1. APPOINTMENT OF CHAIR
   To elect a Chair for the Health and Commissioning Board for the 2016/17 year

2. APPOINTMENT OF VICE CHAIR
   To elect a Vice-Chair for the Health and Commissioning Board for the 2016/17 year

3. DECLARATIONS OF INTEREST
   Board Members to declare any interests which they have in any of the items to be considered as part of the agenda.

4. APOLOGIES FOR ABSENCE
   To note any apologies submitted from Members of the Board.

5. PUBLIC QUESTIONS
   To consider and respond to any questions submitted by Members of the Public related to the remit of the Health and Care Integrated Commissioning Board no later than 24 hours prior to the meeting. Questions should be submitted in writing to laura.latham1@nhs.net

   *Any questions requiring detailed response will be shared with the Board and responded to following the meeting in writing.

6. HEALTH AND CARE INTEGRATED COMMISSIONING BOARD STRATEGIC GOVERNANCE REPORT
   To note the governance arrangements and terms of reference of the Board.

7. INTEGRATED FINANCE AND PERFORMANCE REPORT
   To consider a report detailing the finances of the Pooled Budget and the related performance indicators and measures.

8. REPORT OF THE DIRECTOR OF INTEGRATED COMMISSIONING
   To receive an update report of the Director of Integrated Commissioning.
9. **MULTI SPECIALITY PROVIDER PROCUREMENT UPDATE**

To receive an update on the progress of the procurement of the Multi-Speciality Community Provider.

10. **DATE OF NEXT MEETING**

The next meeting of the Health and Care Integrated Commissioning Board will take place on 29 November 2016 at 2pm.
1. Purpose

The purpose of this report is to update members of the Health & Care Integrated Commissioning Board (HCICB) on the Section 75 Agreement as the underpinning and enabling document shaping the governance arrangements for the Board and approach to pooled budgets and integrated commissioning arrangements.

2. Background and Content of the Agreement

Both Stockport MBC (SMBC) and Stockport CCG (SCCG) (the commissioners) approved a revised Section 75 agreement (The Agreement) as part of individual organisational governance arrangements in March 2016 for implementation from 1 April 2016. It was signed on 21 June 2016 and outlines arrangements for the pooling of budgets to make arrangements to commission both integrated health and care services for person's over 65 years old.

The agreement establishes the Health and Care Integrated Commissioning Board (HCICB) as the strategic joint decision making body of the Commissioners with responsibility for the pooled funds and integrated commissioning arrangements. The governance schedule contained within the agreement sets out the membership of the Board, its roles and responsibilities and Terms of Reference. The Board will work alongside the established governance frameworks of both SMBC and SCCG, including meeting statutory requirements for Local Authority Overview and Scrutiny provisions.

The Board will be supported in its work by a Director of Integrated Commissioning, jointly appointed by both commissioning organisations.

The integrated commissioning arrangements will be funded using a pooled fund to which both SCCG and SMBC will contribute. The pooled fund will be divided into service budgets, each of which will have specified budget manager under the direction of the Director of Integrated Commissioning. The commissioning activities of the Director of Integrated Commissioning and the budget managers will be referred to collectively as the Joint Commissioning Board (JCB) which will be a managerial arrangement.

The agreement contains provisions dealing with the calculation of the pooled fund and each party's contributions to it. The duration of the agreement is for one year ending on 31 March 2017, after which the parties may agree to extend it for subsequent periods of a year for a maximum term of 7 years. There is also provision for early termination in specified circumstances.

Given the innovative nature of the proposed integrated commissioning arrangements, it is inevitable that changes will need to be made to the Section 75 agreement over time.

An appendix is attached which outlines the key elements of the Section 75 Agreement.
3. Integrated Commissioning Principles

The Section 75 Agreement provides the legal mechanism by which commissioners can work collaboratively, pool budgets and commission integrated health and care services for the people of Stockport. It outlines the key principles and commitments of the commissioners to openness and transparency in the arrangements.

It acts as the key enabler and driver for achieving what commissioners in Stockport have set out as part of the ambitious economy wide Stockport Together Programme, in particular commissioning new models of care through a Multi-Speciality Community Provider (MCP). In parallel to the establishment of integrated commissioning arrangements, Providers in Stockport are developing detailed designs for new models of care through integrated provision and the establishment of a Shadow Provider Board.

The Board recognised on its establishment the importance of commissioners in leading the health and care system and in developing an integrated commissioning culture across the system beyond the underpinning legal framework. The agreement should also be read alongside the following principles for integrated commissioning developed collaboratively by members of the Health and Care Integrated Commissioning Board.

The Board will in the coming months, agree how it will measure its leadership impact and progress towards embedding the principles through all integrated commissioning work:

Integrated Commissioning Principles

- The Health and Care Integrated Commissioning Board will be the strategic commissioning leader across the Stockport health and care economy and will develop the culture of an integrated commissioning approach.

- The Health and Care Integrated Commissioning Board will seek to work in a complimentary way as part of a place based approach to governance and will not duplicate work carried out elsewhere.

- The Board will focus on similarities in commissioning approach between both organisations and its strategy will be focussed on blending the best and learning from each other.

- The Board will be guided in its strategic commissioning by local priorities and need (including the Joint Strategic Needs Assessment) and national regulation and statutory frameworks.

- Conflicts of interest exist across the system and need to be proactively managed. They will not be a barrier to progress or an excuse as to ‘why we can’t’.

- The Board will act as a strategic commissioner and will empower those commissioning managers accountable to it to innovate, challenge and deliver high quality commissioning approaches.

- Commissioning decisions made by the Board and at all levels below will be made on the basis of what is right for the people of Stockport and set within the wider context of the ‘Place’ not what is right for individual or collective organisations.

- The Board will seek to ensure continued engagement between the health and care system and the public and patients of Stockport to drive forward behaviour change and healthy lifestyles. This will include a strategic commissioning approach focussed on prevention, reducing health inequalities and patient and public responsibility for self-management.

- The Board will define and articulate clearly what success looks like in terms of integrated commissioning and the role of the Multi-Speciality Community Provider (MCP) as a new organisational form that will deliver the required outcomes.
Decisions will be made on the basis of evidence, challenged and tested prior to decision and should not be personally or organisationally motivated.

Quality shall remain at the heart of the role of the Board as a strategic commissioner and its leadership shall seek to continue to raise quality standards and outcomes for the people of Stockport, including ensuring high levels of service user experience are reflected in both provision and through commissioning outcomes.

In focussing on meeting the known challenges in Stockport within the health and care economy, the Board will take a proportionate approach to balancing risk and the evidence base when taking decisions. Acknowledging that nothing is ever risk free and that to progress, risks and opportunities need to be proactively managed.

The Board will adopt a ‘we could’ approach to leading the integration of commissioning of health and care services within Stockport and will own and deliver this message to stakeholders, staff and the people of Stockport.

The Board will maintain the clinical in commissioning.

4. Recommendations

The Board is requested to:

1. Note the content of the Section 75 agreement as outlined in the Appendix, including the role and responsibilities of the Board.

2. Approve the integrated commissioning principles as outlined in the report.
A brief guide to the contents of the Section 75 agreement. This is not intended to be a definitive interpretation.

<table>
<thead>
<tr>
<th>Clause number in Agreement</th>
<th>Brief description of clause</th>
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<tbody>
<tr>
<td>3</td>
<td>Sets out the Stockport Together vision, which is to achieve service quality improvement by integrating service delivery, and by innovation.</td>
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<tr>
<td>4</td>
<td>Describes the overall structure of the agreement in terms of what it seeks to achieve</td>
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<tr>
<td>5</td>
<td>Briefly sets out the background to the agreement.</td>
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<tr>
<td>6</td>
<td>Contains definitions of the words or phrases that are used in the agreement where they have a special meaning. If there is no definition of any word or phrase in Clause 6 then words used in the agreement will have their ordinary everyday meaning,</td>
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<tr>
<td>7</td>
<td>Establishes the Health and Care Integrated Commissioning Board (HCICB) and commits the parties to move towards fully integrated commissioning with SCCG as the commissioning lead.</td>
</tr>
<tr>
<td>7.1-7.2</td>
<td>Describes the functions of the HCICB:</td>
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<tr>
<td>7.3</td>
<td>1. Agreeing arrangements for a pooled fund to commission integrated services and to approve any budgets relating to it.</td>
</tr>
<tr>
<td>7.4</td>
<td>2. Determine the delegation of financial and managerial responsibilities for the pooled service budgets between the parties.</td>
</tr>
<tr>
<td>7.5-7.6</td>
<td>3. Monitoring the Better Care Fund.</td>
</tr>
<tr>
<td>7.4</td>
<td>4. Receiving quarterly financial and service information from the DIC and pooled fund managers.</td>
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<tr>
<td>7.4</td>
<td>5. Agreeing risk management arrangements.</td>
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<tr>
<td>7.4</td>
<td>6. Approving any measures that may be required to respond to information in 4. Above.</td>
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<tr>
<td>7.4</td>
<td>7. Resolving disputes either directly or through formal procedures</td>
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<tr>
<td>7.4</td>
<td>8. To set objectives and targets and to continually review the effectiveness of the integrated commissioning arrangements in 1. Above.</td>
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<tr>
<td>7.4</td>
<td>9. To report to the parties and any interested bodies on the above</td>
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<td>7.4</td>
<td>10. Any other appropriate function that is agreed between the parties</td>
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<tr>
<td>7.5-7.6</td>
<td>Establishes that SMBC will host the Pooled Fund and will be responsible for providing the HCICB with accounting, audit and financial information about both the fund and the related pooled service budgets.</td>
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<tr>
<td>7.5-7.6</td>
<td>Jointly appoints the DIC to:</td>
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<tr>
<td>7.5-7.6</td>
<td>1. report to the Chief Executive of SMBC and the Chief Clinical Officer of SCCG</td>
</tr>
<tr>
<td>7.5-7.6</td>
<td>2. Implement the instructions and policies of the HCICB in relation to arrangements for integrated commissioning and the pooled fund</td>
</tr>
<tr>
<td>7.5-7.6</td>
<td>3. Provide information about 2. Above to enable the parties responsible officers to meet their statutory obligations.</td>
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</tbody>
</table>
4. Issue commissioning contracts under instruction from the HCICB, either jointly or by one of the parties.

