Chair: Dr Cath Briggs
Enquiries to: Lucy Cunliffe
07827 256 266
Lucy.cunliffe@nhs.net

NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group
Council of Members
Annual General Meeting
A G E N D A

The Annual General Meeting of the NHS Stockport Clinical Commissioning Group will be held at Fred Perry House, Edward St, Stockport SK1 3UR, on Wednesday 25 September 2019 at 1.00pm

	Agenda item	Report	Action	Indicative Timings	Lead
SECTION 1 – Governance Items					
1	Welcome and Apologies	Verbal	To receive and note	1.00pm	Chair
2	Approval of the draft Minutes of the meeting held on 20 September 2018	Attached	To receive and approve	1.00pm	Chair
SECTION 2 – Looking back					
3	Summary of 2018/19 achievements	Presentation	To receive and note	1.10pm	Chair
4	Annual Report and Accounts	Attached	To receive and note	1.20pm	M Chidgey
5	Statement of Public Invovlement 2018/19	Attached	To receive and note	1.30pm	Chair
SECTION 3 – Looking forward					
6	CCG strategic plans	Attached	To receive and note	1.40pm	M Chidgey
7	Public Invovlement and Engagement plans 2019/20	Attached	To receive and note	1.50pm	Chair
SECTION 4 – Questions and Answers					
9	Questions from the floor	Verbal	To receive	2.00pm	Chair
10	Closing Words	Verbal	To receive	2.10pm	Chair
SECTION 5 – Engagement session					
11	Public Engagement session OR Council of Members Meeting	Verbal	For discussion	2.15pm	All
12	Close	Verbal		3.00pm	Chair

NHS
Stockport
Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP

MINUTES OF THE ANNUAL GENERAL MEETING
OF THE COUNCIL OF MEMBERS
HELD AT BREDBURY HALL HOTEL, STOCKPORT
ON THURSDAY 20 SEPTEMBER 2018

PRESENT

Dr I Ahmed (Bramhall Health Centre), Dr Maher Al-Auri (Marple Cottage Surgery), Dr Sarmid Al-Kamil (The Family Surgery), Dr Alex Bayes (Bramhall & Shaw Medical Group), Dr Robert Beardsell (Bredbury Medical Centre), Dr Helena Bower (Manor Medical Practice), Dr Cath Briggs (Bracondale Medical Centre), Dr Greg Carter (Marple Medical Practice), Dr Amjad Choudry (Woodley Village Surgery), Dr David Dawson (Adswood Road Surgery), Dr Mark Gallagher (Alvanley Practice), Dr Tony Gill (Caritas GP Partnership), Dr Anna Gillott (Adshall Road Medical Practice), Dr Geeta Gupta (South Reddish Medical Centre), Dr Steve Hastings (Hulme Hall Medical Group), Dr James Higgins (Brinnington Health Centre), Dr Lucy Housley (Stockport Medical Group), Dr Caroline Hull (Beech House Medical Practice), Dr Najabat Hussain (Park View Group Practice), Dr Rachel Kilroy (Chadsfield Medical Practice), Dr Martin Leahy (Manor Medical Practice), Dr Rebecca Locke (Heaton Moor Medical Group), Dr Catherine Lynch (Caritas GP Partnership), Dr Karen McKewan (Park View Group Practice), Dr Viren Mehta (Cheadle Medical Practice), Dr Robert Mathewson (High Lane Medical Centre), Dr Carmel Morris (Heald Green Health Centre 2), Dr Bonny Needham (Gatley Medical Centre), Dr Morag Needham (Marple Bridge Surgery), Dr Richard Nurcombe (The Family Surgery), Dr Penny Owen (Heald Green Health Centre 1), Dr Graham Parker (Archwood Medical Practice), Dr Raina Patel (The Guywood Practice), Dr Lynda Pozzoni (The Village Surgery), Dr Howard Sunderland (Marple Medical Practice), Dr Raje Thiagarajan (Woodley Health Centre), Dr Jeremy Wynn (Heaton Mersey Medical Practice)

IN ATTENDANCE

Sharon Beaden (Springfield Surgery), Sian Bradshaw (NHS Stockport CCG), Steve Bradshaw (NHS Stockport CCG), Sue Carroll (Healthwatch), Mark Chidgey (NHS Stockport CCG Governing Body), Jennifer Connolly (NHS Stockport CCG Governing Body), Jane Crombleholme (NHS Stockport CCG Governing Body), Michelle Davenport (Heaton Mersey Medical Practice), David Ericcson (Ericcson Management), Sarah Ferguson (Stockport Neighbourhood Care), Mark Fitton (SMBC), Mary Foden (Citizens Representation Panel), Rhona Franks (South Reddish Medical Centre), Joan Gibson (Public), John Greenough (NHS Stockport CCG Governing Body), Zain Harper (Viaduct Care), Irene Harris (Mental Health Carers Group), Monica Hastings (Marple Cottage PPG), Kathy Hern (Mastercall), Jane Hey (Citizens Representation Panel), Deborah Hind (NHS Watch), Rosemary Hyde (Practice Manager, Bracondale Medical Centre),Tony Johnson (Public), Mike Lappin (Healthwatch), Sally Lomax (Woodley Village Surgery), Colin McCabe (Stockport Mind), Cllr Tom McGee (SMBC), David Moore (Home Instead), Karen Nutt (Mastercall), Cllr John Pantall (SMBC), Anna-Helena Platt (Public), Seth Manish (Citizens Representation Panel), Peter Riley (NHS Stockport CCG), Roger Roberts (NHS Stockport CCG Governing Body), Pam Smith (SMBC), John G Thomas (Cheadle Medical Practice PPG), Graham Trickey (NHS Watch), Andy Wedderburn (NHS Watch), Philip Welldrake (Public), Dr Simon Woodworth

(NHS Stockport CCG Governing Body), Jack Wrigley (Public), Laura Latham (NHS Stockport CCG), Dr Cath Briggs (NHS Stockport CCG Governing Body)

1 WELCOME, INTRODUCTIONS AND APOLOGIES

J Crombleholme welcomed the Member Representatives, practice and CCG staff, and members of the public to the meeting.

She noted that in line with the requirements of the CCG's Constitution, the meeting was quorate and explained the voting procedures which were required for items to be determined by the Council of Members. She confirmed that following presentation of Items 3 and 4 there would a brief adjournment of the meeting in order for the votes to be counted and verified.

2 APPROVAL OF THE DRAFT MINUTES OF THE MEETING HELD ON 19 JULY 2018

The minutes of the meeting held on 19 July 2017 were approved as a correct record.

It was noted that the Member Representatives had received the NHS Stockport Clinical Commissioning Group's Annual Report and Annual Accounts 2017/18.

3 PROPOSED CHANGES TO THE CONSTITUTION

J Crombleholme provided an overview of the proposed changes to the CCG's constitution noting that they related to structural changes to the CCG's Leadership Team and changes to the CCG's Committees to ensure they operated as effectively as possible in providing assurance to the Governing Body. She noted that the changes, if approved by the Council of Members would be formally submitted to NHS England for ratification.

She explained that following feedback from the LMC on behalf of GP Members, there was a further recommendation to increase the size of the Governing Body by a further two GP Clinical Leads in order to ensure a GP majority.

Resolved: That the amended Constitution be agreed and recommended to NHS England for final consideration and approval.

4 APPOINTMENTS TO THE CCG GOVERNING BODY

J Crombleholme confirmed that in light of the proposed changes to the CCG's leadership structure and other roles, recruitment activity had been underway in recent months.

Resolved: That the Council of Members

- Appoint Dr Briggs to the post of GP Clinical Governing Body Chair
- Appoint Dr Woodworth to the post of Medical Director.
- Note the appointment of Peter Riley as Lay Member for Primary Care.
- Note the change in portfolio for Christine Morgan as Lay Member for Public and Patient Involvement.

- Note that Jennifer Connolly will fulfill the role requirements of the Director of Public Health as nominated by Stockport Council.

5 GOVERNING BODY PART 2 ITEMS

**C Briggs took the Chair of the meeting. She expressed her sincere thanks to J Crombleholme on behalf of the Governing Body, GP Members, CCG staff and patients of Stockport for her contribution to the National Health Service, continued focus on ensuring the patients received the best care possible and latterly her role as Chair of the CCG.*

C Briggs confirmed that during the 2017/18 year the Governing Body had held 3 meetings to consider items of business in Part 2. She confirmed that in order to ensure transparency, meetings were only held in Part 2 closed session by exception.

Resolved: That the Council of Members notes the content of the update.

6. REFLECTIONS ON 2017/18 AND LOOKING AHEAD

N Dowd provided an overview of the CCG's work during the 2017/18 noting that it had been an important year for the NHS as it had celebrated its 70th Birthday. She noted that complex system transformation was underway to deliver new models of care in Stockport with a view to improving patient care through integration and using the available resource to greatest effect. She provided an overview of the health picture of the Stockport population and the challenges of caring for those patients with multiple long term health conditions who were living longer.

An overview of the successes of 2017/18 was shared which included the following highlights:

- Patient satisfaction with Stockport Practices was higher than the national average with 6 GP practices being nominated for the national GP Patient Award.
- Stockport was ranked top in the country for its flu vaccination programme.
- Investment and success in launching new services with Viaduct Care and Stockport Neighbourhood Care (SNC)
- Increased investment in mental health services

She shared with those present the list of new services which had been mobilised in year which included clinical triage and home visiting, expanded access to services within GP Practices including treatment for those with non-urgent conditions 12 hours a day, expanded 7 Day GP Service being led by Viaduct Care based on a neighbourhood footprint, GP led services including direct access physio, pharmacy and mental health and well-being services, GP streaming in the Accident and Emergency Department at Stepping Hill Hospital and the Steady in Stockport Falls Service.

She highlighted the continued challenge in performance of the urgent care system in Stockport and the importance of working collaboratively to deliver new models of care based within primary and community settings. Priorities for 2018/19 included making continued progress in the development of the integrated commissioner which would be formed of Stockport CCG and Stockport Council and the embedding of the Provider Alliance arrangements and governance including the establishment of Stockport Neighbourhood Care. She also noted there would be continued focus on waiting list management and embedding of new services.

Resolved: That the presentation be noted.

7. FINANCIAL OVERVIEW 2017/18

M Chidgey provided an overview of the CCG's finances for 2017/18 noting the challenging financial context for the NHS both within the Stockport locality and nationally. He noted that by 2020/21 the CCG's 'do nothing' position would create a financial gap for the organisation of £37m which would equate to a £140m gap if added to the locality finance position.

He confirmed that in 2017/18 the CCG had met all required financial duties in the year and had achieved 100% of the Cost Improvement Plan programme. He explained that in 2018/19 the CCG was not required to maintain a risk reserve as had been the case in previous years.

Further investment in mental health had been made in 2017/18 in line with the Mental Health Investment Plan with a number of schemes already in place with further investments due to be made in future years. He noted that the CCG overall received £16m less than the national formula calculated. Investment in primary care was noted including the division of funds between individual practices, GP at scale and into the GP Federation Viaduct Care. Those schemes and services which had been mobilised were confirmed.

He concluded by outlining the context of future financial challenges local to Stockport and nationally for the NHS noting in particular continued investment in priority areas such as mental health and primary care, full mobilisation of the Neighbourhood Model, including continued development of Viaduct Care.

Resolved: That the presentation be noted.

8. QUESTIONS FROM THE FLOOR

The following questions were raised by those present at the meeting and responded to by Members of the CCG's Governing Body**:**

1) When completing the Healthier Together work, it was found that admissions to ED in Stockport were almost double the rate of admission when compared with Salford or Liverpool. Is there any sign of a reducing admission rate?

   It was confirmed that due to enhancements in community based services designed to keep people well and at home longer, it was likely that admission rates would increase through the Emergency Department as when patients decompensate at home, they would be sicker at the point of arrival and therefore more likely to require admission. Overall however the aim was to reduce the overall rate of hospital admissions. It was further confirmed that an increase in 0 day hospital stays was positive as further capacity had been put in place in the hospital to ensure people were treated more quickly and efficiently with a view to discharging them back to their homes as soon as possible.

2) Do you understand the perception of families and carers that there is little focus on mental illness in Stockport and do GPs know about the triangle of care and information sharing policy? Do you know you cannot get beds at Stepping Hill Hospital for patients with mental illness?

The triangle of care was acknowledged and it was noted that the role of carers with critical to supporting those with mental illness. Achieving Parity of Esteem was noted to be a focus in Stockport with further work to do before the ambition could be achieved. The additional £10m investment into mental illness was noted as a positive step but acknowledged that it would not address all known population needs in the area of mental illness at the current time.

3) How much of the £10m investment is going to people in the community?

   The exact figure could not be confirmed but it was noted that several million pounds would be invested into community services. The overall population need and service provision would require consideration.

4) If it is the CCG's view that there is lack of fair funding why has this not been taken up with Simon Stevens and NHS England?

   It was confirmed that NHS funding allowed for 'acceptable tolerance' which for Stockport equated to a £16million funding gap.

5) What is the Stockport position on the future creation of an Accountable Care Organisation?

   The Council Chief Executive Pam Smith was noted to be in the audience representing Stockport Council and it was noted that collaborative work with the Council as a commissioner and a provider was underway. It was noted that the focus was on creating an integrated system, a part of which included integrated commissioning and further building on the existing pooled budget and governance arrangements. Our focus is on the quality of care being delivered to the people of Stockport and not the organisational form which delivers it. We know we need to focus on ensuring the high quality plans we have developed are delivered.

6) The funding for primary care is not proportionate to the work being done in my view and I question whether the hospital is very expensive or inefficient. Who is reviewing where the money is spent?

   As part of the development of the Stockport Together business cases a full review of the level of spend in each sector against national benchmarks was considered and this included an efficiency plan. Our intention is to spend more in primary care but in terms of the cost of care, the majority of technological developments take place in the acute sector. The cost of care across sectors is different and we assess level of need to try and ensure an appropriate amount of funding is spent accordingly.

7) Why do other neighbouring localities spend more on primary care than Stockport? Is it because there is a deficit in secondary care funding?

The funding the CCG receives is linked to health need based on a national formula developed by the University of York. It looks at various factors including average age and deprivation. Therefore spend is relative to the funding received.

8) When will further investment in mental health services delivered by Pennine Care be made?

An increase in funding for the community mental health teams will be in place from 2019/20 and the CCG's Commissioning Managers will work with Pennine Care to ensure that the extra investment is directed to the right areas. There is a commitment across all CCGs to invest to address SAFER and ensure adequate staffing and safety across all wards.

9) The Mental Health Carers Group has tried to engage with Stockport Together but there is a feeling that engagement has gone down in recent years. How can we be involved?

The CCG confirmed that it was committed to engaging with the Group.

10) When the Transformation Fund monies come to an end, will the savings fund the system?

It was noted that some savings had been realised but not all and in order to ensure savings are realised in the future, partners would have to put additional funding into provision. Stockport Together Services should be 90% mobilised by the end of the year.

11) Does the CCG have an action plan to address the low level of performance in the delivery of Talking Therapies and high level of sedation prescribing in Stockport based on Rightcare data?

The use of hypnotics has been highlighted through the Medicines Optimisation Team and there remains a cohort of patients who require them for their treatment and therefore the levels are unlikely to reduce for this group.

12) Why does Stockport have IAPT referrals at the highest rate in its comparator group and significantly higher than the England average? Does this reflect poor mental health?

Statistically Stockport is shown to have a high proportion of low level mental health needs and as a result high levels of IAPT referrals are likely given this is the appropriate treatment route for those patients.

13) Does the CCG support the introduction of an annual Stockport Mental Wellbeing report to highlight the numbers and the factors contributing to mental ill health with an action plan to improve the position?

Reporting on mental health forms a significant part of the Joint Strategic Needs Assessment analysis undertaken and Healthwatch will be supporting some of this work in the future. At the current time the form of the report has not yet been determined.

14) What proportion of staff within primary care have undertaken dementia awareness training?

488 have undergone the training within Stockport. The CCG does not hold records for those who have taken the training outside Stockport.

15) What is the timetable for integrated health and social care into a single trust?

It was confirmed that the timetable for the development of the Strategic Commissioning Function was April 2019 and Provider integration was currently underway.

16) What quick wins have been achieved within Greater Manchester by Devolution?

For Stockport the focus has been on getting new services up and running faster than would have normally have been the case. For example Steady in Stockport or investments in neighbourhoods.

For commissioning the integration with Stockport Council will give a whole commissioning view which is a real positive outcome.

17) Why are the numbers attending Accident and Emergency (A&E) not decreasing?

When the new model of care is fully in place, including neighbourhoods we would expect A&E attendances to reduce. In the interim extra GP capacity is in place within the Department with approximately 10% of patients arriving being seen by a GP to release staff capacity to focus on those arriving by ambulance with more complex medical needs.

18) Why has the Foundation Trust not paid the full cost of service delivery?

It was confirmed that whilst the CCG remained in financial balance, the Foundation Trust was in deficit and was not recovering the full cost because of the national ‘payment by results’ scheme which acts as a national price list for acute activity. Where costs cannot be kept in line with the national pricing system there is opportunity to earn additional costs for some areas but they cannot enter into a pricing negotiation.

19) What progress is being made to ensure that those received fly inoculations at Stepping Hill have their GP record updated automatically?

It was confirmed that IT systems at NHS Stockport Foundation Trust did not allow this to happen. It was intended that flu vaccinations would be delivered within primary care, not by the hospital. This approach had proved very effective in previous years.

NHS
Stockport
Clinical Commissioning Group

Annual Report and Accounts

2018/2019

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NHS Stockport Clinical Commissioning Group

Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule 15 of the NHS Act 2006

Our Annual Report

This report is produced in response to the NHS England requirements, as published in the Department of Health Group Accounting Manual 2018/19. It describes how we carry out our role as NHS Stockport Clinical Commissioning Group (CCG), our responsibilities and achievements, our performance and the challenges we've faced throughout the period 1st April 2018 and 31st March 2019. As required, it is split into three core sections:

- The **Performance Report** which includes a performance overview and performance analysis;

- The **Accountability Report** which includes a Corporate Governance Report, Remuneration and Staff Report and Audit Report; and our

- **Annual Accounts.**

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Foreword

Welcome to the 2018/2019 Annual Report and Accounts for NHS Stockport CCG.

The report will provide a detailed review of what NHS Stockport CCG has achieved over the last twelve months as well as looking ahead at some of our future plans. It also outlines how we have worked with local and regional partners to improve the quality of our commissioned services.

I was appointed to the new role of GP Clinical Chair at the CCG's Annual General Meeting in September 2018. I would like to thank Jane Crombleholme, previous Chair of the Governing Body, Dr Ranjit Gill, former Chief Clinical Officer, and Gaynor Mullins, former Chief Operating Officer, for their significant contribution and dedication to the CCG and local communities over many years.

This year has been exciting and challenging. Nationally and locally, the NHS continues to face rising demand from a growing and older population and the continued challenging financial climate for health and social care services.

Despite this, we have been able to work closely with our partners to continue to improve the health and wellbeing of local residents and introduce a number of new community and primary care services.

We have made it possible for patients to access GP services 8am-8pm and have extended weekend appointments available across the borough. A range of other new community-based services, including Physiotherapy, Falls, Crisis Response and Mental Health and Wellbeing have been launched in each neighbourhood to support patients as close to home as possible.

As we move towards the new Primary Care Networks, outlined within the NHS Long Term Plan, we will be able to bring even more services to a neighbourhood level, ensuring health inequalities are tackled locally. The networks will build on the neighbourhoods we have already developed to bring GPs together with other health, social care and voluntary sector partners by providing even more integrated care and support to communities.

I am very proud of the quality of GP services in Stockport, with every one of our 39 practices rated as 'Outstanding' or 'Good' by the Care Quality Commission (CQC) and patient satisfaction with local GPs is rated amongst the highest across the whole of Greater Manchester. This was reflected in six Stockport practices being nominated for a national GP Patient Award, more than any other part of England.

I also would like to acknowledge the dedication and commitment of the thousands of health and social care staff who work tirelessly every day to make a difference to the lives of local people. This Annual Report details the work of the 2018/19 financial year and celebrates the dedication and hard work of staff.

I look forward to working with our partners over the next year as we continue to shape local services together with our local communities.

Dr Cath Briggs
GP Clinical Chair

PERFORMANCE REPORT

Performance Overview

An overview from our Accountable Officer

Over the last financial year the NHS celebrated its 70th anniversary, a significant milestone in its history, and it is appropriate that as a CCG, we are able to reflect on our achievements over the last twelve months and our ambitions in working with our communities to shape health and care for the future.

The last year has been one of challenges and change for NHS Stockport CCG with continued financial constraints facing the NHS and Local Authorities coupled with increasing demand for health and social care services.

Nationally, the four-hour waiting times within Accident and Emergency (A&E) reached its lowest ever level across England in January 2019 and locally our urgent care performance continues to face challenges, with increased demand and an ageing population. However, Stockport NHS Foundation Trust has worked tirelessly over the last year and there have been clear signs of improvement.

We have introduced a GP streaming service into A&E which has helped reduce some of the non-urgent waiting times and are continuing to work with partners to improve the admission and discharge flow. We have also launched a number of community-based services over the last year to help keep people safe and independent by providing services at home or close to home. Investment into the Stockport New Models of Care, including Neighbourhood working, increased to £15.8m.

Although Stockport NHS Foundation Trust received a CQC rating of 'Requires Improvement', the regulator positively reflected that a number of improvements had been made. The report found that the care provided to patients across Stockport, the High Peak and surrounding areas is both caring and well-led. It also highlighted significant improvements in twelve areas, including community and acute services.

The Trust has also continued to record high levels of satisfaction from patients who have accessed hospital and community health services and the commitment and care from staff has remained unwavering.

Stockport was also ranked first nationally in 2018 for the hard work and dedication of GPs, nurses, pharmacies and the public health team in immunising people against flu with 97,134 residents vaccinated, which is the highest total ever for the borough. The latest figures for 2019 indicate that Stockport may again lead the nation in its flu vaccination programme, which is an outstanding achievement.

The CCG has supported local practices to continually improve through the 'Time for Care' programme that has helped all 39 practice teams in Stockport to manage their workload, adopt and spread innovations that free-up clinical time and develop the skills and confidence to lead local improvement.

The CCG has agreed an investment plan for mental health services across the period 2016/17 to 2020/21. As part of this plan, an additional £6.4m has been invested which has contributed to the improved rating for Stockport's dementia and mental health care which have been rated as "outstanding" and "good" by NHS England. Pennine Care NHS Foundation Trust, the local provider of many mental health services, received a CQC rating of 'Requires Improvement' although it was highlighted that a number of

improvements had been made since the previous inspection. The Trust has made the proactive decision to transfer their community services to other providers in order to consolidate their position as a main provider of mental health services across Greater Manchester.

In September 2018, the Local Authority and CCG received a joint Local Area Special Educational Needs and Disabilities (SEND) review, which was undertaken by Ofsted and the CQC. This resulted in a requirement to submit a Written Statement of Action. This documents how we will work in partnership with children, young people and their families to improve local services.

The report did recognise the hard work and commitment of staff involved in providing support within education, health and social care and the real difference that they are able to make for local families. Since the report was published a series of co-production and engagement activities have taken place. Around 300 local families and carers have shared their experiences of supporting children and young people with SEND in accessing local services. There is a clear need for Stockport's health, care, education and school services to be more aligned and responsive to the needs of children and young people with SEND. This valuable feedback of experience has provided the foundation for Stockport's improvement work. Further detail can be found using the link below:

https://stockport.fsd.org.uk/kb5/stockport/fsd/localoffer.page

The NHS Long Term Plan, published in January 2019, outlined the bold direction for the health service to ensure that as health needs change and society develops, the NHS can continually move forward with services that are fit for the future. Locally and regionally we will be engaging with local people on how the plan will benefit local communities and improve services for them and their future generations.

Over the next year, the CCG will work closely with our partners to strengthen the Primary Care Networks which are to be developed within each of the neighbourhoods. We will further build upon the core of current primary care services and enable greater provision of proactive, personalised, co-ordinated care coupled with more integrated health and social care.

We are reassured that the hard work undertaken to introduce new services and ways of delivering care across Stockport sets us ahead of many other areas of the country.

Whilst we have more challenges ahead, none of the improvements that have taken place over the last year would have been possible without the hard work and commitment of staff to deliver the changes.

There is much we should be proud of from this past year and in the years ahead we will continue to improve, innovate, and re-shape health care services around our local communities.

Noreen Dowd
Interim Accountable Officer

About NHS Stockport CCG

NHS Stockport CCG was formed on 1st April 2013 and was licensed without conditions by NHS England. We are an NHS organisation made up of the thirty-nine GP practices in Stockport (as of March 2019). We commission (buy) health and care services on behalf of patients registered with Stockport GPs. The services that we are responsible for include:

- Planned hospital care;
- Urgent and emergency care;
- Rehabilitation care;
- Community health services; and
- Mental health and learning disability services.

The CCG is also a level three delegated commissioner of primary care services, which means the organisation is responsible for managing the national General Medical Services (GMS) /Personal Medical Services (PMS) contracts with GP practices. We also work closely with patients and health and social care partners to ensure services meet local health needs.

The GP practice membership have appointed a Governing Body to discharge the CCG's responsibilities on their behalf.

How we care for our communities

NHS Stockport CCG is responsible for making sure that the 310,000 people registered with a Stockport GP have access to the healthcare services they need.

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

Stockport continues to be one of the healthiest places to live in the North West, resulting in a population that is generally older than the rest of Greater Manchester. However, this is not the experience of all of our residents. Local communities experience varying levels of affluence and have significantly different health needs. In the least affluent areas, life expectancy is ten years lower than in the most affluent.

Stockport's population has a wide range of health needs. The area has the oldest age profile in Greater Manchester and its population continues to age. Currently 19.4% people are aged 65+ and this is likely to rise to 21.8% by 2024, with an additional 9,681 people aged 65 or over.

Stockport, like other local areas across the country, faces a number of challenges and risks in the delivery of existing health and social care services. These include:

- The success of an ageing population leading to increasingly complex care needs for individuals who are at higher risk of isolation and loneliness. This is because more people live on their own without direct family support;

- A population where birth rates have risen, especially in areas of deprivation. This has led to more children and young people living in low income households where health outcomes are poorer;
- Changes from the most common health issues experienced by the population, to those linked to lifestyles or those which are otherwise preventable;
- A period of economic challenge that affects the incomes and entitlement of the most vulnerable people in Stockport;
- Fragmented services which are complicated to access, have duplications and are not as focussed on the individual's needs as they could be;
- A system where too many people are admitted to hospital when many could be better and more appropriately cared for at home; and
- Increasing financial pressures with deficits forecast for Stockport as demand growth continues if service delivery is not improved.

Challenges and Risks specific to Children and Young People

- Almost 1 in 4 children in Stockport are overweight or obese by the age of 4 rising to almost 1 in 3 by the age of 10;
- Almost 1 in 4 five-year olds suffer tooth decay;
- 8,500 children and young people are estimated to live in poverty;
- Over 70% of young adults are not active enough;
- Anxiety is the major long-term condition affecting young people in Stockport with more than 2,700 cases reported; and
- Self-harm hospital admissions in those aged 10-24 are higher than the national average.

Challenges and Risks specific to Adults and Older People

- 1 in 4 of adults are overweight or obese putting them at greater risk of liver disease, heart disease and diabetes;
- Cancer is the major cause of premature death with 45% of deaths under 75 years;
- Stockport's population is older than the England average, with an increasing number of older people living with dementia and other long-term conditions;
- Half the older population of Stockport has a long-term health problem or disability and 1 in 5 have two or more long-term conditions;
- 1 in 3 older people live alone; and
- 2,700 older residents are living with Dementia.

Our Vision and Values

Vision

The CCG's vision is:

"We exist so that Stockport people will access high quality health services that empower them to live healthier, longer and more independent lives"

This underpins the organisation's approach to everything it does to help improve the health and services across the borough.

Values

The values that lie at the heart of our work are:

- ***Being quality obsessed*** - by putting the patient at the centre of decision-making we will continually improve services.

- ***Keeping a primary and community focus*** - we will deliver care as close to home as possible, with general practice at the heart of care.

- ***Innovation*** – we will continually look for better and more cost-effective ways of delivering care.

- ***Working collaboratively*** - we will look to work constructively with others to shape the future.

- ***Patient responsibility*** - we will work with patients and carers, empowering them to take responsibility for their own health and use NHS resources wisely.

- ***Distributive leadership*** - we will devolve decision making and resources to those best placed to meet the needs of our community.

- ***Behaving Professionally*** - we will be trustworthy, evidence-based, systematic and disciplined.

The CCG's values inspire the organisation to design and commission high quality services for patients. The organisation aims to meet local needs, deliver improved health outcomes and demonstrate best practice with partners.

This same spirit is driving the organisation to continue to widen our partnership working, with the goal of transforming the whole health and social care system in Stockport as part of devolution across Greater Manchester.

The CCG strongly believes that integrated commissioning is the right approach for Stockport in continuing to deliver this transformation, by focusing on self-care and prevention, reducing dependence on hospital care and delivering more services closer to home.

Improving health and social care in Stockport

There have been significant changes in the way people access care since the NHS was established more than seventy years ago. Many people now work long or irregular hours and may not have the same support structures in place as previous generations to look after loved ones if they become unwell. More people now use technology to get answers about health or access appointments and test results via phones or email and by using apps to help manage health and other aspects of life.

Such societal changes mean that the approach to how health and care is provided has become less relevant. More focus and resources are therefore being directed towards

preventing ill health, keeping people out of hospital and in their homes, and adapting services for a growing, ageing and technology enabled population.

Whilst Stockport faces a number of specific local challenges in improving health and care for residents, our vision remains to provide a truly integrated, high quality, sustainable health and care system with partners across health and social care services in Stockport, Greater Manchester, Eastern Cheshire and North Derbyshire. In order to achieve this, we must balance three critical requirements:

- Improve local population health;
- Ensure best quality care and experience of care; and
- Provide value for money.

NHS Stockport CCG is assessed and regulated by NHS England on how we improve outcomes for local people and to ensure the NHS Constitution standards are met. However, the challenges and risks for the CCG in achieving these requirements over the year 2018/19 have included:

- The financial pressures caused by increasing demand combined with inadequate levels of funding;
- Staffing shortfalls in many professions, affecting the ability of the local acute hospital, community and primary care services to deliver;
- Increased demand for health and care services as our population ages and develops more complex needs; and
- Balancing the need to transform and re-design health and care services, whilst maintaining continuity of service for patients.

Strategic objectives:

In collaboration with our GP membership, local people and partners, the CCG has identified four strategic objectives. These are to:

- Transform the experience and care of adults with long term and complex conditions;
- Increase the clinical cost effectiveness of elective treatment and prescribing;
- Improve the quality, safety and performance of local health services in line with local and national expectations; and
- Ensure better prevention of disease and early identification of disease leading to reduced inequalities.

These objectives ensure NHS Stockport CCG focuses on improving services across Stockport so that residents receive integrated health and social care that is designed to keep them well, rather than focusing on treating their symptoms when they become ill.

Delivering our vision

The CCG recognises that our vision requires a collaborative approach to deliver the best outcomes for local people. We are an active partner is Greater Manchester's devolved Health and Social Care Partnership, working with health and social care partners across the metropolitan boroughs to improve health and increase the quality of services.

Locally, the vehicle for change has been Stockport Together, which brings together local health and social care partners with GPs and voluntary organisations to improve services across the borough. We also deliver change in other ways, including the Healthier Together collaboration across the South East Sector of Greater Manchester.

New Models of Care

Our New Models of Care initiative is built around eight Neighbourhood Teams, which bring together primary and social care, physical and mental health services to meet the needs of local people 7-days a week. The neighbourhoods are supported to do this by an integrated Intermediate Tier providing essential community crisis response, intermediate care, reablement and home care services, 24/7, to avoid unnecessary admissions to hospital and support sustainable early discharge. These 8 neighbourhoods will provide the basis for the development of GP Networks within Stockport.

Changes to urgent care optimise how individuals with ambulatory care-sensitive conditions are managed in the community, rather than as a hospital admission. Stockport partners have delivered a range of new services throughout 2018/19 which support the New Models of Care in improving the quality of services across our neighbourhoods. This approach has included the availability of routine evening and weekend GP appointments within all neighbourhoods, the launch of the new 'first contact' physiotherapy services within practices, the community falls service, GP home visiting service, community active recovery team, crisis response team and the new mental health and wellbeing service in every neighbourhood. All these services help to support patients either at home or closer to home and reduce pressure on the very busy A&E service at Stepping Hill hospital. Further information is available via: www.stockportccg.nhs.uk

These improvements will ultimately deliver:

- Improved health and wellbeing with an emphasis on independence;
- A financially sustainable health and care system;
- A reduction in premature mortality from causes preventable by healthcare, with healthy life expectancy increasing fastest in the most deprived areas of Stockport;
- A reduction in the number of people reporting social isolation;
- More people feeling supported to manage their condition;
- Fewer working adults with long-term sickness;
- More people / carers who would recommend the service;
- More people at end of life die in their preferred place of choice; and
- Meeting the NHS constitutional standards.

Greater Manchester Health & Social Care Partnership

NHS Stockport CCG is a partner in the Greater Manchester Health and Social Care Partnership (GMHSCP).

In April 2016, Greater Manchester took charge of its health and care system as one partnership spanning NHS and local government, commissioners and providers of both physical and mental health. In doing so, we embarked upon the most radical health and care transformation programme in the country.

Our city-region has one of the fastest growing economies in the country and yet people here die younger than people in other parts of England. Devolution of health and social care was about changing that for the better.

And three years on since GMHSCP took charge of the £6bn spent on health and care we are starting to turn the tide on the causes of poor health for the 2.8m people here, as well as having an impact across wider policy areas. Since 2016 Greater Manchester has:

- Reduced still birth rates – this is equal to 23 fewer babies a year stillborn;

- Increased the number of children who are "school ready" - around 200 more children were deemed to be at a "good level of development" in school year 1 in 2018/19, compared to the previous year. This is 68% of Greater Manchester children and a 2% improvement. The England average is 71.5%;

- Reduced smoking rates significantly faster than the national average. This has been achieved through measures including treating hospital patients, cutting the proportion of mothers smoking at the time of giving birth twice as fast as the national average and achieving a 64% quit rate by providing vape kits to social housing tenants;

- Helped more than 3,200 long term unemployed people back to work by providing support to those with health conditions or disability to find and sustain work;

- 85% of families who have been part of Greater Manchester's local Troubled Families programme do not go on to require any form of statutory intervention from children's social care during the twelve months after the engagement with the family has ended;

- Improved access to primary care with more GP appointments in early evening and weekends and wider pharmacy services;

- Improved cancer survival rates to almost the national average and recruited 5,000 community 'cancer champions'. By 2017, 150 more patients were estimated to be living with cancer for a year or longer, compared with 2016. People have also been diagnosed and treated earlier. The proportion who needed emergency care for more advanced cancer dropped from 24% to less than 20% and in 2017/18, 85% started treatment within 62 days of being referred to a cancer specialist, which was higher than in England as a whole (82.2%);

- Raised standards in care homes through its "teaching care homes" scheme and seen an increase in care homes rated as 'good' and 'outstanding'; and

- Significantly improved access to mental health services including some of the best access rates in the country for children and young people, new eating disorders services, support for new Mums and better crisis care.

Plans are now underway to build on these successes and consider how Greater Manchester will address the challenges it still faces. These are explored in the documents Taking Charge the next five years (our prospectus), and the White Paper for Unified Public Services. Further detailed implementation plans will be developed with stakeholders and the public over summer 2019.

Taking Charge, the next five years (our prospectus)
http://www.gmhsc.org.uk/wp-content/uploads/2019/03/GMHSC-Partnership-Prospectus-The-next-5-years-pdf.pdf

Prospectus summary
http://www.gmhsc.org.uk/wp-content/uploads/2019/03/GMHSC-Partnership-Summary-Prospectus-.pdf

White paper for Unified Public Services
https://www.gmcvo.org.uk/system/files/13a_gm_model_white_paper_draft_v1.8.6_clean.pdf

Performance Analysis

In December 2016, NHS Stockport CCG agreed its two-year operational plan for 2017/18-2018/19.

Our commissioning intentions for 2018/19 prioritised:

- Providing stability for General Practice whilst developing Primary Care at scale;
- Significantly investing in mental health and community services to enable a sustainable shift in service provision from reactive acute care to preventative and proactive integrated care out of hospital;
- Delivering on key national standards with assurance that there is sufficient acute care capacity to meet need; and
- Developing Stockport Together's new models of care.

Investing in Change and Delivering Improvements

During 2018/19 the CCG has made significant progress and realised achievements in a number of areas. These include:

- Spending £15.8m on New Models of Care and a further non-recurrent £2.6m on enablers and infrastructure, to deliver a reduction in the need for "in hospital care" by investing in integrated neighbourhood based services, additional general practice routine appointments at evenings and weekends and through improvements in prevention and early intervention;

- An additional £1.40m was invested directly into general practice and an additional £3.60m of the New Models of Care investment is contained within our contract with Viaduct Care, the GP Federation. Establishing the GP Federation as a significant provider of "at scale" general practice services deliver a fundamental strand of our strategy. This will increase further in 2019/20. Alongside this, further investment has been made into services commissioned from Mastercall Healthcare to provide more community alternatives to hospital admission;

- An additional £2.9m was invested in mental health services supporting increased capacity in children and young people services, dementia, Early Intervention in Psychosis (EIP), Improving Access to Psychological Therapy (IAPT), suicide prevention, adult Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and inpatient provision providing better care closer to home;

- The CCG's Governing Body, following feedback directly from patient experiences, prioritised an effective and comprehensive community service to complement the high-performing hyper-acute stroke service in Stockport. As a consequence, we are the first CCG in Greater Manchester to commission the new best practice model of integrated community rehabilitation for neurology and stroke patients.

Improving Quality and Meeting National Standards

Monitoring the performance of NHS Stockport CCG is devolved by NHS England to GMHSCP who regularly review our progress against:

- The CCG Improvement and Assessment Framework (IAF) as published on MyNHS; and
- NHS Constitutional Standards.

The latest CCG annual assessment and clinical rating, which was published by NHS England via MyNHS in the summer of 2018, rated NHS Stockport CCG's annual performance as 'good'. This reflected significant improvements in financial management and the performance of mental health services.

The CCG's final 2018/19 rating will be published in the summer of 2019 via MyNHS. Our assessment and clinical ratings to date during 2018/19 are as follow and will show that we have:

- Remained as 'outstanding' for dementia care;
- Improved from 'requires improvement' to 'good' for mental health care;
- Remained as 'requires improvement' for learning disabilities based on the number of placements in specialist beds across Greater Manchester; and
- Remained as 'requires improvement' for diabetes care on the basis of the number of newly diagnosed patients accessing structured education in the latest reporting period.

The table below highlights the progress that we have made between 2015/16 and 2018/19 for those areas that receive a clinical rating published on MyNHS. NHS Stockport CCG is proud to have been rated nationally as 'outstanding' for both cancer and dementia outcomes. For mental health we can demonstrate that increased investment and

development has resulted in significant improvements. Based on the latest available data, we anticipate that our ratings should improve in diabetes and maternity services and that improvements have been made in GP health checks for people with learning disabilities such that the national standard is now met.

CCG IAF Clinical Area	2015/16	2016/17	2017/18	2018/19
Cancer	Top Performing	Outstanding	Outstanding	No assessment undertaken
Mental Health	Greatest Need for Improvement	Requires Improvement	No assessment undertaken	Good
Dementia	Top Performing	Outstanding	No assessment undertaken	Outstanding
Diabetes	Greatest Need for Improvement	Requires Improvement	No assessment undertaken	Requires Improvement
Learning Disabilities	Needs Improvement	No assessment undertaken	No assessment undertaken	Requires Improvement
Maternity	Needs Improvement	No assessment undertaken	Requires Improvement	No assessment undertaken

In 2019/20 we will implement further measures to maintain and improve the ratings in these areas. Examples will include; the next phase of the Mental Health Investment plan, increased access to structured education courses for people who are newly diagnosed with diabetes and, improving partnerships between providers of care for dementia patients.

The CCG Improvement and Assessment Framework

The latest IAF published by NHS England via MyNHS highlighted 12 areas where Stockport's performance is among the best in the country:

- Percentage of children aged 10-11 classified as overweight or obese;
- The indicator which measures achievement of National Institute for Health and Care Excellence (NICE) treatment targets for diabetic patients. This focuses on achievement of three treatment markers for adults (HbA1c, cholesterol and blood pressure) and one marker for children (HbA1c);
- Antimicrobial resistance: appropriate prescribing of broad-spectrum antibiotics in primary care;
- Provision of high-quality care: primary medical services;
- One-year survival from all cancers;

- IAPTs: recovery;
- Mental health crisis team provision;
- Estimated diagnosis rate for people with dementia;
- Patient experience of GP services;
- Primary care access (proportion of people benefitting from extended access services);
- Percentage of patients waiting 6 weeks or more for a diagnostic test; and
- Utilisation of the NHS e-referral service to enable choice at first routine elective referral.

In contrast, the IAF also highlighted 6 areas where Stockport's performance is in the lowest quartile:

- Injuries from falls in people aged 65 and over;
- Urgent care:
  - Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions
  - Population use of hospital beds following emergency admission;

  (Note: whilst A&E 4-hour performance moved out of the lowest quartile in the most recent IAF publication (Apr 19), over the full year performance remained in the lowest quartile nationally).

- Antimicrobial resistance: appropriate prescribing of antibiotics in primary care;
- Choices in maternity care; and
- Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI).

In response, the CCG is working with partners to improve areas of concern and new services have been commissioned and mobilised including a new falls service 'Steady in Stockport'. A greater improvement focus will be given to maternity and children's services and the CCG will continue to work with mental health providers to ensure data quality improvement plans are delivered effectively.

Constitutional Standards 2018/19

Urgent Care

ARP.01	Category 1 (life-threatening) calls - 90th centile appropriate response time (NWAS)	15:00	Mar-19	13:49	13:21	13:02	13:04	13:19
ARP.02	Category 1 (life-threatening) calls – mean time taken for a response to arrive (NWAS)	7:00	Mar-19	8:06	7:56	7:48	7:47	7:54
ARP.03	Category 2 (emergency) calls – 90th centile appropriate response time (NWAS)	40:00	Mar-19	52:43	50:38	52:03	54:12	52:24
ARP.04	Category 2 (emergency) calls – mean time taken for an appropriate response to arrive (NWAS)	18:00	Mar-19	23:53	23:24	24:14	25:17	24:12
ARP.05	Category 3 (urgent) calls – 90th centile appropriate response time (NWAS)	120:00	Mar-19	149:22	158:11	173:27	171:30	163:07
ARP.06	Category 4 (non-urgent "assess, treat, transport" calls only) – 90th centile appropriate response time (NWAS)	180:00	Mar-19	181:52	188:53	197:52	204:04	193:10

E.B.5	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	Mar-19	85.6%	79.5%	74.0%	75.4%	78.7%
E.B.S.5	Number of waits from decision to admit to admission (trolley waits) over 12 hours	0	Mar-19	7	8	34	16	65

Planned Care including Cancer

E.B.3	Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	Mar-19	88.6%	84.8%	84.3%	85.6%	85.6%
E.B.4	Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral	99%	Mar-19	98.8%	99.1%	99.1%	98.9%	99.0%
E.B.6	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	Mar-19	94.0%	89.8%	91.4%	88.3%	90.9%
E.B.7	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	Mar-19	92.0%	76.4%	61.3%	54.2%	71.3%
E.B.8	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	Mar-19	98.8%	98.4%	98.6%	99.3%	98.7%
E.B.9	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	Mar-19	100.0%	97.5%	98.9%	97.5%	98.4%
E.B.10	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	Mar-19	100.0%	100.0%	100.0%	100.0%	100.0%
E.B.11	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	Mar-19	99.2%	100.0%	100.0%	100.0%	99.8%
E.B.12	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	Mar-19	85.7%	83.4%	81.5%	84.9%	84.0%
E.B.13	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	Mar-19	100.0%	91.4%	94.1%	76.9%	90.4%
E.B.14	Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patient	N/A	Mar-19	84.4%	81.6%	83.9%	74.6%	81.1%
E.B.S.2	Number of patients not treated within 28 days of last minute elective cancellation (provider) (Quarterly Measure)	0	Dec-18	16	6	9	10	41
E.B.S.4	Zero tolerance of over 52 week waiters	0	Mar-19	31	8	11	8	8
E.B.S.6	Urgent operations cancelled a second time (provider)	0	Mar-19	0	0	0	0	0

Quality

E.A.S.4	HCAI measure (MRSA)	0	Mar-19	0	0	0	1	1
E.A.S.5	HCAI measure (Clostridium difficile infections)	68	Mar-19	14	25	35	13	87
E.B.S.1	Mixed Sex Accommodation Breaches	0	Mar-19	39	42	29	23	133

Mental Health

E.A.3	IAPT access (target is 4.75% per qtr with annual target of 19%)	19%	Mar-19	5.0%	4.8%	4.9%	5.0%	19.7%
E.A.S.2	IAPT Recovery rate - the percentage of people who are moving to recovery during the reporting period.	50%	Mar-19	57.7%	55.8%	57.1%	56.3%	56.7%
E.H.1	Percentage of people finishing course of IAPT treatment who are treated within 6 weeks of referral	75%	Mar-19	88.6%	82.4%	80.1%	87.3%	84.7%
E.H.2	Percentage of people finishing course of IAPT treatment who are treated within 18 weeks of referral	95%	Mar-19	100.0%	99.3%	100.0%	99.4%	99.6%
E.H.4	Percentage of people experiencing first episode of psychosis accessing treatment within two weeks.	50%	Mar-19	66.7%	81.0%	100.0%	100.0%	81.9%
MH01a	Care Programme Approach - % of people followed up within 7 days of discharge from psychiatric inpatient care	95%	Mar-19	97.8%	98.4%	94.9%	89.3%	95.0%

Notes
Cancer waiting times performance is based on nationally published final data for April to September, and nationally published provisional data for October to March.

All data is based on published data from NHS England, NHS Digital or www.gov.uk with the exception of the IAPT standards. Data for March 2019 has been taken from Contract Performance Reports; figures have been rounded to nearest 5 as with national publication.

Urgent Care

Urgent care performance in Stockport remains challenged with seven out of eight indicators not being achieved for 2018/19.

The A&E department of our main provider Trust, Stockport NHS Foundation Trust, remain significantly below the national constitution standard of four hours and has also reported a considerable increase in the number of people waiting over twelve hours in the A&E department.

Our ambulance provider North West Ambulance Service is not achieving expectations for five out of six of the response time targets.

In response to the continued performance regarding urgent care, the CCG has provided clear and visible leadership by ensuring senior staff presence at the Trust on a daily basis as well as continuing to work in partnership with providers to ensure that pathways are clear, and services are resilient and safe. via the Urgent and Emergency Care Delivery Board, all locality partners worked in collaboration to develop a robust improvement plan for Urgent Care that focuses on:

- Bed occupancy and reducing the number of medically optimised patients awaiting transfers of care or discharge;
- A reduction in unnecessary A&E attendances by ensuring there are appropriate alternatives in the community; and

- A reduction in unnecessary admissions by having appropriate interventions and diagnostics in the right place at the right time.

Delivery of the revised action plan and associated improvement trajectories are the focus of the Urgent and Emergency Care Delivery Board and are managed and monitored via an agreed unified Urgent Care dashboard.

Elective Care

Nationally, there have been significant challenges in delivery of the elective (planned) care standards, NHS Stockport CCG has achieved two out of five of the standards relating to elective care. Improvements are required in 18-week referral to treatment time standard, the 28 day cancelled operations standard and people waiting over 52 weeks for treatment. The CCG's focus has been on reducing the waiting list back to the March 2018 level. Significant progress has been made since August 2018 and Stockport's performance is now in line with the national average. Further progress is planned in 2019/20.

This improvement plan includes commissioning additional capacity from Stockport NHS Foundation Trust to sustainably recover 18-week referral to treatment and working with primary care colleagues to ensure that patients are referred to the most appropriate services. We are also monitoring the quality of care for patients who are experiencing longer waits to ensure safety is maintained.

Cancer Care

Cancer care is rated as outstanding and NHS Stockport CCG has achieved six of nine cancer standards for 2018/19.

Improvements are required in two-week wait cancer referral targets and the 62-day treatment standard. During 2018/19, GPs have responded to NICE clinical referral guidance changes and this has resulted in more patients with suspected cancer being referred into services. Providers, including Stockport NHS Foundation Trust, have not yet been able to keep pace with these increases but this will be addressed during 2019/20. The increase in referrals has meant that more patients with cancer are being identified and treated. There is a particular challenge in Stockport relating to breast services and ensuring that the services are sufficiently resilient to consistently meet access standards.

The CCG has worked with our main provider Stockport NHS Foundation Trust to ensure that patients are seen as soon as possible, and additional investment has been secured to ensure that standards are met during 2019/20.

Quality

The number of reported mixed sex accommodation breaches has increased during 2018/19. It is believed however, that this is predominantly due to greater awareness of the standards resulting in improved reporting at Pennine Care.

Pennine Care NHS Foundation Trust has recently undertaken a detailed engagement exercise to seek the view of patients, carers and a range of stakeholders in relation to mixed sex accommodation. Next steps will be presented to their Board in May 2019.

Countering Fraud, Bribery and Corruption

As part of ensuring the proper use of public funds, NHS Stockport CCG is committed to countering fraud, bribery and corruption. The CCG has a nominated Anti-Fraud Specialist provided via Mersey Internal Audit Agency (MIAA), who is operationally accountable to the CCG Chief Finance Officer and reports on risks and progress to the Audit Committee.

The CCG takes a proactive approach to reducing the risk of fraud, bribery and corruption. Regular information is circulated to staff to raise awareness of the latest fraud alerts and how to identify and report suspected fraud, bribery and corruption. The organisation has policies in place for staff, including declarations of interests and the Anti-Fraud, Bribery and Corruption policy and response plan, which reinforce the commitment of the organisation to maintain an embedded counter fraud culture and to take robust action where allegations of fraud, bribery and corruption are received.

