BUSINESS CASE

ACADEMY OF LIVING WELL

Good housing and good health are at the heart of the Greater Manchester Strategy, 'Start Well, Live Well, Age Well'. As GM Mayor Andy Burnham states: "Housing is a health issue…and we must extend the right to good healthcare to safe housing."

By 2035, Stockport will be one of the best places to live in the UK.

It will be transformed into a Vibrant City where people can learn, play, work and look forward to a positive older age. Stockport will have a wide choice of places and ways to live, providing the right homes underpinned by the right support. This is an opportunity to tackle the health inequalities in the borough and to enable the population to own its own health and wellbeing.

The Academy of Living Well forms a central part of this strategy.

Contents

Business Case Details			
Business Case Title	Academy of Living Well		
Business Case Reference No.	LWH/ALW		
	Name	**Signature**	**Date**
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Confidential financial papers will be provided separately			

Case version control log			
Version no.	**Author**	**Amendment**	**Date**
1.0	Sara McKee	Draft Business Case	26th April 2019

1.1	Sara McKee	Revised Business Case	20th February 2020
1.2	Michelle Moseley	Revised Business Case with Service Delivery Proposal	3rd December 2020
1.3	Michelle Moseley	Academy Project Group revisions	9th December 2020
1.4	Shaun Skidmore	Financial sections provided by CBRE	14th December 2020
1.5	Paul Graham	Removal of financial information to form an appendix	5th January 2021

1. Executive Summary

The *Prospectus for Happy, Healthy Homes to Age Well in Stockport* sets out Stockport Council's vision for where housing, health and social care comes together to enable all Stockport residents to age well and flourish.

Core to this offer is the development of a new multi-storey facility to support transitional care needs closer to the community including, Step Up/Step Down, Discharge to Assess, Rehabilitation and respite care in the heart of Stockport town centre (*anticipated delivery within 24-months of business case approval*).

Our "Academy of Living Well" will enable us to deliver high quality services to Stockport residents who need support to prevent hospital admission, respite for family carers and intensive therapy to enable medically fit patients to leave hospital in a timely fashion and gain the confidence they need to successfully go home. It is in line with Stockport's philosophy of "Home 1st", prevention and self-care.

One of the Academy's core purposes is to provide a real life environment for training and ongoing development and specialisation of our community-led Health & Social Care workforce. Working with our local care providers and educators, we are developing a new curriculum to encourage entrants to embrace social care as a career, with clear pathways to specialism and leadership opportunities. We will be coordinating our efforts with Primary Care partners to jointly recruit candidates, develop blended roles and to ensure there are no barriers in future delivery of health and care across the system. The Academy will provide the real-time teaching environment so that apprentices and students can work with patients every day . A new Stockport Standard of Care is being devised so that the Academy of Living Well becomes the beacon of excellence in social care training.

The Golden Threads that run throughout the Prospectus:

Community: builds age-friendly communities that are fully connected, tackling social isolation

Design: uses inclusive design and HAPPI principles so housing meets and adapts to people's changing requirements over their 100 year lifetime

Integrated: links housing, health workforce and care together to support residents to live and age well

Smart: utilises technology to help provide a choice of great places to live that are affordable and connected, enabling independence

Innovative: tests new models of community based social care alongside technology to focus on "Home 1st", self-care and prevention

Choice: promotes range of housing type, tenures and locations to meet the needs of older people across all spectrums

Accessible: provides easy access to transport, services and the community

Capable: a strong and empowered workforce that provides dignified and safe care and support

The Academy for Living Well will provide locally-based, high impact services with a focus on helping primarily older people and people in need to:

- Access step-up services to prevent hospital admission
- Accelerate hospital discharge whilst providing a safe environment for recovery
- Recover and return home safely from hospital, reducing re-admissions
- Better manage long-term health conditions
- Access respite or short breaks
- Connect them with the wider community, addressing social isolation and loneliness

This multi-storey building will house forms of transitional care including intermediate care, respite care, step up/step down, link to place-based partnerships in the Neighbourhoods.

The visual below sets out what the building will look like.

Rooftop Garden accessible only to residents and staff:

Living Well Environment

Design will be a standout feature of The Academy. Each floor will be home-like, with small households of studio apartments or large en-suite rooms replacing institutional hospital wards. Patients will engage with and support each other and be active participants in their care and recovery. This design gives us ultimate flexibility in future use and fits with clinicians' desire to create spaces that are as close to patients' homes as possible.

The goal of the Academy transitional care service is to help people who are poorly from deteriorating further and therefore requiring acute or residential care. However, in the event that the older person is unable to return home, the co-location with the extra-care housing also means they will be exposed to alternative residential options which will potentially ease their transition from home.

Workforce Transformation

Yet the truly transformative aspect of The Academy is the new social care workforce model, which will be the first-of-its kind. Personal care and support for daily living and independence will be provided by teams of multi-skilled, self-managed and autonomous staff who will work in and own individual care cooperatives (Co-ops). These coops will operate as individual enterprises and will be supported by a central innovation hub. The goal is to build a sustainable social care workforce where care staff are paid better and have greater flexibility and autonomy to deliver care that responds to people's needs and desires rather than being time oriented and task focused.