<table>
<thead>
<tr>
<th>8</th>
<th><strong>Deals with the co-operative arrangements for integrated commissioning between the parties.</strong></th>
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<tbody>
<tr>
<td>8.1</td>
<td>Identifies the services as those specified in Schedule 1 and commits the parties to work together in partnership through the HCICB to introduce capitation-based contracts, standardised commissioning formalities and a common outcome assessment arrangement.</td>
</tr>
<tr>
<td>8.2-8.3</td>
<td>Permits the mutual delegation of functions between the parties in order to implement the integrated commissioning arrangements but limits the delegation to the degree necessary to comply with legislation.</td>
</tr>
</tbody>
</table>
| 8.4 | Sets out the following objectives to be achieved during the move to integrated commissioning:  
1. Introducing a new procurement strategy for the MCP,  
2. New commissioning arrangements using capitation contracts,  
3. Liaising with GMCA in relation to the formulation of the Greater Manchester Strategic Sustainability Plan,  
4. Formulating new scheme specifications where so required and  
5. Providing monthly reports on the Better Care Fund and any over or underspends in the Pooled Fund. |
| 8.5 | Sets out the following specific mutual obligations of the parties whilst working together to achieve the objectives specified in 8.4:  
1. To co-operate with each other  
2. To make any necessary delegations  
3. To make the agreed contributions to the Pooled Fund promptly and without deduction  
4. To make payments from the Pooled Fund in order to provide the services  
5. To operate their other functions in a manner that is compatible with the integrated commissioning arrangements |
| 8.6 | Preserves any existing commissioning arrangements made by the parties pending new arrangements being introduced |
| 8.7 | **Requires the Responsible Officers** of the parties (whose identity is currently under discussion) to agree and then regularly review arrangements to monitor the exercise by the HCICB of its functions in order to ensure that they are exercised lawfully, effectively and appropriately. |
| 8.8 | Records the following mutual obligations of the parties in relation to commissioning integrated services:  
1. To work co-operatively and to exercise due skill care and attention.  
2. To make the required payments to the service providers, to be monitored by the HCICB.  
3. To comply with budget discipline  
4. To inform each other of the services effectiveness and of any departure from agreed spending levels relating to them.  
5. To make any reports to the Health and Wellbeing Board of SMBC that may be required by statute. |
| 8.9 | **Establishes the Joint Commissioning Board (JCB)** as a joint |
management arrangement between the parties which will issue contracts designed to implement the objectives of the HCICB set out in Clause 8.4. The JCB will work under the overall direction of SCCG as lead commissioner through the DIC. It will consist of the employees and contractors who currently deal with the parties commissioning arrangements working together co-operatively under a unified management framework led by the DIC.

Sets out the tasks of the JCB:
1. To comply with the parties legal obligations relating to service planning and commissioning,
2. To undertake defined procurement activities;
3. Making arrangements to plan for and then implement capitation-based contracts using an outcomes framework.

**Establishes the necessary framework arrangements to enable the HCICB to create a Pooled Fund through** which to administer the funds required for integrated commissioning.

Appoints SMBC as the pooled fund host and its Section 151 Chief Financial Officer as the officer responsible for audit, accounting and financial reporting in relation to the pooled fund.

**Specifies the roles of the DIC and the pooled fund budget managers in relation to the pooled fund:**
1. The DIC will be jointly appointed by the Chief Executive of SMBC and the Chief Medical Officer of SCCG to manage the pooled fund arrangements through the JCB.
2. The DIC will determine the delegation of financial responsibility to the relevant budget managers within the JCB in relation to the services to be provided through the pooled fund and establish appropriate budgets for such services.
3. The budget managers will then work through the JCB to commission the services, and will provide information about them to both the HCICB and the parties.

Records that the relevant financial governance arrangements for each budget will be determined by which party is the employer of the manager of that budget, and that this arrangement will then be recorded in that party’s constitutional arrangements.

Obliges the parties will assist the HCICB, the DIC and the budget manager in operating the pooled fund by providing financial and administrative support and SMBC will operate an accounting structure that facilitates this support.

**Records that the DIC and the budget managers will:**
1. Be responsible for the services that they commission.
2. Report to the HCICB on the performance of these services.
3. Maintain appropriate accounting and audit arrangements.
4. Advise the HCICB of any variations from planned expenditure.
5. Prepare an annual financial report for each service, and
6. Send that report to the responsible party for inclusion in its statutory accounts.

Obliges the parties through their finance officers to agree a scheme for recovery of VAT after seeking guidance from HMRC.

**Sets out the budget arrangements for the pooled fund.**
1. Each party’s contribution to the Pooled Fund in the 2016/2017 budget year are set out in Schedule 2.
2. Schedule 2 will form the basis for future contributions, which should be agreed and then formalised in a similar manner.
3. The pending pooled fund budget should be agreed by the 31 March each year.
4. Notice of the planned contribution will be sent to each party within 7 days.
5. SCCG will ensure that value for money is actively secured when making payments under the pooled fund budget.

Where restrictions are imposed by central government on the use of funds that are included in the pooled fund then the relevant budget managers will ensure those restrictions are complied with.

Confirms that all funding between the parties will count towards the pooled fund contributions.

**Describes how the contributions to the pooled fund will be calculated.**

Lists the accounting and financial criteria to be considered when calculating the parties annual contributions.

Requires that any proposed variation to the contributions which may have a detrimental financial impact on either party must first be discussed and then agreed within the HCICB.

Permits the party that does not host the pooled fund (currently the CCG) to pay its contribution on a quarterly basis, the specific sums and dates to be agreed with the host (currently SMBC).

Specifies how the amount of the successive annual pooled funds will be calculated.

Notes that the SMBC contribution will be subject to deduction of any charges, costs and expenses already incurred by it in relation to the service users.

Recognises that the parties may agree to add new budgets and related services as integrated commissioning progresses. In the event that new budgets and services are agreed then they must be recorded by a written notice of contract variation and added to the agreement in Schedule 1.

Limits the use of the pooled fund to the services specified in Schedule 1.

Requires any forecasted changes in expenditure from the pooled fund for the current or following year to be referred to the HCICB for discussion about whether the parties should make additional funds available or how they should utilise any surplus.

Deals with the procedure for responding to unforeseen overspend in the pooled fund, and notes that in general overspend will not be tolerated.

Requires the HCICB to negotiate support arrangements for overspends and notes that the statutory responsibility for service delivery remains with the parties. Overspend arrangements may include robust recovery plans.
| 9.3.13 | Provides a procedure for dealing with budget surpluses. |
| 9.3.14 | Prevents the parties from changing their contributions during the financial year. |
| 9.3.15 | Permits any disputes about contributions to be referred to the mediation procedure in Clause 10. |
| 9.4 | Requires the DIC to submit a quarterly financial report on the pooled fund to the HCICB and to each of the parties. |
| 9.4.1-9.4.2 | **Deals with financial accountability and risk sharing arrangements relating to the pooled fund:** |
| 9.5 | Agrees that each party will retain its existing financial accountability and audit arrangements and bear its own risks in relation to integrated commissioning, and specifically provides for the retention of the parties formal financial procedures. This arrangement will remain under review. |
| 9.5.2 | Specifies procedures for dealing with pooled fund over and underspends. |
| 9.5.3 | Notes that provided SMBC has managed the pooled fund and reported to SCCG in accordance with the agreement then the fact that an overspend has occurred will not automatically be a breach of its obligations as the pooled fund host. |
| 9.6 | Imposes an obligation upon the DIC and pooled service budget managers to alert the HCICB to any changes in the services and to comply with the service specifications. |
| 9.7 | Provides for contributions to the pooled fund to be made by transfers of assets or the provision of services. |
| 9.8 | Permits credits to be sought in relation to the supply of back-office services and premises. |
| 10 | **Notes that no payments made out of the pooled fund can be used for acquiring capital assets.** |
| 10.1 | The status of the HCICB in its relationships with the parties and the JCB |
| 10.2 | Schedule 3 of the agreement sets out the rules and procedures for the HCICB, which may be amended if so required by agreement. |
| 10.3.1 | The HCICB will provide a strategic lead for the JCB through the DIC. |
| 10.3.2 | As the HCICB’s host authority SMBC will provide accounting and audit arrangements for the pooled fund that comply with the relevant legislation. The parties will provide all necessary information and access to documents and personnel to allow the auditors to perform their role. |
| 10.3.3-10.3.4 | At all times the parties will comply with their respective financial, professional...
and clinical governance obligations in the operation of the HCICB and
integrated commissioning. Equal opportunity legislation will be complied with
and equality principles will be positively asserted in each party’s policies and
activities under the agreement.

Commercial confidentiality will be protected in all dealings between the
parties under the authority of the DIC.

Data protection arrangements

Conflicts of interest in any aspect of the activities of the parties, the HCICB,
the DIC and the JCB will be managed in accordance with the principles set
out in Schedule 4.

Describes the mandatory dispute resolution procedure

Deals with the DIC’s appointment, the requirement for the parties to confer
on the DIC all necessary powers and responsibilities to perform his role and
confirms the DIC’s responsibility for management of the pooled service
budgets.

**Deals with liabilities between the parties** and with third parties, sets out
the terms of a mutual indemnity for losses that are attributable to acts or
omissions and describe actions that should be taken when a claim is made
against either party.

The duration of the agreement is set out in Clause 30.

Obligations to continue to co-operate after the end of the agreement

Commissioning contracts made under the agreement will continue in
effect after the agreement is ended.

Excludes third parties from gaining contractual rights under the
agreement.

English law will apply

Sets out the manner in which complaints will be dealt with through a
joint complaints procedure.

Provides a procedure for review and variation of the agreement either
during or at the end of the term in clause 30.

Deals with the parties ability to appoint financial and legal advisors

Relationship with Greater Manchester Strategic Partnership Board

Allocates responsibility for press releases or public statements about
arrangements under the agreement.

Legal and technical provisions.

Sets out duration of agreement and termination arrangements.

Provides for transfer of the agreement if one or both the parties are
superseded by an equivalent but different organisation.

