1. Introduction

1.1 Decisions requested

1.1.1 The Cabinet of Stockport MBC and the Governing Body of NHS Stockport CCG are asked to:

- Consider and scrutinise carefully the feedback from the public consultation, the updated equality impact assessments (EIAs), the views of the Adult Social Care & Health Scrutiny Committee and the proposed response.

- Approve the recommendation at 4.5.2: Approve the approach described in the previously endorsed outline business cases and proceed to implementation subject to recommendations as set out in Section 5 of this report.

- Adopt a series of recommendations regarding our approach to implementation in light of the feedback and as set out in section 5.1.2: Adopt the 7 recommendations arising from the public's feedback.

- Approve the proposals to review progress as described at section 6.1.2: The Health & Care Integrated Commissioning Board (HCICB) will consider in public a report on progress in addressing the recommendations as set out in section 5 of this paper and the EIA action plans. This report will be presented in September 2018 and reviewed again in July 2019.

1.2 Scope of report and regulatory requirements

1.2.1 This paper summarises and reminds members of the process to date and the context and basis for the endorsement of outline business cases made in July 2017 (Sections 1-3). It then describes and responds to the feedback report on the consultation and includes the updated equality impact assessments (EIAs) and associated action plans with three specific recommendations (Sections 4 & 5):

- A recommendation on the policy questions directed to the public (Section 4);
- A recommendation on issues to be addressed in implementation, identified through the consultation feedback (Section 5).

1.2.2 It then concludes with a proposal on how the recommendations will be reviewed and a timeline by which such a review should be undertaken (Section 6).

1.2.3 Section 14Z2 of the NHS Act (as amended) requires the health commissioner to involve the public where there are changes to the manner in which services are provided or the range of services available. The effect of the proposed strategy is

changes to both. Undertaking a public consultation on the proposed strategy demonstrates compliance with the Act.

1.2.4 For a consultation to be lawful the output of the consultation process must be conscientiously considered by the decision makers; that is the report must be read and considered. Similarly, it is important the EIAs are also considered conscientiously to comply with the Public Sector Equality Duty (Section 149 Equality Act 2010).

1.2.5 Members, as decision makers, should actively consider whether they have enough information to make the decision.

1.2.6 CCG Governing Body members are reminded that in making commissioning decisions they must consider the NHS Tests required before making changes. These were considered when endorsing the outline business cases in July 2017, but it is important that the Governing Body remain cognisant of these when making final decisions. Test 5 (Alternative capacity) is specifically part of the consultation.

1. Strong public and patient engagement;
2. Consistency with current and prospective need for patient choice;
3. A clear clinical evidence base;
4. Support for proposals from clinical commissioners;
5. New capacity is in place if bed capacity is likely to reduce.

1.3 Process to date

1.3.1 In July 2017 all the partners of the Stockport Together Programme endorsed a series of ***outline business cases***. That endorsement was subject to a public consultation on the underpinning strategy and policy to be led by the joint commissioners. The Cabinet and Governing Body at the time of endorsement noted a number of caveats to be addressed in implementation (section 1.3.5).

1.3.2 The attached document ‘Stockport Together Independent Consultation Analysis’ provides an ***independent analysis*** on the feedback gathered during the consultation carried out between the 10th October and 30th November 2017. The Cabinet and Governing Body are required to ***take into account this feedback and any new evidence presented before making a final decision***. At the same time we have taken the opportunity to update the EIAs (Appendix 1); these must also be taken into account in making the decision.

1.3.3 The Stockport Together partners are NHS Stockport CCG, Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust, Pennine Care NHS

Foundation Trust, and Viaduct Care CIC (the GP Federation). The CCG and Council as the commissioners undertook the Consultation and are required to make the final decisions.

1.3.4 The Outline Business Cases endorsed by all the partners across June and July 2017 were:

- **Acute Interface:** This described investment in three areas within the Accident & Emergency Department (A&E) at Stockport NHS Foundation Trust and the associated benefits: refinements to triage, an ambulatory ill work-stream and an ambulatory care service. This can be found here: https://www.stockport-together.co.uk/download_file/156/341
- **Intermediate Tier:** This document set out the case for bringing together 20 or more disparate services. The new intermediate tier service will provide effective crisis response to support community staff to avoid unnecessary hospital admission and much improved support on discharge including transfer to assess arrangements. This can be found here: https://www.stockport-together.co.uk/download_file/157/342
- **Outpatients:** The Outpatients Business Case described plans for reducing unnecessary outpatient appointments and better utilisation of modern technology to ensure advice and decision-making is more cost effective and provided where appropriate without a hospital visit; and how GPs and consultants can work together much more as a team. This can be found here https://www.stockport-together.co.uk/download_file/159/345
- **Neighbourhood:** At the heart of our proposals is the vision of a neighbourhood-centric model of health and social care led by GP practices working collaboratively. This case describes neighbourhood investment in new primary care and community-based services including general practice, the third sector, social care and mental health. This can be found here: https://www.stockport-together.co.uk/download_file/158/343
- **Economic Case:** This outline business case pulled together the economic benefits of the above proposals **and** described the further challenges of a potential £150m financial challenge by 2021. It also described in detail how the investments would be funded as well as the risk / gain share arrangements between the partners to support collective ownership of these challenges. This can be found here: https://www.stockport-together.co.uk/download_file/160/346

1.3.5 On endorsement of the outline business cases in 2017, the commissioners noted a number of areas they wanted to see given additional focus during implementation and mobilisation of the schemes subject to the consultation outcome. Briefly the caveats were noted as:

- **Risk*:*** The risk / gain share agreements would be written into contracts with the Stockport Together providers
- **Plans*:*** Fully detailed implementation and benefits realisation plans would be produced for each area
- **Enablers*:*** The system would continue to ensure appropriate support and resources were made available to implement the changes
- **Workforce*:*** A fully developed workforce strategy and plan would be developed
- **Public Engagement*:*** A formal consultation would be undertaken and learning would be applied; and that continual involvement would take place throughout implementation
- **Evaluation:** There would on-going measurement of activity
- **Mental Health:** There would be greater demonstration of the integration of mental health services throughout any implementation, especially in Neighbourhoods, Acute Interface and Intermediate Tier; and that the full mental health investment strategy would be presented to the CCG Governing Body.

