm – 8pm	Assessment staff operating on an East / West Split. Likely cover includes: • 2 Assistant Team Managers (1 for East, 1 for West) covering an evening shift • 4 Social Workers and 4 Social Care

		Officers will be available on each weekend day to cover an agreed shift pattern (so 1 Social Worker and 1 Social Care Officer on an agreed 'early' shift and 1 Social Worker and 1 Social Care Officer on an agreed 'late' shift at each of the two bases open) Appropriate complement of support staff to support hands on delivery

6.9.1 Investment in allied health professional services

Please read in association with **appendix 4**

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

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

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

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

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

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

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

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

6.9.2 Enhanced Care Home Team

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

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

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

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

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

The following outcomes will be achieved through this model[4];

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

[4] Drawn from the British Society of Geriatricians guidance for commissioners

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

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

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

6.9.3 Additional Mental Health (and IAPT realignment)

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

Additional Mental Health Offer

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

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

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

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

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

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

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

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

Direct Offer

This will involve:

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

Indirect Offer

Consultant in Liaison Psychiatry and Specialist Psychologist will provide: -

- Supervision, advice and support to Neighbourhood MDTs for people with complex health and social care presentations

- Training for general practitioners (GPs) and Neighbourhood MDTs in the management of

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

6.9.4 Falls – 'Steady in Stockport'

Please read in association with **appendix 5**

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

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

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

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

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

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

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

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

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

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

6.9.5 Home Care

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

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

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

Key elements of this service development include;

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

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

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

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

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

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

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

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

6.10 Creating healthier communities

Please read in association with **appendix 8**

The strategic aim of this service development is to contribute to the transformation of the relationship between people, services and communities, through delivery of person and community centred care. This will improve people's physical and mental health and wellbeing while reducing demand on primary care and preventing admissions and readmissions to hospital or intermediate care.

Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities and this proposal is a key part of a broader strategy, which draws on existing resources and projects and seeks to embed a new relationship between services, people and communities.

This service development focuses on three key elements:

- Easy access, and empowering people to access, to the information resources and online support that people need to manage their health including long-term conditions
- Capacity to provide targeted coaching support to help people learn the skills, develop the motivation and confidence to manage their own condition
- Growing networks of peer support and voluntary activity to improve social connection and sustain long-term change

Neighbourhoods will contribute to creating healthier communities both by identifying and addressing the needs of people at high risk of serious illness and also by contributing to the Greater Manchester Population Health Plan which addresses the health burden of issues like obesity, alcohol, tobacco, and physical inactivity.

One of the defining features within the new Neighbourhood model is the emphasis that will be placed on changing the culture within our services. The vision described in the 'Stockport Way' will be key to better supporting people with long-term conditions to self-manage by working with individuals and their support networks. This means working collaboratively in a spirit of equal partnership between individuals, families, community groups, voluntary organisations, social enterprises and businesses that make up a local community, to optimise the use and benefits of informal as well as service-based support and activity. The 'Stockport Way' is;

One approach, working together for Stockport, on purpose, all of the time

- Making a conscious effort to think about how we can work together with people, communities and other organisations
- Considering how to achieve the best possible outcomes for individuals, families and wider communities.

Working *with* people, and building on their strengths

- Working *with* people, not 'doing for' or 'doing to'
- Enabling people to identify and access the strengths and resources available to them, as individuals and within family and community networks

Always connecting through conversations and building relationships

- Actively listening, seeking to understand, rather than assess
- Asking "what matters to you?" rather than "what's the matter with you?"
- Making connections and building relationships, to work collaboratively with each other across organisations
- Helping to connect people with supportive networks

Confident to make decisions, acting for the best outcomes for people

- Empowering staff within their organisations
- Enabling staff to be confident in their decisions, not asking permission but ready and able to explain them.

The 'Stockport Way' is enshrined within the healthier communities' programme that will be an essential part of the way the Stockport health and social care system works. It will engage with people who are at high risk of developing Long-term Conditions, recently diagnosed or not successfully managing their condition, including those making additional demands on primary care as a result of low mental wellbeing. This model seeks to mobilise existing and potential assets, to strengthen networks and to promote the kind of reciprocity that can maintain and develop the resilience of individuals, families and communities. This will include recruiting volunteers as community health champions, working with primary care and Integrated Neighbourhood Teams to provide an additional level of support to people at high risk of hospital admission and other

vulnerable individuals in the community. In other areas, this has been demonstrated to significantly reduce demand for primary care appointments. A small Community Investment Fund will support this work by facilitating community-led activity around health, wellbeing and resilience, with a focus on developing peer support groups, activities for people with LTCs, tackling loneliness and increasing social connections.

6.10.1 Accessing Healthy Living and Wellbeing Support in the Neighbourhoods

Accessing Healthy Living and Wellbeing Support in the Neighbourhoods

The new model in the neighbourhoods will work with people as individuals and as members of families and communities, to promote personal growth and resilience, working in line with the Stockport Way. A 'network around the neighbourhood' will provide a layer of support around the Integrated Neighbourhood Team for both the top 15% and the wider population. The new way of working with people and communities, advocated by NHSE and set out in *Realising the Value* programme, involves moving beyond referrals and pathways:

People's needs may be primarily clinical or mainly social, but for those needing most support will usually involve elements of both. As far as possible, referrals and multiple assessments will be avoided and, where specialist input and advice is needed, named colleagues, aligned with the neighbourhood team, will be introduced to the individual. The intention of our approach is that the professional boundaries between physical health, mental health and social care roles should become more flexible; holistic care involves broadening of skills, particularly in relation to mental wellbeing, as we change how we connect with and relate to people. This is key to reducing demand and improving health as we work towards diminishing or eliminating the need for statutory services intervention over time.

It is essential that the mental health services are embedded in this network and the INT, so that mental and physical health and wellbeing needs are addressed holistically through a team working together with each other and the person at the centre. In addition to the four old age psychiatry CPNs are already in post as locality liaison nurses in INTs, the new psychological Medicine in Primary Care service will comprise a team of 1.5 Consultant Psychiatrists, 2 Psychologists, 8 Liaison Practitioners embedded in the INTs offering a combination of a form of enhanced case management and additional case formulation advice i.e. face to face and advisory.

Wellbeing conversations start with the question of "What matters to you?" and draw on the Five Ways to Wellbeing framework to facilitate goal setting and wellbeing planning, which identifies ways of accessing the personal, family and community assets and resources available to help achieve these goals. In these conversations, people's level of 'activation', or confidence and existing skills, will be explored in order to ensure the appropriate level of support is offered; while always promoting autonomous motivation and access to the personal and social assets that they have already have available.

Figure 9 illustrates likely journeys though the network around the neighbourhood as people move towards community-based support. It is important to emphasise that the journeys will not always be linear, and an individual may be supported by a number of services working together either alongside each other or consecutively, sometimes alongside a key worker/care coordinator. Four

roles are key to providing access to the network of support.

Case Manager/keyworker

A key worker or case manager will develop an ongoing relationship with people identified as highest need (15% most at risk of hospital admission) and work with them to access the support and assets (including within their family networks) that are most appropriate to their priorities. This will include having wellbeing conversations with people as a key part of the care planning process, and then continuing to offer support to achieve their health and wellbeing goals within the Enhanced Case Management process.

Wellbeing Navigator

The role of the Wellbeing Navigator would be have the initial wellbeing conversations with people experiencing social or psychological needs, identified by a GP, Practice Nurse or other practitioner, (but not in the top 15% risk group) and introduce them to the network of support available.

Find & Prevent workers/Health Coaches

This role will be complemented by the Find and Prevent workers and Health Coaches (which may be integrated into a single role). They will proactively seek to identify, engage and support those people with, or at high risk of, long-term conditions and work with them in wellbeing conversations and where needed, further coaching support. They will work with them to develop their skills and confidence in managing their own health and wellbeing, including accessing community and voluntary sectors assets such as mutual support groups.

START

START is primarily an access route to the Healthy Stockport family of services, and the workers will undertake the initial conversations with people who want to make changes to their lifestyle, to enable them to access the most appropriate support services (including ABL, Pennine Care, CGL, Life Leisure and Public Health provided support). Those services will cultivate and maintain their own connections with community-based groups such as peer support, sports clubs or creative activity groups. At present, both START and the Healthy Stockport services are centrally based, but it is important that these services should work closely with the practice and neighbourhood based services in delivering holistic responses.