Financial Summary

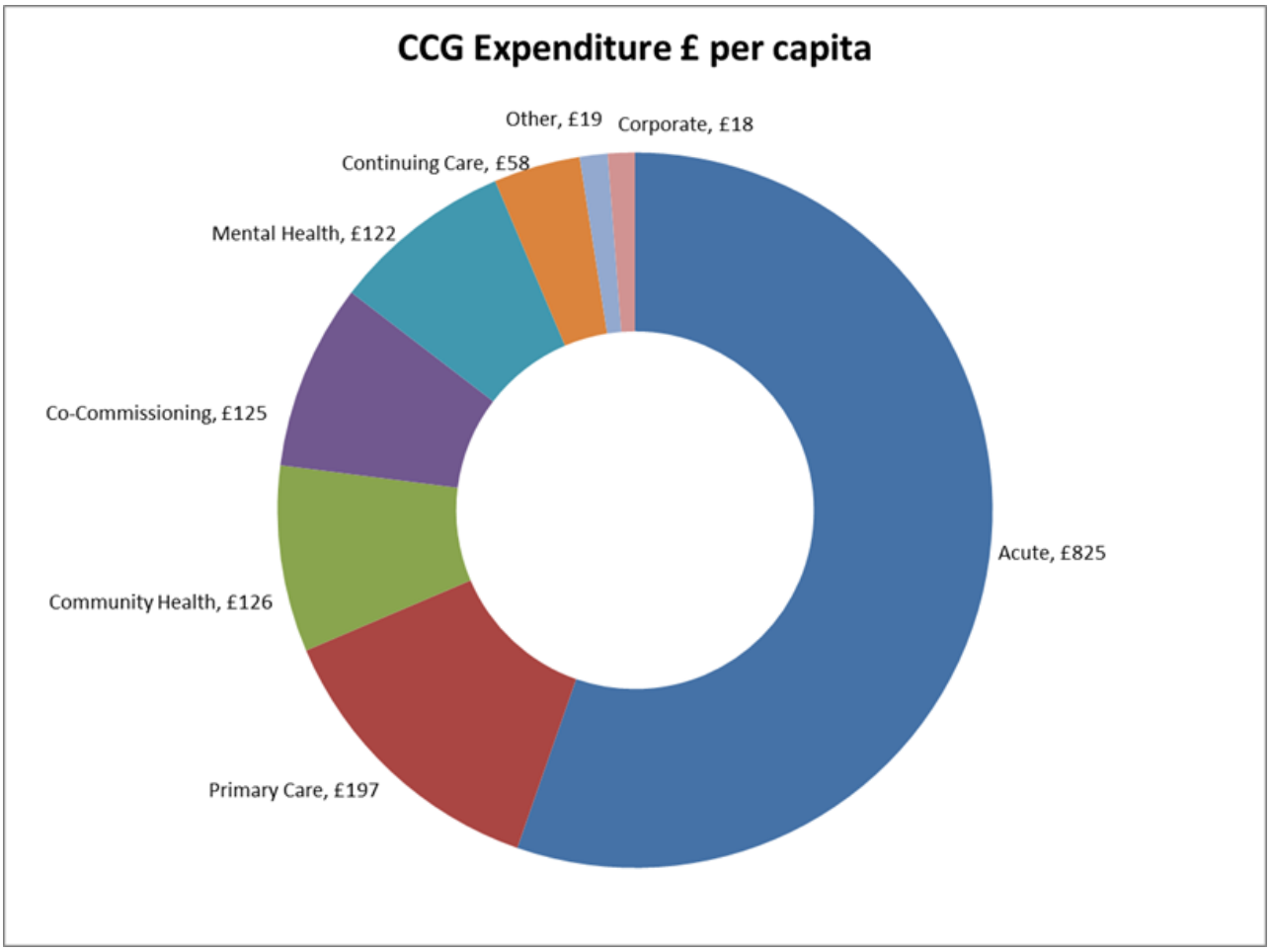
NHS Stockport CCG received an allocation of £467.3m (£461.1m in 2017-18). This is one of the lowest funding levels per capita for any of the Greater Manchester CCGs and is 3.87%[1] or c£16m below the level that NHS England calculates is required to meet the health needs of the Stockport population.

The CCG has achieved all financial requirements, including the delivery of a break-even financial position (surplus of £0.0m). The Stockport system agreed a risk-share arrangement for 2018/19, whereby partners collectively contributed c£6m to enable the continued development of the New Models of Care despite unplanned increases in acute contract expenditure.

The CCG has delivered the planned saving target of £8.4m whilst also re-investing the £0.7m of underspend in management and administration resources back into patient care. Community, primary care and mental health have continued to be priorities for investment, and it is confirmed that the Mental Health Investment standard has been achieved.

[1] Revised CCG Allocations 2018/19 - https://www.england.nhs.uk/wp-content/uploads/2018/02/revised-ccg-allocations-18-19.pdf

The chart below shows how, on average, the CCG spends the £1,490 per capita that we receive to meet the health needs of every person within Stockport.



For 2019/20 the CCG will receive a recurrent allocation of £482.4m with a target surplus of £0.0m; achievement of this break-even position will be challenging for the CCG and significant risks are acknowledged within the 2019/20 financial plan.

Whilst managing these risks we plan to maintain and increase investment into mental health, community and primary care services by building on the neighbourhood model. Simultaneously, we will also contract for additional acute capacity to improve performance across elective, cancer and urgent care.

Sustainable Development

The CCG recognises that as a large employer and consumer of goods, services and resources in the delivery of its work, it must consider the environmental, social and financial benefits from leaner, greener operations and procurement.

As an NHS organisation and as a spender of public funds, NHS Stockport CCG is obliged to work in a way that has a positive impact upon the community it serves when commissioning and procuring healthcare services. Consequently, the CCG's Procurement Policy seeks to commission sustainable, affordable and high-quality services. In addition,

the CCG's financial policies relating to the evaluation of procurements require evidence of prioritised and weighted criteria including sustainability.

We have taken some practical steps to improve our work on sustainability during 2018/19 including the shift to an agile and flexible workforce, enabling staff to work from home and from partner locations and promoting flexible working arrangements in terms of hours and number of days worked over the working week. This has resulted in a reduction in the organisation's office space requirement, expenditure on rent, power, heat and water consumption that contributes to both cost and carbon savings.

Our current policies and office move have reduced the amount of commuting undertaken by staff to the office and to meetings with partner organisations, which when added to the support given to staff via the purchase of annual rail tickets, subsidised bus passes and the "cycle to work scheme" contributes to a reduction in vehicle journeys, serves to improve air quality and reduce carbon emissions. The move to a paper-lite working environment continues to provide benefits in both resource and financial savings, with a continued reduction in the amount of paper used and waste generated.

The move to shared accommodation with the local authority means the CCG can contribute to their sustainability and climate change agenda. Further detail can be located using the following link:

https://www.stockport.gov.uk/sustainability-and-climate-change/sustainability-overview

Finally, NHS Stockport CCG is supportive of GMHSCP's plans to develop a sustainable health and care system across Greater Manchester that works within available environmental and social resources. It supports plans recently set out for Greater Manchester, including the Health & Social Care Prospectus, the White Paper on Public Service Reform and the Local Industrial Strategy. More information can be found at the link below:

http://www.gmhsc.org.uk/wp-content/uploads/2019/03/GMHSC-Partnership-Prospectus-The-next-5-years-pdf.pdf

Improve Quality

A key function of the CCG is to secure continuous improvement in the quality of services it commissions. The safety of the services and the quality of care experienced by patients are paramount and evidenced through improved outcomes. The assurance process relating to the quality of care provision is scrutinised through the contract monitoring framework, quality assurance schedule, deep dives and quality reviews, each reporting through to the bi-monthly quality and performance contract meeting and the CCG's Quality Committee.

Whilst the data scrutinised is largely focused on our main provider Stockport NHS Foundation Trust; the team also have a comprehensive set of minimum quality standards, which are applied to all commissioned providers and services that can be effectively monitored.

This approach ensures that services really are better, using what communities, national guidance and clinical quality standards define as better quality and not just relying on finance or contractual targets.

The CCG has a robust procedure in place for monitoring and recording serious incidents that are reported on the Strategic Executive Information System (StEIS), the platform whereby serious incidents are monitored. By working collaboratively with the governance teams at Stockport NHS Foundation Trust and Pennine Care NHS Foundation Trust, there has been an opportunity to tighten up the reporting, reviewing and finalising of reports. This has resulted in a significant reduction in the number of overdue reports with none currently overdue (in line with the 60-day protocol). Training is planned to further enhance the system of reporting and quality of reports once amendments to the StEIS framework have been finalised.

Themes and trends are monitored by the CCG's Quality Committee via a process of serious incident reports and deep dives/quality reviews. The quality team monitor the 'harm free care' data reports and update the CCG's Quality Committee on progress against this agenda; specifically, around risk.

In 2018/19, a number of quality assurance visits were completed. These included Stockport NHS Foundation Trust's A&E/urgent care; medicine/B3; Bluebell, paediatrics and neonatal unit, Devonshire Unit, Swanbourne Court and Intermediate Care.

Support to the smaller providers, including care homes with nursing, has also been enhanced by the introduction of a Quality Dashboard for nursing and residential homes. Greater Manchester data benchmarks care and nursing home performance. The latest data shows that 77.8% of Stockport nursing homes and 66.8% of residential homes are rated 'good' by the CQC which represents a significant improvement on previous findings.

Locally, Stockport faces a changing environment, with focussed transformation initiatives across the care sector on quality improvement. The CCG and Stockport Council work collaboratively with independent providers driving changes in performance. The outcome of this work is demonstrated in the overall CQC ratings and commissioners are sighted on areas of concern before they reach crisis point. The Enhanced Quality Improvement Team (EQUIP) has been operational throughout 2018/19 and has impacted positively upon quality, CQC outcomes and the urgent care challenges. The organisations also celebrated the very best of care home and home care practice at the third annual Stockport Star Awards event held in February 2019.

The CCG has a robust process in place for monitoring, managing and responding to complaints, information requests and Freedom of Information inquiries. Complaints made to the CCG are managed within the terms of the organisation's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion. Complaints data and response times for providers are monitored through the quality and performance meetings and KPI indicators.

Within the safeguarding team there has been a focus on the development of comprehensive polices including the mental capacity act. The policy reinforces the organisational philosophy that safeguarding and mental capacity is everybody's business and that all staff should respond and act to raise safeguarding awareness and address

emerging issues. The policy details the roles and responsibilities of the CCG as a commissioning organisation and of its employees, directly or indirectly employed.

The local and national context of an increasing number of children becoming 'looked after' continues. The increasing number of children including children placed in Stockport from outside of the area impacts on the timeliness of children receiving their statutory initial health assessment within 28 days of coming into care. Stockport NHS Foundation Trust have increased the number of clinics provided to meet the demand and this is now subject to a full collaborative commissioning review to ensure sustainability and resilience.

Significant work has been undertaken in response to the national multiagency reforms required in safeguarding children arrangements. Stronger duties have been placed on the CCG, Police and Local Authority to work together to safeguard and promote the welfare of children. Stockport's Safeguarding Children Board will transition into the new Safeguarding Partnership. Publication of the new local arrangements is on track to meet the requirement of June 2019. Work in 2019/20 will focus on the three organisations making joint decisions to safeguard children using wider partnerships.

The Continuing and Complex Healthcare (CCHC) team has continued to follow the National Framework for NHS Continuing Healthcare (CHC) and NHS-funded Nursing Care Guidance, which assist in determining eligibility to NHS CHC funding and whether individuals have a 'primary health need'.

All CCGs are monitored on a quarterly basis and NHS Stockport CCG's conversion rate for people who are eligible for NHS CHC funding continued to be consistently missed during the earlier part of 2018/19. However, the CCG saw a rise in compliance at the end of quarter 3 which is encouraging.

Engaging People and Communities

NHS Stockport CCG is committed to working with local people to improve health and secure high-quality healthcare for the people of Stockport, now and for future generations. We want everyone to have greater control of their health and wellbeing, and to be supported to live longer, healthier lives with high quality health and care services that are compassionate, inclusive and constantly improving.

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

As our ambition is to place patients, the public and our local communities at the heart of everything we do; genuine patient and public participation is essential. A number of ways in which we have involved and engaged local people and communities include:

- Stockport Citizens Panel;
- Citizen Space 'have your say';
- Public meetings;
- Social media surveys and polls;
- Prevention and screening events;
- Focus groups;

- Presentations at local groups;
- Patient story podcasts;
- South East Sector Healthier Together Public Voice; and
- Healthwatch attendance at Governing Body and CCG Committee meetings.

During 2018/9 Stockport Citizens Panel, Public Voice, the Mental Health Advisory Group (MHAG) and SEND were the main areas of focus for our involvement and engagement activity. Their achievements are outlined below.

Stockport Citizens Panel

Stockport Citizens Panel includes representatives from local communities and patient groups, including Healthwatch. The Citizens Panel has supported the CCG and wider health and social care economy to gather insight and opinion on a range of local health and social care issues during 2018/19 including:

- The CCG's mental health commissioning intentions for adults, children and young people;
- Greater Manchester Carers Charter;
- Stockport red bag initiative;
- Stockport outpatients project;
- The Improving Specialist Care Programme;
- The launch of new services within Viaduct Care the local GP Federation;
- Neighbourhood developments such as the Health Champions project;
- The development of the Stockport Involvement Strategy;
- The proposal for a new Partnership Involvement Network;
- Stockport Joint Strategic Needs Assessment;
- Pennine Care NHS Foundation Trust consultation on mixed sex accommodation; and
- SEND Local Area inspection.

The Citizens Panel were also actively involved in a number of local events including the Stockport Devolution Difference event, Stockport's NHS70 celebrations and the 'One Size Does Not Fit All' Mental Health Conference.

South East Sector Healthier Together Public Voice

One of the CCG's key programmes of work is the delivery of the Healthier Together programme which aims to implement a range of quality standards to improve patient outcomes as part of a Greater Manchester initiative. NHS Stockport CCG are the lead commissioner for the South East Sector Healthier Together Programme which includes partners from Stockport NHS Foundation Trust, NHS Tameside and Glossop CCG, Tameside and Glossop Integrated Care Foundation Trust, NHS North Derbyshire CCG and NHS Eastern Cheshire CCG.

To ensure patient and public involvement, NHS Stockport CCG led on the development of Public Voice, a patient and public involvement forum for Stockport, Tameside and Glossop, North Derbyshire and East Cheshire. The group is led by a lay Chair who is also

a member of the South East Sector Healthier Together Programme Board to ensure that the voice of local people is at the heart of the Healthier Together Programme.

During 2018/19 Public Voice was involved in a range of key areas including:

- A review of transport implications for Healthier Together Programme;
- A patient review of multidisciplinary team meetings;
- A review of national emergency laparotomy audit data for Stockport;
- A check and challenge sessions on Healthier Together Programme; and
- A mock post admission decision making session to improve these processes from a patient perspective.

Mental Health Advisory Group (MHAG)

The MHAG was set up in 2018 having evolved from the development and introduction of three new mental health services, psychological medicine in primary care, GP navigators and community psychiatric nursing into the crisis team.

The MHAG has representation from NHS Stockport CCG, Stockport Council, Pennine Care NHS Foundation Trust and third sector organisation, who are working in partnership to understand local needs and develop mental health services.

The group meets bi-monthly and has representation from two people with lived experience who provide critical input and suggestions on a range of issues, including suicide prevention, physical health of people with mental illness, crisis support and post self-harm support.

As a result of the collaborative partnership and the direct involvement of patients on the group, Stockport has excellent strategic expertise for implementation and development of mental health services such as suicide prevention to ensure that it reflects the experience of the individual, carers and families in our communities.

Special Educational Needs and Disabilities (SEND)

A Local Area SEND Inspection was undertaken by Ofsted and the CQC in September 2018 which can be found on the Stockport Local Offer.

The inspection was to determine the local area's effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities and evaluate how much progress has been made in implementing the SEND Code of Practice 0-25 years, since its implementation in September 2014. The results of the inspection were that work is needed to ensure that Stockport is fulfilling its functions effectively. As a system, a plan was developed that included the CCG and Council undertaking a number of public workshops and engagement activities, inviting parents, carers and young people to share their lived experience and to work with the organisations in improving local SEND services. This work will continue over the next two years and since November 2018, over 300 families have been actively involved and a proactive programme is now in place to continually engage, inform and involve local communities. This includes parent representatives on the SEND Board and all the SEND workstreams, to ensure that improvements are co-produced.

Feedback from involvement is reported to relevant committees and the CCG's Governing Body and is used to shape commissioning decisions. The formal part of the Governing Body always commences with a patient story, generally via a pre-recorded video. The Governing Body lay member for patient and public involvement plays an active role in a number of the CCG's committees as well as in Stockport Citizens Panel and has provided support to the Chair of Public Voice.

A full breakdown of involvement and engagement activity undertaken in 2018/19 can be found in the Statement of Involvement which outlines:

- When the activity took place;
- How many people were involved;
- What we asked;
- What local people told us?
- What we did as a result of local feedback; and
- Where to find more information on the involvement activity.

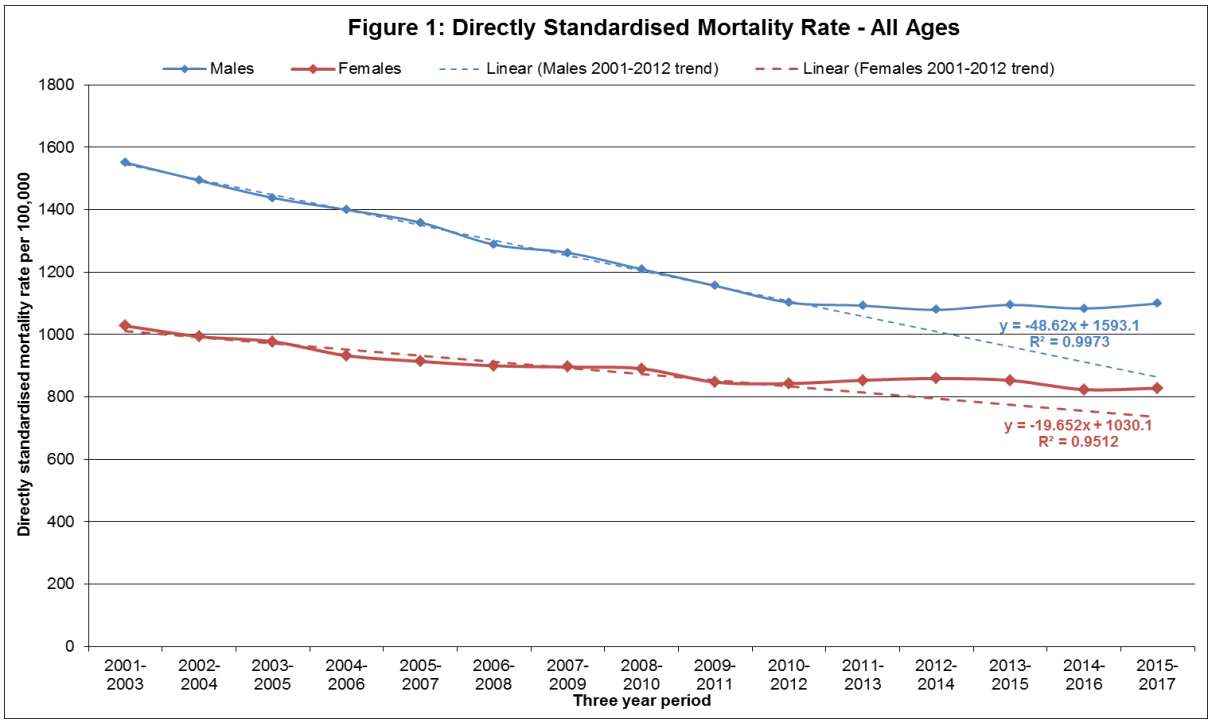
Over the last year we have strengthened our commitment to public and patient involvement by developing a framework to enable the CCG's commissioning managers to better understand how and when to involve people. The new process ensures that public involvement for all plans and proposals is considered and any required impact assessment is completed. To read the CCG's Engagement Framework please visit: www.stockportccg.nhs.uk/about-us/what-are-our-plans-and-priorities/

The CCG publishes an annual Statement of Involvement which provides greater detail on our plans, activity, outcomes and future plans. This can be found on our website at: www.stockportccg.nhs.uk/have-your-say/

Reducing Health Inequality

Stockport is one of the healthiest boroughs in Greater Manchester, and benchmarks well against national and peer comparators. However, the CCG is aware that inequalities in health outcomes endure, with people in the most deprived areas living on average, ten years less than the least deprived areas, and inequalities in healthy life expectancy being even more significant.

Nationally, after many years of sustained progress, since 2011 improvements in the age-standardised mortality rates and life expectancy have slowed down considerably and trends have become more inconsistent. This national position is also reflected across Stockport (see Figure 1) where increases in mortality rates for females in the most deprived areas and deaths in women under 75 years (premature deaths) are a particular cause for concern.



The Stockport population continues to grow and continues to age; these trends are projected to continue. Our focus with partners on supporting healthy ageing and actively responding to the clinical needs of our older patients remains a key priority. In light of a birth rate that has continued at a higher level than at the turn of the millennium, the number of children and young people in Stockport is rising (though at a lower level than the older population). Birth rates are highest in the most deprived populations, so that levels of need, including those for SEND and autism are increasing. This is an area that the CCG is actively working to improve, in partnership, through the SEND Improvement Board by progressing joint commissioning, and developing new pathways to improve access to services.

We are working closely with primary care colleagues on addressing long-term conditions as its prevalence continues to increase, and at a more rapid rate than the population increase with diabetes remaining the fastest growing long-term condition in Stockport. We are pleased that the National Diabetes Prevention Programme has been well received across Stockport this year as reflected in one of the highest uptake rates in Greater Manchester. Rates of smoking continue to fall but remain high in our deprived areas and we continue to work with colleagues in primary care and public health to address this.

Obesity, both in children and adults, continues to increase and particularly for childhood obesity, the theme of higher rates in deprived areas is evident. Unhealthy lifestyles are estimated to contribute to 40% of cancers and are a significant driver of inequalities.

The next phase of the New Models of Care is being implemented to develop services and approaches that aim to reduce health inequalities. Examples include:

- The Find and Prevent programme which aims to reduce the long-term level of disease, providing a better quality of life for patients and their families, and increasing healthy life expectancy, to close the health and wellbeing gap; and

- The Healthy Communities Programme which contributes to the transformation of the relationship between people, services and communities, through the delivery of person and community centred care. This wide range of programmes particularly focuses on self-care, promoting emotional wellbeing, addressing loneliness and supporting community connections.

Case Study: Brinnington and Mental Health

Recent data has shown that residents in Brinnington have some of the highest levels of mental health issues. It is known that depression and low mood are often linked to external stress factors such as poverty, abuse and social connectedness, and are also disproportionately affect certain age groups. Brinnington has a young population: and a much smaller older population when compared to the borough average. Brinnington is an area of multiple deprivation with high levels of social rented accommodation and low income levels. Domestic abuse rates are some of the highest in the borough.

Brinnington Surgery is one of two Stockport general practices that has been assessed as outstanding by the CQC and this high level of achievement, is in part a reflection of the proactive identification and addressing of mental health need.

As part of the investment into the new neighbourhood model of care, sixteen additional wellbeing and self-care workers are now accessible within communities to help GPs manage patients where the underlying mental health concern is caused by social and/or economic challenges. This model was successfully piloted in Brinnington before being extended across Stockport. Public health colleagues across Stockport are working with "Greater Manchester Moving" to look at ways in which Brinnington can access more resources to support people to become more active, which in turn assists with reducing isolation and depression. Public health colleagues have met with local residents, partners, and Brinnington Councillors to ascertain what can be offered and how general practice can provide additional support.

Through the GMHSCP, we are piloting a programme to help Brinnington GPs support residents who are at risk of unemployment or who have recently become unemployed to have rapid access to mental health services. The Council with local staff are also taking a multi-agency approach to tackling the underlying causes of depression (poverty, unemployment, crime, abuse, loneliness and relationship issues) including through Place Based Integration (PBI).

Twice weekly problem solving meetings pick up individuals who repeatedly enter our crisis systems but often fall below the threshold for services, and look to connect them with appropriate community or service offers. GPs have highlighted the need for more services to address domestic abuse and we are looking to how we can participate in the Council's recent successful £500k Home Office funding bid and the recent roll out of Operation Strive and Operation Encompass across the conurbation. GPs are also actively referring their patients to the new Life Leisure Centre at Brinnington which has a comprehensive programme of both traditional health and fitness activity and supported programmes for those who face barriers to engagement and is receiving referrals from a range of agencies including PBI.

Health and Wellbeing Strategy

The delivery of the joint Health and Wellbeing Strategy requires the contributions and involvement of all members of the Stockport Health and Wellbeing Board and its partner organisations. The strategy drives the work of the board and covers the period of 2017-2020 and can be accessed using the following link:

http://www.stockportccg.nhs.uk/download/3818/

The key themes of the strategy are to deliver a health and care system which is:

- Prevention focussed;
- Community asset based;
- Person centred;
- Integrated;
- Delivered through neighbourhoods; and
- Financially sustainable.

During 2018/19, the Chair of the Stockport Health and Wellbeing Board, with partners including NHS Stockport CCG, has led a process of review and refocus in relation to the governance, priorities and membership of the Board. The outcomes of this include:

- Confirmation that to effectively discharge statutory responsibilities, Stockport's Health and Wellbeing Board needs to act as the senior forum in the borough for:

  - Setting health and wellbeing strategy;
  - Assessing performance; and
  - Assuring accountability for action to drive improvement.

- Provider membership should be strengthened with membership extended to include the GP Federation, Viaduct Care CIC;

- New Terms of Reference establish that the Chair shall be the Leader of the Council or their nominated delegate and that the Vice-Chair position will be held by a representative of the CCG; and

- The revisions to the JSNA for 2020 will focus on population segmentation, neighbourhood working and mortality changes.

Noreen Dowd
Interim Accountable Officer
22 May 2019

ACCOUNTABILITY REPORT

Overview

The Accountability Report is required to have three sections as detailed below:

Corporate Governance Report: the purpose of the corporate governance report is to explain the composition and organisation of the entity's governance structures, how these support the achievement of the entity's objectives and how they reflect the generally accepted principles of good governance as stated in the National Health Service Act 2006.

Remuneration and Staff Report: the remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers. In addition, the report provides details on remuneration and staff that users of the accounts see as key to accountability.

Parliamentary Accountability and Audit Report: Entities such as CCGs are not required to produce a Parliamentary Accountability Report but must nevertheless include an audit certificate and report as a component of this Annual Report.

Corporate Governance Report

Members' Report

NHS Stockport CCG's Constitution is available on our website at:

http://www.stockportccg.nhs.uk/download/5684/

The CCG's Constitution sets out how the organisation carries out its duties and makes decisions. The CCG is a membership organisation in which all GP practices in Stockport must be members of the CCG and each GP practice nominates a GP Member Representative who has voting rights. The Member Representatives are collectively known as the Council of Members.

The Constitution was initially made between the Members of NHS Stockport CCG and has been effective since 1st April 2013, when the organisation was established. The Constitution was updated during 2018/19 to reflect changes to the organisation and all GPs in Stockport have confirmed agreement to and signed the revised document. The appropriate processes were followed to make these changes culminating in NHS England approval.

Member profiles

Appendix B of NHS Stockport CCG's Constitution provides full details of the Membership of the organisation as at September 2018. The updated details of the Membership as at 31st March 2019 are attached in **Appendix A** to this Corporate Governance report.

Composition of Governing Body

Meet the Governing Body

The Governing Body has been delegated by its Council of GP Members the power to conduct the overall management of the CCG. The Governing Body meet regularly to conduct their formal business. The papers and minutes of these meetings are published on the CCG's website www.stockportccg.nhs.uk

Members of the public or other interested parties are invited to notify attendance in advance either by telephoning or emailing the CCG reception on 0161 426 9900 or ccg.reception@nhs.net.

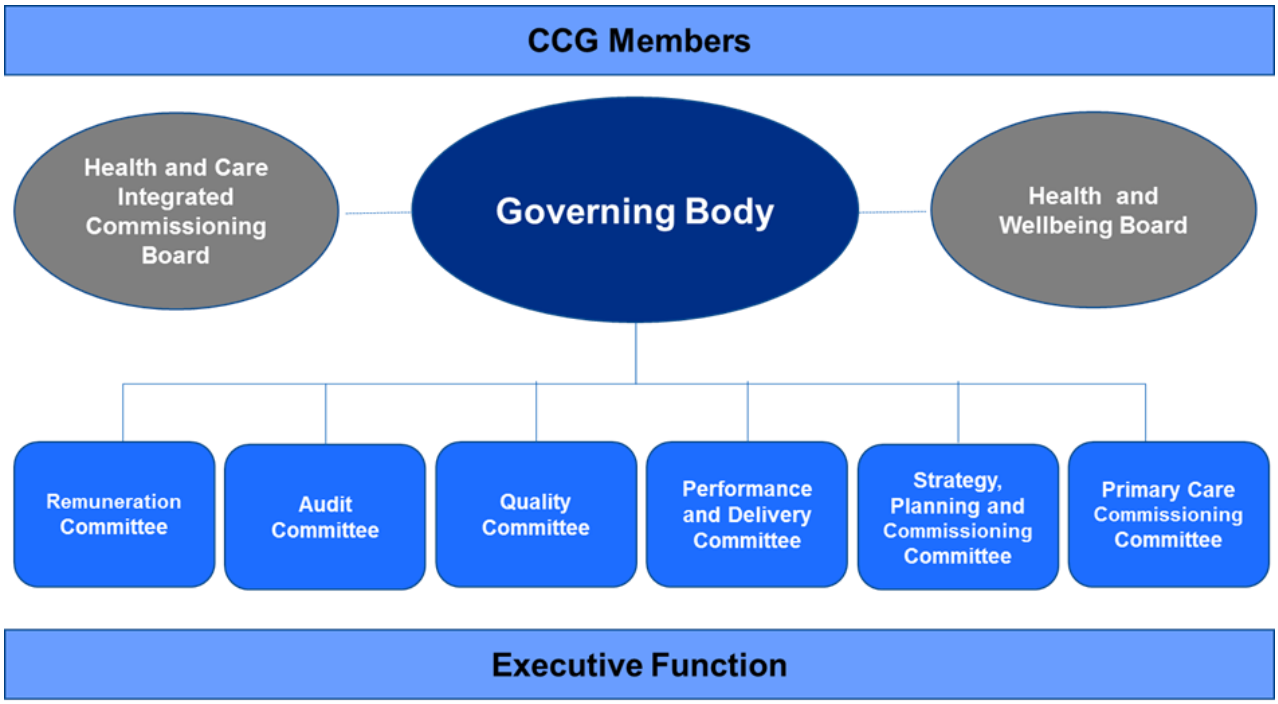
Governing Body Voting Members (part year membership shown in brackets):

Dr Catherine Briggs - Chair (October 2018 - current)
Jane Crombleholme - Lay Chair (April 2018 - September 2018)
Dr Ranjit Gill - Chief Clinical Officer (April 2018 - August 2018)
Gaynor Mullins - Chief Operating Officer (April 2018 - September 2018)
Noreen Dowd - Interim Accountable Officer (August 2018 - current)
Mark Chidgey - Chief Finance Officer
Anita Rolfe - Executive Nurse (Registered Nurse)
Dr Deborah Kendall - Secondary Care Consultant
Dr Simon Woodworth - Clinical Director (Medical Director)
Dr Viren Mehta - Clinical Director (February 2019 - current)
John Greenough - Lay Member
Christine Morgan - Lay Member
Peter Riley - Lay Member (August 2018 - current)
Dr Vicci Owen-Smith - Clinical Director of Public Health (April 2018 - May 2018)
Jennifer Connolly - Consultant in Public Health (June 2018 - December 2018)
Judith Strobl - Locum Public Health Consultant (January 2019 - current)
Dr Andy Johnson - GP Locality Chair
Dr Lydia Hardern - GP Locality Chair (April 2018 - November 2018)
Dr Karen McEwan - GP Clinical Lead (January 2019 - current)
Dr Najabat Hussain - GP Clinical Lead (February 2019 - current)

Directors in attendance (Non-voting)

Tim Ryley - Director of Strategic Planning and Performance (April 2018 - July 2018)
Dr Diane Jones - Director of Corporate Affairs, Policy and Partnerships
Roger Roberts - Director of General Practice Development

Committee(s), including Audit Committee



The changes to the constitution, approved by the Council of Members in September 2018, established the committee structure as highlighted above for the CCG. Locality Committees remain as part of the CCG Constitution but as part of the Integration agenda, it was agreed that GP Clinical Leadership for Neighbourhoods would be established within Stockport Neighbourhood Care to drive this agenda forward. Continuation of Locality Committees alongside the revised Neighbourhood support would have been a duplication and reduced GPs' clinical time with patients. Therefore, the Locality Committees have not met during 2018/19.

In addition, it should be noted that the revised Constitution approved in September 2018 established both the Performance and Delivery Committee and the Strategy Planning and Commissioning Committee as highlighted above. These committees formally replaced the pre-existing Finance and Performance Committee.

Governing Body Committees (and their membership) which operated during the financial year were:

Audit Committee

- John Greenough - Lay Member
- Bernard Braiden - Member
- David Swift - Member
- Dr Andy Johnson - Locality Chair

Remuneration Committee

- John Greenough - Lay Member
- Christine Morgan - Lay Member
- Dr Debbie Kendall - Secondary Care Consultant
- Dr Simon Woodworth - Medical Director*
- Jane Crombleholme - Lay Member, Chair of NHS Stockport CCG*
- Dr Viren Mehta - Clinical Director*

Performance and Delivery Committee

- Dr Cath Briggs - CCG Clinical Chair
- John Greenough - Lay Member
- Peter Riley - Lay Member
- Jennifer Connolly - Public Health Consultant*
- Judith Strobl - Public Health Consultant*

Quality Committee

- Anita Rolfe - Executive Nurse
- Dr Simon Woodworth - Clinical Director
- Christine Morgan - Lay Member
- Dr Debbie Kendall - Secondary Care Consultant
- Julie Parker - Safeguarding Lead Nurse
- Sandra Walker - Senior Commissioning Quality and Performance Lead
- Susan Parker - Allied Healthcare Professional
- Sue Carroll - Healthwatch committee representative
- Jane Crombleholme - Lay Member, Chair of NHS Stockport CCG*

Primary Care Commissioning Committee

- Peter Riley - Lay Member*
- Christine Morgan - Lay Member
- Anita Rolfe - Executive Nurse
- Mark Chidgey - Chief Finance Officer
- Roger Roberts - Director of GP Development
- Judith Strobl - Public Health Consultant*
- Jennifer Connolly - Public Health Consultant*
- Dr Vicci Owen Smith - Clinical Director Public Health*
- Jane Crombleholme - Lay Member, Chair of NHS Stockport CCG*
- Gaynor Mullins - Chief Operating Officer*
- Ranjit Gill - Chief Clinical Officer*

Strategy Planning and Commissioning Committee

- John Greenough - Lay Member
- Christine Morgan - Lay Member
- Dr Cath Briggs - Clinical Chair
- Dr Simon Woodworth - Medical Director
- Judith Strobl - Public Health Consultant

Finance and Performance Committee

- John Greenough - Lay Member
- Dr Vicci Owen Smith - Clinical Director Public Health
- Dr Ranjit Gill - Chief Clinical Officer
- Gaynor Mullins - Chief Operating Officer

**Indicates part-year membership of committee.*

Details of attendance at the Governing Body and its committees are summarised in Appendix B of this Corporate Governance Report.

Register of Interests

NHS Stockport CCG has adopted a Conflicts of Interest Policy which is in line with statutory guidance on managing conflicts of interest within CCGs. In addition, the CCG maintains a Register of Interests which is available on our website at: http://www.stockportccg.nhs.uk/about-us/publications/

Personal data related incidents

There were no Serious Untoward Incidents relating to data security breaches, including any that were reported to the Information Commissioner in 2018/19.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- So far as the Member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and

- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Stockport CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England).

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the CCG's Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error;
- For safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the Group Accounting Manual have been followed, and disclose and explain any material departures in the accounts;

- Assess the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern;

- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity; and

- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Stockport CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Noreen Dowd
Interim Accountable Officer
22 May 2019

Governance Statement

Introduction and Context

NHS Stockport CCG is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). As at 1 April 2013 the CCG was licensed without conditions.

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1st April 2018, NHS Stockport CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Vision

The CCG's vision is "*We exist so that Stockport people will access high quality health services that empower them to live healthier, longer and more independent lives"* and underpins the organisations approach to everything it does to help improve the health and services across the borough.

Values

The values that lie at the heart of our work are:

- ***Being quality obsessed*** - by putting the patient at the centre of decision-making we will continually improve services.
- ***Keeping a primary and community focus*** - we will deliver care as close to home as possible, with general practice at the heart of care.
- ***Innovation*** – we will continually look for better and more cost-effective ways of delivering care.
- ***Working collaboratively*** - we will look to work constructively with others to shape the future.
- ***Patient responsibility*** - we will work with patients and carers, empowering them to take responsibility for their own health and use NHS resources wisely.
- ***Distributive leadership*** - we will devolve decision making and resources to those best placed to meet the needs of our community.
- ***Behaving Professionally*** - we will be trustworthy, evidence-based, systematic and disciplined.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with my responsibilities assigned through Managing Public Money. I also acknowledge the responsibilities as set out under the National Health Service Act 2006 (as amended) and in my CCG Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

Robust, well communicated, understandable embedded corporate governance arrangements are critical to achieving the CCG's objectives.

In accordance with paragraph 14L (2)(b) of the 2006 Act, the CCG conducts its business at all times with reference to generally accepted principles of good governance. These include:

- The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- The Good Governance Standard for Public Services;
- The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles';
- The key principles of the NHS Constitution;
- The Equality Act 2010; and
- Standards for Members of NHS Boards and Governing Bodies in England.

The CCG's Council of Members is accountable for exercising the CCG's statutory functions; however, it may delegate authority to act on its behalf to any of its Members, its Governing Body, a committee or sub-committee of the CCG or to any of its employees.

The extent of the authority to act depends on the powers delegated by the Council of Members as expressed through its Constitution, the CCG's Scheme of Reservation and Delegation and for committees and sub-committees, through their Terms of Reference.

The CCG's Scheme of Reservation and Delegation sets out those decisions that are reserved for the Membership as a whole, acting through the Council of Members and those decisions that are the responsibilities of its Governing Body of the CCG's committees and sub-committees and of individual members and of its employees.

The Council of Members remains accountable for all of its functions, including those that it has delegated.

In discharging the functions of the CCG that have been delegated to them, the Governing Body, any committees and sub-committees of the CCG and individuals must:

- Comply with the CCG's principles of good governance;
- Operate in accordance with the CCG's scheme of Reservation and Delegation;
- Comply with the CCG's arrangements for discharging its statutory duties; and
- Where appropriate, ensure that Member Practices have had the opportunity to contribute to the CCG's decision-making processes.

When a committee, sub-committee or joint committee discharges delegated functions, it must also operate in accordance with its approved Terms of Reference. These are approved by the Governing Body and can be found on the CCG's website.

Objective setting and the appraisal of all Governing Body Members has progressed during 2018/19, and routine, informal Governing Body developmental sessions serve to facilitate the transfer of knowledge and aid aspects of each Member's personal development.

During 2018/19, an external review took place to assess the effectiveness of the organisation and the Governing Body. The outputs identified good experience, skills and knowledge across the executive and non-executive teams with a strong value-based approach to strategy development.

Committees of the Governing Body

To support the successful delivery of its functions and activities, NHS Stockport CCG has several key committees each accountable to the Governing Body. The purpose of each committee is briefly outlined below with a summary of the main highlights of work led and undertaken by each committee subsequently provided.

The structure of the CCG's Committees is presented on page 39 for information.

The **Audit Committee** provides the Governing Body with an independent and object view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. It supports the Governing Body in discharging its duties to effectively, efficiently and economically manage its resources and to adhere to the principles of good governance.

The **Quality Committee** is accountable to the CCG's Governing Body for providing assurance of patient safety, patient experience and clinical effectiveness of commissioned services in line with the CCG's Quality Strategy. It provides leadership to the quality agenda in Stockport and ensures commissioned services are continuously improving, achieving and exceeding national and local standards.

The **Remuneration Committee** makes recommendations to the Governing Body on determinations regarding the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determinations about allowances

under any pension scheme that the CCG may establish as an alternative to the NHS Pension Scheme.

The **Performance and Delivery Committee** is responsible for the development and monitoring of the CCG's Operational Plan and priority areas as linked to the CCG's delivery of financial and performance targets and for making recommendations to the CCG's Governing Body in respect of those areas.

The **Strategy, Planning and Commissioning Committee** is accountable to the CCG's Governing Body for providing assurance of the process for setting direction and future activity and making recommendations, where necessary.

The **Primary Care Commissioning Committee** is responsible for carrying out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act which were delegated to the CCG from NHS England under delegated commissioning arrangements. These commissioning activities include GMS, PMS and APMS contracts, newly designed enhanced services, design of local incentive schemes, decisions regarding the potential establishment of new GP practices, approving practice mergers and making decisions on discretionary payments.

The **Health and Care Integrated Commissioning Board (HCICB),** was established as part of the Section 75 Agreement between NHS Stockport CCG and Stockport Metropolitan Borough Council. although not a formal sub-committee of the Governing Body, the HCICB is accountable and responsible on behalf of both commissioners for the deployment and management of the pooled budget (which incorporates the Better Care Fund) and the commissioning of services from the pool.

The Committees reported the following highlights for 2018/19:

Audit Committee

- Scrutinised the CCG's reported financial position and associated risks;
- Monitored progress against the Internal Audit Plan and completion of associated management responses;
- Monitored progress on Counter Fraud processes and standards within the CCG;
- Considered control risks and issues for reporting to the Governing Body; and
- Provided recommendations to the CCG's Governing Body in adopting this Annual Report and the Financial Accounts for 2018/19.

Quality Committee

- Reviewed quality reports from a range of providers and areas, in line with the quality assurance framework managed by the quality and safeguarding teams;
- Reviewed focused deep dives into patient experience at three providers; Stockport NHS Foundation Trust, Pennine Care and Mastercall Healthcare; and
- Reviewed a number of quality reports including Community Services, A&E Safety Metrics, Pressure Ulcers and Cancer Review.

Remuneration Committee

- Reviewed revisions to the CCG Leadership structure, as agreed at the Annual General Meeting;
- Agreed salary ranges for the posts of Executive Nurse and Medical Director; and
- Considered pay awards for staff not employed under Agenda for Change pay conditions.

Performance and Delivery Committee

- Reviewed the implementation of the new Integrated Performance Framework;
- Considered the prioritisation and delivery of performance improvement plans linked to the outputs of the Integrated Performance Framework; and
- Reviewed achievement of the CCG's target financial plan, including quality, innovation, productivity and prevention (QIPP) and Mental Health Investment Standard.

Strategy, Planning and Commissioning Committee

- Received an update on children's mental health commissioning;
- Provided direction for the draft Stockport Primary Care Strategy; and
- Scrutinised 2019/20 financial and operational plans which were endorsed for sign off at March 2019 Governing Body.

Primary Care Commissioning Committee

- Oversaw the Care Quality Commission results and followed through to achieve good or outstanding in all practices;
- Managed the merger of Heaton Moor Medical Centre and Adswood Road surgery;
- Introduced a new scheme to improve safeguarding in all practices across Stockport.

Joint Arrangements

NHS Stockport CCG is one of 10 CCGs across Greater Manchester. The CCG's GP Chair and Accountable Officer represent our interests at the Greater Manchester Joint Commissioning Board (JCB), the vehicle for joint working and decision-making across the Greater Manchester footprint.

The CCG is also represented at regular meetings of Greater Manchester's Directors of Commissioning and Chief Finance Officers. Through such governance, member CCGs are able to share best practice, access peer support and work collaboratively on a wider footprint to achieve the best possible health outcomes for their patients.

The CCG has also agreed an initiative alongside Stockport NHS Foundation Trust whereby a named CCG director works at Stepping Hill hospital on a daily basis to ensure that there is a senior member of the CCG at daily bed meetings and therefore in a position to support colleagues should service requirements escalate due to A&E department pressures.

NHS Stockport CCG has also entered into joint governance arrangements with other organisations across the Stockport footprint to increase opportunities for collaboration and partnership working. Examples include:

- Membership of both the Stockport Safeguarding Adults Board and the Safeguarding Children's Board;
- Membership of the Health and Care Integrated Commissioning Board;
- Strategic leadership to Stockport's Health and Wellbeing Board (now expanded to include provider organisations as well as commissioners);
- Stockport's Health Partnership Board which was established during 2018/19 to progress the health aspects of our transformation work;
- Stockport's Urgent and Emergency Care Delivery Board which has been refocussed with new leadership to build a single, economy-wide plan;
- The CCG, GP Federation, Local Medical Committee and GP practices working collaboratively to agree a vision for neighbourhoods and subsequent Primary Care Networks; and
- A local SEND Improvement Board which has been established to lead multidisciplinary working to support children with ASD.

UK Corporate Governance Code

The detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies. However, NHS Stockport CCG continues to manage and report on its corporate governance arrangements by drawing upon best practice available, including relevant aspects of the Code the CCG deems to be relevant to its business.

For the financial year ended 31st March 2019 and up to and including the date of signing this statement, the CCG has complied with the provisions set out in the Code and equally applied the principles laid out therein.

Discharge of Statutory Functions

Arrangements put in place by the CCG, and explained within the corporate governance framework, have been developed with extensive expert external legal input to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for the Council of Members and Governing Body's decision and the Scheme of Delegation.

In light of recommendations of the 2013 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness

NHS Stockport CCG defines risk as 'anything that can cause harm to stakeholders to whom we owe a duty of care or which threatens the achievement of our strategic objectives. This includes damage to the reputation of the CCG that could undermine public confidence.'

During 2018/19, the CCG invested in its online risk management system, InPhase, to ensure that a consistent approach to managing risk is taken across the organisation. The system covers project, programme and organisational risks and its functionality has been enhanced to enable more robust reporting. The Project Management Office function within the CCG has provided training for the CCG's workforce to ensure a common understanding across directorates with regards to the capturing, monitoring and reporting of risks. The continued development of the approach to managing risk by the CCG demonstrates our commitment to managing risk in a mature manner which is reflective of the complex internal and external environments.

The CCG's Risk Management Strategy provides the framework in which the organisation works to minimise exposure to unnecessary risks and manage those risks which cannot be avoided. The recording of potential risks allows the CCG to plan for any potential negative impacts and deters them from happening wherever possible. Risks are identified by anyone within the CCG and are formally recorded by the corporate officer responsible for risk using the online risk management system. Guidance is provided within the strategy to allow managers to understand the effectiveness of the controls that are put in place. The controls are articulated within the mitigation section of the risk reporting system.

Each risk is assigned an owner who is responsible for evaluating the impact and likelihood. A combined score is recorded using a defined scoring system as set out in the Risk Matrix Tool outlined in the Risk Management Strategy. The combined score is used to determine the grading of the risk, which runs from low to extreme.

A theme-based approach has been adopted to categorise the risks. Detail regarding risk appetite is included for individual elements in order to guide behaviours at operational and leadership level. The process for managing risk includes risk updating and moderation sessions to ensure a consistent approach is taken to the scoring and understanding of risk by risk owners across the organisation.

NHS Stockport CCG appointed an European Union exit (EU) Senior Responsible Officer (SRO) to oversee preparations for EU exit and to work with system partners as part of the locality Advisory Group, which is chaired by Stockport Council. The CCG's Leadership Team and Governing Body have received update reports and the EU exit has not been assessed as a significant strategic risk for the CCG given the matters being dealt with directly by NHS central bodies and HM Government. The role of EU exit SRO has been maintained following extension of the Article 50 period to 31 October 2019.

The CCG's Conflict of Interest policy is a key mechanism for identifying and monitoring any potential risks which may arise and serves to complement the Risk Management Strategy. All staff are required to make twice annual declarations outlining any current or potential conflicts. The policy clearly articulates the factors that the CCG addresses when commissioning services under delegated commissioning arrangements.

Recognising where and how potential risks arise and dealing with them appropriately, allows the CCG to ensure good governance, robust decision-making and appropriate decisions are made regarding the use of public money.

All of the CCG's healthcare contracts have a requirement for providers to report on compliance with the national Workforce Race Equality Standard each year. The CCG has done this through the inclusion of an Equality, Diversity and Human Rights contract schedule in all third-party contracts. This schedule also requires an overview of Equality Impact Assessments (EIAs) to be undertaken, published online and reported to the equality leads.

When considering awarding contracts for goods and services, due regard is given by the CCG to the Equality Act 2010 and where necessary an EIA is completed to document the effect on equality and demonstrate that we have paid due regard to the Public Sector Equality Duty.

As outlined in our Performance Report earlier in this document, the CCG has carried out a programme of engagement exercises to involve the public in improving services to mitigate risks within any services or pathways. During 2018/19, the CCG has focussed particularly on the Stockport Citizens Panel, Healthier Together, a MHAG, and SEND involvement activities with the public and patients to help mitigate the risk of pathway and service delivery changes.

The CCG does not tolerate fraud, bribery and corruption and aims to eliminate all such activity as far as possible. It is the CCG's policy that no employee will suffer in any way as a result of reporting reasonably held suspicions and can therefore be confident that reporting concerns will not result in any repercussions.

The CCG's Anti-Fraud, Bribery and Corruption policy and response plan was produced by the Anti-Fraud Specialist and is a guide for all employees in relation to anti-fraud, bribery and corruption activities being undertaken within the CCG and the wider NHS; as well as informing all CCG staff of how to report any suspicions or concerns they may have. During 2018/19, an awareness raising session was delivered to Governing Body Members by the Anti-Fraud Specialist.

The CCG has a robust procedure in place for monitoring and recording serious incidents that are reported by providers on the STEIS system. We ensure providers report serious incidents through the national framework and have a robust system for monitoring lower grade incidents where harm has been identified to ensure that learning is captured and embedded.

The CCG also monitors any internal incidents which occur. These are recorded using the national STEIS framework and are reviewed within 60 days by the Nursing and Quality Directorate as per the national guidelines. Any identified learning is communicated and shared within the CCG as appropriate. NHS England authorise closure when the learning has been identified and uploaded onto the STEIS system.

Capacity to Handle Risk

The CCG's strategic risk profile is described within the current Board Assurance Framework. Each strategic risk is reviewed by the risk owner to determine the likelihood of

the risk arising, to consider the effectiveness of the controls and to identify any future events which may impact on the area of risk in either a positive or negative way.

The reviews are undertaken in line with the risk appetite agreed for each theme, which is reviewed by the theme owner as a whole. The impacts of risks remain under continued review, and where environmental factors have changed significantly, impact scores have been altered to reflect increased impact.

The CCG's committee structure allows for the capture and monitoring of risks within the risk management system. Each committee has lay representation ensuring that a broad stakeholder view of risk is taken. The committees maintain logs which capture the risks impacting on the business carried out by or under the review of the committee. From this, risks are identified and registered within the risk management system.

The CCG Leadership Team receives and discusses the risk registers and Board Assurance Framework and provides a moderated view prior to its submission to the Audit Committee for review. After the Audit Committee has reviewed and scrutinised the reports, they are shared with the Governing Body for oversight and discussion. The meetings of the Governing Body are held in public and are minuted, allowing the patients and public of Stockport to ascertain for themselves the degree of rigour the Governing Body applies to monitoring risk.

The CCG's Leadership Team also receives a compliance dashboard in the form of the Integrated Performance Dashboard which sets out the CCG's performance against its areas of statutory requirement.

The Governing Body receives a summary of the NHS England quarterly assurance meetings which has provided an independent assessment of the CCG's performance.

Risk Assessment

During 2018/19, a review of the Board Assurance Framework was initiated by the CCG's Leadership Team to evaluate its effectiveness and to understand any improvements that could be made to further strengthen the systems in place. This review will be completed during 2019/20 and the findings used to improve the risk management processes and procedures used by the CCG.

The annual Board Assurance Framework Review carried out by the CCG's internal auditors assessed the approach the organisation takes to the maintenance and use of the Board Assurance Framework to support the overall assessment of governance, risk management and internal control.

The audit found that the organisation's framework requires improvement to meet the NHS requirements, and could be more visibly used by the Governing Body. This is in line with the CCGs own assessment and the Board Assurance Framework coupled with improving risk management have been identified as key priorities for 2019/20.

The main risks to governance, risk management and internal control over the reporting period are noted below. The CCG has detailed mitigations in place against each of the risks over which the risk owners, the Chair of the Governing Body and the Accountable Officer maintain strategic oversight.

- The organisation's capacity, capability and/or internal engagement are inadequate (Including commissioned support services);

- Providers' capacity and capability fails to deliver in line with the CCG strategy and quality expectations;

- The CCG fails to remain within financial balance and operate within the Business Rules as required by NHS England; and

- The CCG fails to meet its statutory duties for compliance (including procurement).

Other Sources of Assurance

Internal Control Framework

A system of internal control is the design of processes and procedures to ensure that the CCG delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risks entirely. It can therefore only provide reasonable and not absolute assurance of effectiveness.

