Business Case Introduction

Describing the

New Integrated Service Solution

Foreword

Our collective vision is ***a sustainable*** health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care. To achieve this we are delivering ***new forms of care*** to specific cohorts of our population through a ***new form of organisation*** constructed from the GP registered list at neighbourhood level and incentivised by a ***new form of commissioning***. Our model of care will ultimately serve the whole population.

The business cases introduced here will specifically focus on the ***GP registered adult population*** (243,000 people) and the ***new forms of care*** proposed to deliver sustainability and improved outcomes. We refer to these new forms of care collectively as the **Integrated Service Solution.**

Our planned improvements to services described in this overview will reduce non-elective and A&E activity by 30% per year from current levels and they will also reduce length of stay by 50%. Over hospitalisation and length of stay are shown to reduce the independence of older people and thus we are also expecting these proposals to reduce admissions to care homes by 8%. Furthermore, by supporting the most vulnerable in the community and introducing new approaches to the GP / Consultant relationship we expect to reduce traditional outpatient appointments by 50%.

The financial benefit of these changes is calculated to be £38m by 2020.

As well as reducing time spent in a hospital bed or waiting for an outpatient appointment we expect the following improvements in outcomes and service quality for people living in Stockport.

- A reduction in premature mortality from causes preventable by healthcare and healthy life expectancy increasing fastest in the most deprived areas of Stockport
- Reduction in the number of people reporting social isolation
- Increase in the number of people feeling supported to manage their condition
- Reduced proportion of working adults with long-term sickness
- Increased number of people / carers who would recommend the service
- An increased proportion of people at end of life die in their preferred place of choice
- Meeting the national A&E waiting time and other NHS constitutional standards

Our vision has been developed in line with national and Greater Manchester policy. We will deliver these services through a Multi-Specialty Community (MCP) provider developed from general practice as set out in the NHS 5 year forward view. We will develop this in the context of much greater integration of health & social care in commissioning and provision. Our focus is on prevention at scale, a transformation of out-of-hospital care and a richer engagement of our population at both an individual and community level.

To deliver our vision our proposals describe improvements in how we support the most vulnerable in our community and their carers to live more independently through changes in neighbourhood working, the intermediate tier of services, and urgent care hospital front-end. It also describes how we are looking to further enhance the general practice offer whilst relieving the pressure on that part of the system and better utilise community assets before finally addressing the transformation of outpatient services.

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1 Executive Summary

We are proposing to make changes to how health and social care services for Adults and Older People are provided across Stockport

1.1 The Case for Change

We plan to make these changes because the care that we currently provide isn't as good as we would like it to be and if we carry on delivering services in this way with the same level of outcomes then health and social care services in Stockport will have a recurrent financial deficit of £136m (about 25% of its current budget) by 2021.

There are four main reasons for this:

1. **The Stockport population is increasing and getting older**. Older People and Adults with Long Conditions (such as coronary heart disease, diabetes, hypertension and dementia) are the heaviest users of local health and social care services accounting for around 70% of all health and social care spend

   Key Fact: The number of people in Stockport aged over 65 will increase from 55,700 in 2014 to 61,000 by 2020 (an increase of 9.7%)

2. **Too many people in Stockport, particularly those over 65, are admitted to hospital** when they would be better, and more appropriately cared for, at home

   Key Fact: Stockport admits 37% more people to hospital as an emergency admission than the England average - our emergency admission rate for this cohort is also double the average for North West England.

3. **Older People, in particular, stay in hospital far longer than they should, or need to,** because of difficulties discharging them.

   Key Fact: If a person over the age of 75 spends 10 days or more in hospital then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living very difficult. 3,100 Stockport people were in this positon in 2015/16 (this represent 30% of all emergency admissions for people in this age group)

4. **Care is fragmented and not joined up around the patient;**

   Key fact: patients tell us that they are frequently bounced between services before they receive the care they need and they are

required to tell their story multiple times to different health and social care professionals.

1.2 What are we going to do?

In order to remedy this situation, we plan to do four things over the next 5 years:

1. Invest £9m recurrently in Primary, Community and Mental Health Care in order to implement a new joined up model of health and social care that will create the capacity and capability (the community alternatives) to deliver the right care and support in or close to people's homes rather than in hospital. This enabling money has been given to us from the Greater Manchester Transformation fund for this explicit purpose.

2. Implement a model of care which has been designed by patients, carers, clinicians and social care professionals over a 12 month period through the Stockport Together programme and which is based on the best available national and international evidence of what works and what good care looks like.

3. By providing more appropriate evidence based primary and community alternatives to hospital admission and attendance, this will enable us to deliver £38m recurrent savings because primary and community based care is more cost effective to deliver than hospital base care.

4. In order to ensure that local health and social care organisations work together in a more joined up way to deliver this vision, we plan to create a new type of organisation: a Multi-Specialty Community Provider (MCP) which will be based on the registered GP list. Over time, we plan to move towards a single organisation covering all providers of health and social care in Stockport called an Accountable Care Organisation (ACO).

1.3 What is the proposed model of care?

Stockport together has a developed evidence based, integrated model of care which has been designed to deliver care and support that:

- is personalised, joined up and coordinated around the patient
- enables people to maintain their health, wellbeing and independence at home for as long as possible by promoting self-management, community resilience and choice
- recognises and supports the critical role played by carers
- is safe and effective, given by caring, compassionate staff
- is delivered in the right place at the right time, every day of the week, enabling care and support to be delivered wherever possible close to or in people's homes rather than in hospital

- is convenient, easy to access and tailored to local neighbourhood needs
- places greater importance on developing solutions through good relationships and by connecting people together rather than an over reliance on systems and processes.

The new model of care has the following key components each of which are/will be supported by a series of business cases and which operating together form our proposed integrated service solution:

Integrated Neighbourhood Teams **Business Case 1**	Integrated Neighbourhood Teams (INT) will form the hub of all future community-based activity for Adults and Older People in Stockport and will be the first steps towards primary care at scale. We have established 8 Integrated Neighbourhood Teams each serving between 4- 8 GP practices with practice populations ranging from 30-50,000. Each Team will comprise a multi-disciplinary team of professionals including a core team of GP's, community nurses and social care staff together with a wider team of mental health professionals, allied health professionals, pharmacists, acute consultants, integrated health and social care support-workers, third sector staff from the TPA and other linked professionals including housing and Police. Each NT will be co-located as far as practicable, within primary care. This will enable GPs to build effective working relationships with named, identifiable teams of staff. Each Neighbourhood Leadership Team (composed of a GP as clinical lead, nurse and social worker) will determine the best staffing configuration for its INT within the budget delegated to them. INT's will work holistically to meet the health and social care needs of their practice populations (adults and older people) but will work particularly with GP practices to identify and then intensively manage the 15% of their patients (21,000 people) at greatest risk of future admission (i.e. with a risk score of >=18.03) in order to avoid crisis and reduce the risk of a hospital episode through: • Use of formal Risk stratification including use of frailty scores and social factors • Intelligence gathered from GP's, ANP's and social care • Frequent user information from the ambulance service/acute trusts INT's will then coordinate case management for these patients through regular multi-disciplinary team (MDT) meetings, which will: • Ensure patients' wishes are fully considered. • Encompass physical health, mental health, social care and housing provision. • Develop a shared care plan with a range of personalised services wrapped around the patient to meet their needs • Identify a named case manager.

	• Monitor progress against the plan. For people with long-term conditions (LTCs) such as coronary heart disease, diabetes, hypertension and dementia, integrated clinical pathways will offer a holistic review and assessment with specialists working closely with INTs. Teams will identify mental health issues in LTC patients and anticipate future care needs. Named pathway consultants will provide e-mail, telephone, Skype and face-to-face consultations. Preventive programmes for key causes of emergency admission in Stockport such as Falls will be developed and introduced. In addition to working intensively with the 15% of the population most at risk of admission, INT's will introduce a new Find and Treat Service working in partnership with the third sector to identify and then proactively work with those patients that have not been screened or who have high predisposing risk factors that may subsequently go onto make them high users of health and social care services.
Enhanced Primary Care **Business Case 1**	In order to firstly relieve the pressure within General Practice and then create the capacity for GP's to work with INT's to proactively manage complex patients; three schemes offering alternatives to routine GP appointments will be introduced. These are: Direct Access Physiotherapy, Enhanced Pharmacy Support in Neighbourhoods and additional capacity to address low level mental health issues in Practice Populations. All three schemes were identified by GPs themselves.
Intermediate Tier **Business Case 4**	Rapid Response, Intermediate Care and Reablement are key evidence based health and social services which, when properly implemented, have a proven impact on helping people to maintain their independence in community settings rather than being admitted to hospital and in facilitating speedy discharge. Despite spending above the national average, services in Stockport are currently fragmented (over 20 separate teams), are difficult to access and do not have an appropriate balance between step up/step down care, being geared towards the latter rather than the former. Their effectiveness in both admission avoidance and early discharge is therefore limited. These services have been redesigned to provide a 24/7 co-located service integrated with GP out of hours services and with a rebalanced Step Up/Down capability composed of : • A central hub providing for a single point of access and co-ordination • Rapid Response providing a maximum 1 hour response time including Mental Health for those most at risk of admission • An overnight sitting service • Intermediate Care both community and inpatient based • Reablement • Implementing the discharge to assess model - an evidence based model developed in South Warwickshire that is intended to ensure speedy discharge from hospital to home and to deliver

	assessment in the best place. Staff will build strong relationships with INTs and Emergency Departments to ensure that there is joined up care around the patient. To enable this, they will have mobile access to the Stockport electronic health and social care record, EMIS viewer and the AdvantisED system from Day 1 of operation
Healthy Communities **Business Case 3**	Prevention and early-intervention at every level of our integrated service solution co-ordinated by the Third-Sector and embedded within Integrated Neighbourhood Teams is critical to the overall success of our model. A key component is the increased emphasis placed upon building individual, family and community resilience at all levels of the model in order to enable a greater level of self-management of long term conditions by individuals themselves There are seven core elements to this approach • Targeted approaches in the acute setting, Intermediate Tier and Neighbourhoods to support access to community and voluntary assets • Community Health Champions working with General Practice • Peer support capacity development, particularly for carers under pressure • Increased health trainer and social prescribing capacity to deliver health coaching • Improving access to volunteering opportunities • Community Investment Fund to support community driven innovative solutions to improving resilience • Organisational development investment to deliver change in our relationships with people and communities
Acute Interface – Ambulatory Care Pathways **Business Case 6**	A key component of an effective urgent care system that prevents unnecessary admissions to hospital is the provision of ambulatory emergency care (AEC) for what are known as Ambulatory case sensitive conditions at the 'front door' to the hospital. There is a very strong evidence base in this area. Implementing effective ambulatory emergency care ensures that, where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day with ongoing clinical care planned and agreed avoiding the need for an overnight stay in hospital. Processes are streamlined, including review by a consultant and timely access to diagnostics and treatments are all delivered within one working day. This evidence based approach has improved both clinical outcomes and patient experience, while reducing costs through obviating the need for overnight hospital stay. **Three key changes are proposed:**