1.3.6 This report and approvals of any of the recommendations contained within it are understood to be ***building on and strengthening these caveats*** rather than setting them aside.

1.3.7 Following publication of the Independent Analysts report this along with the EIA went to Adult Social Care and Health Scrutiny Committee on the 16th February. The ***full transcript of the discussion is attached*** at Appendix 1.

1.3.8 The committee made a number of observations and asked a number of questions; a summary of these is captured below:

1. Appreciation of the robustness and responsiveness of the public consultation
2. Assurance that the approach would not mean staff are operating at levels beyond their competence (See 5.7.2)
3. Clarification on how we would continue to ensure the quietest and least heard voices are influencing future developments (See 4.4.5 and 5.2.1)
4. Concerns about the safeguarding of personal data if working with the voluntary sector (5.10.3)
5. Assurance that we will reduce hospital resources to an extent that we cannot address future surges in demand

1.3.9 We will pick these up under the relevant responses in Section 4 and Section 5.

2. The Case for Change

2.1 Introduction

2.1.1 Before responding to the feedback from the consultation it is perhaps helpful to remind decision makers of the rationale behind the significant strategy and policy changes underpinning the outline business cases.

2.1.2 In the overarching economic business case, the Stockport Together partnership states its aim as being to '***ensure the best possible outcomes for local people at a time of growing demand and restricted funding'***. This statement brings together both our ambition for better outcomes and the reality of significant financial constraints. The proposals being consulted on set out the plans to address a number of challenges:

2.2 Performance & Quality

2.2.1 Within Stockport ***we currently admit many more people to hospital than similar areas*** across Greater Manchester and England, and we face a number of challenges in meeting national waiting time standards within the Emergency Department.

2.2.2 Current community health and care services are delivered by a number of individual services each with their own line management structures, numerous referral and assessment processes, multiple electronic and paper records, different operating hours and competing expectations. This leads to frustration for both individuals and professionals working in this environment and delays in and ***fragmentation of service delivery***.

2.3 Health Inequalities

2.3.1 Stockport has one of the ***widest Health Inequalities gaps*** within the borough of anywhere in England, people live approximately 11 years longer in the least deprived areas of Stockport compared to the most deprived areas (12.8 years for males and 9.7 years for females). It is a statutory duty of the public sector to seek to narrow this. Whilst many of the factors that drive this gap are wider determinants of health such as education, housing, employment and clean air there are factors that are more directly influenced by health and social care policy.

2.3.2 The strategy underpinning the outline business cases seeks to ensure a greater link between the NHS and the local authority and hence increase the opportunity to address the wider determinants of health. Further, by building and integrating services at a neighbourhood level, the investments can be better aligned

to need, and the scale of services and the way they are delivered can better reflect the needs of the specific and distinctive populations in each area.

2.4 Five Year Forward View

2.4.1 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. Currently 70% of all health and social care spend in Stockport is used by people with one or more long-term condition. These individuals account for 50% of GP appointments, and 7 out of 10 hospital beds.

2.4.2 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 General practice.

2.5 GM Devolution

2.5.1 Greater Manchester Devolution is important in shaping the thinking within our plans. The GM (Greater Manchester) Integrated Health and Social Care Strategy describes five specific themes where change is envisaged and each GM locality is required to demonstrate delivery in these areas. These plans align in particular with Theme 1: Population Health and Theme 2 Transformation and Community Based Services. The award of £19m from the GM Health & Social Care Partnership was predicated on delivery of change in these areas.

2.5.2 In addition, there is significant work underway as part of changes in Greater Manchester which is of specific relevance to enabling areas, including: Estates, Workforce and IM&T. Stockport's enabling approaches are aligned to the sub-regional direction and are actively engaging in this work.

2.6 Economic and financial

2.6.1 Health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current form, the health and social care system is financially unsustainable. If no changes are made, we have forecast that by 2020/21 ***there will be a combined deficit of £157m*** across Stockport's health and social care services.

2.6.2 Even if we did have further significant investment in health and social care we would then face the challenge that ***there are not sufficient levels of qualified staff***. Already the NHS faces significant challenges recruiting doctors and nurses. If existing services expanded in their current form they would soon become clinically unsafe.

2.6.3 Therefore, fundamental changes have to be made to ensure that the people of Stockport continue to receive the highest quality care in the most appropriate environment possible in the current circumstances.

2.6.4 These changes will not reduce the amount of money we spend on health and social care in Stockport. Rather they will mean we can better manage the increased demands within the resources we have available.

2.6.5 The plans are about investing money into different parts of our health and social care system (for example, GP practices and neighbourhood care services) to ensure we can meet the increased care needs that we face.

2.7 A hospital-centric service model

2.7.1 The proposal set out in the business cases is to invest £16.3m by 2021. Most will be ***in services outside of hospital*** or at the front of hospital in the A&E and associated departments. This investment will firstly mean that the current predicted growth in hospital services will not materialise. This will contribute £18m to support the investment described above. It is also expected to mean that £25m of services currently provided in a hospital settings will no longer be needed. This is in line with ***our existing over-use of hospital compared to similar areas*** which also creates an increase in demand for short term residential and nursing care to support early discharges, making the economy a comparatively high user of these services.