The Governing Body is responsible for setting the strategic direction of the CCG and in support of this, approves the annual operational plan. The CCG's Governing Body receive an Integrated Performance Report on a quarterly basis which sets out the CCG's progress against its constitutional requirements and statutory compliance indicators.

The report also presents a strategic overview of performance against key indicators and identifies those areas of underperformance or of significant challenge/ risk coupled with the actions being taken by the Leadership Team to improve performance. In addition, a key component of the CCG's performance reporting is use of its Board Assurance Framework which provides a view of the organisation's performance from the perspective of its strategic risk profile.

The Audit Committee specifically advises the Governing Body on the effectiveness of the system of internal control by the review of both internal and external audit reports. Any significant control issues are routinely reported to the Governing Body by the Audit Committee.

Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016, and as amended 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

On behalf of the CCG, MIAA has carried out our annual internal audit of conflicts of interest. Following the review, internal audit has assigned compliance levels to each area as follows:

Scope Area	Compliance Level	RAG Rating
Governance Arrangements	**Partially Compliant**	●
Declarations of interests and gifts and hospitality	**Partially Compliant**	●
Register of interests, gifts and hospitality and procurement decisions	**Partially Compliant**	●
Decision making processes and contract monitoring	**Fully Compliant**	●
Reporting concerns and identifying and managing breaches / non compliance	**Fully Compliant**	●

Data Quality

The Governing Body is presented with different types of data from a number of sources. During the year the Governing Body has continued to review the volume and type of data it requires to carry out its role effectively and similarly, that required by the wider CCG in the delivery of its work. This has led to continued improvements and refinement in reporting during 2018/19.

Data provided to the Membership and the Governing Body to inform decision making is obtained from trusted sources: NHS data sets; NICE; the Joint Strategic Needs Assessment (JSNA); etc., and from trusted advisers: Greater Manchester Shared Services (GMSS); the National Health Service Litigation Authority (NHSLA); the National Health Service Business Services Authority (NHSBSA); etc.

The Governing Body also receives information which is more of a narrative form including the assurance reports from its Committees. A key element of the CCG's internal control systems is the Governing Body's effectiveness in triangulating these different sources and types of information.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular patient identifiable information.

The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the DSPT. We have

ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

As of 2018, the Information Governance toolkit was refreshed and replaced with the new DSPT. Whilst the standards have been updated, it remains a tool which allows organisations to measure their compliance against law and central guidance and helps identify areas of partial or non-compliance. In addition, there is a contractual obligation for providers to complete the DSPT and they are subject to audit against it.

During 2017/18, an internal audit completed by MIAA found that NHS Stockport CCG demonstrated moderate assurance in relation to the governance processes, policies, and systems in place to complete, approve and submit the DSPT submission and was compliant with its requirements.

Business Critical Models

No significant internal control issues have been identified in this respect as NHS Stockport CCG uses only those quality assurance models prescribed by NHS England.

Third Party Assurances

NHS Stockport CCG has received third party assurance from GMSS through the Head of Internal Audit Opinion & Annual Report for 2018/19. This report provides positive assurance in respect of the governance, risk management and internal control arrangements operated by GMSS.

The Internal Audit arrangements in 2018/19 were well established and audit coverage was approved through the GMSS Senior Management Team. The reviews within the service have concluded that, as an entity, robust internal controls are operating in respect of GMSS. In addition, the follow up of audit recommendations confirmed good progress being made in implementing previously agreed actions.

GMSS provide a number of support services to NHS Stockport CCG. During 2018/19 GMSS have had a number of internal audits undertaken for which they have received ‘substantial assurance.’ These include People Services, Key Financial Systems, Governance & Risk, and the DSPT. This confirms the substantial assurance given in respect of governance, risk management and internal control arrangements operated by GMSS.

Control Issues

The CCG has reviewed both the systems of internal control and external reporting of controls to NHS England to confirm that there are no significant control issues that would

have a material impact on the accounts or adversely affect the delivery of standards expected of the Accountable Officer.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

The Governing Body routinely receives a monthly Finance Report which provides details of the CCG's achievement against surplus targets, its year-to-date financial position and the key challenges to its financial position. In addition, the Governing Body receives an Integrated Performance Report on a quarterly basis which provides in-year performance monitoring. The Governing Body has been supported in its financial oversight and challenge by the Performance and Delivery Committee during 2019/20.

The Audit Committee provides the assurance overview for the effective use of resources, and the internal audit team have an annual work programme that complements that role and focuses upon all work areas covered by the CCG. While CCGs have a responsibility to promote comprehensive healthcare within the resources available, this does not mean an obligation to provide every treatment. As a commissioning organisation, NHS Stockport CCG strives to consider the resources available to it and the competing demands on those resources.

The GMSS Effective Use of Resources (EUR) team works closely with NHS Stockport CCG to facilitate and support making those judgments at an individual patient level known as Individual Funding Requests (IFRs). The GMSS EUR team combines regional best practice and benchmarking with local knowledge gained from a strong client relationship and deep knowledge and expertise. A Greater Manchester overview improves consistency across boundaries, leading to an improved patient experience.

The CCG's IFR panel is chaired by the lay member with responsibility for patient and public involvement and comprises other patient and public health representatives coupled with clinical input from across the CCG, including the Medical Director. Other professionals join the meeting as required to consider specific cases as appropriate.

Delegation of Functions

GMSS undertake a number of functions on behalf of the CCG including some finance activities. In addition, Stockport Council provide a very limited range of service to the CCG. There are no other significant delegated functions that are not already covered elsewhere in the governance statement.

Counter Fraud Arrangements

In line with the requirements of the NHS Counter Fraud Authority (NHSCFA) standards, NHS Stockport CCG has the following arrangements in place regarding its management of counter fraud issues:

- An Accredited Counter Fraud Specialist is contracted from MIAA (Counter Fraud Services) to undertake counter fraud work proportionate to identified risks;

- The CCG's Audit Committee receives a report against each of the Standards for Commissioners at least annually and there is executive support and direction for a proportionate proactive work plan to address any risks that are identified;
- A member of the Leadership Team is proactively and demonstrably responsible for tackling fraud, bribery and corruption; and
- Appropriate action is taken regarding any recommendations made following an assessment carried out by the NHSCFA.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that for the period 1st April 2018 to 31st March 2019:

Moderate Assurance can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. It is provided in the context that NHS Stockport CCG, like other organisations across the NHS, is facing a number of challenging issues and wider organisational factors. It should be noted that this year has seen a change in the classifications of opinion available to CCGs with a 'Moderate Assurance' being comparable to the 'Substantial Assurance' achieved in 2017/18.

During the year, Internal Audit issued the following audit reports:

Area of Audit and Level of Assurance	
SUBSTANTIAL ASSURANCE: There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.	
Key Financial Systems	To provide assurance that the most significant key controls in the areas of General Ledger, Accounts Payable, Budgetary Control (including QIPP) and ESR/Payroll are appropriately designed and operating effectively in practice.
Primary Medical Care Commissioning and Contracting	To evaluate the effectiveness of the arrangements put in place by the CCG to exercise the primary care medical care commissioning function of NHS England as set out in the Delegation Agreement, and to seek assurance regarding the operation and oversight of the Primary Care Commissioning Committee.
Performance Management Arrangements	To examine the processes in place for managing the performance of the CCG against its statutory duties, delivery of its plans and understanding the performance of its commissioned healthcare providers and the internal processes to facilitate this.
MODERATE ASSURANCE: There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.	
Patient & Public Engagement	To undertake an assessment of the CCGs compliance against each of the 10 key actions for CCGs within the NHS England guidance "Patient and public participation in commissioning health and care".
Serious Untoward Incidents (SUIs) & Investigations	To review the effectiveness of the arrangements in place to ensure SUIs and investigations are effectively managed, reported and lessons learned.
Medicines Optimisation	To provide assurance that the CCG has put in place arrangements to ensure that peripheral blood mononuclear cells (PBMCs) deliver defined outcomes and compare the value of this provision with that of employed medicines coordinators. That the CCG arrangements include a medicines optimisation strategy that is underpinned by robust systems and process to deliver the quality outcomes for patients at the best value for money.
Safeguarding	To provide an opinion on the systems in place for Safeguarding Children and protecting Adults at risk, including the CCG's arrangements to work with providers, local authorities and local safeguarding Boards.
Data Security and Protection Toolkit (DSPT)	To provide assurance of the CCG's governance process, policies, and systems in place to complete, approve and submit the DSPT. To review the validity of the DSPT submission based on evidence and to review any wider risk exposures and / or mitigations.

The full Director of Audit Opinion and Annual Report is available at the following link http://www.stockportccg.nhs.uk/have-your-say/annual-report/.

Review of the Effectiveness of Governance, Risk Management and Internal Control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on the performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

In addition, our Board Assurance Framework itself provides me with evidence that the effectiveness of the controls that manage risks to the CCG achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- ✓ The Governing Body;
- ✓ The Audit Committee;
- ✓ Internal Audit;
- ✓ Other specific review/assurance mechanisms; and
- ✓ A plan to ensure continuous improvement of the system is in place.

The Governing Body's role is to provide active leadership of the CCG within a framework of prudent and effective controls that enable risk to be managed. High risks are reported to the Governing Body where gaps in controls and assurances are identified and remedial actions agreed. The Governing Body also receives regular reports giving internal assurances on financial, organisational and quality performance.

The Audit Committee also holds a pivotal role in advising the Governing Body on the effectiveness of the system of internal control by the review of internal and external audit reports. Any significant control issues are reported to the Governing Body by the Audit Committee.

Conclusion

No significant internal control issues have been identified during 2018/19 which would have a significant impact upon the organisation. My review confirms that NHS Stockport CCG has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Noreen Dowd
Interim Accountable Officer
22 May 2019

Appendix A

NHS STOCKPORT CCG – MEMBER PRACTICES

Practice	GP Member Representative
ADSHALL ROAD MEDICAL PRACTICE	Dr Anna Gillott
ALVANLEY FAMILY PRACTICE	Dr Jaweeda Idoo
ARCHWOOD MEDICAL PRACTICE	Dr Graham Parker
BEECH HOUSE MEDICAL PRACTICE	Dr Simon Woodworth
BRACONDALE MEDICAL CENTRE	Dr Adam Firth
BRAMHALL HEALTH CENTRE	Dr Javid Ali (to June 2018) Dr Lynda Pozzoni (July 2018 - date)
BRAMHALL PARK MEDICAL CENTRE	Dr Alexander Bayes
BREDBURY MEDICAL CENTRE	Dr Robert Beardsell
BRINNINGTON HEALTH CENTRE	Dr James Higgins
CALE GREEN SURGERY	Dr Rachel Tomalin
CARITAS GENERAL PRACTICE PARTNERSHIP	Dr Abigail Webster
CHADSFIELD MEDICAL PRACTICE	Dr Rachel Kilroy
CHEADLE HULME HEALTH CENTRE	Dr Ruth Seabrook
HULME HALL MEDICAL GROUP	Dr Steve Hastings
CHEADLE MEDICAL PRACTICE	Dr Tariq Shah
DR H LLOYD'S PRACTICE	Dr Hazem Lloyd
FAMILY SURGERY	Dr Monica Saksena Joye
GATLEY MEDICAL CENTRE	Dr Peter Carne
HEALD GREEN HEALTH CENTRE 1	Dr Penelope Owen
HEALD GREEN HEALTH CENTRE 2	Dr Carmel Morris
HEATON MERSEY MEDICAL PRACTICE	Dr Jeremy Wynn
HEATON MOOR GROUP PRACTICE	Dr Rebecca Locke
HEATON NORRIS HEALTH CENTRE 1	Dr Christopher Marshall
HIGH LANE MEDICAL CENTRE	Dr Robert Mathewson
MANOR MEDICAL PRACTICE	Dr Martin Leahy
MARPLE BRIDGE SURGERY	Dr Morag Needham
MARPLE COTTAGE SURGERY	Dr Andrew Johnson
MARPLE MEDICAL PRACTICE	Dr Howard Sunderland
PARK VIEW GROUP PRACTICE	Dr Karen McEwan
SOUTH REDDISH MEDICAL CENTRE 2	Dr Geeta Gupta
SPRINGFIELD SURGERY	Dr Ameer Aldabbagh
STOCKPORT MEDICAL GROUP	Dr Naomi Lalloo
THE GUYWOOD PRACTICE	Dr Raina Patel
THE SURGERY 3	Dr Abdul Ghafoor
THE SURGERY 1	Dr Hany Azmy
THE VILLAGE SURGERY	Dr Daniel Goldspink
VERNON PARK SURGERY	Dr Suvajit Chattergee
BENTS LANE MEDICAL PRACTICE	Dr Abdul Ghafoor
WOODLEY HEALTH CENTRE 2	Dr Amjad Choudry

Appendix B

Attendance at Governing Body Meetings and Committees in 2018/19

Member	Governing Body (6)	Audit Committee (5)	Remuneration Committee (6)	Primary Care Commissioning Committee (3)	Strategy, Commissioning and Planning Committee (3)	Performance & Delivery Committee (2)	Quality Committee (5)	Finance & performance (3)
Governing Body Voting Members								
Clinical:								
Anita Rolfe	5			2			3	
Dr Cath Briggs*	4				3	2		
Dr Simon Woodworth	5		1	3	3		4	
Dr Najabat Hussain*	2							
Dr Karen McEwan*	3							
Dr Andy Johnson	4	3	5					
Dr Debbie Kendall*	3		6				4	
Dr Viren Mehta*	1							
Dr Vicci Owen-Smith*	1							1
Dr Ranjit Gill*	2							1
Dr Lydia Hardern*	0							
Lay members:								
Christine Morgan	6		1	3	3		3	
John Greenough	5	5	6		3	2		3
Peter Riley*	3			2		2		
Jane Crombleholme*	1		5	1			1	
Non-clinical:								
Noreen Dowd*	4				2			
Mark Chidgey	6			3	3			
Jennifer Connolly*	2			1		1		
Judith Strobl*	3			1	1			
Gaynor Mullins*	2							2

*Indicates part-year membership of the Governing Body and its committees. Further detail can be found in the Corporate Governance Report (page 38).

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Membership of the CCG's Remuneration Committee can be found on page 39.

Details of the number of meetings held throughout the year and each member's attendance is detailed in Appendix B of the Corporate Governance Report (page 61).

Policy on the remuneration of senior managers

The CCG as a membership organisation is responsible for agreeing its own remuneration with all the duties and freedoms that that implies. The CCG is committed to an open and transparent approach to remuneration and has established a Remuneration Committee in accordance with its constitution.

The Remuneration Committee utilises national guidance, benchmarking information and external and independent strategic Human Resources Advisers when making current and future recommendations to the Governing Body on the remuneration of governing body members and very senior managers. The remuneration committee does not set the remuneration, fees and other allowances for the members of the committee.

Remuneration of Very Senior Managers

During the financial year 2018/19 the CCG had three senior managers who were remunerated more than £150,000, two of which were due to payments for redundancy and payments in lieu of notice. The Clinical Directors would have both been remunerated more than £150,000 had they worked for the full year on a full time basis. All senior managers provided clinical or corporate leadership and the CCG has satisfied itself that the remuneration is reasonable through the application of its remuneration policy.

Senior manager remuneration (including salary and pension entitlements)

The CCG is required to disclose the remuneration and benefits of senior managers who have held office during the year.

The definition used for a Senior Manager is "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Commissioning Group. This has been applied as "those who regularly attend the Governing Body meetings".

For each member of the Governing Body who has served during the financial year 2018/19 their remuneration and pension benefits are shown below together with prior year comparatives.

Senior Manager Remuneration (subject to audit)

Name and Title	2018/19					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits[1] (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Dr Ranjit Singh Gill[4] Chief Clinical Officer (left 5th August 2018)	160 - 165	-	-	-	-	160-165
Noreen Dowd[6] Interim Accountable Officer (Commenced 6th August 2018)	155 - 160	-	-	-	-	155 – 160
Jane Marie Crombleholme** Lay Member and Chair (resigned 30th September 2018)	10 – 15	-	-	-	-	10 – 15
John Greenough[2] Lay Member	15 – 20	-	-	-	-	15 – 20
Christine Morgan[2] Lay Member for Patient and Public Participation	5 – 10	-	-	-	-	5 – 10
Robert Peter Riley[2] Lay Member for Primary Care Commissioning (commenced August 2018)	5 – 10	-	-	-	-	5 – 10
Gaynor Dawn Mullins[5] Chief Operating Officer (left 14th September 2018)	280 - 285	-	-	-	’57.5 - 60	335 – 340
Mark Gerard Chidgey Chief Finance Officer	110 - 115	-	-	-	30 - 32.5	140 - 145
Dr Catherine Helen Briggs[2] Clinical Chair (Commenced 8th October 2018)	25 – 30		-	-	-	25 - 30
Dr Viren Mehta						

Clinical Director (commenced February 2019)	5 – 10	-	-	-	12.5 - 15	15 - 20
Clinical Lead (August to Date)	45 – 50	-	-	-	-	45 - 50
Seconded to Stockport Neighbourhood Care (April to July 2018)	25 – 30	-	-	-	-	25 - 30
Dr Simon Woodworth Clinical Director (commenced 1st April 2018) Clinical Lead for Urgent Care GP IT Advisor	30 – 35 10 – 15 15 – 20	- - -	- - -	- - -	-	30 - 35 10 – 15 15 - 20
Dr Lydia Hardern[2] Chair of Stepping Hill and Victoria Locality Council Committee (resigned November 2018)	10 – 15	-	-	-	-	10 – 15
Dr Andrew Johnson[2] Chair of Marple and Werneth Locality Council Committee Clinical Lead for Cancer	15 – 20 5 – 10	- -	- -	- -	- -	15 – 20 5 – 10
Dr Diane Lesley Jones Director of Corporate Affairs, Policy and Partnerships	85 – 90	-	-	-	2 – 2.5	85 – 90
Roger Ian Roberts Director of General Practice Development	85 – 90	-	-	-	-	85 – 90
Timothy Patrick Ryley Director of Strategic Planning And Performance (resigned 4th July 2018)	20 – 25	-	-	-	52.5 – 55	75 – 80
Anita Rolfe Executive Nurse	100 – 105	-	-	-	92.5 - 95	195 - 200
Dr Deborah Kendal[3] Secondary Care Consultant	5 – 10	-	-	-	-	5 – 10
Dr Karen McEwan[9] Governing Body GP Clinical Lead (commenced January 2019)	5 – 10	-	-	-		5 - 10
Dr Najabat Hussain[8] Governing Body GP Clinical Lead (commenced February 2019)	0 – 5	-	-	-	-	0 - 5
Dr Vicci Owen Smith[7] Director of Public Health	-	-	-	-	-	-

(retired May 2018)						
Dr Jennifer Connolly[7] Public Health Consultant (from June 2018 – December 2018)	-	-	-	-	-	-
Dr Judith Strobl[7] Locum Public Health Consultant (January 2019 to date)	-	-	-	-	-	-

1. All pension related benefits represents the annual increase in pension entitlement based on the assumption that pension entitlements will be paid for 20 years from the date of retirement.

2. These members do not receive pensionable remuneration; therefore there are no disclosures in respect of pension related benefits for non-executive members

3. Members whose pension benefits are held and disclosed by another employing authority

4. Dr Ranjit Gill was Chief Clinical Officer in the year to 5th August 2018. Dr Gill left post receiving payment for redundancy and lieu of notice recorded in the exit packages note.

5. Gaynor Mullins was Chief Operating Officer in the year to 14th September 2018. Gaynor Mullins left post receiving payment for redundancy and lieu of notice recorded in the exit packages note.

6. Noreen Dowd was appointed as Interim Accountable Officer on 6th August 2018. The contract for services with Noreen Dowd has been assessed by the CCG as wholly within IR35 and therefore PAYE and National Insurance are deducted prior to payment. In addition to the salary paid to Noreen Dowd the CCG paid irrecoverable VAT totalling £30,000 – £35,000 Noreen Dowd is not a member of the NHS Pension Scheme and the CCG does not pay any employers contributions to any private pension scheme.

7. The Director of Public Health/Public Health Consultant role is employed by Stockport Metropolitan Borough Council and the work undertaken is provided "in kind".

8. Dr Najabat Hussain isn't a member of the NHS Officer Pension Scheme.

9. The information to calculate pension related benefits has yet to be received from NHS Pension Agency

Name and Title	**2017/18**					
	(a) **Salary** **(bands of £5,000)**	**(b)** **Expense payments (taxable)** **to nearest £100**	**(c)** **Performance pay and bonuses** **(bands of £5,000)**	**(d)** **Long term performance pay and bonuses (bands of £5,000)**	**(e)** **All pension-related benefits**[1] **(bands of £2,500)**	**(f)** **TOTAL** **(a to e)** **(bands of £5,000)**
	£000	**£**	**£000**	**£000**	**£000**	**£000**
Dr Ranjit Singh Gill Chief Clinical Officer	100 - 105	-	-	-	50 - 52.5	150 - 155
Jane Marie Crombleholme[2] Lay Member and Chair	20 – 25	-	-	-	-	20 - 25
John Greenough[2] Lay Member	15 – 20	-	-	-	-	15 - 20

Christine Morgan[2] Lay Member Primary Care	5 – 10	-	-	-	-	5 – 10
Gaynor Dawn Mullins Chief Operating Officer	100 - 105	-	-	-	23.5 - 25	125 - 130
Mark Gerard Chidgey Chief Finance Officer	105 - 110	-	-	-	60 - 62.5	165 - 170
Dr Catherine Helen Briggs Clinical Director of Quality and Provider Management (Resigned December 2017)	45 – 50	-	-	-	15 - 17.5	60 - 65
Dr Viren Mehta Clinical Director for General Practice Development	80 – 85	-	-	-	20 - 22.5	100 - 105
Dr Peter Carne[2] Chair of Cheadle and Bramhall Locality Council Committee (resigned January 2018)	10 – 15	-	-	-	-	10 - 15
Dr Lydia Hardern[2] Chair of Stepping Hill and Victoria Locality Council Committee	15 – 20	-	-	-	-	15 - 20
Dr James Higgins[2] Chair of Heatons and Tame Valley Locality Council Committee (resigned January 2018) Named GP Safeguarding	10 – 15	-	-	-	-	10 - 15
	15 – 20	-	-	-	-	15 - 20
Dr Andrew Johnson[2] Chair of Marple and Werneth Locality Council Committee Clinical Lead for Cancer	15 - 20	-	-	-	-	15 - 20
	5 - 10	-	-	-	-	5 – 10
Dr Diane Lesley Jones Director of Service Reform	85 - 90	-	-	-	20 - 22.5	105 - 110
Roger Ian Roberts Director of General Practice Development	85 - 90	-	-	-	12.5 - 15	100 - 105
Timothy Patrick Ryley Director of Strategic Planning And Performance	85 - 90	-	-	-	20 - 22.5	105 - 110
Anita Rolfe Executive Nurse	90 - 95	-	-	-	10 - 12.5	100 - 105
Dr Deborah Kendal[3] Secondary Care Consultant	5 - 10	-	-	-	-	5 – 10
Dr Vicci Owen Smith[6]						

Director for Public Health	-	-	-	-	-	-

Senior Employee Salaries

NHS Stockport CCG has made a commitment in its Constitution to disclose the salaries of all senior employees. The definition of a senior employee is anyone with a salary of £50,000 or above if they were to be paid on a full whole time equivalent basis (WTE).

	2018-19	2017-18
Name & Title	**(a) Salary (bands of £5,000) £000**	**(a) Salary (bands of £5,000) £000**
Aaron Atkinson Head of Strategic Business Intelligence (commenced November 2017)	50 - 55	45 – 50
Elizabeth Bailey Medicines Optimisation Lead	65 - 70	55 – 60
James Brown Head of Communications & Business Support (commenced December 2017)	60 - 65	15 – 20
Lesley Brown Programme Manager (left March 2018)	55 - 60	45 – 50
Sean Capper Associate Director of IM & T	65 – 70	60 – 65
Jaqueline Coleman Specialist Interface Pharmacist	40 - 45	35 – 40
Stacey Davidson Medicines Optimisation Lead Pharmacist	45 - 50	35 – 40
Angela Dawber Head of Planning & Performance	25 – 30	50 – 55
David Dolman Deputy Chief Finance Officer	85 – 90	80 – 85
Gina Evans Joint Commissioning Lead	55 - 60	55 – 60
Sue Gaskell Sagfeguarding Lead	25 - 30	20 – 25
Laura Janda		

Associate Director of Planning & Performance (commenced August 2017)	60 – 65		35 – 40
Andrew Kennedy Assistant Chief Finance Officer (commenced March 2018)	55 - 60		0 – 5
Laura Latham Associate Director Corporate Governance and Organisational Effectiveness (left January 2019)	50 – 55		55 – 60
Gillian Miller Associate Director of Commissioning	70 – 75		60 – 65
Karen Moran Senior Service Reform Manager	55 - 60		55 – 60
Andrew Nuttall Head of Contracts and Procurement (commenced September 2018)	50 - 55		45 – 50
Julie Parker Head of Safeguarding/Designated Nurse Safeguarding Children	60 – 65		55 – 60
Julie Ryley Head of Primary Care Development	50 - 55		50 – 55
Sandra Walker Head of Quality Assurance, Patient Safety and Complaints	50 - 55		45 – 50
Sarah Williamson Associate Director (Continuing & Complex Healthcare) (commenced December 2017)	65 – 70		50 – 55
Susan Parker Clinical Lead for Ophthalmology	5 – 10		0 – 5
Dr Rachel Williams Clinical lead for Urgent Care - 0.02 WTE (commenced March 2019)	0 - 5		N/A
Dr Ruth Seabrook Vice - Chair of Cheadle and Bramhall Locality Council Committee (WTE 0.06)	5 – 10		5 – 10
Dr Najabat Hussain Clinical Lead for Mental health (WTE 0.10) (from April 2018 to January 2019)	10 – 15		10 – 15
Dr Karen McEwan McMillan GP Lead (WTE 0.21) Clinical Lead for Planned Care (WTE 0.2) (from April 2018 to December 2018)	15 - 20 20 - 25		15 – 20 25 – 30
Dr Alan Gilman Chief Clinical Information Lead (WTE 0.2)	25 - 30		25 -30
Dr Steve Bradshaw Neighbourhood Clinical Lead (WTE 0.32)	40 - 45		N/A
Dr James Higgins			

Named GP Safeguarding (WTE 0.2)	40 - 45	30 – 35

Pension benefits as at 31 March 2019 (subject to audit)

For each Senior Manager who served during the year, their pension benefits are shown below:

2018-19	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5000	(e) Cash Equivalent Transfer Value at 1 April 2018	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2019	(h) Employers Contribution to partnership pension
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Dr Ranjit Singh Gill Chief Clinical Officer (left 5th August 2018)	**0**	**0**	**20 - 25**	**65 - 70**	**458**	**5**	**507**	**0**
Gaynor Dawn Mullins Chief Operating Officer (left 14th September 2018)	**2.5 - 5**	**5 – 7.5**	**35 - 40**	**95 -100**	**603**	**49**	**752**	**0**
Dr Viren Mehta Clinical Director (commenced February 2019)	**0 – 2.5**	**0**	**15 -20**	**25 - 30**	**154**	**4**	**198**	**0**
Dr Simon Woodworth Clinical Director (commenced 1st April 2018)	**0 – 2.5**	**0**	**5 - 10**	**20 - 25**	**119**	**14**	**145**	**0**
Mark Gerard Chidgey Chief Finance Officer	**0 – 2.5**	**0 – 2.5**	**35 - 40**	**90 - 95**	**569**	**92**	**693**	**0**
Dr Diane Lesley Jones Director of Corporate Affairs, Policy and Partnerships	**0 – 2.5**	**0**	**35 - 40**	**85 - 90**	**613**	**64**	**707**	**0**
Roger Ian Roberts Director of General Practice Development	**0 – 2.5**	**0 – 2.5**	**40 - 45**	**120 – 125**	**830**	**69**	**939**	**0**
Timothy Patrick Ryley Director of Strategic Planning and	**2.5 - 5**	**2.5 - 5**	**20 - 25**	**50 - 55**	**339**	**19**	**433**	**0**

Performance (resigned 4th July 2018)								
Anita Rolfe Executive Nurse	**2.5 - 5**	**7.5 - 10**	**40 - 45**	**100 - 105**	**621**	**152**	**806**	**0**
Dr Karen McEwan[1] Governing Body GP Clinical lead (commenced January 2019)								

1. The information to calculate pension related benefits has yet to be received from NHS Pension Agency

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

The CCG made no payments during the financial year 2018/19 to any Senior Manager or other employee as compensation on early retirement or loss of office.

Payments to past members

There were no payments made during the financial year 2018/19 to any previous Senior Manager.

Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The annualised full time equivalent banded remuneration of the highest paid director at NHS Stockport CCG in the financial year 2018/19 was £232,500 (2017/18: £167,500). This was 6.23 times (2017/18: 4.71) the median remuneration of the workforce, which was £37,161 (2017/18: £35,577).

In 2018/19, no employees received remuneration in excess of the highest-paid director. Remuneration mid-point bandings ranged from £17,500 to £232,500 (2017/18: £17,500 to £167,500).

The increase in the pay multiple is due to the highest paid director being appointed on an interim basis as a result of the CCG restructure. The appointment of the Interim Accountable Officer, including pay, was approved through the relevant NHS England governance processes.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff Report

As at 31st March 2019 the CCG employed 129 (2017-18 - 142) individuals which equates to 101.72 (2017-18 - 115.77) whole time equivalents (WTE).

Number of Governing Body Members Employed by Band
The table below outlines the number of Governing Body Members employed by pay band.

Number of Governing Body Members Employed by Band	
Payscale Description	**Headcount**
Non-Agenda for Change	18
Agenda for Change Pay Band 8D	3
Total	**21**

Staff composition

In common with most health organisations, women make up the majority of our workforce, with 74% of our employees being female (69.12% in 2018).

Gender breakdown by roles:

Governing Body	Senior Managers	Other Employees	Total
Female = 58%	Female = 65%	Female = 78%	Female = 74%
Male = 42%	Male = 35%	Male = 22%	Male = 26%

Sickness absence data

Sickness absence is reported at organisational level each month to the senior management team as part of the Workforce Performance Report. Monthly reports at individual employee level are shared with line managers and the Human Resource Advisor works closely with managers to proactively manage sickness cases in line with the Sickness Absence Policy.

Staff sickness absence and ill health retirements

	2018-19 Number
Total Days Lost	1,464
Total Staff Years	110
Average working Days Lost	13.3

Staff sickness absence data is based on a calendar year (January-December) due to current financial year data not being available for inclusion within the accounts.

Staff policies

The CCG is committed to its public sector equality duty. Our approach, including our most recent annual Equality and Diversity Report, and how this relates to the workforce is available on our website.

In addition, staff policies are contained within our Staff Handbook including our approach to equality diversity and this is accessible to all colleagues.

Staff numbers and cost (Subject to audit)

Employee benefits and staff numbers 2018-19	ADMIN			PROGRAMME			TOTAL		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	2,698	86	2,786	2,098	260	2,357	4,797	346	5,141
Social security costs	319	0	319	211	0	211	530	0	530
Employer contributions to the NHS Pension Scheme	345	0	345	251	0	251	596	0	596
Other pension costs	1	0	1	1	0	1	2	0	2
Apprenticeship Levy	10	0	10	0	0	0	10	0	10
Termination benefits	345	0	343	0	0	0	343	0	345
Gross Employee Benefits Expenditure	**3,717**	**86**	**3,803**	**2,561**	**260**	**2,821**	**6,278**	**346**	**6,624**
Less: Recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure including capitalised costs	**3,717**	**86**	**3,803**	**2,561**	**260**	**2,821**	**6,278**	**346**	**6,624**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	**3,717**	**86**	**3,803**	**2,561**	**260**	**2,821**	**6,278**	**346**	**6,624**
Staff Numbers – Average number of people employed	**53**	**2**	**55**	**52**	**2**	**54**	**105**	**4**	**109**

Employee benefits and staff number 2017-18	ADMIN			PROGRAMME			TOTAL		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	2,843	107	2,950	1,828	371	2,199	4,671	478	5,149
Social security costs	313	0	312	172	0	172	485	0	485
Employer contributions to the NHS Pension Scheme	381	0	381	220	0	220	601	0	601
Other pension costs	1	0	1	0	0	0	1	0	1
Apprenticeship Levy	8	0	8	0	0	0	8	0	8
Termination benefits	20	0	20	0	0	0	20	0	20
Gross Employee Benefits Expenditure	**3,566**	**107**	**3,673**	**2,220**	**371**	**2,591**	**5,786**	**478**	**6,264**
Less: Recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure including capitalised costs	**3,566**	**107**	**3,673**	**2,220**	**371**	**2,591**	**5,786**	**478**	**6,264**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	**3,566**	**107**	**3,673**	**2,220**	**371**	**2,591**	**5,786**	**478**	**6,264**
Staff Numbers – Average number of people employed	**60**	**1**	**61**	**49**	**4**	**53**	**109**	**5**	**114**

Other employee matters

The CCG is committed to its public sector equality duty. Our approach, including our most recent annual Equality and Diversity Report, and how this relates to the workforce is available on our website.

In addition, staff policies are contained within our Staff Handbook including our approach to equality diversity and this is accessible to all colleagues.

Expenditure on consultancy

During 2018/19 the CCG spent £295,000 (2017/18 £52,000) on consultancy services supporting the following work programmes:

- Stockport Together Programme evaluation £135,000
- Implementation of SEND legislation and guidance £57,000
- Mental Health Baseline assessment supporting sustainable and effective services £45,000
- Organisation effectiveness, review £36,000
- Organisation governance and policy review £22,000

Table 1: Off-payroll engagements longer than 6 months

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, the CCG must publish information on their highly paid and/or senior manager's off-payroll engagements

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

The existing off-payroll engagements have been subject to risk assessment as to whether assurance is required that the individual is paying the correct amount of tax and, where necessary, that assurance has been sought.

Table 2: New off-payroll engagements

The Government has reformed the Intermediaries legislation, introducing Chapter 10 Part 2 Income Taxes (Earnings and Pensions) Act 2003 (ITEPA 2003) supporting Chapter 8 Part 2 ITEPA 2003, often known as IR35. The legislation for the off-payroll working rules within the public sector applies to payments made on or after 6 April 2017.

Under the reformed off-payroll working rules, Departments must determine whether the rules apply when engaging a worker through a Personal Service Company (PSC).

Where the reformed public sector rules apply, entities must disclose all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and March 2019 for more than £245 per day and that last for longer than six months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	1
Number engaged directly (via PSC contracted to department) are on the departmental payroll	0
Number of Engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 Status following the consistency review.	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2018 and 31 March 2019:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	21

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages (subject to audit)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	1	14,775	1	14,775	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	1	126,495	0	0	1	126,495	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	1	204,012	0	0	1	204,012	0	0
TOTALS	2	330,507	1	14,775	3	345,282	0	0

The compulsory redundancy costs were incurred as a result of a CCG organisation restructure in line with the leadership structure which was endorsed and approved at the CCG Annual General Meeting in September 2018. Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Terms and Conditions of Service Handbook.

Table 2: Analysis of Other Departures (subject to audit)

	Agreements	Total Value of agreements
	Number	£s
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**1**	**14,775**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval	**0**	**0**
TOTAL	**1**	**14,775**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number above will not necessarily match the total numbers in Table 1 which will be the number of individuals.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

The statutory instrument requires relevant public sector employers to publish, on an annual basis, a range of data in relation to their usage and spend on trade union facility time.

It is confirmed that the CCG employed two people who undertook relevant trade union duties during the period to 31 March 2019. The total cost of trade union facility time incurred during the relevant period (inclusive of basic salary and employer on-costs) fell within the range of £0-£5,000 (£0-£5,000 2017/18)

The CCG is required to report the following ratios:

Table1 : Total number of relevant union officials during the relevant period.

Number of employees who were relevant union officials during the relevant period	2
Full-time equivalent employee number	1.66

Table 2: Number of relevant union officials employed during the relevant period spending a certain % of their working hours on facility time.

Percentage of time Number of employees	Number of employees
0-1%	1
1-51%	1
51%-99%	0
100%	0

Table 3: Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column Figures	Figures (£000s)
Provide the total cost of facility time (mid-point of range).	2.5
Provide the total pay bill	6,605
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0%

Table 4: As a percentage of total paid facility time hours, the hours spent by employees who were relevant union officials during the relevant period on paid trade union activities.

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	100%

Parliamentary Accountability and Audit Report

NHS Stockport CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report as 81 as required. An audit certificate and report are also included in this Annual Report at page 58 via the enclosed link.

NHS Stockport Clinical Commissioning Group

Annual Accounts

2018-19

FOREWORD TO THE ACCOUNTS

The NHS Stockport Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

These accounts for the year ended 31 March 2019 have been prepared by the CCG under section 17 of schedule 1A of the National Health Service Act 2006 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The National Health Service Act 2006 (as amended) requires the CCG to produce it's Annual Accounts in accordance with the Government Financial Reporting Manual for the relevant financial year, taking account of the application guidance contained in the Department of Health Group Manual for Accounts for the relevant financial year, and CCG specific application guidance issued by NHS England.

CONTENTS **Page Number**

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(6,152)	(1,121)
Other operating income	2	0	(620)
Total operating income		**(6,152)**	**(1,741)**
Staff costs	4	6,624	6,264
Purchase of goods and services	5	466,723	445,865
Depreciation and impairment charges	5	0	5
Provision expense	5	0	(174)
Other Operating Expenditure	5	128	132
Total operating expenditure		**473,475**	**452,092**
Comprehensive Expenditure for the year		**467,323**	**450,351**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	8	0	0
Total non-current assets		0	0
Current assets:			
Trade and other receivables	9	3,991	1,203
Cash and cash equivalents	10	44	260
Total current assets		**4,035**	1,463
Total assets		**4,035**	1,463
Current liabilities			
Trade and other payables	11	(25,652)	(23,048)
Total current liabilities		**(25,652)**	(23,048)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(21,617)**	(21,585)
Assets less Liabilities		**(21,617)**	(21,585)
Financed by Taxpayers' Equity			
General fund		(21,617)	(21,585)
Total taxpayers' equity:		**(21,617)**	(21,585)

The notes on pages 88 to 107 form part of this statement

The financial statements on pages 84 to 87 were approved by the Governing Body on **22 May 2019** and signed on its behalf by:

Interim Accountable Officer
Noreen Dowd

31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(21,585)	0	0	**(21,585)**
Impact of applying IFRS 9 to Opening Balances	(5)			**(5)**
Impact of applying IFRS 15 to Opening Balances	0			**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(21,590)**	**0**	**0**	**(21,590)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(467,323)			**(467,323)**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(467,323)**	**0**	**0**	**(467,323)**
Net funding	467,296	0	0	**467,296**
Balance at 31 March 2019	**(21,617)**	**0**	**0**	**(21,617)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(21,922)	0	0	**(21,922)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(21,922)**	**0**	**0**	**(21,922)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(450,351)	0	0	(450,351)
Total revaluations against revaluation reserve	0	**0**	0	**0**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(450,351)**	**0**	**0**	**(450,351)**
Net funding	450,688	0	0	450,688
Balance at 31 March 2018	**(21,585)**	**0**	**0**	**(21,585)**

The notes on pages 88 to 107 form part of this statement

Statement of Cash Flows for the year ended
31 March 2019

	Note	**2018-19** **£'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(467,323)	(450,351)
Depreciation and amortisation	5	0	5
Non-cash movements arising on application of new accounting standards	9.3	(5)	0
(Increase)/decrease in trade & other receivables	9	(2,788)	845
Increase/(decrease) in trade & other payables	11	2,604	(783)
Provisions utilised		0	(27)
Increase/(decrease) in provisions		0	(174)
Net Cash Inflow (Outflow) from Operating Activities		**(467,512)**	(450,485)
Net Cash Inflow (Outflow) before Financing		**(467,512)**	(450,485)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		467,296	450,688
Net Cash Inflow (Outflow) from Financing Activities		**467,296**	450,688
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(216)**	203
Cash & Cash Equivalents at the Beginning of the Financial Year		**260**	58
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**44**	**260**

The notes on pages 88 to 107 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not it's services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement with Stockport Metropolitan Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled to improve partnership working between organisations and provide integrated and improved services for patients and note 15 provides details of the income and expenditure.

The pool is hosted by Stockport Metropolitan Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Under the arrangement the CCG pools resources for the provision of health services (excluding surgery, radiotherapy, termination of pregnancies, endoscopy, other invasive treatments and emergency ambulance services) provided to people who are registered with a Stockport GP Practice over the age of 65.

1.4 **Operating Segments**

Income and expenditure are analysed in the Operating Segments at note 14 are reported in line with management information used within the clinical commissioning group.

Notes to the financial statements

1.5 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

The note detailing the effect of application of IFRS15 on current year closing balances has not been prepared due to the impact of IFRS not being material.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 **Property, Plant & Equipment**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have control; or, simultaneous disposal dates and are under single managerial
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.1 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.2 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Notes to the financial statements

1.9.1 **The Clinical Commissioning Group as Lessee**
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

1.10 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.11 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.12 **Non-clinical Risk Pooling**
The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.13 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Notes to the financial statements

1.14 **Financial Assets**
Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.14.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.14.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.14.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.14.4 **Impairment**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.15 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.15.1 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.15.2 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.16 **Value Added Tax**
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Notes to the financial statements

1.17 **Foreign Currencies**
The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.18 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.19 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical accounting judgements in applying accounting policies**
There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.20.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.20.2.1 **Prescribing Liability**
The clinical commissioning group receives financial information from NHS Business Services Authority relating to the costs of drugs prescribed by clinical commissioning group prescribers (independent GPs). The information available for actual drug costs prescribed in the year is provided two month in arrears, therefore the actual data received at the Statement of Financial Position date is to 31 January 2019, and an estimate for February and March is required.

Two months of prescribing activity totalling £7,920,261 (2017-18 £7,845,558) has been estimated. The estimation of two months expenditure has been calculated by using the average cost of December and January which is consistent with 2017-18.

1.20.2.2 **Stockport Together Gain and Risk Share Agreement**
On the 1st June 2018 the clinical commissioning group, Stockport NHS Foundation Trust and Stockport Metropolitan Borough Council ("the Partners") entered into an agreement to share equally any surpluses or deficits attributable to the implementation of the Stockport health and social care transformation programme "Stockport Together Programme". The forecast outturn position as at January 2019 was used to estimate a contribution of £2.08 million into the Stockport Together Programme by each Partner.

1.21 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2. Other Operating Revenue

	2018-19 Total	2017-18 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**8**	38
Non-patient care services to other bodies	**5,439**	1,083
Other Contract income	**705**	620
Total Income from sale of goods and services	**6,152**	**1,741**
Other operating income		
Other non contract revenue	**0**	0
Total Other operating income	**0**	**0**
Total Operating Income	**6,152**	**1,741**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

The increase in 'Non-patient care services revenue to other bodies' relates to contributions by Stockport NHS Foundation Trust (£2.08 million) and Stockport Metropolitan Borough Council (£2.08 million) totalling £4.16 million to the Stockport health and social care transformation programme "Stockport Together'.

3. Revenue

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	**Non-patient care services to other bodies**	**Other Contract income**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Source of Revenue				
NHS	1	2,177	386	2,564
Non NHS	7	3,262	319	3,588
Total	**8**	**5,439**	**705**	**6,152**

	Education, training and research	**Non-patient care services to other bodies**	**Other Contract income**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Timing of Revenue				
Point in time	8	5,439	705	6,152
Over time	0	0	0	0
Total	**8**	**5,439**	**705**	**6,152**

4. Employee Benefits and Staff Numbers

4.1.1 Employee benefits **Total** **2018-19**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,795	346	5,141
Social security costs	530	0	530
Employer Contributions to NHS Pension scheme	596	0	596
Other pension costs	2	0	2
Apprenticeship Levy	10	0	10
Termination benefits	345	0	345
Gross employee benefits expenditure	**6,278**	**346**	**6,624**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,278**	**346**	**6,624**

4.1.1 Employee benefits Total 2017-18

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,671	478	5,149
Social security costs	485	0	485
Employer Contributions to NHS Pension scheme	601	0	601
Other pension costs	1	0	1
Apprenticeship Levy	8	0	8
Termination benefits	20	0	20
Gross employee benefits expenditure	**5,786**	**478**	**6,264**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**5,786**	**478**	**6,264**

The increase in employee benefits is due to termination benefits paid in the year. The increase in employee benefits due to the NHS pay award has been offset by a decrease in the average number of staff employed due to vacancies as detailed in note 4.2.

4. Employee benefits and staff numbers continued

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**105**	**4**	**109**	**109**	**5**	**114**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**	**0**	**0**

The average number of staff employed has decreased due to vacancies during the year.

4.4 Exit packages agreed in the financial year

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	1	14,775	1	14,775
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	126,495	0	0	1	126,495
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	1	204,012	0	0	1	204,012
Total	**2**	**330,507**	**1**	**14,775**	**3**	**345,282**

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	2	8,029	2	8,029
£10,001 to £25,000	0	0	1	12,369	1	12,369
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**3**	**20,398**	**3**	**20,398**

Analysis of Other Agreed Departures

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	3	20,398
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	14,775	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**1**	**14,775**	**3**	**20,398**

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Terms and Conditions of Service Handbook. Exit costs in this note are the full costs of departures agreed in the year, which have been recognised in full in 2018-19. The CCG has not agreed any early retirements, the additional costs of which would be met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4. Employee benefits and staff numbers continued

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating Expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,413	1,413
Services from foundation trusts	286,546	268,586
Services from other NHS trusts	14,955	14,233
Purchase of healthcare from non-NHS bodies	72,374	64,378
Purchase of social care	1	1
Prescribing costs	47,658	48,840
GPMS/APMS and PCTMS	36,847	36,534
Supplies and services – clinical	788	954
Supplies and services – general	3,505	7,147
Consultancy services	295	52
Establishment	1,290	985
Transport	60	54
Premises	818	2,446
Audit fees	53	53
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services	17	0
Other professional fees	28	71
Legal fees	23	23
Education, training and conferences	52	95
Total Purchase of goods and services	**466,723**	**445,865**
Depreciation and impairment charges		
Depreciation	0	5
Total Depreciation and impairment charges	**0**	**5**
Provision expense		
Provisions	0	(174)
Total Provision expense	**0**	**(174)**
Other Operating Expenditure		
Chair and Non Executive Members	118	132
Expected credit loss on receivables	(1)	0
Other expenditure	11	0
Total Other Operating Expenditure	**128**	**132**
Total operating expenditure	**466,851**	**445,828**

The £17.8 million (6.7%) increase in expenditure for services from Foundation Trusts is attributable to a £2.5 million investment with the CCG's main mental health provider Pennine Care NHS Foundation Trust, a £3.4 million additional investment with Stockport NHS Foundation Trust as part of the locality transformation programme "Stockport Together" as well as £11.9 million increase in contractual payments, of which, £4.5 million was planned and £7.4 million unplanned relating to in-year activity based increases.

The £8.0 million (12.4%) increase in expenditure "Purchase of Healthcare from Non NHS Bodies" is attributable to additional planned investments into general practice services, an increase in the cost and number of continuing health care and funded nursing care placements and an increase in the levels of elective activity commissioned from the independent sector.

The decrease in premises costs reflects the settlement of invoices disputed with NHS Property Services and the transfer of arrangements related to the occupancy of community services in NHS Property Services managed buildings to Stockport NHS Foundation Trust as detailed at note 7.

During 2018/19 the CCG spent £295,000 on consultancy services supporting the following work programmes:
- Stockport Together Programme evaluation £135,000
- Implementation of SEND legislation and guidance £57,000
- Mental Health Baseline assessment supporting sustainable and effective services £45,000
- Organisation effectiveness, review £36,000
- Organisation governance and policy review £22,000

6. Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	13,172	113,094	13,042	112,029
Total Non-NHS Trade Invoices paid within target	12,886	111,536	12,649	110,043
Percentage of Non-NHS Trade invoices paid within target	**97.83%**	**98.62%**	**96.99%**	**98.23%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,953	303,380	3,041	286,165
Total NHS Trade Invoices Paid within target	2,879	303,056	2,914	284,974
Percentage of NHS Trade Invoices paid within target	**97.49%**	**99.89%**	**95.82%**	**99.58%**

The Better Payment Practice Code requires the CCG to pay 95% of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense			**2018-19**			2017-18
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	725	14	**739**	2,399	15	**2,414**
Contingent rents	0	0	**0**	0	0	**0**
Sub-lease payments	0	0	**0**	0	0	**0**
Total	**725**	**14**	**739**	**2,399**	**15**	**2,414**

The CCG occupies property owned and managed by NHS Property Services Limited. There was no formal leases in place however the arrangements with NHS Property Services Limited fall within the definition of an IAS 17 operating lease and are therefore reported within this note.

On the 3 September 2018 the CCG relocated its headquarters to Stopford House, Stockport and entered into a ten year lease with a break at year five with Stockport Metropolitan Borough Council.

The decrease in minimum lease payments is due to the settlement of invoices disputed with NHS Property Services and the transfer of arrangements related to the occupancy of community services in NHS Property Services managed buildings to Stockport NHS Foundation Trust.

7.1.2 Future minimum lease payments			**2018-19**			2017-18
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:						
No later than one year	173	6	**179**	0	7	**7**
Between one and five years	691	3	**694**	0	0	**0**
After five years	778	0	**778**	0	0	**0**
Total	**1,642**	**9**	**1,651**	**0**	**7**	**7**

Whilst the arrangements that the CCG has with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements with NHS Property Services.

8 Property, Plant and Equipment

2018-19	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2018	23	23
Cost/Valuation at 31 March 2019	**23**	**23**
Depreciation 01 April 2018	23	23
Charged during the year	0	0
Depreciation at 31 March 2019	**23**	**23**
Net Book Value at 31 March 2019	**0**	**0**
Purchased	0	0
Total at 31 March 2019	**0**	**0**
Asset financing:		
Owned	0	0
Total at 31 March 2019	**0**	**0**

9. Trade and Other Receivables	**Current 2018-19 £'000**	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS receivables: Revenue	2,968	0	341	0
NHS prepayments	22	0	18	0
Non-NHS and Other WGA receivables: Revenue	858	0	645	0
Non-NHS and Other WGA prepayments	87	0	193	0
Non-NHS and Other WGA accrued income	35	0	0	0
Expected credit loss allowance-receivables	(4)	0	0	0
VAT	25	0	6	0
Total Trade & other receivables	**3,991**	**0**	**1,203**	**0**
Total current and non current	**3,991**		**1,203**	
Included above:				
Prepaid pensions contributions	0		0	

The majority of the increase in NHS receivables relates to Stockport NHS Foundation Trust £2.08 million contribution to the Stockport health and social care transformation programme "Stockport Together'.

The majority of the receivables are with other government bodies, therefore the risk of non payment is considered to be remote.

9.1 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	**2018-19 Non DHSC Group Bodies £'000**	**2017-18 DHSC Group Bodies £'000**	**2017-18 Non DHSC Group Bodies £'000**
By up to three months	402	173	5	0
By three to six months	0	0	0	0
By more than six months	3	8	1	16
Total	**405**	**181**	**6**	**16**

£146,696 of the amount above has been recovered post the statement of financial position date.