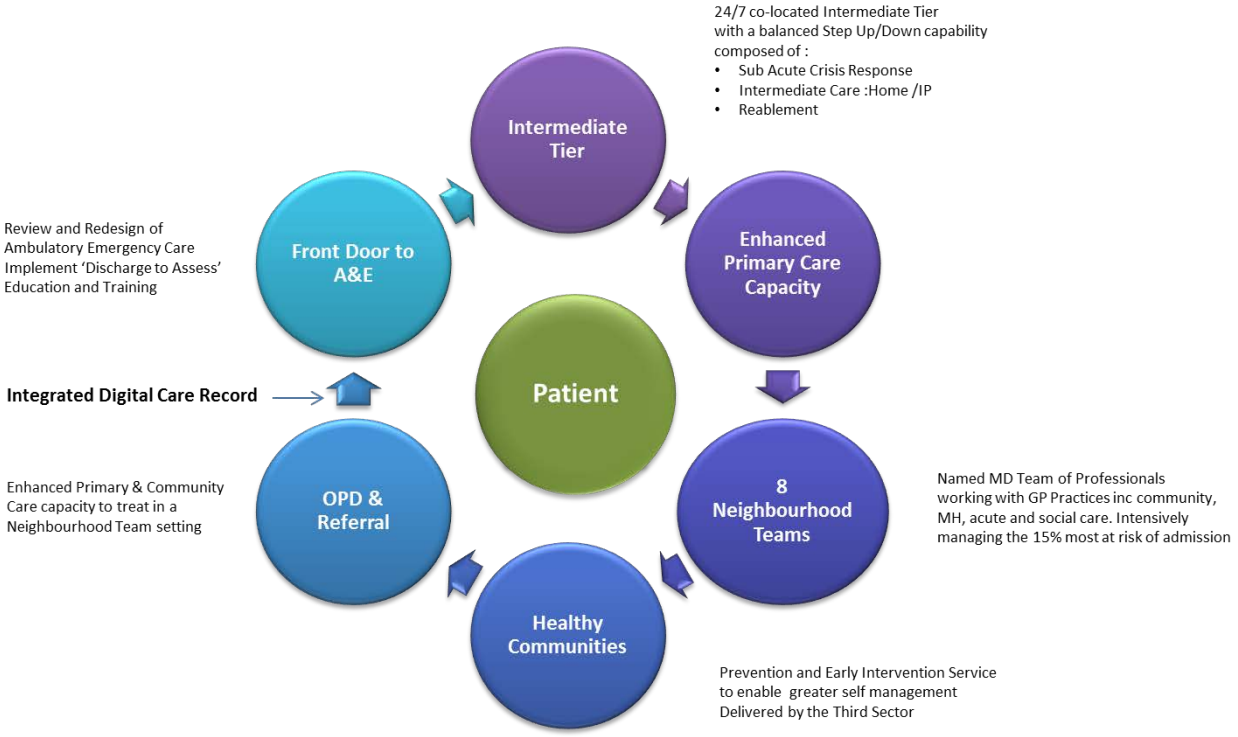
	1. **Extending the opening hours of Medical Admission Unit (MAU)** The current hours will be extended to operate 7 days a week until 2am with the last admission at 10pm (after 10pm there is a drop off in admissions). This will mean we will have the capacity to manage 10 more patients through MAU a day that would have otherwise been admitted to a specialist ward in the hospital. **2. Optimise the use of Ambulatory Case Sensitive Condition (ACSC) Pathways** The current use of ACSC pathways for people presenting with ambulatory care sensitive conditions at the ED department at Stepping Hill varies significantly and offers scope for improvement to bring us more into line with our peer group to ensure that older people in particular are offered AEC as an alternative to admission. **3. Implement Clinical signposting and joined up working with INT's and the Intermediate Tier** Our plan is to deliver a more streamlined approach to triage so that staff working in the ED department are clearer about the community alternatives to admission and can access them easily.
Key enablers **Business Case 8**	To support the delivery of integrated health and social care, we will also implement the following key enablers: **IM&T** An integrated digital health &social care record will be an integration engine to provide all health and social care professionals with a single unified view of patient records including acute, community, GP and social care information. A single NHS electronic patient record across General Practice, Out-of-Hours and community services will further enhance integration. **Workforce** The proposed MCP plans to create a provider workforce that is multi-skilled and multi-professional working without boundaries in a fully integrated system. We will train staff to avoid unnecessary admissions by developing their skills and expertise to deliver key interventions such as intravenous antibiotics/falls management programmes in a patient's home rather than inpatient settings. Increased productivity will also be delivered through the implementation of new ways of working including reducing duplication of appointments,

	eradicating multiple patient assessments and care plans. This will also be enabled through the expansion in staff mobile working, more effective staff rostering and reduced travel.

Four other key business cases are currently in development which will be presented for approval during the period September to November 2016 as these form Phase two of the implementation of the new integrated Service Solution. These are:

- Business Case 2: Care and Home Care
- Business Case 5: Other specialist Borough wide services
- Business Case 7: Out Patients and Referral
- Business Case 9: Reduction in Bed Base and Clinical Capacity

A summary of the key components of the integrated service solution and their interrelationship is set out in the diagram below:



1.4 What outcomes are we expecting to achieve and what is the evidence base to support our model and the assumptions we have made?

We know that 6% of the Adult population in Stockport (14,000 people) account for 60% of the non-elective admissions to hospital. By focusing evidence based interventions on this cohort of people, we believe that the

implementation of our integrated service solution will deliver reductions in acute activity for this cohort at the following levels over the outturn for 2015/16:

- 30% reduction in non-elective admissions & A&E attendances , a saving of £9.6m
- 50% reduction in length of stay for those in the cohort whose admission is not deflected, a saving of £4.5m
- 8% reduction in new nursing/care home admissions, a saving of £2.4m

At a Neighbourhood Team Level this will translate into the following four expected target outcomes:

1. Reduce avoidable hospital admissions:
   - by about 19 admissions per day, every day of the year;
   - 2 per day per Neighbourhood Team

2. Reduce avoidable visits to emergency departments
   - by about 33 per day, every day of the year
   - 4 per day per Neighbourhood Team

3. Reduce avoidable admissions to care and residential homes
   - by about 3 per month

4. Reduce the length of time people who are admitted have to stay in hospital (by about 50%)

We are confident that these levels are deliverable because the national and international evidence supports both our service model and the underpinning assumptions that we have made about their impact on activity reduction particularly when set in the context that Stockport is an outlier in these areas nationally.

A summary of the international evidence on the impact of integrated care by McKinsey 2015 ('The evidence for integrated care', March 2015) and subsequently NHS England 2015 ('Transforming urgent and emergency care services in England', August 2015**)**, concluded that it is the impact of a number of key components operating together that can deliver the sort of step change that systems are seeking.

These are:

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

- **Improve and increase intermediate care capacity:** Early review by a suitably qualified clinical decision maker supported by responsive

intermediate care **(**with the right balance between step up/step down) can reduce admissions by up to a quarter

- **Implement ambulatory emergency care:** consider all potential acute admissions for ambulatory emergency care unless care needs can only be met by an inpatient stay:

They further concluded that reductions in emergency admission and ED attendances as a result of the implementation of integrated care of between 20-30% could be expected. These components are all at the heart of the implementation of our integrated service solution.

1.5 Creation of a Multi-Speciality Community Provider (MCP)

It is intended that this Integrated Service Solution will be delivered by an MCP arrangement that incorporates the 8 integrated neighbourhoods along with borough-wide services and those services that sit at the interface between acute hospital and primary care. This is under procurement currently and is not specifically part of this case. The intention is for a strong degree of devolved responsibility and accountability within the MCP to the front-line neighbourhood teams. The national principles of an MCP which form the basis of our design include:

New Organisational Form

- An integrated provider of out-of-hospital care
- Own organisational capability to hold capitated contract for a population

Core Elements

- Primary medical services, community-based services and social care
- Incorporate some acute specialists e.g. consultant geriatricians, psychiatrists
- Incorporate and be built from the list(s) of registered patients for the population
- A joined-up electronic health record for its registered population
- Dedicated services for different groups of patients
- Majority of outpatient consultations & ambulatory care to out of hospital settings
- Excel at empowering patients and involving local communities.

This overview case sets the scene for the further detailed cases that will come forward over the next few months. It describes a significant change in the way services are delivered to ensure improvements in care, better outcomes and financial sustainability.

2 Scope and Case for Change

2.1 Purpose of document

We are committed to undertaking large whole system change. This requires both a significant number of specific service changes ***and*** an integrated approach to that change. We cannot describe every change in detail at the same time but do need to ensure that each service change is understood in the wider context and that the implications of the change as a whole are described.

This document describes the case for the overall system change and the key components of that change. Each of these changes will have specific business cases that will follow between September and March 2017. This document includes at a system level the economic and financial case for the overall change.

This overview case is in effect the first gateway and later cases will build on this and cannot without full partner agreement reverse the model and approach described within this case.

2.2 Scope and exclusions

We propose an ***integrated service solution*** that impacts on the following 5 **cohorts** of the GP registered adult population, those who:

- use general practice when better alternatives could be made available (c500,000 appointments);
- have already had a non-elective admission and are at a high risk of doing so again (c15,000 people);
- have a range of risk factors that indicate they are at high risk of non-elective admissions and other intensive input in near future (c20,000 people);
- have an unknown disease or unidentified risk factors (c60,000);
- use outpatient and associated diagnostic services (c100,000 people, 360,000 appointments).

Therefore, given these cohorts the commissioning spend and service areas in scope ***within this proposal*** include General Practice; Public Health; Adult Social Care including home care & care home commissioning; Community based health services including mental health provision; some aspects of community pharmacy; third sector contracts; all intermediate tier services including some hospital bed based provision; outpatients and diagnostics; A&E and ambulatory care; ambulance services and Out-of-hours; discharge planning and arrangements within the acute hospital.

This document indicates the ***future form*** of the provider and the ***approach to commissioning*** that will help facilitate the most effective delivery of the benefits described but these ***are not critical to and do not form part of the approval*** of the Integrated Service Solution. Further business cases will follow to relevant partners.

This proposition ***does not*** directly involve any children's services.

Improvement and rationalisation of the public sector estate is an important component of the Stockport Together programme. We believe such developments will enhance the integrated service solution described in this case but are not a prerequisite of it. A separate estates strategy and related business cases will be brought forward in due course and have been developed alongside the integrated service solution described in this proposition but are wider reaching.

2.3 National Context

2.3.1 NHS Five Year Forward View

The NHS five year forward view sets out the challenges facing the NHS , including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. In response, it places much greater emphasis on integration of systems and ways of working. The 2016-17 planning guidance pushes this forward with a much greater emphasis on locality based planning, transformation and transparency. In particular the forward view focuses on:

- Prevention and empowerment
- Greater patient and service user control and choice
- Removal of barriers between care organisations
- A new deal for GP practice
- Requirement to rebalance demand, efficiency and funding of the NHS.

2.3.2 NHS Vanguard

NHS 'Vanguard' sites for new models of care are one of the first steps towards delivering the Five Year Forward View and the integration of services. A number of sites have been selected to build and test new models of care and new organisational forms. Central to this NHS England and Monitor have committed themselves to work together to support these sites. Stockport Together is an NHS Vanguard site, one of **15 MCP (Multi-specialty Community Provider)** sites in England.

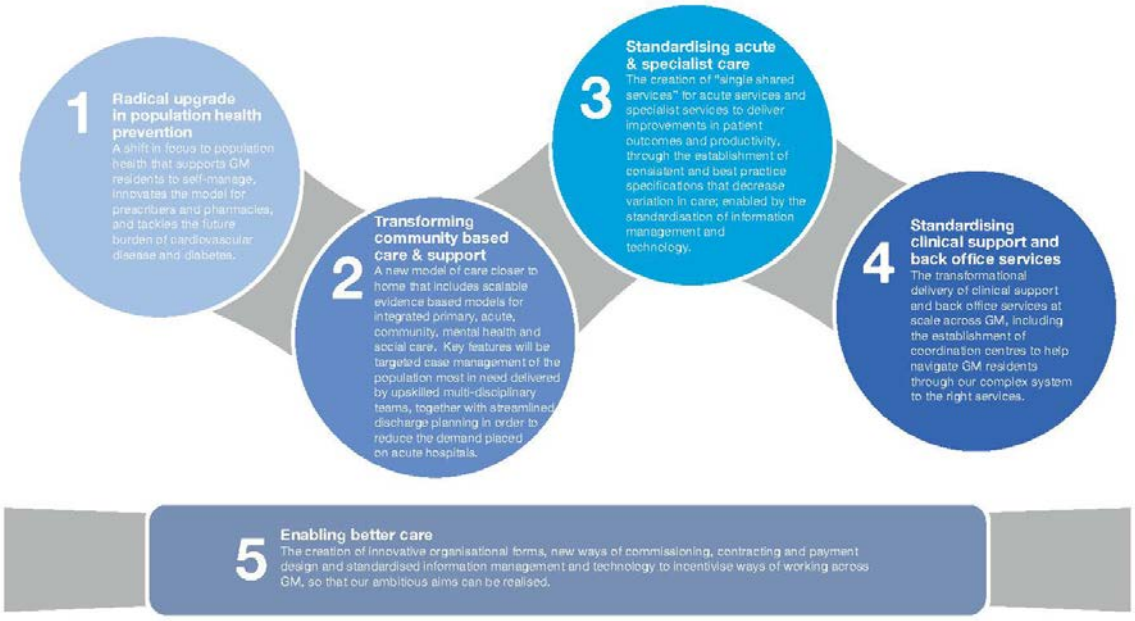
2.3.3 The Care Act 2014

The Care Act aims to provide a coherent approach to adult social care. It consolidates previous health and social care laws, regulations and guidance. As an integrated piece of legislation, different sections of the Act are designed to work together, and will encourage local authorities to collaborate and cooperate with other public authorities. The key impact is that it changes the eligibility criteria and offers a more 'universal offer' to a wider population. It is anticipated by some that the Care Act will increase the demand for Social Care services.

2.4 Greater Manchester Devolution

Greater Manchester Devolution is important in shaping the thinking within our plans. The GM Integrated Health & Social Strategy describes five specific

areas where change is envisaged and each GM locality is required to demonstrate delivery in these areas.



