### Agenda

The next meeting of the NHS Stockport Clinical Commissioning Group Governing Body will be held at Regent House, Stockport at 10am on 30 November 2016

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<td>Any Other Business</td>
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**Date, Time and Venue of Next meeting**

The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 21 December 2016 at Regent House, Stockport. Potential agenda items should be notified to stoccg.qb@nhs.net by 1 December 2016.
PRESENT
Ms J Crombleholme Lay Member (Chair)
Mrs G Mullins Chief Operating Officer
Dr C Briggs Clinical Director for Quality and Provider Management
Mr M Chidgey Interim Chief Finance Officer
Dr P Carne Locality Chair: Cheadle and Bramhall
Dr R Gill Chief Clinical Officer
Dr V Owen Smith Clinical Director for Public Health
Mrs A Rolfe Executive Nurse
Dr A Firth Locality Chair: Stepping Hill and Victoria
Dr D Kendall Secondary Care Consultant
Dr A Johnson Locality Chair: Marple and Werneth (Vice-Chair)
Mr J Greenough Lay Member

IN ATTENDANCE
Mrs L Latham Board Secretary and Head of Governance
Dr D Jones Director of Service Reform
Mr T Ryley Director of Strategic Planning and Performance
Cllr T McGee Stockport Metropolitan Borough Council
Ms S Carroll Healthwatch

APOLOGIES
Dr V Mehta Clinical Director for General Practice Development
Mr R Roberts Director for General Practice Development
Dr J Higgins Locality Chair: Heatons and Tame Valley

53/16 APOLOGIES
Apologies were received from Dr Mehta, Dr Higgins and Mr R Roberts

54/16 DECLARATIONS OF INTEREST
Drs R Gill, C Briggs, P Carne, A Johnson and J Higgins declared an interest with regard to Item 7 (b) on the agenda. The nature of the interest being that the Finance Update included references to GP Contracts. The Chair agreed that the interest did not require any of those affected to take any action.

M Chidgey, G Mullins and A Rolfe declared an interest with regard to Item 16 Reports from Committees Remuneration Committee. The nature of the interest being that the report made recommendations to
the Governing Body which would impact on their remuneration. They did not take part in the discussion or decision making relating to this matter.

55/16 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 27 JULY 2016

The minutes of the meeting held on 27 July 2016 were agreed as a correct record subject to J Greenough being shown as in attendance at the meeting.

56/16 ACTIONS ARISING

The following updates on actions were provided:

- 25 05 2016 Performance Report – Completed and could be removed from the Action Log
- 25 05 2016 Locality Chair’s Report – Completed and could be removed from the Action Log
- 27 07 2016 Patient Story – Completed and could be removed from the Action Log
- 27 07 2016 Resilience and Compliance Report – It was confirmed as relevant to the Resilience and Compliance report that the number of complaints for the period was 9. The action could be removed from the log.
- 27 07 2016 Stockport Together Highlight Report - Completed and could be removed from the Action Log
- 27 07 2016 Finance Report – The Recovery Plan was under development and Governing Body will consider the implications at its November meeting following discussion by the Finance and Performance Committee. The action could be removed from the log.

57/16 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were none on this occasion.

58/16 PATIENT STORY

The Governing Body heard from a lady with diabetes who worked in a Public Health role. She explained that despite understanding the evidence base around the management of her condition she had found it difficult to manage on a daily basis. Following an appointment with her Practice Nurse she had agreed to attend the SOCA Diabetes Programme which took place over 4 days. She explained that the course had been truly life changing and had balanced knowledge and theory with practical approaches to self-care. She felt empowered and confident as a result to effectively count her carbohydrates and adjust her insulin dose in line with patterns in blood glucose levels and based on her lifestyle and regular activities. The course had been attended by a range of different individuals and had impacted significantly on her mental wellbeing. She concluded by explaining the importance and value of diabetes education programmes for Type 1 and Type 2 and the focus on proactive self-care to improve condition management and reduce the costs of care.

D Kendall noted the benefits of structured patient education and shared her knowledge about a Welsh Education Programme for children and families with diabetes which it was hoped would be rolled out more widely in future years. It was noted that referrals into the Stockport programmes were simple and patients were able to self-refer.

It was requested that the number of Type 1 and Type 2 diabetics who had attended education courses be provided along with the number of initial referrals / contacts. C Briggs sought confirmation about the accessibility of the course material for those patients who may have learning disabilities as an example.
R Roberts noted that 7 Day General Practice services could provide access to expert patients for those with diabetes at weekends.

J Crombleholme noted the importance of ensuring that 7 Day Services were focussed on population need and in particular enabled the elements of the recently published Planning Guidance in relation to mental wellbeing / lower levels of mental health to be addressed alongside physical health.

**Resolved:** That:

1. The patient story be noted and thanks expressed to the patient for her sharing her story.
2. The number of Type 1 and Type 2 diabetics who had attended education courses be provided to Governing Body Members along with the number of initial referrals / contacts

**59/16 STRATEGIC IMPACT REPORT**

T Ryley provided an overview of the content of the report, noting that the data represented only the first three months of the year and therefore could not yet be used to determine definitive trends. He explained that the increase in A&E attendances fitted with trends at the end of 2015-16 with 2.5% being attributed to NHS 111 and that there had been a sustained reduction in non-elective admissions over a number of months. Governing Body was informed that the occupied bed days had not declined as far as reductions in admissions and that the growth in length of stay could be linked back to the delayed transfers of care (DTOC) position.

In considering the report it was noted that given the number of complex inter-linked factors it was difficult to attribute performance improvements to individual schemes but that work in general practice had started to impact positively.

J Greenough commented on the positive performance which was beginning to emerge and in particular the reduction in care home admissions. T Ryley noted the positive work in aligning care homes to GP Practices which had impacted on the figures but also acknowledged the overall reduction in care home beds as a further factor.

A discussion took place regarding emergency department attendances and admissions and the performance in Stockport when benchmarked nationally. G Mullins noted that the Stockport Together Programme first phase of changes anticipated to impact on the Emergency Department at Stockport Foundation Trust were due to be implemented in October / November 2016. Overall transformation was focussed on the delivery of the neighbourhood model with longer term implementation / impact expected, a reform of the Intermediate Tier and work around a single point of access and the Emergency Department front end, including pathways for ambulatory care. R Gill noted the significant pressure faced by the hospital emergency department and the need to remain continually cited on the issues as commissioners.

Positive schemes where impact had been reported, in particularly by clinicians included Consultant Connect and the roll out of dermatoscopes. C Briggs noted the importance of ensuring positive messages were fed back to GP members and also across the wider system to acknowledge that a range of factors were coming to fruition positively and to thank all involved for their continued hard work and commitment.

**Resolved:** That Governing Body note the update.
60/16 FINANCE REPORT

The Governing Body considered the CCG’s financial position as at August 2016 and the forecast outturn position for 2016/17. M Chidgey explained that the financial position continued to report in line with the agreed plan however there was risk against the delivery of Cost Improvement Projects. He highlighted the business cases to deliver increased investment in mental health and the need to ensure Stockport Together investments in mental health are reflected in the CCG financial position.

He noted the procurement element of the paper and the decisions required by the Governing Body and those which would be agreed as recommendations to the Health and Care Integrated Commissioning Board (HCICB) where contracts were funded from the pooled budget.

In response to questions regarding investments in mental health it was clarified that the investments would be fully made in line with the agreed plan and implemented prior to the start of the new financial year. R Gill noted the investment in mental health which would be made through the Stockport Together Programme in particular within primary care. It was agreed that a full picture of mental health investments could be included in a future report to Governing Body and the local position would be benchmarked by the Finance and Performance Committee with themes escalated as required to Governing Body.

Resolved:

- Note the year-to-date surplus of £1.145m which is line with plan.
- Note that the CCG is forecasting to deliver the planned surplus of £2.75m.
- Note net risks totalling £6.06m not reflected within the forecast position.
- Note the ability to release the 1% non-recurrent reserve, if required by NHS England, is dependent on delivering CIP of £5.0m which is yet to be identified.
- Note that a recovery plan is being developed to deliver all NHS England’s financial business rules, delivery of which will be extremely challenging.
- Approve the procurement decisions set out at appendix 2.
- Approve the urgent care investment plans set out in appendix 3.
- Request that the Finance and Performance Committee undertake some benchmarking work regarding mental health investment, escalating any themes to Governing Body to be included alongside a picture of the total investment in mental health to be included in the Finance Report to the November 2016 meeting.

61/16 PERFORMANCE REPORT

G Mullins presented the Resilience and Compliance report covering NHS Constitutional Targets for statutory duty and compliance up to July 2016. She noted the range of measures provided a view of patient experience across the system and whether work within Stockport was beginning to impact positively on performance. The two areas of significant challenge in line with previous months were noted to be urgent and planned care. She commented that progress on urgent care admissions had been positive but the challenge for referral to treatment times showed the link between urgent care system pressures and wider system management.

The Governing Body’s attention was drawn to the area of mental health and in particular IAPT waiting times. It was noted that learning from other CCG’s which were successful in this area was important. In response to a question from Cllr McGee G Mullins noted that it was important waiting list management remained in focus and monitored closely and that the number of complex cases in mental health
impacted on performance. It was noted that a Business Care for further investment in mental health had been included in the papers for Governing Body approval.

J Greenough noted the correlation on performance with the Strategic Performance Report in the areas of ambulatory care, mental health and increases in acute care. R Gill noted that as the system transformed through the Stockport Together Programme it was important that risk and performance risk was managed and mitigated, particularly in light of known system pressures in areas such as urgent care. He noted that change had to be brought about at pace but whilst maintaining safety and quality and managing the interface between demand and supply and performance.

A Johnson commented on the positive performance in cancer care and the real impact of investment and clinical work where there was strong clinical leadership and ownership. Other areas of Stockport positive performance were highlighted.

Resolved: That the Governing Body:

1. Notes the content of the Performance Report

62/16 QUALITY REPORT

A Rolfe presented the report of the Quality Committee and highlighted the content of the August 2016 Business Meeting. She noted that the Committee had met prior to the Stockport Foundation Trust Care Quality Commission report had been published. The Governing Body was informed that the Committee had discussed in detail the reporting of serious incidents at Stockport Foundation Trust, the findings of the TOFT review and the serious incident cluster review.

Governing Body was informed that NICE compliance had been reviewed by the Committee and whilst improvements in implementation had been observed, the Committee would continue to monitor closely whilst further work in this area took place. A Rolfe highlighted ongoing discussions regarding the shortfall in district nurse staffing levels and Prevent Training follow ups and other issues which would remain on the Committee’s risk log.

J Crombleholme commented on the area of NICE compliance and highlighted the need for systematisation around implementation. V Owen Smith noted that assurance had improved in recent months and explained escalation processes in place between commissioners and the Foundation Trust.

Resolved: That the report be noted.

63/16 STOCKPORT TOGETHER HIGHLIGHT REPORT

T Ryley provided an overview of the progress of the Stockport Together Programme and noted that reporting timescales within the Programme had been aligned to bring more timely information to partner organisations. He explained that the Health and Care Integrated Commissioning Board (HCICB) had met for its inaugural meeting in September and that the work of commissioners in procuring the MCP continued to be supported by the national NHS England Team.

Provider partners within the programme were noted to have commenced stakeholder engagement regarding the organisational form of the MCP and T Ryley highlighted the continued challenges regarding workforce. He noted the importance of beginning to think differently and innovatively about workforce challenges and designing new models of care which build on existing skill base and
workforce and do not require further staff in areas where there are already known capacity gaps locally and nationally. The importance of ensuring primary care was reflected across all workstreams within the Programme was noted and in particular, the design of the core neighbourhood was noted to be crucial.

V Owen Smith noted with regard to the core neighbourhood design the importance of overcoming current information governance challenges and the capacity for the find and treat preventative element.

A discussion regarding workforce issues took place. A Rolfe noted the need in reducing the size of the hospital to ensure skills and knowledge development of existing nursing staff to allow them to move from acute to community settings. R Gill commented on the importance of understanding current workforce issues in general practice as set within the wider workforce profile.

J Crombleholme requested that consideration be given to how the Governing Body remained cited on Stockport Together Programme risks and in particular those relating to the Core Neighbourhood.

Resolved: That:

1. The report be noted
2. An approach to considering Programme risks (including Core Neighbourhood in particular) be agreed for future meetings / more widely.

64/16 LOCALITY CHAIRS REPORT

On behalf of their Localities, Chairs provided the following updates:

A Johnson highlighted on behalf of the Marple and Werneth Locality the cross over with work on the development of Neighbourhoods which was progressing at pace.

A Firth noted that it was important for those working within Localities and Neighbourhoods to share learning and best practice. It was noted that the Viaduct Leadership Team provided a forum for the exchange of information and ideas.

P Carne provided positive feedback on the Consultant Connect System and the development of neighbourhoods within his Locality. He noted that Business Intelligence support would be required to assist Practices to use and interrogate data to begin to drive performance improvements. He highlighted the potential impact of the Woodford housing development on practices within his Locality.

V Owen Smith noted that the Public Health Team was under taking a pilot with 5 practices using the EMIS system to support trend identification and areas of clinical focus. T Ryley noted that business intelligence capacity would be built into the core neighbourhood business case.

Resolved: That the Governing Body:

1. Note the feedback and issues raised by Locality Chairs
2. Would consider the feedback from J Higgins on behalf of the Heatons and Tame Valley Locality at the CCG’s Wider Leadership Team.
65/16 REPORT OF THE CHAIR

J Crombleholme confirmed that there had not been a Part 2 Meeting prior to the Governing Body Meeting in public.

She reported that she had been elected as the Chair of the Health and Care Integrated Commissioning Board and Councillor McGee elected as Vice-Chair.

Following interview, an offer had been made for the position of Lay Member for Primary Care on the Governing Body. Further details of the successful appointee would be shared in due course.

66/16 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted a number of elements included within the report, in particular noting the high level content of the local transformation plan previously submitted to NHS England for Children and Young People’s Mental Health.

Resolved: That:

1. The content of the report be noted.
2. The full Local Transformation Plan for Children and Young People’s Mental Health be circulated to the Governing Body.

67/16 REPORT OF THE CHIEF CLINICAL OFFICER

R Gill provided an overview of the progress within the Healthier Together Programme and in particular highlighted the progress of work in developing a patient participation Group. D Jones noted the event being planned for October to engage clinicians further in the work being undertaken.

The Governing Body considered the letter from Pennine Acute regarding its Improvement Programme and in particular the collaborative work underway to support the Trust from within Greater Manchester. V Owen Smith noted the potential learning for Stockport with regard to leadership and staff engagement in transformation from other localities within Greater Manchester.

Resolved; That the Governing Body:

1. Notes the content of the report

68/16 REPORT OF THE SYSTEMS RESILIENCE GROUP

C Briggs as Chair of the Urgent Care Delivery Board (UCDB), supported by S Toal, NHS Stockport Foundation Trust provided an overview of the report provided on the request of the Governing Body to outline plans in place to manage the urgent care system within Stockport and plans in place for the Winter period. She highlighted the current performance of the urgent care system and the trajectory as agreed with the Greater Manchester Health and Social Care Partnership and NHS Improvement which was currently subject to review. She highlighted that significant challenges existed in the areas of staffing (medical and nursing), system ownership and leadership and Delayed Transfers of Care (DTOC.) System management and flow was noted to be integral to improving performance.
Governing Body was informed of the actions which were included within the plans to manage and mitigate known system pressures and the processes by which measures would be tracked locally. The 5 key areas of focus for the Urgent Care Delivery Board were highlighted and C Briggs outlined the importance of managing immediate system pressures on a daily basis alongside the whole system transformation underway.

A detailed discussion on the report and the issues raised took place. It was noted that it was important for the Governing Body and all partners, under the leadership of the UCDB to be able to track at the required level actions taken and impact in response in a clear and succinct way. The following key elements were highlighted and responded to as part of the item:

- The role of NHS 111 impacted on a number of the focus areas for the UCDB and was being considered at regional level alongside the development of a clinical hub approach.
- The key focus for all involved in managing urgent care demand and flow was maintaining a safe environment in which patients could be adequately cared for.
- The importance of ensuring that current performance cycles could be broken positively as a result of changed behaviours by system leaders and staff working at all levels.
- The need to ensure streaming in and out of the urgent care system and primary care focus on managing patients who arrive in the Emergency Department without a non-acute problem was key to this.
- Incentivising the system to work collaboratively to manage flow and reduce levels of Delayed Transfers of Care (DTOC) was underway and being managed on a daily basis.
- The importance of leading and embedding the delivery of the Safer Model within the Foundation Trust and the requirement for clinical leadership to champion this work.
- The continued need to focus on the development of quality and levels of provision within the care home market in Stockport to assist with management of flow for those not requiring an acute hospital bed and the need to ensure in particular, adequate provision for the winter period.

G Mullins noted the importance of ensuring all system plans for and impacting on urgent care were aligned and actions implemented tracked closely within the impact monitored. Appropriate capacity was required to manage this work and escalate issues.

A Johnson expressed concern that without sufficient clinical leadership and ownership, financial investment in urgent care would not yield the required improvements. C Briggs noted the challenges of Systems Resilience Group monies being largely directed at schemes rather than sustained investments in trying to change patient behaviours.

*P Carne leaves the meeting.

J Crombleholme sought assurance about how schemes developed were monitored against agreed outcomes and how improvements were implemented and embedded within the system. She noted the quality of implementation planning and management resource to drive change through on the ground was integral.

A discussion took place about the importance of ensuring all staff working within urgent care were aligned under single empowering leadership, clear about the plan they were being asked to deliver against and knew what their role in delivery was. T Ryley noted the need for focussed attention on a small number of schemes where significant real benefit could be delivered.
The Governing Body expressed strong support for a culture in which priorities were identified, a plan agreed and delivery sustained without reactionary diversions which would reduce benefit delivery. It was noted that the Stockport Together Programme provided significant leadership across the system in addition to the UCDB and system issues and risks need to be escalated and tracked as appropriate through the Programme.

R Gill noted the significant challenge which existed within the urgent care system in Stockport and the need to ensure grip and clarity of focus on making significant performance improvements in the area. He noted that without the required clinical leadership and ownership, particularly within the Foundation Trust, the challenges would be more difficult to overcome. He noted that it was important to discuss matters such as this at Board to Board Meetings between the CCG and Foundation Trust Board. The aspiration for the development of the Multi-Speciality Community Provider (MCP) within Stockport would refocus the delivery of care within primary and community settings and he noted the continued need to deliver this at pace to ensure quality and safety of delivery of care to patients and achievement of national constitutional performance measures. S Toal noted the importance of system grip on the issue and not just organisational focus and grip within the Foundation Trust to develop a collaborative whole systems approach to managing known challenges.

The Governing Body acknowledged the significant challenges facing the economy relating to urgent care and the need for clarity of vision, ownership of implemented plans with clear outcomes agreed and performance tracked and clinical leadership and ownership of this at every single level within the system to drive through short term and longer term transformation.

Resolved: That Governing Body:

1. Note the content of the report and the work being undertaken by the UCDB to manage the known system performance challenges
2. Agrees that the matter be discussed at the next Board to Board Meeting between the CCG and NHS Stockport Foundation Trust.

69/16 BOARD ASSURANCE FRAMEWORK

L Latham presented the Board Assurance Framework as at 31 August 2016 and noted the increased exposure to risk across the system as a result of the significant transformation programme underway. She noted that the CCG’s risk position was reflective of this and managing and mitigating known extreme and high risks remained a continued focus for the organisation. She noted the escalation of a new risk relating to workforce and sought Governing Body approval to add that to the framework. The Governing Body’s attention was drawn to the risks outlined in the report where there had been a change in overall risk rating and / or a number of factors of significant impact on the risk.

A discussion took place regarding the known issues relating to care homes in Stockport and the risks posed as a result. It was noted that the Framework was underpinned by an Operational Risk Register to manage lower level risks. Other known and significant risks regarding system wide delivery of change and management of immediate issues in urgent care alongside longer term transformation were discussed by Members.

Resolved: That Governing Body:

1. Notes the revised Board Assurance Framework for the period August 2016.
2. Approves the addition of a new strategic risk relating to capability, capacity and skill mix of primary care workforce
3. Notes the inclusion of strategic risk leadership as part of its ongoing development programme.

**70/16 GENERAL PRACTICE FORWARD VIEW**

P Carne provided an overview of the content of the report on the General Practice Forward View and highlighted the local and national challenges it presented. In particular he highlighted workforce issues and workload pressures being experienced in general practice and noted that in Stockport, 3 business cases in the areas of physiotherapy, mental health and pharmacy had been developed by Viaduct as part of the Stockport Together Programme with the aim of creating improved services for patients and freeing up capacity within General Practice. He noted that schemes such as Consultant Connect and 7 Day General Practice would also have significant impact.

The Governing Body discussed the paper and in particular the acknowledgement nationally of the additional investment required in general practice. R Gill noted that the plans in Stockport needed to address local issues at significant pace and that the Stockport Together Core Neighbourhoods business case was the focus of the work.

A Johnson commented on workforce and general practice recruitment issues, in particular known gaps in particular medical specialties and retention issues. G Mullins noted it remained important to ensure that Stockport was promoted as an attractive place to live and work for GPs. C Briggs explained that GPs needed to continually review what work they undertook currently which could be delivered by another clinical professional in order to release capacity.

T Ryley explained that whilst a robust workforce strategy was integral to developing new models of care, it was the reform of the NHS and Social Care systems, including general practice which would bring about the most significant changes to working practices as the workforce needed to be shaped around the system. It was agreed that issues of clinical governance, responsibility and accountability within General Practice were important in ensuring the future model was sustainable. It was noted that work on demand management in primary care was being undertaken within the Stockport Together Programme and further information would be shared with the Governing Body. It was noted that Viaduct GP Federation as the GP Provider representative within Stockport Together would play a key role in ensuring the views of general practice were represented in particular relating to risk and accountability.

**Resolved:** That Governing Body:

1. Notes the report and the activity outlined with regard to the development and implementation of a primary care workforce strategy and aligned activities.
2. Request that work on demand management in primary care being undertaken within the Stockport Together Programme be shared with the Governing Body

**71/16 REPORT OF COMMITTEES**

**Finance and Performance Committee**

P Carne highlighted the content of the recent meeting of the Committee and sought approval of the business care for Mental Health Liaison in Stockport utilising the RAID Model.

**Resolved:** That Governing Body:
1) Note the position with regards to CIP
2) Note the approval by the committee of the Business Case for Achieving Improvements in Psychological Therapies
3) Approve the business case (attached) for Mental Health Liaison in Stockport utilising the RAID model.

Primary Care Commissioning Committee

J Crombleholme provided an overview of the considerations of the Committee and in particular referred to discussions regarding the provision of primary medical services to those future residents of the Woodford housing development as aligned to the Stockport CCG and Council boundaries. She noted that IM&T costs for a practice merger had been discussed along with matters of primary care quality and areas of focus arising from Care Quality Commission Inspections.

A Part 2 meeting of the Committee had taken place on the rising of the Part 1 meeting to discuss a GP contractual issue.

Resolved: That Governing Body note the report.

Remuneration Committee

*G Mullins, A Rolfe and M Chidgey took no part in the consideration of this item and therefore did not vote.

J Greenough outlined the recommendations contained within the report for the remuneration of the Chief Finance Officer role and changes to the remuneration of the Executive Nurse as a result of increased working hours.

Resolved: That Governing Body:

1. Approve the progression of the recruitment of a substantive Chief Finance Officer for the CCG based on a VSM (Very Senior Manager) contract.
2. The salary range set for the position would be £100,000 - £110,000
3. The spot salary within the range should be agreed between the appointment panel and successful applicant on the basis of experience
4. Requests that if spot salary for the Chief Finance Officer is agreed above that of the Chief Operating Officer a further report to the Committee to review the Chief Operating Officer’s salary be considered.
5. Approve the increase in the number of days worked by the CCG’s Executive

Audit Committee

M Chidgey confirmed that following the consideration of the Audit Panel, an offer of appointment, subject to Governing Body decision had been made to one of the successful bidders to take on provision of the CCG’s External Audit requirements. The decision to confirm would be taken by the Governing Body in November.
**Actions arising from Governing Body Part 1 Meetings**

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<th>MINUTE</th>
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<tr>
<td>28 09 2016 (1)</td>
<td>Patient Story</td>
<td>58/16</td>
<td>End October 2016</td>
<td>L Latham, V Owen Smith</td>
</tr>
<tr>
<td></td>
<td>1. The patient story be noted and thanks expressed to the patient for her sharing her story.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The number of Type 1 and Type 2 diabetics who had attended education courses be provided to Governing Body Members along with the number of initial referrals / contacts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 09 2016 (2)</td>
<td>Finance Report</td>
<td>60/16</td>
<td>November 2016</td>
<td>M Chidgey</td>
</tr>
<tr>
<td></td>
<td>Finance and Performance Committee undertake some benchmarking work regarding mental health investment, escalating any themes to Governing Body to be included alongside a picture of the total investment in mental health to be included in the Finance Report to the November 2016 meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 09 2016 (3)</td>
<td>Stockport Together Highlight Report</td>
<td>63/16</td>
<td>November 2016</td>
<td>T Ryley</td>
</tr>
<tr>
<td></td>
<td>An approach to considering Programme risks (including Core Neighbourhood in particular) be agreed for future meetings / more widely.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Reference</td>
<td>Meeting Date</td>
<td>Approver</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------</td>
<td>-----------</td>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>28 09 2016</td>
<td>Locality Chairs Update</td>
<td>64/16</td>
<td>November 2016</td>
<td>R Gill</td>
</tr>
<tr>
<td></td>
<td>Feedback from J Higgins on behalf of the Heatons and Tame Valley Locality would be considered at the CCG’s Wider Leadership Team.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 09 2016</td>
<td>Chief Operating Officer’s Report</td>
<td>66/16</td>
<td>October 2016</td>
<td>G Mullins</td>
</tr>
<tr>
<td></td>
<td>The full Local Transformation Plan for Children and Young People’s Mental Health be circulated to the Governing Body.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent Care Performance to be discussed at the next Board to Board Meeting between the CCG and NHS Stockport Foundation Trust.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 09 2016</td>
<td>General Practice Forward View</td>
<td>70/16</td>
<td>November 2016</td>
<td>R Roberts</td>
</tr>
<tr>
<td></td>
<td>The work on demand management in primary care being undertaken within the Stockport Together Programme be shared with the Governing Body</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 09 2016</td>
<td>Reports from Committees</td>
<td>71/16</td>
<td>November 2016</td>
<td>M Chidgey</td>
</tr>
<tr>
<td></td>
<td>The decision regarding the appointment of the CCG’s External Auditors be scheduled for the November meeting of the Governing Body.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Strategic Impact Report
Performance against key indicators in operational plan

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.
Executive Summary

What decisions do you require of the Governing Body?
The Governing Body are not being asked to make any specific decisions but should note the content of this report when considering operational planning for 17-18, the finance report and QIPP.

Please detail the key points of this report
- Our aim this year was broadly a plan that saw no growth.
- A&E attendance is up 5.4%
- Non-Elective admissions are still down 2.5% in year but this is a worsening position
- GP referred 1st Outpatients are down 2.8%; a continuation of improvements already seen
- Elective procedures are up 6.5%, but this is reflective of waiting list activity to reduce backlogs
- Prescribing remains marginally above plan at 0.8%.

What are the likely impacts and/or implications?
The improvements in non-elective admissions are better than plan and in line with the many changes being made in the system. Similarly the improvements in referrals are better than plan and in-line with our strategy.

If these reductions are maintained they could have a significant positive impact on the growth planning assumptions for 2017-18 and therefore on the scale of our Cost Improvement Plans. However, the changes to out of hospital services are not yet impacting on A&E attendance and occupied bed days are up slightly minimising the financial benefits.

How does this link to the Annual Business Plan?
These are the key strategic measures of the effectiveness of the combined work set out in the plan to shift to a more sustainable economy

What are the potential conflicts of interest?
None

Where has this report been previously discussed?
Directors meeting

Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 30 November 2016
Agenda item: 7
1. Summary
There is some evidence of parts of our strategic plan starting to deliver benefits in reducing unnecessary hospital activity. However, it is important to remember that just as activity growth can be stimulated by oversupply, so activity reduction can be the consequence of supply side pressures and capacity limits. It is likely that this is a contributing factor as well as the positive changes being made.

2. Urgent Care Activity
Having seen limited growth in A&E demand last year this is now rising at 5.4% in Stockport. This growth is fairly uniform across the borough (4.7% Marple & Werneth to 6.9% Cheadle & Bramhall).

However, despite this growth in attendance non-elective admissions are reducing indicating improvements in the management of complex care across the system as well possibly as supply side capacity limits. It should be noted the reduction in the previous 12 months is now only 2.5% better than plan compared with the April – July position of a 4.5% reduction. This indicates pressure is once again increasing. Most of the improvement is being driven by the Heaton & Tame Valley locality (8.7% reduction). All other localities are virtually flat and thus in line with plan.

It should also be noted that the reductions in care home admission rates are a significant factor in the position both at Stockport level and at individual locality level. Variation in these rates is primarily reflective of changes in care home bed capacity.

Length of stay, reflected in increased occupied bed days per 100,000, is up. This is mitigating much of the benefit of the reduction in admissions.

3. Planned Care
There is a reduction in GP 1st Outpatients which has continued to develop through the year improving markedly from the April and May position. This is the first sustained reduction in a number of years and is corroborated by information indicating Stockport GP referrals at NHS Stockport Foundation Trust are down. The reductions in Cheadle & Bramhall, and in Heaton and Tame Valley are marked (>5%). Considerable work was undertaken by practices with our CCG GP Development team in these areas last year as they were the outliers in both actual numbers and growth rates. Marple & Werneth despite a positive starting position and strong performance last year have continued to see further reductions.

Planned Elective activity is up significantly. This reflects efforts by acute trusts to address waiting time issues and meet referral to treatment times (RTT). This is expected.
4. Prescribing
Prescribing (items) remains broadly if slightly above plan. There is considerable variation across localities with Marple & Werneth continuing to improve on an already good position, down 3.9%.

5. Neighbourhood Variation
Last year there were marked differences between neighbourhoods with Marple & Werneth performing better than plan and better than others in almost all themes. Marple & Werneth continue to strongly support strategy delivery but there have been significant improvements in Heaton & Tame Valley and Cheadle & Bramhall in a couple of important areas. Reducing variation further will make a significant contribution to delivery of the CCG strategy.

6. Summary
This is a broadly positive position and this has been acknowledged by Greater Manchester H&SC partnership at the recent quarterly assurance meeting with the locality. As usual we do need to continue to sound a cautious note due to the complexity of demand and supply side factors. However, we anticipate that within 3 months we should start to see further benefits in admissions as a consequence of significant improvements in A&E streaming and ambulatory care, and in intermediate tier services as described in the Stockport Together report.
### General Practice Dashboard

#### Practice Code: Stkpt
#### Practice Name: All Stockport
#### GP Partnership: 
#### Prescribing Name: 
#### Map: Tel reception: Weighted list 31/10/14

<table>
<thead>
<tr>
<th>Select comparison yr</th>
<th>variance</th>
<th>Practice</th>
<th>Nbhood</th>
<th>Locality</th>
<th>Stkport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent</strong> A&amp;E Attendances</td>
<td>48705</td>
<td>51311</td>
<td>2606</td>
<td>5.4%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Ambulance Conveyance Rate</td>
<td>80.4%</td>
<td>76.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Elective Admissions All</td>
<td>19659</td>
<td>19161</td>
<td>-48</td>
<td>-2.5%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Occ Bed Days per 100,000</td>
<td>31681</td>
<td>31813</td>
<td>133</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>GP Direct Admissions</td>
<td>3209</td>
<td>3525</td>
<td>316</td>
<td>9.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td><strong>LTC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD Admissions</td>
<td>11741</td>
<td>437</td>
<td>4</td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>HF Admissions</td>
<td>2728</td>
<td>269</td>
<td>7</td>
<td>2.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>COPD Admissions</td>
<td>6711</td>
<td>164</td>
<td>210</td>
<td>46</td>
<td>28.0%</td>
</tr>
<tr>
<td>Asthma Admissions</td>
<td>19770</td>
<td>91</td>
<td>87</td>
<td>-4</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Diabetes Admissions</td>
<td>14575</td>
<td>71</td>
<td>52</td>
<td>-19</td>
<td>-26.8%</td>
</tr>
<tr>
<td>LTC Admissions</td>
<td>55525</td>
<td>1032</td>
<td>1066</td>
<td>34</td>
<td>3.3%</td>
</tr>
<tr>
<td>AF Admissions</td>
<td>5732</td>
<td>218</td>
<td>187</td>
<td>-31</td>
<td>-14.2%</td>
</tr>
<tr>
<td><strong>Care Home Admissions</strong></td>
<td>982</td>
<td>851</td>
<td>-131</td>
<td>-13.3%</td>
<td>-13.3%</td>
</tr>
<tr>
<td><strong>Referrals</strong> GP Referred 1st OPA</td>
<td>31536</td>
<td>30652</td>
<td>-884</td>
<td>-2.8%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>3206</td>
<td>2955</td>
<td>-251</td>
<td>-7.8%</td>
<td>-7.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>3497</td>
<td>3208</td>
<td>-289</td>
<td>-8.3%</td>
<td>-8.3%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>5080</td>
<td>5277</td>
<td>197</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>5628</td>
<td>5129</td>
<td>-499</td>
<td>-8.9%</td>
<td>-8.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>672</td>
<td>719</td>
<td>47</td>
<td>7.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>2026</td>
<td>2169</td>
<td>143</td>
<td>7.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1863</td>
<td>1938</td>
<td>75</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1332</td>
<td>1282</td>
<td>-50</td>
<td>-3.8%</td>
<td>-3.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>589</td>
<td>622</td>
<td>33</td>
<td>5.6%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>5165</td>
<td>4987</td>
<td>-178</td>
<td>-3.4%</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>1604</td>
<td>1480</td>
<td>-124</td>
<td>-7.7%</td>
<td>-7.7%</td>
</tr>
<tr>
<td>Other Specialist Medicine</td>
<td>97</td>
<td>119</td>
<td>22</td>
<td>22.7%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Other Specialties</td>
<td>777</td>
<td>767</td>
<td>-10</td>
<td>-1.3%</td>
<td>-1.3%</td>
</tr>
<tr>
<td><strong>Other Referred 1st OPA</strong></td>
<td>18368</td>
<td>19037</td>
<td>669</td>
<td>3.6%</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Planned</strong> Elective Admissions</td>
<td>19626</td>
<td>20895</td>
<td>1269</td>
<td>6.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Prescribing 12</td>
<td>2729355</td>
<td>2751743</td>
<td>22388</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
Finance Report for the period ending 31st October 2016 – Month 7

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.
### Executive Summary

**What decisions do you require of the Governing Body?**

(i) **Note** the year-to-date surplus of £1.61m which is line with plan.

(ii) **Note** that the planned surplus of £2.75m is forecast to be delivered.

(iii) **Note** net risks totalling £2m not reflected within the forecast position.

(iv) **Note** that the position includes provision in full of the 1% non-recurrent uncommitted reserve.

(v) **Note** that due to the level of identified risk it is unlikely that we will be able to deliver a 1% surplus in 16/17.

(vi) **Note** that due to mental health investments not being made at the planned pace delivery of the Mental Health Parity of Esteem (PoE) financial target will be challenging.

(vii) **Ratify** the appointment of KPMG as external auditors to NHS Stockport CCG from 1st April 2016.

### Please detail the key points of this report

- The YTD and forecast outturn surplus are in line with plan however there remains net risk of £2m not within the forecast position.
- Due to the level of risk it is extremely unlikely that that we will be able to improve upon the planned position and deliver the full 1% surplus business rule in 16/17.
- The position on Mental Health Parity of Esteem is improved but remains challenging due to mental health investments not being made at the planned pace.

### What are the likely impacts and/or implications?

Non-delivery of NHS England business rules will result in increased scrutiny and will impact on the CCG’s assurance rating.

### How does this link to the Annual Business Plan?

As per 2016/17 Financial Plan.

### What are the potential conflicts of interest?

N/A

### Where has this report been previously discussed?

2024
All issues have been on agenda at the Finance and Performance Committee – this specific report is being presented for the first time to Governing Body.

**Clinical Executive Sponsor:** Ranjit Gill  
**Presented by:** Mark Chidgey  
**Meeting Date:** 30th November 2016  
**Agenda item:**  
**Reason for being in Part 2 (if applicable)**  
N/A
1.0 Introduction
This report provides an overview of the CCG’s performance against Statutory Financial Duties and Performance Targets highlighting both the year to date and forecast positions for 2016/17.

This report provides an update on:-
• The financial position as at 31st October 2016
• The forecast outturn position for 2016/17

2.0 Statutory Financial Duties and Performance Targets
As a CCG we are required to deliver statutory duties and financial performance targets that we have approved as a Governing Body. Table 1 below RAG rates our financial performance on both a ‘Year to Date’ (YTD) and Forecast Outturn basis.

Table 1: Statutory Duty and Performance Targets

<table>
<thead>
<tr>
<th>Area</th>
<th>Statutory Duty</th>
<th>Performance YTD (Mth 5)</th>
<th>Performance Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue (Dashboard Table 1)</td>
<td>Not to exceed revenue resource allocation</td>
<td>☢</td>
<td>☢</td>
</tr>
<tr>
<td>Running Costs (Dashboard Table 1)</td>
<td>Not to exceed running cost allocation</td>
<td>☢</td>
<td>☢</td>
</tr>
<tr>
<td>Capital – (Note: The CCG has not received a capital allocation in 2016/17)</td>
<td>Not to exceed capital resource allocation</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Area</td>
<td>Performance Target</td>
<td>Performance YTD</td>
<td>Performance Forecast</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Revenue</td>
<td>Deliver a Recurrent Surplus</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>Revenue (Appendix 1 Table 1)</td>
<td>Deliver a 0.7% in-year surplus</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>Cash (Appendix 1 Table 9)</td>
<td>Operate within the maximum drawdown limit</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>Business Conduct (Appendix 1 Table 8)</td>
<td>Comply with Better Payment Practices Code</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>1% Uncommitted Non-Recurrent Reserve</td>
<td>Create a uncommitted 1% Non-Recurrent Reserve</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>CIP (Appendix 1 Table 6)</td>
<td>Fully deliver planned CIP saving</td>
<td>🟢</td>
<td>🟡</td>
</tr>
<tr>
<td>Mental Health Financial Parity of Esteem (PoE)</td>
<td>Growth in Mental Health spend is at least equal to Programme Allocation Growth</td>
<td>🟢</td>
<td>🟡</td>
</tr>
</tbody>
</table>

The 1% Non-Recurrent Uncommitted Reserve has now been provided for in line with the financial recovery plan and is reflected by the green RAG rating (red RAG rating at month 5)

The CIP red RAG rating reflects that there is CIP totalling £3.2m forecasted not to be delivered which will be funded by contingencies and in year non-recurrent benefits.

The Mental Health financial Parity of Esteem (PoE) amber RAG reflects that mental health investments, whilst improved, have not been made at the required pace and therefore the delivery of the PoE financial target will be challenging.
3.0 Financial Position as at 31st October 2016 – Month 7
The financial position as at month 7 is summarised in Table 2 below with further detail provided in Appendix 1 to this report

Table 2: Summary of Financial Position at Month 7

<table>
<thead>
<tr>
<th></th>
<th>Plan (Surplus) / Deficit £000s</th>
<th>Actual (Surplus) / Deficit £000s</th>
<th>(Favourable) Adverse Variance £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 7 YTD</td>
<td>(1,602)</td>
<td>(1,608)</td>
<td>(6)</td>
</tr>
<tr>
<td>Year End Forecast</td>
<td>(2,746)</td>
<td>(2,746)</td>
<td>0</td>
</tr>
</tbody>
</table>

In line with plan the CCG has reported a YTD surplus of £1.61m and a forecast outturn surplus of £2.75m. A significant risk to the delivery of the forecast surplus is continued acute elective and critical care over performance. Elective and critical care risk which is not included within the forecast position has been assessed to be c£2m and may impact on the CCG’s ability to deliver its planned surplus if it materialises.

4.0 Acute
Elective activity is c£1.6m higher than year to date plan mainly due to over-performance at Stockport FT. This rise in activity reflects additional activity in Trauma & Orthopaedics, which has resulted in a positive impact on waiting lists whereas over-performance in other surgical specialties is yet to result in the same benefit. The increase in electivity activity has been partially funded from the £1m reserve agreed within our original plan to reduce the RTT backlog. There is a risk therefore that over-performance will continue and be significantly above the £1m planned.

Non-elective admissions are down by c4% which is a positive reflection of transformation work to reduce admission rates and better manage urgent care needs in the community, for example through the GP Development schemes which included extended General Practice access and Care Home cover. Additionally urgent care changes commissioned at Stockport FT as part of 15/16 winter resilience (the 90 day plan) have impacted as planned. However, what should be a financial gain to the Stockport system of c£0.9m is compromised by commensurate increases in excess bed days as a result of significant increases in Delayed Transfers of Care.

Critical Care is over performing by £0.6m YTD and it has been forecasted to remain within plan for the remainder of the financial year.

Continuing Care
The forecast overspend of £1.6m is largely reflective of the 40% increase in the NHS Funded nursing rate to £156.25 per week, backdated to the 1st April 2016. The increase is estimated to cost the CCG an additional £1.1m recurrently. This has been reported as a firm commitment against the CCG’s contingency reserve. Members should note that this increase will impact negatively on the CCG’s underlying (recurrent) position once materialised. There has also been an increase in the number of continuing health care placements in October which is also contributing to the forecast overspend.

Mental Health
Mental Health expenditure is reported in line with plan both YTD and forecast outturn. However, we are aware that some investments have not been made at the planned pace and this will make it challenging for the CCG to meet the financial Parity of Esteem (PoE) target. The CCG has restated our continued commitment to implement all planned Mental Health schemes and investments.

Members are reminded that NHS England has made a commitment to greater transparency of Mental Health finance and non-financial information and is proposing to publish the following information:-

- 15/16 outturn and 16/17 plan total spend at national level for CCGs and for specialised commissioning
- 15/16 outturn and 16/17 plan total spend at individual CCG level
- Split of 16/17 planned spend for 5 key programme areas at individual CCG level
  - Children and Young People (CYP) , including eating disorders,
  - Increasing Access to Psychological Therapies (IAPT),
  - Liaison Psychiatry,
  - Early Intervention in Psychosis
  - Crisis resolution home treatment

Not delivering the Mental Health Parity of Esteem financial target will result in the CCG coming under increased scrutiny from NHS England and may impact the CCG’s assurance assessment.

5.0 Prescribing
The latest information from the NHSBSA provides actual prescribing expenditure for the months April to August. As this information is published 2 months in arrears, an estimate for September and October has been made in arriving at the cumulative position to October 16.

April to August actual prescribing expenditure showed an underspend compared to plan and therefore a £500k outturn underspend has been forecasted.

The underspend is due to additional savings delivered above planned levels through:

- Category M price reductions
- Impact of Medicines Optimisation Team saving schemes
7.0 Primary Care
The YTD underspend of £218k and forecast underspend of £314k is largely due to pay underspends in the medicines management team and underspend within the Care Planning local enhanced service.

8.0 Running Costs (Corporate)
The CCG is required to operate within its 16/17 running cost allocation of £6.45m. The YTD (£314k) and forecast outturn (£461k) underspends reflect release of a budget for costs that the CCG had committed to in advance of Transformation Funding and with the successful outcome has now been released.

9.0 Cost Improvement Programme (CIP)
To date £10.86m (65%) of CIP has been delivered, of which £3.24m is recurrent. It is forecast that £13.46m (81%) of CIP will be delivered by year end leaving £3.2m undelivered.

Included within the £10.86m of CIP delivered is acute demand QIPP of £4.23m which has been reported as delivered in full non-recurrently as a result of agreeing block contracts for A&E attendances, non-elective admissions and outpatient attendances with Stockport FT.

Members should note that although non elective admissions are down c4% YTD when compared to plan the increase in Delayed Transfers Of Care (DTOC) has offset any savings to the economy as a result of the reduction in non elective admissions.

10.0 Reserves
Table 3 of Appendix 1 sets out the reserves held at month 7.

Investments — include national “must do’s and those agreed collaboratively at a local GM level i.e. GM Risk share.

Contingency — this reflects the £2.2m (0.5%) contingency set aside required for planning purposes. An agreed commitment against this reserve is the estimated £1.1m increase FNC costs.

Savings & Efficiency — the £7.1m reserve reflects the remaining value of CIP savings not yet embedded within expenditure budgets.

11.0 Financial Risks and Mitigations not in Forecast
The CCG has a net risk of £2.0m as detailed in Appendix 1 Table 7 which has not been incorporated into the forecast position as at month 7.

The main risk to the delivery of the financial plan is acute contract risk £2m (Elective and Critical Care). There are no identified mitigations against this risk, therefore if the risk materialised the CCG may not be able to deliver its planned surplus.

12.0 Appointment of External Auditors

At the Governing Body meeting in September it was confirmed that the CCG had completed the procurement process for appointment of external auditors and that a contract offer would be made to the preferred provider. Following notification of the outcome to each of the bidders and completion of the standstill period, it is confirmed that a contract offer has been made to KPMG and a contract is now in the process of being agreed and signed.

The process for appointment of the auditors consisted:-

- Stage 1 – Mini competition (Invitation to Quote) from which the top 3 suppliers proceeded to stage 2.
- Stage 2 – Supplier interview.
- Stage 3 – Contract offer to the preferred provider.

Bids were assessed by a panel, consisting of representatives of the CCG Governing Body (executive and lay membership) and the audit committee.

The final scoring of each bidder’s submission is set out below:-

- KPMG LLP – 82.49%
- Bidder 2 – 77.26%
- Bidder 3 – 67.12%
- Bidder 4 – 50.35% (Score excludes Supplier Interview scoring, as this Supplier was not shortlisted to attend the Interview)

13.0 Recommendations

These are set out on the front sheet of this report.

Mark Chidgey
Chief Finance Officer
November 2016

<table>
<thead>
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<th>Documentation</th>
<th>Statutory and Local Policy Requirement</th>
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Stockport Together

Report on Stockport Together Transformation Programme

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane

Tel: 0161 426 9900 Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org
Executive Summary

What decisions do you require of the Governing Body?

The Governing Body are asked to note and comment on the report.

Please detail the key points of this report

- Significant progress has been made and we are continuing to hit key milestones
- There are a significant set of issues and risks that will impact on further progress and on successful implementation and delivery
- The Stockport Together programme director and executive board are sighted on these issues and risks and mitigations are described

What are the likely impacts and/or implications?

Progress on both milestone delivery and benefits realisation is critical to the delivery of the CCG Strategy and continued receipt of the GM Transformation investment.

The level of risk is not insignificant as might be expected in a programme of this complexity. Unless the issues are addressed delivery will slow and benefits will not be realised.

How does this link to the Annual Business Plan?

Stockport Together forms a substantial component of the CCG’s Strategic and Operational Plans.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

Stockport Together Executive Board
CCG Directors meeting

Clinical Executive Sponsor: Dr Ranjit Gill

Presented by: Tim Ryley

Meeting Date: 30th November 2016

Agenda item: 8
Programme Director Report

*Report November 2016 - Period Covered October*

1. **Summary**

This Stockport Together monthly report is developed from information drawn from individual workstream highlight reports prepared by each programme workstream lead from across Commissioning, Provider Development and the Integrated Service Solution. These reports are then scrutinised and discussed by the programme director with the wider programme team before preparation of a report for the Executive Programme Board. Reports to partners including this are then based on the output of this process.

There will be ongoing and continual work done to improve the report including the highlight reports and process to ensure key issues are escalated effectively. This report seeks to highlight the strategic issues and risks.

Given both the complexity and scale of the transformation we are undertaking and the very challenging financial and performance environment we are operating in it is not a surprise that this report presents a challenging picture. However, it is also important to note how far we have come and what has been achieved even in the last month. In the section below there is a sample of the achievements.

2. **Achievements in the last month**

2.1 **Integrated Service Solution**

*Acute Interface:*

1: The NHS England 100 day programme has been completed with all three teams asking to continue, NHS England asking us to stay in the next wave of the programme and some highly innovative pieces of work bringing together health partners across the system and the third sector. We are going to focus on the learning from this at the next meeting and we have submitted the bid for Wave 2.

2: We have primary care expertise involved in streaming and managing patients in A&E with close working between primary & secondary care clinicians. One experienced GP commented that it was possibly the most rewarding 2 days of his career.
3: The Ambulatory Care business case has made good progress and has been endorsed by the Executive Board subject to further work on the cost benefit analysis.

**Intermediate Tier**

1: The Intermediate Tier business case has made good progress and has been endorsed by the Executive Board subject to further work on the cost benefit analysis.

2: Significant preparation for go live of extended crisis response and the hub in November has been put in place with significant cross partner staff engagement, robust workforce plan and communication plan in place. Crisis Response and Hub have now gone live.

**2.2 Enabler**

Progress has been made on the workforce model

The first business case has been developed and been endorsed by the Executive Board and reflects multi-partner needs and progress towards integration

Work on implementing ICT changes to support first phase mobilisation is progressing in line with required deadlines.

