## Contents

# 1. Introduction

## 1.1 Advice and decision requested

1.1.1 The Governing Body of NHS Stockport CCG and the Cabinet of Stockport Council will be considering in due course (31st January and 6th February 2018 respectively) whether to approve the approach described in the previously endorsed Stockport Together outline business cases and proceed to implementation. Both bodies will also make recommendations on how the changes should be implemented, and how the impact of the changes will be measured

1.1.2 In coming to these decisions they will be asked to consider and scrutinise carefully the feedback from the public consultation that has recently been completed, in particular any new evidence that has been gathered, along with the updated equality impact assessments (EIAs).

1.1.3 Members of the Adult Social Care & Health Scrutiny Committee are asked to scrutinise the consultation process and findings as set out in the attached report along with the updated Equality Impact Assessments. Both the Governing Body of the CCG and the Council Cabinet will be looking for the views of the committee on the legitimacy of the consultation process, the decision or not to proceed, and if they decide to precede any suggestions regarding how issues raised might be addressed.

1.1.4 Further, the Adult Social Care & Health Scrutiny Committee is asked to note and acknowledge the ***change in the previously announced process*** whereby the decisions were to be made in January; in particular to move the decision of Council Cabinet back from the 17th January to the 6th February. It is believed this is appropriate given the scale of the response, the issues raised in the consultation and thus the delay in production of the report. It allows decision makers time to consider the views and recommendations of the committee.

## 1.2 Scope of paper and regulatory requirements

1.2.1 This paper summarises and reminds members of the process to date and the context and basis for the endorsement of outline business cases made in July 2017 (Sections 1-3). It then describes and provides an initial response to the independent feedback report on the consultation and includes the updated equality impact assessments (EIA) and associated action plans.

1.2.2 Section 14Z2 of the NHS Act (as amended) requires the health commissioner to involve the public where there are changes to the manner in which services are provided or the range of services available. The effect of the proposed strategy is changes to both. Undertaking a public consultation on the proposed strategy demonstrates compliance with the Act.

1.2.3 The commissioner is also required to take into account the views of the relevant scrutiny committee in coming to its decision. The relevant scrutiny committee should provide its view once it has reviewed the output from any consultation.

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

## 1.3 Process to date

1.3.1 In July 2017 all the partners of the Stockport Together Programme endorsed a series of ***outline business cases***. This system level endorsement of all the parties was a significant moment reflecting a shared vision and commitment to work together in a new way. Any final decision was subject to a public consultation on the underpinning strategy and policy to be led by the joint commissioners. The Council Cabinet and CCG Governing Body at the time of endorsement noted a number of caveats to be addressed in implementation (outlined below 1.3.5).

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

1.3.3 The Stockport Together partners are NHS Stockport CCG, Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust, and Viaduct Care CIC (the GP Federation). The CCG and Council as the commissioners undertook the Consultation and are required to make the final decisions.

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

- **Acute Interface:** This described investment in three areas within the Accident & Emergency Department (A&E) at Stockport NHS Foundation Trust and the associated benefits: refinements to triage, an ambulatory ill work-stream and an ambulatory care service. This can be found here: https://www.stockport-together.co.uk/download_file/156/341
- **Intermediate Tier:** This document set out the case for bringing together 20 or more disparate services. The new intermediate tier service will provide effective crisis response to support community staff to avoid unnecessary hospital admission and much improved support on discharge including transfer to assess arrangements. This can be found here: https://www.stockport-together.co.uk/download_file/157/342
- **Outpatients:** The Outpatients Business Case described plans for reducing unnecessary outpatient appointments and better utilisation of modern technology to ensure advice and decision-making is more cost effective and provided where appropriate without a hospital visit; and how GPs and consultants can work together much more as a team. This can be found here: https://www.stockport-together.co.uk/download_file/159/345

- **Neighbourhood:** At the heart of our proposals is the vision of a neighbourhood-centric model of health and social care led by GP practices working collaboratively. This case describes neighbourhood investment in new primary care and community-based services including general practice, the third sector, social care and mental health. This can be found here: https://www.stockport-together.co.uk/download_file/158/343
- **Economic Case:** This outline business case pulled together the economic benefits of the above proposals **and** described the further challenges of a potential £150m financial challenge by 2021. It also described in detail how the investments would be funded as well as the risk / gain share arrangements between the partners to support collective ownership of these challenges. This can be found here: https://www.stockport-together.co.uk/download_file/160/346

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

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

1.3.6 Any decisions made by the Council Cabinet and CCG Governing Body in due course will be understood to be ***building on and strengthening these caveats*** rather than setting them aside.

# 2 The Case for Change

## 2.1 Introduction

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

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

## 2.2 Performance & Quality

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

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

## 2.3 Health Inequalities

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

2.3.2 The strategy underpinning the outline business cases seeks to ensure a greater link between the NHS and the local authority and hence increase the opportunity to address the wider determinants of health. Further, by building and integrating services at a neighbourhood level, the investments can be better aligned to need, and the scale of services and the way they are delivered can better reflect the needs of the specific and distinctive populations in each area.

## 2.4 Five Year Forward View

2.4.1 The NHS five year forward view sets out the challenges facing the NHS, including more people living longer with more complex conditions; increasing costs whilst funding remains flat; and rising expectation of the quality of care. In response, it places much greater emphasis on integration of systems and ways of working. Currently 70% of all health and social care spend in Stockport is used by people with one or more long-term condition. These individuals account for 50% of GP appointments, and 7 out of 10 hospital beds.

2.4.2 In particular the forward view focuses on:

- Prevention and empowerment

- Greater patient and service user control and choice
- Removal of barriers between care organisations
- A new deal for GP practice
- Requirement to rebalance demand, efficiency and funding of the NHS General practice

## 2.5 GM Devolution

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

2.5.2 The award of £19.1m (to date we have not received the full £3.1m Digital element of this) from the GM Health & Social Care Partnership was predicated on delivery of change in these areas.

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

## 2.6 Economic and financial

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

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

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

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

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

## 2.7 A hospital-centric service model

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

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

# 3 Consultation and areas for influence

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

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

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

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

- **Changing the way we plan and organise services:** this will focus on key principles including the integration of health and social care; the integration of physical and mental health services; and the underlying shift of resources from acute hospital

provision in order to further address parity of esteem for mental health and strengthen integrated community based services including primary and social care.

- **Neighbourhoods:** the way in which physical health, social care and mental health services are organised at a neighbourhood level. This will focus on the geographical appropriateness of the neighbourhoods as described and their role as the principle organisational construct of the future model of care.
- **Hospital beds:** the test to apply, if the strategies result in the need to decommission acute hospital beds. This will focus on how the partnership will apply the tests set out by NHS England prior to any bed closures if they should arise.

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

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

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

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

# 4 Response to Policy Questions

## 4.1 Consideration of the findings

4.1.1 Officers have considered the independent analyst report and distinguished between the ***findings directly related to the three policy questions*** put to the public and evidence related to those; and a range of other important information related more to ***how we implement the changes*** and undertake work going forward.

4.1.2 Officers considered the following factors to be particularly important to take into account when considering the fundamental policy questions put to the public.

## 4.2 Neighbourhoods and the way we plan and organise services

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

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

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

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*"by combining health and social care the new system will be more efficient, respond to peoples' needs, improve communication and be cost saving…"*
*"…it makes sense to have services for the communities based around the communities themselves. We can share our resources if we work as "neighbourhoods".*[1]

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

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

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

4.2.3 NHS Watch have contributed significantly in the various involvement mechanisms undertaken throughout the development of our plans and culminating in the consultation. They raised a number of matters: the underlying financial driver to the proposals; the alignment with national initiatives such as the STP (Sustainability & Transformation Plans) programme, the potential privatisation of the NHS, concerns about decommissioning of beds, and concerns about some aspects of the evidence base. The financial question and decommissioning of beds were raised by others and will be addressed at section 4.7 and

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

section 4.3 respectively. It is important to note that NHS Watch see the development of neighbourhoods and additional investment in community as positive factors. Specifically they presented counter-evidence in two areas:

4.2.4 NHS Watch suggest the evidence that hospital admissions (and therefore need for beds) are reduced by changing the way community services work (in particular integration) work is weak. They quote the King's Fund (https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers) as an example. We would agree with this evidence, but our proposals do not suggest that the mere act of integration of services will produce such a result but rather that significant additional investment in the community is also required. The evidence for this is stronger particularly as we start from a position of extremity when it comes to the hospitalisation of people.

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

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

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

4.2.8 No further specific evidence was presented that was contrary to the ***policy approach*** that the business cases encapsulated in these areas. However, there was concern expressed about the quite large geographical size of the neighbourhoods and the fear that a single hub in each area would be detrimental.

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

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

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

## 4.3 Basis for decommissioning of beds

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

*"…decommissioning beds is an irresponsible suggestion. Beds will always be needed, regardless of whether care is in the community…"*
*"…the tests…if carried our honestly and rigorously…would deliver the answer that is needed to make the savings that are envisaged…"*

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

4.3.3 There is a natural concern shared by all in the partnership about any reduction in the bed base, and this undoubtedly and understandably informed the views expressed by the public and stakeholder organisations. It would therefore appear that for some the response was to ***bed reductions per-se*** rather than the ***right and proper test*** on whether the need had or had not reduced.

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

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

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

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

## 4.4 More general concerns raised

4.4.1 However, there were a number of more general concerns raised that members should consider when advising decision makers:

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

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*"…don't really understand all the proposals…."*
*"…very little information has been provided to answer this question…"*

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

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

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

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4.4.5 We sought to address the first issue of under representation by not only engaging directly with stakeholder groups with a known interest in the consultation, but also to address the likely bias of this former approach through street surveys. The sample size of the latter was more representative of the population in terms of age and gender. It also included people from every part of Stockport as street surveys took place in each neighbourhood. However, footfall issues meant that there is still a higher representation from affluent areas in the borough. That said there is no significant difference in levels of support or otherwise between areas. We also sought and gained feedback from specific protected characteristic groups. However, during implementation further work to involve the public in developing the specific change proposals required to implement these high-level policy decisions at local level, for example on the location of service delivery points in neighbourhoods will be worth further attention.

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

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

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*"…the document is not sufficiently honest…the driver for change is to make…savings on health and social care in a time of increasing (legitimate) demands…"*
*"…you are not saying anything about the under resourcing of social care. This is a serious omission which makes it hard to assess your proposals…"*

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4.4.8 It is true that the underlying financial challenges driven by demography and inflation are higher than any growth the NHS locally will receive, or that the Council will be able to

fund by raising its income and that these proposals will not address this fully. This is reflective of the national picture. The Economic Case ***explained up-front*** that the estimated shortfall of doing nothing is £157m. The proposals set out in the business cases will deliver £43m towards this. However, that still leaves the individual partners and the changes that are taking place at a Greater Manchester level, needing to deliver £114m. This approach therefore makes a significant contribution to addressing the financial challenges but does not in itself fully resolve the challenge. Through this programme we are attempting to improve the way we use our resources by intervening earlier when the need is lower and by reducing the fragmentation of the system. We do not underestimate the challenge of both achieving the benefits of these proposals nor of addressing the remaining gap.

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

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*"…you are not saying anything about the under resourcing of social care. This is a serious omission which makes it hard to assess your proposals…"*
*"…leader keeps telling people that adult social care will bankrupt the council…"*

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

### 4.5 Summary

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

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

## 5 Approach to implementation

### 5.1 Introduction

5.1.1 In addition to the views and evidence provided regarding the specific policy questions there was a significant amount of important information gathered that should inform how we proceed with the implementation of the models of care described in the business cases. In this section officers have drawn out what they see as the key emerging themes.

5.1.2 These themes are not prioritised in any particular order as each has merit in its own right and scrutiny members may wish to identify others or draw particular attention to one or more.

## 5.2 Involving the public

5.2.1 During the consultation, one of the most common themes to emerge was 'involvement'. Consultees, whether they are individuals or organisations, are keen to be more involved in contributing to key decisions that are being made about the future of our local health and care services. Whilst the engagement process is recognised as important, its 'stop/start' nature frustrates many people. Further improvements that allow both individuals and organisations to work alongside our commissioners and providers to play a more 'substantive' and 'meaningful' role in influencing the shape of our future health and care services will need to be considered.

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

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

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

*"Consult more widely with those least able to respond"*

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Officers considered that the kind of areas that might be looked at in response might include:

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

- Reviewing how we present financial information, and the need to provide greater clarity around how funding is directed (on what services), and how this compares to

previous years. We would hope that greater familiarity of issues, through more regular and consistent 'involvement', creates better understanding of those issues amongst patients and our wider stakeholder groups.

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

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

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

## 5.3 Equality and Diversity

5.3.1 Addressing previous inconsistencies of engagement and involvement, we could more proactively develop the networks we have built over recent months to radically enhance our engagement and involvement with the wide range of protected groups that exist locally in Stockport.

5.3.2 Ensuring the full engagement and involvement of those who are identified as 'protected' under the Equalities Act 2010 should be seen as an ongoing challenge for all operational leads and service providers – and its achievement supported by appropriate development programmes..

## 5.4 Greater involvement of third sector

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

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

*"…there is a need to involve the charitable sector with Stockport Together on much more than consultations."*
*"…there is an opportunity to partner with the sector and better coordinate its response to the needs of Stockport residents without necessarily spending more money…"*

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

5.4.3 Officers are already considering the partnership arrangements as we move into the next stages of change and could look to strengthen the role of the third sector in the partnership arrangements as part of this work.

## 5.5 Mental Health

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

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

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

5.5.3 Other areas under consideration are being firmer in the contracting round on the need for community mental health services to be integrated and strengthen clinical leadership around this agenda at the CCG.

## 5.6 Wider Determinants of Health

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

*"…Stockport Homes Carecall can prevent falls as well as dealing with the aftermath – saves significant number of ambulance call outs…"*
*"…Stockport Homes can give Public Health messages to customers as we see people regular (sic) and can prevent them reaching crisis point…"*

## 5.7 Workforce

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

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

5.7.2 There were also concerns expressed that in reviewing the skill mix we would lower the standards of care and have less qualified staff undertaking tasks only fully qualified staff should undertake. It is important to remind members that these plans have been developed and led by professional staff and commissioners, and will keep safety under constant review.

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

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

5.7.4 Given the importance of this issue to successful implementation of the proposals, and the requirement to demonstrate that new services are safely established in the community before decommissioning beds, the commissioners are working closely with providers to ensure workforce plans are associated strategies sufficiently robust.

## 5.8 Seven-day services

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

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*"…they really need to get a grip of GPs and make them work more late and early evening shifts like the rest of the NHS…"*
*"…can 7-day working mean it please…Illness doesn't stop on Friday nights & restart on Monday morning…"*
*"…social workers should be available 7 days a week. Needs don't go away at weekends!"*
*"…there are already 7-day services in place both in hospital and the community…I do not see how your Business plan will save money in the long term…"*

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5.8.2 It is true that there is already seven-day delivery in some services. The proposals are to invest and thus strengthen community based-services including general practice. In particular the proposals are for those services that are required to intervene quickly to prevent deterioration becoming an unnecessary crisis. A significant element of the investment will be in 7 day community based services.

## 5.9 Running Costs

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

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

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

5.9.3 Even if we were to double these reductions, the impact on the overall efficiency requirement of £157m would be negligible. However, we remain committed to keeping

management costs under constant review and directing as much resource as possible to the frontline.

### 5.10 Integration of Data

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

> *"…having a person's information in one place will reduce duplication, stop errors in communicating between different teams and save time..."*
> *"…develop a common records system across Greater Manchester. It is not good enough when any hospital says, 'you are out of area, we do not have your records'…"*

5.10.2 The move to single electronic record systems is underway in Stockport and through '*Care Centric',* work is being undertaken to ensure information can be shared among providers across Greater Manchester. However, it is important that the public at large and individual patients give consent for the use of their personal information, with appropriate rigorous safeguards by other professionals in place. For the involvement of the third sector to be truly effective, this will need to be beyond the boundaries of public bodies. Stockport remains committed to both appropriate sharing through single record systems and individual consent.

## 6 Next Steps

### 6.1 Monitoring

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

6.1.2 Further consideration will need to be given to how any recommendations made by Adult Social Care & Health Scrutiny Committee and adopted by decision makers if they decide to proceed will be reported back-on and built into the existing mechanisms.

### 6.2 Further Involvement and Consultation

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

6.2.2 Any future approval by the Council Cabinet or CCG Governing Body ***does not negate the need to consult further on significant specific service changes*** that might be made

as a result of policy decisions, for example the location of service delivery points in neighbourhoods.

## 7 Summary

7.1 There has been a significant, considered and important response from the public. It is right that in taking decisions on the key policy questions and proceeding to implementation of the business cases decision makers reviews these carefully. The Adult Social Care & Health Scrutiny Committee plays a vital role in this.

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

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

7.4 The public and key stakeholders also made a number of comments and suggestions about things that could strengthen implementation of plans. In the officers' view these are not in themselves reasons not to proceed, but it is important that they are considered and plans are adjusted and strengthened accordingly.

7.5. Members are therefore asked to reflect on the ***process of consultation***, the consultation findings and advise both the CCG Governing Body and the Council Cabinet on ***whether or not to proceed*** with the decision to adopt the strategy and policy behind the business cases and thus proceed to implementation. If the view is to advise to proceed, Adult Social Care & Health Scrutiny Committee may want to consider what issues they would like ***further attention*** given to and make recommendations to decision makers accordingly.

7.6 Members are also asked to acknowledge the decision to change the previously announced process timeline in order to give Cabinet members greater time to consider the views of the Adult Social Care & Health Scrutiny Committee.

Report

22 December 2017

# Stockport Together Independent Consultation Analysis

# Contents

# 1 EXECUTIVE SUMMARY

## Findings in Brief

### 1.1 Introduction

Stockport Together is a partnership of the five health and social care organisations that serve the people of Stockport:

- NHS Stockport Clinical Commissioning Group (CCG);
- Pennine Care NHS Foundation Trust (mental health services);
- Stockport Metropolitan Borough Council;
- Stockport NHS Foundation Trust (Stepping Hill hospital and community health services); and
- Viaduct Care (a federation representing all Stockport GPs.)

Health and social care in Stockport faces many major challenges, some unique, others in common with the rest of Greater Manchester. Stockport Together has secured £19 million through an agreement with the Greater Manchester Health and Social Care Partnership (GMHSCP) to address these challenges by:

- Reducing inequalities;
- Supporting people to live healthier lives;
- Improving access to GPs and other integrated community health and social care services;
- Increasing access to community mental health services;
- Improving care for vulnerable people; and
- Reducing the pressures on hospital services especially those at Stockport NHS Foundation Trust (Stepping Hill Hospital).

Stockport Together conducted a public consultation (10th October to 30th November 2017) on their broad strategic principles to achieve these aims, prior to formally adopting them. The specific areas on which the consultation sought public views were:

- Changing the way health and social care services are planned and organised in Stockport;
- The plans to organise health, social care, and mental health services in teams that work in eight neighbourhoods; and
- Ensuring hospital services are in place for those that need them while reducing pressure on those services.

In summary:

- The overwhelming majority of respondents support the partnership's aims of changing the ways in which health and social care is planned;
- Again, the majority supported the plans to reorganise services based around a neighbourhood delivery model; and

- There was significantly less support for any reduction in hospital beds, with as many if not more opposing the idea.

The specific details of each service proposal along with some general observations distilled from the consultation findings are discussed in the remainder of this brief summary.

## 1.2 Summary Findings – Service Proposals

Considering the specifics of the service proposals there was broad support for the outline strategic proposals, however, this was less clear around the issue of closing hospital beds.

### 1.2.1 Planning and Organising Services

There was support for the broad proposals to reorganise the way health and social care in Stockport, with:

- 72% of respondents to the online, postal, and face-to-face survey tend to agree or strongly agree with the proposal;
- 87% of respondents to the street survey expressed a common opinion in support.

However, the following also needs to be taken into consideration:

#### Working together

Recognising the benefits of the approach suggested in the Stockport Together proposals being consulted on the opportunity to maximise these through earlier work with the third sector (voluntary and community) was highlighted for consideration.

#### Accessibility

Many respondents expressed concerns over the way in which Stockport residents would be able to access the proposed services if they faced specific difficulties.

#### Consider Local and Individual Need

The Stockport Together partners need be mindful of the variations in need between neighbourhoods in Stockport and of individuals within those neighbourhoods in designing new service provision.

#### Emphasis on Mental Health

Consultees were very clear in directing the Stockport Together consultation to give equal weight in consideration of mental health needs and physical health, and therefore placing an enhanced emphasis than that currently enjoyed.

#### Ensure Social Care is Supported

Within the considerations of the consultation there is a direction that social care funding and more importantly adequate social care provision is available, as well as closer cooperation and coordination between these two elements of the proposals.

#### Scepticism

It is also clear that the consultors (NHS Stockport CCG and Stockport MBC) will have to overcome a level of scepticism from the public over the realism of some aspects of the proposal to be able to achieve the savings it seeks to make.

### 1.2.2 A Neighbourhood Delivery Model

Again, there was very strong support for the proposals to organise health and mental health services into eight neighbourhood teams:

- 71% of respondents to the online, postal, and face-to-face survey tend to agree or strongly agree with the proposal; and
- 71% of respondents to the street survey expressed a common opinion in support.

However, the following factors identified by consultees also need to be taken into consideration:

#### The consultation process and the danger of domination by the articulate and engaged

Specific concern was raised by consultees of the potential for the process to be disproportionately influenced by the articulate middle-class respondents to the consultation. While all contributions are welcome, the issue for consideration by the consultors is recognising the ability of this group to articulate their concerns while recognising the needs of those less able to express themselves.

#### Local provision, knowledge, and accessibility

Consultees recognised the benefits of the proposal to organise service around a neighbourhood model. The key benefits were felt to be:

- Provision of services in a familiar location, in an area people know well and are comfortable in;
- The focus of service around local GPs who generally have an established relationship and a record of need and past care; and
- A central and local location that reduces the burden of travel to service.

#### Where are the resources to support the proposal?

Many consultees expressed an overall concern that the proposals, as detailed in the consultation document, did not provide enough evidence that the proposals were based on sound financial plans. Which in turn led to concerns over the overall sustainability of the proposals.

#### A much-needed focus on mental health, but is it enough?

There was a recognition from consultees that the proposals added a very important focus on caring for those with mental health needs in their own community, which was very well received. However, some consultees felt this service offer did not go far enough in meeting the needs of the residents of Stockport.

#### Are the proposed neighbourhoods too big?

Many respondents to the consultation felt that the scale of the neighbourhood model was not well enough explained in the proposals. This in turn led to concerns that the description of a 'neighbourhood' was too big, and would not be recognised by residents as such, which raised further concerns over the distances to travel and population covered by a neighbourhood centre, an issue which may need to be addressed by the consultors.

#### More questions to be answered before this proposal looks complete

While most consultees recognised the outline advantages of neighbourhood working, many also felt that there was a lack of detail in the proposals in the consultation document which led to more questions. The feeling was that Stockport Together will be required to provide more detail before many consultees felt confident in responding to the consultation, including the role the third sector would or could play in the proposals.

### 1.2.3 Reducing Hospital Beds

The proposals to reduce the number of hospital beds was significantly less welcome by consultees, with

- 40% of respondents to the online, postal, and face-to-face survey tend to agree or strongly agree with the proposal and a third (33%) disagreeing/strongly disagreeing; and
- 41% of respondents to the street survey expressed a common opinion in support, however the majority (55%) expressed opinions disagreeing/strongly disagreeing with the proposals.

In considering these results the following needs to be taken into consideration:

#### Capacity, demand, and the perceived need for hospital based rehabilitation

Many respondents to the consultation felt that the tests were flawed simply because, in their view, the number of hospital beds required for the borough was fixed based on the population level.

Consultees also took the view that Stockport needs more hospital beds not less, and with many stating the opinion that a sensible approach would appear to be some sort of 'mothballing' rather than a real reduction. The premise behind these views being the need to respond to any future upsurge in demand.

This was compounded by a minority view that hospital stays should involve an important element of rehabilitation prior to discharge, which would further increase the requirement for hospital beds.

#### This should be a self-evident truth

A more pragmatic view from consultees was that the proposed tests would be proof in themselves of the need for less beds. If they were incorrect, the number of hospital beds would be likely to remain static.

### Moving people home quicker results in better care - if adequate provision for home care exists

Many respondents to the consultation shared the view that the best care for patients was in their own home, recognising the detrimental impact prolonged hospital stays have on health, particularly for the elderly.

However, this was tempered with realism, in that home care only works in appropriate circumstances, people without a support network will be left isolated and the lack of sufficient after care will result in a return to a hospital bed. All of which are counter to the overall objectives of reducing hospital stays.

### Providing adequate transitional support to the hospital beds

Coupled with concerns over the need for care at home, consultees highlighted the need for the provision of adequate provision of transitional support for those not yet ready to return home, but no longer in need of hospital care. This was interchangeably described as ‘step down’, ‘transitional’ or ‘assessment’ beds, where patients can regain their independence. Without this element being explicitly dealt with within the proposals many were unconvinced.

### Confidence required that the capacity exists in the community to cope

Consultees were only convinced of the reduction in hospital beds if there was evidence to support provision of adequate capacity in community care to support the proposed changes. Many consultees expressed concern that this was not explicit within the proposals contained in the consultation document.

### Starts somewhere else than in hospital

The view of many consultees was that the argument for reduced beds starts outside the hospital and other clinical settings and called for a focus on other social determinants of health, and the ability to influence positive lifestyle changes.

### Savings elsewhere?

Some consultees provided the view that the proposals to cut hospital beds were looking for cost savings in the wrong area, and the reduction in management overhead in the new organisation could achieve much of the saving. A smaller group of consultees took the view that reductions in hospital bed numbers would not be enough, even when considered with efficiency savings elsewhere in the system.

## 1.3 Overall Observation – Common Themes

Aside from the specific comments on the individual proposals for service change there are several common themes emerging from the consultation responses that are important for the consultors to consider. These were:

- **Governance and accountability**

  There was an overall concern that the consultation, although currently only addressing broad strategic themes did not provide confidence that robust arrangements were in

place for governance, measurement, and accountability. Without this detail consultees would find it difficult to decide on specific service proposals.

- **Role of the third sector**
  Throughout the consultation responses the contribution of voluntary and community (third) sector partners is valued and valuable. However, they appear to be observers rather than participants in the process which overlooks the value and experience they bring to the benefit of Stockport.

- **The consultation process – speak and listen**
  There were some specific criticisms of the consultation process, despite the relatively high response rate, which included:

  - The lack of detailed information to decide on;
  - The question/response format being limited restricting the ability of consultees to respond meaningfully;
  - The way in which consultation was conducted, with too much reliance on online and social media and less with face-to-face contact. This was also reflected in the discussion group responses traditional Q&A sessions and not proactive opinion seeking. This could suggest the need for a wider approach to engagement through co-production approaches rather than a reliance on 'set-piece consultation.

  Within this, it is worth considering the complexity of the language and format used in the consultation document, perhaps reflecting on the average UK reading age of 9, and how this impacts comprehension and participation.

- **Equity of consideration – mental and physical health**
  The need to give equal consideration to mental health, which given the perceived status as the poor relation, many felt required preferential treatment.

- **Scepticism**
  Many, but by no means all consultees expressed an ongoing cynicism with the process, feeling that it had all been done before or that the evidence for the changes did not exist. Stockport Together will need to respond constructively to this and provide evidence of positive change to convince this group.

- **We get it, show us transparency and honesty**
  The feeling was the ability of the public to understand the proposals was often underestimated and Stockport Together should provide a consultation that is clear in the benefits and drawbacks of the proposals alongside the rationale and accountability.

- **Access for all**
  The issue of affluent, literate and engage communities was raised as a concern. The specific issues were:

- The potential for disproportionate influence from middle class consultees; and
- Concerns over those with the self-awareness to seek health support (the worried well) predominantly in affluent areas taking a higher 'share' of services than areas less health literate.

- **Cross boundary working**

  Demands on health and social care services are not unique to Stockport and consultees were aware of other initiatives in Greater Manchester and other bordering areas. The concern for consultees was the extent to which this was taken account of in Stockport Together's proposals and the impact on inflowing/outflowing services provided across boundaries.

- **Staff**

  Consultees felt that one of the main challenges to be addressed by Stockport Together in developing and delivering their proposals was the issue of staff, including:

  - Consideration of recruiting more GPs, nurses, care assistants and other clinical roles alongside social care staff to address service demands in the face of national shortages;
  - The willingness and support from GPs to deliver the neighbourhood model;
  - The capability and capacity of community staff to deal with the increased demand.

- **Care homes and transitional support**

  Stockport Together's proposals appear to consultees to rely upon increased care home capacity and the availability of transitional/step down beds to move people from hospital quicker. The level of detail in the proposals does not make it clear if this has been considered and is in place.

- **Changes in lifestyle and behaviour**

  Outside of the proposals there was a strong feeling from consultees that to effect the changes described there is a need for more preventative interventions. The view being that by the time people are being dealt with by the proposed services, it's too late. Early intervention is required in the community, including schools, which is a wider remit than the proposals, but felt to be the motivator for real change and savings.

# 2 INTRODUCTION

## Context and background

## 2.1 Introduction

Stockport Together is a partnership of the five health and social care organisations that serve the people of Stockport:

- NHS Stockport Clinical Commissioning Group (CCG);
- Pennine Care NHS Foundation Trust (mental health services);
- Stockport Metropolitan Borough Council;
- Stockport NHS Foundation Trust (Stepping Hill hospital and community health services); and
- Viaduct Care (a federation representing all Stockport GPs.)

Health and social care in Stockport faces many major challenges, some unique, others in common with the rest of Greater Manchester. Stockport Together has an opportunity to begin to address these issues having secured £19 million through an agreement with the Greater Manchester Health and Social Care Partnership (GMHSCP). The aims of this agreement include:

- Reducing inequalities;
- Supporting people to live healthier lives;
- Improving access to GPs and other integrated community health and social care services;
- Increasing access to community mental health services;
- Improving care for vulnerable people; and
- Reducing the pressures on hospital services especially those at Stockport NHS Foundation Trust (Stepping Hill Hospital).

Against this background the overall objective of the public consultation was to provide the people of Stockport, and other stakeholders in the community, the opportunity to offer comment and questions on these broad strategic principles prior to formally adopting the proposals.

The specific areas in which the consultation sought public views were:

- Changing the way health and social care services are planned and organised in Stockport;
- The plans to organise health, social care, and mental health services in teams that work in eight neighbourhoods; and
- Ensuring hospital services are in place for those that need them while reducing pressure on those services.

## 2.2 The Consultation Process

The Stockport Together public consultation on their broad strategic principles ran between 10th October to 30th November 2017. The consultation followed the principles of a 'continuous dynamic dialogue'[1] and compensating methods were introduced when potential gaps in coverage were identified. The specific methods employed as part of the consultation and included in this analysis were:

- A consultation survey available electronically or in hard copy with submissions received either online, by post or face-to-face;
- A series of consultation discussion groups; and
- An on-street survey, using a slight variant of the standard consultation questionnaire to reflect the methodology, with a representative sample of the population in neighbourhood centres.

Respondents were also invited to provide additional evidence for consideration by the Stockport Together partnership in their deliberations over formal adoption of the proposals.

The consultation was promoted through the following channels:

- Launch communications through local press and online;
- Social media (Facebook, Twitter, etc.) activity throughout the consultation period;
- A consultation document *'Have your say: Stakeholder consultation on the proposed changes to the way health and social care services are organised in Stockport'* (containing key information and a self-complete questionnaire returnable by Freepost), supported by flyers, distributed to:
    - Libraries;
    - Charities/voluntary organisations;
    - GP practices;
    - Pharmacies;
    - Stockport NHS Foundation Trust staff and patients;
    - Key community figures;
- Accessible format versions of the consultation document and supporting information – sensory disabilities, other languages.

Hard copies of the consultation document were used in groups and meetings to support the discussions and capture views in a face-to-face setting.

[1] Taken from the Consultation Institute's definition of consultation.

## 2.3 Responses to the Consultation

In total 527 responses (514 survey responses plus 13 discussion groups) received during the consultation period, were provided for analysis, and included in this report.

| Method | Responses |
|---|---|
| Street Survey | 303 |
| Face-to-Face | 22 |
| Postal | 10 |
| Online | 179 |
| **Total** | **514** |

In addition, notes of fourteen discussions group meetings were provided for analysis as follows:

1. Alvanley Health Champions Patient Participation Group (PPG)
2. Breathe Easy Group
3. Bredbury PPG
4. Cheadle PPG
5. Disability Stockport
6. Healthwatch
7. Marple PPG
8. Mental Health Carers Group
9. Poets Corner Action Group
10. NHS Watch
11. Walthew House Deaf group 1
12. Walthew House Deaf group 2
13. Walthew House Visually Impaired group 1
14. Walthew House Visually Impaired group 2

Additional evidence submitted for consideration as part of the consultation survey was:

| **Question 1c, related to 'the way we plan and organise services':** |
|---|
| ▪ Two personal responses;<br>▪ An alternative view from NHS Watch;<br>▪ Carers UK State of Caring Report 2017<br>▪ Stockport Together Consultation, Response from Liberal Democrat Group;<br>▪ Health and Care Forum response;<br>▪ Mental Health Carers Group response;<br>▪ Effects of health and social care spending constraints on mortality in England: a time trend analysis, BMJ Open, 16/11/17, Watkins J, et al. |
| **Question 2c, related to 'providing care through a neighbourhood model':** |
| ▪ Newquay Pathfinder Evaluation. |
| **Question 3c, related to 'hospital beds':** |
| ▪ Mental Health Carers Scenarios;<br>▪ CQC Stepping Hill Hospital Quality Report. |

### 2.3.1 Demographics Street Survey

The demographic make-up of the street survey sample is shown below (age, gender and residence were the only characteristics captured).

| | Frequency | Percent |
|---|---|---|
| **Age** | | |
| 18-24 | 31 | 10.2% |
| 25-34 | 55 | 18.2% |
| 35-44 | 42 | 13.9% |
| 45-54 | 48 | 15.8% |
| 55-64 | 52 | 17.2% |
| 65+ | 74 | 24.4% |
| Prefer Not to Say | 1 | 0.3% |
| **Total** | **303** | **100%** |
| **Gender** | | |
| Female | 179 | 59.1% |
| Male | 119 | 39.3% |
| Not Answered | 4 | 1.3% |
| Prefer not to say | 1 | 0.3% |
| **Total** | **303** | **100%** |
| **Respondent Postcode** (First characters only provided) | | |
| Cheadle | 1 | 0.3% |
| SK1 | 11 | 3.6% |
| SK2 | 23 | 7.6% |
| SK3 | 8 | 2.6% |
| SK4 | 25 | 8.3% |
| SK5 | 18 | 5.9% |
| SK6 | 89 | 29.4% |
| SK7 | 27 | 8.9% |
| SK8 | 74 | 24.4% |
| SK9 | 2 | 0.7% |
| SK10 | 3 | 1.0% |
| SK12 | 2 | 0.7% |
| SK13 | 3 | 1.0% |
| SK14 | 15 | 5.0% |
| SK22 | 1 | 0.3% |
| Not answered | 1 | 0.3% |
| **Total** | **303** | **100%** |

## 2.4 Demographics, Online, Postal and Face-to-Face Survey

The overall demographic characteristics of consultees providing online, face-to-face, or postal responses to the consultation are shown below.

| | Frequency | Percent |
|---|---|---|
| **Age** | | |
| 16-17 | 1 | 0.5% |
| 18-24 | 2 | 0.9% |
| 25-34 | 13 | 6.1% |
| 35-44 | 20 | 9.4% |
| 45-54 | 28 | 13.1% |
| 55-64 | 48 | 22.5% |
| 65+ | 63 | 29.6% |
| Prefer not to say | 5 | 2.3% |
| Not Answered | 33 | 15.5% |
| **Total** | **213** | **100%** |
| **Gender** | | |
| Female | 122 | 57.3% |
| Male | 60 | 28.2% |
| Transgender | 3 | 1.4% |
| Prefer not to say | 13 | 6.1% |
| Not Answered | 15 | 7.0% |
| **Total** | **213** | **100%** |
| **Ethnicity** | | |
| Asian/British - Bangladeshi | 1 | 0.5% |
| Asian/British - Chinese | 1 | 0.5% |
| Black/British – African | 1 | 0.5% |
| Not Answered | 23 | 10.8% |
| White: British | 167 | 78.4% |
| White: European | 3 | 1.4% |
| White: Gypsy/Traveller | 2 | 0.9% |
| White: Irish | 6 | 2.8% |
| Other ethnicity/race | 9 | 4.2% |
| **Total** | **213** | **100%** |
| **Religion** | | |
| Buddhism | 4 | 1.9% |
| Christianity | 108 | 50.7% |
| Islam | 1 | 0.5% |
| Judaism | 2 | 0.9% |
| No religion | 56 | 26.3% |
| Other | 15 | 7% |

| | Frequency | Percent |
|---|---|---|
| Not Answered | 27 | 12.7% |
| **Total** | **213** | **100%** |
| **Disabled** | | |
| Yes | 48 | 22.5 |
| No | 135 | 63.4 |
| Not Answered | 16 | 7.5 |
| Prefer not to say | 14 | 6.6 |
| **Total** | **213** | **100.0** |
| **Sexual Orientation** | | |
| Bisexual | 2 | 0.9 |
| Gay | 6 | 2.8 |
| Heterosexual/straight | 142 | 66.7 |
| Lesbian | 2 | 0.9 |
| Not Answered | 26 | 12.2 |
| Other | 2 | 0.9% |
| Prefer not to say | 33 | 15.5% |
| **Total** | **213** | **100%** |
| **Is your gender different to that assigned at birth?** | | |
| Yes | 10 | 4.7% |
| No | 151 | 70.9% |
| Prefer not to say | 27 | 12.7% |
| Not Answered | 25 | 11.7% |
| **Total** | **213** | **100%** |

## 2.5 Interpreting the Responses

ASV[2] was commissioned to provide an independent analysis of the consultation. The specific methods applied to analyse the findings were:

- **Quantitative Analysis:** the findings from the survey-based consultation approaches (online, postal, and face-to-face consultation surveys and street survey) were each analysed separately to recognise the differences[3] in the respondents and sampling approach.

  The closed responses were analysed using industry standard proprietary statistical analysis software[4] with manual thematic coding used for the free text responses to group them into themes reflective of the sentiment expressed.

- **Qualitative Analysis:** the findings from the focus group discussion-based consultation approaches are based on an approach where the data from the session notes is analysed and responses grouped into themes that most closely represent the views expressed[5]. This allows us to report the findings based on an accurate reflection of the sentiments expressed, qualitative data does not allow for commentary on the specific number of times comments are made within these coded themes.

The communications to promote the consultation and the methods used were designed to promote maximum participation, allowing all to contribute. It is important to note, however:

- Respondents to the online, postal, and face-to-face surveys are self-selecting, representing the views of those who are aware of and engaged in the topic area. This is more likely to include the views of service users, carers, staff, and others with a direct interest in the services, but cannot be said to represent opinion from the entire population. This is very important opinion, but cannot be treated as being statistically reliable.
- The street survey of residents of Stockport is representative at the population level, considering the views of all irrespective of current service use. This is the only statistically reliable response[6], but does not necessarily reflect the views of services users.

This report presents the result of that independent analysis and is intended to inform decision makers of the views of consultees and to provide them with a summary of additional evidence which they wish them to take into conscientious consideration.

[2] ASV is a trading style of ASV Research Ltd
[3] Online, postal, and face-to-face are treated as one category with similar aims and response mechanisms.
[4] SPSS
[5] Our approach is based in the employment of Classic Grounded Theory.
[6] Using 2016 Mid- Year Population Estimates for Stockport the results of the street survey are reliable to a confidence level of 95% with a confidence interval of +/-5.63.

# 3 SERVICES

## Changing the way we plan and organise services

### 3.1 Introduction - Services

The consultation document provided the following context to inform individual responses.

We know how to work with you to prevent disease. We have the medicines and treatments to improve the health of people with long-term illnesses. We have the skills to provide care when you are vulnerable. It makes sense for us to change the way we work so we can better use these to improve the health of local people, rather than wait until they are so ill they need hospital treatment or completely lose their independence.

Sometimes a stay in hospital is not needed or is only needed for a very short time. We want to reduce the number of people who have to be admitted to hospital by diagnosing them earlier and treating them quicker. For those who do require hospital care we want to support them to return home as soon as possible. We want more services that help diagnose and treat people in their communities. We think that bringing GPs and other health and social care professionals closer together with more resources, will help prevent many people becoming so ill they need to go to hospital and will help others maintain their independence longer.

Older people tell us that going into hospital can be a stressful experience, even when they know they need to. In Stockport there's a higher chance that patients will be admitted to hospital and kept in longer after treatment than in other similar places in England.

In June the partner organisations published four outline business plans that show how they would work together. Through this work, we're planning to do several things:

- Identify the people with long-term illnesses who are most likely to end up in hospital for urgent treatment
- Develop new integrated community health and social care teams built around GPs to help those patients stay well
- Expand and integrate services that provide mental health support in the community developing a more holistic approach to meeting peoples' needs
- Identify those patients who would benefit from rapid short- term support when they arrive at hospital and divert them to a specialist treatment centre that has immediate access to their records and can treat them quickly
- Give patients the support and care they need to return home from hospital quickly, where possible without an overnight stay
- Give patients access to outpatient services traditionally provided at hospital in

different ways utilising modern technology and either in their home, or at neighbourhood health centres.

The effect of these proposals is to move resources from treating people in hospital when they become seriously ill, to identifying and addressing their social care, physical and mental health needs at home and in the community before they become serious enough to require hospital treatment or completely lose their independence. As a consequence of our proposals when people do need hospital care we will be able to offer higher quality care more quickly.

Respondents were asked three questions, one closed and two open about these proposals, these were:

- To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined? (Closed response using a ranking of 1-5 where 1 is 'Strongly Agree' and 5 is 'Strongly Disagree' a sixth option 'Don't Know' was also provided).
- Why do you say this? (Free text response).
- Do you have any additional evidence that decision-makers should consider before they make this decision? (Free text response).

## 3.2 Do you agree with our proposals?

Participants in the consultation, whichever method was used, were all asked the following question.

> *"To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined?"*

Discussed in turn below are the responses from the:

- Online, postal, and face-to-face survey; and
- Street survey.

These data are treated separately to recognise the previously discussed differences in sampling and motivation to participate.

Further details of the responses for the online, postal, and face-to-face survey are shown in Appendix One. Demographics beyond those reported are not available for the street survey.

### 3.2.1 Online, Postal, and Face-to-Face

When overall sample is considered most consultees from the online, postal, and face-face survey support this proposal. **72% of respondents either tend to agree or strongly agree** that Stockport Together should change their approaches to planning and organising health and social care services as shown below.

| Overall agreement/disagreement | Frequency | Percent |
|---|---|---|
| Strongly agree | 79 | 37.1% |
| Tend to agree | 75 | 35.2% |
| Neither agree nor disagree | 9 | 4.2% |
| Tend to disagree | 10 | 4.7% |
| Strongly disagree | 13 | 6.1% |
| Don't know | 11 | 5.2% |
| Not Answered | 16 | 7.5% |
| **Total** | 213 | 100% |

When the consultation responses are considered by consultee age there is little difference in agreement, with the main differences being the 16-18 group who are fully in agreement and the 18-24 group who are significantly lower at 50%. However, these latter variations can most likely be explained by low sample size.

The breakdown is shown on the next page.

- 16-17 100%
- 18-24 50%
- 25-34 92%
- 35-44 85%
- 45-54 79%
- 55-64 77%
- 65+ 71%

When considered by gender women are significantly more in favour of the proposals than men[7].

- Female 80%
- Male 68%

### 3.2.2

[7] The figures shown are a percentage of the sub category – i.e. 88% of all women responding.

### 3.2.3 Street Survey

The majority (87%) of consultees responding to the street survey supported the proposal, either tending to agree or strongly agreeing that Stockport Together should change their approaches to planning and organising health and social care services.

| **Overall agreement/disagreement** | **Frequency** | **Percent** |
|---|---|---|
| Strongly agree | 146 | 48.2% |
| Tend to agree | 118 | 38.9% |
| Neither agree nor disagree | 19 | 6.3% |
| Tend to disagree | 7 | 2.3% |
| Strongly disagree | 4 | 1.3% |
| Don't know | 8 | 2.6% |
| Not Answered | 1 | 0.3% |
| **Total** | **303** | **100%** |

When considered by age of respondent there is no significant variation in opinion.

- 18-24 84%
- 25-34 78%
- 35-44 86%
- 45-54 94%
- 55-64 96%
- 65+ 85%

When considered by gender of respondent there is little difference in opinion between men and women on this proposition.

- 88% of women agree/strongly agree
- 86 % of men agree/strongly agree

## 3.3 Why? (Q1b)

When asked "…*why did you provide that answer…"* participants in the consultation gave a range of responses, these have been analysed and grouped into broad themes representing the overall sentiment.

Recognising the similarity of the responses and for brevity in reporting we have analysed them together irrespective of the method of contribution to the consultation. The main themes developed from the consultation are discussed below, all relating to the question:

> *"To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined?"*

### 3.3.1 Concerns over Funding Proposals

Respondents expressed concerns over the overall funding modelling in the consultation proposals, both for NHS and local authority funding, centred around:

- Concerns over the challenges to services through strategic decisions outside local control, from central government policy. There was also practical recognition that with reduced funding there is a need to manage available resources most efficiently;
- Perceptions that the overall objective of the consultation was designed to cut costs rather than deliver better services; and
- An expressed desire to better understand the way the funding would work under the proposed changes.
    - How it differs to that provided in the current circumstances; and
    - An overall concern that detailed costings are not provided at a level that would help inform decisions.

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*"…without proper funding, resources and staffing, any reorganisation will result in a second-rate system..."*

---

There were also concerns expressed that any savings made through these proposals would be cancelled out by requirements to make budget cuts across health and in particular social care.