The Stockport Together programme as a whole is looking to address four of the five areas and this has formed the basis of our bid to the GM Transformation Fund. Stockport Together is not the programme responsible for standardising acute care; this is led by Healthier Together. The Integrated Service Model within which there are four workstreams; *Core Neighbourhoods, Healthy Communities, Boroughwide Services*, and *Acute Interface* will contribute in particular to:

2.4.1 A radical upgrade in population health & prevention

Our model of care built from the registered list of all general practices within neighbourhoods is designed to support at scale early intervention and prevention in primary care. Within the core neighbourhood work stream we have a ***Find and Treat*** intervention. This is targeted at 60,000 people who have not recently had NHS screening for a variety of issues and/or not recorded data on areas such as blood pressure, atrial fibrillation and CHD and diabetes risk factors. Data mining of the single GP EPR will enable this. In addition we are rolling out the Heathy Living Pharmacy Initiative which is one of the GM wide initiatives utilising pharmacy skills to improve health.

Integrated intensive support teams in each of our 8 neighbourhoods will support older people to stay well longer and to improve the management of complex care and long-term conditions. The development of communities as assets is also an essential building block of our approach: for example ensuring care homes become an integral part of our neighbourhoods. Population behaviour change and self-care support programmes are also components of neighbourhood delivery.

2.4.2 Transforming care in localities

Our approach is predicated on a radical change to the way services are delivered in each neighbourhood with a focus on deep integration between primary, community, mental and social care services. Our neighbourhood model includes moving 50% of outpatient activity out of an acute setting, proactively managing people at home including increasing capacity in primary and community services and significant rationalisation to strengthen the support available in intermediate tier services. This will reduce the requirement for treatment in hospital or attendance at A&E. Alongside this we are focussed on developing the community assets to create additional capacity in primary care without needing to recruit additional already scarce GPs. We will develop alternative professional and third sector alternatives to a GP appointment including physiotherapy, practice based pharmacists and community pharmacy, counselling and signposting to non-health related support services.

2.5 The Stockport Case for Change

2.5.1 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 premature 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.

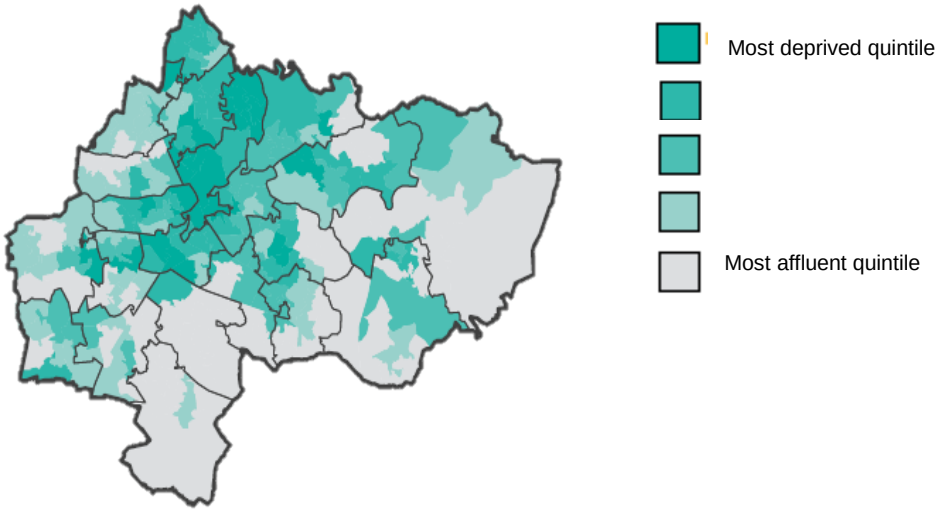
Preventable premature death is driven by a range of factors. Around 25% of adults in Stockport are classified as obese, and 75% are not active enough. Among our population hospital stays resulting from alcohol related harm was 709 per 100,000 in 2013/14, worse than the average for England. On the widest 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.

2.5.2 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).

Stockport inequality map



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

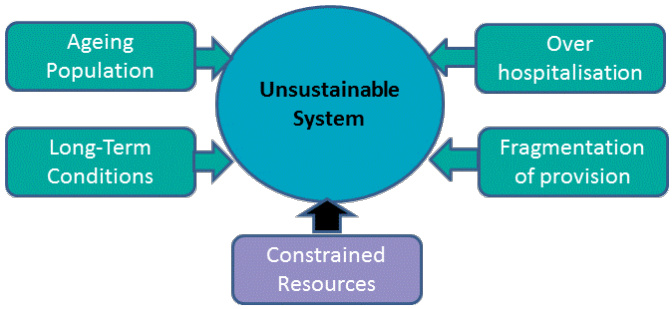
- In the most deprived areas men will on average have 7 years (9.4% of life) in poor health compared to 3 years (3.4%) in the most affluent areas.
- In the most deprived areas women will on average have 5 years (6.8%) poor health compared to 2 years (2.9%) in the most affluent areas.
- In the most deprived 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 channeling resources back into the economy.

2.5.3 Sustainability

We face a number of challenges to the financial sustainability of the health & social care system. Unless we address these collectively they will form a perfect storm that will result in either financial non-viability or diminution of service provision and quality. Whilst the national funding of health & social care is outside our power we should and can address the other local challenges.



Demographic Changes

The number of over 65s 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 65+ is also significantly higher in some neighbourhoods in 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.

Long-term conditions

The increase in people living with other long term conditions is also impacting upon the health and social care system dramatically. This is driven by both the ageing demography, healthy life-expectancy gap and lifestyle factors described above. 30% of our citizens already have one or more long term conditions, which accounts for 50% of GP appointments; 7 out of 10 hospital beds; and 70% of health and social care spend. Stockport Foundation Trust has over 4,000 patients on its outpatient waiting list who are overdue for an appointment for a long-term condition.

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.

Many people with long term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. Costs to the healthcare system are also significant. By

interacting and exacerbating physical illness, co-morbid mental health problems raise total healthcare costs by at least 45% for each person with a mental health problem alongside a long term condition. This means that around £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing. If we want to improve the quality of life for this group of people and reduce the cost to the health and social care system, we have to address their mental health needs.

An increasingly older population also means that the prevalence of dementia will likely rise above the national average and planning care for this group of people will require additional attention.

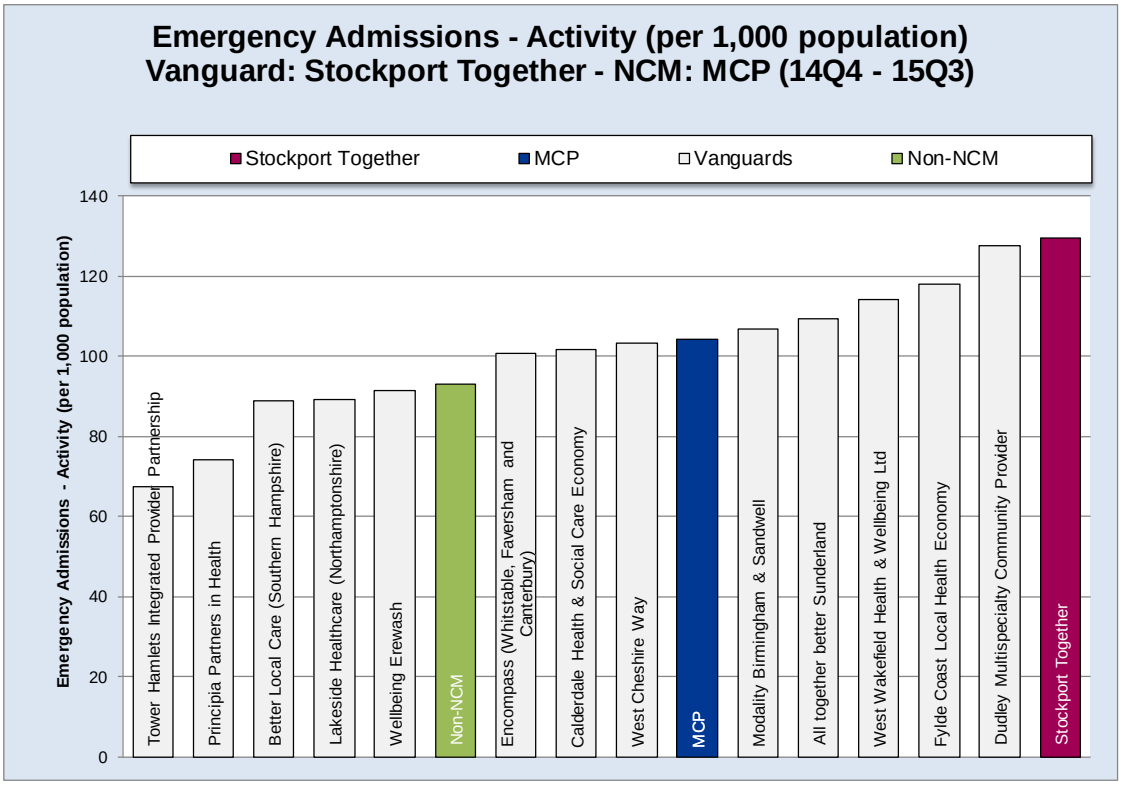
It is estimated that nationally the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport this will equate to an additional 47,700 people living with a condition.

Over hospitalisation of healthcare

Stockport people are already among the highest users of hospital services in the country. Hospital admissions ***are 37% higher than the England average*** and double the North West average even allowing for weighting for age. ***We have the highest admission rate of any of the 15 national MCP Vanguard sites[1].*** The data reflects the case that the current system is overly reliant on hospital services as the key outcomes on which Stockport performs poorly mostly relate to emergency hospital admissions, particularly for conditions that can be better managed in other parts of the system. For example, unplanned hospitalisation for chronic ambulatory care sensitive conditions[2] (1,099 versus 781 England average per 100,000 population), emergency re-admissions within 30 days of discharge (12.7% versus 11.8% Eng. Av.) and emergency admissions for alcohol-related liver disease (36 versus 24 Eng. Av.) To better manage our resources we need to rebalance the proportion of care delivered out of hospital with that in hospital.

[1] Stockport is a 'Vanguard' site, site which the NHS have selected to build and test new models of care and new organisational forms.

[2] Those conditions that should not need a hospital inpatient stay



NHS Better Care, Better Value Indicators provide benchmarking across a range of indicators at Commissioning and Provider level. Comparison (for 2014/15 Q4) identifies various potential areas of improvement including reducing outpatient appointment rates, first to follow up rates, emergency admissions and length of stay.

NHS England's Right Care programme uses benchmarking data to identify where an economy is an outlier in terms of the amount of money it spends and the health outcomes achieved. The Right Care programme produces a series of *Commissioning for Value Packs*. Through devolution, Greater Manchester will use this tool to triangulate our position and manage assurance.

A review of Stockport's Commissioning for Value packs generally supports the direction of travel set out in Stockport Together. The packs highlight Stockport's high use of acute services compared to similar areas, identifying opportunities for savings and service improvements in the following areas:

	Spend & Outcomes	Outcomes	Spend
1	Gastro-Intestinal	Trauma & Injuries	Gastro-Intestinal
2	Trauma & Injuries	Gastro-Intestinal	Circulation
3	Neurological	Mental Health	Trauma & Injuries
4	Mental Health	Neurological	Respiratory
5	Cancer	Cancer	Neurological

National ranking based on the Right Care spend analysis puts Stockport 9th out of 211 CCG areas in terms of the ***highest potential savings*** for non-electives with a savings potential of £11.7m. We are 45th in terms of potential

elective savings with a savings potential of £5.7m. If these savings were met it would just return us to existing peer levels. We are a clear outlier in:

- **Gastro-Intestinal spending**
- **Spending on Circulation**
- **Rates of Falls**, particularly among older people
- **Emergency Admission rates** are a common theme in every data pack in Right Care. Reducing our emergency admission rates is not only key evidence of improved outcomes, but would take substantial costs out.

Fragmentation of system

Health and Social Care services are provided to the population of Stockport via a disparate range of providers and locations. Financial and other incentives further compound this fragmentation. For example we have identified 21 distinct intermediate tier services.

Social care, physical health and mental health are all commissioned and provided separately through a multitude of contracts. The current fragmented system is not meeting the expectations and requirements of people with complex needs who are most likely to suffer problems with co-ordination of care and delays in transitions between services. Furthermore these delays and duplications in the system are wasting resources.

Funding Challenges in Health & Social Care

Nationally whilst the NHS has received a small increase in funding this does not match the growing demands and is estimated to be £22bn short of what would be required without transformation. The financial constraints on local authorities are even more severe and even with the ability to raise extra revenue if they wish through the precept[3] will result in a significant shortfall. Locally we have calculated that the total commissioner financial resource available for health and social care In Stockport in 2015/16 is £457m. If growth in demand continues as experienced in the past few years and we continue to deliver services in the same way, by 2020 the Stockport Health and Social Care system is facing a c£136m shortfall in adult services. This is clearly ***an unsustainable position***. These pressures are already being felt by commissioners and providers in both financial and in service delivery terms.

Implications

We do not believe we can do nothing, nor do we as partners in Stockport believe we can act alone. The impact would be cuts in service provision and reductions in the quality of services.

