INTERMEDIATE TIER OUTLINE BUSINESS CASE EXECUTIVE SUMMARY

Abstract

This business case describes the proposal for the intermediate tier of services, which will be delivered in Stockport from 2017/18 to 2020/21.

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

Executive Summary

Stockport Together

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

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

Business Case Overview

This paper sets out the case for a revised Intermediate Tier of services that collectively support people to recover from ill health and prevent unnecessary admission to hospital or long-term residential care.

The document describes in detail the design of the new model. It sets out investment requirements and a detailed implementation plan, explaining when changes will be made and benefits realised. Finally, this business identifies anticipated risks to delivery of transformation and the mitigations in place to maximise benefits.

The Case for Change

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Intermediate Tier of services is defined as those services that: promote faster recovery from illness; prevent unnecessary acute hospital admission and premature admission to long-term residential care; support timely discharge from hospital; and maximise independent living. In Stockport there are over 20 such services which have developed in isolation over the past ten years. While each service has significant strengths, collectively the Intermediate Tier is fragmented and difficult to navigate.

The current range of services has been designed to manage the effects of the system, rather than tackling its causes. The majority of staff and financial resources are spent on facilitating a hospital discharge - or 'step-down' from secondary care. Much less capacity is used for 'step-up' activity – intensive support to prevent unnecessary hospital admissions. This means that there is not a strong alternative offer to respond to people in crisis and prevent hospital admissions, placing additional demand on the hospital and the Emergency Department in particular. And many patients receive intermediate care interventions in a hospital bed due to the lack of capacity in the community.

Most of the budget is spent on delivering care in community facilities and not an individual's home, reducing independence. As a result, people spend longer in intermediate tier beds than patients in other parts of the country. A point prevalence study of Intermediate Care beds in 2015 found that 33% of patients did not need an intermediate tier bed at that moment in time – resulting in 1,257 excess bed days. The knock on effect can be seen in the simultaneous review of 6 hospital wards, which found that 44.53% of people no longer required a hospital bed, but could not be discharged due to a lack of capacity in community services. The longer patients spend in a bed, the harder it can be for them return home and live independently.

Table 1: Point Prevalence Study of Patients in Intermediate Tier Beds

Bed Based Service	No. of patients	No. who did not need an Intermediate Tier bed	Resulting Excess Bed Days
Blue Bell	24	3	1,126
Saffron Ward	18	9	76
Marbury	38	13	25
Berrycroft	14	6	30
Total	**94**	**31**	**1,257**

Fragmentation of the 20+ services means that many service users rely on multiple teams and referrers are unsure of the availability of services or the criteria for access. Patients report multiple assessments being duplicated by different services. In addition, the current range of services lacks enough mental health and dementia input to support the needs of service users. This situation will only intensify as Stockport's population continues to age. By 2020, the number of people aged over 65 will increase from 55,700 in 2014 to 61,000. Currently 51% of the total adult population of Stockport are known to have one or more long-term conditions. By the age of 85, 87% have at least one and 53% have two or more. And by 2030 dementia prevalence will rise by 50%.

The Proposed Model

We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets. Our vision for the intermediate tier is to create a responsive and person-centred service that supports people's active recovery and provides a strong bridge to transition both to and from hospital.

This business case describes a model of care delivered in a person's normal place of residence or as close to home as possible. It describes a continuum of 24 hour, home and bed based care that works closely with and links hospital and primary care services. Services will urgently wrap around a person to meet their physical, mental health and social care needs and prevent an unnecessary hospital admission. Services will also actively reach into hospital wards to facilitate early discharge and support people to recover at home. The integrated services will promote faster recovery from illness and maximise independence to avoid premature long-term care.

The model will target two population cohorts:

- STEP-UP: people in crisis at high risk of a hospital admission (14,079 individuals)
- STEP-DOWN: people in hospital who are medically optimised but require additional time and support to recover (14,079 individual plus a proportion of elective admissions).

The model is built around six core components:

1. ***Intermediate Tier Hub*** - there will be one single access point for assessment and triage 24 hours 7 days a week via one telephone number.

2. ***Crisis Response*** - multidisciplinary team able to respond to crisis response within an hour or to urgently arrange an alternative care offer in the community to avoid hospital admission; 24 hours a day, 7 day per week. Teams will include nurses, physiotherapists, occupational therapists, health & social care support workers, social workers and mental health practitioners. They will also have access to overnight support, pharmacists, and specialist medical input.

3. ***Bed reconfiguration and management*** - a community bed-based service that brings together health & social care professionals to offer a multi-disciplinary range of care to ensure all needs are met in a short period of time. This will be used to support intensive rehabilitation, sub-acute care, recovery and crisis care. It will combine physical and mental health provision and reduce spot-purchasing of beds by 50 by 2019.

4. ***Active Recovery at Home*** – a community, home based service that brings together health & social care professionals to meet all care needs in a short period of time. This team will support both step-up and step-down pathways. The functions provided by the team at a person's place of residence include: transfer to assess; rehabilitation; reablement; time to recover; and clinically enhanced care.

5. ***Transfer to Assess*** – Once immediate needs have been met, it is important that patients are discharged from hospital in an appropriate and timely manner. This service will ensure speedy transfer from hospital to home and deliver assessment for ongoing needs as close to home as possible.

Changes will be introduced in two stages:

- Phase 1 will create additional capacity and capability to respond to crisis and keep people at home
- Phase 2 will look at the reconfiguration of the community bed base and supporting systems to optimise flow in and out of hospital.

To deliver this model, the business case proposes a considerable increase in capacity to provide more care in a patient's home. Over time, this will allow us to reduce the number of community beds from 150 to 98 by April 2019. This would include the creation of a single facility of 40 intermediate tier beds to be used flexibly to deliver assessments, intensive rehabilitation, reablement and recovery services with nursing, mental health and therapy input.

