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Blackpool Enhanced  
Primary Care  
Model Service Description  
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## Introduction

### Purpose of the Service Description

The purpose of this service description is to outline the vision for Enhanced Primary Care and define the detail regarding the introduction of Integrated Neighbourhood Teams across Blackpool Clinical Commissioning Group (CCG). The Business Case is in development but has yet to be taken through the CCGs governance process, it will not contradict what is described here and is consistent with the Value Proposition assumptions. This paper will cover:

- Context and case for change
- Proposed service model
- Implementation
- Key assumptions
- Benefits
- Risks

The CCG recognises that it is not able to fully quantify the likely benefits, since the proposed model of integrated care is new to the NHS in England, albeit in alignment with national policy and international review. Blackpool CCG aims to work collaboratively with key stakeholders including health, social care and voluntary agencies to govern their pooled resources in order to improve the health and wellbeing of the local population. However, the resource defined in the paper refers only to that element that is commissioned by the CCG.

## Background & Context

Enhanced Primary Care is described in the Value Proposition approved by NHS England as:-

*“...an enhanced level of clinical and social support provided in a community setting through the Integrated Neighbourhood Teams (INT). These teams will comprise of a range of services and provision, some of which is already delivered (but not integrated) across the Fylde Coast, such as:-*

- *Primary Care*
- *Community and District Nursing*
- *Community Mental Health Services*
- *Community Therapies*
- *Care Navigation*
- *Social Care*
- *Third sector and Voluntary services*

*This provision will combine GP’s, practice staff, community and specialist health staff working together to enable individuals to receive a high level of clinical support whilst remaining in a community setting.”*

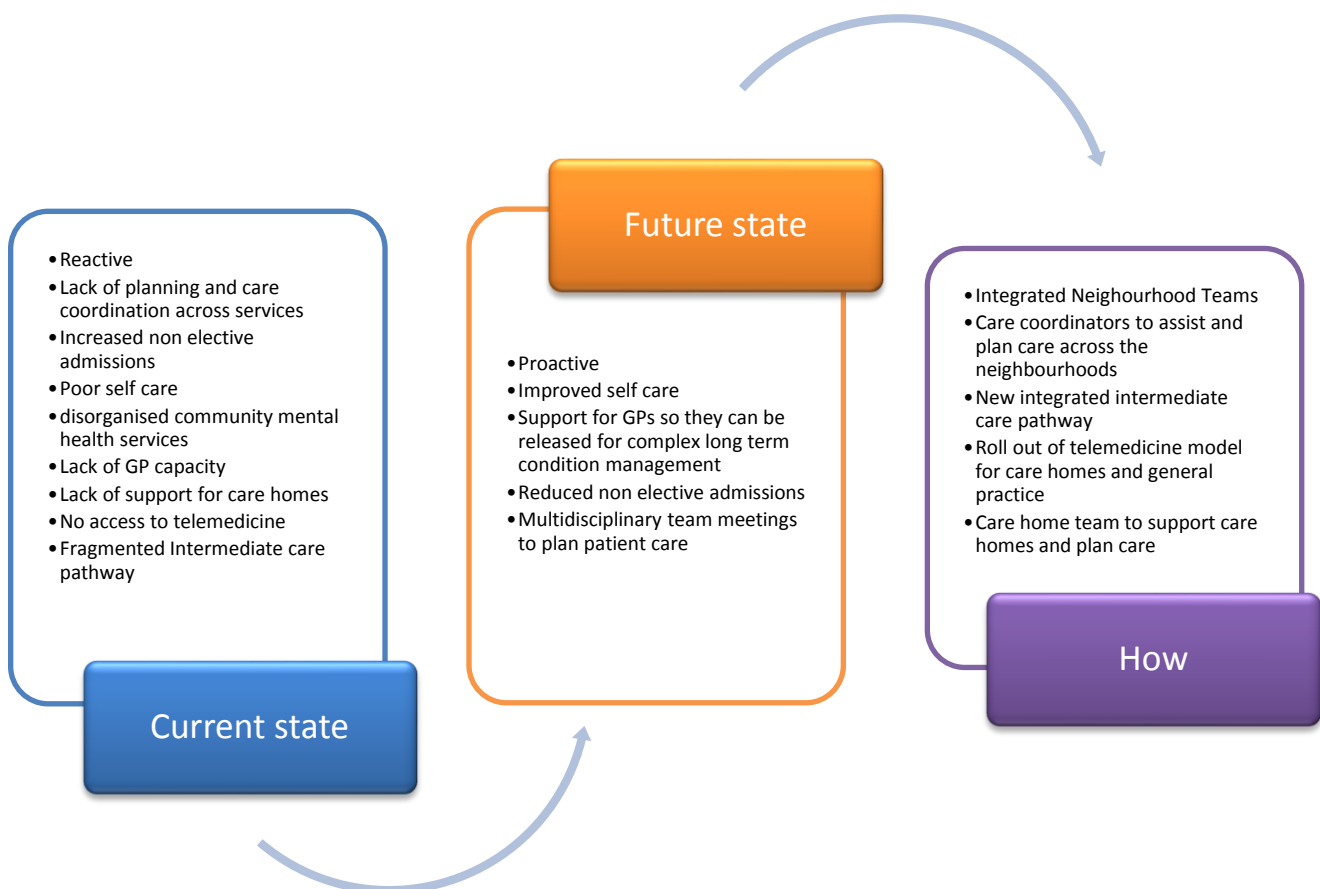
In Blackpool the NHS commissioning organisations, i.e. the CCG and previously the Primary Care Trust, have invested heavily in primary and community care services recognising that it is essential and preferable to treat or maintain people’s health as close to home as possible and avoid the need wherever possible for recourse to secondary care

services which are increasingly under pressure from the growing demand. Some examples of this investment include:

- Premises
- Rapid Response Plus
- Acute Visiting Service

This has ensured that there is a very high standard of primary care provision in Blackpool but it is recognised that this needs to go further to meet the challenges of the future.

## Case for Change – New Models of Care



## Current Position

General practice is, and is likely to remain for the foreseeable future, the first point of contact many people have with health and care professionals when raising issues (perceived or real), with general practice often acting as the main gate keeper.

Given the forecast changes in demographics, public expectations, advancements in treatments and disease management, just maintaining existing services will fail to keep pace with the current and emerging demands on general practice.

Approximately 90% of all contacts with the NHS occur in general practice, and the average consultation time per patient has increased. The volume of GP consultations has risen by 19% from 2008/09 to 2013/14 with just 4.2% growth in GP numbers. Investment in primary care has fallen well below investment in hospitals despite the increase in expectations regarding the volume and type of work that should be carried out in primary care. Between 2003 and 2013 the number of hospital consultants increased by 48% while GP numbers only increased by 14% during the same period. The number of GPs per head of population has fallen since 2009 which is thought to be due in part to recruitment and retention issues (Summons 2015).

Many GPs believe the allotted 10 minutes consultation time with patients is not enough, particularly given the increasing numbers of patients with multiple, often complex, chronic conditions. Often the demands on their time prevent them from spending longer than this, other than in exceptional circumstances. The number of consultations being offered has significantly increased over time and is set to increase further. This is against a backdrop of a reduction in the proportion of funding being invested in general practice as a proportion of the total spend on all health services.

General practice receives funding from many income streams and contracting arrangements vary making it extremely complex to manage leaving practices with uncertainty regarding practice income. Certainty regarding practice income would however enable practices to develop plans for the future and invest in services and staff, as well as allowing flexibility to work in different ways.