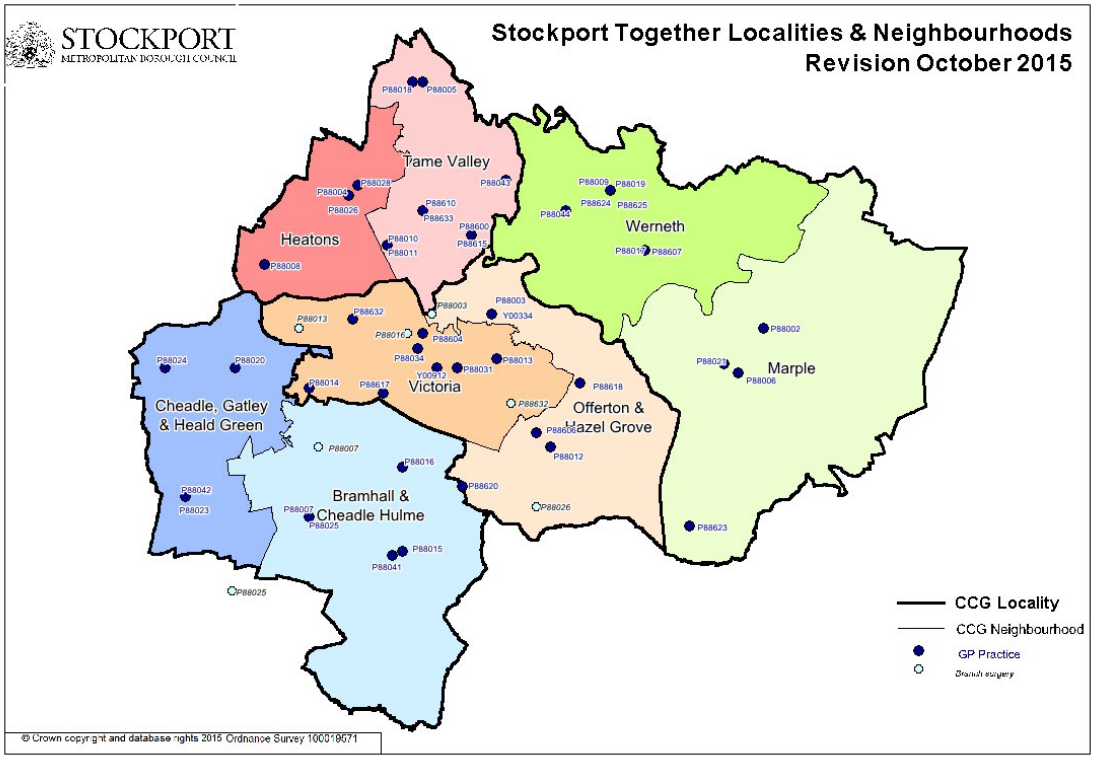
However, working together we believe ***we can much better spend the £457m available*** to us to provide services differently, not only ensuring their quality but improving outcomes for our population. This integrated service solution describes an important contribution to that approach.

[3] The social care precept is the government policy to allow councils which provide social care to adults to increase their share of council tax by up to an extra 2%

2.5.4 Neighbourhoods and General Practice

The Stockport Together proposals are built on the foundation of "neighbourhoods". Each neighbourhood in Stockport is quite different from the others and therefore any approach to improving outcomes and services needs to acknowledge this variation. At the heart of each neighbourhood are GP practices that each has responsibility for people from that neighbourhood from pre-conception through to death.

Stockport Borough is divided into eight neighbourhoods within four localities as shown below with the GP practices indicated.



The eight neighbourhoods have varying characteristics. For example:

- Bramhall & Cheadle Hulme: lowest level of deprivation, longest life expectancy, lowest level of disease prevalence, lowest level of unhealthy lifestyle factors.
- Tame Valley: highest level of deprivation, highest level of disease prevalence.
- Marple: highest proportion of population 65+, lowest level for unhealthy lifestyle factors.
- Victoria: lowest proportion of population 65+, highest level of disease prevalence, shortest life expectancy for 65+.

2.6 What the public have told us

We have undertaken continual engagement with the public as described in **Section 6.4.1.** Overall, views were expressed that services often treat a single condition, rather than looking at the needs of the individual. As a result, individuals feel pushed from pillar to post, with each appointment only dealing

with one aspect of their care needs and a lack of communication between professionals about what care they have received.

A number of specific overarching thematic views from the public events required a response:

Public View	*Our Response*
We should change the way services support people with long-term conditions with greater integration.	Our neighbourhood integrated teams and plans for self-care recognise this.
Many services currently provided in hospital should be closer to home.	Our plans will move much more outpatient activity and diagnostics to neighbourhoods.
Greater emphasis on preventative measures and the better management of long-term conditions through GP Practices and community services.	Neighbourhood teams are built from general practice and include prevention and management.
People don't want to keep repeating their story at each appointment.	We are creating a single shared record and single neighbourhood teams will create greater continuity of care.
GP surgeries should provide more appointments.	We have extended primary care access to 8-to-8 and 7 day primary care.
Mental health is seen as having equal importance to physical health.	We are integrating mental health into local teams.
Online access viewed as right thing to do but some fear less IT empowered people will be disadvantaged.	Online is an enhancement for those who wish to use and not the only route.
The sharing of care records to improve care is generally supported.	There are strong IG agreements in place.
Clearer information about how to access services should be provided.	We have Health app, Simpler access points, and will have a new prevention website.

2.7 Summary of Case

We have long established and significant health inequalities and whilst health outcomes are generally good, life expectancy and healthy life expectancy remain very poor for many. We have a population ageing faster than England averages and like most of the UK predict a significant increase in those living with one or more long-term conditions. We already have one of the most hospitalised health and care systems in England. Taken together these with significant constraints in spending are already resulting in an unsustainable system which will result in poor performance, poor service quality and an

inability to address the drivers of inequality. A do-nothing scenario leaves every major partner unsustainable.

The public want a model of care that is better integrated; that retains personal interaction and builds on advances in digital technology; that gives greater attention to prevention and mental health services; and ensures even better access to primary care. They are supportive, with the right safe guards, of the sharing of information between professionals to support their care in a common or shared record.

National and Greater Manchester drivers are pointing towards greater integration of health and social care, more care delivered out of hospital, a greater focus on prevention and early intervention.

Given the relative strength of general practice in Stockport, our MCP status and the significant variation in health and care needs between neighbourhoods our response is to develop an ***integrated service solution built from the registered list in each of eight neighbourhoods***.

3 Approach to Business Case Development

3.1 Development within Workstreams

This proposal has been developed by the Stockport Together partners over the last 12 months. The new ***Integrated Service Solution*** has been developed by providers and commissioners working collaboratively and bringing together a range of clinical and social care practitioners with managers and members of the public. In some cases we are building on early prototypes and rapid testing of changes that are already underway; in all areas we have built on learning from elsewhere.

The Integrated Service Solution has been developed in ***4 workstreams***;

- Core Neighbourhoods
- Healthy Communities
- (Out of hospital) Borough-wide services
- Acute Specialist Interface

Each of these is a ***working group of the Executive Programme Board*** which has worked to ensure that the interfaces are being addressed to deliver a genuinely integrated service solution. Each workstream has a mix of commissioners and providers and a mix of health and social care leadership and input from the public. Each has a senior Stockport partnership executive as SRO.

The workstreams are developing a number of interventions and thus business cases. Given the scale of the changes it is not possible to bring every business case either together as one all-encompassing case or together at the same time without delaying essential change. Rather we have collectively developed the overall shape of the integrated service solution and identified the key elements described in the document, and will then bring specific cases forward one-by-one, always described within this overall context.

Decision makers are asked to:

- approve the approach to development of cases being taken,
- approve the overall design of the new system,
- approve the overall financial and economic case.

3.2 Neighbourhood the essential building block

At the heart of the transformation we are undertaking is a new primacy within the health and social care system of ***neighbourhoods***. This is a challenge to the current hospital centric system we have and also reflects the very real variation in health & care needs that exists between the different neighbourhoods.

We are constructing the Stockport Health & Care System from the ***core neighbourhood*** level. Clearly not all services can be delivered at a

neighbourhood level but those services outside of the neighbourhood whether ***borough-wide*** out-of-hospital services or ***acute specialist*** services will be realigned to deliver support to the neighbourhood. Services outside the neighbourhoods' principal purpose will be designed to support the neighbourhood to better deliver care and good outcomes for its population.

As a Multi-Specialty Community Provider (MCP, described in section below) Vanguard site the neighbourhoods are defined from the GP registered list. ***All neighbourhood health services*** will be aligned to the registered list of each neighbourhood. Social care services (as far as possible within their statutory responsibilities for the resident population) will also be aligned. This will then form the basis of an integrated neighbourhood team serving a clearly defined population.

The neighbourhood approach will see Stockport health and social services aligned to 8 areas, each with a population of approximately 30 – 50,000 people. Evidence shows that units of approximately this size are the optimum size around which services can be established to achieve the care for their population and remain flexible enough to shape according to the individual's needs. The neighbourhoods are based on a group of GP practices working together and their registered list of patients.

Bramhall
P88007 – Smithy Green Health Centre
P88015 – Bramhall Health Centre
P88016 – Bramhall Park Medical Centre
P88025 – Hulme Hall Medical Group
P88041 – The Village Surgery
Population - 55,329

Heatons
P88004 – Heaton Moor Health Centre 1
P88008 – Heaton Mersey Medical Practice
P88026 – Heaton Moor Health Centre 2
P88028 – Eastholme Surgery
Population - 33,357

Marple
P88002 – Marple Bridge Surgery
P88006 – Marple Cottage Surgery
P88021 – Marple Medical Practice
P88623 – High Lane Medical Centre
Population - 43,440

Stepping hill
P88003 – Manor Medical Practice
P88012 – Beech House Medical Practice
P88606 – Springfield Surgery
P88618 – The Surgery, Fulmar Drive
P88620 – Haider Medical Centre
Y00334 – Little Moor Surgery
Y00912 – Cedar House
Population - 35,967

Cheadle
P88020 – Cheadle Medical Practice
P88023 – Heald Green Health Centre 1
P88024 – Gatley Medical Centre
P88042 – Heald Green Health Centre 2
P88043 – Brinnington Health Centre
Population - 26,056

Tame Valley
P88005 – The Family Surgery
P88010 – Heaton Norris Health Centre 1
P88011 – Heaton Norris Health Centre 2
P88018 – Park View Group Practice
P88607 – The Guywood Practice
P88617 – Adswood Road Surgery
P88610 – South Reddish Medical Centre 1
P88615 – Vernon Park Surgery
P88633 – South Reddish Medical Centre 2
Population - 30,635

Werneth
P88009 – Woodley Health Centre 1
P88017 – Chadsfield Medical Practice
P88019 – Woodley Health Centre 2
P88044 – Bredbury Medical Centre
P88604 – Lowfield Surgery
P88624 – Woodley Health Centre 3
P88625 – Woodley Health Centre 4
Population - 32,910

Victoria
P88013 – Caritas General Practice
P88014 – Adshall Road Medical Practice
P88031 – Bracondale Medical Centre
P88034 – Cale Green Surgery
P88600 – The Surgery, Brinnington Road
P88632 – Stockport Medical Group
Population - 46,524

Each neighbourhood will have a core leadership team and wider leadership team normally led by a local GP, which will:

- Set direction for neighbourhoods within delegated parameters
- Lead neighbourhood strategy, engaging a wide range of practitioners and the local community in the future models
- Be accountable for a devolved neighbourhood budget
- Be accountable for defined health and care outcomes for neighbourhood
- Be accountable for clinical/practitioner governance within neighbourhood
- Design the model of care for the neighbourhood around neighbourhood needs

3.3 Multi-Specialty Community Provider

The Integrated Service Solution will be delivered by an MCP arrangement that incorporates these 8 integrated neighbourhoods along with borough-wide services and those services that sit at the interface between acute hospital and primary care. There will be a strong degree of devolved responsibility and accountability within the MCP to the front-line neighbourhood teams. The national principles of an MCP which form the basis of our design include:

New Organisational Form

- An integrated provider of out-of-hospital care
- Own organisational capability to hold capitated contract for a population

Core Elements

- Primary medical services, community-based services and social care
- Incorporate some acute specialists e.g. consultant geriatricians, psychiatrists
- Incorporate and be built from the list(s) of registered patients for the population
- A joined-up electronic health record for its registered population
- Dedicated services for different groups of patients
- Majority of outpatient consultations & ambulatory care to out of hospital settings
- Excel at empowering patients and involving local communities.

In this latter regard, we have a fourth workstream specifically looking at how we can better empower individuals and build on the rich assets of individual communities to support our ambition of improved health and sustainable services. The ***Healthy Communities*** workstream is taking forward this work again thinking at a neighbourhood level.

