STOCKPORT DELIVERY PLAN 2022/23

Report of the Director of Integrated Commissioning – NHS Stockport CCG

1. INTRODUCTION AND PURPOSE OF REPORT

The ONE Health and Care Plan is our single, system-wide plan for improving the health and wellbeing of all Stockport residents through bringing together health and care services over the next 5 years, with a focus on prevention and early intervention. This Plan was co-designed with all system partners and was informed by extensive engagement with people who live in Stockport and our staff. The ONE Health and Care Plan was approved by the Stockport Health and Wellbeing Board in October 2021.

This report presents the Delivery Plan for the first year of the ONE Health and Care Plan; focusing on the key system key deliverables for 2022/23.

Progress against the actions and measures in the Delivery Plan will be reported to the Health and Wellbeing Board on a regular basis during 2022/23.

2. DETAIL

As reported to the Health and Wellbeing Board previously, a suite of system outcome measures is currently under development. Delivery of improvements in outcomes will be through the nine programmes of work set out in this plan. The impact of these changes will be seen in the following four strategic aims:

- **Stockport residents will be healthier and happier**, with tangible improvements seen in life expectancy; happiness & emotional wellbeing; the proportion of children and young people who are thriving; and reductions in social isolation and loneliness.
- **Health inequalities will be significantly reduced**, as evidenced through healthy life expectancy levels; access to key preventative services such as screening; early diagnosis of cancer, heart disease, and respiratory disease; reductions in smoking and obesity; and reductions in premature mortality among people with the worst health outcomes.
- **Safe, high quality services will work together for you**, resulting in positive CQC and service user ratings for all local services; delivery of national standards; improved access to services and reduced waiting times.
- **Stockport residents will be independent and empowered to live their best lives**, as evidenced through the proportion of people who are active, eat well and drink healthily; reductions in avoidable emergency hospital admissions and permanent admissions to care homes.

The ONE Health and Care Plan sets out the system-wide programmes to deliver these over the next 5 years. Where standards or targets have been set for 2022/23, these are included within the one year Delivery Plan.

The Plan is set out in two distinct but inter-related sections. The first being the specific actions and programmes to ensure that the governance, structures and planning are in

place to enable full delivery of the ONE Health and Care Plan, integrated whole-system working and the relationship and Accountability Agreement between the locality and the GM Integrated Care Board (ICB) from 1 July 2022. This section also includes the system-wide strategies that will be developed in 2022/23 (building from existing organisational strategies and plans).

The second section highlights the specific outcomes, service/pathway developments and performance standards to be achieved in 2022/23 relating to the ONE Health and Care Plan and the NHS Long Term Plan. This section mirrors the nine delivery programmes in the Plan:

- Quality and Leadership
- Early Help and Prevention
- Independence and Reablement
- Mental Health and Wellbeing
- Tackling Inequalities
- Stockport's Neighbourhoods
- Child-Friendly Borough
- Age-Friendly Borough
- Valued Workforce

3. CONCLUSIONS AND RECOMMENDATIONS

The Health and Wellbeing Board is asked to ENDORSE the Delivery Plan 2022/23.

BACKGROUND PAPERS

- ONE Stockport Plan
- ONE Stockport Health and Care Plan
- Stockport Locality Plan
- Stockport Health & Wellbeing Strategy
- The NHS Long Term Plan
- 2022/23 NHS Priorities and Operational Planning Guidance

Anyone wishing to inspect the above background papers or requiring further information should contact Melissa Maguinness, Director of Integrated Commissioning, NHS Stockport CCG via email: Melissa.maguinness@nhs.net