2.7.2 The total benefit of £43m per year is a contribution towards the estimated £157m per year gap we face between current expenditure and predicted growth in demand by 2021 in a ‘do nothing’ scenario. Therefore, the business cases ***do not address the totality of the financial challenge*** the local health and social care economy faces. Each organisation will also need to continue to deliver their own cost improvement plans each year, equating to £88m in total by 2021.

3. Consultation and areas for influence

3.1 Throughout October and November 2017, the two commissioning partners of Stockport Together carried out a public consultation on the underlying strategy and policy set out in full in the Stockport Together business cases.

3.2 The outline business cases were published in June 2017, after having been through the appropriate channels at each of the partner organisations including Adult Social Care & Health Scrutiny Committee. These cases were developed by local professionals (doctors, nurses, social workers and managers) with input from local people and using the best available national and international evidence.

3.3 A listening exercise was undertaken during June and July 2017 in which meetings were held across the borough and individuals were contacted in GP surgeries to shape the issues and questions that should be put to the public and interested stakeholders in the consultation.

3.4 The consultation document, 'Have Your Say', provided abridged information on the Stockport Together plans, focusing on three key policy areas of influence (listed below). The full document can be found at: https://www.stockport-together.co.uk/download_file/229/160. It ***sign-posted interested parties to the business case documents for further information and detail*** (on the Stockport Together website).

- **Changing the way we plan and organise services:** this will focus on key principles including the integration of health and social care; the integration of physical and mental health services; and the underlying shift of resources from acute hospital provision in order to further address parity of esteem for mental health and strengthen integrated community based services including primary and social care.
- **Neighbourhoods:** the way in which physical health, social care and mental health services are organised at a neighbourhood level. This will focus on the geographical appropriateness of the neighbourhoods as described and their role as the principle organisational construct of the future model of care.
- **Hospital beds:** the test to apply, if the strategies result in the need to decommission acute hospital beds. This will focus on how the partnership will apply the tests set out by NHS England prior to any bed closures if they should arise.

3.5 The proposals in the consultation were based on pilot work across the borough, the expertise of our staff, professional experience in other parts of the country, and national and international evidence.

3.6 Members of the public and interested stakeholder organisations were provided the opportunity to state how far they agreed or disagreed with the general direction of travel as set out by Stockport Together.

3.7 Prior to consultation, a mandate was agreed which set out the Stockport Together partners' aim: ***to ask people and organisations in Stockport with an interest in health and care services for their views concerning the proposed changes to the ways health and care services are organised in Stockport.***

3.8 The aim was for the Governing Body of the Clinical Commissioning Group and the Cabinet of Stockport Metropolitan Borough Council to understand the views of the public on the changes proposed and gather any additional evidence that the public or interested stakeholders might wish to present on the efficacy or otherwise of the plans, before making their decisions on whether to proceed with the proposals.

4. Response to Policy

4.1 Recommendation

4.1.1 On the basis of the response to the consultation the broad recommendation is that the approach set out under Stockport Together, as described in the five outline business cases, ***should proceed as described***. However, there are a number of ***changes in the detail of how these are implemented*** that will be described in the next section (Section 5) of this report.

4.1.2 In coming to this recommendation a number of factors have been taken into account and these are set out below.

4.2 Neighbourhoods and the way we plan and organise services

4.2.1 Responses indicated support for the first two proposals: to integrate services and do so on a neighbourhood basis. This is the heart of the proposals and the new way of delivering services and therefore a significant endorsement.

Most consultees from the ***online, postal, and face-to-face*** survey support the proposal to change the planning and organising of services. 72% of respondents either tend to agree or strongly agree. Similarly, the majority (87%) of consultees responding to the ***street survey*** tended to agree or strongly agree in support of the proposal (p8-9, Stockport Together Consultation Analysts Report).

Looking at the intention to move to a neighbourhood model, 71% of consultees from the ***online, postal, and face-to-face*** survey tended to agree or strongly agree with the proposals. The same figure (71%) of ***street survey*** consultees also tended to agree or strongly agree (p22, Stockport Together Consultation Analysts Report).

"by combining health and social care the new system will be more efficient, respond to peoples' needs, improve communication and be cost saving…"

"…it makes sense to have services for the communities based around the communities themselves. We can share our resources if we work as "neighbourhoods".[1]

4.2.2 A number of items of evidence were presented. Two provided some further support to the approach.

- ***Evidence from the BMJ*** on the current risks in the English Health & Care system supports the approach to increase investment in the community. It concludes that: "We suggest that spending should be targeted on improving care delivered in care homes and at home; and maintaining or increasing nurse numbers." (p17, Stockport Together Consultation Analysts Report)

- ***Age UK submitted evidence*** of the pathfinder-led Age Concern Cornwall (p25, Stockport Together Consultation Analysts Report). This showed integrated working (including the voluntary sector) improved health, wellbeing and quality of life whilst reducing costs across the system. It should be noted that the very first pilots for our integrated enhanced case management approach known as *Stockport One* were based on this thinking and we were advised heavily by Cornwall. The involvement of the third sector through The Prevention Alliance (TPA) is indicative of this learning.

4.2.3 NHS Watch have contributed significantly in the various involvement mechanisms undertaken throughout the development of our plans and culminating in the consultation. They raised a number of matters: the underlying financial driver to the proposals; the alignment with national initiatives such as the STP (Sustainability & Transformation Plans) programme, the potential privatisation of the NHS, concerns about decommissioning of beds, and concerns about some aspects of the evidence base. The decommissioning of beds and the financial question were raised by others and will be addressed at section 4.3 and section 4.4.8 respectively. It is important to note that NHS Watch see the development of neighbourhoods and additional investment in community as positive factors. Specifically they presented counter-evidence in two areas:

4.2.4 NHS Watch suggest the evidence that hospital admissions (and therefore need for beds) are reduced by changing the way community services work (in particular

[1] These and all other quotes shown in italics are taken directly from the independent analysis report

integration) is weak. They quote the King's Fund (https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers) as counter evidence to be considered. We would agree with this evidence, but our proposals do not suggest that the mere act of integration of services will produce such a result but rather that significant additional investment in the community is also required. The evidence for this is stronger particularly as we start from a position of extremity when it comes to the hospitalisation of people. We are also insisting as set out in our proposed tests that there is local evidence of impact before any change in bed use is undertaken.