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*"… any financial savings will be swallowed up by massive budget cuts…health and wellbeing of citizens of Stockport will be…worsened as a result…"*

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### 3.3.2 Additional Key Partners

A theme from consultees was the need to consider other partners in the Stockport Together model. Issues highlighted include links between homelessness and poor mental health. Stockport Homes were specifically mentioned as a potential partner to address many health issues.

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

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

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Concern was also expressed that the role of voluntary and community organisations was not adequately explored in the proposals, which in itself was felt to be a considerable oversight.

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

### 3.3.3 Bureaucracy and Management

Concerns were expressed around a perception that the proposals could result in increasing managerial staff, rather than frontline service delivery

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

However, there was a countervailing argument that where resources are available they need to be managed as efficiently and at as low a cost as possible.

*"…you need to manage the funds closely to make sure it's used properly…"*

There were also concerns expressed over the existing senior leadership record of achievement, and the extent to which proposals were based on understanding of the challenges faced by frontline health and social care staff on a day-to-day basis.

*"…have the council leaders…been to spend a day shadowing all health and social care services…I very much doubt it…"*

### 3.3.4 Consultation Complexity

An overall comment from many respondents was the complexity of the consultation subject, the specific service areas, and the wording of the questions themselves, with many feeling this was a barrier to full participation.

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

*"…don't fully understand the question…"*

### 3.3.5 Support for the Proposals

Overall, consultees welcomed the consultation's proposals for rearranging the way services are delivered with the caveat that they are, perhaps, too generalised.

The local focus of the proposals, and specifically developing an integrated service built around GPs was welcomed. However, this was also a point of concern for some in that while welcome placed additional pressure on what was felt to be an already overstretched service.

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*"…local people want good quality services delivered by competent staff in a welcoming and safe environment…"*

---

There was recognition from many respondents of the need to make these changes based both on resources and efficiencies and the improved wellbeing of communities through reduced clinical interventions.

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*"There needs to be a change because there are insufficient resources to carry on as is…";*

*"…because Hospital care and resources are better focused where clinically appropriate and needed…"*

*"…health and wellbeing have been shown in numerous studies to benefit from less clinical approaches in the community…"*

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The proposed rearrangement of services was also seen as providing more efficient communications and the opportunity reductions in duplication of effort between NHS and social care staff.

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

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

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### 3.3.6 Inequalities

Consultees recognised the potential for improvement in health and social care outcomes through the proposals under consultation, however, concern was expressed that the focus on physical wellbeing was prioritised over that of residents' mental health.

> *For too long there has been inequalities between physical health care and mental health care. It is our hope that the changes will present more parity of esteem not only within services, but also within the larger community.*

Many consultees thought this an important issue for the consultation to consider.

### 3.3.7 Specific Needs of Equalities Groups

There was a call for the consultation to consider the specific needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) communities in Stockport, specifically the need for services that revolve around a supportive and understanding GP.

> *"…making prevention more accessible to LGBT people by ensuring that services most likely to be needed… such as drug and alcohol and mental health services, are designed and delivered to meet the specific health needs of this community of identity…"*

### 3.3.8 Service Concerns

Specific concerns were expressed by consultees around the proposals under consultation. First, the issue of social care funding was raised and specifically how the current levels of support for adults will be maintained under the Stockport Together proposals.

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

Coupled with this was a concern expressed over perceptions that the proposals would lead to delivery of community based health and social care services with a lower qualified workforce.

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

### 3.3.9 An Ageing Population

Consultees identified a need for realism in the proposals being consulted on in relation to the ageing population of Stockport. The concern expressed was around the extent to which the proposals had taken the population profile into account, and the need to accurately reflect this in future service provision.

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*"…Stockport NHS has 19.4% above the national average of over 65s…"*

*"…the needs of a changing demographic linked to the changes in society since the foundation of the NHS make it vitally important that we ensure our services are tailored to local need…"*

---

Alongside this call for realism, is the call for the provision of social care packages, on time and in time for the older population to preserve independence and reduce reliance on hospital support.

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*"…my gran is 91 years old and she had to stay in hospital for 6 months as they had no care package available as Marple was fully subscribed…"*

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### 3.3.10 Openness, Honesty, and Transparency

Another overarching theme from consultees was that of scepticism around the intent of the consultation.

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*I remain somewhat sceptical…wonder whether sufficient resources will be made available to preventative services to enable them to be sufficiently available to those who need them?*

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Coupled with this was a concern expressed in varying forms by many consultees, that the consultation was not sufficiently honest in its intent and description of the proposed changes to the delivery of local services in Stockport.

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

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

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This was felt to be mitigated by more transparent planning, monitoring, and reporting of the changes as they progress, along with a more detailed description of costs and service outcomes.

> *"…any plans the new Stockport Together Trust make to achieve the advertised goals should be fully investigated, properly planned and accurately costed…"*

## 3.4 Other Evidence to Consider (Q1c)

When people were asked the question:

> *"Do you have any additional evidence that decision-makers should consider before they make this decision?"*

They were able to respond in two ways by:

i. Uploading documents – either reports, responses, or comments to the consultation website; or
ii. Providing additional comments as free text.

Evidence submitted in these ways, related to "*...changing the way we plan and organise services…"* is discussed in turn below.

### 3.4.1 Uploaded Evidence

In total, eight pieces of documentary evidence were submitted to the consultation for consideration. These were:

- Two personal responses;
- An alternative view from NHS Watch;
- Carers UK State of Caring Report 2017;
- Stockport Together Consultation, Response from Liberal Democrat Group;
- Health and Care Forum response;
- Mental Health Carers Group response;
- Effects of health and social care spending constraints on mortality in England: a time trend analysis, BMJ Open, 16/11/17, Watkins J, et al.

#### 3.4.1.1 Personal Responses

Two personal responses were received, the names and specifics of these are not detailed for reasons of data protection and patient confidentiality, however, in summary their concerns covered:

- An over reliance upon social media as the main means of engaging with the public and patients, when many are not able to access this;
- The need for expert support for GPs when dealing with mental health issues;
- Concerns with the 'Have your say' questionnaire:
  - Confusing and conflicting requests for information;
  - The lack of robust evidence behind the statements;

- Concerns over the wording of questions; and
- Concerns over the depth of equality monitoring questions.

#### 3.4.1.2 An Alternative View from Stockport NHS Watch

Stockport NHS Watch provided an uploaded submission. The submission covered a range of issues in depth, and included a broad and robust challenge to the evidence base used for the consultation and perceived adherence to a national model which could lead to cuts in hospital services. However, the general principles were welcomed, particularly Neighbourhood Hubs, and the need to transfer hospital bed savings to be transferred to community care. An overall concern expressed was the perception that the accountable care organisation created would be vulnerable to privatisation.

#### 3.4.1.3 Carers UK, State of Caring Report 2017

A submission was received as a copy of the State of Caring 2017 report produced by Carers UK. This report highlights the contribution made by carers, the lack of recognition they feel for that £132bn unpaid care, and the impact on their health and wellbeing. The call in the report for a contribution that is understood and valued appears an important message to Stockport Together.

#### 3.4.1.4 Stockport Together Consultation, Response from Liberal Democrat Group

The submission received from the Stockport Liberal Democrat is in support of the overall objectives of Stockport Together. However, there were some specific issues requiring clarification. Including: the role and composition of the Implementation Board; Overall governance and accountability; workforce implications; and the impact evaluation of Stockport Together.

#### 3.4.1.5 Health and Care Forum response

The submission from the Health and Care Forum focused on the key questions they felt need to be addressed by the 'Healthier Stockport – an issues document.'

These included:

- The number of GP practices in Stockport in special measures, the number of full-time equivalent GPs in Stockport; unfilled GP vacancies in Stockport and the extent to which paperwork burdens have been reduced for GPs;
- Bringing to the attention of Stockport Together the wider plans for hospitals in Manchester under the Healthier Together initiative;
- The targets set around Mental Health in the Stockport Locality Plan 2016;
- Concerns that the consultation was not being *"…put to the public in a convincing manner…"* listing 14 detailed issues to support this statement; and
- Concluding, that *"…the aims is good but the means of achieving effective and complete implementation does not convince…"*

#### 3.4.1.6 Mental Health Carers Group response

The submission received from the Mental Health Carers Group provided a number of statistical tables and other information demonstrating impact. Including an extra 330 vulnerable adults discharged from secondary to primary care in Stockport. The overall concern was the apparent lack of focus on serious mental illness in favour of a concentration on wellbeing, ending with questions over the responsibility for duty of care and accountability

#### 3.4.1.7 Effects of health and social care spending constraints on mortality in England: a time trend analysis, BMJ Open, 16/11/17, Watkins J, et al.

A submission was received to the consultation as an upload of a recent article published in the British Medical Journal (BMJ), the abstract for the article states:

**Results** Spending constraints between 2010 and 2014 were associated with an estimated 45 368 (95% CI 34 530 to 56 206) higher than expected number of deaths compared with pre-2010 trends. Deaths in those aged ≥60 and in care homes accounted for the majority. Public Expenditure on Social Care (PES) was more strongly linked with care home and home mortality than Public Expenditure on Health (PEH), with each £10 per capita decline in real PES associated with an increase of 5.10 (3.65–6.54) ($p<0.001$) care home deaths per 100 000. These associations persisted in lag analyses and after adjustment for macroeconomic factors. Furthermore, we found that changes in real PES per capita may be linked to mortality mostly via changes in nurse numbers. Projections to 2020 based on 2009-2014 trend was cumulatively linked to an estimated 152 141 (95% CI 134 597 and 169 685) additional deaths.

**Conclusions** Spending constraints, especially PES, are associated with a substantial mortality gap. We suggest that spending should be targeted on improving care delivered in care homes and at home; and maintaining or increasing nurse numbers.

### 3.4.2 Thematic Analysis

As well as providing the opportunity to upload supporting documents to the consultation website, consultees were also asked if they had any additional comments they would like to add in relation to the way services will be arranged in the future. These have been grouped into broad themes as shown below.

#### 3.4.2.1 Working together

Recognising the benefits of the approach suggested in the Stockport Together proposals being consulted on, the opportunity to maximise these through earlier work with the third sector (voluntary and community) was highlighted for consideration.

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

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

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#### 3.4.2.2 Accessibility

Many respondents expressed concerns over the way in which Stockport residents would be able to access the proposed services if they faced specific difficulties. This included consideration of, among others:

- Elderly and infirm people;
- People with sensory and learning difficulties;
- Homeless people; and
- Those who did not speak English as their first language.

There is a clear call for the consultors to consider the access needs of specific groups

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*"…how do I cope… If I had a low IQ or older age or English was a second language..."*

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#### 3.4.2.3 Consider Local and Individual Need

Consultees called for the consultors (NHS Stockport CCG and Stockport MBC) to be mindful of the variations in need between neighbourhoods in Stockport and of individuals within those neighbourhoods in designing new service provision.

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*"…the decision makers should always have the needs of people/patients uppermost in their minds rather than the easiest way to deliver the budget cuts required…"*

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*"…the more local things are the better - the needs of people in Bramhall are very different to those in Brinnington…"*

#### 3.4.2.4 Emphasis on Mental Health

Consultees were very clear in directing the Stockport Together consultation to give equal weight in consideration of mental health needs with physical health, and, therefore, placing an enhanced emphasis than that currently enjoyed.

*"…it needs to have more of a holistic approach…(relation)… was in Stepping Hill Hospital and they just drugged her up…(then) a specialist care centre and it helped her enormously…"*

*"…mental health and physical health should go hand in hand and receive the same input..."*

#### 3.4.2.5 Ensure Social Care is Supported

Within the considerations of the consultation consultees are clear that for the successful implementation of the proposals, social care funding, and more importantly adequate social care provision is available.

There was a corresponding call closer cooperation and coordination between the heal and social care elements of the proposals.

*"…at present there is no cooperation between the medical staff and the social care staff on the ground…"*

#### 3.4.2.6 Scepticism

It is also clear that the consultors will have to overcome a level of scepticism from the public over the realism of some aspects of the proposal to be able to achieve the savings it seeks to make.

*…the Public consultation before the last JSNA identified access to GP as the most significant problem with health and social care.*

*"…savings are considerable but there is no evidence being given to the general public to substantiate these…"*

# 4 NEIGHBOURHOODS

## Delivering health and mental health services in neighbourhood teams

## 4.1 Introduction - Neighbourhoods

The consultation document provided the following context to inform individual responses.

Stockport Together currently divides Stockport into eight neighbourhoods, each serving the differing needs of the people within that area. The outline business cases set out proposals to organise health and mental health services in teams that work as one in these neighbourhoods. The neighbourhood model we propose will see services working together with general practice at the centre:

**Enhanced Case Management** – GPs, working with local neighbourhood teams, will identify those individuals most at risk of losing their independence or requiring emergency hospital care. They will then work with those individuals and their carers to develop care plans and provide more intensive, proactive, and tailored support across 7-days a week. In doing so they will be able to spot deterioration quickly and intervene more rapidly, reducing the need for people to require care outside their home.

**Direct access physiotherapy** – the aim is to reduce the number of patients with Musculoskeletal (MSK) conditions having to have consultations with GPs before they access physiotherapy services. This will help to provide more timely access to support, improving patient experience, and freeing up GP capacity.

**Mental wellbeing** – significant numbers of GP appointments are spent working with people who have various social needs or low mental wellbeing. Where no specific medical help is required, GPs will be able to refer the patient to a care navigator who will develop a personalised care and wellbeing plan. They will also help people to access a range of services such as self-help, mental health alliance and other voluntary sector groups.

**Find and prevent** – additional support will be put in place to help GPs identify people from their practice who have yet to develop complex care needs, but whose lifestyle would suggest they're at risk of doing so. Individuals will then be invited for enhanced health checks within the neighbourhoods. There will then be a range of local options available to individuals to help them improve their health and reduce the risk of long-term ill health.

**Self-care** – support and coaching will be offered to people with a long-term condition or those with risk factors which increase the likelihood of developing a long-term condition. An assessment of people's ability to manage their conditions will be made. This will identify the right level of support for that person, and allow support to be tailored

Respondents were asked three questions, one closed and two open about these proposals, these were:

- To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined? (Closed response using a ranking of 1-5 where 1 is 'Strongly Agree' and 5 is 'Strongly Disagree' a sixth option 'Don't Know' was also provided).
- Why do you say this? (Free text response).
- Do you have any additional evidence that decision-makers should consider before they make this decision? (Free text response).

## 4.2 Do you agree with our proposals?

Participants in the consultation, whichever method was used, were all asked the following question.

> *To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described?*

Discussed in turn below are the responses from the:

- Online, postal, and face-to-face survey; and
- Street survey.

This data is treated separately to recognise the previously discussed differences in sampling and motivation to participate.

Further details of the responses for the online, postal, and face-to-face survey are shown in Appendix One. Demographics beyond those reported are not available for the street survey.

### 4.2.1 Online, Postal, and Face-to-Face

When considered overall there is overwhelming support for this proposal from respondents to the online, postal, and face-face survey, with **71% of respondents** either **agreeing or strongly agreeing** that health and mental health services should be organised on the neighbourhood model as described.

| Overall agreement/disagreement | Frequency | Percent |
|---|---|---|
| Strongly agree | 90 | 42.3% |
| Tend to agree | 62 | 29.1% |
| Neither agree nor disagree | 15 | 7% |
| Tend to disagree | 11 | 5.2% |
| Strongly disagree | 16 | 7.5% |
| Don't know | 4 | 1.9% |
| Not Answered | 15 | 7% |
| **Total** | **213** | **100%** |

When considered by age of respondent there is overwhelming support for the proposition from those aged 16 to 34, with a drop off to support between 70 and 75% from those aged 35+. While the latter is still supportive it perhaps indicates that there is a need to consider the concerns of older residents in more depth when developing option details and moving into implementation.

- 16-17 100%
- 18-24 100%
- 25-34 100%
- 35-44 70%
- 45-54 75%
- 55-64 75%
- 65+ 75%

Consideration by gender show little difference in levels of support from consultees.

- Female 77%
- Male 73%

### 4.2.2 Street Survey

Overall consultees engaged through the street survey were supportive of the proposition with 71% agreeing/strongly agreeing.

| **Overall agreement/disagreement** | **Frequency** | **Percent** |
|---|---|---|
| Strongly agree | 111 | 36.6% |
| Tend to agree | 105 | 34.7% |
| Neither agree nor disagree | 31 | 10.2% |
| Tend to disagree | 21 | 6.9% |
| Strongly disagree | 16 | 5.3% |
| Don't know | 16 | 5.3% |
| Not Answered | 3 | 1% |
| Total | **303** | **100%** |

When considered by age of consultee the spread of support shows 18-24, 45-54 and 55-64 generally more supportive with around 80% support. The other age groups were still supportive at the slightly lower rate of 65%.

- 18-24 81%
- 25-34 65%
- 35-44 64%
- 45-54 79%
- 55-64 81%
- 65+ 65%

Considered by gender there are no differences between men and women in terms of their support for the proposition.

- Female 71%
- Male 71%

## 4.3 Why? (Q2b)

When asked, why did you provide that answer, participants in the consultation gave a range of responses. These have been analysed and grouped into broad themes representing the overall sentiment of consultees in relation to:

> *To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described?*

Recognising the similarity of the responses and for brevity in reporting, we have analysed all together irrespective of the method of contribution to the consultation.

### 4.3.1 The consultation process and the danger of domination by the articulate and engaged

Specific concern was raised by consultees of the potential for the process to be disproportionately influenced by the articulate middle-class respondents to the consultation. While all contributions are welcome, the issue for consideration by the consultors is recognising the ability of this group to articulate their concerns, while recognising the needs of those less able to express themselves.

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

---

To some extent this could be said to be an extension of the widely discussed concerns over the complexity of the consultation process, and the barrier to participation this places on those less able to respond.

### 4.3.2 Local provision, knowledge, and accessibility

Consultees recognised the benefits of the proposal to organise services around a neighbourhood model. The key benefits were felt to be:

- Provision of services in a familiar location, in an area people know well and are comfortable in;
- The focus of service around local GPs who generally have an established relationship and a record of need and past care; and
- A central and local location that reduces the burden of travel to service.

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*"Your GP's surgery is local, so it is a good idea to have other care based locally…"*

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

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### 4.3.3 Where are the resources to support the proposal?

Many consultees expressed an overall concern that the proposals, as detailed in the consultation document, did not provide enough evidence that the proposals were based on sound financial plans. Which in turn led to concerns over the overall sustainability of the proposals.

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*"…there is not enough financially for care in the community…"*

*"…looks to build on a system already under huge strain!? Sounds good in planning but can…resources…work practically…"*

---

### 4.3.4 A much-needed focus on mental health, but is it enough?

There was a recognition from consultees that the proposals added a very important focus on caring for those with mental health needs in their own community, which was very well received.

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*"…more health services to the neighbourhoods who need them most..."*

*"…there needs to be better Mental health services that residents can access quickly when needed before a crisis escalates…"*

---

However, some consultees felt this service offer did not go far enough in meeting the needs of the residents of Stockport.

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*"…disappointed that only low level mental health needs are explicitly addressed. severe and enduring mental illness is not specifically mentioned…"*

---

### 4.3.5 Are the proposed neighbourhoods too big?

Many respondents to the consultation felt that the scale of the neighbourhood model was not well enough explained in the proposals. This in turn led to concerns that the description of a 'neighbourhood' was too big, and would not be recognised by residents as such, which raised further concerns over the distances to travel and population covered by a neighbourhood centre, an issue which may need to be addressed by the consultors.

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

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#### 4.3.6 More questions to be answered before this proposal looks complete

While most consultees recognised the outline advantages of neighbourhood working, many also felt that there was a lack of detail in the proposals in the consultation document which led to more questions. The feeling was that Stockport Together will be required to provide more detail before many consultees felt confident in responding to the consultation, including the role the third sector would or could play in the proposals.

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

*"…it is hard to give a simple answer to such a complex issue. Service delivery has moved from central to local delivery over periods of time and both have their strengths and weaknesses…"*

*"…continues to not understand or effectively engage with possibilities from the VCS (voluntary and community sectors) …"*

---

### 4.4 Other Evidence to Consider (Q2c)

When people were asked the question:

> *"Do you have any additional evidence that decision-makers should consider before they make this decision?"*

They were able to respond in two ways by:

iii. Uploading documents – either reports, responses, or comments; or
iv. Providing additional comments as free text.

Evidence submitted in these ways, related to *"…delivering health and mental health services in neighbourhood teams…"* is discussed in turn below.

#### 4.4.1 Uploaded Evidence

There was one document submitted for consideration which provided evidence from a neighbourhood-based pilot, led by Age Concern, in Newquay, Cornwall, felt to have relevance for Stockport Together.

##### 4.4.1.1 People, Place, Purpose Newquay Pathfinder Evaluation

The pathfinder led by Age Concern Cornwall and Isles of Scilly, was designed to deliver three key outcomes:

1. Improved health, wellbeing, and quality of life;
2. Integrated working works;
3. Cost reduction across the whole system.

The service provided targeted wraparound support, motivating 'at-risk' older people to achieve their aspirations through a 'guided conversation.' An Age UK worker supports

individuals to identify their goals, and to coordinate a management plan that is delivered by statutory and community services and support. The support, using volunteers, aims to build people's social networks, making them better connected to their community and more resilient. The Age UK worker is part of a multi-disciplinary team which includes GP, district nurse, matron, and social workers

**The benefits**

- 23% improvement in peoples self-reported wellbeing.
- 87% of practitioners say integration is working very well and their work is meaningful.
- 30% reduction in non-elective admission cost.
- 40% drop in acute admissions for long term conditions.
- 5% cost reduction and reduction in demand for adult social care.

### 4.4.2 Thematic Analysis

Respondents provided their thoughts and comments to offer the consultor (Stockport Together) with additional evidence they should consider in making any decisions for the future. These responses have been grouped into broad themes, representative of expressed opinions, as shown below.

#### 4.4.3 Earlier intervention, focusing on preventions

Some consultees suggested the proposals should include earlier interventions in a preventative model, including in primary and secondary school education, both in physical and mental health of Stockport's young people.

> *"… there is growing need in schools for better mental health support through liaisons between practicing doctors and nurses and counsellors and other support workers such as Play Therapists, Speech Therapists, Art therapists etc…"*

Which leads onto a view among many consultees, and agreement with the consultation, that the Stockport Together programme should focus on wider preventative action across the local population at any age. The feeling being, that this would reduce hospital and other clinical interventions, saving cost in the wider system.

> *"…prevention is always better (and more cost effective) than cure…"*

### 4.4.4 Consult more widely with those least able to respond

Consultees commented on their perceptions of the limitations of the consultation mechanisms employed in this initial strategic discussion, and offered some practical solutions for the future, based on:

- Developing some form of outreach consultation approach, engaging with those who are least likely to be able to respond online or in writing;
- Adopting an information sharing approach, telling all households in the borough what changes are being proposed;
- Rely less on external resources (e.g. management consultants) and explore using local people and organisations as consultation enablers.

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*"…go to the…public: how many older and frail people use computers and can fill in online forms?"*

*"…stop paying expensive management consultants…send each household a detailed and truthful account of any sensible changes proposed…discussed thoroughly with…NHS staff who carry out this work…".*

---

### 4.4.5 Equal access

Consultees expressed concern over the cost pressure placed on NHS services by the 'worried well' and a corresponding concern that people from less affluent areas were equally less likely to access services. The issue for the consultor from this appears to be the need to ensure that services are accessed equally, without penalising those who seek care, or threatening the lawful duty of the NHS to provide care free at point of use.

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*"…I heard that spend on people in Bramhall is the highest in Stockport as they seek out services. We should aim to ensure there is an agreed set of things that are treated across Stockport..."*

---

### 4.4.6 Supporting the population, recognising the reality of an ageing population

Respondents to the consultation provided the view that while the proposals are welcome, they also reflect the reality of the population of Stockport and much of the rest of England. The population of Stockport is ageing, and services must adapt to these circumstances - it is the right and proper thing to do.

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*"…it should be viewed as an investment in healthcare services for the future for an increasing and ageing population and must not be*

*either a cost cutting exercise or 'moving the deckchairs around on the titanic'..."*

### 4.4.7 Scepticism

Again, a common theme in the additional evidence and commentary, relate to a level of scepticism in responses with some consultees expressing the view that the consultation is a waste of time.

*"...this is irrelevant as the commissioners have already made this decision and begun an implementation phase…"*

*"…you are wasting people's time. No one wants it..."*

# 5 HOSPITAL BEDS

## Providing services for those that need them and reducing pressure

## 5.1 Introduction – Hospital Beds

The consultation document provided the following context to inform individual responses.

> We are proud of our local hospital and the staff who do an excellent job at looking after patients in their time of need. We want people to know that those staff and services are here to stay for people who need them. We also want to reduce the pressure on those services so when needed, they can offer even higher quality care.
>
> Currently more people in Stockport are admitted to hospital than in other similar areas in England, and when admitted people often stay longer than necessary. Our proposals include supporting people to change lifestyles and so preventing or delaying the onset of ill health; proactively identifying people at risk and intervening earlier; and when people experience being ill, providing additional support in the community. We will also invest in more resources to support people when they go home from hospital. This means they are less likely to be kept waiting for discharge. If decision-makers choose to adopt the approaches and our proposed interventions are successful, we forecast there will be a reduction in the number of people needing treatment at Stepping Hill and other hospitals.
>
> A reduction in people needing treatment may mean hospital beds are no longer needed. NHS England stipulates that if unused hospital beds are to be decommissioned, commissioners must demonstrate that one of the following conditions is met**:**
>
> - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
> - Show that specific new treatments or therapies, such as new anti- coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
> - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting It Right First Time programme).

Respondents were asked three questions, one closed and two open about these proposals, these were:

- To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined? (Closed response using a ranking of 1-5 where 1 is ‘Strongly Agree’ and 5 is ‘Strongly Disagree’ a sixth option ‘Don’t Know’ was also provided).

- Why do you say this? (Free text response).
- Do you have any additional evidence that decision-makers should consider before they make this decision? (Free text response).

## 5.2 Do you agree with our proposals?

Participants in the consultation, whichever method was used, were all asked the following question.

> *"To what extent do you agree that this test would be appropriate, if in the future Stockport Together must consider decommissioning in-patient beds at Stepping Hill hospital?"*

Discussed in turn below are the responses from the:

- Online, postal, and face-to-face survey; and
- Street survey.

These data are treated separately to recognise the previously discussed differences in sampling and motivation to participate.

Further details of the responses for the online, postal, and face-to-face survey are shown in Appendix One. Demographics beyond those reported are not available for the street survey.

### 5.2.1 Online, Postal and Face-to-Face Surveys

When considered as an overall sample, there is some support for this proposal from respondents to the online, postal, and face-face survey, with of 40% respondents either agreeing or strongly this test would be appropriate, if, in the future Stockport Together must consider decommissioning in-patient beds at Stepping Hill hospital. This is less clear cut than other proposals in the consultation with 33% of respondents disagreeing or strongly disagreeing.

| **Overall agreement/disagreement** | **Frequency** | **Percent** |
|---|---|---|
| Strongly agree | 32 | 15.0% |
| Tend to agree | 53 | 24.9% |
| Neither agree nor disagree | 21 | 9.9% |
| Tend to disagree | 25 | 11.7% |
| Strongly disagree | 45 | 21.1% |
| Don't know | 18 | 8.5% |
| Not Answered | 19 | 8.9% |
| Total | **213** | **100%** |

When considered by age there is little significant variation in opinion in overall agreement, except for the 16-17 group, which can be discounted due to small sample size

- 16-17 100%
- 18-24 50%
- 25-34 46%
- 35-44 40%
- 45-54 43%
- 55-64 40%
- 65+ 46%

Considered by gender there is less support from women than men.

- Female 39%
- Male 47%

### 5.2.2 Street Survey

Consultees responding to the street survey were against the proposition with 55% disagreeing/strongly disagreeing and only 41% agreeing/strongly agreeing.

| Overall agreement/disagreement | Frequency | Percent |
|---|---|---|
| Strongly agree | 53 | 17.5% |
| Tend to agree | 71 | 23.4% |
| Neither agree nor disagree | 34 | 11.2% |
| Tend to disagree | 37 | 12.2% |
| Strongly disagree | 95 | 31.4% |
| Don't know | 11 | 3.6% |
| Not Answered | 2 | 0.7% |
| **Total** | **303** | **100%** |

When the responses of consultees to the street survey are considered by age the strongest opposition comes from the 18-24 age group (55%), with 65+ being significantly less opposed (36%).

| | Support | Oppose |
|---|---|---|
| 18-24 | 35% | 55% |
| 25-34 | 42% | 35% |
| 35-44 | 43% | 43% |
| 45-54 | 33% | 48% |
| 55-64 | 38% | 52% |
| 65+ | 49% | 36% |

When considered by gender there is a common level of opposition, however more men tend to support the proposition than women.

| | Support | Oppose |
|---|---|---|
| Female | 38% | 44% |
| Male | 46% | 43% |

## 5.3 Why? (Q3b)

When asked 'why did you provide that answer' participants in the consultation gave a range of responses, these have been analysed and grouped into broad themes representing the overall sentiment of consultees in relation to:

> *"To what extent do you agree that this test would be appropriate, if in the future Stockport Together must consider decommissioning in-patient beds at Stepping Hill hospital?"*

Recognising the similarity of the responses and for brevity in reporting, we have analysed all together irrespective of the method of contribution to the consultation.

### 5.3.1 Capacity, demand, and the perceived need for hospital based rehabilitation

Many respondents to the consultation felt that the tests were flawed simply because in their view, the number of hospital beds required for the borough was fixed, based on the population level.

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*"…cannot see it working - can only fit so many people on a ward…"*

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

---

Consultees also took the view that Stockport needs more hospital beds not less, and with many stating the opinion that a sensible approach would appear to be some sort of 'mothballing' rather than a real reduction. The premise behind these views being the need to respond to any future upsurge in demand.

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*"…as long as it remains possible to re-commission these beds should that become necessary…"*

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

---

This was compounded by a minority view that hospital stays should involve an important element of rehabilitation prior to discharge, which would further increase the requirement for hospital beds.

---

*"…because I think it's important to rehabilitate rather than just discharge them…"*

---

### 5.3.2 This should be a self-evident truth

A more pragmatic view from consultees, was that the proposed tests would be proof in themselves of the need for less beds. If they were incorrect, the number of hospital beds would be likely to remain static.

---

*"…beds will close themselves if these changes work…"*

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

---

### 5.3.3 Moving people home quicker results in better care if adequate provision for home care exists

Many respondents to the consultation shared the view that the best care for patients was in their own home, recognising the detrimental impact prolonged hospital stays have on health, particularly for the elderly.

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*"…less time in hospital and help in the patient's own surroundings sounds good…"*

---

However, this was tempered with realism, in that home care only works in appropriate circumstances. People without a support network will be left isolated and the lack of sufficient after care will result in a return to a hospital bed. All of which are counter to the overall objectives of reducing hospital stays.

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*"…not all people have someone at home to help care. They would feel isolated…"*

*"…only if the after care is followed up and the patient doesn't end up back in hospital…"*

---

### 5.3.4 Providing adequate transitional support to the hospital beds

Coupled with concerns over the need for care at home, consultees highlighted the need for the provision of adequate provision of transitional support for those not yet ready to return home, but no longer in need of hospital care. This was interchangeably described as 'step down', 'transitional' or 'assessment' beds, where patients can regain their independence. Without this element being more explicitly dealt with within the proposals, many were unconvinced.

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*"…decommissioning acute beds needs to be coupled with supply of step up/ step down beds and discharge to assessment facilities..."*

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### 5.3.5 Confidence required that the capacity exists in the community to cope

Consultees were only convinced of the reduction in hospital beds if there was evidence to support provision of adequate capacity in community care to support the proposed changes. Many consultees expressed concern that this was not explicit within the proposals contained in the consultation document.

> *"… assurances that there was sufficient capacity in the community..."*

### 5.3.6 Starts somewhere else than in hospital

The view of many consultees was that the argument for reduced beds starts outside the hospital and other clinical settings. This called for a focus on other social determinants of health, and the ability to influence positive lifestyle changes.

> *"…prevention and support for people to change life styles…"*
>
> *"reduced bed numbers are bad…reduce patients who go to hospital by prevention…"*
>
> *"…more work needs to be done in changing people's behaviours so that they don't end up in hospital - reducing the demand on beds…"*

### 5.3.7 Savings elsewhere?

Some consultees provided the view that the proposals to cut hospital beds were looking for cost savings in the wrong area and the reduction in management overhead in the new organisation could achieve much of the saving.

> *"…how can reducing the amount of beds be a good thing? Reduce meddling managers instead…"*

A smaller group of consultees took the view that reductions in hospital bed numbers would not be enough, even when considered with efficiency savings elsewhere in the system.

> *"...don't believe that more efficient use of GPs, district nurses and other services will lead to…reducing hospital patient numbers. At best it will offset some of the current underfunding of the NHS…"*

## 5.4 Other Evidence to Consider (Q3c)

When people were asked the question:

> *"Do you have any additional evidence that decision-makers should consider before they make this decision?"*

They were able to respond in two ways by:

v. Uploading documents – either reports, responses, or comments; or
vi. Providing additional comments as free text.

Evidence submitted in these ways, related to "*...providing services for those that need them and reducing pressure…"* is discussed in turn below.

### 5.4.1 Uploaded Evidence

In total two pieces of documentary evidence were submitted to the consultation for consideration. These were:

- Mental Health Carers Scenarios;
- CQC Stepping Hill Hospital Quality Report.

#### 5.4.1.1 Mental Health Carers Scenarios

A submission was received that detailed five scenarios from the perspective of mental health carers:

- Getting help in (continual) crisis;
- Getting help to have an acceptable standard of life;
- Getting help to prevent suicide;
- Information sharing with GPs; and
- Getting medical help before a crisis occurs.

The submission concluded with two questions for consideration in the consultation:

1. How can Stockport Together help in these scenarios?
2. What will happen to our loved ones when we are no longer able to support them?

#### 5.4.1.2 CQC Stepping Hill Hospital Quality Report

A submission was provided for consideration in the consultation of the Care Quality Commission's Quality Report for Stockport NHS Foundation Trust Stepping Hill Hospital. The report is dated 3/10/17 and relates to an inspection visit 21, 22 and 28 March 2017. The overall rating for the hospital saw Urgent and Emergency Care rated as Inadequate and Medical Care (including older people's care) as Requires Improvement.

This evidence was submitted to support the following statements:

> *"…My evidence is only apocryphal, but nevertheless telling. A friend of ours who has been disabled with severe arthritis for many years and has had several operations for hip and knee replacements throughout her adult life has just returned home from*

*a knee replacement. She reports that the quality of care has greatly deteriorated since her last operation some years ago, with hard-pressed nursing staff taking much too long to respond to patient calls for bed pans and medication. This is backed up by the recent CQC report marking Stepping Hill as "requiring improvement". At age 69, I am very worried about having to go into hospital in the current climate…."*

### 5.4.2 Thematic Analysis

Respondents provided their thoughts and comments to provide the consultor with additional evidence they should consider in making any decisions for the future. These responses have been grouped into broad themes, representative of expressed opinions, as shown below.

#### 5.4.2.1 Measuring the impact of Stockport Together

As a response to the overall concern over the reduction in hospital beds, perhaps the most unpopular element of the proposals under discussion, many consultees suggested a need to be clear on the impact of the proposals, if implemented. The main concern was around the effectiveness of community care in keeping patients from returning to hospital.

An effective measure to gauge Stockport Together's success was levels of readmissions.

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*"…a measure - readmissions by neighbourhood - should be monitored regularly. Will give a good guide to success or failure…"*

---

#### 5.4.2.2 Closer working with the care home community

Many consultees recognised the potential interdependence between reduced numbers of hospital beds and wider social care, specifically the ability of the care home sector, already under significant financial pressure, to cope with the potential additional demand. Again, focus was on the level and quality of intermediary/'step down' care likely to be available in the borough.

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*"…review how nursing homes and other suitable residential facilities can take people who don't need to be in hospital but are not ready to manage at home yet…"*

*"…needs further investment in residential/short stay beds…"*

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### 5.4.3 A need for increased primary care provision

Most respondents identified the need for the consultor to recognise, within their proposals, the need to develop an increased capacity in primary care, beyond the existing levels to ensure the reduction in beds will be achievable.

> *"…they really need to get a grip of GPs and make them work more late and early evening shifts like the rest of the NHS…"*
>
> *"…they'll need a lot more GPs and district nurses for this to work…"*

# 6 OTHER INFORMATION OR PROPOSALS

## Information or proposals decision makers should consider

## 6.1 Introduction

As a final element of the consultation document, consultees were asked:

> *"Is there any other information or proposals you think decision makers should consider?"*

Participants in the consultation gave a range of responses, which have been analysed and grouped into broad themes representing the overall sentiment of consultees.

## 6.2 Thematic Analysis

The main themes to emerge from consultee responses were as follows.

### 6.2.1 Speak to people first, change second

The principles of consultation were endorsed by respondents, who suggested that post this discussion on the broad strategic principles, Stockport Together should consider engaging with staff and service users to understand the operational perspective.

*"…speak to staff already working for the services…"*

*"…speak to the patients already receiving care in the community / home…"*

### 6.2.2 More services

Consultees also identified the potential for consideration of new or enhanced services to adapt/react to the challenges set by the broad strategic proposals discussed in the consultation. These included:

- The need for gap analysis in service provision considering the suggestions from this consultation and conducting subsequent impact analysis for detailed service proposals;
- The need to develop an increased primary care offer, which is acknowledged as potentially difficult considering shortages of GPs;
- Consideration of changes in social care to foster less reliance on hospital beds and retain people's independence in their own homes.

*"…needs analysis across health and social care to identify the gaps..."*

*"…we need more GPs…"*

*"…better access to more GP/Advanced Nurse Practitioner assessments…"*

*"…in social care...resume an old style "home help " service for shopping, befriending etc, where personal care is not needed but for things that are important to older people…"*

### 6.2.3 Consultation with decision makers

Many consultees expressed the perception that to be successful Stockport Together should have wider discussions with key decision makers before developing solutions.

*"…greater Consultation with NHS England…"*

*"…utilise local MP's by inviting them to see first-hand Stockport NHS facilities especially when stretched so they can also report back to central government…"*

### 6.2.4 Step down/step up care

A further emphasis was placed on the provision of short stay beds for those leaving hospital and unable to return home immediately. Consultees viewed this provision within a social care setting as a key element of the success of the proposals to reduce hospital beds and stays.

*"…consider halfway houses, i.e. the old-fashioned convalescent homes…would relieve the bed blocking in Stepping Hill Hospital…"*

*"…further investment in packages of care and short stay beds. Already too much pressure on current care providers…how will manage the winter pressures…"*

### 6.2.5 The consultation structure and presentation as a barrier to participation

In providing further comment and evidence for consideration by the consultors a recurring theme is around the complexity of the consultation document and the difficulties faced in completion. The main concerns focused around:

- The call for the provision of more information to support the decision consultees were being asked to decide upon;
- The complexity of the questions themselves; and
- The overall format, requiring responses on complex issues within an overly simple format.

*"…I find it hard to complete the questionnaire as the information provided is inadequate…"*

*"…as a large voluntary sector organisation working around local people in later life we are being asked to express our views through this sort of questionnaire. We have started it and left it and struggled to complete it many times as is so hard to offer meaningful comment on such complexity in this format…"*

### 6.2.6 Transparency and honesty

Consultees urged Stockport Together to ensure that the proposals for change were conducted within an environment that:

- Puts patient needs first; and
- Provides best use of public funds, including the avoidance of more bureaucracy.

*"…please don't lose sight of the fact that people who are genuinely ill need compassion and help, not decisions made purely for monetary reasons…"*

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

Within this, there is a call from consultees to recognise the reality of the situation and to continue to be honest with the public, explaining what the NHS can provide and what it cannot.

*"…stop raising public expectations that they can have everything provided by NHS…"*

### 6.2.7 Consideration of other approaches and sectors to support Stockport Together

Consultees, particularly local voluntary and community sector organisations, offered support to Stockport together, not only of the proposal aims, but also of the opportunity to add their resources and experience to aid deliver solutions.

*"…(we) understand the pressures on Stockport Together in the current economy…the need to do things differently…. also, that it offers a fantastic opportunity to change things and would welcome the chance to work more with it…"*

### 6.2.8 Mental health issues don't always exist in isolation

Many consultees raise the issue of more than one condition, in relation to mental health, existing at the same time. This was felt to be an issue of concern for older people, but not exclusively so and Stockport Together was asked to consider the combined needs of mental and physical issues as one issue rather that separately.

*"… (older people) often present with multiple issues over a number of areas - physical mental social etc…"*

### 6.2.9 Real seven day a week working

There was a degree of scepticism around the discussions of seven day working made in the proposals, with many consultees expressing the view that much of current health and social care provision does not reflect the working patterns prevalent in Stockport. Equally, there is a view that a correspondingly large number of services do already work seven days a week, which caused some to question the claimed cost savings in the proposals.

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

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

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

### 6.2.10 Specific services

While consultees welcomed the general principles of the proposals, some felt that the lack of detail was a point of concern, with many raising concerns around the continued or enhanced service provision, including but not limited to:

- Adaptation of service delivery to the needs of Stockport residents with learning or sensory disabilities;
- Specialist provision such as sexual and women's health clinics; and
- Access to services such as weight loss, smoking cessation.

*"…there is no mention of sexual health services, which are a very important aspect of staying healthy… saves money elsewhere in the health and social care economy…"*

*"…I would be particularly concerned, as a parent of a son with a learning disability(LD), that suitable provision was included in these proposals to cater for people with a LD…"*

### 6.2.11 Data Sharing

Many consultees also expressed a desire for Stockport Together to develop a common data sharing platform within the Stockport health and social care system and ultimately across Greater Manchester. This was felt to be an important step in ensuring consistent and good quality care within the proposed changes.

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

# 7 DISCUSSION GROUP MEETINGS

## Discussion groups

### 7.1 Introduction

The Stockport Together consultation team conducted several discussion groups with specific interest groups, between the 16th and 27th of November 2017. Thirteen groups were provided to us for analysis, these were:

1. Alvanley Health Champions Patient Participation Group (PPG)
2. Breathe Easy Group
3. Bredbury PPG
4. Cheadle PPG
5. Disability Stockport
6. Marple PPG
7. Mental Health Carers Group
8. Poets Corner Action Group
9. NHS Watch
10. Walthew House Deaf group 1
11. Walthew House Deaf group 2
12. Walthew House Visually Impaired group 1
13. Walthew House Visually Impaired group 2

Two of these discussion groups were conducted as a series of face-to-face interviews and were included and are analysed in the main consultation feedback (groups 12 and 13). The results from these groups are excluded from the analysis in this section.

The reports from the remainder of these groups have been analysed and grouped into themes representing the sentiment expressed across all groups

### 7.2 Thematic Analysis

While each of the discussion groups followed the initial approach of handing out copies of the consultation document, encouraging the participants to complete online or in hard copy, the remainder of the session followed an unstructured Q&A approach. The resulting thematic responses are relatively wide ranging focused on both issues and potential solutions for consideration by the consultors. The emerging discussion themes, in no order of importance, were as follows.

#### 7.2.1 The implications of cross-boundary working

A consistent theme across the groups was the extent to which Stockport Together has considered and develop mitigation for bordering areas responding to the same challenges and changing their health and social care services. Specifically:

- How are they doing things differently, are we learning from them?
- How is Stockport working with them?
- What agreements exist around continued provision and receipt of services into/from those areas?
- How is duplication of effort between the areas managed? An example of Cheshire East not accepting Stockport assessments, and redoing them was cited.

### 7.2.2 Specific models of support

The groups developed several positive suggestions around the role local voluntary and community sector organisations can play to support the aims of Stockport Together, including:

- The integration of Disability Stockport's local delivery model into the neighbourhood model to foster learning from what works;
- The provision of Citizens Advice services in neighbourhood centres to address wider issues contributing to mental and physical conditions;
- Closer working with specialist organisation, such as Age UK, to deliver the proposals;
- Provision of space in existing community buildings to support neighbourhood working.

### 7.2.3 Access to service

The consensus from the groups was that the key to success of the Stockport Together proposals was addressing the issue of access to services, through:

- Clear communication of the changes in services to ensure all Stockport residents are aware of how to access services;
- Deliver a seven-days a week, twenty-four hours a day, first class service to all residents of Stockport;
- Providing access to care through a single telephone number irrespective of the nature of the service required - health or social care;
- Developing a consistent response from health and social care providers that delivers care personalised to the individual.

### 7.2.4 Retaining and recognising staff

The groups recognised that GPs are at the heart of much of the success of the proposals, as will be other clinicians, alongside a flexible and responsive social care workforce. There were several suggested challenges for Stockport Together to address in moving to delivery of the proposals in this respect, namely:

- There are acknowledged staff shortages for both GPs and nursing staff, how with Stockpot Together respond to this national issue to ensure local services;
- Have the existing staff been consulted on the proposals, without their support it is difficult to see how the proposals can be implemented successfully;
- Have issues such as costs to staff of working such as car parking at NHS and local authority sites been considered;
- Have private care agencies been consulted on the implications for their staff.

However, it should be recognised that this is may include sensitive or individually identifiable data, and due care should be taken in any sharing of this by the consultor.

### 7.2.5 The pressure faced by care homes

The groups demonstrated a consensus of concern over the implications of the Stockport Together proposals around the potential pressure placed on an already overstretched care home sector. This could be addressed through measures such as:

- Nurses and GPs working in care homes, although this needs to be paid for;
- Providing more care in the community to maintain people's independence in their own home;
- Ensuring people with sensory disabilities, such as being deaf, are supported in care homes, with provision of translators and specific activities.