Work undertaken by Blackpool CCG as part of the 2014-19 Strategic Plan, alongside work done in partnership with wider partners over the Fylde Coast has identified clear themes:

- Our population is growing, as is the proportion of older people. On the Fylde Coast the number of those aged over 65 are set to rise to between 31% and 35% by 2028 and there are increasing numbers of people with multiple and complex long-term conditions. These factors are putting a strain on resources, which is not possible to respond to without transformation in the way we provide care.
- Continuing to care for our communities in the same way is not financially sustainable. Forecasts for the next five years show that commissioner deficits could reach £15m. The acute provider deficit is expected to grow to £56m. In addition, each of our local authorities is anticipating spending cuts of 10% during the next two years at least.
- We know more people are cared for in hospital than is necessary and that care can be provided more effectively in the community or at home. The care we provide is not always coordinated as well as it could be and this can lead to poor experience for our patients and their families.
- The workforce challenge that is impacting nationally is compounded locally due to the geography of the Fylde Coast. The RCGP estimates that:
  - More than 1,000 GPs will be leaving the profession on an annual basis by 2022
  - The number of unfilled GP posts has nearly quadrupled in the last three years (2.1% in 2010 to 7.9% in 2013)

**Continuing to do more of the same is not an option.**

## Definition Clarity and Scope

Our New Models of Care approach combines Extensive Care and Enhanced Primary Care enabling services to be provided appropriately across the spectrum of need. However the assumptions that sit behind these tiers of provision differ in response to the level of need that the respective populations present. Therefore we will focus on each tier individually and so this Business Case will cover only those elements that make up Enhanced Primary Care, although reference will be made to the connectivity and flow between tiers. The Integrated Neighbourhood Teams that will support primary care will **act as a catalyst, amplifying the impact that existing care (health, social and third sector) services** have. Through co-ordination and better management of the system we will leverage better outcomes for patients.

## Proposed Service Model

Improved integration of health and social care was the focus of the Better Care Fund (June 2013) and was further stressed in the publication of the Five Year Forward View (October 2014). Partners across the Fylde Coast health and care system, building on earlier work, began to develop New Models of Care in early 2014 when we reviewed successful international models.

The key principles underpinning our New Models of Care are to provide targeted support to those who require services, to ensure a focus on prevention and early identification in the wider population and access to appropriate support where necessary, across the continuum of need.

In this newly designed system of care, people will not experience unnecessary hand-offs, referrals and / or discharges from one team to another. Services will wrap around individuals and manage the system on their behalf. Increased effectiveness will result from pro-active management of patients with long term conditions, the personalisation of treatment and care, improved assessment processes and the development of bespoke care plans. Wherever possible and practical patients will be assessed once, across the health and social care spectrum.

The practice of different specialists visiting patients to assess for particular needs will stop. Care will be coordinated through designated Care Coordinators operating within the Integrated Neighbourhood Team. The teams will be designed to support and manage care from self-management through to periods of crisis. A range of services (existing and new) will be aligned to link with the Integrated Neighbourhood Teams providing a seamless flow for patients and freeing up capacity within general practice to enable the GP to support those with greatest need.

In addition, new roles such as the Wellbeing Support Worker will be introduced to ensure that patient activation remains a key focus. This will enable a 'golden thread' of care to run between the two tiers of our new model of care (Extensive Care and Enhanced Primary Care) supporting patients to move seamlessly between the two tiers of provision depending on their level of need.

## The New Models of Care

There are two main components of our model being implemented under the Vanguard Programme; Enhanced Primary Care (EPC) and Extensive Care, which together will deliver a seamless proactive out of hospital service. Extensive Care is focused initially on patients over 60 years of age with two or more long term conditions. Enhanced



Primary Care will be available for any other patient who requires the enhanced level of support the model will provide. Both components work seamlessly together to provide targeted out of hospital care.

The model is founded on patient's needs, which are then supported by fully integrated health and social care teams. One of the key components of the care model is clear patient accountability. All care decisions are taken by the patient and/or their Carers, supported by the lead professional and their care team. This care team has holistic responsibility for the patient's care, acting as the coordinating point across the local health and social care system, holding other individuals and organisations to account with respect to their patients. This is consistent with the public health approach of community-oriented primary care, basing interventions on community need. EPC requires moving assets across multiple agencies and community organisations to re-focus our efforts from illness to a clinical agenda aimed at enabling people to live well.

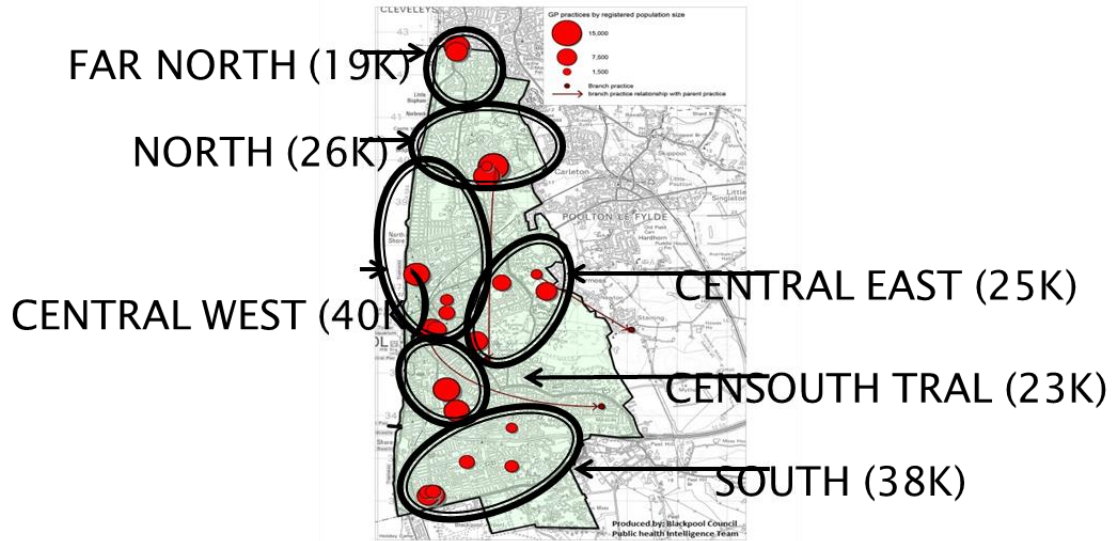
Enhanced Primary Care is supported through a number of **guiding principles**:

- A focus on prevention and not just treatment
- Primary Care at the heart of the system
- Population wide approach and not just responding to needs of individual patients
- Personalised care designed around the patients' needs
- Care planning and shared decision making
- Integrated multidisciplinary locality care teams
- Self care
- Shared assessment and support planning processes
- Primary resource used to help patients manage their own health and wellbeing.
- Patients will be assessed for need once, wherever possible and practical

Workforce structures will be as flat as possible, and will contain as few different types of roles as possible. There will be an emphasis on the multi-skilled element of the roles, maximising flexibility in service delivery such that responsibility is devolved down to the most appropriate level wherever possible

The new model of care will be delivered in six neighbourhoods across Blackpool; integrating a range of primary, community, acute, social, third sector and other services around the registered populations of practices.

Neighbourhoods are based on groups of GP practices covering populations of 20000 to 40000 patients, and builds on their local health, social care and voluntary service and estate assets available to deliver integrated care. Taking a geographic approach enables the various supporting links among statutory, public and third sector services to be maximised. It also ensures that some of the more enduring problems of social isolation, loneliness and poor mental health, much of which underpins poor physical health, will be tackled more effectively.



Neighbourhoods will be empowered to tailor the services to best meet the needs of its population, slow the progression of diseases and support people to stay independent for longer. Involving individuals and communities in designing services will ensure that approaches are relevant locally; that they do not duplicate (and are integrated with) existing services in the community; and that they are more likely to be successful.

