NEIGHBOURHOOD OUTLINE BUSINESS CASE APPENDICES

SERVICE AREA:
MENTAL WELLBEING?

Component	Description
Current. Brief description of existing services (i.e. how many sites, how many staff, functions, ***opening hours***, capacity). (NUMBERS)	Patients with mental health conditions who present at general practice can be complex and time consuming and often the GP appointment is not long enough to explore and manage the underlying issues in great depth. Around 30 % of GP consultations are for patients with low level / social needs / mental health related conditions which could be due to a multitude of reasons. Evidence from a small local pilot and similar services such as those piloted through the Prime Ministers challenge fund show the benefits in GP's having direct access to a service able to explore the issues causing the mental health condition in patients and then connecting the patients to the appropriately services such as social prescribing, self-help, mental health alliance and other voluntary groups. The opportunity of developing a new service provision that particularly focuses on the lower level social and wellbeing Mental Health issues will support the approach of making time and managing demand with greater integration in General practice as recommended by the GPFV and Making Time in General Practice. **PILOT Current** The provision of navigational services for low level Mental Health / Social and Wellbeing conditions in the Tame Valley Neighbourhood covering 8 practices with a combined list size of 47,500~patients. The service is currently being delivered over 5 sites in GP practices within the neighbourhood. The 2 WTE navigators work 8am to 4.00pm (sometimes later at patient request) and the capacity is spread over the five sites based on room availability and weighted list share of hours per practice. As the service is currently still in development full capacity has not been reached.
Problems & Opportunities: What could change – ***2 sentences***	The proposed change is to provide general practice and the neighbourhood teams with direct access to Care Navigators in a local setting. Patients will be given the appropriate consultation time and once the underlying issues are established they are navigated to the most appropriate service based on their needs. In some cases patients may be referred back into General practice once the social issues are resolved to deal with any health related conditions. It is envisaged that not all patients will need to follow this pathway as some patients will be treated by medication or will not be suitable or need this support. Opportunities: To train and develop new staff into the role and involve the skills already available in the voluntary sector.

New service: What people, what processes, what use of technology, what additional capacity, what functions, clinical / professional governance (NUMBERS)	The proposed change is to provide general practice and the neighbourhood teams with direct access to Care Navigators in a local setting. The plan is for 16 Care navigator posts to be shared across the neighbourhoods based on weighted list size. The navigator will hold a minimal caseload with the majority of patients only seen once with one follow up and then discharged (primarily consisting of 'frequent users' of GP practices) with the aim that these patients will experience improved health and wellbeing and a reduction in their use of GP practice resources and also attendance at ED. Hubs will be set up across the neighbourhoods and each practice will have access to book direct appointments with the Care Navigators. The aim of the service is to develop and implement effective action plans that will address the individual's non-medical needs. The service is not a support service. Its purpose is towork with individuals to identify their needs and navigate them to support services or encourage self-referral to community groups or other organisations. Patients will be booked into the service directly by receptionists and via referrals from other professionals. Patients will be offered a face to face appointment/ telephone consultation within one week of referral. Patients will be given 40 minute appointments for their initial assessment in order to identify the underlying issues requiring access to other services. The service is not in itself a therapeutic or counselling service but aims to work with the individual patients to promote confidence in self–care, independence and an improved sense of health and wellbeing. The service, when appropriate, will introduce to the patients the different approaches to health care; to assist and encourage them to make their own decisions and choices. The service will use an enabling approach that draws on individuals' strengths, preferences and support networks. Patients will be provided with self-help information and tools. In some cases it may be more appropriate to a telephone discussion to help patients identify their health and well-being goals. Communication with patients will also include email or text for follow-up Specific service aims are: • To support patients with mental health conditions by providing additional time to listen and identify the underlying issues that underpin their conditions. • To provide a pathway to support, appropriate to their needs. • To provide quicker access to patients in need. • To provide alternatives to medication such as social prescribing. • To provide support to General Practice in providing additional manpower. • To facilitate standardisation of good practice across Stockport. • To provide local services in the neighbourhood. • To pro-actively prevent patients reaching critical point. • To support integrated working across Stockport on a neighbourhood footprint. • To reduce acute admissions and unnecessary secondary care attendances.

	• To provide faster referral pathways into secondary care mental health advice services. • To liaise with GP front of house staff in signposting to services. • To ensure that people have and report a good experience when they access the service.
7 day service – describe the extent to which service offer is over 7 days and links where appropriate to 7 day services – GP or otherwise	Currently it is not planned to include a Saturday and Sunday service but referral pathways should allow for patients seen on those days to be referred into the service and be seen by the navigators in routine appointments Monday to Friday**.**
Benefits: What will it deliver in terms of outcomes, benefits to population, and efficiency improvements (Cash & time) (NUMBERS). What evidence is the basis of this (*National evidence, Local pilots, Assumptions)*	The 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

Costs: What will it cost and how was this derived? (Staffing, technology, start-up non-recurrent and recurrent)

£450,000~ per annum

			WTE	Cost	Total
2017/18 All neighbourhoods					
Workforce				£	£
	AFC Band	XN060 2	**1**	34276.53	
		XN050 2	2	55865.96	
		XN407	12.33	344413.67	£434,556.17
Training					£6,000.00
Estates I&T					£6,000.00
Management cost					£4,000.00
					£450,556.17
2018/19 All neighbourhoods				£	£
Workforce					
	AFC Band	XN060 2	**1**	34619.30	
		XN050 2	2	56424.62	
		XN407	12.33	347857.81	£438,901.73
Training					£6,060.00
Estates I&T					£6,060.00
Management cost					£4,040.00
					£455,061.73

FIND AND PREVENT

Purpose

This business case focuses on three different cohorts of people:

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

This business case looks at how these three groups can be better identified and assessed in primary care settings. By **finding** people through consistent and systematic use of EMIS search and reports, we can develop protocols and processes to invite people for enhanced health checks within the neighbourhoods, following which appropriate **treat** responses can be made.

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

By using **Healthy Living Pharmacies** as well as EMIS Search and Report within General Practice we will further develop our ability to find and assess people in their communities.

These programmes will together reduce:

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

Other Stockport Together business cases are focussing on those who already have multiple long term conditions and who are currently at high risk of exacerbation or admission; this business case is **focussed on the longer term prevention for those who have yet to develop complex care needs** as there is an increasing level of disease, potential disease and levels of complexity due to multiple conditions as the population of Stockport gets older.

The prime rationale is therefore to reduce in the long term the level of disease, providing a better quality of life for patients and their families, and increasing healthy life expectancy, in other words to **close the health and wellbeing gap.**

The secondary rationale is that the current health system was not established to manage long term health problems. Over time it has adapted to do so but is now under severe pressure from the volume of activity that this requires, and therefore a new approach is needed. If we can get ahead of the development of disease and stabilise or prevent the development of disease we can make the **future of the health system more sustainable (closing the funding and efficiency gap).** Without a preventative approach we will continue to be faced with rising demand and soon patients and services will be experiencing the consequences of the predicted diabetes type 2 and other disease time bomb.

A third rationale is to address the **variation in health outcomes (inequalities) and care**

provision (quality gap) across Stockport. It has been shown that improving the health of the population in our most deprived populations to levels experienced in other parts of the Borough would significantly reduce the burden of disease in the borough. Stockport generally has a high quality of care in General Practice, with many examples of innovation and excellence; there is however still variation between practices. This programme will enable the **standardisation of prevention and the sharing of good practice, reducing variation and enabling the lower performing areas to level up to the best.**

A fourth rationale is to give the necessary support and structure to enable the Stockport system to **quickly mobilise to generate referrals into the NHS Diabetes Prevention Programme.** This programme is being extended across Greater Manchester from April 2017, and is only confirmed to be available for a two year period. We need to ensure that as many people at risk of type 2 diabetes as possible are offered the structured prevention programme, funded by NHS England.

A final rationale is to maximise the opportunities from the existing **Healthy Living Pharmacy** programme to ensure that there are ways to engage people beyond the General Practice setting and additionally to ensure that the pharmacy sector is supported through the transition to the new national contract.

Together these rationales build a case for change based on the five year forward view vision of **a radical upgrade in prevention.** General Practice already have many good examples of proactive and preventative approaches to long term condition management, particularly via the QoF and for early identification, such as the NHS Health Checks. The find and prevent programme aims to build on this by **improving the quality of the existing provision, by reducing variation and by extending these approaches in to more conditions**.

Background

LONG TERM CONDITIONS

Over a quarter of the population in England has a long term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes that, "Long Term Conditions are now a central task of the NHS".

People with long term conditions currently use a significant proportion of health care services

- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and healthcare costs are significant. 15.4 million people in England are recorded as having have a long term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million by 2018).

In Stockport, 27% of the population (84,700) have one of the 8 key conditions and this increases with age, from 2% in the 0-4 age band, to 88% in those aged 85 and over. By age 60, half of the people have one or more of these conditions and 15% of the population have two or more of 8 key long term conditions. Many more may also have a condition which is currently undiagnosed.

The table below shows the most common long term conditions in Stockport:

Long-term conditions overview

Stockport JSNA
joint strategic needs assessment

Condition	Number	Gender Profile	Age Profile	Deprivation Profile
Hypertension	44,745		Increasing from mid 40s	Rates increase with deprivation, number decreases
Anxiety (last 10 years)	30,085	Higher in women	Highest from 25 to 50	Rates increase with deprivation
Depression	29,130	Higher in women	Highest in 40s and 50s	Rates increase with deprivation
Asthma	20,545	Slightly higher in women		Rates increase with deprivation, number decreases
Obesity	20,050*			
Diabetes	15,700	Slightly higher in men	Increases from mid 40s	Rates increase with deprivation
Coronary Heart Disease (CHD)	12,230	Higher in men	Increases from mid 40s	Rates increase with deprivation, number decreases
History of Fall	12,150	Higher in women	Increases from 50s, sharply in 80s	Rates increase with deprivation, number decreases
Cancer	8,540		Earlier in women	Rates and numbers decrease with deprivation
Chronic Kidney Disease (CKD)	7,670	Slightly higher in women	Increase from 50s	Rates increase with deprivation, numbers decrease
Chronic Obstructive Pulmonary Disease (COPD)	7,170		Increases from mid 40s	Rates increase with deprivation
Stroke or Transient Ischaemic Attack (TIA)	6,395		Increases from mid 40s	Rates increase with deprivation, numbers decrease
Atrial Fibrillation (AF)	6,200	Slightly higher in men	Increases from 50s	Numbers decrease with deprivation, rates vary
Self harm	3,060*	Higher in women	Highest between 15 and 34	Rates and numbers increase with deprivation
Heart Failure (HF)	3,045	Slightly higher in men	Increases from mid 50s	Rates increase with deprivation
Dementia	2,850	Higher in women	Increases from mid 60s	Rates increase with deprivation, numbers decrease
Severe mental health	2,570		Highest between 30 and 59	Rates increase with deprivation
Glaucoma	2,510		Increases from mid 50s	Numbers decrease with deprivation, rates vary
Epilepsy	2,505			Rates increase with deprivation
Peripheral Arterial Disease (PAD)	2,270	Higher in men	Increases from mid 50s	Rates increase with deprivation
Rickets (last 10 years)	1,895	Higher in women		Numbers decrease with deprivation, rates vary
Rheumatoid Arthritis	1,550	Higher in women	Increases from mid 40s	Numbers decrease with deprivation, rates vary
Acute Macular Degeneration (AMD)	1,520*	Higher in women	Increases from 70s	Rates and numbers decrease with deprivation
Learning disability	1,515	Higher in men		Rates and numbers increase with deprivation
Autism	1,170*	Higher in men		Rates increase with deprivation
Crohn's disease	1,010			
Cerebral palsy	275*			
Down's syndrome	240	Higher in men		
Motor neurone disease	35			

* Undercount of actual prevalence

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People with long-term conditions are the most intensive users of the most expensive

services, not only in terms of primary and acute services, but also in social care and community services. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are overdue for an appointment for a long-term condition.

It is estimated that nationally the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport this will equate to an additional 47,700 people living with a condition. An increasingly older population also means that it is likely that the prevalence of dementia particularly will rise above the national average and planning care for this group of people will require additional attention.

CURRENT SITUATION IN STOCKPORT

The measure of the known population with long term conditions is usually accepted as the Quality and Outcomes Framework (QoF) disease register. These are the people coded on the general practice clinical system as having a disease.

Stockport practices are good at the identification of disease and the prevalence is generally higher than the national averages. Despite this being the case however the known prevalence is often far short of the predicted prevalence proposed by public health modelling of disease prevalence. The table below shows the situation for the six key conditions which **Find and prevent** will focus on in Stockport and gives an idea of the number of people still to be found. It also shows the benefit measure stretch we have set ourselves for 2020/21 as part of the agreement for Greater Manchester Transformation Fund.

Currently pre-diabetes type 2 (non-diabetic hyperglycaemia) is not included in the QoF, and GP practices are therefore not required to maintain a disease register or report this data. Building this register will be a prerequisite for the NHS Diabetes Prevention Programme.

Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find (GMTF Benefit by 2020/21)
Diabetes (type 1 and 2)	14,600	5,600	2,300
Pre diabetes (type 2)	Unknown	Up to 27,150	13,000*
Hypertension	43,600	11,500	4,300
Atrial Fibrillation	5,700	2,150	1,550
Dementia	2,700	1,300	750
COPD	6,700	3,700	-

*NHS Diabetes Prevention Programme commitment by April 2019

There are a potential **29,000 smokers in Stockport who have yet to develop or be diagnosed with a long term condition**, out of a total 40,000 smokers – this apparent disparity is due to the different age profiles of smokers (who tend to be younger) and those with long term conditions (who tend to be older). At each age group smokers are more likely to have long term conditions than non-smokers, but **as many smokers are young there are a large number who have yet to develop or be diagnosed with long term conditions**. This group will be a key priority.

There are also **5,000 obese people in Stockport who have yet to develop or be diagnosed with a long term condition**, out of a total 20,000 identified by GP practices.

There are three national screening programmes to detect certain cancers early, whilst they are still curable, and the national NHS Health Check programme aims to systematically identify people at risk of cardiovascular disease. The data below shows the numbers of people eligible for these programmes and the numbers that have not attended.

Screening programme	Eligible	Not screened
NHS Health Check	91,000	41,000
Cervical Cancer	77,000	5,500
Breast cancer	40,000	11,500 (in last 3 years)
Bowel cancer	24,000	11,000

The reasons that people do not attend screening are many and complex, although it is recognised that deprivation and activation are a factor. Any new system will never address the total gap, but can reduce it and may be able to address the issues of particular communities and reduce the level of inequality in the prevalence of disease.

The Quality and Outcomes Framework (QoF) also provides some useful benchmarks for the proportion of the known population whose treatment is optimised within primary care. For each long term condition there are a range of treatment indicators and the following serve as an illustration of current performance, which on the whole is good:

Condition	Measure	Performance (QoF 2014/15)	To improve management
Diabetes (type 1&2)	HbA1c ≤ 64mmol/mol	80.4%	2,575
Hypertension	Blood pressure ≤ 150/90mmHg	84.6%	6,552
Atrial Fibrillation	Anti-coagulated	85.1%	441
Dementia	With care plan	87.1%	327
COPD	FEV1 recorded	82.9%	1,010

In 2016/17 Stockport successfully launched the **Healthy Living Pharmacy Scheme** with £20,000 pump priming from vanguard funding. To date 18 of Stockport's 63 pharmacies have joined the programme, and in the first five months of delivery more than 505 preventative brief interventions (as per NICE guidelines) have been offered. Pharmacy staff are being offered structured training programmes in a range of preventative health measures and are developing referral pathways to Healthy Communities services and General Practice. Pharmacies are now being enabled to be able to use straightforward clinical testing within the pharmacy setting to extend the scope of the find and prevent programme.

NATIONAL CONTEXT

The Five Year Forward View highlights that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply

rising burden of avoidable illness. That warning has not been heeded as wholeheartedly as it could have been and the NHS is now on the hook for the consequences.

It goes on to highlight three key gaps:

- The **health and wellbeing gap**: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- The **care and quality gap**: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- The **funding and efficiency gap**: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions -for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes type 2 over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes type 2 prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

The model below describes the national approach to prevention, via risk detection and management in primary care and the key outcomes that could be achieved were this vision to be implemented. This evidence, from NHS Right Care and PHE is the foundation of the Stockport Find and prevent Programme.

National guidance from NICE, NHS England and PHE has been collated by NHS Right Care along with case studies from other areas, some of these findings are directly relevant for find

and prevent, others to wider primary care interventions:

Diabetes type 1 and 2:
https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/diabetes/

- Ensure 100% practice participation in the National Diabetes Audit **(FIND)**
- Use audit data to focus quality improvement initiatives to improve achievement of the eight key processes and three treatment targets **(FIND AND PREVENT)**
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up **(FIND AND PREVENT)**
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management **(TREAT)**
- Work with practices and education providers to maximise referral, uptake and retention in patient education programmes **(TREAT)**
- Ensure all patients with diabetes have access to routine care by a trained diabetes nurse **(NOT FIND AND PREVENT)**
- Consider commissioning systematic support for adherence from community pharmacists through medicines use reviews (MURs) **(NOT FIND AND PREVENT)**

Pre-diabetes (type 2):
https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/ndh/

- Undertake systematic audit across practices to identify historical diagnoses of Non-Diabetic Hyperglycemia (NDH) **(FIND)**
- Establish practice registers of individuals with NDH **(FIND)**
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up **(FIND AND PREVENT)**
- Work with practices and NHS Health Check providers to maximise referral and uptake in the 'Healthier You' NHS Diabetes Prevention Programme**(TREAT)**

Hypertension:
https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/blood-pressure/

- Undertake systematic audit across practices.
    - Identify people with possible undiagnosed hypertension **(FIND)**
    - Identify people who are not treated to target **(FIND)**
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up **(FIND AND PREVENT)**
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management **(TREAT)**
- Use practice-based pharmacists to optimise management of hypertension **(NOT FIND AND PREVENT)**
- Commission ambulatory blood pressure monitoring service for diagnosis **(NOT FIND AND PREVENT)**
- Consider commissioning:
    - Systematic support for adherence from community pharmacists through medicine use reviews (MURs) **(NOT FIND AND PREVENT)**
    - BP self-test units e.g. in surgery waiting rooms, community pharmacies, leisure centres **(HEALTHY LIVING PHARMACIES)**
    - Digital solutions for self-monitoring and treatment optimisation**(NOT FIND AND PREVENT)**

Atrial fibrillation:
https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/af/

- Undertake systematic audit across practices (GRASP-AF audit tool).
    - Identify people with possible undiagnosed AF **(FIND)**
    - Identify people with AF at high risk of stroke who are not anticoagulated or not maintained in the therapeutic range **(FIND)**
- Work with practices and local authorities to maximise NHS Health Check uptake and follow up **(FIND AND PREVENT)**
- Build local primary care leadership to challenge unwarranted variation and drive quality improvement in detection and management **(TREAT)**
- Add pulse checking to existing GP and pharmacy enhanced services for people over 65 **(NOT FIND AND PREVENT)**
- Agree local clinical consensus and pathway for anticoagulation including the place of novel oral anticoagulants (NOACs) **(NOT FIND AND PREVENT)**
- Consider commissioning:
    - Technologies such as WatchBP Home A and AliveCor to support AF detection in routine care. **(HEALTHY LIVING PHARMACIES)**
    - New models of anticoagulation control e.g. self-monitoring and community pharmacy monitoring **(NOT FIND AND PREVENT)**
    - Systematic support for adherence from community pharmacists**(HEALTHY LIVING PHARMACIES)**

Dementia:
https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

- Population screening for dementia is not envisaged.
- 'Timely' diagnosis is when the patient wants it. In some cases it may be when the carers need it.
- The current approach is towards raising awareness, especially in the higher risk population – specifically via NHS Health Checks **(FIND AND PREVENT)**

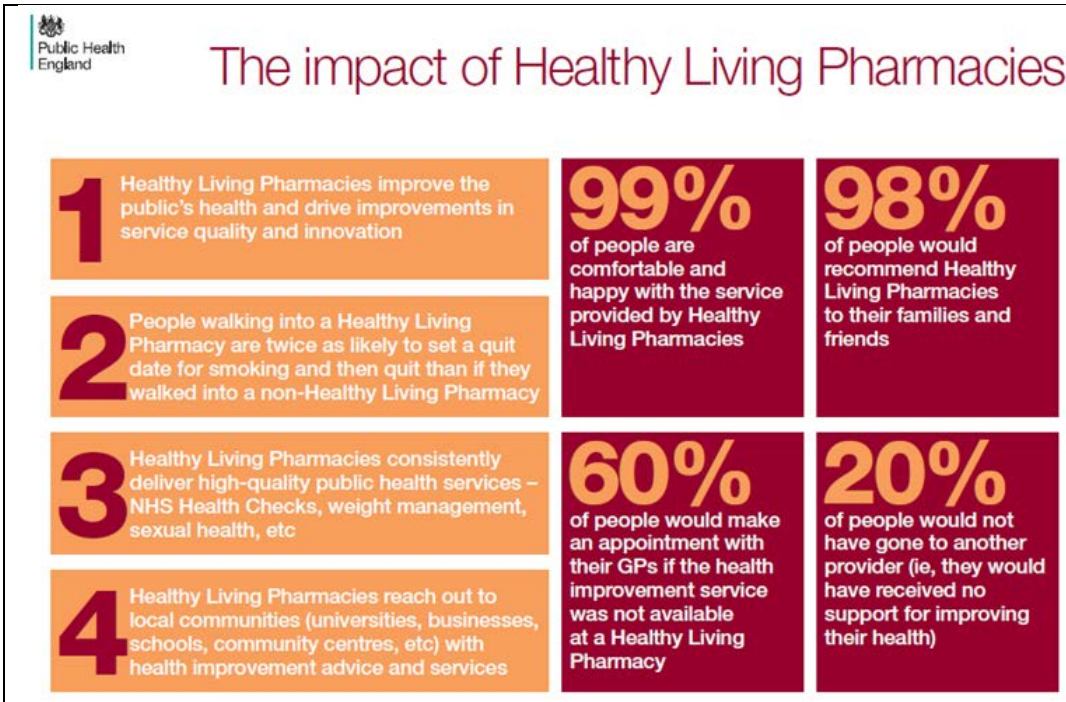
COPD:
https://www.england.nhs.uk/wp-content/uploads/2014/02/rm-fs-6.pdf

- Roll out and implementation of GP audit tools for case finding, such as GRASP-COPD. **(FIND)**
- Audit practice information systems to identify people who receive multiple prescriptions for oral steroids and/or antibiotics **(FIND AND PREVENT)**
- Support implementation of opportunistic COPD case finding in primary care through electronic decision support tools **(FIND AND PREVENT)**
- Discuss the COPD diagnosis with patients and carers, including what they can do to help manage their condition, for example signpost to advice on stop smoking and benefits of exercise **(NOT FIND AND PREVENT)**
- Target case finding based on population segmentation and social marketing described in the COPD Prevention and Early Identification Toolkit 2011 **(FIND)**
- Misdiagnosis of COPD is common so case finding tests should be followed by quality assured diagnostic spirometry, with trained staff interpreting the results. The NHS Improvement guide 'First steps to improving COPD care ' (2012) recommends that COPD diagnoses should have spirometry taken and recorded in the last 15 months other tests may be necessary to confirm the diagnosis, such as a CT scan **(FIND AND PREVENT)**

NHS Health Checks:
www.healthcheck.nhs.uk/commissioners_and_providers/guidance/
Legal duties exist for local authorities to make arrangements:

- for each eligible individual aged 40-74 to be offered an NHS Health Check once in every five years and for each individual to be recalled every five years if they remain eligible
- evidence is emerging about the effectiveness of prioritizing those at the highest risk (**FIND**)

Healthy Living Pharmacies:
http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/



Together these evidence based interventions will lead to a long term reduction in the number of people with disease, and improved health outcomes for those with disease thereby reducing the reliance on acute care settings and removing cost from the system. For each programme estimates of cost effectiveness and cost saving a being identified nationally, for example:

NHS Health Checks:

The original Department of Health (DH) modelling showed the average annual cost of the NHS Health Check programme as £332m each year at full roll out and the benefit as £3.7bn with a cost per quality adjusted life year (QALY) of around £3000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years.

The modelling shows that the NHS Health Check could, on average, prevent 1,600 heart attacks and strokes, saving at least 650 lives each year. As well as preventing over 4,000 people a year from developing diabetes type 2 and detecting at least 20,000 cases of diabetes type 2 or kidney disease earlier, allowing individuals to be better managed.

More recent evidence shows that *NHS Health Checks :*

- a new case of raised blood pressure is found approximately every three to four NHS Health Checks,
- a new diagnosis of hypertension made approximately every 30-40;
- a new diagnosis of diabetes is made for every 80-200 NHS;
- and a person with a cardiovascular disease risk ≥ 20% identified every six to ten.

In Stockport around 50,000 people have had a NHS Health Check – meaning that 1,250-1,650 hypertension diagnosis, 250-625 diabetes diagnosis and 5,000-8,300 people at risk have been found; screening an additional 11,000 would find 275-370 hypertensives, 55-135 diabetics and 1,100-1,800 people at high risk.

NHS Diabetes Prevention Programme

Impact analysis suggests if 390,000 people receive the NHS DPP intervention over 5 years the approximately £1.2bn of health benefits will be gained nationally. On average 15,000 – 24,000 cases of Type 2 diabetes prevented or delayed by the 6th year, which is on average 72 to 115 cases of diabase per CCG. By year 14, the programme will become cost saving at a national level, and this will be earlier locally as the majority of the intervention costs are born nationally.

Across Stockport implementation plans for the two years suggest that between 135 and 215 cases of type 2 diabetes will be prevented.

LOCAL CONTEXT

Health Outcomes and causes of premature mortality

We have a GP-registered population of around 300,000 people, are one of the healthiest places to live in the North West and are comparable with England in terms of health outcomes. We rank amongst the highest in England in terms of cancer survival rates, and have achieved decreasing mortality over a long period of time.

We know through our Joint Strategic Needs assessment (JSNA) that there are four main disease groups which cause 80% of deaths in Stockport; Cancer, Heart Disease, Lung Disease and Mental Health. The environment and lifestyle choices are contributing significantly to the development of these diseases and the higher burden felt in the most deprived areas. Early identification of disease is also essential to improving outcomes, as is supporting individuals to have the knowledge and the confidence to proactively manage their condition and to modify their lifestyles.

Preventable premature death is driven by a range of factors. Around 25% of adults in Stockport are classified as obese, and 75% are not active enough. Among our population hospital stays resulting from alcohol related harm were 709 per 100,000 in 2013/14, worse than the average for England. On the widest measure a total of 6,900 admissions per year can be attributed to alcohol. Around 18% of adults in Stockport are smokers (slightly better than the England average), but rates show significant inequalities so that people in our most deprived areas are more than twice as likely to smoke as the average.

Health Inequalities

We have one of the largest health inequality gaps in England. The overall borough wide health outcomes mask significant differences between the different neighbourhoods across the borough. There is a life expectancy gap between the most affluent and most deprived neighbourhoods of 11 years (for men) and 8 years (for women).

The deprivation gap **for healthy life expectancy** is even greater than that in life expectancy.

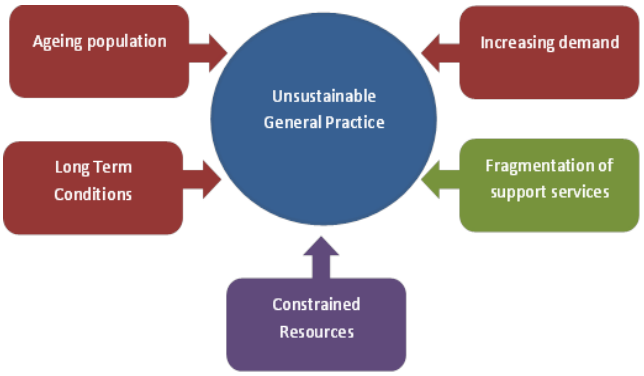
- In the most deprived areas men will on average have 7 years (9.4% of life) in poor health compared to 3 years (3.4%) in the most affluent areas.
- In the most deprived areas women will on average have 5 years (6.8%) poor health compared to 2 years (2.9%) in the most affluent areas.
- In the most deprived areas men will on average have 19 years (25.8%) fair or poor health compared to 12 years (14.1%) in the most affluent areas.
- In the most deprived areas women will on average have 20 years (26.6%) fair or poor health compared to 13 years (15.0%) in the most affluent areas.

In the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas, a gap of 16 years. Even a relatively small increase in healthy life

expectancy in the most deprived boroughs would reduce the 'burden' of ill health and would improve quality of life for a significant number of people, as well as channelling resources back into the economy.

Sustainability

We face a number of challenges to the financial sustainability of the health & social care system. General practice although financed in the main outside the local system, through national GMS or PMS contracts, has similar pressures and is equally unsustainable. Whilst the national funding of health & social care is outside our power we should and can address other local challenges.



Demographic Changes

The number of people aged over 65 in Stockport (19.4%) is above the national average (17.7%) and this figure is expected to continue to grow. By 2020, the proportion of the population of Stockport aged over 65 is expected to reach 21%, an increase of almost 5,000 people.

The number of people aged over 65 will increase from 55,700 in 2014 to 61,000 by 2020 (an increase of 9.7%). The proportion aged over 65 is also significantly higher in some neighbourhoods of the borough than others (already 20.5% in Cheadle and Bramhall).

Older people have greater health needs and a greater probability of developing long term illnesses, meaning co-morbidities increase, thus they account for the most significant amount of health service use. Keeping this group healthy, well and socially active will be vital in reducing the need, and subsequent cost, of health and social care, and improving their quality of life.

Proposed Clinical Model

We wish to create a system that is proactively looking for all people who are at risk of disease and preventing the development of this disease thus improving health and reducing the burden of ill health on people and the health and care system. In this way we wish to reduce the number of people with complex comorbidity in the future and increase healthy life expectancy in all communities.

