Report to: **Integrated Care Board** **Date: 30th October 2024**

Report Title: **ONE STOCKPORT LOCAL, NEIGHBOURHOOD AND PREVENTION PROGRAMME – COLLABORATIVE HEALTH AND CARE**

Report of: **Director for Adult Social Care and Deputy Place Lead, Joint Programme Senior Responsible Officers.**

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1. PURPOSE OF THE REPORT

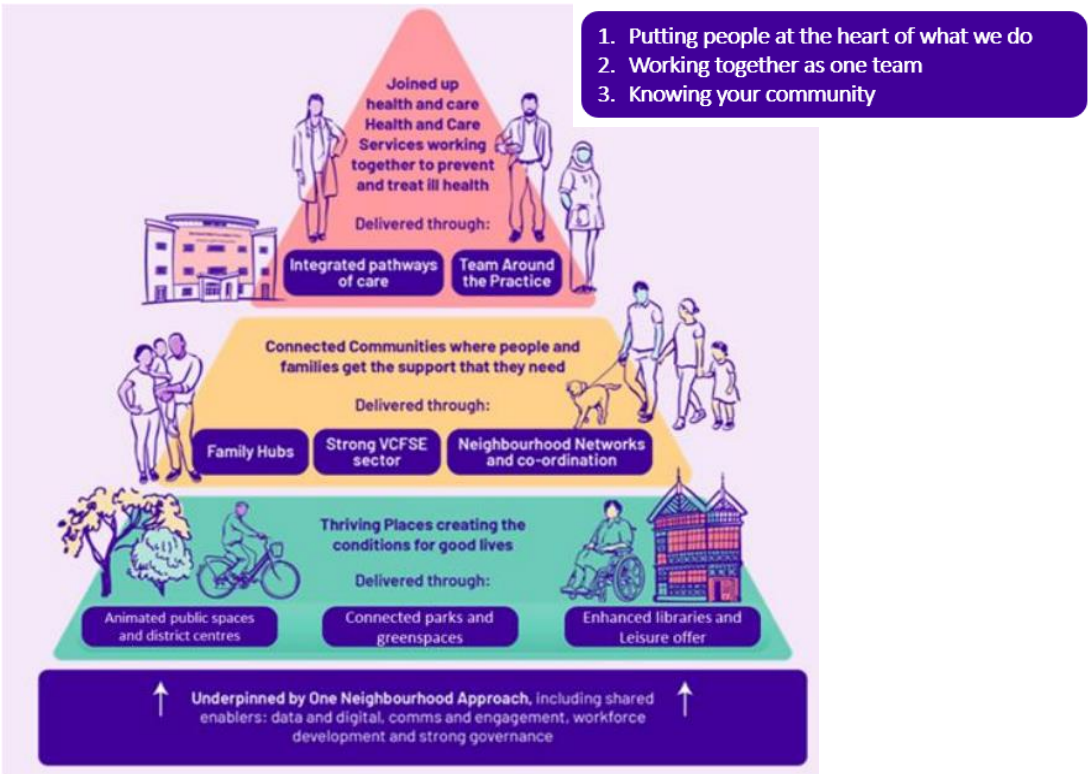
1.1. This report provides an update on the One Stockport Local – Neighbourhoods and prevention programme, specifically activity and achievements from the Collaborative Health and Care pillar.

2. CONTEXT AND SCOPE COLLABORATIVE HEALTH AND CARE

2.1. Our One Stockport Local, Neighbourhood and Prevention programme is being delivered through four pillars of work:

- Collaborative Health and Care
- Connected Communities
- Thriving Places
- One Neighbourhood Approach

Figure 1: One Stockport Local Neighbourhood pillars and how they connect



2.2. As part of One Stockport Local we are bringing together services, organisations, and groups into one place making it easier for people to help themselves, their families, and those that they care for and supporting people with their health and care needs.

