Appendix One – MLCO Neighbourhood Plans on a page (2019/20)

Didsbury (East & West), Burnage and Chorlton Park

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

About our neighbourhood

60,000 people live here - almost 10% of Manchester's population

44,000 people are registered to GPs in the neighbourhood

We are a **diverse** area of different communities with a relatively old population

We have an active voluntary sector with lots of community assets to build on

But we have some health and care issues including higher than average numbers of:

- overcrowded households
- pensioners living alone
- hospital admissions and A&E visits for children under four
- binge drinking adults
- heart disease and COPD rates.

We believe that, by working together, we can help improve health and outcomes in our neighbourhood.

Some of the things we're doing across the city to improve health and social care this year

1. Improving population health

- Deliver the neighbourhood health and wellbeing development programme requirements
- Establish building blocks for pop health
- Ensure health checks are delivered
- Engage MCRActive in neighbourhood delivery
- Ensure Neighbourhoods are Age Friendly.

2. Working with Primary Care

- Support each of the newly forming Primary Care Network across the city to meet Primary Care standards
- Ensure alignment of neighbourhood partnerships and service delivery with Primary Care Networks so they work together to benefit residents.

3. Supporting all Integrated Neighbourhood Teams in their first full year

- Implement and mobilise the key components of the 12 INTs across the city
- Deliver a NESTA-led 100 day challenge in each neighbourhood to kick start partnership working and tackle a key issue of importance to the neighbourhood.

4. Ensuring financial sustainability

5. Developing a partnership with housing

- Deliver the range of programmes linking health and housing as agreed between MLCO, GP Federations and the city's housing providers.

The key things we are going to do in our neighbourhood this year

- Work to keep people well, by exploring ways to increase access and opportunity to support healthier lives offered by **NHS health checks.**
- Support **good mental health**: Increasing access to services and activities that build resilience; support those who most need it, and work together to identify and understand gaps.
- Improve neighbourhood **communication and information sharing**, building on what we have.
- Focus on **partnership**, to work with our neighbourhood strengths, increasing participation and access, co-producing plans and solutions.
- Build strong links with our **GP networks.**
- Share our collective successes to **build a strong neighbourhood** which nurtures our health and wellbeing.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:

Annabel Hammond, Neighbourhood lead
Dr Oli Atkinson, GP lead
Suzanne Leonard, Nurse lead
Niikwae Kotey, Social care lead
Xxxx, Mental health lead
Fiona Vincer, Health development coordinator

@DidsChorBurnINT

Withington and Old Moat

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

About our neighbourhood

We have a resident population of **29,338** with 50,000 people registered with a GP in the neighbourhood.

12.8% of the population are over 50 with 4.8% aged 80 plus.

24.9% are from Black and Minority Ethnic groups and 2.1% have English as an additional language.

High numbers of students live in the neighbourhood.

There's an active and vibrant community, voluntary and social enterprise sector.

We have some significant health and care issues including:

- 41.4% of adults binge drink
- High rates of hospital admissions and mortality rates for coronary heart disease, stroke, COPD and lung cancer.

Some of the things we're doing across the city to improve health and social care this year

1. Population health

- Deliver the neighbourhood health and wellbeing development programme requirements
- Establish building blocks for pop health
- Ensure health checks are delivered
- Engage MCRActive in neighbourhood delivery
- Ensure Neighbourhoods are Age Friendly.

2. Primary Care

- Support each of the newly forming Primary Care Network across the city to meet Primary Care standards
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4. Ensure financial sustainability

5. Develop a partnership with housing

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The key things we are going to do in our neighbourhood this year

- Re-energise the **Transport Task Group** to find solutions to the issues residents experience with getting to and from medical appointments.
- With others, offer support around sustainability to the v**oluntary, community and social enterprise group**s, enabling them to maintain/increase their offer around supporting people to keep well and to stay healthy.
- Get better at **sharing information** about what services are available in our community, that can support people to look after themselves and improve health and wellbeing.
- Work to improve and increase support to **students and young people** with mental health issues.
- Increased support to those aged **65 years and over** around keeping well during the winter months (winter resilience).