Table 2: Staffing Levels

Pathway	Current Staffing WTE (%)	Future Staffing WTE (%)
Step down	125.23 (74%)	95.60 (38%)
Step up	45.02 (26%)	154.57 (62%)
Total	**170.25 (100%)**	**250.17 (100%)**

Significant improvements will be required in IM&T systems including ensuring 24/7 access, a more robust version of the Stockport Health & Social Care Record, the introduction of a bed management system and care home IM&T capability. There will also be a need for estates

changes to enhance the bringing together of the new teams. This and the required organisational development are described more fully in the ***Enabler Business Case***.

Benefits of the Model

Stockport Together's proposed service solution will integrate health and social care services, providing a comprehensive service that meets the increasingly complex care needs of our ageing population.

The Intermediate Tier will provide care as close to home as possible, with the aim to deliver most care in a person's normal place of residence. This will reduce the length of stay in intermediate care beds from the current average of 4 weeks to the national best practice standard of 2 weeks. Reducing length of stay in intermediate care beds and providing more care at home will significantly reduce the cost to health and social care services of spot-purchasing beds in care homes.

There will be a considerable increase in capacity, resulting in services working 24/7. The new model will address the balance of step-up - step-down services to meet local need and prevent unnecessary hospitalisation, taking pressure off the local hospital and cost out of the system.

These changes will contribute significantly to the high level benefits of the Stockport Together programme, though the exact contribution of the Intermediate Tier cannot be extrapolated:

- By increasing access to proactive care for people with complex needs, we will promote independence and reduce ED attendances by 30% per year from current levels
- 24/7 access to crisis response services will reduce emergency admissions by up to 30%
- Investment in out of hospital care will support a reduction in readmissions to hospital within 30 days of discharge and reduce the rate of Delayed Transfers of Care
- As support at home or in a community setting is increased, the average length of stay in hospital will be reduced by 50%
- As we reduce over-hospitalisation and length of stay in hospital, we will support people to remain independent, cutting admissions to care homes by 8%.

By 2020, the financial benefit of these changes is calculated to be around **£45m**. £19m of these savings will be then be re-invested each year in out of hospital services, delivering a net benefit to the system of £26.3m by 2020/21.

Investment Plan

In 2017/18 the Intermediate Tier will require additional transitionary funding of **£2.5m**, falling to £473,000 in 2018/19.

Table 3: Transformation Funding (including double running)

Planned Investments:	2016/17	2017/18	2018/19
Commissioning hub & health element of crisis response	£289,000	£543,300	
Workforce	£509,300	£1,254,700*	
Non-pay	£24,000	£68,200	
Hydration Service/IV Fluids		£170,000	
Additional step up beds (10 beds)	£238,900	£485,300	£473,500*
Total	**£1,061,200**	**£2,521,500**	**£473,500**

* Proportion funded from baseline budget and additional funding from Stockport Together

Going forward, the Intermediate Tier will require recurrent investment of around **£13m**. From 2019/20 onwards it is anticipated that workforce efficiencies of 5% a year will be generated.

Table 4: Cost Profile

	2016/17	2017/18	2018/19	2019/20	2020/21
Recurrent Funding:					
Workforce (recurrent)	£5,571,868	£6,071,502	£9,106,125	£9,109,653	£8,657,752
Workforce efficiency				-£455,483	-£432,888
Beds	£6,560,489	£6,060,855	£5,010,013	£5,010,013	£5,010,013
Total	**£12,132,357**	**£12,132,357**	**£14,116,138**	**£13,664,183**	**£13,234,878**
Transitional Funding:					
Workforce and beds	£1,838,534	£2,521,469	£473,492	£0	£0
Total	**£1,838,534**	**£2,521,469**	**£473,492**	**£0**	**£0**
Total Funding:	**£13,970,891**	**£14,653,826**	**£14,589,630**	**£13,664,183**	**£13,234,878**

Risk Management

The main risks and their mitigation plans are set out in the table below:

Table 5: Risks & Mitigations

Risk	Mitigation
Staff/resources required to make changes are not released to support implementation, impacting success of delivery.	Obtain commitment from executive team/partner organisations to release staff to support implementation.
Timescales associated with full public/staff consultations impact ability to implement significant changes before Winter period.	Identify and plan for asap and flag up any potential impact. Develop phased approach to implement early changes that are not reliant on consultation.
Lack of cohesion with other Stockport Together workstreams/models &/or wider GM transformation result in disjointed pathways.	PMO and close working across programme/workstreams with key stakeholders to ensure connections/dependencies/issues managed.
Failure of new model to prevent forecast level of acute admissions.	Ongoing monitoring/PDSA cycles, benefit reviews at regular intervals to be conducted by the Programme Office.
Not possible to increase capacity (double run) due to workforce shortages with the required level of skills, mean cannot prove concept &/or fully implement model.	Ongoing review/management of plans and close working workforce enabler to develop solutions.
Hospital bed capacity is reduced before the new model is able to demonstrate impact/deflect acute activity, negatively impacting quality/performance.	Ongoing monitoring/PDSA cycles. Engage hospital (FT) stakeholders to develop aligned plans.
Lack of co-location solution (physical location) reduces ability to work in an integrated way.	Ensure early involvement with planning implementation with estates enabler.
The proposed investment required is not made available and therefore unable to implement the model as intended.	Proposed model to be implemented in a phased manner, which would recognise only limited investment could be secured initially and this could be invested wisely if the service was

	managed in an integrated way with fewer teams and one provider taking the lead in its operational management.

Next Steps and Implementation

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

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

If agreed, the business case would be implemented over an approximate 12-15 month period.