ANNEX 1

COMMENTS FROM SCRUTINY COMMITTEES

ADULT SOCIAL CARE & HEALTH SCRUTINY COMMITTEE – 27 JUNE 2017

The Corporate Director for People and Senior Responsible Owner for the Stockport Together Programme (Andrew Webb) submitted six outline business cases (copies of which had been circulated) setting out proposed changes to models of care for health and social care services.

Mark Fitton (Director of Operations, Adult Social Care, Stockport Council), Dr Viren Metha (Viaduct Health), Dr Donna Sager (Deputy Director of Public Health) and Keith Spencer (Director, Stockport Together Providers) attended the meeting to answer questions.

The Cabinet Members for Adult Social Care (Councillor Wendy Wild) and Health (Councillor Tom McGee) also attended the meeting to respond to questions.

The Cabinet Member for Health made introductory remarks, including:-

- Local health and social care partners would be facing a significant shortfall in their finances in coming years of approximately £156m. All partners involved believed that it was therefore imperative that new models of care be implemented as soon as possible to ensure that savings could be achieved.
- £19m of Transition Fund resources had been secured, but this was conditional on continued progress with development of the Stockport Together Programme.
- At this stage the Outline Business Cases were in draft form, and comments were being sought prior to the publication of Final Business Case before the end of the year. Although the proposals may change in the intervening period, 'going backwards' or 'not doing anything' were not options.
- There were a series of listening meetings taking place across the borough.
- The current focus was not about the organisational vehicle, but about getting right the delivery of better models of care. Governance arrangements would be revisited in due course and subject to a full public consultation.

Each business case was introduced and comments and questions invited.

Summary Economic Case

The following introduction was provided:

- It was projected that by March 2021 partners providing health and social care services would have a collective cumulative deficit of £150m.
- Irrespective of financial considerations, there remained an imperative from both patients and practitioners to change and improve services.

- The aim of the programme was to develop joined up services that provided better care to our population.
- It was acknowledged that progress on the development of the Business Cases had been slower than anticipated but this had been due to the level of detail and the need to develop models that were flexible enough respond to changing circumstances.
- Prevention was the primary objective of the Programme, from preventing ill-health to preventing escalation to avoidable interventions.
- The £19m investment from the Greater Manchester Transformation Fund was needed to facilitate the recycling of resources to support the neighbourhood model of care.
- One of the key factors shaping the programme was the NHS internal market and tariff system, which was at variance with other partners cost models, and so processes had been designed to allow partners to move forward with those uncertainties remaining, allowing double running of services although this could not persist forever.
- The modelling underlying the business cases assumed only half the savings required, in part because of non-recurrent funding, and likely reviews of Local Government and NHS funding arrangements. The assumptions were based on those areas where there was confidence that savings could be achieved.

The following comments were made/ issues raised:-

- The document referenced activity paid for by the Clinical Commissioning Group to providers other than the local NHS Foundation Trust. How would the differing models being developed in neighbouring boroughs/ economies be accounted for? In response it was stated that analysis of the specialities involved had determined which would form part of the programme. Furthermore, the starting point for this programme had been general practice where referrals were generated.
- There was emphasis placed on developing a skilled and integrated workforce but little detail. What was proposed? In response the importance of the issue was acknowledged, and its centrality to the programme emphasised. It was also stated that the focus of partners was to identify those posts/roles that could be recruited to, and where not to develop new roles. Further comment was made that there was a need to transform the workforce to meet future challenge, including expanding the ‘hands on’ workforce supporting people in their own home but doing a wider variety of activities. Mention was made of a recent award for training student nurses to deliver public health interventions.
- What controls would be in place to make adjustments to the programme in the event of a delay in implementing the Business Cases? In response it was stated that there was an Implementation Board monitoring this issue.
- When speaking to members of the public about the ambition of Stockport Together, it was very unusual for them to disagree with it, which was an indication that the approach was correct. Although the ambition was simple, it would be difficult to implement.
- Britain leaving the European Union may have an effect on the financial situation of the NHS but also the ability to recruit. In response it was acknowledge that ‘Brexit’ would lead to uncertainty for recruitment, but also for post-EU procurement rules. Specifically in relation to recruitment, it was reiterated that

partners were focussing efforts on those professions where recruitment was feasible to make working in Stockport as attractive as possible.