9.2 Impact of Application of IFRS 9 on financial assets at 1 April 2018

	Trade and other receivables - NHSE bodies	**Trade and other receivables - other DHSC group bodies**	**Trade and other receivables - external**	**Other financial assets**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Classification under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost	260	255	85	645	**1,245**
Total at 31st March 2018	**260**	**255**	**85**	**645**	**1,245**
Classification under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	260	255	85	645	**1,245**
Total at 1st April 2018	260	255	85	645	**1,245**
Changes due to change in measurement attribute	0	0	0	0	**0**
Other changes	0	0	0	0	**0**
Change in carrying amount	0	0	0	0	**0**

9.3 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - NHSE bodies	**Trade and other receivables - other DHSC group bodies**	**Trade and other receivables - external**	**Other financial assets**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Impairment and provisions allowances under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost (i.e. the 1718 Closing Provision)	0	0	0	0	**0**
Financial assets held at FVOCI	0	0	0	0	**0**
Total at 31st March 2018	**0**	**0**	**0**	**0**	**0**
Loss allowance under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	0	0	(5)	0	**(5)**
Financial Assets measured at FVOCI	0	0	0	0	**0**
Total at 1st April 2018	**0**	**0**	**(5)**	**0**	**(5)**
Change in loss allowance arising from application of IFRS 9	**0**	**0**	**(5)**	**0**	**(5)**

10. Cash and Cash Equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	260	58
Net change in year	(216)	202
Balance at 31 March 2019	**44**	**260**
Made up of:		
Cash with the Government Banking Service	44	260
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**44**	**260**
Balance at 31 March 2019	**44**	**260**

11 Trade and Other Payables	**Current 2018-19 £'000**	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS payables: Revenue	3,628	0	2,439	0
NHS accruals	1,426	0	1,044	0
NHS deferred income	0	0	115	0
Non-NHS and Other WGA payables: Revenue	2,248	0	1,464	0
Non-NHS and Other WGA accruals	14,413	0	17,878	0
Non-NHS and Other WGA deferred income	0	0	5	0
Social security costs	1	0	0	0
Tax	0	0	1	0
Other payables and accruals	3,936	0	102	0
Total Trade & Other Payables	**25,652**	**0**	**23,048**	**0**
Total current and non-current	**25,652**		**23,048**	

Other payables include £65,515 outstanding pension contributions at 31 March 2019

The increase in "Other payables and accruals" primary care contract accruals previously reported as "Non-NHS and other WGA accruals". The classification of primary care contractor accruals as "Other payables and accruals" aligns CCG reporting with national reporting requirements.

11.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	**Trade and other payables - other DHSC group bodies**	**Trade and other payables - external**	**Other borrowings (including finance lease obligations)**	**Other financial liabilities**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	0	0	0	0	0	**0**
Financial Assets held at Amortised cost	562	2,921	19,444	0	0	**22,927**
Total at 31st March 2018	**562**	**2,921**	**19,444**	**0**	**0**	**22,927**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities measured at amortised cost	562	2,921	19,444	0	0	**22,927**
Total at 1st April 2018	562	2,921	19,444	0	0	**22,927**
Changes due to change in measurement attribute	0	0	0	0	0	**0**
Other changes	0	0	0	0	0	**0**
Change in carrying amount	0	0	0	0	0	**0**

12. Contingencies

	2018-19 £'000	2017-18 £'000
Contingent assets		
GL Hearn Rate Rebates for GP Premises	162	84
Amounts payable against contingent assets	0	0
Net value of contingent assets	**162**	**84**

13. Financial instruments

13.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

13.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

13.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

13.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

13 Financial instruments continued

13.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Trade and other receivables with NHSE bodies	709	0	709
Trade and other receivables with other DHSC group bodies	2,295	0	2,295
Trade and other receivables with external bodies	856	0	856
Cash and cash equivalents	44	0	44
Total at 31 March 2019	**3,904**	**0**	**3,904**

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Trade and other payables with NHSE bodies	249	0	**249**
Trade and other payables with other DHSC group bodies	5,660	0	**5,660**
Trade and other payables with external bodies	15,806	0	**15,806**
Other financial liabilities	3,936	0	**3,936**
Total at 31 March 2019	**25,651**	**0**	**25,651**

14 Operating Segments

The CCG has one operating segment which is the commissioning of healthcare services to which all income, expenditure, assets and liabilities relate.

15. Pooled Budgets

Section 75 of the NHS Act 2006 allows NHS organisations and local authorities to make contributions to a pooled budget. The purpose of a pooled budget is to improve partnership working between organisations and provide integrated and improved services for patients.

The CCG has entered into a pooled budget with Stockport Metropolitan Borough Council (SMBC) who host the pooled budget. In 2018-19 resources totalling £205.6 million were pooled. Whilst the provisions contained within the section 75 agreement indicate that joint control exists the fund operates through lead commissioner arrangements whereby the nominated lead commissioner enters into legal contract with providers and the non lead commissioner cedes control over the end-contract. Under lead commissioning arrangements an organisation acting as a lead commissioner accounts for its own transactions without recognising its interest in its share of total assets, liabilities, revenue and expenditure that relate to the whole Fund. Each organisation also accounts for any surplus or deficit relating to its own transactions.

The total expenditure on pooled budget activities in 2018-19 by the CCG is £121.6 million (2017-18 £117.4 million) which is the expenditure on those services commissioned by the CCG in the table, plus £14.5 million (2017-18 £14.3 million) contribution to services commissioned by Stockport MBC. The CCG received no income for pooled budget activities.

The NHS clinical commissioning group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2018-19 £'000	2017-18 £'000
Income	0	0
Expenditure	(121,595)	(117,402)

Pooled Budget for statement of accounts 2018/19

2018-19	**Prevention £000**	**Borough wide £000**	**Community / Out of Hospital £000**	**Acute £000**	**Total £000**
Funding provided to the Pooled Budget					
Stockport Council	(20,681)	(7,617)	(72,167)	0	**(100,465)**
Stockport CCG	(156)	(3,900)	(28,022)	(73,056)	**(105,134)**
Total	**(20,837)**	**(11,517)**	**(100,189)**	**(73,056)**	**(205,599)**
Expenditure met from the Pooled Budget					
Stockport Council	20,526	7,386	73,147	0	**101,059**
Stockport CCG	140	3,911	27,598	75,440	**107,089**
Total	**20,666**	**11,297**	**100,745**	**75,440**	**208,148**
Net (surplus) / deficit arising from the pooled budget in year	**(171)**	**(220)**	**556**	**2,384**	**2,549**
Net (surplus) / deficit split by each partner:					
Stockport Council	(155)	(231)	980	0	594
Stockport CCG	(16)	11	(424)	2,384	**1,955**
Total	**(171)**	**(220)**	**556**	**2,384**	**2,549**

* Includes £14.5 million contributed by the CCG to enable SMBC to fulfil its lead commissioner role under the section 75 agreement

Pooled Budget for statement of accounts 2017/18

2017-18	**Prevention £000**	**Borough wide £000**	**Community / Out of Hospital £000**	**Acute £000**	**Total £000**
Funding provided to the Pooled Budget					
Stockport Council	(21,236)	(7,224)	(72,199)	0	**(100,659)**
Stockport CCG	(136)	(4,586)	(27,059)	(70,588)	**(102,369)**
Total	**(21,372)**	**(11,810)**	**(99,258)**	**(70,588)**	**(203,028)**
Expenditure met from the Pooled Budget					
Stockport Council	21,023	6,996	73,134	0	**101,153**
Stockport CCG	136	4,596	26,906	71,417	**103,055**
Total	**21,159**	**11,592**	**100,040**	**71,417**	**204,208**
Net (surplus) / deficit arising from the pooled budget in year	**(213)**	**(218)**	**782**	**829**	**1,180**
Net (surplus) / deficit split by each partner:					
Stockport Council	(213)	(228)	935	0	494
Stockport CCG	0	10	(153)	829	**686**
Total	**(213)**	**(218)**	**782**	**829**	**1,180**

* Includes £14.3 million contributed by the CCG to enable SMBC to fulfil its lead commissioner role under the section 75 agreement

16 Related Party Transactions

Details of related party transactions with individuals are as follows:

The following individuals were members of the CCG's Governing Body during the financial year and the CCG has transacted with other organisations to which the members are connected. Details of these relationships and transactions are set out below:

	2018/2019				2017/2018			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Ranjit Singh Gill, Chief Clinical Officer (left August 2018)								
Senior Partner at Stockport Medical Group	2,269	0	0	0	2,117	0	0	0
Member of Viaduct Care via Stockport Medical Group	2,989	0	0	0				
Mr John Greenough								
Former Partner of KPMG	47	0	13	0	40	0	13	0
Mr Peter Riley, Lay Member (commenced August 2018))								
Lay Member for Integrated Risk at Heywood Middleton & Rochdale CCG	0	4	0	4	58	0	0	0
Son-in-law works for NHS Property Services	763	0	849	1	2,418	0	653	2
Dr Catherine Helen Briggs, Clinical Chair (commenced October 2018)								
GP Partner at Bracondale Medical Centre	692	0	0	0	650	0	0	0
Member of Viaduct Care via Bracondale Medical Practice	2,989	0	0	0				
Ms Noreen Dowd, Interim Accountable Officer (commenced August 2018)								
Previous Professional & Personal Relationship with Maria McCaffry of Maria McCaffry Associates Ltd	42	0	0	0	0	0	0	0
Mark Chidgey, Chief Finance Officer								
Personal Friendship with the Chief Executive of St Ann's Hospice	965	0	0	0	861	0	0	0
Dr Simon Woodworth, Clinical Director (commenced April 2018)								
GP Partner at Beech House Medical Practice	1,096	0	0	0	1,112	0	0	0
Wife works for East Cheshire NHS Trust	2,329	0	10	5	2,316	0	48	5
Elected representative to Stockport LMC	40				111	0	19	0
Member of Viaduct Care via Beech House Medical Practice	2,989	0	0	0				
Dr Viren Mehta, Clinical Director								
GP Partner at Cheadle Medical Practice	1,620	0	0	0	1,502	0	0	0
Member of Viaduct Care via Cheadle Medical Practice & Cheadle GP Neighbourhood Lead*	2,989	0	0	0				
Stockport LMC Committee member	40				111	0	19	0
Dr Karen McEwan, GP Clinical Lead (commenced February 2019)								
GP Partner at Park View Group Practice	1219	0	0	0	1146	0	0	0
Member of Viaduct Care via Park View Group Practice*	2989	0	0	0				
Dr Najabat Hussain, GP Clinical Lead (commenced February 2019)								
GP Partner at Park View Group Practice	1219	0	0	0	1146	0	0	0
Member of Viaduct Care via Park View Group Practice*	2989	0	0	0				
Stockport LMC member	40				111	0	19	0
Dr Lydia Hardern, Chair of Stepping Hill Victoria Locality Council Committee (resigned November 2018)								
Salaried GP at Stockport Medical Group	2,269	0	0	0	2,117	0	0	0
Brother is employed by Salford Royal NHS Foundation Trust	8,742	2	313	0	8,017	5	648	2
Member of Viaduct Care via Stockport Medical Group	2,989	0	0	0				
Dr Andrew Johnson, Chair of Marple and Werneth Locality Council Committee								
GP Partner of Marple Cottage Surgery	1,124	0	0	0	1,078	0	0	0
Member of Viaduct Care via Marple Cottage Surgery	2,989	0	0	0				
Dr Vicci Owen-Smith, Clinical Director for Public Health (retired May 2018)								
Deputy Director of Public Health at Stockport Metropolitan Borough Council	28,007	3,143	2,022	1,423	31,160	933	1,720	484
Trustee of the Together Trust	365	0	24	0	257	0	34	0
Associate Medical Director (honorary) Stockport NHS Foundation Trust	184,687	2,168	191	2,140	175,065	13	40	17
Dr Jennifer Connolly, Public Health Consultant (between June and December 2018)								
Consultant in Public Health employed by Stockport Metropolitan Borough Council	28,007	3,143	2,022	1,423	31,160	933	1,720	484
Dr Judith Strobl, Public Health Consultant (commenced January 2019)								
Consultant in Public Health employed by Stockport Metropolitan Borough Council	28,007	3,143	2,022	1,423	31,160	933	1,720	484
Anita Rolfe, Executive Nurse								
Daughter is employed by The Christie NHS Foundation Trust	4,042	0	73	0	3,672	0	55	0

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. Details of these transactions are set out below:

Stockport NHS Foundation Trust	184,687	2,168	191	2,140	175,065	13	40	17
Manchester University NHS Foundation Trust	53,448	2	1,545	2	49,708	1	857	0
Pennine Care NHS Foundation Trust	30,696	0	526	0	28,189	0	243	0
North West Ambulance Services NHS Trust	10,745	0	231	0	10,525	0	227	0
Salford Royal NHS Foundation Trust	8,742	2	313	0	8,017	5	648	2
The Christie NHS Foundation Trust	4,042	0	73	0	3,672	0	55	0
East Cheshire NHS Trust	2,329	0	10	5	2,316	0	48	5
NHS Oldham CCG	2,137	0	175	0	2,324	0	517	0
NHS Property Services	763	0	849	1	2,418	0	653	2

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Details of these transactions are set out below:

Stockport Metropolitan Borough Council	28,007	3,143	2,022	1,423	31,160	933	1,720	484

17. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the CCG.

18. Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number 2018-19 Number	**Total Value of 2018-19 £'000**	Total 2017-18 Number	Total Value of 2017-18 £'000
Claims abandoned	2	7	0	0
Total	**2**	**7**	**0**	**0**

Special Payments
The CCG made no special payments in the period.

19. Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2018-19 Target	**2018-19 Performance**	**2018-19 Duty Achieved**	2017-18 **Target**	2017-18 **Performance**	2017-18 **Duty Achieved**
Expenditure not to exceed income	473,475	473,475	Yes	455,912	452,092	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	467,323	467,323	Yes	454,171	450,351	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	6,398	5,698	Yes	6,434	5,160	Yes

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS STOCKPORT CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Stockport Clinical Commissioning Group ("the CCG") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer's conclusions we considered the inherent risks to the CCG's operations, including the impact of Brexit, and analysed how these risks might affect the CCG's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 43, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 43, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Stockport CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Stockport CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Robert Jones

Robert Jones
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants

One St Peter's Square
Manchester
M2 3AE

28 May 2019

NHS
Stockport
Clinical Commissioning Group

Statement of **Patient** & **Public** Involvement

2018-2019

1. FOREWORD

In 2018 the NHS celebrated its 70th anniversary, a significant milestone in its history, and it is appropriate that we focus and reflect on the experiences of those who use our services and how they continue to help shape local health and care.

We have all used NHS services at some point in our lives as patients or carers, friends or family, and it plays a vital role in our daily lives. This makes the care the NHS provides important to all of us. This is why we are committed to listening to our local communities so that they continue to have an opportunity to share experiences, and to shape how care is planned, organised and delivered.

The NHS Long Term Plan, published in January 2019, outlines the bold direction for the health service to ensure that as health needs change and society develops, the NHS can continually move forward so that we have a service fit for the future. Locally and regionally we expect to be engaging with local people on how the plan will benefit local communities and improve services for them and their future generations.

Our Statement of Involvement shows how we are working with our communities to make the NHS better for patients and the public across Stockport. It also demonstrates the areas of best practice, and identifies challenges and how we are working to improve.

NHS Stockport Clinical Commissioning Group (CCG), working with local partners is committed to working more closely with the people it serves in order to make improvements to health and care and the quality of people's lives.

Working directly with patients, carers and the public is critical to ensuring local services meet local needs and in developing sustainable solutions. What matters to people must be valued and used as an underpinning principle of any health and care commissioning or provider organisation's way of working.

The challenge is to build this way of working into processes and systems so that it becomes essential to design, delivery and assessment of care.

Stockport CCG intends to build on achievements to date and has ambition and plans to increase and renew the involvement of patients, carers and the public, working alongside its partners, so that it is systematic and consistent in its approach.

Christine Morgan
Chair, Citizen Representation Panel

John Houghton
Deputy Chair, Citizen Representation Panel

James Brown
Head of Communications, NHS Stockport CCG

2. INTRODUCTION

The Statement of Involvement outlines the work NHS Stockport Clinical Commissioning Group (CCG) has undertaken during the financial year from 1 April 2018 up to 31 March 2019 to engage and involve local people and communities.

Stockport CCG is responsible for making sure that the 310,000 people registered with a Stockport GP has access to the healthcare services they need.

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

Stockport continues to be one of the healthiest places to live in the North West, but we know that this is not the experience of all of our residents. Local communities experience varying levels of affluence and have significantly different health needs.

Similar to other local areas across the country Stockport faces a number of challenges in the delivery of existing health and social care services. These issues include:

- An ageing population with increasingly complex care needs and at higher risk of isolation and loneliness. This is because more people live on their own without direct family support;
- A population where birth rates have risen, especially in areas of deprivation. This has led to more children and young people living in low income households where health outcomes are poorer;
- Changes in the most common health issues to those which are linked to lifestyles or are otherwise preventable;
- A period of economic challenge that affects the incomes and opportunities of the most vulnerable people in Stockport;
- Fragmented services which are complicated to access, have duplications and are not as focussed on the individual's needs as could be;
- A system where too many people are admitted to hospital, when they would be better and more appropriately cared for at home;
- Increasing financial pressures with deficits forecasts for Stockport as demand growth continues if service delivery is not improved.

2. INTRODUCTION

Stockport's population has a wide range of health needs, and has the oldest age profile in Greater Manchester. Currently 19.4% people are aged 65 and over and that is likely to rise to 21.8% by 2024 which is an additional 9,681 people.

There are significant health inequalities in Stockport, with life expectancy varying by 10 years between the most and least deprived areas. Smoking cessation rates are improving, but smoking rates are more than twice as high as average in areas of deprivation.

CURRENTLY STOCKPORT'S POPULATION HAS 19.4% PEOPLE AGED 65+, LIKELY TO RISE TO 21.8% BY 2024, AN ADDITIONAL 9,681 PEOPLE.

Children and Young People

- Almost 1 in 4 children in Stockport are overweight or obese by the age of 4 rising to almost 1 in 3 by the age of 10.
- Almost 1 in 4 of 5 year olds suffered tooth decay
- 8,500 children and young people are estimated to live in poverty.
- Over 70% of young adults are not active enough
- Anxiety is the major long term condition affecting young people in Stockport with more than 2,700 cases reported.
- Self-harm hospital admissions in those aged 10-24 are higher than the national average.

Adults and Older People

- 1 in 4 adults are overweight or obese putting them at greater risk of liver disease, heart disease and diabetes.
- Cancer is now the major cause of premature death with 45% of deaths under 75 years.
- Stockport's population is older than the England average, with around 55,600 residents aged 65 and over. Of these, 7,400 are aged 85 or over. By 2025 these age groups are projected to grow to 66,500 and 11,000 respectively.
- Half the older population of Stockport has a long term health problem or disability and 1 in 5 has 2 or more long term conditions.
- 1 in 3 older people live alone.
- 2,700 older residents suffer with Dementia.

2. INTRODUCTION

Stockport: an overview

Likely to rise to
21.8%
by 2024, an additional **9,681 PEOPLE**

Health challenges facing **Stockport**

CHILDREN

1 IN 4 live in poverty

1 IN 4 of 5 year olds suffered tooth decay

8,500 children and young people estimated to live in poverty

70% are not active enough

2,700 cases of anxiety reported

Self-harm admissions are higher than UK average

ADULTS

1 IN 4 are overweight

45% of cancer deaths under 75 years of age

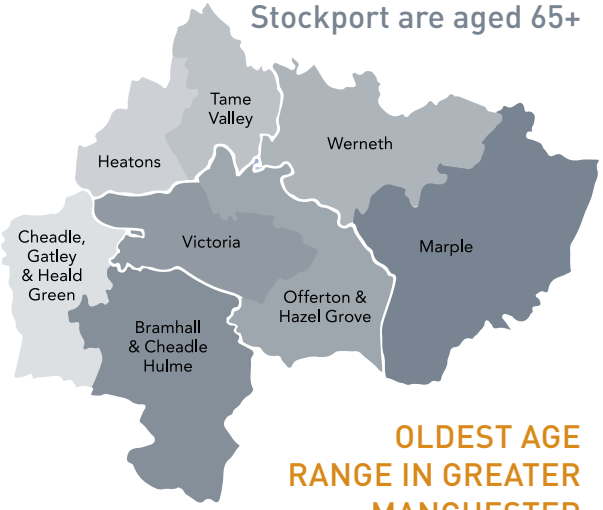
1 IN 5 colder people have 2 or more long term health conditions

1 IN 3 older people live alone

2,700 older residents suffer with Dementia

Stockport's population is older than UK average

19.4%
people living in Stockport are aged 65+



OLDEST AGE RANGE IN GREATER MANCHESTER

Life expectancy varies by
10 YEARS
between the most and least deprived ares

3. WHO WE ARE AND WHAT WE DO

NHS Stockport Clinical Commissioning Group (CCG) is a membership organisation representing GPs from every practice in Stockport with responsibility for planning, designing, buying and monitoring the health services for the local population.

These services include:

- Planned hospital care;
- Rehabilitation care;
- Urgent and emergency care;
- Community health services;
- Mental health and learning disability services.

3.1 Our vision

The CCG's vision is:

"We exist so that Stockport people will access high quality health services that empower them to live healthier, longer and more independent lives."

This underpins the organisations approach to everything it does to help improve the health and services across the borough.

4. PLACING PATIENTS AND COMMUNITIES AT THE HEART OF WHAT WE DO

The CCG aims to work with local partners to improve health and secure high quality healthcare for the people of Stockport, now and for future generations. We want everyone to have greater control of their health and their wellbeing, and to be supported to live longer, healthier lives with high quality health and care services that are compassionate, inclusive and constantly improving.

4.1 Person Centred and Community Approaches (PCCA) in Stockport

Stockport Council and CCG are working towards a more joined-up commissioning function for health and care within the context of place-based commissioning, which is responsive to and works with local communities. The strategy recognises a particular need, in Stockport, to revitalise our approach to supporting, developing and working with the voluntary and community sector.

This work will draw in particular on the Stockport Local approach, which is being developed as a platform for community commissioning, and our innovative approach to place-based community support developed in the Heaton's.

The corporate leadership within the Council and CCG are committed to this agenda and a GMCA supported and fund workshop on the 'Asset-based Area' approach is scheduled for late April. This will equip senior leaders within the Council to support its implementation. These developments represent a real opportunity to build on the work of the Systems Leadership Group which created the 'Stockport Way' to encapsulate a shared vision for how we work with people and communities and initiated the community-focused Place Based Integration early adopter in the Heaton's.

Our PCCA self-assessment highlights a number of areas in which we are making good progress, including:

- Driving forward person-centred conversations as key to our Enhanced Case Management approach, and planned incorporation of the Goals of Care document into the Stockport Health and Care record, to facilitate access and sharing across organisations
- Establishment of our GP-based social prescribing service, the Wellbeing and Self Care team, which will operate as a key pillar of the 'Team Around the Place', alongside the WIN (Wellbeing Independence Network), TPA (The Prevention Alliance)and Stockport Homes
- Establishment to of the Stockport Local fund to invest in community and voluntary activity and emerging third sector collaborative infrastructure.

Key challenges remain including the implementation of Personal Health Budgets, embedding and mainstreaming person-centred approaches and coproduction, and building the relationships, trust and culture that facilitate appropriate information sharing and a focus on shared outcomes. While some innovative work is taking place within the Council, it is recognised that a broader whole system approach to develop the commitment, tools and skills for PCCA is needed.

4. PLACING PATIENTS AND COMMUNITIES AT THE HEART OF WHAT WE DO

Our ambition is to place patients, public and our local communities at the heart of everything we do. To achieve this, genuine patient and public participation is essential.

The NHS Five Year Forward View (2014) and Next steps on the NHS Five year Forward View (2017) describe a new relationship between the NHS, patients and the public, including a commitment to involve communities and citizens in decisions about the future of health. This is particularly relevant following the NHS 70 celebrations and the publication of the NHS Long Term Plan (2019) to ensure that health services continue to develop for future generations.

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

In addition the CCG has a legal duty under Section14U and 14Z2 of the Health and Social Care Act 2012 (see Appendix B) to involve patients in decisions about care and treatments and the public in the commissioning of services.

Within the CCG's constitution we have made the commitment to ensure that there is meaningful public involvement in the planning, development and shaping of local services. These are governed by the following principles:

- Working in partnership with patients and the local community to secure the best care for them;
- Adapting engagement activities to meet the specific needs of the different patient groups and communities;
- Publishing information about health services on the CCG website and through other media;
- Encouraging and acting on feedback;
- Identifying how the group will monitor and report its compliance against this statement of principles.

4. PLACING PATIENTS AND COMMUNITIES AT THE HEART OF WHAT WE DO

The CCG works with a range of partners across the voluntary and third sector and have always worked closely with patient groups, including Healthwatch, in order to engage as wide an audience as possible and to involve them in decision making.

The CCG's Accountable Officer and GP Clinical Chair hold regular meetings with Healthwatch colleagues, who have a place as a representative on the Governing Body. Healthwatch is also represented on the Stockport Citizen's Panel.

In addition, where developments are being planned, commissioners attend Healthwatch briefing sessions to ensure local involvement in shaping plans. Members and officers of Healthwatch are also regularly involved in formal CCG committees and workshop

Our approach to public involvement is to make sure that we use a wide variety of different mechanisms, methods and approaches to engage with people.

The CCG uses a number of methods to involve and engage with our communities and to listen to their views and needs. Some of these approaches include:

4.2 Citizen Panel

The Stockport Citizen's Panel meets quarterly and the forum is engaged over the latest plans on the development of local health and care services. Key questions and comments by the panel are noted and taken back to programme teams for consideration and development of business plans.

4.3 Citizen Space

Citizen Space 'have your say' is the CCG's and Council's online consultation database where members of the public can take part in surveys and keep up to date with the engagement work being undertaking.

The CCG has always been committed to listening to local people in shaping their area and the services that they receive. It is important that consultation and community engagement is being carried out in a coordinated and robust manner.

We use a range of appropriate consultation and engagement methodologies to ensure an appropriate and proportionate approach to enabling stakeholders to have their say on services that affect them. These methodologies are both online using the Citizen Space consultation portal and offline using a range of methods to ensure no group is excluded.

4. PLACING PATIENTS AND COMMUNITIES AT THE HEART OF WHAT WE DO

4.4 Patient story

Patient story videos and podcasts are shown at the beginning of each Governing Body meeting. The stories provide an example of the lived experience of patients to help showcase examples of excellence and where the quality of care was not as it should be.

4.5 Governing Body composition

To ensure that patient views are heard at every level of the organisation, the CCG has appointed lay members to sit on all our committees. A number of important working groups also have patient and public representation including the Individual Funding panel and STAMP.

The Governing Body has appointed four independent Non-Executive Lay Members, who in addition to being full governing body members have additional specialist roles:

- Christine Morgan is the Non-Executive Lay Member for Patient and Public Involvement, the portfolio for which she assumed informal responsibility from January 2018 and formally confirmed at the Annual General Meeting of the CCG in September 2018. Christine also Chairs the Citizen Representation Panel and Individual Funding Request panels.
- John Greenough leads on Audit, Remuneration and Conflict of Interest matters.
- The Governing Body has a representative from Healthwatch Stockport and the Chair of the Health and Wellbeing Board in attendance at all meetings to feed in local views.
- Dr Debbie Kendal is the Non-Executive Secondary Consultant who Chairs the Quality Committee which includes the Non-Executive Lay Member for Patient and Public Involvement and a Healthwatch member.
- Peter Riley Chairs the Primary Care Commissioning committee (from September 2018) which includes the Non-Executive Lay Member with the remit for Patient and Public Involvement, was the previous Chair up to August 2018.
- The Performance and Delivery Committee (replaced the Finance and Performance Committee in September 2018) includes the Non-Executive Lay Member responsible for Audit and Finance.
- The Audit Committee is chaired by the Non-Executive Lay Member responsible for Audit and Finance.
- The Remuneration committee is Chaired by the Non-Executive Lay Member responsible for Audit and Finance and includes the Non-Executive Lay Member with the remit for Patient and Public Involvement.
- The Strategy, Commissioning and Planning Committee is Chaired by the CCG Clinical Chair and includes the Non-Executive Lay Member with the remit for Patient and Public Involvement.

5. PROMOTING EQUALITY AND REDUCING HEALTH INEQUALITY

NHS Stockport values diversity and is committed to reducing inequalities in the workplace, in health outcomes, in access to and experience of local services.

Challenging discrimination and addressing inequalities is key to achieving our vision of high quality healthcare for Stockport.

This report outlines some examples of how we have engaged with different groups and diverse communities within our local population to ensure that their voices are heard.

As a public sector organisation, we have a legal duty under the Equality Act (2010) to ensure equal access to our services for all our diverse communities.

This includes making adjustments so that for those whose first or preferred language is not English or who use sign language as their main means of communication can receive the same level of service as other patients.

The CCG continues to manage the interpretation budget for local Primary Care services on behalf of NHS England, who now commission these services. The service provides interpretation at medical appointments in General Practice; NHS dentistry; NHS pharmacy and NHS optometry.

NHS Stockport CCG holds interpreting contracts with:

- **Stockport Interpreting Unit**, for the provision of face-to-face for foreign language interpreters in over 43 languages.
- **The Big Word**, for the provision of 24/7 phone interpretation services in over 200 languages.
- **Action on Hearing Loss** for the provision of face-to-face British Sign Language interpreters.
- **Sign Video** for the provision of Skype based British Sign Language interpreters.

Over the financial year 2018-2019 interpretation was used for 3,539 healthcare appointments (an increase of 657 compared to 2017-2018). A total of 42 languages were used, in addition to sign language. Farsi was the most commonly used language, followed by Arabic, Kurdish, Urdu, Polish, and British Sign Language.

The total cost of interpretation was £52,999.36 (compared to £47,608.13 in 2017-2018) For the first time this year this amount was jointly funded by the GP Primary Care budget and the CCG's interpreting budget.

6. WHAT OUR PATIENTS AND COMMUNITIES TELL US ABOUT LOCAL SERVICES

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Since it was initially launched in April 2013, the FFT has been rolled out in phases to most NHS funded services in England, giving patients the opportunity to leave feedback on their care and treatment. NHS England publish monthly data on the FFT which can be accessed at www.england.nhs.uk/fft/

Friends and Family Test results for 2018-2019 across the borough are summarised below and the data relates to the most recent NHS England national publication for February 2019:

GP Services: Overall satisfaction with GPs services across Stockport remains high and over 91% of patients would recommend them. This is slightly higher than the 90% in 2018 and above the England average rate of 90%. The percentage of respondents who would not recommend GP services across Stockport is below the England average range at 5% compared with almost 6% nationally.

Accident & Emergency: The percentage of patients who would recommend Stockport A&E services as a place to receive care has increased slightly to 89% compared to 87% in 2018. This is higher than other A&E performances across Greater Manchester, with the exception of Bolton NHS Foundation Trust at 91%.

There has been no change in the percentage of respondents who would not recommend the A&E service remaining at 7% in 2018, which is lower than the England average of 9% and the Greater Manchester average of 10%. It is likely that these results are reflective of the challenging performance seen in A&E departments.

Inpatients: On average 96% of respondents would recommend Stockport as a place to receive inpatient care, which is slightly higher than the rate of 94% reported in January 2018. This is in line with the England average rate of 96% and above the Greater Manchester average of 94%. The percentage of respondents who would not recommend inpatient services across Stockport is also within the England average range of 2%.

Outpatients: On average in February 2018 93% of respondents would recommend outpatient services, which is a slight increase of 1% compared to the previous year and slightly below the England average of 94%. The proportion of respondents stating they would not recommend outpatient services is also within the England average range at 3%.

6. WHAT OUR PATIENTS AND COMMUNITIES TELL US ABOUT LOCAL SERVICES

Maternity: The percentage of patients who would recommend Stockport Maternity services as a place to receive care has increased to 100% (compared 98% in Jan 2018). This is higher than the national England average of 97% and Greater Manchester average of 96%. The proportion of respondents stating they would not recommend maternity services has decreased to 0% which is better than the national average of 1% and regional average of 2%.

Community: On average 92% of respondents would recommend Stockport as a place to receive community care, compared to 90% in 2018 and slightly lower than the national average of 96%. The percentage of respondents who would not recommend inpatient services across Stockport is also slightly higher than the England average range at 3%.

Over the year the CCG received a wide range of queries, compliments, comments and complaints from local communities. In addition, the CCG's manage requests for information submitted under the Freedom of information Act.

All of these contacts from the public are monitored and analysed so that trends in requests or issues are fed into the Governing Body and the relevant commissioning team to ensure that improvements are made as a result of local contacts.

Over 2018-2019, NHS Stockport received:

- 120 Complaints;
- 241 Compliments and enquiries;
- 22 MP letters;
- 243 Freedom of Information requests.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

Over the last 12 months the CCG has worked with a range of communities and local partners across Stockport to involve and engage patients and the public in local plans, commissioning intentions and service development. This involvement has included linking with the Greater Manchester Health and Social Care Partnership (GMHSCP) on the GM Taking Charge programme.

In addition, over the last year the CCG has strengthened its commitment to public and patient involvement by developing a framework to support Commissioners. The new process ensures that public involvement for all plans and proposals are considered and any required impact assessment is completed. To read the CCG Engagement Framework please visit: www.stockportccg.nhs.uk/about-us/what-are-our-plans-and-priorities/

7.1 Devolution Difference Stockport

More than 100 people attended the Devolution Difference event on 9 October 2018. The event was held to reflect on how health and social care in Stockport is changing for the better, helping local people live healthier, happier lives.

The borough was handed the power to begin making these improvements two years ago when Greater Manchester took control of the region's £6bn health and social care budgets with the aim of transforming services.

To mark the anniversary the event showcased the positive changes that have happened in health and social care services in Stockport that are making a difference to the lives of local people.

Jon Rouse, the Chief Executive of Greater Manchester Health and Social Care Partnership delivered a key note speech and there was further insight into the transformation by leaders of NHS Stockport CCG, Stockport Council and Stockport NHS Foundation Trust.

The event was supported by over 25 local voluntary, charity and health and care organisations that formed a drop-in market place, allowing guests to find out more about how the changes will affect them and talk to staff in the services available in local communities.

7.2 Stockport NHS Foundation Trust

Stockport NHS Foundation Trust continues to support the local work, including GM programme, and is able to engage its 5,000 staff and 11,000 trust members through a number of different channels. These include the monthly team brief, screensavers, Chief Exec's Weekly Update, intranet, briefings social media accounts and Stepping Up newsletter and events, including the Annual Members Meeting.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

Next steps

The intention is to continue to strengthen the work and to get better at demonstrating the difference the Trust can really make, by increasing how communities can be involved in shaping services and decision-making.

By 2020 the Trust aims to improve the scale of engagement and representation to ensure that communities and individuals are able to be heard and influence the development of local health and care services.

7.3 Pennine Care NHS Foundation Trust

Mixed Sex Accommodation - 'What Matters to You' - Involving patients, staff and carers

National guidance from the NHS Operating Framework (2011/2012) requires all providers of NHS Health Care to confirm they were compliant with the National definition "to eliminate mixed sex accommodation except where it is in the overall best interest of the patients or reflects patients' choice".

Department of Health (2011) have provided clarity in their guidance relating to breaches.

The CQC inspections held in 2016 and 2017 within Pennine Care NHS Foundation Trust highlighted areas of non-compliance with the guidance and therefore deemed to be regulatory breaches.

What Pennine Care aimed to achieve

The aim of this initiative is to achieve an improved Quality and Safe Care and to be regulatory compliant.

What Pennine Care have achieved during 2018-2019

In June 2018, an engagement and involvement programme – 'What Matters to You' was commenced by the Trust. This included a three stage process:

1. Ward Managers having informal conversations with staff, patients, carers and families as regards the issues around Mixed Sex Accommodation and potential changes to Same Sex Accommodation.
2. A total of 18 facilitated sessions with patients to asl questions about experiences around privacy, dignity and safety, as well as their views on potential moves from Mixed Sex to Same Sex Accommodation.
3. Survey for staff, Commissioners, service user groups, local authority partners, CQC, third sector groups.

Feedback from this survey was combined with feedback from all three stages described earlier to inform an independent analyst report. This feedback report was presented to the Trust Board on the 11th February 2019 as well as the Joint Health and Scrutiny Committee on February 26th 2019.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

- Stage 1 of the process resulted in 327 response forms being returned.
- Stage 2 involved a total of 197 participants in the focus groups.
- Stage 3 on-line survey to wider stakeholder groups resulted in 640 responses.

A number of presentations have also taken place with Governors and Pennine Care NHS Foundation Trust Service Users Group to update on progress. An update presentation was also given to the CQC inspection team.

Other activity includes a review and update to the Bed Management Protocol and MSA algorithms, new signage being deployed onto wards and a MSA poster and leaflet has been designed and is being printed for all wards.

What Pennine Care plan to do next

Findings from the feedback report highlighted the following:

- The Trust needs to provide on all wards at all sites Single Sex Accommodation with En-Suite facilities, in a Mixed Ward environment (“mixed but separate”.)
- Separate Functional (ie schizophrenia or bi-polar) and Organic (ie dementia) patients.
- Involve patients/carers/staff more in design of services.
- Empower staff.
- Increase levels of training for staff.
- Provide greater number of OT’s on wards to increase therapies and activities for patients.
- Provide more activities – and if possible access to quiet outside space.
- Location is important; however, more important is safe patient care.

The Trust Board plans to review the findings in full and is committed to having a solution to the Mixed Sex Accommodation for implementation in 2019-2020.

7.4 Mastercall

Mastercall is a social enterprise organisation, providing a range of ‘out of hospital’ healthcare services for patients across the Northwest, including Stockport.

Patient Engagement Committee (PEC)

The Mastercall PEC is held every quarter and involves key members of staff, other healthcare organisations and patients. The PEC has a number of objectives, including:

- Find out patients experience of the services provided by Mastercall;
- To involve patients in decisions being made about treatment and care;
- Review patient feedback to consider emergent themes in engagement, experience and outcomes;
- Discuss topical subjects to get a patient’s insight and lived experience.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

Over the year the Mastercall PEC have held in depth discussions on a range of topics including:

- Dignity in Care - Mastercall reaccreditation
- Mental Health provision and how to improve signposting to services
- Proposed Introduction of a Council of Members to help shape local services
- Development of a Stockport Involvement and Engagement Strategy
- Review of Patient Experience feedback across all surveys and how it can be used to improve local services
- Patient Experience Software – exploring different ways to gain feedback including SMS, emails, postal, kiosk to help Mastercall to capture and respond to patient views.

Mastercall is committed to ensure that patient and public views are reflected in decision making. This has included the exploration of different channels for patients, including text messaging, Friends and Family cards and kiosks at health sites.

7.5 Viaduct Care

Viaduct Care is the GP Federation of Stockport and is supported by all 39 Practices across the borough and was established as a not-for-profit Community Interest Company (CIC) in April 2018.

The aim of Viaduct is to provide high quality out-of-hospital services, centred around eight neighbourhoods and based on the ethos of co-ordinated, accessible and proactive care for the population of Stockport.

Patient involvement with Viaduct Care

Over the last 12 months Viaduct has begun to engage with a range of partners and the public in developing a range of new community based services including establishing the 7-day Access Service, which allows patients to have a booked appointment with a GP, Nurse or Health Care Assistant in evenings and at weekends; and the First Contact Physio Service and they have implemented direct patient engagement.

Through these services, Viaduct has launched a feedback system that enables people to leave comments and give a rating on the Friends and Family Test. This is then used to further improve the service and future plans include publishing the data on the Viaduct website.

Viaduct has also launched the Wellbeing and Self-Care Service, who provide advice and offer one to one and group work support for patients who have been diagnosed, or are at risk of, long-term conditions, who are frequent attenders at their GP Practice, or who are experiencing loneliness and social isolation. The service has engaged patients to improve access and information to support individuals and to develop case studies to highlight the positive impact it can make.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

Future plans

As Viaduct continues to develop they are committed to working with local partners to improve public and patient involvement in shaping community services. They will also be hosting a public Annual General Meeting and will support other public engagement events over the next year. For more information about Viaduct Care visit www.viaductcare.org.uk.

7.6 Healthwatch Stockport

Healthwatch Stockport is the independent health and social care champion for local people in Stockport. It was created to gather and represent the views of the public and plays a role at both regional and local level to support local health organisations to ensure that the views of the public and people who use services are taken into account.

Healthwatch is an instrumental part of the public involvement network across Stockport and members from the Board sit on a wide range of committees and local decision-making groups, including the Stockport Health Partnership Board and Health and Wellbeing Board, to ensure public views are represented.

Healthwatch Stockport is committed to continuing their role in supporting local health and care organisations by:

- **Informing by** providing **information** and **signposting** about health and care support and services.
- **Involving** and gathering **local views** to ensure **communities are listened to** about what works well and what could be improved.
- **Influencing** the planning and delivery of local health and social care services based on **local views**.

Over the last year Healthwatch has held a series of Network events, bringing together health, social care, charity and voluntary partners to discuss issues and celebrate achievements.

One significant event was the NHS70 Party held on the 5 July to mark the anniversary of the NHS, which was held at St Catherine's Church, Heald Green with around 100 people in attendance. The event included a series of interactive presentations and a memorabilia display, including old uniforms and public health posters from the last 70 years in Stockport.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

In addition to the NHS70 event, Healthwatch held regular engagement activity and events on the following:

- A series of Afternoon Tea Events finding out people's experiences on Domiciliary Care;
- Network Event on updating the Healthwatch priorities;
- Focus group on Diabetic eye screening;
- Members reviewed leaflets intended for the public on pharmacy and mental health;
- Held a mental health strategy briefing session;
- Engaged local people and users of the angiography service about changes to service;
- Members were engaged with the Electronic patient record change over;
- The Director of Adult Social care gave Healthwatch Stockport a briefing on care services;
- Healthwatch Stockport Network Event local health and social care support services provided by the voluntary sector Marple;
- Bosden Farm Carers Event;
- Health and Wellbeing Event, Signpost Stockport for Carers;
- Engaging local people on the Dental Access survey;
- Healthwatch Stockport Annual General Meeting;
- #ItStartsWithYou national Healthwatch campaign promotion;

7.7 Citizen's Panel

The Stockport Citizens' Panel is managed by the CCG and helps to gather local community's insight and opinion on local health and social care issues.

The panel is made up of representatives from local communities and patient groups, including Healthwatch and ensures that partners can regularly seek the views of a sample of local residents on health and social care issues and in planning.

The Citizens' Panel complements and expands to invite other patient representative groups, such as patient participation groups (PPGs) to join meetings when required.

During 2018-2019 the panel scrutinised a number of topics and commissioning plans by the including:

- Mental Health Commissioning intentions for adults, children and young people;
- Greater Manchester Carers Charter;
- Stockport Red Bag initiative;
- Stockport Outpatients Project;
- GMHSCP - Improving Specialist Care;
- Viaduct Care – launch of new services;
- Neighbourhood updates, including Health Champions project;
- Development of a Stockport Involvement Strategy;
- Proposal for a new Partnership Involvement Network;

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

- Stockport Joint Strategic Needs Assessment;
- Stockport Devolution Difference event;
- NHS70 celebrations;
- Pennine Care NHS Foundation Trust – consultation on mixed sex accommodation;
- Mental Health Conference – 'One Size Does not Fit All';
- SEND Local Area inspection.

Clinicians and senior staff led the presentation of these plans and key questions and comments by the panel were noted and taken back to programme teams for consideration.

The Citizen Panel both as a collective group and as individuals are strengthening the ambition of the CCG and local partners to develop working partnerships which lean more towards co-design and coproduction. In this way members can have a strategic view and also work in coproduction on operational strands such as the Outcomes framework, key initiatives, and wider plans.

7.8 Mental Health Advisory Group

The Mental Health Advisory Group (MHAG) was set up in 2018 having evolved from the development and introduction of three new mental health services, Psychological Medicine in Primary Care, GP Navigators and Community Psychiatric Nurse into the Crisis Team.

The MHAG has representation from Stockport CCG, Stockport Council, Pennine Care NHS Foundation Trust and third sector organisation, who are working in partnership to understand local needs and develop mental health services.

The group meets bi-monthly and has two lived experience patients who provide critical input and suggestions on a range of issues, including suicide prevention, bereavement counselling and post self-harm support.

As a result of the collaborative partnership and the direct involvement of patients on the group,

Stockport has excellent strategic expertise for implementation and development of Mental Health services such as Suicide Prevention for example, to ensure that it reflects the experience of individual, carers and families in our communities.

7.9 Special Educational Needs and Disabilities (SEND) Inspection

A Local Area Inspection was undertaken by Ofsted and the Care Quality Commission (CQC) in September 2018 which can be found on the **Stockport Local Offer**.

The inspection was to determine the local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities and evaluate how much progress

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

has been made in implementing the SEND Code of Practice 0-25 years, since its implementation in September 2014.

During the inspection inspectors visited settings, schools and a college, and engaged with over 400 parents, children and young people with SEND.

The final report was critical of health, education and social care services across Stockport and encouraged partners to work more closely with families to improve the quality of services.

The CCG and Stockport Council were required to complete a Written Statement of Action (WSoA) for submission to the DfE.

Since November 2018 the CCG and Council held a number of public workshops and surveys, inviting parents, carers and young people to share their lived experience and to work with the organisations in improving local SEND services.

The work will continue over the next two years and so far over 300 families have been actively involved and a proactive programme is in place to continually engage, inform and involve local communities. This includes parent representatives on the SEND Board and all the SEND work streams, to ensure that improvements are coproduced

7.10 Over-the-counter Medicines

In December 2017 NHS England launched a national public consultation on reducing prescribing of over-the-counter medicines for 35 minor, short-term health conditions. The consultation closed in March 2018 and guidance was issued to CCGs on how to implement the changes.

The consultation included items for a condition:

- That is considered to be self-limiting and so does not need treatment as it will get better on its own without any treatment ; and
- Where self-care would be appropriate, i.e. that the person suffering does not normally need to seek medical care but may decide to seek help with symptom relief from a local pharmacy and use an over the counter medicine.

Each year the NHS spends around £569 million on prescriptions for medicines which can be purchased over-the-counter from a pharmacy and other outlets such as supermarkets. Many have little evidence that they work and many of the conditions treated would get better on their own without doing anything.

The aim of the nationally co-ordinated consultation by NHS England was to develop commissioning guidance on over-the-counter medicines and produce a consistent, national framework for CCGs to use.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

As a result in March 2019 CCGs across Greater Manchester, including Stockport, launched an engagement campaign with communities to consider any local issues that may need to be considered before implementing the NHS England recommendations. Full details on the engagement will be published on the CCG website and Citizen Space.

7.11 Greater Manchester Health and Social Care Partnership - Improving Specialist Care

The Greater Manchester health and social care strategic plan, 'Taking Charge of Our Health and Social Care in Greater Manchester' was published in December 2015.

Part of this work identified that there are significant differences in population health and in outcomes for people across our health and social care system, depending on where they live or receive care in the region; which is unacceptable.

'Taking Charge' identified interlinking themes for the transforming health and social care in the city region, including Stockport. The plan is about improving the health and wellbeing of the 2.8 million people living in Greater Manchester, as much and as quickly possible, by:

- Helping people to better manage their own health
- Providing more joined-up care near where people live
- Working together, across hospitals and practices, to share skills and specialist treatment
- Doing things more efficiently and to the same high standards across all boroughs

Since signing an historic devolution deal with the government, Greater Manchester has taken charge of the £6bn spent on health and social care in the ten boroughs. It also got an extra £450m to transform public services. The Greater Manchester Health and Social Care Partnership was formed to oversee the changes and make them happen together.

What is the Improving Specialist Care Programme?

The aim of the Programme is to support hospitals across the region to work more closely together, and with a variety of health and social care organisations, across a range of clinical services to make sure expertise, experience and efficiencies can be shared widely so that everyone in the region can benefit from the same standards of specialist care.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

The services included in the Programme are:

- Benign Urology
- Cardiology
- Respiratory
- MSK/Orthopaedics
- Paediatric Surgery
- Breast Services
- Vascular
- Neuro-Rehabilitation

They were included because in 2016, Clinicians, Trusts and Commissioners across Greater Manchester identified these services as increasingly under pressure, potentially unsustainable in the future and would require a Greater Manchester wide solution not local or incremental change.

The Programme is producing proposals for new Models of Care (how services are delivered) which can be applied across the region which reduce variations in outcomes for patients, improves access to care and makes services more sustainable for the future.

A range of options will be developed for how each service could be delivered more effectively in the future, these options will be explored with our partners and stakeholders, including patients and carers.

Next steps

As the Improving Specialist Care Programme develops possible options for service change will start to emerge, there will be planned local engagement and NHS Stockport CCG will be part of informing and shaping how that engagement activity can be best delivered in our communities.

7.12 Stockport Council Public Health Team

The Stockport Council Public Health Team delivers a range of interventions and activities to engage local residents in improving their own health. The information below provides an overview for the key successes over the last year.

Stockport Active Ageing

Active Ageing in Stockport is a partnership programme between Stockport Council, Life Leisure, Age UK Stockport, Stockport Homes and Stockport's older population. The programme aims to help people over the age of 65 who are currently inactive and have experienced a life event (as defined in NICE guidance) to become more physically active.

The programme was launched in November 2018 and provides a 12 week peer mentor support scheme, free activity passes, an inclusive activity timetable and on-going support and advice.

A key focus for the programme is to have participants tell their stories through the marketing campaign and inform the future programme development.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

Although still in the early stages, 56 people have either begun the programme or expressed their intent to start and four have successfully trained as peer mentor volunteers.

GP Practice Health Champions

The aim of creating Practice Health Champions was to nurture collaboration between GP Practices and people from the local community. To date Practices in Alvanley, Bracondale, and Heaton Moor have introduced Health Champions.

In the Stockport pilot, local people were invited to volunteer as health champions at three GP Practices to offer new, innovative activities and support to improve the health and wellbeing of the local community.

They have played a particularly strong role in tackling social isolation, with well attended weekly community events, and also helping others to change to a healthier lifestyle with regular walks, healthy eating classes and other targeted activities.

Anecdotally the work of the health champions has led to a reduction in GP appointments particularly amongst "frequent flyers" but the impact will continue to be monitored to ensure the potential benefits to patients is harnessed.

7.13 Stockport - End of Life Conversation

The 'End of Life' Conversation was an engagement event with carers who looked after someone who passed away in last 12 months. As part the review and redesign the palliative care provision in Stockport, the CCG and Stockport NHS Foundation Trust worked together with Healthwatch to organise a focus group to:

- Understand the experiences of informal carers in looking after someone at the end stage of their life;
- Inform the direction of the local implementation plan for palliative care in Stockport.

The aim of the engagement was to learn from experiences of family carers what works well, what needs improvement, what is missing and what suggestions people might have to improve our local palliative care offer.

The feedback from the participants confirmed that the new model needs be developed that acknowledge the different needs between palliative care and bereavement pathway ensure the right balance between support for patients, carers and families. There will also be further exploration for respite opportunities.

Next steps for involvement for the group

The participants have been promised to meet up with commissioner and palliative care lead in nine months' time to keep informed on progress of this redesign work and to further engage on specific elements to ensure it is the right new model.

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

7.14 South East Sector Healthier Together Public Voice

One of the CCGs key programmes of work is the delivery of the Healthier Together programme which aims to implement a range of quality standards to improve patient outcomes as part of a Greater Manchester initiative. Stockport CCG are the lead commissioner for the South East Sector Healthier Together Programme which includes partners from Stockport NHS Foundation Trust, Tameside and Glossop CCG, Tameside and Glossop Integrated Care Foundation Trust, North Derbyshire CCG and Eastern Cheshire CCG.