The Co-ops will work with their NHS colleagues across Intermediate Care, ensuring a truly integrated staffing model that will break down silos and transform culture. Members of the Co-ops will also be trained as Trusted Assessors, working with their NHS colleagues to reduce the numbers and waiting times of people awaiting discharge from hospital and help them to move from hospital back home or to another setting speedily, effectively and safely.

2. Conflicts of Interest

2.1 What actual or potential conflicts of interest have been identified and managed in line with statutory guidance?

The key stakeholders involved in this innovation project are:

- SMBC Adult Social Care – acting as commissioning lead for this project to deliver on the case for change and oversee the commissioning cycle
- MDC – overseeing the development of the full site from a regeneration and heritage perspective and ensuring delivery of The Academy is within the set timescales alongside all other planned residential development.
- Stockport Homes – acting as delivery partners on the wider housing site to create an intergenerational community
- CCG –the strategic commissioning partner for transitional care
- Viaduct Care – potential ground floor tenant and community health partner
- NHS Stepping Hill – signatory to the Service Level Agreement around patient flow

Currently there are no known conflicts of interest; there are clear roles and responsibilities of the above stakeholders. Governance will feature highly in all proposals and is addressed later this in business case.

3. Strategic Case

3.1 Describe what is being proposed in this business case and the rationale (the proposal / case for change / problem to be addressed, scope, population / cohort / solution / evidence base(s)).

The proposal

As part of the redevelopment of the old St Thomas's Hospital site, it is proposed to include The Academy of Living Well as a centre of excellence for both transitional care delivery and the development of a new workforce. The Academy offers an enormous opportunity to completely redesign our approach to Transitional Care, improving access to quality health and social care for people, in particular older people, and the flow through the system.

The Academy will be a purpose-built Health and Wellbeing multi-storey building that brings a number of services under one roof, potentially to include:

- Technology Lab and smart home, plus commercial space for primary care or allied health professionals. Transitional Community Care small households for step-up & step-down services
- It will feature small households of 12+ studio apartments/large ensuite rooms
- Dementia household for short-breaks - aimed at people in emergency situations. The citizens can stay in the dementia household for shorter periods or longer, while alternative options are being considered.
- Rooftop sensory garden (potentially) although shared external space with the Extra Care scheme adjoining will be a key feature
- Within the site a further option is to explore some low numbers of 'student accommodation' on the

basis that students (medical, health and social care ideally) can live there at a much lower, subsidised cost with a payback facility that they must 'volunteer' so many hours within The Academy.

The Technology Lab is an opportunity to provide older people with access to assistive technology and equipment, including an innovative 'smart house' to showcase the latest developments and so people can see the technology in use. This can be funded within the parameters of the Disabled Facilities Grant.

Given the policy focus on helping people to remain living independently at home for longer, it's important we provide signposting, information and advice, as well as bookable spaces for allied health professionals. It also means people who are staying on the Transitional Care floors will easily be able to source the equipment they'll potentially need when they move back home. The space also has significant 'commercial' potential e.g. Shop, Café, Gym, Hydrotherapy, Library etc. and all of this will be age, disability and dementia friendly. The revenue from the commercial lease will help subsidise the rent for voluntary partners who can provide invaluable support like befriending services.

The Transitional Care, dementia/respite floors will follow the small household approach, is based on the proven Evermore and Green House Project small home model. It involves studio apartments/ensuite rooms configured around a central communal living area where residents share their lives and support and motivate each other.

The small household design, consistent with HAPPI principles, purposefully replicates a family home rather than a hospital ward. This provides a familiar environment in which to recuperate and rehabilitation can imitate not simulate life at home. The small household model puts a focus on customers being an active participant in their recovery rather than a passive recipient of care - they get to choose the rhythm of their day and there is purposeful activity to help them get better, quicker. The configuration of the household also ensures they are part of a small community, and they can support each other's recovery and build friendships. This model ensures people are fit, ready and able to move home and a similar approach in the US has seen a reduction in hospital re-admissions by up to 40%

The Transitional Care and dementia/respite care floors will consist of a small household of 12 studio apartments/ensuite rooms that will be fitted with assistive technology. The Transitional Care apartments will include a technology kit that patients will be table to take home with them, which gives both staff and patients the opportunity to get used to the technology. Consideration will be given to some 'guest spaces' like in Extra Care where family members can book an overnight stay to be near to relatives if/when the need arises.

The studio apartments offer ultimate flexibility in terms of potential occupants and future use.

However, the truly unique aspect of this building is the inter-relationship between it and the Extra Care housing. It offers us the opportunity to:

a) design a totally new way of working, with a social care cooperative (Co-op) of multi-skilled staff who will provide support to customers within The Academy as well as the Extra Care housing; and

b) ensure a truly integrated staffing model where NHS and social care staff work in teams within each household, embedding an integrated culture while gaining efficiencies by having nurses and therapy teams working across households and not just in one place.