We will proactively look for people who are at risk of disease and all those with disease whose care could be improved. We aim to ensure that

- more people will take up offers to attend screening either for undiagnosed conditions or as part of national programmes **(FIND)**
- more people with risk factors that put them at risk of developing a long term condition are supported to manage those risk factors **(TREAT)**
- more patents with a long term condition are supported to manage their condition so that complications are minimised **(TREAT)**

We will do this by supporting General Practice and Pharmacies to develop and improve systems that will drive this change. The purchase of **EMIS Search and Reports** will enable validated queries to be written once and shared, before being run either at a practice or

neighbourhood level to identify target groups. We will adapt the national model of risk detection and management (see page 7) to create an evidence based call programme focusing initially on five key conditions:

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

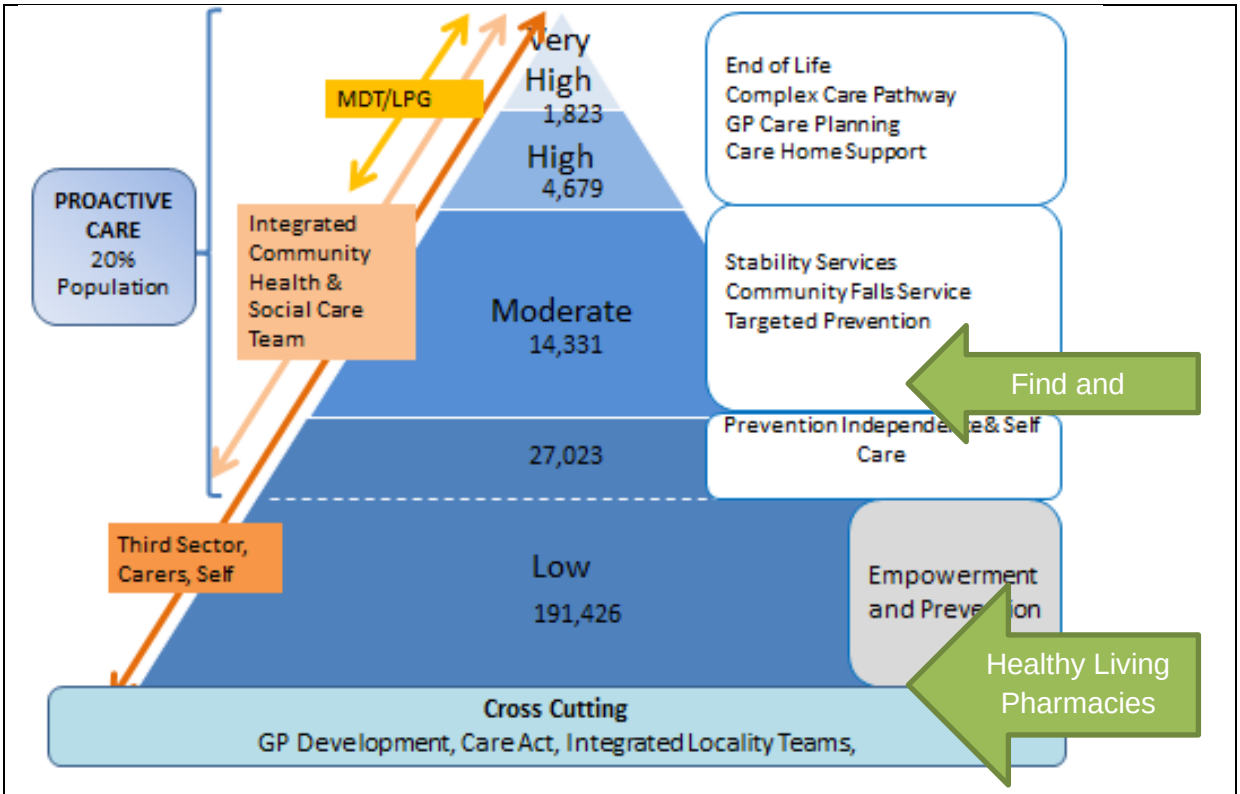
This programme will target people at higher risk of developing one of the five key long term conditions, focusing on those:

- Age 40-74 who have never had a blood pressure recording; or are a smoker without a BP reading in the last 5 years
- Age 40-74 who have never attended a NHS Health Check; or are a smoker without an attendance in the last 5 years
- Any age at risk of diabetes type 2, or with identified but unregistered non-diabetic hyperglycaemia
- Any age with a diagnosed long term condition but do not have optimised treatment using tools such as GRASP-AF
- People with a diagnosed mental health condition who smoke
- People who have not attended cancer screening opportunities

Patients can then be invited to assessment or directly referred into treat services options:

- This programme will be embedded into the core neighbourhoods model and will manage people diagnosed with conditions through the optimising primary care approaches agreed in each neighbourhood (a key element of treat).
- Through the Healthy Communities Business Case we will to improve self-care management and empowerment and improve support for behaviour change in neighbourhood and community settings (via referral to START) and using tools such as the PAM (Patient Activation Model); so that patients are supported to make best use of the available assets and resources, and therefore become less reliant on GP and acute services.
- We will use this programme to establish robust referral pathways for the NHS Diabetes Prevention Programme, which goes live across Greater Manchester in April 2017. This programme offers a 12 session structured education course over several months, to people who are at high risk of developing type 2 diabetes.

This programme aims to target those at the moderate tier of care need, preventing and delaying the need for higher intervention levels. Other business cases will target those at more immediate risk.



EXTENSION 1 – GENERAL PRACTICE

The new model of care will lead to a more proactive and systematic method of identifying the population at risk in General Practice via automated searches of the practice systems using EMIS templates and search and reports. Template searches will be built or validated centrally and then practices / neighbourhoods will be supported to run these searches to identify individuals.

It is envisaged that each neighbourhood will chose their priority health need for this programme for the first year, and that a rolling programme of implementation be developed so that eventually all neighbourhoods have completed the programme. Ultimately the find and prevent approach should be embedded in to the general way of working of the neighbourhood teams, and could extend into other conditions.

In addition opportunities to improve and standardise the approaches to NHS Health Checks and opportunistic identification will be maximised, sharing good practice across Stockport and reducing variation in quality.

Once target populations have been identified, a variety of methods may be used to “treat” populations who may benefit from preventative advice. These will be tailored to levels of activation where possible and may include:

- Sending targeted literature through post, digital media or apps
- Adding alert flags to patient records so opportunistic Health Chats and NHS Health Checks can be delivered by practice or neighbourhood staff
- Inviting people to attend additional screening at Weekend Clinics – these clinics are likely to contain an **enhanced preventative element** and may include:
    - group courses such as DESMOND Walking Away from diabetes type 2 delivered by HCAs
    - enhanced NHS health checks incorporating FEV1, memory tests, cancer screening and immunisation status checks, HAD scores and additional blood test (LFT and creatinine) as well as the traditional GPPAQ, Audit C, Smoking,

BP, Pulse rhythm and blood tests (cholesterol, HbA1C)
    - these options are yet to be fully explored, and may impact capacity analysis in terms of staff need, as appointment lengths vary (group sessions = 15min per person, shorter Health Checks = 20 min, enhanced health check = 30 min)
- Inviting people to attend GP Practice review clinics (QoF)
    - Linking to the optimising primary care business case – any investment required for this is not included in this business case
- Referring people onto (included in Healthy Communities and self care business cases):
    - NHS diabetes prevention programme
    - Lifestyles and wellness services (via START and Healthy Stockport)
    - Social prescribing services (via START)
    - Patient education programmes
    - Mental wellbeing support
    - Targeted Prevention Alliance and Wellbeing and Independence Network
- Empowering people to manage their own condition and behaviours (self care).
- Exploring how people with mental health conditions are best supported to make lifestyle changes

EXTENSION 2 – HEALTHY LIVING PHARMACIES

The opportunities for identifying people through **Healthy Living Pharmacies** and linking them either directly into Healthy Communities services or into General Practices will be further developed, ensuring coverage across all neighbourhoods and into at least two thirds of all pharmacies.

Those achieving HLP Level 2 status will be commissioned to provide a full range of Public Health Enhanced Services (PHES) including smoking cessation and will be encouraged to increase referral rates into lifestyle support services.

Healthy Living Pharmacies in each neighbourhood will be required to focus on the identified priority for each neighbourhood under extension 1; developing local pathways to maximise coverage and impact.

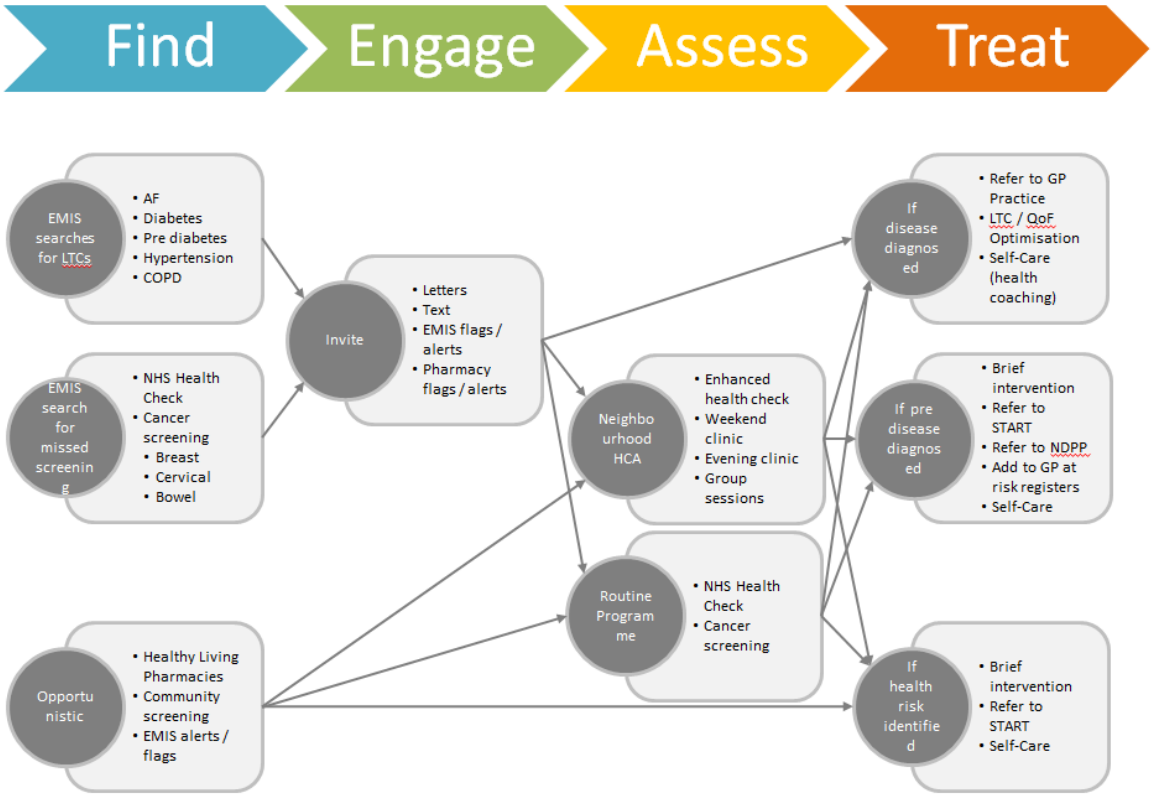
Healthy Living Pharmacies will also be supported to undertake clinical measurements

OVERALL MODEL

The following illustrations show the envisaged **find and prevent** model. Opportunities for identifying people through community engagement will continue to be developed through the Healthy Community business cases and links to other Core Neighbourhood and Healthy Stockport services will be a core part of all pathways.

STOCKPORT TOGETHER

- **ANALYSIS**
  - EMIS Searches for LTCs
  - EMIS searches for missed screening:
    - NHS Health Checks
    - Cancer screening
  - Opportunistic
    - EMIS alerts / flags
    - Healthy Living Pharmacy
    - Community screening
- **ENGAGE AND ASSESS**
  - Invites (letter & text)
  - Neighbourhood HCA service
  - Enhanced brief intervention
  - Referral
- **Core Neighbourhood Model**
  - Optimising LTC / QoF Management
  - Creating at risk registers
  - Diabetes II prevention programme referral
- **START Triage**
  - Lifestyles and wellness service referrals
  - Social prescribing
- **SELF CARE**
  - Patient Education Programmes
  - Health coaching
  - Mental Wellbeing support
  - Social support - TPA / WIN
  - Self care



AMBITION

The ambition for the programme is as follows:

Find

Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find by 2020/21
Diabetes (type 1 and 2)	14,600	5,600	2,300
Pre diabetes (type 2)	Unknown	Up to 27,150	15,000
Hypertension	43,600	11,500	4,300
Atrial Fibrillation	5,700	2,150	1,550
Dementia	2,700	1,300	750
COPD	6,700	3,700	900

Screening programme	Eligible	Not screened	To reduce by 2020/21
NHS Health Check	91,000	41,000	11,000

In total **finding 9,800 new diagnosis of long term conditions and 15,000 people at risk of type 2 diabetes** and screening an additional 11,000 people for general NHS Health Checks in the four year period.

Treat

Condition	Measure	Performance (Qof 2014/15)	To improve to, by 2020/21*
Diabetes	HbA1c ≤ 64mmol/mol	80.4%	85%
Pre diabetes	Referrals into NDPP	-	3,500^
Pre diabetes	Local offer to pre diabetics	-	3,500
Hypertension	Blood pressure ≤ 150/90mmHg	84.6%	90%
Atrial Fibrillation	Anti-coagulated	85.1%	90%
Dementia	With care plan	87.1%	90%
COPD	FEV1 recorded	82.9%	90%

* reducing variations between practices and neighbourhoods
^ NDPP for two years only

In total **improving the management of around 3,900 people** and referring 3,500 people into NDPP programme and 3,500 into local diabetes prevention support offers in the four year period.

Overall this level of ambition **aims to work with around 13,700 patients a year** (excluding double counting of pre diabetes), or 1,700 per neighbourhood; see appendix 1 for more detailed modelling.

COST OF PROGRAMME

More detail is set out in the following two sections but the overall cost of the programme is envisaged to be £962,000 for the five year period:

£000s (k)	2016/17 Yr 1	2017/18 Yr 2	2018/19 Yr3	2019/20 Yr4	2020/21 Yr5
TOTAL	26	72	292	286	286

Cost/Benefit Analysis

POSSIBLE IMPACT

National evidence as set out on pages 7-11 shows the benefit of early identification and prevention in terms of cost effectiveness (QALYs) and patient outcomes – **though it should be noted that this evidence is for the whole pathway and includes interventions included in other business cases such as self-care and optimising primary care.**

Estimating impact on local use of resources is complex. Analysis of admission data suggests that the long term conditions to be targeted by this programme account for 9% of total costs at a total of £12m; two thirds of this activity is emergency care and two thirds for the over 65s (see table below).

2015-16 Stockport registered admissions; SUS data, count of admission and sum of tariff

Primary diagnosis	Elective		Emergency		All admissions (including transfers etc.)		% of all aged 65+
	Count of admission	Sum of Tariff	Count of admission	Sum of Tariff	Total count of admission	Total sum of Tariff	
Diabetes	40	£33,634	250	£418,499	291	£452,969	28.5%
Hypertensive disease	12	£23,527	117	£128,649	129	£152,176	50.4%
Atrial Fibrillation	289	£682,425	548	£838,997	855	£1,595,639	70.5%
Ischaemic heart disease	502	£1,284,489	983	£2,869,496	1,750	£5,219,141	62.8%
Acute myocardial infarction	11	£26,781	493	£1,875,112	562	£2,114,994	65.8%
Cerebrovascular disease	22	£77,884	564	£2,223,033	648	£2,563,684	79.6%
Dementia	1		68	£9,992	71	£9,992	100.0

							%
COPD	25	£47,632	847	£1,954,834	876	£2,015,640	69.2%
All admissions	**47,923**	**£53,114,257**	**40,131**	**£67,914,120**	**98,396**	**£132,607,821**	37.5%
All admissions for key LTCs	**891**	**£2,149,591**	**3,377**	**£8,443,500**	**4,620**	**£12,009,241**	**65.9%**

People with long term conditions will also have activity in Primary Care, Outpatients and ED, however **costs for these services for people with LTCs are not yet possible to estimate**. For the purposes of this estimate therefore impacts are measured on inpatient admissions only.

Assuming a saving proportional to the national evidence set out in pages 7-11 sections and local modelled ambitions by 2020/21 then a **possible saving of £1.4m in admissions through Find and prevent could be realised**:

This £1.4 million has been derived by using the national evidence of the proportion of admissions which should be preventable, and then applying the percentage improvement anticipated by find and prevent (see page17-18) to this proportion and to the total 2015/16 admission costs:

	To find		**To improve treatment**				
Condition	**Number**	**as a %**	**Number**	**as a %**	**2015/16 Admission costs**	**Modelled saving on costs by 20/21**	**Notes**
Diabetes	2,300	15.8%	670	4.6%	£452,969	£92,195	Improving /detection a management of **20%**
Hypertension	4,300	9.9%	2350	5.4%	£152,176	£11,613	50% preventable by E improving /detection a management of 15% therefore 15%* 50% =
Atrial Fibrillation	1,550	27.2%	280	4.9%	£1,595,639	£343,099	67% preventable by A improving /detection a management of 30% therefore 30%* 67% =
Dementia	750	27.8%	80	2.9%	£9,992	£3,065	Improving /detection a management of **30%** with dementia
COPD	900	13.4%	480	7.1%	£2,015,640	£27,076	10% admissions due undiagnosed, improvi /detection and manag 25% of COPD theref 25% = **2.5%**
AMI	-	-	-	-	£2,114,994	£161,399	50% preventable by E improving /detection a management of 15% therefore 15%* 50% =

Other IHD	-	-	-	-	£3,104,147	£236,883	50% preventable by BP, improving /detection and management of 15% of BP , therefore 15%* 50% = **7.5%**
CVD	-	-	-	-	£2,563,684	£551,251	67% preventable by AF, improving /detection and management of 30% of AF, therefore 30%* 67% = **20%**
					Total possible saving	**£1,426,581**	

The possible phasing of this benefit could be as follows:

	17/18	18/19	19/20	20/21
% of full	0%	5%	40%	100%
Impact	0	£71,329	£570,633	£1,426,581

As a check of the reasonableness of this estimate of £1.4million, analysis of NHS Right Care spend opportunities suggests that in Stockport there is a potential £5.6 million saving to be made from admissions relating to circulation, respiratory and endocrine problems, the previous working therefore suggests that 25% of these savings could be made through prevention and early detection.

Disease area	NHS Right Care Spend area	£000 to save
Circulation problems	• Spend on elective and day-case admissions • Spend on non-elective admissions	• £305 • £2,826
Respiratory problems	• Spend on elective and day-case admissions • Spend on non-elective admissions	• £642 • £1,385
Endocrine, Nutritional and Metabolic Problems	• Spend on elective and day-case admissions • Spend on non-elective admissions	• £113 • £319

RETURN ON INVESTMENT

Assuming that savings could be realised on the level of ambition within two years the following profile of spend to impact has been estimated, leaving a recurrent saving of £1.1m per annum from 2020/21 onwards.

	16/17	17/18	18/19	19/20	20/21	TOTAL
Cost	£26,000	£72,000	£292,000	£286,000	£286,000	£962,000
Impact	0	0	£71,329	£570,633	£1,426,581	£2,068,543
Net effect	-£26,000	-£72,000	-£220,671	£284,633	£1,140,581	£1,106,543

Finance

The table below shows the indicative additional costs for the programme, details to show how these have been calculated are set out below.

£000s (k)	2016/17 Yr 1	2017/18 Yr 2	2018/19 Yr3	2019/20 Yr4	2020/21 Yr5
A. Existing Service Costs	26	0	0	0	0
New Spending Plan:					
Healthy Living Pharmacy	24	24	24	24	24
EMIS Search and Reports	2	15	15	15	15
Call / recall consumables	0	1.875	10	10	10
Training – Walking away from diabetes	0	0	10	4	4
POC Testing x 8	0	0	56	56	56
Band 3 admin (8x 0.2 WTE)	0	6.562	35	35	35
Band 4 HCA (8x 0.5 WTE)	0	18	96	96	96
Band 6 Analysts (8x 0.1 WTE)	0	6.562	35	35	35
Band 6 project officer (1x 0.4 WTE)	0	11	11	11	11
TOTAL	26	72	292	286	286

Most of this investment is recurrent, with only the initial training budget for the HCA staff being non-recurrent.

Non workforce costs

This business case will require the ongoing funding of Healthy Living Pharmacy programme and PharmOutcomes licence. **A total of £24,000 per year.**

This business case will require the annual licencing of EMIS Search & Reports for public health, at a cost of £285 per year per practice + VAT. **A total of £14,706 per year**.

This business case will require the development of EMIS Web referral templates and pathways supported by GMSS Data Quality Team and ability for each neighbourhood team to share records. **These costs are to be met in other business cases and from existing resources.**

This business case will require a programme budget to fund the consumables for the call and recall, including postage / letters / leaflets / texts etc. **An indicative total of £10,000 per year.**

This business case will require a training budget to for the HCAs who will deliver the preventative intervention. For example DESMOND walking away from diabetes (£700 per person), NHS Health Checks (£50 per person). **An indicative total of £10,000 for the first year, with £4,000 for each subsequent year.**

This business case may require additional capacity in Public Health commissioned behaviour change services. **These costs are to be met in other business cases**

This business case may require additional capacity in clinic spaces – meeting rooms for group work and consultation space for 1:1 interventions. **These costs are to be met in other business cases.**

This business case will lead to an increase in the number of blood tests to be taken and analysed, these could be collected and dispatched to Stockport NHS FT for testing as per current procedures, however this reduces the quality of the preventative message given at the appointment and increases administration and referral times. An investment in POCT could be made, current costs are being investigated, but reviews from 2009 for HbA1C only suggested annual costs in the range of £5,919-£6,150 per machine. An indicative total (until better estimates are collected) of **£7,000 per PCOT per year.**

Buyer's guide: Point of Care testing for HbA1c. June 2009 http://www.healthcheck.nhs.uk/document.php?o=12

Buyers' guide: Point of Care testing for cholesterol measurement. September 2009 http://www.healthcheck.nhs.uk/document.php?o=11

This programme is also likely to lead to increased use of the services referred onto, and potentially increase prescribing and long term condition management requirements within General Practices. **These have not been costed in this business case, as they should be offset by increases in QoF income and savings in acute care.**

Workforce needs are as follows:

Per neighbourhood:

- 0.1 WTE for Business Intelligence Analysts based in neighbourhoods, (neighbourhood business case proposal) **(new resource)**
- 0.2 WTE for administrative staff to manage call and recall in neighbourhoods (neighbourhood business case proposal) **(new resource)**
- HCA led preventative clinics at Weekend General Practice – 0.3 HCA per neighbourhood (see below for modelling) **(new resource)**
- HCA led preventative clinics at weekday General Practice – 0.2 HCA per neighbourhood (see below for modelling) **(new resource)**
- Support and governance from neighbourhood leadership team **(existing resource)**

Centrally:

- 0.2 WTE for Specialist Public Health Business Intelligence Analysts, LA **(existing resource)**
- 0.4 WTE for Data Quality Officers, GMSS **(existing resource)**
- 0.4 WTE for Primary Care Engagement Officer **(existing resource)**
- 0.4 WTE for project officer **(new resource)**

Phasing for 17/18

It is proposed to phase the roll out of find and prevent, so that the first six months of 17/18 are focused on continuing the implementation of the Healthy Living Pharmacy and in developing the modelling with EMIS search and reports. Over this period the NHS diabetes Prevention Programme will also be rolled out across two neighbourhoods, enabling further testing of the model.

The full programme will go live in two neighbourhoods in October 2017, a further two in January 2018 with extension to the final four neighbourhoods in April 2018. The programme will then run for the three years 2018/19 -2020/21.

This phasing leads to a 17/18 cost of £72,000, 25% of the total annual spend; with:

- £39,000 needed in April 2017
- £22,000 needed in October 2017 (or access to staffing resource of similar value)

- £11,000 needed in January 2018 (or access to staffing resource of similar value)

Find and prevent	Posts (fte)	Grade	2017-8	Spend start	Comment
Healthy Living Pharmacy			£24,000	Apr-17	Continue current programme
EMIS Search and Reports			£15,000	Apr-17	Develop find modelling
Band 3 admin (8x 0.2 WTE)	0.4	Band 3	£8,750	Oct-17	Go Live in 2 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	1	Band 4	£24,000	Oct-17	Go Live in 2 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.2	Band 6	£8,750	Oct-17	Go Live in 2 neighbourhoods
Call / recall consumables			£2,500	Oct-17	Go Live in 2 neighbourhoods
Band 3 admin (8x 0.2 WTE)	0.4	Band 3	£8,750	Jan-18	Go Live in further 2 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	1	Band 4	£24,000	Jan-18	Go Live in further 2 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.2	Band 6	£8,750	Jan-18	Go Live in further 2 neighbourhoods
Call / recall consumables			£2,500	Jan-18	Go Live in further 2 neighbourhoods
Band 3 admin (8x 0.2 WTE)	0.8	Band 3	£17,500	Apr-18	Go Live in final 4 neighbourhoods
Band 4 HCA (8x 0.5 WTE)	2	Band 4	£48,000	Apr-18	Go Live in final 4 neighbourhoods
Band 6 Analysts (8x 0.1 WTE)	0.4	Band 6	£17,500	Apr-18	Go Live in final 4 neighbourhoods
Call / recall consumables			£5,000	Apr-18	Go Live in final 4 neighbourhoods
Training – Walking away from diabetes			£10,000	Apr-18	Enhance programme
POC Testing x 8			£56,000	Apr-18	Enhance programme
Band 6 project officer (1x 0.4 WTE)	0.4	Band 6	£11,000	Apr-18	Cover by self care programme lead until Apr-18
Find and prevent Total			£292,000		

Contractual Arrangements

The only procurement requirements are for **EMIS Search and Reports**, an existing contract is in place for 7 practices already and procurement under normal STaR business procedures will be undertake to extend to all practices.

There are already existing contracts in place for NHS Health Checks and cancer screening programmes.

It is not intended that this programme will directly employ staff, instead these would be woven into the wider neighbourhood model and staff time allocated to the programme – most likely with a lead GP practice or by each neighbourhood or by SNHSFT as part of the neighbourhood based community services team. The programme manager will be employed by the Council within either the Public Health team, Corporate Support Services or the Stockport Together Programme management team.

For point of care testing discussions with the neighbourhood teams about the options, in discussion with SNHSFT Point of Care Testing Coordinator.

Implementation Plan

As detailed in the model above it is planned to implement Find and prevent in a phased approach across neighbourhoods. The recent announcement of the NHS Diabetes Prevention Programme has led to this becoming the highest priority, as we now have a two year window to make maximal use of the service offer.

Current plans (subject to engagement with primary care) are to:

- Roll out the National Diabetes Prevention Programme on a neighbourhood basis,
    - starting with Victoria as this has best levels of NHS Health Check, a number of practices piloting DESMOND and a significant deprived and BME community (i.e. more people at risk)
    - second neighbourhoods to be Cheadle & Gately
- Work with selected pharmacies and GP Practices to pilot the more general find and prevent model for Atrial Fibrillation

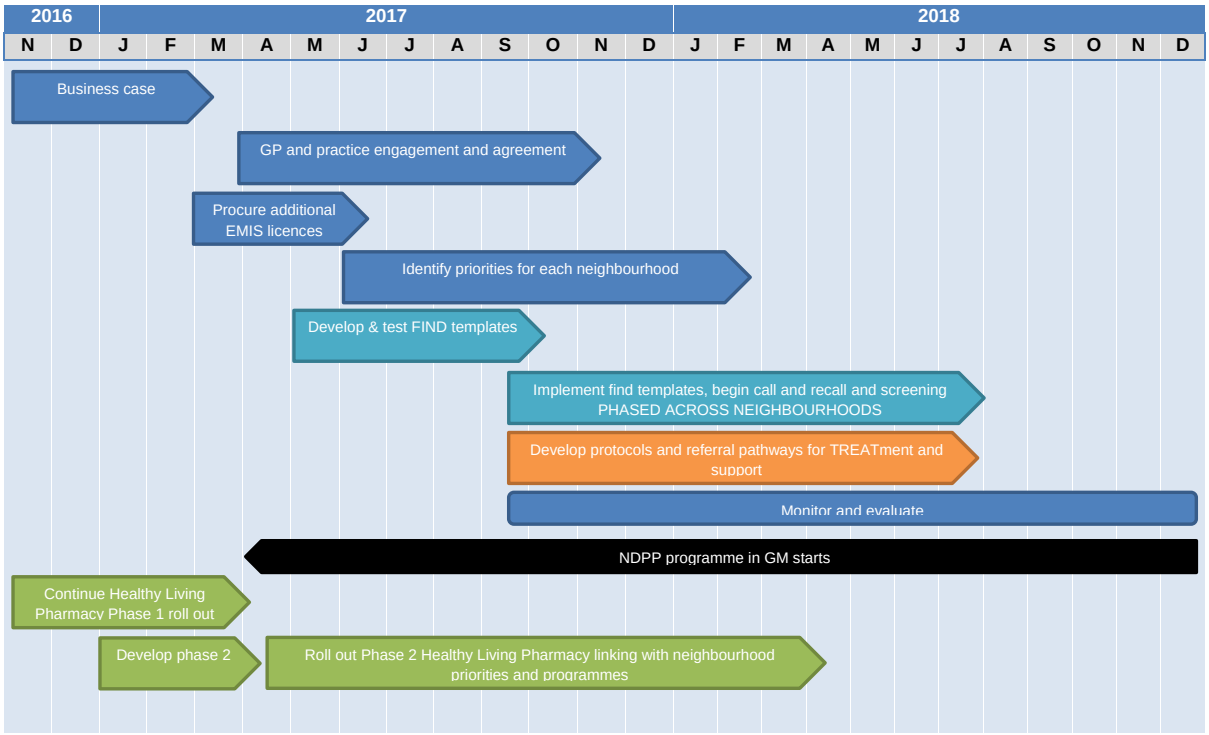
The full find and prevent programme will go live in two neighbourhoods in October 2017, a further two in January 2018 with extension to the final four neighbourhoods in April 2018. The programme will then run for the three years 2018/19 -2020/21. Decisions about the phasing of neighbourhoods are likely to be made in August 2017, in consultation with Primary Care.

In the meantime all neighbourhoods will be supported to improve **the quality of the NHS Health Check** process and onward referral and supported with **cancer screening**; as these programmes are already running within the neighbourhoods.

Healthy Living Pharmacies will continue to implement phase 1 and the achievement of objectives and outcomes will be monitored. Engagement with Pharmacies and neighbourhood teams will identify the phase 2 approach which will include the integration of pharmacy Enhanced Services and extension into other primary care settings.

This business case assumes that a 0.4 WTE Band 6 project officer will support the roll out from April 2018 onwards under the leadership of the existing Early Intervention and Prevention lead in Public Health. During 2017/18 the self-care programme lead will cover this implementation work as well as the self care programme.

An indicative timeline is included below:



RISKS

RISK	Mitigation
Primary care capacity to manage this additional programme and activity • Support for the call and recall and the initial identification are costed into this model, but may rely on existing staff and expertise as well, • More particularly the on-going management of patients identified with disease or at risk of disease are likely to increase activity. Many of these patients will require at least an annual review following diagnosis.	• Risk acknowledged and capacity for optimising primary care built into wider core neighbourhood model. • Ongoing monitoring of impact throughout implementation
Variations in primacy care coding practices and quality • This programme relies on the analysis of patient records to initially identify target patients. • Outside of core QoF measurements, or other programmes where READ / SNOMED codes are specified it is likely that each GP Practice will have their own coding conventions which will mean queries will need to be written to cover a range of options. Some practices may not code and may rely on written notes.	• By purchasing EMIS Search and report six months prior to go live it is hoped to understand the impact of this risk, and put in place mitigating actions. • Liaise closely with GMSS data quality team

• In some practices this may mean that the volume of patients identified is lower than expected	
Patients not engaging with prevention in other words low take up • Cancer screening and over preventative services are seeing a reducing in the proportion of patients who accept invitations to attend services. • There is a risk that that the capacity provided for prevention will not be utilised to its full extent. • A further risk is that those who take up the offer are likely to be the engaged population, and that without effective targeting this programme risks **increasing health inequalities**	• Targeting and considering inequalities at the outset of this programme • Embedding patient activation wherever possible • Using social marketing and other behavioural insights in a targeted way • The programme will be monitored closely and implementation varied to meet the needs of local populations. • New approaches to support people with mental health issues
Increased activity for prevention as a contrast to the above risk: • if more patients than expected take up provision there is a risk that existing services will not be able to meet demand.	• Risk acknowledged and capacity for self-care built into healthy communities model. • Ongoing monitoring of impact throughout implementation

Appendix 1

CAPACITY / ACTIVITY MODELLING FOR HCA WORKFORCE

To assess the likely capacity need for HCAs to deliver find and prevent, the ambitions described in section 9.3 have been modelled into a one year impact so that an anticipated workload can be estimated:

FIND Condition	Diagnosed (2014/15 QoF)	Undiagnosed (gap to prevalence estimate)	To find by 2020/21	To find in year 1
Diabetes	14,600	5,600	2,300	575
Hypertension	43,600	11,500	4,300	3750
Atrial Fibrillation	5,700	2,150	1,550	1075
Dementia	2,700	1,300	750	390
COPD	6,700	3,700	900	190
SUB TOTAL new cases of disease			9,800	2,455
Pre diabetes	Unknown	Up to 27,150	15,000^	7,500
SUB TOTAL new diabetes at risk			15,000	7,500
NHS Health Check	50,000	41,000	11,000	2,750
SUB TOTAL new health check			11,000	2,750
TOTAL FIND			**35,800**	**12,705**

TREAT Condition	Measure	Performance (Qof 2014/15)	To improve by 2020/21	Number of people to improve in 4 years	Number of people to improve in 1 year
Diabetes	HbA1c ≤ 64mmol/mol	80.40%	85%	670	170
Hypertension	Blood pressure ≤ 150/90mmHg	84.60%	90%	2350	590
Atrial Fibrillation	Anti-coagulated	85.10%	90%	280	70
Dementia	With care plan	87.10%	90%	80	20
COPD	FEV1 recorded	82.90%	90%	480	120
SUB TOTAL improved management				3,860	970
Pre diabetes	Referrals into NDPP	-	3,500	3,500^	1,750
Pre diabetes	Local offer to pre diabetics	-	3,500	3,500	875
SUB TOTAL diabetes prevention				7,000	2,625
TOTAL TREAT				**10,860**	**3,595**

^ 2 years

TOTAL FIND AND PREVENT (removing pre diabetes duplicates)	39,660	13,675

Taking this anticipated workload of 13,675 interventions as a starting point the following table models through the required WTE if a 20 minute appointment was used:

20 minute appointments	Total per annum for ST	Per neighbourhood
Number of people to see	13,675	1,710
Fraction of hour per appointment	0.4	0.4
No hours needed	5470	683.75
No hrs /day in clinical time	6	6
No days required per year	912	114
Working days per week	5	5
No weeks	182.3	22.8
Working weeks/yr	50	50
WTE needed	3.6	0.5

At 20 minutes per appointment therefore the Find and prevent programme requires 0.5 HCA per neighbourhood. With the pattern of neighbourhood weekend working to be decided, it is estimated that 0.3 to be delivered at the weekend (2 Saturday sessions, 1 Sunday) and a further 0.2 during the week, although this balance is to be confirmed.

