ONE

STOCKPORT

NEIGHBOURHOODS & PREVENTION PROGRAMME

Where we are and where we are going

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STOCKPORT'S NEIGHBOURHOOD PILLARS

Neighbourhoods and Prevention Board

SRO: Chris McLoughlin OBE

Workstream Focus

One Neighbourhood Approach

SRO: Kathryn Rees

- Narrative and approach
- Cross cutting
- Culture and workforce
- Enablers

Thriving Places

SRO: Emma Stubbs

- Public Realm & estate
- Local Economy
- Housing and community spaces
- Greenspaces and leisure

Connected Communities

SRO: Heidi Shaw

- Family Hubs
- Team Around the Place
- Financial Information and Advice
- VCFSE

Collaborative Health and Care

SRO: Philippa Johnson & Sarah Dillon

- Joined Up Services
- Neighbourhood workforce collaboration
- Tackling Health Inequalities
- Developing coproduction

STOCKPORT'S NEIGHBOURHOOD PILLARS

Neighbourhoods and Prevention Board

SRO: Chris McLoughlin OBE

Workstream Delivery

One Neighbourhood Approach

SRO: Kathryn Rees

- Interactive data profiles
- Overarching framework
- Workforce Culture Change
- Boroughwide service access points
- Digital
- Embedding participation
- Opportunities for co-location

Thriving Places

SRO: Emma Stubbs

- Animated public spaces and DCs
- Connected parks and greenspaces
- Housing and community spaces
- Review of physical assets
- Planning & designing safe, clean community spaces
- Using spaces and facilitating community action to improve local environment.

Connected Communities

SRO: Heidi Shaw

- A better Start to Life
- Connected public services
- Financial and Social Inclusion
- Diversity and Inclusion
- Supporting Families Exec
- Digital Inclusion
- Multiple Disadvantage

Collaborative Health and Care

SRO: Philippa Johnson & Sarah Dillon

- Integrated Pathways of care
- Whole system same day UEC
- Team Around the Practice
- PCN Population Health Plans
- Enabling H&C Programmes

ONESTOCKPORT Health and Care

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WORKSHOP 3 – PLAN ON A PAGE

Moving from Principles to Practice, focusing on Proactive Prevention

Two workshops have been held which have focused, principally, on developing our programme approach and the development of the four pillars. The focus now is on harnessing those pillars and delivering on the ambitions of the programme, much of this is already underway

Session	Activity	Who	Time
Moving from Principles to Practice **How do we focus on Proactive Prevention?**	Arrival (Tea, coffee and biscuits on arrival)		1400-1420
	Welcome	Chris McLoughlin & Viren Mehta	1420-1425
	Community Organiser in Woodley – what can we do to help our communities connect?	Nicola Wallace Dean	1425-1435
	CEO of Pure Insight – Finding community solutions to local and national issues	Sarah Sturmey	1435-1445
	One Neighbourhood Approach	Kathryn Rees	1445-1455
	Thriving Places	Emma Stubbs	1455-1505
	Connected Communities	Heidi Shaw	1505-1515
	Collaborative Health and Care	Philippa Johnson / Sarah Dillon	1515-1525
Afternoon Tea	Traditional afternoon tea consisting of a selection of small sandwiches, scones served with clotted cream and preserves. Cakes and pastries are also served.		1525-1600
Discussion in pillars	Discussion in pillars – how can we continue to build on progress being made?	All, on tables	1600-1645
	CLOSE	Chris McLoughlin & Viren Mehta	1645-1700

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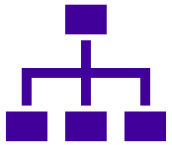
GOVERNANCE & RISK MANAGEMENT

The programme reporting approach across the One Stockport locality is developing. We are using the Neighbourhoods & Prevention Programme to pilot that approach with programme launch documents for each of the four pillars. Running concurrently alongside this is the development of a Smartsheets site for the Neighbourhoods programme which will be drawn upon for updates going forward.



The Neighbourhoods & Prevention Programme is presently governed by the Neighbourhoods Programme SRO Steering Group which meets monthly and is comprised of the SROs of each of the four pillars. Each of the four pillars have their own groups that feed in to the steering group. For example, there is a group consisting of the DPL, DASS, DPH, SFT DoS and Viaduct CEO providing a steer for the delivery of the Collaborative Health and Care Pillar

It is proposed that a full board is devised following the next workshop on November 10th. The board will be comprised of a range of senior colleagues from across the borough.

Risks are presently owned and managed by the Neighbourhoods Programme SRO Steering Group, these are reported in to the Performance, Improvement and Assurance Group as per locality governance arrangements.