3.4 Population Cohorts, Workstreams, and Business Cases

Given the centrality of neighbourhoods and the integrated neighbourhood team we have developed workstreams along the lines of *core neighbourhood*, and then the 3 supporting areas *healthy communities*, *borough-wide* and *acute interface*. However, individuals will need care at various times of their lives from all these areas. As discussed in the scope we have also identified 5 cohorts for whom we will have the biggest impact. Those who:

- use general practice when better alternatives could be made available (540,000 appointments);
- have already had a non-elective admission and are at a high risk of doing so again (c15,000 people);
- have a range of risk factors that indicate they are at high risk of non-elective admissions and other intensive input in near future (c21,000 people);
- have an unknown disease or unidentified risk factors (c60,000);

- Use outpatient and associated diagnostic services (c100,000 people, 360,000 appointments).

To create a cohesive system and fully understand the potential benefits for cohorts we have ***then taken specific elements of each workstream and built the benefit case around each of the cohorts***. In this way we have ensured both the primacy of the neighbourhood in our total model and been able to demonstrate the impact of changes across the whole pathway from neighbourhood to acute. The relationship between cohorts, workstreams and impacts is shown below and is collectively known as the ***Integrated Service Solution.***

Intervention by Workstream, Cohort and Business Case

Cohort	Healthy Communities	Core Neighbourhood	Boroughwide Services	Acute Interface	Critical Enablers
Seeing GP where better alternative should be available	3 Enhanced social prescribing, & lifestyle support 3 Community resilience	1a.Enhanced General Practice.– Physiotherapy, Mental Health, &Pharmacists,			Additional AHP & 3rd sector capacity 8. Shared record through standard (EPR)
15% of people most at risk of admission	3 Peer Support for Carers 3 Health champions 3 Targeted community based support	1b Intensive case management 1c Integrated Teams and proactive care 2 Care Home & Home Care Changes	4 Intermediate Tier 5 Alignment of borough-wide community specialist support	6 Ambulatory Care Pathway and service at front-end	Additional community /domiciliary /3rd sector capacity Additional Medical Leadership 8. Shared record and community EPR
People with unidentified long-term conditions or predisposing risk	3 Improved volunteering opportunities	1d Proactive Find and Treat			Additional Medical Leadership Additional 3rd sector capacity 8.Shared record and community EPR
100,000 people utilising outpatients				7 Virtual clinics and electronic communication 7 Pathway reform 7Additional diagnostics	New Medical rotas Additional medical capacity in community 8 Shared record and enhanced IT connectivity

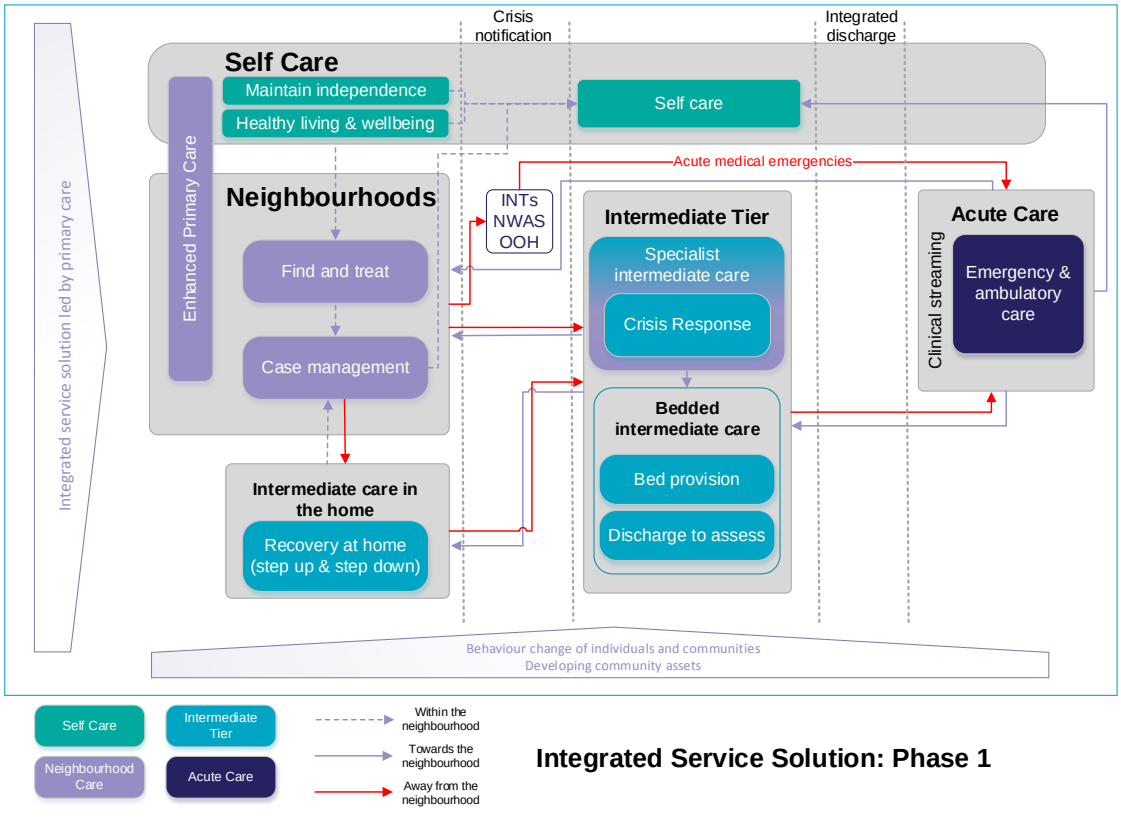
Business Cases: 1a-d Core Neighbourhood; 2 Care Homes and Home Care; 3: Healthy communities; 4: Intermediate Tier; 5 Boroughwide specialist 6 Ambulatory Care ; 7 Outpatients; 8 Various IM&T ;
9: If successful then likely to be ward decommission case

3.5 Summary of Business Cases

Drawing from the diagram above there are 7 specific business cases planned and two other types of business case that will emerge. It is important that decision makers understand each case in the context of the overall Integrated System Solution **and** the overall economic model described in Chapter 5. The cases are listed below.

Case	Date Due
Case 1: Core Neighbourhood	Sept 2016
Case 2: Care Homes/Home Care	Nov 2016
Case 3: Healthy communities	Sept 2016
Case 4: Intermediate Tier	Sept 2016
Case 5: Borough-wide services	Oct 2016
Case 6: Ambulatory care	Sept 2016
Case 7: Outpatients	Oct 2016
Case Area 8: Enablers Various	Various 2016-17
Case Area 9: Bed & Clinic Capacity	Late 2016-17

The various cases make-up one new comprehensive health and social care integrated service solution. Phase 1 of this overall service model is described diagrammatically below and then the various elements of the total case are summarised on the following pages.



Integrated Service Solution: Phase 1

3.5.1 Business Case 1 Core Neighbourhood

1A: Enhanced Primary Care

For the MCP and neighbourhood services to work as envisaged thereby relieving pressure on other parts of the system it is essential the enormous pressures on General Practice are also relieved and not compounded. The medical leadership of the system is a basic component of an MCP and currently the capacity is not available. In addition to leadership the ability of existing GPs to proactively manage complex patients is extremely constrained.

Therefore it is essential that firstly, the excess pressure is removed and that secondly some routine capacity can be released perhaps for longer appointments and leadership roles. Among some of the changes that are possible as practices work together at neighbourhood level will be the introduction of alternatives to GP appointments to the estimated 30% of appointments that could be better managed by someone other than a GP. Local GPs have identified three of these:

- Direct access physiotherapy so that rather than booking to see a GP then being referred to a physiotherapist for muscoskeletal problems the physiotherapists would act as part of the extended primary care team.
- All neighbourhoods with dedicated pharmacists in the extended practice team able to deal with medication reviews, medication enquiries and other medicine related time or appointments.
- Many appointments are for low level mental health issues including anxiety which are not easily addressed in a 10 minute appointment and often result in frequent visits, so increasing through the neighbourhood arrangement access to counsellors and CBT staff as part of an extended practice team will be very beneficial.

These are the first steps towards developing primary care at scale in each neighbourhood.

1B-C: Integrated Teams

Across Stockport c15% of the population has already been identified as either already using acute inpatient services intensively or at high risk of doing so. By bringing together community based health services including mental health practitioners with social and GPs in dynamic neighbourhood teams we expect to much better coordinate care, reduce exacerbations and crisis arising, and respond better when they do. These dynamic teams under local neighbourhood rather than service level leadership will have shared records, modern mobile technology, active support from third sector partners and home care providers, and new ways of working. At the intense end of this cohort there will be care navigators available to support people through the system and at the lower end active self-care and patient activation.

1D: Proactive Find and Treat

The GP electronic patient record (in Stockport soon to be universally EMIS web) has powerful capability to identify those patients that have not been screened, or who have high risk factors. Public health analytical expertise supporting general practice in each neighbourhood will look for individuals and then with the wider neighbourhood team work with GPs to target specific support including behaviour change and lifestyle support and or better compliance with medication.

Case Due: September 2016

3.5.2 Business Case 2: Care and Home Care

The opportunity presented by a single pooled budget with integrated commissioning and a capitated contract mechanism will support the development of an approach that ensures the home care and care home sectors become a more attractive proposition for investors, and that standards can be raised. This case will look at the financial issues and the opportunities to raise quality standards through innovation such as nursing rotation along with close alignment to the integrated neighbourhood teams described above.

Case Due: November 2016

3.5.3 Business Case 3a-f: Healthy Communities

The Healthy Communities design team has drawn on national evidence as well as local experience, to develop a multi-faceted approach based on the five areas identified in *Realising the Value*, as showing significant potential to improve quality of life for people with long-term conditions and deliver benefits across the three dimensions of value. The proposal encompasses seven elements which can deliver early impact as well as longer term benefits, while providing opportunities for testing and evaluating the approach:

- Targeted approaches in the acute setting, Intermediate Tier and Neighbourhoods to support access to community and voluntary assets
- Community Health Champions working with General Practice
- Peer support capacity development, particularly for carers under pressure
- Increased health trainer and social prescribing capacity to deliver health coaching
- Improving access to volunteering opportunities
- Community Investment Fund to support community driven innovative solutions to improving resilience
- Organisational development investment to deliver change in our relationships with people and communities

Case Due: September 2016

3.5.4 Business Case 4: Intermediate Tier

Stockport has 21 Intermediate Tier services. There is much greater capacity to support people out of hospital to return home (step-down) and very little capacity to support people in crisis and prevent them from entering hospital (step-up). Each current service has real strengths but there is less clinical input across the system to manage sub-acute care outside a hospital than we need. This business case will essentially do four things:

- Reduce fragmentation and increase co-ordination through rationalisation and creation of single hub access;
- Increase step-up capacity and care at home ability, whilst reducing the bed base;
- Improve the ability to respond rapidly (within an hour) to support neighbourhood teams;
- Increase the ability of the service to manage sub-acute care.

Case Due: September 2016

3.5.5 Business Case 5: Other Boroughwide Specialist Services

There are currently a range of out-of-hospital specialist services that are managed at Boroughwide level, such as *End of Life* or *COPD*. This business case will undertake two tasks:

Assess which of these (or aspects of them) could be moved to neighbourhood level and when,

Where this is not clinically safe or cost effective will ensure capacity is sufficient and alignment absolute to support the needs of neighbourhood teams.

Case Due: October 2016

3.5.6 Business Case 6: Ambulatory Care Pathways

Whilst the changes to neighbourhood teams and intermediate tier should reduce the number of people attending A&E with ambulatory conditions, they will not eliminate the need for acute interventions. Ambulatory conditions by definition should not normally require an admission but often do. Currently if people attend A&E and are put on this pathway they are usually treated and discharged effectively, but not many people are placed on these pathways and this is not 24/7 service. This case will set out how we can improve triage, increase capacity in the ambulatory care unit including access to necessary diagnostics and specialist opinion, and in doing so not only reduce admission but improve A&E flow and waiting times.

Case Due: September 2016

3.5.7 Business Case 7: Outpatients

The Stockport Together partners have already identified those episodes of care in each specialty which require a face-to-face acute site outpatient visit.

This equates to c50% of the current appointments. Through the better use of technology and shared records and virtual clinics this case will describe how an alternative approach to care based on a team of the *patient*, the *GP* and the *consultant/specialist* will be developed and the potential reduction realised. This will include core principles around moving information not the person and *patient activation*.

Case Due: October 2016

3.5.8 Business Case 8: Various Enabler

A number of IM&T and similar business cases will be brought forward over the next few months which are critical to deliver. Some have already been agreed for example: the Community EPR; EMIS roll-out to all GP practices; development of an outcomes framework and underpinning data systems.

Cases Due: Throughout 2016-17

3.5.9 Business Case 9: Reduction in Bed Base and Clinic Capacity

When the reductions in demand expected from implementation of the new Integrated Service Solution emerge there will a series of reductions in the bed base and clinic capacity required on the Stepping Hill site. Whilst we have pump priming to start many of the changes described above the sustainability of the total model requires costs to come out of acute services. As necessary cases will be developed setting out the details.