**2.3 Integrated Provider Development**

The provider board has completed the high-level options appraisal and agreed on a preferred provider form to deliver the MCP.
3. Milestones, Issues, Risks and Mitigating Actions

3.1 Greater Manchester Level Milestones

Key

<table>
<thead>
<tr>
<th>Completed</th>
<th>On track to deliver by due date</th>
<th>Operational challenges in meeting target but manageable in programme</th>
<th>Deadline missed (&lt;1month) or significant danger will be missed or delivered poorly</th>
<th>Deadline significantly missed (&gt;1month) or will be missed</th>
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</table>

These are the high-level milestones agreed with GM as part of the Investment Agreement associated with the Transformation Agreement. It should be noted that this is the position as of the 31st October 2016 as agreed by the Executive Board at its meeting on the 7th November. During November it is anticipated milestones 2, 3, 5, 12 and 18 will be completed.

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<thead>
<tr>
<th>Milestone</th>
<th>Due date</th>
<th>Last Rating</th>
<th>Current Rating</th>
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<tbody>
<tr>
<td>1 Voluntary Sector targeted support to discharge in place</td>
<td>Nov 16</td>
<td></td>
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<tr>
<td>2 Phase 1 Intermediate Tier reform in place including enhanced crisis response team and dedicated step-up capacity</td>
<td>Nov 16</td>
<td></td>
<td></td>
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<tr>
<td>3 Intermediate Tier single access hub in place</td>
<td>Nov 16</td>
<td></td>
<td></td>
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<tr>
<td>4 Neighbourhood teams integrated management staffing structure in place across all neighbourhoods</td>
<td>Nov 16</td>
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<tr>
<td>5 Full A&amp;E primary care element in triage, with ambulatory illness and strengthened Ambulatory Care Unit in place</td>
<td>Dec 16</td>
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<tr>
<td>6 Intensive case management in place for 6% of population across at least 6/8 neighbourhoods</td>
<td>Jan 17</td>
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<tr>
<td>7 Enhanced primary care for physiotherapy, pharmacy and mental health being tested in at least 2 neighbourhoods for each covering minimum 25 practices</td>
<td>Jan 17</td>
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<tr>
<td>8 A system wide workforce plan in place covering social care and community healthcare to support out of hospital plans</td>
<td>Nov 17</td>
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<td>9 Enhanced Stockport Health &amp; Social Care Record with write capability operational</td>
<td>March 17</td>
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<td>10 Full staff engagement plans completed</td>
<td>March 17</td>
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<td>Milestone Description</td>
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<td>11</td>
<td>Phase 1 detailed design business cases complete and approved by Governing Bodies (Ambulatory Care, Intermediate Tier, Neighbourhood 1, and 3rd Sector discharge support)</td>
<td>Dec 16</td>
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<tr>
<td>12</td>
<td>Final Clinical Outcomes list developed and agreed</td>
<td>Dec 16</td>
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<td>13</td>
<td>Phase 1 Procurement process completed</td>
<td>Feb 17</td>
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<td>14</td>
<td>Integrated Commissioning Functions Agreed</td>
<td>Feb 17</td>
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<td>15</td>
<td>Alignment of Stockport process to national assessment process agreed</td>
<td>Dec 16</td>
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<td>16</td>
<td>Full outcomes framework developed</td>
<td>April 17</td>
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<td>17</td>
<td>All major detailed design business cases completed (All previous plus rest of neighbourhood, outpatients, and healthy communities)</td>
<td>April 17</td>
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<tr>
<td>18</td>
<td>Providers agree on preferred final form</td>
<td>Dec 16</td>
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<td>19</td>
<td>MCP interim arrangements live</td>
<td>Apr 17</td>
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<td>20</td>
<td>Sign-off Investment Agreement</td>
<td>Oct 17</td>
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<td>21</td>
<td>Completed metrics Schedule 2 detail and Schedule 6</td>
<td>Jan 17</td>
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<td>22</td>
<td>Revised Milestone Plan and Governance for 2017-18 agreed &amp; submitted to GM Transformation Fund</td>
<td>March 17</td>
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<td>23</td>
<td>Revised investment template for 2017-19 agreed 7 submitted to GM Transformation Fund</td>
<td>March 17</td>
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<td>24</td>
<td>First phase decommissioning case completed (NEL)</td>
<td>Jan 17</td>
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<td>25</td>
<td>Outpatient decommissioning case completed</td>
<td>April 17</td>
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### 3.2 Escalated Milestones from Business Cases

Once Business Cases are agreed and in-line with monitoring and evaluation this section will only contain escalated areas of concern in delivery (Orange/Red only).

### 3.3 Issues

The following are the principle issues (strategic and operational) that the Governing Body should sighted on. These are currently impacting on delivery of the overall programme. Whilst these are significant in depth and range none of them are insurmountable but they will need to be addressed if momentum and successful benefits delivery are to be achieved. The Executive Board is responsible with the Programme Director wherever possible ensuring all issues drop below level 3.
<table>
<thead>
<tr>
<th>Key</th>
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<td><strong>Level 1</strong></td>
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<table>
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<tr>
<th>Issue</th>
<th>Detail and Impact</th>
<th>Rating</th>
<th>Mitigation</th>
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<tr>
<td><strong>1. Shared Vision and Ownership in Neighbourhoods</strong></td>
<td>Terms such as neighbourhood working and integration, and the role of general practice are differentially interpreted by the partners and there is a lack of ownership of key principles such as alignment to neighbourhoods. This is impacting on engagement, creates some confusion and limiting ambition.</td>
<td>4</td>
<td>1. CCG to set out commissioning intentions letter 2. Business case development led by small group to respond to this by end of December with greater GP leadership with senior commissioner input.</td>
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<tr>
<td><strong>Information Governance</strong></td>
<td>Failure to yet have an agreed Tier 1 agreement let alone Tier 2 agreements particularly with general practice lies behind some of the slow pace in neighbourhood implementation and is now becoming an issue in other areas of implementation. There is as yet little progress on Secondary Use and this is impacting on Outcome Framework development and neighbourhood risk stratification. Unless resolved will impact on degree of integrated working and inhibit benefit delivery.</td>
<td>3</td>
<td>1. Appointed a new dedicated IG lead on secondment from Pennine Care 2. Create a shared IG Framework and update plan 3. Complete Tier 1 and 2 agreements utilising national framework 4. Re-launch IG group and include LMC</td>
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<tr>
<td><strong>Impact of A&amp;E performance on focus and capacity</strong></td>
<td>The necessary focus on resolving the range of system issues affecting A&amp;E performance is diverting transformation resource (core people both operational and programme) from the programme. This is impacting on either key milestones for example in Intermediate Tier or threatening safety and effectiveness of delivery. It can also impact on the ability to embed schemes that have gone live as people are moved on too quickly before benefits realisation is assured.</td>
<td>3</td>
<td>1. Have already aligned Phase 1 Stockport Together work to Urgent Care 2. Executive Board will keep under review and refresh programme leadership.</td>
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<td><strong>Workforce</strong></td>
<td>There is as yet no strategic view of workforce change in place for example addressing wider workforce in primary care and transfer of hospital staff to community roles. The lack of general practice workforce expertise and leadership</td>
<td>3</td>
<td>1. A review of next steps is in place including consideration of how to deploy sufficient strategic leadership capacity</td>
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is a worry for an MCP. Progress has been made on specific workstreams and skill mix principles.

**Leadership**
A number of key players at strategic, operational and programme level have or are leaving Stockport in the next few months. This could be exacerbated by the A&E pressure and efforts to reduce programme costs of interims.

**Contracting**
There has been some confusion about how to contract for some of the changes that are being made this has slowed progress in implementation.

**National Joint Assurance Framework**
The national development of a joint assurance framework and some concerns about Stockport’s approach as is natural for an early vanguard site will require some working through and reflection on by the commissioners and will then require significant work by the partnership to get through various gateways. Will slow down establishment of MCP

### 3.4 Risks
**Key**

<table>
<thead>
<tr>
<th>IMPACT</th>
<th>1</th>
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<td>1 Low</td>
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In addition to the issues described above which are already impacting on current delivery and are risks to future delivery also, there are a number of other risks that need to be noted.
<table>
<thead>
<tr>
<th>Risk</th>
<th>Impact and Level</th>
<th>Score</th>
<th>Mitigation</th>
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<tr>
<td><strong>Risk</strong></td>
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<td><strong>Risk</strong></td>
<td><strong>Impact</strong> and <strong>Level</strong></td>
<td></td>
<td><strong>Mitigation</strong></td>
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<tr>
<td>Fail to engage effectively with staff and staff-side.</td>
<td>- Lack of ownership of change reducing benefits delivery</td>
<td>15</td>
<td>- Ensure robust organisational change policy is in place</td>
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<td></td>
<td>- Potential for challenge from unions to changes</td>
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<td>- Engage frontline staff appropriately in developing models of care</td>
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<td></td>
<td><strong>Impact 5</strong></td>
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<tr>
<td>Significant regulatory action or threat of such action against one or more partners (A&amp;E / Finances)</td>
<td>- Partner forced to disengage from programme limiting scope</td>
<td>20</td>
<td>- Consider slowing programme to support improved position</td>
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<td></td>
<td>- Relational damage to partners</td>
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<td>- Increase frequency of Leaders meetings</td>
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<td></td>
<td>- Loss of transformation resources</td>
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<td>- Identify key pressure points and focus</td>
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<td></td>
<td><strong>Impact 5</strong></td>
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<tr>
<td>Limited evidence of co-production with the public during design and implementation</td>
<td>- Reduce innovation and poor quality of care</td>
<td>12</td>
<td>- Programme Office to work with Chair of Citizens panel to advise and insist on co-production going forward</td>
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<td></td>
<td>- Increase likelihood of successful challenge to changes</td>
<td></td>
<td>- Provider Board to reflect on how best to use co-production in implementation</td>
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<td>- MCP requirement</td>
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<td></td>
<td><strong>Impact 4</strong></td>
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<tr>
<td>Fail to consult public on significant system changes (Thinking bed reductions and changes in Outpatients as well as new provider form)</td>
<td>- Less likely to pass through joint assurance process</td>
<td>10</td>
<td>- Continue conversation with Health-Watch</td>
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<td></td>
<td>- Opens up possibility of judicial review</td>
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<td>- Complete relevant business cases with clear consultation plans and realistic timescales</td>
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<td></td>
<td><strong>Impact 5</strong></td>
<td></td>
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<tr>
<td>Lack of sufficient Business Intelligence capacity and capability</td>
<td>- Slows ownership of issues at neighbourhood level</td>
<td>12</td>
<td>- Move forward at pace review of shared BI function and vision</td>
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<td>- Reduces transformational focus of work</td>
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<td>- Benefits realisation loses focus</td>
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<tr>
<td></td>
<td><strong>Impact 4</strong></td>
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</tbody>
</table>
### Approach to segmentation and outcomes does not influence new Integrated Service Model

- Reduces potential transformation and thus benefit delivery
- Impacts on provider capability to deliver outcomes within budgets
- Reduces likelihood of commissioner agreement on investment

**Impact 4**

### Lack of clear communication of changes to

- Change happens more slowly as confusion grows
- Unity of purpose collapses

**Impact 3**

### Next wave of business cases will operate within the segmentation approach

### Joint ownership of key messages whilst using best provider or commissioner channels

### 4. Business Cases

The first wave of business cases are nearing completion and have been to the Stockport Together Executive Board where they have been endorsed subject to further work on the cost benefit analysis and risk share arrangements. They are likely to be presented to the Governing Body at the December meeting. The cases concerned are:

- Boroughwide - Intermediate Tier
- Acute Interface - Ambulatory Care
- Healthy Communities – Voluntary Sector support to discharge
- Enabler

Summary descriptions of the three clinical cases above are attached to the end of this report.

In addition to these work on the Neighbourhood business including general practice case is progressing with a view to bringing it to the meeting in December.
In the meantime the Stockport Together Executive Board approved the investment in a Carer Business Case as this was within the Standing Financial Instructions (SFI) for attending officers and did not require recurrent funding. A summary of this is also attached.

In order to keep momentum the Executive Board has also approved non-recurrent investments from the GM Transformation Agreement in line with SFI’s and the discussion at the last Governing body in September.

5. Conclusion
The Governing Body are asked to note the report and the actions being taken to address the issues and risks. The scale and complexity of the change being undertaken remains significant and therefore given the challenging performance environment the level of risk remains high.
What is Ambulatory Care?
Ambulatory Care refers to conditions which are commonly accepted as not normally requiring an in-patient stay. Using this definition, in Stockport we admit more than other similar areas - and the gap is growing. This area of work is being developed to reduce the number of people who are admitted to hospital after presenting at A&E (sometimes referred to as Emergency Department) with ambulatory care conditions.

What is covered by the Ambulatory Care business case?
This business case focusses on one of the elements covered by NHS England’s Five Year Forward View, which states that:

*Those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise, to maximise chances of survival and a good recovery.*

The main areas of focus are:

**Implementing primary and secondary care triage function on arrival at A&E between 8am and midnight 7 days per week**

In the new model the workforce will comprise both hospital and primary care clinicians at the front-door of the A&E department. This combination of primary care and hospital experience and expertise will ensure that the most appropriate decision is made about the best care for each person. To ensure that the benefit of this experience is maintained, the primary care clinicians continue to practice regularly in a primary care setting as well as in the triage function.

The enhanced A&E triage capability will be in place between 8am and midnight each day in-line with the peak period of demand. The additional workforce will consist of a senior primary care nurse at all times during this period.

**Provision of co-located primary care (Ambulatory Illness Team) from 8am to midnight**

This service will be staffed by clinicians with primary care expertise, specifically GPs and advanced nurse practitioners (ANPs). They will have rapid access to the Emergency Department and Ambulatory Care Unit (ACU) advice if required and will work alongside this wider team.

The ambulatory illness team will operate between 8am and midnight each day, with ANPs covering from 10am to midnight. Between 8 and 10am when flows are lower the senior primary care nurse will do this.

People transferred out of A&E to this team will be seen within 2 hours and normally discharged. To aid decision making staff in this area will also have access to GP records through the use of EMIS viewer (patient record system) and hence live information on medication, latest appointments, allergies etc.
What will the benefits be?
The Ambulatory Care activity is designed to deliver the following benefits:

- A reduction in the number of patients with an ambulatory care condition presenting at A&E and subsequently being admitted to a hospital bed
- A reduction in the proportion of people presenting at the front-door of A&E and subsequently being managed in the A&E department
- Address the management and flow of ambulatory care patients through the A&E department
- Contribute to a reduction in admissions of patients with ambulatory care conditions across the economy
- Contribute to a reduction in the proportion of people being admitted for any reason after attending A&E
- Contribute to achieving the A&E NHS constitution indicator of 95% of people seen within 4 hours
- Contribute to the move towards 7 day working
- Contribute to an improved working environment in the A&E department
- Ensure that the financial benefits of the changes will be greater than the costs incurred across a 3 year period if no changes occurred

If you would like to understand more about this development and share any views you have please contact STOCCG.stockport-together@nhs.net
What is the Carers Connect Project?
The Carers Connect project has been set up to deliver peer support to connect carers of all ages with each other, as well as their local community, using a range of different mechanisms.

It will bring together community and voluntary sector organisations such as The Stroke Association, Diabetes UK, the Parkinson’s Society, the Alzheimer’s Society and others to provide a collaborative approach to identifying and supporting carers. This will further our understanding of the size and needs of the carer population and enable the sector to reach more ‘hidden’ carers providing them with specialist information and support they need.

The aim of Carers Connect is to achieve the following objectives:

- Provide carers of all ages and in all circumstances to have access to peer support
- Provide carers with access to a new online support resource
- Offer a series of condition-specific information and awareness raising sessions delivered by specialists
- Deliver one to one peer support
- Establish a mixture of generic carers and condition-specific support groups in each of the neighbourhood areas, run by carers for carers
- Strengthen collaborative approaches to carer support among key organisations in Stockport

Why is the Carers Connect project being established?
There are over 32,000 carers in Stockport, with nearly a quarter providing over 50 hours of care a week. National research has indicated that in 82% of cases carers’ own health has been affected, with nearly half suffering from depression and 57% saying they have lost touch with friends. Eight out of ten carers report feeling lonely and forgotten by society.

Signpost’s research shows that 94% of carers felt support from others, including other carers, would be very helpful/useful to carers, especially during periods of change or difficulty.

What is the proposed model?
The service model has been coproduced by Signpost and other voluntary sector organisations, who have worked closely with carers and other people directly involved in unpaid caring roles. The peer support will be in the form of an online carer forum, which will be monitored and updated by carers, one to one peer matching by a specialist worker and new carer-led support groups in all localities.
What will be included?
The Carers Connect project will introduce the following:

- Online resources for social media engagement including forums, online touch points for carers, volunteers and professionals, and links to local community health and wellbeing events and activities
- Training volunteer carer responders to monitor the forums with support from Signpost
- Social media training for carers
- Living Well courses to provide support for long term conditions, with a focus on the carers’ own health and wellbeing, complementing the current Big Lottery Funded project focusing on dementia
- A support worker developing a peer to peer support programme, matching carers in one to one and group settings

What will it achieve?
The project will aim to increase the health, wellbeing and resilience of carers, particularly those who are most vulnerable, and most likely to need more health and social care services as a result of carer breakdown and ill-health.

This will enhance the work of Neighbourhood Teams to maintain the health and wellbeing of those at high risk of hospital admission. It will also contribute to the achievement of measurable impacts, which have will be identified by neighbourhood teams, including population health improvements, service satisfaction, admissions to hospital and residential care, and delayed discharges.

Ultimately, this project will bring:

- Sustainable borough-wide peer online and face to face support networks which will enable carers to better look after their own health and wellbeing
- Improved access to the views, experiences and voices of carers to inform future service improvements
- Increased inter-agency collaboration to support the project involving a range of voluntary sector organisations and linking with the WIN and TPA

If you would like to understand more about this development and share any views you have please contact STOCCG.stockport-together@nhs.net
What is the Intermediate Tier and why is it changing?

‘Intermediate Tier’ means the teams of staff working to transfer and support patients between the hospital, community rehabilitation and long-term care facilities, and their own homes. This is also sometimes referred to as ‘step up’ and ‘step down’ services.

‘Step up’ community services refer to patients who suddenly need some extra specialist help but not at the level a hospital would provide. This might include older patients or those with long term conditions who get regular support from nurses, therapists, or social workers at home and who then deteriorate, requiring additional support.

‘Step down’ services refer to patients who are already admitted to hospital and need to either go home or be admitted to an in-between facility like a rehabilitation centre. Those with longer-term conditions such as dementia, serious mental health problems, or end of life conditions, are admitted to facilities specialising in this care.

Why do these services need to change?

At the moment in Stockport there are over 20 health and social care services providing different kinds of intermediate care. These services each offer high quality care but they have been set up separately over the past 10 years, creating a complicated system that is difficult for the public and health and care staff to understand. It also means it is struggling to respond to people in crisis and prevent admissions to hospital, which puts extra pressure on GPs and hospital services.

At the moment, the vast majority (90%) of the Intermediate Tier’s work focusses on step-down – supporting discharge from hospital. This means only 10% of the service focusses on responding to people in crisis and preventing people from needing to be admitted to hospital. But evidence suggests that for older patients in particular, recovery at home is better than a long hospital stay.

What is going to change?

From 14th November, 2016, the following changes will be introduced in stages:

1. Intermediate Care Hub
   One new 24 hour phone number health and care professionals can ring, staffed by skilled health and social care staff with details of all the different services and access to electronic records. They will assess the person in need of ‘step up or step down’ care and ‘triage’ (refer / send) them to the best service and support.
How are we going to achieve this?

Stockport has been awarded £19m from the Greater Manchester Transformation Fund to invest over the next three years to transform health and care across Stockport. The changes will be led by the Stockport Together MCP – an alliance of local health and social care providers.

Managers and frontline staff have been involved in developing the new models of care and this involvement will continue as the changes come into practice. From October 21st the new Hub and other services will start off small and grow from there, as we need to start making these changes quickly to improve services and reduce pressure on A&E in time for Winter. These challenges will grow as the ageing population increases and we have a chance to improve these services now and strengthen them for the future by investing and making changes.

If you would like to understand more about this development and share any views you have please contact STOCCG.stockport-together@nhs.net
What is voluntary sector support for discharge?
The ‘voluntary sector support for discharge’ project aims to help people who are most at risk of admission to hospital and who need extra support when they are discharged, such as older people who live alone. It will also aim to help people who feel that their only option is to attend accident and emergency, but could take advantage of having support at home instead.

Why do current services need to change?
NHS England delayed discharge figures for June 2016 indicate that more than 6,000 older people are delayed in hospital beds each month for a variety of reasons. This is usually due to a lack of appropriate services available within the community. For example, there may not be a place available in a local care home, or a person's house may need to be altered to help them manage their recovery.

In Stockport the numbers of delayed transfers of care has increased considerably in 2016. A snapshot was taken on one day in June, which found 63 patients awaiting discharge and a total number of 1,703 bed days had been lost that month (the days between being ‘ready for discharge’ and the actual date of discharge). Whilst some of these may be unavoidable, this project will aim to reduce the numbers back to levels achieved in previous years.

Where is the evidence that this will work?
In 2014, Age UK Stockport and Flag carried out a short pilot (4 months) with the REACH* team to support people after hospital discharge. The service was offered to all people using the REACH service in that period; half of those people took up additional support offered by Age UK Stockport and Flag.

The pilot was evaluated and it was shown that those receiving the additional support from Age UK Stockport and Flag were less likely to need other services or support within 6 weeks after discharge from hospital.

Who will the service be aimed at?
The voluntary sector support for discharge service is aimed at people over 18 years with a specific emphasis on older people, people with disability, carers and people with low level depression or challenging lifestyles. It will be available 8am to 8pm weekdays, 9am to 6pm weekends.

*REACH – Reablement and community at home support service
How will the new service work?

- The Wellbeing at Home service will lead and coordinate the service from the hospital

- A co-ordinator for this service will:
  - oversee a virtual team which will be made up of support workers, a handy person, and voluntary sector key workers who are based out in different areas of Stockport
  - work with pre-operative clinics to support people to plan their discharge prior to admission, to deliver a speedier discharge process
  - be skilled in working with people who have mental health needs
  - build relationships to bridge gaps between health, social care and the voluntary sector
  - build resilience in families and communities to reduce dependency on health and social care services

- Handy help staff will provide practical help to ensure that people’s homes are safe and equipped for return from hospital

- Other help could include food shopping, arranging clean-ups, switching the heating on and fitting a key-safe if needed.

- The service will be available 8am to 8pm weekdays with contact for urgent support available 9am to 6pm at weekends

In addition:

- Key workers from the TPA will work with GPs to identify and help people at risk of hospital admission. This could include visiting people on their return home from hospital, to help them engage in community support and activities, such as befriending services, or involvement in social activities.

What will the benefits be?

- Communities will be more equipped and supported to help their families, friends and neighbours when they are most in need
- Speedier discharge for people who have pre-planned treatments
- Reduced length of stay in hospital
- Help people to stay connected or reconnect with others to improve their psychological wellbeing and resilience
- An additional 260 people per month will receive help when discharged from hospital. This will include 60 people who are identified at pre-operative assessment

If you would like to understand more about this development and share any views you have please contact STOCCG.stockport-together@nhs.net
Chief Operating Officer’s update

Chief Operating Officer’s update to the November 2016 meeting of the Governing Body

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org
### Executive Summary

**What decisions do you require of the Governing Body?**

This report provides an update on a number of issues.

**Please detail the key points of this report**

Provides an update on:

1. Integrated Commissioning/MCP Development
2. Quarter 2 Assurance Meeting
3. Statement of Involvement 2015/16
5. CAMHS Plan

**What are the likely impacts and/or implications?**

**How does this link to the Annual Business Plan?**

Supports delivery and meets statutory requirements.

**What are the potential conflicts of interest?**

**Where has this report been previously discussed?**

Directors

**Clinical Executive Sponsor:** Ranjit Gill

**Presented by:** Gaynor Mullins

**Meeting Date:** 30th November 2016

**Agenda item:** 11
Chief Operating Officer Update

1.0 Purpose
1.1 This is the report of the Chief Operating Officer to the Governing Body for November 2016.

2.0 Integrated Commissioning
2.1 Detailed work has been undertaken to map the existing commissioning functions of the CCG and the Council, and identify which of these are planned to be retained by the commissioner and those that are planned to be included in the MCP contract to be discharged on behalf of the commissioner by the MCP. This has been discussed at a recent development session for the CCG Governing Body, and a meeting to discuss this with the Local Authority is planned. This is a complex piece of work, as we are looking to identify the strategic commissioning functions (such as needs assessment) and the tactical functions (such as individual placements) and looking to integrate those strategic functions across health and social care. Stockport is very much at the forefront of this as we are first to start the process of procurement, so we are also working closely with the national team on this issue.

2.2 As part of the work on developing a new contractual framework for the MCP, work is progressing to co-produce an Outcomes Framework, with a draft due for completion in February 2017. A whole population segmentation approach has been used to ensure outcomes are considered across a range of population groups. These include people who are Healthy, Acutely Ill; have Long-Term Conditions, Frailty or Dementia; or are at the End of Life. Outcomes for the different population groups are being developed by expert reference groups, which have clinical leadership and a broad representation of commissioners, professionals and members of the public. Four workshops have been held to prioritise a set of clinical and social outcomes, and a further four workshops will follow in January to review the person-centred outcomes. The final framework will contain a combination of these, focused initially on the over 65 population. Work is also progressing to consider the data requirements to produce baseline positions which will support monitoring of performance against the outcomes framework. Key themes during the discussion highlighted the importance of health inequalities, integrated care and mental health outcomes. Example outcomes that emerged as priorities include:

- Reducing smoking, alcohol consumption and obesity and increasing physical activity;

- Reducing emergency admissions for chronic ambulatory care sensitive conditions, exacerbations of long-term conditions, and during the last weeks of life;

- Reducing complications relating to diabetes and frailty (e.g. serious falls or delirium)

- Reducing disruption by care and increasing time spent at home, particularly for people who are frail or have dementia.

Personal outcomes that will be discussed in future workshops include:
• Feeling free from depression, fear and anxiety
• Feeling treated with dignity and respect
• Being well informed/people being honest
• Reducing social isolation
• Feeling involved in decisions about my care / feeling listened to

2.3.1 The Provider Board has undertaken an options appraisal of the potential organisational forms for the MCP. They have undertaken a period of stakeholder engagement with a range of organisations to inform this options appraisal and have identified that the development of a new Care Trust is their preferred option. This options appraisal and preferred option will be discussed and ratified at each of the constituent provider organisation's Board meetings. Discussion has been scheduled for November Board meetings with a final decision on the providers preferred option scheduled for the end of November. Once the providers have identified their preferred option they will formally communicate this to the joint commissioners via the procurement process, which will then be part of a detailed evaluation and negotiation process as set out in the Procurement Plan.

3. Quarter Two Assurance Meeting
3.1 Greater Manchester Health & Social Care Partnership (GMHSCCP) have developed their approach to the national CCG assurance process, and the quarter 2 assurance meeting took place on 17th November 2016.

3.2 These meetings are now established as a locality ‘system’ meeting and therefore representatives of the CCG, Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust and Stockport Council met with representatives of the GMHSCCP team.

3.3 The meeting covered a range of performance, quality and reform targets and issues. A number of areas of good practice within the locality were identified such as Cancer survival rates, approach to reform and partnership working and stroke care. However, the key performance challenges of urgent care and finance were focused on. A number of issues for further discussion have been agreed, including mental health and quality. A summary of the meeting once received will be circulated to Governing Body members.

3.4 The approach to CCG assurance will be managed on a risk basis, with bi-annual meetings and additional meetings for those areas with the greatest performance challenges.

4.0 Statement of Involvement 2015/16
4.1 The CCG has a duty to involve and consult local people and stakeholders in the planning and development of services. The clinical leadership of the CCG has been very clear that it wants patient views to be at the heart of everything the CCG does. From the 1 April 2015 to the 31 March 2016 NHS Stockport Clinical Commissioning Group spoke to 2853 people about a range of topics, including:

• Stockport Together plans
4.2 A wide variety of communication methods were used, to reach more people, and different groups within Stockport’s community and give the CCG a better understanding of local views on the health service and priorities for change.

5.0 EPRR Statement of Compliance 2016/17

5.1 Governing Body members will recall that the CCG is required to undertake an annual self-assessment of compliance against the NHS England Core Standards for EPRR. This is then reported to the Local Health Resilience Partnership (LHRP). The CCG has assessed itself as Full Compliance. Where areas require further action, this is detailed in the attached EPRR Work Plan and will be reviewed in line with the organisation’s governance arrangements.

6.0 Improving Children and Young People’s Mental Health in Stockport Local Transformation Plan 2015/2020

6.1 The Governing Body considered a high level overview of the Plan at the meeting in September 2016 following submission in line with the required deadlines. The full plan is now attached for retrospective approval.

7.0 Action requested of the Governing Body

1. To note the update of items 1-4
2. To approve the EPRR Compliance in item 5
3. Retrospectively approve the Improving Children and Young People’s Mental Health in Stockport Local Transformation Plan 2015/2020
Statement of Involvement 2015-2016

1.0 Purpose

1.1 NHS Stockport Clinical Commissioning Group is responsible for making sure that the 290,000 people living in the borough have access to the healthcare services they need.

1.2 We recognise that our decisions, policies, and services have a major impact on the lives and wellbeing of the local people, so we actively seek to engage with all sectors of the community to ensure that everyone has an equal chance to have their say before we make major decisions.

1.3 The purpose of this report is to outline what work the CCG **undertook during 2015-16** to engage local people, involve them in decision making and consult on major changes to local health services.

2.0 Why do we consult with patients, carers and the public?

2.1 The NHS Constitution and the Five Year Forward View, set out a clear message that the NHS should put patients and the public at the heart of everything it does. The NHS must be more responsive to the needs and wishes of the public, all of whom will use its services at some point in their lives. We need to ensure that public, patient and carer voices are at the centre of our healthcare services, from planning to delivery, to how involvement is reported and communicated.

2.2 Participation helps us to understand people’s needs, and to prioritise those people who experience the poorest health outcomes – enabling us to improve access and reduce health inequalities. Participation provides opportunities to see things differently and to be innovative, leading to a better use of our limited resources.

2.3 In 2006 patient involvement was strengthened by the NHS Act. Sections 242 and 244 of the Act place a duty on NHS organisations to involve and consult local people and stakeholders in the planning and development of services. It also included a duty to report on this activity in an annual ‘statement of involvement (section 24A of the NHS Act 2006). The report should cover:

- who we consulted
- what information we gave them
- what questions we asked
- what people told us
- what we did with the information they gave us
- and where more information about the consultation can be found.
2.4 Over the period from 1 April 2015 to 31 March 2016 we spoke to 2,853 local people about the wide range of services we commission and decisions taken on behalf of local people. This report summarises that engagement and how local views have shaped our work.

3.0 Our approach to public engagement

3.1 Our approach to public engagement and consultation is to make sure that we use a wide variety of different mechanisms, methods and approaches to engage with people. We need to understand how we can best involve people, when they need or want to be engaged.

3.2 We have a number of ways of engaging with the public and gathering views including:

- Citizen Space ‘have your say’ website
- CCG Patient Panel meetings
- Stockport Together Citizens Representation Panel meetings
- Public meetings
- Consultation events
- Social media surveys/polls and general comments
- Prevention and screening events
- Focus groups
- Information stalls at supermarkets and events
- Self-care education classes
- Presentations at local groups
- Patient story podcasts
- Healthwatch attendance at governing body and committees

4.0 Key messages of the year

The following table provides examples of a selection of the key messages from the year under four themes:

<table>
<thead>
<tr>
<th>Signposting and service information</th>
<th>IM&amp;T</th>
<th>Access</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>People feel passed from pillar to post</td>
<td>The lack of shared IT systems is causing delays and duplication</td>
<td>There are inconsistencies in the ways that people can access care or advice</td>
<td>There are inconsistent messages across organisations</td>
</tr>
<tr>
<td>People feel lost in a complex system</td>
<td></td>
<td></td>
<td>There is distrust that the plans are truly being developed in partnership with the public</td>
</tr>
<tr>
<td>Frontline staff don’t always seem to be</td>
<td></td>
<td>People admit to attending A&amp;E as they perceive there to be long waits at GP</td>
<td></td>
</tr>
</tbody>
</table>
5.0 **Types of Engagement Undertaken**

5.1 In line with the CCG’s communication principles, a number of different communication and engagement methods - tailored in accordance with the target audience - are used to capture patient insight and ensure that as many people as possible can feed in their views. Where necessary a combination of methods is being used in order to achieve maximum coverage.

5.2 Patient and Public Involvement is the responsibility of the whole organisation, with work undertaken across teams and fed into the Governing Body as intelligence to drive tangible improvements to local services.

5.3 **Lay Membership of committees:**
To ensure that patient views are heard at every level of the organisation, the CCG has appointed lay members to sit on our committees and present a patient perspective to discussions and decisions:

- the Governing Body has 2 lay members recruited from the community: one of whom chairs the meetings and takes responsibility for patient engagement, while the other leads on audit, remuneration and conflict of interest matters.
- the Governing Body has also co-opted a representative of Healthwatch Stockport and the Chair of the Health & Wellbeing Board to attend all meetings and feed in local views.
- the Clinical Policy Committee (prior to its disbandment in January 2016) was attended by the lay chair of the CCG and a Healthwatch representative
- the Quality & Provider Management Committee (which operated as the Quality Committee from January 2016 onwards) includes the Lay Member with a remit for Public Involvement and a Healthwatch member
- the Audit Committee is chaired by the lay member responsible for lay member responsible for audit, remuneration and conflict of interest matters
- the Remuneration Committee is chaired by the lay member responsible for audit, remuneration and conflict of interest matters
5.4 **Patient Stories:**

Patient story podcasts have been used at the beginning of CCG Governing Body meetings since March 2012. The patient or carer describes their experience of healthcare in their own words in a short video. The idea is to gain a snapshot view of what it is like as a patient, what was good, what was bad and what would make their experience of healthcare in Stockport more positive. Below is a list of all the patient stories which have been shown during 2015-2016 and the actions that the Governing Body requested as a result.

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Patient Story Topic</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>Osteopenia – lifestyle change made resulted in no need for medication</td>
<td>CCG to promote benefits of walking. An interview was recorded for Imagine FM.</td>
</tr>
<tr>
<td>June 2015</td>
<td>End of life care – care provided by the End of Life Care team</td>
<td>Importance of integrated care emphasised and end of life care to be used as a good example of where this works well</td>
</tr>
<tr>
<td>July 2015</td>
<td>Collaborative care planning (produced by Royal college of GPs)</td>
<td>Assurances sought on training for care planning. Asked to take forward these principles into the Stockport Together planning.</td>
</tr>
<tr>
<td>September 2015</td>
<td>COPD – importance of support for lifestyle changes</td>
<td>Recognised the importance of behaviour change and how integral this will be to a healthier population and more sustainable system</td>
</tr>
<tr>
<td>November 2015</td>
<td>Breast cancer screening – patient diagnosed at 70 years</td>
<td>Video uploaded in GP practices – importance of taking up screening</td>
</tr>
<tr>
<td>December 2015</td>
<td>Stop before the op campaign videos advising on benefits of giving up smoking before an operation</td>
<td>GPs asked to share link to videos and provided with promotional leaflets and posters</td>
</tr>
<tr>
<td>January 2016</td>
<td>Psychological therapies</td>
<td>Video included on psychological therapies website and importance of encouraging self-referral in newsletter</td>
</tr>
<tr>
<td>March 2016</td>
<td>Clostridium difficile</td>
<td>CCG to take part in next antibiotics awareness national campaign</td>
</tr>
<tr>
<td>March 2016 (2nd meeting)</td>
<td>Cervical cancer screening</td>
<td>Video shared widely with practice nurses and used on national website</td>
</tr>
</tbody>
</table>

Where experiences were negative, they have been shared with the service provider and used as a learning tool for continuous improvement. Some
people give consent for the film to be shown at the Governing Body only, some agree for it to be shared with health and social care staff to help improve services and others agree to the much wider sharing on websites and at conferences and events.

With consent some of the patient stories have been uploaded to Youtube.

5.5 Healthwatch

The CCG have always worked closely with Healthwatch – to get messages out to as wide an audience as possible and to feed in their views into CCG decision making.

The CCG’s Chief Operating Officer holds regular meetings with the Healthwatch chair who sits as a representative on the Governing Body. Where changes are being planned, commissioners attend Healthwatch briefing sessions to get feedback on plans.

Members and officers of Healthwatch are also involved in our committees and workshops. In 2015 the Healthwatch officer provided support and advice during the set up of the Citizens Representation Panel.

5.6 Customer Services Monitoring:

In 2015-2016 the CCG’s Customer Services team handled queries, compliments, comments and complaints for the public on a daily basis. In addition, the CCG’s communications team manage requests for information submitted under the Freedom of information Act. All of these contacts from the public are monitored and analysed so that trends in requests or issues are fed into the Governing Body and the relevant commissioning team to ensure that improvements are made as a result of local contacts. Over 2015-2016, NHS Stockport received:

- 40 Complaints
- 30 MP letters
- 217 Freedom of Information requests

Any tweets or facebook messages about patient care are also reported to our patient experience officer in the Quality and Provider management team.

6.0 Work of the Public Engagement Team

6.1 Functional and operational responsibility for engagement sit with the CCG’s corporate and planning function which leads and supports work across all directorates; providing cohesion and consistency in messages, communications and engagement activities.

6.2 In 2015, the CCG head of communications and engagement took on responsibility as strategic lead for communications and engagement of the Stockport Together programme. Within this team there is a communications
lead that is solely dedicated to Stockport Together with additional support from the CCG community engagement officer.

6.3 A number of public engagement methods are used to ensure that the public voice is heard in decision making:

6.4 **Patient Panel**

The CCG has its own Patient Panel, of individuals from across Stockport’s four localities. The Patient Panel has bi-monthly meetings where CCG representatives present and ask for their views on plans and priorities.

The panel has received presentations and taken part in sessions this year on: CCG priorities, feedback/ideas to help with development of the new website, the targeted prevention alliance etc.

6.5 **Citizens representation panel**

The Citizens Representation Panel was set up in October 2015. It exists to ensure that local views are at the heart of decision making in Stockport Together. Members of the panel play a vital role in acting as an initial sounding board to discuss issues and share views to be considered by the Stockport Together teams which contribute to the overall decision making process.

The panel membership is made up of:
- 2 GP practice patient reference group members
- 2 CCG patient panel members
- 2 Foundation Trust governors
- 2 Pennine care governors
- 2 councillors
- 2 voluntary sector members
- 2 members of Healthwatch
- 2 carers

The panel meets bi-monthly and comment on the plans for Stockport Together. Their comments regarding the proposed new model of care (January 2016) included:

“*People without web based access or skills will need help accessing online care or records.*”

“*Mental health will need to be strengthened in the neighbourhood plans.*”

“*Some people face more barriers than others when faced with the need to change lifestyles or behaviour.*”
“More work should be done to train others to cascade health advice.”

“I’m concerned that attempts to reduce hospital referrals will reduce access to specialist advice or care.”

Through their input the panel have further strengthened the case for the appointment of a mental health consultant to the neighbourhoods. There has also been promotion of the consultant connect work to assure patients of the access to specialist advice from hospital consultants.

6.6 Public Engagement:
Public engagement work topics are dependent on the priorities and need of the organisation. In 2014-2015 topics covered included:

- Stockport Together plans
- Care homes
- Self-care
- Intermediate tier
- Stroke
- Winter health
- Dementia care
- Hypertension

6.7 Support to GP Practices’ Patient Reference Groups:
As a membership organisation, the CCG has also supported its Member Practices by enabling them to use the CCGs online survey site and provided speakers for meetings as required.

6.8 Evaluation of the methods
As part of the agreed audit plan for 2015/16 a review of the statement of involvement was conducted.

One of the recommendations was to put in place a formal process to evaluate and monitor the effectiveness of engagement methods. The following steps have been taken to achieve this:

- The team have been trained on following the GCS evaluation framework and using the associated templates


- Any staff that request support with engagement activity must complete a template form that ensures that objectives are clear from the outset
and to ensure that the team can be clear about the impacts of their activity.

- In 2015-16 surveys have been introduced to ask people how they have found the methods we have been using.
- The Citizen Space survey company has also conducted some work on behalf of its users about how to improve surveys and consultations in the future. The results showed that respondents want to:
  - Know upfront how long a consultation will take to complete
  - Hear why their view is important.
  - Know what you will do with their responses.
  - Have the results fed back

These will be taken on board for future surveys.

### 7.0 Impact of Involvement

#### 7.1 All feedback from engagement exercises is reported to the CCG’s Governing Body as a key piece of evidence for consideration in decisions and showing how the views of individual patients are translated into commissioning decisions and how the voice of each practice population is sought and acted upon. One of the key tools for feeding back to local people is the CCG’s new engagement website: [https://stockport-haveyoursay.citizenspace.com/](https://stockport-haveyoursay.citizenspace.com/)

#### 7.2 For those without access to the internet, write-ups of events are also sent out to local groups after they have met with the NHS. Sign-up sheets are also taken at all public events so people who wish to receive a write-up of the event can have this sent to them in their preferred format. Articles summarising formal consultations are included in the local Council publication that is delivered to all households in Stockport. In addition, feedback reports are sent to the Healthwatch for inclusion in their regular newsletter and targeted feedback articles are also included in a wide range of local newsletters.

#### 7.3 A full breakdown of engagement events, surveys and activities can be found in Appendix one, which outlines:
- what we did
- when
- how many local people were consulted
- what people said
- what we did as a result of local feedback
- and where to go to get a full write-up of the consultation and results.

### 9.0 Plans for Next Year

The public engagement plans for the next financial year (2016-2017), will focus on:
• The Stockport Together public engagement and consultation – more focus this year on the individual smaller business cases and any required formal consultation
• Ensuring that co-production is embedded in planning processes
• Developing a more coordinated approach across all the partners to communications and engagement
• Support to the neighbourhoods on developing patient and public involvement opportunities
• Digital empowerment including patient online
• Over the counter medicines – support to the campaign

10.0 Where to get more information

If you would like more information about the work we do, or if you would like to get involved in future engagement and consultation work, please visit our consultation website at:

https://stockport-haveyoursay.citizenspace.com/
<table>
<thead>
<tr>
<th>Title</th>
<th>Responses</th>
<th>Link to Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Commissioning</td>
<td>95</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/commissioning/preventative-commissioning">https://stockport-haveyoursay.citizenspace.com/commissioning/preventative-commissioning</a></td>
</tr>
<tr>
<td>Dementia Care In Stockport - Heald Green Patient Group</td>
<td>28</td>
<td>Report under review</td>
</tr>
<tr>
<td>Sign up to Safety</td>
<td>3</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/2d167e20">https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/2d167e20</a></td>
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<tr>
<td>CCG Website Survey</td>
<td>30</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/communications-team/ccg-website-survey">https://stockport-haveyoursay.citizenspace.com/communications-team/ccg-website-survey</a></td>
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<tr>
<td>Safeguarding Adults in Stockport</td>
<td>1</td>
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<tr>
<td>Staff Safeguarding Survey</td>
<td>223</td>
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<tr>
<td>BP Data Collection Form</td>
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</tr>
<tr>
<td>Service/Workshop</td>
<td>Code</td>
<td>Link</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------</td>
<td>----------------------------------------------------------------------</td>
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<tr>
<td>Dermatology Service</td>
<td>343</td>
<td>Report under review</td>
</tr>
<tr>
<td>Care Home Survey - GP Allocation</td>
<td>12</td>
<td>Report under review</td>
</tr>
<tr>
<td>GP Survey - Care Home Allocation</td>
<td>7</td>
<td>Report under review</td>
</tr>
<tr>
<td>Experience-led commissioning workshop feedback</td>
<td>46</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/communications-team/c4dfdc9a">https://stockport-haveyoursay.citizenspace.com/communications-team/c4dfdc9a</a></td>
</tr>
<tr>
<td>Experience-led commissioning workshop feedback</td>
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<td>Experience-led commissioning workshop feedback</td>
<td>38</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/communications-team/c404e16b">https://stockport-haveyoursay.citizenspace.com/communications-team/c404e16b</a></td>
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<td>Experience-led commissioning workshop feedback</td>
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<td><a href="https://stockport-haveyoursay.citizenspace.com/communications-team/3a5050c3">https://stockport-haveyoursay.citizenspace.com/communications-team/3a5050c3</a></td>
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<tr>
<td>Title</td>
<td>Number</td>
<td>URL</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
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<tr>
<td>Intermediate Tier Sessions</td>
<td>27</td>
<td>open till October 16</td>
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<td>BP Data Collection Form (V2)</td>
<td>214</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/stockport-council/7eb440eb">https://stockport-haveyoursay.citizenspace.com/stockport-council/7eb440eb</a></td>
</tr>
<tr>
<td>Event Description</td>
<td>Response Count</td>
<td>URL</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Stockport Together Consensus Event</td>
<td>100</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/stockport-together/consensus-event/">https://stockport-haveyoursay.citizenspace.com/stockport-together/consensus-event/</a></td>
</tr>
<tr>
<td>Stockport Together Presentation to Stockport Homes</td>
<td>10</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/stockport-together/ststockporthomes">https://stockport-haveyoursay.citizenspace.com/stockport-together/ststockporthomes</a></td>
</tr>
<tr>
<td>Survey on GPs obtaining Consultant advice and guidance</td>
<td>54</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/general-practice-development/e7256a36">https://stockport-haveyoursay.citizenspace.com/general-practice-development/e7256a36</a></td>
</tr>
<tr>
<td>Care Home / Care Home with Nurse Training</td>
<td>2</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/safeguarding-team/457244c4">https://stockport-haveyoursay.citizenspace.com/safeguarding-team/457244c4</a></td>
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<tr>
<td>Stockport Together Presentation to Care Home Forum</td>
<td>18</td>
<td><a href="https://stockport-haveyoursay.citizenspace.com/communications-team/stcarehomeforum">https://stockport-haveyoursay.citizenspace.com/communications-team/stcarehomeforum</a></td>
</tr>
<tr>
<td>Care Home Technology Review</td>
<td>40</td>
<td>Report under review</td>
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<td>BP Data Collection Form (V3)</td>
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<td><a href="https://stockport-haveyoursay.citizenspace.com/stockport-council/6add642e/">https://stockport-haveyoursay.citizenspace.com/stockport-council/6add642e/</a></td>
</tr>
<tr>
<td>Specialist Services Pathway Redesign only 1 person completed this survey</td>
<td>1</td>
<td>Shirley Hamlett</td>
</tr>
<tr>
<td>Stockport Together - GP Consultant Event</td>
<td>70</td>
<td>Not on CS</td>
</tr>
</tbody>
</table>

2809
Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016-17

STATEMENT OF COMPLIANCE

NHS Stockport CCG has undertaken a self-assessment against the NHS England Core Standards for EPRR (v4.0).

After self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2016-17 standards: **Full**

<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Evaluation and Testing Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>Arrangements are in place that appropriately address <strong>all</strong> the Core Standards that the organisation is expected to achieve. The Board has agreed with this position statement.</td>
</tr>
<tr>
<td>Substantial</td>
<td>Arrangements are in place, however, they do not appropriately address <strong>one to five</strong> of the Core Standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.</td>
</tr>
<tr>
<td>Partial</td>
<td>Arrangements are in place, however, they do not appropriately address <strong>six to ten</strong> of the Core Standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.</td>
</tr>
<tr>
<td>Non-compliant*</td>
<td>Arrangements are in place, however, they do not appropriately address <strong>eleven or more</strong> of the Core Standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.</td>
</tr>
</tbody>
</table>

*Should an organisation be non-compliant the LHRP will regularly monitor progress throughout the year until it has attained an agreed level of compliance.

The results of the self-assessment were as follows:

<table>
<thead>
<tr>
<th>Number of applicable standards</th>
<th>Standards rated as Red¹</th>
<th>Standards rated as Amber²</th>
<th>Standards rated as Green³</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>0</td>
<td>0</td>
<td>30</td>
</tr>
</tbody>
</table>

¹Not compliant with Core Standard and not in the EPRR Work Plan within the next 12 months
²Not compliant but evidence of progress and in the EPRR Work Plan for the next 12 months
³Fully compliant with Core Standard

**Includes HAZMAT/CBRN standards applicable to providers: Standards: Acutes 14 / Specialist, Community, Mental health 7

Where areas require further action, this is detailed in the attached EPRR Work Plan and will be reviewed in line with the organisation’s governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been confirmed to the organisation’s board / governing body.

____________________________
Signed by the organisation’s Accountable Emergency Officer

30/11/2016

Date of board / governing body meeting Date signed
Improving Children & Young People’s Mental Health in Stockport

Local Transformation Plan

2015-2020
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<td>Chapter 10 Accountability and Transparency</td>
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<tr>
<td>References and notes</td>
<td>65</td>
</tr>
<tr>
<td>Section A Our Financial Plan</td>
<td>66</td>
</tr>
</tbody>
</table>
Chapter 1

Summary and Introduction

1.1 The importance of emotional and mental wellbeing in Childhood

Wellbeing
A state in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community.

