

Stockport

Local system review report Health and Wellbeing Board

Date of review:
16 – 20 April 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Senior Responsible Officer: Alison Holbourn, CQC
- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Julia Daunt, CQC

The team included:

- CQC Chief Inspector of Primary Medical Services and Integrated Care
- Three CQC reviewers
- One CQC analyst
- Two pharmacy inspectors
- Two CQC inspectors
- Four specialist advisors (one chief executive of a local authority, one former director of adult social services, one clinical commissioning group governing body member, one GP)

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- Senior leaders and managers from Stockport Metropolitan Borough Council (the local

authority), NHS Stockport Clinical Commissioning Group (the CCG), Stockport NHS Foundation Trust (SNHSFT), Manchester University NHS Foundation Trust, Pennine Care NHS Foundation Trust and Viaduct Care.

- Health and social care professionals including social workers, GPs, discharge teams, therapists and nurses and staff from North West Ambulance Service NHS Trust (NWAS).
- Healthwatch Stockport and voluntary, community and social enterprise sector (VCSE) representatives.
- Representatives of health and social care providers.
- People using services, their families and carers. We also spoke with people in A&E, elderly care wards and the discharge lounge of Stockport NHS Foundation Trust and during visits to intermediate care facilities.

We reviewed ten care and treatment records and visited seven services in the local area including the acute hospital, care homes, domiciliary care providers and GP practices.

The Stockport context

Demographics

- 18% of the population is aged 65 and over
- 92% of the population identifies as white
- Stockport is in the 20-40% least deprived local authorities in England

Adult social care

- 48 active residential care homes:
 - One rated outstanding
 - 22 rated good
 - 23 rated requires improvement
 - Two rated inadequate
- 20 active nursing care homes:
 - 12 rated good
 - Five rated requires improvement
 - Two rated inadequate
 - One currently unrated
- 39 active domiciliary care agencies:
 - 19 rated good
 - Seven rated requires improvement
 - 13 currently unrated

GP practices

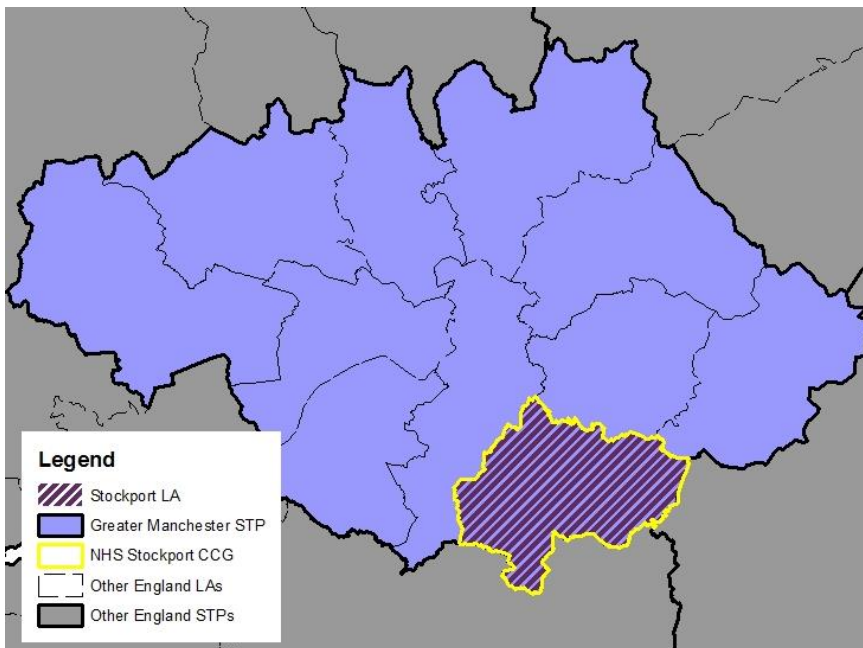
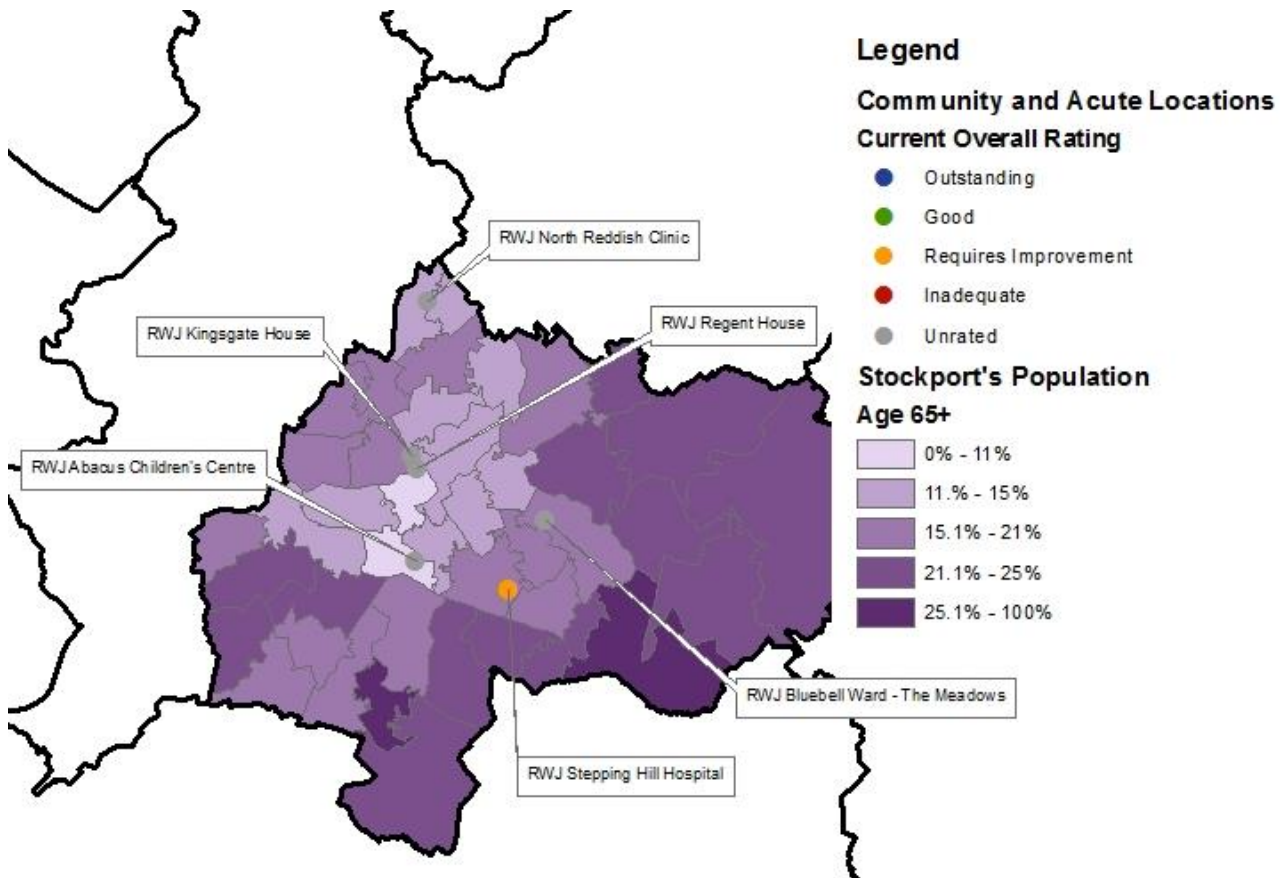
- 39 active locations:
 - Two rated outstanding
 - 36 rated good
 - One currently unrated

Acute and community healthcare

Acute and community healthcare hospital admissions (elective and non-elective) of people of all ages living in Stockport were to:

- Stockport NHS Foundation Trust
 - Received 69% of admissions of people living in Stockport
 - Admissions from Stockport made up 66% of the trust's total admission activity
 - Rated requires improvement overall
 - Also the main provider of community services in Stockport
- Manchester University NHS Foundation Trust
 - Formed of merger between University Hospital of South Manchester NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust
 - In 2016/17, University Hospital of South Manchester NHS Foundation Trust received 16% of admissions of people living in Stockport
 - Admissions from Stockport made up 12% of the trust's total admission activity
 - In 2016/17, Central Manchester University Hospitals NHS Foundation Trust received 11% of admissions of people living in Stockport
 - Admissions from Stockport made up 5% of the trust's total admission activity
- Community healthcare services were also provided by Pennine Care NHS Foundation Trust, rated required improvement overall.

All ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.



Map one, above: Population of Stockport shaded by proportion aged 65+. Also, location and rating of acute and community NHS healthcare organisations serving Stockport.

Map two, left: Location of Stockport LA within the Greater Manchester STP. The co-terminus Stockport CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- The Sustainability and Transformation Partnership (STP) process in Greater Manchester (GM) is unique in its system position with devolution. The 'Taking Charge Implementation and Delivery Plan' sets out an ambitious programme for the integration of health and social care. Stockport is one of ten local authority areas that formed the GM Health and Social Care Partnership. Since our review, GM has been included as one of the first Integrated Care System areas.
- The Stockport health and social care system had a well-defined and articulated strategic vision. The Stockport Together programme began in January 2015; this was where the five main health and social care organisations in Stockport came together to work in partnership to deliver a collective vision. The main aim was to create an integrated health and social care system for the people of Stockport. There were clear lines of communication and accountability, and connected ambition, between the wider GM vision and the Stockport vision.
- It was clear that the Stockport Together programme was tailored to meet the specific needs of Stockport residents. There was strong insight, supported by public health and the Joint Strategic Needs Assessment, about the challenges facing the older people of Stockport and a clear commitment to addressing these both through the GM vision and the Stockport Together programme.
- The new care model ambition and preventative approach delivered through the neighbourhood care model, had the potential to significantly improve health and social care outcomes for people in Stockport. However, it was recognised by all system leaders that they were behind schedule on the implementation of this transformation agenda and there was an urgent need to accelerate the pace of change.

Is there a clear framework for interagency collaboration?

- The vision for interagency collaboration was based on delivering an integrated local care model within eight neighbourhoods, which would be served by multidisciplinary teams encompassing acute healthcare, primary care, mental health, community nursing and social care professionals working collaboratively.
- The governance structure in place did not provide a clear framework for oversight and delivery of integrated working. Work was needed to streamline governance and provide clear lines of communication and accountability from operational delivery to the Health and Wellbeing Board (HWB).

- We found that the HWB was not acting as a system leadership forum for Stockport and needed to strengthen its oversight function. However there was a plan in place to review the HWB's function, including its membership, and to reframe the HWB as the place where system leaders came together to lead and influence the whole system.
- It was not clear where the accountability and drive sat for the realisation of the Stockport Together vision.

How are interagency processes delivered?

- The challenge for the Stockport health and social care system was to push forward with the transformation agenda while also delivering improvements in quality and capacity of services to ensure people were cared for in the right place, at the right time, by the right person. While there had been some improvements in performance shortly before our review, including a reduction in the numbers of delayed transfers of care from Stepping Hill Hospital (the main hospital of Stockport NHS Foundation Trust), this was from a low base and the system's ability to sustain and build on these improvements remained uncertain.
- System leaders acknowledged that the transformation programme was significantly behind in the delivery of its plans. Stockport NHS Foundation Trust (Stepping Hill Hospital) had not been able to address the historic underperformance issues in the non-elective pathway, and this detracted from the strategic implementation of Stockport Together.
- The developing neighbourhood care model had led to a positive impact on outcomes for people within the 12 months prior to our review. Those neighbourhoods where multidisciplinary team (MDT) working was in place enabled staff to be able to share resources and ideas and put together an effective support plan to enable people to be discharged from hospital more quickly and live well in the community. This was especially apparent when the MDT was co-located. However further work was needed to ensure staff were clear about their roles and accountabilities and the management structure within these neighbourhoods.
- There was opportunity to implement or embed more of the high impact change model, (the national model for the management of transfers of care), across the system, including seven day services and the use of Trusted Assessors.
- There were mechanisms in place to consult with wider system partners, including providers, Healthwatch Stockport, Stockport Citizens Panel and voluntary sector organisations. However, the extent to which they felt like true partners and were able to contribute to the transformation agenda varied, with some partners feeling they were not included.

What are the experiences of frontline staff?