4.2.5 NHS Watch also challenged the NHS campaign view that 10 days in hospital can lead to the equivalent of 10 years ageing in the muscles. We reviewed the evidence and accepted that a stay in any bed rather than a stay in hospital beds specifically was where the evidence pointed and will no longer use this statement, despite it being commonly used across the NHS. However, again because of wider evidence and a higher starting point we do believe reductions in length of stay will contribute to our plans. However, we do recognise that this will not be easy and have described in our consultation clear plans to test the system before reducing bed capacity and these tests formed part of the consultation.

4.2.6 NHS Watch expressed the view that the proposals being implemented here are similar to those being undertaken across the country under the banner of STPs. There are undoubtedly similarities in for example the development of stronger out-of-hospital systems preventing and proactively managing ill-health. Equally, one factor in our plans is the need to live within our means, a common challenge. However, our plans differ from STPs in a number of ways. They do not claim to address the full financial challenge; the plan has not been imposed externally but been developed by local clinicians and other professionals and was started before the STP programme came into being, launched at a Care Congress in January 2015; STPs cover a much larger area and thus include hospital reconfiguration in their planning. The Stockport Together proposals do not.

4.2.7 In their opinion, the greater integration of services will lead to increasing privatisation, in particular the creation of Accountable Care type Organisations (ACO). It is important that members bear in mind the distinction between the new models of care with close integration and the formation of a single entity to deliver the services. The outline business cases and the underpinning strategy that was consulted on neither pre-determined nor proposed the creation of a single entity. ***This would require further consultation in due course.*** Therefore in approving the greater integration of service delivery and the development of neighbourhoods, members are not approving the creation of an accountable care organisation.

4.2.8 No further specific evidence was presented that was contrary to the ***policy approach*** that the business cases encapsulated in these areas. However, there was

concern expressed about the quite large geographical size of the neighbourhoods and the fear that a single hub in each area would be detrimental.

"… neighbourhoods may be too big - Tame Valley includes Reddish and Brinnington - will there really only be one neighbourhood centre between them?"

4.2.9 This is predominantly an implementation issue but given it is directly concerned about neighbourhoods it is addressed here. It is important to distinguish between administrative hubs (where district nurse and social care teams come together), and service delivery points (where people receive services). Our plans are not to have a single service delivery point in each neighbourhood. So, for example our plans for ***Heaton and Tame Valley*** GP 7 day services recognise that people Reddish and Brinnington will need services as travel between the two areas would be difficult and counter to addressing health inequalities. It is the local leadership in each area who understand how that area will shape the way in which services are best delivered. A specific recommendation in Section 5 will look to reinforce this.

4.2.10 Other evidence was submitted but was less directly related to the underlying policy and will be addressed in the thematic section related to the approach to implementation (Section 5).

4.3 Basis for decommissioning of beds

4.3.1 There was less agreement on the test for decommissioning beds. 40% of ***online, postal and face-to-face*** respondents agreed they were appropriate; 33% disagreed. In the ***street surveys*** 55% did not agree whilst 41% supported them (p30-31, Stockport Together Consultation Analysts Report).

"…decommissioning beds is an irresponsible suggestion. Beds will always be needed, regardless of whether care is in the community…"

"…the tests…if carried our honestly and rigorously…would deliver the answer that is needed to make the savings that are envisaged…"

4.3.2 It is important to note additional money to invest in models of care that help people stay well enough not to need hospital care is available only as a short term measure. For these new ways of working to be successful in the medium and long

term, budgets for hospital care need to be reduced and the money spent on community care.

4.3.3 There is a natural concern shared by all in the partnership about any reduction in the bed base, and this undoubtedly and understandably informed the views expressed by the public and stakeholder organisations. It would therefore appear that for some the response was to ***bed reductions per-se*** rather than the ***right and proper test*** on whether the need had or had not reduced. ***Our plan is to only close beds if these tests are met and thus our community investments are effective.***

4.3.4 The one piece of additional evidence submitted was the CQC report on Stepping Hill rating the Urgent & Emergency Care as Inadequate. The concern was that an already overstretched hospital would suffer further if beds were removed (p32, Stockport Together Consultation Analysts Report).

"…I would hope that there would always be sufficient hospital beds to cope with winter emergencies, etc…"

4.3.5 On a related matter, a number of people expressed concern that if beds were removed we would not be able to address surges in demand. Adult Social Care and Health Scrutiny Committee also sort assurance about this and the pace at which any beds would be removed. There are not a fixed number of beds in the system currently and we always have more beds open in winter. This ability to flex capacity will remain a requirement even if from a potentially lower baseline if we meet the tests demonstrating a lower overall requirement. Capacity will be retained to allow this flexibility and for a time to readjust our plans should we need to.

4.3.6 Given the reality of the current pressures and the natural concern of the public, it is proposed that members ensure rigorous application of the national test as set out in the consultation document with scrutiny of the statistical validity of any evidence prior to decommissioning of capacity; and that the ability to operationally manage emergencies is described.

4.3.7 There was also concern expressed about what would happen if we were unable to decommission beds, and thus shift resources to the community as the strategy intends. The economic business case describes the response to such a scenario in the risk / gain share arrangements. This will leave individual organisations with significant challenges, but is a shared risk.