If 30 minute appointments were needed (depending on the offer given) this rises to a requirement of 0.6 WTE per neighbourhood, however use of group sessions at 15 minutes per person would reduce this to 0.3 WTE per neighbourhood. An average of 20 minutes has been used as the best proxy.

SERVICE AREA:
PHARMACY LED REPEAT PRESCRIPTION MANAGEMENT

Component	Description
Current. Brief description of existing services (i.e. how many sites, how many staff, functions, ***opening hours***, capacity). (NUMBERS)	Currently individual practices do this with varying methodology, i.e. from over 40 sites involving well over 200 staff and GPs. It takes up a significant amount of time for administrative and GP staff. In an average practice a GP spends at least an hour a day authorising prescriptions and a similar time dealing with queries. At least 1 FTE is needed to produce the prescriptions for a GP to authorise. Services operate usually Monday to Friday in core and extended hours. In addition to this GPs and practice nurses spend a huge amount of time reviewing medication. The current call and recall systems for medication review and therapeutic monitoring are not robust leading to the potential for negative impacts including drug related admissions.
Problems & Opportunities: What could change – ***2 sentences***	The current system leads to significant waste, higher prescription spend and potential poor outcomes or admissions. There is an opportunity to centralise prescription management with benefits from working at scale , using clinical staff alongside non-clinical staff to manage repeat prescriptions, provide medication reviews and ensure therapeutic monitoring.
New service: What people, what processes, what use of technology, what additional capacity, what functions, clinical / professional governance (NUMBERS)	A pharmacist led neighbourhood prescription management and optimisation service is being developed Prescription requests would be accepted by telephone or electronically using trained medicines co-ordinators based on a system tried and tested in Coventry. Staffing required is: 40 FTE band 3 staff some of which may be recruited from existing practice staff. Technicians (20 FTE band 5 staff) would train and support these staff and deal with prescription and patient queries. Provide enhanced support to care homes to manage medicines and support GPs on care home ward rounds. Handle outpatient and discharge communications to process medication changes safely. They would also manage a robust call and recall system for therapeutic monitoring. Pharmacists (20FTE band 7) would authorise prescriptions, provide medication reviews, including home visits for housebound patients. The team would be managed and supported professionally by senior pharmacists 10FTE band 8a. The professional governance would be provided by an enhanced management team who would oversee the service and provide the operational work of the current provision. The service would be organised on a neighbourhood basis and the 8a pharmacist would have a direct relationship with the neighbourhood lead GP. The resilience of the service would be provided by neighbourhoods supporting each other in the event of sickness, leave tec.

7 day service – describe the extent to which service offer is over 7 days and links where appropriate to 7 day services – GP or otherwise	The service would operate between 8am and 8pm on weekdays and offer a reduced service on Saturday and Sunday mornings when the out of hour's service receives a significant number of medication related calls.
Benefits: What will it deliver in terms of outcomes, benefits to population, and efficiency improvements (Cash & time) (NUMBERS). What evidence is the basis of this (*National evidence, Local pilots, Assumptions)*	Benefits are as follows when fully implemented: GP capacity released. Estimated value at £3 million based just 10 minutes per year per patient for managing prescriptions/ meds queries plus completing meds reviews. Evidence from this and NHS Alliance (http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf,) Reduced number of prescription items (estimate an 8% reduction over current levels when the service is fully operational. Based on the work in Walsall (http://arms.evidence.nhs.uk/resources/qipp/1040169/attachment) and Coventry. Value £500k in dispensing fees plus circa £1.5million in drug costs Reduced spend on primary care prescribing (to below the England average). Improvements to therapeutic monitoring leading to reduced medication related admissions. National estimate is 10% of admissions are meds related, Assumption a 2% reduction in this. Increased use of patient on line for making requests to achieve the target of 20% Released capacity from out of hour's provision as the service deals with meds queries. Improved patient satisfaction – evidence from national pilot practice based pharmacists. Increased use of Repeat Dispensing, Patient online and EPS in line with national targets. Demonstrating we are implementing the 5 year forward view. Reduced costs to NHSE in disposing of waste meds Reduced medication related safeguarding incidents in care homes. Increased use of shared care for medicines releasing FT staff time from managing meds which could be provided in the community.
Costs: What will it cost and how was this derived? (Staffing, technology, start-up non-recurrent and recurrent)	The service integrates the current CCG team and some cost may be covered by the NHSE Phase 2 pilot funding for practice Pharmacists. Total additional staff cost £2.5m Funding from NHSE pilot for pharmacists (if successful) It is anticipated premises will be available from the current estate and a number of potential sites have been identified. Costs associated with supportive infrastructure and delivered through the enabler plan.

ALLIED HEALTH PROFESSIONALS (AHP) IN STOCKPORT

Business Case: To determine the role of AHP's as part of the Multi-Disciplinary Teams within the neighbourhood offer

Aim:

To ensure AHP resource is recognised and included in the evolving eight neighbourhood teams. To identify 'gaps' in current capacity and calculate what is required to meet the need of the population cohorts. To align with the aims and objectives specified in the broader neighbourhood business case.

Introduction:

The transformation of Stockport's Health and Social Care system aims to significantly shift activity from secondary to primary and community care. This will mean fundamental change in the provision of some of the current AHP services. A culture of multi skilled healthcare professionals working together as a multidisciplinary team (MDT) to provide pathways of care.

Who are Allied Health Professionals (AHP's)?

Allied health professionals (AHP's) are a diverse group of healthcare professionals. They work across a wide range of locations and sectors in acute, primary and community care. Operating across the holistic pathway of care they provide prevention, assessment, diagnosis, treatment, recovery, maintenance and palliation. AHP's will play an essential role in the integrated MDT neighbourhood offer.

National Context:

Allied Health Professionals (AHP's) make up 6% of the NHS workforce and are the third largest workforce in health and social care in England.

Supporting Case Studies:

Below are two examples of patient case studies.

Example Case Study 1

As someone with an array of long term conditions, I have personally experienced and benefitted from the knowledge and expertise of many caring allied health professionals including prosthetists, orthotists, physiotherapists, occupational therapists, radiographers and dietitians. Whilst these individual professions seem distinctly different in the skills they possess and the services they provide, they share many common goals, including trying to keep people mobile, independent, dexterous and out of hospital. So as someone who continues to benefit from the mobility and independence afforded to me, I feel it can only be to the benefit of all that these opportunities are shared and made as widely accessible as possible.

Steve McNeice - Expert by experience
Centre for Workforce Intelligence
March 2013

Example Case Study 2

I had a case whereby the proactive AHP resource was very helpful. Their ability to visit in a timely fashion and sort out equipment needed meant that this lady could be supported at home and maintain her independence without the need for home care or more costly interventions. Originally I tried to refer to the EAAT team but they were not able to treat the case as high priority. Therefore without proactive AHP resource in our team it would have taken over a week or two rather than the quick response we had for this lady who was high risk of falls.

Having proactive AHP resource in the office is very valuable if we are truly aiming to be integrated with health colleagues as her expertise and willingness to joint work is improving our service as a whole to Bramhall and Cheadle neighbourhood.

Janet Bradbury – Interim Principal Lead (West Localities)
Stockport

The scope of Phase 1 of this Business Case (as below):

Allied Health Profession	In Scope (Phase 1)	Out of Scope
Physiotherapy – Inpatient / Outpatient / Primary Care**/ Community	✓	
Dietetics –Community / Inpatient / Outpatient	✓	
Occupational Therapy –Community / Inpatient / Outpatient	✓	
Chiropody / Podiatry	✓	
Speech & Language Therapy (SALT) – Community / Inpatient / Outpatient	✓	
Orthoptists		✓
Radiographers – Diagnostic / Therapeutic		✓
Paramedics		✓
Prostetists / Orthotists		✓
Osteopaths		✓
Operating Department Practitioners (OPD's)		✓
Therapies – Music / Drama / Art		✓
Intermediate Tier aligned therapy services *		✓
MSK Direct Access Physiotherapy (Primary Care) **		✓
Falls Service ***		✓

* ***The Intermediate Tier business case addresses the specific needs of any aligned therapy services***

** ***The Transformed Primary Care resource associated with the 'direct access physiotherapy pilot' (Marple & Bramhall) will not be included in the scope of this business case.***

*** ***Falls Service is called Steady in Stockport and is a separate programme within the Neighbourhood Business Case.***

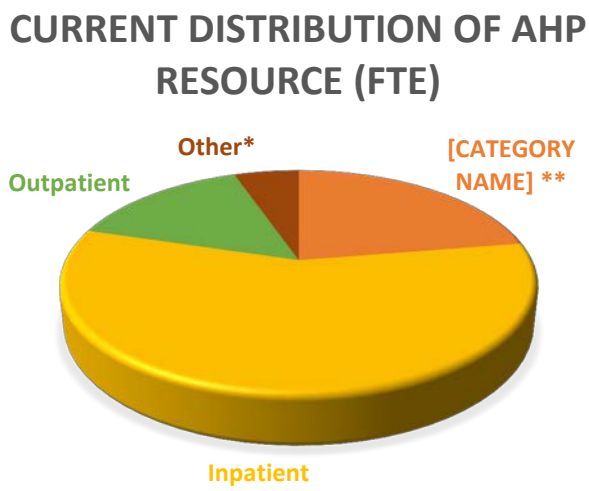
Further break down of the AHP roles within the scope of Phase 1 of this Business Case can be viewed in Appendix A including general details of service delivery by person cohort and setting.

Current Position:

Current AHP resource in Stockport is summarised below. A more detailed breakdown of this resource can be found in Appendix B.

Allied Health Service	Current FTE	Current Cost
Dietitians (94% Qualified)	15.85	£ 544,800
Occupational Therapists * (69% Qualified)	71.91	£ 2,642,019
Physiotherapists (84% Qualified)	124.45	£ 4,769,200
Podiatrists (100% Qualified)	20.76	£ 844,400
Speech and Language Therapists (85% Qualified)	12.05	£ 391,700

*Data includes SMBC staffing. Note that SMBC staffing operates on 55% qualified ratios.



**Patient education (Dietetics and CD Physio; Occupational Health; Cardiac rehab; T&O; EPR; Uro-dynamics (Physiotherapy).*

*** community data based on health staffing only*

Currently the majority of AHP resource is operating in a hospital setting. As part of the implementation phase of this programme we aim to redistribute some of this resource into a community setting in accordance with the needs of the population. The exact % of redistribution of resource will be calculated as part of the implementation phase of this programme and in conjunction with the Outpatient's Business Case removal of activity from the hospital setting. The focus will be on prevention, self-management and treatment within a home or community setting with AHP's as part of a community multi-disciplinary team.

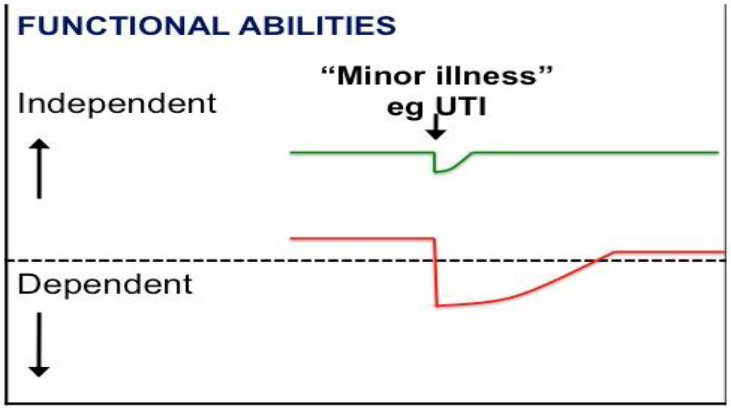
There are two population cohorts to be considered in this phase: Frailty and Musculoskeletal

Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an

apparently minor event which challenges their health, such as an infection or new medication.

Loss of Physiological Reserve Model



[1]

The eFrailty Index (eFI) counts deficits (symptoms, signs, disease or disability). The greater the deficit the greater the loss of physiological reserve.

eFI uses the cumulative deficit model of frailty. The eFI comprises thirty-six deficits, constructed using around 2,000 primary care clinical codes (Read codes). The eFI calculates a frailty score by dividing the number of deficits present by the total possible. The score is a robust predictor of those who are at greater risk of adverse outcomes (e.g. long-term care and mortality).

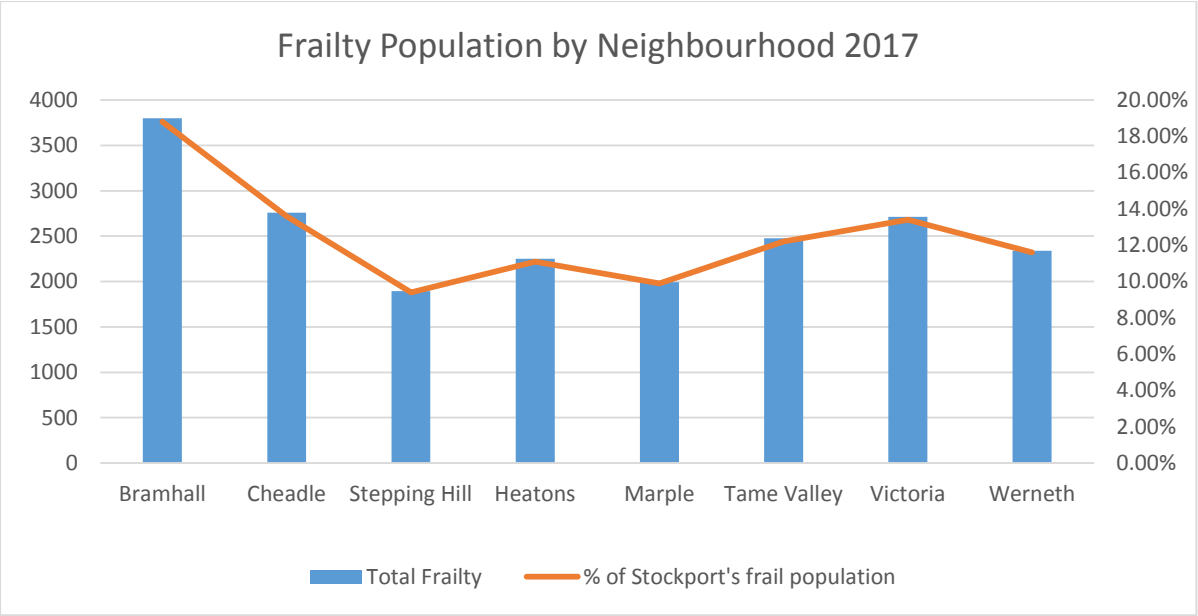
Below shows the 91% of Stockport registered patients over the age of 65 years. As at January 2017, there were 53,000 people aged over 65 years of which, 48,000 have an eFI score recorded.

Stockport's eFrailty Index (>65's)

eFI Score	Definition	Stockport As at January 2017	
		%	Number
0-0.12	**Fit -** People who have no or few long-term conditions that are usually well controlled. This group would be mainly independent in day to day living activities.	58%	28,000
0.13-0.24	**Mild Frailty -** People who are slowing up in older age and may need help with daily living, such as finances, shopping, transportation.	33%	16,000
0.25-0.36	**Moderate Frailty -** People who have difficulties with outdoor activities and may have mobility problems, such as washing and dressing.	8%	4,000
>0.36	**Severe Frailty -** People who are often dependent for personal care and have a range of long-term conditions/multi-morbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6-12 months.	1%	500

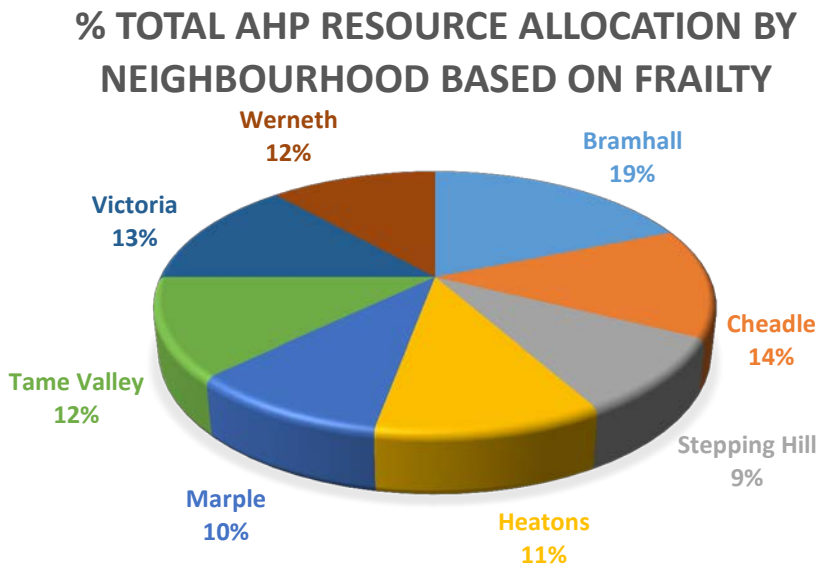
Frailty population broken down between the neighbourhoods as below:

[1] ***Clegg, Young, Iliffe, Olde-Rikker & Rockwood, Frailty in Elderly People - Lancet 2013; 381: 752-762)***



The chart opposite shows the distribution of AHP resource required to meet the **frailty needs** of the eight areas identified within the Neighbourhood Business Case.

this will be viewed alongside neighbourhood data on population size, condition prevalence, and risk of admission when allocating AHP resources to neighbourhoods.



Musculoskeletal

The national evidence is that 20% of GP Consultations are for musculoskeletal conditions and, that 70% of this activity could be managed safely and effectively by a Physiotherapist[2].

The current Primary Care Physiotherapy service sits within the Diagnostics and Clinical Support Services Business Group. The service is delivered across all eight neighbourhoods. Waiting time for a first appointment was 8 weeks in December 2014 (lowest recorded

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

available). Waiting times have shown a steady increase and are currently at 12 weeks (December 2016).

There is growing national evidence that moving from a GP referral model (current) to a self-referral model is a safe and cost effective model of delivery. There is no evidence that it creates a 'surge' in demand unless there is already unmet need. It has been shown that self-referrers need fewer appointments and will seek treatment sooner with minor problems preventing more chronic conditions developing. A self-referral model encourages individual empowerment, self-management and the aim of treating people in their own home or community setting.

Compared with the national average, the current Stockport Primary Care Physiotherapy service has a shortfall of 8.4 FTE staff. However, any proposals relating to investment in MSK physiotherapy must be viewed in conjunction with significant aligned investment in MSK physiotherapy within the Transformed Primary Care element of the business case.

Proposed model

MSK within the neighbourhood would be accessed directly to provide initial triage and direct activity as appropriate; Urgent contact / non-urgent contact / virtual contact / referral for medical opinion. Intervention provided will be either; direct (with a physiotherapist) / indirect (exercise programme, including on-line applications) / advice and guidance only / review and/or discharge.

It is proposed that additional investment through this business case into MSK physiotherapy will primarily support the delivery of longer term direct physiotherapy treatment (identified through own service or Transformed Primary care offer), and MSK physiotherapy support to complex patients receiving enhanced case management from the neighbourhood teams.

Current Position Summary:

There is currently a lack of consistency within and across service provision in relation to patient – centred pathways. This is due to poor communication and coordination across services.

A proportion of AHP services operate integrated pathways across both acute and community settings providing comprehensive care for specific conditions, whilst others operate exclusively in the community or other settings creating the risk of duplication and multiple patient attendances.

AHP services are currently operating with different skill mixes and bandings for potentially similar functions.

There is a need to review the current configuration of AHP services and to make the case for

change to optimise the delivery of patient centred care at neighbourhood level.

Future Model:

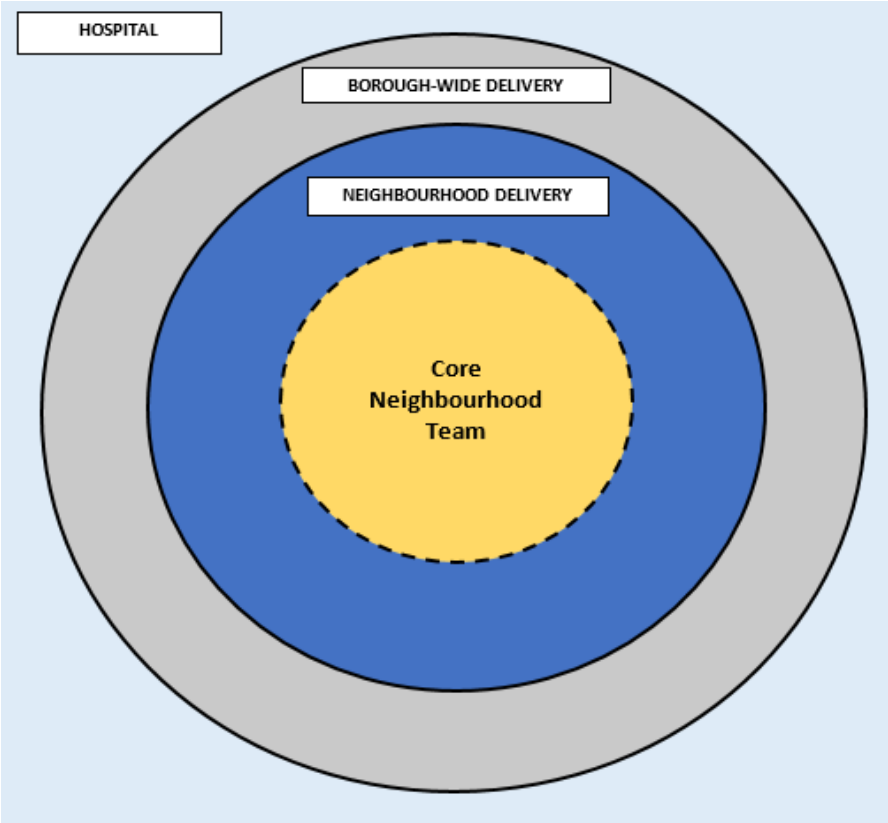


Diagram 1 below provides a visual outline of the proposed future model for delivering borough-wide and neighbourhood services within which AHP services sit as part of the MDT.

There is clearly an opportunity to unlock a huge resource for the benefit of the patient and public, and particularly in the area of early intervention and prevention.

Public Health England. 2014

The guiding principles for the above model are that the service will be:

- Centralised within the community
- Deployed across the health and social care system
- Delivered as close to home as possible

Design focus for AHP services:

Below outlines the initial guiding principles to be considered in determining the configuration and delivery of future AHP services as part of a multi-disciplinary team within the neighbourhood offer:

- AHP services delivering 'in-reach' from the community into hospital as standard ensuring a seamless pathway and continuity of care for patients.
- AHP services focussing on the most complex cases as part of an MDT within the neighbourhoods to manage care closer to home (specialist advice & guidance, and rapid access to assessment and treatment where required)
- Neighbourhoods having the right capacity and capability to provide person-centred care and enhanced case management in accordance with neighbourhood needs
- AHP services focussing on prevention and self-management to deflect unnecessary

activity from GP / Acute/ longer term social care settings.

- Using technology to enable alternative methods of delivery and improve efficiency.

Proposed AHP Delivery Model:

Proposal	Benefits
The AHP resource is centralised within the community	➢ Consistent patient pathways ➢ Optimise resilience ➢ Maximise opportunity for skill mix and cross cover, building on existing examples of good practice ➢ Enable interdisciplinary assistant practitioner / support worker roles ➢ Provide clear, effective management structure ➢ Clarify roles and responsibilities ➢ Reduce duplication of service creating a more efficient patient pathway ➢ Ensure consistent banding of staff ➢ Enable sufficient, flexible capacity to deliver over extended operating hours as required by model.
AHP resource is deployed across the health and social care system, including in-patients	➢ A more reliable service for patients ➢ Flexibility ➢ Capacity consistent with demand ➢ Target priority areas ➢ Enable shift in resource as activity transfers from secondary care
AHP resource is delivered as close to home as possible	➢ Patient get the right care in the right place at the right time ➢ Default is delivery in neighbourhood unless valid clinical reason for other location ➢ Enables virtual/actual MDT working with core teams, including skills sharing

Current State **Benchmarked average**

Row Labels	Sum of FTE	% workforce	Row Labels	Sum of NEW FTE	% change	% of workforce
Community	**44.4**	**19%**	**Community**	**56.9**	**28%**	**24%**
Dietician	2.11		Dietician	6.3		
OT	2.6		OT	2.6		
Physio	18.93		Physio	27.3		
Podiatrist	20.76		Podiatrist	20.8		
Inpatient	**113.37**	**50%**	**Inpatient**	**113.4**	**0%**	**47%**
Dietician	10.65		Dietician	10.7		
OT	34.67		OT	34.7		
Physio	56.76		Physio	56.8		
SALT	11.29		SALT	11.3		
Outpatient	**29.72**	**13%**	**Outpatient**	**29.7**	**0%**	**12%**
Dietician	1.7		Dietician	1.7		
OT	4.26		OT	4.3		
Physio	23.2		Physio	23.2		
SALT	0.56		SALT	0.6		
Intermediate Tier	**30.54**	**13%**	**Intermediate Tier**	**30.54**	**0%**	**13%**
Dietician	0.2		Dietician	0.2		
OT	13.88		OT	13.88		
Physio	16.26		Physio	16.26		
SALT	0.2		SALT	0.2		
Other	**10.49**	**5%**	**Other**	**10.49**	**0%**	**4%**
Dietician	1.19		Dietician	1.19		
Physio	9.3		Physio	9.3		
Grand Total	**228.52**	**100%**	**Grand Total**	**241.07**	**5%**	**100%**

Opposite outlines the proposed 28% increase in AHP resource in Stockport community based provision to ensure we are operating in accordance with the national average.

Note that this benchmarking data will require further review for accuracy and relates to existing models of care, and only includes health staffing data.

A benchmarking exercise is currently underway to address this issue.

INVESTMENT REQUIRED

The investment in AHP's totals £587k. It is proposed that £294k is released in 2017-18, which represents 50% of the total.

Provisional proposals for the investment are as follows. These aim to bring AHP provision up to benchmark, where appropriate. However it should be noted that current benchmarking relates to existing models of reactive care, and also only includes health staffing data. Therefore further analysis in the context of a proactive model of neighbourhood care is required to ensure that AHP investment reflects the needs of the neighbourhoods. These proposals must also be viewed alongside significant additional investment into MSK Physiotherapy within a transformed primary care offer.

DESCRIPTION	INVESTMENT	WORKFORCE		BENEFITS
		Now	Future*	
Physiotherapy	395k	124.45	128.45	Reduce waiting times**; Enable release of GP capacity for MSK conditions;

Occupational Therapy / SaLT		83.96	88.36	Reduce waiting times Enable faster throughput of enhanced case management offer Reduction in longer term packages of home care N'hood contribution to falls reduction pathway
Dietetics	193k	15.88	20.05	Reduce waiting times Frailty is often associated with malnutrition. Malnutrition increases susceptibility to disease, impairs clinical outcomes and increases healthcare use and costs. Dietetic input is vital in resolving malnutrition.

Estimates based on fully qualified workforce increases. Further increases in FTE again investment are anticipated as understanding of new skill mix options are explored.

*****See table 5 below for potential waiting list impact***

(Based on Primary Care Physiotherapy – 2016-17 year to date)

Patients with a 'Primary care physio' referral, but no activity	3124
Additional physio FTE	4
Caseload (Benchmarked average)	201.78
Cases immediately removed from list**	1684.863
Remaining wait list **	1439.137
Reduction in waiting list	-54%

If we employ 4 physios today and gave each a 'benchmarked average' caseload size, alongside aligned investment in Transformed Primary Care physio access, then we could achieve a reduction in the waiting list of up to 54%.

**Including impact of aligned investment in Transformed Primary Care physio access

Next Steps:

In order to develop the implementation stage of this programme a number of actions have been identified:

- Further analysis of benchmarking and pilot data to ensure investment reflects needs of proactive model of neighbourhood care, and makes best use of investment in alignment with benefits outlined in Transformed Primary Care AHP plans.
- Clarification of the current MSK & Frailty pathways including access, resource, gaps,

blockages, duplication of activity. Where support currently sits on the pathways to determine an accurate and informed current position to enable efficient and sustainable transformation supported by all affected parties. This will be achieved through process mapping activity, workshop events and other change management tools as appropriate.

- To develop clear Terms of Reference for the implementation phase of the programme focussed on improving patient pathways, patient experience and providing a neighbourhood offer in line with the needs of the population with emphasis on prevention, self-management (advice and guidance), providing treatment in the home/community setting and reducing unnecessary GP / Acute activity.
- Governance plan - to include a robust centralised management structure, clear project plan with monitored milestone activity, risk analysis, roles and responsibilities. Use key performance indictors to evaluate progress, improvement and adjustments to the milestones as necessary in line with a flexible Agile approach.
- Communications strategy – to include staff engagement activity and regular, relevant updates of information to all parties involved in the programme. This will aid the cultural change aspect of the programme which is recognised as a significant contributor to the success of the programme.
- Resource – Upskilling, cross cover, rotation, training opportunities to be explored to enable a successful and effective multi-disciplinary team culture within the neighbourhood teams. Ensure the right capacity and capability is available in the right place at the right time. Such work will also provide a consistency of skill mix across the system, based on patient needs rather than historical practice and a greater use of unregistered workforce (AfC Band 4 or below) will be incorporated into the future model.
- To research best practice and shared learning and action where appropriate.

Appendix A: Brief summary of Phase 1 Allied Health Professions service delivery by person cohort and location.

AHP:	Examples of service delivery person cohort:	Examples of service delivery settings
Physiotherapy	• neurological (stroke, multiple sclerosis, Parkinson's) • neuromusculoskeletal (back pain, whiplash associated disorder, sports injuries, arthritis) • cardiovascular (chronic heart disease, rehabilitation after heart attack) • respiratory (asthma, chronic obstructive pulmonary disease, cystic fibrosis) • manual therapy (such as massage) • therapeutic exercise • electrotherapy (such as ultrasound, heat or cold)	• outpatients' departments • elderly care • stroke services • orthopaedics • mental health and learning disability services • occupational health
Dietitians	• have digestive problems • need to put on / lose weight after an illness • have an eating disorder • have an allergy.	• mainstream and special schools • community clinics • prisons and young offenders institutions • patients' own homes
Occupational Therapy	• someone adapt to life after major surgery such as a hip replacement • dementia sufferers develop strategies • stroke patients • people suffering from mental illness get back into everyday activities such as work or volunteering • elderly people stay in their own homes by providing adaptation such as level access showers or stair lifts	• social services departments • hospital departments • GP Practice • patients' own homes
Podiatry (Chiropody)	• diabetes sufferers with circulation problems who may be at risk of amputation • people with sports injuries • people needing minor procedures such as nail surgery or laser treatment, using local anaesthetic • people wanting advice about footwear or foot health	• hospital departments or clinics • GPs surgeries • patients' own homes •
Speech & Language Therapy (SALT)	• physical disabilities • communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke, head injury, Parkinson's disease and dementia • head, neck or throat cancer • mental health issues • specific language impairment • cleft palate • voice disorders • selective mutism • learning difficulties	• mainstream and special schools • community clinics • prisons and young offenders institutions • patients' own homes

Appendix B: AHP Current Resource

	Community			Inpatient			Outpatient			Intermediate Tier			Other***			
AHP	**FTE**	**16/17 Cost**	**Activity****	**FTE**	**16/17 Cost**	**Activity****	**FTE**	**16/17 Cost**	**Activity***	**FTE**	**16/17 Cost**	**Activity****	**FTE**	**16/17 Cost**	**Total FTE**	**Total 16/17 Cost**
Dietitian	2.11	£77,200	740	10.65	£334,800	5068	1.7	£73,500	760	0.2	£6,000		1.19	£53,300	15.85	£544,800
OT, M&H, EAO	16.5	xx	/							Delivers across both Community and Int Tier					16.5	xx
OT	2.6	£100,200	28353	34.67	£1,123,800	27343	4.26	£166,400	2131	13.88	£627,700	9783			55.41	£2,018,100
Physio	18.93	£783,900		56.76	£1,799,400	68576	23.2	£1,111,800	32632	16.26	£643,400		9.3	£430,700	124.45	£4,769,200
Podiatrist	20.76	£844,400	43105												20.76	£844,400
SALT				11.29	£358,900	1502	0.56	£25,600	983	0.2	£7,200	77			12.05	£391,700
Grand Total	**44.4**	**£1,805,700**		**113.37**	**£3,616,900**		**29.72**	**£1,377,300**		**30.54**	**£1,278,300**		**10.49**	**£484,000**	**228.52**	**£8,568,200**

* 15/16 full year PLUS est. 20% additional for non-Stockport patients
**16/17 FOT, Stockport incl. non-Stockport patients. SMBC employed OT, M&H, EAO activity measured differently
*** Patient education (Dietetics) and CD physio; Occupational health; Cardiac rehab; T&O; EPR; Uro-dynamics (Physiotherapy)

STEADY IN STOCKPORT

Business case: Prevention and management of falls and (fragility) fractures and improving bone health

Aim:

The aim of the 'Steady in Stockport' programme is to improve quality of life for people by reducing the burden of falls and fractures.