Cases Expected: By early 2017

4 Enablers

4.1 Overview

In order to deliver the models to the scale and pace required for the Integrated Service Solution, the effective mobilisation of enabling services is critical. We recognise that this has to be ambitious and needs to be a step change in terms of pace and innovation in order to optimise the opportunities presented by the new models of care.

As with the Integrated Service Solution model, the enabling work is also closely aligned with the Devolution agenda across Greater Manchester (GM). The integration of Health and Social Care is a key priority for the Greater Manchester Combined Authority (GMCA) and work is taking place across IM&T, Estates and Workforce to look at opportunities for alignment of strategies, sharing of best practice, and GM approaches to resourcing. This is particularly well developed within Estates and IM&T and Stockport's local strategies in these areas both align with those at GM. As such interim, as well as longer term transformation, within these areas will be developed with this sub-regional direction in view.

4.2 Stockport Together Enablers

For the purpose of this Business Case, enabling areas are considered within the following themes:

- Workforce
- Information Management and Technology (IM&T) (including Information Governance and Business Intelligence)
- Estates
- Integrated Support Service

Enabling areas have identified and progressed early requirements which form the foundation of the Integrated Service Solution, from the development of cross-organisational strategies (such as: Health Estates Strategy; Informatics Strategy and Workforce Strategy) to operational support to integrated teams (such as shared Wi-Fi access and COIN, shared record, and the facilitation of workforce engagement activity). This early work has identified the importance of managing the dependencies between enabling areas (for example Estates and IM&T). This will be particularly important as we implement the new models of care. Therefore any enabling activity will need to be seen in the wider context of the Integrated Service Solution and its enabling support.

4.3 Key Enabler Products

In order to understand the ambition and implementation of the models fully, a series of conversations have been taking place between Workstreams and Enablers. Whilst an ongoing process this has identified a number of key enabling requirements which are summarised below:

Enabling Theme	Key Requirements	Examples of Outputs	Stockport Together Workstream			
			CN[4]	HC	BWS	AI
IM&T	Integrated Systems and Digital Care Records	Stockport Health and Social Care Record (SHCR); Clinical and Care Management System Review; Joint Information Governance and Data Sharing Arrangements; Resource and Asset Management e.g. community bed management system	✓	✓	✓	✓
	Connected Infrastructure	Mobile Working Solutions; Shared Resource Domain; shared Wi-Fi	✓	✓	✓	
	Digital Front Door	Assistive technology; Information Advice and Guidance;	✓	✓	✓	
	Health and Social Care Business Intelligence	Neighbourhood level dashboard; access to urgent care dashboard for Neighbourhood and Intermediate Tier Services;	✓	✓	✓	
Estates	Interim Accommodation Solutions	Co-located bases within 8 neighbourhoods; Temporary Intermediate Tier approach to bed reconfiguration.	✓	✓	✓	
	Strategic Estates Plan	Capital Investment Programme including: 4 Community Hubs; Single Intermediate Care Unit. Review and rationalisation of Health and Social Care Estates including Stepping Hill.	✓	✓	✓	✓
Workforce	Strategic Workforce Plan	Workforce transition plan; HR & Recruitment Activity; Skills	✓	✓	✓	✓

[4] CN = Core Neighbourhoods, HC = Healthy Communities, BWS = Boroughwide Services, AI = Acute Interface

Enabling Theme	Key Requirements	Examples of Outputs	Stockport Together Workstream			
			CN[4]	HC	BWS	AI
		Review; Workstream level workforce plan; new role development; staff consultation plan.				
	Culture Change Programme	OD and Engagement Plan informed by cross-cutting Healthy Communities values	✓	✓	✓	✓
Integrated Support Service	Integrated Support Service	Integrated support service specification including approaches to 24/7 support arrangements (e.g. IM&T)	✓	✓	✓	✓

4.4 Next Steps

Delivering these products at the pace and scale outlined within this business case and the detailed workstream models is not without its challenges. To ensure clear accountability and management of enabler dependencies a dedicated Executive SRO is in place that works closely with the Stockport Together Programme Director and Interim MCP Director to ensure resources are co-ordinated effectively.

As part of the mobilisation required for the MCP we have identified focussed enabler teams around workforce, IM&T and estates. These teams are responsible for delivering the headline enabling priorities identified above. As outlined above, and within the workstream business cases, further work is required to fully map out and agree the detail of enabling solutions. This will be done collaboratively with workstream leads to ensure that there is shared agreement on approaches and ambition.

There are resourcing implications in delivering the enabling requirements outlined above. An initial understanding of non-recurrent resources required is outlined within section 10 of this business case. Non-recurrent capital estates requirements are being considered separately by Greater Manchester.

5 Economic and Financial Case

5.1 Economic Benefit of interventions

The CCG, Stockport NHS Foundation Trust and SMBC finance teams working with the workstream leads have undertaken together ***a cost benefit analysis*** of the impact of the various ***workstreams collectively*** on a number of specific population cohorts. The impact **before** investment and optimism bias are applied is shown below. The detailed assessment is attached in **Appendix 1.**

Table of Impact of interventions by year at economy level £,000

Benefit by Cohort	16/17	17/18	18/19	19/20	20/21
15% Intensive Support deflection	958	5,748	8,622	9,580	9,580
15% Length of Stay	908	1,816	2,724	3,633	4,541
15% Residential & Nursing	185	1,110	1,832	2,184	2,406
Outpatients	2,021	7,772	11,970	14,457	15,545
Healthy Communities	494	2,962	4,443	4,936	4,936
Enhanced Primary Care Prescribing	-	-	296	593	988
Total	**4,566**	**19,408**	**29,887**	**35,383**	**37,996**

5.2 Key Assumptions

In undertaking this cost benefit assessment and judging the impact of schemes a number of assumptions were made. The ***principal ones*** are described below with a rationale for making this assessment of benefit are indicated.

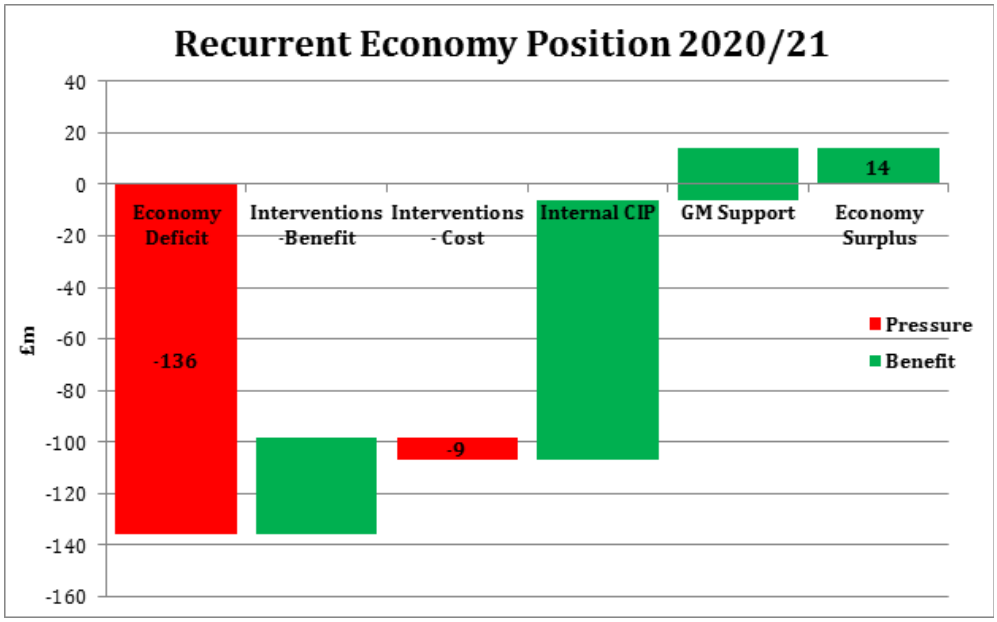
Cohort	Key metrics	Rationale
15% most at risk	30% reduction in non-elective admissions & A&E attendance by cohort 50% reduction in length of stay 8% reduction in nursing/care home admission	The evidence base for a combined system change is a benefit of between 20 and 30% on non-elective and A&E. We have opted for the higher figure as we are a national outlier and have schemes in place across pathway. The evidence base for reductions in length of stay indicates 30-50% and again as an outlier and with plans to introduce discharge-to-assess we expect to have big impact. The evidence for care home admission reduction is 8-15% and we have gone low as current levels are in line with peer group. Our optimism bias reflects the opportunity

		available, the evidence base and the system-wide approach.
Population with unmanaged risk	A further 10% reduction in non-elective admissions & A&E	Currently 85% of our population drive 40% of non-elective activity. We have assumed a 25% reduction in this cohort's contribution to admissions based on earlier identification and this aligns to the evidence base suggesting a 10% impact of such schemes on ***total*** admissions
People Utilising Outpatients	50% reduction in traditional outpatient activity	There is limited evidence for this scale of change and as such our optimism bias is likely to be high. However, we do have local studies in Cardiology and Respiratory indicating a 30% straight discharge or back to primary care without the range of innovations planned. We also benchmark high for both referrals and follow-ups and we have an agreed set of rules that require hospital based outpatients. These rules have been run through local data at specialty level with clinicians twice to establish the 50% figure.

5.3 Contribution to Stockport Locality Plan

As a health and social care economy we are forecasting a c£136m do-nothing gap by 2020-21. In our ***best case scenario*** the already identified interventions described above contribute a benefit of £38m. This will require recurrent investment of £9m, meaning a net impact of £29m recurrently from the interventions.

If we then include partner identified CIPs (£101m) and a conservative £20m (5%) contribution to our deficit from investment being led at GM level from the transformation fund this leaves the economy with a *surplus of c£14m*. This is set out diagrammatically below.



5.4 Optimism Bias and Additional Risks

Assessing the impact of major change programmes perfectly is difficult and so we have therefore added an optimism bias within the business case across different components:

Intervention	**Benefit** (reduces impact)	**Cost** (increases cost)
Integrated Intensive Support	-5%	5%
Outpatients	-25%	5%
Prevention & Empowerment	-5%	5%
Proactive Care – Length of Stay	-5%	5%
Prescribing	-5%	5%
Residential & Nursing	-5%	5%

In all cases benchmarking data indicates a strong likelihood of delivery as described in the assumptions. However, the evidence base behind the outpatients work is not as strong and thus the proportionate scale of change is higher hence the optimism bias being set higher.

This reduces the net benefit from £29m to £11m and leaves us with a c£3m economy deficit.

In addition to optimism bias there are two further risks.

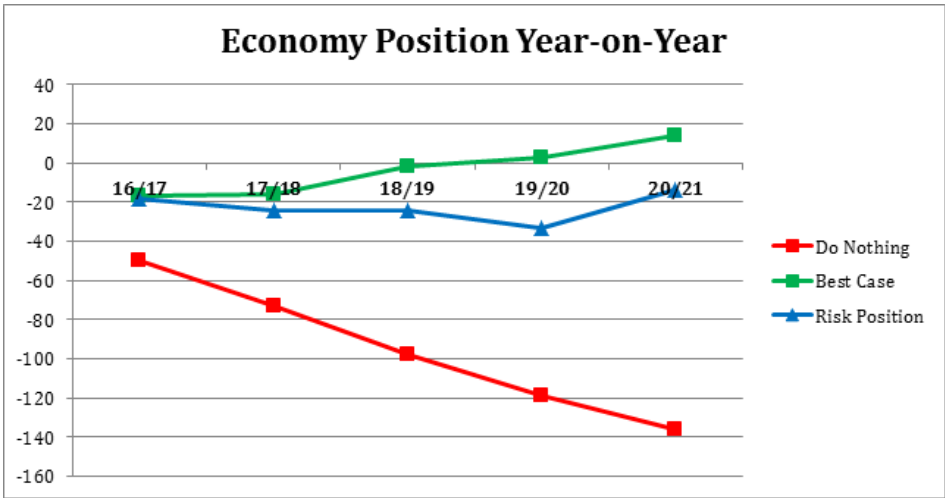
- The speed at which costs can be taken out was not fully captured within the Cost Benefit Analysis tool. Work done together previously on fixed, semi-fixed and variable costs indicates a further £11m of risk

in the 5 year time frame (The full gross benefit of £38m may then only be realised by 2022-23) This leaves us with a £14m deficit by 2020-21.

- The NHS CIP programmes are very demanding and if we included optimism bias here of say 50% based on pass performance then we would have an additional £32m of risk. This increases the total economy deficit to £46m. The joint approach locally to addressing challenges together compared to previous years more adversarial approach will mitigate some of the non-delivery of CIP.

We are then left as indicated below with a forecast economy position of somewhere between a best case £5m surplus and £46m deficit worst case.

If we then run the same assumptions and biases across the economy by year we are presented with the following scenario.



5.5 Financing of investment

We have undertaken a cost analysis on the first drafts of the detailed business cases that are under development and identified the likely investment required across each year from 2016-17 through to 2020-2. This forms the basis of our submission to the Greater Manchester Transformation fund. As we progress these and move into implementation we would expect some variance in the precise figures over the next three years.