The workforce will consist of a Registered Manager and approximately 50 FTE Champions of Care. The team structure will also be supported by Apprentices and Volunteers. The workforce will provide 24/7 care and support. They will be self-managed and autonomous, supported by a central innovation hub that provides training and development, as well as back office administration.

Service Delivery Model

The aspirations for the service delivery model have been designed to accomplish a Beacon of Excellence for intermediate, respite and dementia care within Stockport and set around the principles of Design, Care, Workforce, Culture, Education and Community.

The Service Delivery Model is set out in its entirety in ***Appendix A*** and will form the basis of criteria and performance standards of a Management Agreement.

Case for change

The need for a radically different approach and case for change is clear:

Social care

- Failing on our Personalisation agenda to give people choice and control
- No 'visible' entry route for adult social care information & advice, signposting etc. which is a key requirement of the Care Act
- Missed opportunities to help adults and carers to self-care and self-serve across the system
- Continue to work in 'silo' service delivery across health and social care
- Need a range of care 'continua' to support timely discharge from hospital
- Need high quality, fit for purpose 'step up' to deflect from hospital pathway
- Fragility of residential/nursing care provision – need "Provider of last resort"
- Dementia presentations significantly increasing with increasing complexity
- Suitable Short Break provision for carers to take a well-earned rest and recover from their caring role
- End of life care within the residential and nursing sector needs to be reviewed

Intermediate Care

- Current provision is highly medicalised, and institutional simulating a ward environment
- Void between Intermediate Care setting and the patient's home environment
- Need to optimise sharing of skills and tasks between health and social care – blended roles
- Currently high numbers of repeat admissions with poor flow through the system
- Fragmentation between current health facility and step down into reablement and/or extra care
- Intermediate Care is often disjointed and addressed at point of crisis/DToC; the Academy delivers options for consolidation, economies of scale and improved patient and staff outcomes

The Academy of Living Well will improve flow and capacity but it's not just about releasing beds, it's about providing the best environment for rehabilitation and recovery, which includes people having access to great food and great company. It's about meeting wellbeing needs as much as it is about meeting health needs. Buying more beds in institutionalised settings is unlikely to deliver the same results. Instead, this will create a step change to better and more effective alternatives.

The Academy also represents the joining up of housing, health and social care with the co-location of Stockport Homes proposed extra-care housing.

The NHS is under incredible strain with Ian Dalton, Head of NHS Improvement predicting we will need 80 new hospitals in 10 years' time if we do nothing to manage demand (Source: Daily Telegraph / NHS Confederation Annual Confederation). While Theresa May announced in June 2018 that the NHS budget will be increased by 3.4% after almost 10 years of austerity, the health system will still be expected to deliver productivity improvements.

Social care is in an equally precarious position. It has always been the poorer cousin to the NHS, but now budget cuts and chronic under-funding are severely impacting access to services. Nationally, the number of people receiving council-funded home care has reduced by nearly a third since 2000. (LaingBuisson) And research by Which? found nine in 10 council areas across England could face a shortfall in care home places by 2022.

Moving forward, the ADASS is predicting further reductions in the numbers of people receiving council-funded social care. In 2018 75% of directors surveyed by ADASS said reducing the number of people in receipt of care is important or very important for them to achieve necessary savings. (Source: Association of Directors of Adult Social Services, 2018 Budget Survey)

Within Greater Manchester, the £6 billion spent currently on health and social care has not improved health outcomes. "The challenge is significant; if we don't start to act now to radically change the way we do things, by 2021 more people will be suffering from poor health and we will be facing a £2 billion shortfall in funding for health and social care services." Greater Manchester Health and Social Care Partnership

Social care market challenges

"It appears to be increasingly difficult for some providers to deliver the safe, high quality and compassionate care people deserve and have every right to expect. With demand for social care expected to rise over the next two decades, this is more worrying than ever." (Source: State of Adult Social Care Services)

The state of adult social care services is well known. There are issues with care quality and provider fragility which has a knock-on effect in terms of system capacity and patient flow. The long-awaited social care green paper has been postponed again, yet politicians of all persuasions acknowledge the current system is unsustainable.

Across the country, almost one third of councils (48) have seen home care providers closing or ceasing to trade in the last six months. While 58 councils reported closures of residential or nursing care providers in the last six months. As a result, 78% of directors are concerned about their ability to meet the statutory duty to ensure market sustainability within existing budgets. (Source: Association of Directors of Adult Social Services, 2018 Budget Survey) Locally, seven Stockport care homes have closed in the last two years (Source: Care Home Professional) while over half of Stockport's residential care homes are rated as requiring improvement or inadequate, and 35% of Stockport nursing homes are rated as inadequate or needing improvement. (Source: Stockport System Review 2018, CQC)

The impact of this capacity issue was highlighted in the 2018 CQC system review of Stockport by the CQC in 2018, which found that "if an older person living in Stockport went into crisis and required an emergency hospital admission, they might suffer long waits in A&E and were more likely to remain in hospital longer than required. This was often due to a shortage of homecare packages or the availability of high-quality residential care."