What are we trying to accomplish?

Through an interdisciplinary pathway we want to offer:

Primary prevention:

- Increase the number of people engaging in physical activity throughout their life course.
- Identify people at potential risk of falling or fracture and raise awareness of actions they can take to reduce their risk through a multi-agency approach.

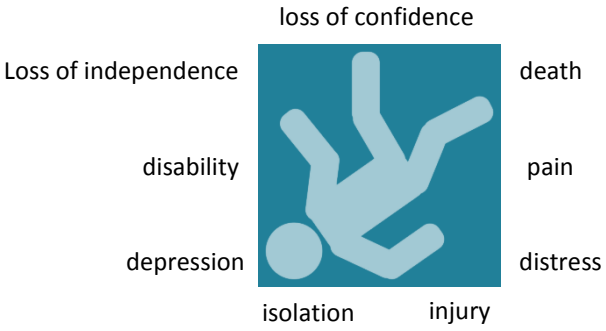
Secondary prevention:

- Identify people who have a high risk of falling including people with fractures, fragility fractures and/or osteoporosis and provide treatment, restore function and undertake multi-factorial assessments and targeted interventions to prevent falls and improve function.
- Work with care providers to prevent falls and fractures in their care environment through multifactorial interventions at an individual and system level.
- Cluster current staff and resources to organise an integrated and interdisciplinary approach across Stockport.

1 in 10 will die within one month and
1 in 4 will die in a year after a fractured hip

Why?

- A fall can have significant physiological and psychological consequences and impacts negatively on people's quality of life. A fall can lead to:



- Falls are the largest cause of emergency hospital admissions for older people.
- The estimated cost to the NHS is more than £2 billion per year, of which £1.1 billion are costs for social care.
- Cost of hospital, community and social care services for patients who fall can be almost four times as much in the 12 months after admission as the costs of the admission itself.
- Many falls are preventable and people who had a fall are more likely to fall again.

Stockport Figures

Data on falls

Table 1: Number and % of the population with a history of fall

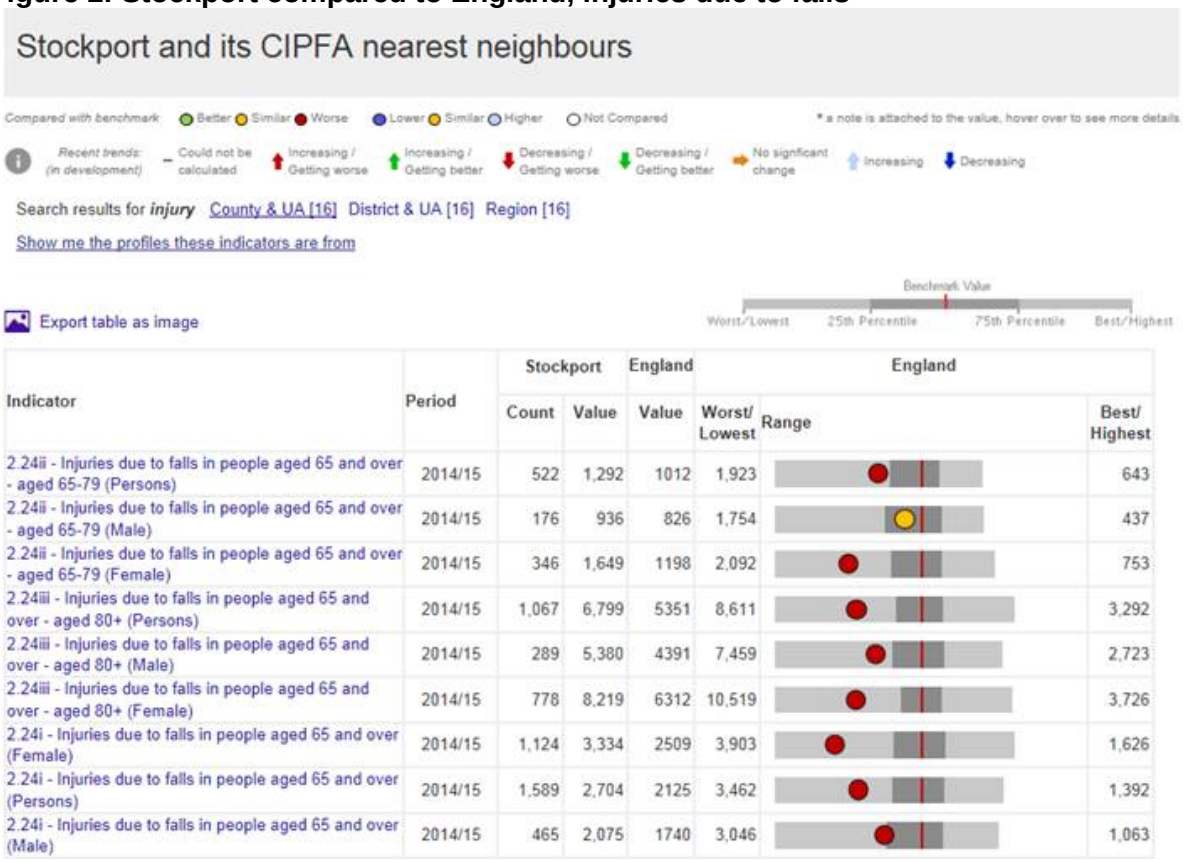
	All		Female		Male	
	Number	% of pop'n	Number	% of pop'n	Number	% of pop'n
All	12,150	4%	7,700	5%	4,450	3%
Age 0-19	1,685	2%	805	2%	880	2%
Age 20-64	4,725	3%	2,875	3%	1,845	2%
Age 65+	5,745	10%	4,020	13%	1,725	7%

- Every year about 30% of people 65+ will have at least one fall: 16680.
- Locally, data from Emergency Department (ED) attendances shows us that 47% (13/14: 3236) of ED attendances with falls, 62% of hospital admissions with falls (13/14: 2133 hospital) and 89% of deaths from falls (13/14 49 deaths) are in the 65+ age group.
- Numbers of falls are fairly stable over the years.
- There is no strong trend in month or time of fall; however 13% of attendances by the older age group are in the early hours of the morning.
- The home is the most likely place for a fall to occur.
- People in the older age group are more likely to arrive by ambulance and more likely to be admitted to hospital rather than discharged from ED.
- Almost a third of hospital admissions in the older age group are not finished after one episode of care, meaning there is a longer spell in hospital.
- Rate of falls generally increases with deprivation. However, there are more people with a history of falls in the more affluent areas of Stockport.
- Compared to the England average, Stockport has significantly more injuries due to falls, for those aged 65-79 and for those 80years and over. This is the case for males and females (see figure 2).
- Compared to the England average, we are also higher for mortality from accidental falls (this is in part as our coroner investigates all deaths with a fall in the last six months). See figure 3.
- NHS Right Care data indicates that compared to the best / lowest performing 5 CCGs of our 10 most demographically similar CCGs we could improve in the following areas (figure 1):

Figure 1: Right Care data

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

Figure 2: Stockport compared to England, Injuries due to falls



Stockport and its CIPFA nearest neighbours

Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher — Not Compared — * a note is attached to the value, hover over to see more details

Recent trends: (in development) – Could not be calculated — Increasing / Getting worse — Increasing / Getting better — Decreasing / Getting worse — Decreasing / Getting better — No significant change — Increasing — Decreasing

Search results for *injury* County & UA [16] District & UA [16] Region [16]

Show me the profiles these indicators are from

Export table as image

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Stockport Count	Stockport Value	England Value	England Worst/Lowest	England Range	England Best/Highest
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Persons)	2014/15	522	1,292	1012	1,923		643
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Male)	2014/15	176	936	826	1,754		437
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Female)	2014/15	346	1,649	1198	2,092		753
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Persons)	2014/15	1,067	6,799	5351	8,611		3,292
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Male)	2014/15	289	5,380	4391	7,459		2,723
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Female)	2014/15	778	8,219	6312	10,519		3,726
2.24i - Injuries due to falls in people aged 65 and over (Female)	2014/15	1,124	3,334	2509	3,903		1,626
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2014/15	1,589	2,704	2125	3,462		1,392
2.24i - Injuries due to falls in people aged 65 and over (Male)	2014/15	465	2,075	1740	3,046		1,063

Figure 3: Trends in mortality from accidental falls

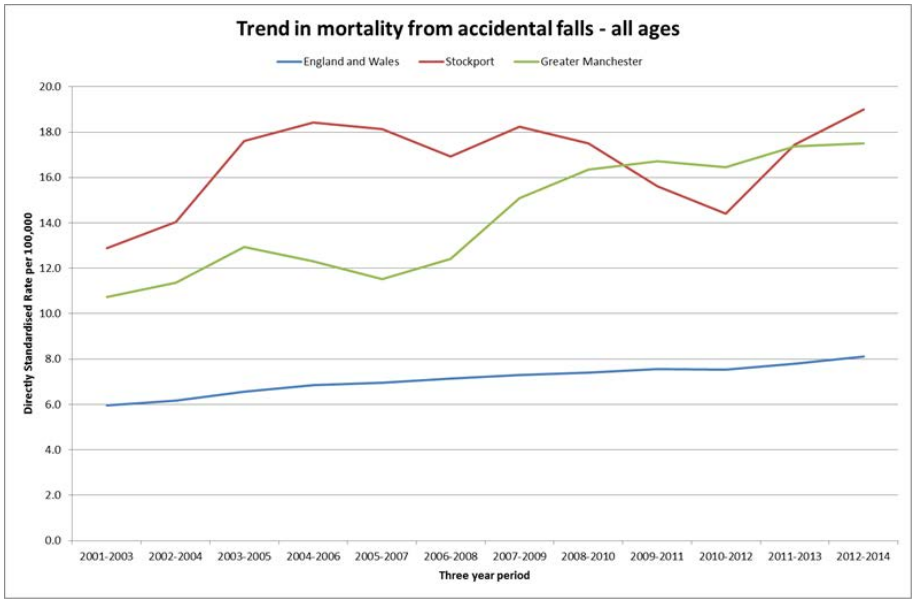


Figure 4: Fall Related Admissions age 50+ - Jan 2016-Jan 2017

DiagFlg	Values Spell Count	Spells for Falls At Home	Spells for Falls at Care Homes	Spell Cost	A&E Cost
# at wrist and hand level	23	8	3	£43,243	£3,558
# of femur	365	195	70	£2,487,275	£54,119
# of Forearm	93	47	3	£193,442	£11,531
# of lower leg, inc ankle	117	60	5	£376,594	£16,460
# of lumbar spine and pelvis	110	73	15	£384,169	£16,145
# of shoulder and upper arm	90	46	8	£269,058	£13,129
# of skull and facial bones	34	13	1	£131,537	£5,857
Open wound of head	263	138	37	£644,091	£46,494
Open wound of wrist and hand	14	7	1	£29,365	£1,951
Other and unspecified injuries of head	143	98	13	£341,086	£24,751
Superficial injury of head	313	171	53	£604,254	£54,602
Other	598	364	65	£1,711,995	£92,485
Grand Total	**2,163**	**1,220**	**274**	**£7,216,109**	**£341,082**

What is the need for change?

We currently have an inconsistent response to preventing and managing falls. People are identified as high risk of falling by various staff in the community but are not systematically assessed and followed up. Many professionals identify people at risk / high risk of falling like

third sector parties, fire and rescue service and Life Leisure (fitness provider) staff but there is no falls service for them to refer these people at risk to. There is an offer of balance and strength programmes but people at risk are not systematically referred and the balance improvement activities are not provided consistently across Stockport. People with fractures receive an intervention through the hospital's fracture clinic and/or falls clinic but this service cannot meet demand and is not providing a full fracture liaison intervention as recommended by NICE guidance. GPs of people over 50 attending ED with a fracture will be advised to arrange a DXA-scan but currently 40% of GPs follow up this advice (SHH, audit 2016).
We are not screening for fragility fractures to provide timely interventions in improving bone health and there is an underdiagnoses of osteoporosis and not everybody diagnosed with osteoporosis receives treatment. As a result Stockport:

- Is an outlier in ED attendance as result of a fall,
- Has a diagnosis gap regarding osteoporosis.
- Has a higher number than average of frequent fallers.
- Has a higher number of people with injured falls (65+) than England's average.
- Has a high number of falls in care homes / hospital environments.

'Steady in Stockport' model

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

The pathway is as follows:

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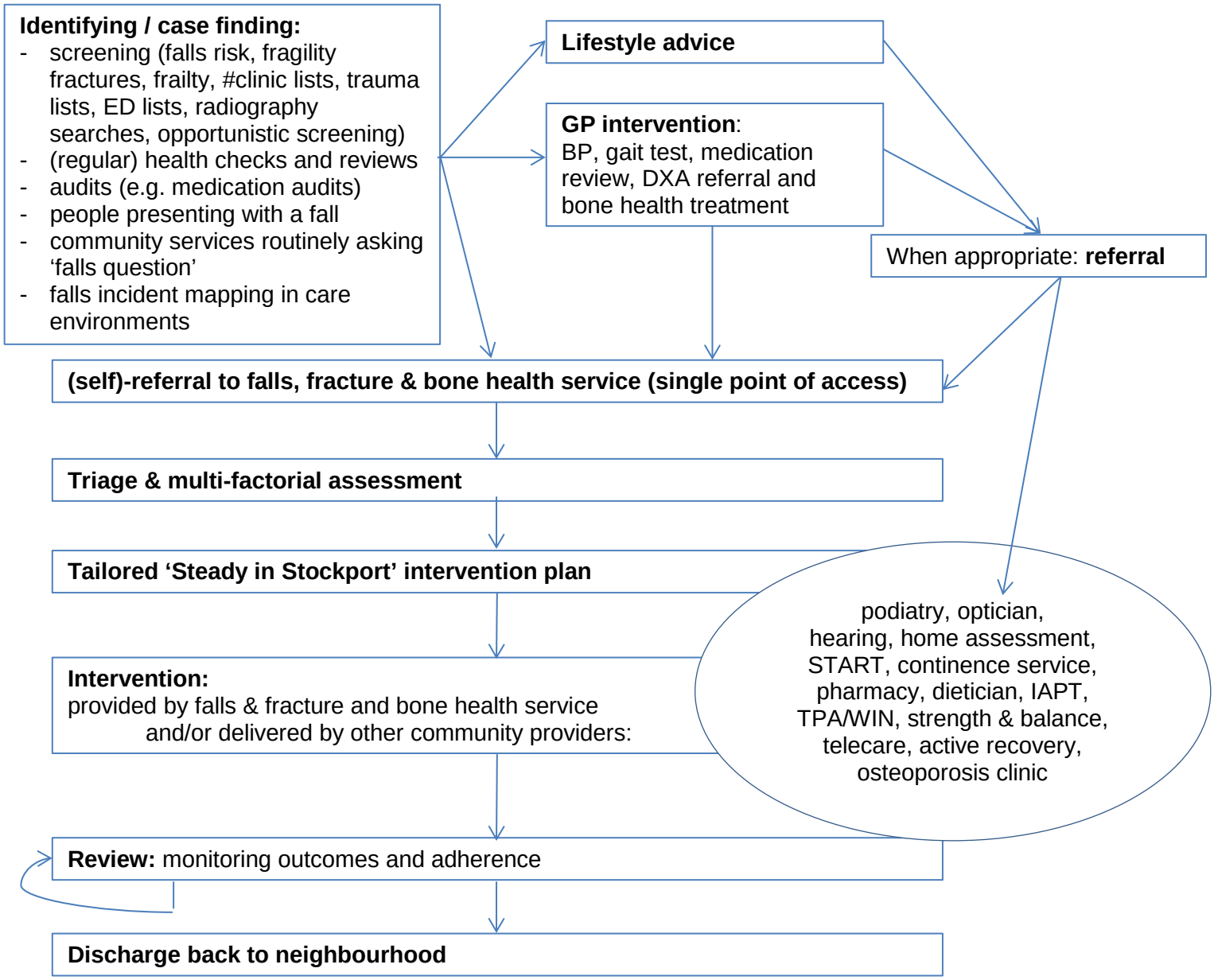

	Case finding	Assessment	Interventions
General public level: - Generic lifestyle improvements which also includes preventing falls risk factors **System level**: - Improving care environments to prevent falls	People aged 40 and older through health checks and other health screening and promotion activities Falls incidents monitoring	Self-assessment through online webtool Health check	**Supporting health improvement and self-management** through falls awareness and prevention initiatives: • Falls Awareness Leaflet • Advice regarding maintenance of health and wellbeing / active ageing / falls prevention • Signposting to address specific falls risk factors **Systematic falls prevention management** in care environments incl. assistive technology (care homes / hospitals)
Individual level: - reducing risk of falls and fragility fractures and improving quality of life - restoring function after fall / fragility fracture - improving bone health High risk of falls: a history of falls, muscle weakness, poor balance, visual impairment, polypharmacy and the use of psychotropic and anti-arrhythmic medicines, environmental hazards and a number of specific conditions (including arthritis, cognitive impairment, depression, diabetes,	Staff working in the community routinely asking people 65+: "have you had a fall / trip / stumble in the last 12 months"? FRAT score 1 or more EMIS-frailty index: mild, moderate, severe FRAX and Q-fracture Audits (hip fracture) / opportunistic screening People presenting with an injurious fall or (unexplained)	Falls prevention, fracture & bone health service: Interdisciplinary multifactorial assessment following NICE guidance (nurse, OT, physio, TPA, pharmacist) Service has direct access to consultants as and when needed and access to diagnostics like DXA scan, blood tests Urgent access based on triage	**Tailored intervention plan** based on one or more of the following elements delivered in the community: • bone health treatment – part of FLS • medication adjustments • rehabilitation • mental wellbeing • mobility • telecare • strength & balance, exercise (home/ group) • safe home environment, incl. equipment • feet and footwear advice • vision/hearing /aids advice • vitamins & nutrition advice • medicines optimisation • continence advice • lifestyle advice and interventions

high alcohol consumption, incontinence, Parkinson's disease, stroke and syncope). High risk of fractures: low bone mineral density, previous fracture, age, female sex, history of falls, glucocorticoids, rheumatoid arthritis, smoking, low BMI, high alcohol consumption, and visual impairment.	fracture (GP, Carecall, NWAS, A&E, CRT) People with poor bone health High risk groups (because of health condition or certain medication usage)	Clinics in community and hospital. Hospital clinic is predominantly a fracture liaison and bone health service (FLS) Telephone advice & reviews / clinic appointments / home visits	(including alcohol, nutrition, diet and smoking) • social work referral Access to consultant / specialist advice (telephone / virtual / clinic) Monitoring and evaluation of intervention plan including medication adherence

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

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

In addition there are specific target groups that have a higher risk of falling and fractures: people with certain medication, people with certain medical conditions, people living in certain areas or sheltered housing / care facilities and people over the age of 65. For these groups a more targeted approach is needed related to 'making every contact count' (MECC) to identify people at risk and to positively stimulate people to get the best possible outcomes in falls prevention. This means that we need to raise public awareness, signpost them to postural stability classes in each neighbourhood and promote home environment checks from Age UK and the Fire & Rescue service.
Various staff members in contact with at risk groups will need to be falls risk aware, able to undertake a FRAT-assessment and need to know when and where to refer people at risk to depending on their needs, e.g. mobility, sensory impairment, balance, medication, cognition, and footwear. All prevention messages need to be aimed at empowerment and support rather than creating fear. Some of this is already in place and it is building on the good work being delivered by the fire and rescue service, Targeted Prevention Alliance (TPA) / Wellbeing and Independence Network (WIN), Age UK and various other health and social care staff groups.

Apart from working with health and social care staff, pharmacies, third sector, fire and rescue service and home care and housing providers, it is also worthwhile engaging with other public facing services like hair dressers, community shops and taxi drivers asking them to give falls prevention messages and hand out a falls prevention leaflet.

It is crucial that when people are identified who could potentially benefit from falls prevention, an easy access to falls prevention intervention is available including a simple online assessment tool on the Healthy Stockport Website that will direct them to the most appropriate interventions (leaflet, strength & balance improvements, visit local pharmacist etc.). This tool can also indicate a higher falls risk and the need to contact their GP for further investigation and/or (self-) referral to the falls, fracture and bone health service.

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

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

<u>Case-finding</u>
It is important to find people at high risk of (another) fall, a fragility fracture or with low bone health. Several actions will be undertaken in the new model:

- Auditing and undertaking opportunistic screening to find people with low bone health and/or with fragility / vertebral fractures.

- Identifying people at high risk of falls or fragility fractures based on frailty, medical conditions and medication usage (GP / practice nurse assessments EMIS-frailty index, FRAX and/or DXA scan, medication audits related to high falls risk or impact on bone health.)
- Identifying people at high risk when they report a (non-injury) fall.
- Identifying people at high risk of falling in care environments (hospital, care homes, extra care housing.)

For all those people at a higher risk of falls and fragility fractures a simple referral pathway into a falls, fracture and bone health service will be available to support the neighbourhood teams with assessing and developing individual intervention plans. This service has two elements:

A) Fracture And Bone Health element of the service (community based with hospital in-reach)[1]
This evidence based service focusses on people 50+ presenting with a new fragility fracture in hospital (ED attendees) or who are found through opportunistic identification of vertebral fractures in routine scans taken for other purposes. All people identified will be offered written information about bone health, lifestyle, nutrition and bone-protection treatments.
People will have a bone health assessment and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident fracture.
People at increased risk of further fractures will be offered appropriate bone-protection treatments.
People at increased risk of further falls will receive a multi-factorial assessment and tailored intervention plan to reduce future falls.
Management plans will be person-centred and integrated between primary and secondary care.
People who are recommended drug therapy to reduce risk of fracture will be reviewed within 4 months of initiation to ensure appropriate treatment has been started, and every 12 months to monitor adherence with the treatment plan (clinic or telephone appointment.)

B) Falls prevention element of the service (community based)[2,3]

Falls prevention interventions will be offered to everybody at high risk of falls. People will receive a multifactorial and holistic assessment to identify areas of improvement in conjunction with the person's own goals.

This assessment is provided by an interdisciplinary team from the 'falls, fracture and bone health service'. Part of the assessment is providing education and information. Following the assessment a multifactorial intervention plan will be developed delivered partly by the service and partly by providers in the community.

The service will also provide training and advice to staff working in 24/7 care environments or providing home care on how to prevent falls, how to raise falls awareness and how to identify people at risk of falling.

C) Service delivery

The falls, fracture and bone health service runs weekly clinics in the community at locality level, provides telephone consultation and runs an in-reach service in the hospital (fracture liaison and bone

[1] NOS, 2015, Clinical Standards for Fracture Liaison Services
[2] NICE, 2017 Quality Standard QS 86: Falls in Older People
[3] NICE, 2013, Clinical Guideline CG 161: Falls in Older People: assessing risk and prevention

health element). The staff provides case finding, assessment, interventions, training and education includes the following core disciplines:

- Nurse (fracture liaison, case finding, education)
- Telephone triage nurse
- Occupational Therapist (falls prevention, education)
- Physiotherapy (falls prevention, education)
- Technical instructors to work in 1-1 situations with people at highest risk of falls
- Administrarive staff

The service will be managed by the borough wide active recovery team and will work in partnership and will be aligned to various services in the community (third sector, fire and rescue service, continence service, community pharmacists, opticians, hearing aid and mobility services) and will especially work closely together with neighbourhood teams (GPs, pharmacists, pysiotherapists and TPA/WIN staff in the neighbourhood), LifeLeisure (strength and balance training), active recovery therapists and health coaches.

The service has good working relationships and fast track access to consultants as and when needed: rheumatologists, cardiologists, orthopaedics, geriatricians, ENT, old age psychiatrists and radiologists.

The service has also direct access to diagnostics, like DXA scans and blood tests and the equipment and adaptations service.

The professionals working in the ‘falls, fracture and bone health service’ have apart from their clinical role (80% of staff time) also a training and education role to promote falls awareness, to train people in undertaking FRAT assessment and prevention techniques and to support residential care providers with falls management (about 20% of staff time).

When appropriate staff of the service can undertake a home visit but it is expected that the majority of the people will attend a clinic or receive their intervention through a telephone appointment. Based on a triage system people can be seen more urgently e.g. to support hospital discharge but normally a referral will be followed up within 3 weeks. People can self-refer and based on a telephone triage will be booked in for an appointment or will receive tailored falls preventing advice via (e-)mail.

3) Investments needed

The key steps in implementing an evidence based ‘Steady in Stockport’ model are:

1) Find and prevent: increasing case finding and screening activities to find people at high risk of falls, having had an injurious fall and/or identified with fragility fractures
2) Establishing a new ‘falls, fracture and bone health service’ with a focus on secondary prevention
3) Increasing postural stability / strength and balance interventions across the borough for the high at risk group
4) Joined up interdisciplinary approach in the community regarding primary prevention and case-finding of people at low/medium falls risk / reduced bone health
5) Working with 24/7 care providers to improve a systematic falls prevention approach.

The following actions and investments will be needed to implement an interdisciplinary falls and fracture prevention and bone health improvement pathway for Stockport.

Actions	Deadline	Costs
Promotion material		
Update current falls prevention education material	01.10.2017	£ print costs
Update current bone health education material	01.10.2017	£ print costs
Training package for community staff	15.01.2018	--
Develop and publish falls awareness assessment tool and intervention advice on Healthy Stockport website	01.12.2017	--
Online resource with up to date information about preventative interventions	01.12.2017	None: managed by falls, fracture and bone health service
Pathway material		
Assessment tool	01.10.2017	--
Template intervention plan	01.10.2017	--
Simple referral form in EMIS / H&SC record including what actions have already been undertaken and what advice has already been given to avoid duplication	01.10.2017	--
Training		
GP masterclass to include frailty assessment, initial falls assessment	01.02.2018	--
Falls awareness training for community / public facing staff / building community assets to raise falls awareness and to inform where to signpost people to	Ongoing start per 01.01.2018	None: delivered by staff in conjunction with community capacity builders and TPA/WIN
Case finding		
Targeted audits / risk stratifications to find risk groups: sensory impairment, polypharmacy, psychotropic medication or steroid users, low BMI	audit plan developed by 01.11.2017	Undertaken by existing staff
Opportunistic screening to find fragility fractures (vertebral fractures) 1. audit to identify most effective approach 2. implementing service	1. audit 01.05.2017 2. identify target group 01.08.2017 3. start screening service 01.10.2017	
Service delivery		
Establishing an integrated 'falls, fracture and bone health service' across Stockport:	01.10.2017	
Identify venue for clinics	01.09.2017	
Access to diagnostics: investment to meet increased demand for DXA scans in hospital and scan availability in the community (heel ultrasound)	01.11.2017	
Increased capacity for access to postural stability and other balance improvement activity programs (Otago) for high at risk groups	01.01.2018	
Increased prescribing for osteoporosis drugs	TBC	

Increased use of assistive technology to prevent falls	TBC	
Develop and roll out falls management system in care homes and other residential community care environments: reporting, monitoring, intervention & workshops	15.01.2018 – 15.01.2019	None: delivered by existing staff in conjunction with neighbourhood staff
Availability of strength and balance and other lifestyle activities across Stockport (SMILE, health coaches, START)	Already available	

4) Benefits and savings

Apart from the improved quality of life, a systematic approach to falls and fracture prevention and improved bone health will also deliver financial benefits to the system.

The NOS evidence based benefit calculator identified the following savings for Stockport when implementing a fracture liaisons service following clinical guidelines including opportunistic screening: Stockport CCG would realise about £2.4 million savings after 5 years of implementation:

Total benefits

Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total
2016	£169,580	£14,399	£4,032	£14,934	£202,945
2017	£305,244	£20,570	£5,760	£29,868	£361,442
2018	£440,908	£26,741	£7,488	£44,802	£519,939
2019	£525,698	£30,855	£8,640	£49,780	£614,973
2020	£576,572	£34,969	£9,792	£54,758	£676,091
Total benefits	**£2,018,002**	**£127,534**	**£35,712**	**£194,142**	**£2,375,390**

Local HES data over the last 3 years has highlighted a steady increase in total patients with osteoporosis that have suffered a pathological fracture resulting in an increase of non-elective in-patient costs from £41,331 to £89,023.

12% of NWAS conveyances to ED (average of 50 attendances a week / 3500 a year) are a direct result of a fall. A further 500 falls related to ED attendances are conveyed by relatives or through patients attending directly. The costs for transport are not included in the NOS benefit calculator.

Recent published evidence[4] indicates that home hazard assessments reduce the rate of falls by 19% and risk of falling by 12% (Cochrane review). This is often undertaken as part of a multi-factorial assessment. These assessments can reduce rate of falls by 24%. Intervention of postural stability also reduces the risk of falling with 20-40% depending on the intensity of the intervention (NICE guidance). Interventions in high-risk care environments will reduce risk of falling with 20-30% (NICE guidance).

[4] Public Health England, January 2017: Falls and Fracture consensus statement – supporting commissioning for prevention

The NOS benefit calculator focusses on costs related to fractures that can be prevented by implementing a fracture liaison service. Other injuries indicate a further spent on acute care that can be prevented. Figures for one year (Jan 2016-2017) were as follows:

Fall Related Hospital Admissions 50+

DiagFlg	Values Spell Count	Spells for Falls At Home	Spells for Falls at Care Homes	Spell Cost	A&E Cost
# at wrist and hand level	23	8	3	£43,243	£3,558
# of femur	365	195	70	£2,487,275	£54,119
# of Forearm	93	47	3	£193,442	£11,531
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Other and unspecified injuries of head	143	98	13	£341,086	£24,751
Superficial injury of head	313	171	53	£604,254	£54,602
Other	598	364	65	£1,711,995	£92,485
Grand Total	**2,163**	**1,220**	**274**	**£7,216,109**	**£341,082**

The table above presents the spells regarding hospital. In addition costs are made in primary care, social care, transport and by Care Call but these are difficult to distinguish from the total costs for these services.