- All staff we spoke with agreed that integrated working was the way to improve services for people and enhance their own working arrangements. However not all staff were engaged with or clear about the long-term strategic vision for the Stockport health and social care system. Due to the lack of effective communication around the transformation agenda and the impact on their roles, some frontline staff stated that they had been left feeling isolated and anxious about the future of their jobs.
- At the time of our review, negotiations were underway with some staff and trade unions to deliver extended operating hours as part of the neighbourhood care model. The staff involved and their union representatives told us that they felt the changes had been poorly communicated. However, at the end of our review we were informed that positive relations had been developed and a proposed strike averted.
- Where services were co-located or integrated, such as in some of the neighbourhoods, staff reported that relationships between professionals, such as district nurses and physiotherapists, were good. This had improved communication and information sharing, resulting in better outcomes for people receiving services.
- However, the lack of a clear accountable management structure around the neighbourhood care model, together with the individual contracting arrangements of different staff groups within the neighbourhoods, meant that there was a risk staff may be reallocated when organisational pressures were high, particularly in Stockport NHS Foundation Trust as they employ community nurses.
- There were some workforce pressures in a number of health and care areas. Community social workers told us that they were under pressure, carrying complex and large caseloads. They also told us they were sometimes called into hospital to undertake assessments in order to support the discharge of people back to the neighbourhood. They stated that this was often because of a lack of hospital social workers, which meant that there was a waiting list for assessments, in particular for University Hospital of South Manchester NHS Foundation Trust's Wythenshawe Hospital.
- Pressures on nursing staff within Stockport NHS Foundation Trust were evident. At the time of our review, the trust had 174 nursing vacancies. Matrons told us that they had to work overtime to support staffing levels. Less than optimal staffing levels on wards can adversely affect the safety and quality of care provided. In one person's hospital notes a nurse had documented that she was solely responsible for 17 patients on that day.
- Although system leaders had plans in place for the rolling out of data sharing systems, staff could not share information on a system wide basis. This had an impact on the effectiveness

of care delivery and resulted in duplication of work and effort. For example, district nurses had to spend time inputting handwritten notes into EMIS, the electronic records system used by community services in Stockport.

What are the experiences of people receiving services?

- People in Stockport had a varied and sometimes unsatisfactory experience of receiving health and social care services. While there had been improvements, people were still not always seen in the right place at the right time by the right person.
- The main acute hospitals accessed by people living in Stockport were Stepping Hill Hospital (the main hospital of Stockport NHS Foundation Trust) and Wythenshawe Hospital which was part of University Hospital of South Manchester NHS Foundation Trust.
- People experienced inequity in services across the two acute hospitals. Those Stockport residents admitted to Wythenshawe Hospital were having a longer wait for an assessment compared to those at Stepping Hill Hospital; for example during our review we found one person was still waiting to see a social work professional after 12 days.
- If an older person living in Stockport went into crisis and was admitted to hospital, data showed they were more likely to experience longer lengths of stay due to a shortage of home care packages and high-quality residential care.
- Older people who attended A&E often had to wait for long periods of time and well in excess of the national four hour standard. This could be distressing for people who were unwell and waiting to be seen.
- People who lived in care homes in Stockport were at a greater risk of avoidable conditions such as pneumonia and urinary tract infections and being admitted into hospital, than people living in similar areas.
- People's access to coordinated support and a seamless journey through health and social care had increased through the implementation of the neighbourhood care model. A multidisciplinary approach to case management, incorporating GP support through enhanced case management, had seen some positive outcomes for people within the last year, which included a reduction in delayed transfers of care from hospital.
- However the neighbourhood care model was in the early stages of development and needed further embedding in order to realise any further significant impact on people's experiences.
- The care and support available for people living with dementia in the community, including their families and carers, was impressive. An initiative called Early Dementia Users Co-

operative Aiming to Educate (EDUCATE) was available to any resident of Stockport diagnosed with dementia. EDUCATE was co-produced and supported by people living with dementia, and offered education, information and support for people living with dementia to stay as well as possible and feel valued.

Are services in Stockport well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interfaces to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

There was a shared clear vision and strategy for Stockport, which was aligned to the overarching vision for Greater Manchester. There was a commitment across system partners to deliver integrated health and social care and achieve better outcomes for the people of Stockport.

There were some barriers to progressing the transformation agenda in Stockport including cultural issues and issues of quality and capacity in both the acute trust and adult social care market. However the system hoped that new leadership in some key roles would bring a renewed focus on integrated working.

The strategic vision for Stockport through the Stockport Together programme needed to be built upon and expanded at pace with a shift of focus from planning to delivery.

Strategy, vision and partnership working

- In February 2015 system leaders in Stockport were among 37 NHS organisations and local authorities that signed the Greater Manchester (GM) devolution agreement with government which would enable them to take control of health and social care spending and decision making in the region. This became effective on 1 April 2016 and set out a vision across GM, which was reflected in the Stockport locality. The GM Transformation plan 'Taking Charge of our Health and Social Care' planned to deliver a fundamental change in the way that people and communities took greater responsibility for managing their own health and wellbeing.
- System leaders confirmed that Stockport health and social care partners were fully engaged in the GM programme and took an active role in leading and contributing to the GM Health and Care Partnership.

- The GM programme presented some opportunities for establishing consistently applied best practice standards which would help to address some of the boundary challenges highlighted during this review. These were set out in the GM implementation plan for 'Taking Charge Together' and plans for population health and primary care. For example, workforce and organisational development were being addressed through a pan-GM approach
- In January 2015, pre-dating GM's transformation plan, Stockport health and social care system had set out their commitment to working differently. They had committed to providing a safe, affordable, integrated health and social care system by bringing together the five main health and care organisations in Stockport as part of the Stockport Together transformation programme.
- The three-year Stockport Together programme focused on creating an integrated health and social care system for the people of Stockport. It had a compelling and well-articulated vision that was consistent with the wider GM perspective. In June 2017 all partner organisations published proposed business plans that set out how they would work together as part of the Stockport Together programme. These included identifying people with long term conditions, developing new integrated community health and social care teams and giving people the support they needed to return home from hospital as quickly as possible.
- Through Stockport Together, the original intention was to create an Accountable Care Organisation (ACO) and Stockport had vanguard status. However in 2017 parties agreed that the process of developing an ACO would be stood down to enable a greater focus on implementation of new models of care to improve performance, for example the development of eight neighbourhoods across Stockport; and consistency with GM transformation plans. We were told by some system leaders that the longer-term ambition was still to create an integrated care organisation.
- The Joint Strategic Needs Analysis (JSNA) for 2016-19, developed by Stockport Health and Wellbeing Board (HWB), reflected the priorities of Stockport Together and was aligned with the HWB Strategy for 2017 to 2020, supporting the delivery of the Stockport Together programme. A HWB Ageing Well Strategy was also in place and contained a high level overview and broad objectives clearly aligned to Stockport Together. However, more work was needed to ensure that system partners were aware of this strategy in order to drive the agreed changes. For example, some primary care staff we spoke with during the review stated they were not aware that Stockport had an Ageing Well Strategy.
- All system leaders in Stockport's health and social care system agreed that there was a strong strategic vision and framework for integrated working. However, it was not clear where the accountability and drive sat for the realisation of the transformation vision; we found a lack of clarity around governance, key roles, responsibilities and accountabilities.

- The HWB, in its existing state, lacked the necessary strategic oversight. We found that the HWB was not acting as a system leadership forum. The HWB had agreed that there should be a review, and this presented an opportunity to refresh and reframe the board as the place where system leaders came together, at a strategic level, to lead and influence the whole system approach to service transformation and delivery.
- Stockport health and social care commissioners had formed a partnership and agreed designated leadership, as part of a section 75 agreement, with intentions of delivering integrated health and social care through joint commissioning underpinned by a large pooled budget of £200m. They came together at the Health and Care Integrated Commissioning Board (HCICB). However, there was limited HWB oversight of HCICB. Although there was a link to the HWB via similar membership, partners were accountable to their respective organisations.
- System partners acknowledged that the three year Stockport Together programme was behind schedule, and the pace of implementation of the programme overall and improvement in the acute trust needed to accelerate. There had been significant churn in leadership roles but we were told that as a result of the new provider leadership there was now an increased energy in the system. Issues regarding the quality, safety and performance at Stockport NHS Foundation Trust (SNHSFT) were seen by all system leaders as being a significant reason why the Stockport Together programme had stalled. Therefore, it was imperative that the new SNHSFT leaders were able to look beyond the trust and adopt a whole system collaborative approach to improvement.
- We noted that the local authority had ensured there was elected member involvement in the strategic leadership. System leaders recognised that maintaining cross party support for the transformation agenda was crucial and was particularly difficult considering the hung council status where reaching a consensus could be challenging.
- We heard that there was willingness for system leaders to come together to engage in the GM transformation vision for health and social care, which was consistent with Stockport Together. We saw strong strategic intent, and a good aspiration to improve outcomes for local people. However, there appeared to be a degree of caution around taking the next steps to true system integration.

Involvement of service users, families and carers in the development of strategy and services

- Engaging people living in Stockport in a meaningful way was seen by system leaders as essential to effective service improvement and system transformation. However, there was limited evidence of people's engagement and involvement in developing Stockport's strategic approach to managing the quality of the interface between health and social care.

- A public consultation had been held in 2017 to seek people's views on the proposed business plans for the Stockport Together programme. The consultation found that overall there was broad support for the proposals. However, the Stockport Consultation Analysis report, shared with us by the system, stated that "the proposals to reduce the number of hospital beds were significantly less welcome by consultees." The partners had drafted a response to the results of the consultation which included a series of recommendations. For example, that the Clinical Commissioning Group (CCG) Governing Body should receive detail about the tests to be applied prior to closure of any beds at NHS Stockport Foundation Trust ahead of any decisions being made.
- Some system partners, including Healthwatch Stockport, felt that despite the consultation in 2017, most of the population knew very little about Stockport Together and were not particularly engaged in the programme.
- As part of Stockport Together, a Citizens Representation Panel (CRP) had been established. This formed part of the formal governance structure with members of the group also sitting on the Provider Alliance Board. The main role of CRP was to discuss and make recommendations about Stockport Together and to support participation and engagement in the programme. Membership included the NHS Stockport CCG Patient Panel, Healthwatch Stockport, voluntary sector and carers.
- However, the CRP told us they felt Stockport Together was resistant to the panel's involvement at a strategic level, despite their involvement being key to ensuring the public voice was represented as the programme progressed. Members of the CRP stated that they had good representation on panels across Stockport's health and care system but they did not feel they had a significant impact on Stockport Together plans. There was a perception that the citizens panel was in place as a "token gesture" towards public engagement. The view of the CRP was that there was more emphasis on telling them what was going to happen rather than asking questions and listening.
- System leaders stated that Healthwatch Stockport was seen as a strong voice for the local population. However, Healthwatch told us they felt that system partners viewed involving them in consultation as a "tick box exercise", in particular health partners. They stated that genuine public consultation and co-production in strategic approach was limited.
- To promote carers and the importance of their involvement in the development of services the local authority led the development of the Stockport Carers Charter. This had been created in collaboration with Signpost for Carers, Stockport Advocacy and Healthwatch Stockport. The charter set out the local authority's commitment to carers including better ways of information sharing and valuing carers' contributions.

Promoting a culture of interagency and multidisciplinary working

- As part of our review, staff at all levels across health and social care told us that “cultural issues” had been a barrier to effective interagency working. We heard from some staff that these cultural issues related to organisational relationships and professional behaviours which fostered a lack of trust. It was hoped that the new provider leadership in place would provide an opportunity to foster a culture of excellence that would address staff behaviour, values and practice issues through a re-energised approach to relationship management and organisational development.
- There were plans to address system-wide cultural issues, including traditional ways of working, through bespoke leadership programmes. Mentoring and coaching were planned to help support staff keep people safe while being less risk averse in their decision making.
- Stockport Together had a Communications and Engagement Strategy that outlined key objectives around engagement with people who live in Stockport and staff. These included supporting culture change and facilitating clinical leadership. Key measures of success were in place; however it was not clear at the time of the review if these had been evaluated.
- Generally, staff engagement was poor across the system. We were not assured that all staff were fully engaged with the Stockport Together programme. Some staff told us that they felt jaded by the perceived high number of initiatives and reactionary models in place without seeing any of the benefits. It was felt that leaders needed to use existing line management structures to better communicate messages and consult with staff.
- However, we did find that some health and community workers we spoke with felt that integrated working as part of the neighbourhood care model had had a positive impact on people receiving care within the 12 months prior to our review. Multidisciplinary team (MDT) triage meetings had been taking place regularly in some neighbourhoods and had been especially effective in those neighbourhoods where the teams were co-located. Staff confirmed that the benefits of integrated working within the neighbourhoods included the ability to put together care packages much more quickly and with greater ease. We were told that the MDT meetings had promoted a better mutual understanding of respective responsibilities and priorities from each staff group. Voluntary, community and social enterprise sector workers were also regularly involved with the MDT meetings and able to support people by addressing issues such as social isolation.
- There were mixed views from social care staff about the neighbourhoods. Senior social care staff agreed that the neighbourhood structure had helped facilitate closer working and that relationships were developing where colocation was in place. However, some social care staff within the neighbourhoods felt that the model was driven by health and led by acute sector priorities. They had concerns that there was a lack of awareness by health colleagues of social workers’ intrinsic responsibilities.