NHS
Stockport
Clinical Commissioning Group

Stockport's Delivery Plan

2022-23

Deliverables in 2022-23

** indicates this is a requirement of the NHS Long-Term plan, as well as a priority under our ONE Health & Care Plan*

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
Governance and Strategy			
Governance & Structures	• Establishment of Stockport Locality Board	Shadow Locality Board in place	Full Board operational at latest from 1 July 2022
	• Agree Section 75 pooled budget	£260m pooled budget	Agree pooled budget for 2022/23 by end of Quarter 1
	• Accountability Agreement between Stockport and GM ICB	N/A	Accountability agreement with clear delegated responsibility, budgets and outcomes in place by end Q1 2022/23
	• Build a Provider Partnership to deliver integrated services in Stockport	Development of Provider Partnership, led by Stockport Foundation Trust (SFT)	Provider Partnership in shadow form from Q1 2022/23
	• Agree governance and development of the All Age neighbourhood model	Number of development groups across the locality, spanning health, care and wider community development	Single, clear governance and strategic plan in place by end Quarter 2 for an All Age neighbourhood model which focuses on improving outcomes for all residents, through full integration of health and care services, prevention and early intervention and the wider determinants of wellbeing

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
Strategy and Planning	• Develop and implement detailed strategies and work plans to sit under and deliver the Health & Care Plan: ○ Joint Workforce Strategy ○ System Charter on Quality ○ LeDeR Improvement Plan ○ All-age Autism Strategy ○ Local Transformation Plan for Children's Mental Health ○ SEND Improvement Strategy ○ SEND Joint Commissioning Strategy ○ Stockport Estate Strategy ○ Early Help Strategy ○ Start Well Strategy ○ Ageing Well Strategy (refresh) ○ All-Age Mental Health & Wellbeing Strategy ○ Digital Prevention Strategy ○ All Age Carers Strategy ○ Active Communities Strategy (refresh)	Existing individual organisational plans/strategies are in place for most of these.	Build on all existing strategies to produce first draft system-wide strategies for consideration by the end of Q2
Outcomes, service/pathway developments and performance standards			
1. Quality and Leadership	• Develop and implement a system wide Quality Improvement Plan	Building from existing organisational plans	System-wide QIP agreed by end Q1 2022/23
	• Recover health and care services post-COVID, reducing waiting lists	44,908 on the waiting list as at December 2021	Begin to return to pre-pandemic levels and reduce long waits Deliver an elective recovery plan during 2022/23 Plans in place to ensure delivery of 10% more

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
			elective activity than before the pandemic Use the national framework and guidance for patient review, to prioritise access (due March 2022)
	• Continuous reduction in 52 week waits*	3,912 people waiting over a year as at December 2021	Eliminate waits of 104 weeks as a priority by July 2022 and maintain this position throughout 2022/23 Eliminate waits of over 78 weeks by April 2023 and conduct 3-monthly reviews for this cohort of patients, extending the 3-monthly reviews to patients waiting over 52 weeks from 1 July 2022. Develop plans that support an overall reduction in 52-week waits where possible Stabilise waiting lists around the levels seen at September 2021
	• Continue to deliver virtual outpatients*	In December 2021 36.5% across first and follow ups were virtual (Consultant-led outpatient appointments)	Increase to 50% across first and follow ups and continue to use greater use of technology
	• Accelerate the progress already made towards a more personalised approach to outpatient follow-up care	Good progress in Patient Initiated Follow-Ups and alternatives to face-to-face	Reduce outpatient follow-ups by minimum of 25% against 2019/20 activity levels by March 2023 by using more flexible follow ups and PIFU (including cancer pathways)

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		appointments	
	• Referral optimisation through the use of specialist advice services to enhance patient pathways	Advice and Guidance in place across most specialties	Deliver 16 specialist advice requests, including Advice and Guidance, per 100 outpatient first attendances by March 2023 Advice and Guidance in place for all relevant specialties
	• Roll-out of the Waiting Well Programme	Waiting Well programme piloted in Orthopaedics. Evaluation to commence March 2022	Roll-out to additional specialties throughout 2022/23, using the nation health inequalities dashboard to support roll-out (dashboard under development)
2. Early Help and Prevention	• Recommissioning of prevention services	Strong prevention services in place to build from	Procurement complete March 2022 with implementation commencing April 2022
	• Increase uptake of Health screening* (including recovery post-COVID)	82.6% offered NHS health check 29.7% uptake 58.3% breast screening (2021) 76.3% cervical screening (2021) 66.8% bowel screening (2021) 75.6% AAA screening 78.6% diabetic eye 99.3% foetal anomaly	Increased uptake above national averages or maintain current rates where we are higher in Stockport: National baselines: Health check – 18.6% Breast screening - 74.1% Cervical screening - 70.2% Bowel screening - 63.2% AAA screening - 76.1% Diabetic eye screening - 81.5% Foetal anomaly screening - 99.1% Infectious disease in pregnancy screening - 99.8%