	Average benefits per year
Fracture prevention impact NOS benefit calculator FLS Benefits Calculator v2.23 Stepping Hill 1-3-17.pdf	**£ 475,078**
Falls prevention impact: Reduction of care call follow up, crisis team activity, primary care time, Mastercall & pathfinder activity, NWAS journeys, DN time, therapy time, ED attendance and hospital admissions for wounds and head injuries related to a fall. And delayed admission into long-term care and reduced need for home care packages.	It is envisaged that savings are included in the overall calculated benefits of Stockport Together's business case. A falls, fracture and bone health pathway will be one of the interventions to ensure savings in 65+ category will be made. It is difficult to distinguish the specific contribution of the pathway to the overall savings. An estimate of direct contribution is based on: 15% reduction in ED & admissions related to injured falls (not a fracture as this is already included in benefit calculator above). 15% of 3.551.073 = **£**

	532.661 (excl social care, primary care, NWAS etc.)
Indication of annual savings	**£ 1.007,739**

	17/18 – 6 months start date 1.10.2017	18/19	19/20	20/21	21/22
Total costs[b,c]:	**£ 239,600[a]**	**£ 428,200**	**£428,200**	**£428,200**	**£428,200**

a) **Included are additional costs of £ 17,000 are for investment of a portable heel ultrasound device to pre-screen osteoporosis in the community clinics. Further research is needed to finalise decision making**

b) **Total costs include opportunistic screening, an audit is planned to establish optimum cohort for screening.**

c) **Assumptions made that pharmacist input is covered in neighbourhood business case and TPA/WIN, health coaches and generic postural stability classes are included in healthy communities' business case.**

See excel document for more detailed cost calculation:

Copy of C902-17 Falls Fracture_ Bone Health Service_ email.xlsx

Appendix 1: Pathway cohorts and key stakeholders regarding assessment and treatment

People at risk of falls [1)]

- History of falls
- Muscle weakness
- Poor balance
- Visual impairment
- Polypharmacy and use of psychotropic and anti-arrhythmic medicines
- Environmental hazards
- Medical conditions including: arthritis, cognitive impairment, depression, diabetes, high alcohol consumption, incontinence, stroke, Parkinson's disease, stroke and syncope

People at risk of fractures and fragility fractures [1,2)]

- Age: women over 65 and men over 75
- Case finding 50+ - vertebral fractures
- In women aged under 65 years and men aged under 75 years in the presence of risk factors:
  - Low bone mineral density
  - Previous fragility fracture
  - History of falls
  - Family history of hip fracture
  - Use of glucocorticoids
  - Rheumatoid arthritis
  - Smoking
  - High alcohol consumption (14 units women 21 units men)
  - Low BMI (less than 18.5 kg)
  - Visual impairment
  - Other causes of secondary osteoporosis
- People under 50 with major high risk factors (use of glucocorticoids, untreated premature menopause or previous fragility fracture)

Case finding:

Health and social care staff, third sector, public sector staff, carers, families, lifestyle services: people pro-actively asked about falls at routine assessments or are reporting a fall / trip / stumble / slowing down;

Pharmacists: polypharmacy
GPs: FRAX / e-frailty index / up & go / Medsreview
NWAS / Carecall / A&E / Crisis response team / GPs / Mastercall: referral related to a fall

Case finding:

GPs: FRAX and bone densitometry (DXA), certain medical condition, medication reviews
Opportunistic screening for vertebral fractures
People presenting with fractures

Falls prevention pathway [5)]

1) Multifactorial assessment for everybody at risk of falling with priority for people who had a fall
2) Individualised multifactorial intervention including interventions such as strength and balance training, home hazard assessment, medication review, hearing / eye-sight review

Bone Health and Fracture Liaison

Treatment fractures / (high risk of) fragility fractures [3,4)]:

1) an assessment of fracture risk, maintenance of mobility, correction of nutritional deficiencies, multifactorial assessment of falls risks
2) people diagnosed with osteoporosis are offered bone-sparing drug treatment (bisphosphonates, calcium vitamins).
3) people with osteoporosis prescribed bone-sparing drug treatment are asked about adverse effects and adherence to treatment at each routine medication review.
4) people with osteoporosis who have been taking bisphosphonates for at least 3 years have a review of the risks and benefits of continuing treatment.

Multifactorial approach in care environments: assessing falls risks, providing strength and balance exercise programs (care homes, extra care housing providers), falls monitoring system

January 2017

[2] NICE Guidance, Osteoporosis: assessing the risk of fragility fracture, Clinical guideline [CG146], February 2017.
[3] NICE Quality Standard, Osteoporosis, draft for consultation, January 2017.
[4] NOGG, Guideline for the diagnosis and management of osteoporosis, March 2014.
[5] NICE Quality Standard (QS86), Falls in older people, January 2017.

REPORT DATED 27 FEBRUARY 2017

External Workforce Business Case;
Future Investment Proposal
`Investment in a package of measures to improve both the quality of provision and market capacity across the Care Home and Home Care markets in Stockport'

1.0 Executive Summary

This paper proposes a recurrent investment of approximately £1.2m per annum, to extend the quality and availability of externally commissioned services in Stockport across the health and social care economy. This proposal is based on the need to achieve both sustainable and transformational change across the external provider market. This will realise many benefits in terms of improved outcomes for people and more effective support at home and will also help reduce expenditure on avoidable hospital admissions and delayed transfers of care. This will be achieved, in partnership with others, through a pro-active change management programme incorporating a package of measures as outlined below.

2.0 The Case for Change

2.1 The national/regional context;

- Demographic Pressures; rapidly increasing demand for care and rising complexity of need.
- Market capacity strained to breaking point; significant numbers of care home beds lost in the last two years and the closure of several home care agencies in the borough.
- Problems with recruitment and retention which can include poor terms and conditions, poor rates of pay, DBS check delays, the image of the sector, training and performance issues and a frequent turnover of staff.

2.2 Partnership working, change management and competing priorities

- Context of change e.g. Stockport Together developments, Devolution Manchester.
- Delayed transfers of Care (DTOC) impacting on the whole system.
- Need to look at whole system including housing, community services, fire services etc. to find new approaches to prevention and asset based models.
- Scarce resources
- Any suspended home or closure represents a loss of potential provision; how to ensure quality, choice and availability of support for vulnerable people;

2.3 Financial context

- Challenge to identify fair costs of care
- Challenges from providers regarding the costs of care, top ups and private market
- Overall financial pressures across the health and social care system

2.4 Care Quality Commission (CQC) context and the urgency of local issues

- The size, scale and composition of the market in Stockport (further information available via the CQC area profile). Some homes not physically fit for purpose, and loss of 151

beds in the last two years

- The regulatory context; until last year due to CQC staffing levels, many homes had not been inspected for some time. In the last year the CQC has ensured a new regime of timely inspections. This has created a useful baseline in terms of the quality of the market but also significantly increased the numbers of homes deemed `inadequate' or in `special measures'; detailed below. This new baseline does offer an enhanced opportunity to directly measure the rate of improvement across the market going forward.

- At the present time there are several areas of provision where intervention of this kind is urgently required, to avert further crises and reduce the increase risk of the problems noted above. Emergency arrangements have been deployed where required in recent months, to address identified risks and help meet joint agency responsibilities.However, a dedicated intervention team delivering a collaborative and supportive approach will offer a much more cost effective and proportionate response.

3.0 Outline of the Proposal

There are four distinct but related elements to this proposal;

3.1 Extended home support based on re-ablement approach; £690,000	3.2 Further development of the Extra Care Housing model £90,600
3.3 Investment in a joint quality intervention team to work across the external market £238.779 (recurrent funding) and £9,000 (one-off investment)	3.4 Supporting seven day flexibility across the sector with weekend on costs £171,200

3.1 Proposal One;

Extending re-ablement focused, asset based approaches across the Home Support market to ensure that more people are supported to live safely and independently in their own homes.

Based on two successful pilot initiatives involving a partnership between the REaCH service and independent home care providers in Stockport, this service will provide more support to

people in their own homes with an increased focus on re-ablement, independence and asset based approaches in the community. This will also incorporate an extension of the existing pilot service to provide overnight home support assessments to avoid hospital admissions or care home placements where appropriate.

Funding is sought to:
a) Ensure that the aligned overnight home support assessment element of the approach also continues beyond March 2017.
b) Roll out the day time support further to support neighbourhood provision and embed the service within multi-disciplinary teams.

This is consistent with the direction of travel for Greater Manchester as endorsed by the Joint Commissioning Board in November 2016, which has recognised the need for new models of care in terms of support to live at home, particularly those which adopt a re-ablement focus. Further work would still be required to roll out the approach across the whole sector, but this proposed approach creates the potential for further development and flexibilities through locality working and blended roles in future.

Description of service

This proposal, based on the above successful pilot, supports a more outcomes focused, re-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.

This model of care is evidence based and has been shaped by previous market tests and also by testing the new winter pressures model, to explore how the home care market can be developed to improve outcomes for the individuals supported. Within this model and in broad terms, referrals are received via the Council's in-house ` REaCH' service which undertakes an initial holistic assessment of the individual's needs. This assessment encompasses a 'Wellbeing planning' approach whereby the worker and the individual explore community network offers whilst working within the principles of self-care. Once the Wellbeing plan has been agreed and the individual's needs have been assessed, the short term package of care transfers to the linked locality provider, who will continue to work to the wellbeing plan with individuals to:

- Prevent further decline by responding to deterioration.
- Optimise the individual's wellbeing and resilience
- Continue to engage people with community activities – reducing Social isolation and loneliness

This wraparound approach also aims to reduce avoidable hospital admissions by providing increased support to people in their own home, supported by additional therapy and Social worker input.

Benefits

<u>Locality based</u>
The commissioned and contracted providers, all of whom will be on the Council's framework of registered and accredited provision, will be linked to the neighbourhood teams and

provide services for a distinct geographical location. This will be aligned to the neighbourhood teams; this will support the recruitment of local people and will aim to reduce the number of 'crossover and handover' between providers in geographical areas, thus improving the continuity for people receiving the service.

Outcome based model

Two pilots have taken place to test the above model. The first took place between April and September 2016. This pilot was an opportunity to respond to an immediate need, when a home care provider served notice to withdraw from ten longstanding packages of care in the local area. A local provider engaged with Adult Social Care and agreed to work to an outcome focused framework to establish that in order to achieve a better outcome for people, we need to take a different approach in planning their support needs and this would:

- Reduce overall avoidable spend on care management.
- Improve the wellbeing of people receiving services and support, making wider and better use of community assets.
- Develop a new model of care that improves the lives of people who need different levels and types of support ranging from profound and basic care through to minimal intervention.
- Identify the skill gap within the private provider market – so we know what we need to offer in order to help them develop.
- Continue to promote the role of social care.

Objectives based on outcome based model

- People are supported to live as fulfilling a life as they can and wish to.
- Staff understand their role and have permission to 'Go to the person not the task'.
- Staff are able to identify all needs and assets for people they work with.
- The profile of home care work is raised and improved.
- People with packages of care do not remain isolated and lonely.
- Staff are aware of the assets in the area or how to access this information.
- The work experience for staff is more rewarding and hopeful of what?.

Demonstrable successes from the pilot

- Staff felt valued.
- Remuneration was increased and based on being able to work flexibly, using initiative and understanding how to make person centred care a reality (e.g. connecting beyond front door).
- Staff now have quality conversations with the people they support and can create a wellbeing plan with the person, their family and care team.
- People with complex needs and clients in a crisis would always have one consistent person to contact, who would be able to access fast track required joint assessments for things like equipment.
- When care workers recognise need for small to medium changes or variation in care or support they are able to get quick decisions and permission.
- All work is judged on outcomes – how has the life of the person supported improved?

- Money is invested in the right things based on ground up feedback– e.g. the consistent contact role.
- People have a named keyworker (with a backup) within home care teams. The whole care team [including the family] will know who the keyworker is.
- Family and friend carers, volunteers care workers etc. are part of the person's care team.
- The keyworker will be on an equal footing with the whole of the person's care team.
- Older people have the option to live in smaller shared space with networks of care with a keyworker, team around the person and situated within communities.
- Contracts that span care and support enable providers to prioritise the persons changing needs with the person and their family–whether that includes basic care, community support wellbeing and social connections.

The Council also secured contracts for additional temporary provision as in previous years, for `winter pressures', but adapted this to the new model of care.

Scheme*	Details of scheme	Value	Contract period
(1A) Home Support – Winter Pressures/System resilience	Over a period of 22 weeks, there will need to be sufficient additional capacity to provide (as a minimum) an additional 280 hours of support per week, across the borough.	£92,400	1st Nov 2016 – 31st March 2017
(1B) Overnight Home Support	Over a period of 22 weeks, there will need to be sufficient additional capacity to provide an additional 280 hours of support per week, across the borough.	£92,400	1st Nov 2016 – 31st March 2017

**This business case relates only to the continuation and extension of the provision procured externally from the independent sector; the elements of the model relating to REaCH are included in the intermediate tier business case and hence not listed here, to avoid duplication.*

Within this tested model and in broad terms, referrals are made via the Council's in-house ` REaCH' service who undertake an initial holistic assessment of the individual's needs. This assessment encompasses a 'Wellbeing planning' approach whereby the worker and the individual explore community network offers whilst working within the principles of Self-care. Once the Wellbeing plan has been agreed and the individual's needs have been assessed and stabilised, the short-term package of care transfers to the linked locality provider, who will continue to work to the wellbeing plan with individuals to:

- Prevent further decline by responding to deterioration.
- Optimise the individual's wellbeing and resilience
- Continue to engage people with community activities – reducing social isolation and loneliness
- This approach supports a more outcomes focused, reablement approach to home support, co-produced and delivered jointly by utilising the enhanced skill sets of both

the in-house provider and independent providers to adjust their focus from that of delivering long term support to a shorter term outcome based approach. This service will be available 24/7, 365 days of the year.

- This wraparound approach aims to reduce avoidable hospital admittances by providing increased support to people in their own home, supported by additional therapy and Social Worker input.

Furthermore, incorporating providers in the wider neighbourhood offer, by inclusion in the neighbourhood Triage and Multi-Disciplinary Team (MDT) will be able to reduce the number of `organisation to organisation' referrals and improve relationships and communications.

Anticipated outcomes for people

The model will follow a person-centred approach; with the individual at the centre of all decision –making. This will be captured in the wellbeing plan which is based on the 7 principles of self-care which supports the ethos of a guided conversation approach; the focus for the plan will be on the individual's abilities, wants, wishes and aspirations.
At the beginning and at the end of the short term service, people will be asked to gauge their own feelings of wellbeing, supported by family and carers if appropriate. People will also be asked to complete a questionnaire at the end of the service to enable us to capture what worked well and what we can improve in the future.

1B Overnight Support and assessment

The purpose of this assessment is to ascertain the individual's support needs, abilities and activities throughout the night, highlighting any aids and equipment and to offer some respite for carers. The team will work between the hours of 10pm -8am and will provide a report at the end of each night. During the period of 1 November 2016 to 30 January 2017, a total of 32 people were supported by the night assessment service. Through discussion with the referring social worker, the feedback about the service was overwhelmingly positive, which helped ensure that people who wished to remain at home were supported to do so and received appropriate support.

1(C) This third element of the proposal is to replicate the 1A model across the neighbourhoods, thereby enabling twice as many people to benefit from this new model. It is recognised for all three elements of this first proposal that recruitment and retention is a significant challenge and that the development of the external workforce in future may require a different approach to employment across the sector, such as the option of `blended roles' (see below). This would not be an immediate feature of the proposed schemes but would be explored further going forward; both as part of the work of the Joint Commissioning Strategy and as part of our broader input to Greater Manchester and North West market shaping initiatives.

Blending roles

This developmental work in Stockport is exploring the benefits of blended roles, whether this is across the registered professional cohort of employees, using the Trusted Assessor as an example or enhancing the skills of frontline domiciliary care workers, enabling them to undertake a number of clinical and therapy tasks. The drive to implement blended roles is underpinned by;

- Full utilisation of the provider market.

- Smarter use of the available capacity.
- The reduction in the referral and assessment processes.
- Reduction in organisation to organisation handoffs.
- An improved seamless service for people in receipt

3.2 Proposal Two;
Developing more flexible and innovative models of extra care in the community as an alternative to residential care

There is already an Extra Care Housing Support Service in Stockport but this investment will enable the model to be enhanced and further developed.

Ability of Extra Care Housing (ECH) to meet complex needs
Whilst ECH can meet the need of people with needs at standard residential level, the service can also meet higher needs. Higher dependency and occasionally EMI and nursing level needs have been met. Whilst people with this level of need are unlikely to be moved into ECH, if they are already resident and their needs increase, every effort is made to meet them and prevent (or delay) them being forced to move on into a residential or nursing placement. There are currently 2 people living in ECH who have care packages of over 40 hours and who moved from a nursing home environment in order to live a more independent life.

This proposal tests the hypothesis that enhanced support would enable the scheme to support people with a broader range of needs as an alternative to residential care. In a recent consultation with health and social care staff, the following issues were raised as being required in a new model; all of which this proposal would seek to address, both through a greater overnight presence and further developmental support.

- Dementia care.
- On site night care support (is currently a mobile service across all sites) – families are concerned about night times
- Mental health teams are not aware of extra care therefore poor relationship with the community psychiatric nurses.
- Age restrictions policy is limiting – there needs to be discretion based on needs, not age.
- Chronic Obstructive Pulmonary Disease (COPD)/Long term conditions specialism.

Extra Care background:

Extra care housing offers an additional housing option for older people; particularly relevant when considering solutions for hospital discharge and to prevent, reduce or delay the need for hospital or residential care. People are motivated to move to extra care housing for physical and emotional security, availability of support and an accessible environment and social contact. People value the opportunities for friendship and social interaction.

The potential of extra care provision is more diverse than our existing Stockport model: the key element of our model is self-contained accommodation and support accessible 24 hours. Meal provision, leisure and other facilities on site vary site to site and the benefit is rarely to the wider community. This proposal offers an opportunity to begin to test more

innovative and diverse options for extending this model.

3.3 Proposal Three; The creation of a quality intervention team;

Based on a successful pilot intervention with a Care Home in Stockport, this joint team of skilled staff from health and social care will work with Care Homes and Home Care agencies across the Borough

This will involve planned, pro-active intervention in partnership with providers (not `doing to' or `doing for') to facilitate sustainable improvement, embedding change and working flexibly out of hours and across the borough. Based on successful pilot approaches, this initiative will help ensure that providers meet and exceed required quality standards. This intervention will consequently have a positive impact on the avoidance of unnecessary placements, hospital admissions or delayed transfers of care.

Proposed Team Composition

- Joint team/Programme lead (costed as an assistant team manager or similar.)
- Three quality improvement officer.s
- Experienced nurse/clinical input (two part time.)
- Experienced Social Worker (proportion of hours) to ensure review.s
- Access to relevant specialist support depending on nature of provision (e.g. pharmaceutical/medication, occupational therapy, dementia specialism.)
- Change Management/service improvement co-ordinator (to influence and embed change.)

Wider team access to expertise & supporting systems

- Care home officer (medication specialism) and medical colleagues.
- Existing quality, safeguarding and contracts staff who monitor and identify concerns for resolution, complaints, corporate services, information governance, procurement support and legal services, training and HR
- Healthwatch Stockport `enter and view', patient panels and advocacy services,
- Neighbourhood Teams,
- Public Health such as infection control expertise
- Education and training leads across health and social care,

Other

IT solutions (a one-off investment is also sought for a joint quality dashboard being developed) and business intelligence

- Moving and handling, occupational therapy, equipment and adaptations, infection control, neighbouring authorities' quality/contracts teams
- Police, CQC, NHS England, NICE, LGO, Elected Members,
- TPA, WIN, Alzheimer's Society, Age UK and other 3rd sector/charities
- National vanguard sites, North West market shapers, Greater Manchester new care models sites (for ideas to enhance the quality of provision)

Principles of intervention

- Intervention will be carefully prioritised/targeted (informed by `RAG' rated business

intelligence triangulated from across the health and social care economy.

- Time limited (intervention timescales will vary but agreed improvements must be sustainable by the provider itself.)
- Pro-active (timely intervention will aim to identify difficulties at an early stage and prevent further deterioration in standards.)
- Locality based (linked to broader support systems as part of ensuring sustainability going forward.)
- Joint approach (Health and Social Care plus others depending on the nature of the support required.)
- Focuses on delivering sustainable changes using change management approaches.
- Provides an educational resource to reinforce key learning.
- Flexible working, not `9 – 5' e.g. an agreed support package may include an out of hours help line or suppor and quality checks at agreed times during evenings, nights or weekends.)
- Evidence based; the intervention model will build on a recent successful pilot as a starting model – but it will also be a learning process which will evolve based on experience. It will be evaluated through a range of measures, both quantitative and qualitative.
- Aligned to specific standards, i.e. CQC and NICE standards. Also using the NHS Quality Surveillance risk tool or other appropriate tools as part of inter-agency approach.
- Asset focused; building on strengths and assets (both at an individual service user level and provider level.)
- Co-production; working constructively with service users, families and providers to identify solutions to problems.
- Use of the joint commissioners' existing legal and contractual frameworks to support the above, to ensure compliance and ultimately take appropriate action if this is not successful to protect quality and safety for service users.
- Support the improvement process but ensure that the legal responsibility associated with regulatory accountability would still stay with the registered providers (normally the independent sector agency which owns/manages the provision.)

Anticipated Benefits of the Above;

Quality

Improving the quality and choice of external market provision in Stockport for service users and their families through;

- Improving outcomes, and quality of experience for the people living in the homes and their families
- Improving and continually developing management and leadership skills to ensure sustained improvement.
- A joint approach ensuring a holistic, asset focused approach to quality.
- Meeting statutory obligations, CQC requirements, NHS England, Care Act and the `5 Cs', mitigating reputational risk in relation to quality and safety.
- Embedding strong multi-agency working, safeguarding and communication; co-ordinating and prioritising quality, health and safety concerns and issues in conjunction with MDT professionals both within and in liaison with, the core team.

- Reducing instances of safeguarding alerts, complaints and critical incidents.
    - Ensuring the approach to support is consistent and standards improved

Capacity

Maximising market capacity and financial sustainability through;

- Influencing change to reduce the risk of market failure (where issues can be addressed through active intervention.)
- Reducing the need to suspend placements (via commissioners or regulators.)
- Keeping `good' providers in the market, encouraging innovation and opportunities for development, enhancement of facilities or support `in kind' e.g. links to training.
- Linking to broader strategies such as staff recruitment and retention of staff to support the deployment of an effective workforce with sufficient, appropriately trained, nurses and carers.
- Sustainability of leadership to continue improvements without further intervention (above in partnership with other agencies offering expertise such as `Skills for Care'); developing a network of similar resources.
- Help maximise any community assets (assisting with the prevention agenda elsewhere) – e.g. a well led home will begin to attract volunteers, maximising social value, helping to engage more residents and supporting people who may wish to enter the workforce in the future.
- Financial stability as lack of capacity is creating huge costs in terms of ad hoc payments and top ups and legal/reputational risk.
- The alternative is that we put more emphasis on contract compliance to address poor standards which could result in a further loss of provision, and where prevention is a better option.
- Helping to reduce unnecessary hospital admissions or avoidable health interventions/pressure on primary care from care homes or home care agencies.
- Facilitating greater capacity and responsiveness within homes to address market pressures and reduce delayed transfers of care.

Summary of Key Costs;

Role	Grade	Cost
Joint team/programme manager (inc on costs)	ATM /SO3	£45,492
Three Quality improvement Officers (inc on costs)	3 x SO1	£115,602
Service Improvement Co-ordinator	1 x 0.5 wte Band 5	£17,674.
Two part time Nurses (or job share)	1 x 0.5 wte Band 6 1 x 0.5 wte Band 6	£44,011

Part time social work resource / backfill		£16,000
TOTAL recurrent funding		£238.779
Additional one-off investment*		£9,000*

*****Additional one-off cost of £9,000 for the software development costs of a shared system wide Quality Dashboard to improve data in relation to the quality of provision

*Benefits are quantified in the summary cost/benefit sheet in Appendix One.

3.4 Proposal Four; Extending the Flexibility of existing Models of Care

This proposition involves looking at the services we already have in the community and considering what would be required to enhance the flexibility and responsiveness of those services.

One of these is the existing Care Home market, which could be enhanced through the provision of additional infrastructure support in relation to weekend admissions

At present there is unprecedented demand on the acute sector to facilitate timely discharges from hospital care for adults over the age of 65. A significant area of pressure is the availability and accessibility of both nursing and residential care. This proposal will outline the support required to improve the ability of both types of residential care to undertake weekend admissions and allow for timely discharge for those medically fit.

It is proposed that this will be undertaken with a specific group of homes and will thus create a `proof of concept' for wider roll out taking into consideration both the longer term 'infrastructure' costs and the contractual expectations of our externally commissioned residential and nursing care homes.
It has been evidenced that during the weekend period there is a marked reduction in resource and capacity to undertake admissions into nursing/residential homes. As a result of this there is virtually no ability for an individual who is medically fit to be discharged to the preferred place of residence over the weekend and this results in a further delay of at least 48 hours and often longer if an assessment cannot be carried out until the following Monday.
To alleviate this pressure during the winter period a ring-fenced capacity of 10 beds was blocked purchased to ensure facilitation of weekend admissions. Whilst these beds have been well used the ability to undertake weekend admissions has not been consistent and limited evidence to suggest assessments were done. The main challenges for this are:

- Sufficient staffing with the appropriate level of experience to undertake an admission at the weekend period in a home.
- Limited social work support to assist in assessment and admissions into a home as well as support with social care needs.
- Limited additional health related support available in particular GP coverage for nursing care and district nursing support for residential care.
- Lack of an appropriate discharge summary from the hospital, medication supply available to cover the weekend period, implementation of trusted assessor model not fully rolled out;
- People discharged to the winter pressure beds were unknown to the care homes.

The obvious case for change to address this current situation is to improve capacity in both our internal systems and the external market to undertake weekend admissions from hospital. This will in turn reduce pressure in the acute sector and ensure beds are free for those requiring hospital care and not occupied by those that are medically fit for discharge. It is clear that homes need to have the reassurance that the needs of those requiring discharge over a weekend period will have the necessary support available to allow for confidence, security and patient safety within the system.

The benefits of improving the ability for homes to undertake weekend admissions would:

- Improve performance for DTOC's over the weekend period;
- Improve efficiency in discharge and admissions into homes (trusted assessor);
- Collaborative approach with external providers to improve processes and outcomes;
- Appropriate place of residence for medically fit individuals with overall improved outcomes for well-being;
- Social and rehabilitative needs met in an appropriate environment;

The proposed approach to improve performance over the weekend period via access to admissions into care homes would entail a combination of comprehensive engagement with providers and a strengthening of the internal resources available within the Stockport Together Programme specifically within the intermediate tier and core neighbourhoods. In the first instance this will build on the trusted assessor model as piloted within the winter pressure beds at Hilltop Court and Plane Tree Court. The preference is to extend capacity to current intermediate tier teams to ensure continuity, staff rotation and more flexibility in cover arrangements, rather than creating a stand-alone team for weekend support.

<u>The specific elements of this proposal:</u>

- A new process for assessing the appropriate of admitting residents will need to be co-produced with providers to allow for consideration of the impact it will have on their capacity and ability to make these admissions in a timely manner. This will be undertaken through a full workshop session that will outline requirements and negotiate the appropriate conditions to ensure acceptance. This will in turn inform short-term requirements where there are providers willing to cooperate but also longer-term contractual arrangements.

- Currently within the service there is a crisis response team (intermediate tier) and this service has the potential to support residential and nursing care support on a daily basis including weekends and out of hours. To improve weekend admissions this team would need to be strengthened and would require the following investments:

- GP support to make visits to the home in particular for end of life pathways or medically complex patients. This would require additional GP hours for the crisis response team or additional 'home visit' capacity provided by Mastercall Out Of Hours / or GP pathfinder over the weekend period from Friday 16.30 to Monday 08:30.

- Social work support would be required for complex social care cases. This would include those without capacity or where there is dispute within families. This would include social work coverage from Friday 16.30 to Monday 08:30 either in the Crisis Response Team or Active Recovery Team.

- Therapeutic support for residents to access physiotherapy and occupational therapy at the point of discharge to facilitate improved physical well-being outcomes and speedier discharge form short-term placements. Two therapist (one OT and one Physio) would need to be available from the Active Recovery Team from 10-3 Saturday / Sunday.

- For those homes that do not provide nursing care, access to nursing support would be required. This would ensure that those that may have less complex medical needs could be supported more effectively in a residential care environment and reduce the potential of readmissions. This would require additional nursing hours to either the Crisis Response Team or Active Recovery Team from Friday 16.30 to Monday 08:30.

  The following table provides a full cost breakdown of this proposal and includes pro-rata salaries to cover the winter period.

0.26 (10 hrs) OT band 6 (£44.011)	£ 11,443 + weekend oncosts = £ 13K
0.26 (10 hrs) physio band 6 (£44.011)	£ 11,443 + weekend oncosts = £ 13K
0.5 fte nurse band 6 (£44.011)	£ 22,006 + weekend oncosts = £ 25K
0.5 GP (£90K a year)	£ 45,000 + weekend oncosts = £ 50K
0.5 Social Work (SO3, £45.492)	£ 22,746 + weekend oncosts = £ 25K
	£126,000 before weekend on costs
TOTAL COST	£171,200 with weekend on costs

4.0 Key Partners in relation to the above four proposals;

- Stockport Council Adult Social Care
- Stockport NHS Clinical Commissioning Group
- Stockport Foundation Trust
- Pennine
- Healthwatch Stockport Ltd.
- 3rd sector and community groups
- Neighbourhood Teams including GPs, District Nurses and colleagues across MDTs
- Colleagues in housing, place based services, fire service etc.

5.0 Further strategic outcomes/benefits

Impact on the wider system

Following reviews of the care home and domiciliary care sectors, the priority is to develop a plan that will transform the sector effectively to achieve a stable market and manage the

demand and supply of care in these markets.

The key areas of focus over the next year will be on joint working with the Clinical Commissioning Group (CCG) and others to commission or further develop new models of care to address issues of capacity in the market and improve outcomes for individuals, ensuring strategic links to both `Stockport Together' and `Greater Manchester' developments. Service quality has been identified as a key theme within this joint commissioning approach, as we further develop a holistic and pro-active quality assurance function in partnership with providers, to prevent or address issues relating to business failure whilst ensuring financial sustainability across the market. As such these initiatives are fundamental to the neighbourhoods business case, since the development of new and enhanced models of community support and the provision of good quality services in the community is not only the core business of Stockport Together but fundamental to its future strategy of reducing reliance on emergency and inpatient services.

Robust planning and partnership links to facilitate all the above will be supported by an Ethical Care framework. The impact of home closure or business failure severely impacts across the whole Health and Social care market. It is increasingly evident that the role Social Care providers play within the community is a fundamental resource required to reduce the number of people admitted to Hospital and to reduce hospital delayed transfers & ultimately fulfil the broader preventative agenda, as part of the Stockport Together vision, to enable people to benefit from an appropriate choice and quality of support in their own homes and in the community.

In conclusion, the above proposals will help ensure both a prompt response and a preventative approach regarding `market failure' and incorporate robust contingency planning. They will help promote market stability, develop strong relationships and build on best practice, influence change in processes and culture, seek to achieve a consistent supply of good quality provision in the market, and work with colleagues across the system to help address delays for people waiting for packages of care, with providers causing concern. Along with a range of colleagues and partner agencies, they will work in alignment with the neighbourhood teams to promote good relationships with commissioners and providers. This dedicated resource will enhance the ability of the local health and social care economy, to address its strategic aims, not only in relation to people with high levels of need but also in relation to its most fundamental aims of keeping people with long term conditions or health and wellbeing needs, safe and well at home and/or in receipt of appropriate support in the community.