- Recruitment and retention in the care sector in Stockport appeared a particular challenge, with staff being 'poached' by NHS partners for better pay and conditions. Would paying more help retain staff? In response it was reiterated that the ambition was to integrate the workforce and removing some of the distinction between hospital and care sector. It was commented that pay was not the only consideration, but included ensuring people had sufficient skills and support.
- The risk assessment of the programme indicated that following mitigation measures the risk to patient care and financial targets remained high – was this an indication that the Programme was likely to ail? In response it was stated that this assessment was an acknowledgement that this major transformation of services was extremely complex. It was also made clear that it was likely only 50% of the savings target would be met. The risk assessment therefore sought to be credible by giving an honest assessment of the challenge.
- With 37% more Emergency Admissions than the average for England this programme was beginning from a position of being a major outlier. In response it was stated that the challenges of non-elective admissions began many years previously and was not unique to Stockport, but that action was not taken promptly to address it. Examples of economies with lower non-elective admissions were outside of the UK and these were also economies with a better balance between hospital and non-hospital care. This Programme was moving toward that ideal. It was also commented that locally 15% of the population accounted for 50% of those non-elective admissions.
- Comment was sought on Stockport having the lowest rate of General Practice funding per head in Greater Manchester. In response it was stated that funding reflected demographics and that local affluence masked the plurality of needs in Stockport. There had been a lack of investment in primary care locally but partners now had the opportunity to try to correct this in part.
- It was important to understand how partners arrived at the current situation. This would be a risk journey, with further 'unknown unknowns' so thought needed to be given to those risks external to the programme.
- To what extent could the ambulatory care model 'deflect' or treat heart-attacks locally? In response it was stated that some of 'deflection' would be a matter of coding cases more appropriately, but ultimately the number of heart attacks could be reduced by responding more effectively to symptoms years earlier to prevent invasive and complex interventions.
- Many areas of Stockport were not covered by the proposed consultation events. In response it was stated that the current activity was not a formal consultation but a 'listening' exercise prior to consideration by partners of the Outline Business Cases and formal consultation would take place in the event of agreement to proceed. The need for a variety of engagement mechanisms was also emphasised.
- Was there a risk for partners in entering into an arrangement with a poor performing acute Trust? In response it was stated that Stockport NHS Foundation Trust performed well in many areas and provided outstanding care in many specialities, but had particular challenges in relation to non-elective admissions and Emergency Department performance. This was partly a reflection of the lack of treatment options outside of hospital but also pressure on care provision to

discharge patients into. Good progress had been made to improve care to prevent hospital attendance but more could be done to work with care providers. The creation of this partnership with all providers would prevent problems being passed from provider to provider and would improve the experience of care.

- Was the Programme not driven by the need to make cuts? In response it was reiterated that were partners to do nothing they would have insufficient resources to meet demand, but emphasised that the modelling underpinning the Programme demonstrated that similar levels of resources would be being spent but to achieve more. It was further commented that many elements of the programme may not have been contemplated without the reductions and pressures on resources, but much of it was improvements partners would have wanted to make. The Economic Case had been developed from suggestions and feedback from front-line staff. In order to make better use of resources, some partners, particularly the hospital Trust, would need to change their activity in ways that would not be financially sustainable for them, so resources needed to be shifted to keep the whole system functioning. It was further commented that the programme sought to achieve a better balance of resource to deliver savings and better quality of care. By improving quality of care savings would be accrued. Trying to force too great a saving was likely to negatively impact care.
- Was it necessary for a GP to lead an integrated neighbourhood team? In response it was clarified that this was not the case.
- Clarification was sought in relation to how premise funding factored into the Business Case. In response it was stated that funding arrangements for GP premises was partly reflected in the national formula but also from centralised sources controlled by NHS Property Services.
- Was Stockport the worse performing area for emergency admissions? In response it was stated that in the North West Stockport was an outlier, and nationally it was in the bottom decile, but this masked the good care actually delivered.
- The need for engagement with professionals was recognised, but assurances were sought on the involvement of other staff and unions. In response it was confirmed that there had been extensive involvement with staff and unions, and that the Neighbourhood Model had been developed through staff involvement.

<u>Neighbourhood Outline Business Case</u>

The following introduction was provided:

- This model was the ‘engine room’ of the change programme. Partners were investing in community based services that would be General Practice led (for clinical governance reasons) and would seek to identify those at risk and to address their complex needs differently to prevent deterioration and hospitalisation.
- A key element of this approach was to manage risk differently, working more effectively with nursing and care home providers.

The following comments were made/ issues raised-

- Further detail was sought on funding opportunities for the co-location of neighbourhood teams. In response it was stated that the NHS Property Services

had grant and capital funding available for improvements to the estate that could be bid into, although this was heavily oversubscribed. Funding opportunities were also available from the Greater Manchester Health and Social Care Strategic Partnership.