The NHS context in Stockport

There is high national and local media portrayal of a failing NHS, particularly around hospital A & E presentations, trolley waits and patient discharge. It is recognised that the reasons are multifaceted, not

helped by austerity and increased demand, whilst adult social care has largely significantly reduced work around prevention and early intervention addressing the needs of older people below the eligibility threshold. It is therefore recognised that this has resulted in more older people 'in crisis' with a default pathway to A & E. Following admission, there are increased pressures on Delayed Transfers of Care with significant social and welfare issues to address that potentially were a factor in the build-up to admission (e.g. hoarding, falls, unsafe housing etc.).

The population (JNSA information is currently being updated in Stockport)

- One in five (55,700) Stockport residents are aged over 65 and this is expected to grow by nearly 10 percent (to 61,000) by 2020. (source: MICRA)
- Growth of people 75 and over is higher than other Greater Manchester boroughs (source: MICRA)
- By age 65, 58% of the population have one long term health condition, 20% have two or more. By age 85 the proportion rises to 87% for one and 53% for two or more long term conditions. (Source: Stockport JNSA)
- 33% of older people in Stockport live on their own leading to the danger of social isolation and vulnerability. (Source: Stockport JNSA)
- In the most deprived areas the decline in health starts at age 55. (Source: Stockport JNSA)
- 2,850 people in Stockport have a dementia diagnosis - rates are higher than the national average, and rates of dementia in the most deprived areas are more than double those in the least deprived areas (Source: Stockport Dementia Strategy)
- There are now over 2,200 emergency admissions for dementia a year - emergency admissions to hospital for dementia as a primary diagnosis have more than doubled in the last eight years. (Source: Stockport Dementia Strategy)
- As deprivation increases, so does the emergency admission rate - the rate in the most deprived areas is almost double the Stockport average. (Source: Stockport Dementia Strategy

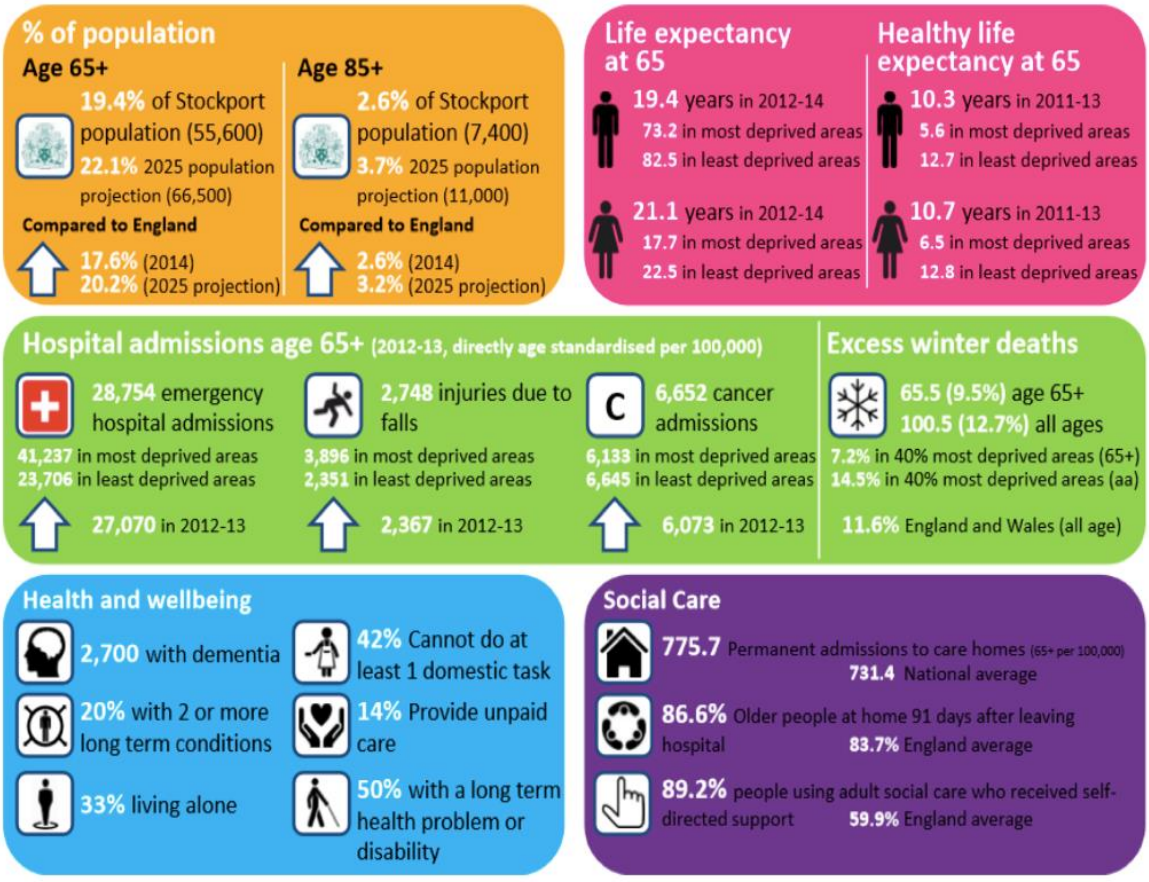
Solution

A key priority of the Prospectus is to radically improve health and care outcomes, through public services coming together in new ways to transform and integrate services. This involves putting people at the heart of these joined-up services, a greater focus on preventing illness, helping older people to stay independent for longer, and recognising the importance of work as a health outcome and health as a work outcome.