World Health Organisation 2011(1)

1.1.1 There has been much research into the rates of poor wellbeing and mental ill health amongst the children and young people’s (C&YP) population. The research shows that one in five children have poor emotional wellbeing and one in ten have a diagnosable mental health problem - conduct disorder, anxiety, depression and hyperkinetic disorders being the most common categories. Furthermore, over half of mental health problems in adult life (excluding dementia) start before the age of 14 years and 75% by the age of 18 years. (2)

1.1.2 Failure to prevent and treat C&YP’s mental health problems comes at a high price; not just in terms of the personal cost to the individual affected and their families, but also in terms of the high cost to society. There is a strong link between mental ill health in childhood and young adult hood and physical ill health, reduced educational attainment, poorer employment prospects, drug and alcohol misuse, teenage pregnancy and offending behaviour. Despite the very compelling case for addressing C&YP’s emotional and mental wellbeing research has shown that between 60-70% of C&YP who experience clinically significant difficulties have not had appropriate interventions.(3)

1.2 The purpose of this Transformation Plan

1.2.1 The purpose of this Plan is to describe how, over the next 5 years, we intend to improve the availability, access, appropriateness and effectiveness of mental health services for C&YP in Stockport. The Plan has been produced by the Stockport Children and Young People’s Mental Health Transformation Project Team; a multi-agency partnership led by Stockport Clinical Commissioning Group (CCG) in collaboration with Stockport Metropolitan Borough
Council (SMBC) which includes representatives from health, social care and education services, voluntary sector organisations and parents.

1.2.2 The Project Team have consulted with wider services, public representatives, parents and carers and have listened to the views of C&YP themselves. In doing so the aim has been to ensure that our priorities, the principal changes we are planning to make, and our commissioning and investment decisions are not only based on good evidence and the needs of the local population (Chapter 2), but are informed by what local people believe will secure and sustain improvements in C&YP’s mental health (Chapter 3).

1.3 A Local Consensus for Transformation

1.3.1 In producing this Plan the Project Team have been guided by clear local recommendations about how mental health care for C&YP in Stockport can be improved. In March 2014 the Stockport Health and Wellbeing Scrutiny Committee of SMBC published their report ‘Mind the Gap: mental wellbeing and mental health services for children and young people in Stockport’ following a comprehensive review of local provision. The Scrutiny Committee made the following specific recommendations to the CCG and the Council:

- to jointly commission future Tier 2 and Tier 3 Child and Adolescent Mental Health Services (CAMHS) through an integrated service delivery model (p. 62)
- to develop assessment and care pathways for C&YP with neurological conditions: Autistic Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD) (p. 39)
- to improve access to mental health support for C&YP with learning disabilities (p. 43)
- to ensure all looked after C&YP and care leavers have access to mental health support (p. 42-5)
- to continue to develop mental health services for C&YP aged 0-25 to ensure young people do not fall between the gap between CAMHS and adult mental health services (AMHS). (p. 44-5)
- to continue to develop tools for schools and colleges to support and improve wellbeing and to deliver a comprehensive and consistent programme of Personal, Social and Health Education (PHSE) (p. 28-9)
- to encourage and support providers of early years care to use appropriate evidenced based tools and interventions to support child and parental wellbeing and emotional resilience (p. 30)
- to develop the Joint Strategic Needs Assessment for C&YP’s mental health and wellbeing. (p. 12-13)

1.3.2 The Stockport Health and Wellbeing Scrutiny Committee’s recommendations are addressed in the relevant sections of this Plan (refer to page numbers in the brackets following each
recommendation above). Most of the recommendations have been fully or partially implemented through the work of the Project Team and where there is still work to do this is reflected in our plans for the future.

1.4 **The Stockport Family Approach**

1.4.1 ‘Stockport Family’ is an ambitious transformation programme across children and family services in Stockport which is currently in progress. The purpose is to establish a single, fully integrated Stockport Family Service that provides the highest support to Stockport’s vulnerable children and families which best utilises our total resources taking into account budget reductions in Council funded services. Integrated Children’s Services (ICS) teams have been established in our four locality areas which are coterminous with the CCG localities in which General Practices are grouped (Stepping Hill & Victoria, Heaton & Tame Valley, Cheadle & Bramhall and Marple & Werneth). These teams are now building relationships with the GPs, schools and other agencies in their localities. Each Stockport Family team includes social workers, midwives, health visitors, school nurses, and staff from children’s centres as well as the new role of Stockport Family Workers.

1.4.2 Restorative approaches are fundamental to the Stockport Family model, whereby the ICS locality team works in an integrated way with families offering coaching and development interventions to enable individuals and families to build on their strengths and resources and gain appropriate support from universal services and their community.

1.4.3 This Transformation Plan for C&YP’s mental health has been developed to align with and to facilitate the Stockport Family model. An integrated CAMHS service will offer advice, consultation and training to Stockport Family teams; they will establish named links with the teams and can be called in to provide specialist interventions at the right time to address need as it arises. All schools within the localities will have a named Stockport Family Worker and a named Social Worker, and when this plan is implemented, they will also have a named Mental Health Worker.

1.5 **A National Consensus for Transformation**

1.5.1 In March 2015 the Department of Health and NHS England published *Future in Mind*: *promoting, protecting and improving children and young people’s mental health and wellbeing*. This report of the Government’s C&YP Mental Health Task Force sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for C&YP with mental health needs.

1.5.2 The Government’s aspirations are that by 2020 we will:
improved public awareness and understanding and less stigma and discrimination around mental health issues for C&YP

C&YP having timely access to clinically effective mental health support when they need it

a step change in how care is delivered away from a system defined in terms of the services organisations provide (the ‘tiered’ model) to one built around the needs of C&YP and families

increase in the use of evidenced based treatments with services vigorously focused on outcomes

making mental health support more visible and accessible for C&YP

improved care for C&YP in crisis so they are treated in the right place at the right time and as close to home as possible

improving access for parents to evidenced based programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour

better care for the most vulnerable C&YP making it easier for them to access the support they need

improved transparency and accountability across the whole system to drive further improvements in outcomes

professionals who work with C&YP are trained in child development and mental health and understand what can be done to provide help and support for those who need it.

1.6 New Flexible Needs Based Model of Care

1.6.1 In Chapter 4 we describe how CAMHS in Stockport are currently commissioned and delivered along the lines of the traditional tiered model of provision. Although the Scrutiny Committee found examples of good joint working between services, they also found that organisational divisions created barriers and fragmented care with C&YP falling in the gaps and experiencing poor and unnecessary transitions between different services. This is a local reflection of the national picture of CAMHS described in ‘Future in Mind’.

1.6.2 Our intention is to move away from the tiered model, in which C&YP have to fit the services, to a more flexible model (such as THRIVE(6)) where services fit the changing needs of C&YP and integrate and collaborate to create seamless pathways of care ensuring C&YP receive the right care, at the right time and with the right person. Stockport has been selected as one of ten national accelerator sites for the i-THRIVE programme. How we intend to forge new accessible care pathways by redesigning services and through the strategic use of new resources is described in Chapter 6.
1.6.3 Crucial to the success of this transformation is the development of the workforce not only within CAMHS so they can provide specialist assessments, evidence-based interventions, and risk management as well as consultation and training to other C&YP services, but also within the wider children’s workforce to enable them to promote good emotional and mental wellbeing and provide early help. Our plans for developing the workforce are described in Chapter 9.

1.7 Structure of this Local Transformation Plan

1.7.1 We have structured this Plan around the main themes of ‘Future in Mind’ and within these themes we have stated the over-all aim, summarised the recommendations, described what we are already doing and what we are planning to do. We have also brought together the outcomes we wish to see in relation to each of the themes and identified some key performance indicators (KPI’s) by which we will monitor if the changes have been successful.

1.7.2 Many of our plans are cost neutral; requiring us to find a different way of working to deliver better care, and some proposals need new investment. We have taken care to map our existing CAMHS resources (investment, workforce, and activity). Much of what we plan to achieve will require us to re-prioritise and re-design within our baseline resources which are described in Section B. Stockport will also receive significant new investment for C&YP mental health to support our Local Transformation Plan and our spending proposals for new funding are detailed in Section A.

1.8 Making Change Happen

1.8.1 This Local Transformation Plan is not set in stone; it is a five year programme of change and as such it is a ‘living document’ and will be subject to regular review by the Project Team to ensure the planned changes are being implemented and achieve the desired outcomes. The aims of this first plan are to set out our collective vision and to describe our first steps, rather than present fine details about the next 5 years. Progress will be monitored by the CCG and our Health and Wellbeing partners (see Chapter 10). The initiatives and service developments proposed in this Plan have been co-produced with key stakeholders and there is a strong element of ‘designing by doing’. If initiatives are not delivering the results we expect our plans for new investment in C&YP mental health services will be revised accordingly.

1.8.2 Finally, Stockport Children and Young People’s Mental Health Transformation Project Team welcomes comments from all interested Parties on existing services and ways of improving provision. You can have your say by completing the following on-line survey at:

http://www.surveymonkey.com/r/FamiliesStockport2

or by emailing your comments about this Plan to:

stockportccg.communications@nhs.net
Chapter 2

Local Needs Assessment

2.1 The Aim

“To use the data we have on the wellbeing of Stockport’s youth population and the data we have from CAMHS and all related mental health services to maximise our ability to meet the mental health needs of Stockport’s children and young people.”

Stockport C&YP’s Mental Health Transformation Project Team

2.1.1 A key theme in ‘Future in Mind’ is the need to make better use of information and data to improve provision for C&YP’s mental health; to ensure outcomes are achieved and enhance value for money. An effective local transformation plan can only be built alongside an information system that provides data that is comparable across all service elements, such as the CAMHS national minimum dataset. This will enable continual improvement to be driven by understanding how individuals benefit from different interventions and what are the optimum pathways through the system overall in terms of achieving equitable access, minimal waiting times and priority outcomes for young people.

2.2 Key Recommendations

- Develop a comprehensive understanding of the local picture in terms of mental health need among C&YP and their access to and use of services including comparisons relating to inequalities.
- Understand fully the differences between predicted and actual patterns of mental health need in the local population.
- Utilise the evolving contract-monitoring anonymised dataset and national CAMHS minimum dataset to map more effectively the young people seen by CAMHS, identify the most prevalent diagnostic groups in Stockport and measure the impact of treatment received.

2.3 Local Needs Assessment

What we know now

2.3.1 CAMHS Referrals:
Referrals to Stockport CAMHS have been increasing rapidly over the last five years. From 1,334 referrals in 2010/11, to 1,645 in 2012/13 up to 2,348 during 2014/15; the number of young people being referred into the core / Tier 3 CAMHS service continues to rise. Referrals to Stockport’s Tier 2 services are also increasing (see Figure 1).

2.3.2 While C&YP from all areas of Stockport are referred to CAMHS, there is a link with deprivation that matches national data on levels of mental health disorders being higher amongst more deprived populations (see Figure 2).

2.3.3 In 2014/15, 52% of the C&YP referred to CAMHS were male, 48% female. This is similar to national data on access to CAMHS services: whilst emotional disorders are more common in girls than boys, conduct disorders – which are the most commonly occurring disorders – are more frequently diagnosed in boys than girls.

Figure 1: Referrals into T3 CAMHS 2010/11 to 2014/15

Figure 2: CAMHS Referrals by Ward
2.3.4 Predicted Need in Stockport:

Predicted levels of need are based on the last comprehensive research carried out in the UK on children’s mental health[7] Based on this 2004 ONS research, we would expect to see around 4,000 children aged 5 to 16 in Stockport living with a diagnosable mental health disorder: approximately 1,500 5 to 10 year olds and 2,500 11-16 year olds. However, it is likely, given the age of this research and the increased demand faced by CAMHS services nationally, that these prevalence rates are now an under-estimation and the true rate of disorders will be higher.

2.3.5 Conduct disorders are the most commonly occurring disorder, followed by emotional disorders, hyperactivity and other, less common disorders. Tables showing the estimated prevalence of different mental health conditions for Stockport are presented below (Figures 3 and 4).

Figure 3: Estimated need for services at each tier for children 0-17 years

<table>
<thead>
<tr>
<th>Tier</th>
<th>National Prevalence</th>
<th>Estimated Stockport Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>15%</td>
<td>9093</td>
</tr>
<tr>
<td>Tier 2</td>
<td>7.5%</td>
<td>4547</td>
</tr>
<tr>
<td>Tier 3</td>
<td>2.5%</td>
<td>1516</td>
</tr>
<tr>
<td>Tier 4</td>
<td>0.5%</td>
<td>303</td>
</tr>
<tr>
<td>Tiers 2-4 combined</td>
<td>10.5%</td>
<td>6365</td>
</tr>
</tbody>
</table>

Source: Z Kurtz, Mental Health Foundation / ONS 2012

Figure 4: Estimated Prevalence of Mental Health Conditions, National & Stockport, Children 5-16 years
<table>
<thead>
<tr>
<th>Condition</th>
<th>National Prevalence</th>
<th>Stockport Estimated Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Conduct Disorders</td>
<td>7.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Emotional Disorders</td>
<td>3.2%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>2.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>1.9%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Any disorder</td>
<td>11.5%</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Source: 2004 Office for National Statistics

2.3.6 Is Stockport CAMHS meeting this need?
In 2012/13, Stockport’s Tier 3 CAMHS received 1,588 referrals for 5-15 year olds. By 2014/15 this had increased to 2,384 – a significant increase, although this still represents only 50% of the child population predicted to have a mental health disorder – a prediction that is expected to be an under-estimation.

2.3.7 Not all young people with a diagnosable disorder will require treatment from CAMHS – and data on referrals necessarily excludes data on those already receiving treatment. However, the information on referrals suggests that a large proportion of Stockport children and young people with mental health disorders are not accessing support for their conditions.

2.3.8 There are two other key areas where the data is currently insufficient for us to understand how well provision is meeting need. These are in relation to the specific needs of Looked After Children (LAC) and in relation to Autistic Spectrum Disorder (ASD).

2.3.9 National data shows a higher level of mental health need among LAC. In Stockport at any one time it is likely that 250 Stockport young people are being looked after and that 350 young people from out of area are placed in Stockport. From this we estimate that 113 Stockport young people and 158 out of area young people would need a mental health service. However, during 2014-2015 just 36 LAC were recorded as seen by CAMHS, but we are not certain that all activity for this group across all services has been captured.

2.3.10 The best estimates indicate that there are 597 young people in Stockport with ASD. However, as shown in Figure 5, below, only a single child is recorded with this as a presenting problem on referral into CAMHS.
2.3.11 **Presenting Problems:**

While Figure 5, below, gives some insight into the most common presenting problems, this information is not always completed or accurately coded and the ‘presenting problem’ is often not the same as the condition identified on assessment. In order to show how effectively CAMHS is meeting the predicted needs of Stockport’s population, we would need to look at data on diagnosis in addition to referral data.

2.3.12 For example, in the data shown, whilst we would expect conduct disorders to make up the majority of referrals to CAMHS, as the most commonly occurring mental disorder, only 10 young people were referred to the service with this as their presenting problem. Similarly, given the burden that ASD diagnoses make on the CAMHS service, this is not accurately represented by the one young person referred for childhood autism. Finally, referral data does not reflect the proportion of the workload within CAMHS that is focused on ADHD. Only 7 children with ADHD were referred to CAMHS in 2014/2015, but 189 are on the case load (and a further 276 are in paediatrics) accounting for between 30-60% of a psychiatrist’s case load depending on their specialism.

Figure 5: Presenting Problem of 2014/15 CAMHS Referrals

2.4 **How we plan to improve our data and information**
2.4.1 We will develop our understanding of the local picture in terms of mental health need among young people and their access to and use of services. Commissioners and providers in the health service and local authority will work jointly to develop a more comprehensive system for capturing essential data.

2.4.2 This will be achieved through the use of a local contract-monitoring anonymised dataset. Development of this is currently in the early stages and will be refined over the coming months, partly in the light of the national CAMHS Minimum Dataset.

2.4.3 This more comprehensive data will enable us to understand more fully the differences between predicted and actual patterns of mental health need in the local population.

2.4.4 The new dataset will also be used to map the young people seen by CAMHS, identify the most prevalent diagnostic groups in Stockport and measure the impact of treatment received. In particular it will enable better understanding of the flow of young people into, through and out of services. Patterns of access, waiting times and achievement of outcomes will all be more effectively monitored, enabling continual improvement driven by accurate data.

2.4.5 The new system will include reporting of data disaggregated by geographical area allowing better understanding of the impact of inequalities on uptake and outcomes for C&YP’s mental health in Stockport.

2.5 Outcomes we expect to achieve?

- A locally agreed contract-monitoring dataset that is compatible with the national CAMHS Minimum Dataset available from all service providers for commissioners and Public Health analysts
- A clear understanding of the mental health needs of C&YP in Stockport and how well services meet these needs, including data on inequalities
- Regular (annual) review of the data to improve service provision in order to enhance access, reduce waiting times and maximise priority outcomes for C&YP in Stockport

2.6 Key Performance Indicators

- Ability to track data on access to services, waiting times and priority outcomes across all providers and for different groups of C&YP
- Locally agreed contract-monitoring dataset in use by all Stockport service providers, commissioners and Public Health analysts
- National CAMHS Minimum Dataset incorporated into locally agreed contract-monitoring dataset
- Annual data reviews are completed and are clearly informing service improvement plans
Chapter 3

The Voice of the Family

3.1 Aim

“Our aim is to develop Stockport’s Children and Young Peoples Mental Health and Well-being pathway in partnership with children, young people and their parents and carers. Stockport families will be able to take an active role in maintaining their own mental well-being and find the best help, care and support easily when it’s needed“

Stockport Children and Young People’s Mental Health Transformation Project Team

3.1.1 Stockport Children and Young People’s Mental Health Transformation Project Team hold the view that C&YP and their families are the experts in their own needs. We, along with their families want the best for Stockport C&YP and share high hopes and aspirations for them and their futures. These hope and plans include C&YP working in partnership with us to lead how our local mental health and well-being services develop. This partnership and collaboration will allow the voice of the family to truly transform our services and ensure that C&YP and families get access to the help that best meets their needs at what can often be a very frightening and worrying time for them. Future in Mind was developed in partnership with children, young people and families and sets out a culture of listening to the voice of C&YP and families.

3.2 Key Recommendations

- C&YP will have the opportunity to set their own treatment goals
- C&YP and families should have the opportunities to shape the services they receive
- Services will listen to experiences of care and respond flexibly to how C&YP and families would like the services to work for them
- C&YP and families will have the opportunity to feedback and make suggestions about services and services we will tell them what has happened as a result of the feedback (i.e. you said we did)

3.3 What we are doing to hear the voices of Stockport families

3.3.1 Our specialist CAMHS have a participation strategy and dedicated small participation support resource. This resource leads and co-ordinates engagement with C&YP and families, ensuring participation is embedded within CAMHS.
3.3.2 A **Young Person's Participation Group** has been established for some time and acts as a resource to drive improvements in quality for children and families using our CAMHS. For example the group have produced a virtual tour of CAMHS, co-produced information leaflets and website information for other young people.

3.3.3 In excess of 20 young people from Stockport have been trained in recruitment techniques and all CAMHS recruitment involves a young person's panel.

3.3.4 Partnership working with children, young people and their families is fundamental to the Improving Access to Psychological Therapies Programme (C&YP IAPT). Stockport has been engaged in the programme since its inception and has developed routine outcome monitoring during and after treatment that ensures C&YP's and families' perceptions of the service and their progress are routinely heard and responded to.

3.3.5 CAMHS CQUIN's (quality improvement programmes) in recent years have brought increasing focus on hearing the voice of Stockport families. In 2012 there was a 360 degree survey of CAMHS which collected valuable views from our families. The current CQUIN for CAMHS is focused on improving access and partnership working and has supported more recent comprehensive engagement with C&YP and families.

3.3.6 The Stockport Children and Young People’s Mental Health Transformation Project Team has representatives from a vibrant parents and carers group (Stockport PIPS).

3.3.7 Stockport PIPS and Senior CAMHS Leaders regularly meet to listen to views collected via the groups meetings and social networking forums

3.4 **What we know now**

3.4.1 Over 150 children, young people and parents across Stockport recently participated in a consultation around mental health and emotional wellbeing.

3.4.2 The majority of participants were satisfied or very satisfied with the services that they have already accessed across the borough whether NHS, Local Authority or third sector. Families particularly highlighted the caring, supportive and understanding nature of services and staff.

3.4.3 When considering access to help in the future, 75% of young people and families would still opt for a one-to-one appointment with a health professional. However, 56% also stated that they would like access to self-help resources and information online which is an area of planned expansion across the borough. Support groups were also a popular option particularly for parents and carers.
3.4.4 Traditional methods of accessing support still ranked highly with 59% stating a preference for GP referral and 51% for referral via school staff, but the most popular option was self-referral, or the ability for a parent to make a referral directly on behalf of their child, with 65% of respondents highlighting this preference.

3.4.5 Home, school and GP clinic were the most commonly chosen locations for accessing support and weekdays remain the most popular time. There was a large proportion (48%) stating that 24 hour access to support would be useful although comments indicate that families would only expect this to be a crisis service.

3.4.6 In chapter 6, the plan for a single point of access (SPA) into services is discussed. 57% of young people and families showed a preference for this SPA to include a wide range of agencies that work with families rather than just those agencies with a mental health and wellbeing focus. When combined with participants who stated they had no preference, it accounts for 75% of responses which is a clear indication of opinion across the borough. There were some concerns which would need mitigation including confidentiality of a multi-agency approach, ensuring referrals weren’t ‘lost’ in the system and ensuring a new system didn’t increase waiting times for families.

3.4.7 The consultation also proposed a variety of ways that CAMHS could offer information, advice and support such as providing a named link to schools and GP practices and delivering training to mental health leads within those organisations. Over 90% of respondents agreed or strongly agreed that these were the correct routes to be taking.

3.4.8 Consistent service experience feedback from families that use our specialist CAMHS is good, however challenges remain regarding access to service, including being unsure of other earlier sources of support and feeling they have to tell their stories to many professionals.

3.4.9 The single most important factor for families is the speed at which they can access support when they feel they need it.

3.4.10 Families want services that are flexible in location of delivery and do not always appear “clinical”.

3.5 Plans for the future
3.5.1 We will grow the dedicated participation resource to allow increased engagement of parents and carers.

3.5.2 We plan to promote information programmes for parents and cares e.g. MindEd.
3.5.3 We will establish open and accessible on-going communication with Stockport families via our websites and social media networks.

3.5.4 We will develop systems to include C&YP and families feedback in all CAMHS workers personal development and review processes.

3.5.5 To develop a consistent approach to the routine use of Outcomes Based Goals (OBGs) and Shared Decision Making (SDM) tools across integrated Tier 2/3 CAMHS

3.6 Outcomes we expect to achieve

- C&YP set their own treatment goals which are meaningful to them
- Decisions about treatment are made in partnership with C&YP and families (Shared Decision Making)
- Services are responsive to the views of C&YP and families

3.7 Key Performance Indicators

- Annual increase in the % of C&YP and families stating that they are satisfied or very satisfied with the services they are receiving
- Annual increase in the % of CYP achieving their OBGs
Chapter 4

Where we are now

4.1 Our current position

Whilst there are many examples of good practice there are also significant challenges around capacity and access to specialist and targeted CAMHS. Information suggests that a large proportion of Stockport C&YP with mental health disorders are not accessing support, that the needs of some C&YP are escalating before they receive a service and that opportunities for earlier intervention are being missed. The fragmented commissioning arrangements for targeted Tier 2 services also results in significant access issues for some small groups of young people.

4.1.1 In this Chapter we describe where we are in 2015, with regard to the current provision of mental health services for C&YP in Stockport. The workforce and the investment that goes into targeted and specialist CAMHS is outlined in Section B. This is very much an overview as each subsequent Chapter in this Plan includes a more detailed section on ‘what we are doing now’ as regards each of the key themes of ‘Future in Mind’ and how we intend to improve the situation.

4.2 Traditional Tiered Model of Provision
4.2.1 Stockport CAMHS are currently commissioned and structured around the traditional tiered model of provision as illustrated in the diagram above. **Tier 1** consists of universal services such as GPs, health visitors, school nurses, early-years staff, school teaching and pastoral staff in schools providing support around emotional health and well-being promotion and interventions to support C&YP with mild difficulties in these areas.

4.2.2 There are a number of **Tier 2** services that provide targeted support for C&YP with more mild to moderate difficulties. These services described below are largely delivered within an education or community setting and are commissioned by SMBC and schools.

4.2.3 Those C&YP with high risk behaviours and moderate to high level mental health difficulties receive input from NHS **Tier 3** CAMHS, based at Stepping Hill Hospital, and managed by Pennine Care NHS Foundation Trust. **Tier 3** is largely delivered through traditional hospital outpatient appointments and commissioned by Stockport CCG, with some elements being co-commissioned with the Council. This service also manages a single point of access (SPA) into Tier 3 and some Tier 2 services (KITE, Jigsaw Teams, YOS) and provides supervision to the practitioners in these services.

4.3 **Stockport CAMHS Tier 2 services**

**The Kite team**

4.3.1 KITE is a small team of mental health practitioners (MHPs) with extensive social work experience, funded by SMBC, integrated into the wider CAMHS pathway and managed by Pennine Care. Their primary work is with C&YP who present with attachment difficulties and emotional difficulties due to loss or separation or difficulties as a result of neglect or abuse. Their remit is to work with C&YP aged 0-18 years who are looked after children (LAC) under the care of SMBC, and vulnerable children known to social care regarded as children in need (CIN).

**Primary Jigsaw**

4.3.2 Primary Jigsaw is a small mental health team working alongside Behaviour Support Services and other local services in mainstream primary schools. The service which is directly funded by schools provides a range of interventions that support the development of positive emotional and well-being for primary aged pupils.

4.3.3 The team of CAMHS practitioners and support workers provide thorough assessment, liaison and intervention for C&YP and their families that are undergoing emotional difficulty. Additionally, they provide support for schools and other services within Stockport working with individual children, small groups, classes, parents, carers and whole families.
Secondary Jigsaw

4.3.4 Secondary Jigsaw is a small mental health team working alongside mainstream secondary schools to improve the emotional, social and educational abilities and opportunities for pupils experiencing mental health difficulties, and to offer support for their families and carers. The service, which is funded by SMBC with some direct funding from schools, comprises specialist teachers, Mental Health Practitioners (MHPs) and a drama therapist.

Central Youth Counselling

4.3.5 This is a small service (currently only 0.8 wte) providing counselling for a range of mild to moderate health difficulties, which is accessed by self-referral and is based in the town centre.

CAMHS Youth Offending Services (YOS) Worker

4.3.6 A mental health practitioner (MHP) is embedded within the Council’s YOS and Parenting Services providing specialist mental health advice and consultation to the youth justice services.

Parenting Services

4.3.7 Stockport has a framework of evidenced-based parenting programmes to support parents across the age ranges which are provided by a number of teams across C&YP services:
- Antenatal / Early Days: Solihull Approach and Mellow Parenting
- 0-primary age: Incredible Years Webster Stratton
- Parents of teenagers where conflict is an issue: Respect
- Parents who are in conflict / parental relationships affecting children: Parent as Partners
- Family relationship difficulties affecting children: Restorative approaches
- Parents whose substance misuse is harming their children: Think Family

Education Psychology Service

4.3.8 Stockport’s child and educational psychologists provide a wide and flexible range of therapeutic support for both individuals and small groups. They are able to provide therapeutic work relating to many issues including: attachment, bereavement and loss, emotional trauma, exam nerves/relaxation, social skills, stress (anger) management and mindfulness.

4.4 Stockport CAMHS Tier 3 services

4.4.1 CAMHS Tier 3 provide a range of evidenced based treatments and interventions to support those C&YP with significant mental health needs. They also provide specialist services for C&YP with a learning disability and mental health problems in close collaboration with the
C&YP’ s Community Learning Disability Service, and a small Transitions Team for 16 -18 year olds who do not meet the criteria for adult mental health services (AMHs) and who’s problems cannot be resolved by accessing provision at Tier 2.

4.4.2 C&YP with the following needs are seen and supported by the specialist Tier 3 CAMHS which is a multidisciplinary team of mental health nurses, social workers, psychiatrists and clinical psychologists:

- emergency or urgent problems that warrant hospital based services e.g. attempted suicide;
- severe mental health disorders;
- severe depression, suicidal ideation;
- psychotic disorders; schizophrenia, bi-polar disorders or drug induced psychoses;
- assessments for neuro-developmental disorder;
- deliberate self-harm with suicidal ideation;
- sexualised behaviour;
- eating disorders.

Tier 3 CAMHS also offer consultation to children’s social care, paediatric services, education services and the wider C&YP workforce.

4.4.3 As part of the service offer to C&YP in Stockport, if the need arises for high level assessment and/or intervention, CAMHS can refer to a specialist nurse-led outreach service, called the Inreach / Outreach Team (IROR) which works across Pennine Care CAMHS. This team is able to provide out-of-hours interventions to assess for and/or facilitate admission to hospital, or as a step down intervention from being in hospital. The IROR team works across a number of settings including the young person’s home or an acute medical ward. A key role of the IROR is to provide support, advice and consultation to medical wards managing YP with serious mental health issues such as eating disorders.

4.5 Tier 4 CAMHS

4.5.1 Tier 4 CAMHS for C&YP in Stockport are commissioned by NHS England. The main services accessed by Stockport C&YP are provided at Fairfield Hospital in Bury (Pennine Care NHS Trust) which provides treatment and support to young people, aged between 13 & 18 years old, who are suffering from a range of mental health difficulties. There are two facilities described below.

- The Hope Unit is an acute psychiatric in-patient service for young people aged 13-18 years whose mental health needs cannot be managed safely in the community. This includes patients detained under the Mental Health Act. Typically the length of stay in this unit is 6-8 weeks with the aim of formulating mental health need, identifying
appropriate support and intervention pathways, stabilising a young person’s mental state and managing risk.

- The Horizon Unit provides treatment and rehabilitation for young people aged 13-18 with more complex and enduring mental health needs such as eating disorders. Typically the length of stay in this unit is 9 months plus.

4.5.2 Within the Greater Manchester area Stockport C&YP may also access:

- Junction 17 at Prestwich Hospital (Greater Manchester West NHS Foundation Trust) which provides inpatient, outpatient day care and outreach service for 12-18 years with severe and complex difficulties. This Trust also provides a regional forensic adolescent consultation and liaison service (FACTS).

- Galaxy House at Manchester Royal Infirmary (Central and Manchester Children’s University Hospitals NHS Trust) provides inpatient, outpatient and day care for C&YP aged 5-15 years.

4.6 Evaluation of our current position – key concerns

4.6.1 Local CAMHS services and access issues have been well evaluated, and details can be seen in the Council’s Health Scrutiny Committee report in March 2014 at: http://democracy.stockport.gov.uk/documents/s39943/Mind%20the%20Gap%20mental%20health%20and%20wellbeing%20services%20for%20children%20young%20people%20in%20Stockport.pdf

4.6.2 There are a number of issues and gaps in key areas of provision that are of particular note:

Capacity at Tier 2

4.6.3 KITE do not accept referrals for C&YP placed in Stockport by other local authorities (LA). Although many of these C&YP will be receiving therapeutic interventions within their placements, there remains some inequity for out of area LAC placed in Stockport who cannot access KITE and non LAC cannot access their specialist areas of expertise.

4.6.4 Stockport has several independent schools within the locality attended by Stockport residing pupils. In addition there are independent schools in neighbouring localities that Stockport C&YP also attend. These schools along with one secondary academy have opted out of the Secondary Jigsaw arrangement and do not have access to this provision.

4.6.5 We have significant waiting times for our targeted Tier 2 services (KITE, Jigsaw and Central Youth) with C&YP waiting between 4 and 6 months to start treatment. And, although these
services offer direct consultation to professionals within their target populations (e.g. KITE offer consultation to social workers, and Jigsaw services to teachers), there are significant gaps in the consultation offer.

**Accessible Specialist Advice**

4.6.6 In recent consultations timely access to specialist advice was ranked as a high priority with professionals wanting named contacts within CAMHS to provide consultation, advice and supervision in a responsive and flexible way. It is clear that teachers also want a named lead within their schools and within other health and wellbeing agencies to ensure robust partnership working.

**Post 16 provision**

4.6.7 There are a number of issues regarding post 16 years provision:

- We have a shortfall in Tier 2 services for YP aged 16-18 with mild to moderate problems.
- Most of the Tier 2 provisions for this age group are restricted to specific groups (e.g. substance misusers, youth offenders, LAC).
- Primary Care Psychological Therapies (Adult IAPT programme) do offer treatment for 16 years plus, but levels of engagement are low.
- Secondary Jigsaw works with school children up to 16 years of age. However there is no equivalent service for sixth form colleges, although colleges do provide some support
- There is currently no targeted mental health resource to support YP transitioning from school to post 16 years environments.

**Care Leavers**

4.6.8 Care Leavers are a particularly vulnerable group of YP for which there is little targeted provision. Existing mental health provision for LAC from KITE and the Transitions Team is up to 18 years. However, it is felt that this vulnerable group would benefit from dedicated mental health provision up to age 25 to address their particular difficulties after leaving care and to assist them to access appropriate adult provision.

**Self-referral**

4.6.9 Central Youth Counselling Service is the only universal mental health service dedicated for YP aged 11-25 years in Stockport that can be accessed by self-referral. Though widely valued for the support it offers the service is very small and the current clinical staffing resource is only 0.8 wte.

4.6.10 In general there is a real shortage of interventions in Stockport that could be accessed universally by C&YP to address low level mental health needs (i.e. group work, guided self-help, digital self-help, self-management workshops, mentoring, supported leisure activities).
**Home Treatment Options**

4.6.11 A key issue is the lack of robust home treatment options as a real alternative to inpatient admission. In particular there are difficulties in stepping down young people with eating disorders from inpatient services into community provision leading to long lengths of stay. Our plans for development of a community eating disorders service set out Chapter 9 addresses this. Our intention is to develop home treatment for ED initially and then utilising the savings from reduced admission to develop home treatment across other care pathways.

### 4.7 SWOT analysis

4.7.1 Pennine Care NHS Foundation Trust (Tier 3) have undertaken a SWOT analysis which has been helpful in informing this Transformation Plan:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>Innovative, creative and committed, highly skilled workforce, who have a strong working ethic and are engaged in the current need for review and reshaping of service for CYP and families;</td>
<td>Education and wider CYP’s workforce interface, lack of understanding of access to services to facilitate step down pathways and effective capacity management;</td>
</tr>
<tr>
<td>Commitment to professional development with staff engaging in improving access to psychological therapies (IAPT) training and transforming of service delivery;</td>
<td>Tension between the need for detailed data collection systems and the impact this has on clinical delivery staff;</td>
</tr>
<tr>
<td>Strong clinical and managerial leadership with clear structures in place;</td>
<td>Lack of embedding of value of consultation as a therapeutic intervention within some areas of the service;</td>
</tr>
<tr>
<td>Strong &amp; supportive local and directorate structure, promotes the sharing of good practice and a positive attitude;</td>
<td>Limited capacity to meet internal and external reporting requirements;</td>
</tr>
<tr>
<td>Highly developed and embedded approach to capacity management;</td>
<td>Capacity management and tight job planning for all practitioners can lead to limited flexibility for unplanned needs and location of delivery;</td>
</tr>
<tr>
<td>New and innovative electronic platforms for young people to access e.g. Buddy App;</td>
<td>Effective external communication of individual case work progress and service purpose, capacity, challenges and successes;</td>
</tr>
<tr>
<td>Strong User Participation Forum that guides major service developments; and</td>
<td>The tier 2 community CAMHS services are seeing less than the predicted number of children expected to need intervention at this level.</td>
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<td>Established problem based pathways supported by robust supervision.</td>
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<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
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<tbody>
<tr>
<td>Highly developed and advancing at pace children’s service integration programme</td>
<td>CAMHS project team need to identify financial efficiencies at times of change and increased</td>
</tr>
<tr>
<td><strong>Opportunities</strong></td>
<td><strong>Threats</strong></td>
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<tr>
<td>‘Stockport Family’ which has synergy with CAMHS transformation work and will support whole system change process at pace;</td>
<td>Demand;</td>
</tr>
<tr>
<td>▪ Local design by doing approach to whole system change, with CAMHS leadership embedded in project group;</td>
<td>▪ Desire to shift focus to earlier intervention and support without any specific transitional funding to manage business as usual, changes processes, etc.;</td>
</tr>
<tr>
<td>▪ High level sign up to CAMHS transformation work and highly functional project team in place with shared local vision;</td>
<td>▪ Increased accessibility and consultation offers required may negatively impact on treatment ability;</td>
</tr>
<tr>
<td>▪ Established CAMHS single point of access functioning over a period of many years, with established pathways between services, which supports integration of tier 2 and 3 services;</td>
<td>▪ Engagement at operational level with service design to afford integrated working model; and</td>
</tr>
<tr>
<td>▪ Engagement of education in expression of interest for national pilot of education and specialist CAMHS link working; and</td>
<td>▪ Access to buildings and community delivery space to implement locality offer.</td>
</tr>
<tr>
<td>▪ Potential for development of more robust eating disorder and parental mental health services via new investment.</td>
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Chapter 5

Promoting, Resilience, Prevention and Early Intervention

5.1 The Aim

“To prevent harm by investing in the early years, supporting families and those who care for children and building resilience through to adulthood. Strategies should be developed in partnership with children and young people to support self-care. This will reduce the burden of mental and physical ill health over the whole life course.”

‘Future in Mind’ (8)

5.1.1 A key theme in ‘Future in Mind’ is the importance of valuing, recognising and promoting good mental health and wellbeing and the need to help children, young people and families adopt and maintain behaviours that build resilience and support good mental health. There is an emphasis on taking early action with those who may be at greater risk and on early intervention as soon as problems arise to prevent more serious problems developing.

5.2 Key Recommendations

- Raising awareness of mental health issues for children and young people and reducing levels of stigma
- Continuing to develop whole school approaches to promoting mental health and wellbeing
- Supporting self-care through the use of digital technology
- Enhancing existing maternal, perinatal and early health services and parenting

5.3 Supporting children and young people to develop good well being

What we are doing now

5.3.1 Public Health and Integrated Children’s Services (ICS) are working together to ensure all early years staff have access to ‘Connect 5’ and the fully evidence-based ‘Living Life to the Full’ training designed to both improve people’s own wellbeing and enable staff to improve their client’s/pupils wellbeing.

5.3.2 Health Visitors and School Nurses have all received training in both motivational interviewing and emotional intelligence (the Solihull Approach) and mechanisms to extend this training across the ICS are being explored. School Nurses are extensively involved in supporting
children and young people around mental wellbeing and in some cases they may be the first contact a young person has with services. School Nurses provide drop-ins in secondary schools and the service is currently working on expanding these to achieve borough wide coverage. Mental wellbeing is a significant presenting factor in these drop ins.

5.3.3 Stockport schools have been provided with tools to support their delivery of the Personal, Social, Health and Economic education (PSHE) and Sex and Relationships Education (SRE) Curriculum including Child Sexual Exploitation (CSE) and Domestic Abuse.

5.3.4 The council is working closely with schools to protect children and young people from in appropriate on line content, and all aspects of bullying including cyber-bullying and exploitation which is a growing concern. Additionally, a borough wide self-harm policy and pathway based on NICE guidelines has been published and a training programme has been rolled out across schools.

5.3.5 Most Primary schools deliver the Social and Emotional Aspects of Learning (SEAL) curriculum to teach children the necessary life skills for emotional literacy. This is supported by termly network support meetings for all Primary school SEAL/PSHE coordinators.

5.3.6 The Restorative Approaches project for all schools and council services is supporting the development of emotionally intelligent climates within schools and other settings to better support emotional wellbeing.

5.3.7 Forest School is developing in Stockport to enable more vulnerable children to develop resilience and an inner locus of control, and in turn helping them to learn and be more resistant to risk taking behaviours.

What we are planning to do

5.3.8 Public Health working with the Educational Psychology Team, School Improvement Staff, Behaviour Support Team and CAMHS aim to develop a ‘whole school approach’ supported by a specific offer for schools aimed at promoting and improving the wellbeing of schools staff themselves as well as the wellbeing of children and families.

This would include:

- Raising awareness and knowledge of the importance of good mental health and the link to achievement; promoting ‘mental fitness’ as part of the school curriculum.
- Specific preparation of vulnerable children at the Primary level for transition to Secondary level to help them access the support they need. This would focus on self-esteem and confidence for managing the transition and could link with a clearly defined ‘welcome’ programme on arrival at secondary school.
Creating opportunities to strengthen staff resilience and develop peer support and supervision for staff dealing with pupils with mental health problems.

5.3.9 Strengthen the mental health and wellbeing focus of existing networking events for primary and secondary PSHE coordinators and including other staff involved in pastoral care including school Counsellors, School Nurses, linked Social Workers, linked Stockport Family Workers and CAMHS workers to share ideas and initiatives. These networking events could be extended to all agencies working with C&YP, and to young people and families to harness and co-ordinate the assets in the local community.

5.3.10 Establish a training team within schools, centred on the CAMHS link worker and including the named School Nurse and named Social Worker attached to the school. Training provided through this team would focus on changing behaviour within the school to that which is more supportive of social, emotional and mental well-being (for example, building on the restorative approach to develop skills in 'difficult conversations' with children and young people). The Public Mental Health Lead and Educational Psychology staff would support these teams in developing materials to integrate social and emotional wellbeing content across the curriculum.

5.3.11 Production of a resource to support schools and ICS in procuring evidence-based mental health input if they are purchasing this independently. This would suggest key questions to ask of providers that would help assess if what they offer is evidenced-based and applies recommended approaches, as well as ensuring this fits with the wider provision across the borough.

5.3.12 Better promotion and routine recommendation of digitally based self-care support programmes such as 'Living life to the Full', 'Stress Busters', 'Friends' and others. This is particularly important for those not accessing higher level support or facing a waiting period.

5.3.13 Production of a local online directory for schools, wider children and young people’s services and for young people and families to show what is offered by whom across the system (NHS, council, voluntary and other third sector organisations) so all in the local community are aware of the support available for children and young people’s mental health. This would include information about pathways into, through and between service elements.

5.3.14 Improve the access to a range of self-care resources and material on key issues identified by children and parents. This will consist of digital and print resources and may include developing resources on specific topics where suitable materials cannot be found. These
resources will also be available through a single portal such as the website ‘With U in Mind’ already developed by Pennine Care NHS Trust.

5.4 Infant mental health services and parenting

What we are doing now

5.4.1 The Parenting Team work with parents of children up to 13 years with social, emotional and behavioural problems to help them understand their child’s behaviour and how they can help improve their child’s difficulties. They provide a range of evidence based interventions including regular Incredible Years (Webster Stratton) courses and provide weekly Parent Support clinics in community venues across Stockport.

5.4.2 The Infant Parent Service (IPS) provides very early intervention for families from pregnancy to 3 years, focusing on early attachment and relationship difficulties. The IPS offers parent-infant psychotherapy, adult psychotherapy and interaction guidance, Solihull and Brazleton approaches. The team plan to develop group work approaches including Mellow Parenting linked to high needs families work.

What we are planning to do

5.4.3 Greater Manchester Early Years New Delivery Model has clearly identified the need for a social, emotional behavioural pathway for 0-5 years. Heath visiting and ICS are now implementing the use of Ages and Stages questionnaire (ASQ3) as a tool for screening development and using the ASQ (Social and Emotional Assessment) in a targeted way with some vulnerable children e.g. in Family Nurse Partnership (FNP) and for routine Looked After Child (LAC) health assessment of 2-4 year olds. As a result of these developments need is being identified earlier and a better pathway for practitioners to consult and access support for young children is needed.

5.4.4 Children aged 3-5 years are currently presenting with a mixture of issues including attachment difficulties, post-traumatic stress, loss and adversity and undiagnosed ADHD and ASD. It is proposed that a joint parenting/CAMHS assessment will avoid duplicate referrals and result in earlier more holistic assessment and interventions.

5.4.5 The plan is therefore to close the existing gap between IPS and CAMHS by enhancing our current Parent Support Clinics with additional specialist expertise so they can provide early assessment and consultation and intervention for children 0-5 years where complex social, emotional and behavioural difficulties need more specialist formulation and planning, particularly for post domestic abuse and LAC.
### 5.5 Outcomes we expect to achieve

- Greater visibility of mental wellbeing/fitness content in school curricula
- Existence of transition plans for vulnerable children; and delivery of transition action plan by schools (primary and secondary)
- Peer support and supervision sessions held for schools staff
- Annual multi-agency Mental Health and Wellbeing Networking Events for school staff
- Training teams established in schools with identified delivery plans, supporting integration of mental health and wellbeing content across the curriculum
- Purchasing support resource developed and available to schools across Stockport
- Comprehensive directory of mental health and wellbeing support options created and available to schools and other partners

### 5.6 Key Performance Indicators

**Baseline measures available now for:**

- Annual increase in % of education staff saying they have good knowledge of local health and wellbeing services including web-based resources
- Annual increase in % in education staff saying they have good knowledge of health and wellbeing issues
- Increase in the number of parenting interventions delivered by the Infant Parent Partnership (0-5yrs)
- Annual increase in consultations provided by IPP to professionals and their parents with attachment difficulties

**Baseline measures by end of Q1 16/17 for:**

- Increase in number of staff in early years services who have completed the children’s emotional health and wellbeing training programmes
- Increase in usage of ‘With U in Mind’ website (as measured by number of hits)
- Increase in number of self-help resources down loaded from ‘With U in Mind’ website
- Increase in number of parenting interventions delivered by all services

(see Annex 3 ‘Tracker’ for baselines and targets)

### 5.7 New funding in this area will be used to:

- Recruit specialist infant mental health practitioners to deliver more parenting interventions for attachment difficulties
- Purchase ‘Incredible Years Beginnings’ training for early years staff"
• Provide evidenced based health promotion and resilience programmes in schools
• Pilot emotional and wellbeing tracking tools for schools and emotional wellbeing tool kits
• Create an annual flexible budget to enable a rolling programme of mental health promotion initiatives for C&YP
Chapter 6

Improving Access to Effective Support – a system without Tiers

6.1 Aim

“Our aim is to change how care is delivered and build it around the needs of children and young people and families. This means moving away from a system of care defined in terms of the services organisations provide to ensure that children and young people have easy access to the right support from the right service at the right time “

Future in Mind (9)

6.1.1 A key theme of ‘Future in Mind’ is to move away from a tiered model of services, which often results in children and young people falling in the gaps between different services, to a more flexible needs based model (such as THRIVE) where services integrate and collaborate to create seamless pathways of care and support.

6.2 Key Recommendations

- One point of information to find out anything children and families want to know
- Single point of access to targeted and specialist CAMHS though multiagency triage approach
- Dedicated named points of contact in targeted or specialist mental health services for every school and primary care provider including GPs
- Strengthening the link between children and young people’s mental health and learning disability services and services for C&YP with special educational needs and disabilities
- Access and waiting time standards
- Choice and flexibility in the way services are delivered away from traditional NHS settings
- Clear and safe access to high quality digital online information and support
- Support and intervention for young people in crisis including intensive home treatment to avoid unnecessary admission to hospital.
- Better coordination of mental health services for young adults and smoother transition between CAMHS and adult mental health services (AMHS).
6.3 **What we are doing now**

6.3.1 There is a local CAMHS website ‘With You in Mind’ (Pennine Care NHS Foundation Trust), which provides information about emotional and mental wellbeing and the resources available in the local community and how to access them. It also provides links to other approved resources that Children and Young People and families and the wider C&YP’s workforce can access offering advice on managing less complex problems.

6.3.2 Local age specific resource directories are available on the CAMHS website, these have been produced for GP’s and wider professional groups to promote access to the range of local services available for different age groups supporting C&YP and families with their emotional health and wellbeing at primary age, secondary age and 16 plus.

6.3.3 A single point of access (SPA), for targeted and specialist CAMHS has been functional for a number of years. Referrals are screened daily for evidence of risk and the need for an urgent response. A weekly referral management panel attended by representatives from Tier 2 (KITE and Jigsaw services) and Tier 3 CAMHS meets to agree the most appropriate service to offer an initial assessment and enables C&YP to step up or down between services with minimum delay. Referrals for the Transitions Service for 16-18 year olds come via a similar process that sits within adult mental health services (AMHS).

6.3.4 The CAMHS urgent care pathway was reviewed and improved following an OFSTED/CQC inspection in 2012 which raised concerns about unnecessary hospital admissions for mental health assessments. Risk Assessment Practitioners now provide daily dedicated slots in CAMHS, the Emergency Department (ED) and the paediatric wards diverting ED attendances, preventing admissions and facilitating early discharge. CAMHS provide training to ED staff in mental health screening and awareness of the care pathways.

6.3.5 The Transition Service works closely with other agencies supporting the mental health needs of young people aged 16 plus, providing weekly consultation to the Access and Crisis Team in AMHS and regular consultation with KITE, the Youth Offending Service (YOS) and MOSIAC (substance misuse service). There is a well-established mental health Transitions Network which meets quarterly to improve collaboration among statutory and third sector providers and develop care pathways for young adults.

6.4 **What we are planning to do**

**New Stepped Care Framework**

6.4.1 As outlined in Chapter 4 Stockport CAMHS services are currently commissioned and delivered around the traditional tiered model of provision and, although there is good collaboration between different services, unintentional barriers to access and fragmentation of care still
remains. Consultation and engagement has taken place with local stakeholders to move away from the tiered model to a new stepped care framework (see diagram below) which aligns very closely to the THRIVE model focusing on clusters of need rather than service structure.