- Across Stockport there were 38 GP practices which were all members of Viaduct Care; a community interest company. Viaduct Care had a clear vision and supporting strategy and was beginning to work as a functioning GP provider with additional primary care services. Viaduct planned to develop wrap-around care services to be deployed in the community around neighbourhoods. However, Viaduct representatives told us that commissioners were not driving change. There was a strong asset base in primary care in Stockport and potential for primary care to play a significant role in the Stockport Together vision but this would require organisational development and clarity on commissioning intent for primary care. Following our review system leads stated that the intention was to commission services from an integrated provider and from an alliance in the interim.
- Mastercall was a social enterprise organisation providing out-of-hours care for the people of Stockport. From an integrated urgent care perspective Mastercall told us that they were not involved in Stockport Together. The executive team were calling for them to be formally involved so that they could be part of the discussions around their role in the integration agenda.

Learning and improvement across the system

- There was shared learning across Greater Manchester (GM) that was brought back to Stockport health and social care system via the Local Care Organisations (LCOs) Network which was attended by Stockport providers and commissioners. Across GM Local Care Organisations was the term used to describe neighbourhood-based integrated delivery, known as neighbourhoods in Stockport. However, at a local level, there was limited evidence of an embedded system-wide approach to learning and improvement.
- GM set some agreed performance metrics in relation to flow. However, there were no integrated metrics between health and social care, and system leaders based monitoring on traditional performance indicators. Some system leaders felt the level of assurance required at GM could be burdensome at times, and could result in too much focus on performance rather than delivery, but this was outweighed by the benefits of a shared endeavour.
- Learning and continuous improvement resulting in improved outcomes for people were not evident within some parts of Stockport's health and social care system. The urgent care pathway within Stockport NHS Foundation Trust remained sub optimal based on previous CQC inspection findings and our review findings. There were a relatively high number of residential care homes in Stockport rated requires improvement. Plans were in place to assess and improve performance and outcomes and we found that system leaders had an understanding of the key improvement priorities. However, there was limited evidence of a coordinated whole system response. There was also a concern from some system leaders that performance targets were prioritised over achieving better outcomes for people.

- A Quality Committee, accountable to the Clinical Commissioning Group's (CCG) Governing Body, was in place. This Committee was responsible for providing assurance around people's safety, experience and the clinical effectiveness of commissioned services.
- However the 2017 CQC inspection of SNHSFT (Stepping Hill Hospital) had found no improvement in the quality and performance of the hospital's emergency department which adversely affected people's flow through the system. This, coupled with a review undertaken by NHS Improvement (NHSI), raised concerns about the robustness of the trust's governance processes and the effectiveness of the oversight into safety and quality from the trust's Quality Committee. In response, NHSI convened an Improvement Board. The Board was made up of representatives of local stakeholders and was chaired by the Chief Officer of the Greater Manchester Health and Social Care Partnership. Its aim was to work with the trust to tackle the issues raised by the CQC in the most effective and efficient manner, while ensuring people continued to receive high quality care.
- NHSI had also appointed a Director of Improvement to work directly with the trust. Their primary focus was around improving SNHSFT's Board governance and the functionality of their urgent care board in reviewing outcomes. Along with the appointment of the Director of Improvement came the ability for SNHSFT to bid for funding from NHSI. The Director of Improvement told us that this was to be used to help the trust improve clinical engagement, support the development of the clinical management structure and engage clinicians more in safety and quality issues.
- A new weekly operational Urgent Care Cabinet oversaw improvements in urgent care and fed back to the Urgent Care Board. However, some system partners raised concerns that the system-wide focus on improvement was too centred on A&E performance measures with little consideration given to community or primary care services.
- Due to these ongoing concerns around SNHSFT's performance, Stepping Hill Hospital had been the subject of a number of external reviews, such as the Emergency Care Improvement Programme. NHSI provided a clinically led programme offering practical advice and support to improve patient care and flow. System leaders raised concerns that these reviews had resulted in different conclusions and multiple and different areas for focus. They felt it would be more beneficial to have one analysis, with one plan so improvements could be implemented and sustained to enable staff to remain engaged and motivated.
- People's choice of good quality care homes in Stockport was considerably limited. A significant number of residential care homes in Stockport were rated as requires improvement by CQC. In response the local authority and the CCG had put in place the Enhanced Quality Improvement Programme (EQUIP) team. This jointly appointed team was a new care home improvement team set up in January 2018 to offer support, guidance and signposting to drive improvements and consequently the quality of service provided. The

support included onsite training and shared learning from incidents. A quality dashboard had been piloted and would be rolled out to all care homes in 2018 to ensure that improvements were measured and monitored on a regular basis. The EQUIP team worked alongside the existing local authority quality assurance team. Although it was a new service we were told that it was already having some positive impact including a reduction in the length of time care homes were in placement suspension. This was corroborated by the CQC adult social care inspection team.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

Providers and commissioners across the health and social care interface had governance systems and processes in place, reporting upwards from the local system to Greater Manchester Health and Social Care Partnership. However the system-level governance structure required streamlining to ensure a clear line of communication and accountability for the delivery of the transformation agenda.

The Chairs of the Health and Wellbeing Board and Adult Social Care and Health Scrutiny Committee acknowledged that the oversight and challenge functions of these bodies were not being used effectively.

Overarching governance arrangements and risk sharing

- Overall we found there was a lack of clarity around the governance arrangements for the system. It was unclear where genuine decision making and accountability for the delivery of integrated working was located. We were not assured that there was a clear line of sight on the delivery of the transformation programme. The governance structure needed streamlining to provide more effective delivery mechanisms through focussed and accountable delivery boards.
- A Health and Wellbeing Board (HWB) has overall responsibility for ensuring that health, social care and wider wellbeing services are effective and meet the needs of people living in their area. In Stockport, representation on the board included Stockport Metropolitan Borough Council, NHS Stockport Clinical Commissioning Group (the CCG), Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust and Healthwatch Stockport. However, partners acknowledged that the HWB would benefit from a strengthening of its oversight and challenge function in relation to the delivery of the transformation agenda. At the time of our review we were informed that work was underway to facilitate this, including a review of the membership of the HWB to enable it to become more of a driver for system transformation.

- The Adult Social Care and Health Scrutiny Committee was responsible for providing overview and scrutiny of health and adult social care services. However, its challenge function was underutilised in terms of the Stockport Together transformation agenda. Members confirmed that there were no regular reports of progress to the committee, but they did receive quarterly reports from the lead member for adult social care that included some metrics influenced by Stockport Together. Members of the Adult Social Care and Health Scrutiny Committee told us that combining the Health and Wellbeing Scrutiny Committee and the Adult Care Services and Housing Scrutiny committee in May 2017 had been a positive move. They felt there was still some way to go but this was a good springboard to a more collaborative approach to scrutiny and performance challenge.
- The governance structures included the relatively new Provider Alliance Board (PAB). The PAB was made up of representatives from Stockport NHS Foundation Trust, Stockport Metropolitan Borough Council, Pennine Care NHS Foundation Trust and Viaduct Care. It had responsibility for ensuring the implementation and development of the Stockport Together programme including Stockport Neighbourhood Care (SNC). The PAB was supported by an alliance agreement; however the accountability and delegations remained within each separate organisation. It was acknowledged that pace of progress was far too slow given that the Stockport Together plan was a three year strategy. We were told that an external audit and assurance company was due to review how the strategic planning had progressed. System leaders hoped that this would help “inject some pace” into the delivery of plans.
- The Stockport Together Programme Board focused on the finances in relation to the transformation programme and reported to the Chief Executive Board on a monthly basis. The Chief Executive Board was where chief executive officers of all partner organisations met to oversee the Stockport Together programme. Reporting to the Chief Executive Board were two joint Senior Responsible Officers and a Programme Director who also reported into the Stockport Together Programme Board.
- The Health and Care Integrated Commissioning Board (HCICB), underpinned by the joint funding of £200 million, was where the integrated commissioning decisions took place. However the HCICB was still in development at the time of the review. System leaders raised some concerns that that the HCICB would be too focussed on health related issues. HCICB members told us that a number of workshops had already taken place to agree how the HCICB would govern and make joint commissioning decisions.
- The Quality Committee, accountable to NHS Stockport Clinical Commissioning Group’s Governing Body, was responsible for providing assurance for people’s safety and experience, and the clinical effectiveness of commissioned services. System leaders told us that this was where they discussed serious incidents and near misses and agreed actions to manage them appropriately and implement any learning.

- The Urgent Care Delivery Board, supported by an Urgent Care Cabinet, ensured that all system partners acted appropriately to make the Urgent Care System work together to benefit people using services. Representation included the Chair of the HWB. However given the ongoing concerns of poor quality and performance in the acute trust's non-elective pathway, the Head of Service Improvement from GM Health and Social Care Partnership was supporting the Urgent Care Board and Quality Committee regarding the Urgent Care Board's governance function and the effectiveness of the Quality Committee. Some work had already taken place to improve the governance framework for safety and quality which meant the quality metrics that fed into the Quality Committee were more meaningful.

Risk sharing across partners

- The Stockport health and social care system was at the beginning of its journey to integration. System leaders and partners at all levels acknowledged there was some isolated working, but there was willingness by system leaders to respond to risks collaboratively.
- Although each business case for Stockport Together had a detailed risk assessment there was not a shared view of risk management across the system. Risks were managed in different forums. For example, the CCG's Primary Care Quality Group monitored Primary Care performance and its Quality Committee oversaw acute trust performance on behalf of the CCG Governing Body.
- We found evidence of clear risk sharing across the system in respect of finance. The Section 75 agreement showed a strong strategic intent with over £200 million in the pooled budget. However, at the time of our review the pooled budget was yet to be spent in a fully integrated way. The Directors of Finance of providers and commissioners had agreed an approach to the management of financial risk including a mechanism of risk and gain share to underpin the implementation of the Stockport Together business cases. Local authority leaders agreed that this was a positive move towards integration but noted that it would only work if members were confident any shared liabilities could be minimised by demonstrating they had a "strong grip" on operational delivery.
- We found that adult safeguarding was not as developed as children's safeguarding in terms of managing risk across the system. We were told that adult safeguarding leads were looking at developing systems for assurance for the interface of health and social care, but this was in very early development. There was also a plan to develop a comprehensive quality assurance framework, including a dashboard, in order to give them a much better understanding of risk. Case reviews and audits occurred but the chair of the Adult Safeguarding Board told us that the Board did not always see the audits. Further work needed to be done to ensure that the Adult Safeguarding Board had oversight of all the areas of risk.

Information governance arrangements across the system

- Although there was some evidence of information sharing, overall it was underdeveloped. There was some duplication of work being undertaken. Staff felt that the lack of an effective way to share information impacted on the quality of service delivery.
- Stockport Health and Care Record (SHCR) provided a holistic view of a person's health and social care information including their care history and plans. The system took live feeds from other systems to create a single record. At the time of the review SHCR contained live GP patient records, social care plans and portals to access acute and palliative care information; additional feeds would be added in 2018. Greater Manchester had adopted the same solution as their standard for the region, which would provide additional opportunities.
- The Stockport Together programme included an Information Management and Technology (IMT) programme plan. This set out the direction how technology could support the transformation programme. We found the plan was ambitious and comprehensive although we had a concern about how complex it would be to deliver. IMT partners had identified key issues for the implementation of this plan, for example how information technology (IT) changes may compete for time and capacity with business as usual and engaging staff. However, it was not clear how these risks would be mitigated or managed. It was also not clear how much of the required funding had been secured. We were told that the programme was due for review in April 2018; however this had not happened at the time of our review.
- IT partners told us that the IMT strategy was beginning to facilitate joint working. While shared records had not yet been fully implemented across the system, at Stepping Hill Hospital A&E department the IT medical records system had facilitated information sharing; A&E staff could access EMIS, meaning that they could log into GP records and access people's medical information to ensure people were receiving joined up care.
- However, community staff told us that two different IT systems were used across adult social care and community healthcare in Stockport; EMIS and Care First. This was a barrier to integrated working and required staff to duplicate work. For example, staff in the crisis response service, a team of health and social care professionals that delivered a step-up response to crisis to keep people in their own homes, recorded all their notes on both systems so that they were available for all partners. GPs relied on EMIS, which was not always available to other system partners, but they could create special notes which could then be shared with others.
- We were told that information had to be inputted to EMIS via a desktop. This meant that staff in the community completed paper notes and then needed additional administrative time to input the notes to the system. Primary care partners told us that some community teams were reluctant to use mobile EMIS devices. However, when this was queried, system leaders told us that EMIS devices were not available for use by community teams at that time.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system was working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

There was a system-wide understanding of workforce challenges facing the Stockport health and social care system.

Stockport's had a health and care workforce strategy, which was aligned to the Greater Manchester strategy, but this would benefit from being reviewed and updated. The system needed to ensure that operational priorities were addressed through an integrated workforce strategy that articulated a detailed, system-wide action plan. However, independent providers were also facing workforce challenges which had not been addressed as part of a system-wide approach.