The opening requirements are set out in the table below:

Summary of Investments by Business Case					
Application	16/17 £000	17/18 £000	18/19 £000	19/20 £000	20/21 £000
Ambulatory Care	£555	£485	£327	£327	£327
Boroughwide	£2,863	£2,333	£1,469	£1,469	£1,469
Core Neighbourhoods	£5,158	£5,770	£5,436	£5,436	£5,436
Enabler	£4,241	£2,636	£1,500		
Healthy Communities	£209	£1,672	£977	£927	£927
Outpatients	£110	£2,400	£3,696	£4,114	£4,114
Grand Total	**£13,136**	**£15,295**	**£13,405**	**£12,273**	**£12,273**

We have then identified the following sources for funding across the next 5 years. This is sufficient to meet the requirements and the remaining recurrent commissioning investment matches the c£9m set out at section 5.3.

Sources of Funding					
SOURCES	16/17 £000	17/18 £000	18/19 £000	19/20 £000	20/21 £000
Transformation Fund	£7,506	£9,190	£3,500		
Better Care Fund	£5,500	£3,575	£3,575	£3,575	£3,575
Commissioner Investment (CCG / SMBC)	£130	£2,530	£6,330	£8,698	£8,698
Total	**£13,136**	**£15,295**	**£13,405**	**£12,273**	**£12,273**

5.6 Release of Funding

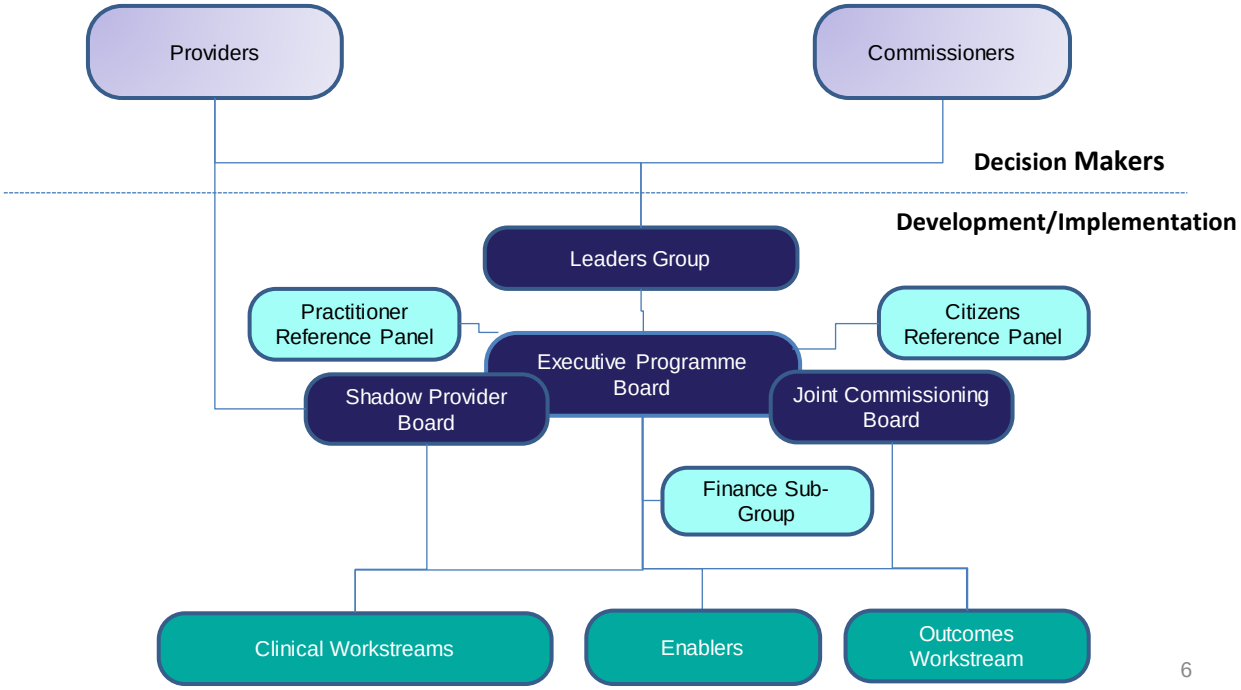
Significant movement within existing resources, any commissioning investment and the majority of the GM Transformation Fund will be released through approval of the detailed business cases as set out in section 3.5. Therefore, when approving this overview case specific commitments will still be required to be made through approval of these individual cases. It is felt taking this approach should enable decision makers to be fully sighted on the overall programme before making individual investments and decommissioning decisions made later in the year.

It should be noted that some of the GM Transformation Fund investments have already been committed at risk in areas such as programme costs, Outcome Framework, EMIS roll-out and Community EPR.

6 Management Case

6.1 Governance and Approach

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



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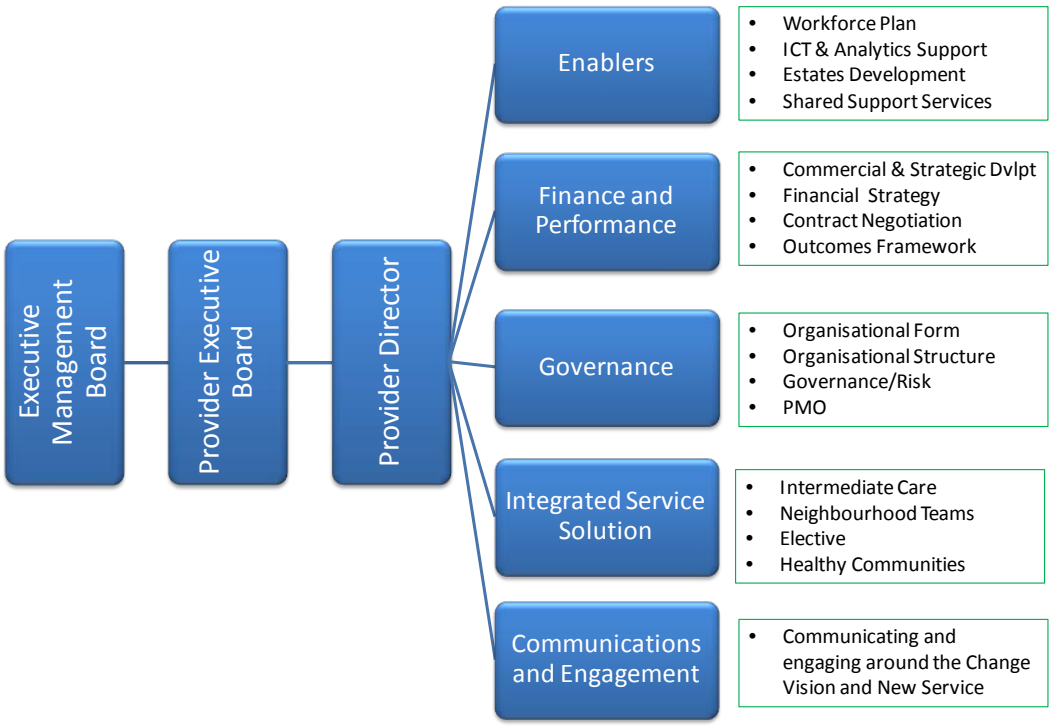
We have put ***in place*** a Programme Director and Programme Office. The Programme Office has Programme Director (0.8wte); A Senior Programme Manager (1.0wte;); A Project Support Officer (1.0wte); Administrators (1.4wte); Head of Communications (0.8wte); Communications and engagement staff (2.0wte); Dedicated BI and Finance support (1.6wte); Evaluation Director (0.4wte). In addition ***each major workstream*** has an identified Executive SRO, Senior Clinical Lead and a full-time Programme Manager, with further project managers as required.

The Providers have appointed an experienced Director to lead development and mobilisation of the Integrated Service Solution (reporting to the Shadow Provider Board), who himself is supported by a dedicated programme management.



We are using, where possible, existing staff to take forward this change, and have recognised that to deliver the degree of ambition and pace required we need a dedicated Executive SRO and Programme Manager coordinating the **enabling resource required** from existing partners' staff. We have adopted a task and finish approach to enabling work, underpinned by an Enabler work programme which is approved on a monthly rolling cycle by the Executive Board.

We have ***enabler teams*** leading workforce, IM&T and estates working with Programme workstreams and the Programme Office to ensure that new models of care and enabling solutions are aligned in development and that constructive challenge is available throughout this process.

Appendix 2. G***overnance Framework*** describes the roles and responsibilities of the individuals and boards within the programme in detail***.*** The programme management ***approach*** defined within Stockport Together is based on the following principles, essential to managing the complex environment of multi-partner transformation:

- Individuals and interactions **are as important as** processes and tools
- Responding to change and opportunity **are as important as** following a plan
- Working solutions **over** comprehensive documentation
- Stakeholder collaboration **over** contract negotiation

Appendix 3. Programme Management Framework. We have adopted an approach that puts the emphasis, where possible, on iterative change led near the frontline adopting agile approaches to change wherever appropriate.

6.2 Risk Management

Appendix 4. is the Risk and Opportunities Assurance Framework. This is the high level strategic risks for the overall Stockport Together programme, rather than risks to implementation of specific workstreams. The framework is reviewed quarterly by the Executive Board.

The Executive Board also receives weekly risk escalation of "immediate risks" e.g. those that are short term but high priority (usually top 5) for the Executive Board to action.

Workstreams also have their own risk logs which contain more detailed risks relating to the implementation of the models of care. For example the Intermediate Tier risk log includes such things as "Demand necessitates more intermediate community beds required than modelled", "Hospital bed capacity is reduced before the new model is able to demonstrate impact/deflect acute activity, negatively impacting quality / performance". The Core Neighbourhood risk log includes such things as "Inability to recruit to a number of key posts within the Programme that the benefits are dependent on e.g. ANPs and GP's" and "Services e.g. homecare that are likely to see a short term increase in demand as they support the move of activity out of the acute system that have not been identified to receive any further investment".

The key risks relating to this business case are summarised below. However, the Provider Board will be undertaking a more risk identification exercise in regarding the risks and opportunities arising from implementation of the integrated service.

Theme	Risk	Mitigation Approach
Service Design	Interfaces between the workstreams are not effectively designed and implemented, resulting in gaps or duplication in service provision.	- Implement as "integrated service solution" via MCP Provider Board - Key interfaces have been identified, management actions being implemented - Test the services with user "personas"
Service Design	Risk that the changes impacts users negatively (e.g. due to new models of care and transition arrangements)	- Changes in service delivery for service users during the transitional period to be constantly monitored through effective engagement. Emerging issues are rapidly addressed by Providers. - Equality impact assessments and consultation will be undertaken to understand impact on service users

