Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 5 December 2017

Subject: Wellbeing Services in Manchester

Report of: The Director of Population Health and Wellbeing

Summary

This report provides the Committee with an overview of the wide range of wellbeing services commissioned by the Population Health and Wellbeing Team at Manchester Health and Care Commissioning (MHCC). For each service there is a description of the service offer and current levels of investment.

The buzz Wellbeing Service is hosted by the Greater Manchester Mental Health Trust who have provided additional information on their service that is also included in the report. Representatives from the service will attend the Committee.

Finally, information on the planned investment in the new Citywide One Team Prevention Programme is also provided.

Recommendations

The Committee is asked to note the report.

Wards Affected: All

Contact Officers:

Name: David Regan
Position: Director of Population Health and Wellbeing
Telephone: 0161 234 5595
Email: d.regan@manchester.gov.uk

Name: Barry Gillespie
Position: Consultant in Public Health
Telephone: 0161 234 3486
Email: b.gillespie@manchester.gov.uk

Name: Marie Earle
Position: Strategic Commissioning Manager
Telephone: 0161 234 6926
Email: m.earle@manchester.gov.uk

Name: Peter Smith
Position: Service Manager, buzz – Health and Wellbeing Service
Telephone: 0161 248 1756
Email: Peter.smith@gmmh.nhs.uk

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

1.0 Introduction

1.1 Following the transfer of public health responsibilities and resources from the Manchester Primary Care Trust to Manchester City Council (MCC) in 2013, the Director of Public Health (DPH) led a programme of reform that included:

- the safe transfer of responsibilities and contract stabilisation (2013-14).
- plans for savings and reinvestment (2014-16)
- the redesign of commissioned public health services (2015 onwards)
- the restructure of the public health staff team at MCC (2015)

1.2 In April 2017 the public health responsibilities and resources transferred into Manchester Health and Care Commissioning (MHCC), the new integrated health and social care commissioning organisation formed by combining Manchester Clinical Commissioning Group (CCG) and Manchester City Council's (MCC) commissioning functions. The DPH was appointed as the Director of the Population Health and Wellbeing (DPHW) Directorate with the Public Health team renamed the Population Health and Wellbeing (PHW) team.

1.3 In advance of the transfer to MHCC, the Council Executive agreed in February 2017 the budget profile for public health and savings for 2017/18 and 2018/19. These are summarised in table one below.

Table 1 MHCC Public Health Budget

£	Savings 17/18 £	Savings 18/19 £
Public Health Resources 27,340,000	600,000	545,000
Total	**600,000**	**1,145,000**

1.4 This report provides an update on the current commissioned wellbeing services including financial information. The services included are:

- buzz Health and Wellbeing Service
- Physical Activity Referral Service (PARS)
- Community Falls Services
- NHS Healthchecks
- Community Weight Management Service
- Oral Health Improvement Service

1.5 The Health Scrutiny Committee will also receive reports on other commissioned services (i.e. drugs and alcohol, sexual health) in the New Year.

2.0 Manchester Population Health Profile

2.1 The health of people in Manchester is generally worse than the England average at all stages of life and a key aim of Manchester's Locality Plan is to 'add years to life and life to years'. Life expectancy at birth for both men and women is currently among the worst in England. The latest figures for 2013-15 show that Manchester has the second lowest (i.e. worst) life expectancy at birth for men and the third lowest life expectancy at birth for women. There are

also significant inequalities within the city such that life expectancy for men living in the most deprived areas of Manchester (Slope Index of Inequality) is 8.2 years lower than for men living in the least deprived areas. The equivalent inequalities gap for women is 6.4 years.

2.2 Healthy Life Expectancy (HLE) in Manchester is also significantly lower than the England average for both men and women. A boy born in Manchester can only expect to live 74% of his remaining years of life in good health compared with 85% of remaining years of life for a boy born in the healthiest part of England – a gap of 10 percentage points. Similarly, a girl born in Manchester can only expect to live 70% of her remaining years of life in good health compared with 82% of remaining years of life for a girl born in the healthiest area of the country. Although men in Manchester live shorter lives on average than women, they spend a higher proportion of their lives in "Good" health.

2.3 Around two-thirds of the life expectancy gap between Manchester and England as a whole is due to three broad causes of death: circulatory diseases, cancers and respiratory diseases. These, in turn, can be linked in part to poor lifestyle. Data from the latest Health Profile for Manchester shows that adults in the city have higher rates of physical inactivity, alcohol misuse and smoking-related conditions. Around 62% of adults in Manchester are classified as overweight or obese. The rate of alcohol-specific hospital stays among those aged under 18 and of alcohol related harm hospital stays in adults are both significantly worse than the average for England. Estimated levels of adult smoking are also worse than the England average and there are around 820 deaths attributable to smoking in Manchester per year. Rates of sexually transmitted infections and TB are also worse than average.

2.4 Poor mental health and well-being has a significant impact on individuals, families and communities in the city. People with higher well-being have lower rates of illness, recover more quickly and for longer and generally have better physical and mental health. Levels of individual/subjective well-being and life satisfaction among adults aged 16 and over in Manchester are lower than the national average. Data from the latest national GP Survey shows that around 19% of patients in North Manchester, 15% in Central and 15% in South report moderate or extreme anxiety or depression compared to 12% nationally and it is estimated that between 1 in 8 and 1 in 10 Manchester adults are prescribed antidepressant medication. Although suicide rates in Manchester remain slightly higher than the national average, the rate in both men and women has been steadily reducing over the last decade and is now the lowest it has been since 1995. A detailed report on suicide prevention will be presented to the Committee at this meeting.

2.5 Although the population of Manchester contains a smaller proportion of older people than other parts of the country, the older people that do live in the city tend have poorer health (and experience this poorer health earlier in their lives) and hence place greater demands on health and social care services. Life expectancy at age 65 in Manchester is the lowest in England and Wales for both men and women. The rate of emergency hospital admissions for injuries due to falls in people aged 65 and over

in Manchester remains significantly statistically higher than the average for both England and Greater Manchester as a whole.

3. buzz Health and Wellbeing Service

3.1 Contract value and length

Provider	Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Service name	buzz Health and Wellbeing Service
Contract value (annual)	£1,901,221
Contract dates	1 April 2016 to 31 March 2019
Last re-design date	New service in April 2016

Service Description

3.2 buzz is Manchester's Health and Wellbeing Service and it aims to improve the health and wellbeing of people and to help them live fuller, healthier, happier and longer lives by increasing healthy life expectancy and reducing health inequalities in Manchester. Self-care and personal resilience is promoted by offering advice, guidance, and signposting to more specialist services.

3.3 buzz operates as one integrated service and is aligned and works with other programmes and commissioned services in Manchester. The service provides a community asset building function, training and a one to one support service underpinned by strong partnerships and knowledge management. The service has three elements:

i) **Health and Wellbeing Advisors** offer a holistic assessment, person-centred one to one support and brief interventions to enable people to improve their physical, mental health and wellbeing. As well as referrals from professionals and other organisations, the service accepts self-referrals, and works in an integrated way with other support services.

ii) **Community Asset Building** uses community centred approaches to improve the health and wellbeing of communities in Manchester. Neighbourhood Health Workers strengthen and increase awareness of community assets and partnerships. Training is offered to the public, volunteers, and organisations who cover mental health, self-care, resilience and healthy ageing. A database of community assets is being developed to be available to the public.

iii) **The Knowledge Service** supports the evidence based practice for the service and for frontline health and social care workers in Manchester, by providing information resources, supporting training and events and developing a range of health and wellbeing initiatives within local and national guidance.

3.4 The service is currently on track to deliver the majority of key performance indicators (KPIs) agreed for year 2 of the contract. The KPIs include:

- Number of community assets mapped
- Number of wellbeing initiatives supported
- Age Friendly networks and plans in place in all 12 neighbourhoods
- Number of people participating in local health related networks
- Number of people attending training sessions
- Numbers of referrals accepted by wellbeing service
- Percentage of service users with an improved wellbeing or outcomes star score
- Percentage of service users with increased physical activity
- Percentage of people who quit smoking after setting a quit date
- People reporting they feel more enabled to self-care, maintain mental good health, and to have improved levels of personal resilience
- Frontline staff reporting they feel more confident to support local people after training
- Frontline staff and volunteers satisfied with value of and access to self-help materials provide or promoted by buzz

3.5 Buzz have provided detailed information about the Health and Wellbeing Advisors and this is attached as Appendix 1. The detailed information on Neighbourhood Health Work is provided as Appendix 2. Case studies are provided below.

3.5.1 Health & Wellbeing Advisor Case Study

Summary

Client A had worked with buzz in the past and had made significant progress in regards to his health. A engaged in a bid to increase muscle mass as he had lost weight after a prolonged lapse in his mental health.

Issue to be resolved
A suffers from MDD (Major Depressive Disorder) and as his mental health often fluctuates but usually stabilises by routinely engaging in muscle strength endurance (MSE) exercise.

A wanted to engage with the service as he made significant progress the first time round. Shortly after engaging A's mother passed away from an illness and his father went to stay with relatives in Australia to help cope with his loss.

The loss of his mother and the expectation for his father to help him rather than look after himself added to his bereavement and worsened his mental health. Because of this A completely shut down, stopped eating on a regular basis, often not eating anything for days at a time. He stopped taking his medication and also disengaged with all other services however he kept in contact with buzz.

Action taken
We worked together to try and establish a routine of eating on a regular basis and

we worked on sleep hygiene and tried to reengage with his MSE exercise programme. I constantly urged the importance of contacting other talking services who could help.

Result
Initially we worked on breakfast, to at least eat once a day and coincide this with taking his medication. In order to facilitate this I would accompany A to his local shops and we would buy the essentials.

Once breakfast was established we progressed to having one hot main meal a day. Again for this to be achieved I accompanied A to the shops and we engaged in gradient exposure exercises until he felt comfortable shopping alone.

Once A began to eat on a semi regular basis we started to complete home based exercise sessions. A has all of the necessary equipment but still could not face leaving the house.

We met once a fortnight and completed upper body workouts as this was an area in which he was particularly conscious.

The first signs of progression became apparent. The exercise sessions helped to further establish a regular eating routine and also improved his nutritional quality The increase in physical activity also had an impact on sleep hygiene as A would feel naturally tired. A began to sleep upstairs rather than sleeping on his sofa in front of the TV.

A was now making significant progress but disclosed that he was not opening his mail. At one of our subsequent sessions we went through all of the unopened mail and created three piles based on priority; act on immediately, not that important and items which could be ignored or thrown away.

While working through the mail my client found a form which needed to be completed as he was due to attend a benefits reassessment. We spent the next appointment going through the form and making sure it was completed correctly.

Next Steps
We have not yet completed all of our sessions but A's mental health is much more stable. We would both like for him to start leaving the house more, ideally to attend his local gym. A is aware that exercise makes a significant difference to his mental health, so I will accompany him to the gym initially until his confidence improves.

Any other information
A would make a fantastic volunteer for the service and could be an expert in mental health engagement for buzz!

3.5.2 Case studies of Neighbourhood Health Work

i) Woodhouse Park

Usha covers Woodhouse Park and is based with Cornishway Surgery in Wythenshawe. She generally has 30+ clients at any one time from 2 surgeries and also undertakes stop smoking and weight management support for clients from Cornishway & Peel Hall Surgeries.

Usha has recently started in Brooklands with the Church of Nazarene Community Centre, every Friday from 2.00-4.00pm and supports clients there with diet and exercise. In order to increase client's physical activity, they are issued with a Gym letters and signposted to additional health and wellbeing activities in their local area.

Clients also come from other partner agencies including Early Help Hub, Job Centre Plus and the Primary Care Mental Health Team.