4.4 More general concerns raised

4.4.1 However, there were a number of more general concerns raised that members should consider when making the necessary decisions:

4.4.2 Firstly, there was a concern expressed by some that the ***changes were too complex*** and others expressed a view that they did ***not have enough detail*** to go on in making the decision.

"…don't really understand all the proposals…."

"…very little information has been provided to answer this question…"

4.4.3 In truth this is a complex and significant set of changes. During the process we presented the high level policy decisions in the consultation document and also referred people to publically available detail on the five outline business cases. We had already done a series of briefings as part of an eight week listening exercise; this then informed the key questions we needed to address in the formal consultation. In both the listening exercise and the consultation, information was available on the business cases in three forms: A high level summary, a more detailed executive summary and a fully detailed business case. We also responded to any group or individual that requested specific clarification either through a face-to-face visit or in writing. However, given the complexity and to ensure that we continue to take the public with us it will be important that we do not see the end of the consultation as an end to public involvement on the issues and we reflect on how we present complex data as simply as possible.

4.4.4 There were also concerns expressed that we might not get a representative response from the population and that the more articulate members of the community would draw resources away from the more deprived areas, and thus increase inequalities across the borough.

"…the more articulate and forceful…middle-class…will demand better services, and… draw resources away from disadvantaged parts of the borough…widening… health inequalities…"

4.4.5 This issue was also raised by the Adult Social Care and Healthy Scrutiny Committee. We sought to address the first issue of under representation by not only engaging directly with stakeholder groups with a known interest in the consultation, but also to address the likely bias of this former approach through street surveys. The sample size of the latter was more representative of the population in terms of

age and gender. It also included people from every part of Stockport as street surveys took place in each neighbourhood. However, footfall issues meant that there is still a higher representation from affluent areas in the borough. That said there is no significant difference in levels of support or otherwise between areas. We also sought feedback from specific protected characteristic groups. However, during implementation, further work to involve the public in developing the specific change proposals required to implement these high-level policy decisions at local level, for example on the location of service delivery points in neighbourhoods will be worth further attention.

4.4.6 In regards the second issue of resource allocation. There are some indications that under the current system the more articulate receive a greater share of resources. One of the reasons for developing the neighbourhood model is to ensure that resource allocation is focussed most on those who need it, and local professionals with local communities design a service delivery approach that best fits their area.

4.4.7 There was a general concern raised in a number of ways, even by those supportive of the general approach, on the chances of success given the underlying seriousness of the ***financial challenge***. There was also a sense that we were masking the scale of the challenge given the situation we currently face.

"…the document is not sufficiently honest…the driver for change is to make…savings on health and social care in a time of increasing (legitimate) demands…"

"…you are not saying anything about the under resourcing of social care. This is a serious omission which makes it hard to assess your proposals…"

4.4.8 It is true that the underlying financial challenges driven by demography and inflation are higher than any growth the NHS locally will receive, or that the Council will be able to fund by raising its income and that these proposals will not resolve these fully. This is reflective of the national picture. The Economic Case explained up-front that the estimated shortfall of doing nothing is £157m. The proposals set out in the business cases will deliver £43m towards this. However, that still leaves the individual partners and the changes that are taking place at a Greater Manchester level, needing to deliver £114m. This approach therefore makes a significant contribution to addressing the financial challenges but does not in itself fully resolve the challenge. Through this programme we are attempting to improve the way we use our resources by intervening earlier when the need is lower and by reducing the

fragmentation of the system. We do not underestimate the challenge of both achieving the benefits of these proposals nor of addressing the remaining gap.

4.4.9 There were particular concerns expressed about the challenges facing Social Care and that these could undermine the overall plans.

"…you are not saying anything about the under resourcing of social care. This is a serious omission which makes it hard to assess your proposals…"

"…leader keeps telling people that adult social care will bankrupt the council…"

4.4.10 The intention behind our proposals in this respect is three-fold. By working more closely with the health service we are looking to mitigate the growing demand for social care through earlier identification of disease and other factors leading to a loss of independence. Further by integrating services we can look to utilise the whole health and social care budget where it is best deployed in the whole system. Thirdly, we will look through closer integration to reduce administrative costs by reducing duplication of processes and management.

4.5 Summary and Proposal

4.5.1 The current versions of Equality Impact Assessments (EIAs) indicate that the changes proposed in the outline business cases will not detrimentally affect protected characteristic groups at a policy or strategy level from a public perspective and generally would be seen as beneficial. There are some impacts on staff groups in terms of changes of hours which have been and will continue to be addressed through staff consultation.

4.5.2 However, there are a number of issues highlighted particularly on accessibility which will need to be addressed during implementation and are addressed in section 5.2 and 5.3.

5. Approach to implementation

5.1 Introduction and Recommendation

5.1.1 In addition to the views and evidence provided regarding the specific policy questions there was a significant amount of important information gathered that

should inform how we proceed with the implementation of the models of care described in the business cases. In this section we will draw out the key emerging themes and make a series of recommendations on action that should follow.

5.1.2 The recommendation that members of the Council Cabinet and the CCG Governing Body are asked to adopt the **7** recommendations arising from the public's feedback.

5.1.3 These themes are not prioritised in any particular order as each has merit in its own right.

5.2 Involving the public

5.2.1 During the consultation, one of the most common themes to emerge was 'involvement'. Consultees, whether they are individuals or organisations, are keen to be more involved in contributing to key decisions that are being made about the future of our local health and care services. Whilst the engagement process is recognised as important, its 'stop/start' nature frustrates many people. These recommendations attempt to address some of these concerns by initiating a way of working that allows both individuals and organisations to work alongside our commissioners and providers to play a more 'substantive' and 'meaningful' role in influencing the shape of our future health and care services.