System level workforce planning

- The Stockport health and social care workforce strategy was developed in 2016. It articulated the vision for an integrated workforce and aligned with Greater Manchester (GM) Health and Social Care Partnership's overarching workforce strategy. However the strategy required further development to provide more detail on the actions needed to translate it into a deliverable, operational plan.
- The GM workforce strategy was overseen by the Health and Social Care Partnership Board, and outlined the workforce challenges and proposed GM-wide solutions in the context of new models of care.
- Workforce leads recognised that they needed to revisit the Stockport workforce strategy. System leaders accepted that the recruiting and reskilling of the workforce would be a key enabler of the transformation programme. They told us the strategy would benefit from a refresh with a clear system wide action plan for a competent sustainable workforce.
- We found, and system leaders acknowledged, that the strategic approach to workforce planning required fundamental changes as the home care and care home markets, as well as general practice, were not sufficiently reflected in the existing plans.
- The neighbourhood care plans described a switch in resourcing and capacity over time between acute and community based care and this called for a single approach in areas such as training, recruitment and retention. In order to deliver this it was proposed, but yet to be agreed, that external expertise be brought in to undertake dedicated work.

Developing a skilled and sustainable workforce

- Workforce leads informed us that the system needed to map existing workforce provision against demand to identify workforce gaps in different staff groups. This should reflect the intended shift from hospital to community settings and the implications for the market. This mapping should not only reflect the required change in staff numbers and skills but also changes to work patterns and types of working environment.
- System leaders told us that a dedicated human resource team had been established to support recruitment to the integrated teams. They were using alternative approaches including open events, recruitment fairs, and “tea and chat” events that included support with applications. They also introduced a whole system view recruitment tracker to ensure ongoing oversight of recruitment activity to enable a joined up approach.
- However, adult social care providers we spoke with told us that they were not involved in workforce planning or recruitment. For example, they said that although several job fairs had taken place they had not resulted in desired levels of recruitment. Prospective staff were being recruited from the same pool by health and social care services. The local authority paid higher wages and travel time to their care workers compared with the home care providers, which meant that independent providers found it difficult to compete. Commissioning leads told us that they were aware of this concern and were planning to help address this through the introduction of the Ethical Care Framework. Providers and commissioners would agree a number of key principles including ensuring the workforce was respected and valued, addressing issues such as remuneration and ensuring that provider agencies were included as equal partners within multi-agency teams, utilising their experience and expertise. However, it was not clear at the time of the review when this would be implemented.
- The recruitment of qualified nurses was cited as a challenge for nursing home providers, as was retaining care staff. Some nursing homes had tried to address this by introducing new roles such as nursing assistants and care worker practitioners to provide a more structured career pathway. The GM Health and Social Care Partnership was developing system wide initiatives across the GM area including the introduction of the Teaching Care Homes programme. This programme was about developing a network of high quality care homes that would be seen as centres of learning and research, with an aim of raising the profile of long term social care as a rewarding career choice.
- Community health and social care partners described the challenges they faced regarding developing a sustainable workforce. Primary care leads told us that GP capacity was proving to be an obstacle in realising the integration agenda in Stockport. We were told that historically Stockport had a large number of training posts in primary care so staffing numbers had generally been good. However, Stockport was now struggling to fill those

training posts. They had been trying to free up GP capacity with the recruitment of practice physiotherapists, pharmacists and nurses.

- Social work leads stated that although historically Stockport had sufficient numbers of experienced social work staff, the numbers had now decreased. Skills for care workforce estimates for 2013/14 to 2016/17 showed that general adult social care vacancies in Stockport had risen from 5.4% to 8.6%. This was higher than the comparator average (6.1%) and England average (6.6%). Social work leads told us that work was being undertaken to recruit unregistered support workers to support qualified social workers. They were also promoting Stockport social worker recruitment with local universities and outside the area.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners were providing a diverse and sustainable market in commissioning of health and social care services.

Future commissioning strategies within Stockport were aligned to the wider Greater Manchester Sustainability and Transformation Partnership 'Taking Charge Implementation and Delivery Plan' with a focus on pathways and the person, rather than individual services.

While there was a joint commissioning strategy, underpinned by a Joint Strategic Needs Assessment and some significant joint funding, at the time of our review commissioning activities and arrangements were collaborative rather than integrated. However, a commissioning outcomes framework was being developed as part of wider Greater Manchester devolution and staff were committed to moving to an integrated approach to commissioning.

Commissioners had taken a number of actions to address performance concerns in the acute trust. However, they had failed to adequately address them and therefore issues with capacity and quality within the non-elective pathway remained significant.

Stockport faced significant market challenges which were widely accepted by system partners. However, responsibility for resolving them was not collective and the Market Position Statement needed updating. There was scope for longer-term gains for the wider system if investment was made shape the care market.

Strategic approach to commissioning

- System leaders in commissioning agreed that the new model of care with its focus on integrated neighbourhood teams would require considerable organisational transformation across commissioners and providers to ensure a fundamental change took place.

- The Joint Commissioning Strategy Group (JCSG) had developed the Adult Social Care Joint Commissioning Strategy and associated work plan to progress key areas of activity, for example provision of care homes, care at home, and extra care accommodation. The strategic approach was informed by the Joint Strategic Needs Analysis and operated within the Stockport Together programme. It was aligned to the wider Greater Manchester Sustainability and Transformation Partnership 'Taking Charge Implementation and Delivery Plan'. However it was acknowledged that this strategy was new (the final review was undertaken November 2017), and was still a work in progress.
- The local authority and the CCG had designated a jointly appointed senior commissioning lead.
- As well as the joint commissioning strategy, there was significant joint funding and a supporting governance structure in place. However, there was limited evidence that joint commissioning was taking place in practice. There was a sense that the commissioning staff across the local authority and the CCG were principally still focussing on their own responsibilities.
- The CCG was keen to adopt a move to single population outcome based commissioning and provision. This would require significant organisational change. The Joint Commissioning Board (JCB) paper referencing this proposal outlined the co-production of a prototype led by the CCG 'Stockport Outcomes Framework' with commissioner, provider and public representatives working together. Gradually providers and commissioners would move to monitoring outcomes, however, this proposal was still under consideration at the time of our review.
- Local authority and NHS commissioners we spoke with had a clear idea about their role and responsibilities within the transformation programme. They told us that there was a structure in place to support joint commissioning. The JCB met monthly and reported into the Health and Care Integrated Commissioning Board (HCICB). The commissioning strategy helped to inform the market, with a focus on how to change the models of work to a neighbourhood care model. The strategy was underpinned by a large joint commissioning fund of £200 million from the Better Care Fund. However, some system partners acknowledged that the joint pool was still being operated as separate budgets.
- There was a need for all parties to take common ownership for effective commissioning to resolve community care issues before admission to, and after discharge from, hospital. System partners had a shared intent to realise joint commissioning. However despite this, quality and accessibility issues for older people in Stockport remained. There was a clear view from all system leaders that Stockport NHS Foundation Trust was a concern in the delivery of urgent care in Stockport. However, this should not be the sole focus of

commissioners and a system wide approach to commissioning was required for true integration to be realised and for outcomes to improve.

- Commissioners informed us that they were working with colleagues in Strategic Housing and Planning to develop a needs assessment for supported housing provision and care homes for the next ten years. We found that the material in the Housing Needs Analysis provided an evidence base to inform strategic decision making and the scale of affordable housing need. Market demand and the range of dwellings required had been reviewed and reflected the needs of different population groups, in particular older people and those requiring specialist support requirements. However, the document was over two years old and may have required updating.

Market shaping

- At the time of our review there was little active market shaping. Although we heard that a number of forums had been set up to facilitate joint working between providers and commissioners, adult social care providers we spoke with described these as a “tick-box” exercise rather than meaningfully engaging them in strategic planning. Commissioning leads acknowledged that the Market Position Statement for Stockport was out of date and needed refreshing. This could then be used to inform the market about future opportunities for providing services, as well as where existing provision could be adapted to meet changing need.
- Stockport faced significant challenges in relation to the social care market, both in terms of quality and capacity and data indicated this was impacting on delayed discharges from hospital, with ‘waiting for adult social care placement’ and ‘waiting for a care package’ being the main reasons for older people experiencing a longer length of stay in hospital. For example, between April 2015 and April 2017 there had been a 4% reduction in residential care home beds and the number of nursing home beds per population, (despite a 6% increase), were far fewer than the national and comparator average. The quality of residential care was worse than average and there were also other issues that impacted on capacity such as embargoes placed on poor performing care homes.
- As of December 2017, CQC rated 10% of nursing homes in Stockport (two) as inadequate and 25% (five) as requires improvement. However, at the time of our review there had been some improvement in ratings and no nursing homes were rated inadequate. This was in line with the national average for requires improvement and better than national average for inadequate ratings. The percentage of residential care home providers rated inadequate was 4% (two) and rated requires improvement was 48% (23). During the review one residential home improved their rating from inadequate, however the numbers of requires improvement ratings were still significant and much higher than the national average of 15%. There were no Stockport domiciliary care providers rated inadequate, however, 18% (seven) were rated requires improvement compared to 11% nationally. Again, during the review there had been some improvements made with a reduction in number of services rated

requires improvement to six. Whilst there had been overall improvements to ratings for adult social care services there was still some work to do to ensure people living in Stockport were not at risk of receiving poor quality care.

- Overall numbers of older people needing admission to a care home for long term support had reduced. Analysis of ASCOF data showed the number of admissions of older people into care homes in 2016/17 being below the comparator group average and the England average at 583 per 100,000 population. Nevertheless older people did still wait for extended periods of time for suitable placement and support.

Commissioning the right support services to improve the interface between health and social care

- The local authority and the CCG had designated a joint senior leader for joint commissioning and had agreed a £200m budget with joint risk sharing. However, we did not find that there was an embedded integrated joint commissioning approach in Stockport.
- Commissioning plans focused on prevention and pathways rather than services. However, at the time of our review these were still to be implemented; commissioning, including that of community services, remained separate and based on meeting national objectives and targets rather than taking a coherent system-wide approach.
- The Joint Strategic Needs Analysis (JSNA) was dated 2016-19 and provided a clear a summary of its purpose; including tackling inequality and focussing on prevention. The JSNA formed a sound basis to inform commissioning decisions. Local authority leaders spoke about the importance of public health's role in work across the whole of the local authority in terms of influencing the wider determinants of good health. The imminent location of public health within the place directorate appeared to be a positive initiative to foster this wider influence.
- Data showed that there was a focus on empowering people to take control of their own care and support through the use of personal health budgets and social care direct payments. Data showed that in the third quarter of 2017/18 uptake of personal health budgets was aligned with the England average, at 8.09 per 50,000 population compared with the England average of 8.24. ASCOF data also showed that a higher percentage of people 18+ using social care services received direct payments in Stockport (5.66 per 50,000 population) compared to nationally (4.65 per 50,000 population). Commissioning leads told us that personal budgets were being offered in line with the Care Act. They also stated that they had embedded the direct payments process, changing the system around this. This had realised an increase in the number of direct payments alongside a rising demand for personal assistants. The local authority's own data on direct payments for April 2017 to March 2018 showed that 33% of all direct payments to people who were not carers had been made to people aged over 65 years and 47% for carers aged over 65 years.

- However, there appeared to be a lack of focus on commissioning services to ensure that Stockport residents admitted to Wythenshawe Hospital rather than Stepping Hill Hospital were supported to have an equitable experience. During the review it was noted that Stockport residents admitted to Wythenshawe Hospital sometimes had a poorer experience. For example, due to lack of hospital social workers for Stockport residents, people and staff told us that they experienced prolonged delays while waiting for an assessment.
- Home care providers were not paid a retainer by the local authority to keep packages of care open if a person was admitted to hospital. Frontline staff reported that this could lead to unnecessary delays while new packages of care were arranged and assessments carried out. It also had an impact on the continuity of care for the person.
- A range of intermediate tier services to support admission avoidance and improve the timeliness of discharges from hospital had been commissioned. For example, the Active Recovery service. This service, made up of a multidisciplinary team of health professionals and support workers, provided short-term physical and social support in people's own homes or a community setting. Building on winter pressures block contracts, additional funding had been secured for an extension of care at home services to provide step-up and step-down support via a number of block and spot purchase contracts.
- We were told that the relationship with the Voluntary Community and Social Enterprise (VCSE) sector partners was open and collaborative with co-production central to this. However, VCSE sector representatives told us that they sometimes felt underutilised and that they were concerned that there were some significant gaps in provision that were not being addressed; in particular for people living with dementia with complex needs.
- The out-of-hours provider executive team, from Mastercall, were keen to see greater commissioning clarity regarding the service. They were frustrated that the commissioning arrangements for the service were for a relatively short period of time, for example one or two year contracts. They stated that a lack of a secure longer term future was giving them less certainty and therefore limiting opportunities to innovate and integrate.

Contract oversight

- At the time of our review contract arrangements for health and social care provision were collaborative rather than joint.
- To tackle the significant number of poor quality residential care home services in Stockport, the local authority and CCG had created an Enhanced Quality Improvement Programme (EQUIP) to provide an enhanced level of support into the market. The team were improving the quality of services, preventing unnecessary closure of homes, reducing the amount of

time homes were under suspension and supporting the safe transfer of service users where closures did take place. The team worked alongside the local authority quality assurance team and prioritised those care homes who the CQC rated as requires improvement. A quality dashboard had been piloted and was due to be rolled out to all care homes this year.