To ensure excellent patient and public involvement, Stockport CCG led on the development of Public Voice, a patient and public involvement forum for Stockport, Tameside and Glossop, North Derbyshire and East Cheshire. The group is led by a lay Chair who is also a member of the South East Sector Healthier Together Programme Board to ensure that the voice of local people is at the heart of the Healthier Together Programme. During 2018/19 Public Voice was involved in a range of key areas:

- A sub group of Public Voice was established to review the impact of the Healthier Together Programme on Patients and carers in regard to transport. The outputs of this work were shared with the Programme Board and indicate the need to fund local voluntary sector transport initiatives in 3 key areas to avoid any inequalities created by the Healthier Together changes;
- In May 2018 the Surgical Teams from Stockport NHS Foundation Trust, along with the team from Tameside and Glossop Integrated Care Foundation Trust and The Christie undertook a mock Multidisciplinary Team meeting enabling Public Voice members to see what happens in such meetings and provide feedback on how the patients thought the process could be improved from their perspective;
- During the year the proposed clinical pathways and financial case for Healthier Together were presented and discussed with Public Voice with their feedback being taken into consideration and amendments being included where possible. The national Emergency Laparotomy Audit data for Stockport, Tameside and Glossop was also explained and shared so that the public and patient members understand why the programme is so important and what the data is telling us;

7. PUBLIC INVOLVEMENT PRIORITIES AND IMPACT OVER THE LAST YEAR

- A number of interactive check and challenge sessions were undertaken so that Public Voice Members could understand, challenge and support the improvement of the whole programme
- A mock post take ward round was also undertaken to enable patient and public involvement in the development of new processes along with the surgical team

8. THE IMPACT OF INVOLVING OUR COMMUNITIES IN DECISION-MAKING

Feedback from involvement exercises is reported to the CCG's Governing Body on a quarterly basis. It is used as a key piece of evidence for consideration in decisions and showing how the views of communities are translated into commissioning decisions.

One of the key tools for feeding back to local people is the CCG's engagement website: https://stockport-haveyoursay.citizenspace.com/

For those without access to the internet, write-ups of events are also sent out to local groups after they have met with the NHS. Sign-up sheets are also taken at all public events so people who wish to receive a write-up of the event can have this sent to them in their preferred format.

Articles summarising formal consultations are included in the local Council publication that is delivered to all households in Stockport. In addition, feedback reports are sent to the Healthwatch for inclusion in their regular newsletter and targeted feedback articles are also included in a wide range of local newsletters.

A full breakdown of involvement and engagement activity can be found in Appendix 1 which outlines:

- When activity took place;
- How many people were involved;
- What was asked;
- What local people told us:
- What was done as a result of local feedback; and
- Where to find more information on the involvement activity.

9. FUTURE PLANS

The Stockport Together public consultation in 2017-2018 made clear recommendations for how the CCG should engage and involve local communities.

The CCG developed five guiding principles from the feedback.

They are:

- Increase local knowledge about the issues needed to address as a health and care system;
- Encourage public to share the lived experience to inform service development;
- Actively supporting local communities to be involved in decision-making ;
- Create opportunities for public to engage with each other;
- Ask people "What Matters to You" as a 'person-centred' approach to care.

The aim is to ensure that the approach will be more systematic, structured and aligned to the commissioning cycle.

9.1 Shaping the way the CCG engages and involves communities

As Stockport adopt a neighbourhood approach to delivering health and social care services, similarly, the CCG needs to consider a neighbourhood approach to engagement and involvement.

Through GP practices and our new neighbourhood leads, there is a key role for working with local people and maximizing connections between existing groups and organisations.

Moving forward, more detailed planning is required between Commissioners and Providers to determine the appropriate levels of engagement.

These considerations will include:

- The statutory requirement of the Joint Commissioner to engage with local populations to assess the overall health and social care needs of that population;
- The advantaged position of neighbourhood leads - having frequent contact with local people through GP practice or specialist services;
- The access to people (including hard to reach and seldom heard groups) that the third sector open up in promoting population health messages and increased levels of engagement and involvement.

9. FUTURE PLANS

9.2 Partnership Involvement Network

Across England many health and social care organisations are working ever more collaboratively to deliver joined-up and consistent involvement with local communities. In Greater Manchester Tameside and Glossop have led the way in introducing a new model of engagement and involvement and Stockport is building support to develop a similar approach.

The proposal is being developed to evolve local engagement which is currently delivered by each organisation separately, into a new Partnership Involvement Network that would be part of a strategic system-wide health and care partnership.

The aim of the Partnership Involvement Network (PIN) proposal would be for it to become part of a partnership approach to provide the patients, carers and local communities with a structured method to influence the strategic planning and development of health and care services and to co-produce issues and ideas.

The key principles behind the proposal for a Partnership Involvement Network (PIN) would be to:

- Actively involve the public, patients and other stakeholders in shaping local services;
- Work collaboratively across public and community sectors so that involvement is joined up across Stockport;
- Continually ask 'What Matters' to the public, patients and other stakeholders when planning and shaping local services.

The new network will establish a coordinated and collaborative forum for people and organisations to ensure their voices are heard and give the opportunity to learn about and influence to the development of public services.

Next steps

The proposals to set up a Partnership Involvement Network will be coproduced and developed with local partners and would become a central strategic involvement forum for representative organisations and individuals across Stockport.

10. CONCLUSION

Stockport CCG is tasked with a number of different roles: from directly commissioning and buying services, to ensuring that local health and care plans are designed to meet the need of local communities. We hope that this review has provided a range of examples of how we have worked in partnership with patients and communities in carrying out our responsibilities.

We want to work closely with patients, carers and communities who have experience of using health and care support or services to make improvements in how that care is planned, organised and delivered.

We know that people share our ambition to continually improve services into the future.

Although we have seen significant changes in the NHS this review demonstrates our continued commitment to improve the way we involve people to shape better health and care services.

However, our intention is to strengthen this work and to get better at demonstrating the difference we can really make, by increasing how communities can be involved in shaping services and decision-making.

As the needs of our local communities and population change, we will continue to work with them together to establish how best to meet new challenges.

Over the next year we will focus on further improvements in how we engage and act on what patients and the public are telling us.

Finally, we would like to thank all of our patients, staff and community partners who have worked with us in to help achieve our goals.

APPENDICIES

Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
01/04/2018	80	Mental Health Training Sessions with TPA	As part of extending confidence in holistic assessments to partner colleagues TPA colleagues asked for training on a list of commonly encountered difficulties relating to clients mental health	To help improve competencies of non-health staff in managing distressed patients within a social prescribing setting, a series of training sessions covering the list was developed and delivered in a small group interactive setting	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/mental-health-training-sessions-with-tpa
01/05/2018	96	Mental Health training with Stockport Homes	We asked: Whilst attending a Public Health led discussion with colleagues from Stockport Homes, ABL, CGL, and START it became clear that they frequently work with distressed or challenging residents. The Clinical Commissioner for Neighbourhoods, Steve Bradshaw, offered to deliver bespoke training sessions to these colleagues to help with these challenges.	Feedback during follow up question and answer sessions reflected better confidence and knowledge subsequent to the training. Colleagues now have a better understanding of communicating with mentally distressed clients and social prescribing to complement their area of expertise.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/mental-health-training-with-stockport-homes

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
14/05/2018		Red Bag Scheme - We would like the Residents and families from the Residential and Nursing homes to give continual feedback that it has supported their transition into hospital and the safe discharge back home again.	A number of positives have been received about the scheme: • Staff at the hospital are engaging with the scheme and service users are coming home quicker. • Families are happy (not losing glasses etc) • Reduced phone calls to the care home • Protects providers – evidence that information has been sent to the hospital- check list • Positive feedback and support from NWAS and ED However there are still some area that require improvement: • GP's / Consultants require training • Notes not always returned -Paperwork needs to stay in the bag. • More promotion in the hospital so all staff are aware, due to high turnover of care and nursing staff. • Person Centred info poor quality or not always read	A Pathway Development Plan has been developed with actions for each of the providers such as Nursing, Residential, Extra Care Homes, NWAS and Hospitals to ensure Champions have been identified and the necessary staff are well trained and fully aware of the scheme.	

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
14/05/2018	13	Continuing and Complex Health Care survey – Families were asked to rate the service they had received from the service	The patient experience survey results are as below: 13 people in total filled in the survey from July 2018 to March 2019. All those asked to think about the Continuing Healthcare process – 9 out of the 13 people asked said they were happy with the CHC process from their first contact with the CHC team to placement or implementation of their care as above. 4 people commented that there was some aspect of communication that could be improved; the team is reviewing to learn from the comments. Did you understand the process? 10 of the 13 asked said that they understood the process, 1 person said 'No' as they were a relative that lived a long distance away and hadn't been involved in the process. 2 people said the process was new to them and found it difficult.		https://stockport-haveyoursay.citizenspace.com/continuing-and-complex-health-care/51d2393f

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
		Continuing and Complex Health Care survey – Families were asked to rate the service they had received from the service (CONT)	Were you kept well informed? 9 out of the 13 people were kept well informed, 1 person said no but indicated that they were invited to the meeting but that they lived far away and could not attend. 3 people commented that there was some aspect of communication that could be improved; the team is reviewing to learn from the comments. There were 0 complaints regarding quality of care of providers and all responses stated that care was good or very good.		

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
29/05/2018	30	Team around the Town meetings - As Neighbourhood Clinical Commissioner, Steve Bradshaw has indicated an interest and wish to be involved in the development of social prescribing networks	As Clinical Commissioner for the Neighbourhoods, Steve Bradshaw was invited and attended three meetings over the last 12 months You said: TPA Community Connectors arrange periodic 'Team around the Place' meetings. These offer the opportunity for local groups/residents to meet and share their values along with what their group can offer as a means of promoting greater local knowledge.	An example of a positive outcome was that at the Marple meeting it was noticed that there was a clash of meeting times between two groups both of whom would have benefited the same group of attendees. Therefore one group agreed to change their meeting times. The overall outcome of all meetings is a better local knowledge between groups of what are already available and potential gaps. This will hopefully also then lead to on-going cooperation and signposting between groups.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/team-around-the-town-meetings

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
11/06/2018	52	Osteoarthritis of the Knee Workshop Questionnaire V4 This is the first time Stockport Together have collaborated to provide this workshop. We would value your feedback, so we can decide if this is a suitable event to run, and how we can improve it for the future		A knee workshop was set up and around 40 patients were invited to attend. Other professionals attended the event such as podiatry, ABL, Patients were given a presentation and invited to ask questions. A survey was circulated to all those that attended which showed patients now had greater confidence in managing their condition.	https://stockport-haveyoursay.citizenspace.com/stockport-together/d2e9fced

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
26/06/2018	11	Citizens Representation Panel 26th June 2018	A number of topics were discussed: Mental Health Commissioning Intensions - Adults and Children and Young People; Stockport's Devolution Difference event; presentation by Karen Snelson and Andrea Stewart on the Outpatients Project.	The attached paper provides an outline of activity for the CCG and Partners to complete on behalf of the CRP.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/crp-26th-june-2018
24/07/2018	100	Healthwatch - NHS 70yr birthday celebration event		During the event members of the public shared their stories of the NHS, and were happy to hear from not only people who have benefitted as patients but also former NHS staff members too.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/mental-health-training-with-stockport-homes
26/07/2018	51	AGM 2018			https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/agm-2018

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
08/08/2018	7	Mental Health Advisory Group	To improve the representation at this multi-agency advisory group we sought user and carer representatives. This was first raised at the August meeting. This was achieved by contacts with Mind and SPARC and meeting with volunteers. The first meeting attended by service users was 10th October. We asked for interested service users/carers to become involved in this multi-agency bi-monthly mental health advisory group.	Two volunteers came forward and after further discussion regarding the nature of the group have joined and attended. In the three meetings held since joining their contribution has been extremely valuable. In particular in respect to suicide prevention and crisis pathway development.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/mental-health-advisory-group-1
25/09/2018	10	Citizens Representation Panel 25th September 2018	Topics for discussion: Theme 3 Dermatoscope and Dermatology Project Commissioning Intentions 2019/20 Neighbourhood Update Update on Heaton's Neighbourhood	The attached paper provides an outline of activity for the CCG and partners to complete on behalf of the CRP	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/crp-25-september-2018

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
08/10/2018	6	Third Sector Contract Review - Reviewing current provision and future aspirations. We asked: What is being done well? Where are the gaps? What could be done better? What are our aspirations?	You said: • During the discussion a number of themes emerged for example: • How Stockport Mind is involved in GM wide developments • Challenges of being a small single borough provider • The activities led through SPARC • Challenges for Carers	All the information from the workshops were considered and discussed. The Local Authority is using this to re-draught contracts and nuance aspiration. These contracts are out for competitive tender at the time of writing this.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/mental-health-third-sector-contract-review

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When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
10/10/2018	21	Devo Difference event - evaluation	More than 100 people attended the Devolution Difference event on 9 October 2018. The event was held to reflect on how health and social care in Stockport is changing for the better, helping local people live healthier, happier lives. The borough was handed the power to begin making these improvements two years ago when Greater Manchester took control of the region's £6bn health and social care budgets with the aim of transforming services. To mark the anniversary the event showcased the positive changes that have happened in health and social care services in Stockport that are making a difference to the lives of local people. Jon Rouse, the Chief Executive of Greater Manchester Health and Social Care Partnership delivered a key note speech and there was further insight into the transformation by leaders of NHS Stockport CCG, Stockport Council and Stockport NHS Foundation Trust.	The event was supported by over 25 local voluntary, charity and health and care organisations that formed a drop-in market place, allowing guests to find out more about how the changes will affect them and talk to staff in the services available in local communities.	https://stockport-haveyoursay.citizenspace.com/communications-team/6a486be0

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When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
01/11/2018	55	Osteoarthritis of the Knee Workshop Questionnaire V5		A knee workshop was set up and around 40 patients were invited to attend. Other professionals attended the event such as podiatry, ABL, Patients were shown a presentation and invited to ask questions. A survey was circulated to all those that attended which showed patients now had greater confidence in managing their condition.	https://stockport-haveyoursay.citizenspace.com/stockport-together/42ef9c4b
10/12/2018	77	SEND Workshop December 2018 - We asked Special Education Needs and Disability (SEND) parents and carers to look at the SEND review undertaken by Ofsted and CQC and give us their feedback	To see a full report of all the feedback and themes please go to the Local Offer page - https://stockport.fsd.org.uk/kb5/stockport/fsd/localoffer.page	The full details of activity, plans and outcomes to date can be found on the 'Local Offer' page via this link - https://stockport.fsd.org.uk/kb5/stockport/fsd/localoffer.page	https://stockport-haveyoursay.citizenspace.com/stockport-together/42ef9c4b

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
11/12/2018	14	Citizens Representation Panel	Topics for discussion: Update from members of key activity, Strengthening involvement & Engagement in Stockport, Mental Health Conference and Send Inspection Report; Neighbourhood Update and Viaduct Care	The attached paper provides an outline of activity for the CCG and partners to complete on behalf of the CRP	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/copy-of-crp-25-september-2018
13/12/2018	8	Tea with the GP - The scheme is simply asking patients to participate once invited, in order to improve their wellbeing by improving contact with GP surgery staff.	Feedback after the event from patients was excellent and it was enjoyed by all.	We are arranging a further event in this Neighbourhood and then approach the charity (Contact the Elderly) to gain permission/obtain funding for further Neighbourhoods.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/tea-with-the-gp

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When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
15/01/2019	Send workshop	SEND Workshop January 2019 - We asked Special Education Needs and Disability (SEND) parents and carers to look at the SEND review undertaken by Ofsted and CQC and give us their feedback.	To see a full report of all the feedback and themes please go to the Local Offer page - https://stockport.fsd.org.uk/kb5/stockport/fsd/localoffer.page	There are a number of actions raised by parents for the Local Authority and CCG to work on. This includes a number of workstreams which all have parent representatives on them The full details of activity, plans and outcomes to date can be found on the 'Local Offer' page via this link - https://stockport.fsd.org.uk/kb5/stockport/fsd/localoffer.page	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/send-workshop-january-2019

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
18/01/2019	5	Practice Champion Scheme - Stepping Hill Neighbourhood We met with the Practice Champions at Bracondale Practice to ask if they would assist a practice in the Stepping Hill Neighbourhood to set up a similar scheme and possibly share activities for patients	The Bracondale Practice Champions agreed they would be glad to assist where they could and would welcome more volunteers working in the neighbouring Stepping Hill Neighbourhood.	Stepping Hill practices are going to decide if they wish to 'host' a Practice Champion scheme and would like more information from Public Health as to what is involved. The Practice Champions will wait to hear if a Stepping Hill practice wishes to engage and work with them later on this year.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/practice-champion-scheme-shillneighbourho

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When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
29/01/2019	19	End of Life Conversation - The aim of the engagement was to learn from experiences of family carers what works well, what needs improvement, what is missing and what suggestions people might have to improve our local palliative care offer. (Continued)	Strengths End of life team at home End of Life assessment Enhanced care team highly valued but only in last 2 weeks of life Advanced care planning works especially well for dementia patients but not necessarily for other conditions Weaknesses Not a person-centred care plan, no choice provided Not possible to book respite care Variable support from GPs: some very supportive GPs and some carers reported not having received much support from their GP Lack of conversations to discuss and plan end of life care No bereavement support offered Lack of training for staff; staff don't know when / how to start conversations and what services are available Treatment for pain was lacking	What we did or will do as a result (ie how this will influence decision-making) Made a split between the palliative care and bereavement pathway to acknowledge the different needs reviewed respite opportunities and are looking in creating more options for respite looked at continuity in support for carers in first days after death improved joint working between elements of the pathway extended enhanced support team involvement looked at training opportunities to up skill staff e.g. home care staff	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/end-of-life-conversation

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
29/01/2019	19	End of Life Conversation - The aim of the engagement was to learn from experiences of family carers what works well, what needs improvement, what is missing and what suggestions people might have to improve our local palliative care offer.	Challenges Adapting home gave stress and had an impact financially; home environment felt less homely Need to start conversations earlier Skills of family carers not appreciated by care home staff when cared for moves into care home Support for deaf people in end phase of life was lacking Barriers Disjointed services Lack of training for family carers	What we did or will do as a result (ie how this will influence decision-making) continued... Made a split between the palliative care and bereavement pathway to acknowledge the different needs reviewed respite opportunities and are looking in creating more options for respite looked at continuity in support for carers in first days after death improved joint working between elements of the pathway extended enhanced support team involvement looked at training opportunities to up skill staff e.g. home care staff	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/end-of-life-conversation

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Appendix A - Involvement and Engagement Activity – 2018-2019

When	No of people	We asked (Activity)	You Said	We Did (Impact)	For more information
04/03/2019	66	Over the Counter Medicines	NHS Stockport CCG wants the views of local patients, the public and other stakeholders on the NHS England recommendations before taking any further decision on whether to remove these products from routine prescriptions locally.	Started in March and is ongoing until 1st April 2019	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/otc
05/03/2019	10	NHS Stockport CCG Meeting with NHS Watch Consortium – an open discussion was held,	A number of topics were discussed, these included: National Signposting Scheme, length of time for GP appointment, Right Care, Right Time services and recruitment of staff.	It was agreed there would be regular discussions with NHS Watch and other colleagues.	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/nhs-stockport-ccg-meeting-with-nhs-watch-consortiu
12/03/2019	13	Citizens Representation Panel 13th March 2018	Topics for discussion included: Update from members on key activity Proposal for Stockport Partnership Involvement Network (SPIN) Update GM Carers Charter Mental Health Advisory Group	The attached paper provides an outline of activity for the CCG and partners to complete on behalf of the CRP	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/crp-12th-march-2019

APPENDICIES

Appendix B - Health and Social Care Act 2012

All Clinical Commissioning Groups have duties outlined within the Health and Social Care Act 2012 to ensure patients are involved. The key elements regarding involvement within the Act are highlighted below.

Full details can be found at www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

14U Duty to promote involvement of each patient

(1) Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to—

a) the prevention or diagnosis of illness in the patients; or

b) their care or treatment.

(2) The Board must publish guidance for clinical commissioning groups on the discharge of their duties under this section.

(3) A clinical commissioning group must have regard to any guidance published by the Board under subsection (2).

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

a) in the planning of the commissioning arrangements by the group;

b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and

c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

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Appendix B - Health and Social Care Act 2012

(3) The clinical commissioning group must include in its constitution;

a) a description of the arrangements made by it under subsection (2); and

b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.

NHS
Stockport
Clinical Commissioning Group

NHS Stockport CCG
7th Floor Regent House
Heaton Lane
Stockport
SK4 1BS

Email: stockportccg.communications@nhs.net

NHS
Stockport
Clinical Commissioning Group

STRATEGIC PLAN

2019-2024

Working Together:
Your Health - Our Goal

NHS
Stockport
Clinical Commissioning Group

Document Title:	Strategic Plan 2019-2024
Author:	NHS Stockport Clinical Commissioning Group
Document Purpose:	5 Year Plans
Publication Date:	September 2019
Signed Off By:	CCG Governing Body & Council of Members
Target Audience:	Health and social care professionals Patients and carers Public
Contact Details:	**NHS Stockport Clinical Commissioning Group** 4th Floor, Stopford House Piccadilly Stockport SK1 3XE **Tel:** 0161 426 9900 **Email:** stoccg.customerservices@nhs.net **Web:** www.stockportccg.nhs.uk

If you require the document in large print, braille, audio or another language, please email:

stoccg.pmo-team@nhs.net

What is a strategic plan?

In January 2019, NHS England launched its Long-Term Plan, setting out expectations for health care over the next ten years. Stockport Metropolitan Borough Council have set out the local ambition that by 2035, Stockport will be one of the best places to live in the UK.

This document explains what NHS Stockport Clinical Commissioning Group will do over the next 5 years to help deliver the NHS and local plans to achieve our vision for health and care in Stockport.

Contents

Foreword

Our population is growing and people are living longer, which is a testament to the success of the NHS over the past 70 years. But as our population changes, people are not necessarily living longer, healthier lives and more of our population are experiencing long-term conditions, needing access to a range of health and social care services. Across the country, services are struggling to reform to meet the changing demands, both in terms of workforce and funding. In light of these challenges, we recognise that providing the same services in the same way will not only add to the issues we face - it is not the right thing for local people.

We believe that services need to work together to meet the increasingly complex needs of our population and focus on delivering improved outcomes. This will require a whole-scale change in our current structures, from commissioning methods and payments systems to how teams of different professionals work together to focus on the needs of the individual.

The good news is that in Stockport, we have been at the forefront of change in the NHS, working to re-shape our local community care offer to better meet local needs. This, along with the wealth of work undertaken through our local transformation programme Stockport Together, Stockport's Joint Health and Wellbeing Strategy, and the Greater Manchester Health and Social Care Partnership, places us in a great position to tackle the change.

This Strategy builds on the work already done and sets out how we intend to continue to reform the health and care system to meet the growing and changing needs of our population within the available budget. Local people - patients, carers, health and care professionals - have helped us to understand needs, to identify what works and what could be improved, and to design our model for the future.

At the heart of these plans is the pivotal role of General Practice as the main point of entry into the health and care system and the navigator of what are often complex and confusing pathways of care. GPs support people through their entire journey: from maternity and infant healthcare; through prevention; identification and management of conditions; referrals into specialist care and managing recovery; to end of life care. With our re-focused neighbourhood approach and Primary Care Networks, GPs will lead multi-disciplinary teams to manage each stage of the journey and focus on improving health and wellbeing in Stockport.

As a local GP and Chair of NHS Stockport Clinical Commissioning Group, I am proud to present this strategic plan, setting out what the CCG will do over the next five years to build a sustainable health and social care system for local people.

Dr. Cath Briggs
Clinical Chair of NHS Stockport CCG

Strategy on a Page

NHS Stockport Clinical Commissioning Group

Our mission is to fundamentally improve health and wellbeing in Stockport

Our vision is to achieve a sustainable, person-centred health and care system, where everyone has the best possible start in life and is supported to live well, age well and die well.

Strategic Aims:

- Start Well
- Live Well
- Age Well
- Die Well
- Lead Well

values — *principles*

Strategic Objectives:

Start Well	Live Well	Age Well	Die Well	Lead Well
Improve the quality and safety of maternity services Commission comprehensive physical and mental health services for children and young people, including those with special educational needs & disabilities	Empower people to look after themselves & make good choices that prevent ill health Improve early identification of health conditions Reduce health inequalities faster Empower people to live well & proactively manage long-term conditions	Support people to remain healthy and independent as long as possible Ensure people can access safe, high quality care when necessary	Patients and their families will receive high quality support at the end of life Support more people to die in the place of their choosing	Improve quality & safety of care Financial balance across the system Co-produce services with patients Implement new & sustainable model of care Highly skilled workforce

Person-Centred · Quality Focused · Collaborative · Professional · Inequalities · Co-Production · GP-Led · Digital First

Strategic Improvement Measures:

Start Well	Live Well	Age Well	Die Well	Lead Well
• More choice in maternity services • Better Births standards • SEND standards • Reduce emergency hospitalisation for asthma, diabetes and epilepsy in under 19s • Better access to children's mental health care	• Reduce inequality in life expectancy • Better antimicrobial resistance • Reduce alcohol related illness • Identify cancer earlier • Increase screening uptake • Reduce emergency admissions for chronic conditions • Reduce length of stay in hospital • Reduce early deaths in people with serious mental illness	• Fewer injuries from falls among over 65s • Reduce delayed transfers of care • Increase uptake of Personal Health Budgets • Reduce early deaths from cancer and liver disease	• Fewer emergency hospital admissions during last weeks of life • More timely palliative care registrations • More people supported to die in the place of their choosing	• All Providers rated 'good' or 'outstanding' • Balance the books across Stockport • Fewer procedures of limited clinical value • Outcomes Framework • Providers fully digitised • Full delivery of NHS standards • Consistently high patient and staff satisfaction levels

Delivery Programmes:

- Primary & Community Care
- Maternity & Children
- Mental Health, LD & ASD
- Planned Care (incl. Cancer)
- Urgent Care
- Enablers

Your Health. Our Goal.

Context

2.1 About NHS Stockport CCG

NHS Stockport Clinical Commissioning Group (CCG) was formed on 1st April 2013. We are an NHS organisation made up of the thirty-seven GP practices in Stockport (see appendix 1). Our role is to commission health and care services on behalf of patients registered with Stockport GPs. The services that we are responsible for include:

- Primary Care;
- Community Health services;
- Mental Health and Learning Disability services;
- Planned Hospital care;
- Urgent and Emergency care;
- Rehabilitation;
- Continuing & Complex Healthcare; and
- Palliative Care.

We work closely with health and social care partners to ensure that local services meet the needs of Stockport's population, delivering Stockport's Health & Wellbeing Strategy.

2.2 Background and context in which we are working

Stockport, like other areas across the country, faces a number of challenges and risks in the delivery of existing health and care services. These include:

- the success of an ageing population leading to increasingly complex care needs;
- a higher than average proportion of older people in our population;
- higher than average birth rates, especially in areas of deprivation, leading to more children and young people living in low income households where health outcomes are poorer;
- growth in the number of people with one or more long-term health conditions, more and more of whom will require complex packages of care;
- a period of economic challenge, affecting incomes and the support available to the most vulnerable people in Stockport;
- significant health inequalities which affect both life expectancy and healthy life expectancy;
- fragmented services which are complicated to access, have duplications and are not as focussed as they could be on the individual's needs;
- a system where too many people are admitted to hospital when many could be better cared for at home; and
- increasing financial pressures in the NHS, with deficits forecast for Stockport as demand for healthcare continues to grow.

As a leader of the local health and care system, we want to ensure that our services can meet these changing needs and are fit for the future, but we recognise that this cannot be done in isolation. This Strategy reflects the fact that Stockport CCG also has role in delivering national, regional and local plans.

a) NHS Vanguards
In 2015 Stockport became an NHS Vanguard[1] site, selected to develop the Multi-Speciality Community Provider (MCP) model, which has helped pave the way for NHS England's new models of care.

b) The NHS Long Term Plan
The NHS Long Term Plan[2], published in January 2019, outlined a bold direction for the health service to ensure that as health needs change and society develops, the NHS can continually move forward with services that are fit for the future. An overview of how we will deliver the NHS plans can be found in appendix 2.

c) GM Devolution
NHS Stockport CCG is a partner in the Greater Manchester Health and Social Care Partnership (GMHSCP). In April 2016, Greater Manchester took charge of its health and care system as one partnership spanning NHS and local government, commissioners and providers of both physical and mental health. In doing so, we embarked upon the most radical health and care transformation programme in the country[3]. The CCG's GP Chair and Accountable Officer represent our interests at the Greater Manchester Joint Commissioning Board.

d) Stockport Health & Wellbeing Strategy
Across Stockport, health and care partners work together through our Health & Wellbeing Board to set the direction for local care. Stockport's joint Health and Wellbeing Strategy[4] drives the work of the board and requires members to collaborate to make improvements.

e) Stockport Together transformation programme
In 2015 health and social care partners in Stockport came together to address some of the challenges noted above. Together, the partners developed a 5-year transformation plan[5] aimed at changing the way in which health and social care services are delivered to improve outcomes. A series of business cases were developed to map our changes. To date a range of changes have been made including investment in primary and community care, the integration of intermediate care services and changes to hospital services.

f) Purpose of this plan
In this context, and in response to the NHS long term plan, all CCGs are required to refresh their local plans and set out clearly how we will deliver the improvements required.

We will do this adopting the common goals agreed across Stockport of:

- reforming the way services are delivered to make them fit for changing populations;
- integrating health and social care services to provide person-centred care;
- more care provided out of hospital, close to where people live;
- focussing on prevention and proactive management of health conditions;
- reducing health inequalities;
- and delivering financial balance.

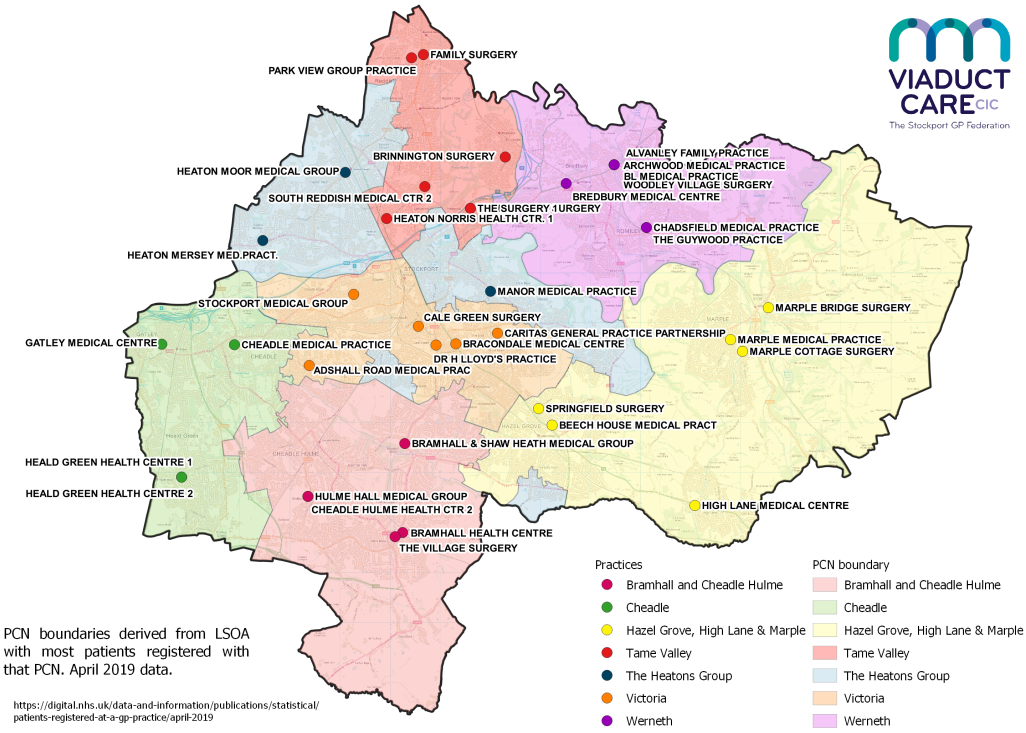
This strategy sets out how we intend to reform the health and care system to meet the growing and changing needs of our population within the available budget.

[1] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
[2] https://www.england.nhs.uk/long-term-plan/
[3] http://www.gmhsc.org.uk/our-plans/
[4] http://www.stockportccg.nhs.uk/stockport-joint-health-and-wellbeing-strategy-2017-2020/
[5] http://www.stockportccg.nhs.uk/have-your-say/stockport-together-plan/key-documents/business-cases-and-summaries/

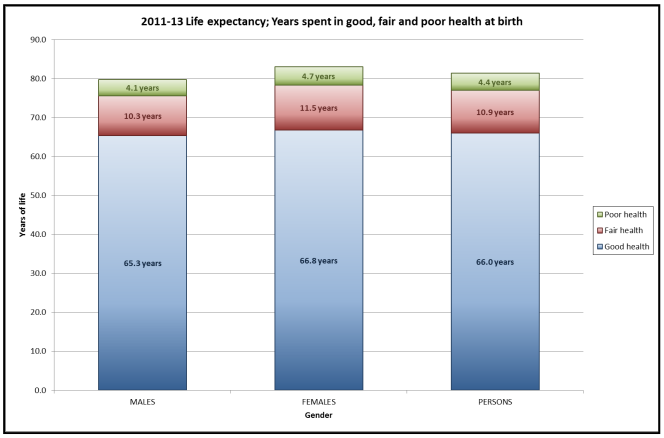
Context (cont.)

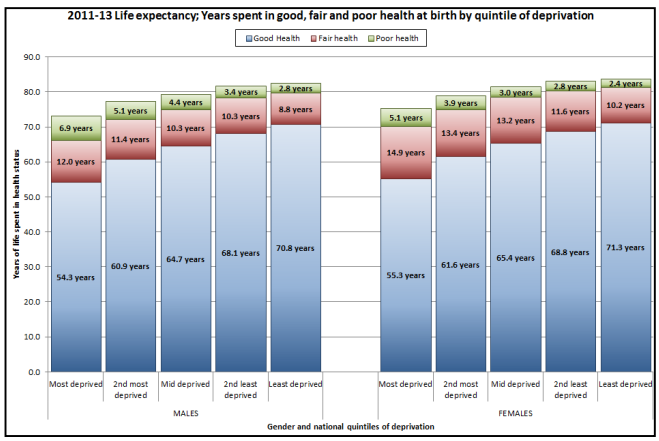
2.3 Our Population

Stockport sits in the South East of Greater Manchester, bordering on the city to the North and on the countryside of Cheshire to the South. Stockport has a population of **291,045** residents, with **313,610**[6] people registered at one of Stockport's 37 GP Practices (see appendix 1). Our population is growing by around 1,000 people a year and is expected to continue to grow at this rate over the life-span of this Strategy.



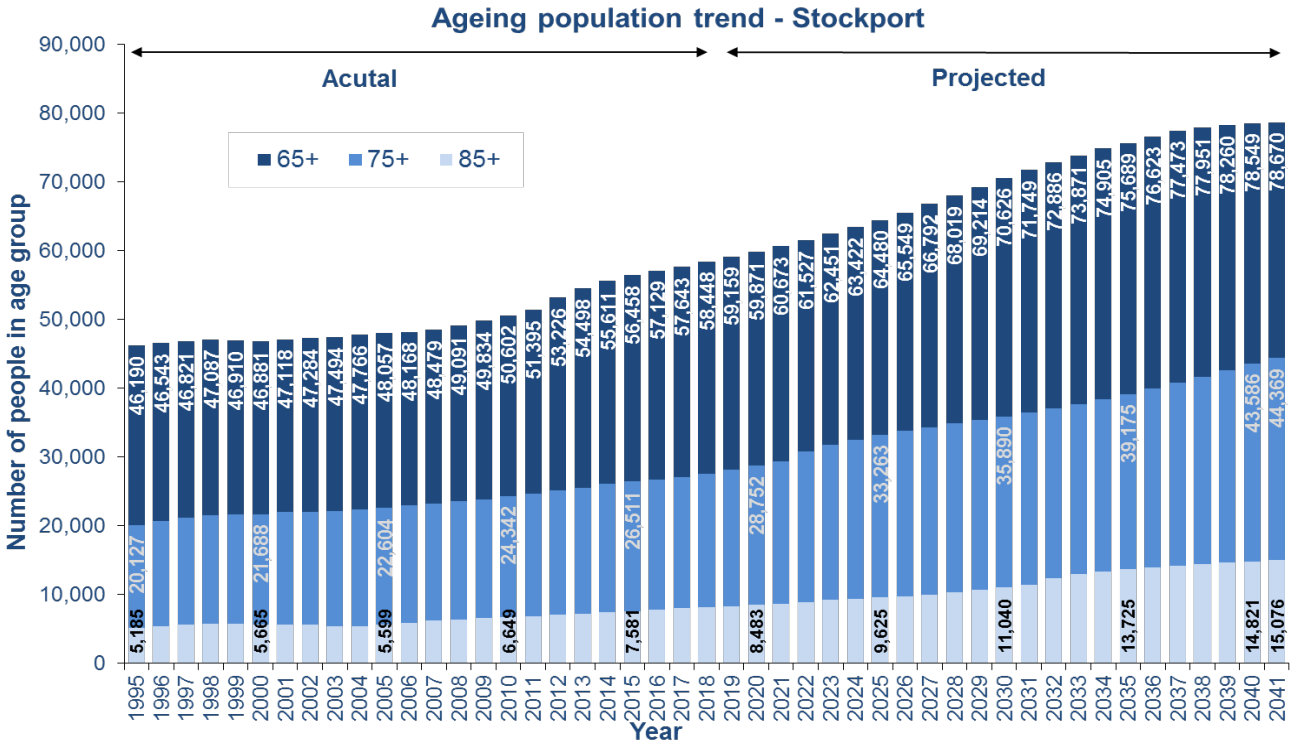
Stockport continues to be one of the healthiest places to live in the North West, with health outcomes similar to the national average. Life expectancy is high, at 83.3 for women and 79.8 for men. Within the borough, however, there is a significant difference in health outcomes between Stockport's more affluent and deprived areas, with men in Bramhall South living 11 years longer than those in Brinnington & Central. Perhaps more significantly, in the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas.



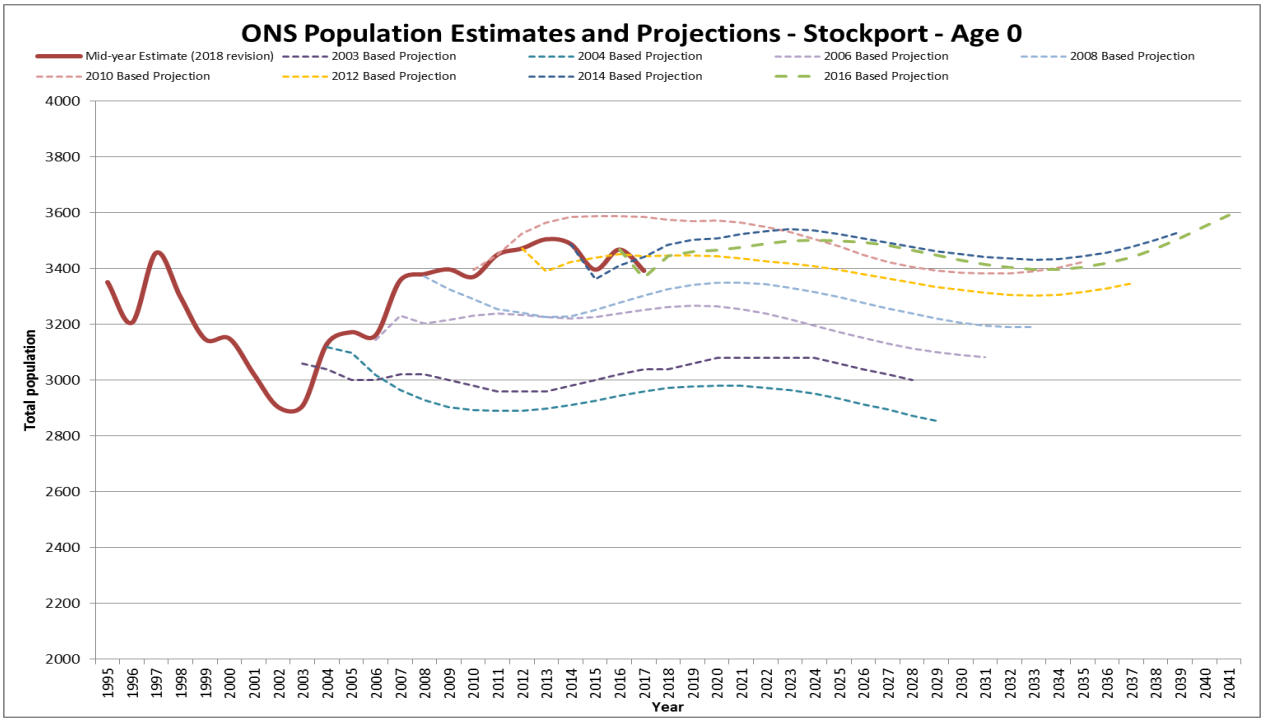


[6] GP registers vary from the resident population as they may include patients who live in a neighbouring borough or students who have gone to university but want to remain registered with their family GP.

Stockport has the oldest age profile in Greater Manchester and the population continues to age. Currently 19.8% of people are aged 65+ and this is likely to rise to 21% by 2024, with an additional 5,800 people aged 65 or over.

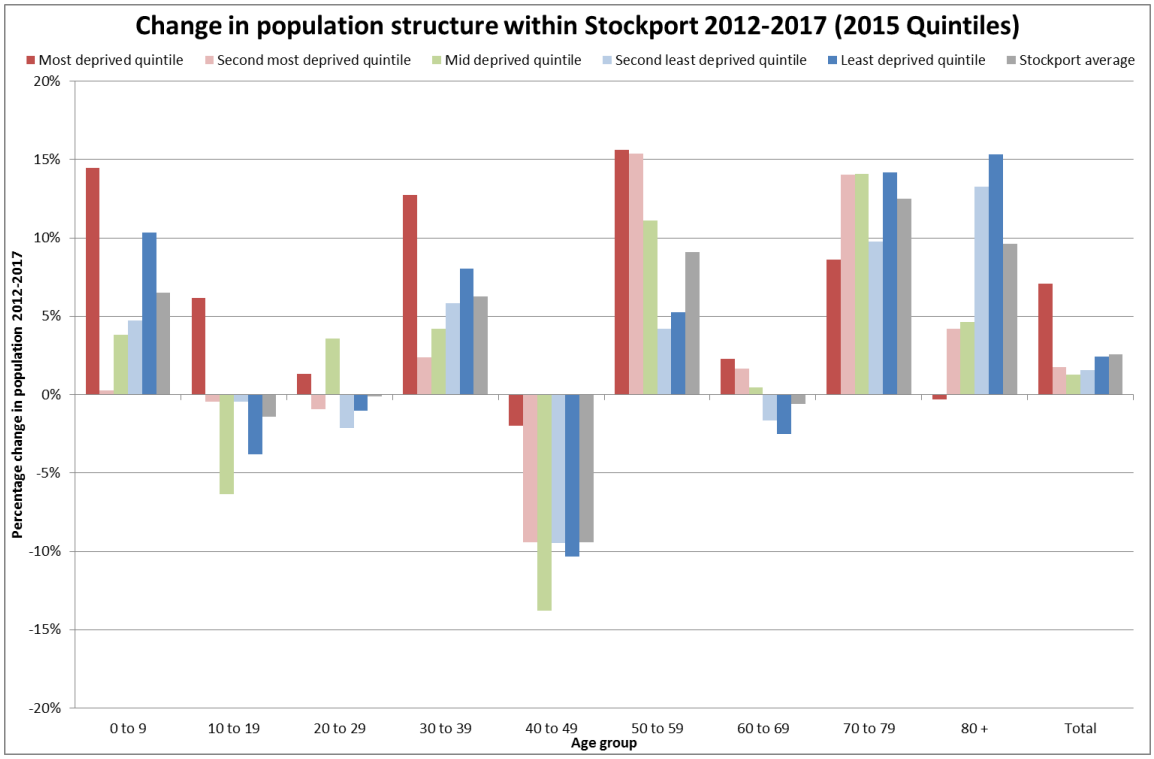


The number of children and young people in Stockport is also rising - though at a lower rate than our older population. There are currently more births than deaths each year, so the population is expected to continue to grow.

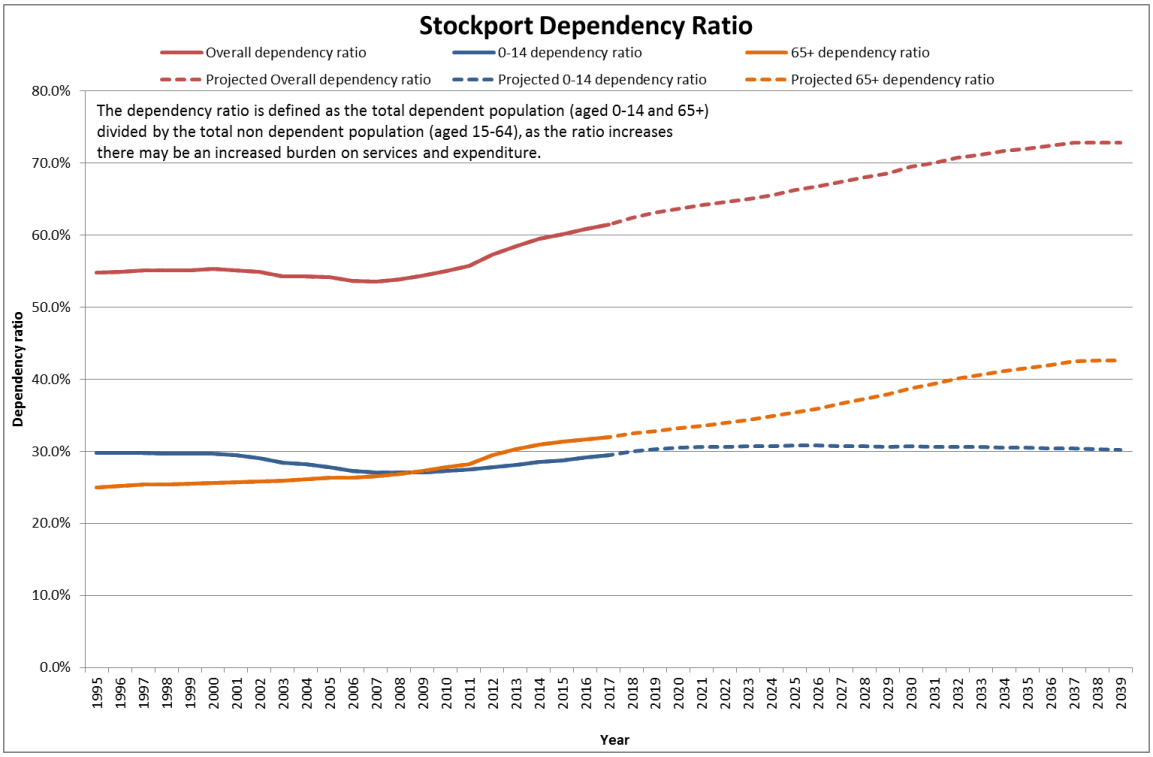


Context (cont.)

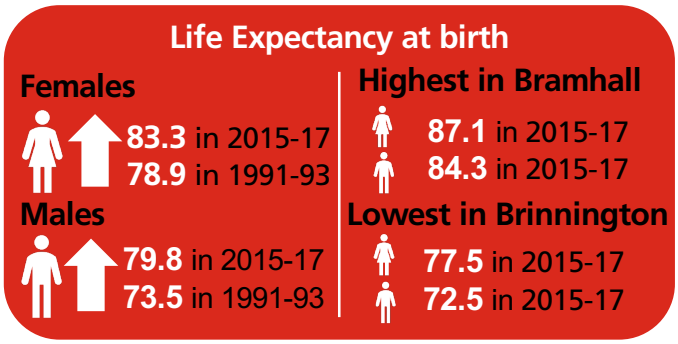
Birth rates and population growth are higher in the most deprived populations and, as a result, the level of need for services is rising, with particular growth experienced by better awareness and identification of children and young people with autism and with special educational needs and disabilities (SEND).

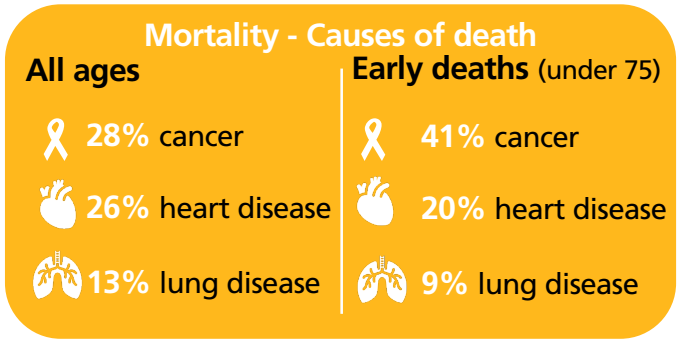


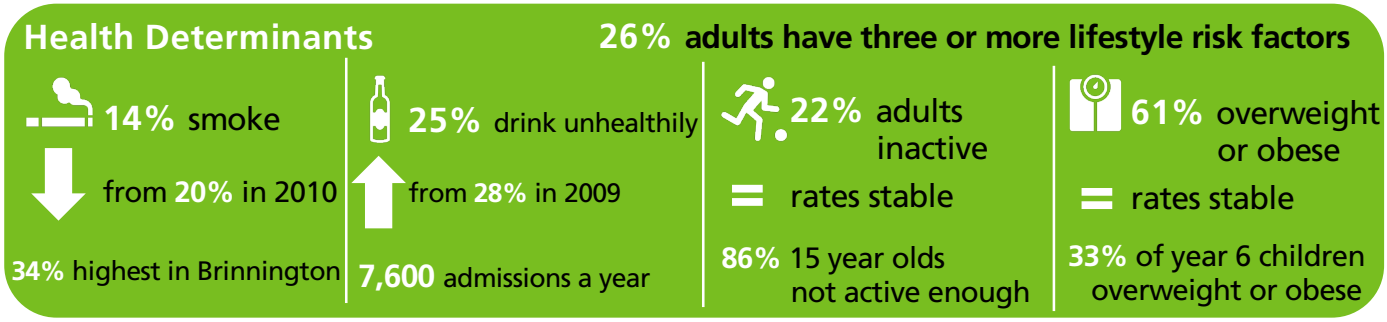
These trends - growth in older and younger population groups - act together to mean that the levels of dependency in Stockport are rising. This has a significant impact of health and care services as these are the population groups that tend to have more healthcare needs.

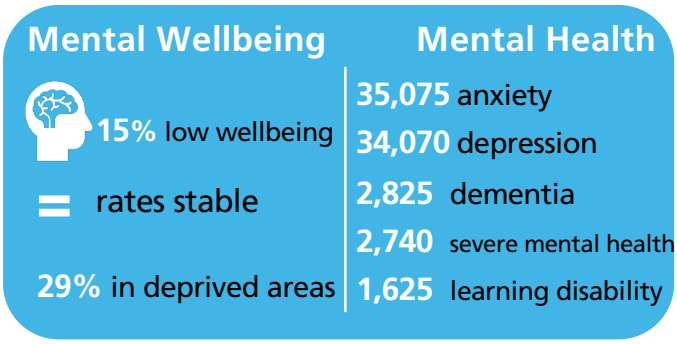


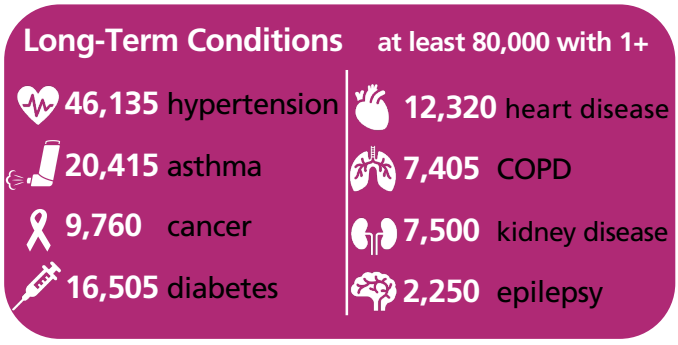
Stockport's population has a wide range of health needs.