2.3. In the Collaborative Health and Care pillar we are building a model of care where collaborative teams focus on prevention, early intervention, and proactive care, supporting people to be healthier, happier, and independent in our neighbourhoods. We know accessing information and support can be complicated and we want to make it easier for people to help themselves, their families and those that they care for. We will ensure that people are supported by the right professional at the right time and that we are efficiently and effectively using the resources and assets that we have in our communities.

2.4. The work that we are doing now in this pillar will set the foundations for us to deliver **One Stockport One Future – Best Health and Care.** Our focus is creating the environment for public services to work together to deliver seamless, integrated advice, support and care close to where people live. To help us to do this we have established a number of workstreams. These are:

- Area leadership teams (ALT)
- Team around the practice (TAP)
- Integrated Pathways
- Out of Hospital Urgent Care
- Proactive Care

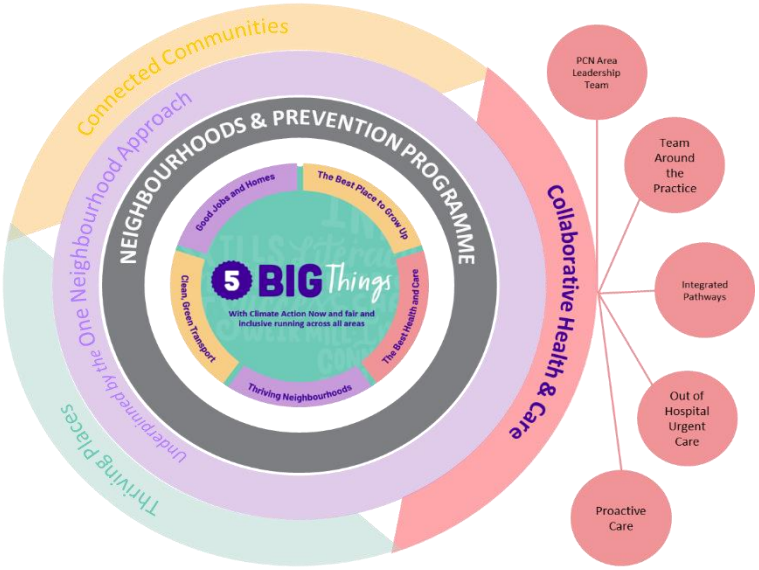


Figure 2 – The workstreams and how they align with One Stockport, One Future

3. PROGRESS AND DEVELOPMENTS

3.1. **Area leadership teams (ALTs)**: ALTs have been convened in Stockport with a purpose of bringing together a single leadership team from the local area across health, social care, and wider partners to drive change in the neighbourhood and address the needs of the local population. Area leadership teams will set the strategic direction, population health priorities and multi-disciplinary working through our Team around the Practice model. This will help us to ensure that we are delivering on the objectives of the neighbourhood and prevention programme, our commitment to delivering the best health and care and are aligned to NHS GM strategic priorities for neighbourhoods.

3.2. We have formed six Area leadership teams which are based on our Primary Care Networks (PCNs) and led by each PCN Clinical Director. These are.
- Bramhall & Cheadle Hulme
- Cheadle
- Heatons
- Stockport East and South
- Tame Valley
- Victoria

3.3. Current focus: during this period, we have been working with our Area Leadership Teams (ALTs) to identify key stakeholders and build relationships. Each ALT now has regular meetings in place and collectively they are working to deliver against their population health plan and to build a model of proactive care that will ensure our residents can access the most appropriate help early and prevent issues escalating into an urgent need. Stockport is the eighth most polarised borough in England, this can be seen in different ways in each of our communities and we know that there are inequalities. To tackle these inequalities and support more people in the community we must engage with population groups facing inequality and tailor our approaches to address the wider determinants of health. We recognise that to successfully deliver a model of proactive care we need to adapt this to meet the diverse needs of each of our neighbourhoods.

3.4. The ALTs population health plans are supported by the work that has been undertaken by colleagues in Public Health and Business Intelligence to build individual neighbourhood profiles which were presented to Local Area Committees during the September meeting cycle.