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		99.6% infectious disease in pregnancy 98.5% new-born blood 97.8% new-born hearing	New-born blood spot - 97.9% New-born hearing test- 98.2%
	• Improve bowel, breast and cervical screening uptake*	Bowel screening– 66.8% in 2021 Breast screening– 58.3% in 2021 Cervical screening– 76.3% in 2021	Recover to pre-pandemic access levels and maintain above national average performance for bowel and cervical screening and increase to national average for breast screening National performance 2021: Bowel – 65.2% Breast – 64.1% Cervical – 70.2%
	• Implementation of Best-Timed pathways to support achievement of the Faster Diagnosis Standard*	In December 2021: 69.7% of patients referred by their GP on a 2WW pathway were seen within 2 weeks (75% Year to Date) 27.6% of patients referred by their GP on a 2WW symptomatic (cancer not initially suspected) breast pathway were seen within 2 weeks	Throughout 2022/23 Achieve National Cancer Waiting Time Standard of 93% Achieve National Cancer Waiting Time Standard of 93%

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		(64.8% 21-22 Year to Date) 67.8% 28 day Faster Diagnosis standard (68.3% Year to Date)	 Achieve National Cancer Waiting Time Standard of 75%
	• Increase uptake of the Diabetes Prevention Programme and online self-management*	Above national average uptake in Stockport	Double capacity to 200,000 places nationally by 2023/24, making good progress by end 2022/23
	• Implement Community Diagnostic Hub (CDH)	Revised Business case to be developed early March 2022	Design phase, including end-to-end pathway redesign Implement PCN-level spirometry and phlebotomy Align community and IS providers to CDH system Implement CDH by end 2022/23 Increase diagnostic activity to a minimum 120% of pre-pandemic levels across 2022/23
	• Development of the Urgent Treatment Centre*	UTC Lite model in place, good progress made towards achievement of the national standards	New model in implementation phase from April 2022 which acts as a Single Point of Access and directs people to the most appropriate service/place for care to meet their presenting needs (including self-care) Meet national standards Reduce 12-hour waits in ED's towards zero and no more than 2% Minimise handover delays between ambulance and hospital, including • Eliminating handover delays of over 60 mins • Ensuring 95% of handovers take place within

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
			30 mins • Ensuring 65% of handovers take place within 15 mins
3. Independence and Reablement	• Revision of Community Neuro Rehabilitation Service and pathway to provide an improved service for Stroke and neurological disorder patients in Stockport	Integrated service model in place, capacity does not meet the increased demand	In place by end Quarter 2
	• Redesign the Intermediate Care offer, including Discharge to Assess (D2A) and procure new beds-based service and enhance home based service • Expansion of the virtual ward model	Interim intermediate tier beds in place to end March 2022. Year to Date: 71% of patients discharged on pathway 0 20% on pathway 1 8% on pathway 2 1% pathway 3	Post pandemic, review current D2A pathways and review delivery and outcomes ensuring a fit for purpose model Ongoing system development throughout 2022/23 to increase the number of people being discharged on Pathways 0 and 1 A Home first approach to embed partnership risk management. 150 Virtual Ward Beds (based on national ambition for 40-50 virtual ward 'beds' per 100k population)
	• Improved crisis response within two hours, and reablement care within two days*	98.1% crisis response within 2 hours in 2020	Sustainable 2 hour crisis response and 2 day reablement in place by end Quarter 2
	• Structured Medication Reviews* All PCN to identify priority groups for focus on SMR achievement based on capacity levels of Stockport Integrated Pharmacy teams	905 Structured Medication Reviews undertaken in October 2021 889 in November	Recover backlog from COVID and increase structured medication reviews of identified priority focus groups to 50% by March 2023.