### 7.2.6 Supporting people, maintaining service, and addressing mental health issues

A key concern to be addressed by Stockport Together, identified by the discussion groups was the ability of the proposed changes to continue to maintain current standards and move to improve them. Concerns centred around:

- The ability of GP practices, at the heart of the neighbourhood model, to maintain current levels of service, which is likely to require more GPs at a time of national staff shortages;
- Dealing with more people with comorbidity, which will require more time to effectively deal with their concerns;
- Supporting people with specific needs to be able to effectively access the neighbourhood services – including learning disabilities and sensory disabilities (deaf, blind, and deaf-blind);
- Dealing with increased numbers of people with dementia in the community.

Set against these issues was the concern that the pressures on neighbourhood services in dealing with the 'usual' will result in less time and attention for people with mental health issues, despite a stated aim to improve this. This was further compounded by concerns over the apparent scarcity of GPs with mental health as a professional specialism.

### 7.2.7 Transition from hospital care to home

Consultees engaged through discussion groups were clear that the proposals were based on an overall reduction in length of hospital stay and bed numbers, however there were concerns that people would need additional support to recover.

> *"… the only solution is to get people through the hospital quickly, but this doesn't mean they're fully recovered…"*

The overall feeling was that the issue of providing transitional support care beds in a social care setting was not adequately described in the proposals and will need to be addressed more clearly.

### 7.2.8 Services free at the point of care?

The tension between the provision of health and social care as one service was recognised by many consultees in the groups, specifically:

- The legal requirement to deliver NHS services free at the point of care; and
- For social care to be means tested.

Solutions being investigated or that should be considered addressing this issue to ultimately deliver costs savings discussed in the groups included:

- Exploring joint commissioning and pooled budgets between health and social care;
- Explaining clearly to patients and service users the tension between 'free' and means tested care; and
- Informing people of the costs of their failed appointments.

### 7.2.9 Other partners

The groups largely felt that the proposals, as they stood, ignored many partners, who can support or hinder successful implementation, including, but not limited to:

- The voluntary and community sector (VCS) in Stockport who have links that NHS and local authority partners will find difficult to duplicate and have the potential to introduce innovation and low-cost delivery;
- GPs, who many recognised as private business and without their buy-in and support the proposals will be difficult to implement;
- Housing sector partners, mostly social but not ignoring private landlords with their access to a large percentage of the resident population;
- Private sector care agencies, who will delivery many of the required social care services;
- The care home sector, who will be required to support the need for additional transitional beds and out of hospital care.

### 7.2.10 People 'get it'; take them with you

The groups identified that the people of Stockport are generally more astute than they're given credit for, with many citing the fact that much so-called 'misuse' is getting the right service at the right time from an unresponsive system. The call was for a clear communication of the benefits and drawbacks of the proposals to allow people to make informed choice on more detailed proposals, included:

- The extent to which the plans are future proofed to withstand future political changes and other systemic shocks; and
- The continuity plans in place to deal with emergency situations and how any issues will be addressed.

### 7.2.11 Is this just another bureaucratic approach - we want services, not managers?

As with other consultation mechanisms, the discussion groups echoed the sentiment of scepticism. Issues discussed included:

- Service for Stockport residents is paramount, the proposals must be clear that they are not just wasting money on more managers and measurement systems.
- The lack of clear evidence that so-called smarter working, will save money;
- A concern that the efforts to respond to the consultation were *'…a waste of time…"* due to the perception that implementation of the proposals were already under way.

# 8 SUMMARY

## Emerging findings for consideration in decision-makers deliberation

## 8.1 Introduction

Consideration of the public consultation conducted by Stockport Together on the partnership's broad strategic principles between 10th October to 30th November 2017 allows us to provide a summary on the following:

- Specific observations on the strategic service proposals; and
- Overall observations on the common themes across all discussion areas and consultation methods.

Each of these is discussed in turn below.

## 8.2 Summary Findings – Service Proposals

Considering the specifics of the service proposals there was broad support for the outline strategic proposals, however, this was less clear around the issue of closing hospital beds.

### 8.2.1 Planning and Organising Services

There was support for the broad proposals to reorganise the way health and social care in Stockport, with:

- 72% of respondents to the online, postal, and face-to-face survey tend to agree or strongly agree with the proposal;
- 87% of respondents to the street survey expressed a common opinion in support.

However, the following also needs to be taken into consideration:

#### Working together

Recognising the benefits of the approach suggested in the Stockport Together proposals being consulted on the opportunity to maximise these through earlier work with the third sector (voluntary and community) was highlighted for consideration.

#### Accessibility

Many respondents expressed concerns over the way in which Stockport residents would be able to access the proposed services if they faced specific difficulties.

#### Consider Local and Individual Need

The Stockport Together partners need be mindful of the variations in need between neighbourhoods in Stockport and of individuals within those neighbourhoods in designing new service provision.

### Emphasis on Mental Health

Consultees were very clear in directing the Stockport Together consultation to give equal weight in consideration of mental health needs and physical health, and therefore placing an enhanced emphasis than that currently enjoyed.

### Ensure Social Care is Supported

Within the considerations of the consultation there is a direction that social care funding and more importantly adequate social care provision is available, as well as closer cooperation and coordination between these two elements of the proposals.

### Scepticism

It is also clear that the consultors (NHS Stockport CCG and Stockport MBC) will have to overcome a level of scepticism from the public over the realism of some aspects of the proposal to be able to achieve the savings it seeks to make.

## 8.2.2 A Neighbourhood Delivery Model

Again, there was very strong support for the proposals to organise health and mental health services into eight neighbourhood teams:

- 71% of respondents to the online, postal, and face-to-face survey tend to agree or strongly agree with the proposal; and
- 71% of respondents to the street survey expressed a common opinion in support.

However, the following factors identified by consultees also need to be taken into consideration:

### The consultation process and the danger of domination by the articulate and engaged

Specific concern was raised by consultees of the potential for the process to be disproportionately influenced by the articulate middle-class respondents to the consultation. While all contributions are welcome, the issue for consideration by the consultors is recognising the ability of this group to articulate their concerns while recognising the needs of those less able to express themselves.

### Local provision, knowledge, and accessibility

Consultees recognised the benefits of the proposal to organise service around a neighbourhood model. The key benefits were felt to be:

- Provision of services in a familiar location, in an area people know well and are comfortable in;
- The focus of service around local GPs who generally have an established relationship and a record of need and past care; and
- A central and local location that reduces the burden of travel to service.

### Where are the resources to support the proposal?

Many consultees expressed an overall concern that the proposals, as detailed in the consultation document, did not provide enough evidence that the proposals were

based on sound financial plans. Which in turn led to concerns over the overall sustainability of the proposals.

#### A much-needed focus on mental health, but is it enough?

There was a recognition from consultees that the proposals added a very important focus on caring for those with mental health needs in their own community, which was very well received. However, some consultees felt this service offer did not go far enough in meeting the needs of the residents of Stockport.

#### Are the proposed neighbourhoods too big?

Many respondents to the consultation felt that the scale of the neighbourhood model was not well enough explained in the proposals. This in turn led to concerns that the description of a 'neighbourhood' was too big, and would not be recognised by residents as such, which raised further concerns over the distances to travel and population covered by a neighbourhood centre, an issue which may need to be addressed by the consultors.

#### More questions to be answered before this proposal looks complete

While most consultees recognised the outline advantages of neighbourhood working, many also felt that there was a lack of detail in the proposals in the consultation document which led to more questions. The feeling was that Stockport Together will be required to provide more detail before many consultees felt confident in responding to the consultation, including the role the third sector would or could play in the proposals.

### 8.2.3 Reducing Hospital Beds

The proposals to reduce the number of hospital beds was significantly less welcome by consultees, with

- 40% of respondents to the online, postal, and face-to-face survey tend to agree or strongly agree with the proposal and a third (33%) disagreeing/strongly disagreeing; and
- 41% of respondents to the street survey expressed a common opinion in support, however the majority (55%) expressed opinions disagreeing/strongly disagreeing with the proposals.

In considering these results the following needs to be taken into consideration:

#### Capacity, demand, and the perceived need for hospital based rehabilitation

Many respondents to the consultation felt that the tests were flawed simply because, in their view, the number of hospital beds required for the borough was fixed based on the population level.

Consultees also took the view that Stockport needs more hospital beds not less, and with many stating the opinion that a sensible approach would appear to be some sort

of ‘mothballing’ rather than a real reduction. The premise behind these views being the need to respond to any future upsurge in demand.

This was compounded by a minority view that hospital stays should involve an important element of rehabilitation prior to discharge, which would further increase the requirement for hospital beds.

### This should be a self-evident truth

A more pragmatic view from consultees was that the proposed tests would be proof in themselves of the need for less beds. If they were incorrect, the number of hospital beds would be likely to remain static.

### Moving people home quicker results in better care - if adequate provision for home care exists

Many respondents to the consultation shared the view that the best care for patients was in their own home, recognising the detrimental impact prolonged hospital stays have on health, particularly for the elderly.

However, this was tempered with realism, in that home care only works in appropriate circumstances, people without a support network will be left isolated and the lack of sufficient after care will result in a return to a hospital bed. All of which are counter to the overall objectives of reducing hospital stays.

### Providing adequate transitional support to the hospital beds

Coupled with concerns over the need for care at home, consultees highlighted the need for the provision of adequate provision of transitional support for those not yet ready to return home, but no longer in need of hospital care. This was interchangeably described as ‘step down’, ‘transitional’ or ‘assessment’ beds, where patients can regain their independence. Without this element being explicitly dealt with within the proposals many were unconvinced.

### Confidence required that the capacity exists in the community to cope

Consultees were only convinced of the reduction in hospital beds if there was evidence to support provision of adequate capacity in community care to support the proposed changes. Many consultees expressed concern that this was not explicit within the proposals contained in the consultation document.

### Starts somewhere else than in hospital

The view of many consultees was that the argument for reduced beds starts outside the hospital and other clinical settings and called for a focus on other social determinants of health, and the ability to influence positive lifestyle changes.

### Savings elsewhere?

Some consultees provided the view that the proposals to cut hospital beds were looking for cost savings in the wrong area, and the reduction in management overhead in the new organisation could achieve much of the saving. A smaller group

of consultees took the view that reductions in hospital bed numbers would not be enough, even when considered with efficiency savings elsewhere in the system.

## 8.3 Overall Observation – Common Themes

Aside from the specific comments on the individual proposals for service change there are several common themes emerging from the consultation responses that are important for the consultors to consider. These were:

- **Governance and accountability**

There was an overall concern that the consultation, although currently only addressing broad strategic themes did not provide confidence that robust arrangements were in place for governance, measurement, and accountability. Without this detail consultees would find it difficult to decide on specific service proposals.

- **Role of the third sector**

Throughout the consultation responses the contribution of voluntary and community (third) sector partners is valued and valuable. However, they appear to be observers rather than participants in the process which overlooks the value and experience they bring to the benefit of Stockport.

- **The consultation process – speak and listen**

There were some specific criticisms of the consultation process, despite the relatively high response rate, which included:

  - The lack of detailed information to decide on;
  - The question/response format being limited restricting the ability of consultees to respond meaningfully;
  - The way in which consultation was conducted, with too much reliance on online and social media and less with face-to-face contact. This was also reflected in the discussion group responses traditional Q&A sessions and not proactive opinion seeking. This could suggest the need for a wider approach to engagement through co-production approaches rather than a reliance on 'set-piece consultation.

Within this, it is worth considering the complexity of the language and format used in the consultation document, perhaps reflecting on the average UK reading age of 9, and how this impacts comprehension and participation.

- **Equity of consideration – mental and physical health**

The need to give equal consideration to mental health, which given the perceived status as the poor relation, many felt required preferential treatment.

- **Scepticism**

Many, but by no means all consultees expressed an ongoing cynicism with the process, feeling that it had all been done before or that the evidence for the changes did not exist. Stockport Together will need to respond constructively to this and provide evidence of positive change to convince this group.

- **We get it, show us transparency and honesty**
  The feeling was the ability of the public to understand the proposals was often underestimated and Stockport Together should provide a consultation that is clear in the benefits and drawbacks of the proposals alongside the rationale and accountability.
- **Access for all**
  The issue of affluent, literate and engage communities was raised as a concern. The specific issues were:
    - The potential for disproportionate influence from middle class consultees; and
    - Concerns over those with the self-awareness to seek health support (the worried well) predominantly in affluent areas taking a higher 'share' of services than areas less health literate.
- **Cross boundary working**
  Demands on health and social care services are not unique to Stockport and consultees were aware of other initiatives in Greater Manchester and other bordering areas. The concern for consultees was the extent to which this was taken account of in Stockport Together's proposals and the impact on inflowing/outflowing services provided across boundaries.
- **Staff**
  Consultees felt that one of the main challenges to be addressed by Stockport Together in developing and delivering their proposals was the issue of staff, including:
    - Consideration of recruiting more GPs, nurses, care assistants and other clinical roles alongside social care staff to address service demands in the face of national shortages;
    - The willingness and support from GPs to deliver the neighbourhood model;
    - The capability and capacity of community staff to deal with the increased demand.
- **Care homes and transitional support**
  Stockport Together's proposals appear to consultees to rely upon increased care home capacity and the availability of transitional/step down beds to move people from hospital quicker. The level of detail in the proposals does not make it clear if this has been considered and is in place.
- **Changes in lifestyle and behaviour**
  Outside of the proposals there was a strong feeling from consultees that to effect the changes described there is a need for more preventative interventions. The view being that by the time people are being dealt with by the proposed services, it's too late. Early intervention is required in the community, including schools, which is a wider remit than the proposals, but felt to be the motivator for real change and savings.

# 9 APPENDIX ONE: ONLINE, POSTAL & FACE-TO-FACE DEMOGRAPHICS

**Disability, Race, Sexuality, Religion, and Gender Reassignment** (note: these were not recorded for street)

## 9.1 Disability

| | Don't know | | Not Answered | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Strongly disagree | | Tend to disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| **Services** | | | | | | | | | | | | | | |
| To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined? | | | | | | | | | | | | | | |
| **No** | 9 | 6.7% | 2 | 1.5% | 58 | 43.0% | 48 | 35.6% | 4 | 3.0% | 8 | 5.9% | 6 | 4.4% |
| **Yes** | 2 | 4.2% | 7 | 14.6% | 15 | 31.3% | 15 | 31.3% | 3 | 6.3% | 3 | 6.3% | 3 | 6.3% |
| **Not Answered** | 0 | 0.0% | 7 | 43.8% | 1 | 6.3% | 6 | 37.5% | 1 | 6.3% | 1 | 6.3% | 0 | 0.0% |
| **Prefer not to say** | 0 | 0.0% | 0 | 0.0% | 5 | 35.7% | 6 | 42.9% | 1 | 7.1% | 1 | 7.1% | 1 | 7.1% |
| **Neighbourhoods** | | | | | | | | | | | | | | |
| To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described? | | | | | | | | | | | | | | |
| **No** | 3 | 2.2% | 2 | 1.5% | 66 | 48.9% | 40 | 29.6% | 11 | 8.1% | 6 | 4.4% | 7 | 5.2% |
| **Yes** | 1 | 2.1% | 7 | 14.6% | 19 | 39.6% | 11 | 22.9% | 1 | 2.1% | 5 | 10.4% | 4 | 8.3% |
| **Not Answered** | 0 | 0.0% | 6 | 37.5% | 2 | 12.5% | 5 | 31.3% | 0 | 0.0% | 3 | 18.8% | 0 | 0.0% |
| **Prefer not to say** | 0 | 0.0% | 0 | 0.0% | 3 | 21.4% | 6 | 42.9% | 3 | 21.4% | 2 | 14.3% | 0 | 0.0% |
| **Hospital Beds** | | | | | | | | | | | | | | |
| To what extent do you agree that this test would be appropriate, if in the future Stockport Together has to consider decommissioning in-patient beds at Stepping Hill hospital? | | | | | | | | | | | | | | |
| **No** | 12 | 8.9% | 2 | 1.5% | 23 | 17.0% | 37 | 27.4% | 17 | 12.6% | 18 | 13.3% | 26 | 19.3% |
| **Yes** | 5 | 10.4% | 10 | 20.8% | 7 | 14.6% | 9 | 18.8% | 3 | 6.3% | 5 | 10.4% | 9 | 18.8% |
| **Not Answered** | 0 | 0.0% | 7 | 43.8% | 0 | 0.0% | 5 | 31.3% | 1 | 6.3% | 0 | 0.0% | 3 | 18.8% |
| **Prefer not to say** | 1 | 7.1% | 0 | 0.0% | 2 | 14.3% | 2 | 14.3% | 0 | 0.0% | 2 | 14.3% | 7 | 50.0% |

## 9.2 Race

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| **Services** | | | | | | | | | | | | | | |
| To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined? | | | | | | | | | | | | | | |
| **Asian/British - Bangladeshi** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100% | 0 | 0.0% | 0 | 0% | 0 | 0.0% |
| **Asian/British - Chinese** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100% | 0 | 0.0% | 0 | 0% | 0 | 0.0% |
| **Black/British - African** | 0 | 0.0% | 0 | 0.0% | 1 | 100% | 0 | 0.0% | 0 | 0.0% | 0 | 0% | 0 | 0.0% |
| **Not Answered** | 9 | 39.1% | 1 | 4.3% | 3 | 13.0% | 7 | 30.4% | 1 | 4.3% | 0 | 0% | 2 | 8.7% |
| **Other ethnicity / race** | 0 | 0.0% | 0 | 0.0% | 5 | 55.6% | 0 | 0.0% | 1 | 11.1% | 1 | 11.1% | 2 | 22.2% |
| **White: British** | 7 | 4.2% | 10 | 6.0% | 64 | 38.3% | 62 | 37.1% | 7 | 4.2% | 9 | 5.4% | 8 | 4.8% |
| **White: European** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 66.7% | 0 | 0.0% | 0 | 0.0% | 1 | 33.3% |
| **White: Gypsy/Traveller** | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **White: Irish** | 0 | 0.0% | 0 | 0.0% | 5 | 83.3% | 1 | 16.7% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Neighbourhoods** | | | | | | | | | | | | | | |
| To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described? | | | | | | | | | | | | | | |
| **Asian/British - Bangladeshi** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Asian/British - Chinese** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% |
| **Black/British - African** | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Not Answered** | 8 | 34.8% | 0 | 0.0% | 5 | 21.7% | 5 | 21.7% | 1 | 4.3% | 1 | 4.3% | 3 | 13.0% |
| **Other ethnicity/race)** | 0 | 0.0% | 0 | 0.0% | 4 | 44.4% | 2 | 22.2% | 0 | 0.0% | 1 | 11.1% | 2 | 22.2% |
| **White: British** | 7 | 4.2% | 4 | 2.4% | 73 | 43.7% | 53 | 31.7% | 13 | 7.8% | 8 | 4.8% | 9 | 5.4% |
| **White: European** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 33.3% | 1 | 33.3% | 0 | 0.0% | 1 | 33.3% |
| **White: Gypsy/Traveller** | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **White: Irish** | 0 | 0.0% | 0 | 0.0% | 5 | 83.3% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 16.7% |

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| **Hospital Beds** | | | | | | | | | | | | | | |
| To what extent do you agree that this test would be appropriate, if in the future Stockport Together has to consider decommissioning in-patient beds at Stepping Hill hospital? | | | | | | | | | | | | | | |
| **Asian/British - Bangladeshi** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Asian/British - Chinese** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Black/British - African** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% |
| **Not Answered** | 9 | 39.1% | 1 | 4.3% | 1 | 4.3% | 6 | 26.1% | 1 | 4.3% | 0 | 0.0% | 5 | 21.7% |
| **Other ethnicity/race** | 0 | 0.0% | 0 | 0.0% | 2 | 22.2% | 1 | 11.1% | 0 | 0.0% | 1 | 11.1% | 5 | 55.6% |
| **White: British** | 9 | 5.4% | 17 | 10.2% | 28 | 16.8% | 38 | 22.8% | 18 | 10.8% | 23 | 13.8% | 34 | 20.4% |
| **White: European** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 33.3% | 1 | 33.3% | 0 | 0.0% | 1 | 33.3% |
| **White: Gypsy/Traveller** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **White: Irish** | 1 | 16.7% | 0 | 0.0% | 1 | 16.7% | 3 | 50.0% | 1 | 16.7% | 0 | 0.0% | 0 | 0.0% |

## 9.3 Sexuality

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % |
| **Services** | | | | | | | | | | | | | | |
| **To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined?** | | | | | | | | | | | | | | |
| **Bisexual** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 1 | 50.0% |
| **Gay** | 0 | 0.0% | 1 | 16.7% | 1 | 16.7% | 3 | 50.0% | 1 | 16.7% | 0 | 0.0% | 0 | 0.0% |
| **Heterosexual/straight** | 2 | 1.4% | 9 | 6.3% | 66 | 46.5% | 48 | 33.8% | 4 | 2.8% | 6 | 4.2% | 7 | 4.9% |
| **Lesbian** | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Not Answered** | 12 | 46.2% | 0 | 0.0% | 1 | 3.8% | 10 | 38.5% | 1 | 3.8% | 1 | 3.8% | 1 | 3.8% |
| **Other** | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 0 | 0.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% |
| **Prefer not to say** | 2 | 6.1% | 1 | 3.0% | 8 | 24.2% | 14 | 42.4% | 2 | 6.1% | 2 | 6.1% | 4 | 12.1% |
| **Neighbourhoods** | | | | | | | | | | | | | | |
| **To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described?** | | | | | | | | | | | | | | |
| **Bisexual** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% |
| **Gay** | 0 | 0.0% | 0 | 0.0% | 3 | 50.0% | 2 | 33.3% | 0 | 0.0% | 0 | 0.0% | 1 | 16.7% |
| **Heterosexual/straight** | 2 | 1.4% | 4 | 2.8% | 74 | 52.1% | 38 | 26.8% | 12 | 8.5% | 8 | 5.6% | 4 | 2.8% |
| **Lesbian** | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Not Answered** | 11 | 42.3% | 0 | 0.0% | 3 | 11.5% | 9 | 34.6% | 0 | 0.0% | 0 | 0.0% | 3 | 11.5% |
| **Other** | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Prefer not to say** | 2 | 6.1% | 0 | 0.0% | 7 | 21.2% | 12 | 36.4% | 3 | 9.1% | 3 | 9.1% | 6 | 18.2% |
| **Hospital Beds** | | | | | | | | | | | | | | |
| **To what extent do you agree that this test would be appropriate, if in the future Stockport Together has to consider decommissioning in-patient beds at Stepping Hill hospital?** | | | | | | | | | | | | | | |
| **Bisexual** | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% |

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % |
| **Gay** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 33.3% | 2 | 33.3% | 1 | 16.7% | 1 | 16.7% |
| **Heterosexual/straight** | 4 | 2.8% | 17 | 12.0% | 25 | 17.6% | 37 | 26.1% | 13 | 9.2% | 19 | 13.4% | 27 | 19.0% |
| **Lesbian** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Not Answered** | 13 | 50.0% | 0 | 0.0% | 1 | 3.8% | 5 | 19.2% | 1 | 3.8% | 2 | 7.7% | 4 | 15.4% |
| **Other** | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Prefer not to say** | 2 | 6.1% | 1 | 3.0% | 4 | 12.1% | 6 | 18.2% | 5 | 15.2% | 3 | 9.1% | 12 | 36.4% |

## 9.4 Religion

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % |
| **Services** | | | | | | | | | | | | | | |
| **To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined?** | | | | | | | | | | | | | | |
| **Buddhism** | 0 | 0.0% | 0 | 0.0% | 1 | 25.0% | 2 | 50.0% | 0 | 0.0% | 1 | 25.0% | 0 | 0.0% |
| **Christianity** | 5 | 4.6% | 5 | 4.6% | 51 | 47.2% | 37 | 34.3% | 2 | 1.9% | 4 | 3.7% | 4 | 3.7% |
| **Islam** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| **Judaism** | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **No religion** | 2 | 3.6% | 3 | 5.4% | 17 | 30.4% | 23 | 41.1% | 4 | 7.1% | 2 | 3.6% | 5 | 8.9% |
| **Not Answered** | 9 | 33.3% | 2 | 7.4% | 3 | 11.1% | 9 | 33.3% | 1 | 3.7% | 1 | 3.7% | 2 | 7.4% |
| **Other** | 0 | 0.0% | 1 | 6.7% | 5 | 33.3% | 4 | 26.7% | 1 | 6.7% | 2 | 13.3% | 2 | 13.3% |
| **Neighbourhoods** | | | | | | | | | | | | | | |
| **To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described?** | | | | | | | | | | | | | | |
| **Buddhism** | 0 | 0.0% | 0 | 0.0% | 2 | 50.0% | 2 | 50.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Christianity** | 5 | 4.6% | 1 | 0.9% | 54 | 50.0% | 32 | 29.6% | 6 | 5.6% | 4 | 3.7% | 6 | 5.6% |
| **Islam** | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Judaism** | 0 | 0.0% | 0 | 0.0% | 2 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **No religion** | 2 | 3.6% | 1 | 1.8% | 22 | 39.3% | 16 | 28.6% | 8 | 14.3% | 5 | 8.9% | 2 | 3.6% |
| **Not Answered** | 8 | 29.6% | 1 | 3.7% | 7 | 25.9% | 7 | 25.9% | 0 | 0.0% | 0 | 0.0% | 4 | 14.8% |
| **Other** | 0 | 0.0% | 1 | 6.7% | 2 | 13.3% | 5 | 33.3% | 1 | 6.7% | 2 | 13.3% | 4 | 26.7% |
| **Hospital Beds** | | | | | | | | | | | | | | |
| **To what extent do you agree that this test would be appropriate, if in the future Stockport Together has to consider decommissioning in-patient beds at Stepping Hill hospital?** | | | | | | | | | | | | | | |
| **Buddhism** | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 25.0% | 1 | 25.0% | 2 | 50.0% | 0 | 0.0% |
| **Christianity** | 6 | 5.6% | 9 | 8.3% | 22 | 20.4% | 26 | 24.1% | 9 | 8.3% | 15 | 13.9% | 21 | 19.4% |

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % |
| **Islam** | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Judaism** | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **No religion** | 4 | 7.1% | 6 | 10.7% | 6 | 10.7% | 15 | 26.8% | 7 | 12.5% | 6 | 10.7% | 12 | 21.4% |
| **Not Answered** | 9 | 33.3% | 2 | 7.4% | 1 | 3.7% | 7 | 25.9% | 1 | 3.7% | 2 | 7.4% | 5 | 18.5% |
| **Other** | 0 | 0.0% | 1 | 6.7% | 1 | 6.7% | 3 | 20.0% | 3 | 20.0% | 0 | 0.0% | 7 | 46.7% |

## 9.5 Gender Reassignment (Is your gender different to that assigned at birth?)

| | Not Answered | | Don't know | | Strongly agree | | Tend to agree | | Neither agree nor disagree | | Tend to disagree | | Strongly disagree | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % |
| **Services** | | | | | | | | | | | | | | |
| **To what extent do you agree or disagree that Stockport Together should change their approaches to planning and organising health and social care services as outlined?** | | | | | | | | | | | | | | |
| **Yes** | 0 | 0.0% | 1 | 10.0% | 2 | 20.0% | 4 | 40.0% | 0 | 0.0% | 2 | 20.0% | 1 | 10.0% |
| **No** | 2 | 1.3% | 9 | 6.0% | 70 | 46.4% | 51 | 33.8% | 5 | 3.3% | 6 | 4.0% | 8 | 5.3% |
| **Prefer not to say** | 2 | 7.4% | 1 | 3.7% | 6 | 22.2% | 11 | 40.7% | 3 | 11.1% | 1 | 3.7% | 3 | 11.1% |
| **Not Answered** | 12 | 48.0% | 0 | 0.0% | 1 | 4.0% | 9 | 36.0% | 1 | 4.0% | 1 | 4.0% | 1 | 4.0% |
| **Neighbourhoods** | | | | | | | | | | | | | | |
| **To what extent do you agree that health and mental health services should be organised on the neighbourhood model as described?** | | | | | | | | | | | | | | |
| **Yes** | 0 | 0.0% | 1 | 10.0% | 4 | 40.0% | 3 | 30.0% | 1 | 10.0% | 0 | 0.0% | 1 | 10.0% |
| **No** | 1 | 0.7% | 3 | 2.0% | 41 | 27.2% | 79 | 52.3% | 11 | 7.3% | 9 | 6.0% | 7 | 4.6% |
| **Prefer not to say** | 2 | 7.4% | 0 | 0.0% | 10 | 37.0% | 5 | 18.5% | 3 | 11.1% | 2 | 7.4% | 5 | 18.5% |
| **Not Answered** | 12 | 48.0% | 0 | 0.0% | 7 | 28.0% | 3 | 12.0% | 0 | 0.0% | 0 | 0.0% | 3 | 12.0% |
| **Hospital Beds** | | | | | | | | | | | | | | |
| **To what extent do you agree that this test would be appropriate, if in the future Stockport Together has to consider decommissioning in-patient beds at Stepping Hill hospital?** | | | | | | | | | | | | | | |
| **Yes** | 1 | 10.0% | 0 | 0.0% | 3 | 30.0% | 4 | 40.0% | 1 | 10.0% | 0 | 0.0% | 1 | 10.0% |
| **No** | 3 | 2.0% | 1 | 0.7% | 79 | 52.3% | 41 | 27.2% | 11 | 7.3% | 9 | 6.0% | 7 | 4.6% |
| **Prefer not to say** | 0 | 0.0% | 2 | 7.4% | 5 | 18.5% | 10 | 37.0% | 3 | 11.1% | 2 | 7.4% | 5 | 18.5% |
| **Not Answered** | 0 | 0.0% | 12 | 48.0% | 3 | 12.0% | 7 | 28.0% | 0 | 0.0% | 0 | 0.0% | 3 | 12.0% |

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# Stockport Together

# STRATEGIC PLAN

# Equality Impact Assessment

## Contents

## 1. Introduction

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Care) are working alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough – Stockport Together.

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Stockport Together programme aims to create a *sustainable* health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

In doing this, we want to ensure that our plans are fair and support all community groups.

### 1.1 The Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different community groups
- foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding.

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

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

Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

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

## 1.2 Scope of this Impact Assessment

This document analyses the potential impacts of the strategic plan for Stockport Together. As such, it is intentionally high level in its review of the programme, focussing on the direction of travel, investment plans and governance of the changes underway.

The Stockport Together programme is made up of four key work streams - the detailed models of care. For each of these work streams, a business case has been developed, outlining: the case for change; the new model of care; investment plans; and intended outcomes. A full Equality Impact Assessment has been undertaken for each of these work streams to note and mitigate any differential impacts on protected groups, which vary by work stream.

All of the business cases can be found on the Stockport Together website at:
https://www.stockport-together.co.uk/business-cases

The Equality Impact Assessments and a report on engagement undertaken with protected groups in our community can be found on the Stockport Together website at:
https://www.stockport-together.co.uk/equalities-information

## 1.3 Stockport Together

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Care) have worked alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough.

It is recognised that over the coming years, health and social care will be subject to increasing demand from an ageing population, combined with a financial position that will not increase in line with this demand. The Stockport Together programme seeks to address these challenges.

### 1.3.1 The Economic Case

The health and social care system in Stockport is unsustainable in its current form. If working practices do not change, the financial position is set to deteriorate so that if no action is taken by 2020/21 there will be a c£156.8m deficit in the Stockport Locality as set out in the table below.

| Financial Forecast - 'Do Nothing' Gap (£000s) | | | | | |
|---|---|---|---|---|---|
| **Partner Organisation:** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **Stockport MBC** | £10,500 | £18,193 | £27,316 | £34,031 | £40,464 |
| **Stockport CCG** | £5,121 | £13,377 | £29,162 | £37,083 | £37,080 |
| **Stockport FT** | £34,398 | £42,400 | £54,400 | £63,622 | £75,764 |
| **Pennine Care** | £0 | £1,661 | £2,266 | £2,871 | £3,476 |
| **Total Deficit** | **£50,019** | **£75,631** | **£113,144** | **£137,607** | **£156,784** |

In response, the partners working across Health and Social Care in Stockport have developed a system-wide sustainability plan to address this significant financial challenge. The plan combines internal cost improvement plans in each partner organisation with investment in Stockport Together's new models of care, which will generate a sustainable system and deliver savings to the system. The plan also includes implementation of the Greater Manchester Health & Social Care Partnership's programmes of change, which will also contribute to financial savings over the 5 years of this plan.

The Stockport Together business cases will require recurrent investment of £16.4m and will deliver a recurrent benefit of £43m, giving a net system benefit of £26.7m.

The sustainability plan will not meet the full anticipated deficit of £156m by the end of the 5 year plan, but will reduce this to around £20.5m as well as creating a new model of care that is sustainable in the face of ongoing population growth, ageing and costs.

| Planned Savings Programmes to Address the Forecast Deficit (£000s) | | | | | |
|---|---|---|---|---|---|
| **Partners' Savings Plans:** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **Stockport MBC** | (£10,500) | (£18,193) | (£20,590) | (£23,669) | (£23,946) |
| **Stockport CCG** | (£7,871) | (£17,444) | (£24,778) | (£33,282) | (£33,882) |
| **Stockport FT** | (£28,836) | (£15,000) | (£30,000) | (£30,000) | (£30,000) |
| **Pennine Care** | £0 | £0 | £0 | £0 | £0 |
| **Investments:** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **Stockport Together** | £0 | £0 | £20,121 | £19,739 | £18,986 |
| **Resulting Savings:** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **Stockport Together** | £0 | £0 | (£23,974) | (£34,080) | (£45,470) |
| **GM Themes** | £0 | (£3,000) | (£7,000) | (£12,000) | (£22,000) |
| **Overall Impact** | **(£47,207)** | **(£53,637)** | **(£86,221)** | **(£113,292)** | **(£136,312)** |

The success of the Stockport Together plans is contingent on the system's ability to ensure that the 15% of people most at risk of hospitalisation are supported to manage their care better, with evidence based community alternatives to avoid unnecessary hospital stays. For this reason, there will be significant investment in:

- GP practices
- GP Practices working together across neighbourhoods
- Integrated community services for both physical and mental health, social care and third sector provision
- Community-based Crisis Response, Intermediate Care and Reablement.

The table below sets out the detail of planned investments in Stockport Together, by work stream, as well as the intended benefits of each area.

| Stockport Together Investments and Benefits by Work Stream (£000s) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Work Stream** | **Investment** | | | **Benefit** | | | **Net Benefit** |
| | **2018/19** | **2019/20** | **2020/21** | **2018/19** | **2019/20** | **2020/21** | |
| **Ambulatory Care** | £2,500 | £2,334 | £2,168 | (£4,871) | (£6,089) | (£6,089) | (£3,921) |
| **Intermediate Tier** | £2,457 | £1,532 | £1,103 | (£3,275) | (£4,003) | (£4,730) | (£3,628) |
| **Neighbourhoods** | £12,106 | £11,445 | £10,987 | (£11,170) | (£14,907) | (£20,465) | (£9,478) |
| **Outpatients** | £2,280 | £2,128 | £2,117 | (£6,833) | (£9,150) | (£11,765) | (£9,647) |
| **TOTAL** | **£19,344** | **£17,439** | **£16,375** | **(£26,150)** | **(£34,149)** | **(£43,049)** | **(£26,674)** |

Taken together, the business cases deliver the evidence-based community alternatives and enhanced capacity which, properly implemented, will avoid unnecessary and costly hospital interventions, making the system financially sustainable for the future.

### 1.3.2 The New Models of Care

The five organisations have developed a strategy for the borough with professionals and leaders across Stockport. The main work streams of the programme are:

- Neighbourhoods
- Intermediate Tier Services
- Outpatients
- Ambulatory Care

The following section provides an overview of each work stream and their potential impacts on protected groups. This is intended as a high level introduction. The full business cases and can be found on the Stockport Together website at:
https://www.stockport-together.co.uk/business-cases

The detailed Equality Impact Assessments for each work stream can be found at:
https://www.stockport-together.co.uk/equalities-information
These EIAs look at the demographics of staff and service users, feedback from protected groups, potential impacts of the work stream, and improvements that mitigate against any negative impact and generate positive impacts for protected groups.

### a) Neighbourhoods

The Neighbourhood model will see Primary Care, Mental Health, Community Healthcare, Adult Social Care and voluntary sector services working together with people and communities to achieve improved health and social care outcomes.

There will be an increased focus on prevention - identifying the causes of poor health, such as an unhealthy lifestyle and helping people to address this – and proactively managing people with complex care needs to stay independent and manage their condition without requiring hospital intervention.

The Neighbourhood business case proposes the development eight neighbourhood teams. These teams will include a number of different health and social care professionals. The overall aim is to ensure that care be delivered closer to home, with particular focus being given to those in the community that need the most support.

Increased prevention work should benefit all protected groups. However, we know that access to our preventative services is lower among some communities than others. Particular efforts should be undertaken to ensure that work on screening uptake is tailored to those protected groups exhibiting lower access to the services, with culturally appropriate campaigns targeting those groups most at risk for different conditions and services.

Integrated neighbourhood teams will have a major beneficial impact on older people, people with disabilities / long-term conditions, and their carers, reducing the need to attend multiple services and repeat stories and tests with each service. Providing more care at home or in the community will also support those with mobility issues, caring or work commitments.

However, specific actions will be needed to ensure high standards for people from all protected groups, including ensuring that venues for community clinics are accessible to all.

To improve access, services should be culturally appropriate and staff should receive training in specific equality issues related to their field.

The full analysis of potential impacts by protected group and an action plan for mitigating impacts and reducing inequalities can be found at:
https://www.stockport-together.co.uk/equalities-information

## b) Intermediate Tier

The 'Intermediate Tier' refers to those health and care services that provide additional support to prevent an unnecessary hospital admissions or an early admission to long-term residential care and that promote faster recovery from illness to maximise independent living.

In Stockport there are over 20 such services which have developed in isolation over the past ten years. While each service has significant strengths, collectively the Intermediate Tier is fragmented and difficult to navigate, resulting in difficulties accessing the right service and duplication for service users. The current range of services focusses mainly on supporting people after their condition has escalated, requiring a hospital admission. As a result, there is little capacity to respond to people in crisis and prevent unnecessary hospital admissions.

This business case describes how care and treatment could be delivered in a person's normal place of residence or as close to home as possible. It describes a 24 hour health and social care system that better meets people's needs, and offers flexible, person-centred care that will help people when they need to move between hospital and primary care settings. At the same time, improvements will be made to community bed-based care, with the aim of reducing the average length of stay from 4 weeks to 2 in line with the national approach.

This work should see a positive impact on the entire community by reducing waste and offering all communities the same service levels. However, we recognise that the impact will be felt most by older people, those with long-term conditions or disabilities and their carers. For the most part, this impact should be positive – ensuring that people are treated as close to home as possible when hospital visits are not necessary, ensuring that everyone receives a high standard of care and appropriate referrals / prescriptions, reducing unnecessary waiting for referrals from one intermediate care service to another, and reducing duplication of assessment and tests undertaken by different teams currently going into a patient's home.

To ensure that no negative impacts are felt by any groups, a full impact assessment of the plans has been undertaken, setting out a detailed action plan to ensure that care provided in people's homes is culturally sensitive, community clinic venues are accessible, and that bed based care is fully accessible to all protected groups.

The full analysis of potential impacts by protected group and an action plan for mitigating impacts and reducing inequalities can be found at:
https://www.stockport-together.co.uk/equalities-information

### c) Outpatients

Outpatient attendances have grown by 17% locally – a 15% growth in GP referrals and 20% growth in referrals from other professionals, including hospital consultants. In our current model, people are referred to hospital and receive specialist advice and support, often followed by recurrent follow-ups. Around 40-50% of outpatient appointments in Stockport result in advice and / or pharmaceutical treatment only, without the need for the patient to physically visit the hospital. Alternative approaches to the traditional model could deliver more effective solutions outside of the hospital, using technology to enable communications, advice and treatment between patients, GPs and specialists.

The outpatients work stream of Stockport Together aims to reduce the number of unnecessary outpatient attendances over the next 3 years by providing alternatives to the traditional way in which they are currently delivered. It aims to improve patient care by providing support, information and advice through improved technology and access to community resources. This will help people to be more confident in managing their own care. As a result, the work stream will reduce waste and offer and cost. However, we recognise that this will have a differential impact on some protected groups – older people; people with disabilities; women – who are more likely to receive referrals from their GP.

For the most part, this impact should be positive – ensuring that people are treated as close to home as possible when hospital visits are not necessary. The full assessment of this work stream looks at ensuring that community venues for outpatient appointments are fully accessible, care provided at home is culturally appropriate and the use of technology includes support for those with disabilities or limited English as well as traditional appointments options for those who struggle with new technology.

The full analysis of potential impacts by protected group and an action plan for mitigating impacts and reducing inequalities can be found at:
https://www.stockport-together.co.uk/equalities-information

### d) Ambulatory Care

While the rate of A&E attendances at Stepping Hill Hospital is on a par with the national average, people in Stockport are much more likely to be admitted to hospital rather than treated and discharged – particularly those with Ambulatory Care Sensitive (ACS) conditions, which should be treatable in the community and not require hospital admissions.

This outline business case proposes changing the way the Emergency Department is set up in three ways:

- Implementing primary and secondary care ***Collaborative Triage***;
- Providing of a co-located primary care ***Ambulatory Illness Team***;
- and extending the operating hours of the ***Ambulatory Care Unit***.

This proposed way of working will strengthen the triage process by improving the availability of senior decision makers within the team. This will include having primary care expertise within the department (for example, having a GP in A&E), access to patients' electronic record (with appropriate safeguards), and improving the decision making protocols and processes.

Behind A&E triage there will be a new service operating 8am to midnight 7 days a week to deal with peak periods of demand. It will meet the needs of people who do not require full A&E services, but may need some lower level support (for example reassurance about a rash). It is estimated this primary care led service will see more than 300 people a week, leaving A&E staff free to work with people with more serious needs more promptly.

The existing Ambulatory Care Unit will extend opening hours so that it will go from seeing 160 to 350 people a week and be open 8am to midnight 7 days per week. The unit will diagnose, treat, stabilise and discharge people where their condition does not require overnight hospital care but short-term medical input. Planned additional capacity, along with access to GP records for the clinical team, revised pathways and dedicated specialist staff and equipment will reduce admissions through ED by 40 per week. More importantly it will ensure people who need a brief medical intervention are treated quickly and returned home safely rather than being admitted unnecessarily.

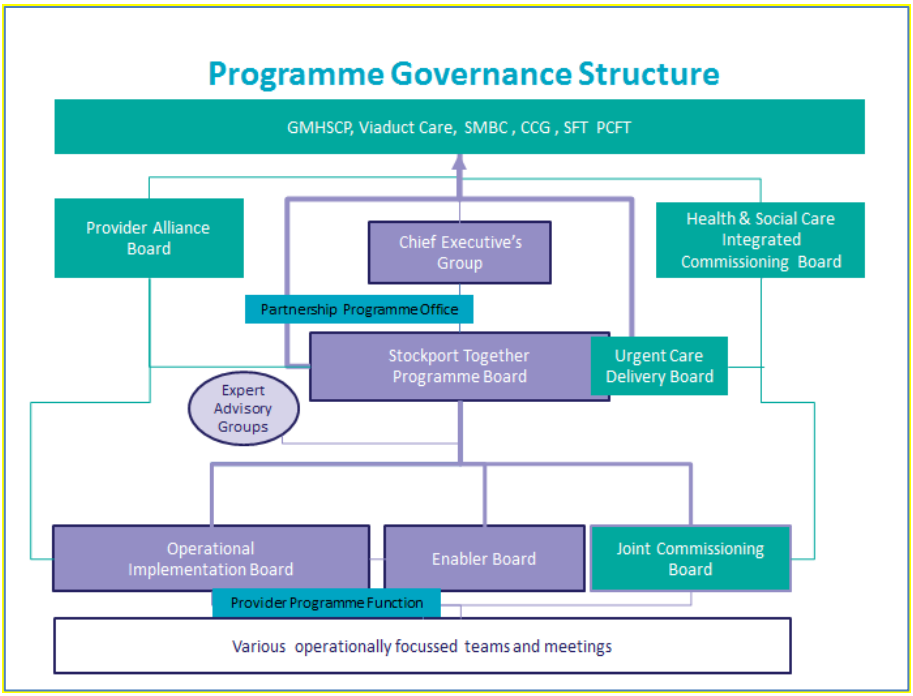
Access to emergency services is vital to all community groups, but the over-use of current services and high rates of emergency admissions are making this unsustainable. This area of work aims to improve the quality of current services, which should have a positive impact on all community groups.

In particular, older people, those in care homes and nursing homes, people with long-term conditions and children are the highest users of current unscheduled care services. This programme will improve the service for these groups, offering improved clinical pathways for conditions, reducing the length of stay in hospital and giving emergency services access to the patient's records so that they receive the right care in the right place.

The full analysis of potential impacts by protected group and an action plan for mitigating impacts and reducing inequalities can be found at:
https://www.stockport-together.co.uk/equalities-information

### 1.3.3 Governance of the Programme

The Stockport Together programme brings together the main public sector organisations in Stockport.




The Chief Executives Group is ultimately accountable for delivery of the Programme, owning and promoting the shared vision, and holding Senior Responsible Officers to account for delivery.

Stockport Together Programme Board seeks assurance on the implementation of the new care models and services, has responsibility for any changes to the programme, oversight of key strategic risks, and manages public consultation and engagement.

A Provider Alliance Board is responsible for the operational implementation of the new care models as outlined in the Business Cases, for addressing issues and supporting staff engagement.

From Spring 2018 governance will be managed in two distinct ways:

- joint commissioners (Stockport Council and NHS Stockport CCG) will take responsibility for ensuring that plans are embedded in provider contracts and for monitoring the delivery of plans, savings and benefits
- Stockport Neighbourhood Care will bring together service providers (Stockport FT, Pennine Care, Adult Social Care, and the GP Federation) to collaboratively deliver changes and provide a fully integrated service to local people.

Commissioner oversight of programme implementation and benefits delivery will track progress on equality action plans and how benefits impact protected groups.