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:

Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@

Brooklands and Northenden

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

About our neighbourhood

An older age profile and many older people living alone

A growing black and minority ethnic (BME) community

A higher percentage of people claiming Universal Credit in this neighbourhood compared with the national average

In Northenden the number of children living in poverty is much higher than the Manchester average and there is increasing childhood obesity

We have higher than average:

- emergency admission rates via Accident and Emergency (A&E) for people under 24 years
- hospital stays for self-harm and alcohol-related harm
- cases of hypertension and asthma on the GP register.

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The key things we are going to do in our neighbourhood this year

Amplify our neighbourhood voice

- Co-produce our neighbourhood priorities & plan
- Host a neighbourhood summit
- Have two neighbourhood representatives on our leadership team.

Visibility of the leadership team in our neighbourhood

- Using different media and engagement methods to establish and promote the neighbourhood team & what we are doing across systems
- Build relationhsips across organisations & voluntary sector.

Deliver integrated prevention campaigns in our neighbourhood

- We will deliver an Integrated 'Health Check' campaign
- We will deliver an 'Integrated Winter Resilience' campaign
- We will work with priority groups to promote social connections and good nutrition.

Focus on 'Our Neighbourhood' cares about mental wellbeing

- A neighbourhood development programme, supporting personalised care, using the strengths of people and our community
- Raise the profile & understanding of social prescribing within the neighbourhood.

Our neighbourhood focus on improving hospital transitions

- Deliver home visit nursing service for people living with long term conditions (and evaluate)
- Work in partnership with housing to improve hospital transitions, bottlenecks & barriers for people in the neighbourhood.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:

Name and name
Neighbourhood representatives

Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@BrookNorthINT

Wythenshawe (Baguley, Sharston and Woodhouse Park)

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

About our neighbourhood

Our GP registered population is 52,000, with 10% of our population aged 50 plus and 30% of households on a low income.

We have an excellent network of voluntary and community groups and 10 Parks and 18 Woodland areas

There are 14,000 social houses which are managed by Wythenshawe Community Housing Group

*85% of people living in Woodhouse park area are likely to require intense support

*35% of attendances at A&E resulted in hospital admission

50% of admissions were for respiratory problems

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The key things we are going to do in our neighbourhood this year

Support people with COPD and other long term conditions to

- Enabling self-care through education and coaching
- Help reduce the anxiety and fear of exacerbation
- Reduce the number of unnecessary hospital admissions.

Improve the physical and emotional health of people

- Through informed food choices, moving more and supporting parents and carers to be knowledgeable and food wise.

Support GP surgeries to access community services

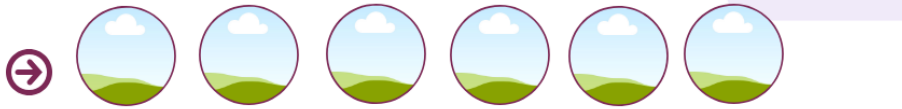
- Connecting GP's to the Bringing services together workstream
- Increasing the community knowledge for volunteers in GP practices
- Support active signposting and social prescribing at GP practices.

Work with primary, secondary Schools, academies & families to

- Improve and increase aspirational life choices for people of Wythenshawe
- Develop educational opportunities around shared understanding of different lives and experiences
- Create intergenerational workstreams which give focus to starting well and aging well.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:



@TeamWythenshawe

Gorton and Levenshulme

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

Powered by:

About our neighbourhood

53,500 people live here at the moment and this number is increasing each year

We have a higher % of younger people and a lower % of over 65's than other parts of the city

We are a richly diverse area - **39%** of the overall population are from a BAME background

We have an active voluntary sector with lots of community assets

But we have some significant health and care issues:

- 35% of children are living in poverty
- life expectancy at birth is 74-78 years with a healthy life expectancy of between 53 and 58 years
- over 40% of children in year 6 are obese
- 13.2% of residents suffer from one or more long term condition (hypertension, asthma and diabetes are the most prevalent)
- 62% of adults are deemed as having wider determinants of need.

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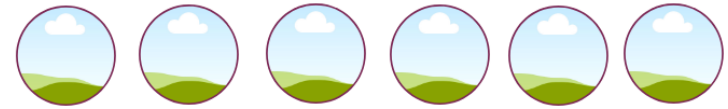
- Deliver the range of programmes linking health and housing as agreed between MLCO, GP Federations and the city's housing providers.