- The local authority had a multidisciplinary Quality Concerns and Action Group attended by adult social care providers and the CCG, ensuring clear joint working in relation to quality issues and concerns in care homes, home care and learning disability services.
- Commissioning leads acknowledged that contract levers, including penalties to manage performance, were necessary, but could often be counterproductive and it was not clear how they resulted in improvements. The main issue within the market was supply, therefore the focus needed to be on performance improvement planning that secured improvements in providers' capacity and capability.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

There were governance structures in place which facilitated transparent and collaborative lines of reporting. There was a shared understanding of the gaps in resource.

There was large pooled budget that signified strong strategic intent to integrate with a risk and gain share approach to jointly manage the financial risk. However system partners need to evidence that any shared liabilities can be minimised by demonstrating they were in control of operational delivery.

- Stockport Metropolitan Borough Council and NHS Stockport Clinical Commissioning Group had a Section 75 agreement with a pooled budget of around £200 million. This agreement included the Better Care Fund (BCF) alongside the local authority's full adult social care budget, the public health budget, the NHS budget for the over 65's and all funding for learning disabilities. Although the budget was pooled, it was not yet being used to spend on integrated or interagency working. However, a jointly funded Director of Integrated Commissioning exercised responsibilities for the pooled budget through a Joint Commissioning Board that reported activities in relation to the pooled budget to The Health and Care Integrated Commissioning Board (HCICB) and HWB. The planning and delivery of the BCF, including the delivery of the Section 75 agreement, was overseen by the HCICB, a committee of the Council and the CCG.
- The Section 75 agreement in place showed a high level of ambition, mature relationships

and strong strategic intent with over £200 million in the pool. There were transparent reporting lines and evidence of positive working relationships between finance departments at the CCG and the local authority. The target spend for the year ahead supported Stockport's transformation vision. We were encouraged by the establishment of the significant pooled budget, however this, and the associated risk share agreement, was the only example we found of an integrated approach to funding flows and shared risk management.

- The directors of finance of providers and commissioners had agreed a shared approach to the management of financial risk including a mechanism of risk and gain share to underpin the implementation of the Stockport Together business cases. However some system partners were still not confident that shared liabilities could be minimised.
- The pooled budget and joint commissioning strategy continued to be developed to enhance support in the community, including:
 - Investing in reablement and preventative based provision supporting clients towards self-care.
 - Supporting local providers to provide the highest quality of care possible by working with them to understand and agree appropriate fee setting.
 - Delivering the Stockport Together new models of care by embarking on greater investment into community health and social care and general practice provision to release capacity from the acute setting.
- We found evidence that benchmarking was being used to drive improvements, for example, mental health investment and investment in the care home market. Rates of admission to residential and nursing care homes to provide long term support for older people in Stockport had declined and were below the England average and that of similar areas. Avoiding permanent admissions is a good measure of delaying dependencies. However, with lower than the national average number of domiciliary care agencies and high numbers of people waiting to be discharged from hospital, the system needed to assure itself that resources were being used effectively to ensure good outcomes for people.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Stockport safe?

There was a system wide commitment to keeping people safe in their usual place of residence. Some preventive services were in place, such as the 'Steady in Stockport' falls service. The recent implementation of the neighbourhood care model provided a foundation for the safe support of people in the community through a multidisciplinary approach and risk stratification to identify the most vulnerable. However, the model was relatively new and the pace of change to ensure risk stratification, including frailty assessments, was well embedded was slow. This meant that support networks were not always sufficiently robust to prevent people from going into crisis.

Despite alignment of GPs with care homes people living in care homes in Stockport were more at risk of being admitted to hospital.

Although the adult safeguarding referrals appeared to be managed well the oversight of system wide risks was not robust. However, we were told that there were plans to develop an adult safeguarding quality assurance framework, which would give the Adult Safeguarding Board a better understanding of the risks across the system.

- The main aim of the recently implemented Stockport Neighbourhood Care model was to keep people safe and well in their usual place of residence. This community model was based on delivering services through eight GP-led integrated neighbourhood teams. These comprised of a multidisciplinary team of health and care professionals. Each neighbourhood team would work with the GP to identify and manage the 15% of people at greatest risk of admission to hospital. This would be done through formal risk stratification including frailty scores. However, at the time of our review there was no formal risk stratification in place. Risk stratified data was being sent to neighbourhoods but the utilisation of this was not fully embedded. In the interim, GPs were working with community services to ensure that those people assessed as being at risk, or with complex needs were identified and supported to stay well. Recently a new Managing Director had been appointed to Stockport Neighbourhood Care to drive the implementation of the model.
- People living in care homes were more likely to be admitted to hospital as an emergency compared with similar areas. Data for the last quarter of 2016/17 showed that the rate of older people admitted as emergencies from care homes in Stockport was 835 per 100,000 people, which was higher than the national average of 713 per 100,000 and their

comparator group average of 745 per 100,000. The data also suggested that emergency hospital admissions from care homes had been consistently higher than national and comparator rates over the last three years. GPs were allocated to care homes to monitor people who were frail or at risk of deterioration. The alignment of GPs to care homes had taken some time to embed and aimed to reduce referrals to hospital. Although we did not see evidence of a direct impact during our review, system leaders told us that there was evidence that it had started to result in a reduction in hospital referrals and bed days used.

- Stockport residents had partial access to their usual GP practice outside of normal working hours. Data from March 2017 on provision of extended access to GP's outside of core contractual hours, showed that 90% of GP practices in Stockport surveyed offered partial provision of extended access through pre bookable appointments on at least one day of the week. This was much higher than the England average of 61%. However, only 10% offered full provision which was lower than the England average (23%) and comparator sites (17%). The system had commissioned a single provider to provide out-of-hours GP support for people.
- Some services maintained people safely in their usual place of residence. For example, the 'Steady in Stockport' service. This was a falls, fractures and bone health programme. The service worked in partnership with care call (pendant alarms), ambulance services, A&E, fire and rescue services, VCSE organisations, care providers and telehealth services. Its aim was to educate people about the risks of falls and how to prevent them. The service provided an easy to complete assessment and was planning to develop a person education booklet, care home toolkit and clinic in sheltered housing and extra care schemes. However this service was very new and therefore the impact could not be measured at the time of the review.
- Frontline staff across health and social care were able to describe the process for reporting safeguarding concerns and other incidents. The Stockport safeguarding team had introduced a "five levels of harm" process for the management of safeguarding referrals, which meant that referrals were investigated according to the level of concern. Staff reported that this referral and investigation process had clarified what actions should be taken and they felt that the safeguarding team were supportive.
- However, the oversight function of the Stockport Safeguarding Adults Board was underdeveloped. Stockport had a joint independent chair of the Children's and Adults Safeguarding Boards but each board was separate with their own membership and priorities. Safeguarding and adult social care leads acknowledged that historically the predominant focus had been on children's safeguarding. The board's ability to have system-wide oversight of risk in adult safeguarding was not as developed. For example, the board did not always have sight of safeguarding alerts and all audits which had been undertaken. The neighbourhood teams managed safeguarding referrals for individuals and domiciliary care

agencies and there was a separate centralised team for residential and nursing home safeguarding referrals. We were told that there were plans to develop a comprehensive adult safeguarding quality assurance framework, including a dashboard, which would give the board a better understanding of the risks across the system. At the time of our review this was in the very early stages of implementation.

Are services in Stockport effective?

The system had a number of services in place, in particular from the voluntary sector, to keep people well in their usual place of residence. There were pockets of good practice across Stockport where these services worked effectively to improve the flow of people through the health and social care system, although this was not consistent. The neighbourhood model was in its infancy and neighbourhood care teams were not fully developed.

There was a system-wide focus on improving the skills of staff to support the new models of care and improve the quality of care in care homes. However, all plans in place were new or just being rolled out and so their impact could not be measured at the time of the review.

There were plans to develop one health and social care record which could be accessed by relevant staff across Stockport; however this was not in place at the time of our review. The supporting infrastructure had been a priority of the digital leads.

- To ensure people were seen in the right place by the right person, the out-of-hours service provider, Mastercall, was responsible for an admission avoidance scheme called the Pathfinder service. This service was provided in conjunction with North West Ambulance Service NHS Trust (NWAS). It was an “alternative to hospital transfer service” for people in Stockport who had phoned for an ambulance. NWAS developed an evidence based algorithm, used as part of the Pathfinder service, to assist ambulance crew to identify people who did not require transfer to hospital but would benefit from a community-based clinical intervention. Mastercall, in consultation with the crisis response service, could then arrange for either an emergency care package or a placement in a step up bed. Care at home could be provided by the crisis response team for up to 72 hours until a step up bed was available. Mastercall data demonstrated that that they had deflected 80-90% of calls from attendance at A&E since the service started.
- Voluntary agencies in Stockport provided comprehensive preventative services through working together, for example the Wellbeing and Independent Network (WIN). The network was made up of three main services which provided practical help to older people who would otherwise find it difficult to organise the support they needed to remain independent and well. The services were provided by a variety of voluntary sector agencies working together. Services were aimed at supporting people to ensure their home environment was suitable, providing community transport and addressing social isolation. They could also signpost people to find the care and support they needed. For example, Age UK could directly refer

people to the Steady in Stockport service, to social workers for assessment of needs and to continence services.

- There was good support for those people living with dementia in Stockport. The Early Dementia Users Co-operative Aiming To Educate (EDUCATE) team, which included people living with dementia, provided training for health and social care professionals, children in schools, people recently diagnosed with dementia and their families and carers. The group supported people living with dementia to make the most of their skills and abilities to stay as well as possible, socialise and feel valued through support groups, management techniques and social events.
- The Stockport Car Scheme, a local registered charity for Stockport residents, provided a transport service for people who struggled to use public transport. We were given examples of people being driven to social gatherings, shops and recreational activities on regular basis to enable them to continue with their preferred activities. For example, one person was driven to the gym on a weekly basis for two years. The scheme used the same volunteer drivers where possible to promote confidence for the more anxious passengers. Feedback suggested that the service improved people's mental health, and reduced isolation.
- Work was being done to ensure the workforce had the right skills to support the effective transition of people between health and social care services. The workforce plan for the neighbourhood care model had been created to place a greater emphasis on blended health and social care roles at the pre-registered, integrated support worker level. Recruitment to, and deployment of, the neighbourhood support worker roles had started, with workers aligned to each neighbourhood to deliver personalised health and social care support. However, this model was new and therefore not yet well embedded. At the end of our review staff were still in dispute via their trade unions about their working hours for the new model of care, but we were assured that positive relations had begun to develop and a proposed strike averted.
- To ensure there was a skilled workforce within care homes the Enhanced Quality and Improvement Programme (EQUIP) team provided training and support for care home staff. For example, staff had been trained in topics such as safeguarding adults, pressure ulcer prevention and infection control.
- Staff across the health and social care system told us that they were not able to easily share information about people in their care. However, there was a single shared health and social care record but system leaders told us that further work was needed to improve data flows into this system and encourage staff to utilise what was available. The digital leads across the Clinical Commissioning Group, local authority and Stepping Hill Hospital were working collaboratively to enable this in the future. There had been work on the Information Technology (IT) infrastructure, which allowed health and social care staff to access their own

networks across the system. This meant that staff could complete their records in a timely manner onto the appropriate IT system; however the systems did not link at the time of the review. Mastercall also used a different IT system, although there were future plans to converge this system onto the EMIS platform.

- To enable a more personalised and integrated approach for people who were supported by the neighbourhood care teams there were plans for a whole-system roll out of the Enhanced Case Management (ECM) system. ECM aimed to ensure that people with the most complex health and social care needs in Stockport had a holistic assessment and support plan which could be viewed and utilised across the health and social care system. It would be applied across the system with the inclusion of the specialist nurses and crisis response team. However, it was not in place at the time of our review

Are services in Stockport caring?

There was a commitment from staff at all levels in the system to provide person-centred care, reduce isolation and to empower people to make decisions. We found some examples where people had been well supported and their decisions documented. However, people often had to tell their story more than once.

Whilst people voiced concerns about the quality of care homes in Stockport, overall those using health and care services were generally happy with the support they received.

People living with dementia had access to good levels of support.

- People, carers and families in the community were able to make informed choices about future plans. Case notes showed that people and their families were included in decision making, with evidence of regular updates and multidisciplinary team meetings. However, people often had to tell their story more than once. We saw in case notes that assessments were often repeated by staff of the same occupation. These were not always shared across teams to promote a seamless transition between services and prevent people having to repeat their stories.
- People who used services told us that there was a perception that there was no money in Stockport, that people had to go into very poor care homes and that the system lost interest in them once they went into a residential or nursing home. ASCOF outcome data for 2016/17 showed that 62% of older people who used adult social care services said they were satisfied with their care and support, which was in line with comparators and the England average. However, this figure had reduced for people who used adult social care in Stockport since 2013.
- People living in Stockport with dementia had good access to support to help them stay well at home. For example, the EDUCATE team signposted people to access support. A health

and local authority jointly commissioned service provided a network of dementia drop in services across the borough. This was led by a dementia education specialist, who provided information and support services to those with dementia or their relatives.