The nature of consultations will change, to better combine clinical expertise with patients' aspirations for wellbeing. Patients will be asked more frequently about their wellbeing, capacity for improving their own health and be offered support to manage conditions themselves (e.g. health information, advice and equipment) or social prescribing. GP capacity will be freed through the Extensive Care service and through having better co-ordinated, integrated services through neighbourhood teams supported by new roles (Care Co-ordinator, Wellbeing Support Worker), so GPs are able to focus on the management of more complex patients, assuring compliance with best practice to improve health outcomes.

Practices, working in neighbourhoods, will work together with their Integrated Neighbourhood Team to:

- Coordinate plans of care, particularly for people who regularly visit the practice and whose health is at risk of deteriorating. If relevant, patients will be offered self-management support and/or social prescribing – directing them onto other information, resources and services available in their local communities
- Provide additional capacity for improving health and wellbeing
- Test new ways to build and improve relationships with local communities
- Establish a map of local community assets that can be harnessed for health and wellbeing
- Identify and develop local community health and wellbeing champions

In addition, the Directory of Services (DOS) of statutory and third sector services will be widely available to assist staff across health, social and voluntary services, supported by Wellbeing Support Workers to refer people to the right service, in the right place, the first time so they receive the right level of care for their assessed needs.



## Target Population

The cohort of patients will be defined by those who will benefit most from the care offered by this tailored service and will be identified by need and care provider knowledge to assess/review their needs and take a proactive approach to personalised care planning to provide the most appropriate interventions for each person.

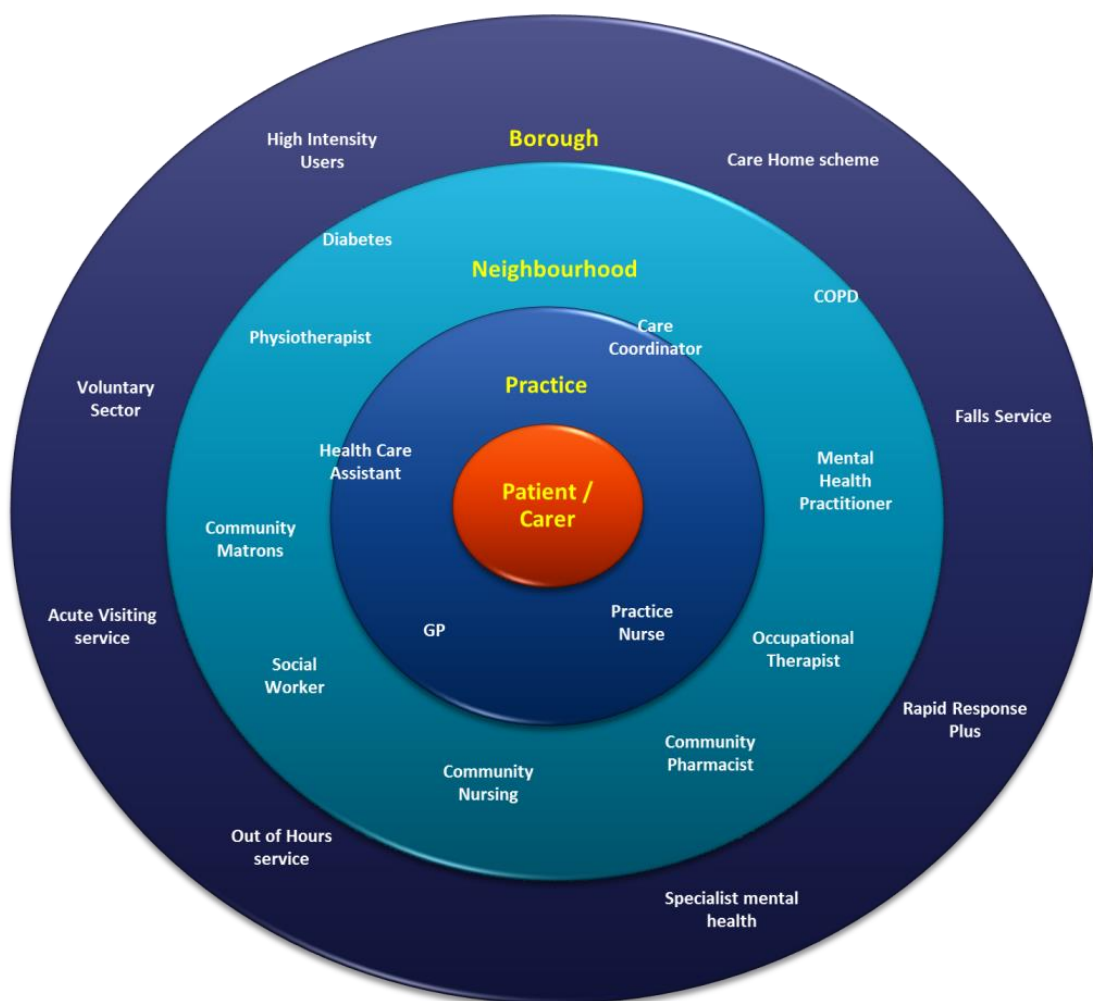
The population includes all patients over the age of 16 (excluding patients actively managed under the Extensive Care service).

Initially implementation will focus on the core Integrated Neighbourhood Team targeting those people with the highest level of needs and who use care services the most, however the model will flex to ensure services are developed to reflect the needs of the neighbourhood demographic, ensuring that those people identified within episodic care can access a wide range of services to meet their needs.

# Service Description

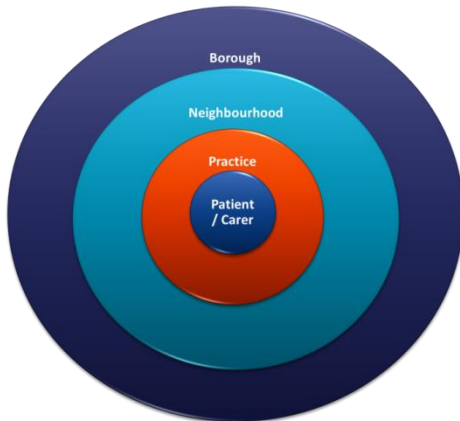
Central to the EPC delivery model is the development of a fully Integrated Neighbourhood Team based in each neighbourhood and centred on these groups GP practices. The teams will incorporate health and social care and will address patient need through a single point of access. The locality based teams will be designed to support and manage care from self-management through periods of crisis. A raft of services (existing and new) will be aligned to link with the neighbourhood based teams providing a seamless flow for patients and freeing up capacity within general practice to enable the GP to support those with greatest need. Integrated Neighbourhood Teams will include primary, community and secondary care services working closely with third and voluntary sector services.

**Enhanced Primary Care will be part of an integrated care system that will wrap integrated care coordination and care provision teams around patients and primary care, at the appropriate scale**



Below are some of the key areas of focus for commissioning services that will support delivery of EPC. This prioritisation draws out the areas where greatest impact is needed to create an environment that will support the development of EPC through a clear evidence base and benefits analysis.

## Practice Level



GMS Plus - The CCG, in collaboration with its member practices has developed a local new contract framework in addition to the core national contracts, to address some of the current inequity in funding and service provision to create a firm baseline for a standardised approach for enhanced services for all 172,000 of the registered population.

There are currently three main contract types operating within Blackpool; general medical services (GMS), PMS, APMS and as a result there is wide variation in funding available based on various historical arrangements. In addition, practices have taken on additional locally commissioned services such as the CCG infrastructure scheme (£5 / head scheme etc.). This has

meant that overall investment in primary care in Blackpool is significantly higher than most other parts of the country and has enabled practices to maintain high standards of care despite the growing pressures. Initially in 2016/17 the CCG will reinvest the PMS premium across all practices, not just PMS, to reduce the variation.

The GMS Plus contract, introduced in shadow form in September 2015, amalgamates a number of local enhanced schemes and coordinates the contract arrangements for services commissioned within the one contract and with one payment mechanism backed by recurrent funding.