The key things we are going to do in our neighbourhood this year

- Create a true **neighbourhood offer** in the community, fully mobilising our health and social care teams and ensuring our Gorton hub new build is the blueprint for working together with you.
- **Engage families and children**, children's health services and schools to help promote healthy weight and reduce the reliance on statutory services
- Take a community approach to **diabetes prevention** and management. Work with partners to undertake health checks, undertake group consultations, give dietary advice and promote health and wellbeing.
- Embed the **coordinated care pathway** – supporting our Care Navigator to connect residents in Gorton and Levenshulme with the right services in our local neighbourhood to address their needs quickly.
- Improve the health and wellbeing of our community – supporting and increasing **voluntary sector participation** and inclusion of service users to improve the mental health of residents in the locality - tackling social isolation and loneliness.
- Prioritise and engage with partners to address the health implications of **poor air quality**. Work closely with neighbourhood and voluntary sector partners to reduce idling, support safe space and encourage activities such as walking and cycling.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:



Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@GortonLevensINT

Chorlton, Whalley Range and Fallowfield

Manchester Local Care Organisation

Integrated Neighbourhood Team plan on a page 2019/2020

About our neighbourhood

Almost 48,000 people live in our neighbourhood

Our neighbourhood is culturally very rich and diverse and has a number of distinct, vibrant communities

Our neighbourhood is rich in community assets with over 170 mapped in a recent exercise; this includes community groups, clubs, places of worship, green spaces etc

However, there are some health and care issues:

- older people living with a mental health condition, a learning disability or dementia
- a higher proportion of frail older people
- higher rates of binge drinking in adults; households that are overcrowded and/or without central heating; older people living alone, A&E attendances in 0-4 year olds and longer stays in hospital after emergency admission

Some of the things we're doing across the city to improve health and social care this year

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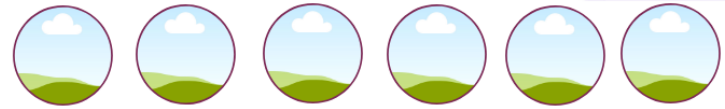
The key things we are going to do in our neighbourhood this year

- Bring together an **Integrated Neighbourhood Team** of Community Nurses and Social Care workers who will be co-located and provide a seamless, coordinated service for our neighbourhood.
- Deliver and sustain the impact of the Nesta 100 day challenge around **mental health** which includes:
  - delivering Mental Health Awareness training to non-clinical front line workers in primary care and other services
  - facilitating closer links and building the relationship between Improving Access to Psychological Therapies services and GP practices
- Embed the **Care Navigator** service in the neighbourhood and develop and refine the coordinated care pathway to ensure those with care needs get the right service, in the right place and at the right time.
- We will develop our **prevention programme** and ensure that the numerous strengths and assets of our communities are mobilised.
  - embedding the revised Buzz Health and Wellbeing service model
  - continuing to work with Be Well to evidence the impact of and sustain the self-referral pilot workers for each practice.
- We will develop and evolve our **Neighbourhood Partnership** to ensure we connect and engage with all stakeholders in the neighbourhood in a meaningful way and ensure that all voices are represented.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:



Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@ChorWhalFallINT

Hulme, Moss Side and Rusholme

Manchester Local Care Organisation

Integrated Neighbourhood Team plan on a page 2019/2020

About our neighbourhood

About **52,000** people live in our neighbourhood which is culturally diverse with more than half of residents from black and minority ethnic communities.

We have a relatively young population compared to the average, with just under 30% aged 16-24. Rates of child development and levels of educational attainment are worse on average.

We have a relatively lower proportion of older people in good health, mainly linked to poor mental health, dementia and long-term conditions - particularly high blood pressure, heart conditions, asthma and diabetes. There are also higher numbers of older people living alone.

We have a very active voluntary and community sector and other partners with an interest in the social determinants of health.

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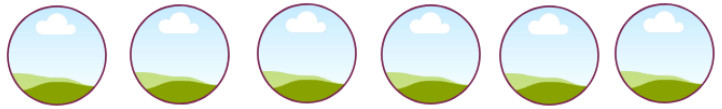
The key things we are going to do in our neighbourhood this year

- There is a long-standing interest in using the **local environment** to help promote mental well-being and we will continue to support opportunities to develop green spaces in the neighbourhood.
- Further **integrate** neighbourhood health and social care services and develop the nurse-led Community Diabetes Education Service.
- Reduce **health inequalities** by improving access for those who struggle with English and may require initial encouragement and support to take-up local opportunities.
- We will look at **child health and wellbeing** and consider how to better support families.
- Evolve our **Neighbourhood Partnership** and work in a way that means that all stakeholders have an opportunity to participate.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:



Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@

Ardwick and Longsight

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

About our neighbourhood

Over 40,000 people live in our neighbourhood and 60,000 people are registered with a GP in our boundaries.