Cancer is the main cause of death in Stockport, but 40% of cancers are preventable as a result of lifestyle choices such as improved diet and exercise. Liver disease is the only area where mortality rates in Stockport are significantly worse than the national or peer average, making alcohol consumption a key issue for the borough.

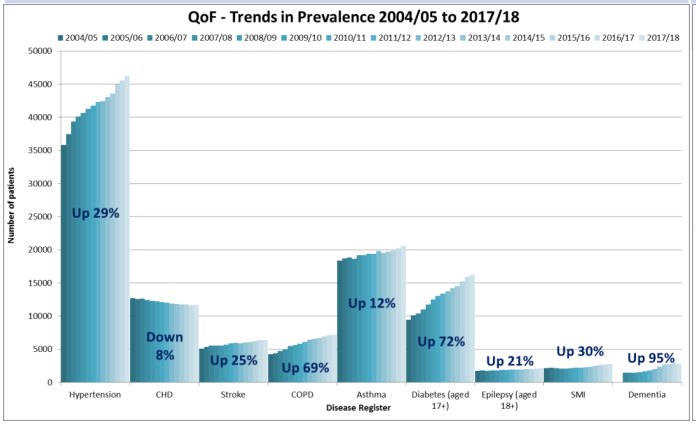
40% of people registered with a Stockport GP have one or more long-term health conditions - this is associated with increasing complexity of care co-ordination needs in the borough (see full list in appendix 3). Hypertension is the most common condition, affecting 46,135 people. Asthma is the major condition affecting school aged children with more than 2,000 cases - and anxiety is the major long-term condition among young adults, the latter affecting over 3,000 people between the ages of 15 and 24.

Prevalence of long-term conditions continues to increase, and at a level more rapid than the population increase. Dementia, Diabetes and Chronic Obstructive Pulmonary Disease (COPD) are the fastest growing long-term and life-limiting conditions in Stockport. Both the number and prevalence of long-term and life-limiting conditions have grown, the former slightly more than the later due to population growth.

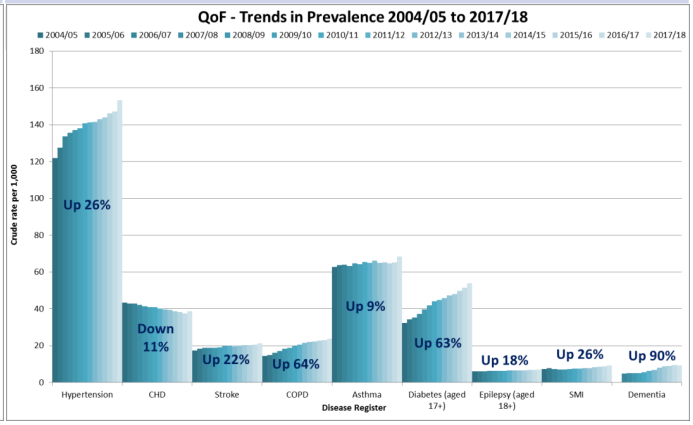
Context (cont.)

Long-Term Conditions Trends 2004/05 - 2017/18

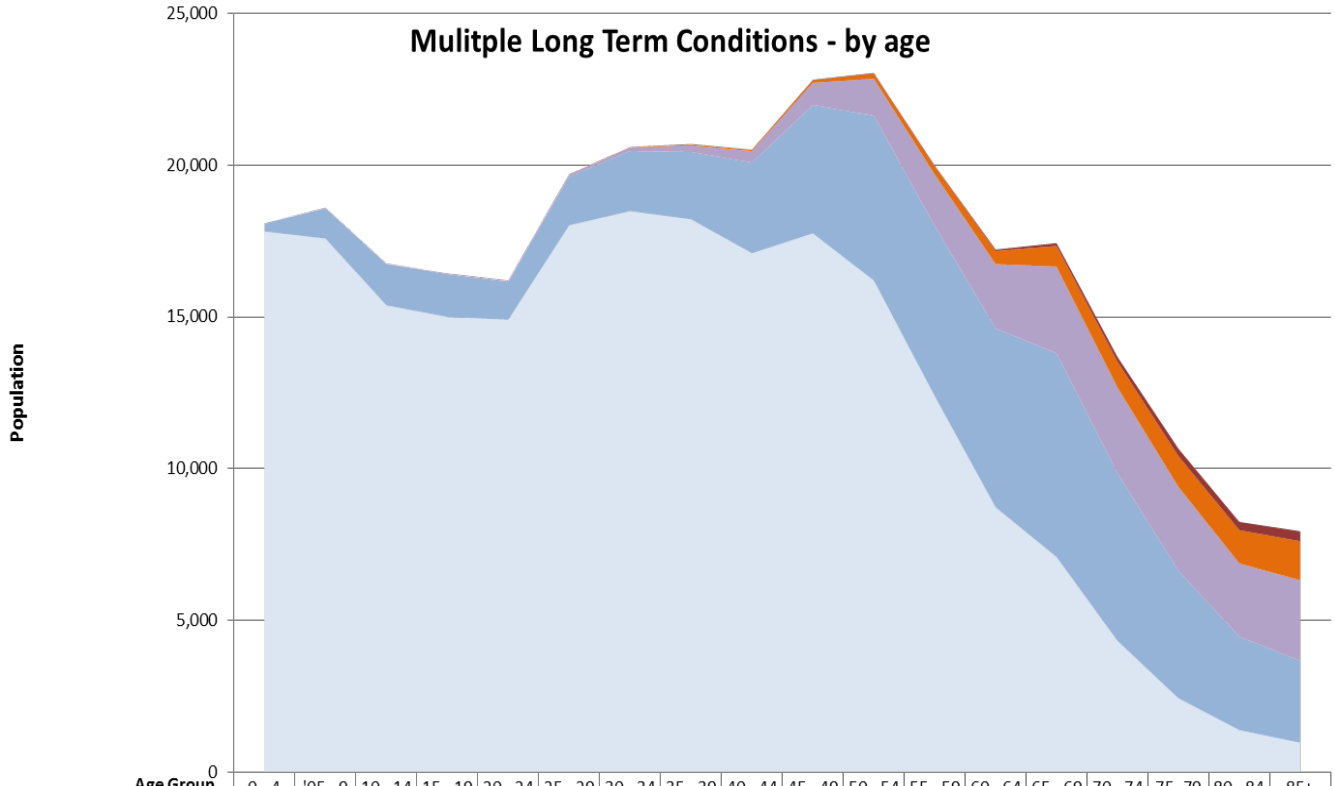
Number



Crude rate per 1,000 population



In line with national trends, long-term conditions are more common among older population groups and as they age, people are more likely to have more than one condition. By the age of 55, half of the population has at least one long-term condition.



Age Group	0 - 4	'05 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85+
4+ of 8 key conditions	0	0	0	0	0	0	0	3	5	13	16	23	41	93	157	246	272	326
3 of 8 key conditions	0	0	0	1	1	3	6	31	37	83	171	266	436	680	845	1010	1094	1287
2 of 8 key conditions	2	9	10	22	44	76	119	223	383	738	1216	1697	2121	2852	2829	2764	2412	2649
1 of 8 key conditions	264	1002	1365	1405	1241	1601	1985	2217	2983	4223	5430	5601	5892	6711	5516	4198	3077	2700
None of 8 key conditions	17816	17583	15383	15004	14909	18019	18485	18218	17099	17754	16202	12396	8730	7095	4333	2445	1396	979

More information about our population and local health needs can be found on Stockport's Joint Strategic Needs Assessment website - www.stockportjsna.org.uk .

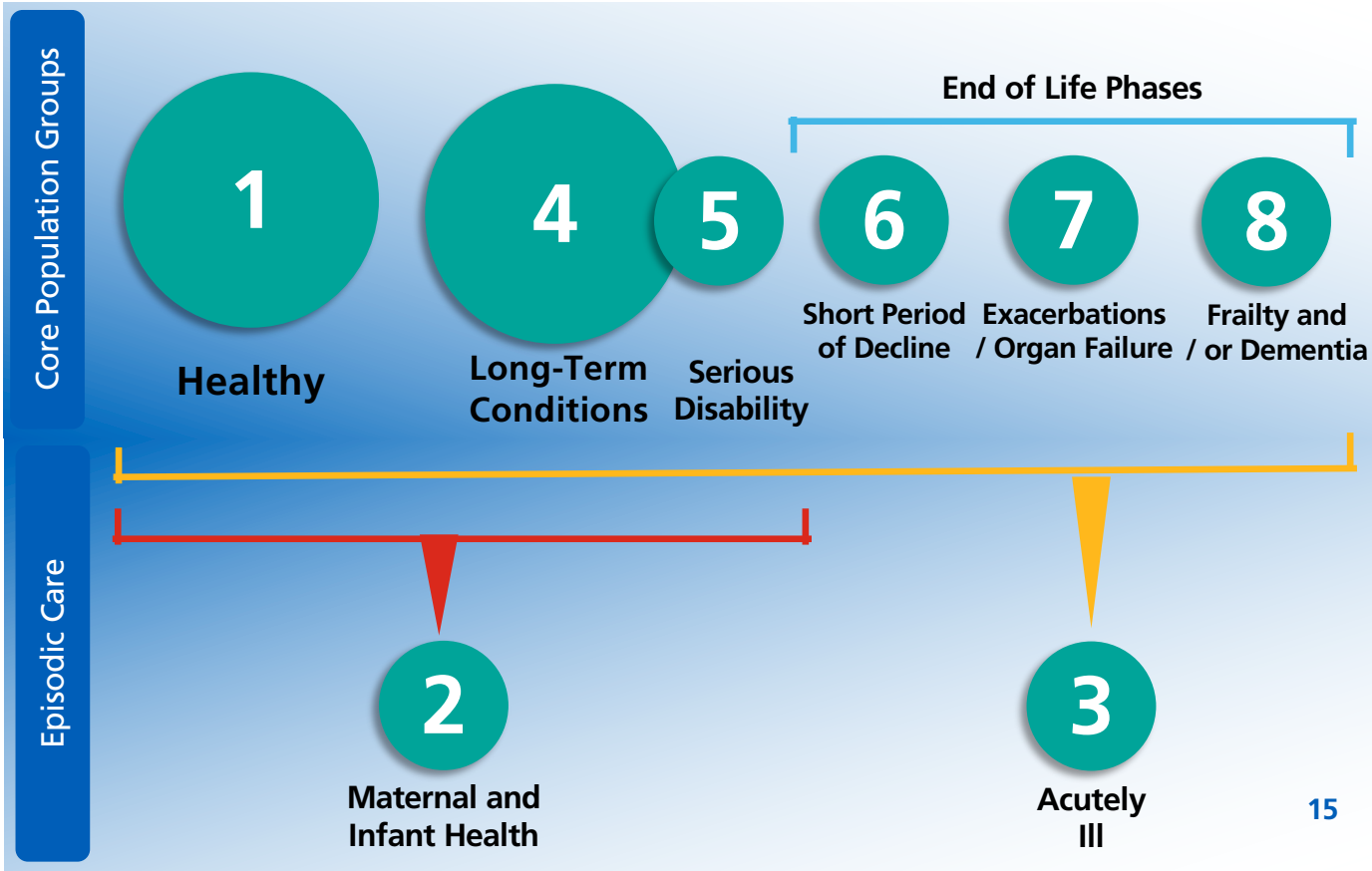
2.4 How will care be organised

In the past, the NHS has been organised by service or specific health conditions. As a result, services only treated a single condition and patients with multiple conditions had to navigate a range of services that did not "talk" to each other. This has led to wasted time for patients and carers; duplication in assessments and tests; potentially conflicting advice from healthcare professionals looking only at their area; different services prescribing various treatments or medications that may not work well together; and our most vulnerable patients or their carers being left with the responsibility of coordinating their care.

We recognise that people are more than just their health condition and that within our population there are differences in ability to participate in care. To improve health outcomes, patient experience and efficiency, we need services that can be more responsive to the individual's needs and ability to participate. To support this, a fundamental part of our strategy is to put patients at the heart of our services and tailor care to their individual needs by asking services and professionals to work together. This includes professionals working in fields outside of the NHS that have a major impact on health, such as housing, benefits and local community groups.

At a commissioning level, we intend to identify population need through the eight segments of the 'Bridges to Health' model (Lynn et al, 2007), so that services can be designed to better meet these needs.

Population segments using the 'Bridges to Health' Model:



Context (cont.)

We intend to reform the incentives and payments made to healthcare providers to support the design and delivery of new models of care, shifting the focus of care onto the delivery of improved outcomes.

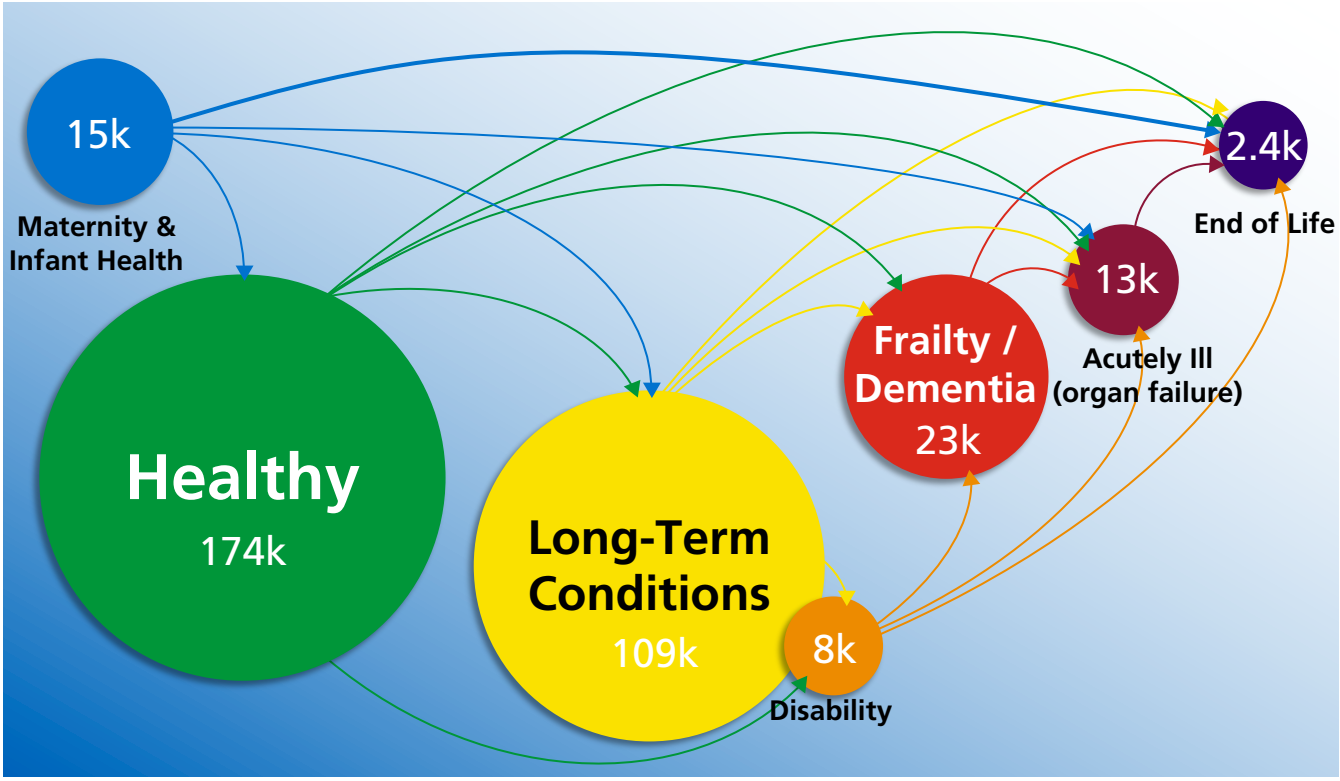
By grouping our population, we can:

- understand the distinctive needs of different parts of the population;
- prioritise the services that are most important to our population;
- define the combinations of care people might need;
- understand the strengths and assets in our communities;
- bring services and professionals together to coordinate and deliver the care needed;
- assign relevant budgets to population groups, changing the payment system to incentivise services to work together and deliver outcomes for the local population (BCF, 2014).

Throughout their life course, people tend to move through segments of increasing acuity as depicted below. Not everyone will go through all segments in their life course and some may cross over into more than one segment at a time.

The numbers on the figure below illustrating flows between population segment provide an estimation of the number of people in each segment in Stockport. The figures reflect the fact that many people will fall into more than one population group at any given time.

Flows between population groups:



Collaborating with local service users, Stockport has led the way in developing a framework against which to specify outcomes. This brings together what is important to people in each of these groups and identifies the clinical, social and personal outcomes they would like to see. The framework will be embedded into our future contracts and used to incentivise delivery of positive health and wellbeing outcomes (see appendix 4).

2.5 Our Services

NHS Stockport CCG manages 149 contracts with a wide range of local providers to deliver the following services:

- *Primary Care* (including: GP practices & Federation; pharmacy; dentistry; ophthalmology)
- *Community Healthcare* (including district nursing; podiatry; diabetic clinics)
- *Intermediate Care* (including: crisis response; community beds; rehabilitation at home)
- *Continuing and Complex Healthcare* (including: case management; nursing care; rehab)
- *Mental Health* (including: all age services for severe mental illness; access to talking therapies; eating disorders; dementia care and treatment)
- *Planned Hospital Care* (including: diagnostics; outpatient clinics; surgery; cancer care; maternity)
- *Urgent Care* (including: out-of-hours GPs; ambulance service; Emergency Department).

On average, each year in Stockport there are around:

- **1,000,000** GP Practice consultations
- **350,000** outpatient consultations
- **508,000** community healthcare contacts
- **141,000** contacts with mental health services
- **105,000** A&E attendances
- **92,000** inpatient admissions
- **39,700** emergency admissions
- **8,500** adult social care clients
- **1,300** people receiving Continuing Healthcare

Context (cont.)

All of Stockport's 37 GP Practices have been rated as 'Good' or 'Outstanding' by the Care Quality Commission. The main hospital provider - Stockport NHS Foundation Trust - was rated as requiring improvement, with examples of good practice in community services, end of life care and caring for patients. The trust also received an outstanding rating for the community health services provided for children and young people. Our main mental health service provider - Pennine Care - was rated overall as requiring improvement, with an acknowledgement of significant improvements. 81.3% of local nursing homes and 74.9% of residential care homes were also rated as 'Good' or 'Outstanding'.

Nationally, CCG performance is rated on a range of measures through the CCG Improvement & Assessment Framework (IAF)[7]. Stockport has been rated as 'outstanding' on two clinical areas - cancer and dementia - and seen significant improvements in diabetes and mental health.

CCG Improvement & Assessment Framework - Clinical Ratings				
Area	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Cancer	Top Performing	Outstanding	Outstanding	No assessment
Dementia	Top Performing	Outstanding	No assessment	Outstanding
Diabetes	Greatest need for Improvement	Requires improvement	No assessment	Requires improvement
Learning Disabilities	Needs improvement	No assessment	No assessment	Requires improvement
Maternity	Needs improvement	No assessment	Requires improvement	No assessment
Mental Health	Greatest need for Improvement	Requires improvement	No assessment	Good

The CCG is in the top performance quartile nationally for 12 measures, including those related to primary care, child health, dementia and cancer. 6 measures remain where the CCG performs in the worst quartile nationally, these relate mainly to urgent care and health inequalities. From 2019/20 onwards, CCGs will be rated through the NHS Oversight Framework[8].

Compared to other areas, Stockport's health and care system relies heavily on hospital care, with high rates of hospital admissions for conditions which could normally be treated out of hospital. While the number of people going to A&E is below the national average, patients are less likely to be treated within the 4 hour target and are more likely to be admitted to a hospital bed.

Over recent years, transformation work and investment in community services has allowed Stockport to stem the growth in non-elective hospital admissions, going against the national trend, whilst planned care has continued to grow.

[7] https://www.england.nhs.uk/commissioning/regulation/ccg-assess/
[8] https://www.england.nhs.uk/publication/nhs-oversight-framework-for-2019-20/

There are considerable opportunities to improve productivity in cardiology and respiratory services, where Stockport spends significantly more than peers. Across all specialisms, reducing the high rate of hospital admissions could realise significant savings for the economy to reinvest in care outside of hospital[9].

In respect of patient experience of care, Stockport performs very well. With the exception of ambulance services, which are rated across all of Greater Manchester, over 85% of patients rate local services positively.

Patient Experience in Stockport		
Service	***Source***	***% rated positively***
GP Practices	GP Patient Survey[10] (Aug 2018) Friends & Family Test[11] (GM Apr 2019)	88% 90%
Community Services	Friends & Family Test (SFT Apr 2019)	93%
A&E	Friends & Family Test (SFT Apr 2019)	87%
Ambulance	Friends & Family Test (GM Apr 2019)	69%
Cancer	CCG IAF - cancer patient survey	89%
Inpatients	Friends & Family Test (SFT Apr 2019)	95%
Outpatients	Friends & Family Test (SFT Apr 2019)	91%
Maternity	Friends & Family Test (SFT Apr 2019)	99%
Mental Health	Friends & Family Test (Pennine Apr 2019)	88%

2.6 Local Views

NHS Stockport CCG is committed to working with local people to improve health and secure high-quality healthcare for the people of Stockport, now and for future generations. We want everyone to have greater control of their health and wellbeing, and to be supported to live longer, healthier lives with high quality health and care services that are compassionate, inclusive and constantly improving.

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

Public involvement helps us to understand local needs and to prioritise those people who experience the poorest health outcomes, enabling us to improve access and reduce health inequalities.

[9] https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-stockport-jan17.pdf
[10] https://www.gp-patient.co.uk/
[11] https://www.england.nhs.uk/publication/friends-and-family-test-data-april-2019/

Context (cont.)

Local involvement provides opportunities to see things differently and to be innovative, leading to a better use of our limited resources. A number of ways in which we have involved and engaged local people and communities include:

- Briefings, presentations and workshops at Healthwatch Stockport;
- Stockport Citizens Panel;
- Stockport Partnership Involvement Network
- South East Sector Healthier Together Public Voice;
- Online engagement through our 'Have Your Say' website[12];
- Public meetings;
- Presentations at local groups;
- Focus groups; Community forums; Workshops
- Prevention and screening events;
- Digital channels (including blogs, websites, social media surveys and polls)
- Print Media (including press releases, paid media and advertising campaigns)
- Patient story podcasts; and
- Healthwatch attendance at Governing Body and CCG Committee meetings.

The CCG and our partners used co-production to involve patients, carers and frontline staff in developing detailed pathways and designing our new models of care. This was followed by a full consultation[13] on the Stockport Together business cases, which form the basis of our plans.

The main themes emerging from our on-going conversations include:

- strong support for health and social care services working together to support patients;
- the need to share data so that patients don't have to repeat their story to multiple services;
- where appropriate, delivering more care closer to home - this included a clear preference to die at home rather than in an institutional setting;
- focussing on keeping people well, rather than fixing them when they become ill;
- better access to primary care 7 days a week, with a wider range of services;
- a willingness to use technology to improve services and for the provision of information;
- investment in mental health services, including dementia care, and support for carers;
- improvements in the support for younger people;
- and improved choice, including expanding our integrated offer to include third sector services.

These views were used to help construct our plans, which were then discussed with: CCG staff; GP member practices; Stockport's Clinical Reference Forum; Public Health; Healthwatch Stockport; and Stockport's Citizens Reference Panel.

Feedback from all of these events has been used to help develop this Strategy. A full write up on patient and public involvement can be found in appendix 5.

[12] https://stockport-haveyoursay.citizenspace.com/
[13] http://www.stockportccg.nhs.uk/have-your-say/stockport-together-plan/

Our Mission

Our mission is to fundamentally improve health and wellbeing in Stockport

NHS Stockport Clinical Commissioning Group was established in 2013 to manage the local healthcare budget and contract with healthcare providers to deliver services meeting the health needs of the 313,000 patients registered with a Stockport GP. We are a membership organisation, made up of our 37 GP Practices. We buy health and care services on behalf of patients registered with Stockport GPs. The services that we are responsible for include:

- GP care;
- planned hospital care;
- urgent and emergency care;
- rehabilitation;
- community health services;
- mental health;
- learning disability services;
- packages of care at home or in a care home.

We also work closely with patients, their carers, health and social care partners to ensure services meet local health needs.

Our core purpose is to understand local needs; to prioritise and effectively commission services with our partners that meet those needs within the available budget; to work with our members and communities to continuously improve outcomes; and empower people to make healthy life choices that promote independence, and manage their conditions.

Our Vision

Our vision is to achieve a person-centred health and care system, where everyone has the best possible start in life and is supported to live well, age well and die well

Our vision underpins the organisation's approach to everything it does to help improve health and care services across the borough and achieve better outcomes for all of Stockport's residents, reducing health inequalities between different groups in our community.

The CCG recognises that our vision requires a collaborative approach to deliver the best outcomes for local people. We are an active partner in Greater Manchester's devolved Health and Social Care Partnership, working with partners across Stockport and the city region to improve health and re-shape services around the needs of our communities.

The CCG strongly believes that place-based reform (GMCA, 2018) is the right approach for Stockport, integrating services within our neighbourhoods to deliver care designed around local needs that focuses on prevention and reduces dependence on specialist care.

To deliver this, we will transform the health and care system over the next five years to create:

- **streamlined strategic commissioning;**
- **enhanced self-care, promoting independence and active prevention;**
- **proactive, person-centred care for those who need it, delivered though integrated service provision;**
- **reformed specialist services in hospitals and other settings;**
- **facilitated by appropriately aligned payments and incentives to improve outcomes for our population.**

Local change will be delivered collaboratively with colleagues, not just across health and social care, but through the wider public sector, including transport, housing, town planning, as well as voluntary organisations and community groups. We will also deliver change across the city region through the Greater Manchester Health & Social Care Partnership.

Our Values

We care about what we do and believe our work matters for local people. In the work we do we will be:

person-centred

caring, compassionate, valuing people and communities

quality focussed

ensuring care delivers outcomes, adopting innovative ways of working and embracing technology

collaborative

involving patients, our members, partners, and the public and removing organisational boundaries to deliver care

professional

fair, respectful, trustworthy, systematic and evidence based, providing high levels of challenge to the system, supported by trust and mutual respect

The CCG's values inspire the organisation to co-design and commission high quality services with patients, families and their carers. The organisation aims to meet local needs, deliver improved health outcomes and demonstrate best practice with partners.

This same spirit is driving the organisation to continue to widen our partnership working, with the goal of transforming the whole health and care system in Stockport as part of devolution across Greater Manchester.

In doing this, the driving principles in how we deliver changes are:

- **Reducing Inequalities** between different groups in our community
- **Co-Production** of services, designed with patients and professionals.
- **GP-Led Care** delivered through our new neighbourhood model
- **Digital First** as a means of improving access, services and efficiency.

As public servants, we work to the Nolan Principles[14] of public life:

selflessness	act solely in terms of the public interest
integrity	do the right thing and avoid conflicts of interest
objectivity	act and take decisions impartially, fairly and on merit, using the best evidence, without discrimination or bias
accountability	accountable to the public for decisions and actions
openness	act and take decisions in an open and transparent manner
honesty	be truthful
leadership	exhibit these values in own behaviour; actively promote the principles; challenge poor behaviour wherever it occurs

[14] https://www.gov.uk/government/publications/the-7-principles-of-public-life

Strategic Aims & Objectives

The CCG exists to improve local health and care for people in Stockport, and we have a role in co-ordinating and leading the health care system to achieve this. On behalf of our population we must balance four critical requirements:

- improving local population health;
- ensuring the best quality care;
- optimising experience of care; and
- providing value for tax payers.

Strategic Aims		Strategic Objectives
	**Start Well** We will ensure that everyone in Stockport has the best possible start in life	• improve the quality and safety of maternity services
		• commission comprehensive physical and mental health services for children and young people, including those with special educational needs and disabilities
	**Live Well** We will support everyone to live well, make healthy choices, prevent ill health and proactively manage health conditions as close to home as possible	• empower people to look after themselves and make good choices that prevent ill health
		• improve early identification of health conditions
		• reduce health inequalities faster
		• empower people to live well and proactively manage long-term conditions
	**Age Well** We will support everyone to age well and remain independent for as long as possible	• support people to remain healthy and independent as long as possible
		• ensure that people can access high quality care when necessary
	**Die Well** We will support patients and their families at the end of life	• patients and their families will receive high quality support at the end of life
		• support more people to die in the place of their choosing
	**Lead Well** We will reform the health and care system in Stockport to build a sustainable system for future generations	• ensure financial balance across the system
		• co-produce services with patients & professionals
		• implement new and sustainable models of care
		• continuously improve the quality & safety of care
		• build a sustainable, highly skilled and supported workforce

These objectives will ensure that NHS Stockport CCG focuses on improving services across Stockport so that residents receive integrated health and social care that is designed to keep them well, rather than focusing on treating their symptoms when they become ill.

Strategic Improvement Measures

These improvements will ultimately deliver:

- Improved health and wellbeing with an emphasis on prevention, self-care and independence;
- A reduction in premature mortality from preventable causes, with healthy life expectancy increasing fastest in the most deprived areas of Stockport;
- More people feeling supported to manage their condition;
- High quality services working together to deliver improved outcomes;
- More people who would recommend local services;
- More people at end of life supported to die in their preferred place;
- A financially sustainable health and care system;
- Delivery of the NHS constitutional standards.

Progress will be measured through the Strategic Improvement Measures set out below.

Measures have been selected to deliver on those priority areas where we hope to see significant improvements as a result of our efforts.

Further measures can be found in the Delivery Programmes, allowing the CCG to track progress on delivery of a wider range of national and local standards. Detailed trajectories will follow in the Locality's response to the Long Term Plan Implementation Framework[15].

The Strategy will also support progress against the new NHS Oversight Framework[16].

[15] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf
[16] https://improvement.nhs.uk/resources/nhs-oversight-framework-201920/

Strategic Improvement Measures				
Aim	**Objective**	**Measure**	**Baseline**	**Target**
Start Well	Improve the quality and safety of maternity services	Increase choice in maternity services to the national standard	56.64%	60.4%
		Full implementation of the Better Births standards	Compliant with 5 standards	All 10 standards delivered
	Commission comprehensive physical and mental health services for children and young people, including those with special educational needs and disabilities	Full implementation of SEND standards	Ofsted recommendations	Full delivery
		Reduce emergency hospitalisation for asthma, diabetes and epilepsy in under 19s to under 400	556.4 per 100,000	Under 400 (national level 272.7)
		Improve access to children's mental health services above the national target levels	37.4% in 18/19	50% (national target 35%)
Live Well	Empower people to look after themselves and make good choices that prevent ill health	Uptake of patient education courses		
		Improve antimicrobial resistance to the national average	1.097	0.965
		Reduce alcohol-related hospital admissions to the national level	689 per 100,000	632
	Improve early identification of health conditions	Increase uptake of breast cancer screening to national average	72.9%	74.9%
		Increase uptake of bowel cancer screening in deprived areas to the Stockport average	53.8%	62.5%
	Reduce health inequalities faster	Reduce inequalities in life expectancy to under 10 years	11 years	under 10 years
		Reduce inequalities in healthy life expectancy to under 15 years	17.3 years	15 (out of worst performance quartile)
	Empower people to live well and proactively manage long-term conditions	Reduce unplanned hospitalisation for chronic conditions to the national average	1,150 per 100,000	822 per 100,000
		Reduce population use of hospital beds following an emergency admission to the national average	601.73 per 1000	499 per 1000
		Increase access to personal health budgets – doubling uptake	17.96 per 100,000	40 (national average 60)
		Reduce early deaths among people with serious mental illness by 150	334.2	200 (Stockport rate for people without SMI 100)

Aim	Objective	Measure	Baseline	Target
Age Well	Support people to remain healthy and independent as long as possible	Reduce the rate of injuries from falls among over 65s to the national level	2624 per 100,000	2051
		Reduce delayed transfers of care to the national average	11.85	10.4
		Continue to reduce early deaths from cancer	136.7	134.6 nationally
		Reduce early deaths from liver disease to the national level	25.0	18.5 nationally
	Ensure that people can access high quality care when necessary	Full delivery of NHS access standards	Full year delivery of 11/30 constitutional standards in 18/19	Full compliance with all standards
Die Well	Patients and their families will receive high quality support at the end of life	Reduce emergency hospital admissions during last weeks of life to the national average	5.99%	5.4%
	Support more people to die in the place of their choosing	Maintain our above average rate of people dying in their usual place of residence	47.6%	Maintain above national levels (46.6%)
Lead Well	Continuously improve the quality and safety of care	All providers rated as 'good' or 'outstanding' by the CQC	SFT – requires improvement PCFT – requires improvement 100% GPs 81.3% nursing homes 74.9% residential care	All 'Good' or 'Outstanding'
	Ensure financial balance across the system	Balance the books across the economy	£156m deficit of by 2021 if do nothing	Surplus levels
		Reduce spend on EUR procedures to the GM average	£15.39 per head of population	£12.17
	Implement new and sustainable model of care	Outcomes Framework in all contracts	0 contracts	149 contracts
	Continuously improve the quality and safety of care in Stockport	Full delivery of NHS standards	Full year delivery of 11/30 constitutional standards in 18/19	Full compliance with all standards
		Secondary care providers that are fully digitised	None	All secondary care providers by 2024
	Build a sustainable, highly skilled & supported workforce	Consistently high staff satisfaction levels	SFT 69% 2017	Consistently high

Delivery Programmes

Delivery of our Strategic Plans will be undertaken through the six key work programmes, set out below, which reflect how individuals move through population segments in the Bridges to Health model.

Detailed 3-year plans will be developed for each delivery programme and feed into the CCG's annual operational plans.

Central to each delivery programme are the common strands of:

- Prevention and self-care;
- Proactive management of conditions when they arise;
- Reducing health inequalities;

This can only be achieved through collaborative working across a range of partner organisations to fully implement Stockport's new model of care.

Primary & Community Care

Maternity & Children

Mental Health, Learning Disabilities & Autism

Planned Care, including Cancer

Urgent Care

Enablers

Primary & Community Care

Overview

Stockport has long benefited from a high quality Primary Care service. Our 37 GP Practices have the best patient satisfaction levels in Greater Manchester and all have been rated as *Good* or *Outstanding* by the CQC.

There have been significant changes in the way people access care since the NHS was established more than seventy years ago. Many people now work long or irregular hours and may not have the same support structures in place as previous generations to look after loved ones if they become unwell. More people now use technology to get answers about health or access appointments and test results via phones or email and by using apps to help manage health and other aspects of life.

These societal changes mean that the traditional model of how health and care is provided has become less relevant. More focus and resources need to be directed towards preventing ill health, keeping people out of hospital and in their homes, maintaining independence and adapting services for a growing, ageing and technology enabled population. As a Vanguard site, Stockport piloted the MCP model of care, putting our strong GP practices at the heart of our integrated service. Over the past year, we have launched a number of community-based services to help keep people safe and independent by providing services at home or close to home.

Where we are now?

Stockport's Primary Care services are rated in the top performance quartile nationally for: provision of high-quality care; appropriate prescribing of broad-spectrum antibiotics in primary care; patient experience of GP services; and primary care access.

Stockport was ranked first nationally in 2018 for the hard work and dedication of GPs, nurses, pharmacies and the public health team in immunising people against flu with 97,134 residents vaccinated. Nationally, Stockport is in the top performance quartile for delivery of diabetes treatment targets and for our screening work, resulting in high one year survival rates from cancer. However, Stockport is in the worst performance quartile nationally for Injuries from falls in people aged 65 and over.

Over recent years the CCG has supported practices through the 'Time for Care' programme that has helped practice teams manage their workload, adopt and spread innovations that free-up clinical time and develop the skills and confidence to lead local improvement. In 2019, after the launch of the NHS Long Term Plan, Stockport's GP Practices came together to for 7 Primary Care Networks (appendix 1). The establishment of Viaduct Care, our GP Federation, has pushed forward our offer of 'Primary Care at Scale' by developing teams of pharmacists, advanced nurse practitioners, social prescribers and physiotherapists to work in our Primary Care Networks, releasing GP time to focus on patients with complex care needs and prevent unnecessary hospital admissions.

Our GP Federation, Stockport NHS Foundation Trust, Pennine Care, Stockport Metropolitan Borough Council and colleagues across the third sector have come together in a Local Care Organisation called Stockport Neighbourhood Care to build multi-disciplinary teams working together in Stockport's neighbourhoods to deliver services that meet the needs of local people 7-days a week.

Where do we want to get to?

We aim to provide a truly integrated health and social care service outside of hospital, led by our GPs. Over the next five years, the CCG will work closely with our partners to strengthen our new Primary Care Networks and align them to our neighbourhood teams, providing a comprehensive multidisciplinary service outside of hospital.

Our integrated teams will Find and Prevent disease and support people to self-care and improve their wellbeing, providing a better quality of life for patients and their families and increasing healthy life expectancy to close the health and wellbeing gap.

Neighbourhood teams will effectively manage long-term conditions outside of hospital, working seamlessly with our Intermediate Tier to provide essential community crisis response, intermediate care, reablement and home care services, 24/7, avoiding unnecessary admissions to hospital and supporting sustainable early discharge.

We will continue to work with our providers to ensure that only the most clinically cost-effective medications are prescribed and reduce medical waste.

We will fully implement the new Liberty of Protection Safeguards, which come into force in October 2020, taking responsibility for the safeguarding of any patient over 16 receiving Continuing Healthcare funding, regardless of whether their care is managed in an NHS provider, at home, or in a private provider.

In line with the NHS 10 Year Plan, we will continue to fully implement:

- a digital first primary care offer by 2023/24;
- trained social prescribing link workers;
- direct access to MSK First Contact Practitioners;
- extension of the lung health checks model;
- Enhanced Health in Care Homes model;
- HPV vaccination for all boys aged 12 and 13;
- HPV primary screening for cervical cancer;
- glucose monitors for patients with type 1 diabetes;
- specialist Alcohol Care Teams ;
- and set up an acute frailty service at least 70 hours a week, achieving clinical frailty assessments within 30 minutes.

Working in collaboration with Local Authority colleagues, we will also support our GPs to continue to deliver vital Public Health services, including NHS Health Checks, contraception, immunisation, cancer screening and lifestyle support.

How we will know we have arrived?

Start Well	• Maintain high rates of immunisation, reducing variation • All boys aged 12 and 13 offered HPV vaccination
Live Well	• Improved access to primary and community care • Increased use of community pharmacy services • Reduction in avoidable emergency admissions for ACS conditions • Maintain high rates of vaccination, with improvements in areas of deprivation • Increase uptake of screening, particularly in deprived areas and for breast cancer • Reduced inequality in life expectancy and healthy life expectancy • Fewer years of life lost to causes amenable to healthcare • Improve primary care prescribing of antibiotics • More adults physically active • Fewer adults overweight or obese • Fewer adults smoking, particularly in deprived areas • More people with a long-term condition feeling supported to manage their condition • Reduction in diabetes complications • Increased number of diabetes patients that have achieved all the NICE-recommended treatment targets • Increased attendance at diabetes education courses • Greater access to Personal Health Budgets • Increased use of telehealth options • Glucose monitors for patients with type 1 diabetes • Specialist Alcohol Care Teams. • Reduce stroke in people with diabetes and / or circulatory conditions • Ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke
Age Well	• Maintain high uptake of flu vaccinations by over 65s • Adoption of carers' passports • Improved quality of life for carers • Reduction in injuries from falls • Integrated frailty care in hospital and community • Acute frailty service 70+ hours a week • Reduction in pressure ulcers, chest infections and UTIs • Reduction in delirium • Fewer people requiring repeat emergency care within 30 days of discharge • Reduction in delayed transfers of care and stranded patients • Reduction in excess winter deaths among over 65s • Fewer early deaths from cancer • Fewer early deaths from liver disease • Reduced risk of sight loss • Delivery of constitutional standards on infection control
Die Well	• Reduction in emergency hospital admissions during the last weeks of life • More timely palliative care registrations in people expected to die • More people dying in the place of their choosing
Lead Well	• Integrated Care System at full maturity • 11,016 fewer 1st outpatient appointments • 19,018 fewer outpatient follow-ups • 1,620 fewer non-elective spells • Better use of the NHS e-referral service to enable choice at referral • More digital interactions between primary and secondary care

Maternity & Children

Overview

Providing a good start in life and supporting children to achieve their full potential is vital to improving population health. Only by focussing on the health and wellbeing of children can we start to reduce prevalence of long-term conditions and deliver a sustainable health and care system into the future.

Stockport's maternity services are well regarded locally with high patient satisfaction levels. However, Stockport's older than average population has meant that services for children and young people have not always been the priority they should be.

In September 2018, a Special Educational Needs and Disabilities (SEND) review was undertaken by Ofsted and the CQC. The report recognised the hard work and commitment of staff involved in providing support within education, health and social care and the real difference that they are able to make for local families. However, the report also resulted in a requirement to submit a Written Statement of Action, documenting how we will work in partnership with children, young people and their families to improve local services through joint commissioning, needs assessment and outcomes monitoring.

Where we are now?

Since the SEND report was published a series of co-production and engagement activities have taken place. Around 300 local families and carers have shared their experiences of supporting children and young people with SEND in accessing local services. There is a clear need for Stockport's health, care, education and school services to be more aligned and responsive to the needs of children and young people with SEND. This valuable feedback of experience has provided the foundation for Stockport's improvement work.

Stockport is in the worst performance quartile nationally for Choices in maternity care, but performs well with regard to smoking during pregnancy and neonatal mortality / stillbirth.

In terms of children and young people's health, Stockport performs well nationally, with below average levels of children aged -11 classified as overweight or obese.

Stockport Family has led the way in the borough in pioneering an integrated service for children, young people and their families, bringing together health, social care, education and community assets.

Where do we want to get to?

Our aim is to give every child in Stockport the best possible start in life and support young people to achieve their full potential. This begins not just with the newborn child, but with the mother's experience of pregnancy and birth.

We will improve the quality and safety of maternity services in Stockport, improving choice and fully implementing the Better Births standards and Saving Babies Lives care bundles. In doing so, we will continue to reduce neonatal mortality and stillbirth rates.

We will work with colleagues across Greater Manchester to reduce instances of Foetal Alcohol Syndrome Disorder and improve outcomes for those affected by FASD.

We will commission comprehensive physical and mental health services for children and young people, with supportive transitions to adult services.

We will fully implement the SEND recommendations and continue to improve children and young people's mental health services.

We will deliver quality and timely services to Looked after Children and to remove any unwarranted variation in accessing services.

We will take on joint responsibility for safeguarding children with the Local Authority and Police in line with the Children and Social Work Act (2017), improving outcomes for children.

We will work collaboratively with public sector partners across education, public health and social care to promote health and wellbeing.

We will support Public Health to improve key early years outcomes, including: reducing smoking in pregnancy; increasing breastfeeding rates; reducing child obesity levels; and childhood accident rates.

In line with the NHS Plan, we will implement:
- improved access to postnatal psychological therapies;
- continuous glucose monitoring to all pregnant women with type 1 diabetes;
- access to maternity notes through smart phones or other devices;
- designated keyworkers for children and young people with a learning disability, autism or both with the most complex needs ;
- vaccination against HPV-related diseases, such as oral, throat and anal cancer for all boys aged 12 and 13;
- faster growth in funding for children and young people's mental health services;
- full access to specialist community-based mental health services for people up to 25 and 24/7 access to crisis care via NHS 111.

How we will know we have arrived?

Start Well	• Improved choice in maternity services • Continued reduction in neonatal mortality and stillbirths • Maintain positive patient experience of maternity services • Improved access to perinatal psychological therapies • Implementation of the new Local Safeguarding Children Board • Promotion of the GMHSCP campaign to make every trimester a #drymester • Reduced smoking in pregnancy • Increased breastfeeding
Live Well	• Reduction in unplanned hospitalisation for asthma, diabetes and epilepsy <19 • Maintain high rates of vaccination, with improvements in areas of deprivation • Increase uptake of screening, particularly in deprived areas • More physically active children • Fewer children overweight or obese • Improved access to children's mental health services • Achievement of national standards for eating disorders • Reduction in hospital admissions as a result of self harm (10-24 years) • Support for young carers
Die Well	• Reduction in emergency hospital admissions during the last weeks of life • Support for families around still birth and sudden infant death
Lead Well	• Maternity digital care records available through smart phones and devices • Digital Red Books for children's immunisations • Full implementation of SEND improvement plan

Mental Health, Learning Disabilities & Autism

Overview

Over the past few years, Stockport has made significant investments into Mental Health services. As a result, the CCG's national rating for mental health services has improved from the 'greatest need for improvement' to 'good'.

Where we are now?

Nationally, the CCG is rated as 'good' for mental health services and 'outstanding' for dementia care. Stockport is in the top performance quartile nationally for IAPT recovery rates and the estimated diagnosis rate for people with dementia.

Over 2018/19 the CCG achieved the national mental health performance standards.

Measure		Target	Q1	Q2	Q3	Q4
E.A.3	IAPT access (target is 4.75% per quarter with an annual target of 19%)	19%	5.0%	4.8%	4.9%	5.0%
E.A.S.2	IAPT Recovery rate - the percentage of people who are moving to recovery during the reporting period.	50%	57.7%	55.8%	57.1%	56.3%
E.H.1	Percentage of people finishing course of IAPT treatment who are treated within 6 weeks of referral	75%	88.6%	82.4%	80.1%	87.3%
E.H.2	Percentage of people finishing course of IAPT treatment who are treated within 18 weeks of referral	95%	100%	99.3%	100%	99.4%
E.H.4	Percentage of people experiencing first episode of psychosis accessing treatment within two weeks.	50%	66.7%	81.0%	100%	100%
MH01a	Care Programme Approach - % of people followed up within 7 days of discharge from psychiatric inpatient care	95%	97.8%	98.4%	94.9%	89.3%

Pennine Care NHS Foundation Trust, the local provider of many mental health services, received a CQC rating of 'Requires Improvement' although it was highlighted that a number of improvements had been made since the previous inspection. The Trust has made the proactive decision to transfer their community services to other providers in order to consolidate their position as a main provider of mental health services across Greater Manchester.

Where do we want to get to?

Our aim is to increase access to mental health services and improve outcomes for local people.

- We will continue to invest in IAPT services for anxiety and depression and extend the offer to people with long term conditions;
- We will continue to reduce out of area placements for acute mental health and reliance on specialist inpatient care for people with a learning disability and / or autism;
- We will continue to work with our mental health providers and other CCG areas to develop new models of care and improve the quality of mental health services;
- We will continue to roll out our new pathways for ASD and ADHD;
- We will increase support for people with severe and enduring mental illness, addressing often-neglected physical health needs and reducing the gap in life expectancy;

- We will continue to address the physical health needs of people with learning disabilities by ensuring that they access annual physical health checks and access other healthcare support, e.g. access to dentistry, optometry and cancer screening;
- We will continue to improve our dementia services and support for carers;
- We will continue to develop mental health liaison in hospital, including the emergency department;
- And we will continue to increase investment in mental health services, in line with the Mental Health Investment Standard.

We will continue to work with Public Health to understand and prevent suicides and promote and support mental wellbeing.

In line with the NHS 10 Year Plan, we will implement:
- full access to specialist community-based mental health services
- 24/7 access to mental health crisis care and improve pathways via NHS 111 and ambulance services;
- smoking cessation for long-term users of specialist mental health and / or learning disability services.

How we will know we have arrived?

Start Well	• Improved access to perinatal psychological therapies • improved access to children's mental health services • Achievement of national standards for eating disorders • Fewer hospital admissions as a result of self harm (10-24 years)
Live Well	• Continued delivery of the NHS Standards for mental health • Full access to specialist community-based mental health services for people • 24/7 access to crisis care via NHS 111 • By 2023/24, 70% of MH liaison services will meet the 'core 24' service standard, working towards 100% coverage thereafter • Achieve standard for addressing physical health checks and interventions for people with severe mental illness • Implement a new universal smoking cessation offer for long-term users of specialist mental health and / or learning disability services • Reduced out of area placements for acute mental health • Increase proportion of people with a learning disability on the GP register receiving an annual health check • Reduced reliance on specialist inpatient care for people with a learning disability and/or autism • Reduce self-harm / injury in people with depression and / or SMI
Age Well	• Improve life expectancy in adults with serious mental illness • Reduction in the dementia prevalence gap
Die Well	• Reduction in emergency hospital admissions during the last weeks of life. • Reduction in suicide
Lead Well	• 1,620 fewer non-elective spells • Mental health will receive a growing share of the NHS budget • Faster growth in funding for children and young people's mental health services • Improve quality of mental health data submitted to NHS Digital

Planned Care, including Cancer

Overview

Since 2008, demand for planned care has grown by 26% nationally. This trend is likely to be magnified by the growing and ageing population. In our current model, people are referred to hospital to receive specialist advice and support, often followed by recurring follow-up appointments. Around 40-50% of outpatient appointments in Stockport result in advice or a prescription, meaning that the patient did not need to physically visit the hospital. Alternative approaches could deliver more effective solutions outside of hospital, using technology to enable communications, advice and treatment between patients, GPs, and specialists.

Where we are now?

As demand for elective care grows, performance standards have slipped. In 2018/19 Stockport achieved just 2 out of the 5 elective care standards. Improvements are required in 18-week referral to treatment time standard, the 28 day cancelled operations standard and people waiting over 52 weeks for treatment. Over 2018/19 the CCG's focus has been on reducing waiting lists through additional investment in planner care.

Cancer care is rated as outstanding in Stockport, with high rates of early diagnosis and 1 year survival rates. An increase in GP referrals has meant that more patients with cancer are being identified and treated. Stockport achieved six of nine cancer standards for 2018/19. Improvements are required in two-week waits and the 62-day treatment standards.

Standard		Target	Q1	Q2	Q3	Q4
E.B.3	Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	88.6%	84.8%	84.3%	85.6%
E.B.4	Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral	99%	98.8%	99.1%	99.1%	98.9%
E.B.6	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	94.0%	89.8%	91.4%	88.3%
E.B.7	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	92.0%	76.4%	61.3%	54.2%
E.B.8	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	98.8%	98.4%	98.6%	99.3%
E.B.9	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	100.0%	97.5%	98.9%	97.5%
E.B.10	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	100.0%	100.0%	100.0%
E.B.11	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	99.2%	100.0%	100.0%	100.0%
E.B.12	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	85.7%	83.4%	81.5%	84.9%
E.B.13	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	91.4%	94.1%	76.9%
E.B.14	Maximum 62-day wait for first definitive treatment following consultants decision to upgrade priority	N/A	84.4%	81.6%	83.9%	74.6%
E.B.S.2	Number of patients not treated within 28 days of last minute elective cancellation (provider) (Quarterly Measure)	0	16	6	9	10
E.B.S.4	Zero tolerance of over 52 week waiters	0	31	8	11	8
E.B.S.6	Urgent operations cancelled a second time (provider)	0	0	0	0	0

Where do we want to get to?

Our aim is to improve the quality of planned care, including cancer care, in Stockport.

We will manage demand for elective care by diagnosing, treating and managing follow-ups for more people out of hospital, where clinically appropriate. The resulting reduction in pressure on hospital services would allow us to reduce waiting times and meet all NHS Constitutional Standards.

We will continue to implement Greater Manchester's Improving Specialist Care programme to reduce variation in specialist care and improve quality.

The CCG's Chair and the Chief Executive of the local Trust will continue to lead Greater Manchester's elective care reform programme across the city region.

We will continue to work with Public Health to develop self-care support and resources for our population.