6.4.2 The aim of the new framework is to improve accessibility to the right step at the right time and with the right person. The model is heavily focused on helping workers within universal and early help services, GP’s and other children’s services to develop skills to support the promotion and management of children’s emotional health within communities. The foundation for the model is in-reach into C&YP’s services and schools by named, suitably skilled and experienced CAMHS workers alongside a cascade model of supervision, consultation and training. The framework will increase access to specialist advice for families and will support the delivery of early help offers whilst managing demand on more intensive pathways.

6.4.3 As described above (1.4) the new framework has been designed to align with and facilitate the new Stockport Family Model and the use of restorative approaches with C&YP and their families.

6.4.4 The implementation of the new Stepped Care Framework is the cornerstone of this Transformation Plan, and making it happen and getting it right early on is our priority. We have expressed interest in becoming an accelerator sight for the THRIVE model and will be targeting the use of new investment on measures that support the implementation of this new way of commissioning and delivering mental health wellbeing services for C&YP.
Multi-agency Single Point of Access

6.4.5 As recommended in *Future in Mind* the intention is to create a multiagency SPA at step 2 rather than at the existing tier 3 to triage all non-emergency mental health and wellbeing (MHWB) related referrals (including self-referral). Options have been drafted on new access pathways, including the proposal that CAMHS workers join the existing Multi-agency Support and Safeguarding Hub (MASSH) to provide expert mental health and well-being input as part of a single point of access arrangement.

6.4.6 As part of a 2015/16 CQUIN (quality improvement programme) agreed with commissioners Pennine Care NHS Foundation Trust are currently consulting on these proposed new access pathways with professionals, children and young people and families via face to face engagement events and an online survey. By creating a single point of access to CAMHS through multi-agency triage and by developing a comprehensive online directory of services will make it easier for other providers (including other primary care providers) to signpost C&YP to mental health services. New access pathways will be published locally and communicated widely.

Improved Collaboration with schools

6.4.7 Stockport is not one of the 15 national pilot sites to improve joint working between school settings and CAMHS. Nevertheless the preparation of our bid has engaged individual schools, who were very keen to be part of the pilot, and schools fora (i.e. Head Teachers Consortia and PARE for Pupils at Risk of Exclusion) in the CAMHS Transformation planning process. Our plan is to use new investment to provide CAMHS named leads to link with schools, to support and encourage schools to assign a named lead on mental health issues, and to develop and agree a local approach to joint working including training, information sharing and communication.

Joint Commissioning Integrated Tier 2 / Tier 3 CAMHS

6.4.8 Work is also underway to design an integrated Tier 2/Tier 3 CAMH service (incorporating existing Tier 3 CAMHS, KITE, Jigsaw teams, and Central Youth counselling services). The intention is that this will be jointly commissioned by the CCG, LA and schools with aligned or pooled funding in line with a single service specification. This will reduce fragmentation in commissioning and service delivery and will include clear standards for improved access including waiting times and will defined a clear Mental Health and Wellbeing (MHWB) Offer from an integrated CAMHS to universal services.

6.4.9 A jointly commissioned integrated Tier 2/Tier 3 CAMHS provides a means of improving access by:
addressing gaps in provision caused by the inclusion and exclusion criteria of separate teams in health, education and social care and by removing inequalities to access for certain groups (e.g. out of area LAC, pupils in non-maintained schools).

avoiding the risk of single agency reductions impacting disproportionately on small teams and adversely affecting particular groups of CYP (e.g. LAC, or pupils at risk of school refusal) or negatively impacting on multiagency care pathway (e.g. multi-agency pathways for diagnosis and management of autistic spectrum disorder.)

introducing more flexible ways of working across the CAMHS workforce; in particular offering a wider range of short evidenced based interventions and, where appropriate, digitally enabled signposting to advice, self-help and support in the community.

Support and Intervention for Young People in Crisis

6.4.10 As well as developing a MHWB offer for universal services from an integrated Tier 2/3 CAMHS we will continue to review and develop support and intervention for young people in crisis. Existing service include:

- 6 day a week 9am -5pm Risk Assessment Practitioners (RAPs) who have daily (except Saturdays) slots in the Emergency Department (ED) and paediatric wards providing MH assessments to avert admissions and facilitate discharge (ages 16 and under)
- 24/7 on- call service from consult psychiatrists (all ages)
- RAID – Rapid Assessment and Interface Discharge MHPs who provide a 24/7 MH Liaison service to ED (all ages)
- 7 day a week In Reach-Out Reach Service (IROR) offering enhanced home interventions to prevent admissions (ages 16 and under)

New investment for Mental Health Liaison is being used to provide additional MHPs for C&YP to work alongside these existing resources. In addition LTP investment is being used to fund MH transitions workers for young people in the Adult Access & Crisis Team. We also plan to review how all these resources (existing and new) can be better utilised to provide a more comprehensive and effective 7 day MH crisis services for YP up to 25.

Mental Health Liaison

6.4.11 Community Mental Health profiles (2014) show that emergency admissions for self-harm per 100,000 population is significantly higher in Stockport than the England average. Furthermore, hospital admissions for unintentional and deliberate injuries ages 0-24 years in Stockport is significantly higher than the England average. We also know that when C&YP attend the emergency department they spend a longer time in the department
because arranging mental health assessments invariably takes longer due to the limited availability of appropriate staff.

6.4.12 In line with NHS guidance for improving access and waiting time standards NHS England have allocated pump-priming investment targeted at delivering effective models of psychiatric liaison in acute hospital settings for all ages. The initial investment will be targeted at liaison mental health services in the emergency departments (ED). We will use this non-recurrent resource to provide additional capacity to work alongside the existing RAID, RAPs and the IROR to support C&YP who present with deliberate self-harm and other mental health crises.

Other support for Young People in Crisis

6.4.13 As mentioned above, the IROR aims to prevent admission through offering enhanced home interventions, however the team only works with young people to age 16; those older than 16 are referred into adult services. We will explore options for reconfiguring this service to provide an intensive outreach/day service up to age 18 reducing the need for young people to be admitted or to remain as inpatients. This review will be done alongside the development of a new intensive community service for those with eating disorders as the expected savings from reduced inpatient care for eating disorders should benefit the wider group needing urgent care. (see Chapter 8). The pump-priming mental health liaison investment will help to bridge the capacity gap in the urgent care pathway until we can re-direct resources from urgent care.

6.4.14 At the same time we are also increasing the CAMHS in-reach to professionals, parents and carers looking after children and young people with complex needs building on the additional MHPs who are now part of the Edge of Care team (see Chapter 7).

6.4.15 We also intend to explore option for increasing CAMHS in reach to short break/respite provision that can be utilised for when a family are no longer able to manage, to avoid young people being admitted to hospital or being kept in custody.

Crisis Care Concordant

6.4.16 The Mental Health Crisis Concordant sets a clear vision about how organisations work together to deliver a high quality response when people of all ages with mental health problems urgently need help either because of suicidal behaviour or intention, extreme anxiety, psychotic episode or other behaviours that seem out of control and pose a danger to self or others. The aim is to reduce the number of people with mental health problems being detained in a police cell as a place of safety (on Section 136 of the Mental Health Act).
6.4.17 In Stockport Children and Young People under 16 apprehended by the police suffering a mental health crisis are usually taken to Accident and Emergency as a place of safety, and those aged over 16, where appropriate, are taken to the 136 suite in the mental health unit at Stepping Hill Hospital. They are then assessed by an approved mental health practitioner and the on-call consultant psychiatrist to decide whether they need to be admitted and/or what follow-up mental health support they require from community services. Stockport has an effective police and health partnership meeting where information is shared on usage of section 136 by the police, As part of the on-going monitoring and review of section 136 we will request a breakdown of information on age profile.

6.4.18 The number of Section 136 presentations for under 18’s in Stockport is approximately 3 per quarter. Our intention is to reduce this by:
- Providing good information to C&YP and families about self-help and who to contact if a crisis occurs
- Recent launch of Street Triage Service with local mental health services and the police
- Embedding a CAMHS worker into the adult Access and Crisis Team to provide a timely and skilled response to young people when they present in
- Enhancing the IROR to support young people as described above.

Strengthening links with LD and C&YP with SEND

6.4.19 Our plan is to undertake a local review of our current care pathways for services for children and young people with ADHD in line with NICE guidance (QS39 & CG72) and new guidance issued by the CAMHS Advisory Group of the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network. Our intention is to use new investment to develop and implement a multi-agency integrated stepped care approach to provide better access to effective care and treatment for C&YP with ADHD and their parents/carers in community settings. ADHD is one of the most common mental health condition seen in C&YP and in Stockport treatment is heavily and unnecessarily focused on hospital based specialist services. For these reasons it is a high priority in our Transformation Plan. We will commission more support for families and enhance primary care liaison from specialist ADHD practitioners to increase the medical management of cases in primary care.

Improving visibility and accessibility of CAMHS

6.4.20 To improve the visibility and accessibility of CAMHS services and improve engagement we will undertake a review of the preferences of C&YP and parents/carers as to how, when and where they would like to access services (this is currently part of the consultation the CAMHS *With u in Mind* website. The findings will inform a review of the accommodation needs of
CAMHS services and the search for opportunities to deliver services in communities, rather than hospital and other NHS settings, and to be co-located with other agencies.

6.4.21 Providing a choice to receive treatment away from NHS settings is particularly important for young people and young adults to enable and encourage their engagement with mental health services and counteract stigma. As outlined below in we are planning to use new investment to embed Mental Health Transitions workers in the AMH Access Team to work specifically with 16-18 year olds and Care Leavers up to 25 years. An important part of their role will be to work with service providers to encourage them to be flexible and find alternative way of engaging with this group.

Improving Transition
6.4.22 We also plan to review and improve the process for Transition between CAMHS and AMHS and other support based on the published good practice (e.g. NHS England model specification transition) and taking into account the views and experiences of young people. Over time the aspiration is to have All-Age stepped care pathways that eradicate divisions in children’s and adult’s services and we will begin with life-long conditions requiring continuity of care e.g. learning disabilities and neurological conditions. Parity of Esteem investment is being used in 15/16 to commission a local ADHD diagnostic and post diagnostic services for young people and adults aged 16 plus who currently have to travel out of area.

6.5 Outcomes we expect to achieve

- Single portal established as route to access online self-help resources an support; comprehensive range of support materials on-line
- Higher rate of digital resources usage
- Improved accessibility and visibility of mental health and wellbeing services
- Delivery of MHWB services for C&YP at a range of community venues
- Equitable access to and provision of MHWB services across Stockport for all C&YP
- Reduction in waiting times for assessment and treatment
- Quicker access to specialist CAMHS advice when needed
- Improved relationships between CAMHS and partner agencies
- Improved communication and efficiency in sharing information
- Increase in the number of C&YP supported at lower steps in the system
- Reduction in the level of demand for higher step CAMHS services
- Improved service user experience and reduction in transitions between services

6.6 Key Performance Indicators
### Baseline measures available now for:

- Referral to treatment (RTT) within 2 weeks for those who experience first episode of psychosis
- 18 week RTT for C&YP receiving CAMHS
- Increased awareness from C&YP and families of the MHWB services across the borough
- Referral to diagnosis within 12 weeks: ASD diagnostic pathway
- Annual increase in number of children with ADHD monitored in primary care
- Annual reduction in the number of C&YP presenting in crisis and requiring urgent mental health care
- Annual reduction in number of C&YP detained in place of safety under Section 136 Mental Health Act

### Baseline measures available by end of Quarter 1 2016/17 for

- Annual increase in the number of CAMHS appointments provided in the community (non-hospital)
- Increased usage of ‘With U in Mind Website’
- Increased number of self-help resources downloaded
- Increase in number of followers for CAMHS twitter account

(see Annex 3 ‘Tracker for baselines and targets)

6.7 **New funding in this area will be used to:**

- Recruit mental health link workers for schools
- Recruit mental health link workers for locality Integrated Children's Services and primary care
- Reduction of the current waiting lists for CAMHS
- Reform of the ADHD pathway to increase access in primary care
- Create a single point of access to CAMHS through MASSH
- Provide digital self-help resources and on-line directory
- Provide community based counselling and self-directed support (incl. mentoring and supported leisure)
- Survey and evaluation of community sites
- Provide IT equipment, database and networking in community sites including voluntary sector delivery partners.
Chapter 7

Care For The Most Vulnerable

7.1 Aim

“Current service constructs present barriers making it difficult for many vulnerable children, young people and those who care for them to get the support they need. Our aim is to dismantle these barriers and reach out to children and young people in need.”

*Future in Mind* (11)

7.1.1 There are some children and young people who have greater vulnerability to mental health problems but who find it more difficult to access help. A key message in ‘Future in Mind’ is that if we can get it right for the most vulnerable, such as looked after children and care leavers, then it is more likely we can get it right for all those in need. The aim is to support staff who work with vulnerable groups by providing access to high quality mental health advice when and where is it needed.

7.2 Key Recommendations

- Making sure that children and young people or their parents who do not attend appointments are not discharged from services
- Developing flexible acceptance criteria, based on need rather than diagnosis, and bespoke care pathways for vulnerable children and young people
- Improving assessment to identify those who have been abused and/or exploited and ensuring referral to appropriate evidence based services
- CAMHS to be actively represented in Multi-Agency Safeguarding Hubs
- Strengthening the lead professional approach to coordinate support and services for vulnerable young people with multiple and complex needs

7.3 What we are doing now

**Looked After Children and Care Leavers**

7.3.1 Annual assessment of the emotional wellbeing of looked after children in Stockport using the Strengths and Difficulties Questionnaire and regular clinical consultations between CAMHS workers and each looked after young person’s lead health professional.
7.3.2 KITE small team of Mental Health Practitioners with extensive social work experience, funded by SMBC, and integrated into the wider CAMHS pathway, managed by Pennine Care Foundation NHS Trust (see Chapter 4). KITE work with children in need and LAC under the care of Stockport Local Authority and provide liaison and training to the wider children’s workforce on working with this vulnerable group.

7.3.3 A specialist Clinical Psychologist provides assessment to inform the emotional, therapeutic and placement needs of Children in Care as well as clinical leadership of the KITE team and strategic overview and development of mental health service provision to Stockport’s LAC population.

7.3.4 A care pathway and care bundle has been developed for LAC up to the age of 18, including consultation to foster carers and residential services, Theraplay informed work and Dialectical Behaviour Therapy (evidenced based treatments for this group).

7.3.5 Additional specialist Mental Health Practitioners and Clinical Psychologist are part of a new multi-agency Edge of Care Team (Stockport Families First) providing intensive support where there is a risk of family breakdown and a child or young person not being able to stay at home and going into local authority care.

7.3.6 CAMHS are active partners in the multi-agency MACE project for victims and those at risk of child sexual exploitation (CSE). The Liberty Project, a third-sector partnership between Beacon Counselling and Relate GMS, provides a range of therapeutic services to help victims of CSE recover from their experiences and to prevent those at risk from becoming victims.

7.3.7 The Leaving Care (16plus) Team have links with CAMHS, Adult Mental Health Services (AMHS), LAC nurse, MOSAIC drug and alcohol and CSE team to support Care Leavers emotional health and wellbeing.

**Children and Young People with SEND**

7.3.8 In 2014/15 Stockport CCG invested ‘Parity of Esteem’ monies to strengthen the link between specialist CAMHS and Learning Disability Services and to bridge the gap between children’s and adult’s LD services. A shared stepped pathway of care has been developed around NICE guidance (CG11) between CAMHS and the Children’s Community Learning Disability Team (CCLDT) to increase access to evidence based treatments for emotional and behavioural difficulties for C&YP (e.g. Positive Behaviour Support Programmes) and reduce the use of medication for challenging behaviour.
7.3.9 Parity of Esteem investment was also used to streamline the multi-agency diagnostic pathway for Autistic Spectrum Disorder (ASD) based around NICE guidance (CG128) which has improved the coordination between services, reduced the waiting time from referral to diagnosis from 12 to 3 months and extended the pathway to 18 years.

**Young Offenders and Young People in Secure Accommodation**

7.3.10 Young people may be in secure accommodation on welfare or on criminal grounds. We aim to prevent C&YP going into secure environments and, if they do, to smooth their transition back to the community. There are well established links between CAMHS and Stockport Youth Offending Team (YOT) and Children’s Social services. A CAMHS Mental Health worker (who has additional training in C&YP IAPT modalities) is embedded in the YOT. They provide assessments, interventions and training to the YOT. CAMHS provide an evidenced based Dialectical Behaviour Therapy programme for young people with harmful and risky behaviour which is accessed by young offenders, those at risk of offending and those in care or on the edge of care. A Consultant from the CAMHS transitions team provides regular consultation, advice and supervision to the YOT.

7.3.11 As described above KITE works to maintain the stability of placements for looked after children. The CAMHS specialist clinical psychologists who provide supervision to the KITE team and to the Edge of Care Team also provide expert advice around appropriate placements, placement support needs, and work to prevent family break down and C&YP becoming accommodated.

7.3.12 We believe the integration of CAMHS workers into the multi agency support and safeguarding hub (MASSH) will enable early identification of those YP at risk of offending and family breakdown providing earlier opportunities to intervene.

7.4 **What we are planning to do**

7.4.1 We are going to move to a needs based model of care (i.e. THRIVE) with flexible acceptance criteria which takes into account the presenting needs of the child or young person and the level of concern about them recognising that many vulnerable young people with very poor emotional wellbeing do not have a diagnosable mental illness or disorder.

7.4.2 With new investment we will ensure there are named, in-reach/link Mental Health Practitioners for the Integrated Children’s Services (ICS) teams in localities, and for the Multi-agency Support and Safeguarding Hub (MASSH) to a) enable early identification of those at high risk b) provide timely assessment for those who have been abused and/or exploited and c) provide appropriate evidence based interventions.
7.4.3 With new investment we will also embed Transition Mental Health Practitioners in the Adult MH Access and Crisis Team and in the Leaving Care (16 plus) Team who will provide direct work with Care Leavers up to age 25 (and other young people up 16-18) who do not meet the criteria for secondary AMH, as well as smoothing the journey into AMH for those that do. These new Transition MHPs will provide timely and skilled response to vulnerable young adults when they present in crisis and will signpost and support them into other emotional health and wellbeing services. They will also work to mobilise other services to adapt their practices to meet the needs of this group. (see link to Crisis Support Chapter 6)

7.4.4 We will provide additional training and support to staff in universal services to help them identify and address the emotional needs of the LAC population.

7.4.5 We plan to evaluate and build on the existing contribution of specialist mental health workers to the multiagency Edge of Care Team (Stockport Families First) providing intensive longer term therapeutic work as part of a coordinated package of support for vulnerable children and young people and their families.

7.4.6 We will undertake a local review of the ‘Did not Attend’ policies and procedures to ensure children, young people and families who DNA are actively followed up and are given help and support to engage with services. The current DNA rate for Consultant appointments is 9.1%. This is not representative of the entire CAMHS provision for which data is not currently available. Our intention is to extend key performance indicators (KPIs) for DNAs across all CAMHS provision and to monitor this routinely.

7.4.7 KITE does not work with children and young people who have been placed in Stockport by other local authorities. We plan to develop arrangements with placing authorities to ensure all LAC have access to the mental health and wellbeing services they require.

7.4.8 We plan to analyse Stockport’s SDQ scores (which are higher than the regional and national average) to see if there are identifiable patterns (gender, age, placement types) that will inform better targeting of mental health and wellbeing services for LAC.

7.4.9 We will ensure that SDQs are completed and scored in advance of a child’s health assessment so that health plans can be fully comprehensive (DfE/DoH guidance).

7.4.10 We intend to provide and promote resilience building opportunities for vulnerable children to help validate and normalise their experiences and proactively develop their emotional strength (e.g. delivering Living Life to the Full Programme to LAC, Care Leavers and Adopted young people).
7.4.11 We also intend to use immediate funding available in 2015/2016 to increase support and therapeutic interventions for LAC, Care Leavers, C&YP who are victims or at risk of child sexual exploitation and those affected by domestic abuse.

7.4.12 We also plan to develop our exiting pathways for trauma treatment and develop partnership between local services and the regional Sexual Assault and Referral Centre to ensure appropriate and timely referral to and follow-up of all cases attending SARC.

7.5 Outcomes we expect to achieve

- Clearer understanding of the needs and access to services of the local LAC population and other vulnerable groups and those with protected characteristics such as learning disability.
- Improvement in the wellbeing of all LAC as measured by SDQ and in the outcomes of all children and young people accessing mental health services
- Reduction in the DNA rates and better engagement of vulnerable children and young people and families in mental health services (this applies to all children and young people).
- Reduction on the number of LAC, Care Leavers and other vulnerable groups, presenting in crisis and requiring urgent mental health care (this also applies to all children and young people).
- Clear pathways for vulnerable C&YP who present in a crisis.

7.6 Key Performance Indicators

Baseline measures available now for:
- Annual % reduction in the SDQ cores of looked after children in Stockport which are higher than the national average
- Increase in % of SDQs completed, scored and made available to the health practitioner prior to undertaking the statutory health assessment
- Annual % reduction in DNA rates for C&YP attending CAMHS appointments
- Annual % reduction in number of C&YP presenting in crisis and requiring urgent mental health care

Baseline measures by end of Quarter 1 2016/17 for:
- Increase in number of LAC completing a resiliency training programme (e.g. Living Life to the Full Programme)
- Increase in number of Care Leavers completing a resiliency training programme (e.g. Living Life to the Full Programme)
- Increase in C&YP with learning disabilities receiving a Positive Behaviour Plan Across home and school
  
  (see Annex 3 ‘Tracker for baselines and targets)

7.7 New Funding in this area will be used to:

- Recruit mental health workers for those in transition (age 16-18) and Care Leavers
- Recruit mental health workers linked to the Multi-agency Support and Safeguarding Hub
- Provide additional therapeutic intervention for LAC & Care Leavers
- Provide additional support and therapeutic interventions for C&YP who are victims or at risk of sex exploitation
- Provide counselling for C&YP affected by domestic abuse
Chapter 8

Eating Disorders

8.1 Aim

“It is vital that children and young people with eating disorders, and their families and carers, can access effective help quickly. Offering evidence-based, high quality care and support as soon as possible can improve recovery rates, lead to fewer lapses and reduce the need for in-patient admissions.”

8.2 Context

8.2.1 About Eating Disorders

Eating disorders (ED) are a range of complex conditions which typically present in mid adolescence and have adverse effects physically, psychologically and socially on a young person. Eating disorders have the highest mortality rate of all Psychiatric conditions.

8.2.2 Eating disorders are characterized by a preoccupation with food, weight, body shape and harmful eating patterns. The three most common ED are Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED).

8.2.3 Eating disorder not otherwise specified (EDNOS) is a diagnosis given when the general symptoms of ED are present but don’t fit the exact criteria for one of the three main diagnostic criteria. This is the most common form of ED seen in clinical practice.

8.2.4 Young people with ED often have other mental health needs, experience guilt and low self-esteem and perceive their ED to not be a problem. These factors impact significantly on presentation to services at an early enough stage and can further impact on engagement and access to treatment. Timeliness of access to treatment is a strong indicator of the outcome and duration of the ED.

8.2.5 The evidence also suggests that young people seen in a generic community based CAMHS have a higher rate of inpatient admission than young people seen in a specialist dedicated ED service.

8.2.6 Currently services for ED are provided in a fragmented way particularly for young people who can access primary care, (Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (AMHS) and third sector organisations both in and out of their resident
locality. This in conjunction with the complexity of presentation means that accurate and reliable data is challenging to source both locally and nationally.

8.2.7 Figures from the the Health and Social Care Information Centre (HSCIC) show a national rise of 8 per cent in the number of admissions to hospital for an eating disorder. In the 12 months to October 2013 hospitals dealt with 2,560 eating disorder admissions, 8 per cent more than in the previous 12 months (2,370 admissions).

8.2.8 In 2012-13 the North West Strategic Health Authority had the fourth highest rate of hospital admissions for an eating disorder (over 4.5 per 100,000 of the population). Total ED referrals for under 18s to Pennine Care services for CCGs in the south (Trafford, Stockport, Tameside and Glossop) increased by 12 % between 2013/2014 and 2014/15 from 49 to 55.

8.3 National Transformation Programme

8.3.1 The Government has made available additional funds of £30 million per year to transform services in England for the treatment of children and young people with eating disorders up to the age of 18. The funding is intended to improve the consistency and quality of eating disorders services, provide new and enhanced community and day treatment care, ensure staff are adequately trained and supervised in evidence-based treatment and effective service delivery, and ensure the best use of inpatient services. Any capacity created by reducing the use of inpatient care is to be re-deployed to support general CAMHS response for those who self-harm or present in crisis.

8.3.2 The Government also intends this funding to be used to implement new national access and waiting time standard for C&YP with an eating disorder. This standard is that National Institute for Health and Care Excellence (NICE) concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.

8.4 Key Recommendations

The Eating Disorder NICE guideline (2004) contains the following specific recommendations;

- Most children and young people should be treated in the community
- Inpatient admission should be considered where there is a high or moderate physical risk
- Admission should be to appropriate facilities with access to educational activities and related activities
- When inpatient admission is required it should be within reasonable travelling distance

In addition the guideline recommends;
8.5 What we are doing now

8.5.1 Current Provision
Within Pennine Care there are a range of services available for C&YP with ED which include inpatient treatment, support from the Inreach /Outreach team (IROR) and community CAMHS intervention (these services are described in Chapter 4).

8.5.2 Total ED referrals for under 18s from Stockport to Pennine Care was 15 in 13/14 and 17 in 14/15. The average length of hospital inpatient stay for those discharged from hospital was 318 days.

8.5.3 Young people presenting with ED would usually access the Horizon Unit (unit for complex and enduring needs) from either a medical inpatient setting or from the community, a pathway which is supported by the IROR which provide outreach consultation and liaison. In response to the increasing presentation of EDs the Horizon Unit has developed additional skills and expertise in managing ED and has recently introduced a day care service to support young people stepping down from inpatient care.

8.5.4 For the under 16 age group there are clear pathways within community services with dedicated staff who have acquired additional skills and experience in ED treatment and are able to offer a range of individual, group and family based psychological therapies. In Stockport education services have also developed expertise in supporting students with ED at Pendlebury Pupil Referral Unit (PRU) which provides an outreach support pathway for mainstream schools.

8.5.5 Stockport CCG commissions an adult community eating disorder service from Oakwood Psychological Therapy Services, formerly North West Centre for Eating Disorders. This service provides individual, family and group therapy for people with a diagnosis of anorexia nervosa, bulimia binge eating disorder and other commonly classified eating disorders. The population covered is people aged 16 years and over.

8.6 Constraints of Current Provision

8.6.1 Identification of true need is a challenge as services only provide support to young people with moderate to severe ED’s. Young people with lower levels of need often don’t access services or if they do find that the right support is not readily available. In addition families/carers may
want to access support even if their child does not and this is hard to manage in generic CAMHS teams – young people have to have been referred and accepted by the service in order for them or their families to receive support.

8.6.2 Paediatric services provide care up to 16 years but there is an identified gap for 16 – 18 year olds in terms of medical input. Within adult medical provision there is a less consistent approach and limited ED expertise.

8.6.3 Dietician time is not integrated into the pathway in generic CAMHS. There is however dedicated and embedded dietician time in the inpatient care pathway.

8.6.4 Capacity within the IROR team and generic Community CAMHS means that intensive home treatment and or day provision is not achievable within existing resources. As such there is no intensive community alternative to inpatient admission for the most severely unwell young people.

8.6.5 Equally capacity within generic CAMHS teams is not sufficient to deliver training, consultation and support to the wider children's workforce in order to promote early intervention and support the prevention agenda.

8.6.6 Young people with moderate to severe ED are small in number but require intensive, long term input from a range of professionals with specific ED skills and knowledge. There are pragmatic challenges to developing mini teams in localities and maintaining the skills and providing on-going training and supervision. In addition such small teams are fragile if staff are absent or leave.

8.6.7 The administrative and governance processes required for referral pathways into specialist services can sometimes inadvertently act as a barrier to access.

8.7 What are we planning to do

8.7.1 The planned improvements in services for C&YP with eating disorders needs to be understood in the context of wider CAMHS transformational reform to improve access to specialist services as described in Chapter 6. By having a single point of access, by accepting referrals from anyone, by increasing the visibility and accessibility of specialist services it is likely that C&YP with ED and their families will feel able to request and receive support at a much earlier stage.
Our intention is to use our new investment for ED to jointly commission a new Community Eating Disorders Service (CEDS) for C&YP up to age 18 in partnership with the other 5 CCGs in the Pennine Care footprint. In partnership with their commissioners and key stakeholders including C&YP and families, Pennine Care NHS Foundation Trust are currently developing a business case for a CEDS comprising two separate teams, one in the south and one in the north, each covering a general population of around 500,000 as recommended in the national guidance.

The service will be structured on an hub and spoke model due to the large geographical areas covered and it has been agreed in principle that the South Hub will be based in Stockport with satellite bases in Trafford and Tameside and Glossop.

We envisage the Hub as a vibrant, child oriented, community facility, located centrally. Based on the stepped care approach the Hub will be staffed 7 days a week and will be the main base offering drop in, groups, assessments and treatments. Our ambition is for it to be a thriving community resource including a library of self-help resources, a café and a centre for training events, groups and meetings/talks. Staff at the hub will be able to offer same day responses to screen referrals and will be able to travel to carry out emergency visits where needed. Routine and specialist services will be available including family based approaches. There will also be a number of smaller satellite bases/sites that can offer assessments and treatments, located conveniently in separate geographical locations.

Outcomes we expect to achieve

- A more equitable and standardised level of provision for children, young people and their families
- More timely access to evidence based community treatment
- Fewer transfers to adult services
- Earlier step down and discharge from inpatient settings
- Reduced use of both medical and mental health inpatient.
- Reduction in crisis presentations and re referrals to specialist services
- Increased awareness and skill within the community including families/carers and peers
- Extend the Early Help offer to include lower level eating disorders
- Release capacity within generic CAMHS to enable shorter access times into the service
8.9  Key Performance Indicators

National Targets:

- Referral to treatment (RTT) within a maximum of 4 weeks for routine cases
- Referral to treatment (RTT) within a 1 week for urgent cases

Local Targets to be agreed as part of business case approval process

- X % reduction in those referred with eating disorders who are admitted.
- X% reduction in the average length of stay for those who are admitted.
- X number of young people already inpatients to be transferred into community services
Chapter 9

Developing the Workforce

9.1 Aim

“It is our aim that everyone who works with children, young people and their families is ambitious for every child and young person to achieve goals that are meaningful and achievable for them. They should be excellent in their practice and be able to deliver the best evidenced care, be committed to partnership and integrated working with children, young people, families and their fellow professionals and be respected and valued as professionals themselves.”

*Future in Mind* (13)

9.1.1 Developing the workforce is a key theme in *Future in Mind*, and much of what is recommended is for action at a national level such as including mental health and wellbeing in Initial Teacher Training (ITT) course and extending the C&YP Improving Access to Psychological Therapies (IAPT) curricula and training programme. However, some of the recommendations are for local action and one of the key tasks of our Local Transformation Project Team is to develop a joined up multi-agency strategic approach to workforce planning to make sure we have a workforce with the right mix of skills, competencies and experience to best support C&YP’s emotional and mental wellbeing.

9.2 Key Recommendations

- Provision of training to all staff working with C&YP in universal settings in C&YP’s development and behaviours so they understand when a child needs help
- Enhanced, multi-professional training across the physical and mental health interface (e.g. greater awareness of mental health problems amongst paediatric staff and visa-versa)
- Local reciprocal multi-agency and multi-professional training programmes so there is a shared understanding of roles and responsibilities across all those involved in the system so CY&P don’t fall between services
- The workforce in targeted and specialist CAMHS should be skilled in the full range of evidenced-based therapies recommended by NICE
- Local areas need to develop a comprehensive workforce strategy, including audit of skills, capabilities, age, gender and ethnic mix.
9.3 **What are we doing now**

9.3.1 There are a number of initiatives and training programmes currently in place for staff working with C&YP in universal services, including schools, to enable them to support C&YP to develop good emotional and mental well-being (see Chapter 5 for details).

9.3.2 We have a local well established accredited (OCN Level 2 and 3) mental health training course for professionals working in schools and other C&YP services. The course entitled, ‘Developing skills in identifying and responding to mental health difficulties in children and young people’, has been running since 2007 and 358 staff have been trained including teaching and support staff in schools, health professionals, social care professionals and trainee teachers (ITT).

9.3.3 Our CAMHS have been participants in the national C&YP IAPT programme since phase 1 which has enabled 10 practitioners from across Tier 2 and Tier 3 to be trained in CBT, parenting, systemic family practice, and evidenced based interventions.

9.3.4 Telephone consultation systems are in place for the children’s workforce to support wider services in working with C&YP with emotional health and well-being difficulties and multi-agency training session have been provided to schools to embed the use of a local Self-Harm Protocol.

9.3.5 Training and development is provided by CAMHS to the Emergency Department and to Children’s in-patient teams and a robust model of supervision is in place from Tier 3 to Tier 2 services.

9.3.6 Our CAMHS LD specialist Team in partnership with our Children’s LD Community Team are currently enhancing their skills in Positive Behaviour Management and plans are in place to roll this training out to wider services working with C&YP with LD, ASD and challenging behaviour.

9.3.7 CAMHS Tier 3 are currently conducting a workforce skills audit (SASAT) that matches the skills and capabilities in the workforce to the presenting needs of C&YP. A recent stakeholder survey has been completed which has begun to identify the training needs around C&YP mental health in the wider workforce.
9.4 **What we are planning to do**

9.4.1 Complete workforce skills audit across all targeted and specialist CAMHS services (SASAT) and develop a CAMHS workforce development plan that is future proofed and aligned to the provision of an integrated service within a stepped care /i/- THRIVE model of delivery within Stockport.

9.4.2 Expand the consultation offer from CAMHS services (see Chapter 6 on improving access) and embed an action learning set model to ensure solution finding to challenges.

9.4.3 Increase capacity for Tier 2 and Tier 3 CAMHS services to provide training and increased supervision to the children’s workforce and greater opportunity for skill modelling in practice.

9.4.4 Our ambition is to train a wider group of school based and Stockport Family staff to develop a range of therapeutic evidenced based interventions. Specifically we are aiming for at least one person from each of our Localities to be trained in each of the C&YP IAPT modalities over the next 5 years.

9.4.5 Beginning this academic year we are piloting an emotional assessment/intervention tool with a select number of schools and hopefully extending to colleges which will involve training education staff to assess the emotional wellbeing of their pupils/students and plan appropriate interventions to support their wellbeing.

9.4.6 We are also developing our Parent Support offer by increasing training to early years providers and nursery staff to help them support young children who are anxious or distressed or need help learning to emotionally regulate. (e.g. through use of Incredible Years Beginnings - a new programme for early years providers).

9.4.7 Because of the amount of development activity there is a danger that work can be fragmented and duplicative or that skills gaps in the workforce across the health, education and social care system will go unaddressed. Therefore, a priority of the Transformation Project Team is to develop a Children’s Mental Health and Emotional Well-being Training strategy and implementation plan for Stockport that targets key groups of staff and uses a range of accessible delivery models to ensure training can be accessed by all target groups.
9.5 Outcomes we expect to achieve

All professionals working with C&YP will

- Feel confident to promote good mental health and wellbeing to CYP and families and identify problems early
- Be able to offer appropriate support and refer appropriately to more targeted and specialist support
- Exhibit the qualities and behaviour that C&YP and families would like to see
- Use feedback from C&YP and families on a regular basis to guide treatment
- Have the skills to work in a digital environment with young people who are using online channels to access help and support
- Be trained to deliver evidenced based care appropriate to their discipline
- Be trained to practice in a safe and non-discriminatory way

9.6 Key performance indicators

Baseline measures available now for:

- % increase in professionals stating they have good knowledge of local mental health and wellbeing services including web-based resources
- % increase in professionals stating they have good knowledge of the referral process into CAMHS
- % increase in professionals stating they have good knowledge of a range of mental health conditions
- Increase in the number of professionals who are trained through CYP IAPT programme

Baseline measures available by Quarter 1 2016/17 for

- Increase in number of staff across integrated T3/T2 CAMHS who are trained in evidence based treatment modalities (following SASAT).

9.7 New funding in this area will be used for

- Workforce skills audit across an integrated Tier2 /Tier 3 CAMHS service
- Development of a multi-agency Children’s Mental Health and Emotional Wellbeing Training Strategy
- Accredited Mental Health training for universal staff – responding and identifying MH difficulties in C&YP
- Targeted training including:
  - Training in evidence-based parenting interventions for those working in early years.
  - Training for EMDR – evidenced based intervention for those working with YP suffering trauma
Chapter 10
Accountability and Transparency

10.1 Aim

“Far too often a lack of accountability and transparency defeats the best intentions and hides the need for action in a fog of uncertainty. Our aim is to drive improvements in the delivery of care, and standards of performance to ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.”

*Future in Mind* (14)

10.1.1 A key message in *Future in Mind* is that agreeing better models of care is not enough. Right now there are too many barrier and obstacles to be confident that new models of care would succeed. The system of commissioning services is fragmented with money sitting in different budgets in different organisations without clear lines of accountability. Also commissioners have limited access to information about how well services are performing and about patient experience and outcomes.

10.2 Key Recommendations

A number of recommendations are for national government i.e.

- A national prevalence survey of C&YP’s mental health to be carried out every 5 years
- A national CQC/Ofsted monitoring framework to monitor the implementation of proposals from *Future in Mind*.
- Bench marking of local service at national level using a set of measures covering access, waiting times and outcomes.

Recommendations for local action include:

- Lead accountable commissioning arrangements for C&YP’s mental health and wellbeing (MHWB) with aligned or pooled budgets
- Investment from commissioners in C&YP MHWB to be fully transparent
- A single integrated plan for child mental health services supported by a strong Joint Strategic Needs Assessment (JSNA) and overseen by local Health and Wellbeing Boards
- Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) shape commissioning decisions
- Developing local applicable quality standards aligned with specific measurable outcomes
10.3 What are we doing now

Local leadership across the system

10.3.1 Strong local scrutiny of local C&YP MHWB services by Stockport Health and Wellbeing Scrutiny Committee with clear recommendations for local improvement, many of which have been addressed.

10.3.2 A high level of local senior leadership for C&YP mental health and commitment to reducing fragmentation in commissioning and strengthening commissioning arrangements. The agreed response of the CCG and the LA to the Health and Wellbeing Scrutiny Review report ‘Mind the Gap: mental well-being and mental health services for children and young people in Stockport (April 2014) is to align and where appropriate pool resources and jointly commission an integrated service through a single service specification for an integrated stepped model of care.

Improving local information and transparency

10.3.3 We have mapped CCG and LA investment in C&YP mental health services and we have begun benchmarking local services in terms of activity, workforce, access, waiting times (section B)

10.3.4 Our public health colleagues are working to develop the local JSNA on C&YP mental health looking at nationally available data such as predicted prevalence rates and gathering local data in order to show how our existing services are responding to needs in the borough, whether there are any gaps and whether our services are reaching out equitably to the whole of Stockport’s C&YP population.

10.3.5 Pennine Care NHS Trust are collecting activity data and outcomes that can be used by commissioners via their membership of the NHS benchmarking collaborative, Children’s Outcomes Research Consortium (CORC) and the C&YP IAPT programme.

10.3.6 Pennine Care NHS Trust have a continuous programme for reviewing compliance with latest NICE guidance and assurance is periodically sought by the CCG Clinical Policies Committee. Services including those for self-harm, autism and challenging behaviour have recently been developed based on NICE guidelines and evidence based practice.

10.3.7 The Greater Manchester Medicines Management Group have recently refreshed shared care protocols on prescribing and we aim to ensure that these are consistently applied across Stockport.
10.4 **What we are planning to do**

10.4.1 Build on existing websites (*e.g.* With U in Mind, CCG website and Council’s Local offer for SEND) to ensure we have an accessible and transparent ‘local offer’ for C&YP MHWB services which describes the range of local services and how to access them. This Local Transformation Plan will also be published on these local websites.

**Strengthening Accountability and Transparency**

10.4.2 The Stockport governance structure for the delivery of this Transformation Plan is shown in the diagram below. Stockport CCG System Resilience Group will oversee the implementation of the plan and will track the delivery of key performance indicators.

**STOCKPORT CAMHS GOVERNANCE STRUCTURE**

10.4.3 As the lead commissioning body Stockport CCG will co-ordinate commissioning for C&YP mental health service provision across the borough in line with this Transformation Plan which will be integrated with the Health and Wellbeing Strategy and will be clearly accountable to the Health and Wellbeing Board. We will work through existing well established wider C&YP partnership structures (*e.g.* Children’s Trust Board) to secure high level strategic engagement and commitment to implementation.

10.4.4 Greater Manchester Devolution provides a unique opportunity for localities to work together to shape health and social care services to address the needs of people of all ages across the conurbation. The GM Devolution programme has identified CAMHS as an early priority for...
implementation and with the establishment of the GM CAMHS Strategy Board will work with local CCG CAMHS commissioners on a range of priority areas which include:

- Identifying standards for specialist provision across Greater Manchester, to include the following areas: crisis support, eating disorders, in-patient CAMHS beds to include learning disabilities
- A focus on co-commissioning CAMHS in-patient beds and looking at alternatives to admission across GM to reduce lengths of stay
- Providing support for CCGs to work collaboratively on developing community ED services
- Developing co-commissioning multi-agency pathways for ADHD across service users lifespan into early adulthood
- Working across GM to meet the emerging needs for perinatal mental health and parent and infant mental health

**Strengthening Joint Commissioning**

10.4.5 Stockport CCG will work with the LA and other commissioning partners including schools to agree a joint local service specification for an integrated T2/T3 CAMHS to deliver clear evidenced-based pathways of care. This will be based on the new model service specification developed by the C&YPMHT Task force for NHS England. We will explore and implement the most appropriate contracting format which supports providers to be flexible, creative and responsive to the needs of C&YP whilst also making them more accountable.

10.4.6 We aim to encourage partnership working between providers in the voluntary, independent and statutory sector to develop creative approaches to improving access to services, particularly for the most vulnerable groups. We are using LTP investment to continue commissioning therapeutic services from third sector organisations for vulnerable groups and to develop their IT systems for effective and secure data collection and monitoring. We are using new investment to develop direct access to self-directed support including mentoring and supported leisure with the intention of developing more partnerships with third sector organisations.

10.4.7 As local commissioners of C&YP MHWB services (CCG, LA, schools) we will work with our providers to agree a common local data set (which will a sub-set of the CAMHS national minimum data and C&YP IAPT outcomes) and reporting framework which will enable us to monitor activity, waiting times and outcomes across all services.
10.4.8 We intend to work with The Child Outcome Research Council to improve the way in which an integrated CAMHS collects and uses outcome data to enhance service provision and improve our understanding of how best to help C&YP with mental health and wellbeing issues.

10.4.9 We will continue to develop the JSNA for children and young people’s mental health utilising the new data set from all service providers. The data that is currently reported locally to commissioners and public health leads for C&YP will be improved to get an accurate picture of the mental health needs in the population and whether services are meeting these needs. Therefore, improving access to information and the development of the JSNA is an early priority and there is an agreed plan of action (see Chapter 2).

10.4.10 As the lead commissioner the CCG will lead the development of a joint commissioning framework across health education and social care which is aligned to the THRIVE model of care which will clarify our roles and responsibilities, commitments and contributions to commissioning for each of the needs based grouping for care i.e. getting advice, getting help, getting more help and risk support. We have been selected as an accelerator site for the i-THRIVE programme.

10.5 Outcomes we expect to achieve

- Strong leadership and accountability for the commissioning and delivery of C&YP mental health service across the borough
- A clearer picture of the mental health needs of C&YP in Stockport and whether these are being met and whether resource are being used effectively
- Strengthen links with Greater Manchester CCGs and Local Authorities through the CAMHS Devolution Programme.

10.6 Key Performance Indicators

- An agreed joint commissioning framework to support the implementation of this Transformation plan
- A strong Joint Strategic Needs Assessment for C&YP mental health
- A joint local service specification for integrated Tier 2/ Tier 3 CAMHS service
- Aligned or pooled budgets for specialist and targeted CAMHS
- An robust Quality and Performance Monitoring Framework to ensure delivery of local quality standards and KPIs
10.7 **New funding will be used in this area for**

- Additional commissioning support to the CCG and LA
- Commission work with the Child Outcomes Research Consortium to improve the way we collect and use outcome data
- To support our participation in the i-THRIVE accelerator programme.
References and Notes


2. Future in Mind; Promoting protecting and improving our children and young people’s mental health and wellbeing, DoH and NHS England, 2015

3. Future in Mind p.26

4. Stockport Health and Wellbeing Scrutiny Committee of SMBC ‘Mind the Gap’: mental wellbeing and mental health services for children and young people in Stockport

5. Future in Mind; Promoting protecting and improving our children and young people’s mental health and wellbeing, DoH and NHS England, 2015


7. The most recent figures for prevalence of common mental health problems in children and young people date from the 2004 ONS prevalence study, a study which up until 2004 had been conducted on a five-yearly basis.

   The Chief Medical Officer highlighted this as a problem in 2012; the British Psychological Society, amongst others, have called for urgent action to remedy this and the 2014 House of Commons Health Scrutiny Committee identified the lack of up-to-date, robust data as a significant problem for CAMHS services across the UK:

   Demand continues to increase - 89% of respondents said there had been an increase in referrals over the last 2 years; percentages ranged from 20-70%. Many respondents noted a change in the mix of referrals seeing an increase in self-harm, complexity and severity.

   Partnerships are reporting rising numbers of both routine and emergency presentations. Partnerships suggest an average increase of 25% in referrals to CAMHS tiers 2/3 since 2012, possibly due in part to the impact of regional and local cuts on community based services and third sector services.

   Given this, a health warning should be applied when looking at predicted rates of illness: as rates of referral have increased rapidly over the last 10 years, it is likely that the prevalence rates for 2004 are now a significant under-estimation.

8. Future in Mind p. 40

9. Future in Mind p.50

10. Mental health Crisis Care Concordant : Improving Outcomes for People Experiencing Mental Health crisis, Department of Health, February 2004

11. Future in Mind p54


13. Future in Mind p.68

14. Future in Mind p.6
## Section A: Stockport New CAMHS funding

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
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<tr>
<td><strong>New CAMHS Income</strong></td>
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<tr>
<td>Community ED (initial allocation on submission of plan – October 2015)</td>
<td>166,843</td>
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<td>Following assurance of (Nov/Dec)</td>
<td>417,624</td>
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<tr>
<td>All</td>
<td>584,466</td>
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<td><strong>Potential Expenditure</strong></td>
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<tr>
<td><strong>Core Programmes:</strong></td>
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<tr>
<td>1 Community eating disorders</td>
<td>166,843</td>
<td>166,843</td>
<td>166,843</td>
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<tr>
<td><strong>Promoting Resilience, Prevention &amp; Early Intervention</strong></td>
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<td>2 Infant mental health and parenting</td>
<td>14,156</td>
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<td>3 Budget for MH promotion and resilience programmes</td>
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<tr>
<td><strong>Improving Access – system without tiers</strong></td>
<td></td>
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<tr>
<td>4 MHPs to link with schools</td>
<td>30,000</td>
<td>80,000</td>
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<tr>
<td>5 MHPs to link with locality Integrated Children’s services -</td>
<td>11,250</td>
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<tr>
<td>6 MHPs embedded in multi-agency support and safe guarding hub</td>
<td>11,250</td>
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<td>7 Range of universal, self-referral, MH programmes or YP age 11-25</td>
<td>35,000</td>
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<tr>
<td><strong>Care for the Most Vulnerable</strong></td>
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<tr>
<td>8 MHPs for those in Transition and Care leavers</td>
<td>15,000</td>
<td>60,000</td>
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<tr>
<td>9 ADHD service development</td>
<td>12,500</td>
<td>50,000</td>
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<td><strong>Non recurrent Programmes /</strong></td>
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<td><strong>Promoting Resilience, Prevention &amp; Early Intervention</strong></td>
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<tr>
<td>‘Seasons for Growth’ – training for schools staff in loss and grief</td>
<td>3,900</td>
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<td>Emotional assessment &amp; tracking tools for schools</td>
<td>4,250</td>
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<tr>
<td>Emotional wellbeing tool kits for use in schools</td>
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<tr>
<td>Evidence-based progs delivered in schools &amp; nurseries (e.g ‘Friends for life’, ‘Special Friends’, ‘Parent Play’)</td>
<td>22,300</td>
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<td>‘Incredible Years Beginnings’ – training for early years staff</td>
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<td><strong>Improving Access – system without tiers</strong></td>
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<td>Survey &amp; evaluation of community delivery sites for CAMHS</td>
<td>2,500</td>
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<tr>
<td>IT equipment &amp; networking for community sites</td>
<td>24,900</td>
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<tr>
<td>C&amp;YP friendly refurbishment of delivery sites / therapeutic space</td>
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<td>Digital resources and online directory</td>
<td>7,700</td>
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<td>Waiting list reduction core CAMHS RTT currently 20 wks</td>
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<td>Waiting list secondary reduction Jigsaw RRT currently 30 weeks</td>
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<td>Piloting of mentoring &amp; supported leisure offer for YP age 11-25</td>
<td>41,700</td>
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<tr>
<td>B2 community based counselling for 11-19 yr olds</td>
<td>8,400</td>
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<td><strong>Care for the most vulnerable</strong></td>
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<tr>
<td>Therapeutic support vulnerable YP: LAC &amp; care leavers</td>
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<tr>
<td>Liberty Project for Child Sexual Exploitation</td>
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<td>Waiting list reduction KITE RTT currently 32 weeks</td>
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<tr>
<td>Specialist support for ASD at home and school</td>
<td>11,200</td>
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<tr>
<td>Additional capacity for ASD post diagnostic support planning</td>
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<tr>
<td>Counselling for C&amp;YP affected by domestic abuse</td>
<td>12,000</td>
<td></td>
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<tr>
<td>EMDR training for trauma focused interventions</td>
<td>2,952</td>
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<tr>
<td><strong>Developing the workforce</strong></td>
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<tr>
<td>Accredited MH training for universal staff</td>
<td>8,250</td>
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<tr>
<td>SASAT - multi-agency workforce and skills audit for C&amp;YP MH</td>
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<td><strong>Accountability &amp; Transparency</strong></td>
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<tr>
<td>Commissioning Support for CAMHS transformation</td>
<td>30,000</td>
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<tr>
<td><strong>Totals</strong></td>
<td>£584,451</td>
<td>£584,466</td>
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Chief Clinical Officer’s update

Chief Clinical Officer’s update to the November 2016 meeting of the Governing Body

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
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Stockport
SK4 1BS

Tel: 0161 426 9900  Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org
Executive Summary

What decisions do you require of the Governing Body?