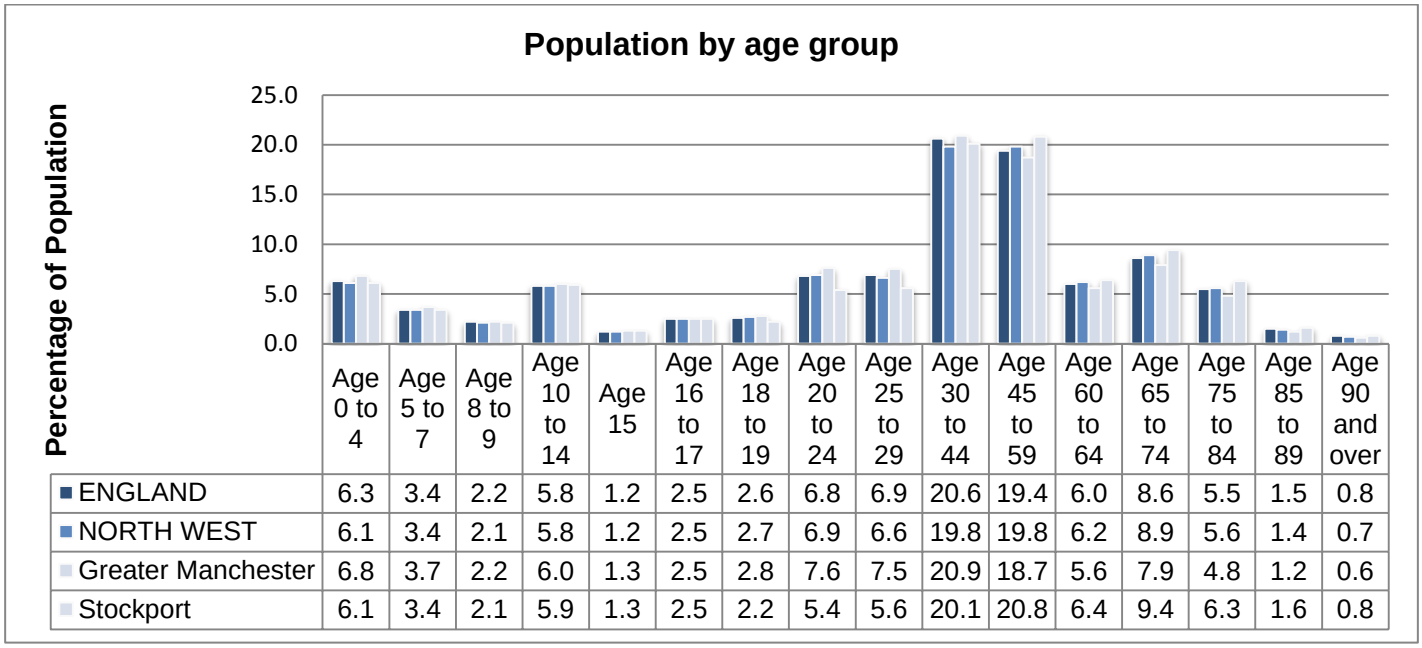
New contracting arrangements will clearly set out the responsibilities of the new integrated provider to ensure equality of access and reduce inequalities in outcomes faced by protected groups.

# 2. Assessing Impact of Stockport Together on the Community

## 2.1 Stockport Community data

The total population of Stockport is currently 286,775 (Mid-year Population Estimates, 2014), a figure which has been relatively stable over the last 10 years. The information below details the population data available in relation to equality and diversity in Stockport. This data has been used alongside feedback from local community groups to consider how the priorities and actions outlined in our plan are likely to impact on different groups.

Stockport has an older age profile than the national average, with comparatively high numbers of residents aged 45-59 and low numbers of 18-44 year olds. The median age at the 2011 census was 41 (up from 39 ten years ago) and recent mid-year population estimates identify that 19.4% of the population is aged 65 or over, which is higher than the national average.



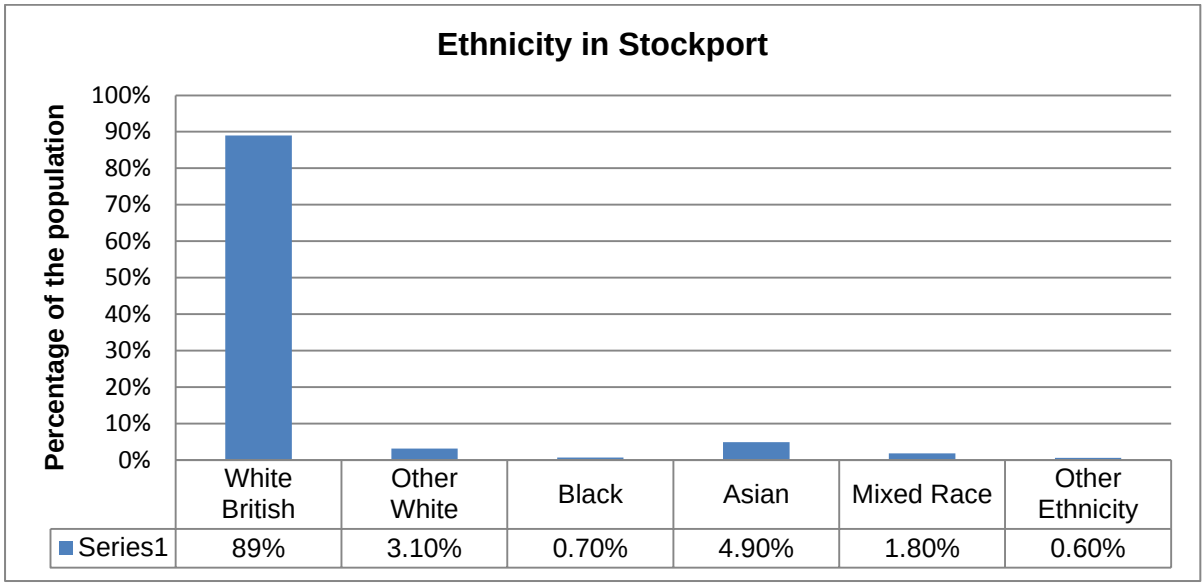

| | Age 0 to 4 | Age 5 to 7 | Age 8 to 9 | Age 10 to 14 | Age 15 | Age 16 to 17 | Age 18 to 19 | Age 20 to 24 | Age 25 to 29 | Age 30 to 44 | Age 45 to 59 | Age 60 to 64 | Age 65 to 74 | Age 75 to 84 | Age 85 to 89 | Age 90 and over |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ENGLAND | 6.3 | 3.4 | 2.2 | 5.8 | 1.2 | 2.5 | 2.6 | 6.8 | 6.9 | 20.6 | 19.4 | 6.0 | 8.6 | 5.5 | 1.5 | 0.8 |
| NORTH WEST | 6.1 | 3.4 | 2.1 | 5.8 | 1.2 | 2.5 | 2.7 | 6.9 | 6.6 | 19.8 | 19.8 | 6.2 | 8.9 | 5.6 | 1.4 | 0.7 |
| Greater Manchester | 6.8 | 3.7 | 2.2 | 6.0 | 1.3 | 2.5 | 2.8 | 7.6 | 7.5 | 20.9 | 18.7 | 5.6 | 7.9 | 4.8 | 1.2 | 0.6 |
| Stockport | 6.1 | 3.4 | 2.1 | 5.9 | 1.3 | 2.5 | 2.2 | 5.4 | 5.6 | 20.1 | 20.8 | 6.4 | 9.4 | 6.3 | 1.6 | 0.8 |

18.4% of Stockport residents are living with a long-term illness or disability. 8 of Stockport's 21 wards have levels of LLTIs above the national average, including all of Stockport's Priority 1 areas (those with the highest levels of deprivation). 8.6% of the population say their long-term condition or disability has a significant limiting impact on their daily activities.

11.3% of the population would describe themselves as unpaid carers. 2.5% provide 50 or more hours of unpaid care a week.

Stockport's birth rate has increased steadily since 2003 - over 3,400 babies were born to Stockport residents in 2008. Birth rates are higher among Stockport's ethnic minority groups and in areas of deprivation.

Stockport's Black & Minority Ethnic (BME) population has risen from just 4.3% in 2001 to around 8% at the 2011 census. If white ethnic minorities are included, such as Irish, Polish and traveller populations, this percentage rises to 11%. Areas to the west of the borough have the highest proportion of ethnic diversity – particularly among younger populations.




The majority of Stockport residents are Christian (63.2% - down from 75% at the last census), which is 4% greater than the national average. 25.1% of Stockport residents have no stated religion (up from 14.2% at the last census), which is in line with the national average. Stockport's second largest religion is Islam, which makes up 3.3% of the population - this is well below the national average of 5%, but the local figure has almost doubled since the last census.

Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend. Life expectancy in Stockport is higher for women at 83 years and 79.7 years for men.

There is currently no demographic data on local trans-gender residents, though recent consultation undertaken as part of Stockport's LGBT needs assessment offers a greater insight into this community group.

There is a lack of reliable data available regarding the profile of the LGBT community in Stockport. The government estimates that between 5% and 7% of the UK population is LGB, which would equate to 14-20,000 people in the borough.

A full break down of local health statistics by protected characteristics can be found in Appendix 1 – *Stockport Context.*

## 2.2 Implications for the Community and Service Users

Anticipated implications at a high level are identified in section 1.3.1.

At the strategic programme level, we anticipate that Stockport Together will have a beneficial impact on service users and the community, by:

- Creating a sustainable system that meets local needs into the future
- Tailoring services to the needs of local people, as identified in Stockport's Joint Strategic Needs Assessment
- Shifting the balance of care from reactive services that support people once they are ill to a preventative and proactive approach that supports people to live well and remain independent
- Treating service users as individuals with a range of health and social care needs, rather than focusing on separate conditions
- Coordinating care to wrap around the individual
- Undertaking care as close to home as possible.

In particular, this should have a positive impact on:

- Older people, who are more likely to need health and social care services
- People with a disability or long-term condition
- Carers, who will benefit in particular from the coordination of care for people with multiple conditions, the integration of services to wrap around the patient and the transfer of care as close as possible to home reducing the burden of travel and coordinating appointments, currently shouldered by carers
- Ethnic minority groups, religious minority groups, LGBT members of the community and men who we know are less likely to use our services and will benefit from more targeted prevention.

Potential negative impacts identified include:

- People using current services may be discharged from the service, seen in a different setting, or by a different professional / team
- A number of protected groups are, for various reasons, less likely to access primary and preventative services, which the programme aims to increase
- Increased use of new technology to manage self-care may be less accessible to some protected groups
- Potential for confusion among integrated teams as to which interpretation service to use (currently primary care, community services, and social care services running) may result in reduced access to interpretation
- New integrated venues will need to be accessible and publicised in a variety of formats
- Increased care in a patient's home will need to be culturally appropriate
- Potential for confusion in navigating services as the system transitions between the old and new arrangements. Patient facing communications and engagement will help overcome this.

In all cases, this redesign is based on health and care need, prioritising the most vulnerable and changing services to provide the most appropriate care to meet needs. Further analysis of detailed designs and equality action plans can be found in the Equality Impact Assessments for each work stream: https://www.stockport-together.co.uk/equalities-information.

## 3. Consultation with Service Users, Carers and the Public

Since 2013 engagement and co-production has been undertaken across Stockport on the integration of health and social care services. In 2013-2014, 700 people were spoken to at a number of events in Marple and Werneth where the initial integrated locality pilot was launched.

In January 2015, 100 leaders and staff from health and social care; NHS Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust and Stockport Metropolitan Borough Council took part in a two day Congress to help shape the future of Stockport's Health and Social Care services.

Following the congress, engagement meetings were re-initiated across the whole of Stockport. Over 500 people fed into the case for change and vision for the future of health and social care.

A Citizen's Representation Panel (CRP) was established in October 2015 to feed in local views throughout the design and implementation phase.

In June 2017, Stockport Together ran a Listening Phase to reach wider groups, giving information on the plans and feeding in views to develop the business cases.

Finally, a formal consultation was undertaken between October and November 2017 to make final recommendations on the decision whether to adopt the business cases and agree investment plans in January 2018.

A wide variety of engagement and communication methods were used to reach more people and different groups within Stockport's community and give a better understanding of local views on the public services and priorities for change. Information was disseminated in a range of formats:

- Online surveys
- Paper surveys
- Public events
- Speakers at local community groups
- Health Information Stalls using accessible infographics
- Patient and Citizen Representation Panels
- Roadshows
- Workshops
- Fliers and consultation documents handed out in clinics and displayed in Libraries, Pharmacies and GP Practices
- Customer services monitoring, including views expressed in letters, complaints, petitions and patient feedback.

One of the key tools for feeding back to local people is the CCG's engagement website: *www.citizenspace.com/stockport-haveyoursay* which allows for the use of translation into other languages, BSL video clips, and easy read images in surveys. The site also allows people to take part in engagement anonymously and provides remote access for those who cannot or do not wish to attend traditional town hall meetings.

For those without access to the internet, more traditional engagement events are undertaken as well as speakers attending existing community group meetings, a presence at local events with information stalls and staff attend local GP Practices and clinics as well as major shopping centres to give out information and take views from people who would not traditionally engage in public sector events.

Events were undertaken in accessible local venues across each area of Stockport, and participants can request interpretation, specific dietary options for catering or other special requirements to allow them to attend and participate.

Write-ups of events were sent out to local groups after they have met with the partners. 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.

Documents include a message explaining how information could be obtained in an alternative language or format.

As well as making efforts to ensure that engagement is accessible to all, public engagement and consultation included targeted meetings with local groups representing protected characteristics to ensure that all voices were heard and all concerns / impacts understood.

The partners have a database of over 1,500 local groups, which is used to involve local people in engagement. The table below sets out the key groups used as points of contact for reaching protected groups. It should be noted that this is not a comprehensive list and protected groups are also involved in other engagement work as individuals fall under a number of categories.

| Protected Characteristic | Local Groups |
|---|---|
| Age | Age UK<br>Bramhall U3A<br>Gatley U3A<br>Stockport College<br>Stockport Savvy<br>Young Minds |
| Disability | Disability Stockport<br>Walthew House<br>Stockport MIND<br>Rethink<br>Stockport Mencap<br>Pure Innovations<br>Alzheimers Society<br>COPD patient group<br>Stockport Cerebral Palsy<br>The Together Trust<br>Rescare |

| Protected Characteristic | Local Groups |
|---|---|
| | Hope 4 Disability<br>Stockport Carers Forum<br>Signpost for Carers<br>Stockport Carers of Adults with Autism<br>Carers of Adults with Learning Disabilities |
| Gender reassignment | Press for Change<br>LGBT Foundation<br>MORF<br>Manchester Concord |
| Pregnancy & Maternity | Maternity Services Liaison Committee |
| Race | African & Caribbean Community Association (ACCA)<br>Ethnic Diversity Service<br>Nexus<br>Nia Kuumba<br>Asian Heritage Centre<br>Wai Yin Chinese Society<br>Siyanda Trust |
| Religion & Belief | Stockport Inter-Faith Network<br>Stockport MELA Forum<br>St Ambrose Church<br>Salvation Army<br>Cheadle Muslim Association<br>Stockport Buddhist Temple |
| Sex | Cheadle Women's Institute<br>Offerton ladies' Circle<br>Women's Royal Voluntary Service, Stockport<br>Stockport Women's Centre<br>Stockport Women's Aid<br>PARIS gym<br>Stockport Taxi drivers<br>Sky & BT (local employers with predominantly male employees) |
| Sexual Orientation | People Like Us Stockport<br>LGBT Foundation<br>Stockport Savvy<br>Under the Rainbow |

The overarching themes from the public events were that:

- People generally understood the need to make changes, given the changing population and numbers of people with long-term conditions
- Many of the services currently provided in hospital could be undertaken closer to home in GP Practices, clinics, or even in the patients' home
- Current services are fragmented and people don't want to keep repeating their story at each appointment.
- Frontline staff don't always seem to be aware of other services and what's available
- We need to look at improving care for Long-Term Conditions and there should be more support for Carers

- People want more information about where to go or what to do when they are ill – they want alternatives to A&E.
- Local people want more care delivered closer to home
- A number of residents have raised issues with the cost of car parking at Stepping Hill Hospital, particularly for those on low incomes and people with multiple long-term conditions who need to attend more than one clinic.
- Older patients, people with disabilities and those with English as a second language have raised issues around communications from the hospital – with appointment letters sent by post in a standard format that does not consider requirements for Braille, large print, Makaton or translation into other languages.
- Access to services – particularly GP appointments and the availability of hospital Consultants – should be improved at weekends
- GP surgeries should provide more appointments
- Local people want there to be more focus on Mental Health
- Services often treat a single condition, rather than looking at the needs of the individual
- Online access viewed as right thing to do but some fear less IT empowered people will be disadvantaged
- Clearer information about how to access services should be provided.
- Communications need to be in an accessible format, whether that is appointment letters, access to booking or information leaflets
- Any new venues need to be accessible
- Staff should be trained to understand and be sensitive to different needs
- It is important that, where possible, patients receive continuity of care, particularly for more vulnerable patients, offering a named lead
- There was a lot of support for preventative measures and the better management of long-term conditions through GP Practices and community services
- Prevention and taking personal responsibility for health came out as the top suggestions from members of the public on how we improve some of the issues facing public services
- There should be a more joined up approach to care

By protected group, the following priorities and issues were raised:

### *Age*

- People want more information about where to go or what to do when they are ill – they want alternatives to A&E.
- Local people want more care delivered closer to home
- A number of residents have raised issues with the cost of car parking at Stepping Hill Hospital, particularly for those on low incomes and people with multiple long-term conditions who need to attend more than one clinic.
- Older patients, people with disabilities and those with English as a second language have raised issues around communications from the hospital – with appointment letters sent by post in a standard format that does not consider requirements for Braille, large print, Makaton or translation into other languages.
- "People without web based access or skills will need help accessing online care or records."
- GP surgeries should provide more appointments

- Online access viewed as right thing to do but some fear less IT empowered people will be disadvantaged
- It is important that, where possible, patients receive continuity of care, particularly for more vulnerable patients, offering a named lead

### *Disability*

- Services are fragmented and people don't want to keep repeating their story at each appointment.
- Frontline staff don't always seem to be aware of other services and what's available
- Services often treat a single condition, rather than looking at the needs of the individual
- We need to look at improving care for Long-Term Conditions and there should be more support for Carers
- People with sensory disabilities report issues accessing services, particularly when letters are all sent in a single format – for some this inaccessibility had resulted in thoughts of suicide
- British Sign Language users expressed issues accessing emergency appointments
- Clinicians tend to treat the 'condition' and not see wider, holistic needs of the patient
- "Mental health will need to be strengthened in the neighbourhood plans."
- Older patients, people with disabilities and those with English as a second language have raised issues around communications from the hospital – with appointment letters sent by post in a standard format that does not consider requirements for Braille, large print, Makaton or translation into other languages.
- Online access viewed as right thing to do but some fear less IT empowered people will be disadvantaged
- "People without web based access or skills will need help accessing online care or records."
- Communications need to be in an accessible format, whether that is appointment letters, access to booking or information leaflets
- Any new venues need to be accessible

### *Gender Identity*

- Trans people experience some of the most significant health inequalities and frequently experience abuse, harassment and violence
- Staff should be trained to understand and be sensitive to different needs
- Local residents noted pockets of good practice, but a general lack of knowledge about how to meet the needs of trans patients among health professionals, particularly in secondary care

### *Marriage & Civil Partnerships*

- Staff should be trained to understand and be sensitive to different needs, including visiting rights for same sex partners

### *Pregnancy & Maternity*

- Changes will likely have a positive impact on parents with young children, who struggle to arrange childcare for hospital appointments
- Changes will likely have a positive impact for pregnant women who may find it harder to travel into hospital for their appointment

### *Race*

- Older patients, people with disabilities and those with English as a second language have raised issues around communications from the hospital – with appointment letters sent by post in a standard format that does not consider requirements for Braille, large print, Makaton or translation into other languages.
- People want more information about where to go or what to do when they are ill – they want alternatives to A&E.
- Clearer information about how to access services should be provided.
- Communications need to be in an accessible format
- End of life care, in particular, needs to be sensitive to cultural differences

### *Religion or Belief*

- Staff should be trained to understand and be sensitive to different needs
- End of life care, in particular, needs to be sensitive to religious beliefs

### *Sex*

- Male patients are less likely to attend medical appointments, in part due to restricted opening times which clash with work
- Flexible opening times could improve access for men
- More information should be made available online – particularly for men who are less likely to go to their GP

### *Sexual Orientation*

- Some people face more barriers than others when faced with the need to change lifestyles or behaviour.
- Access to services – particularly GP appointments and the availability of hospital Consultants – should be improved at weekends
- Staff should be trained to understand and be sensitive to different needs, including visiting rights for same sex partners
- Older LGBT people are more likely to live alone and less likely to have informal support from families and social networks, but often do not get their needs met by adult social care services
- Drug and alcohol services in Stockport should consider the specific needs and experiences of LGBT residents
- Local residents have reported positive feedback of GP and mental health services, which are friendly nd ‘very non-judgemental’
- Community and voluntary sector services were highly praised for meeting LGBT needs
- Sexual health services in Stockport were seen as not meeting LGBT needs and very restrictive in opening times

Feedback from engagement was used to design the Stockport Together programme and to inform Equality Impact Assessments.

A full report of engagement on Stockport Together and a breakdown of engagement by protected groups can be found on the Stockport Together website.

# 4. Assessing the Impact of Stockport Together on the Workforce

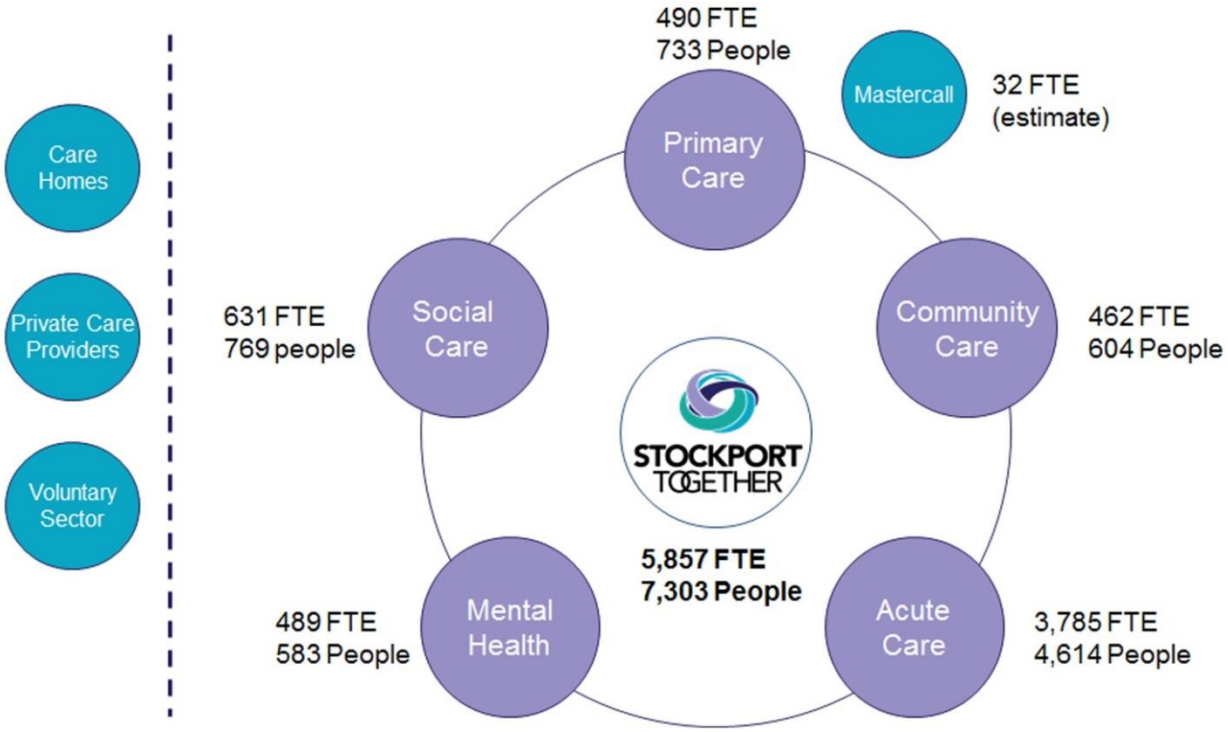
The traditional divide between primary care, community services, mental health, social care, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. An integrated Local Care Organisation (LCO) model brings these teams in a proactive, community-based model that shifts a significant proportion of care out of the hospital and closer to home. However, the model presents more than just a structural change – an LCO requires a major cultural shift to a new way of working, centred round prevention and empowerment of service users and delivering significant efficiencies to sustain high quality services into the future.

## 4.1 Workforce Baseline data

Health and social care in Stockport is overseen by a single Health & Wellbeing Board, given Stockport's geographic footprint which combines a coterminous Clinical Commissioning Group and Local Authority. Services are provided by one local acute hospital, which also runs our Community services; a main mental health provider, 1 ambulance service provider, 47 GP Practices, working towards developing a single primary care Federation model and one out-of-hours GP service.

Services work closely with a range of third sector providers and 64 local care homes. However, this baseline and strategy focuses on the 7,303 staff (5,875 full-time equivalents) directly employed in the above health and social care services.

### *Our Combined Workforce*



The vast majority of staff across health and social care in Stockport are employed by Stockport NHS Foundation Trust - 72.51% of full-time equivalents. This combines the 64.62% of employees working in the hospital with the 7.89% of staff in Community Services.

Adult Social Care and Public Health make up the next biggest chunk of the workforce – 10.77%, followed by primary care (8.37%) and mental health (8.35%).

The following section describes the trends highlighted across the workforce profiles.

### 4.1.1 Full time/part time split

Current structures reveal variation in working patterns across the different parts of the system. Primary Care has particularly high levels of part-time working. Staff working in social care are much more likely to work full-time.

### 4.1.2 Gender

Traditionally, public services have attracted more women than men. In Stockport, the modal employee is a white woman in her 50s who is Christian, heterosexual and has no disabilities

This varies across sectors and roles, though the overarching trend is the same in each service. Community services have the least male employees - just 9% of full-time equivalents. The gender differential is least stark in social care, but even here men make up just a quarter of the workforce.

### 4.1.3 Ethnicity

Primary Care has the most ethnic diversity, the least being in community services, where 94.43 % of employees are white.

Within the sectors, ethnic diversity varies according to roles. In acute services, there is more ethnic diversity among medical and estates teams. In primary care, it is GPs who provide the most ethnic diversity to the overall workforce makeup.

### 4.1.4 Age

The most prominent feature of the workforce is its age profile. The majority of employees across the system are in their fifties. Social care has the oldest age profile of all sectors, the youngest being in hospital services.

A high proportion of the workforce is already in their fifties and therefore more likely to retire in the coming years:

- 54% of community staff
- 50% of social care staff
- 47% of primary care staff
- 41% of mental health staff
- 38% of acute staff

The rates are particularly high among nursing staff – particularly in primary and community care, support workers, admin and managers. This poses a potential problem for the development of an LCO, based on a preventative style of working. The vast majority of these skills lie in primary and community services, where the age profile is higher and staff with the key skills for a preventative, out-of-hospital model are closer to retirement age. Consequently, work will need to be undertaken to support the development of preventative community-based skills among acute staff and to allow for intra-team learning among current staff to ensure that vital skills are not lost when staff retire. This is also a key message for Health Education North West in planning the training of future health and social care staff to ensure that new recruits coming into the system reflect the new balance of skills required in our new model.

### 4.1.5 Sexual Orientation

Declaration of sexual orientation amongst the workforce is low and as such work to develop a consistent understanding of this across the Health and Social Care economy is required. Present data shows a significant proportion of the workforce as 'prefer not to state' and of those that have, the largest proportion have identified themselves as Heterosexual / Straight. Further data analysis will be undertaken to understand this protected group in Stockport.

### 4.1.6 Religion or Belief

The largest religion identified across the workforce is Christinity, for example within Community, Acute and Mental Health between 46 – 52% of the workforce identify themselves as Christian. This is much lower within Social Care (10%) and isn't currently known within Primary Care. As with 'Sexual Orientation' there are large numbers of the workforce who are identified as 'not declared'. Further data analysis will be required for these protected characteristics to produce a consistent understanding across Stockport's Health and Social Care economy.

### 4.1.7 Marriage/Civil Partnership, Gender Reassignment, Pregnancy / Maternity

Staff records do not currently contain data on marital status, gender reassignment, pregnancy and maternity. Further data analysis will be required for these protected characteristics as part of the Equality Impact Assessment on changes to staffing.

## 4.2 Implications for the Workforce

Stockport Together requires a major cultural shift for all employees working within Health and Social Care. A more detailed understanding of the implications for the Workforce is set out within the work stream level EIAs and will be advanced as part of the staff engagement processes that would be standard in developing new service models, and consulting with staff in advance of implementation as required.

It is anticipated that changes could affect staff in the following ways:

- Where they are located;
  - As more care is delivered in a patient's home or in a neighbourhood setting, roles may shift from a hospital to a community setting, or from a provider headquarters to integrated neighbourhood hubs
- Team composition;
  - Line management in multi-disciplinary teams can no longer be restricted by professional background.
- Training and workforce culture;
  - The workforce will be empowered to work more in partnership with carers and volunteers locally, and will help to develop community capacity and skills.
  - Development will be required to support staff to take on new devolved leadership responsibilities and to help autonomous professions to share accountability.
  - Staff will need to learn about the different roles across the system and how to best use capacity. This will require us to address professional hierarchies.
  - Newly integrated teams will need to be developed through values alignment and team building.
  - Whenever possible, training will be undertaken jointly across professions and organisations to support greater awareness and understanding of roles.
  - The workforce themselves must be mobilised and empowered to improve efficiency and effectiveness, adopting a shared approach to change management and quality improvement.
  - A range of knowledge and skills are needed to enable person-centred care and support planning, and a number of approaches and training courses have been developed:
- Where and by whom they are employed;
  - There will be an inevitable shift of capacity from the hospital into community and primary care services.
  - Staff will increasingly need to work across organisational, professional and service boundaries.
- Working Hours;
  - Extending hours and changing shift patterns to enable 7 day working and extended hours for some services.
- Job roles and responsibilities
  - The integration of health and social care will incur role-blurring and result in the development of new generic roles to take the pressure off teams we don't have enough of and cannot easily recruit to.
  - This will reduce the number of very specialist roles in each sector to support multi-disciplinary team working that is more flexible and responsive to local service user needs.

- New roles are required to create a sustainable new model that enables person-centred care, such as: generic health and social care roles; health coaches; care navigators; personal assistants; physicians' assistants; primary care paramedics; advanced practitioners for geriatric care; and community-based specialists.

## 5. Consultation with staff

Ongoing engagement is taking place with staff and a workforce engagement lead has been identified. Formal staff consultation may be required for some services, and is already underway for the services forming part of the Neighbourhoods model and extending social care and district nursing to deliver 7-day and extended hours services. That process is nearing conclusion and is a good example of how Stockport Neighbourhood Care will manage other similar staff engagement for other future service changes.

Given the extent of change and the range of potential implications for the workforce it is recommended that any planned future consultation includes representation or focus groups including individuals from protected groups and is backed up by an Equality Impact Assessment of staff changes.

## 6. Recommendations / Equality Action Plan

This Equality Impact Assessment has highlighted a number of potential impacts of the Stockport Together Strategy on protected groups within our staff and community.

The following plan sets out the high level actions required to mitigate any potential negative impacts on protected groups and to take advantage of opportunities to reduce inequalities in outcomes. It also identifies links to actions within the detailed Equality Impact Assessments of work streams, which will be embedded in work stream implementation plans.

Actions will be embedded into the Stockport Together implementation plan and monitored as part of delivery by the Stockport Together Programme Management Office.

| Theme | Ref | Action | Lead/s | Deadline | Links to work stream actions |
|---|---|---|---|---|---|
| Governance & compliance | ST01 | Equality Actions to be included in Stockport Together Implementation Plan | PMO Manager | 31/01/2018 | AC01; IT01; N01; OP01 (actions to be embedded into work stream operational plans) |
| | ST02 | Ensure ownership and progress of actions | PMO Manager SNC MD | 31/01/2018 | |
| | ST03 | Monthly updates on implementation (including progress on equality actions) monitored by Stockport Together PMO | PMO Manager | 28/02/2018 | AC02; IT02; N02; OP02 (progress reports to PMO) |
| Engagement and active patient / citizen input | ST04 | Develop a robust and meaningful engagement approach which includes protected groups, and maximises the opportunity of Citizens Representative Panel | Head of Communications | 31/03/2018 | AC03; IT03; N03; OP03 (work stream comms / engagement plan) |
| | ST05 | Engagement and complaints to be monitored by protected groups to ensure there are no adverse impacts on any groups | Head of Communications | 31/03/2018 | AC04; IT04; N04; OP04 (patient engagement and complaints monitored by protected group) |
| | ST06 | Communications plan for roll-out of the service changes, including: | Head of Communications | 31/03/2018 | IT10; N08; OP08 |

| | | | | | |
|---|---|---|---|---|---|
| | | • Map of stakeholders (including protected groups)<br>• Communications formats to meet needs to stakeholders<br>• Leaflets and other publicity to use inclusive images and language to demonstrate accessibility to all community groups | | | |
| Contracting | ST07 | Provider contract development to set out the legal requirements of the new integrated organisation to follow duties under the Equality Act and Accessible Information Standard, including:<br>• Equality monitoring & reporting<br>• Interpretation and translation services<br>• Accessible facilities | Programme Director<br>IC Director<br>Commissioning leads | 31/03/2018 | N06; OP06 (provider contracts) |
| | ST08 | Contracts with care home / bed-based care providers to set out the legal requirements to follow duties under the Equality Act and Accessible Information Standard, including:<br>• Equality monitoring & reporting<br>• Interpretation and translation services<br>• Accessible facilities | IC Director<br>Commissioning leads | 31/03/2018 | IT06 |
| | ST09 | SNC to set out how they intend to meet the Accessible Information Standard in the new service model:<br>• Agreement on Interpretation service (currently 3 services at SMBC, Primary Care and SFT)<br>• Collating data on formats required by patients<br>• Equality monitoring process | SNC MD | 31/03/2018 | AC05; N05; OP05 |

| | | | | | |
|---|---|---|---|---|---|
| | | • System for sending patients communications in the correct format (e.g. Braille, large print)<br>• Service Level Agreements in place for translation of information into other formats (Braille, BSL videos, audio format, other languages)<br>• Alternative contact methods to phone for deaf patients (e.g. Text-Relay service; text messaging; email; face-to-face) | | | |
| Service Access | ST10 | Service access to be monitored by protected group and changes as a result of Stockport Together tracked. | SNC MD & work stream operational leads | | AC09; OP13<br>(service user data reporting) |
| | ST11 | Patients and carers' views to be sought in the planning of the new venues, including neighbourhood hubs and community bed based care. | Estates | 31/03/2018 | IT08 |
| | ST12 | Venue of new facilities / clinics assessed to ensure full access, including:<br>• Disabled parking<br>• Disabled toilets<br>• Changing facilities<br>• Hearing loops | Estates | 31/03/2018 | IT09; N07; OP07 |
| | ST13 | Transport options for accessing new venues should be widely publicised to family and carers. | Estates<br>Head of Comms | 31/03/2018 | IT11 |
| | ST14 | IM&T plan developed to include:<br>• Training on how to use any self-care technology<br>• Alternative options for patients who are unable to use self-care technology<br>• Training on how to use skype | IM&T lead | 31/03/2018 | IT12; N09; OP09 |

| | | | | | |
|---|---|---|---|---|---|
| | | technology for virtual appointments<br>• Alternative options for patients who are unable to access virtual appointments | | | |
| Staffing | ST15 | Equality Impact Assessment of how the new service models will affect staff | HR lead | 31/03/2018 | AC06; IT13; N10; OP10 |
| | ST16 | Staff consultation on new service model and any changes to roles / places of work | HR lead | 31/03/2018 | AC07; IT13; N11; OP11 |
| | ST17 | Develop a staff training plan, including:<br>• Equality & Diversity Training<br>• Use of interpretation and translation services<br>• Equality monitoring to comply with AIS | HR lead | 31/03/2018 | AC08; IT15; N12; OP12 |

A free interpreting service is available if you need help with this information:

NHS Stockport Clinical Commissioning Group

0161 477 9000
eds.admin@stockport.gov.uk

如果你需要幫助去了解這份文件的內容，我們可以提供免費的傳譯服務。
eds.admin@stockport.gov.uk 0161 477 9000

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**Tel:** 0161 426 5011

**Email:** stoccg.stockport-together@nhs.net

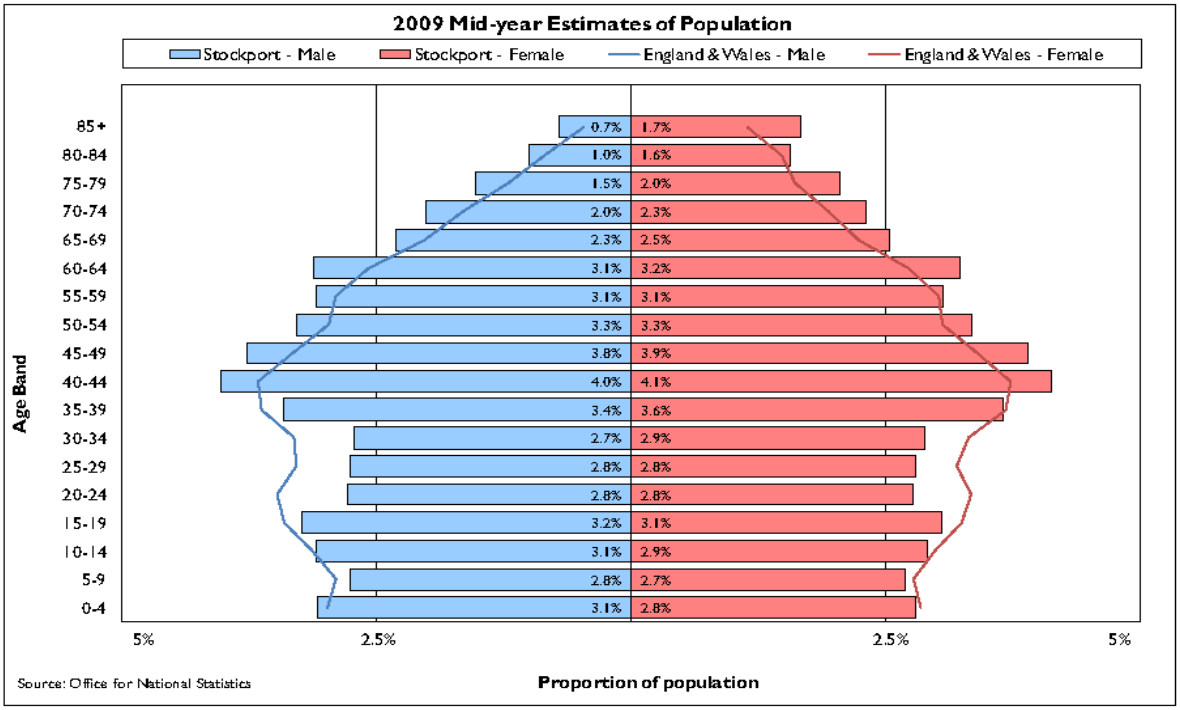
# 7. APPENDICES

## 7.1 Appendix 1 – The Stockport Context of the EIA

Health statistics in Stockport by protected characteristics

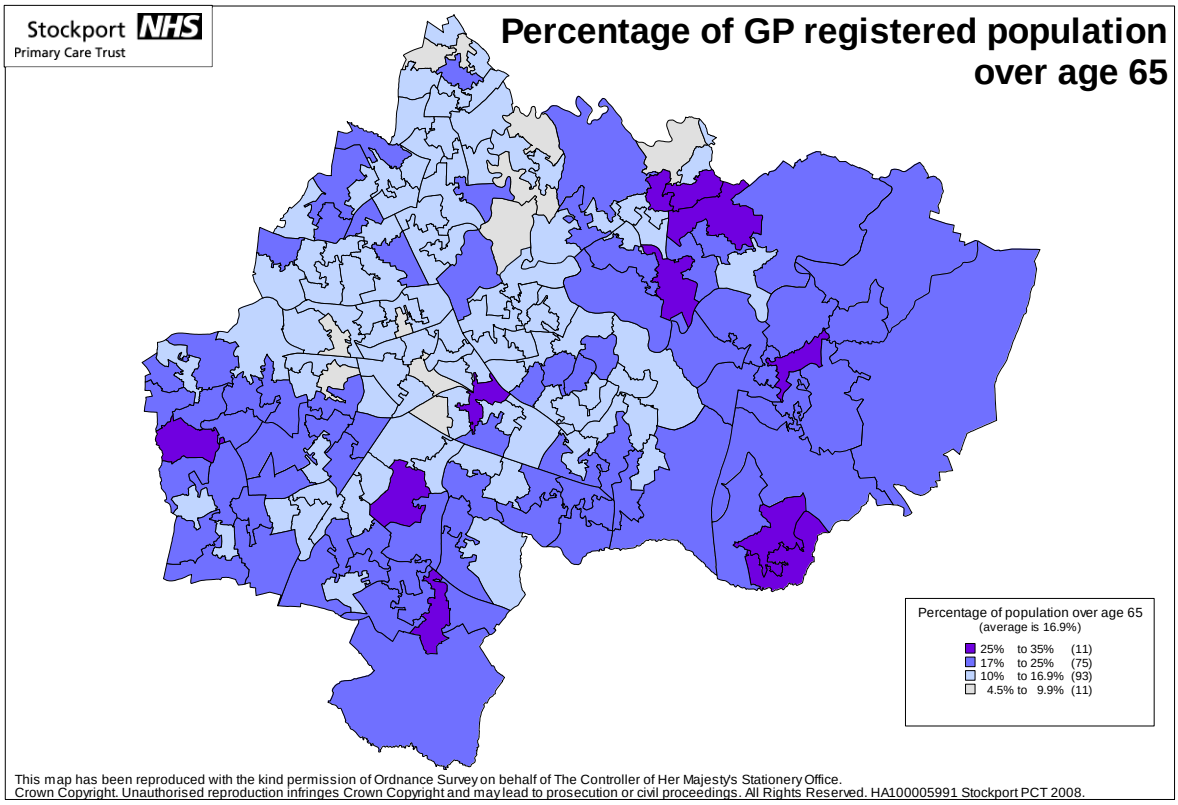
### Age

Stockport has a slightly older age profile than the national average, with a greater number of residents aged 50-59 than the national average and particularly low numbers of residents aged between 20-34 years[1].

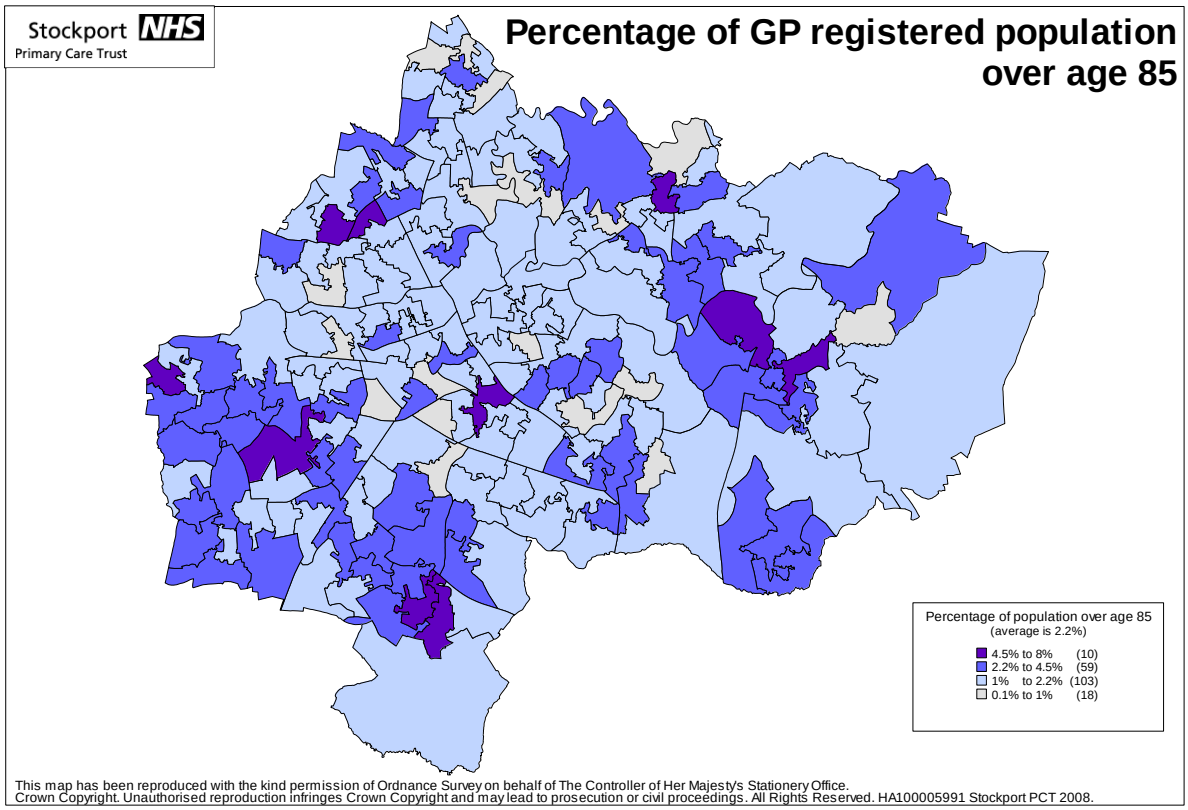



The ageing population is a major demographic trend in the borough. Currently there are 50,823 people in the borough aged 65+ and 6,682 people aged 85+, which is well above the national average.

[1] Stockport's Joint Strategic Needs Assessment, April 2011




Areas of affluence, including Bramhall, Cheadle and Marple tend to have the highest population of people aged 65+. Concentrations of those aged 85+ can be found across the borough clustering around nursing and residential homes.