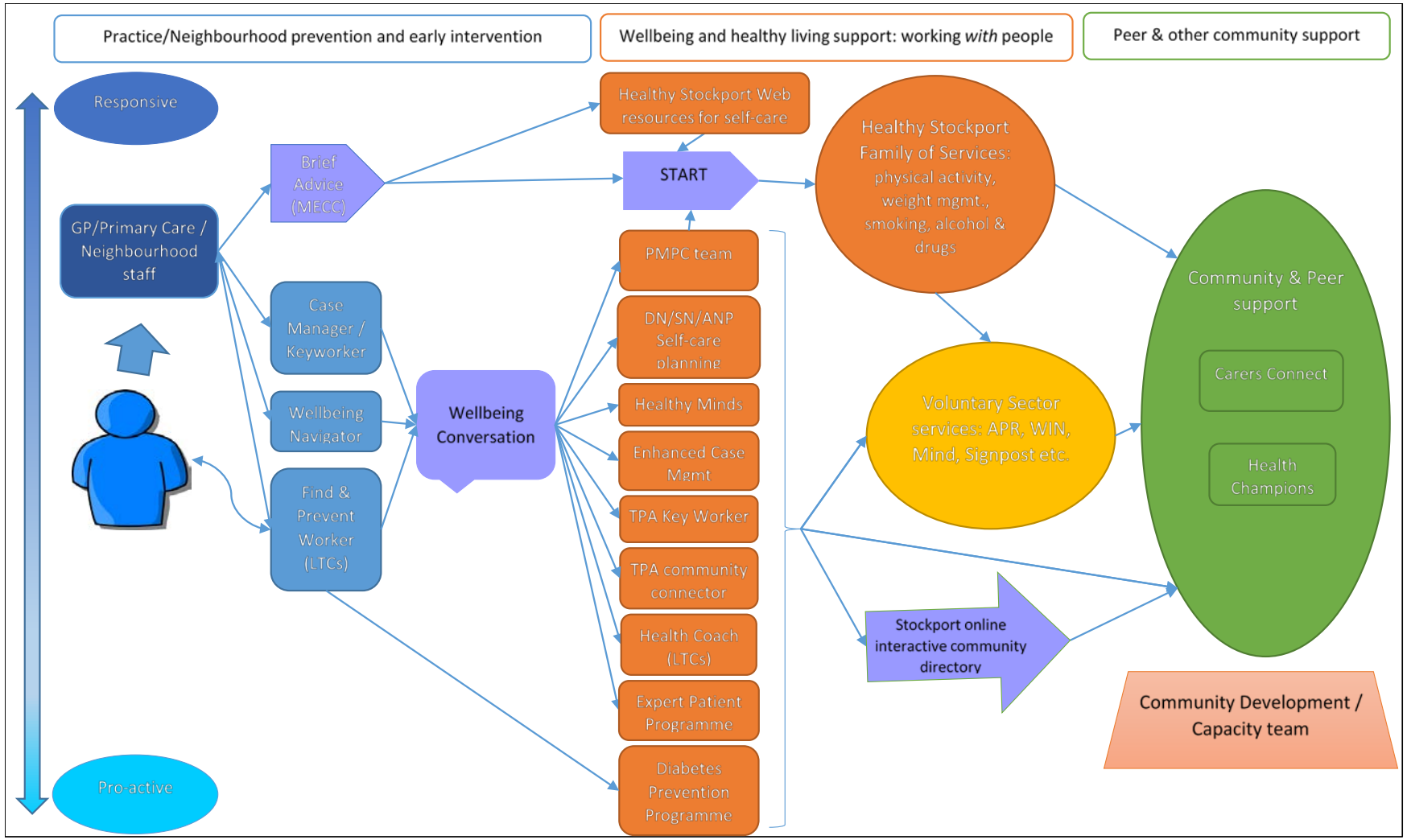
Community Capacity building

To complement this work we will work in partnership with voluntary and community organisations to support them in building their capacity to offer appropriate support when it's needed. The network around the neighbourhood will therefore include the community development workers who are already embedded in the local communities and working with local groups. We are also piloting the practice-based Health Champions – a team of volunteers who can also support and assist people to access community assets and other local resources.

Key to Abbreviations used in diagram:

ANP Advanced Nurse Practitioner
APR Alliance for Positive Relationships (Domestic abuse prevention and support)
DN District Nurse
INT Integrated Neighbourhood Team
LTC Long-Term Condition
MECC Make Every Contact Count
MH Mental Health
PMPC Psychological Medicine in Primary Care
SN Specialist Nurse
START Stockport Triage, Assessment, and Referral Team (for Lifestyle change support)
TPA The Prevention Alliance
WIN Wellbeing & Independence Network

Figure 9 Wellbeing and Prevention Support Journeys



6.11 Quality, safe and effective care

Our eight neighbourhood teams will provide appropriate mechanisms and support for a systematic collaborative approach to quality, safety and effectiveness through:

- strong leadership and accountability
- access to specialist advice when required
- the development of transparent care pathways recognising the needs of adults and older people
- sharing of data directly via EMIS and the Stockport Health & Social Care Record to enable shared dashboard to monitor outcomes and identify risks
- multiagency collaboration to ensure safeguarding of children and vulnerable adults
- embedding 'No decision for me without me' with particular focus on consent and supporting people who lack mental capacity to make decisions
- training, monitoring and supporting all staff within each neighbourhood to provide safe, effective care, working in partnership to offer a standardised approach

Our integrated governance framework will ensure quality, clinical safety and effectiveness are embedded across the health and social care system through:

- agreement of overall quality strategy and plans with commissioners, GPs, social care and health providers enabling a shared focus on the delivery of quality outcomes
- clear neighbourhood structures, accountabilities and governance processes which support the delivery of safe, high quality, clinically effective care
- agreed data sets between partners so that quality improvements can be measured and reviewed
- a culture that supports all staff to learn and improve
- Boards and health and social care leadership group review and approve the assurance frameworks (locality and system wide)

Evaluation of services will be informed by feedback from patients, staff and carers.

6.12 The Stockport Together Outcomes Framework

It is intended that the future commissioning arrangements for services described in this business case and others, will be based on a population based weighted capitation contract which will include an Outcomes Framework.

6.12.1 The Outcomes based approach

Stockport Together's ambition is to implement an outcomes-based model of commissioning. Outcomes based commissioning is a way of paying for health and social care services based on rewarding providers for achieving the outcomes that are important to the people using them, regardless of socio-economic status.

Commissioning for outcomes presents a different proposition from current payment mechanisms, such as payment by results and block contracting, which pay health and social care providers to deliver discrete processes or packages of care. Commissioning for outcomes moves the focus away from volume and activity and towards providing whole-person holistic care.

There is an acknowledgement that no single provider of care is likely to deliver true patient outcomes in isolation of other providers. Achieving outcomes must therefore be a collaborative approach supported by appropriate contracting and reimbursement mechanisms. Commissioning for outcomes in a multi-specialty community provider has the ability to drive integration by incentivising providers to work together, share accountability and deliver outcomes collaboratively.

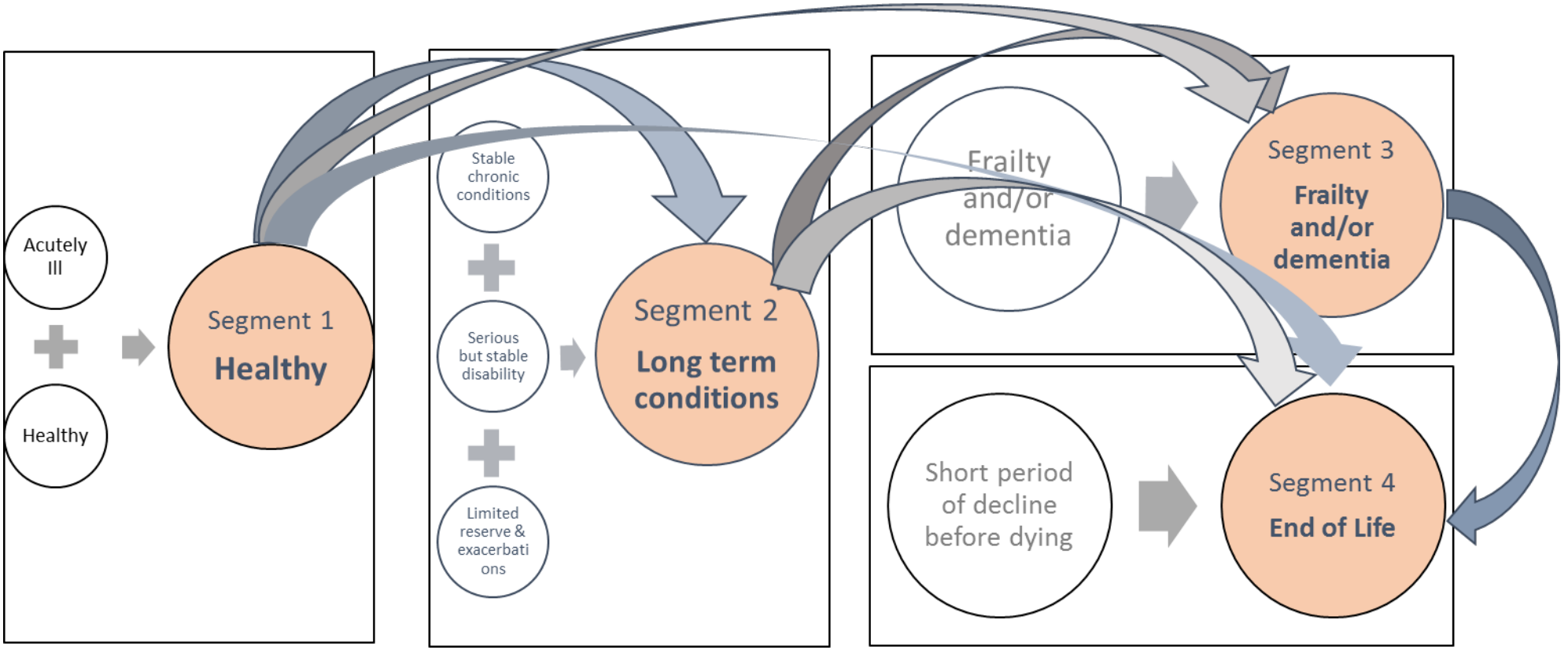
6.12.2 Enabling the delivery of the outcomes based approach

To achieve an outcomes-based model of commissioning, Stockport Together embarked upon identifying outcomes that matter most to the people in Stockport. To ensure that different views from across the system were taken into account, key stakeholders including patients led the development of a Stockport Together 'Outcomes Framework'.

Commonly, outcomes have been considered in the context of disease groups. However, defining optimal heath in this way undermines the 'whole-person' holistic approach and retains focus on providers. In support of Stockport Together's whole population approach, and in view that the responsibility to deliver true patient outcomes is shared amongst multiple providers, the development group agreed that the outcomes should be organised differently to traditional approaches.

In order to identifying sufficiently homogeneous population groups and associated outcomes, Stockport Together adapted the *Bridges to Health* model of segmenting populations. This describes eight population groups which have been condensed into four broader groups each with its own definition of optimal health and priorities among services:

Figure 10: *Stockport Together* population segments and movement between segments based on the *Bridges to Health* model



N.B. Maternal & Infant Health excluded as the MCP for Stockport Together aims to initially contract for the over-65 population

6.12.3 Prioritised outcomes

The Stockport Together Outcomes Framework includes both clinical, social and personal outcomes. Clinical and social outcomes tend to describe clinically relevant outcomes for an individual, such as improved health status (reductions in disease incidence, complications and/or exacerbations). Personal outcomes describe the holistic health status of a person such as their confidence in managing their own health and wellbeing.

Whilst clinical and social outcome can be measured by using data already captured in clinical or administrative systems, measuring personal outcomes generally requires administering surveys or Patient Reported Outcome Measure (PROM) tools.