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		2021 862 in December 2021 948 in January 2022	
	• Enhanced Health in Care Homes*	Care Home support in place	Implement MDT approach by Q2 2022/23
	• Implement the six components of the NHS Comprehensive Model for Personalised Care*	3 components in place • Shared Decision Making • Personalised care and support planning • Social prescribing	Implement the three elements • Ensure provider partnership protects the right to choice • Supported self-management • Increase uptake of Personal Health Budgets
	• Roll out of strengths and asset-based programme across Adult Social Care.	N/A	Workforce Development to take place in Q4 2021/22. New assessment documentation launched in Q1 Embedding of the approach throughout 2022/23
	• Continued development and implementation of the Adult Social Care Operating model. Promoting a reablement, home first approach to enable individuals to remain independent and as connected to their communities as possible.	Implementation and development is ongoing. The programme has been impacted by the covid19 pandemic.	Phase one of the adult social care operating model will be implemented by March 2023. The model will continue to be developed to reflect local and national agendas and legislative changes.

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
	• Review of the commission for the Learning Disability service	Service offer in place which needs to be reviewed and updated including a new Section 75 Agreement and fully resourced integrated model	Review current service offer and establish with partners key opportunities for development of service offer going forwards. Establish a local commissioning arrangement by the end of 2022/23 with respect to the former Section 75 agreement which takes account of the reviewed outcomes and supports/finances an integrated team model and service offer.
4. Mental Health and Wellbeing	• Implement No Wrong Door Policy across all providers	Several entry points to crisis response	Implement No Wrong Door across all mental health providers (all age) including VCSE by end Quarter 3
	• Implement the thrive model for Children and Young People (CYP) emotional wellbeing and mental health	Thrive model agreed but not fully implemented across all services	Full implementation with clear outcome measures
	• Increase IAPT access and reduce waiting times	In November 2021: Monthly access rate of 1.4% for July 2021 (9.2% Year to Date) 6 week waiting time standard – 58% (68.7% Year to Date) 18 week waiting time standard – 97% (99% Year to Date)	National target yet to be confirmed, following which locality target will be set by ICS. Achieve and maintain waits above national standard of 75% within 6 weeks and 95% within 18 weeks

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		Recovery Standard – 48.4% (48.5% Year to Date)	Achieve and retain IAPT Recovery Standard at and above 50%
	• Develop new integrated community models for adults with serious mental illness	Existing adult community services review underway	Redesign and implement by end 2022/23
	• Create a smooth transition for young people into adult services	Variation in age limits for children's services – some only accessible up to 16 years, others to 18 or 25	All children's services extended • Speech and Language Therapy (a review to develop a sustainable 0-25) • Autism (development of all age strategy and Pathway design) • CAMHS extension of service to 18 in the first instance and then to 25 • Design and explore potential development of an all age (up to 25 years) Service Offer between Stockport Family and Adult Social Care for those individuals in the transition process.
	• Fully implement robust online community support for emotional wellbeing (for children, young people and adults	Kooth.com in place for CYP aged 11-18 years. Silvercloud e-Therapy, via IAPT providers available for people aged 16 years and upwards Togetherall in place for 16 years upwards	Full implementation of offer to whole population by end 2022/23

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
	• Development of emotional wellbeing support in schools	Stockport locality is in preparation for Mental Health Support Teams in school and the following initiatives are in place: - Mental Health co-ordinator and clinical lead. Schools Wellbeing Workers delivering CBT informed brief interventions. Emotional Literacy Support Assistant (ELSA) Programme Link Programme with Anna Freud Centre to improve relationships between education and mental health services	Full implementation by end 2022/23
	• Specialist day centre provision for people with dementia	There are a range of support groups for people living with dementia, their families, carers and friends are available	Full implementation by end 2022/23