Local projections based on the population size in 2009 suggest that Stockport will continue to age, with an additional 12,018 people aged over 65 by 2029.

| Year | Population | Aged 0-14 | Aged 15-64 | Aged 65+ |
|---|---|---|---|---|
| **2009** | **282,975** | **48,604** | **183,548** | **50,823** |
| 2014 | 285,975 ↑ | 48,842 ↑ | 179,795 ↓ | 57,338 ↑ |
| 2019 | 287,216 ↑ | 49,937 ↑ | 178,057 ↓ | 59,222 ↑ |
| 2024 | 285,926 ↓ | 50,423 ↑ | 174,715 ↓ | 60,788 ↑ |
| 2029 | 284,003 ↓ | 51,145 ↑ | 170,017 ↓ | 62,841 ↑ |

The biggest increase is expected within the 65-74 year age group as the post-war baby boomers move into retirement. There are likely to be 3,712 more 85+ year olds by 2029. And by 2019 as much as 20.3% of the population could be aged 65+ - an increase of 9,200 people.

The overall aging population, however, is masking an increasing birth rate. Over 3,400 babies were born to mothers resident in Stockport in 2008. This follows a national upturn in birth rates, in part due to mothers who delayed first pregnancy in the 1990s starting their families.

In addition, Stockport has seen a rise in its relatively small Black and Minority Ethnic population since the last census, among which birth rates and family size are traditionally higher. Analysis of births in 2006/07 shows that more than 10% babies born in Stockport were of Black or Minority Ethnic (BME) ancestry, which is significantly higher than the BME proportion of the local population (just 4.3% at the last census). Births of Asian and Asian British ancestries (chiefly Pakistani) were the most common.

## Age & Health

Emerging national evidence suggests that although people are living longer, the number of years for which they are living in poor health at the end of life is also increasing.

The UK's aging population is recognised as having an impact on healthcare, with 35% of people aged 75+ taking 4 or more prescribed medicines. The community healthcare services in Stockport made an estimated 60,800 district nursing contacts with people aged 65+ and an estimated 21,000 contacts with people aged 85+ in 2006/07.

Like other parts of the UK, Stockport is facing a major change in health needs as a result of the aging population. In the next five years there will be an additional 2,700 people aged 65 and over. If nothing else changes this will result in:

- 1,400 additional hospital admissions each year
- 700 additional A&E attendances
- 180 extra nursing and residential care beds (equivalent of 6 new homes)
- 3,400 additional district nurse contacts
- 900 people requiring help with domestic tasks.

At the last census in 2011, the over 65 population in Stockport reported generally good health, with 77.5% categorizing their health as 'good' or 'fairly good'. Of the 22.5% who reported 'not good health', there was a clear link to geography.

A third of people aged 65+ in Brinnington & Central ward reported that their health is not good. This is half as much again as the Stockport level. Manor and Reddish North wards also have particularly high levels. The Priority 1 areas had significantly high levels, rising to double the Stockport percentage in the Town Centre where 41.1% of people report that their health is not good. The proportion in this age group who are not in good health is about double the proportion in the 15-64 age group.

Currently 6,600 older people aged 65+ and 950 older people aged 85+ live in areas of poverty; as the population ages we can expect this level to rise as the local population ages. Brinnington and Central ward has the highest percentage of older people living in the 20% most deprived areas – this accounts for 1,652 older people and is nearly 90% of all older people in the ward. Davenport and Cale Green ward has over a quarter of older people living in the 20% most deprived areas (524 older people) and Offerton ward has a fifth (510 older people). Bredbury Green and Romiley ward also has a high number of older people living in the 20% most deprived areas (510 older people).

Cheadle & Gatley and Marple South have the highest number of older residents requiring social care.

In 2009, over 10,000 pensioners in Stockport were claiming some type of disability benefit. The rate for Stockport has gone up since 2007 from 52 claimants per 1000 residents to 60 per 1000 in 2009.The ward with the highest rate of Disability Living Allowance claimants is Brinnington & Central where there are 105.9 claimants per 1000 population. This compares to a rate of 59.5 for Stockport and 65.5 for England. Davenport & Cale Green ward and Reddish North ward also have particularly high rates.

Over 60% of people aged over 65 in Brinnington & Central reported having a long term limiting illness in the 2001 census, compared to 49% across Stockport and England. There are also high levels in Davenport & Cale Green ward and Reddish North ward. The percentage of people in this age group reporting a limiting long term illness is almost three times the proportion in the 25-64 age group.

Dementia usually affects older people and becomes more common with age. About 6% of those over the age of 65 will develop some degree of dementia, increasing to about 20% of those over the age of 85. Dementia can also develop in younger people, but is less common, affecting about 1 in 1,000 of those under 65.

Although most of the people who develop dementia are over the age of 60, it's important to remember that dementia is not a normal part of growing old, and that most people never develop dementia. Stockport's GP practices have identified a total of 1,538 people on their disease registers for dementia - a level which can be expected to increase over the next five years.

## *Predicted trends in Stockport dementia cases over time – Age & Gender*

| Trends in people with dementia – Stockport residents aged 65+ | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year | Males | | | | Females | | | | All Residents | | | |
| | 64-74 | 74-84 | 85+ | 65+ | 64-74 | 74-84 | 85+ | 65+ | 64-74 | 74-84 | 85+ | 65+ |
| 2008 | 272 | 500 | 355 | 1,127 | 226 | 956 | 1,134 | 2,316 | 498 | 1,456 | 1,489 | 3,443 |
| 2010 | 279 | 515 | 394 | 1,188 | 229 | 970 | 1,159 | 2,358 | 508 | 1,485 | 1,553 | 3,546 |
| 2015 | 305 | 561 | 473 | 1,339 | 248 | 989 | 1,235 | 2,472 | 553 | 1,550 | 1,708 | 3,811 |
| 2020 | 336 | 632 | 571 | 1,539 | 266 | 1049 | 1,336 | 2,651 | 602 | 1,681 | 1,907 | 4,190 |
| 2025 | 318 | 714 | 690 | 1,722 | 249 | 1160 | 1,512 | 2,921 | 567 | 1,874 | 2,202 | 4,643 |

Source: POPPI

Brinnington and Central ward has the highest rate of dementia in the over 16 population, followed by Reddish North ward. Both of these wards have double the Stockport rate of 6.3 per 1,000 people.

National estimates (POPPI) suggest that there is significant under-diagnosis of this condition in primary care, and that in fact there are an estimated 3,550 people aged 65+ with dementia in the area; only 40% of whom are known to primary care services.

According to the NHS Information Centre, in March 2008 there were 1,175 people aged 65+ registered as blind or partially sighted. There is a clear link between age and loss of sight: 79% of all people registered with Stockport Council as blind were aged 65 or over; and 83% of those registered as partially sighted were over 65.

| Registered with the Council as: | All people | Age: | | | | | |
|---|---|---|---|---|---|---|---|
| | | 0-4 | 5-17 | 18-49 | 50-64 | 65-74 | 75+ |
| Blind | 620 | 0 | 15 | 60 | 55 | 50 | 440 |
| Partially Sighted | 885 | 10 | 15 | 55 | 80 | 70 | 665 |
| Total | 1505 | 10 | 30 | 115 | 135 | 120 | 1175 |

However information from the RNIB suggests that 20% of the population aged 75+ will be registered as blind or partially slighted - around 4,900 people in Stockport. Work needs to be undertaken to reconcile these two different sources of information.

According to the NHS Information Centre, in March 2010 there were 710 people in Stockport registered as deaf or hard of hearing. Of these people, 565 were aged 65 or over (79.6%),and 500 were aged 75 or over (70.4%).

| Registered with the Council as: | All | Age: | | | |
|---|---|---|---|---|---|
| | | 0-17 | 18-64 | 65-74 | 75+ |
| Deaf | 135 | 0 | 90 | 10 | 35 |
| Hard of Hearing | 575 | 0 | 55 | 55 | 465 |
| Total | 710 | 0 | 145 | 65 | 500 |

Again, the link between loss of hearing and the aging process is very clear in this data. While only 33% of residents registered as deaf are 65+, local pensioners make up 90.4% of residents registered with the council as being hard of hearing.

In Stockport it is currently estimated that 7,550 people aged 65+ will not be able to manage 'mobility activities' on their own (e.g. walking out-of-doors, using the stairs or getting in or out of bed), 15,670 people age 65+ will be unable to manage 'self-care activities' on their own (e.g. bathing, feeding or cutting their toenails) and 17,100 will be unable to manage 'domestic tasks' on their own (e.g. shopping, vacuuming or dealing with personal affairs).

Rates of falls in the elderly are high in Stockport, particularly in Brinnington & Central Ward at over 8 times the national average. Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the United Kingdom.

## Carers

In 2011, 11.3% of residents said that they provided unpaid care to someone. This figure is marginally higher than the national average of 10%. 2.5% of Stockport residents also report that they provided over 50 hours of unpaid care, similar to the national average of 2.4%. With the number of people requiring complex care packages increasing and the general population ageing, the number of unpaid carers in the borough is likely to increase.

Carers are a valuable resource for the health and wellbeing economy of Stockport, but being a carer can have adverse effects on mental wellbeing and financial stability.

## Carers' Health

Local engagement indicates that many carers in Stockport are too busy caring for others to think about their own health, leading to missed appointments – particularly for preventative measures such as screening. The resulting impact is one of high stress levels and mental health problems.

## Disability

The 2011 census indicates that 18.4% of Stockport residents are living with a limiting long-term illness (long-term illness, health problem or disability which limits daily activities or work). 8 of Stockport's 21 wards have levels of limiting long term illness above the England and Wales average and all of Stockport's Priority 1 areas reported higher levels of LLTIs than the national average.

The likelihood of having a disability is not evenly spread across the population. Unsurprisingly, rates of disability increase with age, and for those aged 65+ almost half of all people reported having a long-term condition. Women are more likely than

men to have a disability, and people from some ethnic and religious groups – especially some Asian Muslims – appear more likely to report an LLTI or disability. In both cases, the differences tend to become more accentuated at older ages, so for example nearly 2 in 3 Pakistani and Indian women over 65 had a LLTI or disability in 2001.

According to the NHS Information Centre, 1,505 people in Stockport were registered as blind or partially sighted in March 2008. In March 2010 there were 710 people in Stockport registered as deaf or hard of hearing. Stockport provides social services to 4,100 adults as a result of physical disability, frailty or temporary illness and there are 4,309 wheelchair users in the borough. 900 people living in Stockport are currently registered with the Council's Learning Disability Service; 430 children living in Stockport aged 0-17 years are registered on the children's disability databases as having moderate learning disability while 70 are registered as having severe learning disability.

Another measure of the number of disabled people in Stockport is the number of vehicle badges in circulation. The Council issues vehicle badges for people who are physically or visually disabled (Blue Car Badges). In 2010, 15,100 people in Stockport held a valid Blue Badge. This equates to around 5% of the local population. However, among residents of retirement age, the figure goes up to almost 25%. (Department for Transport Statistics)

Overall in Stockport the uptake of disability related benefits is lower than the national average with 9,900 claiming Incapacity Disablement Allowance (IB/SDA) and 14,400 claiming Disability Living Allowance (DLA). The uptake of IB/SDA is high across all age groups in Brinnington & Central and Davenport & Cale Green wards, although amongst older people uptake also high in Bredbury & Woodley as well as Edgeley & Cheadle Heath, indicating a potential social care demand.

Challenges are emerging from rising numbers of people at all ages with complex care needs, highlighted particularly by commissioners but also by the public. Areas of particular concern are CAMHs (Child and Adolescent Mental Health), ADHD (Attention Deficit Hyperactivity Disorder) and autism in children and young people and autism and learning, physical and sensory disabilities for adults.

## Disability & Health

It is important to differentiate between disability and ill-health. Having a disability, impairment or long-term health condition does not automatically mean that a person is in a permanent state of poor health.

Nationally, the association between adults with LLTI/disability and poor socio-economic position is linked to the poor employment prospects of disabled people. Families with disabled children also live in greater levels of poverty – in part due to the cost of providing care and the limits that caring for a disabled child can place on parents' economic prospects. There is also evidence that you are more likely to have a child with a disability if you are from a lower socioeconomic background (Spencer, N. 2008. *Health Consequences of Poverty for Children*. London: End Child Poverty).

National research by disability charities and health organisations point to the strong link between many of the inequalities faced by people with a disability – from educational attainment and unemployment rates to bullying and hate crime – to repercussions in mental health and wellbeing.

Similarly, research into coping with long-term conditions points to an increased likelihood of suffering from stress, anxiety and depression.

In England, more people with an LLTI or a disability have a General Health Questionnaire (GHQ) score of 4 or more - indicating mental health problems - compared to people with no LLTI or disability.

| Percentage of people in England with a GHQ-12 score of 4 or more | |
|---|---|
| People with an LLTI or disability | 26% |
| People with no LLTI or disability | 7% |
| Whole Population | 13% (11% of all men / 15% of all women) |

Source: Health Survey for England 2008

Research by the Institute for Health Research at Lancaster University in 2007 suggests that children and young people with learning disabilities are 6 times more likely to have mental health problems than other young people.

There is also a clear association between disability and obesity. Medication side effects, reduced mobility and socio-economic circumstances could all increase likelihood of obesity. In the 2008 Health Survey for England, 72% of people with an LLTI did not have a healthy weight compared with 61% of those without an LLTI.

The Disability Rights Commission's Interim Report in 2005 - Equal Treatment: Closing the Gap - found that one person in three with a learning disability is obese, compared to just one in five of the general population.

## Gender Identity

Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) Transgender, Transsexual, Gender-fluid, Non-binary, Gender-variant, Crossdresser, Genderless, Agender, Nongender, Third gender, Two-spirit, Bi-gender, Transman, Transwoman, Trans masculine, Trans feminine and Neutrois.

Locally we do not have data on how many people in Stockport identify as Trans. However, approximately 1 in 11,500 people in the world are or have gone through gender transition. Since the legislation has provided protection in services and employment the numbers coming forward for gender transition has started to rise.

Gires reported a 24% increase on the previous year in 2009[2]. National estimates now suggest that 1% of the population is gender variant.

## Gender Identity & Health

Gender variance describes the personal discomfort experienced by individuals whose psychological identification as men or as women (the gender identity) is inconsistent with their phenotype and with the gender role typically associated with that phenotype. Both gender role and phenotype may, therefore, be sources of distress. The condition may be experienced to varying degrees, and be expressed in a variety of ways. These may be intermittent or permanent. Sometimes, gender variance that is initially expressed intermittently later becomes permanent.

When gender variance is profound and persistent, it is usually referred to as transsexualism. Since it is a subjective experience, it can only be diagnosed in accordance with what is said by the individuals who experience it. There are no tests that provide an absolute diagnosis. Transsexualism is neither a 'lifestyle' choice nor a mental disorder, but a condition that is now widely recognised to be largely innate and that responds well to medical care.

Trans people experience some of the most significant health inequalities and frequently experience abuse, harassment and violence.

The 'Count me In Too Survey' undertaken in Brighton and Hove in 2008, which had a small sample (N=800) and was geographically specific, nonetheless shows *possible* differences in the experience of transgender people compared to the population as a whole:

- 30% of transgender respondents (N=13) said that their physical health was 'poor' or 'very poor' compared to 8% of non-transgender respondents;
- 44% of transgender respondents (N=19) reported 'good' or 'very good' health status, compared to 77% non-transgender.

However, there is currently no clear evidence from the small amount of data available about the levels of long-standing health problems or disability in this population.

According to the Department of Health, more than 30% of trans people living in the UK report having experiences discrimination from professionals when accessing a range of health care services.

Many people may experience discomfort in their gender from a young age and attempt to repress their feelings and live according to society's rules. Regardless of social position or class after 'coming out', due to limited understanding of their lives, Trans people are at high risk of being shunned by family, friends, colleagues and social networks and these experiences place Trans people at risk of:

- Alcohol abuse
- Depression

[2] Gender Variance in the UK (GIRES June 2009)

- Suicide (1:3 have attempted suicide [UK / USA])
- Self-harm
- Violence (transphobic behaviour primarily toward MTF)
- Substance abuse

35% of the Trans population reporting having made at least one suicide attempt prior to accessing the treatment they are seeking and young people experiencing gender dysphoria are at an increased risk of self-harm and overdose.

Although social attitudes have become more accepting towards trans people, discrimination and prejudice persist, with a resulting impact on the health and wellbeing of this section of the population. These experiences place many trans people at risk of alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV.

Mental health problems can sometimes be seen as a potential symptom of wider difficulties that minorities face within society. The UK's largest survey of trans people (*N* = 872) found that 34% (more than one in three) of adult trans people have attempted suicide.

Stockport's recent LGBT Needs Assessment notes:

"There exists a lack of local and national research into trans communities, with a lack of comprehensive and system wide trans status monitoring meaning that the specific needs of this community, on a national and local level, are often not well evidenced. A 2017 assessment of the needs and experiences of trans people in the UK identified several key areas where trans people experience significant inequalities and substantial barriers, including reduced access to mainstream health and social care services; inequality within specialist gender identity services; poorer mental health; poorer social wellbeing, increased drug and alcohol use; and poorer overall health.

In 2016 Manchester City Council embarked on a series of consultations and engagement activities with local trans people and their organisations in order to improve its own data and to explore the prevailing issues and opportunities experienced by Manchester's trans population. Through this consultation, a number of thematic areas emerged which have a significant impact on the lives of trans people. These are: Young People and Education, Health, Housing, and Domestic Violence. A significant proportion of trans people had experienced transphobic bullying or discrimination, with participants also acknowledging high rates of homelessness, low levels of good health, and high prevalence of domestic abuse. It is likely that the themes and findings unearthed in national and local research will correspond to the experiences of Stockport's trans population."[3]

[3] Stockport LGBT Needs Assessment http://lgbt.foundation/assets/_files/documents/may_17/FENT__1495710514_Stockport_LGBT_Needs_Assessmen.pdf

Stockport LGBT Needs Assessment can be found at:
http://www.stockportjsna.org.uk/wp-content/uploads/2017/06/Stockport-LGBT-Needs-Assessment.pdf

## Pregnancy & Maternity

Stockport's Total Fertility Rate (TFR), calculated as the average number of children per woman, has remained between 1.5 and 2 over the past three decades, rising slightly in recent years. This has been mainly in line with the national average.

Over 3,400 babies were born to mothers resident in Stockport in 2008. This follows a national upturn in birth rates, in part due to mothers who delayed first pregnancy in the 1990s starting their families.

| Live births per 1000 population in Stockport | | | |
|---|---|---|---|
| 2005 | 2006 | 2007 | 2008 |
| 11.2 | 11.7 | 11.8 | 12.0 |

Source: Office of National Statistics

Birth rates are highest in the more deprived areas of the borough and among ethnic minority groups. In Brinnington – one of the priority areas for tackling deprivation – birth rates are 50% higher than the Stockport average.

In addition, Stockport has seen a rise in its relatively small Black and Minority Ethnic population since the last census, among which birth rates and family size are traditionally higher.

| Ethnicity Trends in Stockport Births | White British | White Other | Mixed | Asian / Asian British | Black / Black British | Other Ethnic Group |
|---|---|---|---|---|---|---|
| Hospital Births 2006/07 | 89.5% | 2.6% | 1.3% | 4.2% | 0.8% | 1.6% |
| Total Population at 2011 Census | 89% | 3.1% | 1.8% | 4.9% | 0.7% | 0.6% |

Source: Contract Minimum Dataset & ONS Census of Population 2001

Analysis of births in 2006/07 shows that more than 10% babies born in Stockport were of Black or Minority Ethnic (BME) ancestry, which is significantly higher than the BME proportion of the local population (just 4.3% at the last census).Births of Asian and Asian British ancestries (chiefly Pakistani) were the most common.

Access to Stockport's IVF services over recent years has shown in particular a high rate of service uptake by residents of Pakistani heritage - 5.6% of all patients, despite making up just 1.04% of the local population.

Education services are also reporting increasing numbers of children from BME ancestry reaching school age, along with increasing numbers of children with English as an additional language.

Patterns of birth rates show a clear deprivation profile, as deprivation increases so do the numbers of births. General fertility rates in the most deprived areas are 30% higher than the Stockport average and 65% higher than in the least deprived areas.

Infant mortality is a rare phenomenon, affecting a fraction of a per cent of children born each year.

| Age at Death | Number of Deaths | Percentage |
|---|---|---|
| 0 day | 24 | 34.8% |
| 1 day | 7 | 10.1% |
| 2-6 days | 7 | 10.1% |
| 7-13 days | 6 | 08.7% |
| 14-27 days | 5 | 07.2% |
| 28-56 days | 7 | 10.1% |
| 2-12 months | 13 | 18.8% |
| All Infants 2005-2009 | 69 | - |

Low birth weight is an enduring aspect of childhood morbidity, a major factor in infant mortality, and has serious consequences for health in later life.

In Stockport, the number of children with a low birth weight (defined by the World Health Organisation as less than 2500 grams) is lower than the national average and has remained fairly static over the last decade.

The only real exception is in Brinnington & Central ward. Over the period of 1998-2000 this ward saw a significantly higher proportion of low birth weights than the national average. Over the past decade, this rate has steadily declined to around the national average, but remains above the Stockport level.

Death in the next four years of life (age 1 to 5 years) is even more rare with on average only 2 children in this age group in Stockport dying a year. 70% of the deaths over the last 5 years have been as a result of congenital conditions and prematurity, again causes strongly associated with maternal circumstance, smoking in pregnancy and breastfeeding. 3 deaths were due to accidental causes, causes which should be preventable.

Overall childhood mortality rates in Stockport (children aged 1-15 years) are very rare, but extremely distressing for families involved. Over the past five years, the main cause of death among children aged 1-15 was accidents, assault and self-harm, which accounted to more than a third of all deaths.

| Cause | Deaths 2005-09 | |
|---|---|---|
| | Number | Percentage |
| Infectious & Parasitic Diseases | 1 | 3.6% |
| Cancer | 2 | 7.1% |

| | | |
|---|---|---|
| Endocrine, Nutritional & Metabolic Diseases | 1 | 3.6% |
| Diseases of the Nervous System | 0 | 0.0% |
| Diseases of the Circulatory System | 3 | 10.7% |
| Diseases of the Digestive System | 1 | 3.6% |
| Diseases of the Respiratory System | 3 | 10.7% |
| Congenital Anomalies | 3 | 10.7% |
| Perinatal condition | 1 | 3.6% |
| Accidents, assault and self-harm | 10 | 35.7% |
| Unascertained | 3 | 10.7% |
| Total | 28 | - |

The most common reasons for admissions to hospital in the first year of life in Stockport are respiratory and digestion conditions (especially gastroenteritis).

There are strong associations between smoking in pregnancy and the home and the risk of chest infections in children. Similarly breast feeding is known to be protective; reducing gastrointestinal disorders in babies and young children.

Infant mortality, accident rates, emergency admissions, A&E attendances, teenage pregnancy and poorer educational achievement in school are all associated with deprivation.

Immunisation is one of the most important weapons for protecting individuals and the community from serious diseases and, after clean water, is the most effective public health intervention in the world for saving lives and promoting good health.

In the United Kingdom, a full programme of vaccination is provided for children up to the age of 2 years, with certain boosters before they join mainstream education, to be taken before they reach 5 years. The primary course protects against diphtheria, tetanus, pertussis (whooping cough), polio, haemophilus influenza type b, pneumococcal infection and meningitis C and is given in a series of injections in the first year of life.

After a child reaches 1 year of age they are also offered the MMR vaccine which protects against measles, mumps and rubella (German measles).

## Pregnancy and Maternal Health

Smoking during pregnancy is a key determinant of low birth weight, which in turn is the single most important risk factor in perinatal and infant mortality. Maternal smoking also impacts negatively on the likely future health outcomes of a child.

| Smoking in pregnancy – all Stockport mothers | | | | |
|---|---|---|---|---|
| | 2006/07 | 2007/08 | 2008/09 | 2009/10 |
| Number of maternities | 3,279 | 3,316 | 3,374 | 3,419 |
| Proportion of mothers smoking | 12.4% | 15.7% | 16.4% | 17.8% |

Over recent years, the number of mothers smoking has risen to almost a fifth.

The main focus for NHS Stockport is on reducing levels of smoking during pregnancy – particularly in deprived areas where the smoking rates and fertility rates are higher.

Breastfeeding is accepted as the best form of nutrition for infants, providing all the nutrients a baby needs to ensure the best start in life. Exclusive breastfeeding is recommended for the first six months of an infant's life.

Breastfeeding initiation is a good proxy indicator for infant health as infants who are not breastfed are five times more likely to be admitted to hospital with infections in their first year of life.

Figures show that in 2006/07 72.4% of mothers in Stockport initiated breastfeeding and that 40.5% of new mothers sustained breastfeeding to at least 4 weeks - these figures represented a marked improvement in the long-term trend.

With increased investment in health promotion, this trend has continued to rise, so that in 2009/10, 73.8% of all mothers who delivered babies in Stockport were initiating breastfeeding.

## Race

When compared to the national average, Stockport is not particularly ethnically diverse, however, over recent years the ethnic diversity of the borough has increased significantly. In 2001 only 4.3% of the population were from non-white ancestry compared to 8.7% nationally. By the 2011 census 9.6% of Stockport's population came from a non-White background, compared to14.5% nationally.

| Ethnic Group | | Stockport | North West | England |
|---|---|---|---|---|
| White | All white categories | 90.4% | 90.2% | 85.5% |
| | British | 89.0% | 87.1% | 79.8% |
| | Irish | 1.4% | 0.9% | 1.0% |
| | Gypsy or Traveller | 0.0% | 0.1% | 0.1% |
| | Other White | 1.7% | 2.1% | 4.6% |
| Mixed | All mixed categories | 1.8% | 1.6% | 2.2% |
| | White and Black Caribbean | 0.6% | 0.6% | 0.8% |
| | White and Black African | 0.3% | 0.3% | 0.3% |
| | White and Asian | 0.5% | 0.4% | 0.6% |
| | Other Mixed | 0.4% | 0.3% | 0.5% |
| Asian | All Asian categories | 4.9% | 6.3% | 7.7% |
| | Indian | 1.0% | 1.5% | 2.6% |
| | Pakistani | 2.4% | 2.7% | 2.1% |
| | Bangladeshi | 0.2% | 0.7% | 0.8% |
| | Chinese | 0.6% | 0.7% | 0.7% |
| | Other Asian | 0.7% | 0.7% | 1.5% |

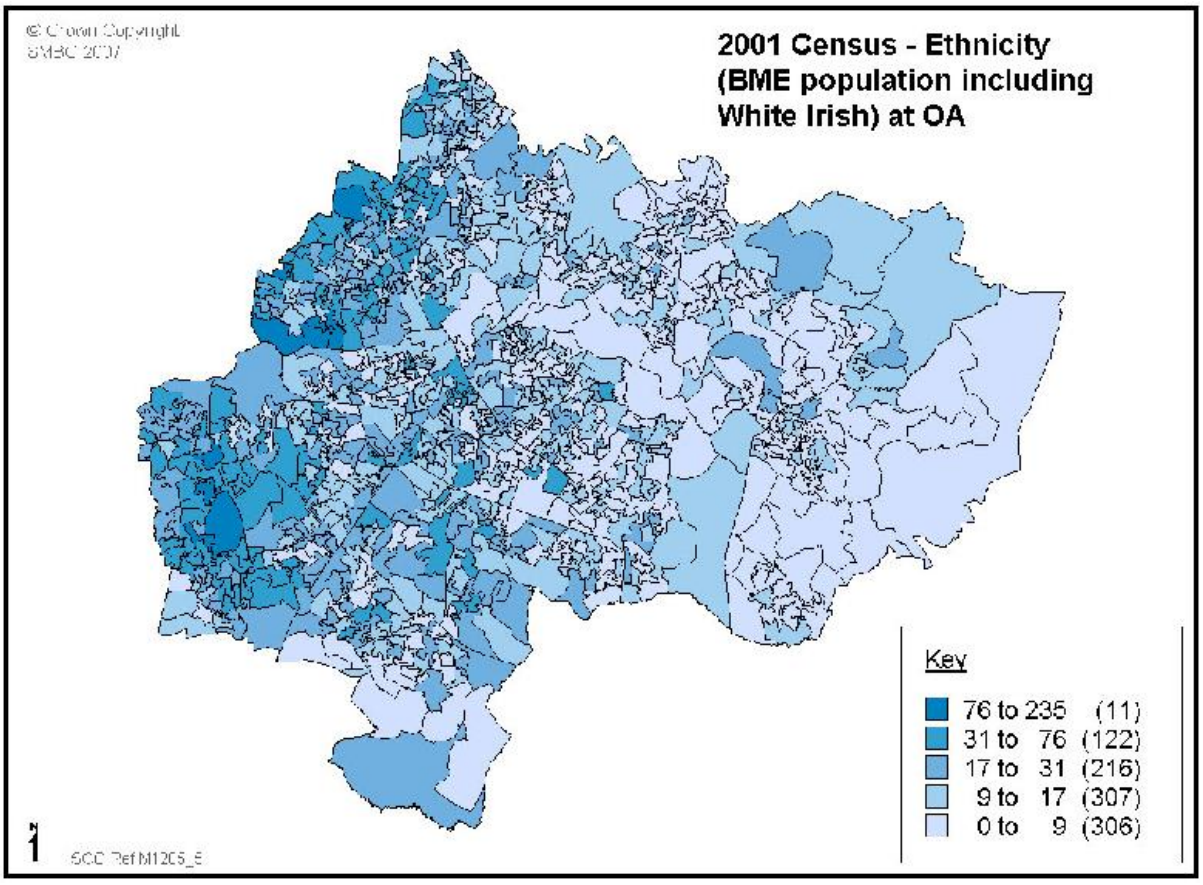
| | | | | |
|---|---|---|---|---|
| Black | All Black categories | 0.7% | 1.3% | 3.4% |
| | Caribbean | 0.3% | 0.3% | 1.1% |
| | African | 0.3% | 0.8% | 1.8% |
| | Other Black | 0.1% | 0.2% | 0.5% |
| Other | All other categories | 0.6% | 0.60% | 1.0% |
| | Arab | 0.3 | 0.3% | 0.4% |
| | Other Ethnic Group | 0.3% | 0.3% | 0.6% |

Source: 2011 Census

Stockport's ethnic minority populations have a younger age profile on average than the White British population. In 2007, 9.8% of primary school children and 6.9% of secondary school children were from Black and Minority Ethnic groups. In 2006/07, 8.8% of babies born were from Black and Minority Ethnic groups.

These trends clearly indicate a continuous growth in Stockport's Black and Minority Ethnic population, which needs to be considered when planning services and undertaking consultation.

The geographical spread of ethnic communities indicates a clear east-west divide, with the Eastern side of the borough exhibiting less ethnic diversity, while minority communities tend to live in the western side of the borough, closer to central Manchester.



To the west, Marple & Bredbury, have the least ethnic diversity, with above average white populations. To the East, Cheadle, Gatley & the Heatons have the most diversity.

Stockport's Black population is particularly under-represented in Marple and Hazel Grove. Significantly, the pockets of larger black communities are to be found in some of the borough's more deprived wards like Offerton or Brinnington & Central.

Heald Green, Cheadle & Gatley and Heatons North wards have particularly well established Asian communities.

Mixed race communities are well represented in the Heatons, Cheadle & Gatley, as are the Chinese community and other ethnic minorities.

## Race & Health

Every individual's health is influenced by a number of factors, including their genes, their experiences in life, and the quality of care and treatment they receive when they need it. A person's ethnicity is a complex mix of their country of origin, ancestry, culture, language and religion. Different elements in this picture will be more or less important at different points in time and in different contexts.

National evidence indicates that Pakistani and Bangladeshi groups are more likely to report 'poor' health than average. These groups are more likely to experience poor mental health, more likely to report a disability or limiting long-term illness, and more likely to find it hard to access and communicate with their GPs than other groups. It is unclear how far these worse-than-average outcomes are related to Pakistani and Bangladeshi people's relatively poor socio-economic position.

At the last census, there were marked variations in rates of long-term illness or disability which restricted daily activities between different ethnic groups in England and Wales. After taking account of the different age structures of the groups, Pakistani and Bangladeshi men and women had the highest rates of disability. Rates were around 1.5 times higher than their White British counterparts. Chinese men and women had the lowest rates.

In some groups the difference between men and women in their rates of disability was much greater than in others. In the Indian, Pakistani, Black Caribbean and Black African groups, women had higher rates than men. In the White British and White Irish groups it was men who had higher rates than women.

Statistically, BME groups have higher rates of diabetes, smoking, heart attacks, cancer, and mental health problems, but lower levels of screening and healthcare access.

New migrant communities have different health needs from established minority communities, and increasing ethnic, linguistic and cultural diversity demands new responses from health services.

Asylum seekers and refugees have particular health concerns due to the impact of relocation and possible past experience of trauma. Research is generally limited on their general levels of health due to the hidden nature of the population.

Asylum seekers and refugees may be affected by:

- the impact of detention, particularly on children if they are detained
- Difficulties accessing GP treatment and consequent increased reliance on Accident and Emergency services
- Uncertainty and lack of clarity among service providers about asylum seekers' eligibility for secondary healthcare services resulting in care being withheld in some cases
- Inadequate response to communicable diseases, particularly Tuberculosis.
- The health of asylum seekers with HIV/AIDs is negatively affected by the policy of dispersal at short notice and chargeable HIV treatment for refused asylum seekers. Also the human rights implications around the deportation of failed asylum seekers with HIV/AIDS

Ethnicity is not systematically recorded by cancer registries in the UK. As a result, the evidence of potential cancer inequalities within and between BME communities is often produced through smaller scale studies, which are statistically less reliable.

*Cancer Incidence By Major Ethnic Group, England, 2002 – 2006*

| Age | White | Asian | Black | Chinese | Mixed | Other | Unknown | Total |
|---|---|---|---|---|---|---|---|---|
| 0-64 | 136,889 | 3,270 | 2,562 | 331 | 578 | 1,403 | 43,230 | 188,263 |
| 65+ | 298,279 | 3,415 | 3,978 | 320 | 480 | 1,791 | 102,069 | 410,332 |
| All | 435,168 | 6,685 | 6,540 | 651 | 1,058 | 3,194 | 145,299 | 598,595 |

Source: Hospital Episode Statistics (HES)

Generally, people from black and minority ethnic groups are at a significantly lower risk of getting cancer than the white population. However, differences were found for some specific cancers:

- Asians are at a significantly lower risk of getting any of the four major cancers (breast, prostate, lung and colorectal), plus several other less common cancer sites (including cancers of the bladder, brain and CNS, kidney, oesophagus, ovary, pancreas and malignant melanoma of the skin)
- Black communities have a significantly lower risk of getting three of the four major cancers (breast, lung and colorectal), plus several other less common cancer sites (including cancers of the bladder, brain and CNS, oesophagus, ovary, pancreas and malignant melanoma of the skin)
- Both the Chinese and Mixed ethnic groups tended to have significantly lower incidence rates than Whites for each of the four major sites of cancer examined
- Mouth cancer rates are higher among Asian women and South Asians of both genders
- Asian women aged 65 and over have a higher risk of cervical cancer, but under the age of 65 the chances of getting cervical cancer are significantly lower among Asian women than white women

- Liver cancer is between 1.5 and 3 times more likely in Asians than in Whites
- In comparison with white ethnic groups, black people have significantly higher rates of multiple myeloma and stomach cancer
- Black males of all ages have significantly more likely to have a diagnosis of prostate cancer than white men
- Both males and females from the Black ethnic group also have higher rates of cancers of the stomach, liver as well as myeloma
- Black females, aged 65 years and over, have a higher risk of cervical cancer compared with Whites
- And a 2008 study suggests that breast cancer occurs at a younger age, and as a more aggressive tumour type among black women (Rowen et al., Early onset of breast cancer in a group of British black women, British Journal of Cancer, 2008).

Lifestyle behaviours of different ethnic groups have a big impact on cancer rates – some positive and some negative:

- BME communities tend to eat more fruit and vegetables than the general population
- BME groups also tend to have a lower fat intake in their diets
- BME communities, apart from the Irish, were found to be much less likely to exceed recommended drinking levels or binge drink
- Minority ethnic groups tend to have lower levels of participation in exercise
- Black African and Black Caribbean communities are more likely to be obese than the general population
- Among men smoking rates appear to be higher among a range of different BME communities, including Bangladeshi, Caribbean, and Chinese
- For women, rates of smoking are generally lower in BME communities
- BME communities tend to have higher levels of chewing of tobacco and related products. Although nationally this is quite rare, a study of the Bangladeshi community for the British Dental Journal found 78% of those questioned chewed tobacco products. (Williams, Dental services for the Bangladeshi community, British Dental Journal, 1999).

Awareness and access to screening programmes is another major factor. Nationally, Black and Minority Ethnic groups are less likely to take part in cancer screening programmes. 43% of Black and Minority Ethnic Women do not practice breast awareness at home, 45% of Black and Minority Ethnic Women over 50 years have never been to a breast screening, 75% of which say this is because they have never been invited.

Attitudes to using preventative services and to specific diseases, as well as the (real or perceived) attitudes of service providers to BME individuals, may act as barriers to uptake of vital screening services. At the same time it is important to remember that BME communities are dynamic between generations, with second generation migrants often having information and support needs more similar to the indigenous population, rather than those of their parents.

Only half of people who are of South Asian heritage are likely to take up bowel cancer screenings, which drops to a quarter for Muslims. This is in comparison to two-thirds of people who are not Muslim or not of South Asian heritage.

There is considerable research nationally which demonstrates that South Asian people living in the UK are 50% more likely to die from coronary heart disease that there White counterparts. (Bhopal et al 'Ethnicity and socioeconomic inequalities in coronary heart disease, diabetes and risk factors in Europeans and South Asians', *Journal of Public Health Medicine*, 25, 2, pp. 95–105, 2004). Men born in South Asian but living in the UK are 50% more likely to have a heart attack or angina and Black adults living in the UK but born in the Caribbean are 50% more likely to die from a stroke related incident that the UK average (Race for Health).

Patterns of mental wellbeing by ethnicity are complex and there are ongoing debates as to how assessment of this issue is affected by cultural and or linguistic differences. In the Health Survey for England 2004, Pakistani men and women, and Bangladeshi men had higher risk of high GHQ-12 scores than the general population

| Percentage of people with a GHQ-12 score 4 or more by ethnicity | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Gender | | Black Caribbean | Black African | Indian | Pakistani | Bangladeshi | Chinese | Irish | General Population |
| Male | GHQ of 4+ | 13% | 11% | 16% | 15% | 18% | 9% | 12% | 11% |
| | Risk ratio | 1.21 | 0.88 | 1.32 | 1.56 | 1.83 | 0.76 | 1.08 | 1 |
| Female | GHQ of 4+ | 18% | 19% | 14% | 20% | 15% | 13% | 15% | 15% |
| | Risk ratio | 1.27 | 1.19 | 0.99 | 1.73 | 1.37 | 0.83 | 0.95 | 1 |
| Risk ratios compared the prevalence for a given ethnic minority group with the prevalence in the general population, after adjusting for age in each group. For example, a risk ratio of 2.0 means that a particular group is twice as likely as the general population to have that condition. | | | | | | | | | |

Source: Health Survey for England 2004

Rates of admission and of compulsory detention in mental health institutions are higher among Black Africans, Black Caribbean, mixed White/Black Caribbean, White/Black African and also Black other groups which represents an enduring and worrying inequality (Care Quality Commission 2009. *Count me in 2009)* – a factor which may be reflected in the higher rates of suicide among young Black Caribbean and Black African men aged 13-24 years.

Black and Minority Ethnic people in the UK are up to 44% more likely to be detained under the Mental Health Act compared to the average, and rates of admission into hospital are three or more times higher for black and white-black mixed groups compared with the average.

The rate of depression is 60% higher in BME groups, and young Asian women are twice as likely as young white women to commit suicide.

Almost one in five people of South Asian origin living in the UK will develop diabetes, compared to one in twenty-five among the general population. This increased prevalence is coupled with earlier disease onset: UK South Asian people tend to develop diabetes eleven years earlier than their white counterparts (at age forty-six versus age fifty-seven) and at a Body Mass Index less than their white counterparts (Mukhopadhyay *et al*., 'A comparison of glycaemic and metabolic control over time among South Asian and European patients with Type 2 diabetes', *Diabetic Medicine*, 2006).

According to research as part of the 1999 Health Survey for England, Bangladeshi men were the most likely group in England to smoke cigarettes (44%), followed by White Irish (39%) and Black Caribbean men (35%). Men from each of these ethnic groups were more likely to smoke than men in the general population (27%). Chinese men (17%) were the least likely to smoke.

Similar proportions of Pakistani (26%) and Indian (23%) men smoked as in the general population.

Like men, White Irish and Black Caribbean women had the highest smoking rates in 1999 (33% and 25% respectively), although only White Irish women had a rate higher than the general population (27%). However, unlike men, women in every other minority ethnic group were much less likely to smoke than women in the general population.

Although very few Bangladeshi women smoked cigarettes, a relatively large proportion (26%) chewed tobacco. This method of using tobacco was also popular among Bangladeshi men (19%), but they tended to use it in conjunction with cigarettes.

## Religion or Belief

The majority of Stockport residents are Christian (63.2% - down from 75% at the last census), which is 4% greater than the national average. 25.1% of Stockport residents have no stated religion, which is 11% higher than at the previous census.

| Religion | Stockport % | National Figure |
|---|---|---|
| Buddhist | 0.3% | 0.5% |
| Christian | 63.2% | 59.4% |
| Hindu | 0.6% | 1.5% |
| Jewish | 0.5% | 0.5% |
| Muslim | 3.3% | 5.0% |
| Sikh | 0.1% | 0.8% |
| Other religion | 0.3% | 0.4% |
| No religion | 25.1% | 24.7% |
| Religion not stated | 6.5% | 7.2% |

Compared to England, Stockport has fewer residents with a religion that is not Christian. However, over the past decade the numbers have increased significantly from 3.7% to 5.1% of Stockport residents.

## Religion & Health

Religious belief may affect the acceptability of aspects of medical care (e.g. diagnostic procedures, certain types of treatment) and also of the potential impact of religious observances on health and/or treatment plans e.g. during periods of fasting.

Nationally, statistics point to a link between religion or belief and health. In particular, minority religious groups in the UK exhibit worse general health. However, locally this correlation is less apparent, possibly due to the geographic spread of Stockport ethnic and religious minority groups, who are less likely to be concentrated in areas of deprivation than the national trends.

The 2001 Census data for Britain revealed large differences in self-reported 'not good' health between religious groups. Among men, 'not good' health was highest among Muslims (13%) and those reporting 'Any other religion' (12%) and lowest among Jewish men (7%).

Among women, the highest percentage was again among Muslims (16%) with the percentage among Sikhs (14%) and 'Any other religion' (14%) also being high, and lowest again among the Jewish group (7%) (compared to around 8% for Christian men and women).

Locally, health reporting among the Christian population mirrors almost exactly the Stockport trends.

| Religion | Good Health | Fairly Good Health | Not Good Health | Life Limiting Illness |
|---|---|---|---|---|
| Buddhist | 60.26% | 30.46% | 8.79% | 12.87% |
| Christian | 67.79% | 22.52% | 9.69% | 18.98% |
| Hindu | 72.93% | 20.09% | 5.83% | 13.27% |
| Jewish | 77.20% | 15.84% | 6.12% | 13.38% |
| Muslim | 73.52% | 19.18% | 6.94% | 13.10% |
| Sikh | 57.27% | 21.59% | 5.29% | 13.22% |
| Other religion | 59.57% | 27.93% | 9.72% | 25.46% |
| No religion | 74.67% | 19.03% | 6.32% | 10.92% |
| Religion not stated | 72.36% | 19.05% | 8.58% | 19.39% |
| All Stockport | 69.61% | 21.82% | 9.09% | 17.80% |

The local Hindu, Jewish & Muslim populations reported above average levels of 'good health' compared to the average Stockport population.

While the Buddhist, Christian, Sikh & 'other religion' communities reported lower than average levels of 'good health' this was made up for by significantly higher than average levels of 'fairly good health'.

'Not good health' was particularly low among the Hindu and Sikh communities.

And reports of 'life limiting illness' were fairly consistent across religious groups, the lowest reports being among atheists and the highest among 'other' religious groups.

## Sex

Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend.

| Area | Population | Male | % | Female | % |
|---|---|---|---|---|---|
| Stockport | 283,700 | 138,400 | 48.9% | 144,875 | 51.1% |
| Greater Manchester | 2,601,000 | 1,325,455 | 49.4% | 1,357,073 | 50.6% |

However, significant differences appear in the gender breakdown of older people with 19.3% of people over 65 being women – also reflected nationally.

Life expectancy in Stockport is higher for women at 83 years, compared to 79.7 years for men.

New experimental evidence for healthy life expectancy suggests that women, although living longer, experience disability at an earlier age than men. Locally, female healthy life expectancy is 64.9 years compared to 65.5 years for men. This is an important finding if proven; a thorough investigation of healthy life expectancy locally is on-going.

## Gender & Health

Nationally, there is evidence across a range of health services that patterns of access, uptake and treatment diverge between women and men. The patterns are, however, complex, so that both men and women appear to be disadvantaged in some areas of healthcare.

Men tend to access GP services less often than women – this may only in part be based on need but on the appropriateness of services and how accessible they are to men. They also appear to ignore symptoms of ill health and delay seeking healthcare more often than women.

Men may be more likely than women to self-medicate in harmful ways, e.g. through use of alcohol and drugs when experiencing mental distress.

However, there is evidence that maternity services frequently fail to provide satisfactory services to women, and particularly to women from ethnic minority backgrounds (Allmark 2010).

Cancer became the most common cause of death for females in 2006 and remained the second most common cause of death for males. For males, death rates from cancer peaked in 1984 at 2,899 per million and subsequently fell to 2,201 per million in 2006. Death rates from cancers for females reached a peak in 1989, at 1,905 per million, and then fell gradually to 1,569 per million in 2006.