- ASCOF data for 2016/17 showed that 75% of people over 65, who were using social care services in Stockport, found it easy to find information about support. This was in line with the England average. However, this percentage had been decreasing for Stockport since 2013.

Are services in Stockport responsive?

There were some good initiatives in place to respond to people's needs and prevent admission.

People were generally well supported by GPs, however social care was less responsive, creating delays and therefore increasing potential risks. Community services varied, with strong provision of support networks for people living with dementia.

There was a focus on a multidisciplinary approach to managing people's needs through the development of the neighbourhood care model. However, the effectiveness of the plans were yet to be proven as they were either new or not in place.

- The core aim of the neighbourhood care model was to provide responsive care services for the people of Stockport to keep them well and at home. This included improved seven day access to primary care services and a greater focus on early intervention and prevention. Plans had been put forward, as part of the Neighbourhood Business Case, to support a prevention agenda. This included clinical triage, where people could be booked into a clinical triage slot and receive a phone call from a clinician to assess their condition and offer a face to face assessment where necessary. This also included an acute home visiting service which would involve GPs within neighbourhoods sharing home visits. Neighbourhood teams would also work jointly to deliver an urgent response to deterioration where required. This response included joint visiting and use of joint support worker roles to deliver bolt-on support. Once established, this service would work alongside access the clinical triage and acute home visiting service. However, all of these plans had either not yet been delivered or were new. Therefore we were unable to assess the impact on keeping people well and in their usual place of residence at the time of our review.
- There were mixed views from care homes about the support from GPs and social care staff. Some care homes reported a lack of responsiveness whilst others told us they had a good relationship with their GPs, who would respond quickly when needed. However, all care homes we spoke with reported concerns about delays from social care staff when people required an assessment of their needs. They described assessments needed to be undertaken at six weeks, taking 12 weeks to be completed. This meant that people may not have been having their needs appropriately met for a considerable amount of time.

- The number of older people attending A&E who had been referred by a GP had been consistently higher than national average and comparator sites since quarter two 2014. In the last quarter of 2017, 12% of A&E attendances of people aged 65+ had been referred by a GP compared with 7% for comparator sites and 8% for the England average. We were told that significant investment was being made in collaborative general practice, aiming to free up GP time to provide more personalised support to people with complex long term conditions. System leaders also told us that there had been a recent reduction from 10.5% to 8.2% in 2017/18 of all A&E attendances from care homes which did indicate that some progress had been made.
- People living with dementia in Stockport were more likely to have an early diagnosis and therefore receive support and treatment earlier. The dementia diagnosis rate for Stockport was good. The NHS England dementia diagnosis indicator for April 2017 showed that the NHS Stockport CCG dementia diagnosis rate was 75.2%; higher than the national estimate of 67.9%, and they had met the national target for at least two thirds of people with dementia to be diagnosed.
- There were multiple community resources which provided drop in services, meetings and support networks for older people. For example, services supporting people to maintain their health and prevent falls, vision, dietary services and dementia support. However, some of the people that helped run those services told us that there was a lack of flexibility with transport arrangements which meant that people with wheelchairs could not always access the services provided. This could lead to inequitable provision of services and unmet need.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Stockport safe?

The systems and processes in place were not always effective at keeping people safe. Older people in Stockport were more likely to be admitted to hospital than people living in other areas.

Risks were not always identified in a timely way and people living in care homes were more likely to be admitted to hospital for treatment of conditions deemed to be avoidable such as pneumonia and accidents and injuries.

A lack of information sharing across the system meant that older more vulnerable people did not always have the benefit of an integrated approach to support to keep them safe.

- The systems and processes in place across the health and social care system to safeguard older people living in Stockport were not always effective. Comparatively higher rates of older people in Stockport were going into crisis and being admitted into hospital. Our analysis of Hospital Episode Statistics (HES) data in the first quarter 2017 showed that the emergency admission rate for people aged 65+ in Stockport was higher at 7,192 per 100,000 compared to a rate in comparator areas of 6,493 per 100,000 and the England average of 6,391 per 100,000. Emergency admissions had consistently remained higher than average since at least April 2014 and indicated there may be a gap in community provision.
- The rate of A&E attendances for older people was marginally higher than the national average at 10,613 per 100,000 compared to the England average of 10,534 per 100,000 but greater than the comparator average of 9,387 per 100,000.
- A lack of information sharing across the health and social care interface placed people at potential risk of avoidable harm. For example an adult social care provider told us about a person who had started to become a frequent attendee at Wythenshawe Hospital A&E. Despite their escalating attendances for the same reason, no information appeared to have been shared across the system, including the care staff providing the person's care, in order to provide a multidisciplinary response to keep the person safe and out of crisis.
- Older people living in Stockport care homes appeared to be more at risk of going into crisis. The data suggested that the rate of A&E attendances from care homes in the last quarter of 2016/17 was higher (1272) than the national average (979) and comparator sites (950). However, this data was based on postcodes where care homes were situated so could include some admissions from the general population. Whilst remaining high, the rate of A&E attendances had reduced since quarter two 2016.
- Hospital Episode Statistics (HES) data also showed that the percentage of 65+ A&E attendees from care homes referred by a GP was higher than the England average and comparator sites. In quarter one 2017, 10% of A&E attendances of older people coming from care homes were referred by a GP, compared to 6% nationally and 5% across comparator areas.
- Our analysis of HES data from October 2015 to September 2016 indicated that higher rates of older people were admitted to hospital with diagnoses for a range of conditions usually deemed to be avoidable. For example, diagnoses of accidents and injuries were higher than average at 506 per 100,000 aged 65+ compared to 392 per 100,000 nationally. This would suggest that people were not always receiving treatment in a timely manner. However, the Enhanced Quality Improvement Programme (EQUIP) team were aware of these concerns and were targeting the poorest performing care homes to provide staff training to support admission avoidance.

Are services in Stockport effective?

People who went into crisis in Stockport had a varied provision of services depending on which hospital they attended. There were some streaming processes at the “front door” of both hospitals to ensure people were allocated to the most appropriate clinical pathways. However staff across both hospitals did not have access to similar services to enable admission avoidance.

Recruitment challenges and low staffing levels placed people at potential risk.

Delays in the assessment and availability of mental health beds meant that there were delays in people leaving the acute hospitals, impacting on bed availability.

- We found an inequity of services available to the people of Stockport across Stepping Hill Hospital and Wythenshawe Hospital.
- There were some similar services and processes in place within each hospital's A&E department designed to assess older people's needs and improve their flow through the health and care system. When older people attended A&E, they were assessed using a standardised assessment tool. They were assessed by the frailty team at Wythenshawe Hospital or the Functional, Risks Equipment, Support and Home Environment (FRESH) team at Stepping Hill Hospital. Both teams would identify any immediate actions that could be taken to promote an early discharge or avoid admission, for example provision of mobility aids, referral to the falls service or treatment through the ambulatory care units. Admission avoidance data had been captured by the FRESH team, and although it showed that they were able to discharge 42% of people assessed on the same day, the data also showed that this figure was lower than data from other hospitals that provided a similar service. This support was also only available during week day working hours which meant that older people who attended hospital at night or at weekends would be more likely to be admitted.
- Stepping Hill Hospital contributed to a national Allied Health Professionals ‘improving the flow’ initiative. Therapists also acted as Trusted Assessors. The therapist undertook assessments then passed the details to the Crisis Response team where the person was assessed at home. This removed duplication of assessment in hospital.
- Frontline staff at Wythenshawe Hospital told us that they did not have access to the Integrated Care Team for Stockport residents who required social support at a time of crisis. This meant that an older person needing some social care support was more likely to be admitted into hospital if attending Wythenshawe Hospital compared to Stepping Hill Hospital.
- To ensure people were seen in the right place by the right person when attending A&E clinical streaming, in the form of a GP, at the “front door” of A&E at Stepping Hill Hospital

was in place. This meant that the GP was able to book people directly into ambulatory care, bypassing A&E. However, despite this service, we saw that older people had long waits in A&E in Stepping Hill Hospital. During our visit, there were 15 people waiting over four hours for a review, of which 13 were over 65 years.

- Both hospitals had acute admission wards, which provided care for the initial 72 hours of a person's stay. Staff within these areas told us that the timescale was generally met, but there were issues with flow to base wards which impacted on the average length of stay. Further complications arose when needing mental health assessments for older people in crisis. There were reported delays in Pennine Care NHS Foundation Trust assessments, which could only be completed in admission areas, and then delays of up to seven days to access a mental health bed.
- Staff from the Wythenshawe Integrated Discharge Team told us that to avoid admissions to hospital, Trafford and Manchester systems had implemented care navigators. We spoke with the care navigator team, who explained that they had forged links with voluntary groups which enabled them to identify solutions to any issues that resulted in people attending A&E. For example, someone who was isolated was signposted to social groups which improved their mental health and reduced A&E attendances. The care navigators followed up each case to track the impact and any outcomes of their service. While the team also saw people from Stockport admitted to hospital, they were commissioned to provide support to the people of Manchester and Trafford, therefore the team could not offer the same level of support to Stockport residents.
- People experienced some inequity in provision of stroke services across Wythenshawe and Stepping Hill Hospital. Stepping Hill Hospital was the acute stroke centre, which meant that when ambulance crews identified a person as having a suspected stroke they were taken directly to Stepping Hill Hospital. People who self-presented at Wythenshawe Hospital, and were identified as having a possible stroke, were assessed to identify where they were on the stroke pathway. If they required urgent treatment, they were transferred to Stepping Hill Hospital. However, if they were outside the urgent treatment timescale, they remained at Wythenshawe Hospital for their recovery. Although the stroke ward at Wythenshawe Hospital provided appropriate rehabilitation, staff told us they were unable to access similar services to those available at Stepping Hill Hospital. For example, they did not have access to Stockport step down facilities, which meant that people may have to remain in hospital longer, therefore increasing their risk of adverse health events. For example, staff told us about people who had acquired pneumonia or other hospital acquired infections during their stay in hospital
- Overall older people stayed in hospital a similar length of time to the national average. Our analysis of HES data showed that in the last quarter of 2016/17, 31% of people aged 65 and over, admitted as an emergency, had a hospital stay lasting longer than seven days, which

was in line with similar areas with an average 31%, and the England average of 32%. The quarterly trends for Stockport showed length of stay had remained consistent since 2015. However Department of Health and Social Care data from September 2016 to August 2017 showed people aged 65+ in the 90th percentile length of stay were staying longer than most comparator sites at 23 days.

- We found that the workforce did not always have sufficient capacity to support the effective transition of people between health and social care. There were staffing shortages across most areas. Stockport NHS Foundation Trust data showed that there were 174.32 whole time equivalent nursing vacancies in March 2018, which included both secondary care and community nurses. Although there were processes in place to ensure safe staffing, one case record we viewed showed that a nurse had recorded the nurse to patient ratio as 1:17. Nurse staffing levels varied according to the acuity of the ward and time of the day, however, the Royal College of Nursing stated that on average the ratio should be 1:7.7 during day shifts and 1:10.1 during night shifts. Ratios greater than these posed risks to the quality of care provided and increased the risk of harm. System leaders told us that the trust had recently completed a Strategic Staffing Review reported to Board of Directors in March 2018. They had also invited an external provider to undertake a more detailed 'deep dive' approach to seven wards in June 2018.

Are services in Stockport caring?

The views of people, their families, carers and advocates were not always taken into account when assessing and planning care. People were not always involved in decision making about their care needs.

People were generally treated with dignity and respect, and we saw polite and courteous communication between staff and members of the public. People were generally happy with the services that they received. However, inpatient survey results for Stockport NHS Foundation trust showed that there had been a decline in satisfaction.

- People in hospital did not always feel cared for. We saw limited evidence from the case notes we looked at or people we spoke with that people, their families and carers were being routinely involved in decision making about their care and support needs whilst in hospital. Records lacked detail of any discussions held with people. Care plans seen were often generic and not individualised.
- We found that people in hospital were not always at the centre of their care planning and there was a lack of involvement of carers, families, advocates and their representatives to help make informed choices. For example, in one case note there was a record of complaint from a family because they had not been involved in the decision about their relative's resuscitation status despite it being appropriate to do so.

- In another case note we read that a person had been referred for a procedure. The referral form stated that the person “lacked mental capacity” however, there was no evidence of a mental capacity health assessment within the notes, and no details of any discussions completed to determine the persons capacity or consideration of best interests.
- Stockport NHS Foundation Trust’s own 2017 inpatient survey showed that overall there was a decline in people’s positive responses from their 2016 audit. Decline had been identified in people thinking there were sometimes, rarely or never enough nursing staff on duty (48% compared to 39% in 2016). There were also declines in areas such as choice of food, not getting clear information from doctors and not knowing what would happen when leaving hospital.
- However, throughout our review we saw that people were generally treated with dignity and respect. During our site visits we saw that staff spoke politely and were considerate when providing care and offering information.