STOCKPORT TOGETHER BUSINESS CASE APPENDIX 1; EXTERNAL MARKET;

SUMMARY OF INVESTMENT PROPOSAL (280217)

Proposal	**TOTAL COST** **£1.2m**	**Lag/Phasing**	**Description of Benefits**	**ESTIMATED TOTAL BENEFITS £2.3m**
1. a) Investment of £230K for delivery of short term re-ablement support (this is the cost of continuing with the current successful pilot, based on a full year's costs, rather than ending this intervention in March 2017.	**£230k**	No lag – Extension of current contract under winter pressures needs to continue from 1 April.	Avoidance or reduction in need for long term home support **£496k** Avoidance of 60 DTOC or non-elective admissions per year **£176k**	**£672k**
1. b) Further investment of £230K to roll out this model further and thus extend delivery of the anticipated outcomes across the neighbourhoods	**£230k**	Estimated time to bring online following agreement to proceed is 3 months.	Avoidance or reduction in need for long term home support **£496k** Avoidance of 60 DTOC or non-elective admissions **£176k**	**£672k**
1. c) £230K to continue with the current pilot for overnight home support	**£230k**	No lag – Extension of current contract under winter pressures needs to continue from 1 April.	Avoidance of 24 care home respite admissions (based on 4 weeks duration at £475); **£46k** Avoidance of 12 care home admissions (52 weeks x £475 x 12); **£296k**	

			Avoidance of 12 non elective admissions*; **£39K**	**£381k**
2. Further investment in Extra Care Housing; (ECH) The Extra Care model in Stockport offers accommodation with support as an alternative to residential care, with more support than domiciliary care. One of the Extra Care Schemes will be given additional staffing cover to extend its offer so that it can take people with more complex needs and avoid unnecessary care home or hospital admissions. This is a pilot to test the hypothesis that increasing the level of support within Extra Care Housing would enable the scheme to admit residents with higher needs and avoid hospital admission. Recent consultations with practitioners indicated that they would have chosen the Extra Care scheme more readily if there had	**£91k**	Estimated time to bring online following agreement to proceed is 3 months.	This is proof of concept but this additional investment could pay for itself, through avoiding residential admissions, non-elective admissions and delayed transfers of care (estimated at £96k in total)	**£96k**

<table>
<tr>
<td>been more support at night. The additional day time support identified would complement this support but also work to develop the scheme further.</td>
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<td>3. Joint Quality Intervention Team (JQIT)

The focus of this approach is on raising standards thus the quality and choice of support for vulnerable people and their families.</td>
<td><u>Summary of Key Costs;</u>

<table>
<tr><td>Joint team/programme manager (inc on costs)</td><td>ATM /SO3</td><td>£45,492</td></tr>
<tr><td>Three Quality improvement Officers (inc on costs)</td><td>3 x SO1</td><td>£115,602</td></tr>
<tr><td>Service Improvement Co-ordinator</td><td>1 x 0.5 wte Band 5</td><td>£17,674.</td></tr>
<tr><td>Two part time Nurses (or job share)</td><td>1 x 0.5 wte Band 6

1 x 0.5 wte Band 6</td><td>£44,011</td></tr>
</table>
</td>
<td>Estimated time for recruitment following agreement to proceed 3 months – could start to recruit at risk prior to agreement to reduce any time lag.</td>
<td>Through the approach outlined, the Joint Quality Intervention team will seek to raise standards, ensuring appropriate transitions or transfers of care where needed and intervening to address avoidable <u>care home/nursing home</u> closures or emergency intervention. Avoiding one NEL p.a for 40 residents would save the health economy

£128k

Intervening in a similar way with home support agencies, the JQIT would seek to avoid emergency intervention for a further 20 people

£64k

If, as a result of JQIT the care homes that are currently rated as</td>
<td></td>
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	Part time social work resource / backfill		£16,000		
	TOTAL recurrent funding		**£238.779**		
	Additional one-off investment*		**£9,000 *** **£248K**		
	***Additional one-off cost of £9,000 for the software development costs of a shared system wide Quality Dashboard to improve data in relation to the quality of provision			`inadequate' improve their quality rating and as a result their emergency admission 'rate per bed', it is estimated that this could deflect 86 emergency admissions per year from the acute health economy, saving **£276k** **This is based at an average tariff cost of ~£3,206 per emergency admission #Based on evidenced higher admission rates from care homes rated as inadequate (figures at 13.1.17)*	**£468k**
4. Investment to enable care homes to undertake weekend admissions and reduce delayed transfers of care.	GP support to make visits to the home in particular for End of Life pathways or medically complex patients. This would require additional GP hours over the weekend period from Friday 16.30 to Monday 08:30 Social work support would be required for complex social care cases. This would include those without capacity or where there is dispute within families. This would include social work coverage from Friday 16.30 to		Propose align to timescale for implementing extended operating hours in the neighbourhoods i.e. early June. However could look to bring on earlier if needed to	The benefits of improving the ability for homes to undertake weekend admissions will include • Improved performance for DTOC's over the weekend period; • Improved efficiency in discharge and admissions into homes (trusted assessor); • Collaborative approach with external providers to improve processes and outcomes;	

	Monday 08:30 Therapeutic support for residents to access physiotherapy and occupational therapy at the point of discharge to facilitate improved physical well-being outcomes and speedier discharge form short-term placements. Two therapists (one OT & one PT) would need to be available from 10-3 Saturday / Sunday For those homes that do not provide nursing care, access to nursing support would be required. This would ensure that those that may have less complex medical needs could be supported more effectively in a residential care environment and reduce the potential of readmissions. This would require additional nursing hours to the Crisis Response Team in Friday 16.30 to Monday 08:30 . Total for the above; **£171k**	support hospital discharge.	• Appropriate place of residence for medically fit individuals with overall improved outcomes for well-being; • Social and rehabilitative needs met in an appropriate environment; • The cost of single day's stay in an hospital bad offset against the cost of residential nursing placement represents quantifiable savings to the wider system; The proposed approach to improve performance over the weekend period via access to admissions into care homes would require a combination of comprehensive engagement with providers and a strengthening of the internal resources available within the Stockport Together Programme specifically within the intermediate tier and core neighbourhoods. In the first instance this will build on the trusted assessor model as piloted within the winter pressure beds at Hilltop Court and Plane Tree Court. **Benefits related to the improved effectiveness of DTOC (Delayed Transfers of Care), will be evaluated in addition to the benefits listed here.**	
TOTAL COST	**£1.2M**		**TOTAL BENEFITS**	**£2.289m**

HEALTHY COMMUNITIES BUSINESS CASE

Purpose

1. *Case for Change*

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

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

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

Our aim is to enable person centred care which begins with the question "What matters to you?" rather than "What is the matter with you?" in order to understand and address people's needs in a holistic way. This assets-based approach will help people to access their own internal social and psychological resources as well as external resources including those within their family and those generated through collective community activity. The investment proposed responds to the evidence for effectiveness of these approaches as set in the *Realising the Value* (Nesta) and NICE guidance[1]

The theory of change (Appendix 1) draws on Self Determination Theory, an established and tested model, which identifies three key factors for personal growth and wellbeing: autonomy, (acting of one's own volition), competence, (self-efficacy and achievement) and relatedness (social connection, caring and belonging).[2] The elements described set out to address these factors in order to deliver outcomes in improved health and wellbeing and impacts on the quality and sustainability of the Health and Social Care system by reducing demand.

The focus of the model addresses the human experiences of health and wellbeing and relationships between the people giving and receiving care. These are not only important in themselves but also as the drivers of need and demand on health and social care, as people with unmet social needs are likely to experience poorer health, including anxiety and depression as well as the physical health consequences of these. Their experiences also

[1] NICE, 2016 *Community engagement: improving health and wellbeing and reducing health inequalities. www.nice.org.uk/guidance/ng44*

[2] See http://selfdeterminationtheory.org/theory/)

	create demand for health and other public services as they seek help from services which are unable to respond appropriately. Viewing demand through the lens of the medical model often leads to medical responses to social problems, while the complexity and fragmentation can lead to 'failure demand' ("demand caused by a failure to do something or do something right for the customer"[3]). This often involves considerable waste of resources in undertaking different assessments and referring people on, or providing no service, due to thresholds and criteria. By failing to address the needs of the person, we generate further presentations or 'demand'. Changing the culture within our services towards the vision described in the 'Stockport Way' (Appendix 2) is key to better supporting people with long-term conditions to self-manage by working with individuals and their support networks. This means working collaboratively to optimise the use and benefits of informal as well as service-based support and activity in a spirit of equal partnership between individuals, families, community groups, voluntary organisations, social enterprises and businesses that make up a local community. Workforce development and culture change will be key to delivery of these objectives, including changing the processes through which we assess people to shift the focus from solely capturing specific 'treatment' needs to working with people to identify their own priorities and the resources they can access to achieve them, including but going beyond services. This is being addressed through the Enabler programmes and cross-cutting transformation work including integrating services in neighbourhoods. *Programme Interdependencies* The components of the Healthy Communities approach outlined in this case are closely aligned to the core neighbourhood model. Where the core neighbourhood will work in a multi-disciplinary team to support individuals identified most at need (the top 6-15%), this programme of work will support those who are on the border of this cohort, currently not managing their condition as well as they could. Additionally, this approach will form part of the offer to those newly diagnosed with a long-term condition, or at high risk of developing a long-term condition, identified through the Find and prevent Project. Finally, this approach also links with the revised model of outpatient support. When an individual with a long-term condition is not currently managing their condition well, but does not warrant referral to a specialist consultant, the health coaching model will be able to support them to improve their self-management of the condition, which will provide primary care clinicians with a suitable route to ensure the individual receives additional support.
2.	**Background** *Current Situation* Over a quarter of the population in England has a long term condition and an increasing proportion of these people have multiple conditions. The Five Year Forward View notes that,

[3] Vanguard and Locality, 2014. *Saving money by doing the right thing: Why 'local by default' must replace 'diseconomies of scale'*

"Long Term Conditions are now a central task of the NHS".

People with long term conditions currently use a significant proportion of health care services;

- 50% of all GP appointments
- 70% of days spent in hospital beds, and
- 70% of hospital and primary care budgets in England

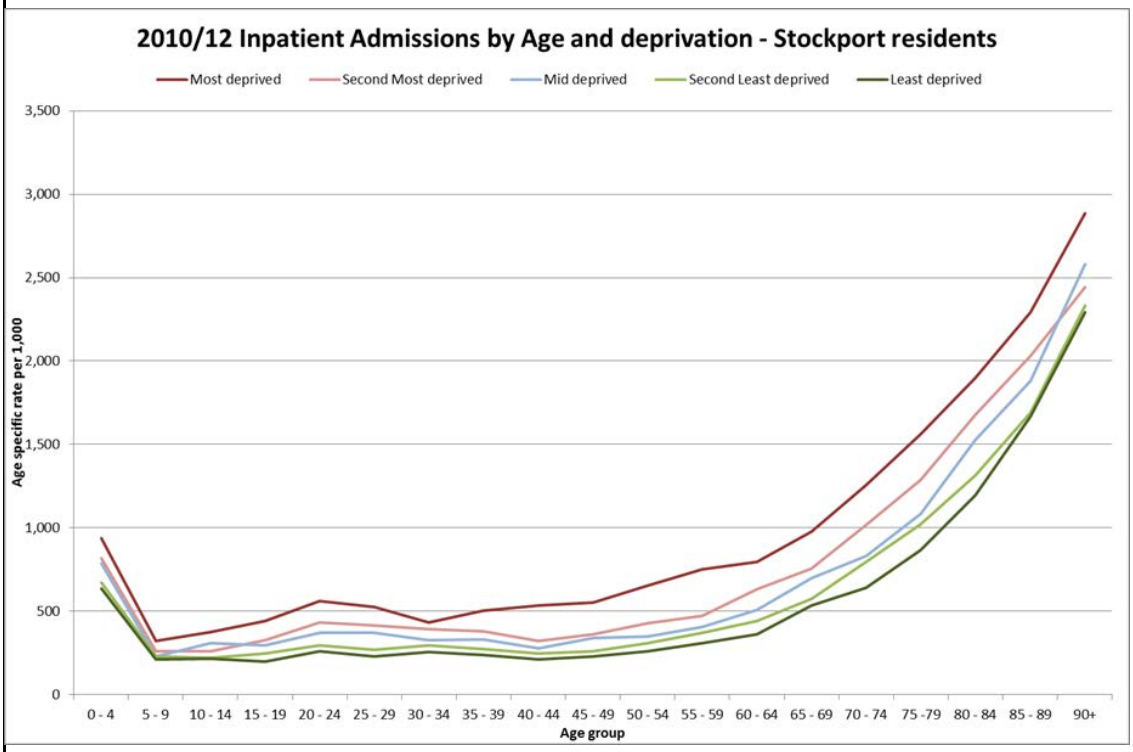
There is considerable and increasing impact of long-term conditions on morbidity, mortality, quality of life and healthcare costs are significant. 15.4 million people in England are recorded as having have a long-term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9million in 2008 to 2.9million by 2018). By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.

In Stockport, 41% of the population (124,000) have one or more long term health condition, and this increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over. By age 55, half of the people have one or more of these conditions and 9% of the population have two or more of 8 key long term conditions. Many more may also have a condition which is currently undiagnosed (see Appendix 3). There are 26,000 people registered with a Stockport GP with a history of depression and there are 40,000 people registered with a history of anxiety. These are commonly associated with other long-term conditions and physical health problems, as well as social isolation. Capacity in mental wellbeing Improving Access to Psychological Therapies (IAPT) services and mental wellbeing prevention is increasing, but the use of anti-depressant prescribing is still increasing and is a significant pressure to the health system.

Rates of hospital admission increase with age and are higher at each age in areas with higher levels of deprivation as shown in the graph below. While the older population is lower in size in the more deprived areas, the people living in these areas tend to have fewer social and economic assets to draw on and therefore may need more support from public and voluntary services. Additionally, people with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people. As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly. In addition, the costs of providing care to this group of people are increased as a result of less effective self-care and other complicating factors related to poor mental health.

We have a range of services and activities working with people who have long term conditions to make lifestyle changes that will support them in the management of their health. These include the Expert Patient programmes; Healthy Stockport family of services;

Cancer Champions; Social prescribers including Walking for Health; voluntary sector alliances (The Prevention Alliance (TPA), Wellbeing and Independence Network (WIN) & Alliance for Positive Relationships (APR)); as well partner agencies such as Stockport Homes, and non-commissioned voluntary and community organisation activity. These are complemented by workforce development such as Connect 5 and Health Chat training. However, clinicians and other front-line staff lack the time to invest in coaching people with long-term conditions (LTCs) to engage with and utilise the resources available in services and communities. This means there is a gap in the capacity to proactively identify, engage with and coach the people who could benefit from better self-care and self-management that is required to bring about the scale of impact on demand that is needed to make the system sustainable.



Research Evidence/Best Practice

Self-care support & coaching

The evidence demonstrates that there is a willingness amongst patients to self-manage, yet current practice shows that there are still millions of appointments nationally for minor ailments and that people with long term conditions are among the biggest users of health care. This occurs due to a lack of confidence in understanding and managing a condition or symptoms; the perceived duration or severity of symptoms; or for reassurance or 'cure' seeking.

Improving self-care requires greater personal responsibility for health and wellbeing. People should be supported to take control of their own health and focus on changing what matters to them. This support can come from informal carers and the organisations and practitioners who provide health and social care. The essence of this support is a collaborative, trusted

relationship between people ('patients' and 'service users') and practitioners (service providers).

When healthcare is designed to empower self-management, people with long term conditions and their carers play a more active role in managing their own health and reduce their need for help from the NHS and social care. NHS England, The Health Foundation and Nesta have recently published findings suggesting that effective self-management is the key to person centred care i.e. care that is personalised, coordinated and enabling. Furthermore, care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes.

Supporting people living with a long term condition requires a partnership with patients over the longer term rather than providing single, unconnected "episodes" of care. Helping patients thrive in the presence of these diseases requires a paradigm shift in health care delivery models; moving from "What's the matter" to "What matters to you?", as described in the "Stockport Way" vision. This means moving away from a paternalistic and dependent consultation model of 'fixing' to one that is empowering and increases patient knowledge, skills, confidence, self-efficacy and healthy behaviours, which are all needed to improve outcomes and reduce healthcare costs. As such it is part of an asset-based approach recognising what people and communities can do for themselves and each other rather than viewing people simply through the lens of 'needs'.

This business case draws on the evidence from the *Realising the Value* programme[4] which addressed the NHS Five Year Forward View vision for a new relationship with people and communities. Based on a review of the evidence, the programme identifies five areas as showing significant potential to improve quality of life for people with long-term conditions and deliver benefits across the three dimensions of value: Mental and Physical health and wellbeing, NHS sustainability and wider social outcomes. These are:

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

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

[4] Nesta, 2016. ***Realising the value:*** *Ten key actions to put people and communities at the heart of health and wellbeing:* www.nesta.org.uk/realising-value-programme-reports-tools-and-resources

Nuffield Trust (2017) *Shifting the balance of care: Great expectations*[5] states that programmes that aim to change patient behaviours are likely to be more successful than those that simply provide information. Where sufficiently supported and funded across the system, IT can be a useful tool in engaging patients and encouraging them to adopt more positive health behaviours. Evidence shows that self-care initiatives, particularly those that rely on e-health or digital tools, are more successful when they are supported by professionals.

Patient Activation

People who have the knowledge, skills and confidence to manage their own health experience better health outcomes. Yet the ability of people to successfully manage their LTCs and to stay well at home can vary considerably from person to person. This is why understanding people's ability to manage their conditions is so important. The Patient Activation Measure (PAM) is a validated tool which enables this and captures the extent to which people feel engaged and confident in taking care of their health. This can be described as their level of activation.

Evidence shows that people at higher levels of activation tend to experience better health, have better health outcomes and fewer episodes of emergency care, and engage in healthier behaviours. On the other hand, patients with lower activation have low confidence in their ability to have an impact on their health and often feel overwhelmed with the task of managing their health and wellbeing.

It has been estimated in the USA that between 25 and 40 percent of the population have low levels of activation (levels 1 and 2)[6]. These people are unlikely to respond to opportunities to improve their health through self-management. They do not understand their role in care process and have limited problem solving skills. Often they have experienced failure in trying to manage and have consequently become passive with regard to their health and wellbeing. As a result, they engage less with preventative healthcare and are involved in more costly emergency care episodes.

Measuring patient activation can drive real improvements as:

- Understanding activation levels help patients and clinicians to determine the realistic "next steps" for individuals to take in term of self-management;
- It allows for training and education resources to be tailored to the levels of activation of different individuals within the population;
- It can support more appropriate allocation of resources towards people at lower levels of activation and who are less confident about their ability to manage their own care.
- It can enable equality and health inequalities to be tackled more effectively by targeting interventions at disadvantaged groups to increase their health literacy and patient activation.

[5] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf
[6] Hibbard JH, Cunningham PJ, 2008. How engaged are consumers in their health and health care, and why does it matter? Res Brief. 2008 Oct; (8):1-9.

Studies show that targeted interventions can increase people's activation scores and their capacity to self-manage their condition more effectively; and when appropriately supported, patients with lowest levels of activation make the most gains[7]. Typically the programmes focus on gaining new skills, encouraging a sense of ownership of their health, supporting changes in their social environment, health coaching and educational classes. People with lower levels of activation are likely to need more in-depth one to one support as compared to people with higher levels of activation.

All of these help to empower people to take greater control of their health, leading to better outcomes and improved experience of the health service and resulting in reduced healthcare costs of these patients in the NHS. A study found that less activated patients had 8 percent higher costs in the base year and 21 percent higher costs in the following year than more activated patients.

Peer and Voluntary support

Around 25% of adults in Stockport report that they volunteer once a month or more. There is considerable evidence for the health and wellbeing benefits of active involvement in voluntary activity, particularly among older people[8], while the increasing numbers of retired people bring enormous personal assets, representing a huge potential resource for health and wellbeing in the borough.

Robin Lane General Practice in Leeds, is one of 60 GP Practices in 16 CCG areas where the Altogether Better approach to generating social action through health and community champions has been delivered and evaluated. By recruiting more than 50 Practice Health Champions, the Practice has been able to increase its patient list by 57% from 8,500 to 13,000 patients without any increase in Primary or Secondary Referrals and a 10% reduction in use of A&E. There is evidence of increased efficiency by dealing with failure demand and the practice have reconfigured their staff team and redesigned their offer to respond to the new challenges, choosing not to appoint to a vacant salaried GP post but instead choosing to invest in a Community Matron and a Wellbeing Coordinator.

Evaluation of work in 30 General Practices, drawing on evidence from the UK Government's Foresight Project and the New Economics Foundation, shows that 216 'types' of Practice Health Champion-led activities brought about improvements in patients' wellbeing, resilience and ability to adapt, cope and live well with long term conditions as well as a gaining a better understanding of how to use services. The evidence tells us that when it works for patients we see significant improvements in mental health and wellbeing and overwhelming support from practice staff to sustain the work:

- 94% of patients surveyed had improved mental health and wellbeing
- 95% of staff surveyed recommend and want to continue after the funded period has ended[9]

[7] See www.kingsfund.org.uk/publications/supporting-people-manage-their-health
[8] JENKINSON, C.E. et al., 2013. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health,* 13, pp. 773

[9] Altogether Better, *Reducing the pressure in General Practice: A new model of care.*

	In other areas patient empowerment approaches have demonstrated significant impacts on demand for health and social care services: Challis et al (2010) found they improved health outcomes, with patients reporting increases in physical functioning). 'Ways to Wellness' is a Newcastle primary care social prescribing initiative providing people with long-term conditions with one-to-one Link Worker support. The net savings to Newcastle West CCG are estimated to be between £2m-£7m. (NHS Constitution, 2014). It has also been shown to reduce unplanned hospital admissions for COPD and asthma (Purdy 2010). Empowering patients to self-care for long-term conditions can reduce visits to GPs by up to 69%; and reduce hospital admissions by up to 50%. (NHS Alliance)
3.	***Proposed Clinical Model*** *Who is it for?* The approach encompasses the entire adult population of Stockport, as everyone brings their own potential assets, including knowledge, experience skills and values that may directly or indirectly impact on their own and other people's need for health and social care services. However, the strategic focus is on the needs and assets of those adults who currently make most use of health and social care services and the staff and carers working with those people. It will work with four of the five cohorts identified in Stockport Together's Greater Manchester Transformation Fund programme Locality Proposal: 1. The 6% of the population accounting for 60% of non-elective admissions; 2. A further 9% at high risk of soon becoming users of hospital services; 3. 60,000 who have an unidentified long-term condition/high risk of developing one; 4. People who account for the 30% of current GP appointments which are not an appropriate use of GP time for whom we can provide better alternative care To deliver this supported self-management of long-term conditions requires enabling individuals to develop the knowledge, skills and confidence in managing their condition(s), and empowering them to know where to seek the right support if and when they need additional help in managing their condition. To ensure that support is tailored appropriately and that patient education courses are well used, co-production methods to should be used develop appropriate systems of support for people with long-term conditions. Therefore this model seeks to both mobilise existing and potential assets and to strengthen networks and promote the kind of reciprocity that can maintain and develop the resilience of individuals, families and communities. As such the greatest impact will be seen among people currently making most demands on services, and those who will do so in future. ***Health Coaching*** A model of health coaching will be implemented which provides for two health coaches in each of Stockport's eight neighbourhoods (16WTE AfCBand4). Each of the health coaches will be supported by a nurse (2WTE AfCBand7) who oversees management and the clinical knowledge required by the coaches. These nurses may be existing District or Practice Nurses working within the Integrated Neighbourhood Teams, but will require specialist knowledge and skills in health coaching as well as clinical knowledge in relation to long-term condition management.

Patients will be eligible for the service if they have at least one long-term health condition. The service will be targeted at two groups initially – those who are living with a long-term health condition currently not well managed and those newly diagnosed with a long-term health condition (identified through general practice including via the Find and prevent approach).

The Coaches will work in person-centred way, empowering the patient to develop knowledge, skills and confidence in managing their condition, including both one to one and some group work, such as the 'Reclaim Your Life' programme. This will include linking people into existing courses or relevant groups and building their skills including understanding when it is appropriate to seek further help and the different routes to the appropriate care.

They will provide an initial session of 1 hour, which will include using the Patient Activation Measure tool to help the individual and their coach understand how well 'activated' the individual is. The PAM score will help the individual and their coach determine the frequency and type of future session (face to face or telephone). The coach will work with the individual for a period to be determined in the initial session, up to a maximum of 12 months. At the end of the intervention the individual will be have their PAM score re-assessed and will be discharged back to primary care, with support from the wider community as per Stockport Together's Healthy Communities approach.

Health coaches will be able to support individuals to access existing services for example:

- Condition specific and general long-term condition patient education courses.
- Disease prevention courses (e.g. DESMOND Walking Away from Diabetes.)
- Lifestyle/behaviour change courses including (via START.)
- Support for other social issues (via TPA.)
- Existing support groups in the community.
- Mental health and wellbeing programmes such as Living Life to the Full and mindfulness training.

The use of the PAM will guide the health coach in tailoring the offer for the individual's level of activation and as such the total time an individual spends with their coach, and the referrals to other services will vary accordingly. As Stockport has been selected as a demonstrator site for NHS England's Empowering People and Communities, provision of the PAM licences is now available through NHS England. As well as in health coaching, we will use PAM to tailor and outcome monitor for people accessing Physical Activity Referral in Stockport (Life Leisure - provider). This service will act as a pilot for using PAM in behaviour change services and we will explore extending its use into other services.

Development of online resources

Many people identified through the Find and prevent process or already known to be living with LTCs will have higher levels of activation and therefore will not need the intensive coaching support, but will need access to trustworthy information and advice about their condition and wider health needs. Online and app-based information and resources for self-care offer a significant opportunity to empower people to take more control and successfully

manage their health and wellbeing. We will build on the newly updated Healthy Stockport website to create a trusted point of information and advice on a range of LTCs in order to make it easy to find the information needed. This will link with and complement the directory of community organisations and activities in Stockport, currently being developed by Stockport Council's Digital by Design programme.

The new web-resources will include interactive information about apps for health and wellbeing to help people navigate the plethora of competing apps available to find those that are both evidence-based and useful. As well as recommendations based on expert opinion it will include opportunities to people to share their experiences of using these apps and tools. It will also have the confidence of clinicians who will be able to recommend this to patients.

In addition to receiving 1:1 coaching, the individuals who are engaged with a coach will be encouraged to assist the development of the online resources, sharing their experience of self-care support information, condition specific advice, and useful web-links etc., which can be shared with others using the service, and other Stockport residents. This will form part of existing web offer (i.e. Healthy Stockport) to ensure that all relevant information is available through one place and the development will be supported by 0.5WTE web developer on a fixed term contract.

Health Champions within the Collaborative Practice and Peer Support
A renewed and expanded approach to growing community health champions who will work with primary care and Integrated Neighbourhood Teams to provide an additional level of support to people at high risk of hospital admission and other vulnerable individuals in the community will be developed. The Health Champions within the Collaborative Practice model is currently being tested in three GP practices, drawing on limited non-recurrent ASC funding, to enable evaluation of the impact initially with a view to extending the model if its impact is demonstrated locally. This is being facilitated by an external provider, Altogether Better. The Altogether Better evidence based approach is normally embedded and becomes self-sustaining within 12-16 months; ASC funding has enabled the approach to be tested for six months but note the need to extend for a further 6 month period.

Building a team of 'Health Champion' volunteers to work with primary care has been demonstrated by Altogether Better to significantly reduce the demand for GP appointments. Health Champions, as members of the local community, can offer time as well as local knowledge to support people who may present to General Practice with non-medical problems, as well as providing social and psychological support to help people cope with and manage their health conditions. Health Champions may play a part in the coproduction of services as well as helping to represent the views and needs of the local community through their engagement with health and social care services.

Community Health Investment Fund
We would propose to develop a small grants investment fund that would be designed to stimulate activity around health, wellbeing and resilience that would primarily focus on developing peer support groups and activities for people with LTCs and for tackling

loneliness and increasing social connections. The small grants would be available to community groups and voluntary organisations across Stockport, including micro grants of £250 and small grants of up to £2,500 and would be awarded on a locality basis with full engagement and support of the Neighbourhood teams, who would outline the local priorities from their needs assessment. Criteria for funding could include:

- Projects/activities that result in groups and communities of people becoming more active in their own communities' health and wellbeing.
- Projects/activities that result in people feeling a greater sense of control of their lives and how they manage their health.
- Ideas that come from communities that bring the communities together to address local issues around isolation or loneliness.
- Ideas that inspire others to get involved and take action in a voluntary role to support health and well-being.

Note that as one of six selected Vanguards for testing 'Health as a Social Movement', small grant funding of £20k has been made in the year 2016-17 with excellent and encouraging results for growing community groups and activities which will impact on health and care demand.

Further non recurrent funding from Adult Social Care has been used to generate community activities linking to this Business Case, for example the Good Gym, a Centre for Social Action Innovation Fund project sponsored by the Cabinet office will be established in Stockport early in 2017, see https://www.goodgym.org/ Adult Social Care has provided half of the £25k needed to establish the Good Gym, the remainder underwritten by Age UK Stockport and the TPA. It will generate 1600 hours of new volunteering time in Stockport in 2017 and over two years, as it becomes self-sustaining through membership fees, will support 78 older, frail individuals referred through the Neighbourhood Teams reducing their use of services. The Community Investment Fund would support evaluated initiatives like the Good Gym to develop in Stockport.

Stockport Council is also developing proposals for an Investment Fund for growing more independent and self-sustaining communities; through aligning these funds the growth of community groups and networks which will have a demonstrable impact on health and wellbeing and demand activity will be ensured, securing empowered and engaged communities built on increased social action and volunteering.

Self-Care Programme Management

As part of our work embedding the Stockport Way, it is proposed that each neighbourhood team should be supported in a self-assessment of how it facilitates self-care, alongside the training to be delivered to all staff (included in the Workforce Enabler business case), and roll-out of the Find and prevent and self-care programmes across neighbourhoods. A tool for this purpose has been developed by Pennine Care and it is recommended that this should be adopted or adapted for use within Stockport Together.

At present we have several education programmes and services supporting people with

long-term conditions, but these have limited capacity. It is proposed that this provision should be reviewed in a collaboration with the Neighbourhood Teams and people eligible to use these services, drawing on the learning from the self-assessment process.

A fixed-term programme manager for self-care will be recruited to:

- Plan, manage and coordinate the development of the new roles and recruitment.
- Commission and plan the training of new and existing staff in coaching skills and methods.
- Develop and deliver the neighbourhood team self-assessment (which would then be owned and maintained within neighbourhoods.)
- Support the development and adoption of tools and resources for asset-based wellbeing conversations and planning in place of deficit-based assessments.
- Manage the piloting, evaluation and roll out PAM.
- Develop and map resources which enable people to access (in a way they understand and want to use) the information they need to care for and support their own health and wellbeing (ensuring that any resources are developed in a sustainable manner.)
- Evaluate the impact of the project and develop and embed a self-care plan for Stockport, which continues to thread this work in to our culture

Activity

Once fully operational, the health coaching service will support 2,400 people living with long-term health conditions per year. The capacity building approach will help ensure the progress made by people engaged is supported in the longer term through engagement in peer support and other community activities which enable continuing mutual support and personal growth. This will mean the numbers benefitting from involvement in such informal support networks will increase cumulatively each year, in addition to the direct support provided, and the benefits of improved self-care will be sustained.

The Health Champions work will engage at least 50 people in volunteering connected to their GP practices and deliver support to at least 250 individuals in their communities. This will be complemented by the establishment and growth of peer support and other health-related community activities in the community. The Community Health Investment Fund will support an estimated 50 health-related community activities per year, depending on their scale and this will bring health and wellbeing benefits to at least 500 people.

The programme will deliver a range of synergistic activities which stimulate the growth of individual and community capacity for and engagement in self-care:

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

4. Benefits

A self-care approach to health and social care is expected to have three main benefits:

- **Empowering patients**. People will be encouraged to participate as equal partners in decisions about their care. This gives people an opportunity to take control of their health and wellbeing rather than health professionals being in control and will lead to improved quality of care and patient satisfaction levels.
- **Managing Demand**. The Department of Health estimates that 15% of A&E attendances and 40% of GP time could be avoided through improved self-care. Over two-thirds of GP visits result in prescribing drugs that are available over the counter. The Wanless review (2002) estimated that for every £100 spent on helping patients care for themselves, £150 could be saved by the reduction of GP and outpatient visits.
- **Improving outcomes**. When people self-care and are effectively supported to do this, a range outcomes are improved. These include: they are more likely to experience better health and well-being; reduce the perceived severity of their symptoms; improve medicines compliance; prevent the need for emergency health and social services; prevent unnecessary hospital admissions; have better planned and co-ordinated care; remain in their own home; and have better mental health and less depression.