Whilst it is recognised that there has been a higher than average investment in primary care in Blackpool, this has been against a backdrop of increasing pressures, difficult recruitment and growth in secondary care.

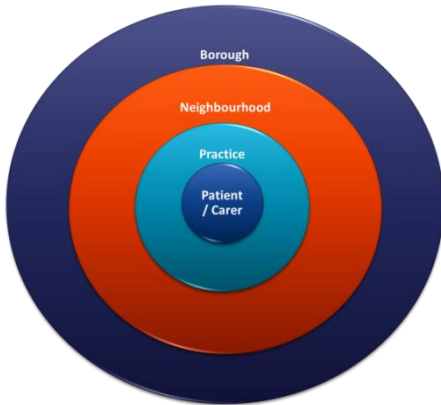
### *GMS Plus Benefit Analysis*

The GMS Plus contract will begin to reduce the variation in practice income, provide simplicity and certainty in the income stream for a standard level of access and quality of service. Therefore the variation in practice outcomes and use of secondary care should be reduced by the standardised approach to agreed care pathways, adoption of best practice and certainty of funding to support longer term planning. It can therefore be assumed that benefits can be planned by the adoption of the GMS Plus contract in financial terms (as well as qualitative) e.g. by reducing the variation in use of other services such as Secondary Care, Walk in Centre, Same Day Health Centre, etc.

Benefits are difficult to accurately quantify as some practices are already providing a number of the services covered by the new service specification, given the current variation in funding and service delivery. A key benefit will be all residents benefiting from access to the same range of high quality of services regardless of which practice they are registered with, and as a minimum there should be a reported increase in patient and staff satisfaction with much more treatment and care being provided closer to home, following the full implementation of the service specification.

The GMS Plus contract provides a solid foundation for an “enhanced primary care” service but to be consistent and effective requires better co-ordination of services currently provided, the organisation of services and the introduction of new roles and new ways of working.

## Neighbourhood Level



Enhanced Primary Care will bring a new approach to delivering care, creating a framework around which practices, working in neighbourhoods can organise themselves to deliver high quality care focused on the goals and preferences of individual patients and tailored to meet individual needs.

The Integrated Neighbourhood Teams (INT) will provide a new multidisciplinary model of enhanced and expanded out of hospital care which will be provided by a range of service providers including the voluntary

sector. The objectives are to:

- Deploy a proactive care planning approach that will identify and respond to the needs of this population earlier than current services, therefore improving quality of life and supporting frail older people and those with Long Term Conditions to continue to live independently for as long as possible.
- Promoting self-care and health and wellbeing through social prescribing and using the third and voluntary sector to support and enable early interventions to be put in place where appropriate
- Provide access to shared records for health, social care and 3rd sector where relevant.
- Shift the provision of care from an acute setting to support people in the community.
- Have a workforce for whom behaviour changes will seek to promote self-care and proactive care planning

Whilst the establishment of multidisciplinary teams is at the core of proposals, there is no intention to provide a uniform approach to the size and mix of teams across Blackpool. Needs in each of the neighbourhoods vary considerably and there will need to be some flexibility applied in establishing local arrangements which, whilst meeting the core objectives of the model of care, are delivered in differing ways. Priorities will be developed through the production of Neighbourhood Plans which will reflect the needs of the population they serve.

### *Integrated Neighbourhood Teams (appendix 5)*

Integrated Neighbourhood Teams are the delivery vehicle for EPC and it is anticipated the delivery model will develop over time, however in its simplest form it can be illustrated below:

### *Working in Integrated Neighbourhood Teams*

EPC is designed to enable clinicians to operate in a more collaborative and cohesive manner across provider boundaries. Integrated Neighbourhood Teams will need to set out their preferred means of interaction for care professionals, including the best way of communicating effectively and the nature and frequency of interactions. These interactions can vary from regular practice meetings, virtual MDTs to full monthly themed MDT meetings.

Each neighbourhood will have a staff skill mix made up of health, social care and the third sector staff:-

- District Nursing
- Care Coordinator
- Physiotherapy/ Occupational therapy
- Mental Health worker
- Wellbeing Support worker
- Pharmacist
- High Intensity User support
- Community social worker

### *Access and Referral*

Information/advice would be provided via a single point of contact either in response to individual enquiries or through outreach arrangements whereby information is provided to some individuals and communities. GPs will have open access to the service for suitable patients; other professionals will be able to refer to the service within agreed referral criteria. This would be supported by a comprehensive health and social care and voluntary sector Directory of Services (DOS) which can be accessed by staff and the public alike. The aim is to provide as much information as possible at this point to:

- Enable the person to manage their own needs and requirements, or
- Signpost them to alternative services which they can access directly, or
- Assess their needs for other health/social care services

### *Assessment and Care Planning*

A holistic person centred assessment will be carried out by the Care Coordinator or appropriate member of the Integrated Neighbourhood Team, and will include the assessment of individuals for the use of assistive technology (tele-care and tele-health). Information recorded will then be shared electronically with other professionals as appropriate to avoid duplication. As needs emerge, discussions would take place with the person and carer/representatives regarding the type of support required, who is best placed to provide it and how the support should be managed.

Development of a personalised care plan should follow the approach described in “Delivering Better Services for People with Long Term Conditions – Building the House of Care<sup>1</sup>.” This represents a departure from the current

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<sup>1</sup> <https://www.england.nhs.uk/house-of-care/>

focus on individual diseases towards a generic approach in which patients' goals drive care delivery and greater attention is paid to the contribution that people make towards managing their own health.



Patients, along with their carers, will be encouraged to play an active role in determining their own care and support needs as part of a collaborative care planning process. This will involve discussing care and support options, agreeing goals the patient can achieve themselves to stay healthy and supporting self-care. The care co-ordinator will review the care plan with the person and their carer at a frequency agreed at initial assessment.

### ***Care Coordination & MDT***

There is no one model of care coordination, but evidence suggests that creating patient centred care that is more coordinated across care settings, particularly for patients with long-term conditions and medically complex conditions who may find it difficult to navigate fragmented health care systems is likely to achieve better results.

The Care Co-ordinator is a pivotal role to the Integrated Neighbourhood Team and will be the interface between service users, carers, primary care, secondary care, community care, social care, mental health, out of hours and voluntary organisations. They will have overall responsibility for the INT meetings and the smooth running of coordinated care within the team setting. The key role of the Care Co-ordinator with administrative support, will be to schedule the Multi-disciplinary Team meetings, manage the meeting agenda items, ensuring that all new referrals are identified and information circulated to team members in advance of the meeting.

Neighbourhoods will create or extend existing forums for discussing the more complex patients across multiple providers. These meetings can be used to improve quality and reduce avoidable admissions through improved coordination.

There will be also be 'themed' quarterly Multi-disciplinary Team meetings which should ideally include professionals from both health and social care. This might include specialist nurses, social services, housing and finance advisors, community matrons, mental health specialists and district nurses depending on the needs of the patient. These will provide the opportunity to review clinical cases, identify where gaps are not being addressed and identify learning and improvement.



A decision about the most appropriate intervention and arrangements for review will be made following multi-disciplinary, multi-agency discussion and assessment. The decision regarding care management and the appropriate level of support required should be made in partnership with the patient and carer, shared at the multi-disciplinary team meetings at GP practice and neighbourhood level, and communicated to all other partners involved in the person's care.

### ***Patients Supported to Manage their Health and Wellbeing***

Not all of the people who fulfil the criteria will need to be case managed. Some people, for example those who need less intensive interventions and those in lower range risk groups, will benefit more from other targeted approaches from a range of practitioners with the skills to support self-managed care.

The Integrated Neighbourhood Team will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing. A culture of self-management support will underpin care coordination, recognising that the personal information that patients, their carers and families bring to the development of care plans can be as important as the clinical information in medical records.