The Governing Body is requested to consider and discuss the information contained within the report.

Please detail the key points of this report

This report provides an update on the following matters:

(a) Healthier Together
(b) EUR Policy Approvals
(c) Update on Greater Manchester Sustainability and Transformation Plan

What are the likely impacts and/or implications?

The implications and impact of each of the reports is outlined within each of the additional appendices or overleaf.

How does this link to the Annual Business Plan?

Regional and sector based work forms a key part of the delivery of the Stockport Plan.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

The individual reports have been discussed at their development bodies.

Clinical Executive Sponsor: Ranjit Gill

Presented by: Ranjit Gill

Meeting Date: 30 November 2016

Agenda item: 12
Chief Clinical Officer’s Report

1. Update on Healthier Together

Following the Greater Manchester Healthier Together clinical sharing event in August the South East Sector held a local clinical event in October at which Mr Ed Dyson, the South East Sector clinical lead for Healthier Together, presented the proposed model of care. More than 60 people attended, the majority of which were clinicians although a small number of managers and patient representatives were also present. Whilst the morning session focused on informing the audience about the background, pathway options and proposed way forward for the South East Sector, the afternoon was devoted to facilitated sessions in 6 clinical areas: acute medicine, A and E, primary care, diagnostics, critical care and anaesthetics and other dependent specialties. The sessions focused on understanding the impact the changes to general surgery will have on other clinical areas. Clinical advisory groups are now being developed for each of these specialist areas to ensure that all of the implications are fully worked through with lead clinicians from Tameside and Stockport prior to the mobilization of the service changes.

Commissioners in Greater Manchester have asked providers to plan for an initial implementation from April 2017. The first phase will include the transfer of high risk elective cases to Stepping Hill Hospital with the transfer of non-elective cases being planned for April 2018. In order to achieve this sectors are developing plans to ensure that there is sufficient capacity at Stepping Hill as well as planning the development of the single service workforce and clear operational policies that will apply across the single service.

Planning the reorganisation of general surgery and associated specialist services across the South East Sector is complex and challenging. Whilst the focus is on reforming the clinical pathway into a single service across two acute trusts, there are also impacts on expenditure, revenue, estate, workforce and technology as well as patients and their carers. The impact of inflows from North Derbyshire and East Cheshire is also being considered. As well as meeting the required Healthier Together standards sectors must also ensure that NHS constitutional standards are not compromised by the changes. Clinicians and managers across the sector are negotiating the intricacies of these changes whilst commissioners and providers consider the contractual ramifications.

Governing Body will remember the original Decision Making Business Case (DMBC) in September 2015 that outlined the activity, workforce, capital, ongoing and transitional revenue and estate requirements. Since then, sectors have been planning the local implementation of Healthier Together and developing the local operating models of care in line with the agreed Healthier Together model and standards. Refreshed analysis of anticipated activity levels has been undertaken with more recent data and other elements of the baseline such as the workforce have changed since the DMBC. An important requirement at this stage is therefore the development of a business
case to support Healthier Together. Sectors are working closely with Greater Manchester Transformation Unit to develop this and it is anticipated that a business case will be ready for early 2017. This will be shared with Governing Body once published.

2. EUR Policy Approvals

The following 2 Greater Manchester Effective Use of Resources (EUR) Policies were approved by the Greater Manchester Association Governing Group (AGG) on the 20th September 2016 and are now Stockport policy:-

- Experimental and Unproven Treatments
- Operation on the Prepuce (Circumcision)

3. Update on Greater Manchester Sustainability and Transformation Plan

A letter is attached.
Dear Colleague

Update on Greater Manchester Sustainability and Transformation Plan (STP) position

You will have seen national media coverage yesterday of the King's Fund report into the Sustainability and Transformation Plans (STPs) being produced across England. There was also some coverage in the MEN in response to a local comment which we, in turn, have responded to. The MEN has now made Greater Manchester’s position clear. Elected members are also being approached by those who oppose STPs nationally.

This letter is to reiterate and confirm the unique GM devolved position, which we have been operating within since February 2015, so there is no confusion about what is, admittedly, a complex national position.

We wrote, published, discussed, engaged on and then agreed our Strategic Plan for the next five years, ‘Taking Charge of our Health and Social Care in Greater Manchester’ from winter 2015 to spring 2016. This plan brought with it a £450m fund for transforming health and social care, in addition to control of the £6bn health and social care budget. The Plan became operational on April 1, 2016.

This Greater Manchester plan pre-dates the national request for STPs. In fact it is no secret that our plan helped shape NHS England’s requirements for the other 43 ‘footprints’ in the country.

NHS England agreed that our Greater Manchester plan process met their STP requirement. We agreed to participate in the milestones in the process to showcase what had taken place here so others could learn from our experiences – and so we could learn from theirs where appropriate.

Our plan has been supported by all 37 organisations across the conurbation: councils, clinical commissioning groups and NHS trusts, as well as wider partners, and outlines a vision and a programme which we all buy into. Significantly, however, it also wraps in ten locality plans for each district within Greater Manchester which provides the local detail and ambition for each place.

Those plans describe the means by which we will join up care and support at the neighbourhood level, how we will work with communities and individuals to help them take more control over their own health and how we can think beyond healthcare to influence and improve those factors which have such an impact on people’s health - the quality of their housing, a child’s readiness to get the best from school, the ability to find and keep good work, the support to maintain friendships and social connections.
Our Greater Manchester plan, along with the ten locality plans, has been the subject of extensive public engagement with many thousands of people over many months. This approach continues as we move in to implementation. We are working with many patient groups as well as the community, voluntary and social enterprise sector to further develop our approach.

We have also engaged extensively with stakeholders inside and outside Greater Manchester. Most recently, on October 18th, Jon Rouse, Chief Officer of Greater Manchester Health and Social Care Partnership, and I met with our Greater Manchester MPs and referenced our unique position in terms of an STP. Jon has also met with council leaders and talked about the same.

Our plan is reviewed every month by the Partnership Board, which I chair. This meeting is open to the public and also live streamed. We also publish all papers online at www.gmhsc.org.uk

Specific reference to the STP process and our unique Greater Manchester position was made at the Partnership Board meeting at the end of October. A written update was sent to leaders, MPs and all GM councillors following that, as it has been every month since the Board began to meet in November 2015.

We also of course continue to make sure NHS England is updated on developments in GM so last month, as STP plans from other areas were being submitted, we sent an update on our progress in the first six months since our plan began to be implemented.

To make this more accessible to colleagues and the public we are finalising two documents: one for stakeholders which covers finance, performance, quality and transformation, and one for the public which gives more tangible examples of the difference devolution is starting to make.

We plan to share these at next week’s Partnership Board and as widely as possible.

However in the spirit of being open, which we constantly strive to be, we will also share the update provided to NHS England in October. It can be found on our website here. As you will see most of this is information you will already have seen or which has already been published. In addition there is an implementation narrative and implementation plans – both at a Greater Manchester level and locality level. We have not published the report we submitted on Estates (our public sector buildings and land) as it contained commercially sensitive information which could compromise future activity.

Jon Rouse will continue to provide further updates to the Strategic Partnership Board over the coming months to ensure all are fully sighted in the key developments with the Greater Manchester Plan. We will continue our written briefings to MP and councillor colleagues following this meeting and are always happy to meet individuals.

Yours faithfully

Lord Peter Smith
Chair
GM Health and Social Care Partnership
Board Assurance Framework

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NHS Stockport Clinical Commissioning Group
7th Floor
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Tel: 0161 426 9900  Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: [www.stockportccg.org](http://www.stockportccg.org)
### Executive Summary

<table>
<thead>
<tr>
<th><strong>What decisions do you require of the Governing Body?</strong></th>
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<tr>
<td>To consider the content and updates to the Board Assurance Framework as at 1 November 2016.</td>
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<tr>
<td>Comments are also sought from Governing Body Members on areas where further attention is required by the CCG.</td>
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<table>
<thead>
<tr>
<th><strong>Please detail the key points of this report</strong></th>
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<tr>
<td>A copy of the Board Assurance Framework is appended to the report.</td>
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<table>
<thead>
<tr>
<th><strong>What are the likely impacts and/or implications?</strong></th>
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<tbody>
<tr>
<td>The areas highlighted are the CCG’s principal risks.</td>
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<tr>
<td>Failure to monitor and put in place mitigating actions will impact directly on the CCG’s ability to fulfil its statutory duties and responsibilities.</td>
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<thead>
<tr>
<th><strong>How does this link to the Annual Business Plan?</strong></th>
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<tr>
<th><strong>What are the potential conflicts of interest?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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<table>
<thead>
<tr>
<th><strong>Where has this report been previously discussed?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG’s Management Team</td>
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</tbody>
</table>

**Clinical Executive Sponsor:** Ranjit Gill

**Presented by:** Tim Ryley

**Meeting Date:** 30 November 2016

**Agenda item:** Item 13

**Reason for being in Part 2 (if applicable)** N/A

**N/A**
**Context**

1.1 The attached version of the CCG’s Board Assurance Framework was updated as at 1 November 2016. The process for updating and moderation is delivered through a workshop style discussion between theme and risk owners with the Board Secretary and Head of Governance to allow for risk specific discussion and group challenge and moderation.

1.2 The Board Assurance Framework provides a structure and process which enables the Clinical Commissioning Group (CCG) to focus on the principal risks to achieving its strategic objectives and be assured that adequate controls are in place to reduce the risks to acceptable ratings. Given the current complex environment in which the organisation is currently operating, it is crucial that risk is managed proactively and horizon scanning takes place regularly to manage risk in the short, medium and long term.

1.3 The Risk Management Strategy also provides the framework in which the CCG can manage known opportunities to maximum effect to support the achievement of strategic objectives.

2. **Detailed Commentary**

2.1 The scale, pace and complexity of the transformation programme currently underway in Stockport continues to increase both for the CCG as an individual organisation and in its role as part of the wider Stockport Together Partnership.

2.2 Current system performance pressures in critical areas are also impacting significantly on the CCG. Resource has been re-aligned to meet immediate requirements and ensure these are managed alongside the commitment to longer term system transformation. The management of organisational resource (clinical and managerial) remains in constant view of the CCG’s Executive Team to ensure proactive approach to the delivery of strategic priorities as aligned to organisational exposure to risk.

2.3 The risk profile of the CCG after a brief period of stabilisation has increased in a number of areas. There are a range of factors which have increased the likelihood of known risks, the detail of which is provided below and as a result of timing and organisational or system context, the impact has for a number of risks also increased.

2.4 The CCG’s Governing Body in its strategic risk leadership role and those theme and risk leads need to remain sighted on and proactively managing risk and opportunity to ensure the organisation’s risk profile is understood and is in line with organisational strategy. Where activity and risk profile do not align, action can be taken to review ahead of further risk profile escalation.

2.5 Key organisational strategic and operational risks remain being monitored in line with the Risk Management Strategy but reporting to Governing Body has been increased given the changing risk profile of the CCG.
2.6 The following updates to the Framework are drawn to the attention of Governing Body:

- **Strategic Risk 02 Failure to commission and design new models of care** – The likelihood of this risk has been increased to 4 from 3. The continued challenges of the performance environment in Stockport when combined with known provider capability issues were the contributing factors for this increase. This risk is now graded as extreme.

- **Strategic Risk 03 Failure to maximise opportunities for membership engagement** – The likelihood score for this risk has remained at 4 but as the CCG has reached a critical juncture in delivery of the Stockport Together and its own Strategy, the impact of failing to maximise opportunities in this area has been increased to a 4. The CCG is working as part of a number of membership organisations communicating with GP Members in Stockport and ensuring the delivery of consistent and clear messages whilst working at pace in a complex environment remains a challenge. Further resource from the CCG which has been provided to support Provider Development through the GP Federation it is anticipated will enable opportunities for membership engagement and communication to be further maximised. This risk is now graded as extreme.

- **Strategic Risk 05 Organisational capacity and capability** – Whilst the risk score for this area has remained the same, organisational capacity remains under constant review by the CCG’s Executive Team. Resource has been made available by the CCG to support continued development of priorities, including development of the GP Federation. Resource has been aligned to support the leadership and management of areas of escalating risk, including system performance challenges.

- **Strategic Risk 06 Providers’ capacity and capability fails to deliver in line with the CCG strategy and quality expectations** – The impact of this risk has been increased from a 3 to a 4 to reflect the current Emergency Department performance position and known resultant challenges within the Stockport economy. This risk is now graded as extreme.

- **Strategic Risk 07 The CCG fails to remain within financial balance and operate within the Business Rules as required by NHS England** – The CCG has implemented a financial recovery plan which will deliver the required planned surplus in 2016/17 and the risk likelihood has therefore been decreased from 4 to 3.

- **Strategic Risk 11 The CCG fails to engage the population in looking after its own health** – The risk score for this risk has remained at 9 however continued priority needs to be placed within the Stockport Together Programme and CCG to ensure the healthy communities work and Business Case remains suitably focussed as a priority across the system.

- **Strategic Risk 12 CCG Leadership role in Stockport Together representing primary care** – Additional capacity has been released and realigned by the CCG to support and represent primary care within the Provider space covering both clinical and managerial elements. The strengthening of primary care leadership in the development of the Neighbourhoods Business Case and the mitigations outlined have
resulted in a reduction of the likelihood score for this risk from 3 to 2 which takes it to the target likelihood level.

- **Strategic Risk 17 Capability, Capacity and Skill Mix of Primary Care workforce** was added to the Framework in September 2016 and a new risk lead has been identified. It is critical that further focus and more developed understanding of primary care workforce challenges and solutions are embedded in the design and implementation of the neighbourhoods business case. This is a significant area of focus for the Stockport Together Programme however until it is further developed, the risk level remains extreme.

2.6 The revised Board Assurance framework is attached as an Appendix to this report.

### 3.0 Recommendations

Governing Body is requested to:

1. Consider the revised Board Assurance Framework as updated on 1 November 2016
2. Note the revised areas of likelihood and risk impact re-scoring and in particular, those strategic risks which are graded as extreme within the Framework.
3. Make recommendations as appropriate regarding areas for particular focused review or increased monitoring.
### Board Assurance Framework

#### Latest BAF Risk Ratings

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>△</td>
<td>Extreme Risk</td>
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<tr>
<td>□</td>
<td>High Risk</td>
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<td>▽</td>
<td>Moderate Risk</td>
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<tr>
<td>⭐</td>
<td>Low Risk</td>
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<tr>
<td>✿</td>
<td>Risk has improved</td>
</tr>
<tr>
<td>⬤</td>
<td>Risk has stayed the same</td>
</tr>
<tr>
<td>⬤</td>
<td>Risk has worsened</td>
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</tbody>
</table>

#### Board Assurance Framework Summary

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<thead>
<tr>
<th>Risk</th>
<th>Risk Lead</th>
<th>Theme</th>
<th>Appetite</th>
<th>Impact Rating</th>
<th>Latest Likelihood Rating</th>
<th>Target Likelihood Rating</th>
<th>Target Date</th>
<th>Events and Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. The CCG does not have adequate systems in place for managing the quality and safety of the services which it commissions.</td>
<td>Rolfe, Anita</td>
<td>Quality Safety</td>
<td>Moderate / Low</td>
<td>3</td>
<td>✓</td>
<td>3</td>
<td>✓</td>
<td>12/2016</td>
</tr>
<tr>
<td>02. The CCG fails to commission and design new models of care as part of the Stockport Together Programme.</td>
<td>Ryley, Tim</td>
<td>Innovation</td>
<td>High</td>
<td>5</td>
<td>✓</td>
<td>4</td>
<td>✓</td>
<td>2</td>
</tr>
</tbody>
</table>

Complexity of new model of care continues to challenge capacity. The current performance environment presents additional challenges.

The CCG has self-assessed against the revised safeguarding framework and standards. The CCG is not yet fully compliant with new standards. 31/08/2016

(M) Locality Meeting arrangements provide opportunity for engagement with GP Members on key
<table>
<thead>
<tr>
<th>Risk</th>
<th>156</th>
<th>Risk Lead</th>
<th>Theme</th>
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<th>Oct 16</th>
<th>Nov 16</th>
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<th>Target Likelihood</th>
<th>Target Date</th>
<th>Events and Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>03. The CCG does not fully maximise the opportunities for membership engagement in the development of its Strategy and priorities.</td>
<td>Ryley, Tim</td>
<td>Partnerships</td>
<td>High</td>
<td>3</td>
<td>4</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>2</td>
<td>12/2016</td>
<td>issues (E) Redevelopment of CCG website will provide for Intranet for communication and engagement with GP Members and Practices. (M) Annual planning and contracting round includes consultation and engagement with Governing Body and wider GP Membership on Strategic priorities and plan implementation. (M) Increased clinical capacity in Viaduct via realigning current clinical leads in CCG. (M) More visible CCG clinical leadership at practice and neighbourhood meetings. (E) Progress being made to put additional capacity and structure into the Stockport Together programme.</td>
<td></td>
</tr>
<tr>
<td>There is some urgency to gaining full member support for strategy has increased. As detail crystallises there is likely to be a requirement to actively manage messages to members and engage on complex and challenging issues.</td>
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<tr>
<td>04. The adoption of clinical best practice guidance and innovation by the CCG is limited or slow (due to provider mobilisation or CCG financial constraints)</td>
<td>Owen-Smith, Vicci</td>
<td>Innovation</td>
<td>High</td>
<td>3</td>
<td>4</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>4</td>
<td>12/2016</td>
<td>(E) Governing Body Development Day November 2016 Outputs. (M) Additional capacity to support CIP being put in place. (E) The CCG no longer has the capacity to work with the FT where the assurance against NICE guidance to the quality committee lacks detail or causes concern.</td>
<td></td>
</tr>
<tr>
<td>There are some areas of NICE Guidance where Stockport NHSFT is not fully displaying best practice. There are a small number of areas where the FT are indicating that there is a clinical risk. The CCG no longer has capacity to develop systems and processes to systematically review those areas of concern and to develop a way of prioritising areas for investment.</td>
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<tr>
<td>05. The organisation's capacity, capability and/or internal engagement are inadequate (Including commissioned support services).</td>
<td>Ryley, Tim</td>
<td>Organisational Development</td>
<td>Moderate</td>
<td>4</td>
<td>3</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>3</td>
<td>12/2016</td>
<td>(M) Continued review of CCG Executive and Management Capacity to ensure sufficient commissioning resource available. (E) Organisational Development programme in place focussing on development capacity to work collaboratively as commissioners (M) Workforce information and requirements linked to Stockport Together Workforce Strategy (M) Retain focus on development.</td>
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<tr>
<td>Flexible alignment of resource to meet areas of key risk and organisational priorities.</td>
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<tr>
<td>06. Providers' capacity and capability fails to deliver in line with the CCG strategy and quality expectations.</td>
<td>Chidgey, Mark</td>
<td>Organisational Development</td>
<td>Moderate</td>
<td>3</td>
<td>4</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>3</td>
<td>12/2016</td>
<td>(M) This will be a key focus of Stockport Together and needs to be extended to include, for example care home providers. (E) Winter 15/16 has seen a significant increase in elective waiting lists. (E) Trajectories for delivery of key constitutional standards have been signed off with main acute provider (M) Financial contingency within plan to deliver RTT standards (E) Further reductions in the care home market. (E) Reductions in care home capacity. (E) Changes to SFT capacity through the finance improvement programme. (M) SRG have received an improvement plan for elective waiting times. (M) The Provider Board have submitted a proposal for investment of the winter resilience monies. (E) SFT have adopted a revised trajectory for ED performance. (E) Sustained emergency department performance below national standard. (E) Sustained increased level of delayed transfers of care (DTOC) (E) Increased regulatory intervention within</td>
<td></td>
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</table>
### Board Assurance Framework Summary

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>07. The CCG fails to remain within financial balance and operate within the Business Rules as required by NHS England.</td>
<td>Chidgey, Mark</td>
<td>Financial Resilience</td>
<td>Moderate</td>
<td>4</td>
<td>3</td>
<td></td>
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<td></td>
<td></td>
<td>12/2016</td>
<td>(M) Revised QIPP Scheme Governance</td>
</tr>
<tr>
<td>08. The CCG fails to put in place arrangements to plan, monitor and track in-year QIPP target activity resulting in overall failure to deliver.</td>
<td>Chidgey, Mark</td>
<td>Financial Resilience</td>
<td>Moderate</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12/2016</td>
<td>(M) Revised QIPP Scheme Governance through the Finance &amp; Performance Committee including In-Year Tracking against Operational Plan (M) The 17/18 QIPP plan will be completed during October.</td>
</tr>
<tr>
<td>09. The CCG fails to meet its statutory duties for compliance (including procurement)</td>
<td>Ryley, Tim</td>
<td>Compliance</td>
<td>Moderate</td>
<td>3</td>
<td>3</td>
<td></td>
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<td></td>
<td></td>
<td>12/2016</td>
<td>(E) Procurement of MCP initiated (E) Vanguard Status and development of new organisational forms to deliver new models of care underway (M) Commissioner role in MCP procurement will include risk assessment of activity and continued provision of legal advice (M) Programme of improvement and compliance audits agreed by Audit Committee on 11 May 2016 including reviews of CCG and Stockport Together work (M) Policy and Procedure Action Plan remains under review by the Audit Committee and Senior Managers with appropriate prioritisation of compliance work in key areas. (M) Information Governance Action Plan 2016/17 agreed and in process of implementation. (E) Approval of Tier 1 Data Sharing Agreement not confirmed. (E) Requirement to consult on new models of care. (E) Publication of MCP guidance. (M) Joint Assurance Process.</td>
</tr>
<tr>
<td>10. The CCG fails to deliver improvements in health inequalities within the borough of Stockport.</td>
<td>Owen-Smith, Vicci</td>
<td>Partnerships</td>
<td>High</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
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<td></td>
<td>12/2016</td>
<td>(E) Stockport together programme documentation focus on inequalities. (E)GMHSCP focus on reducing health inequalities. (E)Reduction of the PH grant. (M) Opportunity to influence through MCP procurement. (M)Stockport Together healthy communities focus on reducing health inequalities. (E) Public Consultation planned for February 2016 on the Healthy Communities Business Case.</td>
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</table>

The increase in impact rating reflects current level of emergency department performance within the Stockport System.

The CCG has implemented a Recovery Plan which will deliver the planned surplus in 2016/17

Recovery Plan implemented will enable CCG to delivery original QIPP Programme and for any lost benefit to be recovered.

Commissioners will proactively use the Joint Assurance Process to ensure regulatory compliance and level of acceptability.

Stockport Together neighbourhoods current focus is on complex care. Find and treat programme not yet embedded. Investment in prevention is a challenge given the current economy financial position.

(M) Focus of Stockport Together work is prevention...
<table>
<thead>
<tr>
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<th>158</th>
<th>Risk Lead</th>
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<th>Target Likelihood Rating</th>
<th>Target Date</th>
<th>Events and Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. The CCG fails to engage the population in looking after its own health.</td>
<td>Ryley, Tim</td>
<td>Innovation</td>
<td>High</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
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<td></td>
<td>12/2016</td>
<td>and empowerment. (E) New models of care will incorporate elements of public consultation in early 2016 to provide engagement opportunity on health education and healthy lifestyles. (M) CCG Communications focussed campaigns on elements of health education. and self-management. (M) Healthwatch have agreed the consultation plan for Stockport Together.</td>
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<td>Stockport Together Executive Board needs to ensure level of priority regarding healthy communities remains in view of other priorities.</td>
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<td>30/11/2016</td>
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<tr>
<td>12. The CCG fails to play a key leadership role in the Stockport Together Partnership and ensure the views of primary care are incorporated.</td>
<td>Mullins, Gaynor</td>
<td>Partnerships</td>
<td>High</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>?</td>
<td>2</td>
<td></td>
<td>12/2016</td>
<td>(M) SRO is Chief Operating Officer of CCG (M) Director of Strategic Planning and Performance acting as Programme Director (M) Good primary care representation in change programme governance and engagement in wider programme. (M) Reviewed clinical leadership (E) MCP Framework document issued. (E) CCG Lead engagement in Vanguard programme nationally to apply learning.</td>
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<td>Governing Body and Wider Leadership Team have proactively assessed clinical leadership and have aligned to the Stockport Together Programme. Primary Care is leading the development of the Neighbourhood Business Case.</td>
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<tr>
<td>13. The CCG fails to maximise the opportunities available for improvements in health and care for Stockport patients as part of the Greater Manchester Devolution</td>
<td>Mullins, Gaynor</td>
<td>Partnerships</td>
<td>High</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>?</td>
<td>2</td>
<td></td>
<td>12/2016</td>
<td>(M) Prioritised CCG CCO and COO to play lead roles in GM Devolution Development at Executive Board Level. (E) Successful bid to GM transformation fund of £19m over three years. (M) CCO increase in capacity (E) Initiation of Provider engagement activity on Organisational Form.</td>
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<td>30/11/2016</td>
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<tr>
<td>14. The CCG fails to support the development of innovative integrated care models and the development of the Multi-Specialty Community Provider</td>
<td>Chidgey, Mark</td>
<td>Innovation</td>
<td>High</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>?</td>
<td>2</td>
<td></td>
<td>12/2016</td>
<td>(M) Stockport Together programmes and leadership. (M) The summary Stockport Together business case was approved at the July GB meeting. (E) Procurement process for MCP initiated (E) CCG / SMBC pooled budget established (M) Successful application to access to the GM transformation fund. (M) Moving clinical leadership across to Viaduct.</td>
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<td>The procurement process will assess the individual and collective provider capability to establish the MCP.</td>
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<td>31/08/2016</td>
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<tr>
<td>15. The CCG fails to maximise the opportunities and benefits arising from commissioning of Primary Care Services through the NHS England Delegated Commissioning Programme.</td>
<td>Mullins, Gaynor</td>
<td>Partnerships</td>
<td>High</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>?</td>
<td>3</td>
<td></td>
<td>12/2016</td>
<td>(E) Application for Level 3 Delegated Commissioning approved December 2016. (M) CCG need to review the capacity required for delegated commissioning (M) Additional primary care contracting capacity and expertise for 6 months in place to lead on transition from Level 2 to Level 3 (M) MOU to be in place between NHSE and CCG to ensure provision of central Greater Manchester support / expertise across key areas and manage the relationship. (E) MCP Framework published.</td>
<td></td>
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<tr>
<td>Capacity continues to be a challenge and how primary care commissioning will fit with the MCP is still to be determined. There is an opportunity to align decisions within the Primary Care committee to the strategic direction of neighbourhood services.</td>
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<td>31/08/2016</td>
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<td>16. Developments in primary care IM&amp;T fail to keep pace with and</td>
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<td>31/08/2016</td>
<td>(E) 97% of practices on EMIS Web with planned final</td>
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<td>Risk</td>
<td>Risk Lead</td>
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<tr>
<td>facilitate delivery of the CCG's Strategy for a single electronic patient record</td>
<td>Ryley, Tim</td>
<td>Reputation</td>
<td>Moderate</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>12/2016</td>
<td>(M) GM Funding has come through to facilitate roll-out of EMIS Web and EMIS Enterprise.</td>
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</table>

17. The capability, capacity and skill mix of the primary care workforce fails to align to the strategic direction of the Stockport economy.

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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Ryley, Tim</td>
<td>Organisatio... Development</td>
<td>Moderate</td>
<td>4</td>
<td>4</td>
<td>▲</td>
<td>▲</td>
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<td>3</td>
<td>12/2016</td>
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Work is underway to ensure continued focus on primary care workforce development and capability and ensure that business cases reflect the requirements of current and future workforce skill mix and capacity. However there is still not the required focus and sufficient understanding of primary care workforce challenges and solutions.

30/11/2016
Safeguarding Annual Report 2015 - 2016

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
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Executive Summary

What decisions do you require of the Governing Body?

1. To acknowledge that the CCG is not fully meeting its safeguarding responsibilities, accept the level of assurance provided and the residual risk.
2. To acknowledge the gaps/risks in the system and the actions in place to address them.

Please detail the key points of this report

1. Identifies how the CCG is meeting the statutory safeguarding requirements.
2. It reports on our providers’ compliance with the CCG safeguarding standards.
3. It incorporates the statutory requirement for the CCG to produce a:
   - Safeguarding Children Annual Report
   - Looked After Children Annual Report
4. As good practice it also includes:
   - Safeguarding Vulnerable Adults Report

What are the likely impacts and/or implications?

The CCG is not fully meeting its statutory safeguarding duties.

How does this link to the Annual Business Plan?

Safeguarding is integral to all aspects of the SCCG business plan

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

Quality Committee

Clinical Executive Sponsor: Anita Rolfe Executive Nurse

Presented by: Anita Rolfe Executive Nurse

Meeting Date: 30 November 2016

Agenda item: 14

Reason for being in Part 2 (if applicable)
1.0 Purpose

The purpose of this report is to review the safeguarding activity that has taken place over the past 12 months and benchmark it against the statutory requirements that Stockport Clinical Commissioning Group (SCCG) is required to meet.

Safeguarding forms part of the CCG compliance framework. NHS England assures compliance through an annual self-assessment audit and the CCG’s participation in the safeguarding nursing collaborative.

Safeguarding for the purpose of this paper includes; Children, Vulnerable Adults and Looked After Children.

2.0 Safeguarding Requirements of Stockport CCG

2.1 Statutory Requirements

The following are the statutory requirements as identified in *Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework June 2015*, and a summary describing how the organisation is meeting these requirements.

2.1.1 CCGs must gain assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year to ensure continuous improvement. [Partially Met]

The CCG safeguarding standards are included in a schedule contained within all clinical contracts for which SCCG is the lead commissioner. Within this schedule, there is a requirement for each provider to complete an annual audit based on the safeguarding standards specified in the contract. The audit is reviewed by the safeguarding team and RAG rated. All action plans resulting from the audit findings are monitored by the safeguarding team. Quarterly meetings are held with our main providers and less frequently with others. Although the CCG is not the lead for Pennine Care NHS FT, quarterly reviews are undertaken jointly with the Designated Nurses from the six CCGs. Failure to progress action plans in a timely manner results in escalation to the Quality Committee who then agree on the next steps.

It should be noted that this year the above process has extended to seeking assurance not only from our main providers but also from:

- Care homes with nursing
- Specialist placements providers
- A number of small contracts including Beacon Counselling, The Women’s Centre, Neuro physiotherapy.

However the process with these organisations was limited to receiving and reviewing of the self-assessment due to team capacity.
The CCG should be informed by a lead commissioner if a provider in its area has been identified as not meeting its safeguarding standards and the CCG commissions services from there. This process is robust around Care Homes with Nursing who are commissioned using the North West framework.

The Quality and Provider Management Committee received a monthly exception report until December 2015 and additional reports in respect to specific areas which are highlighted later in the main body of this report. In January 2016 the committee structure and purpose was revised and bi-monthly reports are now submitted. The committee has brought to the Governing Body’s attention, via the quality report, any issues that it has deemed that the Governing Body require to be sighted on prior to this Annual Report.

The 2015 version of the accountability framework extended the assurance requirement and as a consequence the safeguarding team has been unable to fully meet the required standard. This is identified on the corporate risk register.

2.1.2. To be a member of Stockport Safeguarding Children Board (SSCB), engaged with Stockport Safeguarding Adults Board (SSAB) and work in partnership with local authorities to fulfil their safeguarding responsibilities. [Partially Met]

These requirements are fulfilled as follows:

SSCB – “Working Together to Safeguard Children - 2015” clarifies that the Board representative should be at executive level and the Designated Doctor and Nurse attend as specialist advisors. The Stockport Safeguarding Children Board (SSCB) expects 80% attendance by members. The Designated Professionals and a CCG executive have met the required attendance this year with the Chief Operating Officer attending due to the lack of capacity in the then clinical lead. From April 16 the Executive Nurse now fulfils the role.

The Designated Nurse to fulfil the partnership requirements also chairs one of the SSCB sub groups and attends a further 6 sub-groups, all bi-monthly.

The Designated Doctor attends one sub group bi-monthly and another as required.

The Designated Nurse is also the CCG strategic lead for Domestic Abuse and attends the Supporting Families Executive Steering Group which includes Domestic Abuse as one of its terms of reference.

Vulnerable Adults – currently the Stockport Safeguarding Adult Board (SSAB) representative is the Designated Nurse for Vulnerable Adults, however the Care Act 2014 has made this board statutory and CCG Executive attendance, as with the children’s board, was required from April 2014. This was not achieved until April 2016, when the Executive Nurse was appointed, due to executive director capacity. The Designated Nurse also attends three board sub groups to fulfil partnership requirements.

Looked After Children – Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2014 and underpinned by Children Act
2004 requires the CCG to work in partnership with the Local Authority to meet the needs of Looked After Children. The Designated Nurse attends the Integrated Looked After Children Board (ILAC) quarterly and the Health Steering group monthly. Attendance at the Health Partnership Board and CAMHS Partnership Board also ensure that the health needs of Looked After Children are considered in all the relevant strategic forums.

With the appointment of the Executive Nurse in April 2016 this standard going forward will be fully met.

2.1.3. *To have in place robust processes to learn lessons from cases where children and adults die or are seriously harmed and abuse or neglect is suspected.* [Fully Met]
The designated professionals are required to be involved in any review that the Safeguarding Boards commission or Stockport Safer Partnership, who commission Domestic Violence Homicide Reviews (DVHR). There have been 4 Serious Case Reviews (SCRs) undertaken by the SSCB this year in addition to a number of learning reviews which have resulted in action plans. Action plans are monitored as part of the assurance processes and at the Integrated Health Safeguarding groups chaired by the respective Designated Nurses. The learning is disseminated to the wider health economy and also to GPs via the GP Safeguarding Leads briefings. There has been one DVHR in 2015/16; which has not been completed due to parallel statutory processes and criminal proceedings. The Governing Body has received separate briefings in respect of these reviews, identifying the learning for our commissioned services, member practices and the CCG. The Designated Professionals along with the Named GP are proactively progressing the learning from these reviews.

2.1.4 *Clear policies in place (fully met)*
The Safeguarding Policy was updated in March 2016 to ensure it reflected current statutory guidance. In addition the wording in the safe recruitment, the serious incident, whistle blowing and complaints policies has been strengthened to make safeguarding more explicit.

2.1.5. *Training [Fully Met].*
The SCCG safeguarding training strategy was updated in March 2016 to reflect changes in statutory guidance. Safeguarding is part of the mandatory training requirements for all SCCG staff and compliance is managed via the CCG e-learning portal. For a small number of staff, CHC and Medicine Optimisation, there are additional training requirements. Work has been undertaken to ensure these are captured in individual learning profiles and in 2016-17 face to face sessions will be provided by the safeguarding team to ensure the staff are meeting their required competencies.

Additional training for mental capacity has been delivered to the continuing health care team, GP adult safeguarding leads and the wider health economy using funding from NHS England to ensure that the Mental capacity Act is fully embedded in practice across the Stockport health economy.

PREVENT training is a statutory requirement, however a more proportionate response to the level of training required has been agreed nationally and the
CCG PREVENT lead has ensured that the appropriate materials are available on the CCG e-learning portal.

The CCG closely monitors mandatory training uptake so there is no risk anticipated in maintaining the organisations compliance.

2.2.2 Accountability [Fully Met]. There is a clear line of accountability reflected in the SCCG governance arrangements (Appendix 1).

2.2.3 Co-operation with Partners [Fully Met]. The SCCG co-operates with the Stockport Metropolitan Borough Council (SMBC) in the operation of the SSCB and SSAB, outlined previously, and the Health and Well-being Board.

2.2.4 Information Sharing [Fully Met]. The SCCG has a Caldicott Guardian, Dr Vicci Owen-Smith, to ensure there are effective arrangements for information sharing. This is also addressed in the safeguarding policy.

2.2.5. Designated Posts [Partially Met]. The SCCG has all the appropriate Designated Professionals in place and the Designated Nurse for Vulnerable Adults is the Mental Capacity Act Lead and the Designated Nurse LAC is the PREVENT lead.

The NHS England self-assessment also benchmarked the capacity to deliver these roles against the statutory guidance for Safeguarding Children and Looked After Children. The CCG has a 0.5 wte deficit in the capacity of the Designated Nurse Looked After Children role, however there are no identified risks associated with this.

There is draft guidance in respect to the Vulnerable Adult role which will potentially pose a challenge to the organisation in 2016-17

3.0 Specific Provider Issues
The following issues were escalated to the Q&PM committee in 2015 - 16 and where deemed appropriate were included in the monthly Quality Report to the Governing Body.

3.1 Stockport NHS FT
Maternity – In May 2015 the Designated Nurse tabled a paper at the Quality and Provider Committee outlining findings from safeguarding incidents, multi-agency audits and reviews from 2011 to present. The report demonstrated that the service was failing to embed learning and that the service did not have the appropriate safeguarding systems and processes in place including training and supervision. A robust action plan was agreed with the trust and monitored monthly by the Designated Nurse. The Director of Nursing and Head of Midwifery both attended the committee to provide assurance and demonstrate the organisations commitment to change. Very good progress was made and monitoring is now within the normal quarterly safeguarding assurance meetings

Safeguarding Children Training – following the achievement in March 15 to comply with the 2010 guidance, the Trust then introduced the additional requirements of the 2014 guidance. Initially this led to non-compliance.
However, this has been regained over the year and compliance at all 3 levels is above 80% (the % accepted by CQC).

Safeguarding Adult Training
The Trust achieved compliance.

Mental Capacity Act and Deprivation of Liberty training along with PREVENT became a focus in 15/16 due to national requirements. The organisation worked closely with the Designated Nurse around MCA/DoLS and, with funding from NHS England, plans were put in place to achieve compliance, which was achieved by March 16.

PREVENT
The Trust failed to progress this agenda and despite being a KPI and a national requirement to provide quarterly returns to the Regional PREVENT lead. The issue was to be escalated to the contract meeting, however an interim plan was agreed with the Trust which was implemented and 2016-17 should see the completion of this plan.

Looked After Children
The Trust’s performance in respect to compliance with statutory time scales to complete initial and review health assessments became an issue. The committee received a detailed paper from the Designated Nurse Looked After Children which highlighted that the root problem to this dip in performance was multi-faceted, not all within the FT’s scope to resolve. The committee was updated throughout the year about plans to resolve the issue which still remain ongoing.

3.2 Pennine Care NHS FT
The new model introduced in 2014 to undertake a joint review of the organisation’s safeguarding arrangements was found to be unworkable, with each of the six CCGs still requiring their own borough specific assurance in addition to the contractual safeguarding standards applicable trust wide. How to address this issue was delayed by the appointment of a new Designated Nurse in Heywood, Rochdale and Middleton CCG, the Lead Commissioner (resolved July 16). In 2015-16 it was highlighted that the Trust did not have a training strategy that reflected up to date guidance and was unable to provide accurate training data. A significant number of policies were out of date and the governance arrangements were identified as cumbersome. For Stockport the poor engagement in both safeguarding boards and sub-groups was identified. There was some progress locally in addressing local issues through the Designated Nurse attending the Stockport quarterly Pennine performance meeting convened by the CCG Joint Commissioner. From July 2016, Pennine Head of Safeguarding is meeting quarterly with each CCG’s safeguarding lead to report directly about the local picture.

3.3 Care Homes with Nursing
In was hoped that the attempts to undertake joint assurance work with the local authority would be re visited in 2015 -16. However for a number of factors including team sickness, Local Authority re-structuring and Stockport Together this did not occur; the CCG however undertook its own assurance work.
Issues with care homes with nursing have continued to be highlighted in every report presented to the committee this year. The reports have highlighted homes which have been subject to action plans following inspections by the Care Quality Commission and/or closed to admissions by the SMBC Quality team. Some of these concerns have been due to safeguarding issues. The committee has been assured that the Continuing Health Care Team (CHC) review any patients placed by the CCG whenever concerns are raised. CHC also communicate any concerns to the SCCG safeguarding team and receive support and guidance on appropriate responses and escalation of potential safeguarding incidents.

It was also highlighted to the committee the risk to the economy when one provider de registered some of its EMI beds and two other providers at the time were closed to admissions including EMI.

The whole issue of care homes is now being considered as part of Stockport Together and the Vulnerable Adult Annual report will demonstrate some of the initiatives that have been driven by the CCG Adult Lead.

3.4 Out of Area Providers
This primarily covers Mental Health and Learning Disability providers where individual packages of care are commissioned for Stockport patients. The safeguarding team contacts these providers directly and each completes our self-assessment tool. The commissioners use the information provided in the safeguarding standards audit when deciding the suitability of individual out of area placements.

The level of oversight of these providers in 15-16 has been purely a paper review. Where safeguarding concerns have been notified to the CCG commissioner/CHC case manager, discussions have taken place with the safeguarding team and advice given.

3.5 Third Sector Providers
There has been limited focus on this sector this year. Self-assessments were requested and the majority returned some safeguarding information, however due to competing pressures on team capacity these were not given the attention required. The CCG therefore had very limited assurance in respect to the robustness of safeguarding in our third sector providers that the CCG contracts with.

3.6 Independent providers
Including:-
• BMI Alexander
• Priory Cheadle Royal
• St Ann’s Hospice
• Beechwood Cancer Care Centre
• Mastercall
Each of these providers was visited and their compliance with safeguarding standards monitored. In 15-16 the only issue which required escalation to the committee was in respect to:

**St Ann’s Hospice**

The Quality and Provider Committee closely followed the provider’s response to addressing safeguarding training. At the end of 15-16 the clinical staff had all been trained, however the organisation did not address the recommendation from the Lampard Review which required volunteers also to receive basic awareness training in safeguarding (became statutory in the 2014 Intercollegiate document). This was again escalated through the committee and is now being addressed. Compliance will be achieved in 2016-17.

### 4.0 Other Areas

#### 4.1 Looked After Children 2015/16 Issues

These will be outlined in the Looked After Children Annual report appendix 2.

#### 4.2 General Practitioners

The Named GP took up post in September 2015 as part of the agreed model with NHS England to comply with the CCGs requirement to have a post holder. This has strengthened the safeguarding provision for General Practice and supports the CCG who became delegated commissioners for General Practices in April 16. Despite numerous attempts to progress the additional requirements of the model which were to be a hosted NHS England cross CCG provision no progress has been made and further efforts will be made in 16-17 to resolve this issue.

Since taking up post the Named GP has:
- Produced briefings/summaries of new guidance e.g. FGM
- Produced reports for serious case reviews and domestic homicides
- Shared learning from serious case reviews with GP safeguarding leads
- Facilitated training
- Produced model policies
- Provided advice and support to practices

The Designated Nurses continue to facilitate briefings for the GP safeguarding leads both children and adults to ensure they are provided with up to date information both nationally and locally and provide advice and support.

Clarity re any additional responsibility for safeguarding between NHS England and the CCG following delegated commissioning will be required as current guidance is open to interpretation.

#### 4.3 CQC Thematic Review of Safeguarding Children and Looked After Children

The CQC thematic review was undertaken in December 2014, initial verbal feedback was generally positive and the inspectors did not identify any areas that required an immediate response.

The draft report arrived in March 2015 with the final version not being published on the website until June. A formal action plan could not be
formulated until the finalised report was received. This considerable delay has impacted on the momentum of the providers to progress the actions identified.

Updates on the progress of the action plan have been provided to the Quality Committee. The plan was due to be completed in March 2016 but the considerable SCR activity and CQC inspections of both Stockport NHS FT and Pennine Care FT have delayed final sign-off. It should be noted that the final sign off was linked, in the majority of actions, to re audits to demonstrate that the action had been embedded rather than the action not being progressed.

4.4 **NHS England Safeguarding Collaborative**

There is a requirement in “Safeguarding Vulnerable People in the Reformed NHS”, for the designated professionals to work with NHS England to drive improvements in safeguarding practice across the health economy. The Area Team refreshed the GM wide safeguarding standards and assurance tool and was included in all of the 2015-16 contracts. The area team compiled a dashboard identifying the main NHS providers across GM compliance with the safeguarding standards and presented this at the NHS England QSG. This provides the CCG with a view of the safeguarding arrangements in the providers where it is not the lead. The Designated Nurse would suggest that this dashboard should be treated with caution as there are inconsistencies in how different Designated Nurses RAG rate organisations dependent on their interpretation of the standard. All the CCG Designated Nurses attend the collaborative meetings and assist in progressing pieces of work by being members of Task and Finish groups.

5.0 **Current Challenges/Risks**

5.1 **Adult safeguarding**

The CCG capacity to meet this agenda remains a risk to the organisation. This is partly due to the Care Act putting this agenda on a stronger statutory footing, which has raised both profile and demands and the increasing issues within the care home with nursing sector. Stockport Together and Vanguard will provide new opportunities to reinvigorate the joint assurance work with the local authority that has not progressed this year. Draft guidance which will benchmark the required capacity to deliver this agenda suggests the CCG does not have sufficient capacity within its current resource.

5.2 **PREVENT**

The requirement for monitoring compliance with this agenda was transferred to CCGs in April 2014 and included in the standard NHS contract. Holding the providers to account has been extremely challenging, as the requirements have been changed nationally several times creating uncertainty about what level of information/training has to be provided. There has been some progress in ensuring the workforce across the health economy has received the appropriate level of training but full compliance has not been achieved. With the ever increasing profile of radicalisation, achieving full compliance in this area has to be a priority for 16-17

5.3 **CCG statutory and authorisation safeguarding requirements including Looked After Children**
The non-compliance with the requirements has created a corporate risk and plans will need to be put in place to reduce this risk.

Both the self-assessment audits which were validated by NHS England and verified the risks have generated action plans which will be addressed in 2016/17

5.4 Primary care
Until an agreement is reached about the NHS England model, there is insufficient capacity to build on the work the Named GP has started to develop

6.0 Future Opportunities

Integrated Commissioning
To explore synergies with the CCG and local authorities statutory responsibilities

Service Development
To develop a comprehensive safeguarding web site to ensure information is easily available and the use of digital technology is maximised i.e. podcasts

Named GP
To withdraw from the NHS England model and to use the funding to develop our own resource

This section of the report has addressed SCCG’s statutory and authorisation requirements.

7.0 Quality Committee

The Quality Committee in October 2016 agreed that:
1. The information provided demonstrated that the SCCG is meeting the majority of its statutory and authorisation safeguarding requirements and has an action plan in place to address the gaps.
2. This annual report is a statutory requirement and will be presented to the Governing Body, both the Stockport Safeguarding Children and Stockport Safeguarding Adult Boards and the Integrated Looked After Children Board.

The committee asks that the Governing Body endorses point 1 above and in addition:

The Governing Body confirms that the Designated Professionals will continue to coordinate the safeguarding children, safeguarding adults and looked after children agendas on behalf of the CCG, by providing strategic and clinical leadership both to members of the CCG and to partner agencies across the Stockport economy.
The following sections will address specifically the work undertaken by the
designated professionals in their specific areas of work and identify any risks
and future plans:

Section 1: Safeguarding Children
Section 2: Looked After Children
Section 3: Vulnerable Adults

It must be noted that this report is primarily a position statement at March
2016 for 2015 – 2016 and that work across all three areas has subsequently
progressed beyond this.
### Governance Arrangements

- **CCG Governing Body**
  - Annual reports - Children, LAC and Adults
  - Exception reports
  - Quality report monthly (safeguarding headlines)

- **Quality Committee**
  - Monthly safeguarding reports

- **Designated Nurse Safeguarding Children CCG Safeguarding Lead**
  - Clinical Director for Quality and Provider Management/Executive Lead for Safeguarding Monthly meeting

- **Designated Nurse LAC Prevent lead**
  - Escalation issues

- **NHS England Safeguarding AT Collaborative**
  - National safeguarding lead

- **Appendix 1**
  - Page 13 of 31
Section 1: The 2015 – 16 Safeguarding Children Annual Report

1.0 Purpose

1.1 To fulfill the statutory requirement, as per section 11 of the Children Act 2004, to produce an annual report

1.2 To advise the Governing Body in respect to the level of assurance provided from services commissioned by the CCG in respect to their safeguarding arrangements for children.

1.3 To update the Governing Body on its safeguarding activity during 2015-16.

2.0 Context

2.1 All health organisations have a statutory responsibility to safeguard children - Children Act 1989, 2004.

2.2 The statutory responsibilities are outlined in Working Together to Safeguard Children 2015, and are expanded on in Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework, 2015. Safeguarding Children and young people: roles and competencies for health care staff, inter collegiate document 2014 also provides the statutory guidance relating to training and the roles and responsibilities of named and designated professionals.