ONE NEIGHBOURHOOD APPROACH

Ambition: There is a consistent narrative and united approach to neighbourhood working bringing together work across the 3 pillars- thriving places, collaborative health and care and connected communities.

High-level deliverables:

- Interactive data profiles for each of the seven neighbourhoods
- Further development of overarching narrative and framework
- Workforce Culture change - to further improve collaborative working and adopt a neighbourhood approach,
- Review of boroughwide service access points – digital, telephony and physical
- Digital - shared health and care record and connectivity
- Communication and engagement – embedding co-production and participation
- Estates – identifying opportunities for workforce co-location and touch down bases

Progress:

- SROs are collaborating to develop the overarching narrative and approach.
- Our closer aligned spatial footprints are being tested for finalisation in October.
- Digital access work is underway, the council website will go through re-design and service directory will undergo an options appraisal. Telephony programme underway.
- Data profiles are progressing significantly and will soon be ready for use in Neighbourhoods.
- Workforce culture workstream needs to be scoped with SROs.
- A third workshop is planned for November 10th.

One Neighbourhood Model: Connected people, services, places and spaces

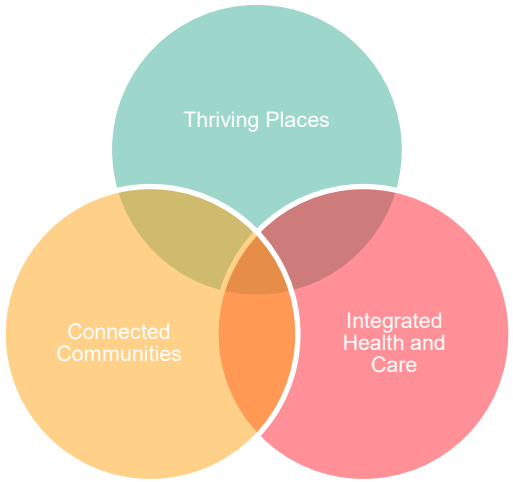
Why: We know that when people face challenges, the causes can be complex and inter-related. Often the best solutions exist at a local level, whether that is through family, social connections, communities or neighbourhoods. Working in this way will achieve better care & support, better outcomes and better value for money, as well as vibrant places and public spaces.

What: We will mobilise to build collaboration, between public-, VCFSE- and business sectors and with communities and residents themselves, understanding the role all play in improving local outcomes. We will build trusted relationships and reduce duplication, leading to resilient, thriving, happy communities.

How: Neighbourhoods are the mechanism by which key/joint strategies are delivered. Working to common service goals and outcomes, and where appropriate, with aligned geographical footprints, which are small enough to know communities well and large enough to allow us to organise & flex around people's needs and deliver support where it is most needed, we can bring public services together to improve outcomes and reduce inequalities.

One Neighbourhood Team

Designed around the Person, Family and Community, with the look and feel of one team



Common purpose and shared strategies (ICS, Safer Stockport, One Stockport Plan)

One approach to multiple disadvantage

Investing in the VCFSE Sector, Asset Based Community Development

Underpinned by shared enablers: data and digital, comms and engagement, workforce development and strong governance

ONE Neighbourhood Approach : A case study of impact

- Meet **Kate.** She is 48 years old and lives with her 13 year old son, Jacob and her 80 year old mum, Sue. Kate is managing ok but her mum's mobility is getting worse and Kate has had to reduce her hours at work to care for her. Kate was worried about leaving her mum alone. This is also starting to effect Jacob who is missing school.

- Kate went **online** to find out what help was available and found it easy to access a range of information. Kate was able to book an appointment at a social care clinic in the **local library** and took her mum. They got lots of great advice from a very **friendly professional** who helped to arrange some sensors and digital equipment to give Kate the confidence to leave Sue at home.

- Sue was worried about using the digital equipment and getting online so the professional referred her to **Digi-Know the digital inclusion alliance** where a volunteer digital champion helped to build her confidence.

- The professional asked Sue about her interests and friends. Sue felt lonely but loved art. Through an **online directory** they were able to identify a range of art classes in the area that Sue could join.

- Kate was worried about money and her reduction in income. The worker signposted her to an event in the library about maximising income and Sue was able to access pension credit. Kate was introduced to **Stockport Jobs match and** work and skills advice to explore alternative career options.

- While at the event, Kate mentioned to a local volunteer that she was worried the impact on her son, Jacob. They were able to introduce her to an children's **early help** worker as they work closely together in Team Around the Place and they provided Kate with some advice and connected Jacob to a local youth group.