3.5. Future focus: We will be working to develop the maturity of the each of our ALTs and to embed a consistent triumvirate leadership approach. We will continue to deliver on the priorities for each of our ALTs which will include greater collaboration with the VCSFE sector, reshaping pathways, increasing the use of data and analytics to inform local decision making and focusing on making every contact count. As part of our 2024/25 winter planning ALTs will support on small-scale tests to improve the multi-disciplinary teams' proactive care approach, with a focus on frailty, supporting the most vulnerable residents over winter.

3.6. Our Bramhall and Cheadle ALTs are also in the initial stages of scoping proactive care pilots for conditions such as heart failure and complex diabetes.

3.7. **One Stockport local appointments** - delivered by Adult Social Care as part of our Care Act functions focusing on prevent, reduce, and delay. They help us to support demand management, providing timely access to social care professionals and ensuring that we are having good Care Act conversations in the community. Promoting independence, well- being and community inclusion. Stockport Local appointments delivered from key community locations, help to reduce social isolation by encouraging individuals into one of our vibrant community settings, such as libraries or into a key partners' building, for example Disability Stockport.

3.8. Current focus: One Stockport local appointments will become the default offer for residents when they require support from Adult Social Care. Teams are encouraged to work in a flexible way which meets the needs of individuals within neighbourhoods. There is now a dedicated Stockport Local social work team manager in post who is working with our Area Leadership Teams to look for opportunities to connect this offer into each ALT. Senior Social Workers from ASC are now in post and are part of the PCN multi- disciplinary approach.

3.9. Within Adult Social Care a programme of work called Gloriously Ordinary Lives (GOL) has been launched. Based on a national programme along with support from Tricia Nicoll (GOL founder) and our Making it Real board we have developed a training and development programme for our workforce, this will help colleagues to understand the key principals of GOL and think about how they can embed this into their role.

3.10. Gloriously Ordinary lives is about supporting people who use our services with the 'mundane' and the 'things that make their heart sing.' It recognises that people need both the ordinary – putting the bins out, washing up or organising the kids. People also need the things that make their heart sing, this may be catching up with an old friend, spending time in the garden or baking a cake. We have already embedded strengths-based working, but we know that based on feedback from people that we have more to do, and that people want to work with us in a different way. As a result, we have committed to ensuring that Stockport Residents have a 'Gloriously Ordinary Life.' Find out more here: Gloriously Ordinary Lives.

3.11. Future focus: Stockport Local appointments will be rolled out across all teams within Adult Social Care. For those teams already delivering services in this way we will continue to embed the model and increase the number of appointments that are delivered. We will work with Area Leadership Teams / Team Around the practice to

identify opportunities to roll this approach out across our locality. We are working towards a model where Stockport Local appointments can be proactively booked – for example by library colleagues, GP's, and individuals themselves.

3.12. We have already started to think about the wider role of Gloriously Ordinary Lives and have started to align this with other pillars in our Neighbourhood and Prevention programme. For example, we are.

- Exploring how we can build Gloriously Ordinary Lives into the neighbourhood induction.
- Seeking to understand the relationship and how it can complement restorative practice, its role within customer experience and impact on our communications.
- Exploring the role of Gloriously ordinary lives with Team around the place, Team around the practice and Area Leadership Teams.

We will progress this further through the Health and Care Pillar and discuss at the Neighbourhood and Prevention SRO meeting.

3.13. **Integrated Pathways** - aligned with the objective set out in our One Health and Care Plan we have committed to developing integrated pathways. Based on the needs of our population we have chosen to focus on four integrated pathways which will be driven through our provider partnership. These are.

- ***Alcohol Related Harm***: to reduce harm caused by alcohol to a minimum for the people of Stockport.
- ***Cardiovascular Disease (CVD)***: to reduce premature cardiovascular disease mortality with a particular focus on disadvantaged groups.
- ***Diabetes***: to implement a model of care and pathway that will enable all system partners to improve outcomes for those at risk or those with diabetes.
- ***Frailty***: to implement a model of care and pathway that will enable the whole system to improve outcomes for frail people including those within the last twelve months of their life.