"Involve first, Change second"
"The need to engage again in order to understand better operational changes emanating from implementation of strategic proposals. More frequent/routine engagement with staff and patients/public".

"Using local people, volunteers as consultation 'enablers', engaging directly with those unable to respond online or in writing"

"Shared leadership – involve wider stakeholders in decision-making, staff, patients, third sector"

"Consult more widely with those least able to respond"

It is recommended that (1):

- We review how, as commissioners and providers, we further engage and involve local people – those who use health and social care services as well as those who do not. We accept that, in the past, consultation outreach has sometimes appeared start/stop. Going forward, we will act on comments made by consultees which suggest we should involve local people in a more consistent, regular, and sustained way.

- From January 2018, Commissioners will consider a method of engagement that involves collaborative working amongst stakeholders. It will build on comments received during this consultation about how we avoid complexity in our communications, promoting innovation and opportunity within our health and care system.

-Through more effective engagement techniques, we will specifically build-in checks and balances to ensure there is an equal and fair representation for people who often do not have their voices heard.

- We will review how we present financial information, and the need to provide greater clarity around how funding is directed (on what services), and how this compares to previous years. We would hope that greater familiarity of issues, through more regular and consistent 'involvement', creates better understanding of those issues amongst patients and our wider stakeholder groups.

- We continue to work closely with the new Citizens Representation Panel to ensure closer working with our operational leads and move closer to a culture of 'shared leadership' in decision making.

- We proactively build on the networks and contacts already achieved and established through this consultation. This will enable us to build greater involvement of local people in decision making about their health and social care services – particularly those less able to access services, for example visually impaired, deaf and disabled people.

- Work with GPs and the new 'Neighbourhood model' structures to establish local networks that create meaningful and early involvement of local people in decision making. We will establish channels of communication and engagement that will regularly update patients and the public on progress – some of these channels will include Patient Participation Groups, collaborative working between patients and clinicians and greater use of digital media to support information flow to both patients and the public.

5.3 Equality and Diversity

Under the Equality Act 2010, certain population characteristics are given protection. They are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

On the lead-up to, and during the consultation process, the CCG reviewed and updated the existing Equality Impact Analysis (EIA) for Stockport Together and the four key work stream areas, as a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

- to consider whether the policy will help eliminate unlawful discrimination, harassment and victimisation
- to consider whether the policy will advance equality of opportunity between people who share a protected characteristic and those who do not
- to consider whether the policy will foster good relations between people who share a protected characteristic and those who do not
- to inform the development of the proposed policy.

The establishment of these EIAs within our operational implementation plans, will require a positive and proactive approach to the **involvement** of protected groups. As a result, we ***recommend that (2):***

> -We adopt the revised equality impact assessments (EIAs) as a common standard of operating, embedding the actions into the implementation plans for each of our work streams and operational plans for our wider health and social care system.
>
> -We regularly monitor the implementation of these standards, updating as appropriate to reflect local need and national ‘best practice’.
>
> -We proactively maintain the networks we have built over recent months to enhance our engagement and involvement with the wide range of protected groups that exist locally in Stockport. We will also commit to building on the foundations of our recent equality impact assessments (EIAs) for each of the business areas. This will include awareness and training sessions for operational leads and service providers, to ensure the full engagement and involvement of those who are identified as ‘protected’ under the Equalities Act 2010.

5.4 Greater involvement of third sector

5.4.1 A number of consultees, particularly among the key stakeholders groups, raised a desire for the third sector to have a greater involvement. There was a concern that when they were involved they were seen purely as providers of predetermined plans rather than having a seat at the decision making table.

"…third sector / voluntary sector is not meaningfully engaged or considered within Stockport Together planning and believe this is missing a key resource that could assist…"

"…there is a need to involve the charitable sector with Stockport Together on much more than consultations."

"…there is an opportunity to partner with the sector and better coordinate its response to the needs of Stockport residents without necessarily spending more money…"

5.4.2 The third sector has been involved with some additional investment earmarked in the business cases for specific schemes; and through The Prevention Alliance (TPA) they are integral to enhanced case management proposals for example.

5.4.3 However, the concern is recognised that the third sector have not had a formal position in the partnership. Therefore, it is ***recommended that (3)***:

- The joint commissioners undertake to ensure that the third sector in Stockport have a more formal position in the partnership arrangements in the review of programme governance recently commissioned by the Chief Executives' group and due to be in place for April 2018.

- Whilst accepting the business cases identify new sets of services, we will re-consider how we integrate the support of the Third Sector, ensuring more robust networks of support for the neighbourhood model.

5.5 Mental Health

5.5.1 There was some disappointment expressed that mental health was not a more significant component of the plans. It was also commented on that it was not clear about the degree of integration between physical and mental health services.

"…there needs to be better mental health services that residents can access quickly when needed before a crisis escalates…"
"…mental health and physical health should go hand in hand and receive the same input..."

5.5.2 In endorsing the outline business cases, the commissioners expressed similar concerns (See section 1.3.5). NHS Stockport CCG has since developed a wider mental health investment strategy which is coming to the CCG Governing Body for approval in January 2018. This will set out investments of £9.6m recurrently.

5.5.3 However, the commissioners recognise the opportunity for greater integration of services in the community needs to be pursued and as such it is ***recommended that (4):***

- The current contracting round ahead of April 2018 sets out a clear intention that community mental health services are integrated with neighbourhood teams; and

- NHS Stockport CCG further strengthens the clinical leadership in mental health with a particular emphasis on integration of mental health with physical health and social care; especially given the priority of parity of esteem on the NHS agenda and to these proposals.