Practices will be supported to develop an infrastructure to provide self-management support for patients with ongoing long-term conditions and support for their carers. Following a new diagnosis of a long term condition all patients will have at least one encounter dedicated to enhancing their ability to self-care, and then frequently according to need thereafter.

The third and voluntary sector has an important role to play to support wellbeing and social prescribing. They will be involved, where appropriate, in both care delivery to support people in the community, reducing the dependence on medical intervention.

### ***High Intensity Users (appendix 2)***

The service will be provided to any individual or family registered with a Blackpool GP who meet the eligibility criteria of existing or emerging high intensity users of primary care and urgent care services, who are experiencing crisis and chaotic lifestyles or who present as vulnerable.

### ***Named Professional***

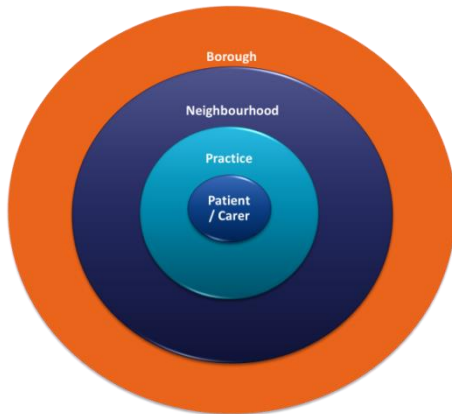
Clinical responsibility will remain with the GP, not with the employing organisation, for patients in EPC. Patients identified as needing coordinated care will have a named professional who will oversee their care to ensure continuity. The Accountable GP will provide continuity of care, either personally or in collaboration with the multidisciplinary team of clinicians and professionals in and around the practice/neighbourhood.

The person who coordinates their care should work with the patient to achieve their goals. For some patients this will require extended consultations, for others it will mean regular contact with the Integrated Neighbourhood Team. The intensity of contact and amount of time spent with the Accountable GP and extended team will fluctuate

in accordance with need, as assessed by risk profiling and regular communication with patients and their family and carers.

If patients go into hospital or transition to other services, including Extensive Care, the named professional should continue to be proactively informed about the patient as they move between services, continuing to coordinate their care if appropriate.

### **Borough Level**



On the borough level footprint services will be commissioned to link and support neighbourhoods.

### ***Community Mental Health (see appendix 3)***

GPs will still have access to a range of specialist mental health services via the Access and Treatment team. However redesign will mean that there are no steps in the future model and that neighbourhoods know who to contact about mental health issues.

It will comprise

- Access and treatment team
- Community mental health team
- Increasing Access to Psychological Therapies

### **Key Outcomes and Timescales**

- Patients and their families should feel able to access services more easily and understand how to navigate the new system.
- The new model should be in place from April 2016
- Patients with Long Term conditions will be more able to access talking therapies in 2016, starting with Diabetes, Cardiac and Pulmonary conditions. This should help people to self-manage by reducing anxiety and depression associated with their conditions.
- Services should be able to be delivered in people's homes where they want it to be.

### ***Intermediate Care***

Blackpool Intermediate Care Review was jointly undertaken by NHS Blackpool CCG and Blackpool Council. Its aim was to identify what intermediate care services were needed and how these would work together to best effect and describe a model which: -

- Promotes independence and wellbeing and prevent, reduce or delay the onset / development of need/s
- Supports care closer to the person's home
- Simplifies intermediate care pathways to provide effective and accessible integrated services
- Prevents people attending or going in to hospital unnecessarily
- Prevents people from having to move in to residential care or nursing care until they really need to

### ***Rapid Plus***

The Rapid Plus service was commissioned following the recommendations of the Fylde Coast Unscheduled Care Strategy which recommended the development of services that provided alternatives to hospital admission. The Rapid Plus service utilises a model of integrated Multi-disciplinary Team meetings working with health and social care with links to condition specific pathways, Primary Care, Out of Hours services and Care Co-ordination services to ensure 24/7 health and social care provision.

The service was built on an existing system (Rapid Response) which was already embedded and well regarded in primary and secondary care.

The service aims to avoid admission for patients with a diagnosed health need and/or urgent social care need and is accessed by a phone call.

An integrated expert health and social care team then provide rapid assessment within 2 hours and mobilisation of appropriate support, referral onwards and signposting to appropriate services.

### ***Falls Pathway Review***

Due to the high number of admissions and conveyances, Blackpool CCG along with Blackpool Teaching Hospital are reviewing the falls pathway.

Each section of the pathway has been reviewed with the provider to ensure it is functioning properly. The Blackpool Falls group have identified gaps in provision i.e. non injury patients in care homes and additional provision for this aspect of the pathway is being reviewed. The review has been working closely with NWAS to ensure the non-injury pathway calls have links to currently commissioned services.

Blackpool CCG is also completing a review of intermediate care services and the falls pathway will be part of the final model. This will then include an element of falls prevention and links to other community services to ensure continuity of care. Blackpool Teaching Hospitals are in the process of setting up an ambulatory care pathway at the urgent care centre which will include falls.

### *Telehealth, Telecare and Telemed Solutions*

Telehealth/Telecare solutions allow the diagnosis and treatment of patients at local level in real time without the need to refer patients to specialised providers. They improve access in areas where specialised services are not easily available and, as a long-distance training tool for health care professionals, supporting the coordination of services.

Our aim is to change the way we manage and treat patients with complex health needs in care homes. These patients often have recurrent exacerbations of their condition and are very likely to have frequent admissions to hospital which need to be managed. As such plans are already underway to broaden the ICT infrastructure to support the wider delivery of care closer to home through the Care Home Connect scheme. This will enable both health and social care services to maximise the clinical outcomes by providing enabling access to software in their normal workplace.

Through the delivery of Care Home Connect, we will be able to deliver remote/virtual video consultation with the patients / residents without the need of a GP, health or social care professional visiting the care home. This will enable rapid access to patients for assessments and also support records to be updated in real time. And with access to equipment and software through Social Services and other community service initiatives, we will enable real time, historic and ongoing monitoring of vital signs to go alongside any remote / virtual consultation, which will give a far greater picture of an individual's health than visual alone.

As we look to deliver intermediate care closer to home, there will be a need to be able to track patients from the point they are identified, through the assessment process, and then through a programme of health and social care into either long term support, enhanced short term support, or full independence.

Those providing care from third sector and voluntary services will also benefit from the developments, as key stakeholders will be able to access, report and, in the future, input clinical / social interventions directly onto interoperable systems in providing better integrated care. Supporting the delivery of the overall strategy of caring for our citizens, through skilled multidisciplinary teams and care home staff who are able to access and follow updated care plans for individuals.

### *Musculoskeletal Clinical Assessment & Treatment Service*

As part of shifting activity into community settings, Blackpool CCG is exploring the commissioning of a Musculoskeletal Clinical Assessment and Treatment Service (MSK CATS). MSK CATS is designed to allow many patients to be managed without secondary care intervention – providing greater capacity at a reduced cost. Research shows that this service would help to alleviate pressures, and while it is not expected to initially reduce referral rate, it will allow the opportunity for patients to be managed more conservatively in the community. This is a nationally recognised model which is utilised by a number of CCGs nationwide.

This Tier 2 CAT service is expected to manage all MSK referrals in Blackpool through a triage and treat model by experienced clinicians, specifically: Consultant Physiotherapists, Extended Scope Physiotherapist and GP's with a Special Interest. Referrals are then appropriately either fed into Community Physiotherapy, kept within the Tier 2 service, or to secondary care.

This service is expected to shift secondary activity into community settings by as much as 40% with aims for an increase in patient satisfaction and GP satisfaction from a more responsive service.

### **Care Homes**

In January 2015 Blackpool had 14 nursing homes and 56 residential homes with a bed total of 1593.