The Services
<table>
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<tr>
<th>Schedule</th>
<th>Description</th>
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<td>2</td>
<td>Pooled fund contributions 2016/2017</td>
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<tr>
<td>3</td>
<td>The HCICB Governance framework</td>
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<td>4</td>
<td>The conflicts of interest principles.</td>
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<td>5</td>
<td>Governance diagram (Clause 4)</td>
</tr>
<tr>
<td>6</td>
<td>Better Care Fund details and risk management arrangements (Clause 8.8.5)</td>
</tr>
</tbody>
</table>
1. Purpose

This is the first report to the Health & Care Integrated Commissioning Board (HCICB) setting out progress against a range of health, performance and improvement priorities and finance. Attached as an appendix to the report is a data pack which provides detailed analysis.

2. Performance & Improvement

- There are gaps in mortality and key outcome data across Stockport, with the most deprived areas still having higher mortality rates. There is a significant programme of prevention as part of Stockport Together which aims to reduce inequalities and improve outcomes, and the development of neighbourhood working is a key part of the strategy to address variation and ensure that services/interventions address local needs. The HCICB will want to ensure that the development of the Outcomes Framework and contracting approach for the MCP support the development of prevention as a key factor in addressing inequalities.

- The system still has significant challenges within the urgent care system. The 4 hour Emergency Department (ED) waiting time standard is seen as a measure of how well the system is performing overall, rather than a simple hospital waiting time standard. At the end of Q1 our performance against this standard for type 1 attendances was 82%, with Stockport NHS FT ranked 7th of 8 NHS Trusts in GM and 97th of 139 Trusts nationally. The GM and National averages were both 85%.

- At the end of Q1, ED attendances had risen 4.0% on last year’s levels but despite a 3.4% reduction in urgent admissions, pressures on beds and performance remain. NHS England has requested a meeting with system leaders across health and social care to understand plans to address this, particularly plans to meet the increased demand which will be experienced over Winter. A significant proportion of the pooled budget is used to commission urgent care and those services that support the wider urgent care system, and therefore the report will include progress on issues in relation to this.

- The report highlights that Delayed Transfers of Care (DTOC) have significantly increased and the balance between step up and step down intermediate capacity continues to be towards step down with the focus on supporting people to be discharged from hospital. There is a major piece of work summarised in the Intermediate Care Business Case to streamline and improve the intermediate care services to support the development of out-of-hospital care and consequently to improve performance against the ED target. A further report on progress will be reported at the next meeting together with the work to reduce the level of DTOC. This work is a significant element of the ED improvement work referenced above.
• There continues to be pressure on care home beds and capacity, specifically in those supporting people with mental health needs. Across the last 12 months there have been a number of care home closures that have not been matched with the opening of new capacity. The next phase of Stockport Together business cases will include one with a specific focus on care home capacity and our Stockport strategy for addressing this issue.

• There are 8 Integrated Neighbourhood Teams in Stockport, with 7 areas having implemented a complex care pathway which includes regular MDT meetings. They have an early focus on the top 2% of the population currently, and from October this will be extended to the top 6% and the 15% by Jan 2017. In addition, the work to align GPs to Care Homes and develop ward rounds has seen Reduction in care home admissions is -88 (-17.4%) in Q1 compared to same period last year which is a positive improvement. These are important developments that must be built upon as the Stockport Together service developments are rolled out.

• The report highlights that Falls is an area that requires development. The Neighbourhood Teams will be looking to identify people at risk/having fallen and providing support, but there is a need to develop specialist falls services and more robust systems and processes. This will have to be a priority for the next phase of development.

3. Quality

• In terms of quality, there are arrangements within both the Council and CCG to monitor the quality of commissioned services. Some of this is already done jointly, and there are discussions to integrate this further. HCICB members will be aware that Stockport NHS Foundation Trust recently received its CQC Inspection report. The CQC inspected and rated the following locations and services:

  • The CQC rated Stepping Hill Hospital as Requires Improvement.
  • The CQC rated the Community Service for Adults as Requires Improvement
  • The CQC rated the Inpatient community services (Shire Hill and the Devonshire Unit), Children and young People services and End of Life Services as Good.

• The CQC collated all the ratings and rated the trust as Requires Improvement overall. The CCG has worked with Stockport Foundation Trust across a number of forums to improve and develop services and will continue to work with SFT to progress the improvement work highlighted by this CQC report. An improvement action plan will be developed by Stockport Foundation Trust in response to the CQC report will be monitored by the CCG Quality Committee over the coming months and reported to the CCG Governing Body. The HCICB will receive updates on this at the next Governing Body Meeting in September.

4. Finance

The integrated performance report identifies a forecast adverse variance of £1.6m, predominantly from acute pressures on elective surgery and critical care. S75 processes to mitigate and manage these cost pressures have been instigated.

The 40% increase in national FNC rates is an unforeseen additional pressure which will need to be managed both recurrently and non-recurrently.
5. Recommendation

The Board are asked to:

- Approve the reduction to the value of the Pool (SMBC contribution of £0.224m).
- Note the financial position at Q1 illustrating a deficit of £1.6m and that relevant S75 processes have been instigated.
- Endorse the procurement decisions approved by Stockport CCG Governing Body.
1. CONTEXT

1.1 Stockport’s health and care organisations are working together to develop an integrated system that meets growing needs and creates a sustainable economy for the future. In 2016/17 Stockport Council and NHS Stockport CCG agreed to pool more resources than ever before under a Section 75 agreement to manage integrated services.

1.2 Joint ownership of the pooled budget is overseen by the Health & Care Integrated Commissioning Board. This report sets out our combined performance as a health and care system in respect of our s75 arrangements. It uses as its performance measures our shared strategic goals set out in Stockport’s Health & Wellbeing Strategy. For the purposes of this report, indicators have been grouped into three categories:

- Better Health
- Better Care
- Sustainability.

1.3 Work is currently underway to co-produce an Outcomes Framework, which will be used as the basis of our capitated contracting arrangements for the s75 funding. Once this framework has been agreed and built into the contract of the new integrated provider (or MCP), this report will monitor performance on the Outcomes Framework, as opposed to the current performance indicators.

1.4 As well as reporting data trends, the document outlines what work is underway across the economy to improve in these priority areas for the conurbation.

1.5 Finally, the report tracks our financial performance on those contracts covered in our Section 75 agreement.

2. LOCAL NEEDS AND PRIORITIES

2.1 The 2015/16 Joint Strategic Needs Analysis (JSNA) for Stockport describes a population that is generally healthy, however one which is older than average and where the proportion of older people is forecast to grow faster than the national average. Stockport has health outcomes that are better than the North West average but faces challenging health inequalities between the most affluent and the most deprived areas of the borough. A&E and non-elective care performance have been poor for a significant time and the economy collectively forecasts a c£130m deficit by 2020/21 unless care is delivered differently.

2.2 The overall objectives for health and wellbeing in Stockport are to improve life expectancy and reduce health inequalities. Following the 2015/16 JSNA analysis of key trends across a range of themes, work has been undertaken to identify the key priorities for health and wellbeing in Stockport for the next three years. These are the major issues that leaders, commissioners and providers of health, care and wider services will need to consider or address:
Priorities 2016-2019

The overall objectives for health and wellbeing in Stockport are to improve life expectancy and reduce health inequalities. The priorities identified in the JSNA to help us achieve these objectives are set out below and developed further at: www.stockportjsna.org.uk/2016-2019-priorities/

<table>
<thead>
<tr>
<th></th>
<th>All Ages</th>
<th>Start Well</th>
<th>Live Well</th>
<th>Age Well</th>
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<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td>Increasing levels of physical activity as an effective preventative action at any age.</td>
<td>Taking action to improve the outcomes in early years’ health and education in deprived communities.</td>
<td>Prioritising a ‘whole systems’ approach to reducing smoking, alcohol consumption and obesity as the key causes of preventable ill health and early death.</td>
<td>Supporting healthy ageing across Stockport, recognising that preventative approaches that promote self-care and independence are essential at every life stage.</td>
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<td><strong>Wellness</strong></td>
<td>Focus on improving healthy life expectancy for all as the priority, focussing especially in the most deprived areas and in a person and family centred way.</td>
<td>Promoting the mental wellbeing of children and families, especially for older children and young adults.</td>
<td>Improve the prevention, early detection and treatment of both cancer, now the major cause of premature death, and liver disease, which is increasing.</td>
<td>Aim to prevent and delay the need for care whilst responding to the complexity of needs that older people with multiple long term conditions may have.</td>
</tr>
<tr>
<td><strong>Systems</strong></td>
<td>Continue work to integrate and improve care systems, especially minimising the use of unplanned hospital care - ensuring that the healthy economy is sustainable and prevention focussed.</td>
<td>Ensuring that the acute care needs of children and young people, especially for injuries, asthma and self-harm are dealt with appropriately and opportunities to promote prevention are maximised.</td>
<td>Giving equal weight to mental wellbeing as a key determinant of physical health and independence; especially for people of working age.</td>
<td>Providing services and housing that are suitable for the changing needs of our ageing population and those with specialist needs.</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Understanding the size and needs of our vulnerable and at risk groups, especially carers, and using JSNA intelligence to inform the appropriate levels of response.</td>
<td>Supporting and safeguarding the most vulnerable children and young people and families, especially looked after children and those with autism, so that they have the opportunity to thrive.</td>
<td>Improving the physical health and lifestyles of those with serious mental health conditions.</td>
<td>Continuing to improve the identification of and support available to those with dementia and their carers.</td>
</tr>
</tbody>
</table>

2.3 As part of the 2015/16 JSNA a review was undertaken of the key national outcome framework performance profiles, highlighting areas of good practice as well as areas of concern across the NHS, Public Health and Adult Social Care (see extract over the page). The full analysis is available at: [http://www.stockportjsna.org.uk/2016-jsna-analysis/outcome-frameworks/](http://www.stockportjsna.org.uk/2016-jsna-analysis/outcome-frameworks/). Key messages arising are:

- Stockport performs better than average on a range of measures, especially in life expectancy, health protection, cancer survival, quality of life and patient experience.
2.4 For all the frameworks, however, **Stockport performs poorly outcomes relating to liver disease, hospital admissions, injuries from falls, and permanent care home admissions.** These are areas where performance has been consistently lower than average.