5.6 Wider Determinants of Health

5.6.1 The greater integration of commissioning arrangements between the Council and the CCG are an important factor underpinning these proposals. In part this is to ensure that the wider determinants of health are considered alongside more traditional public health and medical interventions to prevent ill-health. The consultees mentioned housing in particular as something they felt was missing from the existing arrangements.

"…Stockport Homes Carecall can prevent falls as well as dealing with the aftermath – saves significant number of ambulance call outs…"

"…Stockport Homes can give Public Health messages to customers as we see people regular (sic) and can prevent them reaching crisis point…"

5.6.2 It is therefore ***recommended that (5)*** in moving ahead with implementation of the plans:

- Any considerations for greater integration of commissioning functions set out how the wider determinants of health including housing, leisure and education will be aligned; and

- The joint commissioners undertake to ensure that Stockport Homes has a more formal position in the partnership arrangements in the review of programme governance recently commissioned by the Chief Executives' group and due to be in place for April 2018.

5.7 Workforce

5.7.1. The public sector, ***with or without the proposed changes, faces a significant workforce challenge*** in the next few years. There are already significant shortages of doctors, nurses, and social care staff. This is already impacting on service delivery and was an important driver behind the need to change the model to one of early intervention rather than late intervention, which requires more specialist care. The consultees also expressed concern as have the commissioners in their caveats to endorsement of the business cases (See section 1.3.5).

"… assurances [needed] that there was sufficient capacity in the community..."

5.7.2 There were also concerns expressed that in reviewing the skill mix we would lower the standards of care and have less qualified staff undertaking tasks only fully qualified staff should undertake. The Adult Social Care and Health Scrutiny Committee sort assurance on this point. It is important to remind members that these plans have been developed and led by professional staff and commissioners, and will keep safety under constant review. A detailed functional analysis has been undertaken in drawing up the plans to ensure that tasks are appropriate to the qualification of the staff undertaking them and to ensure that staff spend more of their time undertaking tasks only they are qualified to undertake.

"…there is an element of risk to patient safety from any move to a lower tier care, with less specialist provision. This risk needs to be understood and mitigated..."

5.7.3 Changes to working practice will be as significant as actual numbers and therefore an important consideration within implementation will be culture and organisational development.

5.7.4 Given the importance of this issue to successful implementation of the proposals, and the requirement to demonstrate that new services are safely established in the community before decommissioning beds, the commissioners **are recommended (6)** to require of providers as part of contract agreements:

- A robust and comprehensive workforce plan and strategy to include the planned for establishment, the impact on other important sectors, and organisational development; and

- Monthly reporting against a workforce tracker, tracking actual versus required establishment.

5.8 Seven-day services

5.8.1 Members of the public broadly welcomed the greater range of seven-day service provision. However, there was a degree of scepticism.

"…they really need to get a grip of GPs and make them work more late and early evening shifts like the rest of the NHS…"

"…can 7-day working mean it please…Illness doesn't stop on Friday nights & restart on Monday morning…"

"…social workers should be available 7 days a week. Needs don't go away at weekends!"

"…there are already 7-day services in place both in hospital and the community…I do not see how your Business plan will save money in the long term…"

5.8.2 It is true that there is already seven-day delivery in some services. The proposals are to invest and thus strengthen community based-services including general practice. In particular the proposals are for those services that are required to intervene quickly to prevent deterioration becoming an unnecessary crisis.

5.9 Running Costs

5.9.1 It is imperative that as much of any available resource is directed to frontline staff and service delivery. A number of responses proposed that reductions in management capacity should be the primary source of efficiencies.

"…too many managers, not enough nurses and care staff..."

"…ensure effective transparent use of public funds. Too much is wasted on ever increasing numbers of managers and not enough on frontline clinicians.... if you can find them…"

5.9.2 The greater integration of commissioning and provision set out in our plans is based on an assumption that there will be some efficiency gains in management. So for example, a single neighbourhood team rather than two or three will require less management. The Provider Alliance is expected to reduce overheads once changes are implemented. The Council in its current proposals have set out £350k reductions in social care management costs. NHS Stockport CCG is currently running at c£18per head of population instead of the allowed £22.50 this is equivalent to a saving of £1.35m.

5.9.3 Even if we were to double these reductions, the impact on the overall efficiency requirement of £157m would be negligible. However, we remain committed to keeping management costs under constant review and directing as much resource as possible to the frontline.

5.10 Integration of Data

5.10.1 Among the consultees responding positively there was recognition of the need for effective single records, and not restricting this to just Stockport.

"…having a person's information in one place will reduce duplication, stop errors in communicating between different teams and save time..."

"…develop a common records system across Greater Manchester. It is not good enough when any hospital says, 'you are out of area, we do not have your records'…"

5.10.2 The move to single electronic record systems is underway in Stockport and through '*Care Centric',* work is underway to ensure information can be shared among providers across Greater Manchester. However, it is important that the public

at large and individual patients give consent for the use of their personal information, with appropriate rigorous safeguards by other professionals in place. For the involvement of the third sector to be truly effective, this will need to be beyond the boundaries of public bodies. Stockport remains committed to both appropriate sharing through single record systems and individual consent.

5.10.3 The Adult Social Care and Health Scrutiny Committee raised the concern that data would be too easily available to say volunteers. The current Information Governance safeguards are being robustly applied and we are working closely with the Information Commissioner and the BMA legal advisers. Further all the systems we are putting in have role based access and audit to ensure that only those staff with a right to access can do so, and that consent is always sought.

It is recommended (7) that:

- Further work is undertaken to promote the benefits of sharing information and the efforts being taken to locally protect data from misuse to support consent from the wider public and specific individuals

6. Next Steps

6.1 Monitoring Recommendation

6.1.1 The Council Cabinet, CCG Governing Body and their associated committees will have routine monitoring approaches in place to oversee the implementation of any changes of this nature.