Are services in Stockport responsive?

When older people living in Stockport were in crisis, they were at risk of not being reviewed by an appropriate person in a timely manner. People attending A&E were more likely to wait for long periods of time for assessment, treatment, discharge or admission, and people were more likely to be admitted to hospital.

Although there were front door teams to promote discharge from A&E, the process was new and not fully embedded.

- Ensuring people were not unnecessarily taken to hospital could be further improved. Data we analysed for July 2017 showed that North West Ambulance Service (NWAS) managed 32% of incidents they were called to in the North West without needing to transport the person to A&E. This was below the England average of 38%. This meant that there may be an opportunity to further reduce the numbers of people being transported to hospital. During the same month 10% of 999 calls received by NWAS were resolved by providing telephone advice. This was in alignment with the national average.
- People in Stockport were more likely to wait longer for an ambulance compared to the national average. The Clinical Commissioning Group’s (CCG) Performance Update Report for March 2018 showed that the response times for ambulances for Stockport were below the national standards. For category two (emergency) calls for January 2018 performance was around 40 minutes against a standard of 18 minutes. This had been escalated as a concern to NWAS and the lead commissioner for the service.
- People who attended Stockport NHS Foundation Trust (SNHSFT) Stepping Hill Hospital A&E were likely to have to wait on trolleys before receiving treatment. The CCG

Performance Update Report for March 2018 showed that SNHSFT performed poorly in response to 12 hour waits on a trolley following the decision to admit to hospital. The trust reported four breaches in this target in August 2017, eight breaches in December 2017, and 52 breaches of this target in January 2018. The CCG reported that each breach was being reviewed to identify the circumstances that led to the delays and any subsequent learning. Poor flow of older people through the system meant that there were blockages at ward level, which impacted on the ability to move people from admission areas into a suitable ward.

- People in Stepping Hill Hospital A&E department were more likely to wait over four hours for assessment and treatment. National guidance was that all A&E attendees should expect to be assessed and admitted, transferred or discharged within four hours of arrival. The national standard for emergency departments is that 95% of people should be admitted, transferred or discharged within four hours of arrival in A&E. SNHSFT data for March 2018 showed that this target was not met, with 64.5% of people leaving A&E within four hours. SNHSFT data also showed that their performance was at its lowest point since January 2017; the 95% target had not been achieved throughout this period.
- SNHSFT was promoting people's independence when in hospital through the implementation of the "Dressed is Best" campaign. This was a programme which encouraged people in hospital to wear their own clothing rather than pyjamas. It was felt that this resulted in an increased independence and helped maintain mobility as people were less likely to stay in bed for long periods of time if dressed. The programme had been started on the older person's wards and the trust found that the number of people getting dressed had increased from 18% to 93%. The trust planned to roll out the programme across all inpatient areas.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Stockport safe?

While there were some excellent coordinated responses to ensure people were returned to their usual place of residence or new residence safely, there were some inconsistencies in the safety of the discharge process. Staffing levels at Stockport NHS Foundation Trust did not always facilitate safe discharge from hospital.

Older people living in Stockport care homes were more likely to be readmitted to hospital than if they lived in other similar areas.

Communication, written discharge information and relationships could be strengthened and improved between hospital staff and care homes and domiciliary care providers. People and their carers told us they were not always given enough time to plan.

- Older people living in care homes in Stockport were more at risk of being readmitted to hospital as an emergency. Emergency readmission rates were higher than the England average according to HES data, with 23% of people readmitted to hospital within 30 days of discharge in the last quarter of 2016/17. This was higher than the national average of 20% and above the comparator average of 19%. However, the rate of older people living in their own home being re-admitted into hospital as an emergency was in line with the England average.
- People were at risk of unsafe care due to inconsistent levels of communication from Stockport NHS Foundation Trust (SNHSFT) to care providers and health professionals in the community. Both domiciliary care and care home providers reported that people were discharged home or to their care home with poor quality information about medication, the level of care they needed, or the level of skills needed to care for the person, for example when people required feeding via tube.
- We were told that sometimes people were discharged home without the correct equipment being in place. The Red Bag initiative was not in place or not well embedded. This initiative ensured people being transferred into hospital from care homes travelled with their records and medication. Wythenshawe Hospital did not use the Red Bag system and Stepping Hill Hospital had only recently introduced it. These issues put older people at risk of re-admission.
- While the response rate was small, lack of accurate or detailed information on discharge from the acute hospitals was supported by feedback to our survey on information flow. Five out of the eight respondents we received said they received discharge summaries 50% or less of the time, and four out of five of these responses related to domiciliary care providers. Because of this lack of information flowing from secondary care, domiciliary care providers felt they had to be in constant contact with wards and social workers to ensure they were up to date with a person's care needs.
- Staff shortages at Stepping Hill Hospital were a risk to safe transfers of care for older people. At the time of our review, there were 127 nursing vacancies at the hospital. The Stranded Patient Grand Round was initiated in January 2018. This was a team of senior staff from across the Stockport health and social care system who visited the wards every Wednesday

to review plans for the longest staying people. They identified that a lack of ward and administrative staff was a barrier to transferring people from hospital.

- People's experience of discharge from Stepping Hill Hospital was at times poor. We found, and ward staff and care providers confirmed, that discharge planning was sometimes not started on admission and could be rushed due to bed availability pressures. In some cases, staff started planning straight away, including contacting the hospital social worker; however, this process was not consistently applied across all of the wards in either hospital. People and their relatives told us that wards did not always give them time to make arrangements, especially if the person being transferred lived alone. Staff we spoke with were mindful of the need to transfer older people who were medically fit into a more appropriate setting. However, our case tracking and note sampling showed this was not necessarily balanced with a robust risk management approach or clear communication with people and their relatives.
- System leaders were making efforts to improve the safety and effectiveness of discharge from hospital but these were in the early stages. A management study of older people who had been in hospital longer than seven days had led to a number of projects. Work on flow and safe discharge from SNHSFT was planned as part of the Quality Improvement Programme, but this was not fully established. For example we saw a Discharge Planning Audit Template to be used as a tool to monitor safe practice. However, it was too early in its implementation to see any results from this audit.
- We heard that the risk of medicines errors at SNHSFT had reduced as medicines management systems had improved for older people who were transferred out of hospital. At Stepping Hill Hospital, one pharmacist was designated to process medicines specifically for hospital discharges. Since they were appointed the error rate with medicines had reduced from 34% to zero, however the lead pharmacist felt that improvements were limited due to the number of vacancies for pharmacy technicians.
- Pharmacy staff also liaised by phone with care homes prior to discharge when an older person was returning, and checked stocks in the home to avoid surplus supply. However, this did not always happen due to capacity issues. At Wythenshawe Hospital there was a project looking at ways to reduce medicine errors on transfer of care. Wythenshawe Hospital also had a hotline for people and GPs to raise queries about medicines prescribed on discharge from hospital.

Are services in Stockport effective?

Although there had been some improvement in performance, the number of delayed transfers of care remained high and people were not always enabled to return to their preferred place of residence in a timely way.

Person-centred models of assessment and care were being introduced in Stockport NHS Foundation Trust but they were new and not rolled out across the hospital therefore the impact on delayed transfers of care could not be seen.

People who received reablement had good outcomes but it was offered to a declining number of people. There were step down beds available, in some cases offering very high quality care.

However, improvements were needed in developing a joined up person centred approach for people moving into or returning to a care home or having care at home after being in hospital. There was an opportunity to enhance the effectiveness of the discharge for the person by developing more positive relationships between the hospital and adult social care provider teams, improving channels of communication and seeing care home providers as part of the multidisciplinary team when discharge planning.

- Performance at Stepping Hill Hospital (SNHSFT) was not always sufficiently effective at managing delayed transfers of care when there were a high proportion of older people with complex needs awaiting discharge from hospital. SNHSFT system leaders told us that they had a DTOC target of 15 days. Performance data shared with us from SNHSFT showed a peak in delayed transfers of care (DTOC) of 23 days on 3 April 2018, which coincided with a peak in complex medically optimised people for transfer. However, system leaders reported that this adverse performance was before an exercise was undertaken to benchmark reporting measures across GM to ensure consistency. Following this exercise it was revealed that performance was better than initially reported due to a previously inconsistent application of the reporting guidelines. After this, DTOC performance remained between 11 and 14 days up to 17 April 2018. Therefore meeting their system target of 15 days.
- Older people who suffered from an acute episode of confusion, (delirium), experienced an effective and person centred approach to their care. Saffron Ward, run by Pennine Care NHS Foundation Trust, was a step down ward from Stepping Hill Hospital that cared for people suffering from delirium, dementia and depression. They focused on maximising independence to enable people to return home. The service also provided rehabilitation for people with co-morbidity physical and mental health conditions who were assessed as being able to live at home if provided with suitable rehabilitation services. Mental health specialists including psychiatrists helped people overcome their delirium and return safely to their home or a care home. Length of stay was generally around eight weeks. However, sometimes this increased to 12 weeks, due to difficulties finding a placement in the community or the need to manage family expectation through best interest decision meetings.
- A recurring theme around delayed discharges for people appeared to be the lack of communication between hospital staff and care home staff. Ward staff had concerns that assessments were not completed by care home staff in a timely way; telling us that they often took up to three days to complete. This was however not the view of care home staff

who felt that they responded quickly but were impeded by the often “last minute” nature of requests from the hospital regarding the discharge process.

- Care home and domiciliary care providers told us that there was poor communication between hospital staff and themselves when people they supported were in hospital. They stated that hospital staff did not involve them in early discharge planning and often did not contact them until the person was ready to be discharged. In order to check on the status of the hospitalised person the care home staff said they would have to rely on the person’s family or call the hospital ward themselves.
- Care home providers also told us that people’s Do Not Attempt Resuscitate Cardiopulmonary Resuscitation (DNA CPR) instructions, which should follow the person when they change care settings, were sometimes “lost in the system” once someone was admitted to hospital. This meant that people could be at risk of not having their wishes respected.
- Older people in Stockport who received reablement were more likely to have a good outcome with a high proportion remaining out of hospital. The percentage of people who were still at home 91 days after discharge into reablement was 86.5% in 2016/17, which was better than the performance across comparators and the national average of 82.5%. However, the percentage of older people in Stockport benefitting from reablement was decreasing, and in 2016/17 it fell slightly below the England average. Analysis of Adult Social care Outcomes Framework data showed that the percentage of older people who received reablement services had decreased over the years from 5% in 2011/2012 to 2.5% in 2016/17. The England average in 2016/17 was 2.7%.
- Technological advancements had been made to systems to improve interoperability and to facilitate flow. In the Integrated Transfer Team office in Stepping Hill Hospital, there was an electronic bed availability board with information on the capacity of nursing and residential beds plus intermediate care beds. It showed what was available in real time and what was expected in the next 24 hours.

Are services in Stockport caring?

There were mixed views about the extent to which people, their families, carers or advocates were treated as active partners. People and their families were not always at the centre of decision making.

The system commissioned the voluntary sector to improve the information shared with people, and to offer them a range of services before and after they were discharged from hospital. However staff were hampered in their ability to have robust discussions with people about care choices due to a lack of an embedded choice policy.

- People we spoke with at both acute hospitals had a mixed experience of communication around the discharge process. Communication was inconsistent and some people felt that their transfer home came “out of the blue” and that an estimated discharge date had not been discussed with them. We also found that people who had been transferred to intermediate care were not always given full information about where they were going and for how long. There was a need to strengthen formal and informal communication processes with older people so they were actively included and involved in decisions about their care and future living arrangements.
- Arrangements for transfer out of hospital to home or other accommodation were not always person-centred. Through our case tracking and conversations with stakeholders, we found that relatives were sometimes ill informed about step down choices and options when people were transferred out of hospital. For example, in one case review we saw that a person was transferred out without the correct consent processes being followed.
- In many cases, choice was an aspiration and not a reality. There was a draft choice policy which was being introduced into Stepping Hill and Wythenshawe hospitals. In reality, older people and their family’s choice of care service was restricted by availability of care packages, quality of care homes, bed availability and top up fees.
- Stepping Hill Hospital (SNHSFT) commissioned services from the VCSE sector to help older people understand their choices and adjust once they returned home. Age UK received referrals from the Integrated Transfer Team and then compiled comprehensive list of potential care home placements according to the older person’s needs. The Age UK volunteer then communicated a full list of options with the older person and relatives, listing the homes with vacancies and providing a list of those without beds. This enabled people and their families to make a more informed choice but also managed their expectations.

Are services in Stockport responsive?

There were some systems, processes and services in place to support and respond to the transition of people to their usual place of residence or alternative setting. However too many people were still waiting too long in inappropriate settings. There were a variety of reason for delays with the main reason being lack of availability of care home beds or home at care packages however other reasons included waiting from assessments from social workers or other therapists. There was an opportunity to tackle these smaller causes of delay quickly.