2.3 As part of the CCG’s statutory responsibilities it must:

- Ensure that the providers from which services are commissioned, deliver a safe and effective system that safeguards children
- Ensure robust systems are in place to learn lessons from cases where children die or are seriously harmed and abuse or neglect is suspected
- Be a member of the Stockport Safeguarding Children Board (SSCB)
- It should be noted that the CCG no longer commissions Health Visitors and School Nurses, both key in providing services to children.

3.0 Background

3.1 There are 67,500 0-19 year olds in Stockport (2014) making up 23.5% of the population

3.2 The multi-agency safeguarding and support hub (MASSH), the new front door service into children’s social care received 8,434 referrals in 2015-16 compared to 7,416 the previous year. Of these, 2969 required social work assessment, a very slight increase on 14/15 and the remaining 5,739 were diverted to the supporting families pathway to be assessed as potential families in need, a rise from 4560 in 14/15. This increase in early identification reflects the embedding of the new Stockport Family model which is aiming to reduce safeguarding activity at the high level of harm and high cost end of the system.

3.3 In 2015 – 16 120 initial children protection conferences were held (a considerable decrease of 226 on the previous year) and at the end of March 2016, 191 children were subject to a child protection plan, a continuing downward trend over the previous 4 years. Emotional abuse and neglect continue to account for the
majority of child protection plans. Numbers of children on child protection plans in Stockport are below the national average.

3.4 The number of children present in households where police were called to incidents of domestic abuse has seen a slight fall this year from 1959 in 14/15 to 1920 in 15/16. What needs to be noted is that victims of domestic abuse often suffer a number of attacks before calling the police; therefore these figures do not reflect the true numbers of children who witness domestic abuse. The impact on both children’s and adult’s health is seen across a wide range of health services, including general practice, mental health services and accident and emergency. Domestic abuse therefore remains a key issue for the safeguarding team.

3.5 Early Help and Prevention is one of the key drivers to reduce the number of children requiring intervention from expensive statutory services and will play an ever increasing role going forward with further local authority budget cuts. This has seen a shift in provision, with more children who have high levels of need, being managed by universal services. In 15/16 2145 common assessments were completed by universal services including Health Visitors, School Nurses and GPs (the tool used to assess identified need), compared to 1696 in 14/15.

3.6 **Serious Case Reviews**
There have been 4 SCRs commissioned and one commissioned in 2015/16, three involving babies under six months, one baby tragically died and two teenagers who both also died. The reports are all at various stages and will be published on the Stockport Safeguarding Children Board website when all parallel criminal and coronial proceedings have been completed. A sub-group of the children’s safeguarding board will closely monitor the actions of all services, including health, who were involved in the cases to ensure learning is embedded. The governing body has already received a briefing outlining the individual cases and the findings in respect to health services. The Designated Nurse is actively involved in the whole SCR process from the commissioning to completion and will be closely monitoring the responses from the health providers to ensure they are fully engaged in the process and addressing their actions in a timely manner.

3.7 **Domestic Homicides**
There have been no new homicides involving children commissioned in 15/16. A homicide review which involved a family with a child was completed, though remains unpublished to date. There were no specific recommendations for health as this family had no contact with health services in the year prior to the event.

3.8 **Designated Doctor**
The Designated Doctor has focused this year on training paediatricians not just in Stockport but across the North West, organising two conferences which attracted over 170 delegates. Training has also been provided for GPs and Drs in training. The Designated Doctor also continues to provide expert advice to both the Child Death Overview Panel and the Serious Case Review Panel and attends the Safeguarding Children Board.

4.0 **Resources**
The resources for safeguarding children are:
• Head of Safeguarding / Designated Nurse 1wte
• Designated Doctor 2 PAs/week.
• Shared 0.5 administrative support with Safeguarding Adult and Looked After Children Nurses

There is also a Clinical Director who has safeguarding in her portfolio, from April 16 this will be the Executive Nurse. The CCG Chief Clinical Officer is ultimately responsible for safeguarding.

5.0 Equalities
The safeguarding team strives to ensure that all service users, whatever their disability, sexual orientation, age, race, culture, religion or gender receive the same level of protection from abuse from all our commissioned services.

6.0 Report Context

6.1 NHS Stockport FT (acute and community).

6.1.1 At the March 2016 assurance meeting, 4 out of the 24 safeguarding contractual standards remained on amber. There is an action plan in place to address these issues:
- The standard relating to documenting parents/carers has improved but continues to fluctuate throughout the year. This is monitored via the Trust’s record keeping audit.
- Supervision is provided to all staff members who have contact with children and their families, health visitors, school nurses, allied health professionals, midwives and ED staff. The process in maternity has recently been reviewed and strengthened, however evidence to support its embedding is not yet available. This is monitored by the Trust’s internal safeguarding committee and the quarterly reports are shared with the Designated Nurse and reviewed at the quarterly governance meeting.
- Though named health visitors, school nurses and midwives have been allocated to all the Stockport GP practices, there are still reported difficulties. The Trust has been asked to provide details of where there are difficulties so the Named GP can mediate.
- The Trust is non-compliant in meeting the PREVENT agenda but has provided a trajectory to achieve compliance.

6.1.2 The FT Named safeguarding professionals engage well with the Designated Nurse and Doctor and attend the Integrated Health Safeguarding Group. The Named Nurse accesses supervision from the Designated Nurse and likewise the Named Dr from the Designated Dr

6.1.3 Child Protection Information Sharing Project (CSIP)
SFT implemented this national project in September 2015 which ensures ED services are aware of children on child protection plans or who are Looked After at the point of contact with the service and the information is then automatically shared about their attendance with their lead professional in their home local authority.
6.2 Pennine Care NHS FT
Assurance for this organisation is led by Heywood, Middleton and Rochdale CCG but scrutinised jointly by all the Designated Nurses from the CCGs who commission from them. It has been recognised that this process does not allow for Borough specific assurance to be individually discussed and new arrangements will be put in place for 16-17.

At the March 2016 assurance meeting 3 out of the 22 safeguarding contractual standards applicable to children remained on amber. There is an action plan in place to address these issues:
- No specific audits have been undertaken or planned in relation to safeguarding (as per trust audit calendar).
- Though the safeguarding policy is up to date, a number of other Trust policies are awaiting reviews. This is on the Trust risk register.
- There is a process in place for asking re children and dependents but no audit evidence to demonstrate this is consistently documented and the implications considered.

Quarterly monitoring is now in place to review progress against the actions and to ensure any new guidance is acted upon. The organisation reorganised into boroughs in 2014 -15 and there have been some changes to resource and responsibility for safeguarding. Stockport now shares a Named Nurse for Safeguarding with Tameside, who is supported by an adult lead. Although this is more capacity than previously allocated, Pennine Care still struggles to evidence compliance with the safeguarding standards which apply specifically to each borough rather than the whole organisation. Issues that particularly relate to Stockport are:
- Attendance at some of the safeguarding board sub-groups by the identified leads is below the boards expected level of engagement
- The Named Doctor for Safeguarding Children only fulfils this role in respect to the CAMHS service rather than the whole borough. This is contrary to what the organisation’s governance structure indicates and is a gap in support to Stockport medical staff employed by Pennine.

All these will be addressed as part of the ongoing monitoring of the organisation.

6.3 Mastercall
From a child safeguarding perspective, the organisation is fully compliant with the required safeguarding standards.

6.4 Independent Providers

6.4.1 BMI – Alexander
Whilst SCCG does not commission services for children from this provider, we do commission adult care. Adult-facing staff are required to be appropriately trained in respect to children’s safeguarding and the organisation has appropriate policies in place. Other Greater Manchester CCGs do commission care for children from BMI therefore as lead commissioner we have a responsibility to inform them if the organisation’s safeguarding standards as per contract are not
being met. The organisation is fully compliant with all the required safeguarding standards applicable to children and following the appointment of a new children’s service lead, safeguarding pathways have been further strengthened. A number of good practice examples relating to safeguarding children have been identified this year.

6.4.2 Priory Cheadle Royal
SCCG has no children or young people placed at this hospital but as a provider on our footprint which provides NHS services, the Designated Nurse has a responsibility to audit their safeguarding standards. The organisation has completed the annual self-assessment and provided supporting evidence that demonstrates it is fully compliant with the required safeguarding standards.

6.4.3 A number of adult only providers, St Ann’s Hospice, Beechwood Cancer Care Centre and a range of third sector providers, have all been visited and details of their assurance are included in the adult safeguarding report. Adult-facing health staff are required to have a level of safeguarding children training. Beechwood are compliant, however St Ann’s were not and failed to progress their action plan in a timely manner which resulted in this being escalated to Quality committee and eventually the contract meeting. Progress was made with all clinical staff being compliant by June 2016. The organisation has now introduced safeguarding training for its volunteers as recommended by Lampard and made Statutory in the 2014 Intercollegiate document that identifies the training requirements for health care staff.

7.0 Risks

7.1 Primary Care remains an ongoing risk with NHS England and SCCG still having no clear agreement in respect of who is responsible for safeguarding in primary care, specifically around the provisions of training. As a result, there is no safeguarding assurance audit data available as neither organisation has undertaken this process. As a CCG being responsible for the quality and safety of the member practices, this is a significant gap in the organisation’s intelligence. A proposal was presented to chief operating officers by NHS England outlining two models which addressed the provision of a Named GP. Stockport opted for a model which required the CCG to fund one session of a named GP and to be responsible to recruiting to this post and NHS England would recruit a nursing team which would support this role. Stockport would receive 2 days support from this team. The Named GP was appointed in September 2015 and has been very proactive in promoting good practice (see page 10). The NHS England contribution to this model remains unresolved due to complex hosting arrangements. The CCG in 2016-17, will consider if to opt out of the model and develop its own provision.

The designated professionals are required as part of the Accountability Framework to engage with the GP safeguarding leads. The current arrangement is that three briefings a year are held, where the average attendance is 30. To date, there is no system in place to follow up the practices that do not attend, although they do receive all the material from the briefing, including
presentations, electronically. The Designated Doctor and Nurse have also provided bespoke training to GP practice staff as part of the Masterclass program, which was well attended.

7.2 The changing commissioning arrangements for key services that safeguard children, notably health visiting and school nursing, have challenged the previous provider focused assurance process and the health economy wide responsibilities of the designated professionals. To address this, joint assurance has been undertaken this year with the public health lead for commissioning school nursing and health visiting attending the quarterly Trust assurance meetings. However, the responsibility now lies with a new lead and public health will now undertake their own contract management. The Designated Nurse will continue to have oversight of the economy and will raise with the appropriate commissioner if there is evidence that a provider is not appropriately safeguarding children in Stockport.

7.3 Increased expectation on GPs to be more actively involved in safeguarding processes and increased awareness of GPs as they access training has seen a rise in the number of calls to the safeguarding team for advice. Though NHS England continue to have overall responsibility for safeguarding in primary care, it falls to the Designated professionals to access information for local learning reviews and homicide reviews and to ensure any learning for primary care is disseminated.

7.4 Though the CCG is not fully compliant with the revised Safeguarding Vulnerable People in the NHS 2015, in relation to services commissioned specifically for children there are no specific gaps.

8.0 Progress to Date

8.1 Named GP appointed

8.2 Benchmarked the CCG’s position in relation to the Revised Safeguarding Vulnerable people in the NHS 2015

8.3 Supervision of continuing health assessor responsible for monitoring packages of care for children with complex health needs

8.4 Safeguarding standards have been embedded all the contracts.

8.5 Ongoing work with NHS England to understand the CCG’s responsibilities in respect to Primary Care.

8.6 Compliance with the safeguarding training has improved significantly in our providers

8.7 The Designated nurse plays an active role in all aspects of safeguarding board activity.
8.8 An action plan in response to the CQC was drawn up and has nearly been completed

9.0 Next Steps

9.1 To continue to monitor safeguarding compliance across all commissioned services.

9.2 To ensure that all service developments take safeguarding into account.

9.3 To work with commissioners/CSU/ NHSE to streamline the assurance process.

9.4 To identify emerging safeguarding issues and any associated risks or commissioning requirements to the CCG.

9.5 To engage with the GP safeguarding leads who do not attend the briefings.

9.6 To be a critical friend to Stockport Family model.

9.7 To ensure that the learning from the serious case reviews is throughout the health economy and the actions progressed in a timely manner.

9.8 To ensure that the CQC action plan is completed.

9.9 To put in place a timely and effective process for sharing information between GP’s and Social Services.

9.10 To continue to engage with the NHS England Safeguarding Collaborative to help influence safeguarding arrangements across the GP footprint.

Sue Gaskell
Designated Nurse
Safeguarding Children

Dr Ian Mecrow
Designated Doctor
Safeguarding Children

12th August 2016
Section 2: The Looked After Children Annual Report 2015-16

1.0 Purpose

This is the fourth annual report for Stockport Clinical Commissioning Group (SCCG) in respect to Looked After Children (LAC). The purpose of this report is to:

1.1 Advise the Governing Body on the delivery of services for LAC during 2015-2016.
1.2 Assure the Governing Body of the extent to which the services commissioned by the organisation are meeting their statutory functions and delivering best practice.
1.3 Outline the Governing Body’s statutory responsibilities for LAC and SCCG’s compliance.

2.0 Context

2.1 All health organisations have a statutory responsibility to promote the Health and well-being of Looked After Children.

2.2 Framework

• The statutory responsibilities are outlined in: Statutory Guidance Promoting the Health and Well-Being of Looked After Children’ DH 2015.
• The specific duties for health are explained in ‘Delivering the health reforms for looked after children: How the new NHS will work from April 2013’.
• The Intercollegiate Framework for Professionals working with Looked after Children (2015) provides clear recommendations and expectations for all staff working with LAC.

2.3 The SCCG’s statutory responsibilities are:

• To cooperate with the local authority in fulfilling its duties towards looked after children, including the commissioning of statutory health assessments and reviews.
• To have a Designated Doctor and Nurse for Looked After Children.
• To commission most secondary health care, including for those originally from the CCG area but now placed outside, even where the child registers with a GP practice in the new CCG area in which they have been placed.

3.0 Background

3.1 At the time of reporting, Stockport has 300 Looked After Children of which 86 are placed outside Stockport. As a CCG we are responsible for commissioning services including health assessments for Stockport children. In addition, Stockport needs to provide services for out of area children living in Stockport. As part of the responsible commissioner guidance, the placing authority can be asked to pay; Stockport has introduced this system and is currently negotiating arrangements with the GM area.
3.2 In addition to Stockport’s own LAC, an additional 300-400 LAC from other local authorities reside here. The estimate of this number is due to the notification process when a child moves. Although there is a statutory requirement for notification, there is still not an accurate reflection of numbers placed in Stockport from other local authorities. There is an effective online reporting system in place with the local authority which has resulted in a significant improvement in accuracy.

3.3 The availability of placements for children from other areas is mainly due to the 40 plus residential units that have been granted planning permission in Stockport. These homes are operated by a number of independent providers and are regulated by Ofsted. The young people residing in these units are some of the most vulnerable and challenging and often access multiple services across organisations including health.

3.4 A comprehensive action plan was put in place following the CQC inspection in December 2014; this provided a framework to address service improvement. The 9 recommendations specifically relating to LAC have been addressed and are continuing to be embedded. These actions have been monitored as part of the overall CQC action plan.

3.5 The Designated Nurse LAC has benched marked current provision as part of NHS England’s pilot into CCG commissioning compliance. The standards being RAG rated according to compliance with statutory guidance. The resulting action plan has already produced some service improvements with the remainder of actions being monitored by Quality committee.

4.0 Resources

4.1 The SCCG has a statutory responsibility to have designated health professionals for LAC. We continue to be compliant with authorisation requirements by having the following in post-

- A 0.5wte Designated Nurse LAC.

- A medical resource for Looked after Children - a Designated Doctor who is a paediatrician with 2PAs / week to fulfil this role.

- Administrative support of 0.5 wte is shared with safeguarding children and vulnerable adults’ leads.

However following the benchmarking exercise, the capacity required for the role will need to be reviewed in light of recommendations within the intercollegiate framework and the safeguarding team overall capacity.

4.3 The provider organisation is commissioned to provide a dedicated resource for Looked after Children which sit alongside universal services. Together these fulfil the aim of reducing inequalities and ensuring Looked after Children’s health needs are met, in accordance with statutory guidance – SCCG statutory responsibility 1.
The Foundation trust has used the opportunity of the Specialist Nurse leaving to reconsider the skill mix required to deliver the service outlined within the service specification and to meet the expectations within statutory guidance.

With the restructuring there has been an additional resource, part funded from the CCG, to support care leavers. The additional funding being generated from the provider implementing PBR.

5.0 Equalities

5.1 Looked After Children and young people share many of the same health risks and problems as their peers but often to a greater degree. They often enter care with a worse level of health than their peers, in part due to the impact of poverty, abuse and neglect.

5.2 The vision across Stockport is that Looked after Children will access universal health services in the same way as other children and young people. Additional needs will be met through targeted interventions and specialist services. Furthermore, children and young people who are cared for by any Local Authority, but living in Stockport, will receive the same opportunities to access health services within the borough irrespective of their originating CCG. It should however be acknowledged that this can cause difficulties due to commissioning arrangements for these children within some services.

6.0 Report Context

Services should continue be developed in response to the need to improve outcomes for LAC and take into account the requirements of national guidance and the findings of CCG compliance benchmarking.

6.1 Assurance

6.1.1 Stockport NHS Foundation Trust

- Provide a dedicated resource for LAC which works alongside universal services.
- There is an on-going quality assurance process in place to ensure all health assessments meet the required standard. Stockport has adopted the GM model which is being used consistently in Payment By Results (PBR).
- The specialist LAC health team have been proactive in managing the KPI requirement alongside some difficulties encountered initially with long term sickness and latterly a vacancy within the service. Although the timeliness was not always achieved, the exception reports provided were appropriate and all children received the statutory assessments required.
- There is a planned programme to seek opinions of young people with regard to their experience of health assessments; however this has not yet been achieved due to capacity within the service.
6.1.2 **Pennine NHS Foundation Trust**

- There remains an identified gap in the provision of CAMHS services for LAC, particularly around transition and tier 2 services.
- There is currently no dedicated resource for care leavers.

Both these points remain a challenge but are being considered as part of the CAMHS transformation programme. There has been some additional resource from the transformation program to reduce waiting times and increase the resource for Kite (tier 2 service). There has also been investment in agreeing to fund a dedicated care leaver role. This is currently out to advert and will strengthen the support available for care leavers.

In addition to this, the separate business case for an additional Care-leaver resource to extend the provision within the LAC service (Stockport FT) will be operational from September 2016 when the team is up to full capacity. Working alongside other services, this will support the needs of Care-leavers identified within the service specification and fulfil a CQC recommendation.

6.2 **SCCG statutory responsibilities**

6.2.1 CCGs and NHS England have a duty when fulfilling their Commissioning roles to have regard to the need to:

a) reduce inequalities between patients with respect to their ability to access health services, for the CCG this is access to secondary care and NHS England, primary care, dental care, pharmacy, optometry and specialist services such as tier 4 CAMHS.

b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

6.2.2 Currently there are access issues to some services for LAC, most notably around emotional health and wellbeing and this impacts on their outcomes.

7.0 **Risks**

7.1 **Funding**

There continues to be uncertainty around the implementation of the national tariff and how this will impact on future income.

There is no consistent way in which PBR is being implemented with CCGs locally and nationally choosing to implement the tariff arrangements as they see fit. We are currently in a position in which we are being charged for Stockport children placed out of area and a system is in place to ensure the quality of these assessments. Stockport Foundation Trust has also implemented this charge for completing assessments for children placed in Stockport by other local authorities, with the additional income being used to supplement the additional nurse time required. Income from this may be problematic due to a finance agreement across GM to not cross-charge. The CCG has agreed to underwrite this cost if GM CCG’s refuse to pay this provider charge. This will be an ongoing problem until the Directors of Finance review their agreement, at which time the
funding arrangements for the commissioned service will need reviewing to take into account the impact of any decision made.

7.2 Access to Services
There are two areas where there are difficulties:
• Mental health services
• LAC placed from other areas

Both of these pose a moderate risk to the CCG. There are services available but access is inconsistent and/or there is insufficient capacity. This is being addressed as part of the CAMHS transformation, although there will continue to be a gap in mental health services for young people placed here from other local authorities. Current CAMHS provision will provide an assessment for OLA but will not provide any interventions. The assessment is discussed with the local authority from where they are placed for them to decide where to commission the service from. Stockport services do not offer this additional provision.

7.3 Access to data and information
This is predominantly a risk for Stockport NHS Foundation Trust; however, there is an impact on the SCCG which creates a moderate risk when planning services. The Provider services are looking at data collection for a LAC health profile alongside developments in IT and Child Health, in improving this area.

7.4 Service Delivery

7.4.1 Following the CQC inspection (Dec 2014) the Local Authority, Stockport NHS FT, CCG and Pennine Care NHS FT have worked in partnership to support the action plan and implement the agreed improvements. This service development has proven to be a challenge due in part to on-going service redesign and cuts to services across the economy. Improvements to processes are developed through the Multi-agency Health Steering Group which, in turn, reports to the Integrated LAC board.

7.4.2 The specialist LAC team appears under resourced when benchmarked against the intercollegiate framework (2015). The implementation of PBR has enabled investment into staffing at the same time as restructuring the team. Once the recruitment is complete, the team will have the capacity to continue with the required service improvement and meet the service specification requirements.

7.4.2 SCCG has the duty to commission statutory health assessments but does not commission health visitors or school nurses that carry out the majority of review health assessments. The Designated Nurse works closely with the LA and NHS England to ensure there is on-going scrutiny of the service specifications to ensure this role is included in both service specifications.

8.0 Progress to date

8.1 The Designated Doctor LAC is in post and embedding the role within her job plan. Consideration needs to be given to the Named Doctor and medical advisor
roles identified within the intercollegiate framework and the capacity and expectations required to fulfil the roles.

8.2 There is a specialist looked after children health team service specification in place. The team strive to deliver best practice and review this as new guidance is published. Restructuring of the team has introduced a Named nurse role and some additional skill mix. Final recruitment should be completed in September 2016. There are processes in place to ensure that the Designated Professional's roles and provider services work together to meet the health needs of LAC in accordance with statutory guidelines.

8.3 Service user involvement continues to help shape service delivery. As a CCG we continue to source a range of views to influence future service provision. The Designated Nurse LAC continues to work with Care-leavers as part of New Belongings. New Belongings is a national pilot aiming to create a ‘gold standard’ to support care leavers which can be replicated in other areas. The views of care leavers have also been taken into account in the design of services to support care-leavers and the venue of the proposed ‘drop-in’. Part of this work has been formally recognised as one of two pieces of work within Stockport highlighted in 'not seen, not heard' (CQC, 2016) a national report recognising good practice.

8.4 The Designated Nurse represents the SCCG at a number of multiagency forums which monitor and drive service improvements, the focus being improving outcomes for all Looked after Children – SCCG statutory responsibility 1.

8.6 Work needs to be continued in conjunction with public health in creating a health profile for LAC in Stockport. A template has been developed but there remains the need to be considering the best way of collecting this data in light of IT systems and change in service structuring.

8.7 Ongoing audit and training needs to be embedded into an improvement program. As a feature consistently within action plans this will provide the evidence required so assuring the CCG that desired improvements are embedded.

8.8 The Designated Nurse LAC has continued to provide a ‘Drop in’ session for support and advice for young people at Café Zest as part of the ‘New Belongings’ project. This has enabled the capturing of views and experiences from young people on their access to services across health and listening to what matters to them.

9.0 Next Steps

9.1 Funding

To monitor the financial implications for the CCG following non-payment of PBR from GM CCG in response to the directors of finance agreement.
9.2 Access to services
To work with mental health commissioners and Public Health to support the CAMHS transformation project, specifically in relation to improved access for 16+ age group.

9.3 Access to data

9.3.1 LAC health profiling data needs to be recorded to enable the needs of LAC living in Stockport to feed into the JSNA, benchmark service provision and inform future commissioning.

9.3.2 To provide input on the monitoring and reporting required from a LAC perspective during the development and implementation of the new IT systems, including Child Health IT system across the economy.

9.4 Service delivery

9.4.1 To ensure that the health needs of Stockport Looked After Children placed outside of the area are having their health needs identified and met – SCCG statutory responsibility 3. To benchmark Stockport’s progress against the quality standard for the Health and Well-Being of Looked After Children and Young People (NICE quality standard 31 April 2013) and identify any gaps that the SCCG may need to consider.

9.4.2 To identify if a formal agreement is required with health visitor and school nurse commissioners in respect to the completion of review health assessments.

Jane Hancock
Designated Nurse LAC

10th August 2016
Section 3: The Safeguarding Adults Annual Report 2015-16

1.0 Purpose

1.1 To advise the Governing Body in respect to the level of assurance provided from services commissioned by the CCG in respect to their safeguarding arrangements for adults.

1.2 To update the Governing Body on safeguarding activity during 2015-16.

2.0 Context

2.1 The Care Act 2014 sets out the statutory responsibility for the integration of care and support between health and local authorities.

2.2 All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues.

2.3 Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS.

2.4 Safeguarding adults is integral to complying with legislation, regulations and delivering cost effective care.

2.5 The CCG has a statutory responsibility to:

- Ensure the providers from which services are commissioned, deliver a safe and effective system that safeguards vulnerable adults
- Ensure robust systems are in place to learn lessons from cases where adults die or are seriously harmed and abuse or neglect is suspected
- Be a member of the Stockport Adults Safeguarding Board
- Resources: 1 wte Designated Nurse/ 0.5 shared admin support

3.0 2015-16 Activity

3.1 Serious Adult Reviews
There have been no serious adult reviews commissioned by the Safeguarding Adult Board in 2015-16.

3.2 Domestic Homicide Reviews
There is one review which is ongoing and will be concluded in 2016-17.

3.3 Other Reviews
Any incidents that are reported to the CCG in accordance to the Serious Incident Policy, by any commissioned provider organisation, are reviewed by the Quality Team and if relevant the Designated Nurse is consulted to provide a safeguarding view.
3.4 The Designated Nurse also works closely with the Local Authority Quality Team and participates in reviews of Care Homes with Nursing where concerns have been raised by the CQC or from the number of safeguarding alerts raised.

3.5 The Designated Nurse also works closely with the Local Authority Safeguarding Team and supports the team Healthcare Investigations including Primary Care.

4.0 Provider Assurance

4.1 Care Homes with Nursing – Proactive monitoring of the homes has been limited this year due to the number of homes that have had difficulties and have required intensive joint input with CHC and the Local Authority. The Quality Committee have been regularly appraised of the issues and actions being undertaken to ensure patient safety.

4.2 Independent Providers of specialist adult mental health learning disability placements.

Safeguarding self-assessment audits were sent out to all the providers Stockport currently uses and a desk top review undertaken of the information to ensure that the systems and processes were embedded in practice.

4.3 Third Sector – as above, self-assessment audits were received but due to competing pressures there was no follow up.

5.0 Progress to date

5.1 The focus for this year has been to continue to drive up safeguarding standards within organisations to improve quality and safety.

5.2 All primary care has been offered training around Mental Capacity and Deprivation of Liberty.

5.3 The Designated nurse is now a member of the Channel Panel which reviews young people and adults were concerns have been raised re potential radicalisation.

5.4 The Designated nurse has been an active member of the following multi-agency groups to ensure expert health safeguarding advice has been available:

- Thresholds/harm levels
- Safeguarding Adult Reviews
- Safeguarding Board and sub-groups
- Harm Level Panels
- Channel Panel
- Quality Issues and Concerns Group
- Pressure Ulcer Reduction Group
- Care Home Quality Standards Group
- Stockport Together a Vision for Care Homes
5.5 Adult Safeguarding was audited by Mersey Regional auditors who gave a significant assurance rating. The identified gaps have now been addressed or are part of the overall NHS England Safeguarding Assurance action plan.

5.6 External to the CCG/Stockport Economy the Designated Nurse links with:

- NHS England Safeguarding Collaborative
- GM Safeguarding Adults Forum
- DoLS North West Practitioner Forum

and has participated in Task and Finish Groups to ensure Stockport is not working in isolation when addressing national issues.

5.7 The CCG received funding from NHS England to improve knowledge within Provider organisations in relation to Mental Capacity and DoLS. As MCA lead for the CCG, a range of training was facilitated by the Designated Nurse using external speakers who specialise in specific areas:

- Applications to the Court of Protection when someone is deprived of their liberty in their own home.
- Transition for Young People and Deprivation of Liberty
- Recording a Best Interest decision
- Mental Capacity and DoLS – application of Statutory Code and Case Law

This training was well received and will be ongoing in 2016-17 whilst the funding is still available.

5.8 Development of a care home training package for Healthcare Assistants and Nurses which includes MCA/DoLS.

6.0 Key Areas of Risk/Challenge for 2016-17

6.1 Impact of Safeguarding Adults: Roles and competencies of Healthcare staff – this was published in March 2016 but withdrawn temporarily as all the professional colleges had not endorsed the guidance. The areas of concern would be capacity of the CCG post holder and the provider’s ability to comply with the enhanced standards, particularly relating to training.

6.2 Providing the CCG with proactive assurance around all adult providers who the CCG contracts with in line with the enhanced requirements of Safeguarding Vulnerable People in the NHS 2015.

6.3 Court of Protection cases where someone might be subject to deprivation of liberty within their own home, who pays the legal costs?

6.4 Nurse revalidation within care homes.

7.0 Next Steps
7.1 To re-visit with the Local Authority a shared proactive approach to monitoring quality and safety in our care homes with nursing.

7.2 Along with the named GP, support primary care’s engagement in safeguarding adult reviews and share the learning across the whole economy primary care work force.

7.3 To ensure new models of care being developed through Stockport Together incorporate Safeguard.

Andria Walton
Designated Nurse Vulnerable Adults
08 09 2016
Quality Report

Report of the Quality Committee – October 2016

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.
Executive Summary

The Governing Body is requested to consider whether any of the issues raised in this report require a higher level of escalation.

Please detail the key points of this report

<table>
<thead>
<tr>
<th>Summary</th>
<th>This report summarises the key decisions of the October Quality Committee 2016.</th>
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<tbody>
<tr>
<td>Decisions</td>
<td>None</td>
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<tr>
<td>Attachments</td>
<td>Quality Committee October Issues Log</td>
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How does this link to the Annual Business Plan?

Improving the quality of commissioned services is a key strategic aim within the CCG Annual Operational Plan.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

Quality Committee

Clinical Executive Sponsor: Dr Cath Briggs

Presented by: Anita Rolfe

Meeting Date: 30 November 2016

Agenda item:

Reason for being in Part 2 (if applicable)

Not applicable
The Quality Committee is a sub-committee of Stockport CCG’s governing body that feeds any quality and safeguarding concerns to the Governing Body by the use of an issues log. The Quality Committee meeting in October 2016 reviewed a number of quality reports from a range of providers and areas, which were fed into the quality assurance framework by the quality and safeguarding teams.

The following reports were presented for discussion within the October 2016 meeting:

- Quality Review (Care Homes)
- Quality Report – September 2016
- Quality & Performance – ED Quality Report
- CQC Quality Dashboard - August 2016
- SFT Serious Incident Report
- CQC Report
- Quality and Performance reports on mental health
- Learning Disability Assurance Transformation Register, including LD Mortality Review
- CAMHS Transformation update
- SEND self-assessment and assurance, including CCG Audit Tool
- Update on Children & Young People’s Mental Health Transformation
- Improving Children & Young People’s Mental Health in Stockport
- Safeguarding Exception Report, including Audit & Review Tracker
- Safeguarding Annual Report
- CCHC Report
- Harm Free Care Report
- Healthwatch Report
- Patient Experience Quarter 1 Report
- NICE Compliance report was reviewed by the Committee
- Mortality Report – August 2016
- Issues Log

- The Quality Review meeting due to be held on 9 November 2016 on ED/Urgent Care was cancelled due to the ongoing weekly monitoring meetings on ED Safety, involving GM HSCP (GM Health & Social Care Partnership), NHS Improvement, NHS England, CQC, SFT, SMBC and CCG)

1.0 Decisions of the Quality Committee

1.1 Issues Log:

Issue 1: District Nurse Service. There remained a shortfall in staffing within the District Nurse Service (DNS). It was noted that this issue had been on the log for two years and to date the uplift discussion had not been resolved. It was further pointed out that staffing capacity with the Service could impact on the success of the Stockport Together programme as it is a critical part of the work taking place. The issue had been escalated to an Executive to Executive meeting.
Issue 2: Timely follow-up in gastroenterology. It was agreed to change the status of this issue to amber. The waiting list had started to reduce and the issue is being monitored at Quality and Performance meetings with the Trust. The Quality and Performance Committee have requested an integrated action plan.

Issue 3: PREVENT training at SFT. It was noted that the Trust, whilst not fully compliant, are ahead on trajectory. The issue would continue to be monitored at quarterly safeguarding meetings. It was agreed to remove the item off the log.

Issue 4: RTT backlog. It was noted that there had been a slight improvement to the RTT backlog but despite trajectory not increasing, there had not been significant improvements. It was added that tracking on the trajectory is reviewed by speciality. It was agreed to leave the status as amber.

Issue 5: NICE compliance. The Committee had reviewed the compliance report (item 10.1) but as there remained a number of areas where further clarification was sought, this item would remain on the log as amber.

Issues to be added to the log:

- Gaps in responsibilities of the SEND reform to the Committee Issue Log – marked as amber
- ED performance - red

2.0 Issues highlighted to the Governing Body

This report updates the Governing Body of the discussions at the meeting:

- ECIP (Emergency Care Improvement Programme) would be working with the Trust;
- NWAS is setting up a virtual clinical hub working with Trafford CCG; a successful Pathfinder programme is in place in Stockport;
- A new system was to be implemented at the Trust from 17 October 2016 as part of the Stockport Together programme in line with reconfiguration of medical and surgical beds. This would involve a primary care clinician being co-located at the front door of ED to support the streaming of attendees to the most appropriate place (this could mean self-care or back to primary care);
- A discussion took place on the process for ensuring all LD patients are invited to an annual health check; it was noted that there was due to be a session on LD health checks at the next GP Masterclass session in November 2016;
- S Gaskell raised the issue of obtaining safeguarding self-assessments from Stockport GP Practices – issue to be raised at the Primary Care Co-Commissioning Board;
- PUPoC (Previously Un-assessed Periods of Care) – the CCHC team had met the Department of Health deadline for assessing these cases; total number of referrals: 484. There would be a new period of assessment from 2012 – 2016 therefore the process would commence again;
- It was agreed that a future Quality Review meeting would take place in the new year with a focus on the Diabetes pathway;

### 3.0 Decisions for the Governing Body

The report is provided as an update for discussion, with no decisions required of the Governing Body.

**Compliance Checklist:**

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<td>Service Changes: Public Consultation Completed and Reported in Document</td>
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<td>Paragraph numbers in place</td>
<td>Service Changes: Approved Equality Impact Assessment Included as Appendix</td>
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NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.
Executive Summary

What *decisions* do you require of the Governing Body?

This report provides an overview of the meetings of the Finance and Performance Committee which took place on 12th October 2016 and 8th November 2016.

It is important that Governing Body is aware of the progress in delivering the CCG’s CIP Schemes in year and able to identify schemes which are off track and actions to mitigate / support delivery.

Please detail the key points of this report

A key role of the CCG’s Finance and Performance Committee is to maintain a strategic overview of the delivery of CIP schemes and track progress and implementation.

The report provides an overview of the discussions which took place at the meeting relating to the following matters:

- CCG Recovery Plan
- Parity of Esteem
- Capacity challenges
- Mental Health, Stroke ESD and Spinal Business Cases
- CIP
- Learning Disabilities Health Check Schemes
- Operational Plan
- Consultant Connect

What are the likely impacts and/or implications?

Non delivery of CIP impacts significantly on the CCG’s financial plans and the delivery of required efficiencies (both non-financial and financial.)

How does this link to the Annual Business Plan?

CIP is an integral part of the CCG’s Operational Plan.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

The issues covered by this report were considered at the Finance and Performance Committee meetings on 12 October 2016 and 8 November 2016.

Clinical Executive Sponsor: Ranjit Gill

Presented by: Peter Carne

Meeting Date: 30 November 2016
Agenda item: 15
Finance and Performance Committee Update for Governing Body

1. CCG Recovery Plan

The Committee were provided with an update on progress towards achievement of the target financial surplus. The forecasted position in October shows that the CCG is on track to deliver the target, with £2m of financial risk not included within the forecast which will need to be mitigated should it materialise.

The CFO advised the committee that whilst the target surplus of 0.7% would be achieved it was highly unlikely that the CCG would be able to progress further towards the 1% target in 16/17.

2. Financial Parity of Esteem

The Committee were provided with an update on the CCG's ability to deliver against the Mental Health finance parity of esteem performance target in 2016/17. Risks to achievement of the target included a technical issue relating to prescribing costs and more importantly the pace at which planned investments were being implemented. A review of other investments identified an additional £200k which will be added to the forecast and will bring the CCG closer to parity of esteem.

A detailed analysis of Parity of Esteem will be considered at the December meeting.

3. Capacity Challenges

The Committee discussed the CCGs capacity to deliver its plans and recommends that the CCG reprioritises its resources to maintain delivery of the plan. The committee acknowledged this would present a challenge where management costs were included in the CIP plan.

4. 16/17 CIP Plan and Investments

The Committee received an update on CIP delivery 2016/17.

- The total CIP delivered was reported as £10,860k (65%) as at 31 October 2016 of which £3,240k is recurrent.
- It is forecasted that £13,455k (81%) of CIP will be delivered in-year with £9,983k (99.5%) of identified CIP delivered.

The committee noted the year to date delivery of CIP as at 2016.

5. Operational Plan 17/18 & 18/19

The committee were briefed on the initial draft report which has been submitted to NHS England. Further iterations are due with the final version to be considered by the committee on 14th December before approval by the Governing Body at the December meeting. The current position indicates that the CCG will need to deliver a minimum of £12.5m (2.8%) CIP savings in 17/18 and a further £7.5m (1.7%) in 18/19. The committee were briefed on significant risks that have been identified with regard to allocation adjustments which may impact the ability to deliver the financial business rules. The committee agreed that the risks to deliver needed scrutiny, a further iteration of the operational plan will be considered by the committee on 14 December.
6. Consultant Connect

The committee reviewed an interim report on the Consultant Connect Programme. The report demonstrated the positive impact of the service but also that not enough GPs and Consultant were staying on line to provide the feedback to fully demonstrate the value for money that is being delivered. The committee requested that a full value for money model is developed and brought back to the committee on 8th March 2017.

7. Learning Disabilities Health Checks Scheme

The committee received a progress report on CCG performance regarding the Learning Disabilities Health Check Scheme. The CCG is not achieving this important standard and the committee agreed that both validation of the register is needed and that a proposal regarding the commissioning of the Direct Enhanced Service is sent to the Primary Care Co-commissioning Committee. The committee will continue to receive and scrutinise regular performance reports.

8. Mental Health Business Cases

The committee reviewed two mental health business cases.

- Mental Health Liaison
- Mental Health Safer Staffing

Within the scheme of delegation the committee approved these business cases.

9. Stroke ESD Business Case

The committee reviewed the business case which had been developed with input from the Greater Manchester Stroke Network. Stockport is currently the only CCG in Greater Manchester without a Stroke ESD service. It was reported to the committee that the expected required investment is £570k which should significantly be funded from reduced length of stay.

10. Spinal Pathway Business Case

The committee reviewed a business case to deliver a spinal pathway which provided both rapid access to physiotherapy and a local service for the Stockport population. The committee that with the inclusion of some specific amendments the business case should be approved.

Recommendation

Governing Body is asked to approve:

- Spinal Pathway business case.
- Stroke ESD Business Case
Stockport Spinal Service
Business Case

*NHS Stockport Clinical Commissioning Group* will allow people to access health services that empower them to live healthier, longer and more independent lives.

*NHS Stockport Clinical Commissioning Group*
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900 Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: [www.stockportccg.org](http://www.stockportccg.org)
Executive Summary

Finance and Performance Committee is asked to recommend approval of the attached business case for the Stockport Spinal Service Business case.

The document will set out a case for increasing capacity to the current spinal service to enable end to end treatment locally for patients with spinal complaints. The funding will be used to:

- Increase capacity within the Stockport Orthopaedic Assessment Service to see and treat patients in a primary care setting.
- Enable patients to receive GP Direct Access Physiotherapy within 2 weeks of referral.
- Create extra capacity in local diagnostic services
- Introduce Virtual Multi-Disciplinary Team clinics across pain and surgical specialities enabling patients to be signposted to the right specialist first time.

When the business case is implemented there is a high degree of confidence that the number of spinal cases referred to secondary care services will be reduced as a result of the right treatment being received by the patient at the right time rather than a referral for surgical opinion prior to alternative therapies.

<table>
<thead>
<tr>
<th>Title of Business Case</th>
<th>Stockport Spinal Service Business Case</th>
</tr>
</thead>
</table>
| Executive Summary      | Finance and Performance Committee is asked to recommend approval of the attached business case for the Stockport Spinal Service Business case. The document will set out a case for increasing capacity to the current spinal service to enable end to end treatment locally for patients with spinal complaints. The funding will be used to:
- Increase capacity within the Stockport Orthopaedic Assessment Service to see and treat patients in a primary care setting.
- Enable patients to receive GP Direct Access Physiotherapy within 2 weeks of referral.
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- Introduce Virtual Multi-Disciplinary Team clinics across pain and surgical specialities enabling patients to be signposted to the right specialist first time.
When the business case is implemented there is a high degree of confidence that the number of spinal cases referred to secondary care services will be reduced as a result of the right treatment being received by the patient at the right time rather than a referral for surgical opinion prior to alternative therapies. |

| Value/Cost | £1,429,750 |
| Funding Source | Existing CCG Contract Baseline |
| Business Case Proposed by | Karen Moran |
| Job title | Head of Service Reform |
| Signature | |
| Date | |
| Clinical Support provided by | Dr Karen McEwan |
| Job title | GP and Planned Care Lead |
| Signature | |
| Date | |
| Reviewed by Finance | David Dolman |
| Job Title | Deputy Chief Finance Officer |
| Signature | |
| Date | |
| Approved by Director | Mark Chidgey |
| Job Title | Director of Finance |
| Signature | |
| Date | |
| Finance and Performance Committee | |
| Date | 12.10.16 |
1. Strategic Outline Case

1.1 Summary

This business case will set out a case for investment into a revised pathway to enable more people in Stockport with spinal pain to access therapies in a timely manner and have a good experience of the service. This case will set out the key national and local drivers for change, objectives to be delivered, outline support of key stakeholders, appraise the local options, and demonstrate value for money and effective outcomes.

1.2 Strategic Context

Stockport Health and Social Care Leaders are working together as Stockport Together. Within this programme of work the Acute Specialist Interface supports the reform of pathways to ensure that patients do not have to attend a hospital to receive specialist advice and support which could be obtained, either through their GP, or directly from specialist care without the need for the patient to visit the hospital. Patients also wait longer than necessary to access specialist diagnostics because of the current requirement for some diagnostics to be requested only by secondary care teams. The purpose of this programme is to provide hospital specialist support to primary care colleagues and rapid access to diagnostics (in the hospital setting) which will reduce routine and planned outpatient activity. Where appropriate support currently conducted in the hospital setting will be in the community enabling people to take greater ownership of their care and only access specialist care when needed, and where secondary care services are required the right capacity is in place to meet demand and offer services within a recognised national time frames.

1.3 National and local Driver for Change

REFORM (2015) data suggests that 14% of people claiming Employment Support Allowance (ESA) are suffering from musculoskeletal (MSK) conditions. Application of the percentage of 14% to the Stockport working population claiming ESA equates to 1,519 people.

A further study carried out by the Guardian (2011) looking at Disability Living Allowance Data, suggested that out of a population of 3,202,910, 242,020 report to be suffering with spondylosis or back pain. This would give a percentage of 7.5% for Stockport, equating to 814 people. Therefore it could be stated that somewhere between 814 and 1,519 people, within Stockport, are claiming ESA for back pain.

The fiscal cost of this to the local economy is shown in Table One.1

<table>
<thead>
<tr>
<th>Table One</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximate number of people within Stockport claiming ESA for Back Pain</td>
<td>814</td>
<td>1519</td>
</tr>
<tr>
<td>£ per week paid</td>
<td>113.63</td>
<td>113.63</td>
</tr>
<tr>
<td>Average number of weeks per claim</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>3,174,600</td>
<td>5,924,100</td>
</tr>
</tbody>
</table>

1 Please note that figures are an estimation based on the rationale provided and are not actual figures.
1.4 Current position for patients presenting with Spinal Pain in Stockport

Patients presenting with spinal pain do not have access to services, such as physiotherapy, in a timescale that is conducive to best care and recovery. Best practice for patients presenting with mechanical spinal pain is to receive physiotherapy within approximately 2 weeks. At present these patients are waiting as long as 11 weeks for physiotherapy. As a direct result of this there is evidence that patients are referred to secondary care for consultant surgical opinion as the first line of ‘treatment’. There is anecdotal evidence that the GP referral rate to spinal services at SNHSFT in 14/15 has increased by 22-25%. The increased demand to this service has resulted in SNHSFT having to out-source 136 patients to alternative providers, paying a premium rate, to ensure that they meet 18 week referral to treatment targets.

To help ensure sustainability within physiotherapy services, the CCG area business managers are working in conjunction with practices to reduce wait times for GP access to physiotherapy, one particular project will go live in the Bramhall neighbourhood in October 2016 and the Marple neighbourhood in November 2016.

Alongside this, via Stockport Together, there is work on physiotherapy being undertaken in all neighbourhoods which will have a direct positive impact on the wait times and wider issues for physiotherapy. This work will help ensure that the wait for patients who require direct access physiotherapy for conditions other than spinal pain, for example, sports injuries are also seen in a timely fashion.

The current wait time for a spinal Out Patient First Attendance is 12-14 weeks. The current conversion rate for patients from first out-patient appointment OPFA is 10-15% which supports the need to reform the current pathway of care to help ensure that only the patients who require surgical opinion are seen within a consultant led out-patient clinic. By ensuring that only patients that need surgical opinion are offered a consultant clinic appointment wait times will be reduced.

At present patients are offered spinal services at two providers, Care UK and SNHSFT for the first stages of their pathway and for the vast majority of patients, if secondary care services are required the two services dovetail into one. Due to patients entering secondary care services from one of two potential pathways there is evidence of duplication of appointments and diagnostic tests, which is unacceptable for the patient and does not offer a best value for money service. Of the two providers, Care UK does not offer locally based services. As a direct result of this Stockport patients are required to travel to one of nine locations across Greater Manchester to receive treatment.

Stockport is committed to high quality locally based services for our population and by procuring one local provider to offer spinal services to our population we are able to ensure that duplication is reduced and patients receive a seamless service.

The revised pathway of care has been a collaborative clinically led piece of work by GP’s, Orthopaedic Consultants, Pain Consultants, Specialist Pain Nurses, Extended Scope Practitioners, Radiographers, Physiotherapists, Business Managers and
Commissioners. The aforementioned cohort of staff have come together to develop a pathway of care that can provide a best practice, quality driven spinal service to Stockport patients that avoids duplication, offers best value for money and is responsive to patient’s needs. GP’s have been engaged and supportive of the primary care access to diagnostics and the ability to manage patients within a primary care setting where clinically appropriate.

1.5 Service description/care pathway
The approach is based on a structured patient journey. Please see below

![Care pathway diagram]

Patients will be referred by their GP if they still require clinical input once they have exhausted self-management and primary care options including primary care physiotherapy. Both primary and secondary care will utilise the NHS 24 MSK Help application and guide patients to use the app independently. In the event of a patient being referred for primary care physiotherapy the wait time for this service must be no longer than 2 weeks. The number of physiotherapy treatments will not normally exceed 6. Intervals between sessions will be consistent with good practice.

If the GP deems that an MRI scan prior to onward referral is necessary this will be requested by the primary care clinician and the scan results will be sent alongside the referral letter. Decision to refer for MRI spine must be based on the Royal College of Radiologists publication “Making the Best use of a Department of Clinical Radiology” (5th edition).²

² Lumbar Spine
Sciatica: less than 6 weeks with no adverse features (no red flags or signs) MRI not usually indicated.
Details of the EUR criteria for lower back pain are referenced within the Spinal Pathway of Care Service Specification and will be referenced within the contract.

In the event of the patient requiring an MRI scan the wait time for this diagnostic test from request made must be no longer than 3 weeks with the average wait time acceptable at approximately 2 weeks.

The turnaround time for reporting the scan and scan result to be available to the requesting clinician must be no longer than 3 working days.

On receipt of referral by the spinal care pathway provider the wait time from the referral being received and the patient attending their first appointment with an ESP must be no longer than 4 weeks. If at the first appointment the patient has not received an MRI scan and it is clinically indicated an MRI scan can be requested at this appointment. In the event of the patient requiring an MRI scan at this point in the pathway the wait time for this diagnostic test must be no longer than 2 weeks with the average wait time acceptable at approximately 1.5 weeks. At this point if it is deemed that a referral to a provider for further treatment is required the patient must be offered Choice.