Table 18 outlines the 25 clinical and social outcomes and 14 personal outcomes that have been prioritised by the Outcomes Framework development group. The 25 clinical and social outcomes are measurable and have three-year worth of baseline data. PROM tools are still being reviewed to assess their suitability to measure the 14 personal outcomes prioritised. Some personal outcomes may not be measurable and decisions are still to be made during 2017/18 on some of the more detailed implementation issues associated with measuring personal outcomes.

Table 18 – Stockport together outcomes framework

Stockport Together Outcomes Framework			
	Description of population segment and priorities	Clinical and Social outcomes[5]	Personal outcomes[6]
Healthy	**Who is in this group?** *- adults in the general population* *- not in contact with health services* *- no diagnosed conditions* *- may have underlying conditions/risk factors* *- may have unhealthy behaviours* **What is important to them?** *- staying healthy* *- avoiding developing a disease/condition* *- convenient access to services when unwell* *- longevity* *- maintaining independence, usual lifestyle and activities* *- quality of life and social interaction*	REDUCE avoidable acute admissions	Independence
		INCREASE physical activity	Proactive and confidence in managing health
		REDUCE obesity	Able to maintain usual lifestyle and activities, having a full life
		REDUCE smoking	Time with friends and family, not being alone
		REDUCE alcohol consumption	Well-informed
			Mental wellbeing
			Feeling supported and reassured
			Feeling safe and secure
Term Conditio	**Who is in this group?** *- people aged 65 years and over with a LTC* *- may have stable/normal function managed by medication, treatment or therapy* *- may have serious long-term physical or learning disability*	REDUCE premature mortality in people with Serious Mental Illness	Independence
		REDUCE smoking	Proactive and confident about managing health
		REDUCE obesity	Able to maintain usual lifestyle and activities, having a full life

[5] Three years of baseline data is available for the clinical and social outcomes
[6] Baseline data for the personal outcomes will be collected during 2017/18

	- may have limited reserve, serious exacerbations, progressive deteriorating conditions **What is important to them?** *- effective self-management* *- preventing/limiting disease progression* *- maintaining autonomy* *- confidence to manage their condition* *- avoiding exacerbations or complications* *- avoiding developing more health conditions* *- minimal disruption to life* *- co-ordinated care in the most appropriate place*	REDUCE episodes of ill health requiring emergency admission	Time with friends and family, not being alone
		REDUCE days disrupted by care	In control, involved, listened to
		REDUCE stroke in people with diabetes and/or circulatory conditions	Well-informed
		REDUCE diabetes complications	Mental wellbeing
		REDUCE exacerbations requiring emergency admission in people with organ failure	Feeling supported and reassured
		INCREASE cancers diagnosed at an early stage (stage 1 or 2)	
Frailty and/or Dementia	***Who is in this group?*** *- people aged 65+ who are frail and/or have dementia* *- likely to have comorbidities* *- often vulnerable and dependent on others* ***What is important to them?*** *- avoid disruption to life / time away from home* *- independence* *- prevention of falls or distress e.g. pressure ulcers* *- stronger recovery following falls, fractures or admission* *- timely diagnosis of dementia at an early stage* *- quality of life and social interaction*	INCREASE the proportion of days spent at home	Independence
		REDUCE pressure ulcers	Able to maintain usual lifestyle and activities, having a full life
		REDUCE falls	Time with friends and family, not being alone
		REDUCE delirium	In control, involved, listened to
		REDUCE emergency admissions for UTIs, constipation and incontinence	Well-informed
		REDUCE the dementia prevalence gap	Mental wellbeing
		REDUCE people requiring repeat emergency care within 30 days of discharge	Dignity and respect
		INCREASE people back to previous level of mobility following a hip fracture	Feeling supported and reassured

			Feeling safe and secure
			Anxiety / depression
			Pain and symptom control
			Nutrition
			Disability / functions of daily living
End of Life	***Who is in this group?*** *- people with a terminal illness or advanced progressive deterioration* *- people identified to be in their last 612 months of life* ***What is important to them?*** *- control over their care and place of death* *- early conversations and planning* *- support to live as actively and as well as possible* *- dignity and respect* *- psychological support to themselves and their family*	INCREASE people dying at their preferred place	Time with friends and family, not being alone
		INCREASE palliative care registrations in people expected to die	In control, involved, listened to
		REDUCE the proportion of days disrupted by emergency care for people in their last days of life	Well-informed
			Dignity and respect
			Feeling supported and reassured
			Anxiety / depression
			Pain and symptom control

Table 19 Neighbourhood contribution towards achieving the outcomes in the Outcomes Framework

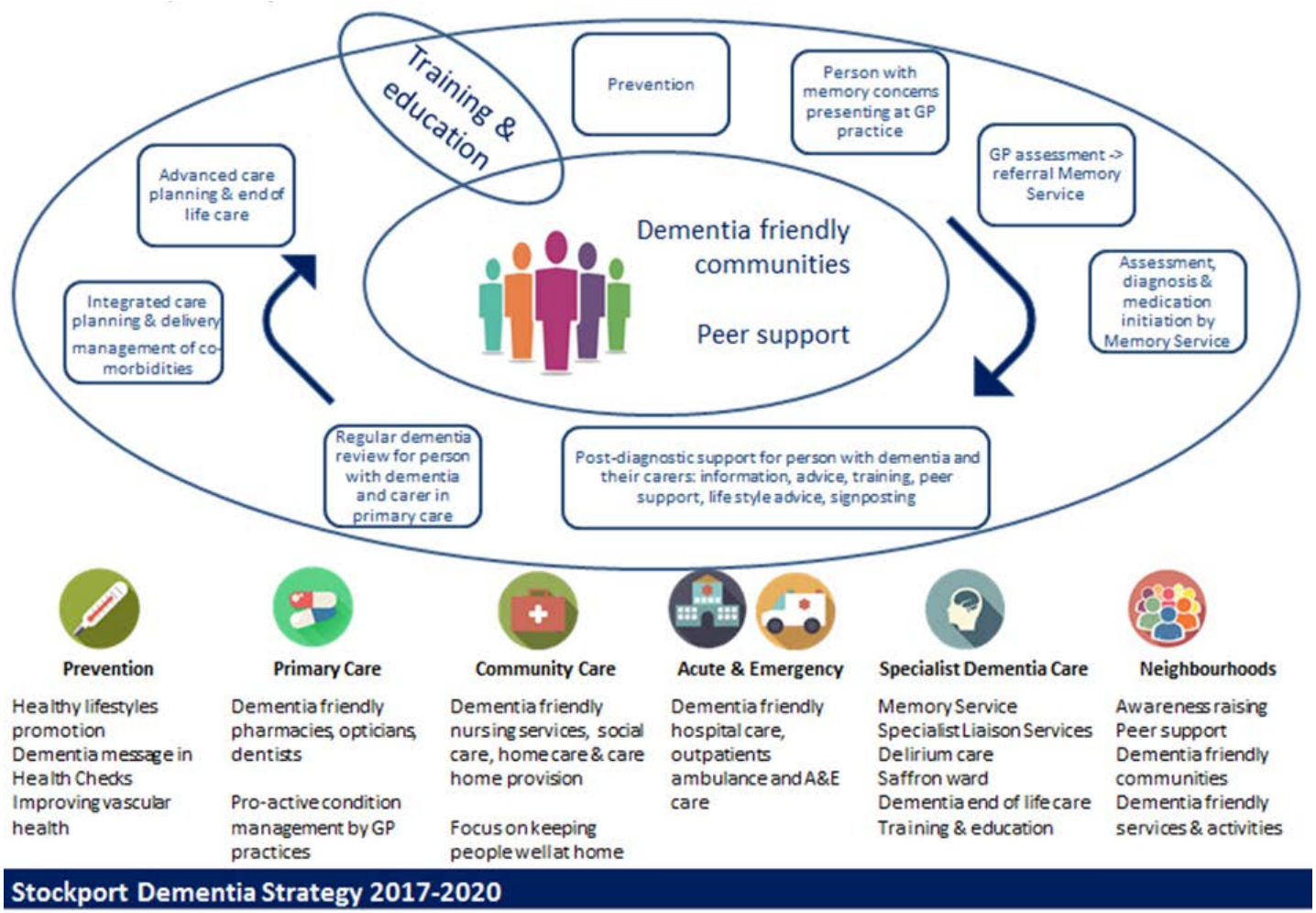
Healthy	**REDUCE smoking**	**REDUCE alcohol consumption**	**REDUCE avoidable acute admissions**	**REDUCE obesity**	**Well-informed**
	Healthy communities programme will support people to access smoking cessation	The Falls 'Steady in Stockport' service will raise awareness amongst staff about risk factors related to falls including reduced alcohol intake	'Find and Prevent' services will systematically identify people 'at risk' of developing conditions and offering enhanced health checks to prevent development of complex care needs.		All neighbourhood teams will be trained to provide advice, support and access to wellbeing services
Long Term Conditions	**INCREASE cancers diagnosed at an early stage**	**REDUCE stroke in people with diabetes and/or circulatory conditions**	**REDUCE days disrupted by care**	**REDUCE exacerbations requiring emergency admission in people with organ failure**	**Proactive and confident about managing health**
	'Find and Prevent' services will target people at higher risk of developing long-term conditions by identifying people who have not attended cancer screening opportunities	'Find and Prevent' services will identify escalation from simply managed conditions such as diabetes to more complex conditions such as stroke.	'Find and Prevent' services will support people at risk of developing LTCs to make lifestyle adjustments	People with LTCs / complex needs will be given intense support by GPs / crisis response to safely maintain them in their homes	People with LTC will be given support and training to be able to self-manage
Frailty and Dementia	**REDUCE emergency admissions for UTIs, constipation and incontinence**	**INCREASE the proportion of days spent at home**	**REDUCE falls**	**Independence**	**Mental wellbeing**
	More evening and weekend GP appointments provide additional support for community teams and patients in exacerbation	Extended hours across all professions improves access and timeliness of support	Specialist falls team provide specific support to reduce incidence of falls Pharmacists supporting medication reviews reducing incidence of falls	MDTs include therapy professionals. Care plans will provide equipment and training to help people remain independent in their own homes	Rapid access to mental wellbeing services will be facilitated by MDTs
End of life	**INCREASE people dying at their preferred place**	**INCREASE palliative care registrations in people expected to die**	**REDUCE the proportion of days disrupted by emergency care for people in their last days of life**		**Well-informed**
	Training for residential homes and nursing teams to have early conversations around wishes	Increased GP and pharmacist support pain control and other medications	Neighbourhood acute visiting to ensure quicker access to medical support	Increased GP and pharmacist support pain control and other medications	Earlier conversations with people and their families provides information and options