Usha links in with the Lifestyle Centre at Woodhouse Park, encouraging clients to participate in the range of subsidised exercise classes.

i) **Bradford**

Steve covers Ancoats, Bradford, City Centre and Clayton where he undertakes one to one health advice and support. Steve has developed a range of innovative initiatives including a regular indoor health walk for clients who have had heart attacks, strokes or clients with breathing difficulties. He also targets clients who experience mobility issues and those who may have conditions such as arthritis and others who may find it difficult to walk outside in cold weather. These walks therefore take place on a Thursday morning at the Velodrome If the client completes four circuits of the velodrome this equates to a one mile walk. As well as supporting physical health the walk also helps to reduce social isolation and loneliness as clients meet on a regular basis to undertake this together.

ii) **Ardwick**

Julia covers Ardwick, Longsight and Rusholme and has surgeries on Monday at the Robert Derbyshire Practice, Tuesday at New Bank Practice and Thursday at the Valance Practice. Whilst Julia covers all aspects of health and wellbeing with her clients, Julia has an expertise around promoting positive mental health, reducing harmful alcohol use and promoting stop smoking. Working with the buzz knowledge service Julia (like all the wellbeing advisors) uses a range of models and resources including the Eat Well Plate, Jar of Tar and the Alcohol Wheels to support people who may have literacy issues and who's preferred learning style is more visual.

4. Physical Activity on Referral Service (PARS)

4.1 Contract value and length

Provider	Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Service name	Physical Activity on Referral Service (PARS)
Contract value (annual)	£395,000.00
Contract dates	01/04/16-31/03/19
Last re-design date	2015-16

Service Description

4.2 The service provides an exercise and fitness service that is targeted at adults who have a chronic disease and/or a long term condition or a condition/injury (such as being at a high risk of a repeat fall.) A structured exercise and fitness based programme is provided as part of the client's rehabilitation and long term care plan. Clients are supported through the programme to achieve the Chief Medical Officers recommended physical activity level or to complete a course of evidence based exercise to reduce the risk of falling.

4.3 The service increases physical and physiological abilities and levels for clients requiring physical activity as part of their clinical rehabilitation and care plan, and aims to achieve behaviour change.

Key Performance Indicators (KPIs)

4.4 The KPIs for this service are:

- Engage 920 clients per year. 746 appointments were made and 700 engaged so performance is on track
- Deliver 2,816 rehabilitation classes per year. From 01/04/17-30/09/17, 1,375 classes were held so performance is on track.
- IPAQ (International Physical Activity Questionnaire) Scores. This compares the amount of physical activity a client is doing at the point of referral compared to their first 12 week review. A snapshot of client reviews in September 2017, confirms 43 clients increased their physical activity scores, 35 showed no significant increase (though activity may have increased but not to a significant level), and 5 decreased activity (mainly due to ill-health.)

Further detail is provided in Appendix 3.

4.5 PARS Case Study

Client T was referred to PARS by their physio at North Manchester General Hospital (NMGH) after completing a rehabilitation course. T has osteoarthritis and coronary heart disease and it was hoped exercise would help him to strengthen his supporting joints and stabilise his heart disease risk factors.

A place was booked for T at Newton Heath health centre where he completed his initial consultation with Stacey; a PARS referral Officer. At the consultation 'T's medical conditions were discussed and some advice was given on how best to strengthen joints through increasing his physical activity exercise without exasperating and flaring up arthritic pain. It was also revealed that 'T' had some coronary heart disease risk factors which would benefit from an increase in physical activity. Stacey agreed some physical activity goals with him and referred him on to a phase 4 cardiovascular rehabilitation class based at Heathfield resource centre delivered by PARS exercise tutor Ruby.

Client T has now completed 12 weeks of the programme and has reported the following at his 12 week consultation review;

"I am 79 years old and have had knee replacement, they couldn't do the second knee which is fine.

Until about three years ago I managed, but had quite a lot of pain and couldn't do the jobs I needed to in the house. I went to see Dr Mansoor and asked if it was possible for me to go to exercise classes, which he very kindly arranged.

I first attended physio at Cornerstone then Crumpsall. The physio's there referred me to PARS at Newton Heath and I attended a class at Heathfield.

I have several friends who are Doctors they've all commented on how much my walking, posture in general and getting up from chairs has improved since going to class. I must say it's something I wouldn't have been able to do without the class, which has a good friendly atmosphere – even though you sometimes feel done in!

5. Community Falls Service

5.1 Contract values and length

Provider	Manchester University NHS Foundation Trust (Central)
Service name	Community Falls Prevention Service
Contract value (annual)	£182,473.00
Contract dates	01/04/16 – 31/03/18
Last re-design date	2015/16

Provider	PAT (Pennine Acute Hospitals NHS Trust)
Service name	Community Falls Prevention Service
Contract value (annual)	£193,794.00
Contract dates	01/07/17 – 31/03/18
Last re-design date	2016/17

Provider	Manchester University NHS Foundation Trust (South)
Service name	Community Falls Prevention Service
Contract value (annual)	£178,886.00
Contract dates	01/10/17 – 31/03/18
Last re-design date	2016/17

Service Description

5.2 The Community Falls Prevention Services conduct risk assessments and carry out falls reduction interventions for a time limited period. The services provide specialist falls advice and support to generic health and social care teams in the community.

5.3 The purpose of the services is to reduce the impact of falls on quality of life by preventing falls in adults (aged 60+) and minimising the risk of future falls for those people who have fallen, are likely to fall or have a fear of falling. In doing this, the services aim to reduce the need for additional health and social care interventions. There are well established links with care home providers and voluntary sector organisations.

5.4 A concern for the Population Health Team up to this year was the inequitable service provision across the city with south Manchester poorly served. Action has been taken to address this and investment for south Manchester is now in place.

Key Performance Indicators (KPIs)

5.5 The Public Health Outcome Framework (PHOF) performance indicators are:

i) Emergency (unplanned) hospital admissions for falls injuries in people aged 65 and over:
The latest data (2015/16) for Manchester shows 1,293 admissions for falls. The number of admissions in Manchester has reduced compared to the previous year, however, the performance is slightly higher than Greater Manchester and England averages.

ii) Emergency (unplanned hospital admissions for fractured femur (hip fracture) in people aged 65 and over:
The latest data (2015/16) for Manchester shows that there were 310 admissions in that year and this performance is rated as not significantly different to the England average

6. NHS Health Checks: GP Provision and the Community Model

6.1 Contract values and length

Provider	GPs across the city
Service name	NHS Health Checks
Contract value (annual)	£162,000
Contract dates	1 April 2013 extended to March 2018
Last re-design date	2013-14

Provider	Northenden Group Practice
Service name	NHS Health Checks and Point of Care Testing (POCT), Community Model
Contract value (annual)	£37,700 £30,000 (Alere POCT)
Contract dates	1 April 2015 extended to March 2018
Last re-design date	Re-design 1 June 2016

Service Description

6.2 The NHS Health Check is a national risk assessment and prevention programme for those aged 40 to 74 who do not have an existing vascular disease, and who are not currently being treated for certain risk factors. The NHS Health Check aims to prevent cardio vascular diseases such as heart disease and stroke, and also checks for early indicators of diabetes, kidney disease, and dementia and includes an alcohol risk assessment. The programme systematically targets the top seven causes of premature mortality, which are high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

6.3 The NHS Health Check incorporates current National Institute of Clinical and Health Excellence (NICE) Guidance recommended public health guidance, ensuring it has a robust evidence base. Economic modelling suggests the programme is clinically and cost effective.

6.4 In Manchester the low uptake issues are now being addressed through expanding the community model.

6.5 In addition to the GP locally commissioned service for health check delivery, the Northenden Group Practice are commissioned to deliver health checks in community venues. The Population Health Team plan to extend this service as it takes pressure off GP practice workloads, and uses point of care testing which enables an immediate delivery of results and advice to people. GP practices are contracted to send out letters to their eligible patients when they are notified that a session is to be held in their neighbourhood.

6.6 The service is nurse led and delivered by trained healthcare assistants. Buzz, Manchester's Health and Wellbeing Service, organises and books suitable community venues and asks local GP practices to invite their eligible patients.

The tables below shows that the community model is performing well and receives referrals from a range of sources.

6.7 **Key Performance Indicators (KPIs) GP Provision**

Cumulative data for April 2013 to March 2017

	Manchester 4 years	**National target 4 years**	**National target 5 years**
People who were offered a health check	58.8%	80%	100%
People who received a health check	24.8%	60%	75%
People who received a health check of those offered	42.2%	60%	75%

6.8 **Key Performance Indicators (KPIs) Community Model**

Service performance for year one: July 2016- June 2017:

Number of sessions	94 (target 80)
Number of different venues	52
Number of health checks delivered	1,309 (minimum 749)
Number of GP practices whose patients received the service	90 (maximum 90)

6.9 Future plans are to commission GP Federations to oversee the programme so that at least one practice in each of the 12 neighbourhood areas delivers Health Checks for the eligible population, combined with an expanded community model. This will be a priority for MHCC, however, it is acknowledged that additional investment will be required.

7. Community Weight Management Service

7.1 Contract value and length

Provider	A Better Life (ABL) Health Ltd
Service name	Community Weight Management (Tier 2) and Nutrition Support Service
Contract value (annual)	£754,000
Contract dates	2016-2018
Last re-design date	2017 and ongoing

Service Description: Weight Management Service

7.2 ABL Health deliver a community based, multi component lifestyle weight management service, that is suitable for early years, children and young people (2-18 years) and their family members or carers (regardless of their weight), in accordance with national guidelines. The intensive phase programme lasts for 12 weeks. Following the intensive phase appropriate ongoing support for all participants who complete the intensive programme is provided for at least 12 months.

7.3 Group programmes are provided for children and young people (2-18 years) and their families, with 1-1 programmes offered to individual families where this better meets their needs e.g. children with learning disabilities.

7.4 ABL are commissioned by MHCC to provide the National Child Measurement Programme feedback to parents/carers of children and young people in reception and year 6, who are overweight and obese. They are required to pro-actively follow up these parents/carers to engage the family into a weight management programme, provided by the service.

7.5 ABL are also commissioned to provide a community based, adults (>18 years) lifestyle weight management programme, in accordance with national guidelines. The community based lifestyle weight management programme is multi-component. Group programmes are provided for adults (>18 years), with 1-1 programmes offered only to individuals where this best meets their needs e.g. adults with learning disabilities.

7.6 Clients attend a 12 week intensive phase programme with sessions offered weekly. Following the intensive phase of the programme the clients are provided with appropriate ongoing support upto 12 months post completion of the intervention. Education and training to support the implementation and delivery of all functions of service delivery is provided.

Service Description: Community Nutrition Support Service

7.7 ABL deliver a citywide community nutrition support service for people identified as malnourished or at risk of being malnourished, in order to improve or maintain their nutritional intake, in accordance with national guidelines. The methods used to improve and maintain nutritional intake in the community include dietary advice, food solutions, oral nutrition support (e.g. sip feeds, fortified snacks etc) and home enteral tube feeding. Nutritional advice is also provided to other services e.g residential care homes or families, to ensure that the menu's/food prepared is nutritionally balanced and meets the patient's needs.

Performance Summary

7.8 The demands for the Community Nutrition Support Service (CNS) since the contract was awarded have increased significantly which has impacted on performance of the Weight Management Service. The Population Health Team has secured additional funding to meet the CNS pressures from MHCC, to enable the weight management service to get back on track for the final two quarters of 2017/18.

8. Oral Health Improvement Team

8.1 Contract value and length

Provider	Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Service name	Oral Health Improvement Service
Contract value (annual)	£174,461
Contract dates	2017-2019
Last re-design date	2016

Service Description

8.2 The Oral Health Improvement Team (OHIT) provides and supports a range of programmes, which aim to provide education and the means to improve self-care oral health behaviour for all age groups in the population, but with a specific focus on children under 11 years of age.