Ambulatory Care Outline Business Case

The following comments were made/ issues raised-

- There was no reference in the document to the pilot Clinical Assessment Service run by NWAS in conjunction with local CCGs that had proved successful in preventing unnecessary admissions. How much involvement were NWAS having in this programme? In response it was stated that these pilots were key and that the local approach had been one of the most successful so there would be close working with NWAS to develop this further. Nevertheless, even this limited public contact with the service was a possible indication of something failing and the reasons for the call needed to be understood.
- Comment had already been made about the need to intervene earlier to prevent crisis or acute episodes. Would these interventions need to get earlier over time, reducing demand on ambulatory care? In response it was commented that the Healthy Communities Programme was designed to provide these early interventions, which would focus primarily on lifestyles but also on opportunities to expand coaching and social prescribing. Further comment was made that there were currently perverse incentives within the health system that discouraged a focus on prevention and encouraged acute inventions. An example of the need to prevent diabetes-related amputations through prevention was cited.
- In response to comments about preventing diabetes-related amputations clarification was sought on what more could be done to reduce these largely avoidable invasive interventions. In response it was commented that changing the language used by professionals, but also to tailor support and goals to ensure it had greater importance for patients.
- Further detail was sought on the primary care triaging at the Emergency Department. In response it was stated that the current daily 12-hour provision dealt with approximately 40 patients a day. It was important to understand the reasons that people had for attending ED for non-emergencies over other more appropriate options. In response to a further query about whether this provision may attract activity, it was acknowledged that this was a risk, but that due to pressures experienced at ED this measure had been implemented earlier than initially planned.

Outpatients Outline Business Case

The following introductory comment was made:-

- No changes would be made to services without sufficient capacity in community services. Some outpatient clinics provided good economies of scale and services that would not benefit from any change. Changes would only be made where it was needed or justified.

The following comments were made/ issues raised-

- There were references in the document to increased workloads for specialist nurses. Appropriate stress assessments were undertaken to ensure this would be accommodated. In response it was clarified that it was anticipated that caseloads would increase, rather than workloads, and that much of the routine workload would be absorbed by the Neighbourhood Teams, leaving specialist nurses to focus on their specialist work.
- The challenge and difficulty associated with these proposals was recognised, not least because it would impact on long established ways of working for consultants and their teams who would need reassurance that patients would continue to receive the care they needed. Nevertheless, there was significant resource tied up in less efficient ways of working that needed to be addressed.
- There were examples elsewhere in the country of hospitals accrediting GPs who train to develop more advanced specialist skills to allow more community based services to be provided. In response, the opportunities provided by Stockport Together to reduce the barrier between primary and acute care were emphasised, such as the work to develop 'Consultant Connect' that had already proved successful. There had been too negative a focus from some that these proposals were stripping out services whereas they were actually improving connections between primary and acute care and upskilling staff.
- With greater cooperation between general practices what scope was there to collaborate and share specialist services, or even to centralise some services? In response it was stated that the 'super-practice' model was not necessarily the best model for Stockport as greater emphasis was being given to continuity of care and this might otherwise be lost. Rather than centralising services it was import to ensure appropriate expertise could be drawn upon when needed.
- In light of the cap on NHS wages and the opposition of the British Medical Association to Sustainability and Transformation Plans, what had been the level of staff engagement in the Stockport Together Programme? In response it was stated that staff had been heavily involved in developing and delivering these new models of care. As local partners had little or no control over wage caps and levels of funding, the focus had been on making working in Stockport and its health and social care economy as attractive a working environment as possible and reflective of what new professionals expected.
- There were examples of partners already upskilling staff, such as nurses providing carpal tunnel surgery. Training and skill development should not just be for those already highly skilled but for everyone.

The Chair thanked councillors, officers and partners for their work in preparing the Outline Business Cases and in their contributions to the discussion at the meeting.

RESOLVED – That the Cabinet be informed that in relation to the Stockport Together Outline Business Cases that the view of the Scrutiny Committee was generally supportive of the proposals contained in the Outline Business Cases but there remained concerns about the risks associated with the programme.

CORPORATE, RESOURCE MANAGEMENT & GOVERNANCE – 4 JULY 2017

The Corporate Director for People submitted Outline Business Cases (copies of which had been circulated) describing how partners would by working together more closely deliver these new models of care and associated benefits to many more people on a permanent basis. It was important that before proposing making these changes permanent that partners hear from a wider group of patients and the public to ensure that their thinking was right and was shaped by public/patient experiences and expectations.

The Scrutiny Committee considered the Economic Case and the Enabler Outline Support Plan.

Stockport Together partners had been working together and with the public and patients to test and trial new ways of working that improved people's experience of treatment and care and their outcomes. The results of this initial work had been encouraging.

The final approval of these Outline Business Cases was subject to the learning from a period of wider patient and public involvement. In the meantime funding from the Greater Manchester Health & Social Care Partnership would enable the continuation to of the development and testing of the proposals. Changes wouldn't happen overnight and there would be continual adjustment of ideas as the plans are implemented. This was just one of many stages at which there was a need for patients and the public to be involved if the people of Stockport are to have the best health and care services available so they can live healthier and happier lives.

The Leader of the Council (Councillor Alex Ganotis) attended the meeting to answer members' questions.

The following comments were made/ issues raised:

- There was a need to continually re-evaluate and review the business cases to ensure the changes were working and saving were being realised.
- The business cases were very detailed and this Scrutiny Committee would welcome reports which concentrated on specific detail rather than overarching reports.

RESOLVED – (1) That the Outline Business Cases and the consultation on these proposals be noted.

(2) That regular reports be submitted to this Scrutiny Committee in relation to the financial & Governance arrangements.