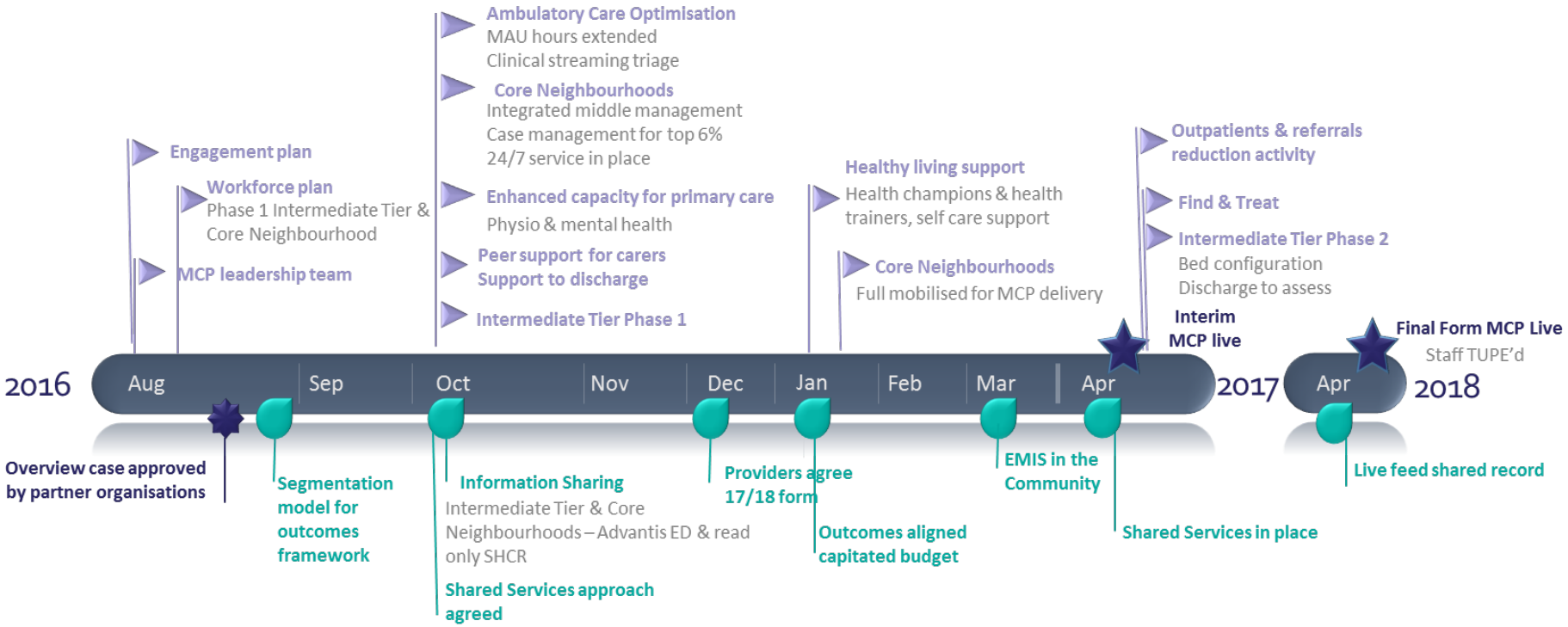
System Sustainability	Failure of new model to prevent forecast level of acute admissions, ED attendance and free up primary care services	- Robust benefits realisation processes to be put in place, including: workstream KPIs to monitor process changes, system indicators to monitor impacts on health, quality and sustainability - Rapid testing/Plan Do Check Act approaches to test new approaches with quick indicators regarding success. Intervene quickly where benefits are not realised (regular reporting to Executive Board)
Resourcing	Inability to increase capacity due to delays in recruiting suitable workforce. Workforce for double running may not be available in the market place resulting in delay to implementation of the models and realisation of benefits	- Workforce plan to be completed 12th August 16. Risk assessment to be undertaken on availability of required workforce (use of locums). Interim measures to cover winter may be required. - Implement programme to rotate staff from acute to community - Further discussion required with Provider Board to ensure providers (including outside Stockport Together) are primed to fulfil roles.
Resourcing	Staff/resources required to make changes are not released to support implementation, impacting success of delivery.	Provider Board to prioritise implementation and release staff so that the changes can be operationally led
Contracting Approach	Contracting incentives to support the integration (outcomes framework) will not be in place in time for implementation of the new service model. This could result in less effective delivery as payment flows won't follow the model of care until April 17	- Commissioners to work together to ensure that plans to move to an outcome framework are aligned - Work with regulators to highlight where regulatory mechanisms don't support the objectives for moving to an outcomes framework
Organisation Culture	Failure to achieve cultural change or adopt new values and behaviours in an already de-motived workforce who have "change fatigue". This could mean the benefits of integrated working aren't realised.	- Investment in OD support has been identified in GM Bid. - MCP will need to have a strong "brand" with clear values, behaviours and culture which align to the clinical model - This is an opportunity to motivate staff who have a desire to "do the right thing" for patients
Engagement of Stakeholders	Engagement with both the public and front line staff has been limited due to the short timescales for production of the business cases. This could result in difficulty to implement a model that hasn't been co-designed	- Robust engagement plan to be created for the implementation of the MCP (by end of July 16) - Workstreams to ensure that users are involved in detailed implementation - Continued use of Citizens Reference panel to advise on public engagement
Engagement	The model encourages and relies upon	- Effective, widespread campaigning

of Stakeholders	behaviour changes by the public, towards more self-care, activation and a willingness to be managed by less “specialist” services. There is a risk that the public will still want and use acute services as they are today, resulting in failure to deliver the benefits, or reputational risk due to complaints.	to embed messages into the public consciousness about why we are making these changes (sharing the evidence) and how services are best used. Messaging needs to be embedded into service provision and contacts. - Investment in resources for community activation - Systems Leadership Group to engage other public service providers to support these messages
Infrastructure	Lack of co-location solution (physical location) reduces ability to work in an integrated way	- Neighbourhood and Integrated Team estates requirement identified. Plans are in place but could not be realised until Q1 17/18. - Risk mitigation plan required once estate timescales are confirmed
Infrastructure	Information governance arrangements aren’t sufficient to allow for sharing of data and tracking of patients through the services. This could result in reduction in quality of patient care (due to incomplete information), inability to measure the success of the neighbourhood model and patients may not be offered services that would improve their health	- Plan to ensure Tier 1 and Tier 2 data agreements are signed (engagement plan with GPs required) - Plan and deliver training and development with front line staff to support data sharing and information governance agreements - Longer term plan to deliver the MCP will reduce IG issues
Infrastructure	Integrated digital care record with live feeds will not be available for in 16/17 which reduces the effectiveness of integration and realisation of benefits	Implement following interim arrangements to the SHCR by October 16: - Health to access to social care documentation (GRCR[5] & support plan, read only) - Intermediate tier and social care staff to access SHCR with single sign on (gives read only view of GP care records, district nurse activity, and end of life plan)
Engagement of Stakeholders	Timescales associated with full public/staff consultations impact ability to implement significant changes before Winter period	- Phased approach so that elements not requiring public and staff consultation can be implemented by October 16. All other changes to follow due process

[5] Goals, risk and capacity record

6.3 High Level Implementation Plan Milestones

A more detailed implementation plan is in Appendix 5.



6.4 Four Tests

The design process used the four tests set out in the 2014/15 Mandate from the Government to NHS England. Proposed service changes should be able to demonstrate evidence of:

- strong public and patient engagement;
- consistency with current and prospective need for patient choice;
- a clear clinical evidence base;
- support for proposals from clinical commissioners.

6.4.1 Strong public and patient engagement

Since 2013 engagement and co-production has been undertaken across Stockport on the integration of health and social care services. In 2013-2014, 700 people were spoken to at a number of events in Marple and Werneth where the initial integrated locality pilot was launched. Since the Care Congress and vision launch in January 2015, over 500 people have been engaged and their views sought on the case for change and the vision for future of health and social care.

A variety of different events and surveys have been used including experience-based design, workshops, public and staff surveys and standard presentation and discussion sessions. Many of these conversations and events have been enabled by Healthwatch and other local voluntary sector partners, for example, carers of adults with Learning Disabilities, University of the 3rd Age and patient reference groups.

We are committed to ongoing engagement and co-production within design and implementation. The Citizens reference panel are being closely aligned to each workstream to constructively support and challenge teams. Healthwatch are also a member of the Executive Programme Board.

The learning from these events is captured in **Section 2.5**

6.4.2 Consistency with current and prospective need for patient choice

There is nothing in these plans that will actively reduce existing choice particularly at the point of referral to secondary care. The Outpatient Business case will specifically address this issue. The procurement strategy and future new contracts will set out the requirements to protect patient choice. They will also set out clearly the restrictions on the provider in-sourcing provision currently procured without prior approval of the commissioner. Whilst there will be one MCP, the establishment of 8 semi-autonomous neighbourhood teams gives a continued dimension of choice in primary care provision.

Bringing together health & social care will allow for further development of personalised budgets which should in turn enhance choice.

6.4.3 A clear clinical evidence base

We have developed an evidence base pack which lies behind both the clinical model design and the assumptions we have made in calculating the benefits (Appendix 6). As a Vanguard site we have been encouraged to develop new approaches and adopt or adapt national and international models of care. As well as table-top exercises we have learnt from other parts of the UK including visits to and from Newquay, Sunderland, West Wakefield, Tower Hamlets and other work going on across Greater Manchester in Oldham and Wigan for example. Each intervention described previously includes some of this learning.

6.4.4 Support for proposals from clinical commissioners

The CCG is a co-sponsor of these plans and as such subject approval by its Governing Body has demonstrated its support to the changes.

6.5 Consultation

6.5.1 Public

Areas for Formal Consultation

This introduction to the integrated service solution describes a whole set of system changes. We have engaged members of the public, service users, carers and patients on the development of these ideas. Many of them are improvements to existing service provision and as such we do not believe require formal consultation before implementation, however there are a number of aspects that will be changes to service provision and as such do require formal consultation. The table below indicates which with an explanation of the view.

Major Intervention / Change	Formal Consultation?	Rationale
Integrated Neighbourhood Teams	No	We have engaged heavily on this and it is an improvement in the way that services are coordinated and delivered rather than a change in the availability of service provision.
Intermediate Tier Phase1	No	These aspects of the Intermediate Tier are service improvements in terms of coordination and improving capacity to increase timeliness of response.

Intermediate Tier Phase 2	Yes	These aspects will require consultation as they require changes to the bed-based capacity in the intermediate sector including potentially to wards on the Stepping Hill site.
Ambulatory Care Pathways	No	This is an improvement in the existing pathways and service capability linked to the A&E department, and does not affect the function, standing or capability of the A&E department.
Outpatient Changes	Yes	This will involve significant changes in the way outpatient and diagnostic services are delivered including potentially less direct face-to-face access to hospital doctors and closure of outpatient facilities.
Further ward closures	Yes	As we introduce new capability and capacity out of hospital it is intended that we will need fewer wards on the Stepping Hill site. Whilst in normal operational terms there are often instances of opening and moth-balling wards, if decisions to remove wards permanently and possible demolish part of the site then this will need a further business case and consultation.

6.5.2 Staff Consultation

Workforce transformation is a critical component to delivering the new models of care outlined within this business case. Throughout the development of Stockport Together there have been ongoing staff engagement exercises to inform the development of the new models. This has been particularly focussed at staff who will be part of the integrated neighbourhood teams and as the Programme moves in to a wider implementation phase then workforce engagement activity will be expanded to include all staff in scope of direct change (e.g. Intermediate Tier Services) as well as Stockport Together more widely. To deliver this, an Engagement and OD plan will be developed as part of implementation planning.

With regards to formal staff consultation, given the scale of transformation and the ambition to move towards a single accountable care organisation formal staff consultation is going to be required.

Changes to the contracts of staff can only be made in two ways: with the agreement of the staff affected or by using the agreed organisational change policy that forms part of the contract. The approach that is required will be dependent on the type of change.

If a change is minor and all staff are fully engaged, supportive of the new way of working and an agreement can be made to make that change from a certain date, this can be implemented as soon as the teams can be aligned to the new service model.

If the change is more significant the formal process described in the appropriate organisational change policy should be used. Each of the partner organisations has an organisational change policy but the principles are very similar. It is recommended that one process for all staff affected should take place with one set of documentation and one approach to consultation. If a fragmented change process is started staff hear inconsistent messages which will undermine the intention of integration. As such, staff consultation will be carried out consistently across all organisations and will be in line with local and national best practice and guidance with regards to timings and approach. In addition, regular union consultation and briefing throughout this process will be carried out.

In order to minimise the risk of multiple staff consultation exercises over the next 2-3 years it is intended that within the initial phase of transformation the models will largely be delivered through an alignment of the existing workforce (e.g. integrated neighbourhood teams) without changes to their employer or terms and conditions. In some areas of the model, staff reconfiguration is planned and as such staff consultation is anticipated, this is particularly anticipated within parts of the Intermediate Tier Service (e.g. Recovery at Home and Crisis Response). A 45 day consultation window has been planned given the number of staff in scope, however this will be kept under consideration in line with further refinement of the model to take into account any changes to the model and in scope staff.

6.6 Equality Impact assessment

The Stockport Locality Plan has in place a draft Equality Impact Assessment (EqIA). See Appendix 7 for details. This is constantly kept under review within the programme and will be updated to reflect consultation and further data analytics. Given the breadth of the new model outlined in this business case, individual workstreams will be producing detailed EqIAs for their areas. The overarching EqIA will consider any cross-cutting implications that emerge from workstream EqIAs and be developed further to address those that need to be considered from a system-wide perspective.

7 Overview and Business Case Approval Process

This overview is working through the individual partner governance arrangements as deemed appropriate by each partner. ***Alongside this will be the specific business cases noted in 3.5 as ready for September***:

- *4th July 16 – 15th July 16:* The Executive Board members engage with senior decision makers in their own organisations regarding the content of the draft business case, understanding any challenges or changes requested.
- *6th July:* The draft overview and process is discussed at Stockport Together Leader's Group.
- *18th July 16:* Stockport Together Executive Board endorse the draft overview and recommend them to individual partner organisations.
- *18th July 16:* - 31st August 16: Draft overview business case goes through individual organisation governance processes for formal approval including discussions with Overview and Scrutiny Committee.
- *1st September* – 30th September: First set of detailed cases approved.
- *1st October– 30th November:* Formal consultation with the public and staff deemed as required is undertaken.

8 Decisions Requested

Members are asked to approve the approach to business case approval described in Section 3.

Members are asked to approve the summary clinical model described in Section 3.

Members are asked to approve the overall summary financial plan as described in Section 5 subject to detailed case agreement.

Members are asked to agree the approach to Consultation in Section 6.5.

9 Further Information, Appendices and Queries

In the first instance please contact the Stockport Together programme office via:

Email: STOCCG.stockport-together@nhs.net

Telephone in office hours: 0161 426 5011

They will arrange for the best placed member of the team to address your enquiry either by email or through a telephone conversation. Please ensure you leave contact details.