- Good online information advice, use of estates to deliver services in neighbourhoods, a workforce using strengths based practice and good relationships with colleagues and the voluntary sector helped Kate and her family.

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THRIVING PLACES

Ambition: Delivering exciting and safe places to live, work and socialise with vibrant public spaces across Stockport, thriving local businesses, enabling cohesive and connected communities as well as providing an environment where people thrive and positively impacting their health in the future

High-level deliverables:

- Animation of public spaces and district centres - action plans
- Connected parks and greenspaces, nature rich, increasing active travel, improving physical and mental wellbeing
- Review of physical assets including system-wide public estate, businesses and community assets/ buildings
- Planning and designing safe, clean community spaces
- Understanding how communities connect with places, facilitating community action to improve local environment.

Progress:

- The pillar team have undertaken a series of workshops with stakeholders in this space to capture input for initial pillar plan.
- Requirements are being scoped with SROs and ‘Animation Plans’ will be developed for each of the Neighbourhoods/District Centres in September/October.
- There is also a data gathering exercise on work in progress that will help support the delivery of the pillar to ensure everything is pulled in, aligned and duplication is avoided.

Thriving Places: A case study of impact on the people in Stockport communities – Sam's Story

- **Meet Sam.** He's 87, he enjoys being in he park near his home for his daily exercise. He is able to get fresh and strengthen his muscles in an accessible and safe greenspace.
- There are many opportunities for Sam to get involved in gentle activities such as crown green bowling or potting up plants with the Friends of the Park Group which has a positive impact on his mental wellbeing.
- Being able to move around more means that Sam can use the dedicated walking route near his home or the bus services so that he can get to the district centre in his neighbourhood. Here he can access library services who offer help and advice including bereavement counselling to support him through his grief following the loss of his wife. There are befriending services who will link him with people like him, with common interests, to combat his feelings of loneliness.
- Sam is interested in the heritage of his local area. The library are also able to direct him to historical buildings and events celebrating culture in his neighbourhood.
- The district centre has been planned with accessibility in mind and there are many benches available for him to sit and relax whenever he needs to. He can also shop or be served by the local businesses in the area, which is kept clean and tidy by community members taking positive action to pick up litter, supported by public services.
- Although Sam visits his GP less frequently now, it is situated close to all of the other services and amenities he needs in his neighbourhood

Sam feels more confident to reconnect with old friends and enjoys the thriving neighbourhood in which he lives!

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CONNECTED COMMUNITIES

Ambition: A collaborative dynamic system that means all relevant sectors are aligned and connected in the support that is available responding to need. Within each sector there is improved connection as well as between sectors, to build on strengths and solve problems together.

High-level deliverables:

- One Neighbourhood Network - Providing better coordinated support to address a range of needs catalysed through Team Around the Place, Family Hubs, TAS/TEAY, Resident Advice Service, VCFSE strategy
- Supporting Families – Placing a special emphasis on children young people and their families
- Financial and Social Inclusion - Embedding our existing approach to social and financial inclusion into our neighbourhood offer, with a specific focus on IAG redesign, adult learning libraries, food network partners, social prescribing
- Diversity and Inclusion - Supporting marginalized groups, promoting equal access to education, healthcare, and employment, and fostering an environment that celebrates diversity.
- Multiple Disadvantage – Viewing Multiple Disadvantage through a broad lens rather than through single or limited lenses to respond more effectively as a system
- Digital Inclusion - Working with the DigiKnow programme to ensure that residents can get online

Progress:

- Currently developing detailed impact measures, milestones and associated timeline.
- Formalising delivery requirements for TAPs, working with TAPs and constituent organisations to establish delivery plans each with their own one thematic area to deliver against and gain momentum
- Soft launch of Family Hubs in August. Virtual Hub and remaining Family Hub sites to be launched over course of 2024.
- VCFSE Strategy launched, VCFSE Alliance to be launched coupled with more funding to the sector through One Stockport Local Fund

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Connected Communities : A case study of impact on the people in Stockport communities - Victoria Health checks pilot

Victoria PCN has a lower than average rate (51%) of people with severe mental illness accessing their annual health checks. When funding was made available through 10GM and the GM Integrated Care Partnership, Victoria Team Around the Place (TAP) was able to quickly pull together a partnership between SPARC, Boost, Victoria PCN and Viaduct Care to access funding to test, learn and evaluate new ways of working. The project helps people with mental ill health to access physical activities, which boosts their mental and physical wellbeing and by developing trust is able to improve access to a health check through their GP.