To help improve quality, reduce unnecessary admissions and reduce the demand on primary care, the Blackpool care home model would provide a dedicated clinical triage hub that would enhance primary care by managing patients in care.

- The scheme would be initially piloted in one neighbourhood
- Clinical triage hub staffed by Blackpool Care home team to operate 8 – 6 weekdays and 9 – 1 at weekends. The service would hand over to the out of hours care coordination service.
- The service would coordinate and triage calls from care homes, coordinate GP visits and sign post as required
- The team would provide 'ward rounds' to the care homes to assist in the planning of care for the care home residents
- To continue to provide some education and training for care homes
- Each care home and GP practice would have phone, Wi-Fi and telehealth links for video conferencing.

#### **Objectives:**

- To provide additional support to primary care
- To reduce conveyances, A&E attendance and NEL admissions
- To provide continuity of care for care home patients and reduce primary and community care demand
- Improve community urgent care communication
- Empower remote assessment of patients to escalate appropriately and defer confidently
- Meaningful coaching for Care Home staff
- To improve medication review processes for care homes via links to practice pharmacists and reduce waste.

### **Workforce**

The new model is not a simple restructuring exercise and will be developed to facilitate neighbourhood working with the clear ambition of creating service and financial resilience for the whole economy. We will take a highly granular approach to designing the pathways of activity that the core INT will deliver to patients. This will allow us to build a

staffing model from the ground up ensuring the right professional is doing the right task at the right time. This optimises staff efficiency and gives professionals the most patient-facing time possible.

Designing activities in this way, coupled with the recruitment challenges across the system, drives us to move away from traditional staff roles where highly qualified professionals are too often used inefficiently, carrying out tasks that can be done by a lay person or supporting professional. The way care is currently delivered also lacks the right level of standardisation with staff regularly duplicating similar, or the same assessments, when one trusted opinion would suffice.

Our staffing model will eliminate this waste in the system and create new professional roles which bring together skills and competencies from different care settings and backgrounds forming a core skill set that will not only make the delivery of care more effective but bring a new and exciting prospect for potential candidates considering working in the area.

A new staffing model for the neighbourhoods also presents us with an opportunity to reverse a trend of over-specialisation in some clinical professions; unique skills and competences will not be shared and staff will not be expected to undertake tasks for which they are not competent. Over time, teams will be able to capitalise on skill sharing and role blurring, in recognition of shared core skills across professions. This will enable staff to provide a more coordinated approach to a person's care, rather than depending on a number of different professionals being involved.

We also have an opportunity through EPC to take a much greater advantage of the skills and resources of the voluntary sector as we aim to have a significant volunteer presence within the neighbourhoods. Care Coordinators, supported by Wellbeing Support Workers will act as a focal point of contact for each patient with the neighbourhood; coordinating all aspects of the individuals care, navigating the wider health system and performing suitable assessments and management.



# Implementation

Delivering our vision represents a huge change both organisationally and culturally and a holistic approach across the whole Health and Social Care economy will not be achieved in a single step. The development of EPC and in particular the Integrated Neighbourhood Teams, will be incremental with the initial roll out beginning in North and Far North neighbourhood in April 2016. Further roll-out to South will be carried out in parallel to South Central in June 2016 and finally Central West and Central East in September 2016. This approach minimises the risk to full roll out and provides an opportunity to develop the model, and transfer the learning to the other neighbourhoods ensuring a smoother transition to the new ways of working.

In Blackpool we already have good primary care and community services. We have a responsive social care sector and a large third sector. The challenge is that they to often work as different systems and as a result there is a too much duplication and time and resource in being wasted.

Through the delivery of Extensive Care and EPC it will free up GP time, through having to spend less time addressing their patient's issues that do not require their expert input. Through more appropriate support patients will be able to have less of a requirement to visit their GP. This will allow GP time to be better utilised to focus on patients where their expertise is put to better use and also provide strong clinical leadership for EPC.

## Timescales

<b>Short-Term Outcomes</b> (Relevant patient cohorts)	<b>Medium-term outcomes</b> (Registered population)	<b>Long-Term Impacts</b> (Registered population)
<p><b>Neighbourhoods established</b> EC/EPC and other primary / community services integration</p> <p><b>Clinical Care / Safety/Quality</b> Improved management of exacerbations of conditions. Hospitalisation rates (-50%). Increased prevalence rates.</p> <p><b>Patient Experience/Health and Well-Being</b> - increased knowledge and management of own health. Increased confidence in service responses by patients &amp; carers.</p> <p><b>Funding and Efficiency</b> Reduction in acute costs of £5.1m for CCGs</p> <p><b>Workforce</b> - new generic worker roles and professionals with improved generic skills</p> <p><b>ICT</b>- tele-health/care deployed. Use of 'apps' by patients to improve condition self-management. Directory of Services in place.</p>	<p><b>MCP established</b> – following agreed legal/governance forms</p> <p><b>Clinical Care /Safety/Quality</b> Improved diagnosis rates of long term conditions. Hospitalisation rates (-30%) Earlier diagnosis for cancer. Hospital mortality levels within expected range.</p> <p><b>Patient Experience/Health and Well-Being</b> – lower levels of social isolation. Improved patient and carer satisfaction. Increased personal resilience. More positive lifestyle choices.</p> <p><b>Funding and Efficiency</b> – health/care services financially and clinically sustainable and £25.6m saved by CCGs</p> <p><b>Workforce</b> – recruitment and retention rates sufficient. Skill mix changes in primary care</p> <p><b>ICT</b> – integrated health and care records.</p>	<p><b>MCP/ACO in place</b> – as a long term model for services</p> <p><b>Clinical Care/Safety/Quality</b> Increased life expectancy. Reduced health inequalities. Reduced years of life with a debilitating condition.</p> <p><b>Patient Experience/Health and Well-Being</b> - patient satisfaction levels high for all services. Lower levels of worklessness. Increased participation rates in social activities. High personal resilience.</p> <p><b>Funding and Efficiency</b> – sustain the levels achieved at medium term.</p> <p><b>Workforce</b> – happy staff. Skill mix changes that maximise the use of all team members.</p> <p><b>ICT</b> – real time clinical predictive analytics.</p>

The diagram above shows the outcomes (on a Fylde Coast basis for NMoC). To achieve these outcomes Blackpool will evolve the model described to act as a catalyst for further system change. During 2016/17 there are key tasks outlined below that will achieve the short-term outcomes.

In 2017/18 the Integrated Neighbourhood Team and GP time that has been freed up, will leverage change across the wider health and care economy to change how we care for all registered patients. This will begin to address the aspirations for the medium/ long term outcomes.

### **Dec 15 – March 16**

The project team will, during this period, be working intensively with health and social care staff to develop the model and agree the structure for how the new neighbourhood teams will operate. Working with enablers to ensure that the estates, IM&T and HR elements are in place to ensure that neighbourhood teams will be co-located with appropriate IT access and information sharing agreements in place to enable teams to work efficiently and collaboratively.

### **April 16 – June 16**

Following phase one implementation, the CCG will work closely with providers and GP practices to develop the ongoing model for the other neighbourhoods, further refining the working practices of the neighbourhood teams. Recruitment will commence for the roll out of phase two in June.

### **Aug 2016**

Final implementation will commence with findings from early adopters incorporated. Redesigned borough wide services will form part of a wider neighbourhood Service, bringing services into the neighbourhoods where appropriate. They will be closely aligned to and work side-by-side with the wider INT, and will include 3rd and voluntary sector services.

Within the wider neighbourhood service supporting EPC, we anticipate the following to have been established and operational:

- GPs to have formed six neighbourhood groups, corresponding to the neighbourhood team geographies, which are working collaboratively amongst themselves, and with the integrated neighbourhood team, to deliver services to their GP registered population.
- The Wellness Service will have been commissioned and beginning to operate across the borough, delivering preventative and wellbeing services to the population.