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		across Stockport. The Weekend Day Centre will be moving to Ada Kay Centre and providing a support over 5 days a week for people with dementia and their families	
	• Increase access to CAMHs*	Access rate 40.7% against a standard of 34% (latest position November 2021)	Maintain and aim to increase current rate
	• Continued expansion of CYP mental crisis services so that there is 100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions*	All age mental health liaison (24/7) -CYP Rapid Response Teams -Access to Safe Zones -CYP Home Treatment Teams are currently operational. Further work is needed to ensure effective integration	100% coverage of fully integrated 24/7 crisis provision for CYP by 2023/24
5. Tackling Inequalities	• Long-COVID pathway implementation	Pathway agreed and implementation	Full implementation by end Quarter 1

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		commenced	
	• Increase uptake of Health Checks* with a specific focus on people with a Learning Disability (LD) or Severe Mental Illness (SMI)	LD - Performance up to December 2021 Year to Date 33.1% SMI – 39.8% had all 6 physical health checks in November 2021 – Measured on 12 month rolling performance Breakdown of health checks: Alcohol – 54.9% Blood Glucose – 61.6% Blood Lipid – 57.5% Blood Pressure – 71.3% BMI – 95.4% Smoking 88.3%	70% update by end of 2022/23 (75% ambition in 2023/24)
	• Lung Health Checks and an increase in referrals to pulmonary rehab services*	Pulmonary Rehab: to end of Sept 21: • 213 referrals • 754 face to face contacts	Increase referrals to pulmonary rehab services in 2022/23 Full restart of the primary care spirometry service Increase Lung health checks from 2021/22 levels

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
	• Implementation of Rapid Diagnostic Centre for cancer services*	N/A	Stockport FT are working in conjunction with Tameside and are looking at a joint model. This should be operational from Quarter 1 Extend coverage of non-specific symptom pathways – with at least 75% coverage by March 2023 Ensure at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung oesophago-gastric, gynaecology and head and neck cancer meet times pathway milestones
	• Implement the pathways and outcomes from the GM Cancer plan	Best Timed pathways fully implemented for lung, prostate, lower GI	Roll out of further Best Timed pathways in line with GM Cancer these will include HPB, upper GI and ovarian.
	• Roll-out of stratified follow-up pathways for cancer*	Prostate pathway in place	Full implementation for colorectal pathway by 2023
	• Reduce reliance on inpatient services for people with Learning Disabilities*	This standard is measured is on a GM footprint and each locality have a share of a target. 2021/22 Target for Stockport CCG = 4 CCG commissioned in-patient beds – 5	Reduce to national standard of 17.5% or below

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		currently in beds and 2 are on discharge pathways 3 NHS specialised commissioned beds– 5 currently in beds and 3 are on a discharge pathway	
	• Development of the neurodevelopmental pathway (all age)	Separate pathways for CYP and adults and gaps in service provision	Fully integrated all age pathway in place by end 2022/23
6. Neighbourhoods	• Develop a single, all-age neighbourhood model for Stockport, including Integrated Neighbourhood Teams that wrap around GP practices and their populations. • Recognition of the diversity of neighbourhoods which require different responses and services	Stockport Family Neighbourhood Teams PCNs in place ASC social work teams based across eight neighbourhoods	Develop a shared vision for neighbourhood model. Strengthen the Neighbourhood model to be inclusive of third sector and care providers, Consistent delivery of the model and offer to local people by end Quarter 4 Ensure that assessments are person centred and focus on the strengths of the individual and the community assets that they have access to.
	• Baseline of health and wellbeing needs in each neighbourhood	Initial data review in place	Neighbourhoods to review local health data and agree priorities by Quarter 2
	• Baseline of neighbourhood workforce and assets	Initial baseline collation underway	Clear workforce and asset mapping complete by end Quarter 2