Between 1971 and 2008, the age-standardised incidence of cancer has increased by around 24 % in males and 49 % in females.
There is evidence from varied sources that men are less likely than women to take up preventive measures, such as screening. For instance, the evaluation of phase 2 of the National bowel cancer screening programme in England found lower rates of uptake in men than women (48% versus 56%).

| Area | Number of Cancer Registrations | | Number of Deaths | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| Stockport | 643 | 658 | 399 | 383 |
| North West | 14,700 | 15,000 | 9,640 | 8,990 |
| England | 105,000 | 107,000 | 67,300 | 61,900 |
| UK | 134,000 | 136,000 | 85,100 | 78,500 |

There are clear gender differences when specific mental health disorders are examined. Anxiety, depression and eating disorders are more commonly reported in women, substance misuse and anti-social personality disorders are more commonly reported in men.

For men, there are particular concerns around the under-diagnosis, and therefore lack of treatment for mental health conditions which are not captured in evidence in the previous points. These are believed to account, at least in part, for the much higher risk to men of becoming homeless or being imprisoned, for example.

Nationally, women are more likely than men to receive treatment for minor mental health conditions. However, more than twice as many male as female psychiatric inpatients are detained and treated compulsorily (Allmark 2010).

Men (66%) are significantly more likely than women (55%) to be overweight or obese. However, despite this men are hugely under-represented in weight management programmes. For example, only 26% of people attending scheduled weight loss management programmes in GP practices, 26% of participants of in “Counterweight”, a national primary care intervention programme, and 12% of attendees of a pilot partnership programme involving “Slimming World” were men.

National data suggests that women are more likely to eat healthily than men, but many women do not get enough exercise.

## Sexual Orientation

There is a lack of reliable data available regarding the profile of lesbian, gay & bisexual community in Stockport and indeed in the UK. However, the government estimates that between 5% and 7% of the UK population is lesbian or gay, which is also accepted by Stonewall. This would equate to around 14-20,000 people in the borough.

In the 2009-10 Integrated Household Survey included a question about sexual orientation for the first time.

- 95% of adults identified themselves as Heterosexual/Straight
- 1% of adults identified themselves as Gay or Lesbian
- 0.5% of adults identified themselves as Bisexual
- 0.5% identified themselves as 'Other' •
- just under 3% of adults stated they 'Don't know' or Refused the question
- fewer than 1% of respondents provided No response to the question

| Sexual Identity | Men | Women | All Adults |
|---|---|---|---|
| Heterosexual / Straight | 94.6% | 94.9% | 94.8% |
| Gay / Lesbian | 1.3% | 0.6% | 1.0% |
| Bisexual | 0.3% | 0.7% | 0.5% |
| Other | 0.5% | 0.5% | 0.5% |
| Don't know / Refusal | 2.8% | 2.9% | 2.8% |
| No response | 0.6% | 0.4% | 0.5% |

Source: Integrated Household Survey April 2009 – March 2010, ONS

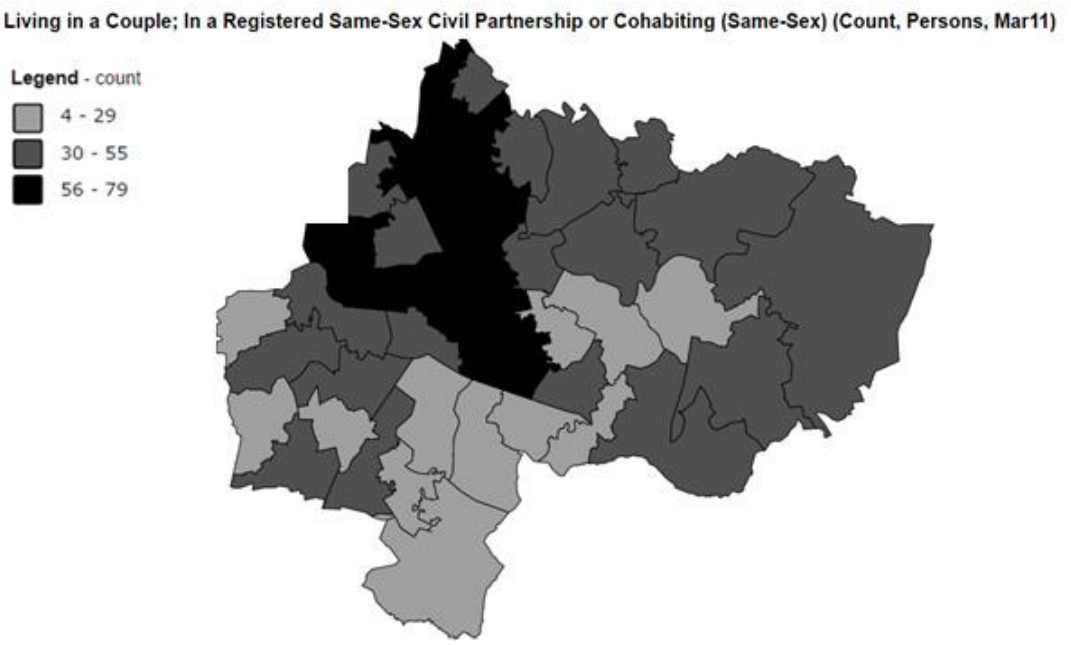
Broken down by region, the percentage of respondents identifying themselves are gay / lesbian or bisexual adults goes up to around 1.5% in the North West.

0.2% of people in the 2011 census were in a civil partnership – a figure which is consistent across Stockport, the North West and nationally.

In 2017 Stockport published its first ever LGBT Health Needs Assessment.

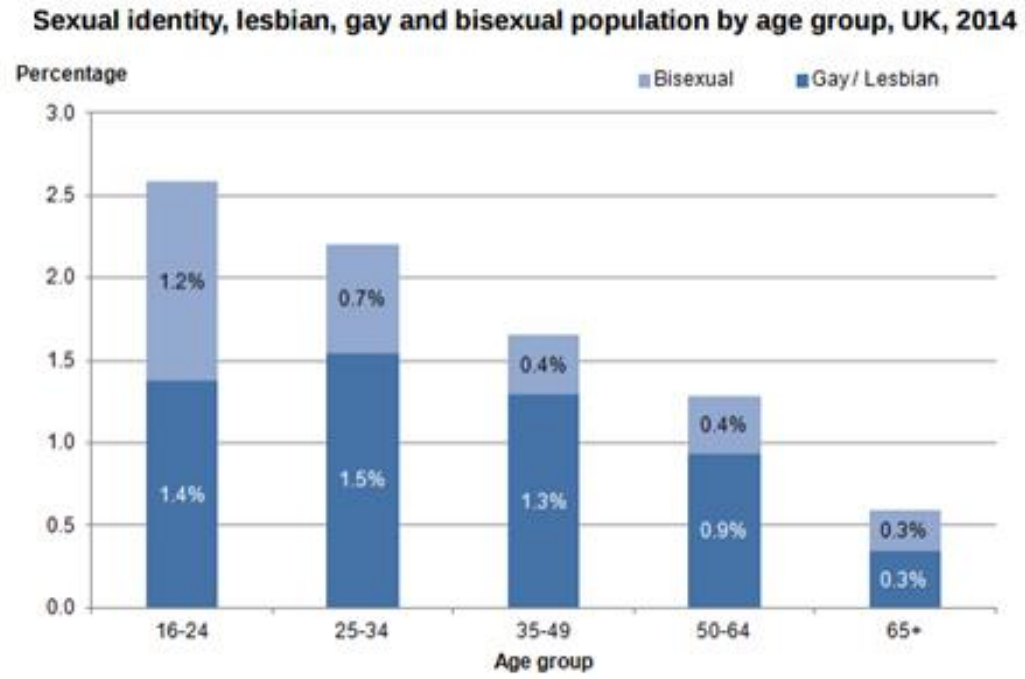
Local research demonstrates that those in younger age groups are more likely to identify as LGBT, probably due to the increase in social acceptability of 'coming out' within this age group . This may account for the higher percentage of LGB people in work and lower percentage retired than for the heterosexual population of Stockport. This is likely to change over time, as these individuals age, leading to an overall increase in the percentage of the population.

Stockport's highest concentration of LGBT people appears to be in the North West of the town. This is likely to continue to be the case due to expected changes in housing.



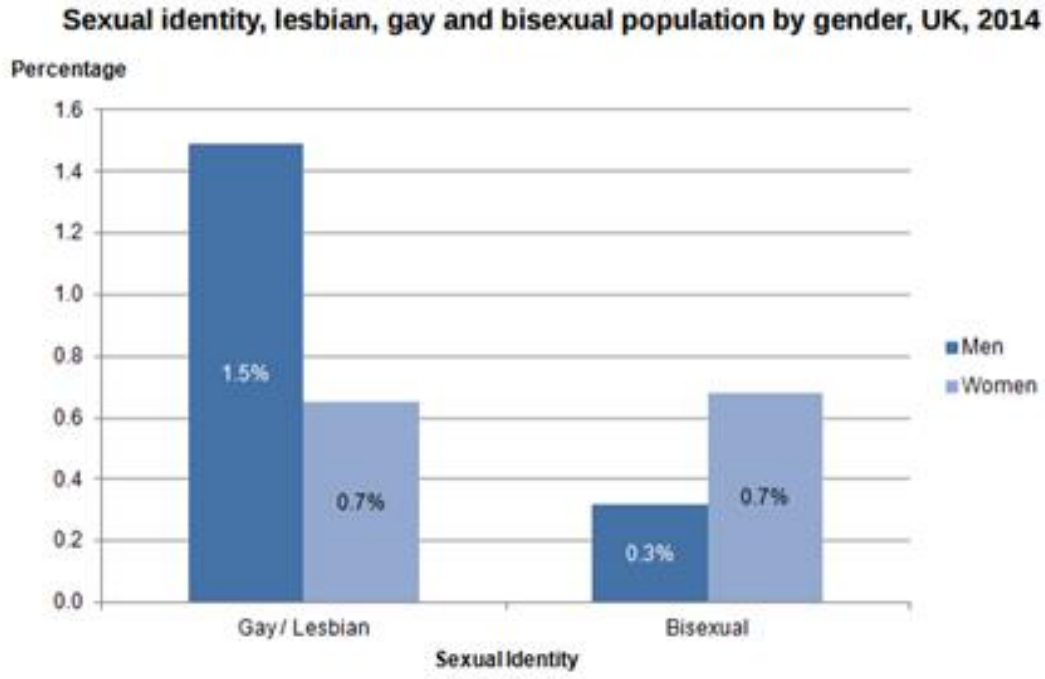

The Integrated Household Survey 2014 found the likelihood of an adult declaring an LGB identity decreased with age. In 2014, 2.6% of adults aged 16 to 24 identified as LGB, decreasing to 0.6% of adults aged 65 and over. A YouGov poll in 2015 found that 49% of young people did not identify as exclusively heterosexual[4], which may indicate higher prevalence of LGB identities within the under-18 age group, or a higher prevalence of willingness to be open about having an LGB identity within this age group.

[4] YouGov Poll, August 2015. Available: https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/7zv13z8mfn/YG-Archive-150813-%20Sexuality.pdf




Source: Integrated Household Survey - Office for National Statistics

In 2014, twice as many men responding to the IHS identified themselves as gay (1.5%) when compared with women who identified themselves as gay or lesbian (0.7%). By contrast, women were more than twice as likely to identify themselves as bisexual (0.7%) compared to men (0.3%). These statistics are closely matched with the 2013 IHS.



## Sexual Orientation & Health

Data for England and Wales from the Citizenship Survey in 2007 indicates that perceived health levels for LGB respondents were largely similar to heterosexual respondents, and similarly that there is no significant difference between levels of LLTI/disability.

*Prescription for change*, a large-scale opportunistically recruited survey which explored the general health of over 6,000 lesbian women from England, Scotland and Wales reported similar findings: 80% of lesbians who completed the survey reported good or excellent health whilst 2% reported 'not good' health.

In the 2009/10 household survey, gay men and lesbian women (80.4%) were marginally more likely than heterosexuals (78.8%) to report being in good health, but bisexuals (73.6%) were much less likely to report being in good health.

Adults aged over 18 who identified as LGB were more likely to be smokers, or to have smoked in the past, than those who identified as heterosexual:

- 22.7% of heterosexual respondents reported currently smoking cigarettes and 34.9% were ex-smokers.
- In comparison, 33.3% of people who identified as LGB currently smoked and 32.4% were ex-smokers
- 42.4% of adults who identified as heterosexual have never smoked, compared with 34.3% of people who identified as LGB
- Adults aged 18 and over who identified as bisexual were less likely to smoke than those who identified as gay or lesbian: 39.8% of bisexual respondents had never smoked compared with 31.5% of gay and lesbian respondents.

Although the majority of LGB people do not experience poor mental health, research suggests that some LGB people are at higher risk of mental disorder, suicidal behaviour and substance misuse.

According to Stonewall, 42% of gay men have clinically recognised mental health problems compared with just 12% of predominantly heterosexual men, but 55% of gay men are scared to come out to their GPs due to fear of homophobia or confidentiality issues .

Gay men are at higher risk of sexually transmitted infections (STIs), including chlamydia, syphilis, hepatitis and herpes. Rates of gonorrhoea among gay men in England have climbed steadily over the last 10 years. GMFA estimates that in 2005 almost 4,000 gay men were treated for gonorrhoea in sexual health clinics in England, with incidence being considerably higher in London than in other areas (Gay Men Fighting AIDS www.gmfa.org.uk/).

Health behaviour can differ between lesbian women and heterosexual women: they attend less frequently for routine screening tests such as mammography and cervical smears, and may therefore be less likely to benefit from early detection of cancers (Cochran, SD, Mays, VM, Bowen, D et al. (2001) Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women, *American Journal of Public Health*).

National data makes it clear that there is a real gap in awareness about cancer screening needs – both among lesbian women and healthcare professionals:

- as few as 64% of lesbians, compared to 80% of all women, have had a cervical screening in the past 3 years
- 15% of lesbian and bisexual women over the age of 25 have never had a cervical screening, compared to 7% of women in general
- over half of lesbians have had no sexual health screening in the last 3 years
- approximately 75% of lesbians have had sexual intercourse with the opposite sex, but penetrative sex is not the only contributing factor to cervical cancer
- 10% of lesbians have shown smear abnormalities

In a national survey, 12% (128 out of 1,066) of eligible lesbians had never had a smear test. Those surveyed were also less likely to practise breast awareness on a regular basis and were less likely to re-attend for breast screening (Fish, J and Anthony, D (2005) UK national lesbians and health care survey, *Women and Health*).

Being lesbian is not a risk factor for breast cancer, but there are a number of lifestyle issues that may increase their risk (Fish, J and Wilkinson, S (2003) Understanding lesbians' healthcare behaviour: the case of breast self-examination, *Social Science and Medicine*), such as being:

- more likely to delay childbirth (until their 30s);
- less likely to have children;
- less likely to seek regular gynaecological care;
- more likely to be overweight; and
- more likely to drink alcohol than heterosexual women.

Stockport LGBT Needs Assessment can be found at:
http://www.stockportjsna.org.uk/wp-content/uploads/2017/06/Stockport-LGBT-Needs-Assessment.pdf

## Socio-Economic Status

Although Stockport as a whole is a relatively affluent borough, there are particular areas within the borough that have high levels of deprivation.

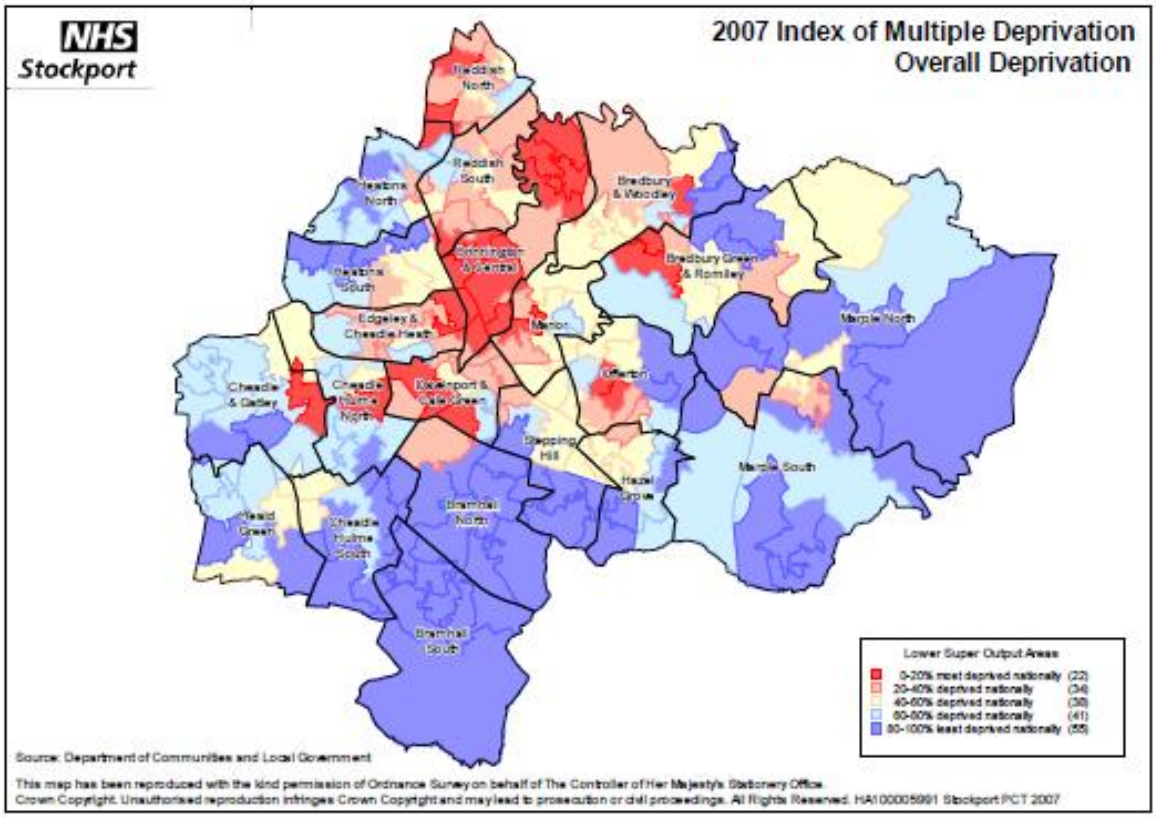
Heaton's & Tame Valley are the most deprived areas, especially the Brinnington & Central wards. Other significant areas of deprivation are Stepping Hill & Victoria. There are also smaller pockets of deprivation in Bramhall & Cheadle and Marple & Werneth that are masked by analysis even at ward level.

11% of the population live in one of 22 small areas that fall within the top 20% most deprived in England.

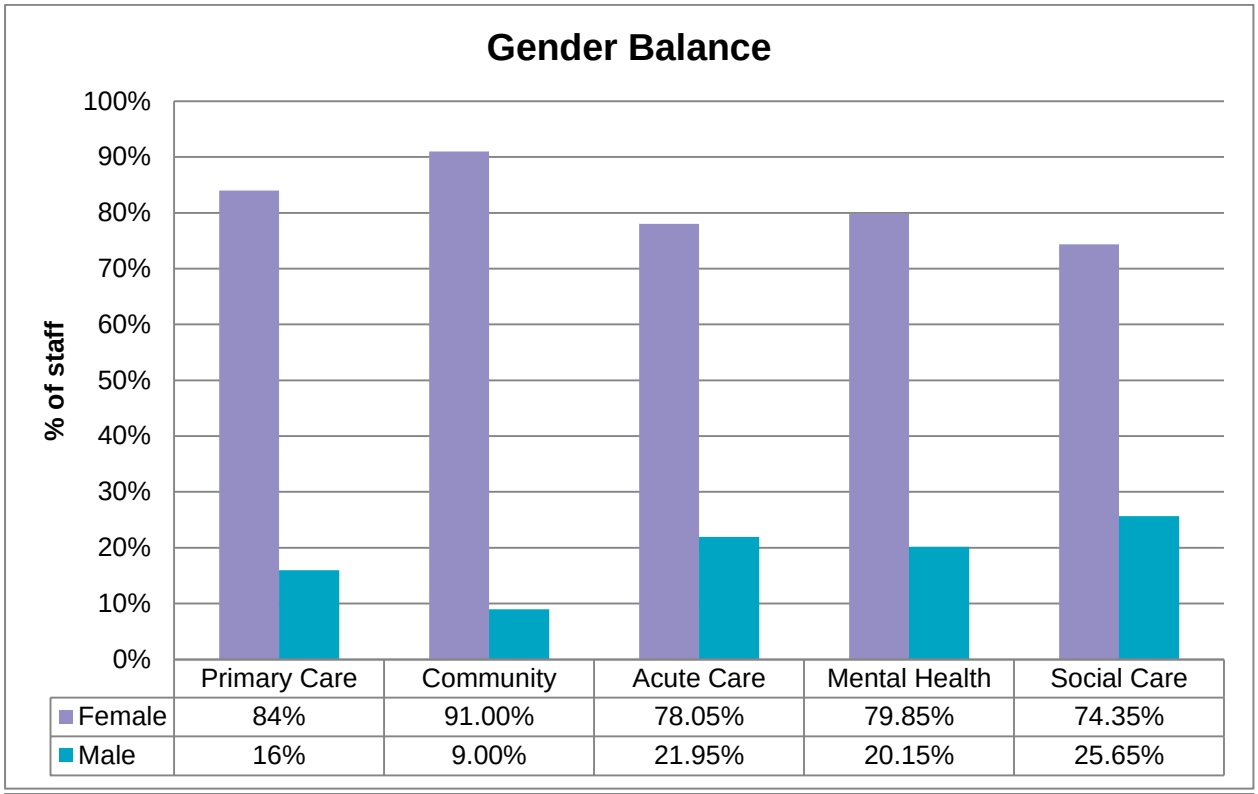
Stockport has a slightly higher than average rate of people who are economically active (69% compared to 67% nationally). However, this can vary significantly across wards, for instance in Brinnington just 59% of people are economically active.

The gap in life expectancy between Stockport most affluent and deprived areas is currently 13.6 years for men and 9.9 years for women, highlighting the key impact of deprivation on health outcomes.

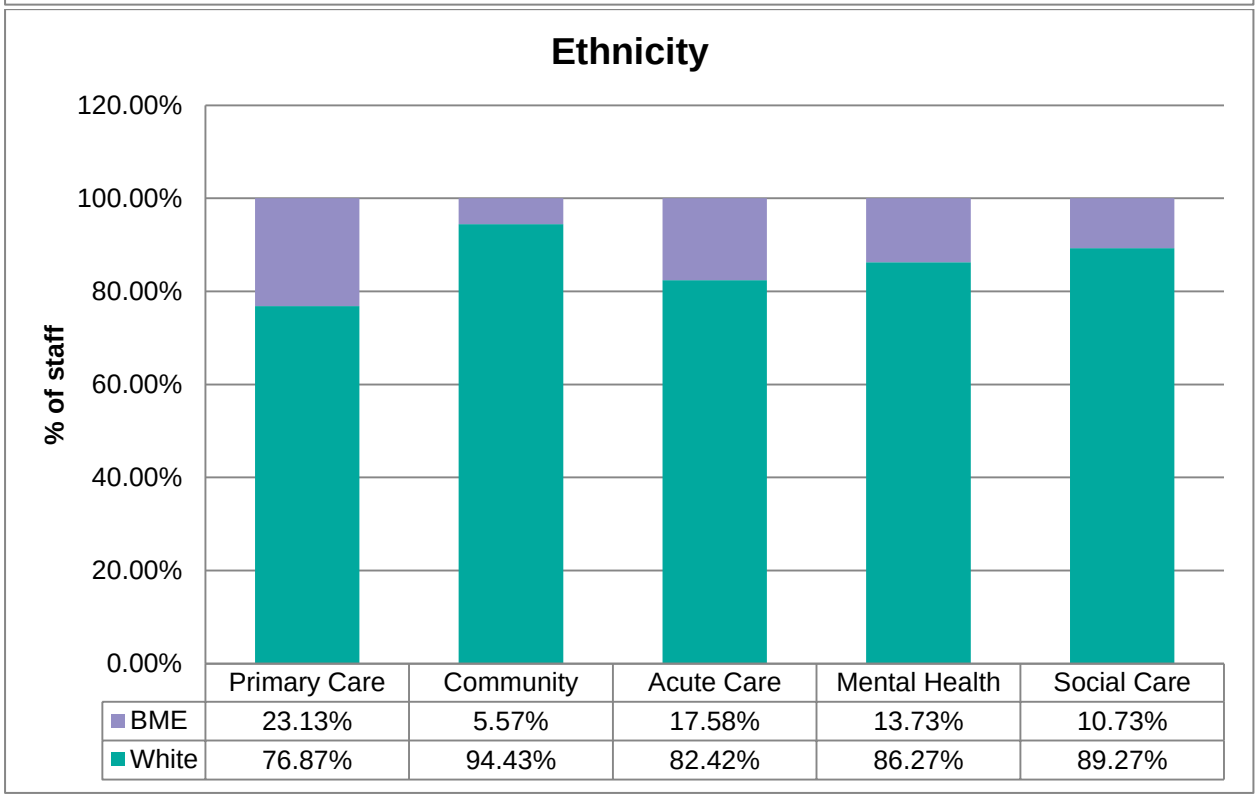
This remains a major priority in Stockport and a key issue in the Health & Wellbeing Strategy.



## 7.2 Appendix 2 – Workforce Profiles

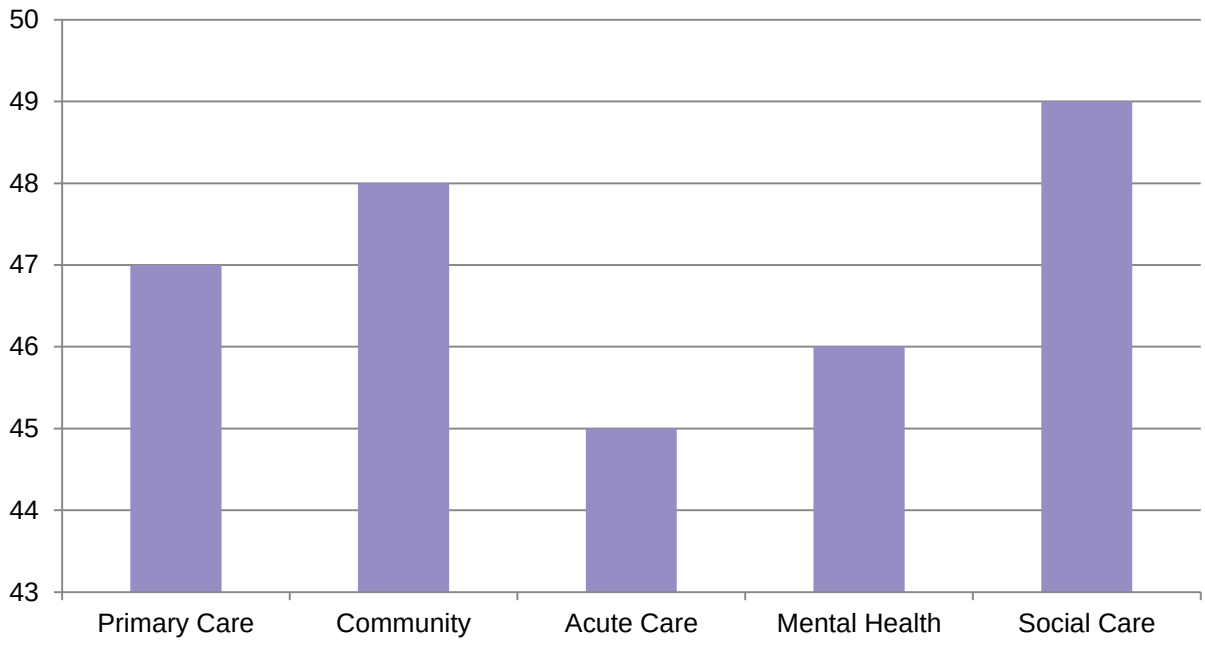



| | Primary Care | Community | Acute Care | Mental Health | Social Care |
|---|---|---|---|---|---|
| Female | 84% | 91.00% | 78.05% | 79.85% | 74.35% |
| Male | 16% | 9.00% | 21.95% | 20.15% | 25.65% |

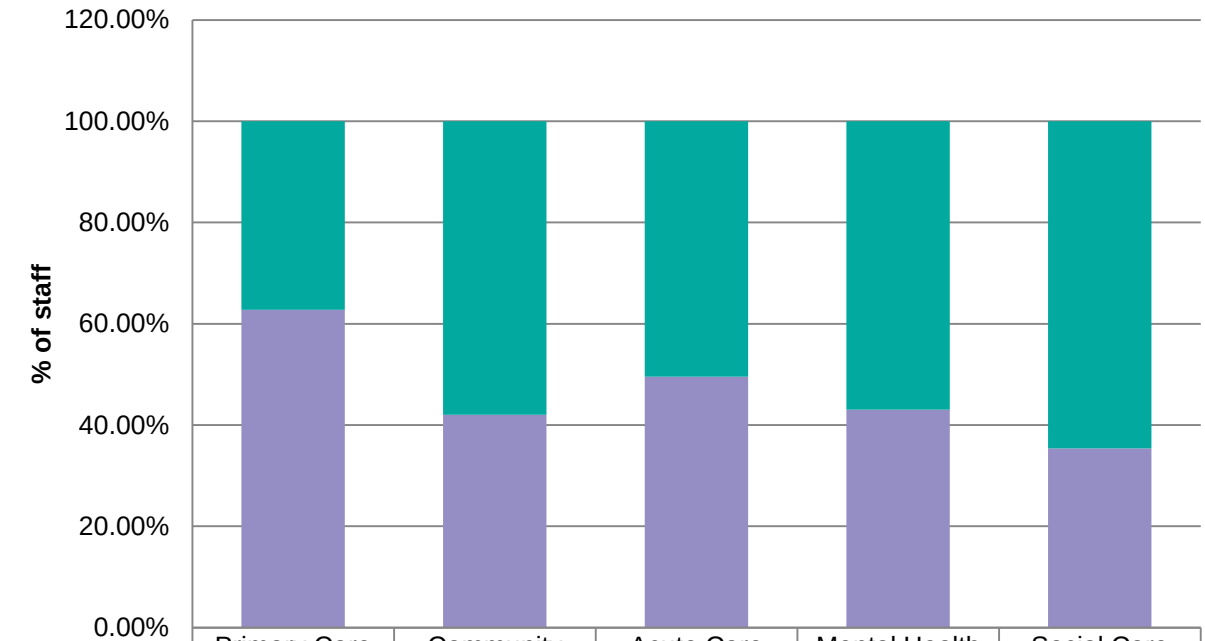



| | Primary Care | Community | Acute Care | Mental Health | Social Care |
|---|---|---|---|---|---|
| BME | 23.13% | 5.57% | 17.58% | 13.73% | 10.73% |
| White | 76.87% | 94.43% | 82.42% | 86.27% | 89.27% |

## Age profile




## Working Patterns




| | Primary Care | Community | Acute Care | Mental Health | Social Care |
|---|---|---|---|---|---|
| Full-time | 37.25% | 57.95% | 50.43% | 56.95% | 64.63% |
| Part-time | 62.75% | 42.05% | 49.57% | 43.05% | 35.37% |

# Stockport Together

# AMBULATORY CARE BUSINESS CASE

# Equality Impact Assessment

## 1. Introduction

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Care) are working alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough – Stockport Together.

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Stockport Together programme aims to create a *sustainable* health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

In doing this, we want to ensure that our plans are fair and support all community groups.

## 2. The Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different community groups
- foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding.

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

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

Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

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

## 3. Scope of this Impact Assessment

A full equality impact assessment of the Stockport Together programme has been undertaken and can be found on our website at:

https://www.stockport-together.co.uk/equalities-information

The high level Strategy is backed up by four detailed work streams, which each address changes to different service areas:

- Neighbourhoods (Healthy Communities and Core Neighbourhood Services)
- Intermediate Tier Services
- Acute Interface Ambulatory Care
- Acute Interface Outpatients

The purpose of this document is to look in detail at the practical and operational impacts of proposed changes to the way Ambulatory Care is provided.

Actions arising from this impact assessment will be embedded into the Ambulatory Care implementation plan and monitored as part of delivery by the Stockport Together Programme Management Office.

## 4. Equality Impact Assessment

| AMBULATORY CARE EIA | | |
|---|---|---|
| 1. | **Name of the Strategy / Policy / Service / Project** | Stockport Together – Ambulatory Care Business Case |
| 2. | **Champion / Responsible Lead** | Dr Karl Bonnici? / who is the operational lead? Jen Harrop?? |
| 3. | **What are the main aims?** | Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.<br><br>We believe that a reconfiguration of existing services is required to reduce waste, to coordinate care for our most vulnerable service users and to meet the growing demand for health and social care within our combined budgets.<br><br>Changes to the operation of the Emergency Department will be introduced to include:<br>• Implementing primary and secondary care ***Collaborative Triage***;<br>• Providing of a co-located primary care ***Ambulatory Illness Team***;<br>• and extending the operating hours of the ***Ambulatory Care Unit***.<br><br>The proposed model will strengthen triage arrangements improving the seniority of front-end decision makers, including primary care expertise access to clinical staff to patients' electronic record with appropriate safeguards, and improving decision making protocols and pathways.<br><br>Behind the ED triage there will be a new primary care service operating 8am to midnight 7 days per week to address peak periods of demand. It will meet the needs of the ambulatory ill who do not require full ED services. It is anticipated this service will see 315 people per week on average, leaving ED staff free to meet more serious needs more promptly.<br><br>This business case proposes increasing the Ambulatory Care Unit's capacity and opening hours so that it will go from seeing 160 people per week to seeing 350 people per week and be open 8am to midnight 7 days per week – reflecting known periods of demand. The unit will diagnose, treat, stabilise and discharge people where their condition does not require overnight hospital care but short-term medical input. Planned additional capacity along with access to GP records for the clinical team, revised pathways and dedicated specialist staff and equipment will reduce admissions through ED by 40 per week. More importantly it will ensure people who need a brief medical |

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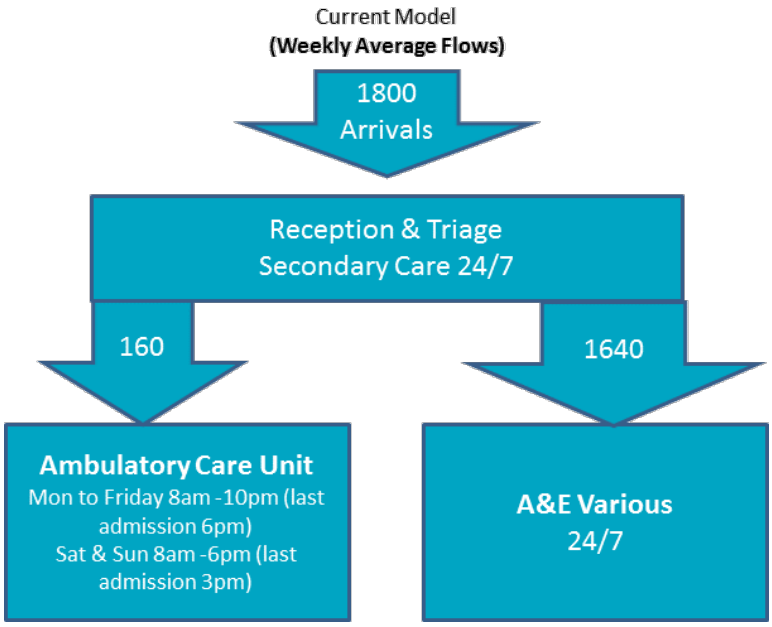
| | | intervention are treated quickly and returned home safely rather than being admitted unnecessarily. |
| **4.** | **List the main activities of the project:** | • Implement collaborative triage and streaming function in Stepping Hill Emergency Department<br>• Implement new primary care specialist stream in Stepping Hill Emergency Department<br>• Extend the hours of the Ambulatory Care Unit Stepping Hill emergency department and improve flow to manage patients home safe that day through effective utilisation of ACU pathways. |
| **5.** | **What are the intended outcomes?** | Ultimately, Stockport Together aims to develop a ***sustainable*** health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care. The Ambulatory Care work stream of Stockport Together should:<br>• Reduce the number of patients with an ambulatory care condition presenting at ED who are subsequently admitted to a hospital bed<br>• Reduce the proportion of people presenting at the front door of ED who are subsequently managed in the ED<br>• Address the management and flow of undifferentiated ambulatory care patients through the ED<br>• Contribute to the reduction in the number of admissions of patients with ambulatory care conditions admitted to hospital across the economy<br>• Contribute to the reduction in the proportion of people attending ED who are admitted for any reason<br>• Contribute to delivering the ED NHS constitution indicator of 95% of people seen within 4 hours<br>• Contribute to the move towards 7-day working<br>• Contribute to an improved working environment in the ED<br>• Ensure that the financial benefits of the changes will be greater than the costs incurred across a 3 year period. |
| **IMPACT ON SERVICE USERS** | | |
| **6.** | **Who currently uses this service?** | Any person presenting to Stepping Hill Emergency Department (including direct referrals from Stockport GPs).<br><br>The number of people attending the Emergency Department at Stepping Hill Hospital is average for the Greater Manchester area, however the number of those urgent attendances which result in an admission to hospital is high.<br><br>Stockport's Joint Strategic Needs Analysis reports that there are around 94,000 ED Attendances made by Stockport residents each year. Attendances are highest for children and over 65s. Trends of ED attendance by deprivation show a similar pattern as admissions with rates far higher in the most deprived areas at all ages.<br><br>Anecdotal evidence suggests that homeless people, asylum seekers, refugees and those new to the country are more likely to use the ED due to difficulties |

registering with a GP or a lack of awareness of local services.

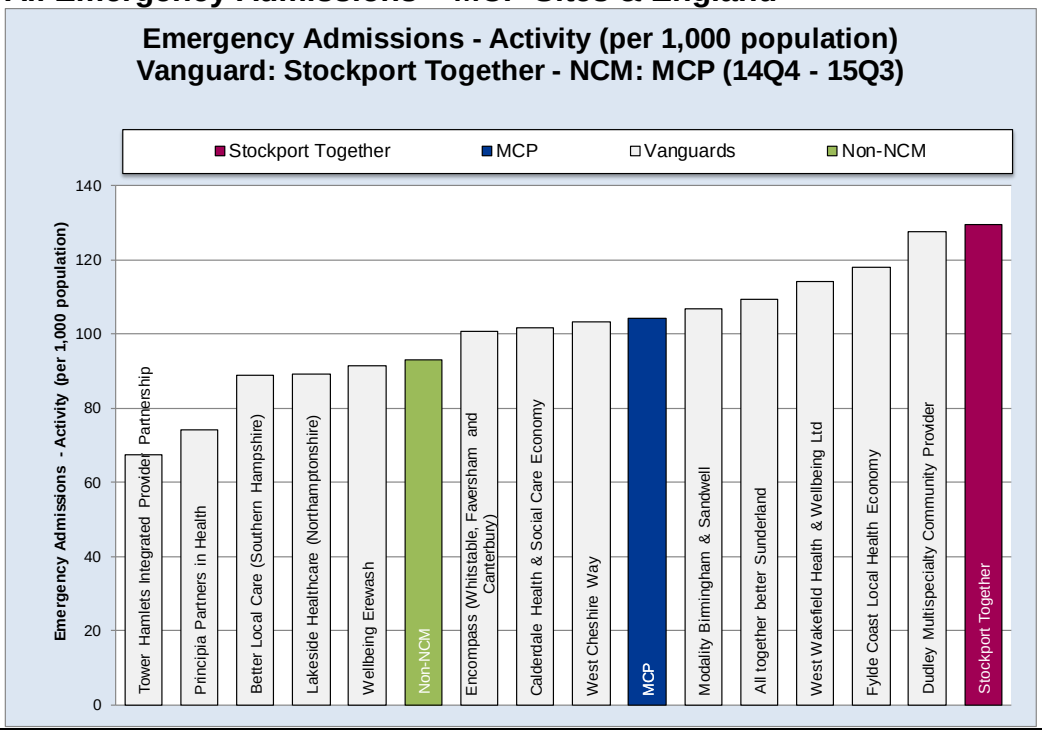
Men and residents in the more deprived areas of Stockport are also more likely to use the ED as the main access point to healthcare as they are less likely to attend their GP practice, screening and preventative services.

**Weekly number of attendances at the Emergency Department at Stepping Hill** (April 2016)




Stockport has a high non-elective admission rate per head of population, and a higher than typical proportion of those attending the ED are admitted (c30%).