8.3 The service targets vulnerable groups experiencing the highest levels of health inequalities e.g. looked after children and homeless families with children. In order to meet the needs of such groups, OHIT provides support to early years workers, school staff and others to provide oral health education to the most vulnerable families and children.

8.4 Key Performance Indicators (KPIs) Summary Table

KPI	***Target***	***Performance measure evidence to support achievement Indicators: Measures for AY 16-17 unless otherwise stated***
Facilitate the drinking of fluoridated milk at primary schools and special schools in Manchester	5,000 children drink dental milk on a daily basis	Number (percentage) of children drinking dental milk in primary schools including special schools. • 60 primary schools currently taking part in this academic year • Number of children drinking dental milk will be available once all nursery children have started school. Estimated figure is 4,850 children drinking dental milk on a daily basis
Maintain the number of targeted schools and Early Years (EY) establishments who deliver a daily supervised tooth	70%	Number of schools and EY settings with a supervised tooth brushing scheme. • 82/138 Private Nurseries (59%) • 78/100 most deprived Schools (78%)

brushing scheme		• 22/39 out of top 20 schools (56%) • 23 child-minders are now doing the supervised brushing scheme. • 6 special needs schools and 1 16+ college have brushing programmes
Prevention activity in General Dental Practices (GDPs) is evidence informed and consistent	85% of GDPs involved	Figures to show numbers and proportions of practices engaged in activities, and at what levels and how it influences the prevention activities for their clients • 94% 70/74 • 28 practices have achieved bronze, 22 Silver and 17 Gold • 16 practices have been supported with 18 staff trained
Buddy Practice Scheme to increase attendance among pre-school children and their families	16 practices 30 schools	Number of schools and GDPs involved (especially in deprived wards) • Phase 1 for this academic year has just started with 11 schools and 7 practices this month
	40%	Figures and numbers to show impact on numbers of pre-school children accessing dental treatment services • Phase 2 results for 16/17 academic year will be available in Quarter 3
Facilitate fluoride varnish applications with 3- 5 year old children in EY settings	70% of the children involved or 90% of those seen within the programme	Number of children seen within the buddy practice programme who have fluoride varnish applied twice yearly or Number of children receiving 2 fluoride varnish applications in 1 academic year. • Phase 2: 424 (88%) children had fluoride varnish applied

More detailed information on the Buddy Practice Scheme is provided in Appendix 4.

9. One Team Prevention Programme Overview

9.1 The fiscal and population health imperative for prevention is clear and has been articulated in Manchester's locality plan "A Healthier Manchester", The GM strategy "Taking Charge of Our Health and Social Care" and the NHS Five Year Forward View. The One Team Prevention Programme is a core component of the radical upgrade in population health and prevention that is required to improve health and life expectancy and reduce health inequalities in Manchester.

9.2 The four-year programme will enable integrated health and care services to take a person and community-centred, asset-based approach to delivering care and promoting health and wellbeing for the residents of the 12 One Team neighbourhoods. This approach is fundamental in transforming the care we deliver, so it is person-centred and enables people to live as independent a life as possible. This will reduce demand on health and care services, whilst promoting community resilience, self-care and improving health outcomes.

9.3 The 5 objectives of the programme will be for neighbourhood teams to;

- Support residents in strengthening the social determinants of health such as employment and skills, finance, housing and social connectedness
- Support the adoption of healthy lifestyle choices across the life course such as physical activity, nutrition, smoking cessation and emotional wellbeing
- Improve the quality of life, health outcomes and life expectancy of people with long-term conditions by identifying long-term conditions early ("finding the missing 1000s"), and facilitating a proactive approach to management of long-term conditions
- Optimise the health of people with long term conditions, both by enhancing standards of clinical care and supporting the mental health and social needs of people with these conditions
- Use asset-based, personalised and holistic approaches to enable self-care.

Service Description

9.4 The One Team Prevention Programme (OTPP) will be delivered citywide. Implementation is already underway in the North locality, and will begin in Central and South shortly. All services across the city will be based on the same model, although providers may be different in North locality than in Central and South. The OTPP will be aligned to the Buzz Wellbeing Service and Health and Work Programme.

Health Development Coordinators

9.5 The aim of this service is to enable the 12 neighbourhood leadership teams to develop and implement neighbourhood plans that (i) make the most of local assets to target local needs and (ii) are co-produced with local community groups and residents. This will include projects that promote physical and mental health and wellbeing and address the social determinants of health,

and place-based activities to identify people will long-term conditions who have not been diagnosed. This work will build on existing engagement mechanisms and assessments of health needs and asset mapping. Health development coordinators will be recruited and located in each of the 12 neighbourhood teams. They will:

- develop an understanding of local assets and factors that have an impact on health and wellbeing
- be part of the neighbourhood leadership team and facilitate connections between this team and local residents, groups and organisations (including the local voluntary and community sector)
- pull together a range of knowledge and intelligence that has been gathered by various organisations, to build a picture of their neighbourhood
- support neighbourhood teams to work with communities to develop local action plans, implement small-scale projects and feed into city-wide plans
- have access to a neighbourhood health fund to invest in the new ways of working

Community Links for Health

9.6 The aim of this service is to provide a coherent citywide social prescribing model to give people who access health and care services, a link to social and non-medical support within the community. The service will support One Team health and care practitioners (starting with GPs) to quickly and easily connect people with various sources of support that address the social determinants of health, and support the development of asset-based approaches to health. This will be targeted at those individuals with an element of risk which could lead to adverse health outcomes at a later date. It will also enable holistic care for people in more acute risk cohorts, by addressing the social factors that affect their physical and mental health and quality of life. There are two elements to the service model:

i) A Community Links for Health Hub, which will:
   - Provide a single point of contact for referrals, and carry out initial assessments to determine the best course of action for each referred individual
   - Provide telephone signposting, and one-to-one health coaching and community-based support to help individuals address issues impacting on their health and wellbeing
   - Provide specific support for people who are out of work to get into volunteering, training and employment, and support to address health needs of people in work
   - Provide a specialist smoking cessation service for North Manchester residents

ii) Community Connectors, which will:
   - develop an in-depth knowledge and understanding of the various social sources of support and community assets available in a local area

- make, develop and maintain connections with local groups and organisations in the neighbourhood which can promote health and wellbeing
- contact people referred to the service and assess the types of groups, activities and community assets which may best meet their needs
- link people up with the relevant community assets and sources of support for them – either by passing on information or by supporting individuals to enable them to attend and benefit

Investment Profile

9.7 Funding for the Prevention Programme elements outlined above comes from two different sources. Funding for the Health Development Co-ordinators and Community Links for Health in North Manchester is from the previous NHS Manchester CCG (North Manchester Investment Programme) for the financial years 2017-18 to 2020-21. Funding for the Health Development Co-ordinators and Community Links for Health in Central and South Manchester will come from the Greater Manchester Transformation Fund for the financial years 2017-18 to 2020-21. Across these two sources, approximately £12.2 million additional funding is being invested in prevention for the city over a 4 year period.

9.8 Community Links for Health for North Manchester will be provided by a consortium of Greater Manchester Mental Health (GMMH) Foundation Trust, Northwards Housing, Pathways Community Interest Company (CIC), and Northern Health. A 2 year contract for the service was awarded to GMMH as the lead provider, following a competitive open tender process conducted by MHCC earlier this year; the service is due to go live in December 2017. The service will initially only take referrals from GPs and other primary care settings.

9.9 Now that the GM funding has been secured the service for Central and South will be procured in accordance with the MCC and NHS procurement framework.

10. Summary

10.1 The commissioned services described in this report will continue to be monitored closely under the new MHCC arrangements.

10.2 It must be acknowledged that there have been significant national reductions in the resources available to invest in public health. However, the planned investment in the OTPP and the commitment to prioritise work on the wider determinants of health by MHCC is very welcome.

11. Recommendations

The Committee is asked to note the report.

Appendix 1: Health and Wellbeing Advisors Activity to September 2017

1. Introduction

All the Health and Wellbeing Advisors work on supporting their clients to adopt healthier lifestyles. The topics the client can choose from are

- Healthier diet,
- Isolation and loneliness,
- Managing a long term health condition,
- Increasing physical activity,
- Positive mental health,
- Reducing your Alcohol intake
- Stopping smoking.

2. Summary Data

This report shows the numbers of referrals by current referral state for each Scheme where the date of referral falls within the selected date range

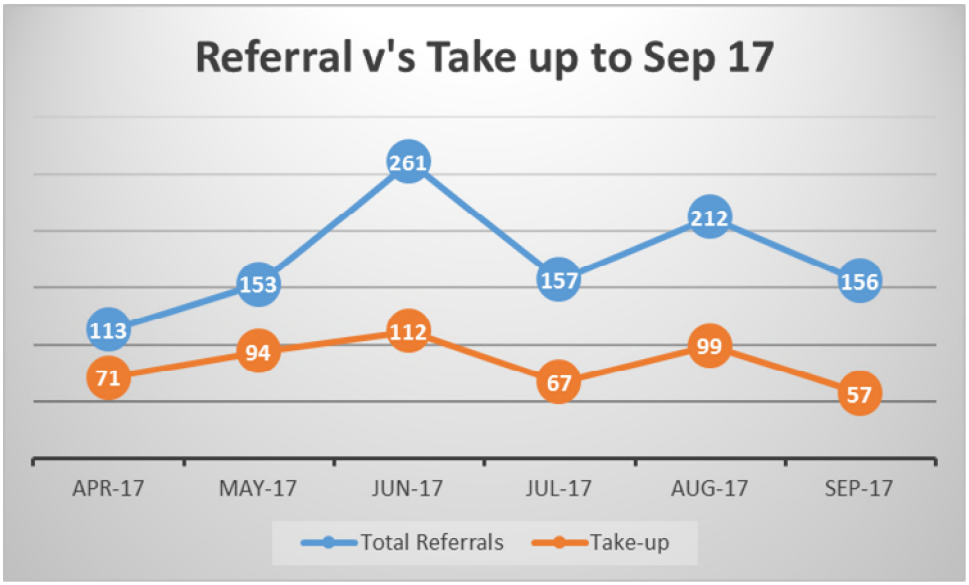
Take-up is a product of Participating, Completed and Left Early (i.e. at some point all of these referrals have started on the programme)

Table 1 Data 01.04.2017 – 30.09.2017

	Referrals		Activated Referrals			Non-Completing Referrals				
Scheme	Awaiting Processing	Awaiting Authorisation	Actively Participating	Intending To Participate	Completed	Not Participating	Left Early	Authorisation Rejected	Total Referrals to October 17	Take-up
April 17	0	0	10	0	47	42	14	0	113	(71) 62.8%
May 17	0	0	20	0	53	59	21	0	153	(94) 61.4%
June 17	2	0	27	2	56	145	29	0	261	(112) 42.9%
July 17	28	0	21	1	34	61	12	0	157	(67) 42.7%
August 17	25	0	52	5	35	83	12	0	212	(99) 46.7%
September 17	47	0	36	9	18	43	3	0	156	(57) 36.5%

	Referrals		Activated Referrals			Non-Completing Referrals				
Scheme	Awaiting Processing	Awaiting Authorisation	Actively Participating	Intending To Participate	Completed	Not Participating	Left Early	Authorisation Rejected	Total Referrals to October 17	Take-up
Totals	102	0	166	17	243	433	91	0	1,052	(500) 48.8%

Graph 1 : Referral and take up



3. Breakdown of Ethnicity to September 2017

Report for Wellbeing Advisors between **01/04/2017 and 30/09/2017**

This report shows the numbers of referrals by current referral state for each client ethnicity where the date of referral falls within the selected date range

Take-up is a product of Participating, Completed and Left Early (i.e. at some point all of these referrals have started on the programme)

Table 2 Breakdown by ethnicity

Any other Black or Black British background	2		Mixed Background (Other)	3
Asian British Background (Other)	6		Mixed White & Black African	1
Asian or Asian British Bangladeshi	2		Mixed White & Black Caribbean	7
Asian or Asian British Indian	7		Other ethnic group	18

Asian or Asian British Pakistani	**71**		**Pakistani**	**15**
Bangladeshi	**4**		**Somali**	**4**
Black or Black British African	**30**		**White Background (Other)**	**7**
Black or Black British Caribbean	**15**		**White British**	**209**
Chinese	**1**		**White Irish**	**8**
Indian	**2**		**Not Disclosed/Unknown**	**634**
Middle Eastern	**6**		**Total**	**1,052**

Nb. Not disclosed/not known figure includes those that have not yet had initial assessment, those that were completed without an initial assessment (Advice given or signposted) and those that chose not to take up Service (Not participating).