3. **OVERVIEW OF DATA**

3.1 The following data tracks performance over the last few years to explain the ongoing impact of joint working across the economy. On the whole the data reflects the position described in the Joint Strategic Needs Assessment: strong health outcomes on the whole, with pockets of underperformance in the deprived areas of the borough; good patient experience; but no discernible improvement in reducing our dependency on hospital-based care, which is the focus of our integrated commissioning and investment in Stockport Together.

3.2 The purpose of this report is to support HCICB to monitor the impact of our investments in integrated service provision; to monitor spending on shared contracts; to track progress on joint-projects; and to steer improvement projects to ensure that we continue to see progress in our common aims.

4. **BETTER HEALTH**

Question for the Board: *Is the health of the population of Stockport improving?*

4.1 **Are Mortality rates improving?**

The graphs below show the trend in mortality rates for men and women has improved consistently since 2005 and has stabilised since 2014. We should expect to see the downward trend continuing, so therefore need to be concerned about the stagnation of this trend. Stockport benchmarks as average nationally.
4.2 What are we doing to improve?

One of the key work streams of Stockport Together is focused on prevention. The aim is to support local people to have a better understanding of their health, to increase the uptake of screening and to ensure early identification of health and care needs. To date we have developed a Stockport Health and Care phone app - downloaded by over 2,000 people – to help signpost people to the right care for their needs. We have run hypertension and COPD awareness campaigns, testing the blood pressure of over 2,000 people and the lung age of around 1,000 residents.

The remaining Stockport Together work streams focus on proactively managing people with existing health and care needs to prevent escalation of conditions and to better respond to conditions amenable to healthcare when they do escalate. Integrated intensive support teams in each of our 8 neighbourhoods will support people to stay well longer and to improve the management of complex care and long-term conditions.

Holistic care plans have been developed for 2% of the population with the highest support needs to ensure that their conditions are well managed outside of hospital. Multi-Disciplinary Team meetings are convened to ensure that staff across organisations come together to discuss and coordinate care plans for service users. GP ward rounds now take place in care homes to prevent unnecessary hospital episodes and training has been provided for care home staff. We have piloted real-time tests for asthma patients in Primary Care using video consultations and a new Consultant-Connect service, allowing GPs immediate access to advice from a hospital consultant. Additional patient education courses have been funded to support people with long-term conditions to manage their condition well.

4.3 Is the mortality rate in deprived areas improving more than for Stockport overall?

The graphs below show that the trend in mortality rates in deprived areas has also improved over the long term. However mortality rates are still significantly higher in deprived areas, and the pace of change has meant gaps have not narrowed. There is a concerning upward trend for women’s mortality in deprived areas. We should expect to see a step change in mortality rates in deprived areas, especially for the female population.
4.5 What are we doing to improve?

Prevention work has been focussed primarily in areas of deprivation, with the main targets in the Healthy Communities work stream focussing on improvement in the most deprived areas. Key improvements will be to reduce smoking, unhealthy levels of drinking, inactivity, obesity, depression, social isolation and low wellbeing. The neighbourhood approach of Stockport Together means that work in each area will be varied to adapt to local population needs.

4.7 Is mortality for people with mental illness improving?
The graph below shows that there has not been a significant improvement in reducing premature mortality in adults with serious mental health and that the mortality rate for this group is more than three times higher than average. Stockport benchmarks as average nationally.

4.8 What are we doing to improve?

Over 2015/16 work was undertaken with our mental health provider to increase the rate of physical health checks for people with mental illness.

In 2016/17 Stockport is increasing investment in mental health services by an additional £2.5m. Investment will be used to support improvements in safe staffing levels, to fund 1:1 observations, to improve crisis care, mental health liaison teams in hospital to respond to overdose / self-harm presentation, and additional recruitments to provide Early Intervention in Psychosis.

5. BETTER CARE

Question for the Board - *Are more people being treated closer to home?*

5.1 Are fewer people attending Accident and Emergency?

The chart below shows that the number of A&E attendances for the Stockport CCG population has slightly increased. We would expect to see these numbers reduce as we invest in primary care access and integrated neighbourhood teams.
In May 2016 ED attendances were up 3.4% on the previous year. 1% of this is attributable to the impact of the national NHS111 service, which is streaming on average an additional 6 patients a day to the ED.

5.2 What are we doing to improve?

Our neighbourhood model aims to proactively manage complex care needs at home including increasing capacity in primary and community services and significant rationalisation to strengthen the support available in intermediate tier services through. This will reduce the requirement for treatment in hospital or A&E.

To create additional capacity in primary care Stockport Together is recruiting professional and third sector alternatives to a GP appointment including physiotherapy, practice based pharmacists and community pharmacy, counselling and signposting to non-health related support services.

5.3 Are Fewer People being admitted to hospital?

Stockport aims to reduce emergency hospital admissions by 50%. However, the chart below shows that there has been an increase in the number of emergency admissions. Stockport is an outlier nationally in emergency admissions.
Among the over 65 population the rate of non-elective admissions per 1,000 population has improved from 300 in 2014/15 to 291 in 2015/16, however this is still significantly higher than the North West rate of 247.

5.4 What are we doing to improve?

Our main focus as an economy has been on the hospital processes for managing people in the ED. The Acute Interface work stream of Stockport Together has undertaken a review of pathways for ambulatory care sensitive conditions to ensure rapid assessment and streaming to an Ambulatory Emergency Care unit to ensure same day diagnosis and treatment, including review by a consultant, timely access to diagnostics and treatments all being delivered within one working day. This has improved both clinical outcomes and patient experience, while reducing costs.

Over 2016/17, Stockport FT intends to extend the opening hours of the Medical Assessment Unit to operate 7 days a week until midnight, allowing the hospital to manage 10 more patients a day who would otherwise have been admitted to a specialist ward in the hospital on average for 5.6 days.

5.5 Are fewer people being re-admitted to hospital as an emergency?

The chart below shows that there has been a reduction in emergency readmissions at Stockport FT for the Stockport CCG population since late 2014.
This trend has continued into 2016/17 with rates of readmission within 30 days among over 65s reducing from 18.7% in April to the NorthWest average of 17.4% in May.

5.6 What are we doing to improve?

Improvements have been supported by proactive management of people with complex care needs through care planning, extended GP opening hours, longer GP appointments for people with long-term conditions and Multi-Disciplinary Team meetings to assess complex care needs.

The further development of integrated neighbourhood teams over 2016/17 and the integration of Intermediate Tier services to better support patients after discharge should support this improvement.

5.7 Are people being discharged from hospital when they should be?

Stockport benchmarks above the national average for delayed transfers of care and is also high in relation to its peer group, as shown in the chart below.
The chart below shows that there has been an increase in the number of days that patients are delayed in the transfer of care from hospital, reflecting a number of inter-related causes.

5.8 What are we doing to improve?

Stockport’s Systems Resilience Group manages DTOC improvement projects. A new Short Stay for Older People ward has been established to proactively work with patients to ensure that they receive specialist multi-disciplinary care as soon as they arrive in hospital and a holistic discharge plan to avoid unnecessarily long stays in hospital. Funding has been prioritised to continue Stockport’s assertive in-reach team to work with patients on wards and support early discharge by assessing ongoing care needs and coordinating the necessary packages of care.
We have self-assessed against the ECIST improvement programme and we are now following ECIST’s recommended 8 high-impact changes, led by the Local Authority. We expect outcomes in 2016/17 to include: integrated discharge team; home first as a principle; discharge to assess; and a focus on the resilience of our care home market and domiciliary providers.

5.9 Are more people accessing Intermediate Care services (instead of hospital)?

Intermediate Care is split into two main categories: ‘Step-Up’ in care to prevent hospitalisation; and a ‘Step-Down’ service to support rehabilitation after hospital or community rehab.

There is a declining trend in the number of people entering step-up services since April 2015. A significant drop occurred in February 2016 and although the overall trend has increased since then, the number of entrants is still lower than it was before January 2016. Occupancy levels of step down services are also lower than they were before January 2016, with the biggest decrease in reablement services.
In contrast, the number of people entering step down services has been increasing and the same trend is exhibited in occupancy levels. This increase has been particularly sharp from January 2016 onwards and is attributed to reablement.

The shift in balance of provision has been led by a significant demand for step-down services to meet local needs. Given that the reablement service is able to use staff to provide both step up and step down support, this service has been utilised to support the growing demand.

5.10 What are we doing to improve?

Stockport Together is developing a business case around the integration and transformation of the current 20+ services providing intermediate care in the borough. By merging teams, they aim to reduce duplication, referrals and waiting times, increase capacity and skill sets within teams.

Plans include greater capacity to support people in their own homes at less cost than a hospital bed, effective use of resources to enable 24/7 service provision and improved management of community beds.
to meet demand. Crucially, the plan aims to balance the proportion of step-ups and step-downs to prevent unnecessary hospitalisation and relieve pressure on hospital beds that impacts on DTOC.

5.11 Are people still at home after reablement / rehabilitation services?

The chart below shows a high proportion of older people still at home 91 days after receiving reablement services.

The data also shows a slight upward trend from October 2015 onwards. In October 2015 a new model of providing complex equipment was introduced. This was designed around changing practice in acute care in managing complex discharges. The new model has bedded in well and has had a profound impact on the numbers of reported DTOC delays attributable to equipment, which have now been virtually eliminated.

5.12 What are we doing to improve?

Stockport’s in-house provider delivers reablement alongside the personal care and therapy practice component of intermediate care. The close working with clinical staff that this necessitates has enabled the service to be targeted at people directly following an enhanced rapid response assessment and to a higher risk group of people leaving hospital.

The integration of all intermediate tier services will bring further improvements in embedding a reablement / rehabilitation approach across all intermediate tier services.

5.13 What proportion of the population is admitted to residential and nursing care?

The chart below shows the number of admissions each month per 100,000 population to residential and nursing care homes has not shown a statistical change since 2014. It is expected that this will continue over the next year due to increased support in out of hospital care, in particular packages of care within an individual’s own home.
5.14 What are we doing to improve?