6.12.4 Dementia friendly

Stockport Together's business cases are all aligned with the recently launched Stockport Dementia Strategy 2017-2020 (http://www.stockportccg.nhs.uk/dementia) and the Greater Manchester Dementia United initiative. This neighbourhood case supports the following objectives of Stockport's dementia strategy:

- **Dementia prevention** message 'what is good for your heart is also good for your brain' will be disseminated by front-line staff to make the public aware of the positive effect a healthy lifestyle can have on primary and secondary prevention of dementia
- **Dementia diagnosis**: with support from the neighbourhood teams and staff in healthy community initiatives, more people with concerns about their memory will be positively encouraged to seek a dementia diagnosis timely
- A dementia diagnosis will be included in the **health and social care record** to ensure the specific needs of a person with dementia are taken into account at each point of contact with a health or social care staff member
- As dementia affects many aspects of life, like someone's health and wellbeing, carer's wellbeing, social connections and finances, an **holistic and integrated approach** as envisaged to be delivered through the neighbourhood teams will contribute to the quality of life of the person with dementia and their carer. Staff will receive further **dementia awareness training** to understand the specific needs of the person with dementia and their carer throughout the journey
- Through the integration of health, social care and mental health in the offer for people with dementia, there will be more focus on **advanced planning and ongoing pro-active care**. This will result in better (self)management and ongoing post-diagnostic support tailored to the person's needs. In addition, more opportunities for **support at home** instead of an admission to an unfamiliar environment of a hospital or a care home will result in better outcomes for the person with dementia
- Improved partnership working will result in a more **joined up approach** to manage dementia in relation to co-morbidities like diabetes, stroke, Parkinson and delirium
- The existing **shared care pathway** between primary and secondary care will be further refined to address the increasing need in the later stages of dementia
- Building on the work undertaken in the hospital, various GP practices and community services, the neighbourhood teams and borough wide services will all become **dementia friendly** and supporting the development of Stockport as a dementia friendly borough.

Figure 11 – Dementia pathway



7 System impact

7.1 Safe and sustainable general practice

The Stockport system is making a significant investment in general practice to;

- Ensure general practice is safe and sustainable
- Support transformation and delivery of neighbourhood level services
- Provide more local support and services
- Move towards early intervention, prevention and self-care

There is a total investment of £10.04m (£32.41 per head) in primary care, which includes £1.87m (£6.22 per head) to ensure a safe and sustainable general practice and has no additional commissioner requirements, £1.55m (£5 per head) to deliver the GM standards for primary care and £6.28m (£20.27 per head) will deliver collaborative general practice. Please see **section 6.6.2** – investment in primary care for full breakdown of new funding.

7.2 Narrowing the financial challenge

This business case is the core building block of the whole new approach to care delivery, the full integrated service solution. Therefore, without it the planned net savings envisaged through the Stockport Together programme will not be delivered. The investment into neighbourhoods will specifically contribute £9.48m net (£20.47m gross) benefit towards this total. Please see overarching economic case for full detail.

There will be an investment from the transformational fund and external sources in 2017/18 of £11.21m;

- Making existing services more safe and sustainable
- Address some of the historic underfunding in areas such as general practice and community nursing, and
- Avoid future cost growth by better management of individuals through earlier identification, preventative, integrated and proactive care.

7.3 Narrowing the health outcomes gap

Poor health outcomes and therefore the health inequalities gap is driven by a number of factors. Poor lifestyle and early diagnosis are significant contributors as are low mental wellbeing, social isolation and poor mental health. These challenges vary across the borough. This business case will contribute to addressing these drivers of inequality by:

- Increasing the capability of primary care to identify early the main causes of early mortality and extended morbidity through a proactive data driven approach to find and prevent,

- Investing in greater capacity to support individuals to change their lifestyle once risk factors and or conditions are diagnosed,
- Investing in greater mental wellbeing and mental health services including more effective community based approaches to address social isolation, and
- Giving the neighbourhood health & social care team greater flexibility on how they invest resources in and for their own area.

7.4 Improving patient experience

Through full implementation of this business case, there will be a range of improvements to patients experience;

- Reduced duplication
- Reduced need to tell the story on multiple occasions
- More holistic and personalised care is provided
- Reduced gaps between health and social care planning
- Reduced delays in discharge
- More support and advice at an early stage
- Improved accessibility at a local level
- Greater opportunity to shape health, care and wellbeing support around personal networks and goals
- Greater flexibility with packages of care

7.5 Deflection of activity from the acute setting

This business case will address the growth in demand discussed earlier that would otherwise materialise and reduce the higher than average use of hospital care evidenced in Stockport. The case when fully implemented will result in lower use in hospital services and care home admissions compared to that predicted for the existing service model:

- 6,400 fewer A&E attendances
- 5,100 fewer Non-elective admissions
- 30,200 fewer outpatients,
- 1,300 fewer elective procedures, and
- 721 fewer care home beds.

8 Benefits and evidence base of the Neighbourhood Model

8.1 Benefits

Our goal is to implement a new fully integrated 24/7 neighbourhood based model of health and social care which is based on the best available evidence and which has an emphasis on prevention and self-management. This will create the capacity and capability (in both primary and community care alternatives) to deliver the right care and support in or close to

people's homes rather than in hospital. It will enable delivery of the following high level outcomes;

- Keeping people independent at home for longer
- Ensuring safe and sustainable General Practice
- Reducing avoidable hospital admissions for those most at risk
- Substantially reducing avoidable visits to accident and emergency departments
- Reduce avoidable admissions to care and residential homes
- Reduce the average length of time people stay in hospital
- Transforming the traditional approach to outpatient and elective activity
- Better flow through system
- Providing a workforce available to offer more proactive, real time response for people than current out of hours offer.
- Reduced unnecessary admissions to hospital
- Improved offer to people
- Increased capacity in and support for the external provider market

Quantified benefits can be found in **tables 20a to 20d,** on pages 100 to 103 of this document.

The key patient benefits will be;

- People only tell their story once
- More coordinated, timely care
- Services available over extended hours
- More care provided locally
- Reduced confusing transfer between organisations and services
- Increased breadth of provision in local GP practices

The key system benefits will be;

- Practitioners working to shared population groups and priorities
- Efficiencies through shared assessment, care plan and reduction in formal referral processes
- Parity of esteem given to mental and physical health
- Reduced handoffs and costly repetition
- More appropriate use of resources
- Increased ability to rapidly move resource to where it is most needed
- Greater value achieved for each health and care pound
- Reduced 'gaps' where vulnerable people could be lost
- Greater focus on personalised approaches across the H&SC system – including joint commitment to holistic assessments, personalised planning, shared decision making, better use of community assets, greater focus on self-management

The key benefits for adult social care will be;

- More people are enabled to remain independent for longer
- Greater focus on personalisation across health and social care
- More opportunities to support early intervention and prevention

- 50% increase in capacity
- Greater control over wider resources required to deliver step up in response to deterioration
- Greater support for care homes
- Better planning and use of community resources
- Greater ability to meet care package requirements at a neighbourhood level
- Increased support from primary and community care on a seven-day basis

The key benefits for primary care will be;

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

The key benefits for community health will be;

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

The key benefits to care and nursing homes;

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

The key benefits for mental health;

- Increased opportunity for physical health training for mental health staff (peer to peer)
- Increased opportunity for mental health training for physical health staff (peer to peer)
- Increased multidisciplinary support for those with mental health support needs
- Informal support more aligned with formal support
- More opportunities for raising public awareness and informal guidance

- Parity of esteem for mental and physical health

8.2 Evidence base

The success of this business case is almost entirely contingent on the system's ability to ensure that the 15% of people most at risk of being admitted to hospital are able to manage their care better and that there are sufficient evidence based community alternatives to avoid unnecessary hospital based interventions.

Our analysis shows that there are a relatively small number of people in Stockport who are the heaviest users of health and care services. These are the 36,000 residents (15% of the overall population) who, at any one point in time, have the highest risk of being admitted to hospital in the next 12 months. (based on the Combined Predictive Model). This top 15% of those people most at risk, as at June 2016 accounted for 50% of all A&E attendances and 79% of all emergency admissions during the period July 2015 to June 2016. **Within this cohort at least 36% of these admissions (14,885 admissions) were in some way sensitive to ambulatory care and therefore potentially avoidable**

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

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

We are confident that these levels are deliverable because the local, national and international evidence supports both our service model and the underpinning assumptions that we have made about their impact on activity reduction particularly when set in the context that Stockport is an outlier in these areas nationally. A summary of the international evidence on the impact of integrated care by McKinsey 2015 ('The evidence for integrated care', March 2015) and subsequently NHS England 2015 ('Transforming urgent and emergency care services in England', August 2015), concluded that it is the impact of a number of key components operating together that can deliver the sort of step change that systems are seeking.

These are:

- **Implement Case Management within better, more joined up Neighbourhood Teams with greater capacity**: Assertively Managing acutely at risk populations through individual care planning and multi-disciplinary teams delivered primarily in primary and community care

- **Improve and increase Intermediate Care capac**ity: 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 recent local evidence. This business case relies heavily for the impact on non-elective activity of what is called the enhanced care and case management approach. In particular, the case has used the findings from the Fylde Coast Extensive Care Approach due to its similarity to the Stockport Neighbourhood Model.