3.14. Current focus: the work to develop integrated pathways is interdependent with the work that we are doing to develop our Area Leadership Teams and Team Around the Practice model. We have undertaken a number of deep dives and exploratory multi-disciplinary workshops over the summer period to help us to identify our current landscape and opportunities for development. We are aligning our work with Greater Manchester initiatives for example the GM Alcohol related harm strategy and the NHS GM multiyear prevention plan which has a year one focus on diabetes and cardiovascular disease.

3.15. Our locality leads met with NHS GM colleagues this month:

- To share plans at GM system level and locality level on cardiovascular disease (CVD) and diabetes prevention.
- To improve understanding of the current and planned work on CVD and diabetes prevention at different spatial levels across NHS GM, including the governance for this work.

- To explore opportunities to build on current plans and achieve greater connectivity to improve impact and outcomes.
- To agree future ways of working to maintain connectivity and promote joint working.

Feedback from the meeting indicated Stockport locality are in a strong position to deliver on the plans with positive refence to our strong collaborative cross system working.

3.16. Future focus:

- ***Alcohol Related Harm*** - Identify any further alcohol related harm work which may arise because of the soon to be published Drug and Alcohol needs assessment for Stockport and continue to collaborate with Greater Manchester (GM) colleagues on GM alcohol related harm strategy.
- ***Cardiovascular Disease –*** Task and finish groups mobilised to deliver on the key priorities through the oversight group including the projects being delivered through the Area Leadership Teams.
- ***Diabetes*** – Task and finish groups to lead on improvement work in the following areas: Prevention and early intervention, optimisation, managing complexity and complications, maternity and paediatric and reducing health inequalities.
- ***Frailty*** – Review local system data, to enable a single point of truth and standardised approach. Review areas of opportunity across Stockport community services to increase consistency and standardisation. Complete a self-assessment using the Frailty toolkit assessment. Our locality team are developing a proactive care program of work to support those with moderate and severe frailty as part of the ALTs priorities.

4. DEMONSTRATING IMPACT: SOME EXAMPLES

4.1. The priority aim of the population health plan for Tame Valley is to reduce alcohol related harm. Work is in development on how to reduce alcohol related harm from our role as place shapers when license applications are received, through prevention, to improved pathways to access support, through to when a person is in the acute setting.

4.2. As part of the focus on reducing alcohol related harm, we have started delivery of training programme for people working in primary care, housing, local authority, and the voluntary sector to increase confidence in starting a conversation with those who may be drinking in excess. We are working alongside a lived experience support group and have seen a notable increase in participation since the training started. The next steps for this piece of work are to develop a training programme for people with lived experience who are keen to become mentors and ambassadors.

4.3. The Tame Valley area leadership are also currently mapping out pathways and processes to assess the potential impact of intervention at each touch point across a wider stakeholder group.

4.4. Promotion of community groups and re-instating the Life Leisure group has seen a sizeable increase in numbers of people attending. These community groups support people to take the next steps and is proving to be more effective than direct referrals via health care professionals.

4.5. The aims of the population health plan for Cheadle Area Leadership Team include.

- Focus on the needs of the South Asian population through collaboration with Cheadle Mosque and partners.
- Reduce inequalities for people with long term conditions, increase uptake of public health interventions such as cervical screening and vaccinations, particularly around pockets of deprivation.
- Address additional issues for frail population, such as falls, respite for carers, digital exclusion, and loneliness.

4.6. In response to this, Cheadle neighbourhood have successfully held a tea with the GP events which had over 150 attendees from the local community. The cohort in attendance were older people who were frail and or experiencing social isolation. Those in attendance had the opportunity to engage with both statutory services and community voluntary sector offers locally who can support individuals to maintain independence and connect with others. Planning is now underway to deliver a tea with the GP in the coming weeks working in partnership with a local mosque.