Stockport Together’s integrated neighbourhood model will increase capacity in primary and community services to provide packages of care in an individual’s own home, reducing reliance on care homes.

5.15 Are falls resulting in harm reducing?

Stockport is in the lowest performance quartile nationally for the rate of injury from falls: 2,735 people per 100,000 population aged 65 and over, compared to the national rate of 2,027. Stockport’s high rate of injuries from falls can in part be attributed to our older population who are more likely to experience a fall and more likely to be injured as a result. In addition, older people attending Stockport FT as a result of a fall are more likely to be admitted than at other hospitals.

The graph below shows no statistical change in the number of admissions for the Stockport CCG population for injuries and harm resulting from a fall in the last two years.
5.16 What are we doing to improve?

There are currently no specific improvement projects around falls, however the development of integrated neighbourhood teams will support the proactive management of vulnerable people.

5.17 Are people reporting an increased experience of services?

Patient experience is reported by Provider and cannot be aggregated into a summary chart.

The chart below shows Friends and Family results for Stockport Foundation Trust, the largest provider of health and care services in Stockport. Patient experience is typically average or better than average compared to the GM and national position.

<table>
<thead>
<tr>
<th>Department</th>
<th>% of patients who would recommend Stockport FT to Friends &amp; Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>90%</td>
</tr>
<tr>
<td>Inpatients</td>
<td>96%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>89%</td>
</tr>
<tr>
<td>Community</td>
<td>90%</td>
</tr>
</tbody>
</table>

Stockport patients reported the best experience of GP services across Greater Manchester. 87.5% of patients rated their experience of GP services as good, compared to 84.9% across GM and nationally.

5.18 What are we doing to improve?

Investment in Primary Care through a GP Development Scheme has extended opening times and stopped all half-day closures as well as providing additional capacity to manage long-term conditions and coordinate care. Provision of care closer to home responds to local engagement.
6. SUSTAINABILITY

6.1 Introduction

The following section sets out our combined financial performance on the contracts within the Section 75 pooled budget for Quarter 1 (data as at 30 June 2016). The style of reporting is a work in progress and will be updated in line with improved monitoring and reporting processes.

6.2 Budget Position at Quarter One

The table below provides a summary by commissioning organisation of the total budget resources available as at Quarter One within the s.75 pooled budget agreement. The quarter one position below reflects a proposed virement out of the pooled budget for Adult Social Care, which is as a result of the movement of operational management for the out of hours service to the Children and Families Portfolio.

Table One: Budget Position at Quarter One

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Original 2016/17 Budget £m</th>
<th>Movement(s) £m</th>
<th>Proposed 2016/17 Q1 Budget £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stockport Council</td>
<td>84,736</td>
<td>(224)</td>
<td>84,512</td>
</tr>
<tr>
<td>Stockport CCG</td>
<td>114,323</td>
<td>0</td>
<td>114,323</td>
</tr>
<tr>
<td>Total</td>
<td>199,059</td>
<td>(224)</td>
<td>198,835</td>
</tr>
</tbody>
</table>

6.3 Quarter One Outturn Forecast 2016/17

Based on the data from Quarter One, a summary of our forecast outturn position is set out in the table below. In summary, the anticipated outturn at Quarter One is a £1.6m deficit. (+0.8% variance).

Table Two: Quarter One Outturn Forecast 2016/17

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>Service / Portfolio</th>
<th>Proposed 2016/17 Q1 Budget £000</th>
<th>Forecast Outturn Q1 £000</th>
<th>Forecast Variance Q1 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stockport Council</td>
<td>Adult Social Care</td>
<td>67,622</td>
<td>67,905</td>
<td>283</td>
</tr>
<tr>
<td>Stockport Council</td>
<td>Health</td>
<td>16,890</td>
<td>16,824</td>
<td>(66)</td>
</tr>
<tr>
<td>Stockport CCG</td>
<td>Acute - NHS Providers</td>
<td>64,170</td>
<td>65,362</td>
<td>1,192</td>
</tr>
<tr>
<td>Stockport CCG</td>
<td>Acute – Independent sector</td>
<td>3,308</td>
<td>3,548</td>
<td>240</td>
</tr>
<tr>
<td>Stockport CCG</td>
<td>Non Acute and Other Health</td>
<td>46,845</td>
<td>46,845</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>198,835</td>
<td>200,484</td>
<td>1,649</td>
</tr>
</tbody>
</table>

To align the commissioning strategy within Health & Social Care, services have been illustrated based on Points of Delivery (PODs). These are described below and provide a new framework for financial reporting to the HCICB.
The table below outlines the current outturn forecast for 2016/17 based on Q1 with services aligned by POD’s. Appendix 1 provides further analysis with regards to the outturn forecast.

**Table Three: Point of Delivery Analysis**

<table>
<thead>
<tr>
<th>Points Of Delivery</th>
<th>Commissioner</th>
<th>Proposed Budget Plan £000</th>
<th>Quarter One Forecast £000</th>
<th>Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>SMBC</td>
<td>21,978</td>
<td>21,738</td>
<td>(240)</td>
</tr>
<tr>
<td></td>
<td>SCCG</td>
<td>368</td>
<td>368</td>
<td>0</td>
</tr>
<tr>
<td>Stability Services</td>
<td>SMBC</td>
<td>6,432</td>
<td>6,192</td>
<td>(240)</td>
</tr>
<tr>
<td></td>
<td>SCCG</td>
<td>4,660</td>
<td>4,660</td>
<td>0</td>
</tr>
<tr>
<td>Community / Out of Hospital</td>
<td>SMBC</td>
<td>70,302</td>
<td>70,999</td>
<td>697</td>
</tr>
<tr>
<td></td>
<td>SCCG</td>
<td>41,817</td>
<td>41,817</td>
<td>0</td>
</tr>
<tr>
<td>Acute</td>
<td>SMBC</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>SCCG</td>
<td>67,478</td>
<td>68,910</td>
<td>1,432</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>SMBC</td>
<td>(14,200)</td>
<td>(14,200)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>198,835</strong></td>
<td><strong>200,484</strong></td>
<td><strong>1,649</strong></td>
</tr>
</tbody>
</table>

### 6.4 Prevention (SMBC) surplus: £0.240m

A surplus of £0.066m exists within the Health & Wellbeing service due to staffing and commitments against the remaining health policy grant. The remaining surplus of £0.174m predominantly relates to the Safeguarding service and within other Third Sector provision.

### 6.5 Stability Services (SMBC) surplus: £0.240m

Within the Intermediate Care service there are vacancies within social care and health care posts creating a forecasted surplus of £0.145m.

Other smaller surpluses exist mainly relating to REaCH and staffing support in the equipment service. This overall additional surplus totals £0.095m.

### 6.5 Community / Out of Hospital (SMBC) deficit £0.697m

A budget pressure of £0.440m exists within the Integrated Neighbourhood Service for Residential and Nursing Care. This is due to a forecasted net increase of clients in receipt of services including short term bed based provision. The anticipated increase in demand will continue to be monitored on a monthly basis to establish any further financial pressures on this service.

The £0.325m deficit outturn forecast in the Learning Disability Internal tenancy provision predominantly reflects that currently £0.300m of the £1.100m saving target aligned to the service is yet to be realised in year. The service is progressing with the phased outsourcing of tenancies however this is experiencing some delays.

The other significant budget pressure of £0.629m exists within other services supporting Adult Social Care. The main factor for this is the £1.500m Intermediate Care saving aligned to Adult Social Care. In 2015/16 non recurrent funding was used while Business Cases were being prepared through Stockport Together to redesign Intermediate Tier and Borough wide services. £0.750m has
been illustrated as being used non recurrently from resources available to Stockport Together to part mitigate this issue in year while the new service configuration is implemented. The remaining pressure of £0.750m is part offset by £0.121m of surpluses mainly relating to staffing of support services and Extra Care Housing.

The deficits described above are part offset by £0.604m from a combination of a forecasted underspend in internal staffing provision and from recharges relating to health posts. A £0.093m surplus has also been identified from other purchasing budgets illustrated within the service.

6.6 Acute (SCCG) deficit £1.432m

The deficit within the acute services is due largely to forecast over performance positions within Stockport FT, University Hospitals South Manchester and Central Manchester FT (£1.192m). The main areas of increased performance are due to elective care c£0.8m and critical care c£0.4m activity being above plan.

Non elective activity is also noted to be underspending but this is offset by over performance in activity across all other POD’s.

Critical Care is being reported as over performing YTD however it is forecasted to be within plan at year end and that the YTD cost pressure is primarily a timing issue rather that an indication of a sustained increase in demand.

Within the independent sector the forecast overspend (£0.24m) is largely due to an over performance on the Optegra contract where the number of cataract procedures performed is above planned levels.

7.0 Risks and Issues

On the 13th July a Department of Health communication set out that the rate for NHS Funded nursing care will increase by 40% to £156.25 per week, backdated to the 1st April 2016. The increase is estimated to cost the CCG an additional £1.1m recurrently. The CCG GB agreed at its July meeting to utilise non-recurrent contingency against this cost pressure. As part of the finance lead meeting noted below options will be considered as to the most efficient management of this issue within the context and objective of the overall pooled budget.

8.0 Mitigations and Reserves

The aggregate reported financial position sets out a forecast deficit of £1.6m across the pool. The section 75 agreement sets out the processes and accountability to be followed in such a scenario and these have been instigated.

The Outturn forecast discussed in Section 3 is supported by non-recurrent funding held within the Council’s reserves totalling £0.656m.

- £0.258m funding from reserves to offset 2016/17 savings target for reduction in Social Work capacity at hospital, which is unlikely to be achieved in year.
- £0.300m contribution to offset residential and nursing care expenditure.
- £0.098m funding to support 3.00 fte Social Work support to Learning Disability Tenancy Outsourcing project.

This is in addition to the £4.212m discussed in Section below.
There is a material forecast variance of £1.4m on CCG pooled budgets. The respective finance leads are to meet to agree the combination of mitigations and reserves which are to be identified and transacted respectively through the pool to address this variance.