The Academy for Living Well provides an opportunity to provide integrated health and social care to cater for an older population whose health and needs are not being met. It will help avoid hospital admission and readmission, improve capacity and flow resulting in a reduction in length of stay, and provide vital services which are currently lacking from dementia care to a dignified death.

Flow is a key factor to current system issues; transition remains fragmented both within health from the hospital, through Intermediate Care and out to community, and also between the two elements of health and care. Patients find themselves 'stuck' in a system where processes are not intuitive and each element is working to a different set of measures and timeframes.

The Academy allows the system to manage flow in a completely new and innovative approach. The citizen is either stepped up from their home or down from an acute hospital bed at the appropriate time for their recovery and needs, utilising a model of trusted assessment between all disciplines. Once in the facility they can move between the rehabilitative settings to a more long- term, suitable home: Home 1st.



In the current model, health and care remain separate entities; the model for rehab at home following in-patient stay is one pathway and extra care and reablement is another. At The Academy the options beyond Transitional Care are integrated, utilising both extra care and home based rehab to meet the complete needs of the patient. We often find in our Transitional Care units patients respond positively to the environment of sharing meal times, rehabilitation

approaches and conversations and often struggle with the transition back to the isolation of home. For citizens that have transferred out to extra care as a transitional move often request to stay in that facility rather than going home due to the points mentioned above. The added benefits mentioned through the small household approach will only enhance this experience.

What's more, it provides an opportunity to deliver integrated working and reconfigure the social care workforce into a Co-op model so It becomes an attractive career path, supporting a more sustainable and stable market. Members of the social care Co-op can be trained as Trusted Assessors to undertake social care assessments in order to reduce waiting times and improve the citizen's experience.

It is a neighbourhood focused proposition that focusses on local people providing the services needed by local people. It will contribute to a key Prospectus 2035 outcome which is improving the number of people supported to stay well and live independently wherever possible.

Evidence base

The small household model is a recognised approach to improving the health and wellbeing of older people built on more than a decade of experience. It was pioneered by The Green House Project and has delivered significant improvements, including:

1. Residents are happier and healthier
- Green House elders report improvement in seven domains of quality of life (privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment and individuality) and emotional well-being.

2. It costs less
- Green House costs $USD1300-2300 less per resident when compared to traditional nursing homes SW
3. More direct care time
- 23–31 minutes more direct care time per elder per day in a Green House environment
- Staff are 4 x more engaged with residents outside of direct care

4. Greater satisfaction from families
- Family members are engaged overall in the residents' care and are willing to travel further to secure a place for their loved ones.

5. Improved staff retention
- Direct caregivers in a Green House setting had lower staff turnover than care workers at traditional nursing homes

6. Citizens don't go to hospital
- Traditional nursing homes had readmission rates that were 7 points higher than Green House homes (Thrive research)

Summary here - http://jewishhome.org/innovation/the-living-center-greenhouse/research-shows-life-flourishes-in-a-green-house/

While this blog provides an insight into the difference of rehabilitation in a small household from the patient's perspective -
http://blog.thegreenhouseproject.org/?s=rehabilitation

3.2 Identify key relevant national and GM priorities supported by this proposal

NATIONAL PRIORITIES

"We have an obligation to help our older citizens lead independent, fulfilled lives, continuing to contribute to society." *Industrial Strategy, the Grand Challenges*

A directive from the Prime Minister

Creating a society where people can live and age well is a national priority. This is highlighted by the Industrial Strategy's 'Healthy Ageing Grand Challenge' with the Prime Minister setting a mission of at least 5 extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest. Success in this mission will help people remain independent for longer, continue to participate through work and within their communities, and stay connected to others to counter the epidemic of loneliness.

In response to the Prime Minister's announcements last year, Dr Anna Dixon from the Centre for Ageing Better said the NHS must take a more strategic and forward-thinking approach to healthy ageing if we are to meet the ambition of increasing people's healthy life expectancy by five years. "This means a focus on prevention and maintaining independence – not seeing people as a collection of diseases or viewing old age as an inevitable time of frailty and decline."

The NHS Long Term Plan

There is an increased expectation that the NHS will work harder to prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital to community. The NHS Long Term Plan, published in January 2019, identifies a new NHS offer of urgent community response and recovery support which aims to free up more than one million hospital beds. Stated objectives include:

- Over the next five years all parts of the country will be asked to increase the capacity and responsiveness of community and intermediate care services.
    - Community health crisis responses services will need to deliver services within two hours of referral.
    - Reablement care will need to be delivered within two days of referral.