4. Client Referral Route to September 2017

Report for Wellbeing Advisors between **01/04/2017** and **30/09/2017**

This report shows the numbers of referrals by current referral state for each Referring Organisation where the date of referral falls within the selected date range

Take-up is a product of Participating, Completed and Left Early (i.e. at some point all of these referrals have started on the programme)

Table 3 Client referral route

Aleeshan Medical Centre Count	1		Manchester Customer Service Centre Count	1
Alexandra Park Health Centre Count	4		Manchester Mental Health & Social Care Trust Count	11
Ancoats Primary Care Centre Count	2		Manchester Royal Infirmary Count	2
Ashcroft Surgery Count	1		Manchester Shared Lives Count	1
Ashville Surgery Count	1		Moss Side Medical Centre Count	5
Barlow Medical Centre Count	1		Newton Heath Health Centre Count	8
Bodey Medical Centre Count	1		Newton Heath Job Centre Count	1
Bowland Medical Practice Count	2		NHS Health Checks Count	145
Brooklands Medical Practice Count	1		North Manchester General Hospital Count	8

Brooks Bar Medical Centre Count	1		Northenden Group Practice Count	1
Brownley Green Health Centre Count	6		Park View Medical Centre Count	4
Buzz Team Count	66		PARS Count	4
Central Manchester University Hospitals NHS Foundation Trust Count	31		People First Housing Association Count	7
Charlestown Road Medical Practice Count	3		Plant Hill Clinic Count	1
Cheetham Hill Job Centre Plus Count	16		Rusholme Health Centre Count	7
Cheetham Primary Care Centre Count	12		Salford University: Health Hub Count	1
Citizens Advice Manchester Count	1		Self Help Services Count	9
Clayton Health Centre Count	3		Self-Referral Count	360
Collegiate Medical Centre Count	6		Simpson Medical Practice Count	2
Cornbrook Medical Practice Count	4		Studio - one Count	1
Cornerstones Centre Count	5		Supported living home Count	1
Cornishway Group Practice Count	33		The Jolly Medical Centre Count	13
Demo Surgery Count	3		The Alexandra Practice Count	11
Dickenson Road Medical Centre Count	2		The Docs Surgery Count	1
Didsbury Job Centre Count	2		The Pankhurst Centre Count	4
Early help hub Count	4		The Robert Darbishire Practice Count	4
Five Oaks Family Practice Count	2		The Work Company Count	4
Gorton Medical Centre Count	2		Urban Village Count	2
Gorton Parks Intermediate Care Unit Count	1		Victoria Mill Medical Practice Count	9
Great Places housing association Count	1		Website Self-referral Count	65
Greater Manchester Mental Health Trust Count	33		West Point Medical Centre Count	1
Harpurhey Health Centre Count	1		Whitley Road Medical Centre Count	4
Information Support Manchester Count	1		Withington Community Hospital Count	4
Kingsway Medical Practice Count	1		Woodlands Medical Practice Count	1
Ladybarn Group Practice Count	5		Woodville Sure Start Centre Count	7
Leg Circulation Service Count	2		Wythenshawe Health Care Centre	3

			Count	
Levenshulme Health Centre Count	28		Wythenshawe Hospital Count	9
Longsight Health Centre Count	2		Zion Community Resource Centre - You First Count	3
Manchester City Council Count	36		Total	1,052

Appendix 2 : Neighbourhood Health Work (NHW)

1. Training

Table 1: NHW – Training Courses and number of Participants April – September 17

		Training Courses	Participants
Boost		20	129
Connect 5		15	142
Relaxation		1	7
Food & Mood		2	21
Healthy Eating		1	20
Sleep Workshop		1	6
Healthy Ageing		1	8
5 ways to wellbeing		2	12
Unwind your mind		1	6
distress to de-stress		1	10
build yourself up		1	6
cook and taste		1	29
Total		47	396

2. buzz Neighbourhood Health Workers

(please note the information below is a snap shot of neighbourhood activity in the south, centre and north of the city. Not all neighbourhoods have been included in this snap shot but the buzz team will be able to provide detailed information on request for all 12 areas)

2.1 South Activity report to November 2017

Ward	Activity
Baguley	**NHS Health Checks** From Aug 16 to present • The Tree of Life Centre – 56 people completed health checks **Connect 5 training course:** • Connect 5 session 1 – Tree of Life Centre (with staff/volunteers), May 2017 **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Tree of Life – Mental health Day – 10 wellbeing conversations (October2017) • Health Zone at Wythenshawe Games – approx. 1200 people visited the health zone (July 2017) • Community Conversations as part of Wythenshawe Age Friendly Network; at Tree of life • Wythenshawe Age Friendly Network: over 90 members, from all sectors including voluntary, NHS and housing, Wythenshawe-wide, meetings rotate to venues across the area, including Tree of Life, the Firbank Pub and Royal Oak Centre. Held a successful launch at the Forum, plus a Showcase Fortnight with a map to promote local opportunities for local older residents in the 5 wards. During the Fortnight held a cream tea at Tree of Life, which is now a regular afternoon tea. Age Friendly work is linked into the One Team Neighbourhood Provider Partnership Groups by the buzz NHWs. Next plans: to produce a Directory, to support the Take A Seat Campaign and to link it to the Age Friendly Manchester Charter & Pledge. • One Team: attending the Wythenshawe Neighbourhood One Team meetings. Produced info to be distributed by pharmacists re: local offer for older people, and travel and buddying for housebound patients. • Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Asset mapping • Attending Community Explorers meeting
Brooklands	**NHS Health Checks** • Brooklands Church of the Nazarene – 24 checks done (November 2017) • Manchester Health Academy – 21st and 22nd Feb 2018 **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Health Zone at Wythenshawe Games – approx. 1200 people visited the health zone (July 2017) • Community Conversations as part of Wythenshawe Age Friendly Network; at Alf Morris Court • Wythenshawe Age Friendly Network, facilitated by buzz NHW: over 90 members, from all sectors including voluntary, NHS and housing, Wythenshawe-wide, meetings rotate to venues across the area. • Held a successful launch at the Forum, plus a Showcase Fortnight with a map to promote local opportunities for local older residents in

	the 5 wards. During the Fortnight held a cream tea at the New Dawn Centre. Age Friendly work is linked into the One Team Neighbourhood Provider Partnership Groups by the buzz NHWs. Next plans: to produce a Directory, to support the Take A Seat Campaign and to link it to the Age Friendly Manchester Charter & Pledge. • One Team: attending the Northenden/Brooklands Neighbourhood One Team meetings. Produced info to be distributed by pharmacists re: local offer for older people, and travel and buddying for housebound patients. Plus working with local NHS Care Navigator to link people to local projects. • Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Asset mapping • Attending Community Explorers meeting
Burnage	**NHS Health Checks** • St Margaret's Church – 22 people completed a health check • Burnage Buddies – 10 people completed a health check **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Attendance at Burnage Buddies, Burnage Community Centre and St Bernard's lunch club. • Working closely with Ambition for Ageing in Burnage; supporting outreach work • Working with Irish Community Care to target health checks at men, leading to health checks at St Mary's (Levenshulme) • Supporting small, local groups e.g. Peter Quinn Friendship Group, Spoon and Ladle, the Farmer's Arms • Attendance at Community Explorers meetings and Neighbourhood One Team meetings
Chorlton Park	**NHS Health Checks** • Barlow Moor Community Centre: 36 people from Merseybank Estate completed a health check **Mental Health and Well-Being:** • Linked MIND worker to BMCA to deliver Wellbeing Course for local residents • Developed and delivered mental well-being sessions with workers at BMCA • Linked Self-Help Services with BMCA to re-establish a presence in Merseybank • Delivered to sessions to French speaking African women at Dynamic Support **BOOST:** • Course delivered at Darley Road Children's Centre Dec – Jan 17 • 1 course delivered to parents at Birches School **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • With local councillor, Quids In shops and Southway Housing to

	identify needs of older people on the Merseybank estate • Working with resident's group to organise a age friendly afternoon tea • Working with Quids In shop to plan and put on a Hallowe'en event • Conversations with local people about local health & well-being – on-going • Family food/cooking sessions x 2 at BMCA • Supporting promotion and delivery of Winter Warmer events in partnership with Southway Housing • Asset mapping • Attending Community Explorers meetings
East & West Didsbury	**NHS Health Checks** • 106 people have completed an NHS Health Check (West Didsbury) – Didsbury Mosque • 2 days at Emmanual Church, 3 days at the Old Parsonage; 60 people completed a health check, (working with Barlow Medical Centre) **Mental well-being sessions (one offs):** • Food and Mood Session; The Parswood, drop in mental health session. **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Working in partnership with Didsbury Good Neighbours to plan and deliver successful information exchange event celebrating DGNs 50th birthday. Buzz NHW linked local NHS staff to the event in a "health" marquee in Didsbury Park • Networking with local groups – U3A, Didsbury Coffee Morning, the Parsonage, De Paul Hostel, Emmanual Church, The Parswood mental health drop-in – with aim to explore health and well-being • Working with local residents to explore mental health needs of young people and to shape a proposal to the Mental Well-being Fund • Attendance at ward meetings when appropriate • Attendance at Neighbourhood One Team meetings • Attendance at Community Explorers
Northenden	**NHS Health Checks** • 42 people have completed an NHS Health Check (Northenden) – Northenden Methodist Church **BOOST courses:** • South Asian women's group – Saheli. 6 week emotional wellbeing course (April/May 2017) 8 attendees Benchill Community Centre **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Community Conversations as part of Wythenshawe Age Friendly Network; at Northenden Methodist Church, Northenden Social Club, Northenden Cricket Club • Supporting local resident to develop an Age Friendly newsletter for Northenden • Wythenshawe Age Friendly Network, facilitated by buzz NHW: over 90 members, from all sectors including voluntary, NHS and housing,

	Wythenshawe-wide, meetings rotate to venues across the area. Held a successful launch at the Forum, plus a Showcase Fortnight with a map to promote local opportunities for local older residents in the 5 wards. During the Fortnight held a cream tea at Northenden Social Club with Wythenshawe Good Neighbours. Age Friendly work is linked into the One Team Neighbourhood Provider Partnership Groups by the buzz NHWs. Next plans: to produce a Directory, to support the Take A Seat Campaign and to link it to the Age Friendly Manchester Charter & Pledge. • One Team: attending the Northenden/Brooklands Neighbourhood One Team meetings. Produced info to be distributed by pharmacists re: local offer for older people, and travel and buddying for housebound patients. Plus working with local NHS Care Navigator to link people to local projects. • Asset mapping • Attendance at Community Explorers meetings
Sharston	**NHS Health Checks** • St Richard's Church 28th and 30th Nov (37 confirmed appointments) **Connect 5 training course** • Session 1 (half day) and 2 (full day) with Homestart volunteers and staff - 10 attendees each session (November 2016) **Mental Well-Being one off sessions:** • Food and mood sessions with parents working with Homestart (Jan 2017) • Food and Mood session plus Wellbeing session – The Carer's Forum, Crossacres – 10 attendees (May 2017) • Creative Support x 2 wellbeing sessions – The Shawe – 5 attendees (May and August 2017) **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Community Conversations as part of Wythenshawe Age Friendly Network at Crossacres Resource Centre and St Andrew's Church • Wythenshawe Age Friendly Network, facilitated by buzz NHW: over 90 members, from all sectors including voluntary, NHS and housing, Wythenshawe-wide, meetings rotate to venues across the area. Held a successful launch at the Forum, plus a Showcase Fortnight with a map to promote local opportunities for local older residents in the 5 wards. During the Fortnight held a cream tea at Crossacres Resource Centre as part of the Memory Garden launch. Age Friendly work is linked into the One Team Neighbourhood Provider Partnership Groups by the buzz NHWs. Next plans: to produce a Directory, to support the Take A Seat Campaign and to link it to the Age Friendly Manchester Charter & Pledge. • One Team: attending the Wythenshawe Neighbourhood One Team meetings. Produced info to be distributed by pharmacists re: local offer for older people, and travel and buddying for housebound patients. Plus working with local NHS Care Navigator to link people to local projects.

	• Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Asset mapping • Attendance at Community Explorers meetings
Withington and Old Moat	**NHS Health Checks** From July 2016 to present: • 84 people have completed an NHS Health Check (Withington & Old Moat) – Withington Baths, St Cuthbert's Church and Manchester Islamic and Cultural Centre **Confirmed Health Checks for 2017/18:** • Withington Fire Station – 17th and 19th Jan 2018 **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** **Age Friendly Projects** From July 2016 to present: • 5 Age Friendly Network meetings with health partners, local statutory organisations, volunteers, businesses and local residents (36 network members in total): o To support existing and new projects for older people in the area o To raise awareness of community projects, activities, events and services for older people to access within the local community. • Health and wellbeing event at Withington Methodist Church – 24th May 2017: o 90 people attended the health event o 22 health and wellbeing stallholders attended to promote local services o 38 pledges completed by residents and businesses for Age Friendly Charter • New Age Friendly leaflet promoting regular local activities developed and updated by buzz Neighbourhood Health Worker in June 2017: o At present 1,600 leaflets have been distributed to local venues by partners, buzz volunteers and Age Friendly volunteers. o 12 large A3 posters promoted and updated at local noticeboards - Copson Street, post office (Withington Civic Society) & Southway Housing notice boards.

Withington Baths and Leisure Centre:

- March 2017: buzz Neighbourhood Health Worker developed and supported the free Silver Circuit fitness class for over 65's. Over 400 attendees with a number of individuals making health improvements. Connected Withington Baths with Co-Op (Copson Street) to provide free health snacks and refreshments.
- June 2017: PARS participants exercising at Withington Baths are targeted with local health and wellbeing information/activities to support and prevent health issues.
- Oct 2017: buzz Health and Wellbeing Advisor located at Withington Baths to provide one to one health support/improvements.
- Oct 2017: buzz Neighbourhood Health Worker organised and facilitated filming by Portuguese State TV on how older people live in Old Moat. Interviews organised for Southways Housing, local residents and Withington Baths and Silver Circuit fitness class.
- Oct 2017: buzz Neighbourhood Health Worker facilitated and organised a Winter Warmth event for Nov in partnership with Southways Housing to support older people during the winter months. 7 local health and wellbeing partners invited to raise awareness, along with hot food, promotional materials and freebies.
- Nov 2017: buzz Neighbourhood Health Worker developed an Over 50's Table Tennis project by sourcing table tennis table & equipment from MCC, promotional material, funding for instructor and support funding proposal from Manchester Wellbeing Fund.
- Nov 2017: buzz Neighbourhood Health Worker provided support and guidance in applying for the Manchester Wellbeing Fund – to develop physical activity classes for discharged PARS clients to continue physical exercise within the local community.

Withington Assist:

- September 2017: buzz Neighbourhood Health Worker provide support and guidance in applying for the Manchester Wellbeing Fund – proposal ideas to be confirmed

Old Moat Sure Start Centre:

- Oct 2017: buzz Neighbourhood Health Worker setup a coffee morning project and to invite older people from the Old Moat estate to meet nursery school children at the Sure Start centre.

Le Bas House:

- Apr 2017: buzz Neighbourhood Health Worker sourced 25+ DVD films for Le Bas House to show as part of their new film club. buzz developed new poster and promoted locally to increase awareness and attendance.
- Apr 2017: buzz Neighbourhood Health Worker developed new poster for chair based activity at Le Bas House to increase awareness and attendance of activity.

Neighbourhood Provider Partnership Group –Withington & Fallowfield (Old Moat)

From Aug 2017 to present:

- Aug 2017: Social Prescribing Project – a list of patients with specific health needs i.e. on GP's frailty list are contacted by GP's receptionist to encourage patient to link up with buzz to prescribe community health projects such as local chair based activity classes, coffee social groups, arts and craft groups, etc. buzz Neighbourhood Health Worker has contacted and supported 4 patients with community health projects.
- Sep 2017: buzz Neighbourhood Health Worker setup health information points at GP's promoting local community health service such as local Tea Dance club, PARS, Health and Wellbeing Advisors, health walks, snooker club, etc.
- Oct 2017: buzz Neighbourhood Health Worker invited to attend flu clinics at Bodey Medical Centre to engage and promote local community health services to over 70 patients.

Targeted Promotional Campaigns

- Withington Methodist Church:
  - May 2017: buzz redeveloped promotional material for Men's snooker club to increase attendance from 4 participants to 8 by targeted local awareness campaign.
- St Cuthbert's Church:
  - March 2017: buzz support the Tea Dance project to increase attendance though promotional campaigns in the local area and to partners.
- Withington Methodist Church:
  - April 2017: buzz redesign promotional materials for Men's Snooker club. Increased attendance by 50% in 3 months.
- The Hive Community Kitchen:
  - Oct 2017: buzz setup promotional display of local community health and wellbeing services.
- Withington Library:
  - Jul 2017: buzz setup promotional display of local community health and wellbeing services.

buzz Volunteers Support

From Aug 2016 to present:

	• NHS Health Checks – 114 hours completed by buzz volunteers by promoting local health checks, signing local people up for health check & facilitating health check with the Health Check Team at Northenden Group Practice. • Health Information Point (Withington library) – 36 hours completed by buzz volunteers by promoting local community health and wellbeing activities and national health campaigns. • Health and Wellbeing events – 18 hours completed by buzz volunteers by supervising and support local events. • Promoting local health and wellbeing activities – 28 hours completed by buzz volunteers by distributing leaflets/posters, health consultation & awareness raising. **Asset mapping** **Attendance at Community Explorers meetings**
Woodhouse Park	**NHS Health Checks** • Wythenshawe Forum and Woodhouse Park Lifestyle Centre – 90 people completed a health check **Mental Well-Being one off sessions:** • Food and Mood - Heart Support Group, Dandelion Centre - 7 attendees (September2017) **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • International Women's Day – The Forum – 12 wellbeing conversations (March 2017) • Community Networking event at the Forum – 20 wellbeing conversations (February 2017) • Community Conversations as part of Wythenshawe Age Friendly Network; at Frank Price Court, Forum Library, Paint Potts Group, Grand Day Out, Walking Football and Wythenshawe Tenants Conference. • Wythenshawe Age Friendly Network, facilitated by buzz NHW: over 90 members, from all sectors including voluntary, NHS and housing, Wythenshawe-wide, meetings rotate to venues across the area. Held a successful launch at the Forum, plus a Showcase Fortnight with a map to promote local opportunities for local older residents in the 5 wards. During the Fortnight held a cream tea at Woodhouse Park Lifestyle Centre. Age Friendly work is linked into the One Team

	Neighbourhood Provider Partnership Groups by the buzz NHWs. Next plans: to produce a Directory, to support the Take A Seat Campaign and to link it to the Age Friendly Manchester Charter & Pledge. • One Team: attending the Wythenshawe Neighbourhood One Team meetings. Produced info to be distributed by pharmacists re: local offer for older people, and travel and buddying for housebound patients. Plus working with local NHS Care Navigator to link people to local projects. • Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Facilitated an event with mental health service users at St Andrew's Church to map local activities and to explore proposals for the Mental Well-Being Fund • Asset mapping • Attendance at Community Explorers meetings

2.2 North Manchester Activity report to November 2017

Ward	Activity
Bradford	**NHS Health Checks** From January 2017 to date: • Church of Resurrection and St Barnabas - 58 completed a health check over three days and a number of drop in clients who could not been seen were put on a waiting list, and invited to subsequent future health checks. • Beswick Library – 10 people completed a health check **Mental Wellbeing Sessions:** • Parenting Aspiration sessions at Ashbury Meadows Sure Centre in Beswick to establish parent's wellbeing needs / wants. From this we planned and delivered three wellbeing workshops e.g. Build Yourself Up, Improve your Mood, Food and Mood. **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Established strong links with Donna Dolan and Angela Daley at Beswick Library – currently arranging another round of Health Checks to be held at the library in January 2018. This will focus on a 'New Year, New You' theme, and encourage people to keep their New Year's resolution by having a Health Check. • Community Conversations held with 'Just for Men' group at Beswick Library, which runs every Thursday from 2pm till 3.30pm. NHW plans to do some form of health exploration session in December 2017. • Involved with Swim England and the Dementia Friendly Swimming Project, based at the National Squash Centre in Beswick. We sit on the steering group; helping to shape and promote the sessions which are now in Leisure Centres across Manchester. • Strong links established with the Grange Community Centre. Age Friendly Network launch meeting at this venue in February. 15 people were in attendance from across Bradford, Ancoats and Clayton wards.