In reviewing the likely impact of interventions proposed in this Business Case we have considered three key types of outcomes:

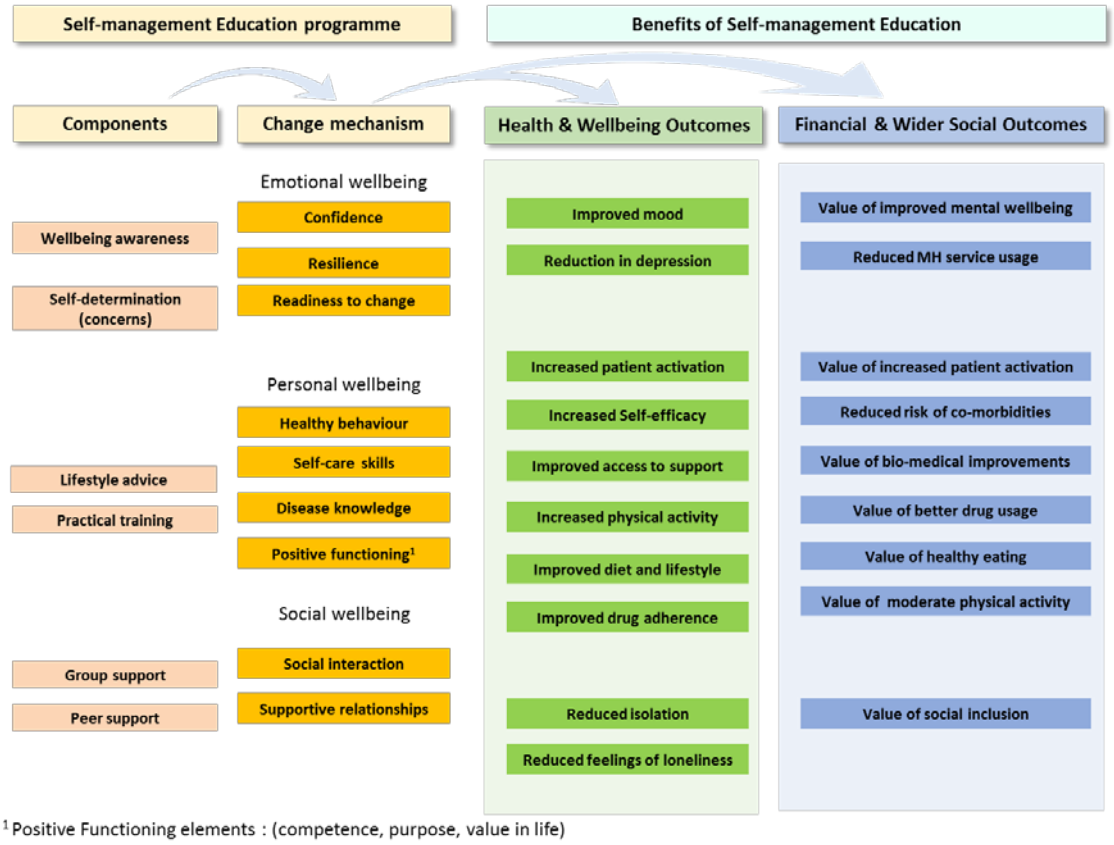
- **Financial outcomes:** translates into net financial impact on Commissioners due to the intervention (i.e. activity reductions, cashable savings). NB. Some of these have not been possible to calculate for the business case i.e. social care cost avoidance, Community Health services demand reduction.
- **Health and wellbeing outcomes**: represents the non-financial positive impacts on the health and wellbeing of service users including: clinical outcomes and wellbeing outcomes; long-term health preventative benefits; and reduced health inequalities.
- **Wider social outcomes**: financial and non-financial benefits that wider society will experience due to the intervention, but are not attributable to commissioners savings' (i.e. absenteeism reduction, voluntary, value of social inclusion, workforce health, wellbeing and engagement.)

Self-care: Evidence suggests that self-care can have a positive impact, although it is often not clear which component makes it effective. Self-care in long-term conditions has been shown to reduce A&E attendances, in particular for adults with Chronic Obstructive Pulmonary Disease (COPD) and asthma, and possibly heart failure. It can also improve adherence to treatment. A systematic review found self-management support was associated with reductions in cost, a small significant improvement in quality of life and significant reductions in health care utilisation, with evidence being strongest for respiratory and cardiovascular disorders. This covered a number of conditions, such as respiratory, cardiovascular, mental health, arthritis and other pain conditions[10].

Self-management education: Self-management education programmes provide people with knowledge about their condition and provide them with tools and skills to manage it on a daily basis. When people are able to manage their condition, this reduces its impact on their daily life, leads to considerable health improvements and reduction in health care use.

[10] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf

Overall health and wellbeing improvements have been noted like engaging in physical activity and therapy compliance, but also more particular improvements like control of blood glucose levels in diabetes patients. Such improvements have been shown to reduce the need for health care currently (A&E and hospitalisations), but also reduce the risk of long-term complications that potentially have a large impact on people's life and would require intensive care.



[1] Positive Functioning elements : (competence, purpose, value in life)

Peer Support

Peer support is defined as "a range of approaches through which people with similar long-term conditions or health experiences support each other in order to better understand the condition and aid recovery or self-management."

People receive support and coaching from a person that has experienced similar challenges or health conditions. This person can help to better understand their conditions, support recovery and self-management. Peer support can be delivered on a one-to-one basis, which may be in person or through telephone support, or through a peer support group.

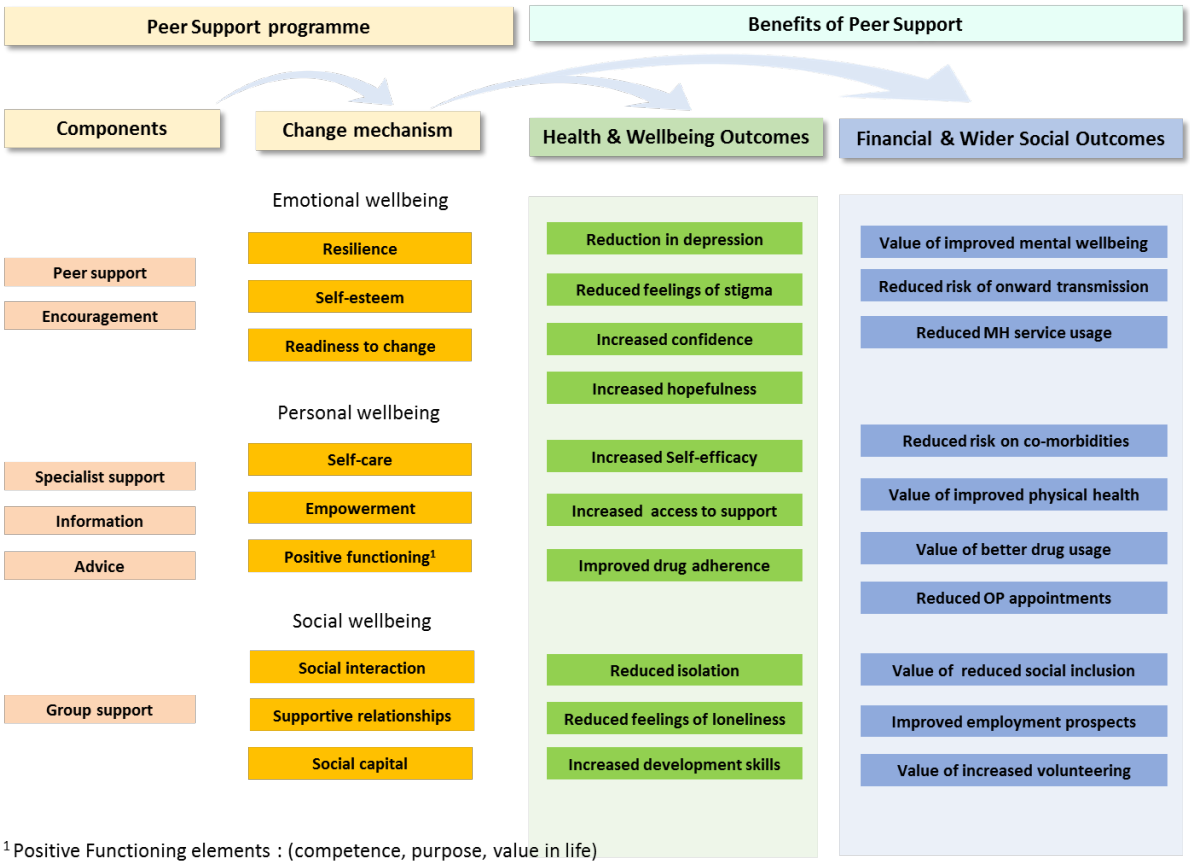
The benefits map below shows that social support is the driving force behind many of the outcomes. The strength of peer support as an intervention lies in the emotional and constructive support that a peer brings with his or her unique perspective based on their own experience.

In terms of health and wellbeing, peer support makes people feel more socially supported and participants report to benefit from increased confidence, resilience and readiness to

change. This places social support as a driver for empowerment and self-efficacy. Research evidence as well as local experience shows that peer support reduces depressive feelings and increases feelings of hopefulness.

Additionally, a number of behavioural 'health' improvements were reported. Elderly people with Coronary Heart Disease (CHD) spent an over 1.5 hour more on physical activity per week (compared to a control group) (Coull, et al., 2004). Also, improvements in glucose-control were noted (Dale, 2012).

The benefits extend beyond the individual as population improvements in mental wellbeing are of considerable value to the wider society. For example, a programme in Canada supporting people with serious mental health conditions reported a reduction of 116 days in length of stay following peer support compared to the control group which received usual care (Forchuk et al., 2005, in Repper et al., 2001).



[1] Positive Functioning elements : (competence, purpose, value in life)

Health coaching: There is a substantial variety of indicators that depict potential financial savings for local health systems. Together health coaches and participants improve the participant's self-esteem and patient activation. Reported benefits include change towards more healthy behaviours, a reduction of depressive symptoms and reduction in health care use amongst people with mental health issues, diabetes and cardio-vascular diseases.

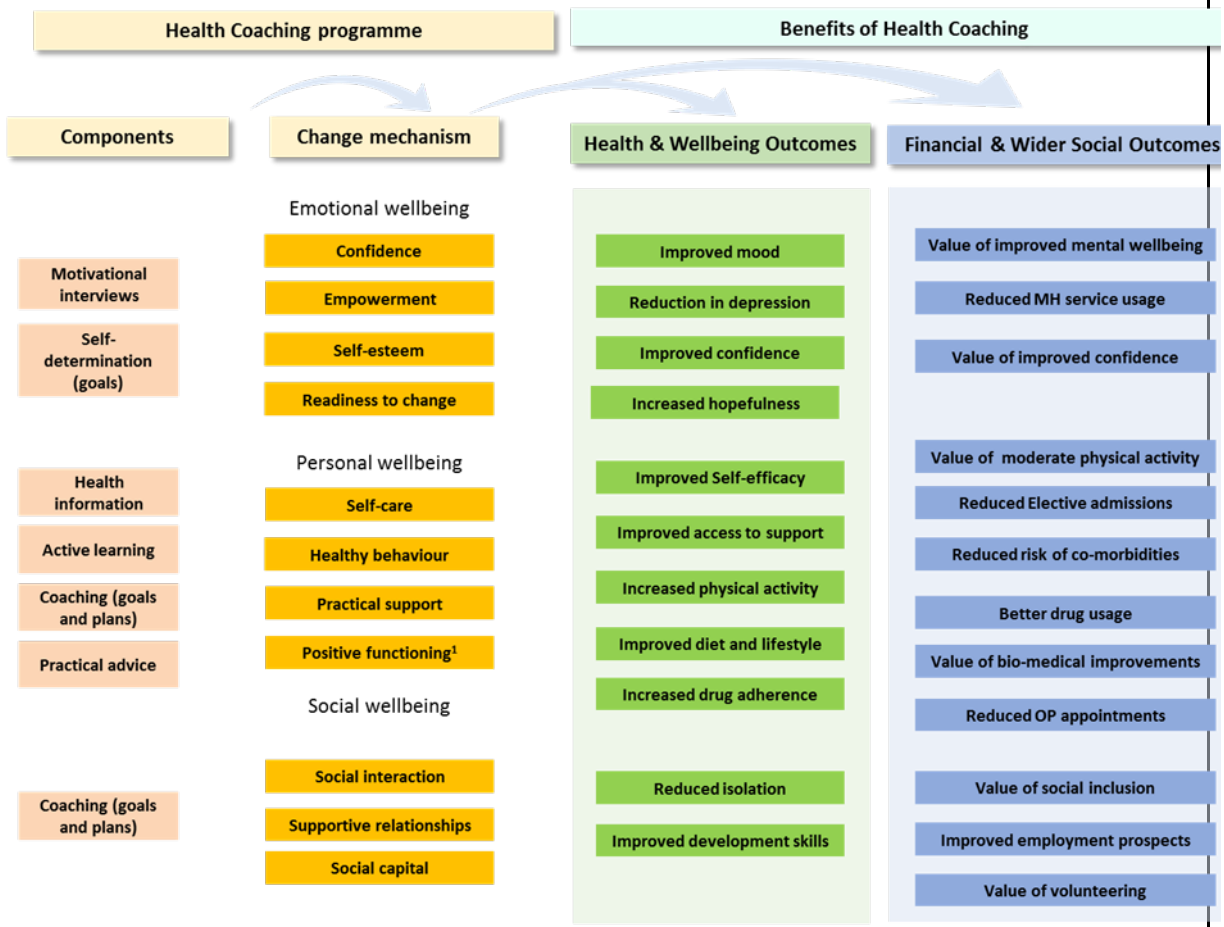
In order for individuals to experience behavioural change, a strong sense of emotional wellbeing needs to be experienced. With the support from the health coaches, the person's self-esteem and confidence are strengthened, which increases their 'readiness to change',

or in other terms their level of patient activation. This in itself has shown to improve people's mood and even reduce depressive symptoms.

From a more physical health and wellbeing perspective, people will have a better understanding of the factors that influence their health and how they can personally influence these through their behaviours. Empowered and equipped with the right tools, the individuals engage more in healthy behaviours, for example improving their diet, exercising more and taking their medications regularly as prescribed.

Health coaching also has the potential to improve people's social wellbeing. This will depend on the approach that is chosen to support behaviour change. For example, this can involve measuring wellbeing in strengthening familiar relationships, or undertaking activities in group format. Although improving social wellbeing may not be the dominating primary goal across health coaching interventions, health coaching has been found to successfully reduce social isolation in elderly individuals.

These behaviour and wellbeing improvements correlate with a wider reaching impact that goes beyond the individual. Most notably, with healthy behaviour and adequate disease management, the need to use health care resources could be reduced.



[1] Positive Functioning elements : (competence, purpose, value in life)

5. Financial Case

Costs

The costings for the proposals described is set out below, not including the costs which fall within the enabler business case.

Healthy Communities Business Case costings						
Item	Posts (fte)		2017-8	2018-19	2019-20	2020-21
Self Care Programme lead	1	M Band 4	£40,019	£53,887		
Self Care digital & web developer	0.5	Band 7	£9,730	£19,652		
Self Care Lead Nurses	2	Band 7	£20,200	£81,608	£82,424	£83,248
Self Care Coaches	16	Band 4	£72,720	£391,680	£395,597	£399,553
Programme Development Budget			£10,000	£8,000	£8,000	£8,000
Health Champions Pilot			£32,000	£3,000	£3,000	£3,000
Community Health Investment Fund			£25,000	£25,000	£25,000	£25,000
Total			**£209,669**	**£582,827**	**£514,021**	**£518,801**

Impact on demand and costs

Due to the nature of the outcomes described in section 4, the impact of this business case will result in savings which are accounted for within the Outpatients business case. These savings have therefore not been included in the impact modelling which follows, but it should be noted that those savings will be in part dependent on the delivery of this model. Furthermore, it should be noted that this modelling does not account for cost avoidance in relation to social care, community nursing and ambulance services which would be realised due to this programme (e.g. care and support following a stroke).

The savings identified in the Find and prevent model, copied below, are dependent on the provision of coaching and peer support to the people identified as having lower levels of activation. Given this interdependency and the benefits of continuity of care, it is proposed that the workforce requirements for specialist Healthcare Assistants HCAs in the two business cases are combined into one generic Health Coach role.

Condition	To find		To improve treatment		2015/16 Admission costs	Modelled saving on costs by 20/21	Notes
	Number	as a %	Number	as a %			
Diabetes	2,300	15.8%	670	4.6%	£452,969	£92,195	Improving /detection and management of **20%** of diabetics
Hypertension	4,300	9.9%	2350	5.4%	£152,176	£11,613	50% preventable by BP, improving /detection and management of 15% of BP, therefore 15%* 50% = **7.5%**
Atrial Fibrillation	1,550	27.2%	280	4.9%	£1,595,639	£343,099	67% preventable by AF, improving /detection and management of 30% of AF, therefore 30%* 67% = **20%**
Dementia	750	27.8%	80	2.9%	£9,992	£3,065	Improving /detection and management of **30%** of people with dementia
COPD	900	13.4%	480	7.1%	£2,015,640	£27,076	10% admissions due to undiagnosed, improving /detection and management of 25% of COPD therefore 10%* 25% = **2.5%**
AMI	-	-	-	-	£2,114,994	£161,399	50% preventable by BP, improving /detection and management of 15% of BP , therefore 15%* 50% = **7.5%**
Other IHD	-	-	-	-	£3,104,147	£236,883	50% preventable by BP, improving /detection and management of 15% of BP , therefore 15%* 50% = **7.5%**
CVD	-	-	-	-	£2,563,684	£551,251	67% preventable by AF, improving /detection and management of 30% of AF, therefore 30%* 67% = **20%**
					Total possible saving	**£1,426,581**	

The possible phasing of this benefit could be as follows:

	17/18	18/19	19/20	20/21
% of full	0%	5%	40%	100%
Impact	0	£71,329	£570,633	£1,426,581

The proposals in this business case are essential to addressing the short-term demand created by uncovering previously unidentified need for prevention and self-care support through Find and prevent, and further to this, based on the evidence cited above, it is estimated that demand for other primary care services will be reduced as set out in the following table.

	Number of appointments per year [1]	Number due to LTCs (50%) [2]	Number saved due to self care (6% of LTC)	Average cost of appointment (15 mins for GP, 20 for nurses) [3]	Estimated saving
GP	349,499	174,750	10,485	£ 50.00	£ 524,249
Nurse	138,728	69,364	4,162	£ 12.00	£ 49,942
HCA	114,672	57,336	3,440	£ 12.00	£ 41,282
OOH GP	92,122	46,061	2,764	£ 50.00	£ 138,183
OOH Nurse	50,592	25,296	1,518	£ 12.00	£ 18,213
TOTAL	745,613	372,807	22,368	-	£ 771,869

1 Stockport Together
2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf
3 www.pssru.ac.uk/project-pages/unit-costs/2016/index.php

Return on Investment

The combined impact of the Find and prevent and Healthy Communities proposals are set out below:

	17/18	18/19	19/20	20/21	TOTAL
F&T cost	£72,000	£292,000	£286,000	£286,000	£936,000
HC cost	£209,669	£582,827	£514,021	£518,801	£1,825,317
Combined cost	**£281,669**	**£874,827**	**£800,021**	**£804,801**	**£2,761,317**
F&T Impact	0	£71,329	£570,633	£1,426,581	£2,068,543
HC add impact	£72,362	£385,934	£771,869	£771,869	£2,002,034
Total impact	**0**	**£457,263**	**£1,342,502**	**£2,198,450**	**£4,070,577**
Net effect	**£281,669**	**£417,564**	**-£542,481**	**-£1,393,649**	**-£1,309,260**

Sources of Funding

Funding sources	2016-7	2017-8	2018-19	2019-20	2020-21	Total
GM Transformation Fund		£281,669	£874,827			£1,156,496
Recurrent funding required				£800,021	£804,801	£1,604,822
NHS England (PAM licence provision)		£600	£1,260	£1,800	£1,800	£5,460
Total		**£282,269**	**£876,087**	**£801,821**	**£806,601**	**£2,766,778**

6. Contractual Arrangements & Implementation Plan

It is proposed that the Self-care Coaches and Lead Nurses will be employed by either a lead GP practice for each neighbourhood or by SNHSFT as part of the neighbourhood based community services team. The programme manager and digital and web development posts will be employed by the Council within either the Public Health team, Corporate Support Services or the Stockport Together Programme management team.

It is proposed the implementation of the programme will be phased across neighbourhoods and as set out below. This will to enable planning an engagement with the neighbourhoods and the people expected to benefit from the services, as well as testing and learning from the early adoption neighbourhoods and refinement of the model.

	Total Posts	Grade	Total staff in post						
Self Care Staffing Requirements			Apr-17	Jul-17	Oct-17	Jan-18	2018/19	2019-20	2020-21
Self-Care Programme lead	1	M Band 4		1	1	1	1	0	0
Self-Care Lead Nurses	2	Band 7			1	1	2	2	2
Self-Care Coaches	16	Band 4			4	8	16	16	16
Self-Care digital & web developer	0.5	Band 7			0.5	0.5	0.5	0	0
Self Care Total FTE	19.5		0	1	6.5	10.5	19.5	18	18

Key milestones for implementation are set out below:

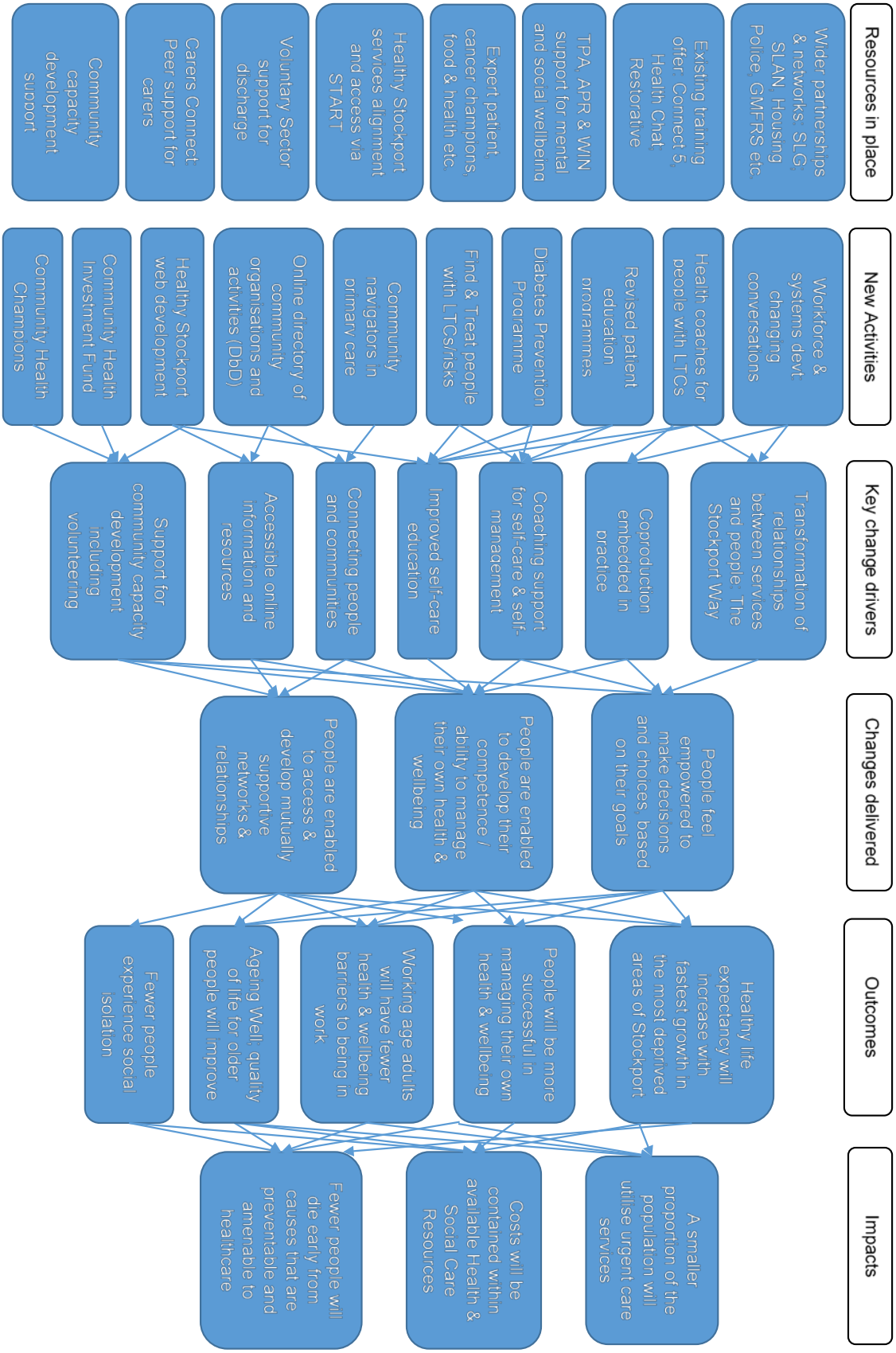
Milestone	Date
Funding approval	April - June 17
Health Champions contract extension decision	June 17
Programme Manager appointed	July 17
Community Health Investment Fund launched	September 17
Self-care coaches & Nurse lead in two neighbourhoods	October 17
Self-care digital and web-develop in post	October 17
Self-care support extended to four neighbourhoods	January18
Initial implementation review completed	February 18
Self-care support extended to all neighbourhoods	April 18
Full implementation review completed	October 18
Initial impact evaluation completed	March19
Implementation project closed	March 19

Risks

Risk	Mitigation action
The programme relies heavily on co-production and whilst this has been initiated in many areas of the Business plan we feel that this can be extended further	We are working with the active support of Christine Morgan to guide this work and utilising the information secured from previous consultations. However all this work will be scaled up in the implementation phase.
Failure to achieve cultural change or adopt new values and behaviours	Be active participants in the neighbourhoods work to design own values and behaviours through the ongoing series of workshops with both INS and IT Team Leaders. Investment in OD support to the project
Self-care apps and resources are being developed alongside the Digital by Design work and this may impact on proposed timescales	Active engagement in the DbD programme and extensive integration of the Business case programme timescales to be prioritised

Lack of cohesion with other Stockport Together work streams/models &/or wider Council	Review of all programmes by PMO to explore synergies, identify duplication and streamline work programmes
Failure of new model to prevent forecast level of acute admissions, ED attendance and free up primary care services.	Utilise evidence base from other areas and pilot changes within speedy implementation plan
Not possible to increase capacity due to delays in recruiting workforce with the required level of skills, mean cannot prove concept &/or fully implement model.	Early discussion with the providers to explore capacity and realignment of existing staff to prioritise the ways of working
Variability in neighbourhood understanding and engagement in this area of work.	Work with the willing neighbourhoods and use successes in these areas of work to engage other neighbourhoods
Lack of co-location solution (physical location) reduces ability to work in an integrated way. Clinical services may be prioritized to such an extent that there are fewer facilities for delivery of community programmes	Neighbourhood and Integrated Team estates requirement identified. Proposals and options developed and being discussed with the Estates Enabler group
Limited resources at scale to make detrimental impact on all aspects of programme delivery through failure to change our relationships with people	Identify and explore other external funding mechanisms via partners to accelerate and extend this work
Limited senior level buy in to embed transformation of the ways in which we work with people and communities throughout Stockport Together	Improve communication and engagement with Senior leaders and Senior clinicians and ensure that Cllr members champion this way of working
Immature and multiple recording systems in partners prevent difficulty in assessing impact	Extend the work currently being developed by the TPA outcome recording system and seek out further work with the New Economy to develop new ways of evaluation to capture the outcomes of this work programme

Appendix 1: Theory of Change



Appendix 2: The Stockport Way

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

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

Working *with* people, and building on their strengths

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

Always connecting through conversations and building relationships

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

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

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

Appendix 3 Long-term Conditions Data

Key Findings – long term conditions

Stockport JSNA
joint strategic needs assessment

Condition	Number (Aug 15)	Gender pattern	Age trend	Deprivation
Hypertension	43,589		Highest 45+	Increase with dep
Anxiety	40,114	Higher in F.	Highest 40-59	Increase with dep
Depression (18+)	26,088	Higher in F.	Highest 40-54	Increase with dep
Obesity (16+)	20,544*			Increase with dep
Asthma	19,933			Increase with dep
Diabetes	14,816		Highest 45+	Increase with dep
Coronary Heart Disease (CHD)	12,304	Higher in M.	Highest 45+	Increase with dep
History of Fall	11,433	Higher in F.	Highest 75+	Increase with dep
Cancer	7,992			Decrease with dep
Chronic Kidney Disease (CKD)	7,698		Highest 50+	Increase with dep
Chronic Obstructive Pulmonary Disease (COPD)	6,959		Highest 45+	Increase with dep
Stroke or Transient Ischaemic Attack (TIA)	6,224		Highest 45+	Increase with dep
Self harm	6,054*	Higher in F.		Increase with dep
Atrial Fibrillation (AF)	5,903		Highest 50+	
Heart Failure (HF)	2,812		Highest 55+	Increase with dep
Dementia	2,695	Higher in F.	Highest 65+	Increase with dep
Glaucoma	2,504		Highest 55+	
Severe mental health	2,434			Increase with dep
Epilepsy	2,389			Increase with dep
Peripheral Arterial Disease (PAD)	2,233	Higher in M.	Highest 55+	Increase with dep
Rickets	1,570	Higher in F.		
Learning disability	1,495	Higher in M.		Increase with dep
Rheumatoid Arthritis (16+)	1,482	Higher in F.	Highest 45+	
Acute Macular Degeneration (AMD)	1,428*	Higher in F.	Highest 75+	Decrease with dep
Autism	927*	Higher in M.		
Cerebral palsy	275*			
Downs Syndrome	234	Higher in M.		

* Undercount of actual prevalence

Information about the number of people in Stockport with certain illnesses or disabilities has been analysed from Stockport GP practice registers - this excludes acute health needs, for example infections, so is not a measure of all needs and demands.

- Overall, **41% (124,000) of the people registered with Stockport GPs have one or more of the conditions analysed**
- It is important to note that the 59% of people not in this analysis may have undiagnosed conditions or have poor health generally, and equally the people with long-term conditions may be healthy and well self-managed.
- The proportion with at least one condition increases with age, from 2% in the 0-4 age band, to 90% in those aged 85 and over
- **By age 55, half of the people in Stockport have one or more of these conditions.**
- **Asthma** is the major condition affecting **school aged children** in the borough (more than 2,000 cases aged 5-14) , **anxiety** affect those **aged 15-24** in particular (more than 2,700 cases).

27

Key Findings – multiple long term conditions

Stockport JSNA
joint strategic needs assessment

In addition to looking at each of the conditions individually it is also useful to understand trends in the number of conditions people are living with, and how this varies over the life course – as this gives some measure of the complexity of issues, co-morbidities and treatments patients and health carers may be dealing with. Analysis focussed on 8 groups of diagnoses, excluding some conditions where data quality is lower or where people may not need clinical management permanently.

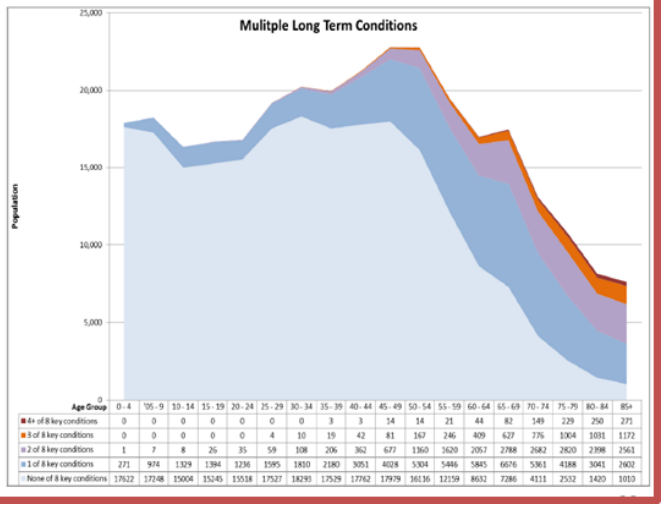
9% (26,250) of the population have two or more of 8 key long term conditions

These key conditions are strongly age related.

- By age 65, 58% of the population have at least one of the key conditions, with 20% having two or more.
- In the **oldest age group**, 87% have at least one condition, with **53% having two or more of the conditions**

The rates of these key conditions show a strong deprivation profile. As the number of conditions increase, the deprivation profile becomes more pronounced.