Reducing Delayed Transfer of Care (DTOC) also continues to be a focus. The goal over the next two years is to achieve and maintain an average Delayed Transfer of Care (DTOC) figure of 4,000 or fewer delays, and over the next five years to reduce them further.

The Long Term Plan also states that carers will benefit from greater recognition and support, recognising that older people make up a large number of unpaid carers.

Healthwatch's 2019 list of priorities based on public feedback identifies social care as a priority. Adult social care, particularly support for the elderly and their carers, has come a close second with over half (51%) of local Healthwatch planning to do work on this issue in the next 12 months. Issues that people have already raised with local Healthwatch include concerns about high staff turnover and a lack of training leading to poor care.

People have also told Healthwatch they are not being given the support they need to help them recover properly when they leave hospital.

The Care Act

The Care Act requires local authorities to help develop a market that delivers a wide range of sustainable high-quality care and support services, that will be available to their communities.

Under the Care Act, local authorities have new functions. This is to make sure that people who live in their areas:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- can get the information and advice they need to make good decisions about care and support
- have a range of provision of high quality, appropriate services to choose from

The Academy of Living Well responds directly to these national priorities and issues, providing integrated services close to older people's homes that will help them to avoid hospital and live independently through the provision of intense care in support in a homely environment. The cooperative model fosters efficiencies, sustainability and cohesiveness between health and social care. It also helps the Council meet its responsibilities under The Care Act.

GM Policies

"Until we understand that social care does not exist just to take pressure off the NHS, but rather to enable people with needs to be the most that they can be, we will never get the relationship between the two right."
Jon Rouse CBE, Chief Officer of the Greater Manchester Health and Social Care Partnership

The Academy of Living Well directly links to GM Health & Care Partnership Board priorities including:

Taking Charge of our Health and Social Care in Greater Manchester

Population health outcomes, 'Age Well':

Outcome: More people will be supported to stay well and live at home for as long as possible.

Measure: Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

The Greater Manchester Strategy – Our People, Our Place (GMCA Led)

Priorities

- Good jobs, with opportunities for people to progress and develop
    - The Social Care Coop will contribute to a stronger economy, helping more people get into better-paid jobs, support progression and skills development in work.
- Safe, decent and affordable housing
    - We're adding to the regeneration of Moss Side, bringing together housing, health, education and skills, commercial development, leisure, and public services to create neighbourhoods of choice.
- Safer and stronger communities
    - Enabling communities to support themselves and co-design the public services they need, to increase inclusiveness and community cohesion, and reduce loneliness and isolation.
- An age-friendly Greater Manchester

- Helping more people to stay well and live at home for as long as possible, we're improving health services, tackling loneliness and social isolation and strengthening community connections.

Other relevant Greater Manchester strategies and programmes include:

- Dementia United
- Greater Manchester Spatial Framework
- Greater Manchester Health and Social Care Workforce Programme

Dementia United, the dementia strategy for Greater Manchester, sets out a plan to make Greater Manchester (GM) the best place to live with dementia. The three of the domains identified by Dementia United which are essential to improving post diagnosis support:

- Living Well – establishing dementia-friendly communities, networks and support AND ensuring EVERY person has access to tailored post diagnostic advice/ support
- Supporting Well – regular access to the health and social care system as required which reduces the number and duration of emergency admissions, re-admissions and care home placements. Ensuring care continuity, irrespective of the location of the individual
- Dying Well – Focusing on understanding where people with dementia are dying and continuously striving to ensure that place of death is aligned with the person and family preference

The Greater Manchester Spatial Framework has recently been redrafted following concerns raised during the period of consultation on the first draft of the Framework (published October 2016). The redrafted Spatial Framework aims to make the most of Greater Manchester's brownfield sites and to reduce the impact on greenbelt. The first draft of the Framework emphasised the importance of improving Greater Manchester's health care due to the substantial health inequalities experienced across the sub-region. **Policy GM22 states that it is a priority to provide health facilities in conjunction with new developments and to support the successful operation of Greater Manchester's hospitals.**

Greater Manchester Health and Social Care Partnership workforce programme has identified four strategic priorities including investing in talent development, growing the workforce, creating a vibrant employment brand, and tackling long term skill shortages and capacities. Through the social care cooperative model, the council can create a strong proposition for prospective employees as well as improving long term sustainability.

4. Economic Case / Options appraisal

4.1 Identify the key implementation options (i.e. how the proposal can be delivered) and evaluate how well each of these support achievements of the key success criteria / outcomes outlined in Section 3.

Option:	**Outline:**
Option 1: Do nothing	Doing nothing will not improve flow or health and wellbeing outcomes for residents in Stockport, nor address the budget shortfall
Option 2: temporary changes to existing stock	Refurbish existing estate to increase intermediate care, dementia and palliative care capacity – buy more of the same. It's been proven that older people can deteriorate physically and/or mentally due to a hospital stay, experiencing muscle deterioration, confusion, agitation and worse. This approach does not facilitate integrated working and continues siloed working which produces delays in flow.