5. PROGRESS AND DEVELOPMENTS: Out of Hospital, Urgent Care Model

5.1. The purpose of the Out of Hospital, Urgent Care Model workstream is for us to build a comprehensive urgent care offer in a joined-up way to ensure people receive the best possible outcomes, at the point they are identified as having an urgent need. By working together as One Stockport this will help us to improve the outcomes and experience of our Stockport residents and enable people to be cared for in the right setting for their needs and managed efficiently and effectively.

5.2. How and when people use urgent and emergency care services are not the same within our Stockport population. People living in our more deprived neighbourhoods including our vulnerable residents are far more likely to attend the emergency department, be admitted to hospital as an emergency, and have worse health outcomes.

5.3. There are disparities in access to, and experience of, our services, and variations in health outcomes across different geographies and groups of our population. A small segment of our population uses emergency care frequently. Usually, these individuals have multiple health issues and challenging circumstances including housing, financial hardship, social isolation, and substance misuse. To tackle these inequalities and support more people in the community we must engage with population groups facing inequality and tailor our approaches to address the wider determinants of health.

5.4. Through our area leadership teams we will embed a proactive approach that will ensure our residents can access the most appropriate help early and prevent issues escalating into a crisis or urgent need. We want to maximise our digital solutions so that more people can be cared for in their own homes remotely, with improved shared care record utilisation and ideally interoperability across partners IT systems.

5.5. Current Focus: We have mapped our existing pathways, and from this we have developed a picture of all the offers in the community which has become known as our ‘tube map” due to the complexity and multiple entry and access points. This exercise has identified that we have a complex offer, multiple providers working to criteria led service specifications and potential for people to fall between the gaps. We recognise why accessing these services are confusing for both professionals and residents.

5.6. To help us to address these issues we have been working with the national Emergency Care Improvement Support Team (ECIST) to look at best practice and support our understanding of.

- Where this works well and what would a more integrated offer look like in Stockport.
- How we engage and learn from our communities to support them in accessing the right care, at the right time and closer to home to improve their experience.
- How we evaluate our services and interventions to see how they impact different groups of people, and outcomes.
- How we coordinate care and make sure peoples needs are met in a timely way

5.7. A workshop took place on 17th October 2024 to bring together key stakeholders from across our locality. The session started with setting the scene, aligning our work to that of One Stockport, One Future – Best Health and Care and Wellbeing in Neighbourhoods. We then focused on building a shared understanding of the complexities of our system and ownership of how we can work together as One Stockport to tackle these issues. This was achieved through facilitated conversations focusing on real scenarios. The workshop was attended by three people with lived experience.

5.8. Future Focus: Learning from the session / Next Steps.

5.9. With good representation and system working across all partners the learning from the session included common themes.

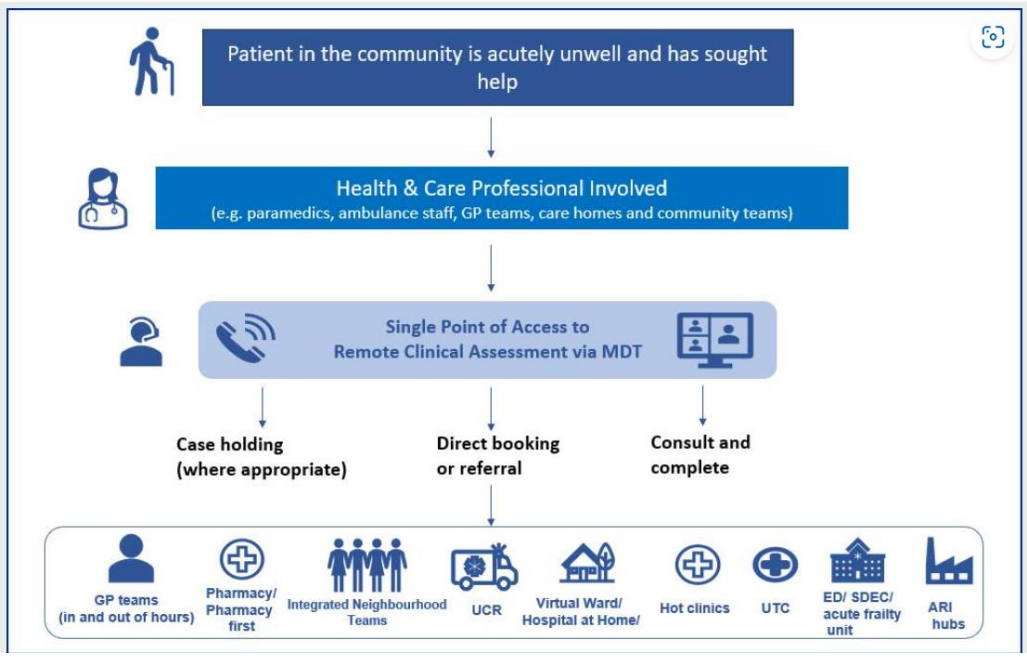
- The Stockport out of hospital urgent care model requires a care coordination hub/ single point of access by using existing services, improving the interface across services and pathways in a more joined up way.
- The need to maximise the digital solutions and enable the right technology.
- To identify ways the utilisation of the GM shared care record can be improved for all partners.