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
	• Improvement plans for each neighbourhood based on local needs	Baseline data analysis of needs and performance	Each neighbourhood to agree priorities and develop an improvement plan by end of Quarter 2
	• Recruitment to additional PCN roles*	45.09 WTEs in place in April 2021	As at 07/02/22 there are the following WTEs: 34 Clinical Pharmacists 14 Pharmacy Technicians 29 Care Co-ordinators 1 Advance Practitioner 17 First Contact Physios 1 Nursing Associate 1 Trainee Nursing Associate By April 23 plan is to have the following further PCN roles: 2 Pharmacy Technicians 1Clinical Pharmacist 2 FCPs 2 Occupational Therapists 1 Care Co-ordinator 2 Nursing Associates 1 Advanced Practitioner OT 1 Dietician 1 Health & Wellbeing Coach
	• Ensure access to First Contact Practitioners (FCP) by 2023/24*	13.86 First Contact Physiotherapists in PCNs	5 additional FCPs by April 2022 3 further FCPs by April 2023
	• Shared care records	All NHS services have access to shared record with data from GP records, community	Roll-out training and the implementation of the SoP for accessing and updating shared record and care plans. Neighbourhood teams and other practitioners

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		services, mental health and all 10 GM hospitals fed in. Development of Standard Operating Procedure (SoP) for updating and using shared record including care plans by March 2022	to actively use the shared record to ensure that a holistic view of an individual's care and support needs are considered. Development of Graphnet capabilities to maximise the impact for neighbourhood working
	• Development of anchor institutions as community hubs in each neighbourhood	Positive examples in Alvanley Family Practice and the Start Point Café in Woodley	Identify anchor institutions in each neighbourhood. Further build the model
7. Child-Friendly Borough	• Fully implement Team Around the School (TAS) Model	TAS model implemented in all primary and secondary schools	Enhance the TAS to include education inclusion services so that wider discussions can take place where children have specific emerging needs for example SEND emerging needs
	• Develop and implement transition pathways between services and stages of development	Variation in age limits for children's services – some only accessible up to 16 years, others to 25	All services and transition stages have clear pathways embedded
	• Develop and implement a comprehensive holistic programme to reduce childhood obesity	45.9% of children physically active 24.2% of Reception	Partnership programme and signposting into new offer by end 2022/23

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		children in Stockport overweight or obese 33% of Year 6 children in Stockport overweight or obese	No mandated target aligned to this due to impact of Covid but future trajectories to be set when the 1st post covid NCMP dataset has been published.
	Implementation of the Better Births Standards*, including:		
	• Saving Babies Lives care bundle	Compliant with all 5 SBL standards 31/03/21	Maintain At least 85% of women expected to give birth at less that 27 weeks' gestation are able to do so in hospitals with appropriate on-site neonatal care
	• Continuity of Carer (CoC)	Strong progress being made to ensure CoC for all women (51% at August 2021)	From March 2022 CoC to be the default model of care for all women
		57% of BAME / Vulnerable women on COC pathway as at August 2021 60% of those from most deprived decile	Develop an enhanced CoC model which provides extra support for women from the most deprived areas for full implementation from April 2023
	• Ockenden review	All 7 actions underway 8 additional WTE midwives recruited	Full implementation of 7 actions Recruit 13.8 midwives and 1.7 obstetric consultants by end of Quarter 2

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
	• Implement the SEND strategy and joint commissioning plan	SEND strategy and joint commissioning plan underway	Methodology currently under development, to capture and embed feedback from Children and Young People (baseline to be established for 2022/23)
8. Age-Friendly Borough	• Activity-based social prescribing	Positive examples of Walk and Talk and BOOST	Development of locality-wide social prescribing offer with the VCSE
	• Active Ageing Programme	Programme in place in partnership with SMBC, Stockport Homes, Life Leisure and Age UK	Revised Active Communities Strategy 2022-2030 launched, to include targeted programmes to increase activity levels for older people (with a specific focus on 75+)
	• Volunteer Hub development	Volunteer Hub established during COVID and managed by Healthwatch	Partnership enhancement of the Hub to improve market sustainability by end Q3
	• ONE Stockport Age Friendly Network	4 Network meetings held in 2021/22 (so far) 10 residents and services attending each Network meeting Number of volunteers recruited to be Stockport	12 Network activities held in 2022/23 49 volunteers in total recruited to be Stockport Community Champions 80 Age UK Stockport staff in total recruited to be Community Champions