	A more homely setting with a focus on rehabilitation, independence and companionship would more effectively address this and improve the likelihood of older people returning successfully to their normal place of residence
Option 3: deliver innovative ways to utilise public funding to deliver a step change in health and social care	Design a purpose-built building that provides a homely environment more conducive to recovery, nourishing physical, mental and emotional wellbeing, while offering respite/short breaks for people living with dementia and increasing choices for people who want a dignified death. Integrating health and social care teams to deliver a more efficient and effective service closer to people's homes, while improving the sustainability of the social care market through an innovative workforce model

4.2 Identify the preferred option / rationale.

The preferred option is option 3 - develop The Academy of Living Well as the first transformative and innovative health and wellbeing hub in GM.

This is our opportunity to pioneer ground-breaking integrated health and social care model in Greater Manchester, showcasing an innovative approach to transitional Care, as well as meeting the growing demand for dementia care in non-institutional, supportive settings. The approach provides better quality care and support, improves flow and outcomes, responds to community needs, and leads the way in creating a sustainable social care workforce that will create jobs and opportunities.

4.3 Summarise the expected measurable improvements (benefits) or consequences (e.g. dis-benefits) relating to the preferred option and the time period over which these will be realised. (This will inform future quality/ performance monitoring and evaluation if approved.)

The Academy of Living Well will provide considerable improvements:

- **Create significant social value** – the combination of local jobs created through construction and the operation of The Academy will deliver significant social value. This is further strengthened through the involvement of the voluntary sector in the delivery of the Technology Lab.
- **Increase capacity** – we will provide additional Transitional Care dwellings for 30+ people
- **Greater efficiencies –** integrated health and social care teams will work across The Academy, the extra care housing and the local community. There will be less wastage from duplication and inefficiency of operation.
- **Reduce hospital admissions** – traditional nursing homes had readmission rates that were **7** points higher than Green House homes, on which the Evermore small household is modelled.
- **Enable swift discharge from hospital, reducing length of stay** – integrated teams will help make the discharge process more efficient, plus patients who are admitted to hospital can be collected as soon as they are medically fit and convalesce in The Academy of Living Well apartment and small household.
- **Dramatically improve social care market sustainability and integration** with health services
    - Social care workers will be part of a social care cooperative, giving them greater ownership, autonomy and pay
    - The mix of care Co-op and NHS staff will deliver true integration of health and social care, plus economies of scale through the same staff operating across The Academy, the extra care housing and the local community

- The additional feature of there being a new Extra Care scheme being proposed and approved for the overall site means that there is a creative opportunity to do something different with the extra care procurement of care staff.

- **Avoid residential care**
  - The step-up and step-down services will help older people avoid residential care, plus the co-location with extra care housing will expose them to alternative accommodation and demonstrate it's a great place to live
- **Improve overall health & wellbeing**
  - The Academy of Living Well provides a care continuum - people can benefit from different floors or move into extra care. It will help people age in a dignified way with the appropriate support
  - The small household model focuses on companionship and active participation in life in the household, it encourages people to drive their recovery and work together with other patients in their rehabilitation
  - Dementia respite provides a much needed short-break for both the person living with dementia and carers
- **Meeting adult social care's statutory duties under the Care Act**
  - The provision of adequate and timely advice, information and signposting is an integral part of the Care Act duties. The Independent Living Centre, run by a procured VCSE partner, will be able to develop a universal access service that provides high quality information and support and beyond. For example, citizens may call the telephone helpline (Front Door) and be advised that they can collect small items of independent living equipment straightaway from The Academy of Living Well. Similarly, residents can call into the building and receive confidential 1-2-1 advice, taking away a range of leaflets and service information to help them decide what to do about health and care concerns
- **Ability to flex with the Household Model**
  - We've adopted the household model because it delivers an environment that is flexible and can accommodate a variety of need from hospital step down, long term complex conditions, through to residential care and dementia. It is future-proof and a safe environment.The key

These benefits can be appropriately summarised below:

Benefits	Reductions
↑ Social Value	↓ Hospital admissions
↑ Capacity in the health and care system	↓ Hospital length of stay
↑ Making best use of existing budgets and spend	↓ Need for residential care
↑ Market stability	↓ Carer breakdown
↑ Innovation across the health and care economy	↓ Information/knowledge to self-care and self-serve
↑ Health and Wellbeing	↓ Silo working
↑ Information, advice and signposting (Care Act)	

Further metrics will be developed in Phase 2 via a performance workshop

5. Commercial Case – feasibility

5.1 Outline the key market and / or supplier considerations, including likely contestability, reliability, ability and capability to deliver requirements?

We aim to identify an operator that can work with us to develop the workforce of the future and provide the service as outlined in our Service Delivery Proposal. Soft market testing is planned for the Spring 2021.