	• A further Age Friendly meeting was held at the Church of the Resurrection and St Barnabas on 6th April 2017. 10 people attended the meeting; both professionals and residents alike. One of the big issues identified was local transport links, which were described as 'awful' with people having to take two buses to reach local neighbourhoods e.g. Ancoats, Miles Platting. It was also felt that local older people were not aware of the activities at their disposal, and there was much concern about the streamlining of local services and community resources. We linked Clive at Growing the City (and Growing East Manchester) / Men's Shed with Phil Pennill the Community Sport Manager at the National Cycling Centre, who then went on to discuss the possibility of establishing a free bike maintenance course with men who attend the Men's Shed facility. • Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Asset mapping • Attending Community Explorers meetings **Boost Course** • We have developed a partnership with Manchester City Academy and plan to deliver BOOST courses there in the New Year (2018). • Working with Manchester Mind to establish a referral pathway into buzz for participants attending the Building a Healthy Future Courses run by Mind, and whom want to further increase their emotional resilience by taking part in Boost Sessions. Attended Building a Healthy Future Session in Openshaw to talk about buzz and the Boost course with participants. **Targeted Health Events** • Manchester College Openshaw Campus – Fresher's Fair – health and wellbeing conversations held with new students around sexual health, drugs and alcohol, and mental wellbeing.
Higher Blackley	**NHS Health Checks** • Health checks are being arranged to take place in Higher Blackley in February/March 2018. Details are currently being finalised and will be cascaded to our networks in due course. **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Working with Eat Pennines, a social enterprise that is based in Heaton Park and that works with young adults (18+) to educate them in culinary processes – food growing, cooking skills etc. We are currently liaising with the project coordinator around establishing a Winter Warmer event for older people. • Supported Higher Blackley Sure Start Centre to set up a Space Hive crowd funding project to develop Bailey Wood into a more family orientated space. Explored opportunities for engaging centre users -

	litter pick and Den Building day. • Age-friendly consultation in February 2017 with residents of Northwards Housing supported living schemes in Blackley and Charlestown. 30 responses received. This information was used to assist in the development of an age-friendly action plan for Harpurhey, Charlestown and Higher Blackley AF Network. • Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Asset mapping • Attending Community Explorers meeting
Charlestown	**NHS Health Checks** • Whitemoss Community Centre – 53 people attended • The Avenue Library – 38 people attended. **Community Capacity building – including asset mapping, partnership work, community engagement, linking people to assets and age friendly work** • Age Friendly Network meeting – The Avenue Library – 16 people attended • Age Friendly Network Meeting – Whitebeck Court – 22 people attended. • Age Friendly Network Meeting & Community Health Event (North Network) – Khizra Mosque, Cheetham Hill – 20 people attended the network meeting (and approx. 250 people attended the health event). Although not in Blackley, Bradford or Charlestown Ward this is event is significant to all the neighbourhoods of North Manchester as network members from all four neighbourhoods were invited to come together for a larger 'North' network meeting and community health event. At this meeting a number of network members expressed concerns that they did not have capacity to attend four separate age-friendly network meetings and so the group took the decision to form a North Network, which would be grown to include service providers, groups and local residents from all four North Manchester neighbourhoods. The network has since met in September and again in November, with venues being chosen from a different North Manchester ward each time. Terms of reference for the North Network have been put together and consulted on, and the group have decided that they would like to host a Winter Warmer event at the end of January 2018. Our partner Donna Gyles at GM FRS has provisionally booked GM FRS Training and Development Centre as a venue and a request has been made for network members to sit on a steering / planning group to organise the event. It is anticipated that the group will be made up of a minimum of two people from each of the four neighbourhoods, to ensure the event is equitable. The steering group will also comprise of buzz Neighbourhood Health Workers. • Supported Donna Gyles at GM Fire and Rescue Service by connecting her to local assets that could assist her in developing the Shed 17 project. This is community shed project that will be funded by GM FRS and housed at Blackley Fire Station. It is similar to the Men's Shed projects, but will have a whole community approach. Donna is

	currently waiting on final health and safety approval to enable the Shed to open. Donna is keen to involve buzz in building the capacity of the Shed users; using community development tools and methodologies, delivering Boost training packages and wellbeing workshops. • Whitebeck Court – Our Neighbourhood Health Workers linked activity coordinators to an active citizen who was willing to run a weekly intergenerational craft class at the centre. Approximately 14 people attended every week, mainly grandparents with their grandchildren. Also at Whitebeck Court our NHW engaged in consultation with residents who indicated that they would like to utilise the outdoor gym equipment. Six female residents, all 70+ attended weekly sessions over ten weeks, which were run by a buzz Wellbeing Advisor who is a qualified person trainer. Outcomes were excellent with all participants reporting enhanced mood, and increased physical mobility and range of motion. Sessions have stopped for autumn/winter, but will recommence in Spring 2018. • Attended North Manchester Community Games at Boggart Hole Clough to deliver health and wellbeing advice. Also encouraged local residents to take part in our physical activity challenge and to find out more about diet, physical activity and the effects on physical and mental wellbeing. Our NHWs sit on the North Manchester Games Community Forum, and have strong links with Scott Flitcroft, Community Activator. • Attendance at Ward meetings as appropriate. • Working with local groups to encourage/support them to apply to the Mental Well Being Fund • Asset mapping • Attending Community Explorers meeting **Boost Courses** • Blackley Fire Station – January 2017 – 10 participants referred to us from the Stroke Association. All participants had a physical disability and most experienced low mood / anxiety / or low-self-esteem and confidence levels at the start of the course. WemWeb data was collected at the pre-session, then again at sessions 3 and 6. Outcomes were excellent with all participant reporting enhanced wellbeing at the end of the course. The group of participants decided that they would like to continue to meet on a weekly basis and after a discussion that was supported by the Neighbourhood Health Team decided that they would like to form a walking group, which was set up in conjunction with the National Cycling Centre at Manchester Velodrome because of its 'all weather' indoor setting and ease of access for wheel chair users. This walk continues to operate every Thursday from 10am to 12noon, as is now lead by a buzz Wellbeing Advisor. Other outcomes from this BOOST course include a gentleman who reported increased confidence and who went on volunteer in a local charity shop, and who then went on to travel to the Philippines by himself, which is something that he reports he wouldn't have considered doing prior to completing the course.

	• Blackley Fire Station – September 2017 - 8 participants from Charlestown and Higher Blackley wards. All participants completed WemWebs at the pre-session, session 3 and then again at session 6. All participants reported an increase in wellbeing, to include: increased confidence and self-esteem, reduced feelings of loneliness and isolation and being able to cope with pain and long term physical health conditions better.

2.3 Central Manchester Activity Report to November 2017

Mapping Exercise (Number of new assets added)	**Gorton and Levenshulme** Being there LEAP Roma Voices Turn2Us **Fallowfield, Chorlton and Whalley Range** ● Active People's Retirement Group. Mondays 11.30am – 2.30pm St Kent's Irish Social Club. Over 50s Social Group. Free of Charge. Music, Armchair Exercises, Bingo and Raffle, Tea, Sandwiches. Contact Zara at Irish Community Care 07833940729. ● City Girls Football Development Session – Tuesdays 5 – 6pm at Platt Lane Sports Complex. £3 per session or 6 for £15. Contact Damian Flynn on 07753 467 171 or email damian.flynn@cityfootball.com
Community Asset Building/ Community Engagement (Anything to do with community development work really including where, with who, how many people, any outcomes)	**Gorton and Levenshulme** <u>Promotion of "Belle Vue and Gorton Story Sessions"</u> Update from last months report. Following the event Emma Bryning (Learning and Community Officer at Gorton Monastery) gave the following feedback: "Jean Lamb from Age UK Manchester arranged for 7 clients, 3 staff members and one volunteer to attend the October 'Belle Vue & Gorton History and Heritage Club', 'The Belle Vue Story in 20 Objects', at the Monastery. The clients were from a day centre for local older people with dementia. The group came for about two hours and they seemed to really enjoy themselves, with everyone at the sessions singing together at the end." <u>Community update</u> The monthly Community Update newsletter was sent out to 86 recipients in my network and was also sent to the central community explorer's via their mailing list. <u>Stroke Association</u> Helen Gilbertson the Stroke Recovery Coordinator at the Stroke Association had asked for help in identifying organisations who may be able to provide PARTNERSHIP OF PEOPLE POST STROKE (POPPS) sessions for her. I passed on contact details for the following: ● Stephanie Rothwell- One Manchester. ● Rich Browning- Healthy Me Healthy Communities.

	• Ruth Morgan- Freelance Cookery Tutor (former cook and taste sessional worker for buzz). • Ailsa Smith- Healthy Gorton. • I also suggested contacting '4 lunch' and ABL Health although I don't have any direct links with them. <u>Pride of Gorton Awards</u> I submitted a nomination for Doreen Martin for her work as the manager of Gorton Community Centre for many years, which deserves receive recognition for the positive effect it has had on the community. The nomination was for the "Making a Difference Award" in the Pride of Gorton Awards , a local voluntary sector award ceremony now in its 5th year held at Gorton Monastery attended by approximately 300 people including local councillors and the Lord Mayor Eddie Newman. The nomination described the work she has been doing at the centre and the benefit to the community. She was selected as a finalist for the award alongside two other community members. At the ceremony The nomination was read out, and talked about the work she has contributed to the area via the Community Centre, and Doreen was selected as the winner. Information about the awards: https://www.manchestercommunitycentral.org/news/pride-gorton-awards Pictures of the ceremony: https://www.flickr.com/photos/gribbenphotos/albums/72157689499256586/page3 <u>Active Case Managers</u> I met with the new Active Case Manager for Gorton, Julie Hursthouse. We talked about the What's on guide and the Community Update with a focus on the services for housebound patients and how to refer to the newly mapped services listed above in the Mapping Exercise section. I sent an email to her team with this information and made a connection with the new lead for Gorton Good Neighbours to ensure they could refer to the service. <u>Focused Care Practitioners</u> I sent an email to this team with the What's on guide and the Community Update and newly mapped services listed above in the Mapping Exercise section. I additionally made a connection between them and the new lead for Gorton Good Neighbours to ensure they could refer to the service. <u>Health Visitors</u> I visited the team of approx. 7 Abbey Hey Health Visitors to establish a relationship with them. We discussed potential projects and they suggested running an intergenerational project that could bring together older residents and Socially Isolated Families with the aim of improving the wellbeing of all involved. They said they could identify and connect us with the Socially Isolated Families. I said that when capacity becomes available to develop this I would bring it to the Age Friendly Network to take it forward.

	Gorton Good Neighbours I have been In touch with the new area Lead for Gorton Good Neighbours, Victoria Kay. I put her in touch with the lead for Levenshulme Good Neighbours, the Active Case Managers, the focused care practitioners and the local GP Federation Lead Alex Walter to help maintain the referral pathways with these services. Through this connection Victoria has agreed with Alex to attend the next GP federation locality meeting to develop a relationship with the GP's in the area. Studio One I spoke with Charlotte Brown, the Recovery Pathways Lead with Studio One to share information of activities I am aware of and to develop ties with Studio One, I sent over the What's On guide and Community Update and agreed to start attending the Studio One Central What's on meeting to share information with them. Mid Term Events Gorton Monastery Gorton Monastery shared information about a week long programme of events for families during the mid-term break. I shared details with the local Sure Start, Library and a youth worker at Sacred Heart Community Centre in South Gorton and asked them to print it off display the poster and make families aware of the activities. Gorton Oasis Re Build Programme I developed a relationship with the coordinator of the Gorton oasis Community Support Team called "The RE-BUILD Program" for crisis support. I agreed to share information that I find out which would further enable them to support those who use their service. I have shared the what's on guide, Community update and newly mapped services listed above in the Mapping Exercise section Roma Voices I met with Ramona Constantin who is a representative of the Roma Community in Gorton / Levenshulme. She made me aware of issues facing the Roma community to see if any support could be given. She explained that community members have been having difficulty accessing NHS services and that they are worried about using NHS services as secondary care can incur fees for those without permanent residency. I connected her with various services including: -Rosi Hunter at the Citizens Advice Bureau for general support, - NHS England for support with difficulties with GP's - PALS for support with any issues relating to Hospitals - also with Patient Services, North West Commissioning Support Unit (NWCSU) and the Independent Complaints Advocacy (ICA). Further information about these services was supplied through the following website: https://www.mhcc.nhs.uk/contact-us-2/ I supplied info about the Council's Health and Support Hub: https://hsm.manchester.gov.uk/kb5/manchester/directory/home.page Finally I suggested contacting the Ethnic Health Forum as source of support:

http://www.ethnichealth.org.uk/projects.html

Romana suggested setting up a consultation with Roma Community members to explore the difficulties faced with accessing services. I have escalated this with Carlos Tait and he has suggested raising this issue at the next team meeting for the whole Neighbourhood Health service because this issues of accessing services may affect people in other areas too, so a coordinated approach may be needed.

Hulme Moss Side and Rusholme Report

- **Richie's Barbershop:** Update from last report. Follow on conversations with Ali Morgan about doing some Health Check promotion in Richie's Barbers Shop. Ali is looking at what time she has to do this work. Richie agreed that we could do some men's health promotion in the shop. No date arranged yet waiting for Ali to get back to me with a date. Emailed Steve Hoy at Manchester United FC asking for support with the event in terms of freebies. Also, need to contact Manchester City FC Community development worker to see what support they could offer.