Number of key conditions	Number of people	% of people
0	222,993	73.0%
1	56,331	18.4%
2	19,575	6.4%
3	5,588	1.8%
4	984	0.3%
5+	96	<0.1%



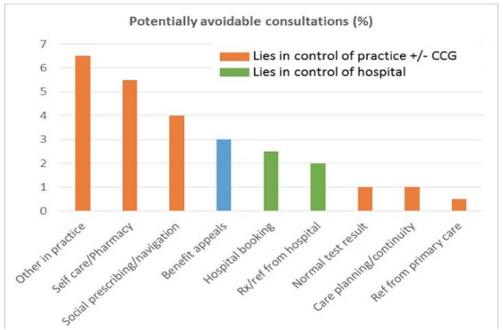
CAPACITY MODEL

		Avaialble resource				Activity under new neighbourhood model									Utilised hours			
Complete columns B, C, D, G, I & K		Number of staff (FTE)		Hours available per		Retained activity (from existing		Activity diversion (under neighbourhood model)										
Core Component (of neighbourhood model)	Specialism / grade	Current	Future (20/21)	Current	Future	Per individual per day	System level per day	Hours diverted per Individual per day to other professionals (diverting away)	System level - total hours diverted to other professional groups (per day)	Diverted from?	NEW activity taken on per individual per day (hours)	System level - total NEW activity taken on (hours)	Time dedicated to managing growth in demand	% diverted	Per individual	System	Utilisation (%)	Assumptions
General practice	GPs	161.0	161.0	1207.5	1207.5	4.725	760.73	2.78	446.78						4.7	760.7	63.0%	
	ANP	12.0	12.0	90.0	90.0	7.5	90								7.5	90.0	100.0%	
	Practice nurses	55.0	55.0	412.5	412.5	7.5	412.5								7.5	412.5	100.0%	
	HCA's	42.0	42.0	315.0	315.0	7.5	315								7.5	315.0	100.0%	
	Managers	58.0	58.0	435.0	435.0	7.5	435								7.5	435.0	100.0%	
	Other non clinical	460.0	460.0	3450.0	3450.0	7.5	3450								7.5	3450.0	100.0%	
	Pharmacy/prescribing	50.5	90.0	378.8	675.0	7.5	378.75			GP	0.74	66.41		5.5%	4.9	445.2	66%	
	Psychological medicine/unexplained symptoms	0.0	5.0	0.0	37.5	0				GP	0.00	0.00			0.0	0.0	0.0%	NO VARNAM EVIDENCE FOR THIS
	Direct access Physiotherapists	0.0	12.0	0.0	90.0	0	0			GP	6.54	78.49		6.5%	6.5	78.5	87.2%	12 band 7s
Primary Care at Scale	Dietitians	2.1	6.3	15.8	47.3	7.5	15.75				7.5	31.5			7.5	47.3	100.0%	
	GPs (Acute visiting and clinical triage)	0.0	8.0	0.0	60.0					GP	15.09	120.75		10.0%	15.1	120.8	201.3%	
	Find & Treat - Admin	0.0	1.6	0.0	12.0						7.50	12.00			7.5	12.0	100.0%	
	Find & Treat - HCA	0.0	4.0	0.0	30.0						7.50	30.00			7.5	30.0	100.0%	
	Find & Treat - Analyst	0.0	8.0	0.0	60.0						7.50	60.00			7.5	60.0	100.0%	
	Find & Treat - project officer	0.0	0.4	0.0	3.0						7.50	3.00			7.5	3.0	100.0%	
	Mental wellbeing navigators	0.0	16.0	0.0	120.0					GP	1.91	30.55		2.5%	1.9	30.5	25.5%	
	Safeguarding	0.0	6.4	0.0	48.0						7.50	48.00			7.5	48.0	100.0%	
	Healthy Communities - Self care coach	0.0	16.0	0.0	120.0					GP	1.91	30.55		2.5%	1.9	30.5	25.5%	
	Healthy Communities - Self care nurse	0.0	2.0	0.0	15.0					GP	1.93	3.86		0.3%	1.9	3.9	25.8%	
	Navigation (practice reception)	45.0	45.0	337.5	337.5	7.5	337.5			GP	1.91	85.97		7.1%	9.4	423.5	125.5%	
	Workflow optimisation																	
Integrated Community Teams (Excludes non-recurring BCF funded posts)	SMBC - Neighbourhood Team Leader	4.0	4	30.0	30.0	7.5	30	0.00		GP	0.07	0.3	0.9%	0.02%	7.6	30.3	100.9%	
	SMBC - Neighbourhood Senior Practitioner	5.3	8	39.8	60.0	7.5	39.825	20.18		GP	0.07	20.7	1.8%	0.04%	7.6	60.5	100.9%	
	SMBC - Neighbourhood Practitioner	49.9	48	374.5	360.0	7.5	374.475	-14.48		GP	0.07	-11.2	10.8%	0.27%	7.6	363.3	100.9%	
	SMBC - Neighbourhood Key Worker	39.9	59	299.3	442.5	7.5	299.325	143.18		GP	0.07	147.2	13.3%	0.33%	7.6	446.5	100.9%	
	SMBC - Assistant Neighbourhood Practitioner	31.9	48	239.1	360.0	7.5	239.1	120.90		GP	0.07	124.2	10.8%	0.27%	7.6	363.3	100.9%	
	SMBC - Neighbourhood Support Worker	0.0	26	0.0	195.0	7.5		195.00		GP	0.07	196.8	5.8%	0.15%	7.6	196.8	100.9%	
	SFT - Senior Clinician	0.0	8	0.0	60.0	7.5		60.00		GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.9%	
	SFT - Neighbourhood Team Leader	4.0	4	30.0	30.0	7.5	30	0.00		GP	0.07	0.3	0.9%	0.02%	7.6	30.3	100.9%	
	SFT - Neighbourhood Senior Practitioner	25.8	20	193.6	150.0	7.5	193.575	-43.58		GP	0.07	-42.2	4.5%	0.11%	7.6	151.4	100.9%	
	SFT - Neighbourhood Practitioner	64.1	49	480.5	367.5	7.5	480.45	-112.95		GP	0.07	-109.6	11.0%	0.28%	7.6	370.8	100.9%	
	SFT - Assistant Neighbourhood Practitioner	9.6	19	72.2	142.5	7.5	72.15	70.35		GP	0.07	71.6	4.3%	0.11%	7.6	143.8	100.9%	
	SFT - Neighbourhood Support Worker	8.1	39	60.6	292.5	7.5	60.6	231.90		GP	0.07	234.5	8.8%	0.22%	7.6	295.1	100.9%	
	SFT - Neighbourhood Support Worker	6.2	31	46.7	232.5	7.5	46.65	185.85		GP	0.07	188.0	7.0%	0.17%	7.6	234.6	100.9%	
	PenCare - Mental Health Liaison Workers	0.0	8	0.0	60.0	7.5		60.00		GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.9%	
	JQIT - Programme manager	0.0	1.0	0.0	7.5	7.5		7.50		GP	0.07	7.6	0.2%	0.01%	7.6	7.6	100.9%	
	JQIT - Quality improvemet officers	0.0	3.0	0.0	22.5	7.5		22.50		GP	0.07	22.7	0.7%	0.02%	7.6	22.7	100.9%	
	JQIT - Service improvement coordinator	0.0	0.5	0.0	3.8	7.5		3.75		GP	0.07	3.8	0.1%	0.00%	7.6	3.8	100.9%	
	JQIT - Nurse	0.0	1.0	0.0	7.5	7.5		7.50		GP	0.07	7.6	0.2%	0.01%	7.6	7.6	100.9%	
	SMBC overnight - Neighbourhood Senior Practitioner	0.0	2	0.0	15.0	7.5		15.00		GP	0.07	15.1	0.4%	0.01%	7.6	15.1	100.9%	
	SMBC overnightNeighbourhood Practitioner	0.0	8	0.0	60.0	7.5		60.00		GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.9%	
	SMBC overnightNeighbourhood Key Worker	0.0	8	0.0	60.0	7.5		60.00		GP	0.07	60.5	1.8%	0.04%	7.6	60.5	100.9%	
	Physiotherapists	18.9	27.3	142.0	204.8	7.5	141.98	62.78		GP	0.07	64.6	6.1%	0.15%	7.6	206.6	100.9%	
	Occupational therapists	2.6	2.6	19.5	19.5	7.5	19.5	0.00		GP	0.07	0.2	0.6%	0.01%	7.6	19.7	100.9%	
	SALT	0.0	0	0.0	0.0	7.5	0	0.00		GP	#DIV/0!	#DIV/0!	0.0%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	Entire SALT resource sits outside of community. Included here as reference only
	Podiatrists	20.8	20.8	156.0	156.0	7.5	156	0.00		GP	0.07	1.4	4.7%	0.12%	7.6	157.4	100.9%	
														37.00%				
System wide		1134.42	1403.20	8508.15	10524.00													

	Data		
Component	Current FTE	20/21 FTE	% Change
General practice	838.5	895	7%
Integrated Community Teams	248.82	394.5	59%
Primary Care at Scale	47.1	113.7	141%
Grand Total	1134.42	1403.2	24%

Local Deflections used

Pharmacist	5.5%
Direct access physio	6.5%
Social prescribing/self-care	12.50%
Neighbourhood teams	2.5%
Psychological medicine/unexplained symptoms	-
Neighbourhood clinical triage	10.0%
Neighbourhood acute home visiting	
Remain with GP	63.0%



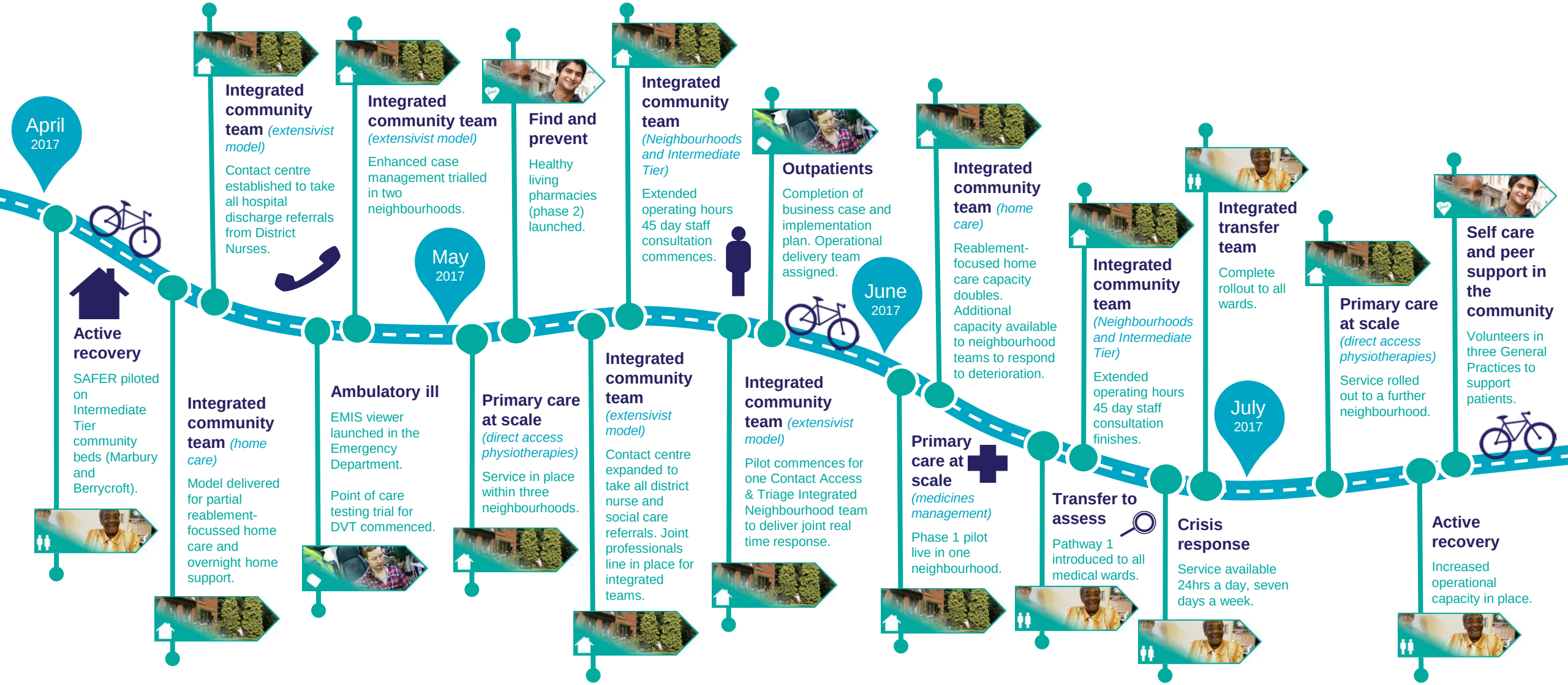
Questions/broader assumptions

7 day business case - again, where does this fit in?
Falls business case - no workforce 'ask'
This whole model assumes that activity passing from profession 1 to 2 would result in the same time demands. I.e. every profession takes the same time to do the same 'task'
The integrated teams FTE requirements were constructed from the activity levels - i.e. they must balance back to 100% WITHOUT any diverted activity from GPs - If GP activity is additional, this will push the respective utilisation above 100%

There is no "conversion factor" from GP consultation time to non-GP time. It's all standard % of hours available.
What % of GP time is actually spent in consultation because we're using 27% reduction from the WHOLE and the evidence is 27% reduction from consultation time.

The Stockport Together Programme

Our journey



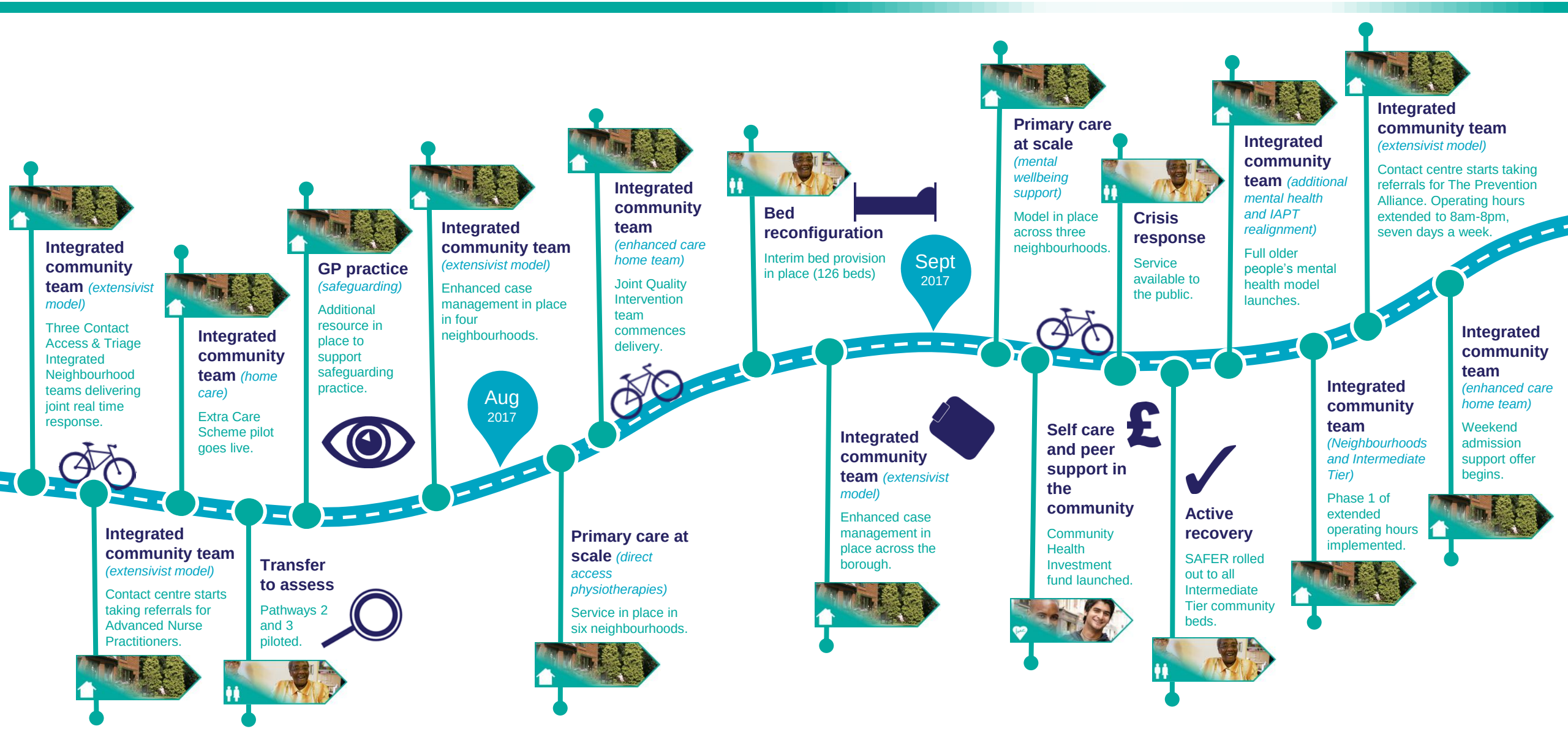
What will be implemented, when

Neighbourhoods | Intermediate Tier | Healthy Communities | Acute Interface

April 2017- July 2017

The Stockport Together Programme

Our journey



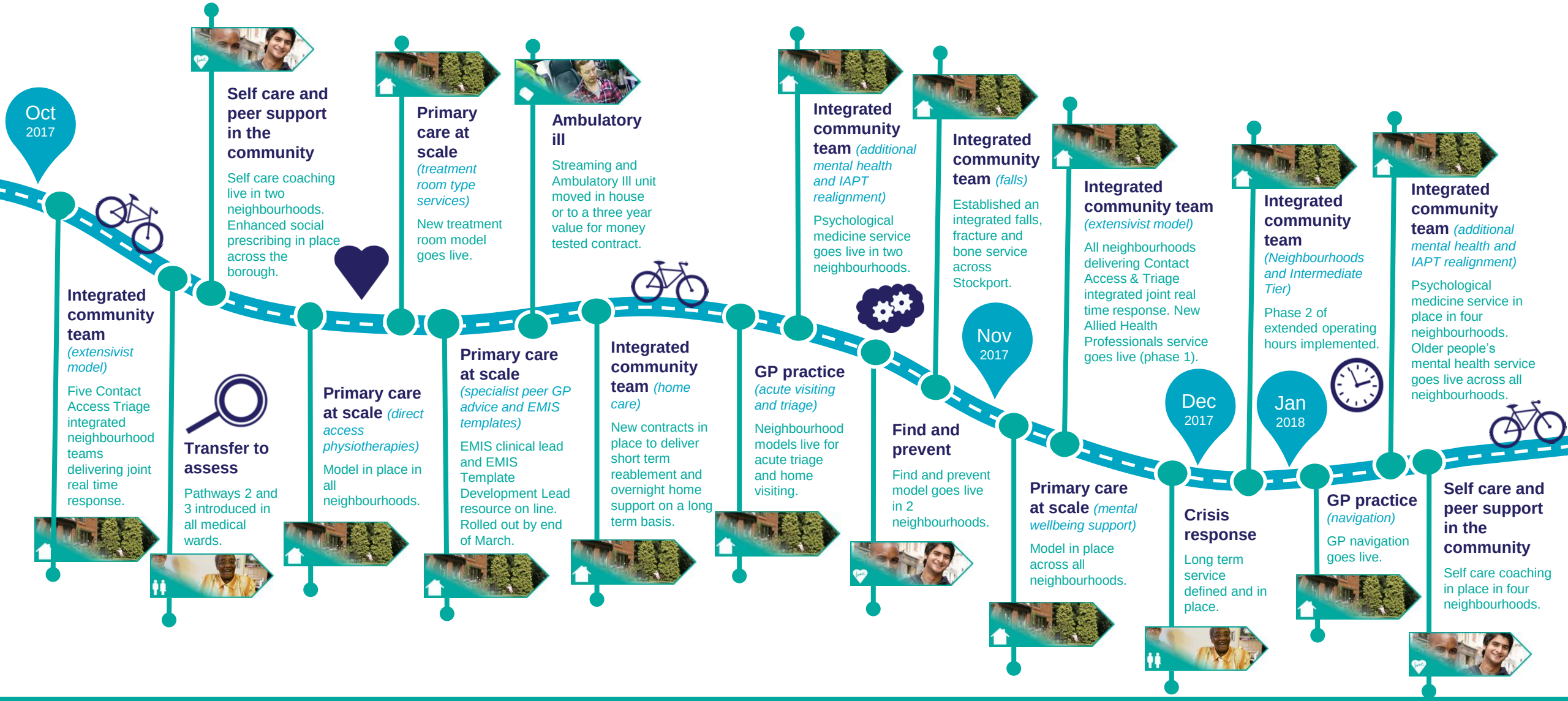
What will be implemented, when

Neighbourhoods | Intermediate Tier | Healthy Communities | Acute Interface

July 2017- Sept 2017

The Stockport Together Programme

Our journey



What will be implemented, when

Neighbourhoods | Intermediate Tier | Healthy Communities | Acute Interface

Oct 2017 – Jan 2018

The Stockport Together Programme

Our journey

Feb 2018

Integrated community team *(falls)*

Increased capacity for access to postural stability and other balance improvement activity programmes.

March 2018

Primary care at scale *(medicines management)*

Phase 2 model live in two neighbourhoods.

Bed reconfiguration

Interim bed provision in place (116 beds)

Primary care at scale *(medicines management)*

Phase 2 model in place in three neighbourhoods.

Integrated community team *(additional mental health and IAPT realignment)*

Psychological medicine service in place in six neighbourhoods. Older people's mental health service delivering 100% capacity across all neighbourhoods.

April 2018

Self care and peer support in the community

Online self care resources launch.

Primary care at scale *(medicines management)*

Phase 2 model in place in four neighbourhoods.

GP practice *(acute visiting and triage)*

Model extended to include care homes and hospital discharge. Neighbourhood hubs delivering acute appointments.

Integrated community team *(additional mental health and IAPT realignment)*

Psychological medicine service live in all neighbourhoods.

Find and prevent

Find and prevent process live in all neighbourhoods.

Outpatients

Implementation of business case begins.

July 2018

Integrated community team *(extensivist model)*

Allied Health professionals service expanded (phase 2).

Primary care at scale *(medicines management)*

Phase 2 model live in all neighbourhoods.

Oct 2018

Jan 2019

Integrated community team *(falls)*

Develop and roll out falls management system in care homes.

Integrated community team *(extensivist model)*

Stockport care coordination centre goes live.

Bed reconfiguration

Future bed provision in place (98 beds).

March 2019

Peer support for carers

Eight neighbourhood carer support groups established.

What will be implemented, when

Neighbourhoods | Intermediate Tier | Healthy Communities | Acute Interface

Jan 2018 - March 2019

Stockport Together | Key Implementation Milestones

Workstream	2017-18 Monthly												2018-19 Quartlery				2019-20	2020-21
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr- June 2018	July-Sept 2018	Oct-Dec 2018	Jan-March 2019		
Neighbourhoods																		
Primary Care at scale- Direct access physiotherapy				**Primary care at scale |** Direct access physiotherapy service in place within three neighbourhoods.		**Primary care at scale |**Direct access physiotherapy service in place within four neighbourhoods.	**Primary care at scale |** Direct access physiotherapy service in place within six neighbourhoods.		**Primary care at scale |** Model in place in all neighbourhoods								
Primary Care at scale - Mental Wellbeing Support						Contract in place for mental wellbeing support service	Recruitment of Mental Health Navigators	Model in place across three neighbourhoods		Model in place across all neighbourhoods.								
Primary Care at scale - Medicines management		Recruitment of staff for pilot	Phase 1 pilot live in one neighbourhood								Phase 2 model live in two neighbourhoods	Phase 2 model live in three neighbourhoods	Phase 2 model live in four neighbourhoods	Phase 2 model live in all neighbourhoods				
Collaborative General Practice - Specialist peer GP advice and EMIS templates		EMIS Clinical Lead and EMIS Templates developed.					EMIS clinical lead and EMIS Template Development Lead resource online. Rolled out by end of March.											
Primary care at scale - Treatment room type services			Relevant recruitment commences				New treatment room model goes live											
GP practice - navigation				Practice navigator training commences						GP navigation goes live.								
GP practice - acute visiting and triage							Neighbourhood models live for acute triage and acute home visiting.						Model extended to include care homes and hospital discharge. Neighbourhood hubs delivering acute appointments.					
GP practice - safeguarding		Recruitment to additional posts commences, where required.		Additional resource in place to support safeguarding practice.														
GP 7 Day Service	GP 7 Day Service piloted in the Heatons.				GP 7 Day Service in place in two neighbourhoods	GP 7 Day Service in place in four neighbourhoods	GP 7 Day Service commences in six neighbourhoods	7 Day Service live in place in all neighbourhoods										
Integrated community team - additional Mental Health (and IAPT realignment)	Additional older peoples mental health recruitment commences		Commence recruitment to additional psychological medicine posts.	Additional older peoples mental health recruitment fully in post.		Key psychological medicine capacity in post. Full older peoples mental health model launches.	Psychological medicine service goes live in two neighbourhoods.			Psychological medicine service in place in four neighbourhoods. Older Peoples mental health liaison service goes live across all neighbourhoods		Psychological medicine service in place in six neighbourhoods. Older Peoples mental health liaison Service delivering 100% capacity across all neighbourhoods	Psychological medicine service live in all neighbourhoods.					
Integrated community team - Falls:							Establish an integrated falls, fracture & bone service (Steady in Stockport) across Stockport			Increased capacity for access to postural stability and other balance improvement activity programmes						Develop and roll out falls management system in care homes.		
Integrated community team - home care	Model delivered for partial reablement focussed home care and overnight home support.	Recrtuiment to workforce for Extra Care scheme pilot commences.	Re-ablement focussed home care capacity doubles. Additional capacity availble to neighbourhood teams to respond to deterioration.	Extra Care Scheme pilot goes live.			New contracts in place to deliver short term re-ablement and overnight home support on a long term basis											
Integrated community team - enhanced care home team		Joint Quality Intervention Team recruitment commences		Recruitment commences on resources to support weekend care home admission	Joint Quality Intervention Team in post.	Joint Quality Intervention Team commences delivery.	Care homes weekend admission support offer commences.					Formal joint evaluation of progress.	Full rollout of the Joint Quality Intervention team,					
Integrated community team - extensivist model		**Extended operating hours |** Extended operating hours 45 day consultation commences.	**Extended operating hours |** Extended operating hours 45 day consultation ends.			**Extended operating hours |** Phase 1 of extended operating hours implemented.			**Extended operating hours |** Phase 2 of extended operating hours implemented.									
	Contact Access & Triage (CAT) | Contact centre established to take all hospital discharge referrals from district nurses.	**CAT |** Contact centre expanded to take all district nurse and social care referrals. Joint professionals line in place for integrated teams. **CAT |** Contact centre recruitment complete.		**CAT |** Contact centre starts taking referrals for Advanced Nurse Practitioners.		**CAT |** Contact centre starts taking referrals for The Prevention Alliance. Contact centre operating hours extended to 8am-8pm, seven days a week.										**CAT |** Stockport Care Coordination Centre goes live		
		CAT integrated neighbourhood teams (INT) | Real time response pilot commences in one neighbourhood.		**CAT integrated neighbourhood teams (INT) |** Three neighbourhood teams devlivering integrated real time response.			**CAT integrated neighbourhood teams (INT) |** Five neighbourhood teams devlivering integrated real time response.	**CAT integrated neighbourhood teams (INT) |** All neighbourhood teams devlivering integrated real time response.										
							Allied Health Professionals | Recruitment to 17/18 posts	**Allied Health Professionals |** New Allied Health Professionals service goes live (phase 1).					**Allied Health Professionals |** Allied Health Professionals |Recruitment to 18/19 posts **Allied Health Professionals |** Allied Health Professionals service expanded (Phase 2)						
		Enhanced case management | Enhance case management trialled in two neighbourhoods.	**Enhanced case management |** Full imementation plan (including percentage of population covered) complete.	**Enhanced case management |** Enhanced case management in place in four neighbourhoods.	**Enhanced case management |** Enhanced case management in place across the borough.													
			100% 17/18 senior and support worker capacity online.	1st July - 100% key worker capacity online. 1st July - 100% Senior Practitioner capacity online	100% neighbourhood practitioner capacity online		50% ANP capacity in place			100% Assistant Practitioner capacity online			100% ANP capacity in place Small reduction in Neighbourhood Practitioners (ASC), 100% 18/19 DN support worker capacity online				Reduction in senior and neighbourhood practitioners (Nursing and ASC)	
Healthy Communities																		

Stockport Together | Key Implementation Milestones

Workstream	2017-18 Monthly												2018-18 Quartlery					
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr- June 2018	July-Sept 2018	Oct-Dec 2018	Jan-March 2019	2019-20	2020-21
Health Champions			Health Champions Extension Decision	Volunteers in three general practices to support patients.				Evaluation & forward plan completed										
Peer Support for Carers												400 carers accessing online support				Eight neighbourhood Carer Support Groups established		
Self Care & Peer Support in the community	NHS E approval of Patient Activation Model (PAM)	Recruitment of project manager NHS E release of PAM licence to Stockport	Decisions re use of patient activation measure as part of the NDPP	Project Manager in post	Recruitment of self care coaches	Community Health Investment fund launched	Self care coaching live in two neighbourhoods. Self-care digital and web-develop resource identified	Enhanced social prescribing in place across the borough.		Self care coaching in place in four neighbourhoods		Online self care resources launch.	Self care coaching live across all neighbourhoods.					
Find & Prevent	**National Diabetes Prevention programme |** GM provider for NDPP (National Diabetes Prevention Programme) appointed	Healthy Living Pharmacies (phase 2) launched	**National Diabetes Prevention programme |** NDPP live in Victoria			**National Diabetes Prevention programme |** NDPP live in Cheadle	Find & Prevent model goes live in two neighbourhoods		**National Diabetes Prevention programme |** NDPP live in Tame Valley				Find & Prevent model live in all neighbourhoods - April **National Diabetes Prevention programme |** NDPP live in Werneth (May). NDPP live in Stepping Hill (June)	**National Diabetes Prevention programme |** NDPP live in Heatons (Sept)	**National Diabetes Prevention programme |** NDPP live in Bramhall (Dec)	**National Diabetes Prevention programme |** NDPP live in Marple (March)		
Place based integration	**Place based work |** Approval of the Heatons Joined Up Services programme	**Place based work |** Launch of the Heatons Joined up service programme and start of community conversation	**Place based work |** Programme deliverables confirmed															

Acute Interface

Ambulatory III	EMIS Viewer launched in the Emergency Department.	Cost benefit analysis of AI completed with options appraisal	Future requirements spec for delivery of AI from October 1st completed include market testing. Commission future AI service delivery and complete any legal requirements.	Commence recruitment of permanent ACU capacity			Streaming and Ambulatory III unit moved in house or to a three year value for money tested contract.	Contract variation completed										
	Point of care testing (POCT) 3 month trial for DVT go live commenced (1st Apr)	Mid point review of POCT	Review trial of POCT															
	ACU operating at full capacity.		Audit effectiveness of ACU pathways.															
Outpatients		Completion of outpatients business case and implimentation plan. Operational delivery team											Implementation of business case begins.					

Boroughwide services

Crisis Response:			Service available 24hours a day, 7 days a week.		Recruitment to 17/18 posts Phase 2 (24/7) - Optimised	Service available to the public	Phase 2 & 3 - Optmised	Long term service defined and in place										
Active Recovery:	SAFER piloted on Intermediate Tier community beds (Marbury and Berrycroft)			Increased operational capacity in place.	Recruitment to 17/18 posts	SAFER rolled out to all Intermediate Tier community beds. Phase 2 - Optimised												
Bed Reconfiguration:					Interim bed provision in place (126 beds)							Interim bed provision in place (116 beds)				Furture bed provision in place (98 beds)		
Integrated Transfer Team:			Complete rollout to all wards.															
Transfer to Assess:			Transfer to assess pathway 1 introduced to all medical wards.	Pathways 2 and 3 piloted.		Pathways 2 and 3 introduced to all medical wards. Optimise T2A pathway 1		Optimise Transfer To Assess pathways 2 & 3										
Trusted Assessor Development:			Implement Phase 1 - T2A	Implement Phase 2 - Active Recovery	Implement Phase 3 - Crisis Response	Implement Phase 4 - Care Homes						Implement Phase 5 - N'hoods						