- To improve the directory of services with regular updates so that residents and professionals understanding of what is available and how to access it is made easier.
- The recognition that the voice of the resident in decision making of where they receive care should be stronger.
- The challenges our residents face when transitioning from mental health childrens to adult services.
- The importance of all teams who have contact with our residents and identify a need for additional support being able to navigate the individual or their families to support offers in the community for earlier intervention and prevent escalation.

5.10. We will review the above themes and compare the feedback we received from our locality to national guidance. All systems without a single point of access (SPoA) are required as an absolute minimum meet the SPoA foundation components for winter 2024/25, with full case management to be implemented by March 2025 at the latest. This includes.

- Clear pathways in place for provision of remote clinical assessment and advice through a SPoA prior to a decision to convey or attend ED (Emergency Department).
- Ambulance services enabled to identify patients prior to dispatch for alternative pathways, as well as adopting ‘call before convey.’
- Direct referral pathways from SPoAs into community services such as UCR (Urgent Community Response) and VWs (Virtual Wards).
- Priority access to clinical advice for paramedics/ambulance staff and extending this in time to other health and care professionals, care homes, primary care (in-hours and out-of-hours GP services), community and other services.

This can be summarised in the following diagram:



5.11. The national guidance and the above themes from the workshop will be reviewed by the delivery group to identify priority areas of work, with final sign off by the Collaborative Health and Care steering group in line with the governance and leadership systems in place. We will then mobilise the task and finish groups with representation from all partners, collaborative agreeing the delivery programs for each priority area. To successfully deliver our priority areas of work a One Team approach will be required, with each key partner and organisation making resources available to support the work.

6. RISKS

6.1. The key risks associated with the Collaborative Health and Care pillar are as follows.

- ***Workforce Capacity*** – Each workstream within this programme has identified the availability of colleagues to deliver this programme is their key risk. Due to the reactive nature of the services, we deliver in times of high demand colleagues time can be taken away from delivery of programme work.
- ***Change Fatigue*** – In recent years there has been a significant amount of nationally driven change, as well as change within the Stockport locality. There is the risk that colleagues will face change fatigue. This can be mitigated though our One Team approach and through the wider neighbourhood and prevention workforce enabler.
- ***Financial Pressures –*** The financial pressures faced within both the NHS and local government are likely to result in reductions to prevention budgets. This in turn will have a negative impact on the delivery of this programme of work.

7. CONCLUSION & RECOMMENDATIONS

7.1. Members of the locality board are asked to note the progress and achievements outlined in this report. We welcome comment and feedback on the priorities described.

7.2. Members of the Locality Board are asked to note that to deliver on the next phase of this programme that capacity will be required from colleagues from across the locality to participate in the delivery of each of the Collaborative Health and Care programme.

Anyone requiring further information should contact the Senior Responsible Officers for this pillar Sarah Dillon (sarah.dillon@stockport.gov.uk) or Phillipa Johnson (philippa.johnson1@nhs.net)