**All Emergency Admissions – MCP Sites & England**



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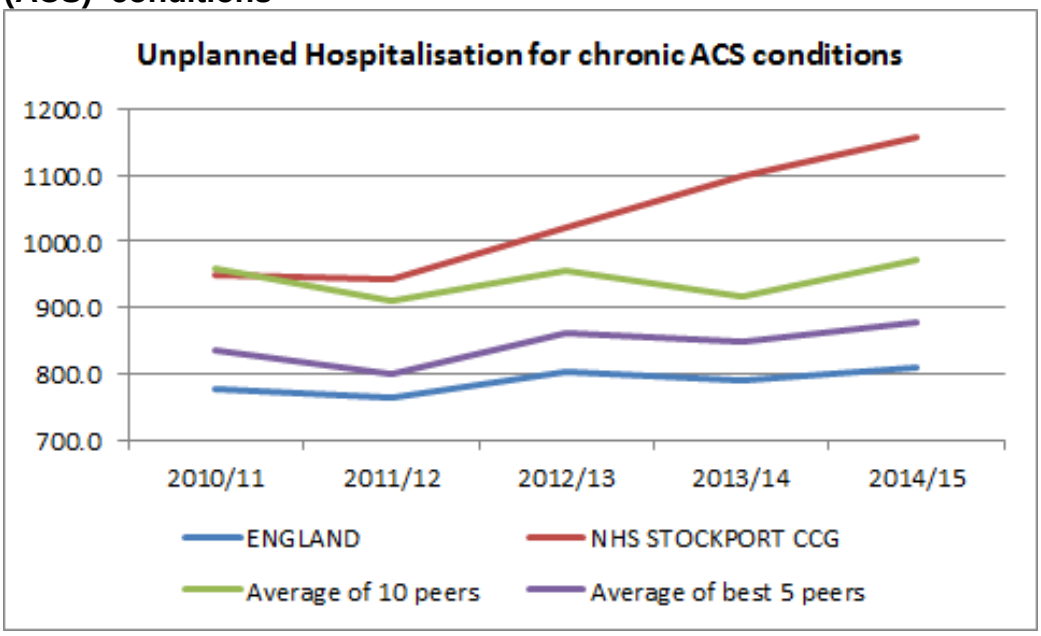
|---|---|---|
| | | One of the areas where Stockport benchmarks high is in admissions for people with Ambulatory Care Sensitive Conditions, where effective management in the community should prevent the need to attend the hospital. As such, people with a disability and their carers tend to be higher users of the ED.-<br><br>**Unplanned Hospitalisation for those with Ambulatory Care Sensitive (ACS) conditions**<br>  <br><br><br>Further information on protected characteristics within Stockport's population can be found in the full Equality Impact Assessment of the Stockport Together Strategy:<br>https://www.stockport-together.co.uk/equalities-information<br><br>A breakdown of local service users and their needs can also be found in Stockport's Joint Strategic Needs Assessment: http://www.stockportjsna.org.uk/ |
| **7.** | **Are there any clear gaps in access to this service?** (e.g. low access by ethnic minority groups) | The Emergency Department is open 24/7 to anyone who arrives at the hospital. Access tends to be higher among a number of protected groups for various reasons:<br>• Men are less likely to attend their GP practice and instead use A&E as a last resort<br>• Similarly, residents in more deprived areas of Stockport, who are less likely to attend screening, preventative and primary care, are higher users of the ED<br>• ED attendances are high among young children and older patients<br>• Refugees, asylum seekers and new residents who are unaware of community services tend to rely on hospital care<br>• Homeless people who struggle to register with a GP practice also tend to rely on the ED for medical care. |

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| **8.** | **Are there currently any barriers to certain groups accessing this service?** (e.g. no disabled parking / canteen doesn't offer Kosher food / no hearing loop) | The Emergency Department is open 24/7 to anyone who arrives at the hospital, However, community groups have noted particular issues accessing emergency care for those with English as a second language and for deaf patients, who struggle to find interpretation and often have to rely on distressed and untrained family members to translate.<br><br>Local residents have noted issues with the lack of car parking available at the hospital site, as well as the cost of parking charges, which is particularly felt by those from deprived areas, the unemployed, pensioners and carers. |
| **9.** | **How will this project change the service offered?** (is it likely to cut any services?) | The proposed changes to the ED service will result in:<br>• Enabling more people to be effectively managed home on the same day of ED attendance<br>• Preventing unnecessary hospital stays and by doing so preventing complications related to a hospital stay (infections, muscle weakness, reduced confidence / skills)<br>• Avoiding duplication<br>• More joined up working between health and social care and with third sector.<br><br>This project will change processes to improve the quality of clinical referrals and reduce unnecessary surgery or treatment.<br><br>As such, it should have a positive impact on all service users, particularly those protected groups who are more likely to attend the ED. |
| **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?) | There are no cuts to services as a result of this business case. All patients will be seen by an appropriately qualified clinician on presentation at ED. Anybody who attends ED and is assessed as requiring more intensive support whether short-term or requiring a bed will receive the necessary care. |
| **11.** | **If you are creating any new services, who most likely to benefit from them?** (Will any equality group be more or less | People attending ED will have access to the most appropriate health professional to manage their level clinical need in a timely fashion. The new service will be equitable for all groups.<br><br>The main beneficiaries will be people with Ambulatory Sensitive Conditions which will include many people with various long-term conditions. Many of these people will be older and people with a disability. |

| | | |
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| | likely to benefit from the changes?) | |
| **12.** | **How will you communicate the changes to your service?** (What communications methods will you use to ensure this message reaches all community groups?) | Patients should see no real change when they attend ED as this is mainly a procedural change. However, the design and implementation of the service has been undertaken in consultation with various groups, including staff engagement sessions, attending GP locality meetings, partnership working with ambulance service, patient reference groups, Citizens' Reference Panel, patient stories to highlight change, information at GP practices, newsletters and information at website and social media.<br><br>Public engagement and consultation included meetings with local groups representing protected characteristics to ensure that all voices were heard and all concerns / impacts understood.<br><br>Information was disseminated in a range of formats:<br>• Online survey<br>• Paper surveys<br>• Public events<br>• Fliers and consultation documents handed out in clinics and displayed in Libraries, Pharmacies and GP Practices<br><br>The consultation document included a message explaining how information could be obtained in an alternative format. Events were undertaken in accessible local venues across each area of Stockport, offering interpretation where required. |
| **13.** | **What have the public and patients said about the proposed changes?** (Is this project responding to local needs?) | Engagement with the Citizens' Reference Panel was received positively. Representatives felt it would ensure people's health would be managed in the most appropriate way according to clinical need. (See Section 5.1 in the main business case).<br><br>A full write up of engagement can be found on the Stockport Together website at: https://www.stockport-together.co.uk/key-documents |
| **14.** | **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?*** |
| | | **IMPACT** / **MITIGATION** |
| | *Age* | Young children and older people are high users of the Emergency Department and, as such, are more likely to be impacted by the changes / This represents a positive impact on a protected group which is objectively justifiable under the Equality Act, as the changes aim to ensure that everyone attending the ED is seen by the most appropriate clinician and receives the right |

| | | | |
|---|---|---|---|
| | | | course of treatment for their needs, reducing unnecessary hospital stays which can have negative impacts on health and independence. |
| | *Carers* | ED admissions are particularly high among people with ACS conditions. A such, their carers are likely to be impacted by the changes | Again, this represents an objectively justifiable impact on a protected group, reducing the burden on carers of unnecessary hospital stays and improving the service in the ED. |
| | *Disability* | ED admissions are particularly high among people with ACS conditions, who are covered by the protected characteristic of disability.<br><br>Deaf and hard of hearing patients have noted issues with a lack of BSL interpretation in the ED. | Again, this represents an objectively justifiable impact on a protected group, reducing the burden of unnecessary hospital stays and improving the service in the ED.<br><br>The new service should offer access to skype BSL interpretation (currently available in primary care) and staff training on how to access this to ensure that deaf patients have equal access to emergency care. |
| | *Gender Reassignment* | | |
| | *Marriage / Civil Partnership* | | |
| | *Pregnancy & Maternity* | ED admissions are particularly high among parents of young children. | Again, this represents an objectively justifiable positive impact on a protected group, improving the service in the ED and reducing unnecessary hospital admissions. |
| | *Race* | Anecdotal evidence suggests that refugees, asylum seekers and new residents are more likely to attend the ED due to a lack of awareness of local services.<br><br>Residents have noted issues accessing interpretation in an emergency. | This represents a positive impact on a protected group, improving services for all users.<br><br>The service should include phone interpretation services and staff training on how to use this, to ensure equal access for people with English as a second language. |
| | *Religion & Belief* | | |
| | *Sex* | Men are less likely to attend preventative services and GP practices, attending ED as a last resort when conditions escalate. As such, they are more likely to be impacted by the changes in the ED. | Again, this represents an objectively justifiable impact on a protected group, reducing unnecessary hospital stays and improving the service in the ED. |
| | *Sexual* | | |

| | | | |
|---|---|---|---|
| | *Orientation* | | |
| **IMPACT ON STAFF** | | | |
| **15.** | **How many staff work for the current service?** | There are currently 313 people – 278.59 full-time equivalents – working in emergency care at Stepping Hill Hospital across the Emergency Department, Ambulatory Care Unit, Medical Assessment Unit, Transfer Unit and Discharge Lounge:<br>• 169 were nursing staff, 40 medical or dental, 78 worked in Additional Clinical Services; 36 worked in admin<br>• 258 were female and 55 were male<br>• 70 employees were in their 20s; 88 in their 30s; 74 in their 40s; 66 in their 50s; and 15 employees were in their 60s<br>• 6 had a disability; 231 had no disability; and 76 did not wish to declare their disability status<br>• 243 where White British; 12 from a minority white background; 22 Asian; 5 mixed race; 3 Black; 4 recorded their ethnicity as 'other' backgrounds; and 24 did not state their ethnicity<br>• 162 employees recorded their religion as Christian; 28 Atheist; 6 Muslim; 1 Buddhist; 1 Hindu; 20 recorded their religion as 'other'; and 95 did not wish to record their religion or belief<br>• 212 employees were heterosexual; 5 employees were LGB; and 96 did don't wish to declare their sexual orientation | |
| **16.** | **What is the potential impact on these employees?** (including potential redundancies, role changes, reduced hours, changes in terms and conditions, locality moves) | This business case will mostly see a change in the procedures used in the Emergency Department.<br><br>The balance of staff may shift to more people working in the Ambulatory Care Unit, which will open for longer hours, or the Medical Assessment Unit, so that patients are appropriately monitored rather than being admitted to a hospital bed.<br><br>A new GP Streaming Service will bring in additional primary are employees to manage those ED attendances that do not require hospital care. | |
| **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?** | |
| | | **IMPACT** | **MITIGATION** |
| | *Age* | The balance of age among current employees is reasonably evenly spread, so changes are not likely to have a differential impact on the basis of age | Any changes in roles or working patterns will be subject to staff consultation and will be managed under HR policies, offering equal opportunities for TUPE, reasonable adjustment and flexible working rights. |
| | *Carers* | Staff with caring responsibilities may be limited in any changes they can | |

| | | | |
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| | | make to shifts or working hours | No redundancies are expected as a result of this change. |
| | *Disability* | Staff with disabilities may require reasonable adjustments to their working hours or duties | |
| | *Gender Reassignment* | | |
| | *Marriage / Civil Partnership* | | |
| | *Pregnancy & Maternity* | | |
| | *Race* | The majority of employees are White British, as such, most likely to be impacted by the change | |
| | *Religion & Belief* | | |
| | *Sex* | The majority of employees are female, and as such women are most likely to be impacted by change | |
| | *Sexual Orientation* | | |
| **18.** | **What communication has been undertaken with staff?** | A range of staff have been involved in design sessions for Stockport Together representing a wide range of roles.<br><br>Staff engagement sessions, team briefs, newsletters, 1 to 1s, drop-in Q&A sessions and daily reviews in the ED have been used to communicate changes with staff as well as HR support, team building and culture change sessions. | |
| **19.** | **Do all affected workers have genuinely equal opportunities for retraining or redeployment?** | Yes – this is part of the work force development plan | |
| **IMPACT ON STAKEHOLDERS** | | | |
| **20.** | **Who are the stakeholders for the service?** | ED Staff,<br>Urgent Care operational delivery leads<br>Clinical Directors<br>Business Managers at Stockport NHS FT<br>Mastercall (providers of primary care specialist function) | |
| **21.** | **What is the potential impact on these stakeholders?** | Changes to ways of working<br>Changes to system process<br>Release / source funding and spend responsibly<br>Contract negotiations | |

| | | |
|---|---|---|
| 22. | **What communication has been undertaken with stakeholders?** | Regular meetings, presentations and emails have been used to keep stakeholders up to date on progress. |
| 23. | **What support is being offered to frontline staff to communicate this message with service users / family / carers?** | There is regular support from the operational delivery teams to support them in their discussions. |
| 24. | **How will you monitor the impact of this project on equality groups?** | Equality data is collected by providers including: deprivation (postcode), age, disability, ethnicity; gender; religion; sexual orientation. This will be mapped against the equality data for Stockport as a borough as part of the public sector equality duty. If this highlights potential underrepresentation of certain groups, further analysis will be undertaken to understand the reason and an action plan will be developed to improve equality. Patient and carers surveys might also highlight inequalities which will then be acted upon. |
| 25. | **Action Planning** | An action plan has been set out at the end of this document to capture all actions identified through the course of this Equality Impact Assessment required to:<br>• Mitigate any potential negative impacts<br>• Take advantage of opportunities to reduce inequalities<br>• Respond to patient and public engagement.<br><br>Actions in this plan will be included in the implementation plan for delivery of the Outpatients changes.<br><br>At a strategic level, progress on the EIA action plan will be monitored regularly by the Stockport Together Programme Management Office as part of the governance framework for delivery of the work stream. |
| | **EIA SIGN OFF** | |
| 26. | **Sign off** | EIAs should be approved by the work stream's Senior Responsible Officer and sent to an equality specialist for quality assurance before sign off.<br><br>Final EIAs should be attached to the final Strategy / Policy / Business Case before being presented to the relevant decision making Board. |
| a. | **SRO Approval** | **Name:** Dr Karl Bonnici?<br>**Date of approval:** x |
| b. | **Quality Assurance** | **Quality Assured by:** Angela Dawber<br>**Date:** 20/12/2017 |

| | | | |
|---|---|---|---|
| **c.** | **Board Approval** | **EIA considered by / Date:** | Joint Commissioning Board – 04/01/2018<br>Scrutiny Committee – 16/01/2018<br>SMBC Cabinet – 17/01/2018<br>CCG Governing Body – 31/01/2018 |

## 5. AMBULATORY CARE Equality Action Plan

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| AC01 | Equality Actions to be included in Ambulatory Care Implementation Plan | Operational Lead | 31/01/2018 |
| AC02 | Ambulatory Care programme to send monthly updates on implementation (including progress on equality actions) to Stockport Together PMO | Operational Lead | 28/02/2018 |
| AC03 | Develop future engagement strategy for the work stream, identifying key stakeholders (including protected groups) and optimal communications methods (including translation and interpretation requirements) | Operational Lead | 31/03/2018 |
| AC04 | Patient engagement and complaints to be monitored by protected groups to ensure there are no adverse impacts on any groups | Operational Lead & SNC management | 31/03/2018 |
| AC05 | Stockport Foundation Trust to outline the process for meeting the Accessible Information Standard in the new service model:<br>• Agreement on Interpretation service (including phone access for foreign languages and skype access for BSL in the ED)<br>• Collating data on formats required by patients<br>• Equality monitoring process<br>• Alternative contact methods to phone for deaf patients (e.g. Text-Relay service; text messaging; email; face-to-face) | Operational Lead & SFT management | 31/03/2018 |
| AC06 | Equality Impact Assessment of how the new service model will affect staff | Operational Lead & HR | 31/03/2018 |
| AC07 | Staff consultation on new service model and any changes to roles / places of work | Operational Lead & HR | 31/03/2018 |
| AC08 | Develop a staff training plan, including:<br>• Equality & Diversity Training<br>• Use of interpretation and translation services<br>• Equality monitoring to comply with AIS | Operational Lead & HR | 31/03/2018 |
| AC09 | Establish baseline data for the number of service users by protected groups and then monitor on a regular basis as the changes are implemented. | Operational Leads | 31/01/2018 |

# Stockport Together

# INTERMEDIATE TIER BUSINESS CASE

# Equality Impact Assessment

## 1. Introduction

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Care) are working alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough – Stockport Together.

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Stockport Together programme aims to create a *sustainable* health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

In doing this, we want to ensure that our plans are fair and support all community groups.

## 2. The Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different community groups
- foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding.

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

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

Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

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

## 3. Scope of this Impact Assessment

A full equality impact assessment of the Stockport Together programme has been undertaken and can be found on our website at:

https://www.stockport-together.co.uk/equalities-information

The high level Strategy is backed up by four detailed work streams, which each address changes to different service areas:

- Neighbourhoods (Healthy communities and Core Neighbourhood Services)
- Intermediate Tier Services
- Acute Interface Ambulatory Care
- Acute Interface Outpatients

The purpose of this document is to look in detail at the practical and operational impacts of proposed changes to the Intermediate Tier services.

Actions arising from this impact assessment will be embedded into the Intermediate Tier implementation plan and monitored as part of delivery by the Stockport Together Programme Management Office.

## 4. Equality Impact Assessment

| Intermediate Tier EIA | | |
|---|---|---|
| 1. | **Name of the Strategy / Policy / Service / Project** | Stockport Together - Intermediate Tier Business Case |
| 2. | **Champion / Responsible Lead** | Margaret Malkin / Paula Friggieri?? |
| 3. | **What are the main aims?** | Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.<br><br>The Intermediate Tier of services is defined as those services that: promote faster recovery from illness; prevent unnecessary acute hospital admission and premature admission to long-term residential care; support timely discharge from hospital; and maximise independent living. In Stockport there are over 20 such services which have developed in isolation over the past ten years. While each service has significant strengths, collectively the Intermediate Tier is fragmented and difficult to navigate.<br><br>The current range of services has been designed to manage the effects of the system, rather than tackling its causes. The majority of staff and financial resources are spent on facilitating a hospital discharge - or 'step-down' from secondary care. Much less capacity is used for 'step-up' activity – intensive support to prevent unnecessary hospital admissions. This means that there is not a strong alternative offer to respond to people in crisis and prevent hospital admissions, placing additional demand on the hospital and the Emergency Department in particular. And many patients receive intermediate care interventions in a hospital bed due to the lack of capacity in the community.<br><br>Most of the budget is spent on delivering care in community facilities and not an individual's home, reducing independence. As a result, people spend longer in intermediate tier beds than patients in other parts of the country. A point prevalence study of Intermediate Care beds in 2015 found that 33% of patients did not need an intermediate tier bed at that moment in time – resulting in 1,257 excess bed days. The knock on effect can be seen in the simultaneous review of 6 hospital wards, which found that 44.53% of people no longer required a hospital bed, but could not be discharged due to a lack of capacity in community services. The longer patients spend in a bed, the harder it can be for them return home and live independently. |

| | | |
|---|---|---|
| | | **Table 1: Point Prevalence Study of Patients in Intermediate Tier Beds**<br><br>**Bed Based Service** / **No. of patients** / **No. who did not need an Intermediate Tier bed** / **Resulting Excess Bed Days**<br>**Blue Bell** 24 3 1,126<br>**Saffron Ward** 18 9 76<br>**Marbury** 38 13 25<br>**Berrycroft** 14 6 30<br>**Total** **94** **31** **1,257**<br><br>Fragmentation of the 20+ services means that many service users rely on multiple teams and referrers are unsure of the availability of services or the criteria for access. Patients report multiple assessments being duplicated by different services. In addition, the current range of services lacks enough mental health and dementia input to support the needs of service users. This situation will only intensify as Stockport's population continues to age. By 2020, the number of people aged over 65 will increase from 55,700 in 2014 to 61,000. Currently 51% of the total adult population of Stockport are known to have one or more long-term conditions. By the age of 85, 87% have at least one and 53% have two or more. And by 2030 dementia prevalence will rise by 50%. |
| **4.** | **List the main activities of the project:** | • Implementing a fully integrated team to deliver care at place of residence and/or community intermediate tier beds<br>• Implementing a single point of access (intermediate tier hub)<br>• Implementing a crisis response model<br>• Implementing an active recovery model<br>• Implementing the model of 'transfer to assess'<br>• Implementing an integrated transfer team |
| **5.** | **What are the intended outcomes?** | Ultimately, Stockport Together aims to develop a ***sustainable*** health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care. The Intermediate Tier work stream of Stockport Together will:<br>• Create an '**Intermediate tier Hub'** that provides a streamlined single point of access/triage function and enables better co-ordination of care.<br>• Shift resources within system to build **greater capacity to support in peoples own home** at less cost than a hospital bed.<br>• Review and develop the **rapid response** function of intermediate care to create a service that is designed and better equipped to prevent avoidable acute admissions.<br>• Form a fully **integrated team** with a common purpose, shared values, protocols and a single competencies framework.<br>• Develop one **holistic assessment** and joint care planning (supported by technology) that avoids duplication and fragmentation.<br>• Make more effective use of resources to enable **24/7 service provision** |

based on the needs of individuals.

- Arrange 'in-reach' by **aligned specialist practitioners** to support rapid assessment, diagnostics and rehabilitation.
- To ensure that the future number of **intermediate care beds matches demand**.

## IMPACT ON SERVICE USERS

**6. Who currently uses this service?**

Predominantly people over 65 who are in transition and would benefit from short term support to regain or maintain their level of independence.

The services in scope of this business case and current usage for 15/16 are shown in the table below:

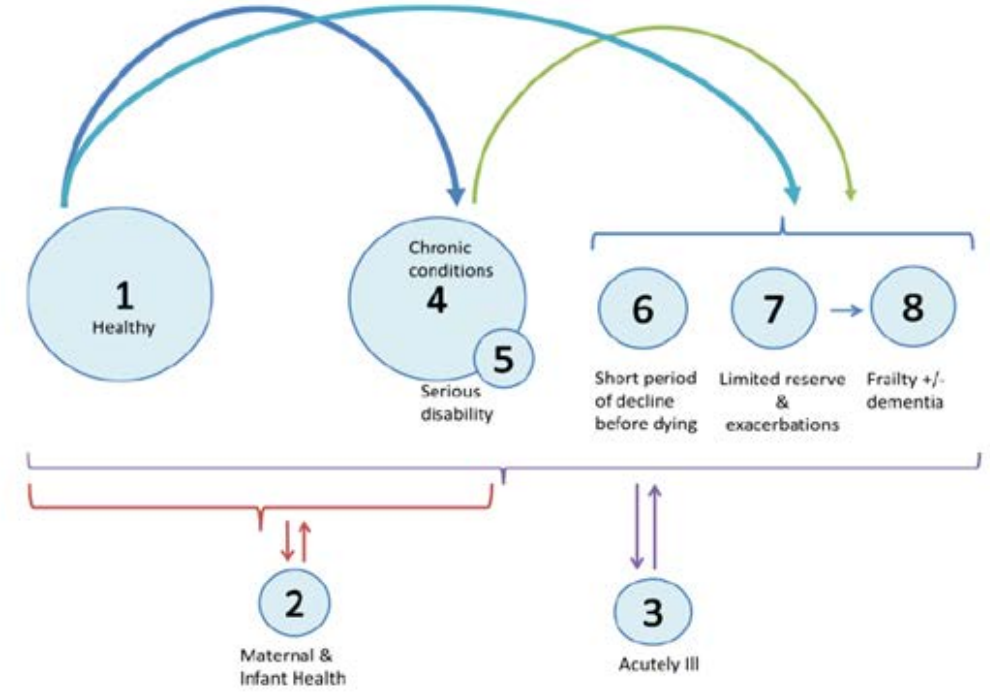
| Service name | Service Description | Activity 15/16 |
|---|---|---|
| ***Adult Community Treatment Team (ACTT)*** | Short-term community therapy intervention (OT & Physio) | 8415 ftf contacts<br>301 telephone contacts<br>3264 referrals |
| ***Assessment& recovery Beds*** *(19 Newlands & 9 Meadway)* | Community beds for recovery & assessments regarding longer term care needs | Weekly ward rounds<br>120 admissions Newlands, LOS 46days |
| **Bluebell Ward** (The Meadows) | Continuing health care and end of life care | 9,125 bed days |
| ***Community Assertive In Reach (CAIR-ID)*** | Facilitating hospital discharge up to 72hrs after discharge | 5231 ftf contacts<br>33 telephone contacts<br>2428 referrals |
| **Community beds in residential care homes** | Spot purchases to support recovery and carer breakdown (SMBC) | **Estimate: 400** placements spot purchased |
| **Equipment & Adaptations Services** | Equipment, home adaptations, moving & handling for independent living | |
| ***GP cover to intermediate tier beds*** | Medical support to patients in Intermediate tier | Variation of daily and weekly ward rounds |
| ***Community Rehabilitation Workers*** | Supporting patients with transfer from bed based to home based intermediate care | |
| ***Intermediate Care – bed based*** *(Marbury & Berrycroft)* | Intensive rehabilitation in high dependency 24/7 care facility | Step up home 74 admissions<br>Step up bed 53 admissions<br>Step down home 300<br>Step down bed 459<br>LOS step up 26 days<br>LOS step down 32 days |
| ***Intermediate Care – home based*** *(East & West teams)* | Clinically led therapeutic intervention & rehabilitation | |
| **IV Therapy** (Mastercall) | IV antibiotics in the home – up to 3 times a day | 645 referrals; 530 accepted of which 377 GP referrals; 3781 visits; 3448 bed days saved (average of 7 per patient) |

| | | |
|---|---|---|
| **NWAS Pathfinder** (NWAS & Mastercall) | Ambulance redirect to community provision | 2042 referrals; deflection rate 88%; average referral 5 a day |
| ***Rapid Response Assessments (in hours 9am-5pm and out of hours4:30pm-8.30pm; weekends and BH 12:30-8.30pm)*** | Assessments in the community to prevent hospital admissions | 527 referrals in hours; 45% admitted to hub bed<br>789 referrals (13-14 OOH) |
| ***20 Rapid Response hub beds*** *(4 localities)* | Recovery beds where unsafe for patients to stay at home or carers breakdown | |
| ***Re-ablement / REACH 7am-10pm 7d; limited night support*** | Support after care to regain independence (incl. night cover) | 1184 episodes (1050 referrals), avg length 29 days |
| ***Saffron Ward – 23 beds*** *(The Meadows)* | Community beds for intermediate mental health care | 9125 bed days; average length of stay 29 days |
| ***A10*** | Hospital ward | |

The new model is targeting two population cohorts.

1. People in crisis that are at high risk of acute admission (step up). Population size: 14,079
2. People in hospital who are medically optimised but require additional time and rehabilitation to recover (step down). Population size: 14,079 + proportion of elective admissions

The future commissioning arrangements for a population based weighted capitation contract will look to commission specific outcomes for specific population segments. The approach being taken to this is built on the *Bridges to Health* approach identifying 8 population segments. These are described diagrammatically below. At any given time nobody is in more than one of the six upper segments and can exacerbate from any of these to the Acutely ill segment (3).

| | | |
|---|---|---|
| | | **Evaluation of Whole Population Segmentation and an Implementation Approach for the 'Bridges to Health' Segmentation Model"** (OBH, August 2016)<br>  <br><br>The Intermediate Tier business case when considering step-up functions will be predominantly dealing with significant exacerbations of people in Segments 4 and 5 (chronic Conditions) and Segment 7 (Limited reserve & exacerbations), but may also occasionally support people in Segments 6 and 8. When it is looking at step-down it will be focussed on how it transfers individuals back home from an acutely ill state (Segment 3) in such a way as to minimise their decline towards limited reserve and further exacerbations (Segment 7) or towards frailty and dementia (Segment 8).<br><br>Further information on protected characteristics within Stockport's population can be found in the full Equality Impact Assessment of the Stockport Together Strategy:<br>https://www.stockport-together.co.uk/equalities-information<br><br>A breakdown of local service users and their needs can also be found in Stockport's Joint Strategic Needs Assessment: http://www.stockportjsna.org.uk/ |
| **7.** | **Are there any clear gaps in access to this service?** (e.g. low access by ethnic minority groups) | The current service is open to all patients who reside in Stockport. Access is via referral into the Step-Up services from GP or community service, or Step Down on discharge from hospital. However the current situation is that people have difficulty in accessing the existing services due to lack of clarity what is on offer and services not working together. It is envisaged that in the new situation people will have one clear single point of access and receive a response based on an integrated, person-centred action plan. |
| **8** | **Are there** | Currently, the service is predominantly 'step down' and predominantly bed |

| | | |
|---|---|---|
| . | **currently any barriers to certain groups accessing this service?** (e.g. no disabled parking / canteen doesn't offer Kosher food / no hearing loop) | based instead of home based many people, especially people with cognitive impairment are disadvantaged. This patient cohort would benefit from receiving treatment in their own familiar place of residence when possible.<br><br>One significant barrier to access is in the provision of bed-based care. Many of the care homes providing intermediate tier beds do not have capacity to support patients with dementia who require support overnight. As a result, dementia patients are mainly accommodated on the Bluebell ward or must stay in hospital. The number of care homes with nursing facilities is also limited, creating an access barrier for patients with ongoing care needs or disabilities. |
| 9. | **How will this project change the service offered?** (is it likely to cut any services?) | The proposed changes in the intermediate tier services will result in:<br>- An increased workforce supporting more people in their own place of residence<br>- Preventing unnecessary hospital stays and by doing so preventing complications related to a hospital stay (infections, muscle weakness, reduced confidence / skills)<br>- A more pro-active and responsive approach in case of (non-acute) emergencies<br>- More joined up working between health and social care and with third sector<br>- Avoiding duplication<br>- 24 hour crisis response service<br>- A new build or existing care home building – location to be determined<br>- Support workers in the home to reduce need for hospital stay and support for carers |
| 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?) | The only reduction will be a shift in usage and a reduction in the bed based service but this is a safe and preferable option because there will be more staff available to support people in their own home during day and night and thereby preventing an admission to a community bed. Beds can still be 'spot purchased' if required. |
| 11. | **If you are creating any new services, who most likely to benefit from them?** (Will any equality group be more or less | By increasing capacity in the crisis response service and the community based active recovery model, more older and frail people who otherwise would have been admitted to hospital will be able to stay at home and receive their treatment there.<br><br>By creating an integrated transfer team and by implementing the transfer to assess model it is envisaged that the discharge process of each person leaving hospital will be better prepared and coordinated. By introducing more mental health professionals in the service people with mental health needs will receive |

| | | |
|---|---|---|
| | likely to benefit from the changes?) | an improved service offer. |
| 12. | **How will you communicate the changes to your service?** (What communications methods will you use to ensure this message reaches all community groups?) | The implementation of the service is combined with communication to various groups to inform them how and when to access intermediate tier services. This will be done through newsletters, staff engagement sessions, attending GP locality meetings, partnership working with ambulance service, ED and hospital, meetings with expert patient groups and patient reference groups, meeting with HealthWatch, patient stories to highlight change, information at GP practices and information at website and social media. As the access is predominantly through referral, most attention goes into informing professionals rather than the public. |
| 13. | **What have the public and patients said about the proposed changes?** (Is this project responding to local needs?) | The case for change was built based on engagement with the public and professionals. Public engagement and consultation included meetings with local groups representing protected characteristics to ensure that all voices were heard and all concerns / impacts understood.<br><br>Information was disseminated in a range of formats:<br>• Online survey<br>• Paper surveys<br>• Public events<br>• Fliers and consultation documents handed out in clinics and displayed in Libraries, Pharmacies and GP Practices<br><br>The consultation document included a message explaining how information could be obtained in an alternative format. Events were undertaken in accessible local venues across each area of Stockport, offering interpretation where required.<br><br>The key messages from engagement activity were:<br>- Services are not clear on what is on offer and how to access<br>- Disconnect when being referred from one service to the other, duplication of tasks like assessments<br>- Treatment is broken down in steps delivered one at the time by different teams rather than integrated and interdisciplinary<br>Based on JSNA and other local data our current system is more step down than needed.<br><br>A full write up of engagement can be found on the Stockport Together website at: https://www.stockport-together.co.uk/key-documents |

| 14 | 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?* | |
|---|---|---|---|
| | | **IMPACT** | **MITIGATION** |
| | *Age* | The service is likely to impact the elderly the most, as those most likely to require intermediate care. However, service access will be based on need not age – with no age restriction other than 18+. | This represents a positive impact on a protected group, reducing the length of stay in hospital, increasing independence and delivering more care close to home. This positive impact is objectively justifiable under the Equality Act. |
| | *Carers* | The new service model is predicted to reduce hospital attendances, which will mean patients do not have to travel into hospital for their appointment.<br><br>Carers who need to visit patients in the new unit could potentially be disadvantaged by the new location.<br><br>With fewer sites it will make it harder to visit a relative or friend. | This is likely to have a positive impact on carers, whether the carer looks after the patient or is the patient themselves. This is because they will not have to take time out of their lives to attend a hospital appointment.<br><br>Carers needs will become integral to the care plan. The new system will be designed to be more responsive and provide more support in the home environment and community.<br>There should be carer and public views taken into account in the planning of the new location.<br><br>Transport options should be widely publicised to family and carers. |
| | *Disability* | The majority of service users are likely to have a disability or long-term condition. As such, disabled people will be more impacted by the change than others.<br><br>Potential difficulties with communication and in understanding changes that are to be made, such as how to make care at home accessible, for example through the ability to send and receive texts to cater for deaf individuals rather than telephone conversations or using BSL apps. | This represents a positive impact on a protected group which is objectively justifiable under the Equality Act.<br><br>If certain technology is not accessible to disabled groups, we will provide direct support to the individual. SNC will develop a plan on how to implement the Accessible Information Standard to ensure that patients receive information in the format that is |

| | | | |
|---|---|---|---|
| | | Dependant on individual needs, home care may not be an option for some patients. | right for them.<br><br>For those people with disabilities as with all people who access the services, assessments will be made at the homes to identify requirements. Where a more supportive environment is needed patients can be transferred to a temporary placement such as a community bed, or a transitional placement such as extra care housing, until such time the person can be supported to return home. |
| | *Gender Reassignment* | Access to same-sex accommodation in the patient's chosen gender. | Contracts with care homes to include the requirement to comply with the Gender Recognition Act. |
| | *Marriage / Civil Partnership* | Some private care homes may not provide shared living accommodation for same sex couples | Contracts with care homes to include the requirement to comply with the Equality Act and provide equal access. |
| | *Pregnancy & Maternity* | | |
| | *Race* | The proposed changes may have a negative impact on any individual who does not speak English proficiently. This is because individuals may not understand documentation explaining the purpose of any changes. | It is recommended that leaflets explaining the service are available in the most common languages spoken in the Stockport area.<br><br>SNC to ensure that the integrated service provides clarity on access to interpretation services.<br><br>SNC to ensure that staff training plans include equality and diversity and how to access interpretation services. |
| | *Religion & Belief* | Increased care in the patient's home may raise issues for those with religious-based cultural differences, such as care providers taking off shoes in the home or requirements for gender specific care staff.<br><br>Bed based care may not cater for different dietary needs, quiet space for prayers, or facilities for ablutions. | Staff training plans to include equality and diversity, with staff working in patients' homes given a good understanding of cultural and religious diversity to meet local needs.<br><br>Contracts with care homes to include the requirement to comply with the Equality Act. |

| | | | |
|---|---|---|---|
| | *Sex* | Life expectancy is greater among women, who constitute a greater percentage of the over 65 group who will most benefit from these changes. | This represents a positive impact on a protected group, which is objectively justifiable under the Equality Act. |
| | *Sexual Orientation* | The proposed changes may have a negative impact on individuals who are concerned about experiencing stigma based on their sexual orientation. This has been reported as a potential barrier to individuals accessing healthcare, or revealing information that may benefit their care. | Staff training plans to include equality and diversity, so that all staff have a good understanding of diverse local needs. |

**IMPACT ON STAFF**

**15. How many staff work for the current service?**

The number of staff who currently work for the service is 170.25 Whole-Time Equivalents. The proposal is to increase this to 250.17 WTE as part of the Intermediate Tier Business Case.

It is envisaged that the new intermediate tier service will broadly operate within the existing financial envelope of in scope services, however there will be an increased workforce and a shift towards increased step up capacity to enable people to remain at home and avoid admission into hospital.

Detailed workforce modelling has been undertaken taking into consideration anticipated demand on the service and the skill mix required to support the new model, in summary the staffing will look as follows:

| Pathway | Current Staffing WTE (%) | Future Staffing WTE (%) |
|---|---|---|
| Step down | 125.23 (74%) | 95.60 (38%) |
| Step up | 45.02 (26%) | 154.57 (62%) |
| Total | 170.25 (100%) | 250.17 (100%) |

The additional capacity will enable a greater number of people to be cared for at home, for example once all permanent Home Support Workers are in post within Active Recovery this will enable a total of 13 teams across the borough, each team supporting up to 7/8 people, based on 4 visits per day between the hours of 7am -10pm this equates to approximately 100 people on any given day.

**16. What is the potential impact on these employees?** (including potential redundancies,

The additional capacity will enable a greater number of people to be cared for at home, for example once all permanent Home Support Workers are in post within Active Recovery this will enable a total of 13 teams across the borough, each team supporting up to 7/8 people, based on 4 visits per day between the hours of 7am -10pm this equates to approx.. 100 people on any given day.

This change will result in a shift of staff from ‘step down’ work to ‘step up’ roles, with place of work more dominantly in the community.

<table>
<tr><td></td><td>role changes, reduced hours, changes in terms and conditions, locality moves)</td><td colspan="2">Plans to roll out 7 day working will also create changes in working patterns, with extended hours and weekend working required. However, any changes to roles would be subject to staff consultation and all employees would have equal employments rights under their HR policies, including: TUPE, flexible working, reasonable adjustments.</td></tr>
<tr><td rowspan="13">17.</td><td rowspan="2">Is the potential impact on staff likely to be felt more by any protected group?</td><td colspan="2">If so, can you justify this difference? If not, what actions have you put in place to reduce the differential impact?</td></tr>
<tr><td>IMPACT</td><td>MITIGATION</td></tr>
<tr><td>Age</td><td>Members of staff with young families/childcare responsibilities may struggle with shift patterns and job rotation</td><td rowspan="11">Any changes in roles will be subject to staff consultation and will be managed under HR policies, offering equal opportunities for TUPE, reasonable adjustment and flexible working rights.</td></tr>
<tr><td>Carers</td><td>Staff with carers duties may struggle with shift patterns and job rotation</td></tr>
<tr><td>Disability</td><td>Working more in patients’ homes may not be accessible for staff with a disability</td></tr>
<tr><td>Gender Reassignment</td><td>No negative impact expected</td></tr>
<tr><td>Marriage / Civil Partnership</td><td>No negative impact expected</td></tr>
<tr><td>Pregnancy & Maternity</td><td>Working more in patients’ homes may create a health and safety risk for pregnant staff</td></tr>
<tr><td>Race</td><td rowspan="2">More working in a patient’s home could present cultural difficulties for minority groups</td></tr>
<tr><td>Religion & Belief</td></tr>
<tr><td>Sex</td><td>The majority of employees are female – as such women are more likely to be impacted by changes</td></tr>
<tr><td>Sexual Orientation</td><td></td></tr>
<tr><td>18.</td><td>What communication has been undertaken with staff?</td><td colspan="2">A range of staff have been involved in design sessions for Stockport Together representing a wide range of roles.<br><br>Staff engagement sessions, team briefs, newsletters, 1 to 1s have been used to communicate changes with staff as well as HR support, team building and culture change sessions.</td></tr>
<tr><td>19.</td><td>Do all affected workers have genuinely equal opportunities for retraining</td><td colspan="2">Yes – this is part of the work force development plan</td></tr>
</table>

| | | |
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| | **or redeployment ?** | |
| **IMPACT ON STAKEHOLDERS** | | |
| **20.** | **Who are the stakeholders for the service?** | Key stakeholders are:<br>• The public<br>• The Ambulance Service<br>• NHS 111 Service<br>• Stockport GPs<br>• Stepping Hill Hospital (A&E and wards)<br>• Stockport Care Homes<br>• Extra Care<br>• Council Social Services<br>• Targeted Prevention Alliance |
| **21.** | **What is the potential impact on these stakeholders ?** | Ambulance service / 111 will have an alternative offer for patients.<br>GPs / Care homes / extra care housing can use the crisis response team instead of sending someone to A&E.<br>Hospital receives support from the intermediate tier services to plan for a timely and successful discharge to place of residence or community bed and A&E has more choice to refer someone to the community instead of admitting someone. |
| **22.** | **What communicatio has been undertaken with stakeholders?** | The approach to developing the new intermediate tier service model and business case has engaged a number of stakeholders between June 2015 and June 2016, these include the following activities:<br>• Patient survey intermediate care (July 2015)<br>• Staff / stakeholder online survey intermediate tier (July 2015)<br>• GP consultation via pin board at various meetings (July 2015)<br>• GP consultation on rapid response via online survey (March 2015)<br>• A series of one-to-one discussions with key individuals to inform and help identify the key issues and any critical issues from either a particular organisational or professional perspective. (June 2015 to June 2015)<br>• Task & Finish group work with service managers/staff (August - November 2015).<br>• Stakeholder workshops at key stages of design:<br>• Current state validation<br>• Design workshop<br>• Check-in & Interface workshop with other workstreams to define boundaries and understand key questions to be addressed.<br>• Presentation of outline model to the Stockport Together Practitioner Design & Steering Group (June 2016)<br>• Presentation and discussions at Citizens Panel (June 2016)<br>• Engagement events with all staff within scope of Intermediate Tier (September 2016)<br>• Engagement at Neighbourhood leadership event (September 2016) |

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| | | As the project moves into implementation further engagement is required. The project will engage face to face with stakeholders (including service users) with a significant interest in the project and with those stakeholders where alternative communication methods are more appropriate, e.g. newsletters, briefings, etc.<br>A communications & engagement plan will be developed to ensure that there is effective two way communication with all those affected by the changes to the intermediate tier.<br>The project will seek to empower staff groups who will be delivering a new capability and a new patient-centred service so that the design, development and implementation has the full involvement and engagement of health and social care professionals, as well as end users of the intermediate tier services.<br><br>It is also anticipated that given the proposed changes to the provision of bed based services, that the intermediate tier service changes may require public consultation and the implementation plan has been developed on that basis. |
| **23.** | **What support is being offered to frontline staff to communicate this message with service users / family / carers?** | New uniform to mark the change, new patient leaflet, new format for an individual health and wellbeing plan, patient stories to highlight change and improvements<br><br>There is regular support from the operational delivery teams to support them in their discussions. |
| **24.** | **How will you monitor the impact of this project on equality groups?** | Equality data is collected by providers including: deprivation (postcode), age, disability, ethnicity; gender; religion; sexual orientation. This will be mapped against the equality data for Stockport as a borough as part of the public sector equality duty. If this highlights potential underrepresentation of certain groups, further analysis will be undertaken to understand the reason and an action plan will be developed to improve equality. Patient and carers surveys might also highlight inequalities which will then be acted upon. |
| **25.** | **Action Planning** | An action plan has been set out at the end of this document to capture all actions identified through the course of this Equality Impact Assessment required to:<br>• Mitigate any potential negative impacts<br>• Take advantage of opportunities to reduce inequalities<br>• Respond to patient and public engagement.<br><br>Actions in this plan will be included in the implementation plan for delivery of the Intermediate Tier changes.<br><br>At a strategic level, progress on the EIA action plan will be monitored regularly by the Stockport Together Programme Management Office as part of the governance framework for delivery of the work stream. |

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| **EIA SIGN OFF** | | | |
| **26.** | **Sign off** | EIAs should be approved by the work stream's Senior Responsible Officer and sent to an equality specialist for quality assurance before sign off.<br><br>Final EIAs should be attached to the final Strategy / Policy / Business Case before being presented to the relevant decision making Board. | |
| **a.** | **SRO Approval** | **Name:** Margaret Malkin / Paula Friggieri<br>**Date of approval:** x | |
| **b.** | **Quality Assurance** | **Quality Assured by:** Angela Dawber<br>**Date:** 20/12/2017 | |
| **c.** | **Board Approval** | **EIA considered by / Date:** | Joint Commissioning Board – 04/01/2018<br>Scrutiny Committee – 16/01/2018<br>SMBC Cabinet – 17/01/2018<br>CCG Governing Body – 31/01/2018 |

## 5. INTERMEDIATE TIER Equality Action Plan

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| IT01 | Equality Actions to be included in the Intermediate Tier Implementation Plan | Operational Lead | 31/01/2018 |
| IT02 | Intermediate Tier programme to send monthly updates on implementation (including progress on equality actions) to Stockport Together PMO | Operational Lead | 28/02/2018 |
| IT03 | Develop future engagement strategy for the work stream, identifying key stakeholders (including protected groups) and optimal communications methods (including translation and interpretation requirements) | Operational Lead | 31/03/2018 |
| IT04 | Patient engagement and complaints to be monitored by protected groups to ensure there are no adverse impacts on any groups | Operational Lead & SNC management | 31/03/2018 |
| IT05 | Stockport Neighbourhood Care to outline the process for meeting the Accessible Information Standard in the new service model:<br>• Agreement on Interpretation service (currently 3 services at SMBC, Primary Care and SFT)<br>• Collating data on formats required by patients<br>• Equality monitoring process<br>• System for sending patients communications in the correct format (e.g. Braille, large print)<br>• Service Level Agreements in place for translation information into other formats (Braille, BSL videos, audio format, other languages)<br>• Alternative contact methods to phone for deaf patients (e.g. Text-Relay service; text messaging; email; face-to-face) | Operational Lead & SNC management | 31/03/2018 |
| IT06 | Contracts with care home / bed-based care providers to set out the legal requirements to follow duties under the Equality Act and Accessible Information Standard, including:<br>• Equality monitoring & reporting<br>• Interpretation and translation services<br>• Accessible facilities | Lesley Brown & Gillian Miller | 31/03/2018 |

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| IT07 | Patients and carers' views to be sought in the planning of the new location.<br>• | Operational Lead & Estates | 31/03/2018 |
| IT08 | Patients and carers' views to be sought in the planning of the new location. | Operational Lead & Estates | 31/03/2018 |
| IT09 | Venue of new bed based facility assessed to ensure full access, including:<br>• Disabled parking<br>• Disabled toilets<br>• Changing facilities<br>• Hearing loops | Operational Lead & Estates | 31/03/2018 |
| IT10 | Communications plan for roll-out of the service changes, including:<br>• Map of stakeholders (including protected groups)<br>• Communications formats to meet needs to stakeholders<br>• Leaflets and other publicity to use inclusive images and language to demonstrate accessibility to all community groups | Operational Lead & Comms | 31/03/2018 |
| IT11 | Transport options for accessing the new bed based facility should be widely publicised to family and carers. | | |
| IT12 | IT plan developed to include:<br>• Training on how to use any self-care technology<br>• Alternative options for patients who are unable to use self-care technology<br>• Training on how to use skype technology for virtual appointments<br>• Alternative options for patients who are unable to access virtual appointments | Operational Lead & IT | 31/03/2018 |
| IT13 | Equality Impact Assessment of how the new service model will affect staff | Operational Lead & HR | 31/03/2018 |
| IT14 | Staff consultation on new service model and any changes to roles / places of work | Operational Lead & HR | 31/03/2018 |
| IT15 | Develop a staff training plan, including:<br>• Equality & Diversity Training<br>• Use of interpretation and translation services<br>• Equality monitoring to comply with AIS | Operational Lead & HR | 31/03/2018 |

# Stockport Together

# OUTPATIENTS BUSINESS CASE

# Equality Impact Assessment

## 1. Introduction

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Care) are working alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough – Stockport Together.

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of £156m across Stockport's health and social care services.

The Stockport Together programme aims to create a *sustainable* health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

In doing this, we want to ensure that our plans are fair and support all community groups.

## 2. The Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different community groups
- foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding.

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

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

Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

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

## 3. Scope of this Impact Assessment

A full equality impact assessment of the Stockport Together programme has been undertaken and can be found on our website at:

https://www.stockport-together.co.uk/equalities-information

The high level Strategy is backed up by four detailed work streams, which each address changes to different service areas:

- Neighbourhoods (Healthy Communities and Core Neighbourhood Services)
- Intermediate Tier Services
- Acute Interface - Ambulatory Care
- Acute Interface - Outpatients

The purpose of this document is to look in detail at the practical and operational impacts of proposed changes to the way Outpatient appointments are managed.

Actions arising from this impact assessment will be embedded into the Outpatients implementation plan and monitored as part of delivery by the Stockport Together Programme Management Office.

## 4. Equality Impact Assessment

| OUTPATIENTS EIA | | |
|---|---|---|
| **1.** | **Name of the Strategy / Policy / Service / Project** | Stockport Together - Outpatients Business Case |
| **2.** | **Champion / Responsible Lead** | Dr Cath Briggs / Andrea Stewart |
| **3.** | **What are the main aims?** | Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.<br><br>Since 2008/09 the rate of first outpatient appointments has risen by 26% nationally. Outpatient attendances have grown by 17% locally – a 15% growth in GP referrals and 20% growth in referrals from other professionals, including hospital consultants. These trends are likely to be magnified in future by demographic and epidemiological pressures.<br><br>In our current model, people are referred to hospital and receive specialist advice and support, often followed by recurrent follow-ups. Around 40-50% of outpatient appointments in Stockport result in advice and / or pharmaceutical treatment only, without the need for the patient to physically visit the hospital. Alternative approaches to the traditional model could deliver more effective solutions outside of the hospital setting, using technology to enable communications, advice and treatment between patients, GPs and specialists.<br><br>The outpatients work stream of Stockport Together aims to reduce the number of unnecessary outpatient attendances over the next 3 years by providing alternatives to the traditional way in which they are currently delivered. |
| **4.** | **List the main activities of the project:** | • Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice<br>• Support for GPs in clinical decision making<br>• Appropriate clinical triage of referrals and diagnostics Alternative mechanisms for traditional appointments and support to enable discharge from outpatient clinic<br>• Identifying outpatient activity that can be stopped |

| | | |
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| | | • Coordinated support for complex patients |
| **5.** | **What are the intended outcomes?** | Ultimately, Stockport Together aims to develop a ***sustainable*** health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care. The Outpatients work stream of Stockport Together should reduce the number of unnecessary hospital appointments, ensuring that:<br>• Patients access self-help, signposting and support at the earliest opportunity.<br>• Patients are confident and supported to take control and make positive decisions about their conditions and planning their care.<br>• Primary Care has access to specialist advice and support to encourage and enable management of conditions in a local, neighbourhood setting.<br>• GPs have access to appropriate training and education to manage patients in primary care that might otherwise have been referred to secondary care.<br>• Referrals are triaged systematically and specialists provide suitable advice to ensure that patients are managed in the most applicable setting by the most appropriate health professional.<br>• Diagnostic tests take place at the earliest opportunity in a patient pathway to inform the most appropriate treatment. This includes discharge with advice for patient and GP, and review by allied health professionals in non-acute settings.<br>• The amount of traditional outpatient activity is reduced by up to 38% over a 4 year period (2017/18-2020/21) including the identification and removal of unnecessary outpatient activity.<br>• Patient pathways are optimised and streamlined.<br>• Alternatives models of outpatient care are developed to move away from traditional specialist outpatient face-to-face appointments where appropriate.<br>• Patients have more flexible access to a specialism rather than having to attend traditional face-to-face appointments.<br>• Patients receive care in a hospital setting only when it is needed.<br>• Patients receive one-stop coordinated care where possible.<br>• Unnecessary urgent care is reduced through strengthened planned and urgent OP care. |
| **IMPACT ON SERVICE USERS** | | |
| **6.** | **Who currently uses this service?** | In theory, any person registered with one of Stockport's GP practices can be referred into the hospital for an outpatient appointment.<br><br>Outpatient attendances have grown by 17% locally – a 15% growth in GP |

referrals and 20% growth in referrals from other professionals, including hospital consultants.