5.2 How will we secure a value for money service / contract for this service (e.g. single tender action, tendering / procurement route) and how does this adhere to procurement guidance and / or standing financial instructions (reference advice required / received)? **Document advice received from procurement / contracting / finance teams.**

Building of the Academy:
Wilkinson Cowan Patnership (WCP) have been jointly appointed by SMBC and Stockport Homes Group (SHG) to advise on the procurement of a main contractor for the St Thomas's development and comment on how the proposed route will provide value for money. A procurement report has ben provided and a two stage tender procurement route recommended.

Service Delivery at the Academy:

Having greater influence and control over the local intermediate tier and care home market, would provide greater sustainability of the local joint commissioning arrangements in particular managing annual fee rate uplifts with individual care homes.

Current concerns around utilisation of block contracting would be better managed through system ownership of flow and occupancy management of the home.

To maximise value for money, due consideration will be given to the optimum mix of bed provision.

We will work within the Council to establish benchmark costs and dependant on affordability options will be explored that give due regard to value for money and could range from a partnership approach where the Council and others would manage and operate the Academy, conversely options could be explored that would allow for contracting of this to a third party.

6. Financial Case

6.1 Identify the full cost of the development, one-off costs (e.g. implementation programme costs, legal, consultancy evaluation etc), recurrent costs and phasing

We have undertaken an initial Financial Operating Model for The Academy on the assumption that it will be operated by an experienced third party operator under a management agreement incorporating our service delivery model.

A full confidential financial analysis is provided within a separate appendix.

7. Management Case

7.1 Timescales, key milestones, phases, dependencies, project resources

The timeline for the building of The Academy of Living Well is as follows:

Stage	Key Milestone	Date
Consultation with professionals, partners and residents	Clear brief and consensus obtained to inform the final design	February 2020
Design	Final Design	August 2020
Planning	Application Submission	September 2020
	Decision	February 2021
	Discharge of pre-commencement conditions	May 2021
Construction	Start on site	July 2021
	Build Completion	Summer 2023

Leading up to the build's completion, there are a number of critical stages including:

- Refinement of the Service Delivery Model
- Trial of the household model of care in local neighbourhood
- Workforce recruitment
- Design of interiors
- Design of Bistro
- Co-production of services with local community
- Selection of complimentary tenants for the ground floor
- Design of the Technology Lab and Tender for voluntary sector partner to run
- Facilities management

7.2 Key risks (e.g. clinical, political, environmental, social, technological, financial, organisational – their impact, mitigation and risk owner) – ensure key risks are captured within the risk management system, as necessary.

There are a number of risks identified in the table below in relation to finance, workforce development and clinical practice. This is not an exhaustive list, is seen as the key areas for consideration, with proposals on how to mitigate each issue.

Risk description and impact if not mitigated	Indicative risk rating (H / M / L)	Mitigating actions	Risk owner
Financial			
Securing funding	M	*The business case sets out the capital borrowing sensitivity analysis and grant funding currently available to support all aspects of the build and kit out costs.*	

Delays to construction programme – the wider development site is complex with numerous project dependencies	M	Project implementation group to continue to meet on a regular basis to manage financial and operational risks arounds delays. A level of contingency has been factored in to the overall build cost	
There is insufficient budget to deliver the vision for the scheme	H	Scrutiny of ongoing build cost through collaboration with the chosen developer will be in place and is essential to the cost management of the development. There will be ongoing consideration to maximise the investment into the development of the facility and realise efficiencies without reducing quality where appropriate.	
Mix of residents and demand for provision		Health and Social Care Commissioners will work closely with the chosen operator with regards to utilisation and mix of residents to ensure the Academy remains financially sustainable. Ongoing demand modelling is required to ensure the facility retains flexibility within the household model to adapt to the changing demands for step up provision from community and step-down provision from hospital	
Organisational			
Provider fully adopting the service delivery model.	M	A robust Management Agreement will outline the specification.	
Recruitment of Academy staff could be delayed.	M	A high profile communications plan highlighting the career opportunity.	

7.2 Applicable governance, including any consultation to date / planned.

Accordingly, the first 'stab' at a governance model looks like this:

1. ASC & CCG – will ensure there is sufficient commissioning oversight of this project and is supported strategically. Where it is emerging that there are concerns, these will be escalated to the Project Steering Group.
2. SMBC – will ensure that there is sufficient commissioner oversight of this project from both the introduction of new delivery models and also the redesign of intermediate care
3. Project Steering Group – will have memberships from MDC, ASC, Strategic Development, Stockport Homes, Finance, CCG, CBRE, PRP

4. Project Sub Group – memberships will flex around the different specialisms and report into the Project Steering Group where decisions need to be ratified and signed off.
5. CLT – will receive regular briefings on the progress of the Programme.
6. Lead Members/Portfolio Holders briefings.

8. Other supporting information or references

8.1 Please reference any other supporting information for this proposal (e.g. appendices, service specification, case material from proven pilots in other areas, patient stories).

Site Plans

Service Delivery Proposal

Stakeholder Engagement Plan

St Thomas' Pre Planning Consultation

St Thomas' Gardens Prospectus

The Prospectus for All Age Living