9.0 Savings

Below is a summary of savings / Continuous Improvement Plan (CIP) affecting the pooled budget in 2016/17 and their status:

Table Four: 2016/17 Saving Proposal

<table>
<thead>
<tr>
<th>POD</th>
<th>Proposal</th>
<th>Risk Rating</th>
<th>Value £m</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Preventative Commissioning – ASC</td>
<td>Green</td>
<td>0.500</td>
<td>Achieved in full as part of new Prevention framework</td>
</tr>
<tr>
<td>Prevention</td>
<td>Preventative Commissioning - Public Health</td>
<td>Green</td>
<td>0.500</td>
<td>Achieved in full as part of Health Promise</td>
</tr>
<tr>
<td>Community / Out of Hospital</td>
<td>Outsourcing of tenancies</td>
<td>Amber</td>
<td>1.100</td>
<td>£0.500m achieved from transport service ending. Also included in Q1 position £0.300m achieved through restructure, £0.300m remaining gap under review.</td>
</tr>
<tr>
<td>Community / Out of Hospital</td>
<td>Mental Health re-structure</td>
<td>Green</td>
<td>0.140</td>
<td>Achieved, internal restructure completed.</td>
</tr>
<tr>
<td>Stability Services</td>
<td>Reach Service vacancies</td>
<td>Green</td>
<td>0.470</td>
<td>Achieved, internal restructure completed.</td>
</tr>
<tr>
<td>Community / Out of Hospital</td>
<td>Cessation of transport service</td>
<td>Green</td>
<td>0.530</td>
<td>Achieved, service now ended.</td>
</tr>
<tr>
<td>Community / Out of Hospital</td>
<td>Current assessment of management structure</td>
<td>Green</td>
<td>0.290</td>
<td>Achieved, internal restructure completed.</td>
</tr>
<tr>
<td>Community / Out of Hospital</td>
<td>Reduction of the hospital social work team</td>
<td>Red</td>
<td>0.258</td>
<td>Being funded from ASC reserves non recurrently</td>
</tr>
<tr>
<td><strong>Adult Social Care Subtotal</strong></td>
<td><strong>3.788</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>Block Contract with Stockport FT</td>
<td>Green</td>
<td>2.606</td>
<td>Achieved, partial block contract agreed with Stockport FT</td>
</tr>
<tr>
<td><strong>Health Subtotal</strong></td>
<td><strong>2.606</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health and Adult Social Care Total</strong></td>
<td><strong>6.394</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Savings highlighted above for Adult Social Care is £4.212m of non-recurrent funding from corporate reserves to in part support the £8.0m total saving requirement for the service.

Health saving of £2.606m have been reported as a result of agreeing block contracts for A&E attendances, non-elective admissions and outpatient attendances with Stockport FT. The delivery of this acute demand related saving will only be reported as delivered recurrently when acute activity can be consistently evidenced as at or below planned levels.
10.0 Procurement Decisions

As a consequence of both the establishment of the HCICB and the increase in the section 75 pooled budget, there is a need for visibility by the HCICB of relevant procurement decisions. At the CCG Governing Body in July, recommendations with regards to a number of CCG contracts were considered and agreed. Where the expenditure relating to a contract has been wholly or significantly pooled then the HCICB are now requested to endorse the lead commissioner decision.

It is confirmed that the CCG NHS procurement policy has been followed in arriving at each recommendation.

The relevant contracts and the associated recommendation are detailed below.

<table>
<thead>
<tr>
<th>Provider/Service</th>
<th>Above / Below EU procurement regulations threshold</th>
<th>Procure</th>
<th>Do not Procure</th>
<th>Stockport Together</th>
<th>Decision Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beechwood cancer care</td>
<td>Specialist palliative care</td>
<td>Above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Anne’s Hospice</td>
<td>Rapid Response</td>
<td>Below</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practices - Intermediate tier</td>
<td></td>
<td>Above</td>
<td></td>
<td></td>
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<tr>
<td>Future Directions CIC</td>
<td>Care Homes - LD &amp; MH</td>
<td>Above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mastercall OOH</td>
<td>Out of Hours</td>
<td>Above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viaduct Health</td>
<td>BPH monitoring and spirometry</td>
<td>Above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care home Framework agreement</td>
<td>Continuing Healthcare</td>
<td>Above</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Procurement regulations threshold is €750,000 euro = £196k p.a. for a 3 year contract.

Key:
- "Procure" – A procurement process will be commenced during 2016/17.
- "Do not Procure" – Negotiation for a new contract of up to 3 years will be initiated with the existing provider.
- "Stockport Together" – These services are within scope of the Stockport Together redesign process. Consideration will be given to short term extension of the existing contract.
- "Decision Pending" – The initial outcome for this service is "procure" but further consideration is required, this includes national guidance and the national Urgent Care strategy.

An aggregate procurement plan covering all contracts due for a procurement decision during 2016/17 will be brought to the next meeting of the HCICB.
## Appendix 1: Analysis of Q1 Forecast Outturn

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service</th>
<th>Proposed Budget £000's</th>
<th>Q1 Forecast £000's</th>
<th>Q1 Variance £000's</th>
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</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
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</tr>
<tr>
<td>CCG Pennine Care</td>
<td>Dementia / Memory Services</td>
<td>£56</td>
<td>£56</td>
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<tr>
<td>CCG GP</td>
<td>Flu Services</td>
<td>£91</td>
<td>£91</td>
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</tr>
<tr>
<td>CCG SMBC</td>
<td>Dementia Services</td>
<td>£8</td>
<td>£8</td>
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<tr>
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<td>SMBC Various</td>
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<td>SMBC Various</td>
<td>Health and Wellbeing</td>
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<tr>
<td>SMBC Various</td>
<td>ASC Preventive Services</td>
<td>£5,088</td>
<td>£4,914</td>
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<tr>
<td><strong>Total</strong></td>
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<td></td>
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<tr>
<td><strong>Community / Out of Hospital</strong></td>
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<td></td>
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<td>CCG Stockport FT Community</td>
<td>District Nursing, Palliative Care and Tier Two Services</td>
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<td>Crisis Resolution, Mental Health Teams, Liaison</td>
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<tr>
<td>CCG GP</td>
<td>Care Homes Development and Care Home Planning</td>
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<td>CCG SMBC</td>
<td>FNC, Neighbourhood Services, ESS, Reablement, R Response</td>
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<td>CCG Various Care Homes</td>
<td>Continuing Care / Domiciliary</td>
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<td>CCG Mastercall</td>
<td>IV Therapy and Pathfinder</td>
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<td>CCG Various 3rd Sector</td>
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<td>CCG SMBC</td>
<td>Mental Health</td>
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<td>S256 - FACS &amp; Demographics</td>
<td>£3,746</td>
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<td>CCG SMBC</td>
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<tr>
<td>CCG SMBC</td>
<td>S256 - Social Care Protection</td>
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<tr>
<td>CCG SMBC</td>
<td>S256 - ASC Demographics / FACS</td>
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<td>Care Act</td>
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<td>Programme Management Services</td>
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<td>SMBC Care Home Providers</td>
<td>Integrated Locality Services - Residential &amp; Nursing care</td>
<td>£16,137</td>
<td>£16,577</td>
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<td>SMBC Homecare / Community Providers</td>
<td>Integrated Locality Services - Non Residential Services</td>
<td>£11,336</td>
<td>£11,255</td>
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<td>SMBC Integrated Neighbourhood Services</td>
<td>Reablement and Rapid response</td>
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<td>£110</td>
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<td>SMBC Homecare / Community Providers</td>
<td>Learning Disability - Non Residential Services</td>
<td>£13,140</td>
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<td>SMBC Learning Disability</td>
<td>Internal Tenancy provision</td>
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<td>SMBC Care Home Providers</td>
<td>Mental Health - Residential &amp; Nursing care</td>
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<td>SMBC Homecare / Community Providers</td>
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<td>SMBC Various</td>
<td>Operational staffing support</td>
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<td>£7,390</td>
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<td>SMBC Various</td>
<td>Other services incl ASC support services</td>
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<td>£3,459</td>
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<td>SMBC Better Care Fund Contribution</td>
<td>BCF</td>
<td>-£14,200</td>
<td>-£14,200</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Acute</strong></td>
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<tr>
<td>CCG Stockport FT Acute</td>
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<td>CCG Pennine Care</td>
<td>General Psychiatry</td>
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<td>CCG Various Independent Sector</td>
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<td>£3,308</td>
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<tr>
<td>CCG NHS Trusts</td>
<td>A&amp;E, Medicine, Ophthalmology, ENT, T&amp;O and Other</td>
<td>£16,802</td>
<td>£17,062</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stability / Recovery Services</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CCG Pennine Care</td>
<td>Rehabilitation and Recovery Services</td>
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<tr>
<td>CCG SMBC</td>
<td>Non Acute Services for Older People and Equipment</td>
<td>£4,593</td>
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<td>SMBC Various</td>
<td>Stability Services</td>
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<tr>
<td><strong>Total</strong></td>
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<tr>
<td><strong>Grand Total</strong></td>
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Total £198,834 £200,484 £1,649
1. Purpose

The purpose of this report is to update members of the Health & Care Integrated Commissioning Board on the development of integrated commissioning across the Council and the CCG.

2. High Level Milestones

A number of high level milestones have been agreed for integrated commissioning which are being taken forward (attached) along the themes of:

- Governance
- Commissioning and Procurement
- Resource Planning
- Leadership and Management
- Delivery of Outcomes

These have guided the work programme of the commissioners and progress against key issues will be reported at each Integrated Commissioning Board. Progress against a number of specific issues is detailed below:

3. Multi-Specialty Community Provider (MCP)

The main priority area for integrated commissioning team in terms of commissioning and procurement for 2016/17 is the procurement of the MCP which started in April 2016. The development of the MCP is at the heart of the Stockport Together proposals for integrated service delivery and a move to a capitated, outcomes based approach to contracting. This is a very different form of contracting arrangement which will require a different organisational form.

The Council and CCG started the MCP Procurement process in April 2016, and as this is an on-going procurement limited information will be made available until the process has concluded. The Joint Commissioning Board is overseeing the process of the procurement and the HCICB will make the ultimate decision about award of contract. There have been a number of national framework documents on MCP development and procurement and we are aligning our processes and timescales to these. A more detailed timetable will be provided to members once that alignment process has taken place.