In the event of the patient requiring a follow up appointment following their initial appointment the wait time must be no longer than 2 weeks. If at the follow up

RCGP guidelines indicate that conservative management is appropriate in sciatica without adverse features. MRI reserved for sciatica which does not resolve within the 6 week period.

Sciatica: Failed conservative management MRI indicated
Clinical radiological correlation is important, as a significant of disc herniation’s demonstrated on MRI are asymptomatic.

Low back pain with adverse symptoms or signs MRI spine indicated

Acute Cauda Equina MRI indicated
(Urgent referral via A+E or Neurosurgery route)
Sphincter or gait disturbance Saddle anaesthesia.

Mid line chronic low back pain—without progression MRI not usually indicated
In the absence of focal or neurological signs, asymptomatic chronic degenerative changes are a common finding. A trial of non-interventional treatment (exercise, physiotherapy, chiropractor treatment may be appropriate).

Chronic facet joint symptoms and signs – but without radiation down leg. MRI Not Usually Indicated.
Non-invasive treatment is often effective. MRI should be reserved for cases unresponsive to conservative management or with atypical symptoms.

Thoracic Spine
Isolated Chronic Back Pain - Without adverse features or radiation MRI Not Usually Indicated.
MRI very rarely identifies treatable lesions in the absence of focal features. Imaging is rarely useful in the absence of neurological signs or pointers of metastases or infection.

Thoracic pain with radicular radiation - long tract signs or persistent symptoms. MRI Thoracic Spine Indicated
In adults thoracic radicular pain may be an early sign of impending cord compression. Acute thoracic pain in elderly patients may require more urgent referral for imaging to assess for vertebral collapse. Plain radiographs are often adequate with MRI reserved for complex cases.

Cervical Spine Neck pain with brachalgia and/or neurological signs MRI Cervical spine Indicated
In patients where pain affects lifestyle, is unresponsive to conservative treatment or there are adverse features (eg long tract signs) MRI is most useful where there are single root symptoms and signs, and least useful where symptoms and signs are referable to multiple dermatomes.

Acute Neck pain MRI not Usually Indicated
Severe or adverse features only. Most neck pain resolves on conservative treatment. Degenerative changes are invariably seen on MRI beginning early middle age and are often unrelated to symptoms.

Chronic Neck Pain MRI Not Usually Indicated
Degenerative changes are invariably seen on MRI beginning early middle age and are often unrelated to symptoms.
appointment it is deemed that a referral for further treatment is required Choice must be offered.

1.6 Population Covered
This service is available for all patients, over the age of 18 years, registered permanently or temporarily with a Stockport CCG General Practice in Stockport presenting with spinal pain.

An Equality Impact Assessment has been completed to assess the potential impact of this service on our patients and staff whilst reflecting the needs of our patients and stakeholders.

1.7 Strategic Fit
This scheme fits within the CCGs Strategic plan. The Stockport Spinal Pathway supports CCG priorities, improving patient experience and quality of services and will seek to address improvements for people with spinal complaints.

In relation to the NHS Outcomes Framework Domains & Indicators the service aims to:

- Help people to recover from episodes of ill-health or following injury
- Ensure people have a positive experience of care
- Treat and care for people in safe environment and protecting them from avoidable harm

1.8 Objectives
The objectives of this service are to:

- Improve access to specialised clinical services and ensure patients are offered the most appropriate treatment or management in the shortest possible time.
- Limit the physical and associated disabilities that are caused by musculoskeletal back conditions.
- Support General Practice by making available a pathway of care that enables increased access to primary care diagnostics and physiotherapy.
- Reduce pressure on secondary care services and enable 18 weeks target to be met by the service operating within the 18 week rules and the utilization of Choose and Book for secondary care referrals.
- Offer a pathway of care that removes duplication and promote the integration and co-ordination of services across primary and secondary care.
1.9 Constraints and Dependencies

- Ensuring that the staff are supported effectively and receive adequate clinical supervision.
- Clearly defined care pathways, operational policies and procedures and effective systems and processes will be needed across the system, particularly between primary and secondary care services.
- Sufficient management and administrative staff to support the service
- Recognition and procurement of capacity to meet patient demand
- Patients being treated at the right time in the right place, first time.
- Collaborative working and communication between primary and secondary care clinicians and administration staff.
- The existing wait times for primary care direct access physiotherapy are approximately 11 weeks. However, this business case intentionally does not address the issue that the spinal service must start to deliver the pathway of care with a wait time of no more than 2 weeks for GP DA physiotherapy for spinal complaints. An audit was undertaken earlier in 15/16 to ascertain the resource that would be required to enable capacity within the service to do this. At that point in time it was agreed that just under £150k of non-recurrent capacity funding would be necessary to enable the reformed pathway of care to commence with a maximum 2 week wait for GP DA Physio for spinal patients. The funding and decision to do this is outside of this business case.

2.0 Strategic Options

On the basis of the information presented above the following options have been considered:

- Maintain the status quo/do nothing
- To utilise additional funding to provide a Stockport based Spinal Service with our local secondary care provider which will enhance the primary care services and offer services to people locally.

3 Economic Case

3.1 Two options have been identified to progress the business case. They have been selected based on the objectives to be achieved.

Option 1

Maintain status quo/do nothing

Patients continue to be offered spinal services at two providers, Care UK and SNHSFT for the first stages of their pathway. At present there is evidence of duplication of appointments and diagnostic tests which create tension in the system. Patients attend for unnecessary appointments which do not offer a best value for money service. Stockport patients are required to travel to one of nine locations across Greater Manchester to receive treatment.
Option 2

To utilise the new investment to increase the capacity of the existing SNHSFT Spinal Service and offer the reformed pathway of care to patients registered with Stockport GP practices.

This option will involve recruiting physiotherapists, ESP’s and additional administrative staff to continue to work within the reformed pathway of care. In this option as more therapists are recruited this will extend the capacity of the service to treat people within the national waiting time standards and reduce wait times for GP DA physiotherapy. This locally based service will offer care closer to home for Stockport residents whilst supporting the Stockport Together partnership by reducing the number of referrals from primary care to SNHSFT. Administration staff will be in place to support the therapists to progress referrals through the pathway and efficient communication back to referring clinicians.

3.2 Preferred Option

Option 2, Utilise the existing resources to increase the capacity of the existing SNHSFT Spinal Service and offer the reformed pathway of care to patients registered with Stockport GP practices.

Increasing capacity to the existing service is the preferred option. The benefits cited above will be realised by increasing capacity to the SNHSFT spinal service by recruiting ESP’s and physiotherapists alongside increased availability of diagnostic tests. ESP’s will have direct access to diagnostics tests enabling the patient pathway to be more streamlined for the patient and reduce the number of referrals from primary care to SNHSFT. The ESP’s are trained MSK specialists who can provide a range of treatment modalities for people who are experiencing spinal problems. The additional administrative support will enhance the service by improving systems and processes with referral, discharge and data support mechanisms. By increasing the capacity within GP direct access physiotherapy services workforce there is a high degree of confidence that the 2 week wait time for patients requiring physiotherapy for spinal conditions will be met.

It recommended that a review of the service takes place in one year.

4 Commercial Case

This case seeks to extend and enhance the existing service for people requiring treatment for spinal conditions at SNHSFT. It is therefore recommended that a contract variation is required.

A service specification has been shared with SNHSFT for the delivery of the reformed pathway of care and both organisations are committed to delivering this pathway of care, however due to the period of financial negotiations within the project being longer than anticipated, the start date of 1st April 2017 is now a risk. The current contract with Care UK expires in March 2017 and it is recommended that this contract is extended by the CCG until the 31st July 2017 to allow for SNHSFT to mobilise their new service with a view to a start date of 1st August 2017. This would allow for physiotherapy backlog to be cleared, enabling a 2 week wait for patients
with spinal conditions, alongside recruitment of staff to deliver the other facets of the pathway of care.

5 Financial Case

Total Value of the business case/Cost of the entire service at SNHSFT;

£1,429,750

The high level breakdowns of these costs are set out below:

<table>
<thead>
<tr>
<th>SNHSFT Spinal Service</th>
<th>Recurrent Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtual Multidisciplinary Team Clinic</td>
<td>£55,900</td>
</tr>
<tr>
<td>Orthopaedic Assessment Service</td>
<td>£303,450</td>
</tr>
<tr>
<td>Primary Care Physiotherapy</td>
<td>£596,800</td>
</tr>
<tr>
<td>Radiology</td>
<td>£343,600</td>
</tr>
<tr>
<td>Overheads</td>
<td>£130,000</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>£1,429,750</strong></td>
</tr>
</tbody>
</table>

Prior year 15/16 total costs equated to £1.4m. This recurrent resource has been identified and the proposal meets within the affordability criteria set within the CCG’s financial plan for 17/18.

The financial analysis below compares the funding that we currently pay to our existing providers, for those elements of the pathway where similar comparisons can be made.

<table>
<thead>
<tr>
<th>Service</th>
<th>Proposal SFT</th>
<th>Current Provider</th>
<th>VFM</th>
<th>Planned Activity</th>
<th>Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physio</td>
<td>£51.70</td>
<td>£59.90</td>
<td>-£8.20</td>
<td>12,665</td>
<td>-£103,848</td>
</tr>
<tr>
<td>MRI</td>
<td>£159.81</td>
<td>£130.94</td>
<td>£28.87</td>
<td>2,365</td>
<td>£68,287</td>
</tr>
<tr>
<td>OAS</td>
<td>£111.27</td>
<td>£102.17</td>
<td>£9.10</td>
<td>3,000</td>
<td>£27,285</td>
</tr>
</tbody>
</table>

Therefore, for the planned activity levels provided, the above table demonstrates that the SNHSFT reformed spinal pathway is within the financial affordability and would cost £8k less than the current providers, Care UK and SNHSFT, providing this level of activity. This highlights that the overall cost of reforming the pathway is cost neutral.

Of the total cost of £1.4m, SNHSFT recognises that £578k is already currently funded to them as part of the existing service and pathway. Therefore it is understood by both organisations that the current activity and the funding attached to it will transfer into the reformed pathway with a marginal payment to deliver the full pathway.
### Key Risks

<table>
<thead>
<tr>
<th>Key Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timely recruitment of therapists</strong></td>
<td>Stockport NHS FT has staff in place who are highly trained and experienced spinal ESP’s looking to increase their contracted hours on a permanent basis. Job descriptions for additional staff have been developed and are ready for release.</td>
</tr>
<tr>
<td><strong>Increased demand for the service</strong></td>
<td>Clear eligibility criteria will be established for access to services. Any referral must show evidence that all self-care options have not been successful. Performance management of the pathway is imperative to help ensure that the service works within its agreed timescales.</td>
</tr>
<tr>
<td><strong>Increased demand for MRI services</strong></td>
<td>Only requests for MRI that meet the GM EUR criteria for lower back pain will be accepted. Performance management of the pathway is imperative to help ensure that the service works within its agreed timescales.</td>
</tr>
<tr>
<td><strong>Current wait times for GP DA physiotherapy are at 11 weeks</strong></td>
<td>Aside from the business case there has been non recurrent funding within the CCG’s 16/17 budget of £147,278 to increase the capacity of primary care physiotherapy appointments to clear the backlog of patients waiting to be seen for spinal conditions at SNHSFT. This should alleviate the pressure on the service and enable new patients entering the system next year to wait no longer than 2 weeks. Work is being undertaken to reduce wait times for GP access to physiotherapy, this project will go live in the Bramhall neighbourhood in October 2016 and the Marple neighbourhood in November 2016. Via Stockport Together there is work on</td>
</tr>
</tbody>
</table>
physiotherapy being undertaken in all neighbourhoods which will have a direct positive impact on the wait times and wider issues for physiotherapy.

**Provider requirement of six months mobilisation period from offer of service to go live.**

SCCG to commence service with SNHSFT from 1st August 2017 and continue with current provider until 31st July 2017. Therefore extending the CCG current contract with Care UK for the months Apr/May/June/July 2017 (inc).

### 6.1 Implementation and Core Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>By Whom</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval of Business Case by CCG Finance and Performance Committee</td>
<td>SCCG DoF</td>
<td>October 2016</td>
</tr>
<tr>
<td>SCCG Governing Body Approval of Business Case</td>
<td>SCCG DoF</td>
<td>November 2016</td>
</tr>
<tr>
<td>Recruitment of therapists and administrative support</td>
<td>AD for Surgery SNHSFT AD for Diagnostics and Support Services SNHSFT</td>
<td>November 2016</td>
</tr>
<tr>
<td>SNHSFT Spinal Pathway of Care go live</td>
<td>AD for Surgery SNHSFT AD for Diagnostics and Support Services SNHSFT</td>
<td>August 2017</td>
</tr>
</tbody>
</table>
# Equality Impact Assessment

<table>
<thead>
<tr>
<th></th>
<th>Name of the Strategy / Policy / Service / Project</th>
<th>Stockport Spinal Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Champion / Responsible Lead</td>
<td>Mark Chidgey</td>
</tr>
<tr>
<td>3.</td>
<td>What are the main aims?</td>
<td>Increase capacity in the Stockport Orthopaedic Assessment Service to enable end-to-end treatment for patients with spinal complaints in a primary care setting. Enable patients to receive GP Direct Access Physiotherapy within 2 weeks of referral. For patients to receive primary care-led requests for MRI / diagnostics.</td>
</tr>
</tbody>
</table>
| 4. | List the main activities of the project:         | - Commission additional capacity within the Stockport Orthopaedic Assessment Service to see and treat spinal patients in a primary care setting.
- Commission additional GP Direct Access Physiotherapy for spinal patients.
- Create extra capacity in local diagnostic services
- Introduce Virtual Multi-Disciplinary Team clinics across pain and surgical specialties enabling patients to be signposted to the right specialist first time.
- End the current contract for spinal care with Care UK, which is based outside of the borough. |
| 5. | What are the intended outcomes?                 | - Reduce waiting times for GP Direct Access Physiotherapy for spinal patients to 2 weeks
- Offer patients a locally based service. |

## IMPACT ON SERVICE USERS

<table>
<thead>
<tr>
<th></th>
<th>Who currently uses this service?</th>
<th>Patients with spinal complaints who require orthopaedic assessment, diagnostics and treatment.</th>
</tr>
</thead>
</table>
| 7. | Are there any clear gaps in access to this service? (e.g. low access by ethnic minority groups) | The existing waiting times for primary care Direct Access physiotherapy are approximately 11 weeks.

The current service with Care UK is outside of Stockport, creating problems for patients with limited mobility or those who do not have access to transportation.

Patient engagement shows that older patients and those with mobility problems have difficulties making multiple appointments at the hospital. |
| 8. | Are there currently any barriers to certain groups accessing this | The current service with Care UK is outside of Stockport, creating problems for patients with limited mobility or those who do not have access to transportation. |
Patients with complex needs and their carers report difficulties travelling to multiple appointments in secondary care.

Waiting times are currently high, given the size of the service.

<table>
<thead>
<tr>
<th>9. How will this project change the service NHS Stockport offers? (is it likely to cut any services?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The main change for local patients will be the new option of an out-of-hospital service, based in Stockport.</td>
</tr>
<tr>
<td>• Improve access to specialized clinical services and ensure patients are offered the most appropriate treatment or management in the shortest possible time.</td>
</tr>
<tr>
<td>• Limit the physical and associated disabilities that are caused by musculoskeletal back conditions.</td>
</tr>
<tr>
<td>• Support General Practice by making available a pathway of care that enables increased access to primary care diagnostics and physiotherapy.</td>
</tr>
<tr>
<td>• Reduce pressure on secondary care services and enable 18 weeks target to be met by the service operating within the 18 week rules and the utilization of Choose and Book for secondary care referrals.</td>
</tr>
<tr>
<td>• Offer a pathway of care that removes duplication and promotes the integration and co-ordination of services across primary and secondary care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. If you are going to cut any services, who currently uses those services? (Will any equality group be more likely to lose their existing services?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This plan will expand existing services and offer additional services that are closer to home for Stockport residents.</td>
</tr>
<tr>
<td>The Care UK option will no longer be available, but will be replaced by a local offer, outside of hospital that has greater capacity than the care UK contract.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. If you are creating any new services, who most likely to benefit from them? (Will any equality group be more or less likely to benefit from the changes?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The change will expand access to Orthopaedic Assessment Services, supporting local patients with spinal complaints. The benefits of reduced travel to hospital out of area and reduced number of appointments through multi-disciplinary team working will be particularly felt by those with disabilities, mobility problems and transport issues as well as their carers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. How will you communicate the changes to your service? (What communications methods will you use to ensure this message reaches all community groups?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close engagement with Healthwatch. Information on our website and local health app, which signposts people to our services.</td>
</tr>
<tr>
<td>The main route into the services will be through Stockport GPs and Practice Nurses as the referrers. We will communicate the new pathway to our member practices through Locality meetings, Area Business Managers, and the GP Newsletter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. What have the public and patients said about the proposed changes? (Is this project responding to local needs?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This project is in response to the CCG’s five year Strategy, which was fully consulted upon and responded to local views that where possible care should be provided closer to home.</td>
</tr>
<tr>
<td>Anecdotally, local GPs report that their patients have fed back negative experiences of the current service at Care UK.</td>
</tr>
<tr>
<td>Issues have also been raised about the current long waiting times</td>
</tr>
</tbody>
</table>
from referral by GPs for Direct Access Physio for spinal conditions.

Secondary care colleagues have also reported that the current pathway is fragmented, creates duplication and confusion for patients – particularly those most vulnerable members of our community.

<table>
<thead>
<tr>
<th>14.</th>
<th>Is this plan likely to have a different impact on any protected group? (Can you justify this differential impact? If not, what actions will you add into the plan to mitigate any negative impacts on equality groups?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT</td>
<td>MITIGATION</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Older patients are more likely to use health services and are therefore more likely to be impacted by the changes, though the services are open to all adults.</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>This project will lighten the load on informal carers by reducing travel requirements.</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>All patients with long-term conditions such as those using these services are covered by the protected characteristic of disability and, therefore more likely to be impacted by changes.</td>
</tr>
</tbody>
</table>

| **Gender Reassignment** |
| **Marriage / Civil Partners** |
| **Pregnancy & Maternity** |
| **Race** | As with all local healthcare services, interpretation is available to patients with English as a second language or communication support needs. |
| **Religion & Belief** |
| **Sex** |
| **Sexual Orientation** |

**IMPACT ON STAFF**

<table>
<thead>
<tr>
<th>15.</th>
<th>How many staff work for the current service?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service forms part of a multi-disciplinary approach in Care UK, making it impossible to break down how many staff work solely on spinal cases for Stockport CCG.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16.</th>
<th>What is the potential impact on these employees? (including potential redundancies, role changes, reduced hours, changes in terms and conditions, locality moves)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The current service provided by Care UK is part of a contract which is coming to an end in March 2017. This change should be factored into Care UK’s business planning.</strong></td>
<td></td>
</tr>
</tbody>
</table>
The additional local services will create employment opportunities in Stockport for existing and new NHS staff.

<table>
<thead>
<tr>
<th>17. Is the potential impact on staff likely to be felt more by any protected group? If so, can you justify this difference? If not, what actions have you put in place to reduce the differential impact?</th>
<th>IMPACT</th>
<th>MITIGATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local NHS follows national HR laws around recruitment, based on equality and diversity principles, meaning that new opportunities created will be equally available to all spinal staff, regardless of protected characteristics.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Carers</th>
<th>Disability</th>
<th>Gender Reassignment</th>
<th>Marriage / Civil Partnership</th>
<th>Pregnancy &amp; Maternity</th>
<th>Race</th>
<th>Religion &amp; Belief</th>
<th>Sex</th>
<th>Sexual Orientation</th>
</tr>
</thead>
</table>

| 18. What communication has been undertaken with staff? | Staff within Stockport practices will receive information via their practice manager, Area Business Managers, referral coordinators, Locality meetings and the GP Newsletter. Staff within the Care UK spinal service will receive communications from their management teams as a result of the contract coming to an end. |

| 19. Do all affected workers have genuinely equal opportunities for retraining or redeployment? | Yes, new roles will be advertised and recruited in line with NHS policy. |

**IMPACT ON STAKEHOLDERS**

<table>
<thead>
<tr>
<th>20. Who are the stakeholders for the service?</th>
<th>Spinal Patients, GPs and Practice Nurses referring into the Service, relevant spinal staff, Healthwatch.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>21. What is the potential impact on these stakeholders?</th>
<th>Improved access to services, through increase in capacity. Services available closer to home.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>22. What communication has been undertaken with stakeholders?</th>
<th>Healthwatch – Monthly meetings with CCG clinical lead Patients – ongoing feedback from patients to GPs GPs – information regarding project will be communicated via the GP newsletter and individual emails. Clinical Staff – SFT spinal clinicians have been integral to the development of the reformed pathway of care. There are also regular meeting with business managers and accountants at SFT.</th>
</tr>
</thead>
</table>

<p>| 23. What support is being offered to frontline staff to communicate this message with service users? | Clearly defined pathways communicated to primary care staff. |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>family / carers?</td>
<td>Locality meetings, Area Business Managers updates. Additional information available on the Stockport Health App and the CCG Website.</td>
</tr>
<tr>
<td>24. How will you monitor the impact of this project on equality groups?</td>
<td>On-going engagement with Healthwatch and review of patient feedback. Lessons learned regarding communication and engagement will be applied to future change projects within this specialty.</td>
</tr>
</tbody>
</table>

**EIA SIGN OFF**

25. Your EIA should be sent to Head of Compliance for approval and publication: angela.dawber@nhs.net 0161 426 5610

Date of EIA Approval: 18/10/2016
### Commissioning a Stroke Early Supported Discharge (ESD)/ Integrated Community Stroke Team (ICST) Service in Stockport

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Business Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number:</td>
<td>2</td>
</tr>
<tr>
<td>Date:</td>
<td>June 2016</td>
</tr>
</tbody>
</table>

#### Lead Author:
- V1 Wendy Webster, Interim Stroke Redesign Manager, NHS Stockport CCG
- V2 Sarah Williamson, Quality and Performance Lead, NHS Stockport CCG

### Endorsed by:

<table>
<thead>
<tr>
<th>Name of Lead Clinician/Manager or Committee Chair</th>
<th>Position of Endorser or Name of Endorsing Committee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr P Carney</td>
<td>Chair of Finance and Performance Committee</td>
<td>9th November 2016</td>
</tr>
</tbody>
</table>
Commissioning a Stroke Early Supported Discharge (ESD) Team as part of the wider Integrated Community Team Service in Stockport; it is proposed that this specialist team will be known as the Integrated Community Stroke Team (ICST). The ESD will be developed within this model with a clear view that the direction of travel will be to integrate Stroke and Neuro rehabilitation in the future as per the recommendation of the network.

2. SUMMARY

NHS Stockport CCG, working with Stockport NHS Foundation Trust and 3rd sector providers proposes to develop an integrated community stroke team (ICST) with elements of Early Supported Discharge (ESD) which will significantly enhance the services available to our population. This will include bed-based and integrated health and social care services to enable people, once medically stable, to return to local services for recovery and rehabilitation.

Stroke has a devastating and lasting impact on people’s lives and on the nation’s health and economy. Strokes are a blood clot or bleed in the brain which can leave lasting damage, affecting mobility, cognition, sight and/or communication. The effects can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems.

The State of the Nation report highlights that stroke is estimated to cost the UK economy around £9 billion a year. This comprises direct costs to health and social care of £4.38 billion, costs of informal care of £2.4 billion, costs because of lost productivity of £1.33 billion and benefits payment totalling £841 million.(NICE Quality Standards 2010 updated April 2016)

Key national data which give a context to the scale of stroke include:
- Every year approximately 110,000 people in England have a stroke.
- Stroke is the third largest cause of death in England, causing 7% of deaths. It contributes to the gap in life expectancy between the most deprived areas and the population as a whole
- 20-30% of people who have a stroke die within a month
- 25% of strokes occur in people who are under the age of 65
- There are over 900,000 people living in England who have had a stroke
- Stroke is the single largest cause of adult disability. 300,000 people in England live with moderate to severe disability as a result of stroke
- People from certain ethnic minorities are at a higher risk of stroke

Intensive rehabilitation immediately after stroke, operating across the seven-day week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home, ensuring that health, social care and voluntary services together provide the long-term support people need, as well as access to advocacy, care navigation, practical and peer support.

The development of an ICST will optimise outcomes for stroke survivors and reduce length of stay in hospital. It will also lead to improved recovery which will reduce the need for complex care packages.
An individual requiring continuing health care and complex care packages resulting from a stroke is likely to cost in the range of £50k per annum. The impact of stroke can be life changing and therefore effective treatment and rehabilitation will mitigate these costs.

In 2012, the Stroke Association produced a report looking into the financial impact of stroke survivors and their families. Nationally, the findings are as follows;

- 69% of 25-59 year olds were unable to return to work.
- 65% of 25-59 year olds reported a decrease in household income.
- Household expenses increased for 58%, including heating bills, transport costs, contributions to care services and household adaptation expenses.
- 63% were living in fuel poverty.
- 40% had cut back on food.

Stroke is the largest cause of complex disability with half of all stroke survivors being left with a disability. Stroke has a greater disability impact on an individual than any other chronic disease. Over a third (37%) of stroke survivors in England, Wales and Northern Ireland are discharged from hospital requiring help with activities of daily living. The greatest phase of recovery is usually within the first days and weeks after stroke – it is currently not certain whether this is due to therapy input or spontaneous recovery, but is likely to be a combination of the two.

Transferring patients to their homes to complete their rehabilitation achieves outcomes that are at least as good or better than those achieved in in-patient settings, may reduce patient institutionalisation, contextualises the rehabilitation and is no more costly than in-patient rehabilitation. It achieves the objectives of High Quality Care for all by providing accessible high quality care in the patient’s home and will contribute to a reduction in healthcare acquired infections.

Since the opening of the hyper acute stroke unit at Stepping Hill Hospital there have been 386 confirmed strokes (11 months actual figures) this is the number of patients with stroke who have been admitted via the centralised stroke pathway. Furthermore, there have also been 150 patients confirmed to have suffered stroke that have been admitted onto other wards due to other co-morbidities or have been re-patriated from other stroke units other than Stockport.

Stroke outcomes in the UK compare poorly internationally, despite our services being among the most expensive, with unnecessarily long lengths of stay and high levels of avoidable disability and mortality (Leal J, et al 2006).

Rehabilitation services should be commissioned to reduce limitation in activities, increase participation and improve quality of life for people with stroke using adaptive strategies. With stroke being the third largest cause of disability in the UK (Newton et al, 2015 (Ref ID 1023)), providing effective rehabilitation is cost-effective in reducing long-term disability and the costs of domiciliary and institutional care.

Specialist coordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability, (National Stroke Strategy 2007). There is
robust evidence showing the benefits of ESD services, and a consensus (A Consensus on Stroke: ESD, Fischer et al, Stroke AHA, 2011) to guide the implementation of evidence based ESD service. As we move towards a fully integrated care model the ESD should now form part of the integrated community teams with specialist skills in Stroke rehabilitation.

There is research evidence supporting the implementation of ESD services including work by Langhorne et al 2005 & 2007 and the ESD consensus work from CLAHRC (Collaboration for Leadership in Applied Health Research and Care). The latter states that ESD teams should be stroke specific and multidisciplinary, offering co-ordinated and planned discharge from hospital and continued rehabilitation when patients are settled at home. The intervention is beneficial for a subset of the patient population; those of mild-to-moderate stroke severity.

Healthcare for London (HfL) guidance describes ESD as enabling a seamless transfer of care from hospital to home. This gives stroke patients the opportunity to continue rehabilitation, while being supported in their own surroundings and with input from a specialist stroke team.

The recommendation for rehabilitation input is 45 minutes of each active therapy that is required, for a minimum of five days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from therapy and are able to tolerate it (Cochrane review and NICE Guidance 2010).

HfL guidance indicates that every commissioning group should commission an early supported discharge service for people who would benefit. This service should include staff with specialist stroke skills and must meet all of the performance standards.

The development of the Hyper Acute Stroke Centre at Stepping Hill Hospital has seen increased numbers of attendances with stroke related symptoms, with at least double the number of stroke admissions expected (predicted to be over 2500), there will be increased pressure on patient flow through the inpatient Stroke Pathway in Stockport. The centralisation of acute stroke services assumes the availability of local ESD teams with capacity to pull patients through the stroke pathway from acute to rehabilitation.

Stockport currently does not have any stroke specialist community based provision for this rehabilitation. In May 2014 the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network reviewed Early Supported Discharge provision in greater Manchester found that current provision is inequitable and that this “lack of fully resourced, effective ESD teams is an operational risk to the flow of stroke patients from acute to community services”.

The National Stoke Strategy (2007) comments that, ‘the numbers of patients suitable for ESD will vary according to eligibility criteria, but in trials an average of 41% of patients were found to be suitable.’

This Business Case outlines the need for a commissioned Stroke Early Supported Discharge/Integrated Community Stroke Team (ESD/ICST) service in Stockport. There is currently no ESD provision commissioned for Stroke patients and therefore does not meet the National Standards for Stroke set out by the National Institute for Health and Care Excellence (NICE) and the Royal College of Physicians (RCP) or the locally recommended Greater Manchester (GM) Specification for Stroke Rehabilitation.

The standards aim for 40% of stroke admissions to access a timely discharge to an ESD service, in Stockport that 40% approximates to 214 patients per year requiring ESD.
An ESD service should be a complete multidisciplinary team able to provide contact within 24 hours of discharge and a level of therapy similar to that which should be provided in an inpatient setting for a short term period. The proposed service will operate 6 days a week, therefore, will be able to offer a timely response and support discharges around weekends to enhance the patient flow from acute settings.

The approval of this Business Case will ensure:

- A commissioned Stroke ESD/ICST Service that meets the National Standards and recommended GM Specification will exist in Stockport
- Stockport Stroke patients will be able to be supported at home as soon as possible after their stroke with the same levels of intervention that they could expect in an acute hospital setting
- The flow of patients from acute to community services can be enhanced; supporting the centralisation of stroke services in Greater Manchester and reducing costs for additional bed days as patients remain in the acute rehabilitation ward.

The proposed service would cost £591,180 in recurrent costs with an additional £20,000 in initial set up costs plus a grant to a Stroke third sector organisation for on-going information advice, self-management strategies and peer support.

Recommendations:-

The Clinical Commissioning Group is asked to consider the investment required for this Business Case; £591,180 in recurrent costs with an additional estimated £20,000 in initial set up costs.

The recommendation is that the full cost of the service will be released from the level of acute bed day cost which we believe can be released as a result of bed day modelling.

However, the CCG recognises that there are set up costs and a period of ‘double running’ required before bed day capacity can be fully realised and as such the set up costs of £20,000, plus an additional funding for 3 months of the service should be funded by the CCG at a cost of approximately £170,000.

3. STRATEGIC CONTEXT – CURRENT SERVICE PROFILE

The national drive for implementation of Early Supported Discharge/Integrated Community Stroke Team (ESD/ICST) within stroke services dates back to the National Stroke Strategy (2007) and continues to feature within current documents (NICE, 2016). ESD/ICST was initiated in response to the development of services that could accelerate the discharge of stroke patients admitted to hospital. It was hypothesised that such schemes could improve stroke patient care by providing a seamless service that spans the period of discharge home, a time that patients and carers frequently find difficult (Langhorne, 2003).

In 2005, an individual patient data meta-analysis concluded that appropriately resourced Early Supported Discharge services, provided for a selected group of stroke patients can reduce long term dependency and admission to institutional care as well as reducing the length of hospital stay (Langhorne 2005).
The State of the Nation (2016) publication by the Stroke Association states “It is estimated that hospital length of stay will decrease by an average of more than five days if all stroke patients have access to ESD. (ref National Audit office, Department of Health, Progress in improving stroke care. Report by the comptroller and audit general. HC 291 Session 2009-2010 3 February 2010).

The centralisation of acute stroke services across Greater Manchester assumed the availability of local ESD teams with capacity to “pull” patients through the stroke pathway from acute to rehabilitation. This assumption results in the availability of ESD/ICST teams equitably within each locality becoming operationally dependent of the acute centralisation project.

At present, the Standard Operating Procedure, as agreed by hyper acute and ESD services, is to transfer a patient to a District Stroke Centre as there is no ESD facility within Stockport resulting in unnecessarily utilising an acute stroke bed. Excess bed days during the first 12 months since the hyper acute unit opened at Stepping Hill Hospital totalled 1384 where Stockport patients were deemed fit for discharge to an early supported discharge service but remained as in-patient due to no service available. This equates to a cost of £310,000 for the period.

The proposed pathway for Stroke patients in Stockport is outlined in appendix 1; the element of the pathway that this Business Case attempts to gain investment in is highlighted in red.

3.1 ESD Potential Activity
A summary of the potential Stroke ESD activity based on Dec 2015 to March 2016 figures is detailed in Appendix 2.

3.2 Outcome Measures
The Stroke ODN currently has a task & finish group considering outcome measures throughout the Greater Manchester area. This will ensure consistent performance and quality measures are reported and will enable trusts to compare performance. Some measures already in use include:-

3.2.1 Barthel
The Barthel scale is an ordinal scale used to measure performance in activities of daily living (ADL); a higher number is associated with a greater likelihood of being able to live at home with a degree of independence following discharge from hospital.

3.2.2 Modified Rankin Scale
The modified Rankin Scale (mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke. The scale runs from 0-6, running from perfect health without symptoms to death.

- 0 - No symptoms.
- 1 - No significant disability. Able to carry out all usual activities, despite some symptoms.
- 2 - Slight disability. Able to look after own affairs without assistance, but unable to carry out all previous activities.
- 3 - Moderate disability. Requires some help, but able to walk unassisted.
- 4 - Moderately severe disability. Unable to attend to own bodily needs without assistance, and unable to walk unassisted.
• 5 - Severe disability. Requires constant nursing care and attention, bedridden, incontinent.
• 6 - Deceased.

3.3 Patient Experience/Involvement
Patient experience should be at the centre of the development of Stroke ESD/ICST in Stockport. The Stroke Quality Review report (submitted and discussed at the CCG Quality Board meeting Jan 2016), highlighted the need for patient feedback. To address this a short questionnaire will be sent to stroke patients who have attended the hospital within the last three months. The questionnaire will seek to obtain patient feedback on the support they have received since they were discharged from an acute setting.

3.3.1 Patient Survey – Stoke Association, patient feedback 2014
The Stroke Association carried out a review of their services in Stockport. The aim of the review was to obtain feedback from stroke survivors, carers and relatives, on their experience of living with stroke in Stockport and the services provided by the Stroke Association.

Although the survey was designed to provide patient feedback on their experiences with the Stroke Association involvement, some comments were in relation to the care patients had received within the local healthcare system.

Sample of comments:-

“I was feeling abandoned by the NHS. Following a call from the Stroke Association and a home visit from a coordinator, who listened to my problems, she was able to promptly organise a course of neuro physiotherapy. This is what I desperately needed and I am feeling the benefits both physically and mentally already”

Particularly to do with physiotherapy and neuro physio. “I felt abandoned when I left hospital” (x2)

“Hospital didn’t provide any help and the Stroke Association helped with my speech. More confidence” (x2)

“I understand that there are a lot of people who are in a much worse position than myself, but the Stroke Association is an invaluable service for those who are and have struggled. Once someone has left hospital, the necessary services are practically NON-EXISTENT”

“Would not have known/understood stroke if the Stroke Association hadn’t visited me – the hospital doesn’t explain the effects of stroke”

“There would be no progress or help for my husband. He would have just been discharged and left”

How much did the Stroke Association help you? “Enormously – a co-ordinator directed us to a complex neuro physiotherapist who we did not know existed. I cannot ever forget that as the NHS gave up on us”
One carer said “*I found the information the Association gave me invaluable as a carer and partner, support which is not available through the doctor’s surgery or hospital*”.

### 3.3.2 Focus Group
As patient feedback is limited, it is proposed to hold a service user focus group to obtain comments and suggestions.

### 3.4 Sentinel Stroke National Audit Programme (SSNAP)

SSNAP is a programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards. SSNAP builds on the work of the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP).

SSNAP will provide regular, routine, reliable data to benchmark services nationally and regionally supporting clinicians in identifying where improvements are needed and celebrating success.

It is anticipated that SSNAP will be the single source of data for stroke; SSNAP will provide the data for all other statutory data collections including the NICE Quality Standard and Accelerating Stroke Improvement (ASI) metrics.

SSNAP will be the chosen method for collection for stroke measures in the NHS Outcomes Framework and the CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework or COF).

### 3.5 Population Data

#### 3.5.1 2015 Stroke SSNAP Data

The table below outlines the population demographics sourced from the SSNAP Data submitted by Stockport NHS FT on the 105 Stockport stroke Patients admitted to Stockport NHS FT between Oct-Dec 2015.

This data demonstrates that a fairly even split in incidence between male and females having a stroke and that stroke is more prevalent as age increases; over 80% of the Stockport people admitted to Stockport NHS FT with a stroke being over the age of 70.

The data also points to those people suffering a stroke have a high incidence of other significant health issues; the most prevalent comorbidities being hypertension – 50.5%, and diabetes – 24.8%. 30.5% of patients have suffered a previous stroke or a TIA.

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>52</td>
<td>49.5</td>
</tr>
<tr>
<td>Females</td>
<td>53</td>
<td>53.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;60</td>
<td>8</td>
<td>7.6</td>
</tr>
<tr>
<td>60-69</td>
<td>12</td>
<td>11.9</td>
</tr>
<tr>
<td>70-79</td>
<td>28</td>
<td>26.7</td>
</tr>
<tr>
<td>80-89</td>
<td>44</td>
<td>41.9</td>
</tr>
<tr>
<td>90+</td>
<td>13</td>
<td>12.4</td>
</tr>
<tr>
<td>NIHSS on arrival (completed for 292 patients)</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>0 No stroke symptoms</td>
<td>8</td>
<td>9.4</td>
</tr>
<tr>
<td>1 - 4 Minor stroke</td>
<td>42</td>
<td>49.4</td>
</tr>
<tr>
<td>5 - 15 Moderate stroke</td>
<td>26</td>
<td>30.6</td>
</tr>
<tr>
<td>16 - 20 Moderate to severe stroke</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>21 - 42 Severe stroke</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>In atrial fibrillation before stroke</td>
<td>17</td>
<td>16.2</td>
</tr>
<tr>
<td>Congestive heart failure before stroke</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>In hypertension before stroke</td>
<td>53</td>
<td>50.5</td>
</tr>
<tr>
<td>Diabetes before stroke</td>
<td>26</td>
<td>24.8</td>
</tr>
<tr>
<td>Stroke / TIA before this stroke</td>
<td>32</td>
<td>30.5</td>
</tr>
<tr>
<td>Outcome / Discharge Destination</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Died in Hospital - Numbers of deaths in hospital reported annually, therefore unavailable at present</td>
<td>Unavailable</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Discharged to care home</td>
<td>15</td>
<td>13.8</td>
</tr>
<tr>
<td>Discharged home</td>
<td>37</td>
<td>35.4</td>
</tr>
<tr>
<td>Transferred to a community team</td>
<td>17</td>
<td>15.8</td>
</tr>
<tr>
<td>Discharged somewhere else</td>
<td>3</td>
<td>2.9</td>
</tr>
<tr>
<td>Transferred to a non-participating inpatient care team</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>Transferred to a non-participating community team</td>
<td>13</td>
<td>12.5</td>
</tr>
</tbody>
</table>

4 patients were placed on palliative care pathway within the first 72 hours following admittance.

3.5.2 Stockport Stroke Population Projections

Stockport currently has 55,600 residents over the age of 65 (JSNA 2014) this is 19.4% of the Stockport population and it is estimated that by 2025 this will rise to 22.1% ie 66,500 residents. This cohort of residents includes 7,400 over the age of 85 rising to 11,000 by 2025. The population of Stockport is currently estimated to be 280,000 people. Incidence rates in the UK vary depending on the country or region being researched. It can range from 115 per 100,000 population to 150 per 100,000 population depending on the study.(Feigin VL, et al. (2013). Global and regional burden of stroke during 1990-2010: findings from the Global Burden of Disease Study 2010. The Lancet, Early Online Publication, 24 October 2013; Wang Y, Rudd AG, Wolfe CDA (2013). Age and Ethnic Disparities in Incidence of Stroke Over Time. Stroke.2013;44:3298-3304).
4. STRATEGIC CONTEXT – CASE FOR CHANGE

4.1 National Context

There are a number of National Standards that identify the requirement for an ESD Service in Stroke within each locality. The RCP Guidelines for Stroke 4th Edition 2012 state that commissioning organisations should commission:

- An inpatient stroke unit capable of delivering stroke rehabilitation as recommended in this guideline for all people with stroke admitted to hospital
- An early supported discharge team to deliver stroke specialist rehabilitation at home
- Rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages
- Services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services, as recommended in this guideline

The NICE Stroke Rehabilitation Guidelines 2013 (updated 2016) recommend that ESD should be part of a skilled stroke rehabilitation service and should consist of the same intensity of therapy and range of multidisciplinary skills available in hospital. It should not result in a delay in delivery of care. These guidelines also state that ESD should be offered to people with stroke who are able to transfer from bed to chair independently or with assistance, as long as a safe and secure environment can be provided.

NHS Improvements produced a document to guide commissioning of stroke rehabilitation and ESD (Stroke Rehabilitation in the Community: Commissioning for Improvement) which included the example of a Stroke ESD pathway below:
4.2 Local Context

Given the often complex and long-term needs of people with stroke, collaboration between commissioners from health and social care is required to deliver comprehensive, integrated services. Partnership working may also be required between commissioners across geographical boundaries, for example in providing hyper-acute stroke care and tertiary neuroscience services. Clinical Networks with an understanding of the complexity of the stroke pathway have brought commissioners and providers together, and have proved to be successful in quality improvement and service re-design. There needs to be an acknowledgement that investment of resources in one particular part of the pathway, for example acute stroke care by health services, may lead to a reduction in demand for services in another part of the pathway, for example long-term care needs. Commissioners and providers need to work closely to ensure that financial disincentives do not become barriers to the provision of seamless, evidence-based care and in achieving better outcomes for patients. Services must always be designed around the needs of patients with stroke, and not around misplaced organisational priorities. All of the recommendations about transfers of care require close collaboration between those who commission and provide care in hospital and in the community. Service redesign based around the needs of the patient often requires a willingness to shift resources from one sector to another if that is where care is more appropriately and effectively provided.

These recommendations should result in a comprehensive stroke service that is more coherent, responsive and cost-efficient. In some instances there will be costs associated with start-up or with changes in practice, but the evidence suggests that well-organised services generally deliver better outcomes at approximately the same cost. Early supported discharge services are a good example of this, with resources being transferred out of the hospital sector into
community provision. Achieving change consistent with these recommendations will require considerable initial effort and commitment involving negotiations with many parties including health services, local government, voluntary and community groups, patient and carer groups and private providers. Consideration should be given to decommissioning any service or part of the pathway with a provider which falls short of these requirements and recommissioning the service or pathway from an alternative provider.

The Greater Manchester & Cheshire Stroke Network developed a set of Quality Standards for Stroke Rehabilitation in 2012 and developed further guidance in 2016 for a common integrated community stroke model for Greater Manchester; pulling together the national standards and consensus into one document intended to inform standards of service provision required within each locality.

These standards included the following sections relevant to ESD in Stroke:

- Patients with enduring impairments or activity limitations should be referred to an Early (or Timely) Supported Discharge team or specialist stroke skilled community services following discharge from hospital
- 40% of all stroke patients should be supported by a stroke skilled Early Supported Discharge team
- Early supported discharge is defined as a comprehensive stroke skilled MDT who manage patients at their place of residence and who are able to provide rehabilitation and care of similar intensity to that of an in-patient rehabilitation stroke unit
- Composition of an ESD team would usually include co-ordinator/manager, PT, OT, SLT with support from nursing, psychology and social care
- Stroke patients should be contacted within 24 hours of discharge from hospital by the ESD Team
- All patients who are able to tolerate it should receive at least five sessions of each therapy per week of Occupational Therapy, Physiotherapy & Speech and Language Therapy, (Weeks start when treatment starts; on-going to enable patients to meet goals)
- Nursing/ personal care support offered up to 4 times per day, including getting out and into bed, if required
- Stroke patients should have a review at 6 months following stroke. (New guidelines will expand this requirement to a review at 6 months and then annually following stroke). The CCG recommend that this is provided within the model but by a third party provider such as the Stroke Association.
- Early supported discharge teams should have staffing levels in accordance to national recommendations. CLAHRC consensus minimum staffing levels for a stroke specialist, multidisciplinary ESD team (For 100 patients per year caseload):

<table>
<thead>
<tr>
<th>Profession</th>
<th>Staffing levels (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapist</td>
<td>1.0</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1.0</td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>0.4</td>
</tr>
<tr>
<td>Physician</td>
<td>0.1</td>
</tr>
<tr>
<td>Nurse</td>
<td>1.0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>0.05</td>
</tr>
<tr>
<td>Assistants</td>
<td>Depends on model and remit of team</td>
</tr>
</tbody>
</table>
The stroke service at Stockport NHSFT currently provides a 13 bedded acute stroke unit that delivers assessment and delivery for thrombolysis to patients Greater Manchester wide that present within 4 hours of stroke and a complete acute bundle of care for Stockport residents admitted with stroke. Stockport NHSFT also has a 16 bedded stroke rehabilitation unit for Stockport residents.

There is no capacity within the team to in-reach and drive appropriate referrals and transfers of care, therefore, the onus is currently on inpatient therapists to continue therapy for longer periods of time before being able to refer patients to the Community Rehabilitation, STAR or Home Based Integrated Care Teams.

5. STRATEGIC CONTEXT – MARKET ANALYSIS

The Stroke Rehabilitation in the Community: Commissioning for Improvement document states that where effective community rehabilitation teams are in place ESD services should still be offered, ESD services should have appropriate staffing levels to provide ESD for suitable patients, and that there may be benefits to having the ESD team and community rehabilitation team in one location.

6. STRATEGIC CONTEXT – NATIONAL AND LOCAL OBJECTIVES

6.1 National Objectives
There are a number of national documents and research articles outlining the importance of delivery of and providing an evidence base for an ESD/ICST Service in Stroke. Some of these documents have also set out the more specific standards for ESD/ICST service provision. Please find below a summary of these.

National Stroke Strategy (2007)
NHS Improvement Stroke Rehabilitation in the Community: Commissioning for Improvement A Consensus on Stroke: ESD, Fischer et al, Stroke AHA (2011)
For the ESD Trialists. Services for reducing duration of hospital care for acute stroke patients (Langhorne et al 2005)
For the ESD Trialists. ESD after stroke (Langhorne et al 2007)

6.2 Local Objectives
The recommendations from the above national policy and guideline documents relating to stroke ESD/ICST have been built into the Greater Manchester & Cheshire Stroke Network Quality Standards for Stroke Rehabilitation (2012) and inform the required standards of local service provision.
Patients with enduring impairments or activity limitations should be referred to an Early (or Timely) Supported Discharge team or specialist stroke skilled community services following discharge from hospital

40% of all stroke patients should be supported by a stroke skilled Early Supported Discharge team

Early supported discharge is defined as a comprehensive stroke skilled MDT who manage patients at their place of residence and who are able to provide rehabilitation and care of similar intensity to that of an in-patient rehabilitation stroke unit. Composition of the team would usually include co-ordinator/manager, PT, OT, SLT with support from nursing, psychology and social care

Patients should be contacted within 24 hours of discharge from hospital by Early Supported Discharge

100% of patients should be given a set of short and long-term goals that have been negotiated with them, their family/carers and the rehabilitation team within two weeks of admission to the community rehabilitation service. The patient and their family/carers should receive a copy of the goals which is appropriately formatted for their individual needs

100% of patients should have a record of comprehensive assessments of the patients’ impairments and activity limitations using standardised measurement tools (such as the G-MASTER toolkit within one week of arrival to, and one week of discharge from ESD

All patients who are able to tolerate it should receive at least five sessions of each therapy per week of Occupational Therapy, Physiotherapy & Speech and Language Therapy, (Weeks start when treatment starts; on-going to enable patients to meet goals)

Nursing/ personal care support offered up to 4 times per day, including getting out of, and into bed, if required

Early supported discharge teams should have staffing levels in accordance to national recommendations

7. DESCRIPTION OF PROPOSAL

The proposal is that a Stroke ESD/ICST Service is commissioned in Stockport that meets the requirements of relevant local and national guidelines. The Stroke early supported discharge service enables the accelerated discharge of stroke patients to their home (family home) providing specialist rehabilitation and social support in the community comparable to that of an in-patient stroke unit. Service provision would be focused around time specific patient goals and will embrace the needs and ability of patients and their carers.

In order to ensure Stockport Stroke patients receive a quality service across the patient pathway which generally meets the GM Specification and the relevant clinical guidelines it is proposed that the following ESD/ICST Team is required and needs to be formally commissioned to manage a predicted caseload of 350 patients per year (Based on SFT figures, SSNAP, SUS and SLAM data and comparison with a similar populated CCG area). This estimation has also been considered by the GM Operational Development Network for Stroke.