We are a diverse community in which 70% describe their ethnicity as 'non-white UK'. Our population is relatively young with 8.9% of all people aged 19-34 in Manchester living here. We have a significantly higher number of older people living alone.

We have a committed community based voluntary sector.

But we have health and social care issues:

- GPs report diabetes, hypertension and asthma as the main health conditions
- We have the highest level of child poverty and deprivation in the city and some of the areas are in the top 5% of the most deprived areas in England
- High 0-4 years attendance at A&E.

Some of the things we're doing across the city to improve health and social care this year

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The key things we are going to do in our neighbourhood this year

- **Child health and wellbeing** - Including working together in relation to attendance at A&E for 0-4 year-olds and focus on positive outcomes.
- Establish the **Integrated Neighbourhood Team** to support the bringing together of services to share a vision focused on the individual and their family.
- Develop our **Multi-Agency Meetings** (MAMS), to facilitate a coordinated approach to care planning, promoting early intervention and using strength-based approaches.
- **Isolation and older people** - work with the community and partners to develop services and support to reduce isolation and promote the wellbeing of this population.
- **Diabetes:** education and support to reduce and manage the condition within our community.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:

Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@ArdwLongINT

Miles Platting & Newton Heath, Moston and City Centre (Piccadilly & Deansgate)

Manchester Local Care Organisation

Integrated Neighbourhood Team plan on a page 2019/2020

About our neighbourhood

A neighbourhood with distinct and large variations on a ward by ward basis, with high levels of health inequality between areas

Miles Platting & Newton Heath and Moston have, in general, a higher proportion of older residents, often living with a higher than average number of long term health conditions

The City Centre has a younger population, growing rapidly in size. There are older residents, as well as a cohort of homeless people with a high number of complex needs.

Childhood obesity, child development at age five and GCSE A-C attainment are all significantly worse than the national average.

People deliver a higher number of hours of unpaid care than the national average.

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The key things we are going to do in our neighbourhood this year

- We will work to **integrate health and social care services** and make better links with local assets, to ensure that they operate more seamlessly for our residents.
- We will develop improved working links between GP's services, children's health services, schools and local VCSE services to **improve children's physical & mental health.**
- We will increase the amount of opportunities that local residents have for **physical activity** - particularly supporting the Winning Hearts & Minds programme.
- We will support the **carers** in our community.
- We will build on our NESTA 100 Day Challenge and provide sustainable opportunities to reduce **social isolation.**

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:

Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@MilesINT

Higher Blackley, Harpurhey and Charlestown

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

About our neighbourhood

52,000 people live in Higher Blackley, Harpurhey & Charlestown.

The population has a relatively high proportion of children aged under 19 (10.5%) but a low proportion (6%) of people aged 19 – 34. There is also a relatively high proportion of older people (aged 50 and over) living in the neighbourhood.

Our key health and care issues include:

- The neighbourhood has a far lower proportion of adults (10%) and older people (4%) in the Good Health cohort compared to the overall Manchester population (37% and 9.7% respectively)
- The neighbourhood has a slightly higher proportion of people with long term conditions with the main issues being hypertension, asthma and diabetes
- There are wider issues including long-term unemployment, social isolation and people providing more than 50 hours of unpaid care.

Some of the things we're doing across the city to improve health and social care this year

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The key things we are going to do in our neighbourhood this year

- Deliver **integrated working** in the neighbourhood and establishment of the Integrated Neighbourhood Team.
- Establish the **neighbourhood governance** in order to review and determine the neighbourhood priorities.
- Test and revisit the assumptions from **neighbourhood engagement** and ensure validity so our future plans are representative of what local people and partners think.

Who's who in the neighbourhood?

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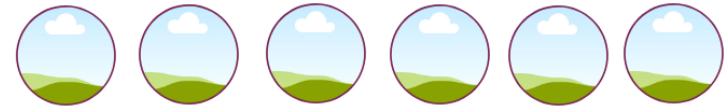

Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@

Ancoats, Bradford and Clayton

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

Powered by:

About our neighbourhood

Around 43,000 people live in our neighbourhood but it is forecast that there could be up to 13,000 more people living in the area in 10 years' time.