Immediate benefits:

- Improving uptake of health checks among people with severe mental illness
- More funding for local services
- Improved physical and mental wellbeing for local residents
- Better social connections for residents

Other benefits:

- Testing out cross sector partnership arrangements
- Long term benefits of social connection for people with mental health issues
- Building capacity of local VCFSE organisations
- Improved use of community assets

Possible longer term benefits:

- Better social connection for people with mental health issues
- Reduced demand on statutory services for people with mental health issues

The plans contained within the Connected Communities pillar will see the **Team around the Place (TAP)** and **Family Hubs** developing to further enable collaboration and improved access. This is a real example facilitated by the local TAP, we will work to ensure this is consistent and regular practice across the borough with increased partners involved in identifying the key neighbourhood challenges to come together around.

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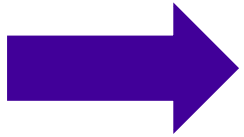
COLLABORATIVE HEALTH & CARE

Ambition: A collaborative dynamic system that means all relevant sectors are aligned and connected in the support that is available responding to need. Within each sector there is improved connection as well as between sectors, to build on strengths and solve problems together.

High-level deliverables:

- Integrating our pathways – Focusing on particular conditions, improving continuity of care and collaboration Starting with Frailty, Diabetes, Alcohol-related harm, Cardiovascular Disease
- Team Around the Practice - Developing MDTs in each GP practice that focuses on collaborative case holding and case finding
- PCN Population Health Plans - Practices will work at a PCN level with a preventative approach to develop population health improvement plans for their PCN population as per the LCS.
- Whole System Urgent Community / Neighbourhood Response and Directory of Service - Enhancing and integrating our urgent / same day offer to provide urgent care to people in their home or the community
- Enablers (Delivering in conjunction with One Neighbourhood Approach Pillar) – GM Health and Care Record / Integrated Care Plans, Use of estates, Integrated Information, Advice and Guidance service, A focus on integrated commissioning, Workforce development



Progress:

- Integrated pathways work is to be led by Stockport Provider Partnership. This work is already underway with the Frailty pathway making significant progress.
- Team Around the Practice work is also underway and is being scoped by a group comprised of GPs, Social Workers and Community Health colleagues. Drafting of PCN Population Health Plans has commenced.
- Scoping of what our locality-wide urgent care in the community should look like is underway.

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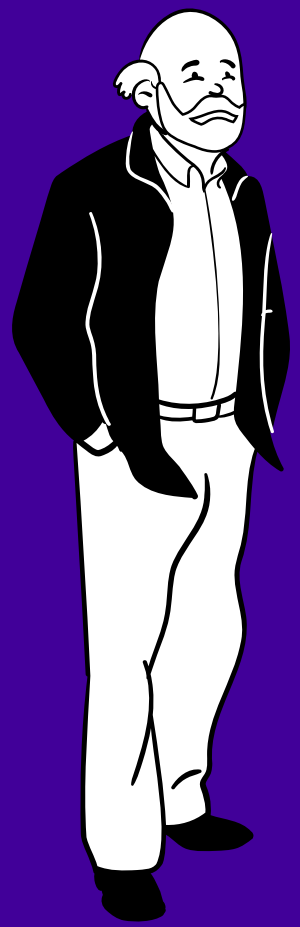
Collaborative Health and Care: A case study of impact on the people in Stockport communities – Sam's Story



- **Meet Sam.** He's 87, he suffers from emphysema, Type 2 diabetes and arthritis. Sam was coping pretty well until his wife passed away but is now feeling lonely.
- Sam frequently visits his GP, but finds it difficult to discuss all his needs in a brief consultation. If Sam can't get hold of his GP when he feels he is in a crisis, he calls an ambulance.
- Each time, Sam spends time in ED and is often admitted to a ward. He sees lots of different HCPs and has to explain his story a number of times. When he gets home a lack of coordination between core services in his neighbourhood often means he doesn't get the right care, in the right place at the right time.
- Eventually, after several hospital visits, it is decided that Sam should be admitted to a care home. But what if Sam's journey was more joined up? What if one of the many HCPs involved in Sam's journey could've taken overall responsibility for coordinating his care whilst working in a joined-up way with Sam's DNs, Social Worker, GP and VCFSE workers.

The plans contained within the Health and Care pillar would see a **Team Around the Practice** uniting around Sam. This team will collaborate together to design a plan that they can all access online, working with Sam to manage his conditions at home and prevent admission to hospital. Sam has access to his **integrated pathways** for his diabetes and should he need a higher level of support he is supported by his Team Around the Practice to prevent crisis or there is an effective **Whole System Urgent Care** offer in the community to support him to remain at home. The Team Around the Practice and the development of **PCN Population Health Plans** combine to focus on proactively case finding people so they can avoid finding themselves in crisis like Sam