The development of an outcomes framework is essential to the development of a new population based outcomes contract. This process is being co-produced across commissioners and providers, using expert reference groups including professionals and members of the public. The aim is to have a first draft early in 2017, and we plan to have a session with the HCICB to discuss and agree the framework to ensure that it will support the priorities set by the HCICB. The development of the Outcomes Framework is being based on international and national evidence and best practice and we have commissioned external support to support the development. Once agreed we will need to develop the reporting and tracking systems to monitor the outcomes framework, as currently our systems are not configured to support this.
4. Governance

The first priority has been to establish the HCICB and agree reporting arrangements for the existing pooled fund, and these are now in place. The Joint Commissioning Board is working to develop proposals for how the interim governance and reporting arrangements linked to integrated commissioning will operate in the short / medium term, which will need to be signed off at a future HCICB. The arrangements will continue to adapt as the integrated commissioning work progresses, but the principle already agreed is that we build on existing structures, ensuring continued efficiency and reducing duplication. It is proposed that one of the early Organisational Development sessions will focus on governance and reporting and how the HCICB would like this to develop in the future.

5. Integrated Commissioning

NHS and Council commissioning teams have started to do some detailed work to look at what a future integrated commissioning arrangement could look like. They have undertaken some detailed work to map existing statutory duties and functions and identify:

- which functions are likely to remain as commissioning
- which functions the MCP could discharge
- where we can integrate functions across health and social care, and in particular early priorities for integration

A further meeting is planned for early September to finalise this which will then form the basis of proposals to develop more integrated arrangements for agreement by organisations. As part of this a number of early priorities for integration have been identified.

6. MCP Intensive Support Site

Stockport economy is one of a number of sites working with NHS England as part of their MCP Intensive Support programme. As a national MCP Vanguard site being part of this programme is very helpful in providing support to commissioners and providers to develop the MCP and the contracting arrangements. Members of the national team have been attending local meetings to understand the work and issues that we are managing and we have been able to get access to their technical expertise and it has also provided an opportunity to share learning with other sites.

7. Better Care Fund

Attached for information is a letter confirming that our Better Care Fund plan has been approved.

8. Recommendation

- To note the content of the report, highlighting any areas for more detailed reporting to the Board in future meetings.
To: (by email)
Councillor Tom McGee, Chair of Stockport Health & Wellbeing Board
Eamonn Boylan, Chief Executive, Stockport Council
Dr Ranjit Gill, Chief Clinical Officer, Stockport Clinical Commissioning Group

13 July 2016

Dear colleagues

BETTER CARE FUND 2016-17

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government’s commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as ‘Approved’. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England’s powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and Wellbeing Board area as to the use of the funding.

You should now progress with your plans for implementation. Ongoing support

High quality care for all, now and for future generations
and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

**NHS England**

Copy (by email) to:
Richard Barker, Regional Director, North of England
Anthony Kealy, Programme Director, Better Care Support Team

*High quality care for all, now and for future generations*
## Integrated Commissioning High Level Milestones 2016/17

### Governance
- HCICB Established
- Board Development Plan agreed
- Approach to reporting to HCICB agreed
- Section 75 agreement and wider operation reviewed after initial period of operation
- Links to individual organisational governance arrangements established
- Reporting to Stockport Together agreed.
- Assurance arrangements for development of MCP developed

### Commissioning and Procurement
- Procurement process for MCP concluded successfully
- Integrated commissioning intentions drafted for 2017/18
- Financial sustainability plans for 2017/18 drafted
- Outcomes Framework and payment mechanisms first phase approved for implementation April 2017
- Aligned contract database developed and maintained
- Protocols for managing pooled funds developed
- Contract management protocols and processes established

### Resource Planning
- Resource requirements for development of Integrated Commissioning approach assessed
- Resource plan for 2016-17 developed
- Commissioning functions review undertaken on behalf of both organisation
- Incremental approach to aligning commissioner knowledge and expertise be developed
- Strategy for managing and aligning risks agreed and implemented

### Leadership and Management
- Director of Integrated Commissioning appointed
- Commissioners from both organisations working through the Joint Commissioning Board
- Schedule of work agreed for the year
- Options appraisal undertaken for approach to development of integrated function.
- Organisational Development Plan for integrated function agreed

### Delivery of Outcomes
- Identify range of financial and non-financial metrics against which can be tracked in year.
- Develop and implement system for tracking, monitoring and escalating outcome delivery and benefits
Report Title

MCP Procurement Update

Summary

The purpose of this report is to:
- Provide the Health and Care Integrated Commissioning Board (HCICB) with a summary of the current position regarding the procurement process employed by the Joint Commissioning Board (JCB)

Recommendations

The recommendation of this report is that the Joint Committee:
- Note the contents of the report

Contact person for access to background papers and further information:

Name: Sharon B Robson
Phone: 07817 882 169

STAR Procurement, a shared service for Stockport, Trafford and Rochdale Councils is providing procurement support to the Joint Commissioning Board.
1. **Background**

1.1 The Joint Commissioning Board (JCB) is actively progressing the long-term vision of a fully integrated, population-based system of health and social care provision that is funded and rewarded on the basis of a capitated, outcomes-based contract. These services are proposed to be supplied principally through a Multi-Specialty Community Provider (MCP), which will act both as the principal provider of the services and the integrator so that the individual services are supplied and operated more effectively. The long term vision is that the MCP manages the whole population capitated budget on behalf of the population for the vast majority of health and social care services. The development of the MCP will initially focus on services for the over 65 population of Stockport.

1.2 The MCP will be the vehicle for delivering significant services. The Shadow Provider Board will consider and make proposals regarding the organisational form of the MCP through the procurement process. The CCG and the MBC, through the JCB and Health and Care Integrated Commissioning Board (HCICB) established under the S75 agreement, will respond to those proposals.

1.3 External legal advice was sought as to the most appropriate route which allowed us to progress at pace (and in line with the expectations of being a Vanguard site), whilst complying with regulatory requirements with regard to procurement legislation.

1.4 The proposed procurement of the MCP vehicle is complex because of differing regulatory requirements between Health and Local Government. External legal advice was sought to consider and recommend the approach in view of the procurement law duties for the CCG and SMBC.

2. **Procurement Approach - CCG Duties**

2.1 Prior to the 18th April 2016 the procurement of NHS Health Services by CCGs took place under specific NHS Procurement Regulations (the section 75 Procurement Regulations). The procurement process for the Stockport Together MCP commenced on the 14th April 2016 and so the section 75 Regulations apply to this process.

2.2 An additional consideration is whether there is a need to publish a public notice in relation to the MCP procurement. Such a notice would be required in the event that there is a realistic prospect that a potential provider in another
EU state would be interested in providing the MCP services. After careful consideration and seeking legal advice, it was decided that there was little prospect of cross border interest and so no public notice was required.

3. **Procurement Approach - SBC Duties**

3.1 The position for SMBC is different to the CCG, as the Section 75 Procurement Regulations do not apply. The range of services that SMBC will commission from the MCP fall within the services covered by what is known as the Light Touch Regime (LTR) within the Public Contract Regulations 2015. The LTR permits SMBC to devise a flexible procurement process to select the MCP provider.

4. **Procurement Strategy Employed**

4.1 The CCG and SMBC considered the procurement options that were available to jointly commission the MCP. The commissioners concluded that to achieve the intended population benefit, to avoid service disruption by securing the continued involvement of the fixed point providers and to establish an MCP that has a significant role in service integration, they should seek to establish the MCP within a procurement process that involves negotiation with the current service providers (Appendix 1). The rationale for this approach is that as the MCP model is the desired provider mechanism and the fixed point providers of the services will continue and indeed must be, the providers after the MCP is established, they are best placed to plan and then deliver that arrangement.

4.2 Procuring these services without an open, competitive process will involve some element of risk due to the possibility of challenge from other external suppliers on the basis that the opportunity should have been openly advertised. However, the view of the commissioners, which is supported by external legal advice, is that the benefits in terms of service continuity associated with the closed procurement process that has been adopted, outweigh the risks associated with a legal challenge arising from not going to the open market.

5 **Current Position**

5.1 Expressions of Interest were sought from the current providers on the Provider Board on 14th April 2016, the providers collaborating through a Provider Board.
5.2 The Provider Board Members provided their initial responses on 28th April 2016.

5.3 Further questions were asked with responses to the questions required by 30th May 2016.

5.4 Appraisal was undertaken, and clarification questions were sought. Additional guidance from NHS England was issued and released to the Provider Board on 3rd August 2016, to consider as part of their response. The involvement of NHS England is necessary in order to ensure that the MCP arrangements in Stockport are compatible with national MCP developments, in which NHS England is leading.

5.5 The providers’ responses to the further clarification questions were received on 19th August and appraisal is currently being undertaken.

5.6 The commissioners have recognised that the establishment of an MCP is a significant innovation and will require careful planning across the provider organisations. Given this complexity it is unrealistic to expect the providers to have a fully articulated business model which addresses all elements of organisational structure, governance and delivery pathways at this point in the procurement process. The providers’ responses to the clarification questions will enable the commissioners to gauge progress to date and assess the suitability of the proposed approach to establishing the MCP.

5.7 The responses will now be formally appraised with a view to assessing whether or not they represent proposals that are likely to result in an MCP that meets the commissioners’ requirements. If the appraisal outcome is positive then the next stage will be identification of specific issues including the legal structure for the MCP and the contractual arrangements that will need to be implemented for its establishment.

5.8 In the event that the appraisal has a negative outcome then other options to achieve the benefits of the MCP will need to be considered.

5.9 If the appraisal is positive then a negotiation strategy has been developed to enable commissioners and providers to work together and develop the existing dialogue with a view to eventually agreeing detailed proposals. These proposals will eventually need to be formalised in contractual agreements. Subjects to be covered in this dialogue will include organisational form and exchanging information relating to Finance & Resources, Clinical, Performance, and Corporate Governance.
5.10 NHS England as the national lead for MCP development, will be issuing a proposed standard MCP contract in September 2016 and this will inform further thinking. The Joint Commissioning Board is liaising with NHS England in order to contribute to the development of the Standard MCP Contract, to share our experiences of establishing an MCP and to influence where possible the relevance of the National Contract to the Stockport Together programme.