In line with the NHS 10 Year Plan, we will implement:

- glucose monitors for patients with type 1 diabetes
- an acute frailty service for at least 70 hours a week, achieving clinical frailty assessment within 30 minutes of arrival.

How we will know we have arrived?

Live Well	• Delivery of the NHS Standards for Planned Care • Continued increase in cancers diagnosed at an early stage, particularly in deprived areas • Continued improvement in one-year survival from all cancers • Maintain positive cancer patient experience • Ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke • Reduce stroke in people with diabetes and / or circulatory conditions • Reduction in surgery waiting lists
Age Well	• Fewer early deaths from cancer • Reduction in procedures of limited clinical value
Lead Well	• Reduce the number of EUR procedures undertaken to GM average • Transform outpatient pathways to improve the efficiency of the elective system by up to 30% • 11,016 fewer 1st outpatient appointments • 19,018 fewer outpatient follow-ups • Digital and phone outpatient appointments

Urgent Care

Overview

The Stockport health and care economy has struggled with urgent care pressures for some time now. While the number of attendances at A&E is significantly below the national average, the hospital struggles to treat and discharge or admit patients to a hospital bed within the national 4 hour timeframe. Root cause analysis suggests that the main issues include: complexity of patient needs; a lack of senior staff able to take decisions quickly and avoid hospital admissions; and a lack of beds on hospital wards for those patients who need to be admitted.

Where we are now?

In 2018/19 Stockport only achieved one of the 8 urgent care standards in the NHS constitution. The CCG is in the worst performance quartile nationally for emergency hospital admissions for chronic ambulatory care sensitive conditions and population use of hospital beds following an emergency admission.

Standard		Target	Q1	Q2	Q3	Q4
ARP.01	Category 1 (life-threatening) calls - 90th centile appropriate response time (NWAS)	15:00	13:49	13:21	13:02	13:04
ARP.02	Category 1 (life-threatening) calls - mean time taken for a response to arrive (NWAS)	7:00	8:06	7:56	7:48	7:47
ARP.03	Category 2 (emergency) calls - 90th centile appropriate response time (NWAS)	40:00	52:43	50:38	52:03	54:12
ARP.04	Category 2 (emergency) calls - mean time taken for an appropriate response to arrive (NWAS)	18:00	23:53	23:24	24:14	25:17
ARP.05	Category 3 (urgent) calls - 90th centile appropriate response time (NWAS)	120:00	149:22	158:11	173:27	171:30
ARP.06	Category 4 (non-urgent "assess, treat, transport" calls only) - 90th centile appropriate response time (NWAS)	180:00	181:52	188:53	197:52	204:04
E.B.5	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	85.6%	79.5%	74.0%	75.4%
E.B.S.5	Number of waits from decision to admit to admission (trolley waits) over 12 hours	0	7	8	34	16

In response to the continued performance issues regarding urgent care, the CCG has provided clear and visible leadership by ensuring senior staff presence at the Trust on a daily basis as well as continuing to work in partnership with providers to ensure that pathways are clear and services are resilient.

In 2018/19 we introduced a GP streaming service into A&E, which has helped reduce some of the non-urgent waiting times we are continuing to work with partners to improve the admission and discharge flow. Outside of the hospital, Stockport partners have delivered a range of new services to support management of long-term conditions across our neighbourhoods, including routine evening and weekend GP appointments, a community falls service, GP home visiting service, community active recovery team, crisis response team and a new mental health and wellbeing service in every neighbourhood. All of these services help to support patients either at home or closer to home and reduce pressure on the busy A&E service at Stepping Hill hospital.

Where do we want to get to?

Our aim is to radically improve urgent care in Stockport and deliver the standards set out in the NHS Constitution.

Stockport's Urgent and Emergency Care Delivery Board has developed a robust improvement plan for Urgent Care that focuses on:

- bed occupancy and reducing the number of patients awaiting transfers of care or discharge;
- reducing unnecessary A&E attendances by ensuring there are appropriate alternatives in the community; and
- reducing unnecessary admissions by having appropriate interventions and diagnostics in the right place at the right time.

In line with the NHS 10 Year Plan, we will also implement:

- an Urgent Treatment Centre in Stockport; and
- agreed clinical care plans for patients within 14 hours of admission, including an expected date of discharge.

How we will know we have arrived?

Start Well	• Reduction in unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
Live Well	• Delivery of the NHS Standards for Urgent Care (ambulance and ED waits) • Reduction in avoidable emergency admissions for ACS conditions • Reduced length of stay in hospital after an emergency admission • Reduction in Delayed Transfers of Care and Stranded Patients
Age Well	
Die Well	• Reduction in emergency hospital admissions during the last 90 days of life.
Lead Well	• 1,620 fewer non-elective spells • Same Day Emergency Care • Integrated Urgent Care Services.

Enablers

Overview

As one of the leaders of the local health and care economy, the CCG understands the need to work with our partners to deliver the changes needed to improve lives in Stockport.

Across Greater Manchester's city region, devolution has offered the opportunity for public services to work together, reducing waste and achieving outcomes that no service can deliver alone. The "Greater Manchester Model" of public service delivery places health and wellbeing at the centre of public policy, bringing together not just health and social care, but recognising the vital impacts of education, transport, housing, environment, business and security on the work we do.

Consequently, our Strategy takes a broad approach to change, looking at the role of the NHS as an 'anchor institution' with a significant influence over our community's health and wellbeing (Reed et al, 2019). To 'lead well', the CCG must use the influence of the CCG as an employer and a commissioner of a wide range of services in the borough to make positive changes in our community, such as: purchasing more locally to support employment; widening access to high quality work; and taking responsibility for the environmental impact of public services.

Delivery of our Strategic Aims will require input from a range of enabling services, including:

- Finance
- Estates
- Workforce
- Commissioning & Procurement
- Communications & Engagement
- IM&T.

Where do we want to get to?

The purpose of our Enablers Delivery Programme is to support the CCG's aim to 'lead well'. In line with the GMHSCP, we want to deliver 'social value' by ensuring that the taxpayers' money we spend delivers the greatest possible economic, social and environmental benefits to our communities.

We will work collaboratively with health and care partners to reduce waste and share costs, ensuring financial balance across the economy. And we will meet the 5 financial tests.

We will effectively manage estates to support integrated working in buildings that are fit for the future and able to respond to changing needs. We will ensure that the services we commission deliver the greatest possible environmental benefits to our communities.

We will support parity of esteem, by investing more in mental health, with faster growth in children's mental health services.

We will invest in our workforce, increasing cross-organisational and multi-disciplinary learning to develop a cohesive end engaged workforce with the right skills. And we will make Stockport a place where people want to come to work and stay.

We will implement new models of care by integrating commissioning across health and social care and contracting with providers to work together and deliver outcomes for local people. All contracts will include our Outcomes Framework, incentivising providers to collaborate and deliver real improvements for people. And we will reform the payment system to move away from payments by results and ensure a majority of funding is population-based.

We will effectively communicate with local people, giving access to information and tools, empowering them to manage their own care. And we will embed co-production as our method of designing services and pathways. Working across the economy with partners, we will ensure that patients have easy access to localised self-care information for common long-term conditions.

We will work together to understand our changing population and health and care needs, delivering a review of Stockport's Joint Strategic Needs Assessment (JSNA) with our partners in 2020.

We aim to embrace technology to improve the efficiency, access, and quality of our services. We will take an innovative and solution-focussed approach to IM&T that enables our workforce to access the information they need, when and where they need it. We will offer online and mobile options for healthcare, enabling greater access to services while reducing the burden of growing demand.

In line with the NHS 10 Year Plan, we will implement:

- maternity digital care records so all women will be able to access their maternity notes and information through their smart phones or other devices;
- online 'digital' GP consultations;
- access to care plans and communications from care professionals via the NHS App;
- home-based and wearable monitoring equipment connected to health records;
- fully digitised secondary care by 2024; and
- a robust IT infrastructure and cyber security to capture, stored and transmit data electronically.

How we will know we have arrived?

Start Well	• digital maternity care records • faster growth in funding for children and young people's mental health services
Live Well	• every patient will have the right to online 'digital' GP consultations • care plan access via NHS App • home-based and wearable monitoring equipment connected to health records • mental health will receive a growing share of the NHS budget • Summary care record rolled-out
Age Well	• accessible services in neighbourhood locations
Die Well	• Roll-out of the Electronic Palliative Care Coordination system (EPaCCS), including the palliative care outcomes scale (IPOS)
Lead Well	• integration of strategic commissioning functions • Local Care Organisation delivering shared outcomes and system benefits • financial balance across the economy • increased utilisation of the NHS e-referral service • increased digital interactions between primary and secondary care • all core transactional services, such as processing invoice payments, automated over the next five years • consistently high staff satisfaction levels • full recruitment across the system • 2% improvement in staff retention rates

Financial Plan

Financial Assumptions

Over the lifecycle of this Strategic Plan, we anticipate that:

- ***Growth*** - demand for services will grow by 2.2% a year
- ***Inflation*** - the cost of delivering those services will grow by 2% a year

As in previous years, the CCG is committed to meeting the NHS financial rules:

- requirement to break even in-year
- maintain a cumulative underspend of at least 1%
- Plan for a minimum 0.5% local contingency
- mental health investment to grow at least at a rate with allocation uplift.

Financial Plans

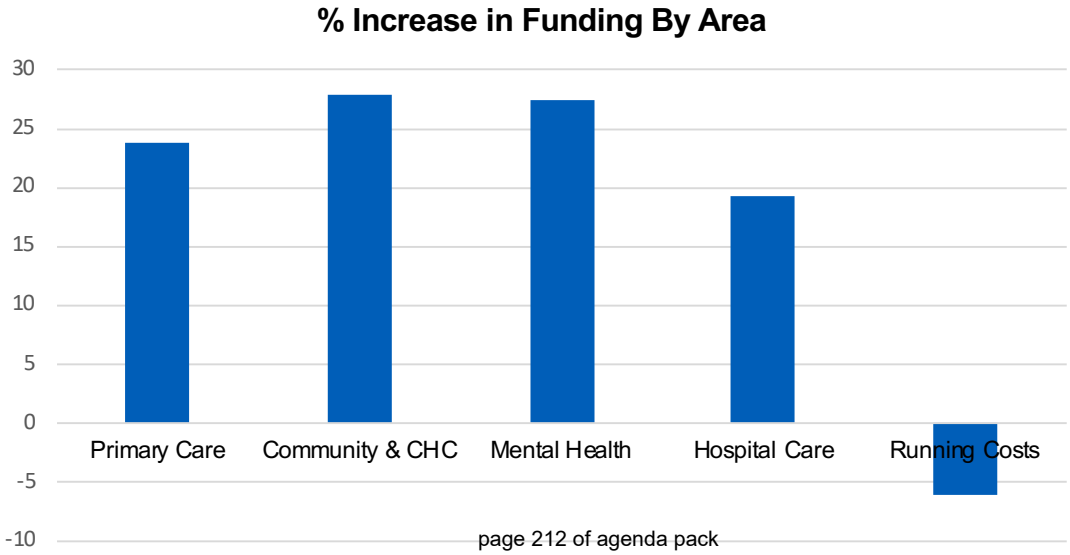
To support CCGs to plan over the long-term, NHS England has set out indicative allocations for the next five years.

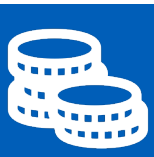
Year	2019/20	2020/21	2021/22	2022/23	2023/24
Budget	£482.44m	£501.18m	£521.41m	£540.89m	£559.88m
Year on Year Growth	5.1%	3.9%	4.0%	3.7%	3.5%

The CCG's budget is expected to grow by around 22% over the next five years, though running costs will be cut in 2020/21 by £0.76m (11.81%) and then remain static.

Our goal is to rebalance the use of resources, with more spending on preventing people from becoming ill and proactively managing conditions outside of hospital, reducing the need for higher-cost hospital services. Over the next five years, we forecast that:

- spending on Continuing Care and Community services will increase by 27. 9%
- spending on Mental Health will increase by at least 27.3%
- spending on Primary Care (excluding prescribing) will increase by 23.7%
- spending on Hospital Care will increase, but at a slower rate of 19.3%
- with spending on running costs decreasing by 6.0%.





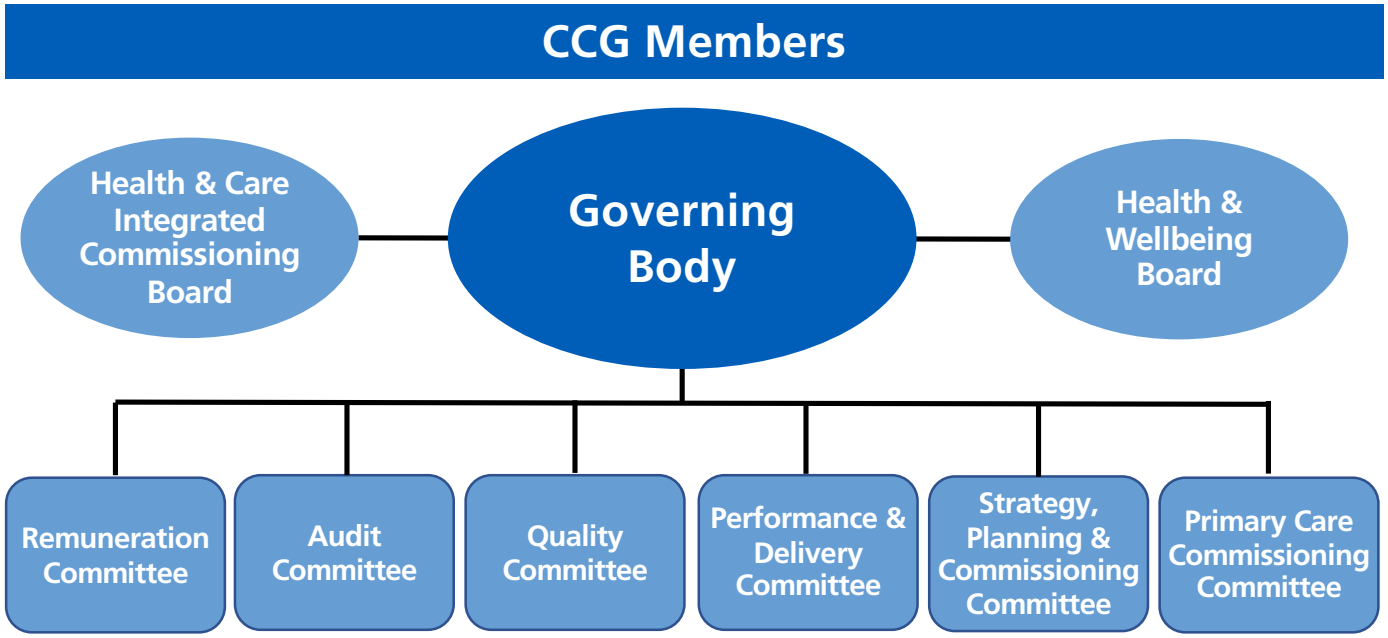
A detailed, 5-year financial plan will be developed collaboratively with our partners across Stockport. This plan will detail spending, activity and workforce assumptions over the next five years to deliver this Strategy and ensure that Stockport meets the Government's 5 financial tests set out in the Long-Term Plan.

- **Test 1:** The NHS (including providers) will return to financial balance;
- **Test 2:** The NHS will achieve cash-releasing productivity growth of at least 1.1% per year;
- **Test 3:** The NHS will reduce the growth in demand for care through better integration and prevention;
- **Test 4:** The NHS will reduce unjustified variation in performance;
- **Test 5:** The NHS will make better use of capital investment and its existing assets to drive transformation.

Governance

Clinical oversight and accountability

The CCG is a membership organisation, with member Practices nominating a representative to sit on the Council of Members. The Council has delegated power to the CCG Governing Body to conduct the overall management of the CCG through regular public meetings and sub-committees to undertake detailed work.



Development of the Strategy was led by the Strategy, Planning and Commissioning Committee - a sub-committee of the Governing Body. The strategy has been shaped from the on-going engagement with our population, then developed by clinicians, executives, staff and lay members.

A draft was reviewed by the committee alongside a full report of local involvement undertaken and recommendations based on the views expressed. The Committee then recommended a draft to the Governing Body and the final Strategy is due to be considered for agreement at the end of September by the Council of Members at its Annual General Meeting.

Delivery Approach

Strategic planning is a core component of the CCG's annual business cycle. The purpose of this Strategy is to set the direction of the organisation, which will influence commissioning intentions, service design, and our operational plans.

Delivery of our plans will take a collaborative approach across health and social care organisations.

Progress will be monitored by the CCG's Programme Management Office (PMO) and reported bi-monthly to the Performance and Delivery Committee, which holds members of the CCG's Leadership Team to account for delivery of plans and achievement of outcomes, providing assurance to the Governing Body.

Risk Management

NHS Stockport Clinical Commissioning Group (Stockport CCG) endeavours to minimise risks to all its stakeholders through a comprehensive system of internal controls whilst providing maximum potential for flexibility, innovation and best practice in the delivery of its strategic programmes.

It is clear, however, that the future sustainability of the NHS and its founding values will require creative solutions to ensure that risk and innovation are not perceived as mutually exclusive.

The CCG has developed this Strategy and its supporting Delivery Programmes to mitigate these future risks and to support the wider system in terms of financial and operational performance.

Through the development of the Governing Body Assurance Framework the CCG documents the risks to the achievement of the CCG's objectives. This framework provides a structure by which the Governing Body and its Committees identify their assurance requirements and through regular review ensures that the risks are mitigated.

Equality Impact Assessment

As a publicly funded organisation, NHS Stockport CCG is subject to legal duties to give due regard to the impact of our plans on groups protected under the Equality Act (2010).

An equality impact assessment can be found in appendix 6.

Local Input into the Strategy

A full report of local involvement in the Strategy can be found in appendix 5.

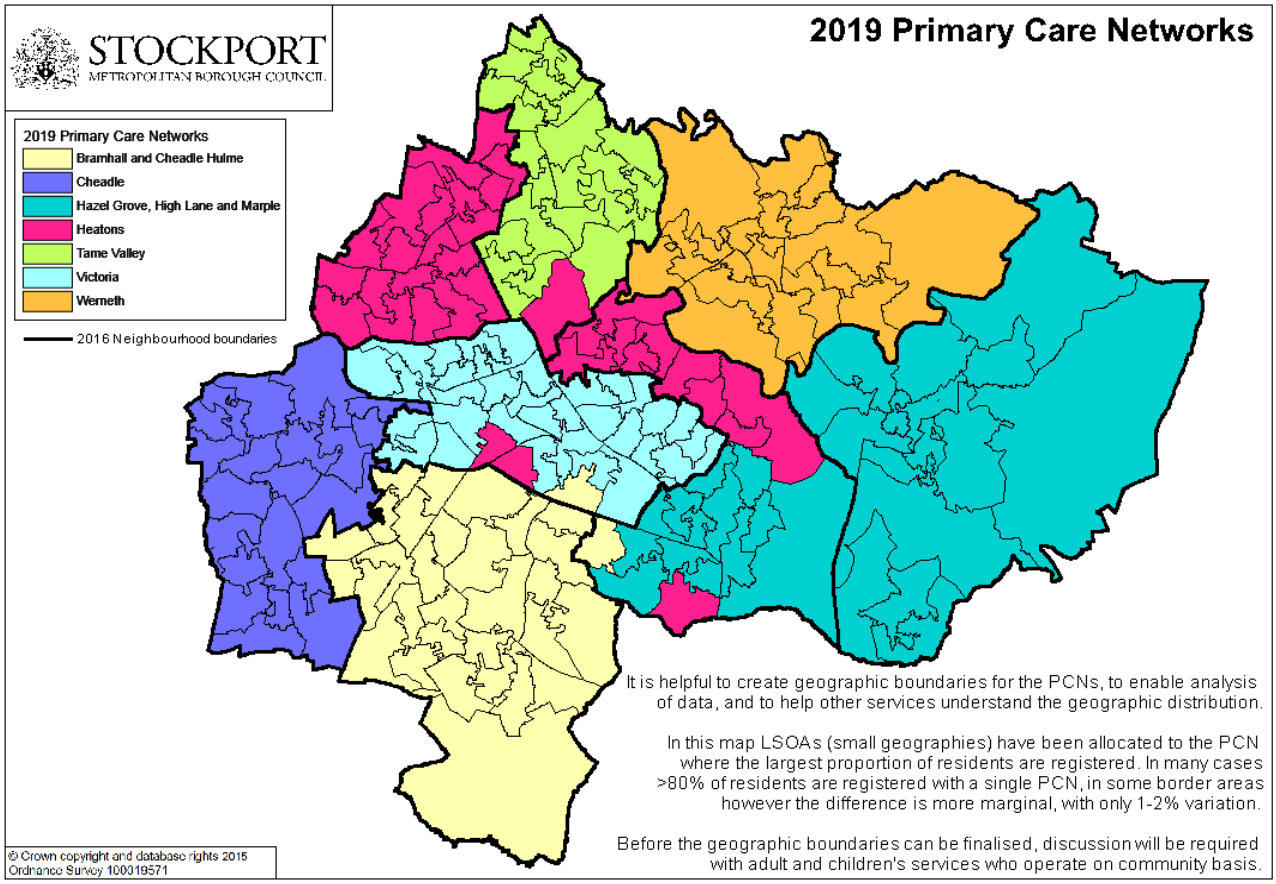
Appendices

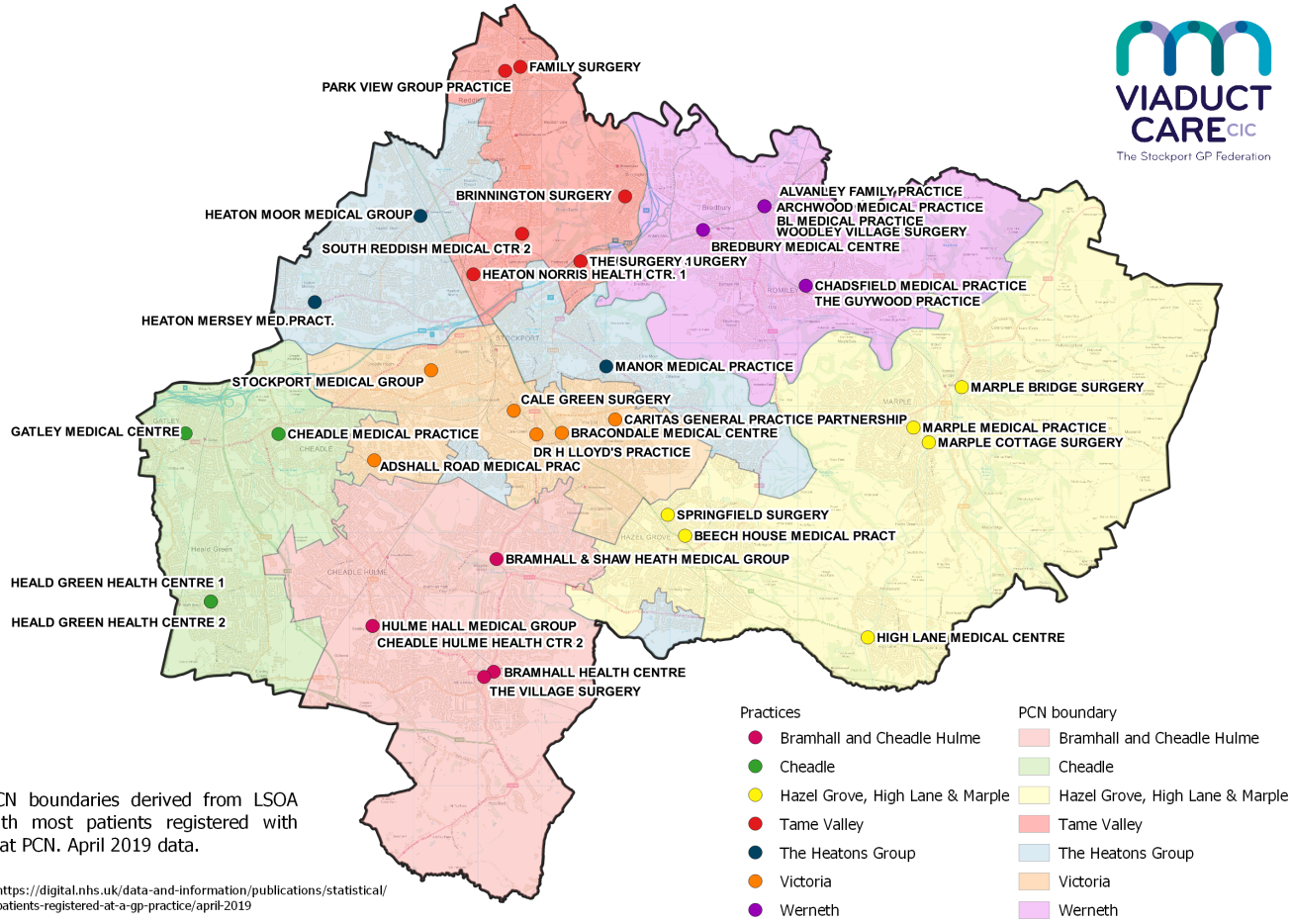
1. NHS Stockport CCG's Member GP Practices & Primary Care Networks
2. Implementation of the NHS Long Term Plan
3. Long-Term Conditions Prevalence in Stockport
4. Draft Outcomes Framework
5. Local Input into the Strategy
6. Equality Impact Assessment
7. Glossary of Terms
8. References

Appendix 1

NHS Stockport CCG's Member GP Practices & Primary Care Networks

Primary Care Network	GP Practice	Partners	Registered Patients
Bramhall & Cheadle Hulme (57,249 patients) Clinical Director: Dr. Louise Monk	Bramhall & Shaw Heath Medical Group	Dr A Bayes & Partners	14,378
	Bramhall Health Centre	Dr L Pozzoni & Partners	12,816
	Cheadle Hulme Health Centre	Dr RJ Seabrook & Partners	12,974
	Hulme Hall Medical Group	Dr AM Shipston & Partners	11,069
	The Village Surgery	Dr D Goldspink & Partners	6,012
Cheadle Network (34,514 patients) Clinical Director: Dr. Viren Mehta	Cheadle Medical Practice	Dr V Mehta & Partners	12,023
	Gatley Medical Centre	Dr AJ Davison & Partners	9,462
	Heald Green Health Centre (1)	Dr P Owen & Partners	6,581
	Heald Green Health Centre (2)	Dr C Morris & Partners	6,448
Hazel Grove, High Lane & Marple (40,598 patients) Clinical Director: Dr. Howard Sunderland	Beech House Medical Practice	Dr S Woodworth & Partners	8,173
	High Lane Medical Centre	Dr RCL Mathewson & Partners	6,006
	Marple Bridge Surgery	Dr MJ Needham & Partners	6,430
	Marple Cottage Surgery	Dr A Johnson & Partners	7,275
	Marple Medical Practice	Dr M Valluri & Partners	7,135
	Springfield Surgery	Dr Aldabbagh & Partners	5,579
Heatons Group (60,119 patients) Clinical Director: Dr. Rebecca Locke	Heaton Mersey Medical Practice	Dr J Wynn & Partners	8,197
	Heaton Moor Medical Centre	Dr DL Dawson & Partners	42,934
	Manor Medical Practice	Dr M Leahy	8,989
Tame Valley (44,108 patients) Clinical Director: Dr. James Higgins	Brinnington Surgery	Dr AR Gilman & Partner	8,940
	Family Surgery, Reddish	Dr IW Dickie & Partners	11,870
	Heaton Norris Health Centre	Dr C Marshall & Partners	7,346
	Park View Group Practice	Dr N Hussain & Partners	9,061
	South Reddish Medical Centre	Dr G Gupta	3,595
	The Surgery	Dr HH Azmy	1,759
	Vernon Park Surgery	Dr S Chatterjee	1,537
Victoria (45,910 patients) Clinical Director: Dr. Paul McGuigan	Adshall Road Medical Practice	Dr Gillott & Partners	4,811
	Bracondale Medical Centre	Dr C Briggs & Partners	5,326
	Cale Green Surgery	Dr R Tomalin	3,809
	Caritas General Practice	Dr Jane Whittaker & Partners	13,066
	Cedar House	Dr H Lloyd	2,230
	Stockport Medical Group	Dr RS Gill & Partners	16,587
Werneth (31,116 patients) Clinical Director: Dr. Abdul Ghafoor	Alvanley Family Practice	Dr M Gallagher & Partner	5,345
	Archwood Medical Practice	Dr G Parker & Partners	8,228
	Bredbury Medical Centre	Dr R Beardsell & Partners	4,547
	Chadsfield Medical Practice	Dr M Mather & Partners	6,964
	The Guywood Practice	Dr R Patel & Partner	2,907
	Woodley Health Centre	Dr A Choudry	3,161
NHS Stockport Clinical Commissioning Group		**37 GP Practices**	**313,610 patients**





PCN boundaries derived from LSOA with most patients registered with that PCN. April 2019 data.

https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/april-2019

Implementation of the NHS Long Term Plan

It is our intention with this Strategy to deliver all the commitments within the NHS Long Term Plan. Delivery will be phased across the 5 years of this strategy, prioritising local need and those areas where Stockport does not perform as well as other areas.

The table below maps the headline metrics in the Long Term Plan (LTP) to the key delivery plans and measures in the CCG Strategy.

No.	LTP Headline Metrics	CCG plans	Page
A new service model for the 21st century			
1.	Primary and community services: • annual implementation milestones for 5-year GP contract • new community services response times and teams.	GP-led care is one of the principles of this Strategy We will continue to invest in primary and community services Primary & Community delivery programme sets out our plans and measures	P23 P43-44 P30-32
2.	Comprehensive ICS coverage including a partnership board, drawn from and representing commissioners, trusts, primary care networks, and - with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners.	Primary & Community delivery programme sets out our plans and measures for an ICS	P30-32
3.	Emergency care: on agreed trajectory for Same Day Emergency Care and Integrated Urgent Care Services	Urgent Care Delivery Programme	P39-40
More NHS action on prevention and health inequalities			
4.	Prevention (1): increase uptake of screening and immunisation	Primary & Community delivery programme	P30-32
5.	Inequalities: inequalities reduction trajectory	Primary & Community delivery programme	P30-32
6.	Prevention (2): alcohol care teams, tobacco treatment services, and diabetes prevention programme	Primary & Community delivery programme Planned Care delivery programme	P30-32 P37-38
Further progress on care quality, access and outcomes			
7.	Maternal and children's health: on agreed trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025	Maternity & Children Delivery Programme	P33-34
8.	Improve cancer survival: Improve one and five-year cancer survival; on agreed trajectory so that 75% of cancer patients diagnosed at stage 1 or 2 by 2028	Primary & Community delivery programme Planned Care delivery programme	P30-32 P37-38
9.	Learning disability and autism: on agreed trajectory for halving inpatient rate by 2023/24 and increasing learning disability physical health checks to 75% of people aged over 14	Mental Health & Specialist Groups delivery programme	P35-36

A new service model for the 21st century			
No.	**LTP Headline Metrics**	**CCG plans**	**Page**
10.	Mental health: on track for locally agreed service expansion, and increase in investment for mental health services as a share of the NHS budget over the next five years by 2023/24	Mental Health & Specialist Groups delivery programme Financial Plan	P35-36 P43-44
11.	Implementation of agreed waiting times/clinical standards for urgent and emergency care, elective care, cancer and mental health, from April 2020, and the maintenance and improvement of performance for cancer treatment and A&E until that point.	Urgent Care Delivery Programme Planned Care delivery programme Mental Health & Specialist Groups delivery programme	P39-40 P37-38 P35-36
NHS staff will get the backing they need			
12.	Workforce metrics will be agreed through development of the NHS People Plan but will include: • Staff retention: retention rate to improve by at least 2% • Leadership: CQC well led indicator, and staff engagement indicator • Diversity/inclusion: BME representation, gender, bullying/harassment	Enablers Delivery Programme	P41-42
Digitally enabled care will go mainstream across the NHS			
13.	Outpatient reform: 30% reduction trajectory, outpatient digital role out	Planned Care delivery programme Enablers Delivery Programme	P37-38 P41-42
14.	Empowering people: Summary care record roll out.	Enablers Delivery Programme	P41-42
15.	Access to online/telephone consultations in primary care.	Enablers Delivery Programme	P41-42
Taxpayers' investment will be used to maximum effect			
16.	Test 1: The NHS will return to financial balance	Enablers Delivery Programme Financial Plan	P41-42 P43-44
17.	Test 2: The NHS will achieve cash-releasing productivity growth of at least 1.1% per year	Financial Plan	P43-44
18.	Test 3: The NHS will reduce growth in demand for care through better integration and prevention	Primary & Community delivery programme	P30-33
19.	Test 4: The NHS will reduce variation in performance across the health system	Primary & Community delivery programme Maternity & Children Delivery Programme	P30-33 P33-34
20.	Test 5: The NHS will make better use of capital investment and its existing assets to drive transformation	Enablers Delivery Programme Financial Plan	P41-42 P43-44

Appendix 3

Long-Term Conditions Prevalence in Stockport

Long-Term Condition	Number (Jul 2018)	Demographic trends		
		Gender	Age	Deprivation
Hypertension	46,135		Highest 45+	Increase with dep.
Anxiety (last 10 years)	35,075	Higher in women	Highest 25-49	Increase with dep.
Depression	34,070	Higher in women	Highest 40-59	Increase with dep.
Asthma	20,415			Increase with dep.
Pre-Diabetes	17,565		Highest 45+	Increase with dep.
Diabetes	16,505		Highest 45+	Increase with dep.
History of Fall	13,430	Higher in women	Highest 75+	Increase with dep.
Coronary Heart Disease (CHD)	12,320	Higher in men	Highest 50+	Increase with dep.
Cancer	9,760		Highest 50+	Decrease with dep.
Chronic Kidney Disease (CKD)	7,500		Highest 50+	Increase with dep.
Chronic Obstructive Pulmonary Disease (COPD)	7,405		Highest 45+	Increase with dep.
Atrial Fibrillation (AF)	6,745		Highest 50+	
Stroke or Transient Ischaemic Attack (TIA)	6,645		Highest 55+	Increase with dep.
Osteoporosis	6,355	Higher in women	Highest 50+	Increase with dep.
Heart Failure (HF)	3,625	Higher in men	Highest 60+	Increase with dep.
Self-harm	3,155	Higher in women	Highest 15-34	Increase with dep.
Dementia	2,825	Higher in women	Highest 65+	Increase with dep.
Severe mental health	2,740		Highest 30-59	Increase with dep.
Rickets (last 10 years)	2,725	Higher in women		
Glaucoma	2,520		Highest 55+	Decrease with dep.
Peripheral Arterial Disease (PAD)	2,270	Higher in men		Increase with dep.
Epilepsy	2,250			Increase with dep.
Acute Macular Degeneration (AMD)	1,675	Higher in women	Highest 65+	Decrease with dep.
Learning disability	1,625	Higher in men		Increase with dep.
Rheumatoid Arthritis	1,595	Higher in women	Highest 45+	Increase with dep.
Autism	1,585	Higher in men		Increase with dep.
Crohn's disease	1,075			
Cerebral palsy	285			
Down's syndrome	230	Higher in women		
Motor neurone disease	30			

Appendix 4 - Draft Outcomes Framework

Population Segment	Who's in this group?	What's important to them?	Clinical & Social Outcomes	Personal Outcomes
Maternity & Infant Health	Children and young people under 18 Pregnant women	To be developed	To be developed	Independence Proactive and confidence in managing health Able to maintain usual lifestyle and activities, having a full life Time with friends and family, not being alone Well-informed Feeling supported and reassured Feeling safe and secure In control, involved, listened to Dignity and respect Anxiety / depression Pain and symptom control Nutrition Disability / functions of daily living Mental wellbeing Carers' health and wellbeing
Healthy	Adults in the general population Not in contact with health services No diagnosed conditions May have underlying conditions / risk factors May have unhealthy behaviours	Staying healthy and avoiding developing a disease / condition Convenient access to services when unwell Longevity Maintaining independence, usual lifestyle and activities Quality of life and social interaction	Reduce avoidable hospital admissions Increase physical activity Reduce obesity Reduce smoking Reduce alcohol consumption	
Long-Term Conditions	People ages 18 and over with a long-term condition May have stable / normal function managed by medication, treatment or therapy May have serious long-term physical or learning disability May have limited reserve, serious exacerbations, progressive deteriorating conditions	Effective self-management Preventing / limiting disease progression Maintaining autonomy Confidence to manage their condition Avoiding exacerbations or complications Avoiding developing more health conditions Minimal disruption to life Coordinated care in the most appropriate place	Reduce premature mortality in people with serious mental illness Reduce smoking Reduce obesity Reduce episodes of ill health requiring emergency admission Reduce days disrupted by care Reduce stroke in people with diabetes and / or circulatory conditions Reduce diabetes complications Reduce exacerbations requiring emergency admissions in people with organ failure Increase cancers diagnosed at an early stage Reduce self-harm / injury in people with depression and / or SMI Increase employment for those in secondary mental health services Increase adults in contact with secondary mental health services living in stable and appropriate accommodation	
Frailty and / or Dementia	People who are frail and / or have dementia Likely to have comorbidities Often vulnerable and dependent on others	Avoid disruption to life / time away from home Independence Prevention of falls or distress (e.g. pressure ulcers) Stronger recovery following falls, fractures of hospital admission Timely diagnosis of dementia at an early stage Quality of life and social interaction	Increase the proportion of days spent at home Reduce pressure ulcers Reduce falls Reduce delirium Reduce emergency admissions for UTI, constipation and incontinence Reduce the dementia prevalence gap Reduce people requiring repeat emergency care within 30 days of discharge Increase people back to previous level of mobility following a hip fracture	
End of Life	People with a terminal illness or advanced progressive deterioration People identified to be in their last 6-12 months of life	Control over their care and place of death Early conversations and planning Support to live as actively as possible Dignity and respect Psychological support to themselves and their family	Increase people dying in their preferred place Increase palliative care registrations in people expected to die Reduce the proportion of days disrupted by emergency care for people in their last days of life	

Appendix 5

Local Input into the Strategy

1. Overview

In January 2019, NHS England launched its Long-Term Plan, setting out expectations for the health sector over the next ten years. All CCGs are required to refresh their Strategic Plans by the Summer to set out how we will deliver the NHS Long-Term Plan.

NHS Stockport CCG's Strategic Plan will set out the CCG's vision for the next 5 years and prioritise our work to deliver the NHS plan.

2. Why Engage?

We recognise that our decisions, policies and services have a major impact on the lives and wellbeing of local people. NHS Stockport CCG is committed to working with local people to improve health and secure high-quality healthcare for the people of Stockport, now and for future generations. We want everyone to have greater control of their health and wellbeing, and to be supported to live longer, healthier lives with high quality health and care services that are compassionate, inclusive and constantly improving.

Public involvement helps us to understand local needs and to prioritise those people who experience the poorest health outcomes, enabling us to improve access and reduce health inequalities. Local involvement provides opportunities to see things differently and to be innovative, leading to a better use of our limited resources.
Level of Involvement

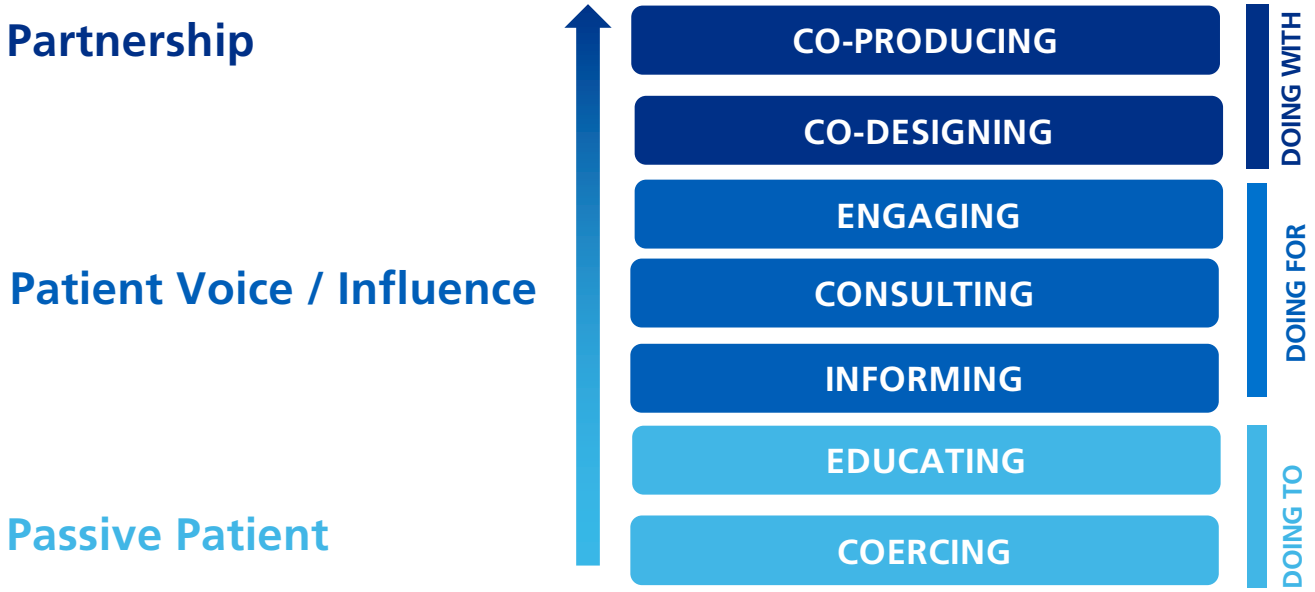
The CCG's Strategy must deliver a range of clearly defined commitments:

- NHS Long-Term Plan;
- the GMHSCP transformation strategy;
- the Stockport Health & Wellbeing Strategy
- and our system transformation plans under Stockport Together.

With regard to the GM Strategy, our Health & Wellbeing Strategy and the Stockport Together plans, the CCG has already consulted widely, involving staff, partners, patients and the public in shaping our new model of care and prioritising investments in the future.

In light of significant involvement by stakeholders in developing the elements of the Strategic Plan through Stockport Together, the level of involvement used for refreshing the Strategy was Informing / Engaging (see the ladder of co-production model below).

Ladder of Co-Production



Adapted by the National Co-Production Advisory Council and Think Local Act Personal from Sherry Arnstein's model of participation

3. Objectives

The purpose of our involvement plan was to:

- Gain feedback from key stakeholders on the proposed strategy for 2019-2024
- Share the CCG's mission and vision with partners, patients and the public

4. Stakeholders

Key stakeholders included:

- CCG Leadership
- CCG Staff
- GP Members
- Clinicians
- Partners (SMBC, SFT, PCFT, GM, HWBB)
- Patients, carers and the public.

5. Engagement Methods

A range of engagement methods were used to maximise involvement:

- Events, including partnership engagement events;
- Focus groups;
- Meetings (internal and external);
- Workshops;
- Surveys;
- Newsletters;
- Briefings.

6. Involvement

Involvement was undertaken between May and September 2019. Around 400 people were involved in the development of the Strategy, through a range of different methods as set out in the table below.

Date	Stakeholder Group	No. engaged	Engagement Method	Detail
12-Apr-19	Staff	11	Meeting	Presentation on requirements and process at senior managers Planning Meeting
18-Apr-19	CCG Leadership	5	Meeting	Paper to Leadership Team for discussion
24-Apr-19	CCG Leadership	20	Workshop	Mission, Vision and Values presentation and workshop at Governing Body
25-Apr-19	CCG Leadership	6	Meeting	Paper to Leadership Team for discussion
08-May-19	CCG Leadership	10	Workshop	Aims & Objectives workshop at Strategy, Planning & Commissioning Committee
22-May-19	GP Members	100	Partnership Event	Presentation on progress to date at GP Conference and table discussions
May-June-19	Staff	-	Briefings & Newsletters	Updates via Accountable Officer's floor brief and staff newsletter
May-June-19	Staff	10	Workshop	Mission, Vision & Values review in staff break room
May-June-19	Staff	5	Survey	Strapline design
05-Jun-19	Clinicians	8	Focus Group	Clinical Reference Forum review of Strategic Aims and Objectives
10-Jun-19	Staff	10	Meeting	Presentation and discussion at the Wider Management Team meeting
11-Jun-19	Staff	11	Meeting	Presentation and discussion at the CCG Planning meeting
11-Jun-19	Patients & Public	12	Focus Group	Healthwatch Stockport - presentation and discussion
18-Jun-19	Patients & Public	11	Focus Group	Citizen's Reference Panel - presentation and discussion
20-Jun-19	GP Members	1	Meeting	Strategy Session with Clinical Chair
24-Jun-19	Partners	5	Meeting	Presentation and Discussion at the Public Health senior management team
21-Jun-19	Staff	20	Virtual review	Input to draft from senior staff
27-Jun-19	CCG Leadership	8	Meeting	Review of draft strategy at Leadership Team
09-Jul-19	Staff	100	Workshop	Presentation and workshop discussions at the CCG Start of Year Conference
10-Jul-19	CCG Leadership	9	Meeting	Review of draft strategy and engagement report at Strategy, Planning & Commissioning Committee
17-Jul-19	Staff	9	Meeting	Presentation on latest draft at senior managers Planning Meeting
24-Jul-19	CCG Leadership	16	Meeting	Review of draft strategy at the CCG Strategy at Governing Body
25-Jul-19	Partners	6	Meeting	Review of Strategy with Stockport NHS FT Strategy & Planning Leads
25-Sept-19	Partners		Meeting	Review of Strategy at Stockport Health & Wellbeing Board
25-Aug-19	CCG Leadership & GPs		Meeting	Sign-off of the CCG Strategy at Governing Body & Annual General Meeting
Total Number of People Involved:		**387**		

7. Responses

Feedback from staff, clinicians, patients and the public was generally supportive of the proposal for the CCG's Strategy.

People recognised the influence of previous engagement and co-design work on the delivery plans set out and urged the CCG to focus on implementing changes.

Key themes expressed included:

- the importance of tackling health inequalities among community groups
- the need to invest more in mental health services
- the importance of preventing ill health
- an acknowledgement that previous plans did not include enough on children's health
- the need for public services to work together to support individuals
- support for more care undertaken closer to home.

The following table identifies changes made to the Strategy as a result of stakeholder involvement:

Theme	You Said	We Did
Mission	Mission and Vision need to be condensed down to a shorter sentence	Text revised and shortened
	Should not start "We exist to ..."	Format changed
	Since the last strategy was written, our remit has grown to be wider than just health	Mission is to improve health ***and wellbeing***
Vision	CCG vision should cover whole system, not just healthcare, to reflect the CCG's leadership role	Vision is system-wide
	Public don't understand the terms "integrated care" and "joined-up care"	Changed wording to "person-centred" to reflect that people are at the heart of care
Values	Too many values	Cut values down to the 4 with the most support and referenced Nolan Principles as Governing Body way of working
	Patients should be first on the list explaining 'collaborative'	Amended the list accordingly
	CCG Leadership needs to be available to listen to views and accountable in using those views in decision making	Nolan Principles of Public Life are outlined as a way of working in the Governing Body
Principles	Although not a value, we need to have a golden thread running through the Strategy that highlights our commitment to: • a GP-led model of care • co-producing services • harnessing technology to improve care • reducing inequalities	Added a principles section to highlight these areas
	Engagement should be at the start of work so that patients and the public can influence change	Co-production added as a principle

Theme	You Said	We Did
CCG Purpose	Staff should agree a strapline for the CCG to ensure they own our strategy	Staff engagement undertaken to develop a strapline, with options voted upon at the Staff Conference.
Structure	We should use population segmentation to structure our strategy	Strategic Aims, outcomes and delivery programmes aligned to population segments
Strategic Aims	Previous Strategies have focused on older people and not given enough thought to children's services	Added 'Start Well' as a strategic aim
	Safeguarding Team should be involved in the Start Well aim, given the rise in Sudden Infant Death nationally	Safeguarding Team edited final draft section
	GPs should be paid to keep us well, not treat us when we're sick	Added 'Live Well' as a strategic aim
	End of Life Care should be a separate strategic aim	Added 'Die Well' as a strategic aim
	Consider merging the transactional aims (system reform, sustainability, workforce) into one to focus more on people	Created a "Lead Well" aim to cover workforce and transactional back-office functions
	Important to have workforce as a strategic priority as this is a major issue nationally and will make or break transformation plans	
Strategic Objectives	Reducing inequalities needs to be more prominent in the Strategy Health inequalities should be included in each area	Health Inequalities has been added as one of the principles / golden threads of the Strategy. Each delivery programme now includes measures linked to reducing inequalities
	We should spend money wisely, based on evidence and need	Sustainability is a key objective
	Good health starts with healthy lifestyle, not accessing of services	Objectives include prevention
	Need to provide more support for people with serious mental illness	"Live Well" aim includes objectives around SMI Mental health delivery plan includes a range of measures around physical and mental wellbeing for this group
	Patient Safety is key	Amended 'quality' to define it not just as performance or ratings, but also levels of safety. Included safeguarding work in delivery programmes

Theme	You Said	We Did
Measures	Should change title to Strategic "Improvement" measures, not achievement measures	Title changed
	Prevention is key - particularly in the Start Well section to prevent ill health later in life	Took plans to Public Health team and added a range of prevention measures, which will be delivered collaboratively with Public Health and neighbourhoods
	Rather than "longer lives" we should focus on quality of life and wellbeing	Strategy will also measure 'healthy life expectancy'
	Childhood immunisations are generally good, but low in some areas - need to address variation	Added as an achievement measure in the Maternity & Children Delivery Programme
	While Stockport benchmarks well on childhood obesity levels nationally, the trend over time is going in the wrong direction and needs to be addressed	Added as an achievement measure in the Maternity & Children Delivery Programme
	While Stockport performs well on screening, uptake is lower in areas of deprivation	Added as an achievement measure in the Primary Care Delivery Programme
	While Stockport has low rates of smoking compared to the national average, it is still the biggest preventable contributor to early death	Added as an achievement measure in the Primary Care Delivery Programme
Delivery Programmes	Estates needs to be included in the sustainability plan	An 'Enablers' programme was added to cover estates, finance, digital, comms and engagement
	Communications / IT are key - many patients have issues with telephony and contacting their GP Practice	Communications and IT included in enablers delivery programme
	In light of the new models of care, shouldn't Primary Care and Neighbourhoods be merged into a single delivery programme?	Delivery Programmes were merged
Imagery	NHS plans should not be overly-medicalised - consider changing the icons on delivery programmes	Icon changed from a syringe to a house
	previous public engagement has fed back a dislike for the older person icon	Icon changed to an oak tree

8. Next Steps

Feedback was reported to the Strategy, Planning and Performance Committee for discussion and the recommended Strategy sent to the Governing Body and AGM for sign-off.

The CCG's engagement website includes a 'You Said, We Did' function. The full write up of involvement will be published on this site, setting out how local views influenced decisions and the final strategy. Reports will also be sent to specific groups engaged.

Appendix 6

Equality Impact Assessment

1. Overview

In January 2019, NHS England launched its Long-Term Plan, setting out expectations for the health sector over the next ten years. All CCGs are required to refresh their Strategic Plans by the Summer to set out how we will deliver the NHS Long-Term Plan.

NHS Stockport CCG's Strategic Plan will set out the CCG's vision for the next 5 years and prioritise our work to deliver the NHS plan.

2. Why Assess the Impact of our Strategy?

Everyone in Stockport is likely to use NHS services at some point in their life, whether it be visiting your local GP, asking the pharmacist for advice on cold and flu medication, going into hospital for an operation, or using our stop smoking services. We recognise that our decisions, policies and services have a major impact on the lives and wellbeing of local people.

At NHS Stockport Clinical Commissioning Group we believe that whoever you are and whatever your health needs you should receive a high quality service every time you walk through our doors.