- **Health Checks:** Had a meeting with Patricia Carmody, Customer communications manager at Moss Care St Vincent's Housing Group (MCSV) on 9th October about delivering Health Checks from their offices on 23rd and 24th November. We agreed that MCSV would send letters to their tenants in the age category and they would provide space for the Health checks. Letters went were sent out to tenants on Wednesday 25th October and have already received some responses and appointments booked. Robert Derbyshire practice and Wilmslow Road medical centre have also sent out the invitation letters.

- **Edith Avenue Community Garden**. Ongoing conversations with Jon Ross from Sow the City, Pauline Clarke and Sally Coates the MCC Neighbourhood officers for Moss Side about developing a community garden project for the residents of Edith Avenue, Driffield St and Lloyd St. Met with them on 30th October to agree questions and arranged a date for door knocking. No date agreed yet but it will be sometime in November.

- **Our Moss Side. International day of older People**. **19th October** Held a stall at the Ibrahim Maine Centre in Moss side with Sadie Roberts, Wellbeing Advisor. Although Tony, the project lead put a lot of effort into planning the day by organising food and having some good Age UK resources about pensions, benefits & PIP attendance was poor. I engaged with one resident from the Somali community who agreed to be a community representative for the Manchester Wellbeing Fund meetings. *Outcome for me to email her the dates of the meetings and to update Sue Tellet the focused care practitioner who recommended her.*

- **Hulme Winter Festival and Winter Warm event.** Planning meeting took place on 20th October with Patrick Hanfling manager for Hulme MCC Neighbourhood Team, Matthew Youngson AFA, Belinda Rourke One Manchester and People First**.** Agreed the date for the festival as 1st December. Discussed having a Winter Warm element to it for older people. Outcome for me to sort out entertainment for the festival and contact Ged's Disco and Dan Hartley musician

	who were both funded projects from Ambition for Ageing Hulme and Moss Side. Ged was funded for disco equipment decks speaker's lights and publicity; Don was funded for studio time to record his backing tracks. I have a meeting arranged with the Angela the Community Colleague from Asda Hulme on Monday 6th November to discuss how ASDA could support the festival. Ongoing work about the Winter Warm element of the festival chase Julie Roberts from the fire station as they have agreed to provide a stage and some winter warm packs for older people, also waiting for the CAB to confirm their involvement. ● **Saheli support group for women affected by domestic violence. Met with Sonal Chaun and Mahudo Mahad** discussed the possibility of running a Boost course. Met some of the women who attended the Saheli mentoring course induction session on Wednesday 25th October. The course is due to start at Fallowfield Library on Monday 30th November. Agreed to do a Health Exploration session on 15th December with the Severa group, part of Saheli, who meet weekly in Moss Side. ● **Martinscroft Children's Centre Hulme.** Met with Centre manager who is keen to run a Boost course and possibly connect 5 (for parents and volunteers), also discussed the dad's group that meet monthly. *Outcome to go back, meet the group with a view to running a Health Exploration session, and discuss Boost and the taster session in more details.* **Fallowfield, Chorlton and Whalley Range** ● Update from last report. Met with Bernie (a South NHW) to plan next session at Dynamic Support, which is on 10th November. They have requested information around Healthy Eating and Vitamins, especially focused on their age and over winter. ● Update from last report. Contacted Eve Holt, local resident and coordinator of the 'Whalley Range on Wheels' project to discuss assistance with a cycling project at Dynamic Support. Also, contacted Yvonne (project lead) at Dynamic Support with details of TFGM's Women's Cycling Funding event in November, which she is now attending. ● Attended Fallowfield Secret Garden's Open Day and met the co-ordinator Mark Roberts. Have added him to our mailing list as well as sending him information around the Wellbeing Fund and discussing the Age Friendly network. ● Coordinated two days of Health Checks at Fallowfield Library – Weds 4th and Friday 6th October. Saw 13 people in total for health checks. Unfortunately, 2 GP practices failed to send out letters when requested, but one surgery did send last minute text messages (although it was probably too short notice.) Note: 14 people were turned away due to health check criteria, but were signposted to local pharmacists

Other (Anything else you want to include)	**Hulme, Moss Side and Rusholme** ● **People, partner, Place (Asset based approach) training**. During the training I suggested that they include some real stories of how community engagement has changed people's lives. North Manchester Ambition for Aging Neighbourhood team has good examples so I put her in touch with Jude Wells the coordinator for Moston AFA team to discuss further. ● **Attended the Caribbean and African Health Network Health and Wellbeing Launch** (CAHN) at Longford Park on 27th October. Prof Gus John spoke about services paying more attention to Stroke care, diabetes, sickle cell, HIV eradication programmes and the role faith organisations play in supporting people with long term health conditions and promoting health messages. He also discussed the impact of the epidemic of gun and knife crime on a community. An example given was if a school-aged person were involved with knife/gun crime, it would affect at least 100 people within that school. I had a conversation with one of the delegates about the lack of counselling/ ongoing support for young people and their families after these incidents and the possibility of low-level depression. *Outcome is to explore more and contact Mothers and Fathers against violence to see what work they do in the community. I will feedback details of the CAHN at the next NHW team meeting.* ● **Manchester Wellbeing Fund conversations** Spoke with the following: - Shirley Smith about her plans for a Dementia /Befriending project and doing an expression of interest also getting involved as a community representative. Shirley is on the AFA Hulme and Moss Side board she is a full time carer so thought she would be a good community rep. Unfortunately, she does not have the time to be involved. - Meeting arranged to meet with Links Outreach project (discussed in a previous report) in Hulme to discuss an application to the fund for computers. - Contacted Hanif Bobat who runs the Ethnic Health Agency based in Moss Side who is interested in taking part as a Community representative. I have emailed him the dates. **Fallowfield, Chorlton and Whalley Range** • At the People, Partner, Place training session I met a Social Worker who complained that no one at buzz (Wellbeing Advisors) had gotten back to her re: a citizen she was working with. Offered to chase this up for her. Gave email address for her to contact me with details so could help. However, initially heard nothing from her. Update: discovered she has emailed my Council email address even though I gave her my GMMH one. When the client's details were finally received, I ensured they were progressed and can confirm that the person has been allocated to a health and wellbeing advisor. • Met citizen at Health Check who was interested in activities in Gorton and volunteering. Passed details to Noah and gave her details of One Manchester volunteering co-ordinator because buzz no longer have volunteers. • Met with Jane Goetzee (resident worker) re: catch up on her sheltered housing scheme project. Linked her into Irish Community Care's social activity at St Kentigern's for a citizen she is working with. To arrange meeting with herself,

	Claire Keogh and Carlos to see if there is any work we can do together including involvement in the Age Friendly network that is being developed. • Met Fiona from Northmoor Community Centre and a community event and she asked if a health check event could be held there. Passed on to Carlos in Rose's absence. He has spoken with Fiona and agreed to look into doing a HC event at their venue (in Longsight). Carlos has confirmed that he has asked the team and they have agreed to develop a HC event at Northmoor Community Centre in the new year (due to current staff shortages). Fiona has been informed of this. • Attended Chorlton Core Group meeting (GPs). The GPs at the meeting reported that there are a high number of under 5s being presented at A&E. They believe that this is due to first time parents being away from family support and not feeling confident in managing their child's illness home and not knowing when to present. They are looking to develop workshops to teach parents how to deal with illness at home. Laura send the meetings coordinator information about the health Gems project which may be able to help: http://www.sharedhealthfoundation.org.uk/healthy-gems-comes-gm • This month I've sent two information emails out to my mailing list with details of jobs, training, local activities / events and funding. Note: • 3 Central NHW's and the Senior NHW attended the People, Partner, Place (asset-based training) Module 2 of 3 (and previously attended module 1). The aim will be to utilise the training to develop / shape strengths based projects and engagement tools in the area (we'll be piloting this approach for the whole service). • 3 Central NHW's and the Senior NHW attended the NHW's Team Review Day which considered the following: - The role of and NHW - The barriers to doing the role - options to address the barriers. The outcome from the event is that an action plan is being developed to enhance the NHW's effectiveness in their role based on their views. • 3 Central NHW's and the Senior NHW attended the Central Wellbeing Fund meeting and contributed to the process of developing the project.

3. Age Friendly

Age Friendly plans have been developed and in those areas where Ambition for Ageing Initiatives are already in place, following consultation with Age Friendly Manchester and community members, alternative provision has been developed. The examples of Age Friendly work include:

3.1 South (Withington and Old Moat)

5 Age Friendly Network meetings with health partners, local statutory organisations, volunteers, businesses and local residents (36 network members in total):

To support existing and new projects for older people in the area

To raise awareness of community projects, activities, events and services for older people to access within the local community.

Health and wellbeing event at Withington Methodist Church – 24th May 2017:

90 people attended the health event

22 health and wellbeing stallholders attended to promote local services

38 pledges completed by residents and businesses for Age Friendly Charter

New Age Friendly leaflet promoting regular local activities developed and updated by buzz Neighbourhood Health Worker in June 2017:

At present 1,600 leaflets have been distributed to local venues by partners, buzz volunteers and Age Friendly volunteers.

12 large A3 posters promoted and updated at local noticeboards - Copson Street, post office (Withington Civic Society) & Southway Housing notice boards.

3.2 North Manchester

- Strong links established with the Grange Community Centre. Age Friendly Network launch meeting at this venue in February. 15 people were in attendance from across Bradford, Ancoats and Clayton wards.
- A further Age Friendly meeting was held at the Church of the Resurrection and St Barnabas on 6th April 2017. 10 people attended the meeting; both professionals and residents alike. One of the big issues identified was local transport links, which were described as ‘awful’ with people having to take two buses to reach local neighbourhoods e.g. Ancoats, Miles Platting. It was also felt that local older people were not aware of the activities at their disposal, and there was much concern about the streamlining of local services and community resources. We linked Clive at Growing the City (and Growing East Manchester) / Men’s Shed with Phil Pennill the Community Sport Manager at the National Cycling Centre, who then went on to discuss the possibility of establishing a free bike maintenance course with men who attend the Men’s Shed facility.

3.3 Central

3.3.1 Gorton and Levenshulme

- Agenda setting and Chairing the Network Meeting at Gorton Oasis on 17/10/17
- Updated the what's on guide of activities in Gorton and Levenshulme. 67 local community assets for older people in the area have been verified by the providers.
- Network attendees shared information about their work relating to older people, the hope being that they would receive support from fellow network members.
- Take a seat campaign
  Cathy Ayrton is the Age Friendly Officer for Southway Housing and the lead for 'Take a Seat'. The buzz team are linked in with the project which may happen in Gorton Gorton Events Committee have added this to the agenda for their next meeting and have also arranged to meet with One Manchester to take this forward.

- University of Manchester Health Services Research Centre, contact made with by Mhorah Goff, Research Associate at the Health Services Research Centre regarding conducting a study in the Levenshulme area to assess the potential benefits of using the Village Model to benefit the health of older people.

3.3.2 Fallowfield, Chorlton and Whalley Range

Carlos (senior NHW) attended the Whalley Range & Chorlton Age Friendly AGM on 6th October, and did a 30-minute presentation on the buzz service to 8 residents and 1 worker.

3.3.3 Hulme, Moss Side and Rusholme

- Meeting to look at Age Friendly Rusholme and Fallowfield and acknowledged the issue with the ward boundary change due in April 2018, as some partners will fall into different wards when the boundaries change.
- Meeting with Manchester Carers regarding intergenerational work in Manchester who are based in Ancoats.

4. Community Mapping of Assets

The neighbourhood health workers continue to identify community assets in their respective localities. Since April 2017, an additional 358 community assets have been identified, verified and added to the buzz community asset mapping database. This is currently being developed into an online interactive database due to go live mid-January 2018. This exciting new initiative will

enable health and social care workers and members of the community to add to the database identifying assets in their own area.