Set out in the tables below, is a detailed analysis of the evidence bases that have been used to support each of the key interventions within the business case. The evidence base is set alongside the benefits in **tables 20a, 20b, 20c and 20d**, below;

Table 20a - Reference guide	
5	McKinsey 2015 ('The evidence for integrated care', March 2015)
6	NOS, 2015, Clinical Standards for Fracture Liaison Services, NICE, 2017 Quality Standard QS 86: Falls in Older People, NICE, 2013, Clinical Guideline CG 161: Falls in Older People: assessing risk and prevention
7	http://www.local.gov.uk/documents/10180/12193/Evidence+for+integrated+care+-+Review+November+2013/8f73b31d-4ed8-4a4a-831d-9bfa8b2c1ad3
8	http://www.medeconomics.co.uk/article/1286630/benefits-employing-pharmacists-gp-practices
9	www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/self-referral
10	www.england.nhs.uk/wp-content/uploads/2016/03/releas-capcty-case-study-4-104.pdf
11	http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf

Table 20b – Benefits and evidence for service developments in GP practice

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
GP Practice						
Navigate and Signposting	5.5%		£376,450	£0	0	• NHS Alliance 'Making Time in General Practice' suggests that 4% of GP time could be saved through enhanced navigation and signposting in General Practice. [11] • Local assessment suggests this could be up to 8% of GP time. • We have used the NHS alliance data which constitutes the lower of the two figures
GM Standards			£1,500,000	£0	0	
Total			**£1,876,450**	**£0**		

Table 20c Benefits and evidence for service developments in Collaborative general practice

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Collaborative general practice						
Find & Treat			£286,000	-£1,426,581	3,860 non-elective admission deflected for Diabetes, COPD, Hypertension, AF & Dementia	National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies for each disease group
Enhanced Pharmacy & Repeat Prescribing offer	5.5%		£2,000,000	-£5,000,000	Not applicable	• GP 5 year forward view • The Journal of MedEconomics[8] estimated that employing Pharmacists in Primary Care can save 7% of GP time just in dealing with patient medication queries generated by patient requests for prescriptions. This excludes other areas of GP workload that Pharmacy could impact • GP Magazine reported a reduction in GP workload of 30-40% through the employment of primary care Pharmacists across East London.
Enhanced physio offer	6.5%		£620,000	£0	Not applicable	• GP 5 year forward view • The Chartered Society of Physiotherapists suggests that up to 30% of GP appointments are for MSK and could be impacted by Direct Access Physiotherapy[9] • Physio First, West Wakefield found that 20% of GP appointments were for MSK complaints. They were able to impact 70% of these appointments. [10] For consistency, we have used the lower Wakefield findings which gives a net impact of 14% on GP workload
Mental wellbeing support			£450,556	£0	Not applicable	GP 5 year forward view
Neighbourhood treatment room & minor injury			£250,000	£0	Not applicable	GP 5 year forward view
Back office (EMIS)			£100,000	-£846,385	5632 in Out Patient First appointments	GP 5 year forward view
Healthy Communities	3.5%		£571,514	£0	Not applicable	• NHS Five Year Forward View: Empowering People & Communities, • Realising the Value economic modelling & five year key impact: peer support, self-management education & health coaching, group activities to support health & wellbeing, asset based approaches in a health and wellbeing context, JSNA data. • We have assumed that this service supports the deflections already set out in the Extensivist model set out above
Neighbourhood clinical triage	5.0%		£100,000	-£27,175	618 A&E (minors)	
Neighbourhood acute visiting	5.0%		£100,000	£0		
Primary care 7 day service			£1,890,146	£0		
Total			**£6,368,216**	**-£7,300,141**		

Table 20d Benefits and evidence for service developments in integrated services

DESCRIPTION	Reduction in GP workload	Increased capacity	Re-provision cost	Tariff Benefit Value 2020/21	Activity REDUCTION 2020/21	Evidence base
Integrated multidisciplinary teams						
Remodelled Neighbourhood Teams	2.5%	20%	£2,115,902	-£10,864,874	5,805 A&E Attendances 4,373 Non-elective admissions 3,058 Outpatient first appointments 21,591 Outpatient follow up appoint 569 Elective	• The evidence[1] for the impact on non-elective activity of what is called the Extensivist Care and Case Management approach ranges from 25-30% reduction for the high user cohort. • This business case has used the findings from the Fylde Coast Extensive Care Approach due to its similarity to the Stockport Neighbourhood Model • We have profiled the impact of the model on the top 6% of users in 2017-2019 and the top 15% of users in 2019-2021 • The evidence for Falls Prevention is well documented and subject to NICE Guidance[2]
Home support worker night service			£428,558			
Neighbourhood Teams Extended Hours			£677,485			
Mental Health	3.5%		£704,648			
Integrated Fall Service			£428,200			
Home care support / Care home support		Additional 65 long term care packages (net 4% increase)	£1,190,579	-£2,300,000	97 care home respite admissions 624 care home admissions 624 non elective admissions per week.	The Local Government Association undertook a review of the evidence regarding the impact of integrated care in general and case management specifically and found that there is evidence that it has resulted in a reduction in use of residential and nursing homes and an associated increase in use of home care services[3]
Enhanced Allied Health Professionals (Borough wide)			£587,343		Not applicable	
Total			**£6,132,715**	**-13,164,874**		
Grand TOTAL			**£14,377,381**	**-£20,465,015**		

9 Capacity and activity diversion (to release GP capacity)

Please read in association with **appendix 9** which gives fully detail per professional group

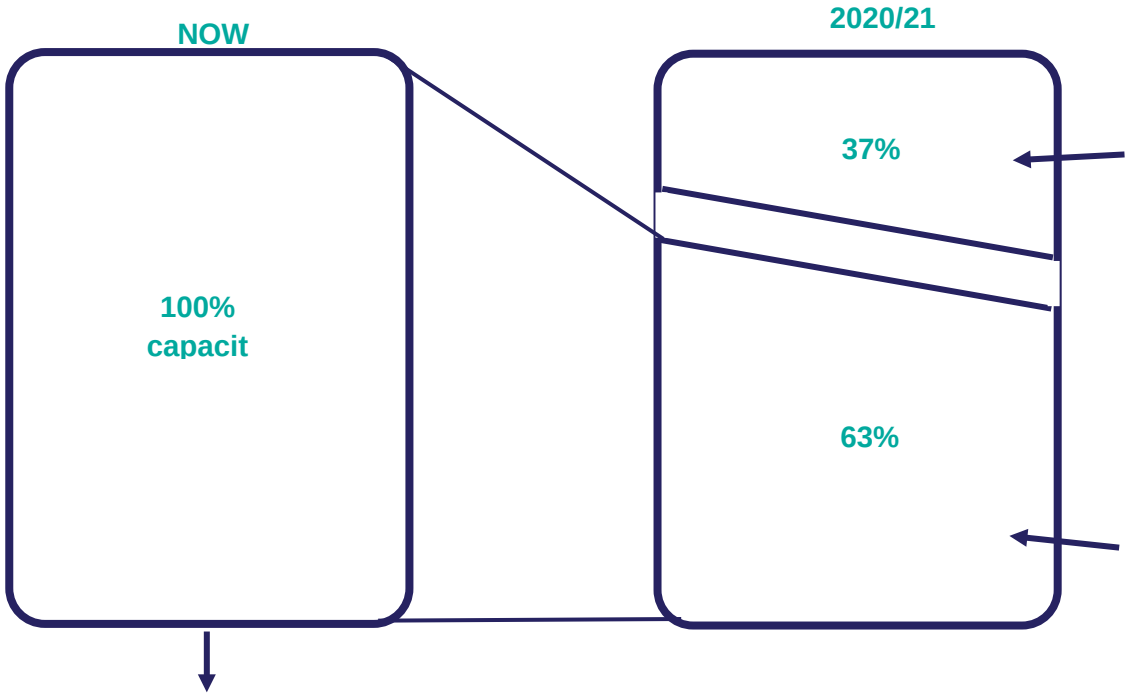
The neighbourhood model is projected to provide a total additional community / primary care capacity of 24% (of professional hours) by 20/21. For the purposes of this business case this is modelled upon national evidence points. A snapshot audit was conducted of potential activity diversion in Stockport, the results of which indicated total achievable diversion was consistent with the national evidence but root of diversion will vary (**Figure 13)**. It is therefore acknowledged that the ultimate neighbourhood delivery will vary based upon the needs of the local population. Neighbourhood leads will be able to flex delivery but must ensure equality of service offering across Stockport.

The underpinning model of MDT working, expanded primary care offer, integration and diversion of activity to the most appropriate member of the team will ensure greater efficiency through reduced duplication and reduced hand-offs. Of particular importance to the new model of care is freeing GP capacity, enabling this group to provide greater support for those with long-term conditions. This increased focus will underpin the required activity deflection from the acute setting. As represented in **Figure 12 on p105** the expanded primary care and neighbour team structures will enable the diversion of sufficient activity to release up to 37% of GP time. **Figure 13 on p106** provides detail of where this activity could be picked up. Additional capacity has been built into the service developments which will pick up the diverted activity from GP's (**Table 21**);

Service development	Increased capacity (hours per day across system)
Pharmacists	296
Physiotherapists (direct access)	90
Mental health and wellbeing	120
Neighbourhood teams	146
Healthy communities	135
Practice navigation	0
Neighbourhood clinical triage & acute visiting	30

Note – The anticipated utilisation figure is based solely upon the achievement of levels of activity diversion described in national evidence (**Tables 20a to 20d** on p100 to p103 and **table 22** on p107), cross referenced to the currently provisioned workforce. The figure does not consider additional activities, outside of diverted from GP's.

Figure 12 – total diversion of GP activity;



Capacity freed up to allow GPs to focus on delivering support for people with long-term Conditions.

Supporting safe and sustainable GP practices.

Ensuring more localised care can be delivered to those people who need more personalised support.

Time left to carry out 'residual duties', such as standard appointments.