NHS Stockport CCG is committed to working with local people to improve health and secure high-quality healthcare for the people of Stockport, now and for future generations. We want everyone to have greater control of their health and wellbeing, and to be supported to live longer, healthier lives with high quality health and care services that are compassionate, inclusive and constantly improving.

While our aim with this Strategy is to improve health and wellbeing for everyone in Stockport, we recognise that some people will require more support than others and that not everyone access our services in the same way. We want to ensure that our plans are fair and that they support improvement in health and wellbeing for *all* of our community groups.

Impact assessment is a way of considering the effect of our planned changes on different groups to:

- ensure the Strategy will not have a negative impact on the quality of services;
- consider whether the Strategy will help eliminate unlawful discrimination, harassment and victimisation;
- consider whether the Strategy will advance equality of opportunity between people who share a protected characteristic and those who do not;
- consider whether the Strategy will foster good relations between people who share a protected characteristic and those who do not; and
- inform the development of the proposed Strategy.

3. 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.

4. Stockport's Population

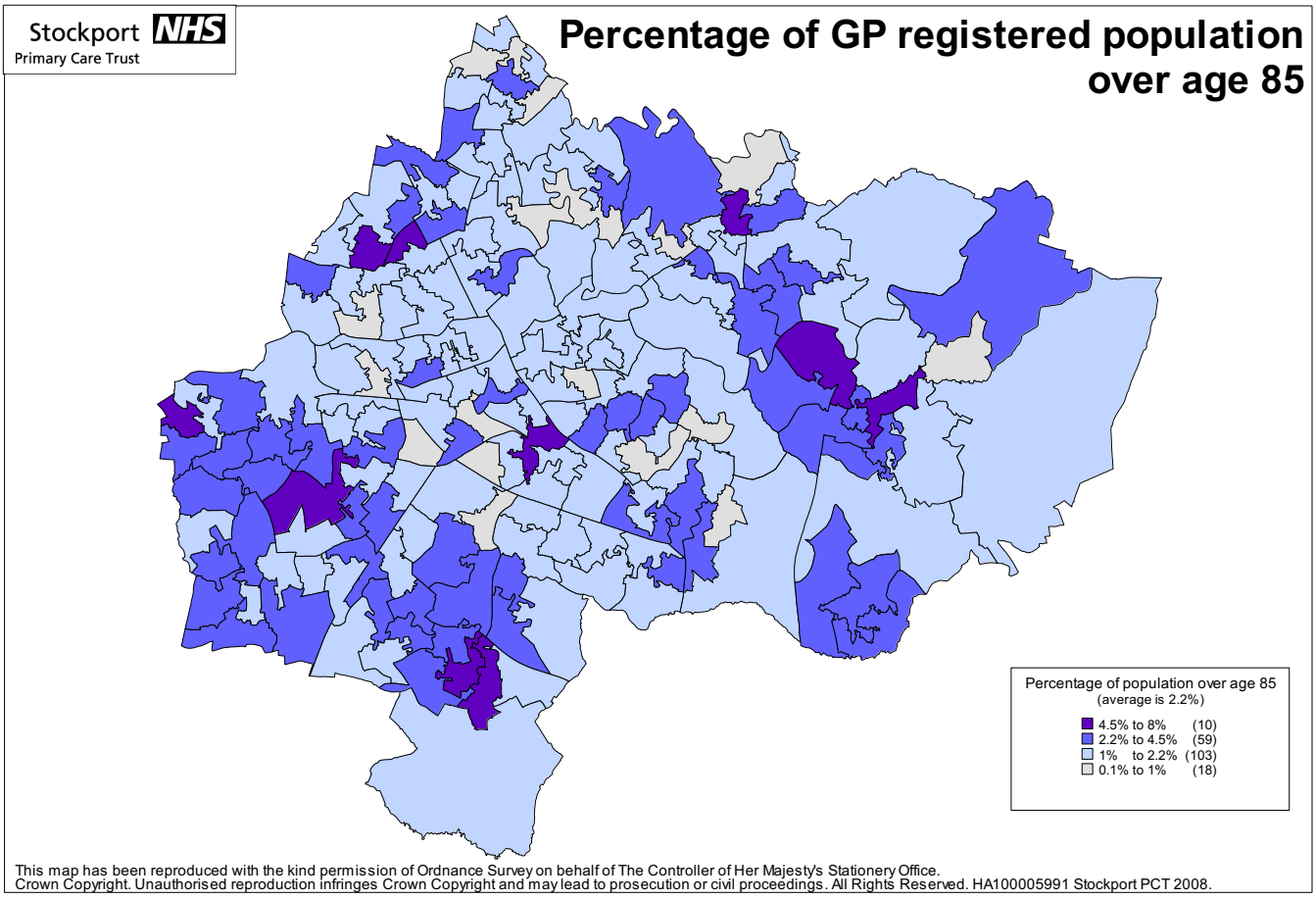
Stockport sits in the South East of Greater Manchester, bordering on the city to the North and on the countryside of Cheshire to the South. Stockport has a population of **291,045** residents, with **313,646** people registered at one of Stockport's 39 GP Practices. Our population is growing by around 1,000 people a year and is expected to continue to grow at this rate over the life-span of this Strategy.

Stockport continues to be one of the healthiest places to live in the North West, with health outcomes similar to the national average. Life expectancy is high, at 83.3 for women and 79.8 for men. Within the borough, however, there is a significant difference in health outcomes between Stockport's more affluent and deprived boroughs, with men in the most affluent areas living 11 years longer than those in the most deprived areas of the borough. Perhaps more significantly, in the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas.

Age

Stockport has the oldest age profile in Greater Manchester and its population continues to age. Currently 19.8% people are aged 65+ and this is likely to rise to 21.0% by 2024, with an additional 5, 800 people aged 65 or over.

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.



Older People - Key Information:

- Stockport's population is older than the England average, with an increasing number of older people living with dementia and other long-term conditions;
- 58% of older people in Stockport have a long term health problem or disability;
- 1 in 5 have two or more long-term conditions;
- By age 85 the proportion rises to 87% for one and 53% for two or more long term conditions;
- 11,400 people in Stockport have a history of falling, a key risk for loss of independence
- 33% of older people in Stockport live on their own leading to the danger of social isolation and vulnerability
- The frequency of use of hospital care increase significantly from age 65 onwards.
- 7,274 people over 65 are carers;
- 2,700 people have been diagnosed with dementia in Stockport

The number of children and young people in Stockport is also rising - though at a lower rate than our older population.

Children and Young People - Key Information:

- Almost 1 in 4 children in Stockport are overweight or obese by the age of 4 rising to 1 in 3 by the age of 11;
- More than 1 in 4 five-year olds suffer tooth decay;
- 8,165 children and young people are estimated to live in poverty;
- Over 70% of young adults are not active enough;
- Anxiety is the major long-term condition affecting young people in Stockport with more than 4,000 cases reported;
- 2,115 children and young people are carers; and
- Self-harm hospital admissions in those aged 10-24 are higher than the national average.

Disability

40% of people registered with a Stockport GP have one or more long-term health conditions, increasing the complexity of care needs in the borough.

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) or Personal Independence Payment (PIP) . 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.

The 2011 Census showed there are 31,982 unpaid carers in Stockport. 6,970 (22% of all carers) provide 50+ hours of care per week. Signpost for Carers estimate the total value of unpaid care in Stockport is £570 million a year.

Gender Reassignment

It is estimated that 1% of the UK population is gender variant, based on referrals to and diagnoses of people at gender identity clinics. This would equate to 3,000 people in the borough.

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.

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.

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
- Suicide (1:3 have attempted suicide [UK / USA])
- Self-harm
- Violence (transphobic behaviour primarily toward MTF)
- Substance abuse

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, and 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.

Pregnancy & Maternity

On average there are over 3,300 births to Stockport resident mothers each year

- Infant mortality rates are low in Stockport, at around 4.2 per 1,000.
- 73.9% of mothers initiate breastfeeding and 50.3% maintain up to 6-8 weeks.
- Smoking in pregnancy is low, at just 11.7%, but in Brinnington this rises to 42%.

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.

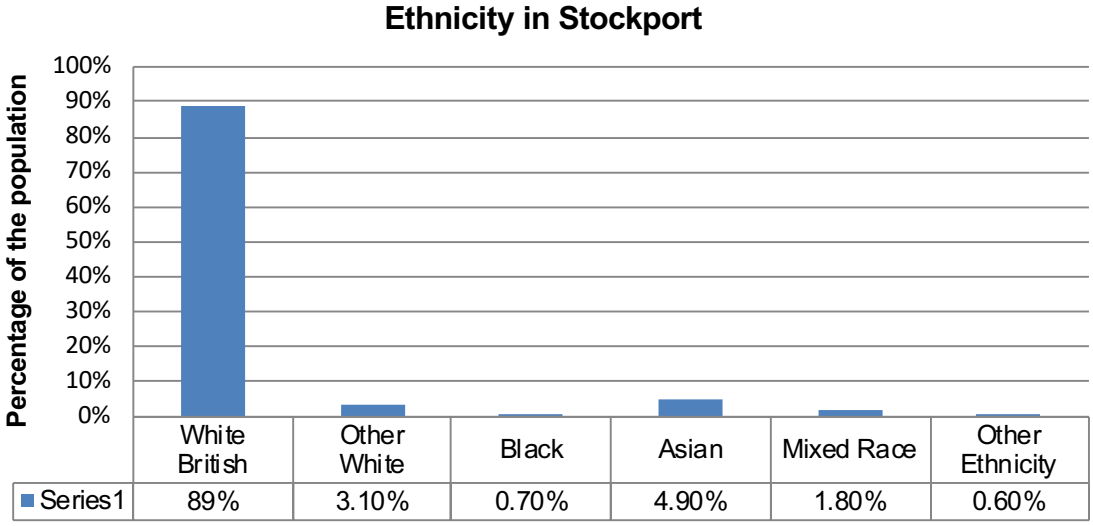
Education services are also reporting increasing numbers of children from BME ancestry reaching school age, along with increasing numbers of children with English as an additional language.

Birth rates and population growth are higher in the most deprived populations and, as a result, the level of need for services is rising, with particular growths in Special Educational Needs and Disabilities (SEND) and Autism.

There are currently more births than deaths a year, so the population is expected to continue to grow.

Race

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.



Based on data from benefits claims, there are 100 asylum seeker households and 2,700 who are looking for work.

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.

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 experience barriers accessing services and communicating with professionals. 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.

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.

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).

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.

Religion & 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 (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.

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%

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 local Hindu, Jewish & Muslim populations reported above average levels of good health compared to the average Stockport population.

While the Buddhist, Christian, Sikh & other religious 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 Ð also reflected nationally.

Women in Stockport live around 3.5 years longer than men

- Female life expectancy - 83.3
- Male life expectancy - 79.8

However, women spend less of their lives in good health:

- Males in Stockport will spend 82% of their lives in good health,
- women will spend 80% in good 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.

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.

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.

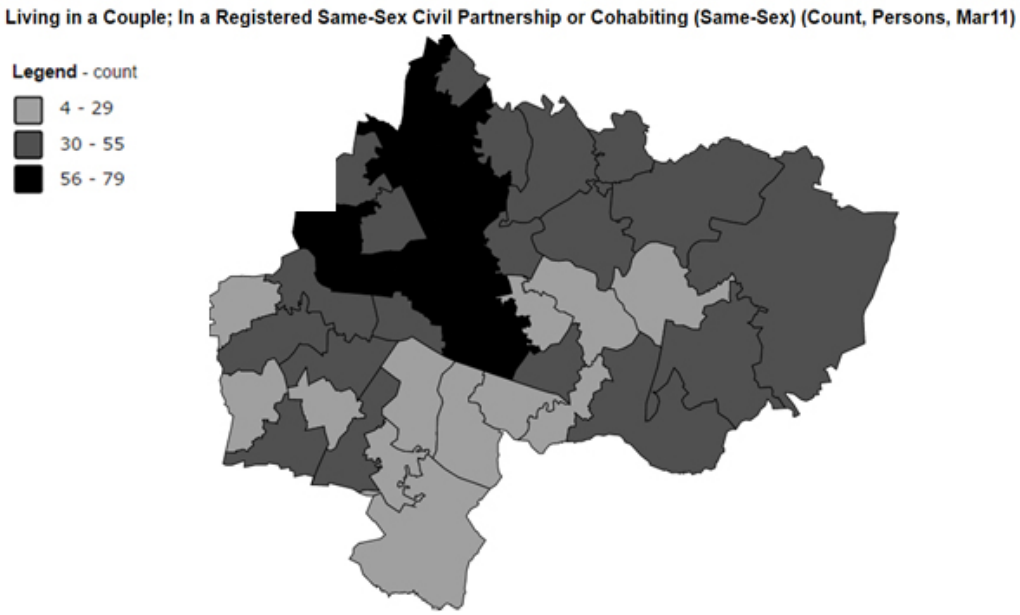
Sexual Orientation

It is estimated that 5-7% of the UK population is LGB, which would equate to 15-21,000 people in the borough.

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.

Local research demonstrates that those in younger age groups are more likely to identify as LGB, 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 LGB 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, 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.

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.

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.

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/).

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*).

5. The CCG's Strategy 2019-2024

The overarching purpose of the CCG's Strategy is to support people in Stockport to live healthier, longer and more independent lives.

The plan builds on Stockport's Joint Strategic Needs Assessment and Health & Wellbeing Strategy as well as local consultation on needs.

Over recent years NHS Stockport has worked to ensure that equality and diversity are mainstreamed into all of the work that we do. As a result, each section of the Strategy offers a range of benefits to local people from protected groups. Below is a breakdown of how protected groups will be affected by each area of the plan and what measures are in place to ensure positive outcomes.

At the strategic level, we anticipate a beneficial impact on service users and the community through this Strategy, 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;
- Children, through a new emphasis on child health;
- 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. The section below looks at anticipated impacts by strategic aim.

Start Well

The CCG recognises that previous transformation work has focused particularly on older people. As such, this strategic aim intends to focus on the support provided to children to ensure that everyone in Stockport has the best possible start in life. This section will have beneficial impact on the protected groups of pregnancy & maternity and age.

However, specific actions will be needed to ensure high standards for people from all protected groups, such as:
targeted promotion of smoking cessation in pregnancy work particularly in areas of deprivation where smoking rates are almost double
ensure that new interpretation services at Stockport FT provide adequate support to women and families with English as a second language
work with GP practices to improve immunisation rates and reduce variation.

Live Well

Increased prevention and better management of long-term conditions should benefit all protected groups. However, we know that access to our 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 - men; LGBT groups; ethnic minorities; people with disabilities; some religious groups.

Tailored campaigns should be developed for protected groups, including:
- flu campaigns for pregnant women;
- immunisation campaign for travellers;
- improved signposting to alcohol treatment and other lifestyle services among LGBT groups;
- breast and cervical cancer screening for Muslim women;
- breast and cervical cancer screening for women with disabilities;
- cervical screening among lesbian women;
- health checks for men.

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. Neighbourhood services will need to be in accessible locations and provide interpretation services. Home care will need to be culturally appropriate.

Age Well

Over recent years Stockport has had significant success in increasing life expectancy. We are proud of our achievements and now want to focus on ensuring that our services adapt to meet the increasing and diversifying care needs of our older populations.

This entire area will have a major beneficial impact on older people, people with disabilities / long-term conditions, and on carers.

However, specific actions will be needed to ensure high standards for people from all protected groups, such as:
targeted promotion of mental health services among minority groups
understanding the links between long-term conditions and mental health
analysing patient satisfaction data by protected characteristics to ensure that improvements are made with all communities and no single group is left behind.

Die Well

This strategic aim will benefit all community groups, particularly older people, people with serious health conditions, and carers.

The CCG recognises that the specific needs of children in this area differ greatly from those of adults and, as such, the aim is to tailor services to meet local needs.

However, specific actions will be needed to ensure high standards for people from all protected groups, such as:

- ensuring that the end of life work is tailored to meet the distinct needs of different religious groups
- analysing patient satisfaction data by protected characteristics to ensure that improvements are made with all communities and no single group is left behind.

Lead Well

This strategic aim is more internal in nature, focussing on the changes the CCG needs to make to develop a sustainable system, fit for the future.

Acute sector reforms will have a positive impact on all community groups by reducing unnecessary waste and undertaking more care close to home. 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. Attention will be paid to 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.

Next Steps

Progress will be monitored and published on an annual basis through the organisation's annual equality publications. Reports will be published on the organisation's website by the 31st January each year.

Responsibility for tracking progress will lie with the Governing Body.

Appendix 7

Glossary of Terms

Acronym	Title	Definition
A&E	Accident & Emergency	The emergency department in the hospital dealing with life-threatening emergencies.
ADHD	Attention Deficit Hyperactivity Disorder	A behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness.
ASD	Autism Spectrum Disorder	Autism is a different way of thinking and feeling that affects how you experience the world around you.
	Bridges to Health	A model for segmenting the population into groups to coordinate and integrate care, focussing on outcomes
CCG	Clinical Commissioning Group	clinically-led statutory NHS bodies responsible for planning and commissioning health care services for their local area.
CCG IAF	CCG Improvement & Assessment Framework	Key indicators to monitor performance of CCG's nationally
CCHC	Continuing & Complex Healthcare	Packages of care funded by the NHS to support complex and ongoing health needs.
COPD	Chronic Obstructive Pulmonary Disease	An umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, and refractory non-reversible asthma. This disease is characterised by increasing breathlessness.
CQC	Care Quality Commission	Independent regulator of all health and social care services in England
DTOC	Delayed Transfer of Care	When a patient is medically fit to go home but cannot be discharged from hospital as there is no support in the home
EIA	Equality Impact Assessments	A method of assessing planned changes to ensure that they do not have a negative impact on groups protected under the equality act.
EIP	Early Intervention in Psychosis	National measure to ensure that people experiencing an episode of psychosis receive the correct care within a reasonable timeframe.
ED	Emergency Department	The accident and emergency department in the hospital (see A&E above)
EUR	Effective Use of Resources	NHS policy for managing NHS resources effectively by ensuring that treatments of limited clinical value are only funded in clinically exceptional cases
FASD	Foetal Alcohol Syndrome Disorder	A group of conditions that occur in a person whose mother drank alcohol during pregnancy. These effects can be physical, behavioural or impact on learning. Often a person with a FASD has a mixture of these effects.

Acronym	Title	Definition
FT	Foundation Trust	NHS service providers
GMHSCP	Greater Manchester Health & Social Care Partnership	Devolved health and social care partnership across Manchester.
GP	General Practitioner	Family doctor
HW	Healthwatch	Organisations covering for every local authority area in England that work to ensure the views and experiences of patients, service users and the public inform the commissioning, delivery and scrutiny of local health and social care services.
IAPT	Improving Access to Psychological Therapy	NHS programme for treatment of anxiety disorders and depression.
IFR	Individual Funding Requests	Process to request NHS funding for a procedure not normally paid for by the NHS
JSNA	Joint Strategic Needs Assessment	Local assessment of health needs in the population
LCO	Local Care Organisation	The form by which we bring together teams of health and social care professionals to deliver integrated care outside of hospital.
LTC	Long-Term Conditions	A range of chronic health conditions such as cancer, diabetes, asthma or epilepsy.
LTP	Long Term Plan	The NHS's 10 year plan
MCP	Multi-Speciality Community Provider	A new model of care, integrating primary, community, mental health and social care teams to deliver out of hospital care
Nolan	Nolan Principles	The 7 principles of public life
OF	Outcomes Framework	Section in a contract, setting out the outcomes to be delivered
PbR	Payments by Results	A system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.
PCN	Primary Care Network	Networks of GP Practices and expanded neighbourhood teams made up of pharmacists, district nurses, community geriatricians, dementia workers, physiotherapists, social care and the voluntary sector
QIPP	Quality, Innovation, Productivity & Prevention	NHS programme to improve quality and reduce costs
RTT	Referral to Treatment Time	National standards for the maximum time within which a patient should be treated after a referral is made
SEND	Special Educational Needs and Disabilities	Support for children and young people with special educational needs and disabilities

Acronym	Title	Definition
SMBC	Stockport Metropolitan Borough Council	Local Authority for Stockport
SNC	Stockport Neighbourhood Care	Stockport's Local Care Organisation, made up of: • Viaduct Care (GP Federation) • Stockport NHS Foundation Trust (community services) • Stockport Metropolitan Borough Council (social care) • Pennine Care (mental health) • Total Provider Alliance (voluntary sector)
Vanguard	NHS Vanguard sites	In 2015 the NHS appointed 50 localities as Vanguard sites to trial and develop new models of care. NHS Stockport CCG was a Vanguard site, developing the MCP model.

Appendix 8

References

- Better Care Fund Task Force. (2014). 'Population Segmentation, Risk Stratification and Information Governance' in *BCF Technical Toolkit*. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/09/1-seg-strat.pdf (Accessed: 19 June 2019).
- Committee on Standards in Public Life (1995). *The 7 Principles of public life*. Available at: https://www.gov.uk/government/publications/the-7-principles-of-public-life. (Accessed: 19 June 2019).
- Greater Manchester Combined Authority. (2018). 'The Greater Manchester model: Further, Faster'. Available at: https://www.greatermanchester-ca.gov.uk/media/1676/greater-manchester-model.pdf (Accessed: 27 August 2019)
- Greater Manchester Health and Social Care Partnership. (2015). 'Taking Charge of our Health & Social Care in Greater Manchester'. Available at: http://www.gmhsc.org.uk/our-plans/ (Accessed: 19 June 2019).
- Lynn J, Straube BM, Bell KM, Jencks SF, Kambic RT. (2007). 'Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model.' The Milbank Quarterly. 2007;85(2):185-208. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690331/ (Accessed: 19 June 2019).
- National Co-Production Advisory Group and Think Local Act Personal (2016). *Ladder of Co-Production*. Available at: https://www.thinklocalactpersonal.org.uk/_assets/COPRODUCTION/Ladder-of-coproduction.pdf (Accessed: 03 July 2019)
- NHS England. (2018). *CCG Improvement and Assessment Framework*. Available at: https://www.england.nhs.uk/commissioning/regulation/ccg-assess/ (Accessed: 19 June 2019).
- NHS England (2019) *Friends and Family Test Data*. Available at https://www.england.nhs.uk/publication/friends-and-family-test-data-april-2019/. (Accessed: 19 June 2019).
- NHS England (2018) *GP Patient Survey*. Available at: https://www.gp-patient.co.uk/. (Accessed: 19 June 2019).
- NHS England. (2019). *NHS Long-Term Plan*. Available at: https://www.england.nhs.uk/long-term-plan/. (Accessed: 19 June 2019).
- NHS England (2015). *NHS Vanguard Programme*. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf (Accessed: 19 June 2019).
- NHS RightCare. (2017). *Commissioning for Value where to look pack*. Available at: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-stockport-jan17.pdf. (Accessed: 19 June 2019).

Reed S, Göpfert A, Wood S, Allwood D, Warburton W. (2019). 'Building healthier communities: the role of the NHS as an anchor institution'. The Health Foundation: London. Available at: https://www.health.org.uk/sites/default/files/upload/publications/2019/I02_Building%20healthier%20communities_WEB.pdf (Accessed: 27 August 2019)

Stockport Health & Wellbeing Board. (2017). *Stockport Joint Health & Wellbeing Strategy*. Available at: http://www.stockportccg.nhs.uk/stockport-joint-health-and-wellbeing-strategy-2017-2020/ (Accessed: 19 June 2019).

Stockport Health & Wellbeing Board. (2016). *Joint Strategic Needs Assessment*. Available at: www.stockportjsna.org.uk (Accessed: 19 June 2019).

Stockport Together. (2018). *Business Cases*. Available at: http://www.stockportccg.nhs.uk/have-your-say/stockport-together-plan/key-documents/business-cases-and-summaries/. (Accessed: 19 June 2019).

NHS
Stockport
Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group
4th Floor, Stopford House
Piccadilly
Stockport
SK1 3XE

Tel: 0161 426 9900
Email: stoccg.customerservices@nhs.net
Web: www.stockportccg.nhs.uk

NHS
Stockport
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Involvement and Engagement Strategy
2019-2021

Ask *What Matters*
Listen to *What Matters*
Do *What Matters*

1. Introduction

This involvement and engagement strategy sets out the approach, principles and recommendations for ensuring meaningful involvement with local communities, individuals and representative groups in shaping health and care services and ensuring person-centre care.

The development and delivery of health and care is often complex and has a major impact on the lives and wellbeing of the local people. As a result the CCG will actively involve local communities and service users (and their carers) to ensure that everyone has an equal chance to have their say before any major decisions are made.

There is also an opportunity for the CCG to work with local partners to ensure a shared and consistent approach to involvement and engagement across Stockport.

Public involvement helps to provide greater understanding for local needs and asking 'what matters' for people. It can reach the more vulnerable members of our community and promotes targeted support and equality of opportunity for those with additional or specialist needs and to prioritise those people who experience the poorest health outcomes – enabling improved access to services and reduces health inequalities.

Involvement can provide the opportunity to see things differently and to be innovative, leading to a better use of limited resources.

2. Background and Context

Health and care providers and commissioners for Stockport are responsible for making sure that the almost 310,000 patients registered with a Stockport GP have access to the health care services they need.

Stockport continues to be one of the healthiest places to live in the North West, resulting in a generally older population than the rest of Greater Manchester. However, this is not the experience of all of our residents. Local communities experience varying levels of affluence and have significantly different health needs, in the least affluent areas life expectancy is 10 years lower than in the most affluent.

On average each year our local health and social care activity includes:

- **98,000** A&E attendances
- **89,00** hospital admissions
- **543,000** community contacts
- **8,500** adult social care clients
- **700,000** GP practice visits
- **11,000** people in touch with Pennine Care

Stockport, like other local areas across the country, faces a number of challenges in the delivery of existing health and social care services. These issues include:

- The success of an ageing population leads to increasingly complex care needs for individuals who are at higher risk of isolation and loneliness. This is because more people live on their own without direct family support;
- A population where birth rates have risen, especially in areas of deprivation. This has led to more children and young people living in low income households where health outcomes are poorer;
- Children with complex health, care needs and disabilities
- Changes in the most common health issues experienced by the population, to those linked to lifestyles or are otherwise preventable;
- A period of economic challenge that affects the incomes and entitlement of the most vulnerable people in Stockport;
- Fragmented services which are complicated to access, has duplications and are not as focussed on the individual's needs as they could be;

- A system where too many people are admitted to hospital when many could be better and more appropriately cared for at home;
- Increasing financial pressures with deficits forecasts for Stockport as demand growth continues if service delivery is not improved.

Stockport's population has a wide range of health needs. Stockport has the oldest age profile in Greater Manchester and the population of the area continues to age. Currently 19.4% people are aged 65+ and this is likely to rise to 21.8% by 2024, with an additional 9,681 people.

Children and Young People

- Almost 1 in 4 children in Stockport are overweight or obese by the age of 4 rising to almost 1 in 3 by the age of 10.
- Almost 1 in 4 of 5 year olds suffered tooth decay.
- 8,500 children and young people are estimated to live in poverty.
- Over 70% of young adults are not active enough.
- Anxiety is the major long term condition affecting young people in Stockport with more than 2,700 cases reported.
- Self-harm hospital admissions in those aged 10-24 are higher than the national average.

Adults and Older People

- 1 in 4 of adults is overweight or obese putting them at greater risk of liver disease, heart disease and diabetes.
- Cancer is the major cause of premature death with 45% of deaths under 75 years.
- Stockport's population is older than the England average, with an increasing number of older people living with dementia and other long term conditions.
- Half the older population of Stockport has a long term health problem or disability and 1 in 5 has 2 or more long term conditions.
- 1 in 3 older people live alone.
- 2,700 older residents suffer with Dementia

There is also often a gap in the transition for children and young people (and their carers) when they move into adult services. This can often be at a critical point in their care and results in an inconsistent level of quality support that is needed, as a result of the wide variance between adult and children's pathways. Progress is already being made by the CCG to review the functioning of adult therapy services to enable better alignment when children move into adult services.

2.1 Legal duties

The NHS Five Year Forward View (2014) and Next steps on the NHS Five year Forward View (2017) describes a new relationship between the NHS, patients and the public, including a commitment to engage and involve communities and citizens in decisions about health services.

In addition there are a number of statutory duties and national requirements placed on NHS organisations to ensure that they engage and reflect the needs of the local communities they serve.

The following sections outline the legal duties the CCG needs to adhere to:

2.2 Health and Social Care Act 2012

The Health and Social Care Act 2012 places a legal duty to involve patients, service users and their carers and representatives, in decisions which relate to the prevention or diagnosis of illness in patients or their care or treatment.

2.3 Equality Act 2010

There are a range of duties set out in the Equality Act 2010 that apply to the CCG. It requires the organisation to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

To support NHS organisations in meeting the duties, NHS England introduced the Equality Delivery System (EDS2) to guide involvement with local partners, including local communities, to review and improve performance for people with characteristics protected by the Equality Act 2010.

The four aims of the Equality Delivery System are:

- Better health outcomes;
- Improved patient access and experience;
- A representative and supported workforce;
- Inclusive leadership.

2.4 Children and Families Act 2014

For children, young people and families the requirements of the Children & Families Act 2014 and associated SEND Code of Practice 2015 provide the mandate for involvement with families to drive and inform service planning and development across health and partner organisations.

2.5 NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of rights and responsibilities which are a legal entitlement protected by law.

One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- In the development and consideration of proposals for changes in the way those services are provided
- In the decisions to be made affecting the operation of those services.

3 Differences between involvement and consultation

Involving local patients, public, carers and patient representative groups is important to the CCG so that we can be assured of commissioning the best possible services that meet the needs of local communities and that represent the best possible value for money.

3.1 What is involvement?

Involvement describes the continuing and on-going process of developing relationships and partnerships so that the voice of local people and partners is heard and that plans are shared at the earliest possible stages.

Examples of this type of involvement would include patient participation groups, Citizen's Panel and partnerships with Healthwatch and other local representative groups where they are involved in decision-making.

It also describes activity that happens early on a formal consultation process, including holding extensive discussions with a wide range of people to develop a robust case for change.

3.2 What is a 'formal consultation'?

'Formal consultation' describes the statutory requirement imposed on NHS bodies to consult with overview and scrutiny committees (OSCs), patients, the public and stakeholders when considering

a proposal for a substantial development of the health service, or for a substantial variation in the provision of a service.

Formal consultation is carried out if a change is 'significant'. This is determined where the proposal or plan is likely to have a substantial impact on one or more of the following:

- Access (eg. reduction or increase in service due to change of location or opening times)
- Wider community (eg. economic impact, transport, regeneration)
- Patients or users (either current or future)
- Service delivery (eg. methods of delivery or relocation of services)

3.3 Gunning Principles.

The Gunning Principles were developed as a direct result of a judicial review and the case law sets out the legal expectations of what is deemed as appropriate in formal consultation. Any consultation requires careful planning and continual assessment throughout the process.

Outcomes of the consultation need to be robustly examined to ensure that all the specified intentions have been met and all the resultant responses considered.

There are four guiding principles (known as the Gunning Principles) for public sector organisations to meet when undertaking formal consultation:

- Consultation must take place when the proposal is still at a formative stage
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account

The outcome of a formal consultation must be reported to the CCG Governing Body, together with the feedback received, and must show how this has been taken into account in any recommendations and decision-making.

4. Aim

The overall aim of this strategy is to outline how the CCG will deliver meaningful involvement and engagement with local communities, patients, service users, carers, families and public in shaping local health and care.

This will be achieved by asking "What Matters" and acting upon the feedback to ensure it informs local decision-making.

5. Objectives

The overall objectives of the strategy are to ensure CCG staff consider 'What Matters' to a broad range of people when planning new services or service improvements by involving people in decision-making.

In designing and delivering services it is important to:

- **Ask** *What Matters most to those receiving health and care services;*
- **Listen** to *What Matters to patients, service users, carers and communities;*
- **Do** *What Matters to improve the way health and care is delivered.*

In addition, achieving the objectives of the policy will:

- Ensure meaningful involvement and engagement with a wider range of communities and individuals.
- Mean that the CCG works in close partnership with third sector and voluntary organisation to increase involvement and engagement.
- Ensure involvement and engagement opportunities are visible and fully accessible.
- Increase and improve the opportunities for involvement of seldom heard people and groups.

5.1 What Matters?

The 'What Matters?' approach was developed by NHS Scotland and has expanded internationally to encourage and support meaningful conversations that are open and engaging.

Locally health and care staff and organisations can use the approach to improve the quality of how they engage and involve others in decision making and shaping services.

The experience and evidence from the 'What Matters' programme demonstrates that focusing on what really matters to people can lead to big improvements for staff, services and communities, and can improve the quality and effectiveness of care and better health outcomes.

'What matters' is a simple question that can deepen the connection between health and care staff and service users, communities and partners, helping to truly understand what matters to an individual. in receiving services.

This in turn can lead to services that are more person-centred and tailored to the needs of the individual. It can also help empower staff and services to lead innovation and ensure that care reflects the needs of individuals and communities.

The approach could have a significant impact on improving the quality of how the health and care is commissioned and meets the challenges of integrating services and working more closely with patients, communities and partners.

Across Stockport partners will ask what matters; listen to what matters and do what matters to support staff and in turn improve the quality of local services and patient experiences.

6. Involvement and Engagement principles

It is essential that all involvement and engagement activities are:

- Open, honest and transparent
- Consistent and compelling
- Timely and relevant
- Clear and free of jargon
- Accurate, fair and balanced
- Encourages participation

7. Understanding key stakeholders

Stakeholder mapping sets out the key stakeholders and partners. This will inform involvement and engagement action planning and can be used to gain more detailed insight into the needs and interest of individual stakeholders and groups e.g. patients, carers, the general public, staff, providers, the voluntary sector and monitoring organisations.

The following sections outline the people of Stockport in the key protected characteristics that need consideration when engaging and involving communities.

Black Minority Ethnic (BME)
Stockport has a BME population (non-white descendants) of approximately 8% (2011 ONS census). This equates to around 22,500 people residing in the Borough. These communities experience access issues due to barriers such as language and cultural issues. Another significant barrier is a lower level of awareness of early warning signs for cancer among some of these groups.

The distribution of the BME population across Stockport is not even; the areas of Heald Green, Cheadle & Gatley and Heatons South are particularly diverse. Consideration needs to be made regarding formats, language and accessibility of information and services for BME groups.

Older Citizens:
There are around 55,624 people (19.4%) aged 65 years and over residing in Stockport (according to the 2014 JSNA population figures). From this group 26,132 (9.1%) are aged 75+; 7,397 (2.6%) are aged 85+; and 2,698 (0.9%) are aged 90+

It is important that services are commissioned and procured to meet the complex needs of older citizens, to consider the relationship with disability, for example dementia, and to support them to live in their own homes for longer. It is estimated 2,850 people in Stockport have a diagnosis of dementia, an increase of more than 900 over the last five years. There are a further estimated 1,000 people living with dementia who have yet to be diagnosed. (Source: Stockport JSNA).

Children and Young People:
Advancing the health needs of children and young people requires tailoring services to meet the needs of boys and girls of different age groups. In particular, those services most relevant to this group such as mental health, teenage pregnancy, sexual health, and alcohol and weight management.

Stockport school aged children have lower rates of overweight and obesity combined than the England average, however, this still equates to 1 in 4 children being overweight or obese by the age of 4 rising to almost 1 in 3 by the age of 10. In addition around 25% of 5 year olds suffered tooth decay. It is estimated that 8,500 children and young people are estimated to live in poverty across Stockport (Source: Stockport JSNA).

Self-harm hospital admissions in those aged 10-24 are higher than the national average and anxiety, asthma and depression are the major long term conditions affecting Stockport young adults. Chlamydia detection rates are higher in Stockport young adults than the national average, although teenage conception rates are lower (Source: Stockport JSNA).

This data shows that intervention in early years is a key priority that will enable us to tackle health inequalities in Stockport.

Disability, Long-Term Conditions and Mental Health:
The Department of Work and Pensions estimates that around ten million people in the UK are disabled and have difficulty carrying out day-to-day activities. The Equality Act 2010 protects those with long-term conditions including cancer, diabetes, COPD, CVD and dementia. It is also essential that services are accessible and consider the needs of people with mental health conditions.

It is estimated that in Stockport there are around 56,000 people who suffer from a common mental condition (Source: Stockport JSNA). In Stockport there 6,874 children with Special Education Needs, 1,515 children with learning disabilities and around 640 children living with autism.

In Stockport 41% of people registered with a Stockport GP (124,000) have one or more long term conditions. By age 55 this increases to half of the registered population and by age 85+, 9 in 10 people have at least one long term condition. (Source: Stockport JSNA).

Lesbian, Gay, Bisexual and Transgender (LGBT):
A disproportionate number of the LGBT community experience mental health issues. These communities face disadvantages in relation to access and health outcomes. There is no direct evidence for the total number of the population who are LGBT within Stockport, however the JNSA report estimates that between 2,250 (1%) and 11,250 (5%) would be within the approximate range, using evidence from national research and anecdotal local evaluation.

Gender:
Men and women display different behaviours in relation to accessing services. Life expectancy varies between men (79.9 years) and women (83.0 years), although there are significant gaps between the most deprived areas. Men and women experience different illness and conditions, so appropriate and targeted services are essential. For example, it is important that women receive appropriate and targeted gynaecological and screening services. It is a key priority to ensure that men access appropriate prevention services to reduce unhealthy lifestyle behaviours (Stockport JSNA).

Religion/Belief:
Religion and belief is extremely important to many residents in all aspects of their lives. Particular consideration of religion and beliefs needs to be taken with end of life services. The is a wide diversity across Stockport in relation to religion, with around 63% identifying as Christian, over 3% Muslim, 0.6% Hindu, 0.5% Jewish and 25.1% stating no religion (Stockport JSNA).

There are around 1,700 voluntary and charity organisations that provide support and advice for people across Stockport that would also need consideration when engaging and involving communities. A growing number of these groups are coming together to form an alliance and provide greater consistency in involvement an provide a platform to ensure their voices are heard.

6.1 Stakeholder Matrix

The stakeholder matrix below provides an outline for those groups and individuals the CCG should consider when planning any involvement activity.

Involve/Consult • Patients • Carers • Health & Care Staff • Citizens Representative Panel • Patient Participation Groups • Health Champions • General Public • Councillors & MPs • Health Overview & Scrutiny Committees • Healthwatch • Voluntary Sector (Sector 3/Synergy)	**Liaise closely/partner** • GP Practices • GMHSCP • NHS England • NHS Improvement • NHS & Non-NHS Providers • Care Quality Commission • Stockport Health & Well Being Board • Other Partners (Police / Fire / NWAS)
Monitor/Key opinion formers • Professional bodies (Royal Colleges) • Regulators (GMC, NMC etc) • Local Medical Council • Public Health England • National Institute for Health & Clinical Excellence • Department of Health & Social Care • Community Groups (ie NHS Watch) • Media	**Keep informed/consider** • Pharmacies • Dental Practices • Opticians • Healthwatch - out of area • Audit Commissioning • Neighbouring CCG's • Care & Residential Homes

7. Models of involvement and engagement

The CCG has recommended that the 'Ladder of Participation' be used as the model for considering the level and type of involvement required.

The model has been adapted from the work undertaken by the New Economics Foundation (Nef) and Think Local Act Personal (TLAP) and is used alongside the values and principles of the NHS England and Coalition for Collaborative Co-production Model.

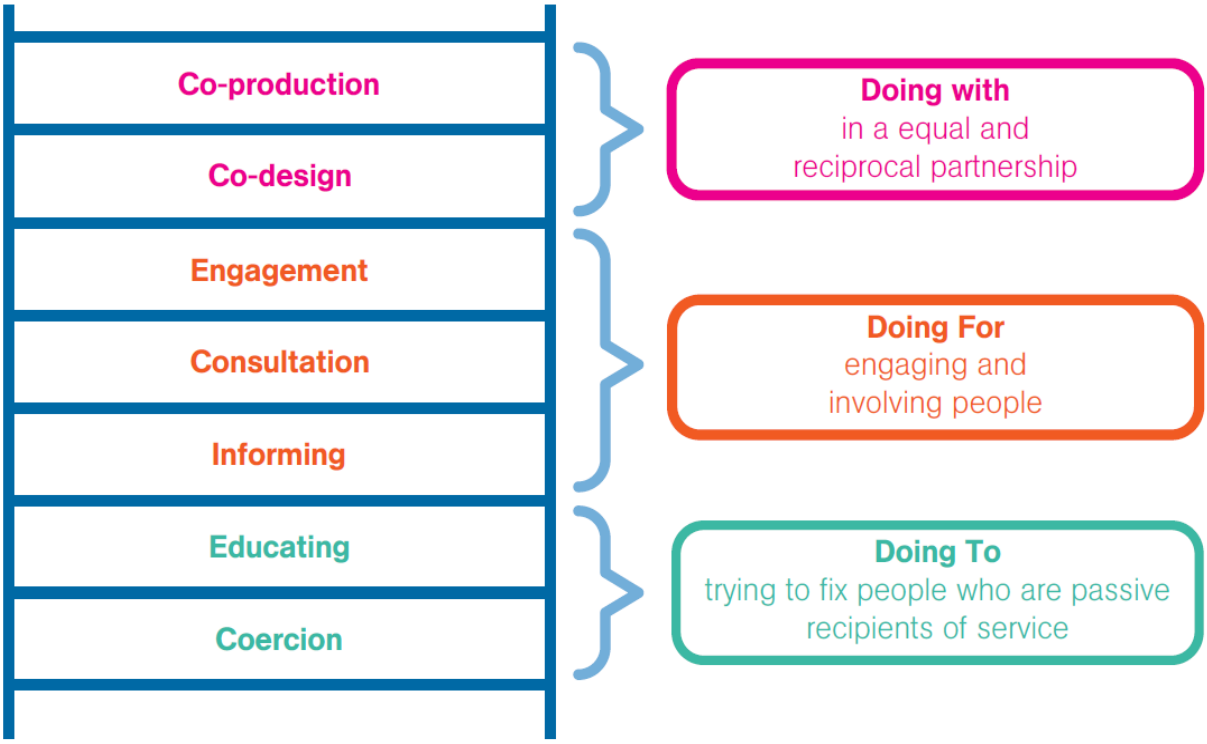
7.1 Ladder of Participation

(Adapted by New Economics Foundation and Think Local Act Personal model of participation)

A widely accepted model of involvement is the 'Ladder of Participation' which assists in planning the level of involvement needed and moves along a continuum, or ladder, to determine the best approach.

The purpose of the model is to enable organisation to evolve involvement to a meaningful partnership that has shared decision-making at the heart. This is often referred to as 'co-production' when applied to public service design and provision.

One perceived limitation of using the model is that implies going up the ladder is best. However, by recognising that different levels of engagement and involvement are appropriate at different times and in different situations the model provides a helpful guide.



7.2 Co-production Model (NHS England/Coalition for Collaborative Care

A Co-production Model

Five values and seven steps to make this happen in reality

What is co-production?

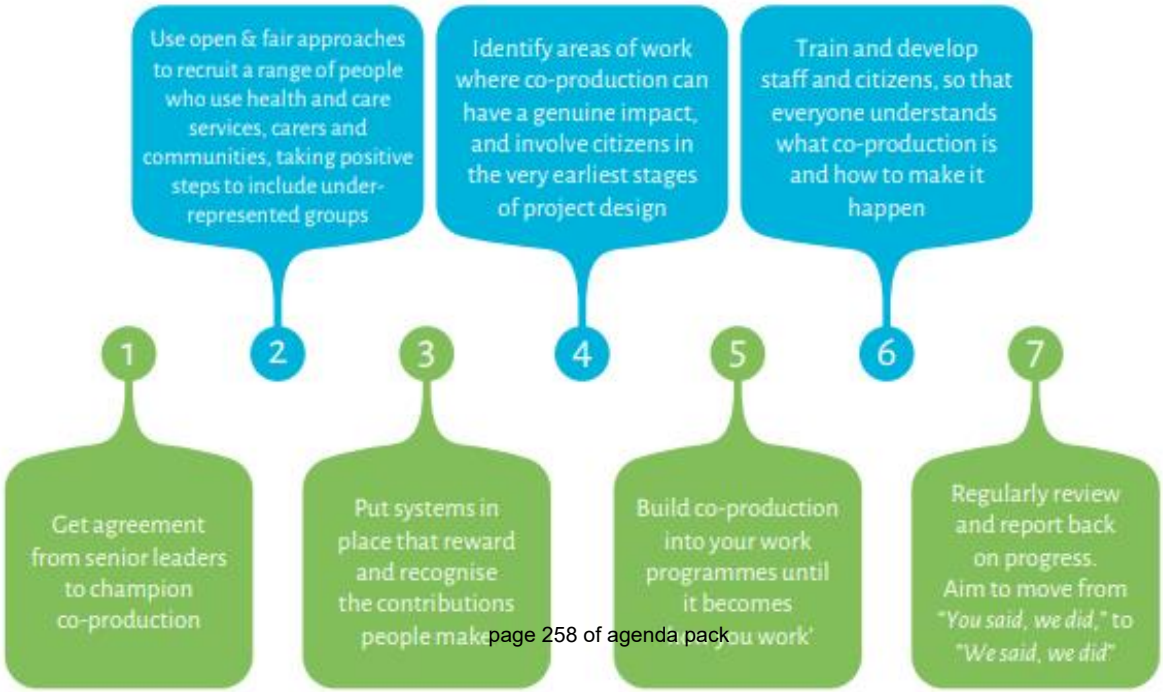
Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.
Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches.

Values and behaviours

For co-production to become part of the way we work, we will create a culture where the following values and behaviours are the norm:

How to do it?

Seven practical steps to make co-production happen in reality:



8. Methods of involvement and engagement

There are a range of methods that can be used in delivering engagement and involvement:

A blend of approaches can be used to engage, involve and actively seek out the views of local people and community groups. It is expected that all methods are evidence based and are appropriate for the intended audiences:

- Events, including partnership engagement events.
- Focus groups
- Community forums
- Meetings (internal and external)
- Workshops
- Face-to-face
- Surveys
- Formal consultations
- Publication of strategies, plans, reports and other formal publications
- Newsletters and publications
- Digital channels (including websites, social media and blogs)
- Briefings
- Media (including paid media and advertising campaigns)

It is essential that all information is accessible and that processes are in place to provide information in differing formats on request (e.g. large print, other languages, Braille or audio). In all engagement and involvement activity information should be clear, in plain language and free of jargon and abbreviations.

9. Roles and responsibilities

Effective meaningful involvement and engagement is everyone's responsibility and all CCG staff have a duty to work closely with patients and communities, to ask 'What Matters' and ensure there are real opportunities for them to influence decision-making.

The roles and responsibilities were developed from feedback and analysis of the Stockport Together consultation in 2018 and provide the key principles to work towards.

Ref	Category	Action	Detail	Lead
1	Governance & Compliance	Equality actions to be included within all new service implementation plans	Ensure EIAs are undertaken and involvement stakeholders in service developments	All CCG Commissioning Leads
2	Governance & Compliance	Quarterly updates on involvement and engagement activity	Regular updates on activity to involve and engage stakeholders	CCG Governing Body
3	Involvement & Engagement	Develop strategy for involvement and engagement.	Including identifying key stakeholders and optimal communications Methods.	Head of Communications
4	Involvement & Engagement	Patient engagement and complaints to be monitored by protected groups	To ensure there are no adverse impacts on any groups or individuals	Head of Communications / Customer Services Team
5	Involvement & Engagement	Engagement plans for new service, changes to delivery or commissioning intentions.	Including: map of stakeholders (ie protected groups), communications formats to meet needs to stakeholders, leaflets and other publicity to use	Commissioning Leads Head of Communications

			inclusive images and language to demonstrate accessibility to all community groups.	
6	Contracting	All contracts to set out the legal requirements of organisation and providers to follow duties under the Equality Act and Accessible Information Standard.	Equality monitoring & reporting, interpretation and translation services, accessible Facilities	Commissioners Finance
7	Service Access	Venues of new neighbourhood bases, clinics or bed based facilities assessed to ensure full access.	i.e. Disabled parking, Disabled toilets, changing facilities, hearing loops.	Commissioning Leads
8	Service Access	IT & Digital Technology	Delivery of plan and training for patients on how to use any self-care technology, training on how to use Skype technology for virtual appointments and alternative options for patients who are unable to use technology.	Head of IT
9	Staffing	Develop a staff training plan	Ensure all staff across Stockport receive equality & diversity training, and are aware how to access support services (ie interpretation and translation services).	Director of Corporate Affairs, Policy & Relationships

10. Partnership Involvement Network

Across England many health and social care organisations are working ever more collaboratively to deliver joined-up and consistent involvement with local communities. In Greater Manchester Tameside and Glossop have led the way in introducing a new model of engagement and involvement and Stockport is building support to develop a similar approach.

The proposal is being developed to evolve local engagement which is currently delivered by each organisation separately, into a new Partnership Involvement Network that would be part of a strategic system-wide health and care partnership.

The aim of the Partnership Involvement Network (PIN) proposal would be for it to become part of a partnership approach to provide the patients, carers and local communities with a structured method to influence the strategic planning and development of health and care services and to co-produce issues and ideas.

The key principles behind the proposal for a Partnership Involvement Network (PIN) would be to:

- Actively involve the public, patients and other stakeholders in shaping local services;
- Work collaboratively across public and community sectors so that involvement is joined up across Stockport;
- Continually ask ‘What Matters’ to the public, patients and other stakeholders when planning and shaping local services.

The new network will establish a coordinated and collaborative forum for people and organisations to ensure their voices are heard and give the opportunity to learn about and influence to the development of public services.

Next steps
The proposals to set up a Partnership Involvement Network will be coproduced and developed with local partners and would become a central strategic involvement forum for representative organisations and individuals across Stockport.

11. Risks log

Below are the potential risks and mitigations that need to be considered in the delivery of public involvement.

No	Risk	Description	Mitigation
01	Negative media	Potential for negative media stories relating to engagement or commissioning decisions	Media issues to be managed and appropriate statements provided.
02	Engagement	Potential for gaps in communications or misinterpretation of information	Provide information through a variety of channels to reduce any potential gaps
03	Engagement	Uncertainty or confusion during process for individuals or communities.	Ensure FAQs and information is available online for staff
04	Delivery of involvement	Ensure public are informed early of any plans or updates to maximise involvement/	Must provide access to support information throughout the process
05	Other partners	Ensure the coordination of involvement activity by other partners are planned to avoid confusion.	Manage engagement with other communications leads
06	Engagement	Limited resources within the to deliver detailed involvement and engagement projects.	Identify area leads within the system.
07	Engagement	Failure to regularly and meaningfully listen and involve individuals, communities and groups.	Ensure clear priorities and processes are in place to support and engage with local communities.

12. Conclusion

The Involvement and Engagement Strategy will lead and shape participation and shared decision-making across the diverse communities of Stockport.

It is essential to work closely with patients, service users, carers and communities who have experience of using health and care support or services to make improvements in how that care is planned, organised and delivered.

Locally the aim will be to engage and involve staff and the public by:

- **Asking** *What Matters most when receiving health and care services*
- **Listening** to *What Matters to patients, service users, carers and communities*
- **Doing** *What Matters to improve the way health and care is delivered.*

The outcome will be to demonstrate how local engagement can make a real difference by increasing how communities can be involved in shaping services and decision-making.

Contributors in developing the Involvement and Engagement Strategy

The Involvement and Engagement Strategy has been developed in partnership with a range of individuals and organisations including:

- Parents in Partnership (PIPs)
- Citizens Representation Panel (CRP)
- Stockport Healthwatch
- Stockport Clinical Commissioning Group
- Stockport Council
- Stockport Neighbourhood Care
- Stockport NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Viaduct Care
- Mastercall
- Action Together