## **Neighbourhood development**

The whole programme delivery will require a significant culture change, in particular with GPs, practice managers and wider practice staff. The NMoC will not be successful without GP engagement, involvement and ownership. The CCG will facilitate a discussion with the neighbourhoods collectively and individually to discuss:

- What do we mean by 'neighbourhood working'?
- What are the benefits/challenges of neighbourhood working?
- What does a 'ready neighbourhood' look like?
- What work is needed to prepare neighbourhoods for EC/EPC?
- What is the current position in each neighbourhood?

- What is the leadership within each neighbourhood? For example: will lead GP / Practice Manager / Practice Nurse time be 'back-filled'?
- What work is needed to be done within each neighbourhood for successful implementation of Extensive Care and EPC – immediate issues; short-term issues; medium-term issues; long-term issues?

This will direct the immediate tasks required to support the neighbourhoods to prepare and make the cultural shift that will be needed to move toward a new model for primary care in Blackpool that will lead the improvements across the whole care economy.

## Optimum Service Delivery Model

In order to define the optimum service model for implementation of the Integrated Neighbourhood Team model considerable work has been done by design groups supported by Business Intelligence and Finance colleagues, to understand the required workforce skill mix and capacity, activity and impact assumptions. It is important to note that despite this detailed work the model proposed is still based upon assumptions and as such these may need to change as the model is implemented and evidence is gathered of actual activity, performance and impacts.

To assist in planning, the CCG has segmented its population into tiers corresponding to New Models of Care. Workforce and potential savings have been identified against these tiers with the patients with higher risk score (and secondary care spend) will require a higher level of support but also offer a greater opportunity for potential savings by reduction in avoidable secondary care activity.

**NB.** Although these cohort numbers have been used as a baseline for modelling the Design Group strongly recommends that the access to support from the Integrated Neighbourhood Team is wider and covers any patient who would benefit.

The Integrated Neighbourhood Team modelling (appendix 5) assumes a range of case loads for each team member that was co-created with providers of similar roles in the care economy. The workforce model is the starting point only. An agile learning approach will enable us to understand the operational reality and we will further develop the modelling with each iteration. As care shift into a community setting and the secondary care sector shrinks, resource will shift accordingly. Scenario 3 is thought to provide an optimum level of support from these types of roles to ignite change in the care system.

The potential costs are outlined in appendix 4.

## Impact on Acute Activity

The table below sets out the assumed activity impacts from EPC. The lead time to deliver these impacts, and associated reductions in PbR (Payment by Results) activity (under the PbR PODS of Accident & Emergency (A&E), Non Elective Admissions (NEL), Elective Admissions (EL) and Out Patient activity (OP)), is anticipated to be 12 months from full implementation of the New Models of Care (Extensive Care and Enhanced Primary Care). The estimates for Extensive care describe an assumption that the net cost of the service is neutral. It is recognised that current assumptions are based on PbR cost reduction and as such a saving for the CCG but it doesn't necessarily represent savings to the care system. Fixed costs will need to be modeled by the secondary care provider before they can be built into the assumptions.

**Table 2 - Activity Deflection Assumptions**

Patient Category	Number of Patients	Confidence of Deflection	Average Attendances for category	Attendances Avoided	Average Cost of Attendance	PBR Avoided
Extensivist - NEL	2,564	45%	0.79	911	£1,933	£1,760,794
Extensivist - EL	2,564	45%	1.20	1,383	£933	£1,290,094
Extensivist - A&E	2,564	45%	0.93	1,078	£94	£101,298
Extensivist - OP	2,564	45%	4.67	5,387	£105	£565,583
EPC Cohort 1 Tranche 1 - NEL	1,547	50%	1.59	1,231	£2,023	£2,490,313
EPC Cohort 1 Tranche 1 - EL	1,547	50%	1.72	1,328	£846	£1,123,488
EPC Cohort 1 Tranche 1 - A&E	1,547	50%	2.10	1,625	£94	£152,703
EPC Cohort 1 Tranche 1 - OP	1,547	50%	5.13	3,967	£105	£416,483
EPC Cohort 2 Tranche 1 - NEL	19,814	10%	0.16	309	£1,905	£589,217
EPC Cohort 2 Tranche 1 - EL	19,814	10%	0.48	941	£963	£906,376
EPC Cohort 2 Tranche 1 - A&E	19,814	10%	0.28	565	£94	£53,063
EPC Cohort 2 Tranche 1 - OP	19,814	10%	2.22	4,394	£105	£461,328
EPC Tranche 2 - NEL	40,199	10%	0.11	436	£1,905	£831,152
EPC Tranche 2 - EL	40,199	10%	0.35	1,398	£963	£1,346,659
EPC Tranche 2 - A&E	40,199	10%	0.29	1,150	£94	£108,138
EPC Tranche 2 - OP	40,199	10%	1.68	6,770	£105	£710,850
Episodic - NEL	78,775	0%	0.05	0	£1,905	£0
Episodic - EL	78,775	0%	0.18	0	£963	£0
Episodic - A&E	78,775	0%	0.20	0	£94	£0
Episodic - OP	78,775	0%	0.90	0	£105	£0
<b>Total</b>	<b>142,899</b>			<b>32,871</b>	<b>£766.68</b>	<b>£12,907,536</b>

## Risks

The main risks with regard to the model are:

- Unable to recruit to the required numbers of Integrated Neighbourhood Team workforce resulting in a delay in delivery of the full model and resultant negative impact on the assumed savings
- The model is fully implemented but fails to deliver the assumed benefits

In order to mitigate the workforce risks, the CCG as part of the Vanguard, is benefitting from a dedicated HR manager who will focus on the mechanics of the recruitment, such as job descriptions, agenda for change banding, advertising and appointment to ensure that this work receives an appropriate level of support. In addition, the CCG as part of the Vanguard, is also benefitting from a dedicated Workforce expert who is contributing to the strategy that this piece of work requires, as well as contributing to the workforce development that will be required.

The majority of the Integrated Neighbourhood Team focuses on un-qualified, generic posts with clear competency skills where a training programme will be provided. It is believed that we will be more likely to be successful in recruiting to these posts. Response to recruitment within Extensive Care to similar low level posts has been very good and it is fair to assume good levels of interest in similar posts within the Integrated Neighbourhood Team.

The detail contained in the modelling scenarios and business case is as robust as it can be but it is based on assumptions. The agile approach to implementation and learning will enable the model to be reviewed and the learning applied to each iteration of the model and in this way the assumptions about activity and savings can be similarly reviewed and updated in order to more accurately reflect the change in the system.

## Appendix 1 – Care Coordinator

### REVIEW EC ROLE TO ENSURE IT COMPLIMENTS AND INCORPORATE DETAIL BELOW

The Care Coordinator will;

- Coordinate care and if a health professional will also provide some, but not all, care
- Care coordinate and secure care and support arrangements to meet the person's care plan
- Through the Wellbeing Support worker, signpost the person and their carer to appropriate voluntary sector services including carer support services
- Is likely to be the person with the most frequent contact with the individual and may not necessarily be the professional who carried out the initial assessment. The person's care co-ordinator is not expected to frequently change
- Act as the link between the person and the other health and social care services required, both in and outside the integrated care team
- Review the care plan with INT colleagues, the person and their carer/ family to a frequency agreed with the individual
- Ensure the patient's care plan is readily available for other agencies/ services (as agreed with the individual)
- Multidisciplinary Team Meetings



## **Appendix 2 - High Intensity Users**

The service will be provided to any individual or family registered with a Blackpool GP who meet the eligibility criteria of existing or emerging high intensity users of primary care and urgent care services, who are experiencing crisis and chaotic lifestyles or who present as vulnerable.