Investment in primary care and increased capacity in neighbourhoods to divert workload from GPs via:

* Pharmacists
* Direct access physiotherapists
* Training for care homes
* Low level mental health support
* Improved workflow management
* Support to meet safeguarding requirements
* Informal support through 3rd sector and voluntary organisations
* Support for people to carry out better self-care

Figure 13 – anticipated GP activity diversion by key theme

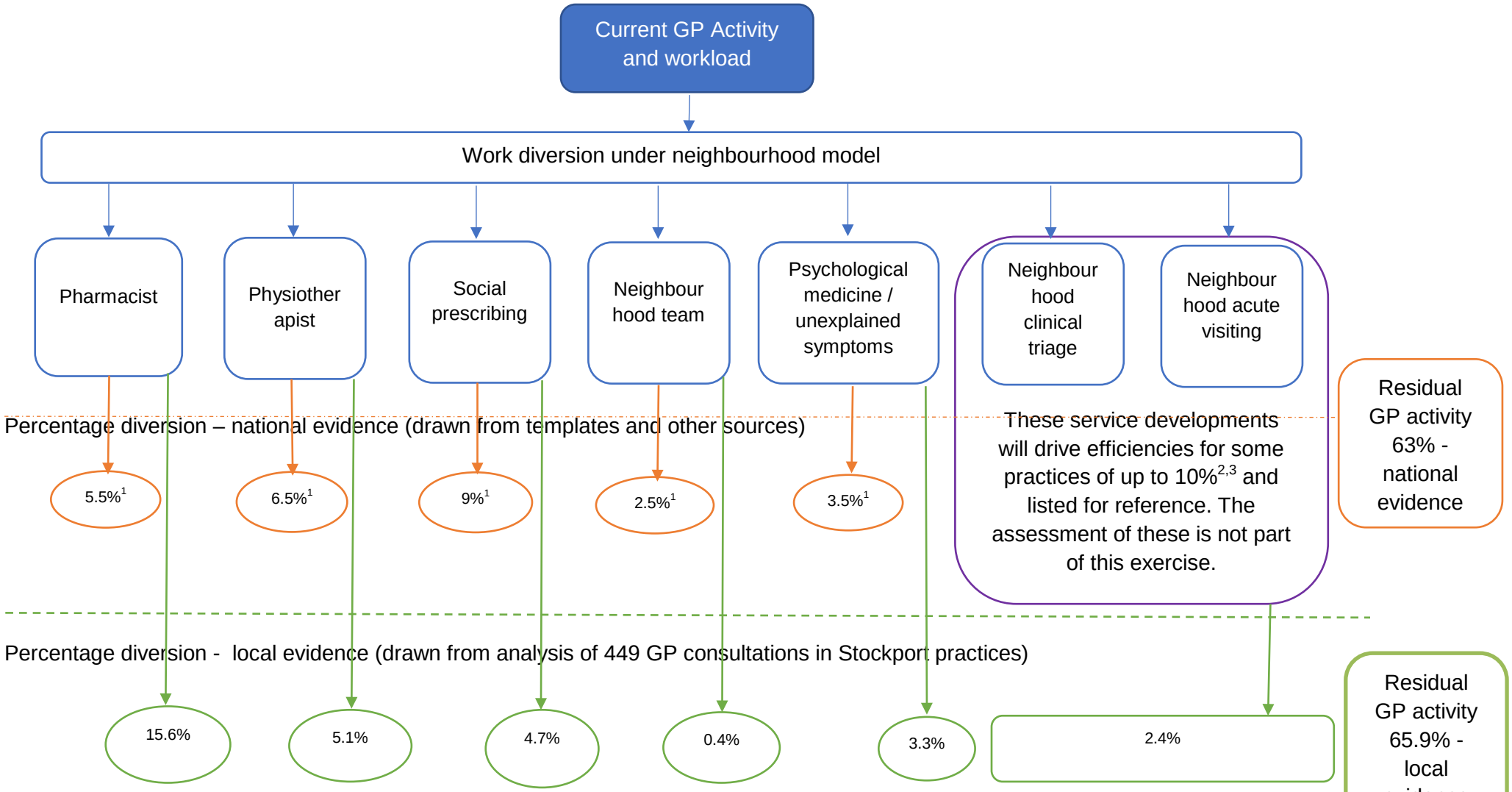


Table 22 - Evidence points for GP activity diversion

Ref	Evidence points for GP activity diversion
1	The future of general practice - Releasing the potential. Dr Robert Varnam - Head of general practice development NHSE. Primary Care can divert up to 27% of consultations to other professionals and community opportunities; Data collected from 5,128 consultations
2	**http://www.primarycarefoundation.co.uk/urgent-care-in-general-practice.html** **http://www.stoursurgery.co.uk/website/J00700/files/StourAccessSystemBrochure.pdf** **https://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf** **http://thelancet.com/journals/lancet/article/PIIS0140-6736(14)61058-8/fulltext?rss%3Dyes** **http://www.minorillness.co.uk/downloads/derbyshire.pdf** **http://www.nhsalliance.org/making-time-in-general-practice/** **http://gpaccess.uk/wordpress/wp-content/uploads/2013/01/Comparison-of-access-modes-AE-effect-v3-GPA.pdf**
3	http://www.pulsetoday.co.uk/home/practical-commissioning/how-our-acute-visiting-service-reduced-emergency-admissions-by-30-per-cent/20002277.fullarticle

9 Capacity and activity diversion (to release GP capacity)

9.1 Modelling assumptions and confidence

9.1.1 Assumptions

The above modelling has a range of associated assumptions;

- The diversions levels within **Figure 13** need refining are representative of the whole of Stockport
- Individual neighbourhoods will have access to data to be able to shape the workforce to meet local need and achieve the required outcomes
- The workforce modelling in Collaborative general practice is based upon individual service lead requests. This has not yet been modelled as a whole workforce. This exercise is likely to identify skill mixing opportunities and further efficiencies
- Equitability of an hour between professionals is not the same but mapped as (e.g. physio time is not equitable to GP time.
- It is thought that there will be patients who fall into multiple categories of diversion but the scale of this is currently unknown
- Future likely workforce of General practice (GP numbers, AHP etc.) is not known
- Growth in population will attract increased funding through national formula
- It is not currently possible to identify what percentage of increased capacity is going to absorb future growth, avoid growth (due to early intervention) and to support acute deflection
- It is not currently possible to confirm how much of the new capacity will be required to ensure safe and sustainable primary care
- The 27% in the Varnam paper refers to GP consultation time – our model is using GP total system hours, which are obviously different things. This will be clarified through the pathway work with clinicians
- The model currently uses ‘hours’ as the currency and assumes activity transfer has equitable time diversion. This is unlikely to be the case and will be clarified through pathway work with clinicians
- Benefit analysis at this stage is based on tariff reduction and further analysis is needed to equate benefit into cost reduction

9.1.2 Confidence

Given the above limitations the following confidence levels should be applied to key information;

Table 23 – confidence in data / modelling

Modelling area	Confidence level
Evidence base	
Strategic context	
Activity diversion levels	
Workforce requirements (overall)	
Workforce requirements (at individual neighbourhood level)	
Deliverability of outcomes framework (at individual neighbourhood level)	
Funding required	
Modelling of benefits realisation (at individual neighbourhood level)	

Note; Confidence has increased since previous versions of the neighbourhood business due to the completion of additional local modelling and caseload analysis. This work demonstrates that the activity diversion levels described in the national evidence are similar to those achievable in Stockport. Each neighbourhood has a different patient profile so will require a different workforce. Modelling at a neighbourhood levels is underway and once complete, will enable confidence level on the remaining 3 categories to be raised to green.

10 The Economic and financial case

The financing of this business case is contingent upon three factors;

1) In the short term (2017/18) initial levels of investment will be funded from a combination of;

    - Transformation Funding secured from Greater Manchester as part of the Investment Agreement
    - External funding bids to cover the costs of the significant additional pharmacist capacity (3 year NHSE funding achieved)
    - CCG allocations relating to specific developments in General Practice and the GP Forward View

2) In the medium and longer term (2018/19 – 2020/21) maintaining the CCG allocations and the release of the Stockport Together benefits, delivered through a combination of reducing acute capacity and managing growth in acute demand.
3) Across this whole period, a risk share agreement that underwrites the investment risk across the Stockport Together partners. This agreement is described in further detail in the summary economic case.

The profiling of investment and sources of funding are described in the table below;

Table 24 – investment and source profiling

	17/18	18/19	19/20	20/21
Funding	PYE	FYE	FYE	FYE
Savings	£0	-£11,170,168	-£14,907,353	-£20,465,015
Transformation fund	-£5,289,390	-£455,787	£0	£0
CCG funding	-£1,890,146	-£1,890,146	-£1,890,146	-£1,890,146
GM Standards	-£1,500,000	-£1,500,000	-£1,500,000	-£1,500,000
CCG Transformation fund	-£1,750,000	£0	£0	£0
BCF (Falls)	-£75,000	£0	£0	£0
NHSE Pharmacy funding	-£705,000	-£480,000	-£262,500	£0
Total Funding	**-£11,209,536**	**-£15,496,101**	**-£18,559,999**	**-£23,855,161**

Table 25 describes the detailed investment to be made. In addition to the contributions from Stockport Together savings elsewhere in the system it includes for completeness £3.4m of CCG investment Primary Care 7 day access and Greater Manchester Primary Care standards.