In total, there were 101,315 first outpatient appointments for Stockport residents in 2016/17 and 243,005 follow-up appointments. Activity is particularly high among older residents and people with long-term conditions.

The latest Joint Strategic Needs Assessment (JSNA) indicates that around 51,000 of the first appointments (FA) and 175,500 of the follow up appointments (FUs) are attributable to the cohort 'all adults over the age of 18 that are in the 15% of the registered adult population identified as most at risk of emergency admission. A more detailed breakdown of patient demographics by protected groups has been requested as part of this EIA's action plan and will be monitored to ensure that all protected groups have equal access to services in the new model of care.

The top five specialties by first outpatient attendance volume together account for over 40% of the total first attendances. They have remained stable in the last four years:

| Outpatient Activity at Stockport NHS FT**: | First Appointments | | Follow-up appointments | |
|---|---|---|---|---|
| | 2015/16 | 2016/17 | 2015/16 | 2016/17 |
| Trauma & Orthopaedics | 12,206 | 12,378 | 19,710 | 19,324 |
| General Medicine* | 9,386 | 10,609 | 4,800 | 14,968 |
| Ophthalmology | 6,130 | 6,300 | 7,719 | 17,067 |
| Ear Nose & Throat | 5,992 | 5,993 | 8,557 | 7,164 |
| General Surgery | 5,875 | 6,047 | 6,647 | 6,430 |
| Anti-Coagulant | 560 | 536 | 44,259 | 40,902 |

* General Medicine includes Cardiology, Respiratory, Gastroenterology, Diabetes and Endocrinology
** This activity only relates to outpatient appointments commissioned at Stockport FT.

Further information on protected characteristics within Stockport's population can be found in the full Equality Impact Assessment of the Stockport Together Strategy:
https://www.stockport-together.co.uk/equalities-information

A breakdown of local service users and their needs can also be found in Stockport's Joint Strategic Needs Assessment: http://www.stockportjsna.org.uk/

**7. Are there any clear gaps in access to this service?** (e.g. low access by ethnic minority

The current service is open to all patients registered with a GP in Stockport. That said, we know that:

- Men are less likely to attend their GP Practice, where initial referrals into secondary care are made
- Outpatient referrals rates are higher in more affluent areas of the borough

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| | groups) | • Patients with limited mobility, people in deprived areas, adults in full-time employment, and those with caring responsibilities have noted issues attending multiple appointments at the hospital<br><br>As noted above, more detailed monitoring has been requested as part of the action plan to this EIA so that the impact of changes to the service can be tracked. |
| **8.** | **Are there currently any barriers to certain groups accessing this service?** (e.g. no disabled parking / canteen doesn't offer Kosher food / no hearing loop) | A number of residents have raised issues with the cost of car parking at Stepping Hill Hospital, particularly for those on low incomes and people with multiple long-term conditions who need to attend more than one clinic.<br><br>Older patients, people with disabilities and those with English as a second language have raised issues around communications from the hospital – with appointment letters sent by post in a standard format that does not consider requirements for Braille, large print, Makaton or translation into other languages.<br><br>It is recognised that technology based solutions will need to be accessible to all patients and alternative, traditional access methods available for those patients who are unable to use technological solutions. |
| **9.** | **How will this project change the service offered?** (is it likely to cut any services?) | The proposed changes in the outpatient service will mean that people will be supported to manage health by the most appropriate professional in the most appropriate setting by the most appropriate way to meets their clinical need.<br><br>This will mean a reduction in unnecessary trips to hospital and more care closer to home, such as in a local GP practice or community clinic. It will also include options such as follow-up appointments by phone or skype. |
| **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?) | There will be a reduction in the number of unnecessary outpatient appointments in a hospital setting; however the changes will not prevent people from accessing services.<br><br>The service users will still receive the care that is needed, however it may be that it is delivered in a different way such as a follow-up in the local GP Practice.<br><br>Where a patient's condition requires input from specialist consultants, they will continue to receive this level of care, though this may be in a community setting, rather than in the hospital. The move of routine follow-ups into the community will reduce waiting times for these higher risk patients for seeing a specialist. |
| **11.** | **If you are creating any new services, who most** | These changes will apply to any patient who is registered with a Stockport GP, however, given the higher use of elective services among women, older people and those with a disability or long-term condition, the impacts of more proactive care, reduced hospital trips and care closer to home will be of most |

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| | **likely to benefit from them?** (Will any equality group be more or less likely to benefit from the changes?) | benefit to these protected groups. |
| **12.** | **How will you communicate the changes to your service?** (What communications methods will you use to ensure this message reaches all community groups?) | The implementation of the service is combined with communication to various groups to inform them how they will receive outpatient care. This will be done through newsletters, staff engagement sessions, attending GP locality meetings, partnership working with ambulance service, ED and hospital, meetings with expert patient groups and patient reference groups, meeting with HealthWatch, patient stories to highlight change, information at GP practices and information at website and social media.<br><br>Public engagement and consultation included meetings with local groups representing protected characteristics to ensure that all voices were heard and all concerns / impacts understood.<br><br>Information was disseminated in a range of formats:<br>• Online survey<br>• Paper surveys<br>• Public events<br>• Fliers and consultation documents handed out in clinics and displayed in Libraries, Pharmacies and GP Practices<br><br>The consultation document included a message explaining how information could be obtained in an alternative format. Events were undertaken in accessible local venues across each area of Stockport, offering interpretation where required. |
| **13.** | **What have the public and patients said about the proposed changes?** (Is this project responding to local needs?) | Initial consultation across a sample of Outpatient clinics reflects broad support for the planned changes with the caveat that standards of care are maintained.<br><br>Patients were asked a range of questions relating to their experience in the clinic they attended and their views about possible alternative approaches:<br>• 81% would consider seeing other appropriate healthcare professionals within the community.<br>• 54% would be happy for your care to be delivered in other ways rather than face to face.<br>• 90% would be happy to become involved in ways of directly managing/ monitoring your own health.<br><br>A full write up of engagement can be found on the Stockport Together website at: https://www.stockport-together.co.uk/key-documents |

| 14. | 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?) | |
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| | | **IMPACT** | **MITIGATION** |
| | *Age* | Older people are more likely to use elective outpatient services | This impact will be a positive one, reducing unnecessary hospital appointments, moving more care to a local setting and reducing waiting times for patients who require specialist input. This positive impact on a protected is objectively justifiable under the Equality Act. |
| | | Some older people struggle with the use of technology for alternative appointments or self care monitoring | Training should be made available on how to use any self-care equipment or technology such as skype for virtual appointments and alternative options should be given for those who struggle to use new equipment |
| | *Carers* | Local carers have noted issues taking patients to multiple appointments and the cost of parking in hospitals | This impact will be a positive one, reducing unnecessary hospital appointments, moving more care to a local setting and reducing waiting times for patients who require specialist input. |
| | *Disability* | People with one or more long-term condition are more likely to require elective procedures. | This impact will be a positive one, reducing unnecessary hospital appointments, moving more care to a local setting and reducing waiting times for patients who require specialist input. |
| | | Local disability groups have noted issues with the format of communications from the hospital | Contracts for the new neighbourhood services will include requirements to ensure that patient communications are undertaken in the most appropriate format for the individual. |
| | | Additional access requirements at any new community venues | Venues for new community clinics will be required by contract to meet access standards. |
| | | People with physical or learning disabilities may struggle with the use of | Training should be made available on how to use any self-care |

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| | | technology for alternative appointments or self care monitoring<br><br>The service could have a negative impact on individuals with a learning disability or dementia, who may be less able to initiate a follow-up appointment. | equipment or technology such as skype for virtual appointments and alternative options should be given for those who struggle to use new equipment<br><br>Consider alternative methods of communication such as how to make telephone services accessible, for example through the ability to send and receive text to cater for deaf individuals. |
| | *Gender Reassignment* | | |
| | *Marriage / Civil Partnership* | | |
| | *Pregnancy & Maternity* | The service will likely have a positive impact on parents with young children, due to a reduced requirement for parents to arrange childcare around hospital appointments.<br><br>It is likely to have a positive impact for pregnant women who may find it harder to travel into hospital for their appointment. | This represents a positive impact on a protected group, which is objectively justifiable under the Equality Act |
| | *Race* | While interpretation is provided for most hospital appointments, local residents have reported appointment cancellations due to a lack of interpretation and issues understanding communications sent from the hospital. | Contracts for the new neighbourhood services will include requirements to ensure that patient communications are undertaken in the most appropriate format for the individual and interpretation services are provided. |
| | *Religion & Belief* | | |
| | *Sex* | Women are more likely to use elective outpatient services than men and, as such, will be more impacted by changes.<br><br>Men are less likely to attend their GP Practice, as such they are less likely to | This represents a positive impact on a protected group, which is objectively justifiable under the Equality Act - reducing unnecessary hospital appointments, moving more care to a local setting and reducing waiting times for patients who require specialist input.<br><br>Evidence suggests that flexible opening hours and improved |

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| | | benefit from the changes. | information available online could be levers that could make use of the service more accessible for men. Demographics should be measured to ensure that similar proportions of men and women are accessing follow-ups. Leaflets would also benefit from including images of men and the leaflet should be written in a gender neutral format. |
| | *Sexual Orientation* | The proposed changes may have a negative impact on individuals who are concerned about experiencing stigma based on their sexual orientation. This has been reported as a potential barrier to individuals accessing healthcare, or revealing information that may benefit their care | Staff training should include equality and diversity.<br><br>Engagement plan should include work with LGBT groups.<br><br>Patient data monitoring should include sexual orientation to ensure equal access and that no group receives a worse service.<br><br>Consideration should be given to use of imagery in publicity / leaflets to demonstrate accessibility. |
| **IMPACT ON STAFF** | | | |
| **15.** | **How many staff work for the current service?** | The current service is delivered across a wide range of specialties based at provider sites.<br><br>Currently, 117.54 Full-Time Equivalents work in Outpatients at Stockport NHS FT:<br>• 36.6% are nurses; 23.53% work in admin; and 39.87% are classed as additional clinical services<br>• 96.73% are female and 3.27% are male<br>• 7.84% were in their 20s; 18.95% were in their 30s; 16.99% in their 4s; 38.56% in their 50s; 16.34% in their 60s; and 0.65% were in their 70s<br>• 85.62% are White British; 3.92% come from a White Minority background; 1.96% are Asian; 2.61% are Black; and 5.88% have not stated their ethnic origin<br>• 56.86% were Christian; 11.76% atheist; 6.54% reported following another religion; and 24.84% did not declare their religion or belief<br>• 7.84% reported a disability; 71.9% reported no disability; and 20.26% did not declare<br>• 74.51% reported being heterosexual; 1.31% were LGB; and 24.18% did not declare their sexual orientation.<br><br>In addition, 356.75 FTEs work in surgery; and 148.93 FTEs are employed in trauma & orthopaedic surgery, who may also be impacted by the changes. As | |

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| | | part of the staff consultation on changes, all employees affected by the changes will have a chance to give their views and any impacts will be assessed by protected group. |
| **16.** | **What is the potential impact on these employees?** (including potential redundancies, role changes, reduced hours, changes in terms and conditions, locality moves) | Stockport Together aims to reduce the number of outpatient appointments at Stepping Hill Hospital by 38% - 107,513 fewer appointments - by 2020/21.<br><br>The new model of care for outpatients depends upon a more integrated and aligned approach. The redesigned pathway moves away from a traditional approach where a patient is passed from GP to specialist to involve a wider spectrum of health professionals, who may be better placed to provide different aspects of patient care throughout the patient journey. This will inevitably require a more flexible, responsive and potentially complex approach to bring the right skill-mix of people together, at different points across the pathway e.g. community support, specialist nurses, pharmacists, GPwSI. GPs, specialists and other health professionals as required.<br><br>The workforce may be required to work in an alternative setting and will require changes to job plans to enable them to work in a different way to traditional service delivery of outpatients.<br><br>In order to deliver the model to the ambitions described a review of the existing workforce will be required to inform the development of a detailed workforce plan which describes the sequence of the proposed service changes and the associated impact on the workforce across the services. This proposal should include plans to deliver:<br>• Clear clinical governance<br>• New job roles<br>• Training and development programme<br><br>It is not envisaged that there will be redundancies at this stage. However, any changes to roles would be subject to staff consultation and all employees would have equal employments rights under their HR policies, including: TUPE, flexible working, reasonable adjustments. |
| **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?* |
| | | **IMPACT** / **MITIGATION** |
| | *Age* | The average age of SFT employees is 45. There are more employees in their 40s or 50s than in their 20s or 30s. Older employees are more likely to work part-time and in nursing roles, which may limit options for potential job changes. / Any changes in roles will be subject to staff consultation and will be managed under HR policies, offering equal opportunities for TUPE, reasonable adjustment and flexible working rights. |

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| | *Carers* | 49.57% of SFT employees work part-time. Those with caring responsibilities may be limited in their ability to move or in working hours | |
| | *Disability* | 2.89% of SFT employees report having a disability. Changes in roles may require reasonable adjustments for those with a disability | |
| | *Gender Reassignment* | No data is recorded by SFT on gender identity, however HR policies will apply ensuring that all staff have equal opportunities. | |
| | *Marriage / Civil Partnership* | No | |
| | *Pregnancy & Maternity* | SFT HR policies follow national legislation on legal rights for employees during pregnancy and maternity | |
| | *Race* | 82.42% of SFT employees are white, with higher rates of BME staff among consultant roles and auxiliary positions. | |
| | *Religion & Belief* | 52.49% of SFT employees record their religion as Christian | |
| | *Sex* | 78.05% of SFT employees are female – 96% of outpatients staff. Representation of men is higher in medical roles (64.52%) and particularly low in nursing roles (7.4%). | |
| | *Sexual Orientation* | 1% of SFT employees record their sexual orientation as homosexual and 0.39% as bisexual | |
| **18.** | **What communication has been undertaken with staff?** | A range of staff have been involved in design sessions for Stockport Together representing a wide range of roles.<br><br>Staff engagement sessions, team briefs, newsletters, 1 to 1s have been used to communicate changes with staff as well as HR support, team building and culture change sessions. | |
| **19.** | **Do all affected workers have genuinely equal opportunities for retraining or redeployment?** | Yes – this is part of the work force development plan | |

| IMPACT ON STAKEHOLDERS | | |
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| 20. | **Who are the stakeholders for the service?** | It is recognised that the proposed new model of care for outpatients is complex and involves a range of stakeholders whose engagement and active participation will be key to the successful delivery of this business case. Key stakeholders include:<br>• **Patients** – are central to the proposed model of care in relation to becoming activated and taking greater control of their own care and in accepting the proposed changes to their care.<br>• **GPs** – will work in closer partnership with specialist clinicians to manage the care of their patients with appropriate advice and support from clinicians and healthcare professionals.<br>• **Specialist clinicians** – will be expected to work differently providing specialist advice, guidance, protocols and care management plans so that where appropriate patients can self-manage or be managed by other healthcare professionals. Their knowledge, expertise and specialist clinical judgement is vital to informing the feasibility of future plans.<br>• **Appointment booking teams** – will be required to operate potentially more varied and flexible approaches to provide patient access to the most appropriate clinical support. This will require more streamlined approaches and flexibility to adapt to changing pathways.<br>• **Neighbourhood and borough wide teams and other health professionals** – will be responsible for delivering different aspects of patient care including specialist nurses, pharmacists, physiotherapists etc. in addition to the provision of an effective contact, access and triage infrastructure to enable the ongoing care of patients with long-term conditions.<br>• **Third sector and community support groups** – are essential to providing a support mechanism for patients to share experiences, learning and support. |
| 21. | **What is the potential impact on these stakeholders?** | Potential increase in activity for community and primary care staff<br>Potential decrease in activity for secondary care staff<br><br>Changes to the service delivery could impact place of work and changes to job plans. |
| 22. | **What communication has been undertaken with stakeholders?** | Consultation exercises with clinicians and patients have been undertaken to test and identify opportunities to support and enable this approach.<br><br>Clinicians noted a wide range of areas where outpatient activity could be managed differently, through GP and nurse-led clinics, one-stop clinics, virtual appointments and more joint working.<br><br>81% of patients said they would consider seeing different healthcare professionals in the community for follow-up appointments. 54% would be happy for care to be delivered in other ways rather than face-to-face. 90% would be happy to become involves in directly managing / monitoring their |

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| | | own health.<br><br>Key findings can be found in Appendix 3 of the Outpatients Business Case.<br><br>In addition, regular meetings, presentations and emails have been used to keep stakeholders up to date on progress. |
| **23.** | **What support is being offered to frontline staff to communicate with service users / family / carers?** | There is regular support from the operational delivery teams to support them in their discussions. |
| **24.** | **How will you monitor the impact of this project on equality groups?** | Equality data is collected by providers including: deprivation (postcode), age, disability, ethnicity; gender; religion; sexual orientation. This will be mapped against the equality data for Stockport as a borough as part of the public sector equality duty. If this highlights potential underrepresentation of certain groups, further analysis will be undertaken to understand the reason and an action plan will be developed to improve equality. Patient and carers surveys might also highlight inequalities which will then be acted upon. |
| **25.** | **Action Planning** | An action plan has been set out at the end of this document to capture all actions identified through the course of this Equality Impact Assessment required to:<br>• Mitigate any potential negative impacts<br>• Take advantage of opportunities to reduce inequalities<br>• Respond to patient and public engagement.<br><br>Actions in this plan will be included in the implementation plan for delivery of the Outpatients changes.<br><br>At a strategic level, progress on the EIA action plan will be monitored regularly by the Stockport Together Programme Management Office as part of the governance framework for delivery of the work stream. |
| **EIA SIGN OFF** | | |
| **26.** | **Sign off** | EIAs should be approved by the work stream's Senior Responsible Officer and sent to an equality specialist for quality assurance before sign off.<br><br>Final EIAs should be attached to the final Strategy / Policy / Business Case before being presented to the relevant decision making Board. |
| **a.** | **SRO Approval** | **Name:** Dr Cath Briggs<br>**Date of approval:** x |
| **b.** | **Quality** | **Quality Assured by:** Angela Dawber |

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| | **Assurance** | **Date:** 20/12/2017 | |
| **c.** | **Board Approval** | **EIA considered by / Date:** | Joint Commissioning Board – 04/01/2018<br>Scrutiny Committee – 16/01/2018<br>SMBC Cabinet – 17/01/2018<br>CCG Governing Body – 31/01/2018 |

## 5. OUTPATIENTS Equality Action Plan

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| OP01 | Equality Actions to be included in Outpatients Implementation Plan | Operational Lead | 31/01/2018 |
| OP02 | Outpatients programme to send monthly updates on implementation (including progress on equality actions) to Stockport Together PMO | Operational Lead | 28/02/2018 |
| OP03 | Develop future engagement strategy for the work stream, identifying key stakeholders (including protected groups) and optimal communications methods (including translation and interpretation requirements) | Operational Lead | 31/03/2018 |
| OP04 | Patient engagement and complaints to be monitored by protected groups to ensure there are no adverse impacts on any groups | Operational Lead & SNC management | 31/03/2018 |
| OP05 | Stockport Neighbourhood Care to outline the process for meeting the Accessible Information Standard in the new service model:<br>• Agreement on Interpretation service (currently 3 services at SMBC, Primary Care and SFT)<br>• Collating data on formats required by patients<br>• Equality monitoring process<br>• System for sending patients communications in the correct format (e.g. Braille, large print)<br>• Service Level Agreements in place for translation information into other formats (Braille, BSL videos, audio format, other languages)<br>• Alternative contact methods to phone for deaf patients (e.g. Text-Relay service; text messaging; email; face-to-face) | Operational Lead & SNC management | 31/03/2018 |
| OP06 | SNC Contract to set out the legal requirements of the new integrated organisation to follow duties under the Equality Act and Accessible Information Standard, including:<br>• Equality monitoring & reporting<br>• Interpretation and translation services<br>• Accessible facilities | Lesley Brown & Gillian Miller | 31/03/2018 |

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| OP07 | Venues of new clinics assessed to ensure full access, including:<br>• Disabled parking<br>• Disabled toilets<br>• Changing facilities<br>• Hearing loops | Operational Lead & Estates | 31/03/2018 |
| OP08 | Communications plan for roll-out of the service changes, including:<br>• Map of stakeholders (including protected groups)<br>• Communications formats to meet needs to stakeholders<br>• Leaflets and other publicity to use inclusive images and language to demonstrate accessibility to all community groups | Operational Lead & Comms | 31/03/2018 |
| OP09 | IT plan developed to include:<br>• Training on how to use any self-care technology<br>• Alternative options for patients who are unable to use self-care technology<br>• Training on how to use skype technology for virtual appointments<br>• Alternative options for patients who are unable to access virtual appointments | Operational Lead & IT | 31/03/2018 |
| OP10 | Equality Impact Assessment of how the new service model will affect staff | Operational Lead & HR | 31/03/2018 |
| OP11 | Staff consultation on new service model and any changes to roles / places of work | Operational Lead & HR | 31/03/2018 |
| OP12 | Develop a staff training plan, including:<br>• Equality & Diversity Training<br>• Use of interpretation and translation services<br>• Equality monitoring to comply with AIS | Operational Lead & HR | 31/03/2018 |
| OP13 | Establish baseline figures for people accessing the services from protected groups then monitor these levels as the service changes are implemented. | Operational Leads | 31/01/2018 |

# Stockport Together

# NEIGHBOURHOODS BUSINESS CASE

# Equality Impact Assessment

## 1. Introduction

The partner organisations across Stockport (Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council and Stockport's GP federation, Viaduct Care) are working alongside GPs and voluntary organisations to develop a single strategic plan to improve health and social care services across the borough – Stockport Together.

Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current fragmented form, the health and social care system is financially unsustainable. If no changes are made, by 2010/21 there will be a combined deficit of **£156m** across Stockport's health and social care services.

The Stockport Together programme aims to create a *sustainable* health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

In doing this, we want to ensure that our plans are fair and support all community groups.

## 2. The Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different community groups
- foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding.

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

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

Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

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

## 3. Scope of this Impact Assessment

A full equality impact assessment of the Stockport Together programme has been undertaken and can be found on our website at:

https://www.stockport-together.co.uk/equalities-information

The high level Strategy is backed up by four detailed work streams, which each address changes to different service areas:

- Neighbourhoods (Healthy communities and Core Neighbourhood Services)
- Intermediate Tier Services
- Acute Interface Ambulatory Care
- Acute Interface Outpatients

The purpose of this document is to look in detail at the practical and operational impacts of the implementation of the Neighbourhoods proposal.

Actions arising from this impact assessment will be embedded into the Neighbourhood implementation plan and monitored as part of delivery by the Stockport Together Programme Management Office.

## 4. Equality Impact Assessment

| Neighbourhoods EIA | | |
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| 1. | **Name of the Strategy / Policy / Service / Project** | Stockport Together – Neighbourhood Business Case |
| 2. | **Champion / Responsible Lead** | Dr Viren Mehta / Operational Lead?? |
| 3. | **What are the main aims?** | Like many areas across the country, health and social care services in Stockport are subject to growing demand from an ageing population with increasingly complex care needs. In its current form, Stockport's health and social care system is unsustainable. If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be a funding gap of around **£156m**.<br><br>27% of the population (84,700) have at least one long-term condition. By age 60 this rises to 50% and by age 85, 88% of the population have at least one long-term condition. The number of Stockport residents aged 65 and over is set to rise from 55,700 to 61,000 by 2020. It is therefore estimated that the number of people living with a long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease.<br><br>Rising prevalence of dementia has also contributed to increasing complexity in social care. We know that there are 2,850 people in Stockport who have dementia, with a further 1,000 people undiagnosed – this is higher than the national average and increasing. By 2030 dementia prevalence will be 50% higher than it is currently. Emergency admissions for dementia have doubled in the last 8 years with 2,200 emergency admissions for dementia per year.<br><br>For many years, Stockport has had a much higher rate of emergency hospital admissions than peers or the England average. Unnecessary or overlong stays in hospital are neither good for individuals nor the finances of the system. If a person over the age of 80 spends 10 days or more in hospital then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living difficult.<br><br>High rates of expensive non-elective admissions have resulted in a chronic underfunding of primary and community services. Stockport spends £5.43 a head less on primary care than Greater Manchester colleagues. Compared to the national average, Stockport over-funds hospital care and underfunds both physical and mental health out of hospital. |

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| | | If working practices do not change, the financial position is set to deteriorate so that by 2020/21 there will be an economy deficit of around £156 million. The current system is also unsustainable in terms of workforce capacity, with significant recruitment challenges for: Consultants; GPs; nurses; and social workers. Even if we had the resources to fund growing demand, it is unlikely that we would have the professional workforce to run an enlarged version of the existing system. |
| **4.** | **List the main activities of the project:** | • Implementing neighbourhood teams<br>• Implementing multidisciplinary teams<br>• Implementing seven-day services (primary care and wider neighbourhood services)<br>• Implementing neighbourhood hubs / treatment centres<br>• Implementing new models of care for primary care and collaborative general practice. |
| **5.** | **What are the intended outcomes?** | Ultimately, Stockport Together aims to develop a ***sustainable*** health & care system for the people of Stockport delivering improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care. The Neighbourhoods work stream of Stockport Together will:<br>1. Create 8 neighbourhood teams with primary care at the centre<br>2. Deliver increased capacity in community and primary care to enable the shift in care from the acute setting<br>3. Align resources into multidisciplinary teams to provide focused and personalised support for those most at risk of admission to hospital<br>4. Implement a reshaped primary care team, able to defect activity from GPs' thus releasing time to care (additional support for those most at risk of admissions) and ensure safe and sustainable general practice<br>5. Implement find and prevent, self-care and lifestyle based support for those at risk of developing a long -term condition<br>6. Services (physical and mental health and social care) wrapped around the needs of people<br>7. To ensure neighbourhood capacity meets the local need<br>8. To align resources to where they are most needed<br>9. To facilitate the move to early intervention and prevention |
| **10. IMPACT ON SERVICE USERS** | | |
| **6.** | **Who currently uses this service?** | The current services include primary care, community care, mental health and adult social care services. The principle service areas directly in scope of this business case are:<br>• All adult services provided by Stockport NHS Foundation Trust through its community contract.<br>• All adult services provided in the community by Pennine Care NHS Foundation Trust, excluding Learning Disabilities and drug and alcohol services.<br>• All non-core services provided through general practices in Stockport |

and through their local GP Federation Viaduct Care.
- Several pertinent services provided by the Targeted Prevention Alliance (TPA.)

The model will be developed for the whole GP adult registered population, however, the focus of the new neighbourhood model is predominantly people over 65 with complex needs / one or more long-term condition:

- 70% of all health and social care spend goes on long term conditions
- 50% of GP appointments and 7 out of 10 hospital beds are utilised by people with one or more long-term conditions
- Over 4,000 patients overdue for an appointment for a long-term condition on the Stockport Foundation Trust Outpatients waiting list.

The table below details the eight most prevalent long-term conditions in Stockport.

| Long-term condition | Number of people |
|---|---|
| Hypertension | 44,745 |
| Anxiety | 30,085 |
| Depression | 29,100 |
| Asthma | 20,545 |
| Obesity | 20,050 |
| Diabetes | 15,700 |
| Coronary heart disease | 12,230 |
| History of falls | 12,150 |

*Source: Stockport JSNA 2015-19, Long Term Conditions October 2016 http://www.stockportjsna.org.uk/wp-content/uploads/2016/11/2015-19-JSNA-Long-term-Conditions.pdf*

27% of the population (84,700) have at least one of these eight conditions and this increases with age, from 2% in the 0-4 age band, to 88% in those aged 85 and over. By age 60, half of the people have one or more of these conditions and 15% of the population have two or more of eight key long-term conditions. Many more may also have a condition which is currently undiagnosed. It is estimated that the number of people living with more than one long-term condition will increase by 53% in the next decade, which will challenge the traditional way of delivering services and managing disease. For us in Stockport this will equate to an additional 47,700 people living with a condition.

Prevalence of dementia has contributed to increasing complexity in social care. We know that there are 2,850 people in Stockport who have dementia, with a further 1000 people living with dementia who have not had a diagnosis. Dementia prevalence is higher than the national average and increasing. By 2030 dementia prevalence will be 50% higher than it is currently. Emergency admissions for dementia have doubled in the last 8 years with 2200 emergency admissions for dementia per year.

Further information on protected characteristics within Stockport's population

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| | | can be found in the full Equality Impact Assessment of the Stockport Together Strategy: https://www.stockport-together.co.uk/equalities-information<br><br>A breakdown of local service users and their needs can also be found in Stockport's Joint Strategic Needs Assessment: http://www.stockportjsna.org.uk/ |
| **7.** | **Are there any clear gaps in access to this service?** (e.g. low access by ethnic minority groups) | Current services are open to all community groups who reside in Stockport. However, we know that:<br>• men are less likely to attend their GP practice, with inflexible opening times often given as a reason<br>• Refugees, asylum seekers and new residents who are unaware of primary and community services tend to rely on hospital care<br>• Homeless people have noted issues registering with a GP practice. |
| **8.** | **Are there currently any barriers to certain groups accessing this service?** (e.g. no disabled parking / canteen doesn't offer Kosher food / no hearing loop) | The current services are fragmented with variable access. Those with complex needs often find it difficult to navigate between providers and services. It is envisaged that people and carers will be support by multidisciplinary teams to access the required services and have a single care plan. This will reduce the complexity of navigating the system and improve first time access.<br><br>Stockport's over-reliance on hospital care can be difficult for people with multiple and complex care needs and their carers – this business case aims to support the delivery of more care close to home, reduce this access issue. |
| **9.** | **How will this project change the service offered?** (is it likely to cut any services?) | The proposed changes in neighbourhood services will result in:<br>• An increased workforce supporting more people in their own place of residence<br>• An increase in workforce based in neighbourhoods<br>• Increase local access to primary care and extended primary care services<br>• Provide seven-day access, tailored to meet the needs of local people<br>• A shift in place of care from the acute to neighbourhood setting<br>• Reduction in duplication<br>• More joined up working between health and social care and with third sector<br>• More choice of appointment times for GP and extended services<br>• More choice of 'first contact' professional<br>• Greater coordination of services for those most at risk of admission to hospital<br>• Increased system leadership from GP's<br>• A shift in focus from illness management to early intervention and identification and prevention<br>• Improved accessibility for people not registered with a GP (homeless / no fixed abode, travellers) |

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| **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?) | The only reduction will be a shift in usages and a reduction in the bed based service but this is a safe and preferable option because there will be more staff available to support people in their own home during day and night and thereby preventing admissions.<br><br>No equality group will be more likely to lose their existing service. |
| **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?) | Capacity in neighbourhoods will be increased based upon need and weighted for deprivation. The multidisciplinary approach will support those most at risk of admissions. The overall impact will be increased support and provision for the most vulnerable and disadvantaged with reduced variation in quality and access. Older people, carers, hose with a disability, complex care need or mental health requirement will benefit the most. There will also be increased opportunities for people who are not registered with a Stockport GP but part of the Stockport health and care system to access services. |
| **12.** | **How will you communicate the changes to your service?** (What communications methods will you use to ensure this message reaches all community groups?) | The implementation of the service is combined with communication to various groups to inform them how and when to access services. This will be done through newsletters, staff engagement sessions, attending GP locality meetings, partnership working with ambulance service, ED and hospital, meetings with expert patient groups and patient reference groups, meeting with HealthWatch, patient stories to highlight change, information at GP practices and information at website and social media. |
| **13.** | **What have the public and patients said about the proposed changes?** (Is this project responding to local needs?) | The case for change was built based on engagement with the public and professionals. Public engagement and consultation included meetings with local groups representing protected characteristics to ensure that all voices were heard and all concerns / impacts understood.<br><br>Information was disseminated in a range of formats:<br>• Online survey<br>• Paper surveys<br>• Public events<br>• Fliers and consultation documents handed out in clinics and displayed in Libraries, Pharmacies and GP Practices |

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| | | The consultation document included a message explaining how information could be obtained in an alternative format. Events were undertaken in accessible local venues across each area of Stockport, offering interpretation where required.<br><br>The key messages from engagement activity were:<br>• Services are not clear on what is on offer and how to access<br>• There is currently significant repetition and need to repeat a story is commonplace<br>• Services are disconnected<br>• There is significant duplication (e.g. assessment)<br>• People would like more services closer to home<br>• People would like to access services at convenient times, reflecting their working and home lives<br><br>A full write up of engagement can be found on the Stockport Together website at: https://www.stockport-together.co.uk/key-documents |
| **14.** | **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?*** |
| | | **IMPACT** / **MITIGATION** |
| | *Age* | Services are designed predominantly for 65+ so the service is likely to impact the elderly the most.<br><br>All age groups will have a reduced number of hospital appointments, thereby reducing time taken out of their lives to attend appointments and the associated costs for travel and/or car parking. |
| | | Service access is based on need not based on age so there will be no age restriction other than 18+.<br><br>However, this focus on over 65s represents a positive impact on a protected group, which is objectively justifiable under the Equality Act. |
| | *Carers* | Positive impact expected as the service is predicted to reduce attendances, which will mean patients do not have to travel into hospital for their appointment.<br><br>Extended hours will enable working carers to attend evening and weekend appointments<br><br>The needs of carers will be assessed at the same time as the patient |
| | | This is likely to have a positive impact on carers, whether the carer looks after the patient or is the patient themselves. This is because they will not have to take time out of their lives to attend a hospital appointment.<br><br>Again, this represents a positive impact on a protected group, which is objectively justifiable under the Equality Act. |

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| | *Disability* | This service is targeted at residents with multiple and complex care needs, who are protected under the characteristics of 'disability'.<br><br>Some patients with disabilities may experience greater difficulties in understanding the changes or less able to benefit from new technologies for self-care at home. | The new model aims to take a proactive approach to managing disabilities and long-term conditions, preventing deterioration and improving independence. Care and support will be coordinated by a Multi-Disciplinary Team, reducing the need for repeating their story and improving patient experience.<br><br>This represents a positive impact on a protected group, which is objectively justifiable under the Equality Act.<br><br>Stockport Neighbourhood Care will set out a plan of how it will meet the Accessible Information Standard, providing information in the correct format for aptients, such as the ability to send and receive texts to cater for deaf individuals rather than telephone conversations or using BSL apps. If certain technology is not accessible, assessments will be made as to whether carers could support the use of this technology and traditional support in a GP practice or community clinic will be made available to those who cannot use the technology.. |
| | *Gender Reassignment* | | |
| | *Marriage / Civil Partnership* | | |
| | *Pregnancy & Maternity* | | |
| | *Race* | The proposed changes may have a negative impact on any individual who does not speak English proficiently. This is because individuals may not understand documentation explaining the purpose of any changes. | The NHS and Council already provide an interpreting service for anyone who does not speak English proficiently. Stockport Neighbourhood Care will assess the best use of interpretation as an integrated service. |
| | *Religion & Belief* | Increased care in the patient's home may raise issues for those with religious-based cultural differences, | Staff training plans to include equality and diversity, with staff working in patients' homes given a |

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| | | such as care providers taking off shoes in the home or requirements for gender specific care staff. | good understanding of cultural and religious diversity to meet local needs. |
| | *Sex* | Life expectancy is greater among women, who constitute a greater percentage of the over 65 group who will most benefit from these changes. | This represents a positive impact on a protected group, which is objectively justifiable under the Equality Act. |
| | *Sexual Orientation* | The proposed changes may have a negative impact on individuals who are concerned about experiencing stigma based on their sexual orientation. This has been reported as a potential barrier to individuals accessing healthcare, or revealing information that may benefit their care. | Staff training plans to include equality and diversity, so that all staff have a good understanding of diverse local needs. |
| **IMPACT ON STAFF** | | | |
| **15.** | **How many staff work for the current service?** | Over 1500 Full-Time Equivalent staff are currently employed across primary care, community care, adult social care and mental health in Stockport:<br>• 490 FTEs in Primary Care<br>• 462 FTEs on Community Care<br>• 631 FTEs in adult social care<br>• 489 FTEs in mental health, though many are hospital-based.<br><br>In Primary Care:<br>• 84% of employees are female<br>• 76.87% are White British<br>• The average age of staff is 47<br>• 52% work in admin; 29% are GPs; 11% are nurses; and 8% are other direct care practitioners<br><br>In Community Care:<br>• 78.05% of employees are female<br>• 82.42% are White British<br>• The average age of staff is 45<br>• 52.49% are Christian<br>• 32.2% work in nursing; 27.9% admin or estates; 20% are clinical; 7.7% are medical; 8% are other direct care practitioners; 6.2% are Allied Health Professionals; and 5.51% are healthcare scientists.<br><br>In Adult Social Care:<br>• 74.35% of employees are female<br>• 89.27% are White British<br>• The average age of staff is 49<br>• 10.5% are Christian<br>• 48% are support workers; 20% work in admin; 20% are social workers; 1% occupational therapists; 0.23% are nurses; 0.21% are dieticians. | |

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| | | In Mental Health:<br>• 79.85% of employees are female<br>• 86.27% are White British<br>• The average age of staff is 46<br>• 33% work in nursing; 27% are clinical; 15.75% admin and estates; 12% prof scientific; 5% allied health professionals; 4.5% medical / dental; and 1.3% healthcare scientists. |
| **16.** | **What is the potential impact on these employees?** (including potential redundancies, role changes, reduced hours, changes in terms and conditions, locality moves) | The neighbourhood business case provides for an increase in workforce of over 20%, therefore more career opportunities will be created.<br><br>Most of the services will be 24/7: staff will therefore be asked to work more flexibly.<br><br>Staff will be expected to work in multidisciplinary / integrated teams, with changes to venues so that different teams can work together to support shared patients.<br><br>It is not envisaged that there will be redundancies at this stage. However, any changes to roles would be subject to staff consultation and all employees would have equal employments rights under their HR policies, including: TUPE, flexible working, reasonable adjustments. |
| **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?*** |

| | **IMPACT** | **MITIGATION** |
|---|---|---|
| *Age* | Members of staff with young families/childcare responsibilities may struggle with shift patterns and job rotation | Any changes in roles will be subject to staff consultation and will be managed under HR policies, offering equal opportunities for TUPE, reasonable adjustment and flexible working rights. |
| *Carers* | Staff with carers duties may struggle to work new shift patterns as part of the extended hours plan. | |
| *Disability* | Staff with disabilities may require reasonable adjustments, including accessible venues and disabled parking | |
| *Gender Reassignment* | | |
| *Marriage / Civil Partnership* | | |
| *Pregnancy & Maternity* | Working more in patients' homes may create a health and safety risk for pregnant staff | |
| *Race* | More working in a patient's home could present cultural difficulties for minority | |
| *Religion & Belief* | | |

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|---|---|---|---|
| | | groups | |
| | *Sex* | The majority of employees are female – as such women are more likely to be impacted by changes | |
| | *Sexual Orientation* | | |
| **18.** | **What communication has been undertaken with staff?** | A range of staff have been involved in design sessions for Stockport Together representing a wide range of roles.<br><br>Staff engagement sessions, team briefs, newsletters, 1 to 1s have been used to communicate changes with staff as well as HR support, team building and culture change sessions. | |
| **19.** | **Do all affected workers have genuinely equal opportunities for retraining or redeployment?** | Yes – this is part of the work force development plan | |
| **IMPACT ON STAKEHOLDERS** | | | |
| **20.** | **Who are the stakeholders for the service?** | Key stakeholders are the GPs, community health, adult social care, mental health, hospital, care homes. | |
| **21.** | **What is the potential impact on these stakeholders?** | GP's will receive significant additional funding enabling safe and effective general practice, delivery of GM standards and provision of extended services across seven-days. GPs will be expected to work in MDTs.<br><br>AHPs, nurses and social workers will be expected to work across seven-days and within MDTs.<br><br>Some hospital provision will be reduced / stopped to enable funding for increased provision in the neighbourhoods.<br><br>Increased provision for mental health in neighbourhoods<br><br>Potential increase in activity for community and primary care staff<br>Potential decrease in activity for secondary care staff<br><br>Changes to the service delivery could impact place of work and changes to job plans. | |
| **22.** | **What** | Various presentations have been given to stakeholders, meetings have been | |

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| | **communication has been undertaken with stakeholders?** | planned to discuss and align pathways, information sheets, leaflets and other promotion material (pens and business cards with telephone number) have been developed. |
| **23.** | **What support is being offered to frontline staff to communicate this message with service users / family / carers?** | New uniform to mark the change, new patient leaflet, new format for an individual health and wellbeing plan, patient stories to highlight change and improvements. |
| **24.** | **How will you monitor the impact of this project on equality groups?** | Equality data is collected by providers including: deprivation (postcode), age, disability, ethnicity; gender; religion; sexual orientation. This will be mapped against the equality data for Stockport as a borough as part of the public sector equality duty. If this highlights potential underrepresentation of certain groups, further analysis will be undertaken to understand the reason and an action plan will be developed to improve equality. Patient and carers surveys might also highlight inequalities which will then be acted upon. |
| **25.** | **Action Planning** | An action plan has been set out at the end of this document to capture all actions identified through the course of this Equality Impact Assessment required to:<br>• Mitigate any potential negative impacts<br>• Take advantage of opportunities to reduce inequalities<br>• Respond to patient and public engagement.<br><br>Actions in this plan will be included in the implementation plan for delivery of the Neighbourhoods changes.<br><br>At a strategic level, progress on the EIA action plan will be monitored regularly by the Stockport Together Programme Management Office as part of the governance framework for delivery of the work stream. |
| **EIA SIGN OFF** | | |
| **26.** | **Sign off** | EIAs should be approved by the work stream's Senior Responsible Officer and sent to an equality specialist for quality assurance before sign off.<br><br>Final EIAs should be attached to the final Strategy / Policy / Business Case before being presented to the relevant decision making Board. |
| **a.** | **SRO Approval** | **Name:** Dr Viren Mehta<br>**Date of approval:** x |
| **b.** | **Quality Assurance** | **Quality Assured by:** Angela Dawber<br>**Date:** 20/12/2017 |

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| **c.** | **Board Approval** | **EIA considered by / Date:** | Joint Commissioning Board – 04/01/2018<br>Scrutiny Committee – 16/01/2018<br>SMBC Cabinet – 17/01/2018<br>CCG Governing Body – 31/01/2018 |

## 11. NEIGHBOURHOODS Equality Action Plan

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| N01 | Equality Actions to be included in the Neighbourhood Implementation Plan | Operational Lead | 31/01/2018 |
| N02 | Neighbourhood programme to send monthly updates on implementation (including progress on equality actions) to Stockport Together PMO | Operational Lead | 28/02/2018 |
| N03 | Develop future engagement strategy for the work stream, identifying key stakeholders (including protected groups) and optimal communications methods (including translation and interpretation requirements) | Operational Lead | 31/03/2018 |
| N04 | Patient engagement and complaints to be monitored by protected groups to ensure there are no adverse impacts on any groups | Operational Lead & SNC management | 31/03/2018 |
| N05 | Stockport Neighbourhood Care to outline the process for meeting the Accessible Information Standard in the new service model:<br>• Agreement on Interpretation service (currently 3 services at SMBC, Primary Care and SFT)<br>• Collating data on formats required by patients<br>• Equality monitoring process<br>• System for sending patients communications in the correct format (e.g. Braille, large print)<br>• Service Level Agreements in place for translation of information into other formats (Braille, BSL videos, audio format, other languages)<br>• Alternative contact methods to phone for deaf patients (e.g. Text-Relay service; text messaging; email; face-to-face) | Operational Lead & SNC management | 31/03/2018 |
| N06 | SNC Contract to set out the legal requirements of the new integrated organisation to follow duties under the Equality Act and Accessible Information Standard, including:<br>• Equality monitoring & reporting<br>• Interpretation and translation services<br>• Accessible facilities | Lesley Brown & Gillian Miller | 31/03/2018 |
| N07 | Venues of new neighbourhood teams assessed to ensure full access, including: | Operational Lead & | 31/03/2018 |

| Ref. | Action | Lead | Deadline |
|---|---|---|---|
| | • Disabled parking<br>• Disabled toilets<br>• Changing facilities<br>• Hearing loops | Estates | |
| N08 | Communications plan for roll-out of the service changes, including:<br>• Map of stakeholders (including protected groups)<br>• Communications formats to meet needs to stakeholders<br>• Leaflets and other publicity to use inclusive images and language to demonstrate accessibility to all community groups | Operational Lead & Comms | 31/03/2018 |
| N09 | IT plan developed to include:<br>• Training on how to use any self-care technology<br>• Alternative options for patients who are unable to use self-care technology<br>• Training on how to use skype technology for virtual appointments<br>• Alternative options for patients who are unable to access virtual appointments | Operational Lead & IT | 31/03/2018 |
| N10 | Equality Impact Assessment of how the new service model will affect staff | Operational Lead & HR | 31/03/2018 |
| N11 | Staff consultation on new service model and any changes to roles / places of work | Operational Lead & HR | 31/03/2018 |
| N12 | Develop a staff training plan, including:<br>• Equality & Diversity Training<br>• Use of interpretation and translation services<br>• Equality monitoring to comply with AIS | Operational Lead & HR | 31/03/2018 |