The focus of the HIU work includes early intervention of homeless persons or those with housing problems, those who self-harm and medical/social presentations, who were not accessing scheduled services and, therefore, rely heavily on unscheduled services for their health care.

### **Aim**

To identify and manage vulnerable individuals and families who are current or emerging high intensity users of primary care, in order to improve their health and wellbeing and reduce avoidable A&E attendances and NELs.

### **Objectives**

- Identify and manage those at greatest risk of attending A&E and non-elective admissions.
- Support vulnerable individuals and families to improve their health and wellbeing.
- To manage the top high intensity users of GP surgeries.
- Form a robust network of community health, social care, mental health and police contacts to manage patients, creating true integrated working, including support to other services, INT and Early Action.

### **Referral and assessment Process**

Access to the service will be via referrals from GP practices (directly) or Integrated Neighbourhood Team. However, High Intensity Users may be also identified through data gathered from BTH and primary care data i.e. those who call more than 4 times in a month are identified and patient data accessible to the clinical lead to be managed. This will be at the discretion of the HIU lead clinician and any recruitment will be communicated to the Care Coordinator from the patients' INT.

Each referral is contacted by phone and assessed using a personalised approach to uncover the 'real' reason for calling 999. Following the initial telephone consultation, a process of support ensues with concordance underpinning changes in behaviour rather than compliance through fear of isolation from supportive services or fear of legal restrictions. The lead acts as an advocate for each patient, guiding them through the complex journey and multifaceted approach which has resulted in appropriate use of unscheduled care. Whether the reason for calling is clinical, social, mental health, addiction, loneliness or a combination of any of these factors, the project lead will identify and adapt the support to meet the need.

**Interdependencies**



## Appendix 3 - Community Mental Health Team

### Access & Treatment Team (ATT)

- 7 days a week 24 hours per day
- The ATT will be the main access point into mental health services. All referrals will be triaged by the team for level of need and urgency and an appropriate response will be provided dependent on this need
- When risk is deemed high, the service user will be provided with a prompt assessment which will be the same day wherever possible or the next day dependent on other factors e.g. on time of referral
- Service users contacting the ATT 'out of hours' will be given support via the telephone or directed to the A&E department when there is a medical emergency. An assessment will be arranged the following day when indicated
- The ATT will provide the initial phase of care and treatment for all people entering mental health services
- After 8.00pm the ATT will provide an out-of-hours telephone response to service users experiencing crisis and/ or relapse of their mental health

### Community Mental Health Teams (CMHT)

- Monday – Friday
- Core working hours will be 9am to 5pm though some teams will have some needs led out of hours working
- Aligned to two or three Integrated Neighbourhood Teams
- A neighbourhood resource with clear links and named responders for the practices
- Service users, previously known to the CMHT, who present with relapsing features of long-term mental health conditions, will be promptly directed via the ATT to the CMHT if this course of action is described in their discharge care plan. This prompt route to the CMHT will avoid a re-assessment in ATT wherever possible
- Multi-disciplinary approaches to care
- Recovery-focused care for those service users with severe and enduring mental health and ongoing needs
- Anti-psychotic monitoring including physical health

### IAPT (psychological therapies services)

- IAPT will be a standalone service covering all the neighbourhoods and patients will be able to self-refer in the future and receive their treatment within six weeks - in line with national targets. Targeted employment support will be available to run concurrently to talking therapy in Blackpool.

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## Appendix 4 - Finance summary

The estimated gross costs to deliver Integrated Neighbourhood Teams in 2016/17 are set out in the table below. One of the key themes of NMoC is that GP capacity is freed up through the introduction of Extensive Care and EPC.

- The cost of Integrated Neighbourhood Teams is based on the design groups assumption (appendix 5, scenario 3)
- The Primary Care cost is based on the proposed local GP plus contract
- Additional community nursing is the investment that has already been made by the CCG
- Other EPC costs describes the Fylde coast work, not detailed in this document

**Table 1 - Cost Summary**

	£000s	Funding Source
Integrated Neighbourhood Teams	2,687	Vanguard
Social care	600	Vanguard
Other EPC costs	2,000	Vanguard
Primary Care	4,700	CCG
Additional Community Nursing	300	CCG
<b>Total</b>	<b>10,287</b>	

Note – The above costs are the gross costs of delivering Enhanced Primary Care. The borough level schemes are funded through existing budgets and any redesign to facilitate EPC delivery will be completed within existing resource.

**The Vanguard related costs are consistent with the Value Proposition document.**

## Appendix 5 – Staffing model

EPC Staffing Models - Integrated Team										
	Neighbourhood	South Central	South	North	Far North	Central West	Central East	Total		
<b>Caseload Scenario 1</b>										
Role	Band	Caseload	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Total Cost
Pharmacist	8a	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 448,886
MH Support Worker	5	25	4.13	6.89	4.56	3.82	7.80	3.67	30.87	£ 1,095,601
AHP	5/6	25	4.13	6.89	4.56	3.82	7.80	3.67	30.87	£ 1,176,295
Care Coordinator	5	50	2.06	3.45	2.28	1.91	3.90	1.84	15.43	£ 547,801
Wellbeing Support Worker	3	25	4.13	6.89	4.56	3.82	7.80	3.67	30.87	£ 717,014
High Intensity User Service	6	25	0.50	0.50	0.50	0.50	0.50	0.50	3.00	£ 126,699
Admin	3	-	0.50	0.50	0.50	0.50	0.50	0.50	3.00	£ 69,681
<b>Total</b>			<b>16.48</b>	<b>26.85</b>	<b>18.10</b>	<b>15.32</b>	<b>30.25</b>	<b>14.77</b>	<b>121.76</b>	<b>£ 4,181,977</b>
<b>Caseload Scenario 2</b>										
Role	Band	Caseload	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Total Cost
Pharmacist	8a	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 448,886
MH Support Worker	5	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 273,900
AHP	5/6	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 294,074
Care Coordinator	5	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 273,900
Wellbeing Support Worker	3	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 179,253
High Intensity User Service	6	25	0.50	0.50	0.50	0.50	0.50	0.50	3.00	£ 126,699
Admin	3	-	0.50	0.50	0.50	0.50	0.50	0.50	3.00	£ 69,681
<b>Total</b>			<b>5.16</b>	<b>8.62</b>	<b>5.70</b>	<b>4.77</b>	<b>9.75</b>	<b>4.59</b>	<b>38.59</b>	<b>£ 1,666,394</b>
<b>Caseload Scenario 3</b>										
Role	Band	Caseload	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Total Cost
Pharmacist	8a	100	1.03	1.72	1.14	0.95	1.95	0.92	7.72	£ 448,886
MH Support Worker	5	50	2.06	3.45	2.28	1.91	3.90	1.84	15.43	£ 547,801
AHP	5/6	50	2.06	3.45	2.28	1.91	3.90	1.84	15.43	£ 588,148
Care Coordinator	5	50	2.06	3.45	2.28	1.91	3.90	1.84	15.43	£ 547,801
Wellbeing Support Worker	3	50	2.06	3.45	2.28	1.91	3.90	1.84	15.43	£ 358,507
High Intensity User Service	6	25	0.50	0.50	0.50	0.50	0.50	0.50	3.00	£ 126,699
Admin	3	-	0.50	0.50	0.50	0.50	0.50	0.50	3.00	£ 69,681
<b>Total</b>			<b>9.29</b>	<b>15.51</b>	<b>10.26</b>	<b>8.59</b>	<b>17.55</b>	<b>8.26</b>	<b>69.46</b>	<b>£ 2,687,522</b>
<b>Notes re assumptions:</b>										
Staffing requirements modelled on a 42 week productive year										
Assumed 80% of time each week is patient centred / facing										
All posts costed at top of scale with oncosts										