5 Work supporting the NHS Health Checks Programme

The neighbourhood health workers continue to work in partnership on the NHS Health Checks and since April 2017 have run 13 sessions in a variety of community venues including a mosque, sheltered housing, Withington Baths and library settings. During these sessions 251 people have undertaken a check.

6 Knowledge Service

- ***Activity 2017/18***

	October 17/18	September 17/18	Quarter 2 17/18	Quarter 1 17/18	Total 17/18
New Members	66	65	170	41	342
Library Loans	722	623	2,177	476	3,998
buzz leaflets issued	2,954	1,509	4,385	11,645	20,493
Total leaflets issued	5,466	4,588	9,833	20,145	40,032
Number of events attended	3	5	10	6	24
Number of Literature searches	20	11	42	21	94
Access to E-Resources (Athens)	529	413	1,455	644	3,041

6.1 Impact Interviews

In order to demonstrate the impact of knowledge services, impact interviews are conducted with staff to assess how information has been used and how service delivery might be improved. During September, staff from the Knowledge Service conducted impact interviews following literature searches and outlined below are the results of one example:

The Knowledge Service carried out a literature search on behalf of a Neighbourhood Health Worker within buzz Manchester Health and Wellbeing Service for evidence on the impact of social networks and community led chair-based exercise groups on health & well-being. The search would be used to inform a fundraising plan for the South Manchester Good Neighbours Group. As a result of funding issues, community groups put together a fundraising plan and have secured a temporary future. The literature search was to inform a fundraising plan.

The search results included health statistics on falls prevention in Manchester and admissions to hospital nationally due to falls. This type of data would not be available to the community groups without the links with the Neighbourhood Health Worker and the Knowledge Service. The access to data strengthened the bid but the wider results of the search identified that there was a lack of evaluations relating to community groups delivering this sort of activity. This could be detrimental to the group as this could lead to the groups being misunderstood and ultimately continuing to have funding issues. The search results will be used to help the group become more sustainable over the next 3-5 years. The information is also being used by MACC Bid Writer in a bid for MACC/buzz to run the groups in a different way that includes service evaluation.

Appendix 3 : Physical Activity on Referral Service (PARS) Data

PARS clinic data

	September 17/18		October 17/18		Quarter 2 17/18		Quarter 1 17/18		Total 17/18	
Attended appointments	1,710		2,018		4,875		4,822		13,425	
DNA %	3.3%		3.2%		2.7% (avg.)		2.4% (avg.)		2.9% (avg.)	
New referrals opened	254		248		690		653		1,845	
Gender of referrals opened	**Female** 148	**Male** 106	**Female** 160	**Male** 88	**Female** 393	**Male** 297	**Female** 392	**Male** 261	**Female** 1,093	**Male** 752
New appointments made	136		130		356		390		1,012	
Follow up review appointments	178		117		510		467		1,272	
Rehab classes held	214		190		803		572		1,779	
Referrals closed (Treatment completed)	56		58		155		166		435	

Rehab class commenced October 2017

	October 17/18	
	Number of sessions	**Number of attendees**
Back rehab classes	40	253
Cardiovascular classes	81	851
COPD Classes	23	180
Strength and balance classes (PSI)	40	164
Other rehab classes	6	76
Total	190	1,524

Who Referred into PARS?

	October 17/18	September 17/18	Quarter 2 17/18	Quarter 1 17/18	Total 17/18
GP	78	72	188	158	496
Physiotherapist	79	105	247	184	615
Practice Nurse	7	4	14	34	59
COPD Rehabilitation	21	7	45	46	119
Community Stroke Team	3	3	13	14	33
Falls service	2	16	20	24	62
Vascular team	16	26	99	85	226
Wellbeing advisors	8	4	8	7	27
Cardiac Rehab	16	10	25	45	96
Sleep Clinic	0	0	1	3	4

ABL	0	0	0	1	1
Community MHT	0	0	0	2	2
Other	6	3	6	27	42

Main Referral Reason into PARS	**October 17/18**	**September 17/18**	**Quarter 2 17/18**	**Quarter 1 17/18**	**Total 17/18**
Lower back pain	15	10	44	101	170
MSK	69	97	205	120	491
Cancer	3	11	14	7	35
COPD	26	21	75	95	217
Diabetes	23	13	60	49	145
Falls risk	16	17	40	27	100
PAD	12	24	89	88	213
CVD	6	1	31	22	60
Cardiac	39	35	74	84	232
Fibromyalgia/chronic fatigue	0	0	4	17	21
Neurological	5	8	14	9	36
Obesity/other	21	4	32	38	95

Referrals by Ethnicity	**October 17/18**	**September 17/18**	**Quarter 2 17/18**	**Quarter 1 17/18**	**Total 17/18**
Unknown	18	29	51	67	165
White British	84	112	236	217	649
White Irish	4	0	9	8	21
Other White back ground	1	0	4	10	15
Asian Pakistani	14	26	49	30	119
Asian Bangladeshi	5	0	14	7	26
Asian Other	0	6	15	23	44
Asian – British	0	1	3	8	12
Asian Indian	0	0	1	5	6
Black Caribbean	1	10	22	10	43
Black African	10	7	18	16	51
Black British	3	7	18	7	35
Mixed White/Black African	0	0	2	0	2
Arab	0	0	0	1	1
Other back ground	2	1	3	17	23

Referrals to Manchester Leisure sites	**October 17/18**	**September 17/18**	**Quarter 2 17/18**	**Quarter 1 17/18**	**Total 17/18**
New members referred to leisure	36	27	106	75	244
Leisure patronage at all sites	365	382	1,046	921	2,714

Appendix 4 : Oral Health Improvement Team, Buddy Practice Scheme (Phase 1 and 2 October 16 – July 17)

1. Introduction

The benefits of evidence based preventive advice and the application of fluoride varnish for dental decay reductions are clear (British Dental Association (BDA) 2012). The Cochrane review (2013) found that young people treated with fluoride varnish experienced on average a 43% reduction in decayed, missing and filled tooth surfaces in the permanent dentition and the effect of fluoride varnish on first or baby teeth the evidence suggests a 37% reduction in decayed, missing and filled tooth surfaces. However there is still a proportion of children in Manchester whose parents and/or carers are unable or unwilling to ensure that they attend a dentist to receive preventive advice and interventions. It is important for children to benefit from early prevention and to benefit from early access to dental care.

This project aims to find those children not accessing care and ensure that they do not miss key preventive interventions and advice. The initiative aims to ensure schools and dental practices are linked up to safeguard children and support parents and/or carers to take responsibility for oral health improvement.

The scheme brings primary dental care dental practices and schools together in partnership. Parents of children in nursery or reception classes are asked about their child's dental attendance and those children who either had no dentist or who had not attended for some time were identified and consent was sought and provided. The parents of non-attending children were then invited to a 'meet the dentist' session at the school. These take place first thing in the morning as children arrive to encourage as many parents to stay as possible.

Establishing a regular attendance pattern emphasised and assisted, either by the clinician or a member of the Oral Health Improvement Team is a vital aspect of the programme. Details of the partner practice are given and information on the dental helpline to assist parents to make appointments elsewhere if they chose. All children are also given toothbrushes (1450 parts per million fluoride) and a toothbrush. The attendance of each of the children is checked following the 'meet the dentist' sessions, after 4-6 months the programme is repeated for those children who still do not attend. After this follow up the small number of children, with identified clinical need, who have still not been taken to a dentist, are followed up and the School Nurse/ Health Visitor is contacted with the child's details.

2. Outcomes and Impact

- There are still some schools with over 50% of the children in the nursery class who have not attended a dental practice.
- In some of the schools that have been involved since the programme started 5 years ago, there are fewer children to see as they are already registered before they start school. This may be due to the children having older siblings who have already been through the programme. The schools where numbers were below 10 the parents / carers were given a voucher to attend the dental practice.
- Many children who had been suffering pain and infection have received urgent care either via the dental practice or Manchester Community Dental Service.
- This programme primarily is about quality and access to care, if this programme was not in-place some children in Manchester schools would be experiencing severe caries, pain and swelling and probably visiting A and E as a result. One example is of a child who had been waiting 10 months for a GA appointment and the mother was concerned the child was in pain and on repeated antibiotics. The service was able to use the referral number for the dental hospital, contact them and explain the situation and the child was seen the next week.
- 22 schools involved in the programme have a higher than 50% proportion of BME pupils, 7 schools have higher than 75% of their pupils.
- 17 schools involved are within the top 10 deprived wards and 36 are within the top 20.

2.1 Results:

Measure First Phase	**Total**	
Number of children seen without a dentist	**782**	
Number of parents attending and receiving advice	**428**	**54%**
Number of children prescribed and received FV	**663**	**85%**
Number of children with treatment need Ref GDP	**147**	**19%**
Number of children with treatment need Ref MDS	**14**	**2%**
Number of children going to the practice for a check-up after 4 months.	**190**	**24%**
Measure Second Phase		
Number of children seen without a dentist	**480**	

Number of parents attending	**252**	**53%**
Number of children prescribed and receiving FV	**424**	**88%**
Number of children with a treatment need Ref GDP	**98**	**20%**
Number of children with a treatment need Ref MDS	**5**	**1%**
Number of children going to the practice for a check-up after 4 months	**195**	**41%**

Please Note:
Not all schools involved in the programme have data, as not all schools have been able to undertake the programme. This has been mainly due to staffing issues at the dental practices, at the schools or how nursery children attend nursery either staggered or part time. These children will be seen in Reception class instead. The schools not involved in phase 1will be given priority and involved during phase 2, these are listed below.
There were 4 schools who were found to only have a couple of children without a dentist within phase1, each parent/carer received advice, information and a voucher to attend the dental practice.
Not all practices had results available for the number of children who have attended 3 months following the initial visit to school and the number attending the practice is low in some schools due to the length of time lapsed for recall.

Schools not involved in phase 1	Post C M19 2UH M19 2UH Codes	Reason for none involvement in phase 1	Schools with low numbers who received vouchers only	Schools covered by Kick Start MCDS	Post Codes
St James	M18 8LW	Staggered nursery	St Elizabeth's	All Saints	M12 5PW
St Andrews	M19 2UH	Part time	St Augustines	Asbury Meadow	M11 3NA
Crumpsall Lane	M8 5SR	Dentist not available	Holy Trinity	Broadoak	M20 5QB
Bowker Vale	M8 4NB	Dentist not available	St Edmunds	St Clements	M11 1LR
Crab Lane	M9 8NB	Dentist not available		Church of the Resurrection	M11 3TJ
St Dunstans	M40 9HF	Dentist not available		Claremont	M14 7NA
Moston Lane	M9 4HH	Dentist not available		Heald Place	M14 7PN
Ravensbury	M11 4EG	School		Holy Name	M15 6JS
Abraham Moss	M8 5UF	School		St Barnabas	M11 2JX
Mount Carmel	M9 8BL	School		New Moston	M40 3QJ
Saviour	M40 7RH	School		Varna Street	M11 2LE
Harpur Mount	M9 5XR	School		St Ambrose	M21 7QA
Lily Lane	M40 9JP	School		Broadhurst	M40 0BX
St Malachy's	M40 7RG	Dentist not available		St Brigids	M11 3DR
				St Francis	M12 5LZ

				St John Fisher	M22 9NW
				Higher Openshaw	
				St Margaret Mary's	M40 0JE
				St Mary's (Moston)	M40 0DF
				St Mary's RC (Levenshulme)	M19 2QW
				St Peter's	M23 2YS
				St Philips	M15 6BT
				Webster	M15 6JU