There are stark differences between the types of people living in certain parts of our neighbourhood, which means that the needs of the population are not all the same.

We have many active community groups and voluntary sector organisations, of all sizes.

We have a smaller proportion of adults and older people without a diagnosed health condition compared with the overall Manchester population. Smoking, hypertension and obesity are the most common. For many people, the difference in their health is related to the social, economic and environmental factors that shape their lives.

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4. Ensure financial sustainability

5. Develop a partnership with housing

- Deliver the range of programmes linking health and housing as agreed between MLCO, GP Federations and the city's housing providers.

The key things we are going to do in our neighbourhood this year

Promoting healthy living

- Deliver health checks in our neighbourhood
- Deliver more of our services closer to where people live e.g. hold clinics, drop-in sessions in community spaces.

Building on vibrant communities

- Make connections across our neighbourhood so we can better understand our local priorities, and how we can support and celebrate the strengths of our area together.

Keeping people well in the community

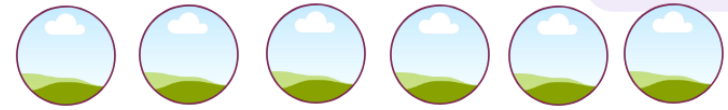
- Bring together an integrated health and social care team with effective links to specialist and community services and our communities
- Improve ways of working within our teams, focusing on ease of access, appropriate sharing of information and delivering timely services when people need them.

Supporting people in and out of hospital

- Implement a Manchester Case Management service to provide pro-active support to people at highest risk of admission to hospital
- Build a close relationship with our lead homecare provider to prevent people needing to go into hospital if they start to become unwell.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:



Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

@AncBradClayINT

Cheetham Hill and Crumpsall

Integrated Neighbourhood Team plan on a page 2019/2020

Manchester Local Care Organisation

Powered by:

About our neighbourhood

45,000 people live here – that's 7.4% of Manchester's population and our community is really diverse: 64% of our community from non-white backgrounds.

Our population is relatively young with **9.3%** of children under 19 living in the neighbourhood and lower numbers of 65 – 79 year olds.

We have an active voluntary sector and lots of community assets to build on.

But we have some health and social care issues including higher than average numbers of:

- overweight and obese children in reception year and year 6
- incidence of lung cancers
- rate of emergency hospital admissions for circulatory diseases (heart disease and stroke) and COPD
- rate of hospital admissions for self harm and hospital stays for alcohol-related harm
- premature mortality (under 75) for cancers and circulatory diseases.

Who's who in the neighbourhood?

The health and social care leadership team working in this neighbourhood are:

Name
Neighbourhood lead

Name
GP lead

Name
Nurse lead

Name
Social care lead

Name
Mental health lead

Name
Health development coordinator

Some of the things we're doing across the city to improve health and social care this year

1. Population health

- Deliver the neighbourhood health and wellbeing development programme requirements
- Establish building blocks for pop health
- Ensure health checks are delivered
- Engage MCRActive in neighbourhood delivery
- Ensure Neighbourhoods are Age Friendly.

2. Primary Care

- Support each of the newly forming Primary Care Network across the city to meet Primary Care standards
- Ensure alignment of neighbourhood partnerships and service delivery with Primary Care Networks so they work together to benefit residents.

3. Support all Integrated Neighbourhood Teams in their first full year

- Implement and mobilise the key components of the 12 INTs across the city
- Deliver a NESTA-led 100 day challenge in each neighbourhood to kick start partnership working and tackle a key issue of importance to the neighbourhood.

4. Ensure financial sustainability

5. Develop a partnership with housing

- Deliver the range of programmes linking health and housing as agreed between MLCO, GP Federations and the city's housing providers.

The key things we are going to do in our neighbourhood this year

- We will increase the number of people that attend their **health checks** and have immunisations to help our community lead healthier lives.
- We will build a strong and collaborative **VCSE voice** and role in the delivery of services in our neighbourhood.
- We will develop an **integrated neighbourhood pathway** so that people living and working in our community get the services that they need
- We will develop a **strong service user/community voice** so that we know that we are delivering the right support and services
- We will improve the **outcomes for children** in our area so that they can lead healthy and fulfilling lives.

@CheetCrumpINT