Some elements of the high impact change model had begun to be implemented across the system, for example the Trusted Assessor role, but this was not consistently applied or embedded.

Stepping Hill Hospital was not meeting the targets set out in its Urgent Care Plan designed to help reduce delayed transfers of care. However, the system had initiated a Stranded Patient

Grand Round of the hospital to identify “bottlenecks” and this was leading to some improvement actions.

Significantly fewer people living in Stockport were being found eligible to receive NHS continuing healthcare funding compared to the England average and comparator areas. This included fast track funding for people at the end of their life.

- In 2017 Stockport was the ninth worst performing health and social care system in England in terms of delayed transfers of care (DTC). Analysis conducted by the Department of Health and Social Care showed that in March 2018, Stockport was still performing below average. During March 2018 the average daily number of days transfers of care were delayed per 100,000 population aged 18+ was 16.8 while it was 10.4 for comparators and 11.4 for the England average. There had been a slightly improving trend with DTC figures reducing to 12.5 days in December 2017. However, there was then a month on month increase to reach 16.8 days in March 2018.
- Performance data showed that the system was not addressing delayed transfers of care quickly enough. The majority of Stockport residents delayed in one of the acute trusts were waiting to be transferred out from Stepping Hill Hospital. Outcomes relating to transfer of care and length of stay were reported to the Stockport NHS Foundation Trust (SNHSFT) Urgent Care Board. Information provided to the Urgent Care Board included the tracker from the Urgent Care Plan. This showed that the system was behind schedule with key actions intended to improve DTC performance. For example, the system failed to increase the proportion of early discharges to at least 25% of all hospital discharges. In the first week of March 2018 the proportion of early hospital discharges was just 13.3%. In addition, the Functional, Risks, Equipment, Support, Home Environment (FRESH) team had a target to reduce length of stay to 72 hours. In March 2018, length of stay had been reduced from 8.4 to 4.6 days. Although this was a reduction, the expected target had not been met.
- NHS England data between July and September 2017 showed that the main reason older people living in Stockport were more likely to experience delays in their transfer of care from hospital was availability of care home beds or domiciliary care packages. However, we found that some causes of delay were within the remit of the hospital to manage. System leaders found during their regular Wednesday Stranded Patient Grand Round at Stepping Hill Hospital that out of 209 people in hospital for longer than seven days, around 125 were medically fit. These people had an average age of 78 and an average length of stay of 26 days. Representatives of the Grand Round team told us that they had established that some of the reasons for delay included waiting for a care home assessment or waiting for occupational therapist or physiotherapist assessment.
- People from Stockport admitted into Wythenshawe Hospital could experience a less responsive service than people admitted into the hospital from Manchester or Trafford. There

was only one hospital based Stockport social worker at Wythenshawe Hospital. The hospital had set up a new integrated discharge team made up of social workers, neighbourhood team representatives and hospital staff so communication around discharge had improved for Manchester and Trafford residents, but Stockport residents had not benefitted from this. As a result, some older people from Stockport had to wait for a community social worker to come into the hospital and undertake their assessment, which could cause unnecessary delays. Staff told us that this also impacted on fast track continuing healthcare (CHC) assessments for those people in Wythenshawe Hospital who were at the end of their life.

- People living in Stockport, who were in hospital, had access to some bed-based intermediate care services. This was where they could receive ongoing support and some reablement from health care professionals outside of the acute setting. For example, OPAL (Older Persons Assessment and Liaison) House and Marbury House each had 41 beds for people who were medically fit but whose discharge from hospital was complex and therefore they required more support. However, people's transfer out of these services back to their home or a care home was constrained by the same care packages and care home availability issues as from the acute wards.
- A focus on discharge and discharge planning started on admission, may help to reduce people's length of stay in hospital and allow for a smoother transition into another care setting or their home. However, from the case files we reviewed for both acute trusts, there was limited evidence that discharge planning was started early on in the person's journey. From our site visit to Stepping Hill Hospital, progress towards embedding the Red and Green Bed Days process; a visual management system to assist in the identification of wasted time in a person's journey, where applied was working well. However, it was not applied consistently across all wards and therefore there were pockets of people not experiencing good progress towards discharge.
- The Clinical Commissioning Group's Performance Update Report for March 2018 highlighted that SNHSFT had implemented the SAFER programme; a practical tool to reduce delays for people on wards. This included an early senior doctor review, all people having an expected date of discharge, flow of people from assessment units to wards as early as possible, early discharge and a review of those people with extended lengths of stay. However, the report suggested, and our site visit and review of case notes confirmed, that the programme was not embedded or consistently applied.
- The Active Recovery service at Stepping Hill Hospital offered a joint team response to returning people home as soon as possible. People from Stockport who had been treated in Wythenshawe Hospital could also benefit from this service. The team, which included nurses, physiotherapists, occupational therapists, social workers and healthcare assistants, found people step down accommodation and sourced further care packages. The team offered overnight assessment, significant increases in reablement support worker capacity,

and new skill mixes to deliver additional frontline therapy capacity. Although staff told us the team was very good, there was limited measurement of outcomes.

- As part of the system's implementation of the high impact change model, the Transfer to Assess model was being rolled out at Stepping Hill Hospital. More assessments were starting to take place in older people's own homes or usual place of residence. Staff felt that they had deflected a lot of admissions since February 2017, although data was not available to support this. Following success within the short stay ward areas, there were plans to roll the Trusted Assessor model out across all wards, however, there was no timescale for completion. We were told that there were challenges in embedding the changes to practice and the team were awaiting a designated doctor to support the process.
- Within recent months people in Stockport, who had been assessed for NHS Continuing Healthcare (CHC) funding, were more likely to have the funding agreed. However, significantly less people than comparator areas or the England average were deemed eligible for CHC funding.
- NHS England data showed that between quarter one in 2017/18 and quarter three, the assessment conversion rate from referral to receiving care had increased from 11% to 21% which was similar to the England average of 22%. This suggested that processes for accurately identifying people for CHC were improving and a lower proportion of people were entering into the CHC process to subsequently be denied funding
- However, the number of people deemed eligible for CHC funding in Stockport was lower in comparison with Greater Manchester (GM) and across England. Stockport's eligibility rate for the year to date, (excluding Fast Track), was 44.5 per 50,000 population aged 18+. This was lower than GM (69.31) and across England (63.84). Fast track eligibility, a CHC pathway tool often used for people who were at the end of their life to ensure they were supported in their preferred place of care as quickly as possible, was also low. The Fast Track eligibility rate for Stockport was 34.39 per 50,000 population aged 18+. This was much lower than GM (104.77) and across England (106.55). This meant that people at the end of their life may not receive care and support in their preferred place in a timely way.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Stockport?

- Stockport was at the start of its journey to integration. The system had a well-defined and articulated strategic vision, Stockport Together, which was well established, and which aligned well to the Greater Manchester Health and Social Care Partnership 'Taking Charge Implementation and Delivery Plan'. However, delivery was in its early stages despite the vision dating back to 2015. It was widely recognised in Stockport that the pace of transformation and delivery needed to be accelerated. The Stockport Together programme set out plans for system-wide integrated care and the delivery of place-based care through a Stockport Neighbourhood Care (SNC) model. It was based on a robust assessment of needs and clearly focused on people living in Stockport.
- The draft SNC maturity assessment in February 2018 acknowledged that there were delays in its development; reasons included operational focus on hospital delays performance, urgent care pressures taking up SNC capacity, and delays in staff consultation. The emerging priorities for 2018/19 included focusing on a realignment of resources and developing a leadership programme for the SNC team.
- There was a lack of clarity around system-level governance arrangements. While there was an agreed approach to the management of financial risk, there were no clear reporting lines for the delivery of the transformation programme. It was not clear where decision-making and accountability for integrated working lay and the roles of the Health and Wellbeing Board and the Adult Social Care and Health Scrutiny Committee needed to be reviewed and strengthened.
- Historical cultural and relationship challenges remained a barrier to integration. New leadership in the system presented an opportunity to foster a culture of excellence that would lead to greater staff engagement. There were plans to address system-wide cultural issues through operational delivery and bespoke leadership programmes, but these plans were at the very early stage of implementation.
- There was a clear commitment from system leaders to work in partnership and deliver integrated health and social care through joint commissioning arrangements. However, these plans were in their infancy and despite a joint commissioning strategy and large improved Better Care Fund, the local authority and clinical commissioning group were separate and focused mainly on their own responsibilities.
- Stockport faced significant market challenges, but to date a traditional approach to shaping

the health and social care landscape had been in place. The Market Position Statement was in need of updating and commissioning arrangements were collaborative rather than integrated. A commissioning outcomes framework was being developed as part of the wider Greater Manchester devolution, but the system should continue to address Stockport-specific challenges in the interim. There was scope for longer-term gains for local people if system partners jointly made the investment to actively shape the market.

- There was a shared understanding of resources. System leaders articulated a clear intent to work jointly and this was demonstrated by the establishment of a pooled budget of £200m for health and care. However, with limited home care capacity and high numbers of people waiting to be discharged from hospital, the system needed to assure itself that resources were being used most effectively to ensure good outcomes for people.
- The Stockport Health and Care Workforce Strategy needed changes to reflect workforce requirements in the home care and care home markets and in general practice. Workforce leads recognised that the strategy would benefit from a revision with a clear system-wide action plan for a competent sustainable workforce.
- Information sharing between services, although improving, remained underdeveloped. This impacted on service delivery and led to duplication of work by staff. The Stockport Health and Care Record (SHCR) was a positive step, providing live GP information, social care plans and portals to access acute and palliative care information. The system should continue to push ahead with plans to develop this further.
- There was a shared commitment to pursue the prevention agenda and this was underpinned by the strategic vision for Stockport. Pathways across primary, community and secondary care were starting to support the wider objectives of health maintenance, with the expectation that there would be further benefits once neighbourhood models were implemented and embedded. There had been some improvements made, but there was less emphasis on primary and community services owing to pressures in the system; the system needed to ensure that progress was tracked with relevant outcome measures.
- There was recent impetus to drive the neighbourhood care model through the appointment of a Managing Director. However, while the neighbourhood care model teams were collaborative they were employed by different organisations. There was not clarity on how the governance and managerial accountabilities for the delivery of the neighbourhood model would evolve, and how this would work alongside primary care and the Provider Alliance Board.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- The delivery of the Stockport Together strategic vision, which is congruent with the Greater Manchester plan, must be accelerated in order to secure positive outcomes for the people of Stockport.
- System leaders must ensure the Stockport-wide workforce strategy, in alignment with the Greater Manchester workforce strategy, articulates a clear system-wide action plan to provide a competent, sustainable workforce. Independent adult social care providers should be included in the ongoing development of the workforce strategy so that recruitment and retention across all health and social care sectors can be improved.
- System leaders must work together with care providers to shape the market, recognising independent providers as system partners and ensuring they are involved in strategic planning and market shaping, to determine how the needs of the people of Stockport can be effectively met.
- The local authority must fulfil its statutory obligation under the Care Act 2014 to provide assurance that there is appropriate capacity of good quality services within the social care market to ensure people receive person-centred, safe, high-quality care.
- The challenge and oversight functions of the Health and Wellbeing Board and Adult Social Care and Health Scrutiny Committee should be strengthened.
- System-level governance arrangements should be clarified, ensuring there are straightforward clear lines of accountability and reporting.
- Joint strategic commissioning intentions between Stockport NHS Clinical Commissioning Group and the local authority should be developed. The move to single population outcome-based commissioning and provision should be completed at pace. All parties need to take common ownership for effective commissioning to resolve community care issues prior to admission to hospital and after people leave hospital. Commissioning approaches to delivering integrated primary care, community nursing and out of hospital delivery in the neighbourhoods needs to be strengthened.
- System leaders should work to ensure that people receive consistent quality and access to care, and address the inconsistencies in people's experiences across the two acute hospital trusts.

- Organisational development should be undertaken to improve communication and address cultural issues (at an organisational and system level) in order to share learning and improve levels of trust and understanding across the health and social care interface.
- System leaders should develop improved comprehensive engagement strategies, including working with Healthwatch Stockport, to facilitate effective communication with the public and with frontline staff to ensure they are involved and engaged in the transformation plan.
- System leaders should work together to ensure that people's secondary care experiences are consistent. This should address ongoing performance concerns in relation to Stockport NHS Foundation Trust and the non-elective pathway at Stepping Hill Hospital.
- The system should continue to implement the high impact change model to facilitate more timely discharges from hospital.
- The system must ensure discharge planning is consistently started at the beginning of a person's journey through hospital and remains a key focus throughout their stay. The SAFER programme and 'Red and Green bed days' should be implemented and embedded across all wards. Care home and home care providers should be involved in discharge planning at an early stage of the person's stay in hospital.
- Performance in relation to continuing healthcare should be reviewed to ensure people's rights are being met and those who are eligible to receive support are being identified, referred and assessed in a timely manner.
- System leaders should review the Information Management and Technology strategy to ensure that actions are funded and risk assessed; working towards interoperability of systems and shared health records as a priority.