The team staffing requirement has been based on analysis of local patient need and evaluation of existing ESD Models and National Recommendations; the proposed staffing levels for managing 40% of Stockport Stroke patients in Stockport is based on the recommendations
based on CLAHRC Model. This model is outlined in the table below and was arrived at following development of an activity plan which is calculated at the highest intensity of treatment required for each ESD patient, by each professional group, for the total of Stockport stroke patients per year. This model, therefore, is a model developed in order to meet the needs of local patients rather than to exactly match either of the recommendations.

| Stockport (Case load: 348 patients / year) |
|---------------|-----------------|-----------------|-----------------|
|               | Proposed Stockport Model | Recommendations Camden | Recommendations CLARHC |
| Occupational Therapy | 3                | 6.96            | 3.48            |
| Physiotherapy    | 3                | 6.96            | 3.48            |
| Speech and Language Therapy | 1.5             | 3.13            | 1.32            |
| Nurse           | 1                | 3.13            | 3.48            |
| Physician       | 0                | 0               | 0.34            |
| Dietician       | 0                | 0.87            | 0               |
| Psychology      | 1                | 1.74            | 0               |
| Social Worker   | 0                | 1.32            | 0.17            |
| Rehab Assistants| 3                | 4.35            | Dependent on Model |
| Team Co-ordinator | As part of senior therapist/nurse role | 1.0            | 0               |

(NB: The Team Co-ordinator role will be played by one of the senior therapists/nurse within the team)

Access to dietician, social work support, mental health support and intermediate tier (active recovery support) will be critical to the success of the ESD Service in Stockport and a decision will be required on whether specific Social Work Support will be funded to sit within the ESD Team as above or whether access to Social Work is delivered through the Stockport’s Together boroughwide or neighbourhood pathway.

The stroke ESD service will accept patients who meet all of the following criteria:

- Patients Registered with a Stockport GP
- Diagnosis of a new stroke following a clinical decision made by a consultant and/or CT scan result
- Medically fit for discharge home with appropriate medical assessments and investigations completed/planned
- Compliant with rehabilitation programme and goals identified prior to discharge
- The existing ESD/ICST requirement for patients to be able to transfer independently or with support from one trained person / carer will be amended to being able to transfer with assistance in order to enable more dependent patients to be supported in ESD/ICST
- Nursing and AHP management plan in place appropriate for the ESD/ICST Service including medicine management
- Appropriate home environment with Social needs that can be met by the ESD/ICST Service
Patient and carer consent will be sought for discharge into the Stroke ESD/ICST when patients have been identified as eligible.

When the mental capacity of the patient to make a decision re: ESD/ICST is in question, the decision for discharge should be made in the best interests of the patient by the MDT following appropriate assessment and discussion with the next of kin or carer.
7.1 Proposed Clinical Care Pathway

- **Identifies Patient's suitability for ESD/ICST**
  - **Yes**
  - **No**

  - **MEETS CRITERIA FOR EARLY SUPPORTED DISCHARGE**
    - **Yes** (1st contact within 24hrs)
    - **No**

    - **WITH INTENSITY OF INPUT IDENTIFIED TO MEET CLINICAL NEED**
      - **STANDARD COMMUNITY REHABILITATION**
        - **LOW INTENSITY**
        - **MEDIUM INTENSITY**
        - **HIGH INTENSITY**

    - **PATIENT COMPLETES SUPPORT**

    - **ESD/ICST HANDOVER TO NEIGHBOURHOOD OR INTERMEDIATE TIER IF FURTHER INTERVENTION IS REQUIRED**

    - **PATIENT RECEIVES 6 MONTH REVIEW**

    - **PATIENT REQUIRES ON-GOING SUPPORT FROM GENERAL REHABILITATION**

- **ESD/ICST HANDOVER TO NEIGHBOURHOOD OR INTERMEDIATE TIER IF FURTHER INTERVENTION IS REQUIRED**
7.1.1 Stroke Pathway Flow

All patients are assessed in the HASU setting for their eligibility to enter ESD against the Network provided criteria.

Those patients that meet the criteria would then be discharged into ESD directly from HASU. If the ESD Service is resourced as per the Business Case patients would not be required to remain as in-patient on a rehabilitation ward.

There will be some patients who require a period of rehabilitation to get them to a point that they are eligible to enter ESD, i.e. patients may require a period of rehabilitation to get them to a point where they can transfer independently or with support of a carer. Based on Stockport NHS FT data the average length of stay for this patient group on the rehabilitation ward is currently 23 days. Provision of ESD to this patient group enables the patient to be discharged home when they are eligible for ESD rather than them having to stay as inpatient for further rehabilitation.

7.2 Service Provided to Patients

Hospital Phase

- On the Acute Stroke Unit patients will be identified as potentially suitable for the Stroke ESD Service via daily ward round. The MDT will then discuss patients identified, reviewing them against the criteria to come to a joint decision on the patients suitability.
- On the Stroke Rehabilitation Unit all patients will be reviewed weekly on how they are achieving their goals within set timeframes at MDT meetings and they will be identified as suitable for ESD through this process.
- All stroke patients will also be categorised using the Modified Rankin Scale and the Barthel 20; these will be completed by stroke clinicians within the service and will inform the MDT decision.
- Once a patient is identified as suitable for ESD then the decision will be discussed with the patient and their family/carers. An identified member of the MDT team would take the lead in facilitating the discharge for that patient and they will be the professional likely to have most involvement with the patient.
- A member of the ESD/ICST team will attend the MDT and facilitate appropriate communication between the FT and the ICST.
- Appropriate assessments, investigations, interventions and management plans will have been completed prior to discharge for each profession involved.
- Patient focused, MDT goals (using the standardised format of goal setting) will have been documented in the patient’s records with an appropriate treatment plan prior to discharge from hospital. These will also be written in the Stroke MDT Discharge Summary that is given to the patient prior to discharge.
- The patient will be given an initial appointment for first contact by the ESD Service prior to discharge from hospital. Discharge arrangements i.e. discharge summaries, prescriptions; TTO’s etc will be completed as per the current Discharge Policy and in line with Network Recommendations
- Appropriate training of relatives or carers in relation to patient care and patient handling will have taken place prior to discharge within the hospital setting / or domiciliary setting via a home visit if required. Examples of training that could be given include training on how to support transfers and mobility, assist with functional activities, prepare
food/drinks and manage medications.

Post Hospital Discharge Phase

- Patients discharged under the Stroke ESD service will have contact with a member of the team within 24 hours of their discharge home, 6 days a week as per clinical reasoning.
- The service will provide input dependent upon patient rehabilitation potential and individual patient centred, time specific goals. Patients will undergo as much therapy appropriate to their needs as they are willing and able to tolerate.
- Each intervention will be recorded as appropriate in accordance with professional documentation standards and recorded on the Trust data collection system.
- The patient centred goals will be evaluated regularly and discussed within the MDT as appropriate.
- Should the patient experience a new medical problem, the teams would seek support from relevant medical staff to provide a diagnosis for the problem. Initial care would be provided by the patient’s GP or the Out of Hours Service as appropriate, a significant deterioration or new stroke/TIA would require the patient to go directly to A+E.
- Should the patient deteriorate or issues arise that the carers are struggling to cope with, or the patient is no longer appropriate for ESD, then a member of the Stroke ESD Service would ensure appropriate care was provided through appropriate referral to other community or Intermediate tier services i.e. such as referral for rehab in bedded facility.
- Length of input will vary dependent on patient need with a target maximum length of stay of 6 weeks in the service. An episode of care is ended when the patients goals agreed with the team are achieved or the individual no longer requires the intensity of intervention provided by the ESD team.

Discharge from ESD Phase

- On discharge the patient / carers will be provided with a management plan as appropriate and onward referral to appropriate other services will be agreed and completed.
- Patients requiring further treatment by the Community Rehabilitation Team (CRT) will be handed over.
- The patient, the GP and relevant others will be notified in writing of discharge, outcome of treatment and any onward referral or future plans.

7.3 Proposed Staffing and Roles

A description of the proposed staffing roles and the activity undertaken by each member of the team can be found in Appendix 3. The staffing ensures appropriate professional skill mix to provide a good quality and efficient service that can meet all the requirements of the GM Standards

7.4 Location / Accommodation requirements

The ESD Team will be a community based team which will require a base. It is proposed that this could be accommodated in the existing office space at Hazel Grove Clinic or could become aligned to one of the bases of the intermediate tier active recovery teams. (To be agreed)
7.5 Stockport Stroke ESD Positioning

The following 2 options for the positioning of the Stroke ESD Team within Stockport have been appraised:

<table>
<thead>
<tr>
<th>Options</th>
<th>Advantages/Benefits</th>
<th>Disadvantages/Risks</th>
</tr>
</thead>
</table>
| 1. ESD Service to sit with Stroke Inpatient Services | **Operational Impact:** Direct access to stroke-specialist therapy support/supervision  
**Operational Impact:** Aligned with existing Acute Stroke Clinical Governance structures  
**Impact on Patients:** Greater presence on acute site could give improve ability to pull patients  
**Impact on Patients:** Co-located with the Acute part of the stroke pathway; therefore, improved communication and ability to achieve seamless transition at this point. | **Operational Impact:** Would require new lone worker systems to be set up for ESD team  
**Operational Impact:** Limited options for cross cover due to acute caseload priorities.  
**Operational Impact:** Increases the FT footprint within the area and does not fit with the developing programme of works in relation to the Stockport Together plans for a fully integrated healthcare service.  
**Impact on Patients:** Risk of staffing getting drawn into support inpatient caseload demands rather than pulling patients out  
**Impact on Patients:** Risks to effective communication and seamless transfer at the end of ESD as not co-located with CRT |
| 2. ESD Service to sit with the Community Rehabilitation Team | **Operational Impact:** ESD is predominantly provision of input to patients in their own homes and is closely aligned to the intermediate tier’s active recovery model  
**Operational Impact:** Shared lone worker and other community systems | **Operational Impact:** Potential governance issue as would sit outside hospital stroke services although links into Stroke Clinical Governance |
<table>
<thead>
<tr>
<th>Clearer definition of budget / activity plan aligned with existing community contract</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Options for cross cover for sickness etc from within intermediate tier</td>
<td></td>
</tr>
<tr>
<td>Reduces the FT footprint and is more in line with the Stockport Together programme of work to develop a fully integrated health and social care system in the area.</td>
<td></td>
</tr>
</tbody>
</table>

**Impact on Patients:**
Co-located with the longer term rehab part of the stroke pathway (intermediate tier / borough wide services and neighbourhood care and support model); improved communication and ability to achieve seamless transition at this point.

**Impact on Patients:**
Risks to effective communication and seamless transfer on hospital discharge not co-located with acute inpatient team, however, ESD team would in-reach into acute services to mitigate this

### 8. INTEGRATED CARE

The proposed ESD Service closely aligns with the aim of Stockport’s Together Integrated Health and Social Care Programme to promote independence for older people, delivering:
- Better health and Social Care Outcomes
- Improved experience for service users and carers
- Reduced health and social care costs
- Supports a single point of access once the system is developed

This ESD team would be an integrated team providing specialist assessment, rehabilitation and reablement with the patient at the centre. In providing this the service would contribute to the further aims of the programme outlined below:
- Provision of pro-active care post discharge follow-up
- Providing people with information about their conditions, promoting healthy behaviours and helping with the emotional impact of chronic illness
- Helping people to gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified goals.

Members of the ESD team could link into the planned Multi-Disciplinary Groups for their patients enabling the targeted support for older people who are most at risk or are at high risk of re-
admission. Patients discharged into ESD would have an individualised joint Health and Social Care plan and this would support the integrated care plan that will be implemented as part of the programme. If required for their patients, members of the ESD team could contribute to Multi-Disciplinary Group Case Conferences for those with the most complex needs.

In supporting patients at home following their stroke the ESD team will also have an impact on supporting the management of this group of patient’s other long term conditions i.e. blood pressure monitoring and management. They would also have a role in monitoring the patient’s wellbeing and would be able to signpost / activate other services required i.e. diabetes management, continence etc.

9. BENEFITS OF PROPOSAL

A recent Cochrane Review of ESD Services for Stroke (Fearon & Langhorne 2102) which looked at 14 trials including 1957 patients concluded the following:

- The ESD group showed significant reductions in length of hospital stay equivalent to approximately 7 days
- The ESD group showed improvements in patients’ extended activities of daily living scores and satisfaction with services
- Patients receiving ESD services were more likely to be independent and living at home 6 months after stroke than those who received conventional services
- There were no differences seen in carers’ subjective health status, mood or satisfaction with services
- The greatest benefits were seen in trials evaluating a co-ordinated ESD Team and in stroke patients with mild to moderate disability.
- Economic analysis was included in 7 trials and all concluded that the opportunity savings from hospital bed days released tended to be greater than, or similar to, the cost of ESD. Realising such cost savings in practice can be difficult but ESD services appear to offer one way to manage increasing demand for a finite number of hospital beds

Reference: Fearon, P, Langhorne, P. Services for Reducing Duration of Hospital Care for Acute Stroke Patients (Review) Cochrane Database of Systematic Reviews 2012, Issue 9

This proposal ensures that the National and Local Standards / Guidelines for Stroke will be achieved in Stockport as outlined below:-

- 40% of all Stockport stroke patients will be able to be supported by a stroke skilled Early Supported Discharge team following discharge from hospital, with the first contact being within 24 hours of discharge.
- Patients entering Stroke ESD in Stockport will have access to a comprehensive stroke skilled MDT which includes PT, OT, SLT, Nursing, Psychology and Social Care.
- Patients in Stroke ESD will have access to rehabilitation and care of similar intensity to that of an in-patient rehabilitation stroke unit. Where appropriate, patients who are able to tolerate it can have up to five sessions of each therapy per week of Occupational Therapy, Physiotherapy & Speech and Language Therapy under ESD.
- All stroke patients will receive a review 6 months following stroke. (This requirement will extend to a 6 month review with annual reviews thereafter).
The proposed ESD service will have the capacity to ‘pull’ patients through the stroke pathway from acute to rehabilitation; ensuring timely discharge of Stockport Stroke patients, thus, ensuring the flow of patients which will be key to the success of the planned centralisation of acute stroke services across Greater Manchester.

Taking into account the Cochrane Review above the other expected benefits are highlighted below:

- A reduced hospital length of stay for patients discharged into ESD.
- An increase in the amount/intensity of therapy intervention provided to Stockport Stroke patients in the community supporting improved patient functional outcomes
- More dependent patients will be able to be discharged earlier after Stroke with support from ESD.
- Improved access to SALT, and other support as part of the ESD MDT.
- Access to specialist Stroke Nurses to support patients/carers in the community in the immediate post-discharge phase.
- Improved information given to patients, carers and improved emotional support with increased access to Psychology input.
- Improved patient satisfaction
- Compliance with the national SSNAP Audit programme for Stroke

Prospective benefits:

- Potential reduction in the time spent by primary care on management of this patient group in the immediate post discharge phase in areas such as blood pressure management, medications management.
- Potential reduction in the numbers of patients requiring further long term rehabilitation under CRT.
- Contribution to the Integrated Care Programme aims as outlined in Section 8 above.
- Contribution to achievement of elements of the various Outcomes Framework as outlined in Section 10 below

10. PERFORMANCE / OUTCOME MEASURES AND EVALUATION

A clear performance framework will be developed that reflects national and local priorities. This will include clinical outcome measures, service user and carer feedback and the views of key partners / referrers to the service in addition to activity measures.

The following measures collected as part of the SSNAP Audit will underpin this and can be benchmarked against national averages for other ESD Services.

- % of all Stockport stroke patients being supported by a stroke skilled Early Supported Discharge team following discharge from hospital
- % of patients having their first contact by a member of the ESD team within 24 hours of discharge
- % of applicable patients having rehabilitation goals set under the Stroke ESD team
- % of patients who demonstrate positive improvement following intervention from ESD team
- Number of days from start of ESD to rehabilitation goals being set for applicable patients
- Duration of treatment under Stroke ESD team
- Discharge destination from Stroke ESD team
- Review at 6 months following stroke
- Intensity of Therapy (number of days and minutes) provision whilst under ESD; specifically Physiotherapy, Occupational Therapy, SALT, Psychology
- Modified Rankin/Bartell Score on discharge from ESD team
- Proportion of patients admitted onto the stroke ward with confirmed stroke diagnosis (70%)

An appropriate patient/carer experience measure will be used to gain service user feedback on the service provided.

The table below identifies how the ESD Service will impact on, contribute to and support achievement of some of the Outcomes within the different Outcomes Frameworks.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Framework Outcomes</th>
<th>ESD Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-admissions</td>
<td>Emergency Admissions within 30 days of discharge from hospital (National Health Service Outcomes Framework 3b &amp; Public Health Outcomes Framework Domain 4)</td>
<td>Re-admission rate within 30 days for ESD patients</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Improving people’s experience of integrated care (Adult Social Care Outcomes Framework 3E and National Health Service Outcomes Framework 4.9)</td>
<td>Patient / Carer experience</td>
</tr>
<tr>
<td></td>
<td>Overall satisfaction of people who use services with their care and support (Adult Social Care Outcomes Framework 3A)</td>
<td></td>
</tr>
<tr>
<td>Reablement / Recovery</td>
<td>Proportion offered rehabilitation following discharge from acute or community hospital (National Health Service Outcomes Framework 3.6ii)</td>
<td>% of stroke patient being supported by ESD on discharge</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of reablement services (Adult Social Care Outcomes Framework 2E)</td>
<td>Modified Rankin Score on discharge from ESD team</td>
</tr>
<tr>
<td></td>
<td>Proportion of stroke patients reporting an improvement in activity/lifestyle on</td>
<td>Modified Rankin Score collected at 6 month review</td>
</tr>
</tbody>
</table>
the Modified Rankin Scale at 6 months by Stroke Association

| Discharge Destination | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (Adult Social Care Outcomes Framework 2B and National Health Service Outcomes Framework 3.6i) | Discharge destination from stroke ESD team |

11. FINANCIAL IMPLICATIONS

<table>
<thead>
<tr>
<th>Pay Costs</th>
<th>Profession</th>
<th>WTE</th>
<th>Cost inc Enhancements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Costs</td>
<td>Occupational Therapist (Band 7 &amp;6)</td>
<td>3</td>
<td>£142,500</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Physiotherapist (Band 6)</td>
<td>3</td>
<td>£132,000</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Speech &amp; language therapist (Band 6)</td>
<td>1.5</td>
<td>£66,000</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Nurse (Band 6)</td>
<td>1</td>
<td>£44,000</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Social Worker</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Rehab Assistants (Band 3)</td>
<td>4</td>
<td>£80,880</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Psychologist (band 7)</td>
<td>1</td>
<td>£60,400</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Admin (Band 3)</td>
<td>1</td>
<td>£24,100</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>Therapy lead Saturday cover (rota)</td>
<td></td>
<td>£21,300</td>
</tr>
</tbody>
</table>

| Non-Recurrent Set Up Costs | IT/Phone Equipment | £3,000 |
| Non-Recurrent Set Up Costs | Uniforms etc | £2,000 |
| Non-Recurrent Set Up Costs | Stationery | £1,500 |
| Non-Recurrent Set Up Costs | Equipment/Maintenance/consumable | £13,500 |
| Non-Recurrent Set Up Costs | Total Non-Recurrent Costs | £20,000 |

It is proposed that, if approved, this service would operate under a block contract for the first year with a subsequent review as to how this service is commissioned within a capitation approach.

Cost

The proposed service would indicatively cost £591,180 in recurrent costs with an additional £20,000 in initial set up costs. Below is modeling based on original plan, current activity and potential activity post ESD, this indicates that a potential saving of 7 beds could fund the
majority of the ESD model after the initial period of 3 months of double running proposed funded by the CCG.

**ESD Impact Model**

**Original Plan - (Stockport CCG only)**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Bed Days</th>
<th>ALOS</th>
<th>Beds @ 90% Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>512</td>
<td>1,536</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>238</td>
<td>357</td>
<td>1.50</td>
<td></td>
</tr>
<tr>
<td>Hyper-Acute</td>
<td>750</td>
<td>1,893</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Stroke</td>
<td>512</td>
<td>8,781</td>
<td>17.15</td>
<td></td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>238</td>
<td>714</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute and Rehab</td>
<td>750</td>
<td>9,495</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>35</td>
</tr>
</tbody>
</table>

**Forecast Actual from M08 - (Stockport CCG only)**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Bed Days</th>
<th>ALOS</th>
<th>Beds @ 90% Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>350</td>
<td>912</td>
<td>2.61</td>
<td></td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>359</td>
<td>950</td>
<td>2.65</td>
<td></td>
</tr>
<tr>
<td>Hyper-Acute</td>
<td>708</td>
<td>1,862</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Stroke</td>
<td>182</td>
<td>4,334</td>
<td>23.88</td>
<td></td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>44</td>
<td>992</td>
<td>22.79</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>257</td>
<td>1,562</td>
<td>6.09</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>482</td>
<td>6,887</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Bed Days</th>
<th>ALOS</th>
<th>Beds @ 90% Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyper-Acute</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke (40% of patients)</td>
<td>-140</td>
<td>-1,957</td>
<td>14.00</td>
<td></td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>-17</td>
<td>-244</td>
<td>14.00</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Activity post ESD

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Bed Days</th>
<th>ALOS</th>
<th>Beds @ 90% Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>350</td>
<td>912</td>
<td>2.61</td>
<td>6</td>
</tr>
<tr>
<td>TIA / Mimic</td>
<td>359</td>
<td>950</td>
<td>2.65</td>
<td></td>
</tr>
<tr>
<td>Hyper-Acute</td>
<td>708</td>
<td>1,862</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                  |          |          |      |                      |
| Stroke           | 42       | 2,376    | 56.99|                      |
| TIA / Mimic      | 26       | 748      | 28.66|                      |
| Other            | 257      | 1,562    |      |                      |
| Total            | 324      | 4,686    | 15   |                      |

Total 21

ESD cost 571,180

Bed Impact at Rehab Tariff of £210 -£482,895

Other Cost Savings

Potential long term cost savings could be made:-

- **Neurophysio** contract could be reduced by 42% i.e. £65,184 (based on reduction in activity post ESD)
- **Excess bed days** (as per SLAM data) - reduction in excess bed days could save £310,000 (based on 2015/16 figures for 12 months)
- **Intermediate care beds** - Data from the therapy team based at the FT show that in the months Dec 2015 – March 2016, 14 patients were referred to the Home Based Intermediate Care (HBIC) team and 2 were referred to a Bed based (BBIC) facility. Whilst exact costs cannot be obtained for the bed based service it is anticipated that the majority of stroke patients would receive therapy within their own home once an ESD service is established and therefore would not require BBIC intervention.
12. IMPACT ON ACTIVITY

Activity modelling for this service is based on activity analysis from the various stroke data sources and on analysis of the future projected Stockport’s stroke population. This data indicates a population of approximately 645 strokes per year (including those admitted via other routes than HASU); therefore, using the assumption of 40% of this group requiring therapy via an ESD team, this give a projected 258 patients per year. The remaining patients requiring minimal input from the team.

This Business Case uses the assumption of 350 referrals to an ESD service per year based on population size and in comparison with a similar size area.

13. WORKFORCE

The Activity Plan for the proposed staffing can be found in Appendix 2 with supporting detail on proposed staffing roles and productivity in Appendix 3.

14. IMPACT ON OTHER DEPARTMENTS

The provision of an ESD Service in Stockport is new activity; the Community Rehabilitation Team (CRT) has provided longer term rehabilitation for Stroke patients in Stockport and will continue to do so as part of the boroughwide active recovery intermediate tier service.

Patients not meeting the criteria for ESD on discharge from hospital will continue to be referred to intermediate tier, if required, for necessary follow-up. The intermediate tier team will continue to accept referrals from GP’s for patients who have had a previous Stroke if they require further assessment and intervention.

As identified in the GM Specification if ESD Services are to be successful then personal care support is also required for some patients, up to 4 times per day, 7 days per week.

The Stroke Association will continue to provide limited follow-up and support to Stroke patients after discharge following their existing pathway. This is currently the provision of a co-ordinator available two days per week, who can offer advice and signposting to other organisations at a cost of £15,000 per year. To provide a full pathway offer more opportunities for peer support, information and advice for patients and carers should be made available to encourage self-management and improve quality of life.

15. TIMESCALE

To enable the Early Supported Discharge service to be fully implemented there will be a necessary recruitment and induction period. It is anticipated that most staff would be in post 3 / 4 months after being successful with the bid. A full timetable for recruitment and implementation would need to be produced if the Business Case is approved.

16. SUPPORT – STAKEHOLDERS AND PARTNER ORGANISATIONS
The model for the Stockport Stroke ESD reflects that described in the National and Local Guidelines as well as the Greater Manchester Network Service Specification.

17. RISK ANALYSIS

Please see Appendix 4
Appendix 1 – Pathway
Stroke Services – Early Supported Discharge/Integrated Community Stroke Team

Pathway

Stroke patient on Acute unit or Rehab unit

Assessment for suitability for discharge home to include:

- Medical assessment
- OT/PT Assessment
- Assessment of social / home situation

Pt remains inpatient

MDT Decision re suitability

Plan discharge to:

- In acute
- Residential or Nursing Home

Referral to ICST for follow up

ESD/ICST response by CRT

(1st contact within 72 hrs with Moderate intensity input for up to 6 weeks)

Standard CRT

Response planned, discharge planning completed, appropriate support package in place

Patient discharged home with information when ESD/ICST Input will commence

Specialist Stroke Therapy intervention provided

Medical care transferred to primary care via discharge summary

Medical review at 4-6 weeks post discharge

GMAS Review at 6 months
Appendix 2

Activity based on figures from FT Dec 15 - March 16
Based on all patients requiring high intensity therapy

<table>
<thead>
<tr>
<th>No of Pts</th>
<th>Staff Member</th>
<th>Total contacts</th>
<th>Treatment</th>
<th>No of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>per pt.</td>
<td>Av</td>
<td>inc</td>
</tr>
<tr>
<td>Dec</td>
<td></td>
<td></td>
<td>time</td>
<td>travel</td>
</tr>
<tr>
<td></td>
<td>PT</td>
<td>18</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>OT</td>
<td>14</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>SLT</td>
<td>9</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Jan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PT</td>
<td>18</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>OT</td>
<td>16</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>SLT</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Feb</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PT</td>
<td>24</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>OT</td>
<td>26</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>SLT</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Mar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PT</td>
<td>27</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>OT</td>
<td>26</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>SLT</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Psychology</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

For full period based 37.5hr weeks Based 48 wks Based 42 wks

| PT Hours | 2074 | 6220.5 | 165.9 | 3.45 | 3.9 wte |
| OT Hours | 1954 | 5862.9 | 156.3 | 3.25 | 3.7 wte |
| SLT Hours | 773 | 2317.7 | 61.8 | 1.2 wte | 1.4 wte |
## Appendix 3 – Staffing Roles & Productivity

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Roles</th>
<th>Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team Co-ordinator</strong></td>
<td>The team lead / co-ordinator role will be performed by one of the senior therapists/nurse in addition to their clinical responsibilities.</td>
<td>Treatment sessions for high and moderate intensity patients average at 65 minutes per session which includes travel time</td>
</tr>
<tr>
<td><strong>Physiotherapist</strong></td>
<td>Specialist assessment and provision of neuromuscular functional rehabilitation programmes – treatment to start within 24 hours if clinically indicated and provided up to as often as daily, dependent on intensity categorisation.</td>
<td>Treatment sessions for low intensity patients average at 50 minutes including travel time</td>
</tr>
<tr>
<td></td>
<td>Attendance at weekly ESD MDT</td>
<td>MDT Meetings take approx. 2 hours/week</td>
</tr>
<tr>
<td></td>
<td>Goal planning</td>
<td>Goal planning will take approx. 2 hours/week</td>
</tr>
<tr>
<td></td>
<td>Liaison with patient, carers and other clinical services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation and activity recording</td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapist</strong></td>
<td>Specialist assessment and provision of functional and cognitive rehabilitation sessions – treatment to start within 24 hours if clinically indicated and provided up to as often as daily dependent on intensity categorisation.</td>
<td>Treatment sessions for high and moderate intensity patients average at 65 minutes per session which includes travel time</td>
</tr>
<tr>
<td></td>
<td>Attendance at weekly ESD MDT</td>
<td>Treatment sessions for low intensity patients average at 50 minutes including travel time</td>
</tr>
<tr>
<td></td>
<td>Goal planning</td>
<td>MDT Meetings take approx. 2 hours/week</td>
</tr>
<tr>
<td></td>
<td>Liaison with patient, carers and other clinical services</td>
<td>Goal planning will take approx. 2 hours/week</td>
</tr>
<tr>
<td></td>
<td>Documentation and activity recording</td>
<td></td>
</tr>
</tbody>
</table>
| **Rehabilitation Assistant** | Supporting the delivery of rehabilitation programmes; assisting qualified therapists with treatment sessions requiring more than one therapist and delivering on-going interventions to patients in the high intensity category, following an agreed rehabilitation plan. The assistants will also support other functions of the team i.e. checking BP’s directed / supervised by Nursing staff.  
Attendance at weekly ESD MDT and contribution to Goal planning  
Documentation and activity recording | Treatment sessions average at 65 minutes per session which includes travel time  
  
MDT Meetings take approx. 2 hours/week  
Goal planning will take approx. 2 hours/week |
|---|---|---|
| **Nursing** | Coordination and review of patients referred to ESD (in-reach to inpatient settings at board rounds/MDT meetings to ensure timely appropriate referrals and support transfer of care).  
Initial contacts and assessments/reviews of goals and care needs post discharge within 24 hours, support of delivery of interventions to achieve therapy goals.  
Contacts for specialist review if required for example medication, continence, smoking cessation, sex / relationship advice.  
Education re stroke and future stroke prevention, monitoring of BP and oversight of stroke relevant new medicines.  
Co-ordinate family meetings / discharge meetings, liaison with GP, Social Services and other relevant services i.e. case manage any stroke specific concerns.  
Attendance at weekly ESD MDT  
Goal planning | In-reach to hospital board rounds approx. 7 hours/week  
Discussions re: ESD with patients, families and carers in hospital approx. 4 hours/week  
Contacts average at 80 minutes per session which includes travel time  
MDT Meetings take approx. 2 hours/week  
Goal planning will take approx. 2 hours/week |
| **Liaison with patient, carers and other clinical services** |  |
| **Documentation and activity recording** |  |
| **SALT** | Continued Specialist Assessment, management and/or rehabilitation of communication and/or swallowing difficulties, as required by the patient. SALT are expected to see approximately 25% of the overall ESD caseload. Intervention can be provided up to as often as daily for those patients in the high intensity group. Attendance at weekly ESD MDT where required. Goal planning Liaison with patient, carers and other clinical services Documentation and activity recording | Treatment sessions average at 65 minutes per session which includes travel time |
| **Psychologist** | All ESD patients will be assessed / screened for mood and cognition, using validated tools, by the assistant psychologist with up to twice weekly intervention then being provided to the high intensity group. This would ensure ESD MDT psychological care is undertaken, such as, providing advice and information for adjustment, goal-setting and problem-solving. Normalising whilst not minimising patient and family issues eg mood, cognitive impairment, fatigue and emotionalism. The Assistant Psychologist would also gather assessment information for mild to moderate psychological problems to inform understanding of psychological problems and drive interventions | MDT Meetings take approx. 2 hours/week Goal planning will take approx. 2 hours/week |
before implementing brief psychological interventions to the individual patient and carers/family. Examples of intervention include adapted CBT and motivational interviewing for anxiety management (including graded exposure) and low mood (including behavioural activation), cognitive rehabilitation in collaboration with other MDT members, such as, Occupational Therapists.

The assistant psychologist would also ensure that all ESD clients with more severe and complex cognitive, mood or behavioural psychological needs are referred to specialist psychological care.

Attendance at weekly ESD MDT where required and contribution to goal planning

Documentation and activity recording

| **Team Admin** | **Supervision / Consultation with Stroke Psychologist** approx. 2.5 hours/week |
| **Team Admin** | **MDT Meetings** take approx. 2 hours/week |
| **Team Admin** | **Goal planning** will take approx. 2 hours/week |
| **Team Admin** | **Approx 30 mins per referral for registration and supporting admin.** |
| **Team Admin** | **Approx 1.5 hours day co-ordinating appointments and diaries and making calls** |
| **Team Admin** | **Approx 2 hours/week support to MDT’s** |
| **Team Admin** | **Approx 1 hour / week collating and submitting data** |

Registration of referrals on Patient Centre

Co-ordination of appointments and clinician’s diaries, making and receiving phone calls to and from patients/carers other services

Administrative support to MDT meetings

Recording and inputting data required for SSNAP and other performance measures
### Appendix 4 - Risk Analysis

#### Risk Score Key:

<table>
<thead>
<tr>
<th>Description</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>1 - 3 = L</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>4 - 6 = M</td>
</tr>
<tr>
<td>High Risk</td>
<td>8 – 15 = H</td>
</tr>
<tr>
<td>Extreme Risk</td>
<td>16 – 25 = E</td>
</tr>
</tbody>
</table>

#### Risk Category

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Description of Risk</th>
<th>Impact/Consequences (1-5)</th>
<th>Likelihood (1-5)</th>
<th>Risk score (impact x likelihood)</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks to Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the ESD Business Case is not approved then an ESD Service would not be provided to Stockport Patients</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Dependent on Outcome of Business Case Submission</td>
</tr>
<tr>
<td></td>
<td>If an ESD service</td>
<td></td>
<td></td>
<td></td>
<td>Development and</td>
</tr>
<tr>
<td>Risk Category</td>
<td>Description of Risk</td>
<td>Impact/Consequences (1-5)</td>
<td>Likelihood (1-5)</td>
<td>Risk score (impact x likelihood)</td>
<td>Controls</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>does not exist for Stockport Patients then Patient's recovery time and outcomes will be affected</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>submission of Business Case</td>
</tr>
<tr>
<td></td>
<td>Risks to patients being discharged early post stroke</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>Patients will have received 72 hour bundle prior to discharge and will be appropriately screened for ESD</td>
</tr>
<tr>
<td></td>
<td>Reductions in Stockport Council’s adult social care service due to changes to FAC’s criteria and the resultant impact on stroke patients with moderate social care needs</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>ESD Service will provide support to this group and enable them to become more independent more quickly</td>
</tr>
<tr>
<td><strong>Risks to CCG</strong></td>
<td></td>
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<tr>
<td></td>
<td>Provision of stroke services in Stockport not meeting National / Local Standards and associated impact on reputation</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>Development and submission of Business Case</td>
</tr>
<tr>
<td></td>
<td>Financial Risk associated with commissioning of ESD</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>CCG review of ESD costing</td>
</tr>
<tr>
<td><strong>Risks To Stockport NHS FT</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Without an ESD team there continues to be an increased inpatient length of stay on the Stroke Rehab Unit.</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Development and submission of Business Case</td>
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<td></td>
<td>If there was an increased length of</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Development and submission of</td>
</tr>
<tr>
<td>Risk Category</td>
<td>Description of Risk</td>
<td>Impact/Consequences (1-5)</td>
<td>Likelihood (1-5)</td>
<td>Risk score (impact x likelihood)</td>
<td>Controls</td>
</tr>
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<tr>
<td></td>
<td>stay on stroke rehab ward this would impact patient flow and reduce capacity on the Hyper Acute Stroke Unit.</td>
<td></td>
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<td></td>
<td>Business Case</td>
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<tr>
<td></td>
<td>In the absence of an ESD team the service would not be able to meet national guidance and best practice in Stroke rehabilitation.</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Development and submission of Business Case</td>
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<tr>
<td></td>
<td>If patients are discharged without access to an ESD service then readmission rates may increase.</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Business case proposed to support funding of the ESD team.</td>
</tr>
<tr>
<td><strong>Risks to Partner Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Risk of increased input required in primary care</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>ESD Service set up to have appropriate MDT to support patients in the community without additional input from primary care required</td>
<td></td>
</tr>
<tr>
<td>Increased patients requiring Intermediate Home Care Support</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Identified expected number of patients requiring Intermediate Home Support. Monitor activity for increased impact above expectations</td>
<td></td>
</tr>
</tbody>
</table>

Development and submission of Business Case.
Definitions:-

Stroke is defined as a clinical syndrome, of presumed vascular origin, typified by rapidly developing signs of focal or global disturbance of cerebral functions lasting more than 24 hours or leading to death (World Health Organization, 1978). Stroke is a major health problem in the UK. The Stroke Association’s report State of the Nation, highlighted that stroke accounted for around 40,000 deaths in the UK in 2015, which represents 7% of all deaths. Each year there are approximately 152,000 cases of stroke in the UK, of which about 25-33% are recurrent strokes. Most people survive a first stroke, but often have significant morbidity. Around 80,000 people are hospitalised with acute stroke in England and Wales each year (Intercollegiate Stroke Working Party, 2015), and cerebrovascular disease was the third leading cause of disability in the UK in 2013 (Newton et al., 2015). It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al., 2011). About 1.2 million people in the UK live with the effects of stroke, and over a third of these are dependent on other people.

Transient ischaemic attack (TIA) is defined as an acute loss of focal cerebral or ocular function with symptoms lasting less than 24 hours and which is thought to be due to inadequate cerebral or ocular blood supply as a result of low blood flow, thrombosis or embolism associated with diseases of the blood vessels, heart, or blood (Hankey and Warlow, 1994). A recently suggested ‘tissue-based’ definition is ‘an event lasting less than 1 hour without cerebral infarction on a magnetic resonance imaging brain scan’, but this requires early scanning and is thus limited in generalisability, especially in low-income countries. In practice the precise definition used is not of great importance as however quickly or slowly recovery occurs and whether or not there is evidence of permanent damage on brain imaging, the investigations and medical treatment will be broadly similar. A conservative estimate for the incidence of TIA in the UK is 35 people per 100,000 population per year. TIA is associated with a very high risk of stroke in the first month after the event and up to 1 year afterwards, and all suspected cerebrovascular events need to be taken seriously and treated with urgency.

Subarachnoid haemorrhage (SAH) is a haemorrhage from a cerebral blood vessel, aneurysm or vascular malformation into the subarachnoid space (i.e. the space surrounding the brain where blood vessels lie between the arachnoid and pial layers). The presentation of SAH is usually different from the presentation of other types of stroke, as it typically presents with sudden onset of severe headache and vomiting, and non-focal neurological signs which may include loss of consciousness and neck stiffness. It affects 6–12 people per 100,000 population per year in the UK. Approximately 85% of patients bleed from an intracranial aneurysm, 10% from a non-aneurysmal peri-mesencephalic haemorrhage and 5% from other vascular abnormalities including arteriovenous malformation (van Gijn and Rinkel, 2001).
NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

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Executive Summary

What decisions do you require of the Governing Body?

This report provides an overview of the considerations at the Primary Care Commissioning Committee at its meeting on 2nd and 16 November 2016.

Please detail the key points of this report

The Primary Care Commissioning Committee has been established by the CCG to exercise the management of the delegation functions and the exercise of the delegated powers from NHS England in relation to the commissioning of primary care medical services.

The Committee held two Part 1 meetings in November to focus on a range of business, including the ongoing monitoring and quality across general practice within Stockport.

The meeting on 2 November considered the options available in response to the notice to terminate the existing contract as served by the current contract holder. Options available included re-procuring a new provider and dispersing the patient list. In determining the outcome the Committee considered the responses to the consultation and adherence to patient choice requirements. The Committee approved Option 2 as outlined in the report which was a managed list dispersal to only those surrounding practices that had expressed an interest in registering patients.

The meeting on 16 November 2016 considered the following key items:

- Proposed changes to the Committee’s Terms of Reference were approved to ensure compliance with Conflicts of Interest Guidance and reflect the appointment of the Lay Member for Primary Care. These are attached for Governing Body approval.
- Quality Update covering a range of issues relating to primary care quality, including the results of recent Care Quality Commission Inspections.
- An application to increase the practice boundary of Dr H Lloyd at Cedar House to include part of the catchment area of Haider Medical Practice which would disperse its patient list by 31 December 2016. This was approved.
- The approach to safeguarding self-assurance of general practice and compliance was discussed following a referral from the CCG’s Quality Committee. The Committee considered the triangulation of data on safeguarding from a range of sources, including Care Quality Commission Inspections and noted the resource and workload pressures being experienced by General Practice at the current time. It was agreed that a further report would be received at the next meeting of the Committee following consideration of existing information held by Commissioners to enable compliance and any related risk in this area to be more fully considered. The importance of continuing to ensure the safety of vulnerable children and adults was noted to be of paramount importance. The Committee also noted ongoing work to ensure safeguarding was embedded in the development and operation of the Neighbourhood Model.

What are the likely impacts and/or implications?

The work of the Primary Care Commissioning Committee is integral to managing the delegated functions from NHS England and ensuring the continued high quality provision of primary care medical services in Stockport.
**How does this link to the Annual Business Plan?**

The work of the Committee supports the delivery of the Annual Business Plan and ensures the CCG complies with its statutory duties.

**What are the potential conflicts of interest?**

Conflicts of interest for members of the Primary Care Commissioning Committee continue to be managed in line with the NHS England Statutory guidance, in particular for those members of the Committee who are GPs.

**Where has this report been previously discussed?**

The issues covered by this report were considered at the Primary Care Commissioning Committee on 2nd and 16 November. Some issues were also discussed by the Primary Care Quality Committee.

**Clinical Executive Sponsor:**

**Presented by:** Jane Crombleholme

**Meeting Date:** 30 November 2016

**Agenda item:**
Terms of reference – NHS Stockport CCG Primary Care Commissioning Committee

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Stockport CCG. The delegation is set out in Schedule 1.

3. The CCG has established the NHS Stockport CCG Primary Care Commissioning Committee (“Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations:
   - NHS Stockport Clinical Commissioning Group
   - Stockport Healthwatch -non-voting
   - Stockport Metropolitan Borough Council (via Health and Wellbeing Board) – non voting
   - NHS England – non voting

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.
7. **Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:**

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

8. **The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act**

   - Duty to have regard to impact on services in certain areas (Section 13O)
   - Duty as respects variation in provision of health services (Section 13P)

9. **The Committee is established as a committee of the Governing Body of NHS Stockport CCG in accordance with Schedule 1A of the “NHS Act”.

10. **The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.**
Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Stockport, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Stockport CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities:
a) To plan, including needs assessment, primary [medical] care services in Stockport

b) To undertake reviews of primary [medical] care services in Stockport

c) To co-ordinate a common approach to the commissioning of primary care services generally;

d) To manage the budget for commissioning of primary [medical] care services in Stockport

e) To coordinate and oversee a common approach to the management of primary care estates

Geographical Coverage

17. The Committee will comprise the area covered by NHS Stockport CCG as defined within its Constitution.

Membership

18. The Committee shall consist of:

- The Lay Member with responsibility for Patient and Public Participation
- A Lay member specifically recruited to the Committee
- The Nurse Member of the Governing Body
- The Chief Operating Officer
- The Chief Finance Officer
- A Locality Council Committee Chair or Vice-chair
- Deputy Director of Public Health
- Chief Clinical Officer
- Clinical Director General Practice Development

19. The Chair of the Committee shall be the Lay Member with responsibility for Patient and Public Participation for Primary Care

20. The Vice Chair of the Committee shall be the Lay Member specifically recruited to the Committee with responsibility for Patient and Public Participation.

21. The following will have a standing invitation to attend the meetings of this Committee in a non-voting capacity:

- A Representative of the Stockport HealthWatch
Meetings and Voting

22. The Committee will operate in accordance with the CCG’s Standing Orders. The Board Secretary and Head of Governance to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

22-23. GPs appointed to the Committee should not have voting rights in order to ensure conflicts of interest are managed effectively. This does not preclude GPs on the Committee from taking part in strategic discussions on primary care provided that conflicts of interest are appropriately managed.

24. Each remaining member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and casting vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

23-25. Where an urgent decision is required the provisions existing within the Constitution will be applied in order to discharge the functions of the Committee.

Quorum

24. The quorum for the Committee shall be one third of the Committee Membership and must include one Lay Member and one Clinical Member of the Committee.

25. If the meeting is not quorate within thirty minutes of its planned start, the Chair of the meeting must decide to adjourn the meeting or to proceed and ensure all decisions are ratified at the next meeting.

Frequency of meetings

26. The Committee shall meet no less than four times a year. A meeting of the Committee can be called by any member in liaison with the Chair, with seven days’ notice given. Papers will be distributed to members no later than seven days before the meeting.

27. Meetings of the Committee shall:
   a) be held in public, subject to the application of 23(b);

   b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the
Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

28. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

29. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

30. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

31. Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Constitution.

32. The Committee will present its minutes to the Greater Manchester Area Team of NHS England and report to the governing body of NHS Stockport CCG each month quarterly for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

33. The CCG will also comply with any reporting requirements set out in its constitution.

34. It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

**Accountability of the Committee**

35. The membership of the CCG has established a Governing Body in order to discharge its statutory functions. The Committee is accountable to the Governing Body. Membership of the Governing Body is representative of the membership through the elected Locality Chairs and through the appointment of Clinical Executive Directors and the Accountable Officer.

36. Appropriate consultation with patients and the general public is undertaken through the CCG’s Patient Panel and in line with the national and locally adopted guidance

**Procurement of Agreed Services**

37. The CCG will make procurement decisions as relevant to the exercise of its delegated authority and in accordance with the detailed arrangements regarding procurement set out in the delegation agreement.
Decisions

38. The Committee will make decisions within the bounds of its remit.

39. The decisions of the Committee shall be binding on NHS England and NHS Stockport CCG.

40. The Committee will produce an executive summary report which will be presented to the Greater Manchester Team of NHS England and the governing body of NHS Stockport CCG quarterly for information.
Schedule 1 – Delegation as listed within the Body of the Terms of Reference

Schedule 2 - List of Members as included in the Body of the Terms of Reference.
Audit Committee Report to Governing Body

NHS Stockport Clinical Commissioning Group will allow People to access health services that empower them to live healthier, longer and more independent lives.

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Website: www.stockportccg.org
<table>
<thead>
<tr>
<th><strong>What decisions do you require of the Governing Body?</strong></th>
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<tr>
<td>To note the issues considered by the Audit Committee at its October 2016 meeting, including the endorsement of the Detailed Financial Policies and the committees Work Programme for the 2017/18 year.</td>
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<th><strong>Please detail the key points of this report</strong></th>
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<tr>
<td>This report provides an update on the recent activity undertaken by the Audit Committee at its meeting held on 12 October 2016.</td>
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<tr>
<th><strong>What are the likely impacts and/or implications?</strong></th>
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<tr>
<td>The CCG’s Audit Committee is a key mechanism for control and review of the CCG’s activity and operates within the statutory functions and delegations provided by Governing Body. Failure to have operate an effective Audit Committee would lead to significant risks for the CCG.</td>
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<th><strong>How does this link to the Annual Business Plan?</strong></th>
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<th><strong>What are the potential conflicts of interest?</strong></th>
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<tr>
<th><strong>Where has this report been previously discussed?</strong></th>
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<td>Audit Committee</td>
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**Clinical Executive Sponsor:** Ranjit Gill

**Presented by:** John Greenough

**Meeting Date:** 30 November 2016

**Agenda item:** 15

**Reason for being in Part 2 (if applicable)**

N/A
1.0 Update from Audit Committee meeting 12 October 2016

1.1 The most recent meeting of the CCG’s Audit Committee was held on 12 October 2016 to consider a range of matters as detailed in its comprehensive annual Work Programme. Before the formal meeting started the Committee held a private meeting with both sets of auditors. This is considered to be best practice. There were no matters arising from this meeting which the Committee wished to refer to the Governing Body.

1.2 The Committee discussed a range of matters which included the following:

**Review of Draft Governance Statement**

The Audit Committee considered a mid-year review of the draft governance statement, noting it to be good practice in keeping the statement live and relevant. In considering this the Committee noted the importance of the review of Economy, Efficiency and Effective Use of Resources acknowledging it as an issue and agreeing to reflect more fully upon it. The review highlighted that the CCG has an action plan in place to ensure the requirements of the revised Conflicts of Interest Guidance are met. The CCG had implemented a new Risk Management Strategy in early 2016 and the statement reflected the increased understanding of risk across the organisation and the continued work in developing this. The Information Governance framework continues to be developed and is on track for completion within the agreed timescales. The CCG has continued roll out of RAIDR tool to General Practice to assist with the provision of data and information to practices.

**Internal Audit**

The Committee considered the Internal Audit Progress Reports and noted that the Governing Body Reporting review had been completed and obtained significant assurance with 2 medium recommendations. Overall the constitutional requirements had been met and the Governing Body structure was noted to be appropriate. The Committee noted that the report recommended regular reporting of progress made within Stockport Together and suggested it as a standing item on the Governing Body agenda. This was noted to have been actioned prior to the completion of the review.

The Committee approved the following changes to the 16/17 Audit Plan: Removal of the NHS England Self-Certification and Financial Control Evaluation self-assessment which are not required and add a Conflicts of Interest Review in Q4.

**Anti-Fraud**

The Committee considered the Anti-Fraud Progress Report and noted that the submission of the NHS Protect Standards for Commissioners Self-Review Toolkit (SRT) which had an overall rating of “Green”. That work was being undertaken as part of the National Fraud Initiative.

The Committee reviewed the Staff Survey Benchmarking Report and noted that responses rates were broadly comparable with other CCG’s.

The Committee reviewed the External Audit Progress Report.

The Committee reviewed the Internal Audit Charter.
The committee approved the Detailed Financial Policies.

The committee approved its 17/18 Work Programme.

In addition to these items the Committee noted as part of its discussion:

- The financial challenges faced by the organisation in 2016/17 as outlined within its Financial Plan

1.3 The Committee will next meet in December 2016.