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		Community Champions each month = 3 Number of staff recruited to be Stockport Community Champions each month = 3	
	• Develop an all age living campus, including intergenerational housing and an Academy of Living Well	Business case developed for the Academy and Planning Permission submitted and approved	Construction will have started and Test of Change underway on the operationalisation of the Academy.
	• Invest in tele-care, health and technology assisted living	Creation of the Universal Offer (Telecare)	Further development of the investment plan for technology enabled care and embedded in adults operating model
	• Invest in digital platforms for Care Homes	Care Homes platform trialled during COVID for virtual GP ward rounds	Roll-out of Safer Steps and Care Home Platform during 2022/23
	• Development of the Frailty Pathway in the hospital	Frailty pathway being fully implemented (as part of Same Day Emergency Care	End-to-End pathway development and full implementation

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
		[SDEC])	
9. Valued Workforce	• Establish and develop a public sector workforce steering group	Individual organisational groups in place	Map out all existing HR and OD capacity, skills and plans and establish a baseline
	• Co-create a Joint Workforce Strategy	Individual organisational workforce strategies in place	• Understanding of professional roles and multidisciplinary approach by Q1 • Support teams to work collaboratively across professional and organisational boundaries to support residents. • Implement Joint Workforce Strategy • Undertake a joint recruitment approach for key roles • Reduce vacancy rates • Improved retention rates • Consistently high learning outcomes from workforce training
	• Evaluate existing wellbeing offers and look for opportunities for joint delivery and support across organisations	Individual offers and support available across organisations	• Ensure staff wellbeing programmes are accessible and effective • Improve levels of colleague engagement and morale by Q1 • Consistently high levels of colleague engagement and morale • Consistently high levels of staff satisfaction • Improve sickness absence and wellbeing of colleagues
	• Focus on the ageing workforce	Baseline of age profile of workforce across individual organisations	• Clear understanding of workforce demographics • Utilise learning and development opportunities to ensure strong succession

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
			plans are in place for those who are working towards retirement • Reduce agency level of staff by Quarter 4
	• Introduce new ways of working including flexible, agile and digital	Individual policies and procedures in place across organisations	Improve levels of colleague engagement and morale by Q1
	• Focus on becoming best in class for equality, diversity and inclusion - delivery of targets for BAME representation in the workforce*	Baseline of best practice underway	• Improved representation of diverse communities in our workforce • Increase BAME representation in middle management roles
	• Engage with schools and higher education to grow local talent	Some examples of good practice to build on	• Invest in career path opportunities, including for residents with additional needs such as care levers and young people with SEND • Increase apprenticeships and the numbers of colleagues in 'new roles' • Options appraise the potential for a "Career Academy" to deliver a Stockport Standard of Care
	• Launch a multi-professional leadership development programme	Programmes in place across individual organisations	In place by October 2022 • Consistently high learning outcomes from workforce training • Support teams to work collaboratively across professional and organisational boundaries to support residents
	• Phased implementation of the Trauma informed education and training across all sectors	Build on programme implementation from 2021/22	Roll out of the tiered programme across health, social care, education and VCSE throughout 2022/23

Area	Deliverable	Baseline 2021/22	Aim by end 2022/23
	• Specialist mental health training for staff across the system	Individual organisational examples of good practice	In place by October 2022
	• Training for staff across the system in taking an asset-based approach	Individual organisational examples of good practice	In place by October 2022
	• Delivery of targets for BME representation in the workforce*	Baseline data collated	Increase BAME representation in middle management roles