6.1.2 ***It is proposed that in addition*** to these, The Health & Care Integrated Commissioning Board (HCICB) will consider in public a report on progress in addressing the recommendations as set out in section 5 of this paper and the EIA action plans. This report will be presented in September 2018 and reviewed again in July 2019.

6.2 Further Involvement and Consultation

6.2.1 All the stakeholder groups who participated in the Consultation have been sent a copy of the report and, following approval of the response, will be offered the opportunity to discuss them further with senior commissioners.

6.2.2 The approval does not negate the need to consult further on significant service changes that might be made in the future as a result of policy decisions being taken today, for example the location of service delivery points in neighbourhoods.

6.3 Notification and Contracts

6.3.1 On behalf of the Council Cabinet and CCG Governing Body, the Joint Commissioning Board will publish the decision and recommendations and will formally notify all relevant service providers of the intention to contract accordingly.

6.3.2 The Joint Commissioning Board will then move to ensure that the proposals as set out in the outline business cases are contracted for with the alliance partners both collectively and individually as required.

7. Summary and Proposal

7.1 There has been a significant, considered and important response from the public. It is right that in taking decisions on the key policy questions and proceeding to implementation of the business cases decision makers reviews these carefully.

7.2 The main thrust of the proposals (the creation of, and investment in, a more integrated and community based system delivered in neighbourhoods) was strongly supported by the public.

7.3 However, there were greater concerns and scepticism expressed about one-of-the mechanisms to fund this investment (decommissioning of hospital beds) and the tests to ensure that we had fundamentally altered the need for these beds.

7.4 The public and key stakeholders also made a number of comments and suggestions about things that could strengthen implementation of plans. Whilst not in themselves being reasons not to precede it is important that they are considered and plans are adjusted and strengthened accordingly.

7.5. It is therefore recommended that the approach described in the previously endorsed outline business cases is approved and we proceed to implementation subject to a series of recommendations as set out in Section 5 of this report.

8. Table of recommendations

Recommendation 1: Involving the public	We review how, as commissioners and providers, we further engage and involve local people – those who use health and social care services as well as those who do not. We accept that, in the past, consultation outreach has sometimes appeared start / stop. Going forward, we will act on comments made by consultees which suggest we should involve local people in a more regular, meaningful and sustained way.
	From January 2018, Commissioners will consider a method of engagement that involves collaborative working amongst stakeholders. It will build on comments received during this consultation about how we avoid complexity in our communications, promoting innovation and opportunity within our health and care system.
	Through more effective engagement techniques, we will specifically build-in checks and balances to ensure there is an equal and fair representation for people who often do not have their voices heard.
	We will review how we present financial information, and the need to provide greater clarity around how funding is directed (on what services), and how this compares to previous years. We would hope that greater familiarity of issues, through more regular and consistent 'involvement', creates better understanding of those issues amongst patients and our wider stakeholder groups.
	We continue to work closely with the new Citizens Representation Panel to ensure closer working with our operational leads and move closer to a culture of 'shared leadership' in decision making.
	We proactively build on the networks and contacts already achieved and established through this consultation. This will enable us to build greater involvement of local people in decision making about their health and social care services – particularly those less able to access services, for example visually impaired, deaf and disabled people.
	Work with GPs and the new 'Neighbourhood model' structures to establish local networks that create meaningful and early involvement of local people in decision making. We will establish channels of communication and engagement that will regularly update patients and the public on progress – some of these channels will include Patient Participation Groups, collaborative working between patients and clinicians and greater use of digital

	media to support information flow to both patients and the public.
Recommendation 2: equality and diversity	We adopt the revised equality impact assessments (EIAs) as a common standard of operating, embedding the actions into the implementation plans for each of our work streams and operational plans for our wider health and social care system.
	We regularly monitor the implementation of these standards, updating as appropriate to reflect local need and national 'best practice'.
	We proactively re-establish the networks we have built over recent months to radically enhance our engagement and involvement with the wide range of protected groups that exist locally in Stockport. We will also commit to building on the foundations of our recent equality impact assessments (EIAs) for each of the business areas. This will include awareness and training sessions for operational leads and service providers, to ensure the full engagement and involvement of those who are identified as 'protected' under the Equalities Act 2010.
Recommendation 3: greater involvement of the third sector	The joint commissioners undertake to ensure that the third sector in Stockport have a more formal position in the partnership arrangements in the review of programme governance recently commissioned by the Chief Executives' group and due to be in place for April 2018.
	Whilst accepting the business cases identify new sets of services, we will re-consider how we integrate the support of the Third Sector, ensuring more robust networks of support for the neighbourhood model.
Recommendation 4: mental health	The current contracting round ahead of April 2018 sets out a clear intention that community mental health services are integrated with neighbourhood teams.
	NHS Stockport CCG further strengthens the clinical leadership in mental health with a particular emphasis on integration of mental health with physical health and social care; especially given the priority of parity of esteem on the NHS agenda and to these proposals.
Recommendation 5: wider determinants of health	Any considerations for greater integration of commissioning functions set out how the wider determinants of health including housing, leisure and education will be aligned.
	The joint commissioners undertake to ensure that Stockport Homes has a more formal position in the partnership arrangements in the review of programme governance recently

	commissioned by the Chief Executives' group and due to be in place for April 2018.
Recommendation 6: workforce	A robust and comprehensive workforce plan and strategy to include the planned for establishment, the impact on other important sectors, and organisational development.
	Monthly reporting against a workforce tracker, tracking actual versus required establishment.
Recommendation 7: Integration of data	Further work is undertaken to promote the benefits of sharing information and the efforts being taken to locally protect data from misuse to support consent from the wider public and specific individuals.