Table 25 – Cost and benefit table

DESCRIPTION	17/18 Phasing	18/19		19/20		20/21		Start date
		Cost	Benefit	Cost	Benefit	Cost	Benefit	17/18
	PYE							
Integrated multidisciplinary teams								
Remodelled neighbourhood teams	£2,528,617	£3,242,223	-£6,395,013	£2,575,420	-£8,148,655	£2,115,902	-£10,864,874	Q1 & 2
Home support workers night service	£321,418	£428,558	£0	£428,558	£0	£428,558	£0	Q2 July 17
Neighbourhood teams extended hours	£508,114	£677,485	£0	£677,485	£0	£677,485	£0	Q2 July 17
Home care support / Care home support	£1,054,000	£1,190,579	-£2,300,000	£1,190,579	-£2,300,000	£1,190,579	-£2,300,000	Q2 July 17
Mental Health	£352,324	£704,648	£0	£704,648	£0	£704,648	£0	Q3 Oct 17
Falls service	£218,350	£428,200	£0	£428,200	£0	£428,200	£0	Q3 Oct 17
Enhanced AHP	£293,672	£587,343	£0	£587,343	£0	£587,343	£0	Q3 Oct 17
Total	**£5,276,496**	**£7,259,037**	**-£8,695,013**	**£6,592,233**	**-£10,448,655**	**£6,132,715**	**-£13,164,874**	
Collaborative general practice								
Find & Treat	£73,000	£286,000	-£71,329	£286,000	-£570,633	£286,000	-£1,426,581	Q4 Jan 18
Enhanced pharmacy & rpt prescribing offer	£1,000,000	£2,000,000	-£1,500,000	£2,000,000	-£3,000,000	£2,000,000	-£5,000,000	Q3 Oct 17
Enhanced physio offer	£620,000	£620,000	£0	£620,000	£0	£620,000	£0	Q1 Apr 17
Mental wellbeing support	£337,917	£455,062	£0	£455,062	£0	£450,556	£0	Q2 July 17
Neighbourhood treatment room & minor injury	£125,000	£250,000	£0	£250,000	£0	£250,000	£0	Q3 Oct 17
Back Office (EMIS)	£50,000	£100,000	-£870,276	£100,000	-£857,871	£100,000	-£846,385	Q3 Oct 17
Healthy Communities	£142,864	£559,406	£0	£565,424	£0	£571,514	£0	Q4 Jan 18
Neighbourhood clinical triage	£50,000	£100,000	-£33,549	£100,000	-£30,194	£100,000	-£27,175	Q3 Oct 17
Neighbourhood acute visiting	£50,000	£100,000	£0	£100,000	£0	£100,000	£0	Q3 Oct 17
Primary care 7 day service	£1,890,146	£1,890,146	£0	£1,890,146	£0	£1,890,146	£0	
Total	**£4,338,928**	**£6,360,614**	**-£2,475,154**	**£6,366,632**	**-£4,458,698**	**£6,368,216**	**-£7,300,141**	
GP Practise								
Enhanced admin 'banding'	£94,113	£376,450	£0	£376,450	£0	£376,450	£0	Q4 Jan 18
GM Standards	£1,500,000	£1,500,000	£0	£1,500,000	£0	£1,500,000	£0	
Total	**£1,594,113**	**£1,876,450**	**£0**	**£1,876,450**	**£0**	**£1,876,450**	**£0**	
TOTAL	**£11,209,536**	**£15,496,101**	**-£11,170,168**	**£14,835,316**	**-£14,907,353**	**£14,377,381**	**-£20,465,015**	

11 The Commercial Case

The range of services set out within this business case spans a number of pre-existing and future contracts, these are:-

- The national uplift for GP services. This is covered by the national GMS/PMS contract negotiation process. These are contracts in perpetuity and therefore no procurement process will be undertaken.
- The local stability payment to General Practice. This is a payment that can only be made to holders of GMS/PMS contracts in Stockport. The Stockport GP Development Scheme contracts will be varied to include the GM standards and the associated contract payment.
- 7-day access services. NHS Stockport CCG has an existing contract agreement with Viaduct Care to provide 7-day access services.
- Non-recurrent payments for services funded by the Investment Agreement. These will be transacted as fixed term contract variations to existing contracts with the individual providers.
- Integrated 7-day Community Services – there are two potential provider models to deliver these services: -
- A partial or fully integrated MCP. Stockport CCG and Stockport MBC initiated a procurement process in April 2016 for a Stockport MCP. A significant volume and value of the services described within the integrated 7-day community services fall within the scope of this procurement process.
- A virtual integrated MCP. As set out in the national MCP guidance a procurement process is not required where an alliance agreement is established and existing contracts remain fundamentally unchanged. It is anticipated that such an alliance agreement will inevitably be required because;

a) Service delivery will commence in advance of completion of the procurement process and all services must be delivered within an appropriate contract.

b) Not all services will fall within the scope of the MCP procurement but these are covered by existing contract agreements.

It should be noted that the most significant funding source is services already included within existing agreements. The impact of this business case is therefore not to increase the value of contracts in aggregate but firstly to reduce the value of the contracts in scope and secondly to redistribute income across services / sectors.

11.1 Strategic Objective

The local commissioners (NHS Stockport CCG and Stockport MBC) have commenced procurement for a Multi-Specialty Community Provider (MCP). The commissioners have identified three fixed-point providers. This is subject to the successful outcome of that procurement process and nothing in this section will prejudice that process.

This business case therefore describes who the commissioners will contract with for the various elements of the service model under existing arrangements. If the procurement of an MCP is concluded successfully contracts will novate accordingly in line with the negotiated agreement and mobilisation timescale of the said MCP.

11.2 Options and Approach

Schedule 1 Commercial Detail (to follow), describes in detail which service elements described in the business case will be contracted with and by whom; the contractual basis of this arrangement, and the time frame.

Given that the majority of these services will be provided by the fixed-point providers or their chosen partners as described above the principle means of contracting in 2017-18 onwards will be via variations to existing contracts. Broadly these can be summarised as:

- Uplift will be applied to existing GMS/PMS contracts by the CCG under its delegated powers from NHS England
- Additional services at GP practice level will be variations to the existing GP Development Scheme held between the CCG and individual practices
- Collaborative general practice services will be via a contract variation of the existing arrangements Between the CCG and Viaduct Care
- Additional investment in community health services will be via a variation in the existing community health service contract held between the CCG and Stockport NHS Foundation Trust
- Additional investment in community mental health services will be via a variation in the existing contract held between the CCG and Pennine Care NHS Foundation Trust

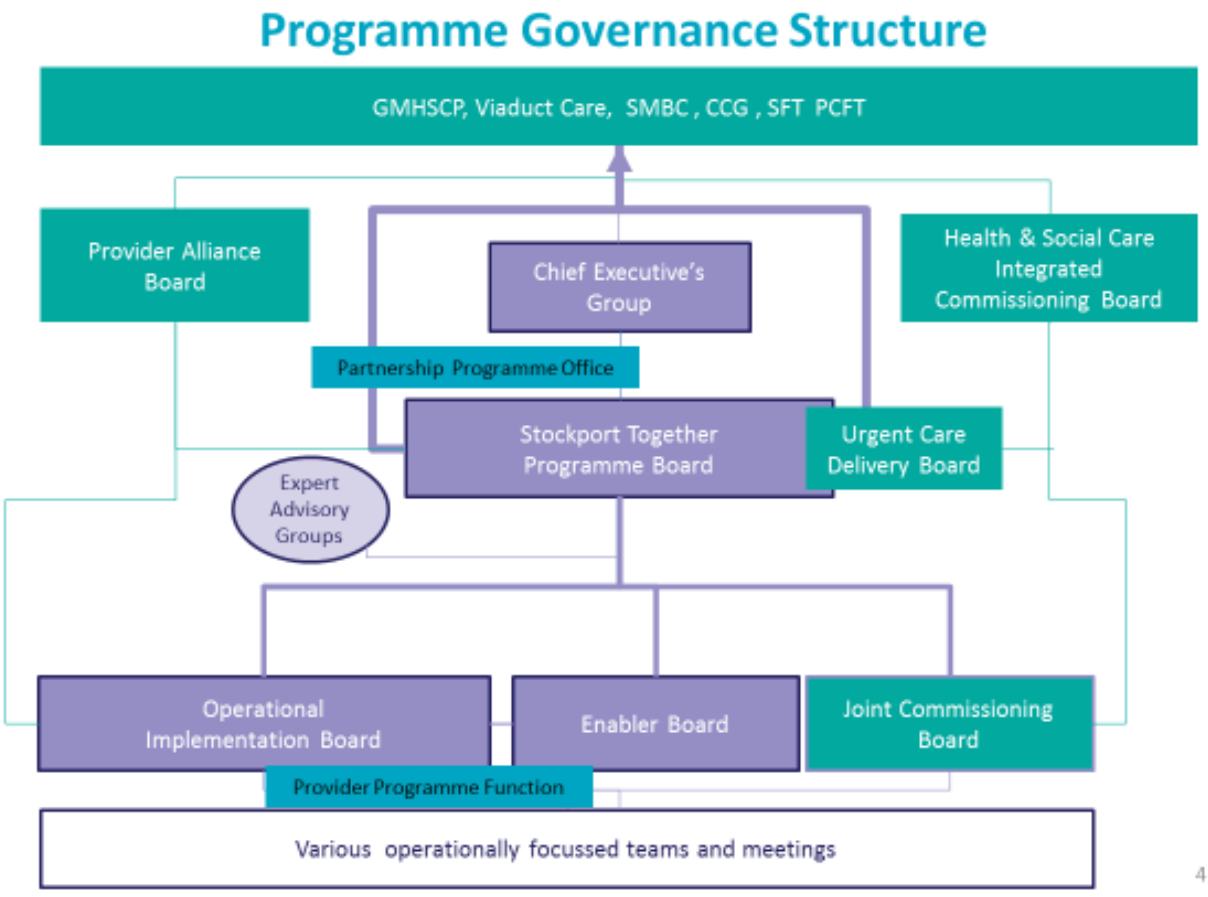
Contracts funded through the Section 75 pooled fund will be overseen by the Health & Social Care Integrated Commissioning Committee of the Council and CCG.

12 The Management Case

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

The Stockport Together programme has had a clear governance structure and formal governance arrangements in place for 2 years which are regularly reviewed. These arrangements have overseen development of the plans and will oversee implementation of the Integrated Service Solution including the Core Neighbourhood Business Case

These are set out below in **Figure 14 – Governance structure**



The Leaders Group is composed of the Chief Executives of all five statutory health and care organisations in Stockport. It provides and communicates the vision and strategic direction for Stockport Together and the Integrated service solution. The group also manages the external messages and relationships and resolves any unresolved issues at Executive Programme Board

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

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

The mobilisation and implementation of the business case and benefits realisation will be supported by access to a single integrated Stockport Health and Care Programme Office and Transformation Team augmented with commissioned support from external agencies including AQuA, ECIP and Skills for Health. This will comprise a core team of 25 wte including Programme Managers, Change managers, Workforce Advisers, Communications experts and OD specialists.

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

A draft Service Development implementation timeline fully aligned to benefits realisation is included as **appendix 10**

13 Risks

The risk assessment was under-taken against a framework of risk areas and then assessed against impact (I) and Likelihood (L) to give a risk rating (R). Each risk was rated o a scale of 1-5 against impact and also 1-5 against likelihood. The overall risk rating is impact x likelihood.

Table 26 – risk matrix

Level	Score	Colour
Extreme	20-25	
Very High	15-19	
High	10-14	
Moderate	6-9	
Low	1-5	

13.1 Strategic

The strategic risks listed here **(table 27)** are taken from the summary economic case, relating to failure to release benefits across all the business cases.

Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
	Failure to effectively manage demand for acute hospital urgent and planned care interventions as set out in the benefits realisation plan				• 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			

1		4	5	20	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	3	4	12

					Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health			
2	Failure to effectively implement the new service model, leverage the required change in system and workforce behaviours and implement new ways of working across a disparate workforce	4	5	20	• A well-resourced single programme management office will oversee the implementation and change programme • Providers will implement a Transitional management structure which will establish single line management accountability across Providers for all in-scope services • The Executive Management Board will be responsible for change control and ensuring that the implementation delivers the expected benefits • The new models of care will be supported by access to a comprehensive and tailored programme of Organisation, Team and Personal development to drive the required cultural change enabled by a single Stockport Health and Care Programme Office and Transformation team with commissioned support from external agencies including AQuA, ECIP and Skills for Health • Internal Change teams will be	3	4	12

					created and staffed by people from across organisations with appropriate external support and facilitation • Providers will implement a formal alliance supported by integration agreements setting out delegated authority powers • Leadership will drive system thinking and breaking down of silos • Barriers to joint working will be addressed (whether IT, IG, cultural)			
3	Failure to increase out of hospital capability and capacity to that required in the business cases to deliver the quality care for people in the community by successfully recruiting a new type of workforce whilst retaining, developing and retraining existing teams	4	4	16	• Development of a clear and comprehensive Workforce Strategy integrated across Providers • Implementation of Integrated Recruitment and Retention strategies which make a compelling offer to the unqualified workforce not currently engaged in care • A new offer to the External Homecare market • A well-resourced, capable single programme management office will oversee the mobilisation, implementation and change programme • Development of HR shared services across Stockport	3	3	9

					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 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			
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	3	4	12

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

The operational risks listed here **(table 28)** are directly applicable to the implementation of the neighbourhood business case and if realised, would ultimately manifest in the non-delivery (partial or full) of the benefits (i.e. realisation of the strategic risks in section 13.1).

Risk	Description	Prior to mitigation			Mitigation	Post-mitigation		
		Likelihood	Impact	Rating		Likelihood	Impact	Rating
1	The availability and suitability of estates within each neighbourhood is not clear. Subsequently it is unclear whether adequate physical space exists to support the delivery of the neighbourhood model. The risk is that the described model is undeliverable due to variable estate options across neighbourhoods and unknown estates constraints.	3	4	12	• Full neighbourhood estates review planned to be completed by July 2017 • The implementation of the model will be different in each neighbourhood, reflecting available resources • Co-location of front line staff, enabling integration and collaboration will be prioritised Estate will be considered across sectors rather than in silos (with commitment to avoiding variable and disproportionate pricing) • Where less than ideal estates solutions are available applications for new funding through national funding opportunities will be made as and when they arise • New working patterns and enabling technology will allow greater flexibility and more efficient use of estate	2	3	6

2	Assumptions (based on national evidence) have been made as to how much GP activity can be diverted to other professions. The released capacity is required so GP's can support new ways of working and provide additional support to those with LTC's, thus enabling the safe reduction in acute activity. The risk is assumptions around activity diversion are not effectively enacted or base assumptions are inconsistent with what is achievable in Stockport / in an individual neighbourhood. If the risk materialises GP's will be unable to provide the additional time for patients with complex needs meaning the acute activity will not sufficiently reduce. (links to risks 3 and 4)	3	5	15	• Neighbourhood level patient need profiling will be conducted prior to implementation, ensuring the prominence of specific service developments and provided workforce match the needs of local people and align with the delivery of overall benefits and outcome measures • Funding will be distributed between neighbourhoods based upon weighting for deprivation and demographic profile • Benchmarking across GM, England and relevant NHSE groups (e.g. new models of care) will be used to support ongoing identification of opportunities for additional gain / sharing of best practice	2	4	8
3	This business case and the successful implementation of the model is critical to the future sustainability of the Stockport health and social care system. There are significant changes in setting for funding and where activity must be conducted. There are key concerns within the system around this; 1. Primary care needs to be	4	5	20	• Modelling will be shared with all stakeholder groups prior to implementation (final plans will be post public consultation) • Appropriate contracts will be signed with all relevant parties • Initial 'quick wins' around outpatients (described in the outpatients business case) will be used to build confidence within primary care	3	4	12

	confident that long-term funding will switch from the acute to primary care setting, thus enabling more patients to be supported out of hospital 2. Acute care needs to be assured that sufficient activity will switch in the required time to enable the management of cost base and income diversion These 2 concerns are the same situation but considered from 2 different viewpoints. There are 2 key risks. **Risk 1 of 2** – Concerns around timing of funding shift delay the model implementation, leading to insufficient activity switch during the time when transformation funding is available (links to risks 2 and 4)				• Wide involvement of primary care in the implementation will support ownership and confidence development • Commitment from Stockport FT and Viaduct will be joint and widely communicated • All GP's will have the opportunity to discuss and inform final plans prior to implementation • Viaduct will take a leadership role in ensuring GP's are informed and able to express opinions			
	This business case and the successful implementation of the model is critical to the future sustainability of the Stockport health and social care system. There are significant changes in setting for funding and where activity must be conducted. There are key concerns within the				• A single programme management office will oversee the change programme • Change teams will be staffed by people from across organisations • Leaders from across the system shall taking joint responsibility for the delivery of change			

4	system around this; 1. Primary care needs to be assured that long-term funding will switch from the acute to primary care setting, thus enabling more patients to be supported out of hospital 2. Acute care needs to be assured that sufficient activity will switch in the required time to enable the management of cost base and income diversion These 2 concerns are the same situation but considered from 2 different viewpoints. There are 2 key risks. **Risk 2 of 2** – All system partners commit to enacting the new model but existing structures fail to adapt quickly enough to enable sufficient activity shift prior to transformation funding running out (links to risks 2 and 3)	4	5	20	• Providers will jointly sign partnership / integration agreements • Providers shall sign risk / gain share agreements, committing to collective responsibility • Leadership will drive system thinking and breaking down of silos • Barriers to joint working will be addressed (whether IT, IG, cultural	3	3	9
5	The outcomes framework has been developed to ensure improved public health and avoided annual future recurrent costs of £14m by 2020/21. The risk is that current system pressures and focus on managing	4	4	16	• The draft outcomes framework has been developed to reflect the ability of providers to impact on outcome measures • A clear evidence base has been used to build the outcomes framework, ensuring deliverability • Performance monitoring will	2	3	6

	immediate demand prevents sufficient focus on early intervention and prevention, thus failing to deliver the required changes in public behaviour and improvements in population health.				reflect the achievement of outcomes, giving early indications of variance • Service developments such as find and prevent have been designed to target those at risk of developing an LTC • New support around lifestyle change is resourced through this business case and others • The neighbourhood model draws on local knowledge, expertise and assets to ensure maximum impact • Integration will ensure staff learn from other sectors and are able to deliver an holistic, person centred approach which draws on the individual's abilities, networks and ambitions • MDT's will include voluntary sector representation ensuring close working and knowledge of what is available locally • Additional capacity has been built into the voluntary sector, selfcare support and lifestyle coaching services			
	Sharing data between health and social care has been challenging, reducing the ability to accurately map joint caseloads within the 15% high use cohort.				• Information sharing agreements have been signed between all partners (including all individual GP practices) • The implementation of EMIS as the single use community system			

6	The risk is that operational delivery of the new model / this business case (particularly integrated care / services) will be inhibited due to an inability to effectively share data	3	4	12	will ensure shared view and reduce duplication • MDT's and integrated working will ensure close practitioner to practitioner relationships, enabling sharing of knowledge in the best interests of patients • Medium term data indexing options will provide greater digital integration	2	3	6
7	Public consultation is yet to happen and may change the Stockport Together plan. The risk is that changes mean the model does not deliver the required system benefits	4	4	16	• Financial and clinical benefits will be remodelled following public consultation to understand any changes in benefits • The public consultation will make clear the need and rationale for change to ensure the public can provide informed commentary • Local press will be engaged with the process • Significant elements of the neighbourhood model (particularly integration, MDT approach, community development, early intervention and prevention, selfcare etc.) would not be subject to Public consultation and the development has been driven through significant patient, staff and public engagement	3	4	12
8	Some service developments within Primary Care are yet to be fully developed, costed and mapped to				• All the larger service developments have been more accurately mapped, leaving work			

	the required level of benefits realisation. The risk is that incorrect amount of resource has been applied to deliver the required benefit (particularly release of GP time) having a knock-on effect of the neighbourhood model having insufficient of the correct resource to be able to support the required numbers of patients in community and primary care setting.	3	3	9	to do on some of the medium to smaller impact developments	2	3	6
9	There are an estimated 51,400 undiagnosed incidents of key long term conditions in Stockport (covering diabetes, pre-diabetes, hypertension, atrial fibrillation, dementia and COPD). The neighbourhood business case anticipates identifying 21,900 of these incidents by 2020/21. This is 41.6% of the total estimate. The Stockport Together / Neighbourhood models are designed to manage this number of people. The risk is that the Find and Prevent service successfully identifies more people than this and the capacity to support these additional people is not in place.	3	4	12	• Numbers of cases identified through the find and prevent service will be monitored. Over performance will be escalated • Impact of the find and prevent service will be monitored in terms of released capacity at the acute trust and avoided complications • Should more people be identified / the target be hit sooner that 2020/21, sufficient evidence will have been compiled to accurately evidence cost benefit and justify further diversion of income to fund the early intervention programme.	2	3	6
	The delivery of the neighbourhood				• A new quality and transformation			

10	model requires the home care and care home market to work in a new way, with adequate capacity to ensure people are able to return home after periods of acute care in a safe and timely way. The risk is that these sectors are unable to respond effectively to the commissioning intentions.	3	4		team is funded through the Neighbourhood business case to support the change programme • Initiatives to support effective transfer are being developed / implemented, including discharge to assess • SMBC will implement effective contract management and provider engagement processes to ensure alignment to the Stockport Together model.	2	3	

14 Implementation milestones

Please see **appendix 11**, Programme milestone