5.11 It is currently proposed that following broad agreement on the way forward, detailed negotiations on the establishment of the MCP and a new contract will commence in November 2016. Fundamental elements of this contract will be the outcomes framework and capitation based payments.

6 **Summary**

6.1 The establishment of an MCP represents a complete re-shaping of health and social care provision within Stockport and is a significant and challenging ambition. Wide ranging changes will be required to service delivery arrangements, including the adoption of a common outcomes framework which requires considerable planning and preparation. This work has been commissioned and is underway.

6.2 Within the Vanguard programme it is clear that Stockport’s aim to work across the whole of health and social care sector is one of the more ambitious approaches to an MCP model. Commissioners believe that this is necessary and appropriate to maximise benefit for the whole population.

The intent is to have an MCP contract in place by 1st April 2017 and commissioners continue to work at pace towards this aim. However, achieving the right business and contractual model for the Stockport Together MCP is the primary objective. With this in mind, and in view of the complexity of the systems involved, it is anticipated that certain aspects of the contractual arrangements will not be fully operationally on the 1st April 2017.

6.3 The Joint Commissioning Board will continue to review the schedule as the programme progresses.

7 **Recommendations**

7.1 To note the content of the report.
7.2 The Joint Commissioning Board will provide a further update at the next Health and Care Commissioning Board.

**Report Appendices**
1. Fixed Point Provider Schedule
## Appendix 2: Indicative Timeline

<table>
<thead>
<tr>
<th>Level 1: From:</th>
<th>Level 2: Activity</th>
<th>Completion Dates</th>
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<tbody>
<tr>
<td>Approach to MCP Procurement v1.0 (3) document</td>
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<tr>
<td><strong>Process of formal and management of engagement between Commissioners and Providers</strong></td>
<td>Prepare JCB position and response to Stage 1 &amp; 2 respondents</td>
<td>Early Aug ‘16</td>
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<tr>
<td></td>
<td>Issue JCB position and response to Stage 1 &amp; 2 respondents as to next stages</td>
<td>Early / Mid Aug ‘16</td>
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<tr>
<td></td>
<td>Submission of Detailed Operational Model (Stage 3) from Provider Board</td>
<td>Mid Sept ’16</td>
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<tr>
<td><strong>Stage 3 Procurement Evaluation Panel Convened</strong></td>
<td>Paper Based Assessment of Responses (Stage 3)</td>
<td>Mid / Late Sep ’16</td>
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<tr>
<td><strong>Commencement of contract negotiations for 2017/18 year</strong></td>
<td>Engage with legal support on development of draft contracts</td>
<td>September - November</td>
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<td>Agree areas not open for negotiation, and parameters for negotiation elsewhere</td>
<td>Late Aug / Early Sep ’16</td>
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<td>Agree who will be on negotiation panel, chair, etc. and their roles</td>
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<td></td>
<td>Issue invitation for initial responses and contract for formal comments to Provider Board (incl. indicative dates and themes for negotiation meetings)</td>
<td>Mid / Late Sep ’16</td>
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<td>Deadline for responses</td>
<td>Mid / Late Oct ’16</td>
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<td></td>
<td>Review responses, and seek legal opinion as relevant to suggested changes prior to any meetings</td>
<td>Late Oct / Early Nov ’16</td>
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<td></td>
<td>Initial meeting with Provider Board to discuss Theme 1</td>
<td>Early Nov ’16</td>
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<td></td>
<td>Consider results of initial meeting, and amend contract documents as appropriate</td>
<td>Mid Nov ’16</td>
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<td></td>
<td>Issue amended documents (2nd Theme)</td>
<td>Mid Nov ’16</td>
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<td></td>
<td>2nd meeting with Provider Board to discuss Theme 2</td>
<td>Late Nov ’16</td>
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<td>Consider results of 2nd meeting, and amend contract documents as appropriate</td>
<td>Late Nov / Early Dec ’16</td>
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<td>Issue amended documents (3rd Theme)</td>
<td>Early Dec ’16</td>
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<td>3rd meeting with Provider Board to discuss Theme 3</td>
<td>Early Dec ’16</td>
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<td>Consider results of 3rd meeting, and amend contract documents as appropriate</td>
<td>Mid Dec ’16</td>
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<td>Issue amended documents (4th Theme)</td>
<td>Mid Dec ’16</td>
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<tr>
<td><strong>Christmas Period</strong></td>
<td>4th meeting with Provider Board to discuss Theme 4</td>
<td>Early Jan ’17</td>
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<td>Consider results of 4th meetings, and amend contract documents as appropriate</td>
<td>Early Jan ’17</td>
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<td>Event</td>
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<tr>
<td>Issue amended documents (5th Theme)</td>
<td>Mid Jan ’17</td>
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<tr>
<td>5th meeting with Provider Board to discuss Theme 5</td>
<td>Late Jan ’17</td>
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<tr>
<td>Consider results of 5th meeting, and amend contract documents as appropriate</td>
<td>Late Jan / Early Feb ’17</td>
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<tr>
<td>Issue amended documents (Final Review and Agreement)</td>
<td>Early Feb ’17</td>
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<tr>
<td>6th and final meeting with Provider Board to agree final contractual documents and any sticking / missed issues (Mop Up)</td>
<td>Mid Feb ’17</td>
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<tr>
<td>Issue final docs for written formal agreement to contents</td>
<td>Late Feb / Early Mar ’17</td>
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<tr>
<td>Issue hard copies of documentation for signature</td>
<td>Late Feb / Early Mar ’17</td>
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<tr>
<td>Contract Signature</td>
<td>Early / Mid Mar ’17</td>
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<tr>
<td>Contract Commencement</td>
<td>1st April 2017</td>
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Implementation of Shadow MCP should commence straight away
Appendix 3: The fixed point providers

1. Viaduct Healthcare
2. Stockport NHS Foundation Trust
3. Stockport MBC

1. Viaduct Healthcare:

Viaduct has been established as a corporate entity by the local GP consortium. The consortium proposes that Viaduct will act as a medium of communication between the partners and the local GP practices, which are autonomous partnerships or sole practitioners that provide NHS GMS and PMS services and other clinical and healthcare services under contracts negotiated with NHS England, NHS Stockport CCG, Stockport MBC and other service commissioners.

Management of certain aspects of the PMS and GMS contracts have now been delegated by NHS England to Stockport CCG, although at this stage these delegated activities will not be brought within the Stockport Together arrangements.

The GP practices are a fixed point in the local provision of clinical, health and social care services to the served populations. They are the principal providers of primary care clinical services. Critically the GMS and PMS contracts awarded to them are:-

1. awarded by processes outside of the scope of this procurement.
2. for the registered list which is fundamental to the successful delivery of the neighbourhood model.
3. contracts in perpetuity and cannot ordinarily be withdrawn or terminated by the CCG.

Consideration will need to be given to a GP practice population which changes through time. *Fundamentally it is the GP practice population and not Viaduct which is the fixed point.* However, Viaduct is the organisational form through which Stockport GP practices currently choose to use to act as a single organisational form.

For clarity if a GP practice resigned its membership of Viaduct then how this GP Practice was represented within the MCP would need to be planned and negotiated or determined.
2. Stockport NHS Foundation Trust (SFT)

SFT runs Stepping Hill Hospital, and some other specialist centres, as well as community health services across Stockport. Its specialist services include emergency medicine and specialist abdominal surgery, stroke, urology, trauma & orthopaedics.

It is the only local provider of NHS acute, secondary and tertiary clinical services within the Borough of Stockport, and the only centre for the provision of accident and emergency medical treatment. It is the principal strategic provider of medical services within the area of the proposed integrated services.

The above, in combination with the fact that neither the CCG nor SMBC are able to re-procure A&E services in isolation determines that SFT are a fixed point provider.

Its participation in the integrated services arrangements and engagement within the MCP is critical to the success of both developments.

3. Stockport MBC (SMBC)

SMBC has a statutory obligation to provide a range of adult social care services under various statutes. The principal group of employees who deliver the services are social workers. The nature of the services that the social workers deliver are set by central government but SMBC has a wide discretion as to how the social workers are organised. Thus, whilst SMBC must ensure that the services are available, it is not obliged to be the main provider of them and subject to specific rules, has flexibility in how they are provided. This flexibility rests with SMBC and its own decision making processes. Therefore a decision to include within any procurement cannot be enforced externally onto SMBC. This is why SMBC is both a fixed point provider and is also a party to the integrated commissioning arrangements.

SMBC has historically employed social workers within its adult social care service (ASCs), as this was a reasonable way to organise the ASCS when SMBC was the only ASC provider and the ASC budget was provided by SMBC alone. The proposal to integrate ASC with HC and have a pooled budget responsible for both HC and SC presents a new set of delivery arrangements. In future social workers will work with GPs and other healthcare professionals within a ‘seamless’ service in which HC and SC form part of a single spectrum of service provision. In this new arrangement, the ASCS may either remain coterminous within SMBC, be relocated in an existing provider organisation or be located in a separate entity specially established for that purpose. Which of these options is suitable will be to a large extent determined by the agreed relationship between SMBC and both the current provider board and the future MCP.

Providers who are not fixed points
There are a range of providers who deliver services within Stockport who have not been assessed as being fixed point providers based. It should be noted that:-

- Membership of the Provider Board is not restricted to the fixed point providers.
- The current provider board membership and future MCP membership may differ.
- It is possible for a fixed point provider to not be a member of the MCP. For example the MCP could establish a partnership arrangement or sub-contracting arrangement for provision of services and/or expertise.
- It is possible for non-fixed point providers to be members of the MCP.

**Community Services**

The commissioner view is that community providers (mental health and physical health) do not meet the criteria for fixed point providers. Therefore a response is requested on the approach and relationship of the future MCP with the current main community providers, these being:-

- Pennine Care FT
- Stockport NHS FT

It is not believed that Stockport CCG, in isolation from the provider board / MCP, could instigate a re-procurement of Community Services.